By: Representative Currie

To: Insurance

HOUSE BILL NO. 40

AN ACT TO REQUIRE THAT EVERY INSURANCE POLICY ISSUED, AMENDED, OR RENEWED ON OR AFTER JANUARY 1, 2026, THAT PROVIDES HOSPITAL, MEDICAL, OR SURGICAL COVERAGE TO PROVIDE COVERAGE FOR MEDICALLY NECESSARY TREATMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS; TO PROHIBIT INSURERS FROM LIMITING BENEFITS OR COVERAGE FOR CHRONIC OR PERVASIVE MENTAL HEALTH AND SUBSTANCE USE DISORDERS TO SHORT-TERM OR ACUTE TREATMENT AT ANY LEVEL OF CARE PLACEMENT; TO PROHIBIT INSURERS FROM LIMITING BENEFITS OR COVERAGE FOR MEDICALLY NECESSARY SERVICES ON THE BASIS THAT THOSE SERVICES SHOULD BE OR COULD BE COVERED BY A PUBLIC ENTITLEMENT PROGRAM; TO PROHIBIT INSURERS FROM ADOPTING, IMPOSING, OR ENFORCING TERMS IN ITS POLICIES OR PROVIDER AGREEMENTS THAT UNDERMINE, ALTER, OR CONFLICT WITH THE REQUIREMENTS OF THIS ACT; TO REQUIRE INSURERS TO USE CURRENT GENERALLY ACCEPTED STANDARDS OF MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE TO DETERMINE THE MEDICAL NECESSITY OF HEALTH CARE SERVICES AND BENEFITS FOR THE DIAGNOSIS, PREVENTION, AND TREATMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS; TO REQUIRE INSURERS, IN CONDUCTING UTILIZATION REVIEW OF ALL COVERED HEALTH CARE SERVICES AND BENEFITS FOR THE DIAGNOSIS, PREVENTION, AND TREATMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS, TO APPLY THE LEVEL OF CARE PLACEMENT CRITERIA AND PRACTICE GUIDELINES SET FORTH IN THE MOST RECENT VERSIONS OF SUCH CRITERIA AND PRACTICE GUIDELINES, DEVELOPED BY THE NONPROFIT PROFESSIONAL ASSOCIATION FOR THE RELEVANT CLINICAL SPECIALTY; TO REQUIRE INSURERS TO TAKE CERTAIN ACTIONS TO ENSURE THE PROPER USE OF THE CRITERIA DESCRIBED IN THE PRECEDING PROVISION; TO PROVIDE THAT IF AN INSURER CONTRACT CONTAINS A PROVISION THAT RESERVES DISCRETIONARY AUTHORITY TO THE INSURER TO DETERMINE ELIGIBILITY FOR BENEFITS OR COVERAGE, TO INTERPRET THE TERMS OF THE CONTRACT, OR TO PROVIDE STANDARDS OF INTERPRETATION OR REVIEW THAT ARE INCONSISTENT WITH THE LAWS OF THIS STATE, THAT PROVISION IS VOID AND UNENFORCEABLE; TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO ASSESS CIVIL PENALTIES AGAINST INSURERS FOR EACH VIOLATION OF THIS ACT; TO AMEND SECTIONS 41-83-31, 83-9-27, 83-9-39, 83-9-41 AND

83-9-43, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS; TO BRING FORWARD SECTIONS 83-9-29, 83-9-31 AND 83-9-37, MISSISSIPPI CODE OF 1972, WHICH RELATE TO INSURANCE COVERAGE FOR TREATMENT OF ALCOHOLISM AND MENTAL ILLNESS, FOR THE PURPOSES OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. Definitions. As used in Section 1 through 4 of this act, the following terms shall be defined as provided in this section:

(a) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(b) "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression

of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care;

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration and

(iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(c) "Mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this paragraph as long as a condition is commonly understood to be a

mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(d) "Utilization review" means either of the following:

(i) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds; or

(ii) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(e) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

SECTION 2. Coverage for medically necessary mental health and substance use disorder services. (1) Every insurance policy issued, amended, or renewed on or after January 1, 2026, that provides hospital, medical, or surgical coverage shall provide

coverage for medically necessary treatment of mental health and substance use disorders.

(2) An insurer shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement.

(3) All medical necessity determinations made by the insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of Section 3 of this act.

(4) An insurer that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's later rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's later determination that it did not make an accurate determination of the insured's or policyholder's eligibility. This subsection shall not be construed to expand or alter the benefits available to the insured or policyholder under an insurance policy.

(5) If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timeliness access standards set by law or regulation, the insurer shall arrange coverage to ensure

the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subsection, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the insured within geographic and timely access standards. The insured shall pay no more in total for benefits rendered than the cost sharing that the insured would pay for the same covered services received from an in-network provider.

(6) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(7) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(8) If the Commissioner of Insurance determines that an insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty not to exceed Five Thousand Dollars ($5,000.00) for each violation, or, if a violation was willful, a civil penalty not to exceed Ten Thousand Dollars ($10,000.00) for each violation. The civil penalties available to the commissioner under this subsection are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under the insurance laws.

SECTION 3. Medical necessity determinations must follow generally accepted standards. (1) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care. All denials and appeals shall be reviewed in accordance with the requirements for prior authorization in the Mississippi Prior Authorization Reform Act (Sections 83-5-901 through 83-5-937) and utilization review in Section 41-83-31.

(2) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and

treatment of mental health and substance use disorders in children, adolescents, and adults, an insurer shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines, developed by the nonprofit professional association for the relevant clinical specialty.

(3) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subsection (2) of this section, an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in subsection (2) of this section. If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in subsection (2) of this section to the provider of the service.

(4) To ensure the proper use of the criteria described in subsection (2) of this section, every insurer shall do all of the following:

(a) Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria;

(b) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives;

(c) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients;

(d) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process;

(e) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made;

(f) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities; and

(g) Achieve interrater reliability pass rates of at least ninety percent (90%) and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(5) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by an insurance policy, including prescription drugs.

(6) This section applies to an insurer that covers hospital, medical, or surgical expenses and conducts utilization review, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(7) If the Commissioner of Insurance determines that an insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty not to exceed Five Thousand Dollars ($5,000.00) for each violation, or, if a violation was willful, a civil penalty not to exceed Ten Thousand Dollars ($10,000.00) for each violation. The civil penalties available to the commissioner under this section are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under the insurance laws.

(8) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

SECTION 4. Discretionary clauses prohibited. (1) If an insurer contract offered, issued, delivered, amended, or renewed on or after January 1, 2026, contains a provision that reserves

discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(2) For purposes of this section, the term "discretionary authority" means a contract provision that has the effect of conferring discretion on an insurer or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(3) This section does not prohibit an insurer from including a provision in a contract that informs an insured that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

SECTION 5. Section 41-83-31, Mississippi Code of 1972, is amended as follows:

41-83-31. (1) Any program of utilization review with regard to hospital, medical or other health care services provided in this state, including, but not limited to, any prior authorization as defined in Section 83-5-907, shall comply with the following:

(a) No determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of hospital, medical or other health care services without prior evaluation and concurrence in the adverse determination by a physician licensed to practice in Mississippi. The physician who made the adverse determination shall discuss the reasons for any adverse determination with the affected health care provider, if the provider so requests. The physician shall comply with this request within seven (7) calendar days of being notified of a request. Adverse determination by a physician shall not be grounds for any disciplinary action against the physician by the State Board of Medical Licensure.

(b) Any determination regarding hospital, medical or other health care services rendered or to be rendered to a patient which may result in a denial of third-party reimbursement or a denial of precertification for that service shall include the evaluation, findings and concurrence of a physician trained in the relevant specialty or subspecialty, if requested by the patient's physician, to make a final determination that care rendered or to be rendered was, is, or may be medically inappropriate.

(c) The requirement in this section that the physician who makes the evaluation and concurrence in the adverse determination must be licensed to practice in Mississippi shall not apply to the Comprehensive Health Insurance Risk Pool

Association or its policyholders and shall not apply to any utilization review company which reviews fewer than ten (10) persons residing in the State of Mississippi.

(2) In addition to complying with the requirements of subsection (1) of this section, any program of utilization review with regard to hospital, medical or other health care services provided for medically necessary treatment of mental health and substance use disorders shall comply with the provisions of Sections 1 through 4 of this act.

SECTION 6. Section 83-9-27, Mississippi Code of 1972, is amended as follows:

83-9-27. (1) Notwithstanding any provision of any policy of accident or sickness insurance as defined by Section 83-9-1, issued on or after January 1, 1975, whenever such policy provides for the reimbursement for loss resulting from sickness, or from bodily injury by accidental means, or both, *** * *** the reimbursement shall include health service benefits to any insured or any person covered thereunder, on the same basis as other benefits, for care and treatment of alcoholism. In addition, every such policy issued, amended, or renewed on or after January 1, 2026, shall comply with the provisions of Sections 1 through 4 of this act.

(2) For purposes of Sections 83-9-27 through 83-9-31, alcoholism is defined as the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost

the power of self-control with respect to the use of such beverages.

SECTION 7. Section 83-9-29, Mississippi Code of 1972, is brought forward as follows:

83-9-29. The provisions of Sections 83-9-27 through 83-9-31 shall apply only to group policies or group plans of health affording coverage from sickness, or bodily injury by accidental means, or both, or nonprofit health plans corporations regulated by the Mississippi Insurance Commission issued or renewed after January 1, 1975.

The provisions of Sections 83-9-27 through 83-9-31 shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy.

SECTION 8. Section 83-9-31, Mississippi Code of 1972, is brought forward as follows:

83-9-31. The coverage required under Section 83-9-27 shall not exceed One Thousand Dollars ($1,000.00) during any calendar year, and shall extend only to treatment and services rendered by a physician and hospitals licensed by the state wherein the service or hospitalization is rendered.

SECTION 9. Section 83-9-37, Mississippi Code of 1972, is brought forward as follows:

83-9-37. As used in Sections 83-9-37 through 83-9-43, Mississippi Code of 1972:

(a) "Alternative delivery system" means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), individual practice association (IPA), medical staff hospital organization (MESH), physician hospital organization (PHO), and any other plan or organization which provides health care services through a mechanism other than insurance and is regulated by the State of Mississippi.

(b) "Covered benefits" means the health care services or treatment available to an insured party under a health insurance policy for which the insurer will pay part or all of the costs.

(c) "Hospital" means a facility licensed as a hospital by the Mississippi Department of Health.

(d) "Health service provider" means a physician or psychologist who is authorized by the facility in which services are delivered to provide mental health services in an inpatient or outpatient setting, within his or her scope of licensure.

(e) "Inpatient services" means therapeutic services which are available twenty-four (24) hours a day in a hospital or other treatment facility licensed by the State of Mississippi.

(f) "Mental illness" means any psychiatric disease identified in the current edition of The International Classification of Diseases or The American Psychiatric Association Diagnostic and Statistical Manual.

(g) "Outpatient services" means therapeutic services which are provided to a patient according to an individualized treatment plan which does not require the patient's full-time confinement to a hospital or other treatment facility licensed by the State of Mississippi. The term "outpatient services" refers to services which may be provided in a hospital, an outpatient treatment facility or other appropriate setting licensed by the State of Mississippi.

(h) "Outpatient treatment facility" means (i) a clinic or other similar location which is certified by the State of Mississippi as a qualified provider of outpatient services for the treatment of mental illness or (ii) the office of a health service provider.

(i) "Partial hospitalization" means inpatient treatment, other than full twenty-four-hour programs, in a treatment facility licensed by the State of Mississippi; the term includes day, night and weekend treatment programs.

(j) "Physician" means a physician licensed by the State of Mississippi to practice therein.

(k) "Psychologist" means a psychologist licensed by the State of Mississippi to practice therein.

SECTION 10. Section 83-9-39, Mississippi Code of 1972, is amended as follows:

83-9-39. (1) (a) Except as otherwise provided herein, all alternative delivery systems and all group health insurance

policies, plans or programs regulated by the State of Mississippi shall provide covered benefits for the treatment of mental illness, except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies and negotiated labor contracts.

(b) Health insurance policies, plans or programs of any employer of one hundred (100) or fewer eligible employees and all individual health insurance policies which are regulated by the State of Mississippi which do not currently offer benefits for treatment of mental illness shall offer covered benefits for the treatment of mental illness, which must include the treatment of mental illness by community mental health centers operated by a regional commission established under Section 41-19-33 or by a public or private entity under contract with a regional commission to operate the center, except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies and negotiated labor contracts.

(c) Alternative delivery systems and group health insurance policies, plans or programs regulated by the State of Mississippi shall not deny any community mental health center or contract entity described in paragraph (b) of this subsection the right to participate as a contract provider if the community mental health center or contract entity agrees to provide the mental health services that meet the terms of requirements set forth by the insurer under the policy or plan and agrees to the

terms of reimbursement set forth by the insurer. Certification/licensure of all mental health providers by the Board of Mental Health in accordance with Section 41-4-7(r) shall be recognized by the insurer and shall not be used as a reason to deny any mental health provider the right to participate as a contract provider.

(2) Covered benefits for inpatient treatment of mental illness in insurance policies and other contracts subject to Sections 83-9-37 through 83-9-43 shall be limited to inpatient services certified as necessary by a health service provider.

(3) Covered benefits for outpatient treatment of mental illness in insurance policies and other contracts subject to Sections 83-9-37 through 83-9-43 shall be limited to outpatient services certified as necessary by a health service provider.

(4) Before an insured party may qualify to receive benefits under Sections 83-9-37 through 83-9-43, a health service provider shall certify that the individual is suffering from mental illness and refer the individual for the appropriate treatment.

(5) All mental illness, treatment or services with respect to such treatment eligible for health insurance coverage shall be subject to professional utilization and peer review procedures.

(6) The provisions of this section shall apply only to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed after July 1, 1991. Beginning on January 1, 2026, each insurance policy and

each alternative delivery system to which this section applies shall comply with the provisions of Sections 1 though 4 of this act. If there is a conflict between any provision of this section and any of the provisions of Sections 1 through 4 of this act, the provisions of Section 1 through 4 of this act shall control.

(7) The exclusion period for coverage of a preexisting mental condition shall be the same period of time as that for other medical illnesses covered under the same plan, program or contract.

SECTION 11. Section 83-9-41, Mississippi Code of 1972, is amended as follows:

83-9-41. (1) Covered benefits for services in this section shall be limited to coverage of treatment of clinically significant mental illness.

(2) Treatment under this section shall be covered for a minimum of thirty (30) days per year for inpatient services, a minimum of sixty (60) days per year for partial hospitalization, and a minimum of fifty-two (52) outpatient visits per year.

(3) The rate of payment for inpatient services, outpatient services, and partial hospitalization shall be the same as provided for any other condition.

(4) If there is a conflict between any provision of this section and any of the provisions of Sections 1 through 4 of this act, the provisions of Section 1 through 4 of this act shall control.

SECTION 12. Section 83-9-43, Mississippi Code of 1972, is amended as follows:

83-9-43. (1) Methods of determining levels of payment or reimbursement for services or for the type of facility charges eligible for payment or reimbursement pursuant to Sections 83-9-37 through 83-9-43 shall be consistent with those for medical illnesses in general and shall take into consideration customary charges for those services. Deductible or co-payment plans, methods of determination, and limits on total amounts payable to an individual in a calendar year or lifetime payment limits may be applied to benefits paid to or on behalf of patients during the course of treatment as described in Sections 83-9-37 through 83-9-43, but in any case shall not be less favorable than those applied to medical illnesses generally in each policy or contract, except as provided under Section 83-9-41 *** * ***.

(2) If there is a conflict between any provision of this section and any of the provisions of Sections 1 through 4 of this act, the provisions of Section 1 through 4 of this act shall control.

SECTION 13. This act shall take effect and be in force from and after July 1, 2025.