MISSISSIPPI LEGISLATURE REGULAR SESSION 2001

By: Representative Fleming

To: Insurance;
Appropriations

HOUSE BILL NO. 106

AN ACT TO ESTABLISH AND AFFIRM AS THE POLICY OF THE STATE THAT EVERY PERSON HAS A RIGHT TO THE HIGHEST QUALITY HEALTH CARE AVAILABLE; TO PROHIBIT ANY PRACTICES BY HEALTH INSURERS THAT DENY ANY PERSON THE RIGHT TO THE HIGHEST QUALITY HEALTH CARE AVAILABLE, FOR FINANCIAL OR ANY OTHER REASONS; TO PROVIDE THAT IT SHALL BE UNLAWFUL TO OPERATE A HEALTH MAINTENANCE ORGANIZATION (HMO), MANAGED CARE ORGANIZATION, OR ANY HEALTH INSURANCE PROGRAM THAT PRACTICES MANAGED CARE OR SEEKS TO CONTROL COSTS BY LIMITING NECESSARY HEALTH CARE SERVICES PROVIDED TO PATIENTS; TO REPEAL SECTIONS 83-41-301 THROUGH 83-41-365, MISSISSIPPI CODE OF 1972, WHICH ARE THE HEALTH MAINTENANCE ORGANIZATION, PREFERRED PROVIDER ORGANIZATION AND OTHER PREPAID HEALTH BENEFIT PLANS PROTECTION ACT; TO REPEAL SECTIONS 83-41-401 THROUGH 83-41-417, MISSISSIPPI CODE OF 1972, WHICH ARE THE PATIENT PROTECTION ACT OF 1995; TO AMEND SECTIONS 7-5-303, 25-11-141, 37-115-31, 41-7-173, 41-7-189, 41-9-215, 41-19-33, 41-63-1, 41-63-3, 41-63-21, 41-83-1, 41-83-5, 41-93-7, 41-95-3, 41-95-7, 43-13-117, 43-13-303, 71-3-217, 73-15-18, 83-1-151, 83-5-1, 83-5-72, 83-9-6, 83-9-32, 83-9-34, 83-9-35, 83-9-37, 83-9-45, 83-9-46, 83-9-47, 83-9-51, 83-9-101, 83-9-107, 83-9-205, 83-9-213, 83-18-1, 83-23-209, 83-24-5, 83-41-214, 83-47-3 AND 83-63-3, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS; AND FOR RELATED PURPOSES.

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

SECTION 1. (1) It is established and affirmed as the policy of the State of Mississippi that every person has a right to the highest quality health care available.

(2) Any practices by health insurers that deny any person the right to the highest quality health care available, for financial or any other reasons, are prohibited.

SECTION 2. It shall be unlawful to operate within the State of Mississippi a health maintenance organization (HMO), managed care organization, or any health insurance program that practices managed care or seeks to control costs by limiting necessary health care services provided to patients.

SECTION 3. (1) Sections 83-41-301, 83-41-303, 83-41-305, 83-41-307, 83-41-309, 83-41-311, 83-41-313, 83-41-315, 83-41-317, 83-41-319, 83-41-321, 83-41-323, 83-41-325, 83-41-327, 83-41-329,

83-41-331, 83-41-333, 83-41-335, 83-41-337, 83-41-339, 83-41-341, 83-41-343, 83-41-345, 83-41-347, 83-41-349, 83-41-351, 83-41-353, 83-41-355, 83-41-357, 83-41-359, 83-41-361, 83-41-363 and 83-41-365, Mississippi Code Of 1972, which are the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act, are repealed.

(2) Sections 83-41-401, 83-41-403, 83-41-405, 83-41-407, 83-41-409, 83-41-411, 83-41-413, 83-41-415 and 83-41-417, Mississippi Code of 1972, which are the Patient Protection Act of 1995, are repealed.

SECTION 4. Section 7-5-303, Mississippi Code of 1972, is amended as follows:

7-5-303. (1) As used in this section:

(a) "An insurance plan" means a plan or program that provides health benefits whether directly through insurance or otherwise and includes a policy of life or property and casualty insurance, a contract of a service benefit organization, workers' compensation insurance or any program or plan implemented in accordance with state law *** * ***.

(b) "Insurance official" means:

(i) An administrator, officer, trustee, fiduciary, custodian, counsel, agent or employee of any insurance plan;

(ii) An officer, counsel, agency or employee of an organization, corporation, partnership, limited partnership or other entity that provides, proposes to, or contracts to provide services through any insurance plan; or

(iii) An official, employee or agent of a state or federal agency having regulatory or administrative authority over any insurance plan.

(2) A person or entity shall not, with the intent to appropriate to himself or to another any benefit, knowingly execute, collude or conspire to execute or attempt to execute a scheme or artifice:

(a) To defraud any insurance plan in connection with the delivery of, or payment for, insurance benefits, items, services or claims; or

(b) To obtain by means of false or fraudulent pretense, representation, statement or promise money, or anything of value, in connection with the delivery of or payment for insurance claims under any plan or program or state law, items or services which are in whole or in part paid for, reimbursed, subsidized by, or are a required benefit of, an insurance plan or an insurance company or any other provider.

(3) A person or entity shall not directly or indirectly give, offer or promise anything of value to an insurance official, or offer or promise an insurance official to give anything of value to another person, with intent to influence such official's decision in carrying out any of his duties or laws or regulations.

(4) Except as otherwise allowed by law, a person or entity shall not knowingly pay, offer, deliver, receive, solicit or accept any remuneration, as an inducement for referring or for refraining from referring a patient, client, customer or service in connection with an insurance plan.

(5) A person or entity shall not, in any matter related to any insurance plan, knowingly and willfully falsify, conceal or omit by any trick, scheme, artifice or device a material fact, make any false, fictitious or fraudulent statement or representation or make or use any false writing or document, knowing or having reason to know that the writing or document contains any false or fraudulent statement or entry in connection with the provision of insurance programs.

(6) A person or entity shall not fraudulently deny the payment of an insurance claim.

SECTION 5. Section 25-11-141, Mississippi Code of 1972, is amended as follows:

25-11-141. The board of trustees may enter into an agreement with insurance companies, hospital service associations, medical or health care corporations, * * * or government agencies authorized to do business in the state for issuance of a policy or contract of life, health, medical, hospital or surgical benefits, or any combination thereof, for those persons receiving a service, disability or survivor retirement allowance from any system administered by the board. Notwithstanding any other provision of this chapter, the policy or contract also may include coverage for the spouse and dependent children of such eligible person and for such sponsored dependents as the board considers appropriate. If all or any portion of the policy or contract premium is to be paid by any person receiving a service, disability or survivor retirement allowance, such person shall, by written authorization, instruct the board to deduct from the retirement allowance the premium cost and to make payments to such companies, associations, corporations or agencies.

The board may contract for such coverage on the basis that the cost of the premium for the coverage will be paid by the person receiving a retirement allowance.

The board is authorized to accept bids for such optional coverage and benefits and to make all necessary rules pursuant to the purpose and intent of this section.

SECTION 6. Section 37-115-31, Mississippi Code of 1972, is amended as follows:

37-115-31. The teaching hospital and related facilities shall be utilized to serve the people of Mississippi generally. The teaching hospital and related facilities shall have the power necessary to enter into group purchasing arrangements as deemed reasonable and necessary * * *. There shall be a reasonable volume of free work; however, that volume shall never be less than one-half of its bed capacity for indigent patients who are eligible and qualified under the state charity fund for charity

hospitalization of indigent persons, or qualified beneficiaries of the State Medicaid Program. The income derived from the operations of the hospital, including all facilities thereof, shall be utilized toward the payment of the operating expenses of the hospital, including all facilities thereof.

SECTION 7. Section 41-7-173, Mississippi Code of 1972, is amended as follows:

41-7-173. For the purposes of Section 41-7-171 et seq., the following words shall have the meanings ascribed herein, unless the context otherwise requires:

(a) "Affected person" means (i) the applicant; (ii) a person residing within the geographic area to be served by the applicant's proposal; (iii) a person who regularly uses health care facilities * * * located in the geographic area of the proposal which provide similar service to that which is proposed; (iv) health care facilities * * * which have, prior to receipt of the application under review, formally indicated an intention to provide service similar to that of the proposal being considered at a future date; (v) third-party payers who reimburse health care facilities located in the geographical area of the proposal; or (vi) any agency that establishes rates for health care services * * * located in the geographic area of the proposal.

(b) "Certificate of need" means a written order of the State Department of Health setting forth the affirmative finding that a proposal in prescribed application form, sufficiently satisfies the plans, standards and criteria prescribed for such service or other project by Section 41-7-171 et seq., and by rules and regulations promulgated thereunder by the State Department of Health.

(c) (i) "Capital expenditure" when pertaining to defined major medical equipment, shall mean an expenditure which, under generally accepted accounting principles consistently applied, is not properly chargeable as an expense of operation and

maintenance and which exceeds One Million Five Hundred Thousand Dollars ($1,500,000.00).

(ii) "Capital expenditure," when pertaining to other than major medical equipment, shall mean any expenditure which under generally accepted accounting principles consistently applied is not properly chargeable as an expense of operation and maintenance and which exceeds Two Million Dollars ($2,000,000.00).

(iii) A "capital expenditure" shall include the acquisition, whether by lease, sufferance, gift, devise, legacy, settlement of a trust or other means, of any facility or part thereof, or equipment for a facility, the expenditure for which would have been considered a capital expenditure if acquired by purchase. Transactions which are separated in time but are planned to be undertaken within twelve (12) months of each other and are components of an overall plan for meeting patient care objectives shall, for purposes of this definition, be viewed in their entirety without regard to their timing.

(iv) In those instances where a health care facility or other provider of health services proposes to provide a service in which the capital expenditure for major medical equipment or other than major medical equipment or a combination of the two (2) may have been split between separate parties, the total capital expenditure required to provide the proposed service shall be considered in determining the necessity of certificate of need review and in determining the appropriate certificate of need review fee to be paid. The capital expenditure associated with facilities and equipment to provide services in Mississippi shall be considered regardless of where the capital expenditure was made, in state or out of state, and regardless of the domicile of the party making the capital expenditure, in state or out of state.

(d) "Change of ownership" includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements,

cash and/or stock transactions or other comparable arrangements whenever any person or entity acquires or controls a majority interest of the facility or service. Changes of ownership from partnerships, single proprietorships or corporations to another form of ownership are specifically included. However, "change of ownership" shall not include any inherited interest acquired as a result of a testamentary instrument or under the laws of descent and distribution of the State of Mississippi.

(e) "Commencement of construction" means that all of the following have been completed with respect to a proposal or project proposing construction, renovating, remodeling or alteration:

(i) A legally binding written contract has been consummated by the proponent and a lawfully licensed contractor to construct and/or complete the intent of the proposal within a specified period of time in accordance with final architectural plans which have been approved by the licensing authority of the State Department of Health;

(ii) Any and all permits and/or approvals deemed lawfully necessary by all authorities with responsibility for such have been secured; and

(iii) Actual bona fide undertaking of the subject proposal has commenced, and a progress payment of at least one percent (1%) of the total cost price of the contract has been paid to the contractor by the proponent, and the requirements of this paragraph (e) have been certified to in writing by the State Department of Health.

Force account expenditures, such as deposits, securities, bonds, et cetera, may, in the discretion of the State Department of Health, be excluded from any or all of the provisions of defined commencement of construction.

(f) "Consumer" means an individual who is not a provider of health care as defined in paragraph (p) of this section.

(g) "Develop," when used in connection with health services, means to undertake those activities which, on their completion, will result in the offering of a new institutional health service or the incurring of a financial obligation as defined under applicable state law in relation to the offering of such services.

(h) "Health care facility" includes hospitals, psychiatric hospitals, chemical dependency hospitals, skilled nursing facilities, end stage renal disease (ESRD) facilities, including freestanding hemodialysis units, intermediate care facilities, ambulatory surgical facilities, intermediate care facilities for the mentally retarded, home health agencies, psychiatric residential treatment facilities, pediatric skilled nursing facilities, long-term care hospitals, comprehensive medical rehabilitation facilities, including facilities owned or operated by the state or a political subdivision or instrumentality of the state, but does not include Christian Science sanatoriums operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts. This definition shall not apply to facilities for the private practice, either independently or by incorporated medical groups, of physicians, dentists or health care professionals except where such facilities are an integral part of an institutional health service. The various health care facilities listed in this paragraph shall be defined as follows:

(i) "Hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation services for the

rehabilitation of injured, disabled or sick persons. Such term does not include psychiatric hospitals.

(ii) "Psychiatric hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons.

(iii) "Chemical dependency hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, medical and related services for the diagnosis and treatment of chemical dependency such as alcohol and drug abuse.

(iv) "Skilled nursing facility" means an institution or a distinct part of an institution which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

(v) "End stage renal disease (ESRD) facilities" means kidney disease treatment centers, which includes freestanding hemodialysis units and limited care facilities. The term "limited care facility" generally refers to an off-hospital-premises facility, regardless of whether it is provider or nonprovider operated, which is engaged primarily in furnishing maintenance hemodialysis services to stabilized patients.

(vi) "Intermediate care facility" means an institution which provides, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require health related care and services (above the level of room and board).

(vii) "Ambulatory surgical facility" means a facility primarily organized or established for the purpose of performing surgery for outpatients and is a separate identifiable legal entity from any other health care facility. Such term does not include the offices of private physicians or dentists, whether for individual or group practice, and does not include any abortion facility as defined in Section 41-75-1(e).

(viii) "Intermediate care facility for the mentally retarded" means an intermediate care facility that provides health or rehabilitative services in a planned program of activities to the mentally retarded, also including, but not limited to, cerebral palsy and other conditions covered by the Federal Developmentally Disabled Assistance and Bill of Rights Act, Public Law 94-103.

(ix) "Home health agency" means a public or privately owned agency or organization, or a subdivision of such an agency or organization, properly authorized to conduct business in Mississippi, which is primarily engaged in providing to individuals at the written direction of a licensed physician, in the individual's place of residence, skilled nursing services provided by or under the supervision of a registered nurse licensed to practice in Mississippi, and one or more of the following services or items:

1. Physical, occupational or speech therapy;

2. Medical social services;

3. Part-time or intermittent services of a home health aide;

4. Other services as approved by the licensing agency for home health agencies;

5. Medical supplies, other than drugs and biologicals, and the use of medical appliances; or

6. Medical services provided by an intern or resident-in-training at a hospital under a teaching program of such hospital.

Further, all skilled nursing services and those services listed in items 1. through 4. of this subparagraph (ix) must be provided directly by the licensed home health agency. For purposes of this subparagraph, "directly" means either through an agency employee or by an arrangement with another individual not defined as a health care facility.

This subparagraph (ix) shall not apply to health care facilities which had contracts for the above services with a home health agency on January 1, 1990.

(x) "Psychiatric residential treatment facility" means any nonhospital establishment with permanent licensed facilities which provides a twenty-four-hour program of care by qualified therapists including, but not limited to, duly licensed mental health professionals, psychiatrists, psychologists, psychotherapists and licensed certified social workers, for emotionally disturbed children and adolescents referred to such facility by a court, local school district or by the Department of Human Services, who are not in an acute phase of illness requiring the services of a psychiatric hospital, and are in need of such restorative treatment services. For purposes of this paragraph, the term "emotionally disturbed" means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory or health factors;

2. An inability to build or maintain satisfactory relationships with peers and teachers;

3. Inappropriate types of behavior or feelings under normal circumstances;

4. A general pervasive mood of unhappiness or depression; or

5. A tendency to develop physical symptoms or fears associated with personal or school problems. An establishment furnishing primarily domiciliary care is not within this definition.

(xi) "Pediatric skilled nursing facility" means an institution or a distinct part of an institution that is primarily engaged in providing to inpatients skilled nursing care and related services for persons under twenty-one (21) years of age who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

(xii) "Long-term care hospital" means a freestanding, Medicare-certified hospital that has an average length of inpatient stay greater than twenty-five (25) days, which is primarily engaged in providing chronic or long-term medical care to patients who do not require more than three (3) hours of rehabilitation or comprehensive rehabilitation per day, and has a transfer agreement with an acute care medical center and a comprehensive medical rehabilitation facility. Long-term care hospitals shall not use rehabilitation, comprehensive medical rehabilitation, medical rehabilitation, sub-acute rehabilitation, nursing home, skilled nursing facility, or sub-acute care facility in association with its name.

(xiii) "Comprehensive medical rehabilitation facility" means a hospital or hospital unit that is licensed and/or certified as a comprehensive medical rehabilitation facility which provides specialized programs that are accredited by the Commission on Accreditation of Rehabilitation Facilities and supervised by a physician board certified or board eligible in Physiatry or other doctor of medicine or osteopathy with at least two (2) years of training in the medical direction of a comprehensive rehabilitation program that:

1. Includes evaluation and treatment of individuals with physical disabilities;

2. Emphasizes education and training of individuals with disabilities;

3. Incorporates at least the following core disciplines:

(i) Physical Therapy;

(ii) Occupational Therapy;

(iii) Speech and Language Therapy;

(iv) Rehabilitation Nursing; and

4. Incorporates at least three (3) of the following disciplines:

(i) Psychology;

(ii) Audiology;

(iii) Respiratory Therapy;

(iv) Therapeutic Recreation;

(v) Orthotics;

(vi) Prosthetics;

(vii) Special Education;

(viii) Vocational Rehabilitation;

(ix) Psychotherapy;

(x) Social Work;

(xi) Rehabilitation Engineering.

These specialized programs include, but are not limited to: spinal cord injury programs, head injury programs and infant and early childhood development programs.

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(i) "Health service area" means a geographic area of the state designated in the State Health Plan as the area to be used in planning for specified health facilities and services and to be used when considering certificate of need applications to provide health facilities and services.

(j) "Health services" means clinically related (i.e., diagnostic, treatment or rehabilitative) services and includes alcohol, drug abuse, mental health and home health care services.

(k) "Institutional health services" shall mean health services provided in or through health care facilities and shall include the entities in or through which such services are provided.

(l) "Major medical equipment" means medical equipment designed for providing medical or any health related service which costs in excess of One Million Five Hundred Thousand Dollars ($1,500,000.00). However, this definition shall not be applicable to clinical laboratories if they are determined by the State Department of Health to be independent of any physician's office, hospital or other health care facility or otherwise not so defined by federal or state law, or rules and regulations promulgated thereunder.

(m) "State Department of Health" shall mean the state agency created under Section 41-3-15, which shall be considered to be the State Health Planning and Development Agency, as defined in paragraph (s) of this section.

(n) "Offer," when used in connection with health services, means that it has been determined by the State Department of Health that the health care facility is capable of providing specified health services.

(o) "Person" means an individual, a trust or estate, partnership, corporation (including associations, joint stock companies and insurance companies), the state or a political subdivision or instrumentality of the state.

(p) "Provider" shall mean any person who is a provider or representative of a provider of health care services requiring a certificate of need under Section 41-7-171 et seq., or who has any financial or indirect interest in any provider of services.

(q) "Secretary" means the Secretary of Health and Human Services, and any officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

(r) "State Health Plan" means the sole and official statewide health plan for Mississippi which identifies priority state health needs and establishes standards and criteria for health-related activities which require certificate of need review in compliance with Section 41-7-191.

(s) "State Health Planning and Development Agency" means the agency of state government designated to perform health planning and resource development programs for the State of Mississippi.

SECTION 8. Section 41-7-189, Mississippi Code of 1972, is amended as follows:

41-7-189. (1) Prior to review of new institutional health services or other proposals requiring a certificate of need, the State Department of Health shall disseminate to all health care facilities * * * within the state, and shall publish in one or more newspapers of general circulation in the state, a description of the scope of coverage of the commission's certificate of need program. Whenever the scope of such coverage is revised, the State Department of Health shall disseminate and publish a revised description thereof in like manner.

(2) Selected statistical data and information obtained by the State Department of Health as the licensing agency for health care facilities requiring licensure by the state and as the agency which provides certification for the Medicaid and/or Medicare program, may be utilized by the department in performing the statutory duties imposed upon it by any law over which it has authority, and regulations necessarily promulgated for such facilities to participate in the Medicaid and/or Medicare program; provided, however, that the names of individual patients shall not

be revealed except in hearings or judicial proceedings regarding questions of licensure.

SECTION 9. Section 41-9-215, Mississippi Code of 1972, is amended as follows:

41-9-215. Each individual and group policy of accident and sickness insurance * * * shall provide benefits for services when performed by a critical access hospital if such services would be covered under such policies or contracts if performed by a full-service hospital.

SECTION 10. Section 41-19-33, Mississippi Code of 1972, is amended as follows:

41-19-33. (1) Each region so designated or established under Section 41-19-31 shall establish a regional commission to be composed of members appointed by the boards of supervisors of the various counties in the region. It shall be the duty of such regional commission to administer mental health/retardation programs certified by the State Board of Mental Health. In addition, once designated and established as provided hereinabove, a regional commission shall have the following authority and shall pursue and promote the following general purposes:

(a) To establish, own, lease, acquire, construct, build, operate and maintain mental illness, mental health, mental retardation, alcoholism and general rehabilitative facilities and services designed to serve the needs of the people of the region so designated; provided that the services supplied by the regional commissions shall include those services determined by the Department of Mental Health to be necessary and may include, in addition to the above, services for persons with developmental and learning disabilities; for persons suffering from narcotic addiction and problems of drug abuse and drug dependence; and for the aging as designated and certified by the Department of Mental Health.

(b) To provide facilities and services for the prevention of mental illness, mental disorders, developmental and learning disabilities, alcoholism, narcotic addiction, drug abuse, drug dependence and other related handicaps or problems (including the problems of the aging) among the people of the region so designated, and for the rehabilitation of persons suffering from such illnesses, disorders, handicaps or problems as designated and certified by the Department of Mental Health.

(c) To promote increased understanding of the problems of mental illness, mental retardation, alcoholism, developmental and learning disabilities, narcotic addiction, drug abuse and drug dependence and other related problems (including the problems of the aging) by the people of the region, and also to promote increased understanding of the purposes and methods of the rehabilitation of persons suffering from such illnesses, disorders, handicaps or problems as designated and certified by the Department of Mental Health.

(d) To enter into contracts and to make such other arrangements as may be necessary, from time to time, with the United States government, the government of the State of Mississippi and such other agencies or governmental bodies as may be approved by and acceptable to the regional commission for the purpose of establishing, funding, constructing, operating and maintaining facilities and services for the care, treatment and rehabilitation of persons suffering from mental illness, mental retardation, alcoholism, developmental and learning disabilities, narcotic addiction, drug abuse, drug dependence and other illnesses, disorders, handicaps and problems (including the problems of the aging) as designated and certified by the Department of Mental Health.

(e) To enter into contracts and make such other arrangements as may be necessary with any and all private businesses, corporations, partnerships, proprietorships or other

private agencies, whether organized for profit or otherwise, as may be approved by and acceptable to the regional commission for the purpose of establishing, funding, constructing, operating and maintaining facilities and services for the care, treatment and rehabilitation of persons suffering from mental illness, mental retardation, alcoholism, developmental and learning disabilities, narcotic addiction, drug abuse, drug dependence and other illnesses, disorders, handicaps and problems (including the problems of the aging) relating to minimum services established by the Department of Mental Health.

(f) To promote the general mental health of the people of the region.

(g) To pay the administrative costs of the operation of the regional commissions, including per diem for the members of the commission and its employees, attorney's fees, if and when such are required in the opinion of the commission, and such other expenses of the commission as may be necessary. The Department of Mental Health standards and audit rules shall determine what administrative cost figures shall consist of for the purposes of this paragraph. Each regional commission shall submit a cost report annually to the Department of Mental Health in accordance with guidelines promulgated by the department.

(h) To employ and compensate any personnel that may be necessary to effectively carry out the programs and services established pursuant to the provisions of the aforesaid act, provided such person meets the standards established by the Department of Mental Health.

(i) To acquire whatever hazard, casualty or workers' compensation insurance that may be necessary for any property, real or personal, owned, leased or rented by the commissions, or any employees or personnel hired by the * * * commissions.

(j) To acquire professional liability insurance on all employees as may be deemed necessary and proper by the commission,

and to pay, out of the funds of the commission, all premiums due and payable on account thereof.

(k) To provide and finance within their own facilities, or through agreements or contracts with other local, state or federal agencies or institutions, nonprofit corporations, or political subdivisions or representatives thereof, programs and services for the mentally ill, including treatment for alcoholics and promulgating and administering of programs to combat drug abuse and the mentally retarded.

(l) To borrow money from private lending institutions in order to promote any of the foregoing purposes. A commission may pledge collateral, including real estate, to secure the repayment of money borrowed under the authority of this paragraph. Any such borrowing undertaken by a commission shall be on terms and conditions that are prudent in the sound judgment of the members of the commission, and the interest on any such loan shall not exceed the amount specified in Section 75-17-105. Any money borrowed, debts incurred or other obligations undertaken by a commission, regardless of whether borrowed, incurred or undertaken before or after the effective date of this act, shall be valid, binding and enforceable if it or they are borrowed, incurred or undertaken for any purpose specified in this section and otherwise conform to the requirements of this paragraph.

(m) To acquire, own and dispose of real and personal property. Any real and personal property paid for with state and/or county appropriated funds must have the written approval of the Department of Mental Health and/or the county board of supervisors, depending on the original source of funding, before being disposed of under this paragraph.

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(n) To enter into contracts, agreements or other arrangements with any person, payor, provider or other entity, pursuant to which the regional commission assumes financial risk

for the provision or delivery of any services, when deemed to be necessary or appropriate by the regional commission. Any action under this paragraph affecting more than one (1) region must have prior written approval of the Department of Mental Health before being initiated and annually thereafter.

* * *

(o) To meet at least annually with the board of supervisors of each county in its region for the purpose of presenting its total annual budget and total mental health/retardation services system.

(p) To provide alternative living arrangements for persons with serious mental illness, including, but not limited to, group homes for the chronically mentally ill.

(q) To make purchases and enter into contracts for purchasing in compliance with the public purchasing law, Sections 31-7-12 and 31-7-13, with compliance with the public purchasing law subject to audit by the State Department of Audit.

(r) To insure that all available funds are used for the benefit of the mentally ill, mentally retarded, substance abusers and developmentally disabled with maximum efficiency and minimum administrative cost. At any time a regional commission, and/or other related organization whatever it may be, accumulates surplus funds in excess of one-half (1/2) of its annual operating budget, the entity must submit a plan to the Department of Mental Health stating the capital improvements or other projects that require such surplus accumulation. If the required plan is not submitted within forty-five (45) days of the end of the applicable fiscal year, the Department of Mental Health shall withhold all state appropriated funds from such regional commission until such time as the capital improvement plan is submitted. If the submitted capital improvement plan is not accepted by the department, the * * * surplus funds shall be expended by the regional commission in the local mental health region on group homes for

the mentally ill, mentally retarded, substance abusers, children or other mental health/retardation services approved by the Department of Mental Health.

(s) In general to take any action which will promote, either directly or indirectly, any and all of the foregoing purposes.

(2) The types of services established by the State Department of Mental Health that must be provided by the regional mental health/retardation centers for certification by the department, and the minimum levels and standards for those services established by the department, shall be provided by the regional mental health/retardation centers to children when such services are appropriate for children, in the determination of the department.

SECTION 11. Section 41-63-1, Mississippi Code of 1972, is amended as follows:

41-63-1. (1) The terms "medical or dental review committee" or "committee," when used in this chapter, shall mean a committee of a state or local professional medical, nursing, pharmacy or dental society or a licensed hospital, nursing home or other health care facility, or of a medical, nursing, pharmacy or dental staff or a licensed hospital, nursing home or other health care facility or of a medical care foundation, * * * or any trauma improvement committee established at a licensed hospital designated as a trauma care facility by the Mississippi State Department of Health, Emergency Medical Services program, or any regional or state committee designated by the Mississippi State Department of Health, Emergency Medical Services program, and which participates in the trauma care system, or similar entity, the function of which, or one (1) of the functions of which, is to evaluate and improve the quality of health care rendered by providers of health care service, to evaluate the competence or practice of physicians or other health care practitioners, or to

determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health care services in the area and includes a committee functioning as a utilization review committee, a utilization or quality control peer review organization, or a similar committee or a committee of similar purpose, and the governing body of any licensed hospital while considering a recommendation or decision concerning a physician's competence, conduct, staff membership or clinical privileges.

(2) The term "proceedings" means all reviews, meetings, conversations, and communications of any medical or dental review committee.

(3) The term "records" shall mean any and all committee minutes, transcripts, applications, correspondence, incident reports, and other documents created, received or reviewed by or for any medical or dental review committee.

SECTION 12. Section 41-63-3, Mississippi Code of 1972, is amended as follows:

41-63-3. (1) Any hospital, medical staff, state or local professional medical, pharmacy or dental society, nursing home, * * * medical care foundation, * * * or other health care facility is authorized to establish medical or dental review committees one of the purposes of which may be to evaluate or review the diagnosis or treatment or the performance or rendition of medical or hospital services, to evaluate or improve the quality of health care rendered by providers of health care service, to determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable under the circumstances.

(2) Any person, professional group, hospital, sanatorium, extended care facility, skilled nursing home, intermediate care facility or other health care facility or organization may provide medical or dental information, reports or other data relating to the condition and treatment of any person to the Mississippi State Medical Association, Mississippi Dental Association, Mississippi State Pharmaceutical Association, Mississippi Medicaid Commission, any allied medical or dental organization or any duly authorized medical or dental review committee, to be used in the evaluation and improvement of the quality and efficiency of medical or dental care provided in such medical, dental or health care facility, including care rendered at the private office of a physician or dentist. Such data and records shall not divulge the identity of any patient.

SECTION 13. Section 41-63-21, Mississippi Code of 1972, is amended as follows:

41-63-21. The term "accreditation and quality assurance materials" as used in Sections 41-63-21 through 41-63-29 means and shall include written reports, records, correspondence and materials concerning the accreditation or quality assurance of any hospital, nursing home or other health care facility and any medical care foundation * * * or similar entity. However, the term does not include reports, records, correspondence and materials concerning accreditation or quality assurance that are prepared by the State Department of Health. The confidentiality established by Sections 41-63-21 through 41-63-29 shall apply to accreditation and quality assurance materials prepared by an employee, advisor or consultant of any hospital, nursing home or other health care facility and any medical care foundation * * * or similar entity and to materials provided by an employee, advisor or consultant of an accreditation, quality assurance or similar agency or similar body and to any individual who is an employee, advisor or consultant of a hospital, nursing home or

other health care facility and any medical care foundation * * * or similar entity or accrediting, quality assurance or similar agency or body.

SECTION 14. Section 41-83-1, Mississippi Code of 1972, is amended as follows:

41-83-1. As used in this chapter, the following terms shall be defined as follows:

(a) "Utilization review" means a system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients as to necessity for the purpose of determining whether such service should be covered or provided by an insurer, plan or other entity.

(b) "Private review agent" means a nonhospital-affiliated person or entity performing utilization review on behalf of:

(i) An employer or employees in the State of Mississippi; or

(ii) A third party that provides or administers hospital and medical benefits to citizens of this state, including: * * * a health insurer, nonprofit health service plan, health insurance service organization, * * * or other entity offering health insurance policies, contracts or benefits in this state.

(c) "Utilization review plan" means a description of the utilization review procedures of a private review agent.

(d) "Department" means the Mississippi State Department of Health.

(e) "Certificate" means a certificate of registration granted by the Mississippi State Department of Health to a private review agent.

SECTION 15. Section 41-83-5, Mississippi Code of 1972, is amended as follows:

41-83-5. No certificate is required for those private review agents conducting general in-house utilization review for hospitals, home health agencies, * * * clinics, private physician offices or any other health facility or entity, so long as the review does not result in the approval or denial of payment for hospital or medical services for a particular case. Such general in-house utilization review is completely exempt from the provisions of this chapter.

SECTION 16. Section 41-93-7, Mississippi Code of 1972, is amended as follows:

41-93-7. (1) The State Department of Health may establish, maintain and promote an osteoporosis prevention and treatment education program in order to raise public awareness, educate consumers and educate health professionals and teachers, and for other purposes, as provided in this section.

(2) The department may design and implement strategies for raising public awareness on the causes and nature of osteoporosis, personal risk factors, value of prevention and early detection and options for diagnosing and treating the disease.

(3) The department may develop and work with other agencies in presenting educational programs for physicians and other health professionals in the most up-to-date, accurate scientific and medical information on osteoporosis prevention, diagnosis and treatment, therapeutic decision-making, including guidelines for detecting and treating the disease in special populations, risks and benefits of medications and research advances.

(4) The department may conduct a needs assessment to identify:

(a) Available technical assistance and educational materials and programs nationwide;

(b) The level of public and professional awareness about osteoporosis;

(c) The needs of osteoporosis patients, their families and caregivers;

(d) Needs of health care providers, including physicians, nurses, * * * and other health care providers;

(e) The services available to osteoporosis patients;

(f) Existence of osteoporosis treatment programs;

(g) Existence of osteoporosis support groups;

(h) Existence of rehabilitation services; and

(i) Number and location of bone density testing equipment.

(5) Based on the needs assessment conducted under subsection (4) of this section, the department may develop, maintain and make available a list of osteoporosis-related services and osteoporosis health care providers with specialization in services to prevent, diagnose and treat osteoporosis.

SECTION 17. Section 41-95-3, Mississippi Code of 1972, is amended as follows:

41-95-3. As used in this chapter:

(a) "Authority" means the Mississippi Health Finance Authority created under Section 41-95-5.

(b) "Board" means the Mississippi Health Finance Authority Board created under Section 41-95-5.

(c) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient or ambulatory care to two (2) or more unrelated persons, and shall include, but shall not be limited to, all facilities and institutions included in Section 41-7-173(h).

(d) "Health care provider" means a person, partnership or corporation, other than a facility or institution, licensed or certified or authorized by state or federal law to provide professional health care service in this state to an individual during that individual's health care, treatment or confinement.

(e) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, * * * and, to the extent permitted under federal law, any administrator of an insured, self-insured or publicly funded health care benefit plan offered by public and private entities.

(f) "Resident" means a person who is domiciled in Mississippi as evidenced by an intent to maintain a principal dwelling place in Mississippi indefinitely and to return to Mississippi if temporarily absent, coupled with an act or acts consistent with that intent.

(g) "Primary care" or "primary health care" includes those health care services provided to individuals, families and communities, at a first level of care, which preserve and improve health, and encompasses services which promote health, prevent disease, treat and cure illness. It is delivered by various health care providers in a variety of settings including hospital outpatient clinics, private provider offices, group practices, * * * public health departments and community health centers. A primary care system is characterized by coordination of comprehensive services, cultural sensitivity, community orientation, continuity, prevention, the absence of barriers to receive and provide services, and quality assurance.

SECTION 18. Section 41-95-7, Mississippi Code of 1972, is amended as follows:

41-95-7. (1) The Mississippi Health Finance Authority Board shall formulate and carry out all policies regarding services within the jurisdiction of the authority, and shall adopt, modify, repeal and promulgate necessary rules and regulations after due notice and hearing and where not otherwise prohibited by federal or state law. It shall be the duty of the Mississippi Health Finance Authority to provide, to the fullest extent possible, that basic health care benefits are available to all Mississippians.

Toward this end, the Mississippi Health Finance Authority Board shall conduct the following activities:

(a) The Mississippi Health Finance Authority shall conduct such research as is necessary to analyze current expenditures for health care for Mississippians, patterns of utilization of health resources, accessibility of providers and services, as well as other factors including, but not limited to, the demography and geography of Mississippi, which affect the quality and cost of health services. Potential savings through such measures as preventive and primary care, * * * reduction of cost shifting and group purchasing shall be identified and analyzed. The Mississippi Health Finance Authority is authorized to obtain, collect and preserve such information as determined by the authority to be needed to conduct this research and carry out all other duties. No health care provider, health care facility, state agency, insurance company or related entity may refuse to provide the information required by the authority, but may charge a reasonable cost for the collection and reporting of the information. Information received by the authority shall not be disclosed publicly in such manner as to identify individuals or specific facilities. Information collected by the authority that identifies specific individuals or facilities is exempt from disclosure under the Mississippi Public Records Act. Information obtained by the Mississippi Health Finance Authority shall be governed by state and federal laws, and regulations applicable to the agency from whom information is received.

(b) The Mississippi Health Finance Authority shall determine what basic health services will best serve the needs of the citizens of the State of Mississippi, and in conjunction with such determination, shall identify such additional measures as are desirable to encourage employer participation, promote competition, contain costs and otherwise increase the availability of health benefits to Mississippians.

(c) In conjunction with paragraph (b) of this subsection, the board shall develop a plan for the provision of basic health services to state and local government employees, teachers, persons currently receiving Medicaid benefits, and as many additional persons with no other health benefits as the Mississippi Health Finance Authority Board determines economically feasible, as specifically provided in subsection (2) of this section. The Mississippi Health Finance Authority Board, in developing the plan, may propose graduated levels of participation proportionate to the participant's level of economic circumstances. This plan should include realization of savings identified through paragraphs (a) and (b) of this subsection.

(d) If different health plans are proposed, the Mississippi Health Finance Authority shall require written disclosure of treatment policies, practice standards or practice parameters, and any restrictions or limits on normal health services, including, but not limited to physical services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, and radiological examinations, by each health plan, unless the authority specifically determines it inadvisable to do so.

(e) The Mississippi Health Finance Authority shall determine what criteria are appropriate for certification of purchasing alliances, to protect the health and safety of the beneficiaries of health services provided pursuant to Sections 41-95-1 through 41-95-9.

(f) Effective upon approval of the plan by the Legislature, the Mississippi Health Finance Authority shall establish procedures for the solicitation of bids and subsequent purchase of benefits for persons listed in paragraph (c) of this subsection. In contracting for health benefits, the Mississippi Health Finance Authority shall require such information gathering, reports and other measures as are necessary to monitor the

provisions of health benefits and the accounting of all financial transactions therein. These shall include any data to continue the research and analysis set forth in paragraph (a) of this subsection.

(2) (a) From and after July 1, 1995, the Mississippi Health Finance Authority Board shall establish the Mississippi Health Care Purchasing Pool for the purpose of coordinating and enhancing the purchasing power of health care benefit plans of the groups identified under this section. It is not the intent of the Legislature to exacerbate cost shifting or adverse selection in the Mississippi health care system through the creation of the Health Care Purchasing Pool. In offering and administering the purchasing pool, the board shall not discriminate against individuals or groups based on age, gender, geographic area, industry and medical history. The board may include in the purchasing pool all employees, retirees and dependents covered by the group health insurance plans of the following entities:

(i) The State of Mississippi;

(ii) The state institutions of higher learning;

(iii) Employees of school districts and community/junior college districts as administered by the Department of Finance and Administration;

(iv) Any political subdivision or municipality, including any school district, that chooses to participate in the pool;

(v) Such portions of the Medicaid caseload as the board deems proper. Access to medical care or benefit levels for Medicaid recipients shall not diminish as a result of participation or nonparticipation in the pool;

(vi) Such portions of the uninsured caseload as the board deems proper; and

(vii) Any private entity that chooses to participate in the pool.

On and after July 1, 1995, the board may make the purchasing pool available to any employer, group, association or trust that chooses to participate in the pool on behalf of the employees or members of the group, association or trust.

(b) In administering the purchasing pool the authority may:

(i) Contract on behalf of participants in the pool with health care providers, health care facilities and health insurers for the delivery of health care services, including agreements securing discounts for regular, bulk payments to providers and agreements establishing uniform provider reimbursement;

(ii) Consolidate administrative functions on behalf of participants in the pool, including claims, processing, utilization review, management reporting, benefit management and bulk purchasing;

(iii) Create a health care cost and utilization data base for participants in the pool, and evaluate potential cost savings; and

(iv) Establish incentive programs to encourage pool participants to use health care services judiciously and to improve their health status.

(c) On or before December 15 of each year, the authority shall report to the Legislature on the operation of the purchasing pool, including the number and types of groups and group members participating in the pool, the costs of administering the pool, and the savings attributable to participating groups from the operation of the pool.

(d) This subsection (2) shall not be implemented unless (i) the necessary federal waivers have been granted, or (ii) the Secretary of the federal Department of Health and Human Services certifies that federal law permits this state to implement this program, and (iii) the Secretary of the federal Department of

Health and Human Services certifies that full implementation of waiver programs shall receive federal funding at current participation rates, and (iv) further amendment to this section by the Legislature has been enacted and has become law during the 1995 Regular Session or subsequent sessions.

SECTION 19. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

43-13-117. Medical assistance as authorized by this article shall include payment of part or all of the costs, at the discretion of the division or its successor, with approval of the Governor, of the following types of care and services rendered to eligible applicants who shall have been determined to be eligible for such care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients. The division shall be authorized to allow unlimited days in disproportionate hospitals as defined by the division for eligible infants under the age of six (6) years.

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid Capital Cost Component utilized to determine total hospital costs allocated to the Medicaid program.

(c) Hospitals will receive an additional payment for the implantable programmable pump implanted in an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per

year per recipient. This paragraph (c) shall stand repealed on July 1, 2001.

(2) Outpatient hospital services. Provided that where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care. The division shall develop a Medicaid-specific cost-to-charge ratio calculation from data provided by hospitals to determine an allowable rate payment for outpatient hospital services, and shall submit a report thereon to the Medical Advisory Committee on or before December 1, 1999. The committee shall make a recommendation on the specific cost-to-charge reimbursement method for outpatient hospital services to the 2000 Regular Session of the Legislature.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding fifty-two (52) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the fifty-two-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem. The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

(c) From and after July 1, 1997, all state-owned nursing facilities shall be reimbursed on a full reasonable cost basis.

(d) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the

facility is subsequently converted to a nursing facility pursuant to a certificate of need that authorizes conversion only and the applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing such conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility pursuant to a certificate of need that authorizes such construction. The reimbursement authorized in this subparagraph (d) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be authorized to make the reimbursement authorized in this subparagraph (d), the division first must have received approval from the Health Care Financing Administration of the United States Department of Health and Human Services of the change in the state Medicaid plan providing for such reimbursement.

(e) The division shall develop and implement, not later than January 1, 2001, a case-mix payment add-on determined by time studies and other valid statistical data which will reimburse a nursing facility for the additional cost of caring for a resident who has a diagnosis of Alzheimer's or other related dementia and exhibits symptoms that require special care. Any such case-mix add-on payment shall be supported by a determination of additional cost. The division shall also develop and implement as part of the fair rental reimbursement system for nursing facility beds, an Alzheimer's resident bed depreciation enhanced reimbursement system which will provide an incentive to encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

(f) The Division of Medicaid shall develop and implement a referral process for long-term care alternatives for Medicaid beneficiaries and applicants. No Medicaid beneficiary shall be admitted to a Medicaid-certified nursing facility unless a licensed physician certifies that nursing facility care is appropriate for that person on a standardized form to be prepared and provided to nursing facilities by the Division of Medicaid. The physician shall forward a copy of that certification to the Division of Medicaid within twenty-four (24) hours after it is signed by the physician. Any physician who fails to forward the certification to the Division of Medicaid within the time period specified in this paragraph shall be ineligible for Medicaid reimbursement for any physician's services performed for the applicant. The Division of Medicaid shall determine, through an assessment of the applicant conducted within two (2) business days after receipt of the physician's certification, whether the applicant also could live appropriately and cost-effectively at home or in some other community-based setting if home- or community-based services were available to the applicant. The time limitation prescribed in this paragraph shall be waived in cases of emergency. If the Division of Medicaid determines that a home- or other community-based setting is appropriate and cost-effective, the division shall:

(i) Advise the applicant or the applicant's legal representative that a home- or other community-based setting is appropriate;

(ii) Provide a proposed care plan and inform the applicant or the applicant's legal representative regarding the degree to which the services in the care plan are available in a home- or in other community-based setting rather than nursing facility care; and

(iii) Explain that such plan and services are available only if the applicant or the applicant's legal

representative chooses a home- or community-based alternative to nursing facility care, and that the applicant is free to choose nursing facility care.

The Division of Medicaid may provide the services described in this paragraph (f) directly or through contract with case managers from the local Area Agencies on Aging, and shall coordinate long-term care alternatives to avoid duplication with hospital discharge planning procedures.

Placement in a nursing facility may not be denied by the division if home- or community-based services that would be more appropriate than nursing facility care are not actually available, or if the applicant chooses not to receive the appropriate home- or community-based services.

The division shall provide an opportunity for a fair hearing under federal regulations to any applicant who is not given the choice of home- or community-based services as an alternative to institutional care.

The division shall make full payment for long-term care alternative services.

The division shall apply for necessary federal waivers to assure that additional services providing alternatives to nursing facility care are made available to applicants for nursing facility care.

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as

amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of such services to handicapped students by public school districts using state funds which are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of such services using state funds which are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

On July 1, 1993, all fees for periodic screening and diagnostic services under this paragraph (5) shall be increased by twenty-five percent (25%) of the reimbursement rate in effect on June 30, 1993.

(6) Physician's services. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seven percent (7%) of the adjusted Medicare payment established on January 1, 1994.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed sixty (60) visits per year.

(b) Repealed.

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act, as amended). "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

(9) Legend and other drugs as may be determined by the division. The division may implement a program of prior approval for drugs to the extent permitted by law. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Health Care Financing Administration (HCFA) plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the estimated acquisition cost (EAC) as determined by the division plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the providers' usual and customary charge to the general public. The division shall allow five (5) prescriptions per month for noninstitutionalized Medicaid recipients; however, exceptions for up to ten (10) prescriptions per month shall be allowed, with the approval of the director.

Payment for other covered drugs, other than multiple source drugs with HCFA upper limits, shall not exceed the lower of the estimated acquisition cost as determined by the division plus a

dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the providers' usual and customary charge to the general public.

Payment for nonlegend or over-the-counter drugs covered on the division's formulary shall be reimbursed at the lower of the division's estimated shelf price or the providers' usual and customary charge to the general public. No dispensing fee shall be paid.

The division shall develop and implement a program of payment for additional pharmacist services, with payment to be based on demonstrated savings, but in no case shall the total payment exceed twice the amount of the dispensing fee.

As used in this paragraph (9), "estimated acquisition cost" means the division's best estimate of what price providers generally are paying for a drug in the package size that providers buy most frequently. Product selection shall be made in compliance with existing state law; however, the division may reimburse as if the prescription had been filled under the generic name. The division may provide otherwise in the case of specified drugs when the consensus of competent medical advice is that trademarked drugs are substantially more effective.

(10) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 1999, all fees for dental care and surgery under authority of this paragraph (10) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999. It is the intent of the Legislature to encourage more dentists to participate in the Medicaid program.

(11) Eyeglasses necessitated by reason of eye surgery, and as prescribed by a physician skilled in diseases of the eye or

an optometrist, whichever the patient may select, or one (1) pair every three (3) years as prescribed by a physician or an optometrist, whichever the patient may select.

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the eighty-four-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective, and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

(b) All state-owned intermediate care facilities for the mentally retarded shall be reimbursed on a full reasonable cost basis.

(c) The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

(13) Family planning services, including drugs, supplies and devices, when such services are under the supervision of a physician.

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility which is not a part of a hospital but which is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services which may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seven percent (7%) of the adjusted Medicare payment established on January 1, 1994. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred

sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

(15) Home- and community-based services, as provided under Title XIX of the federal Social Security Act, as amended, under waivers, subject to the availability of funds specifically appropriated therefor by the Legislature. Payment for such services shall be limited to individuals who would be eligible for and would otherwise require the level of care provided in a nursing facility. The home- and community-based services authorized under this paragraph shall be expanded over a five-year period beginning July 1, 1999. The division shall certify case management agencies to provide case management services and provide for home- and community-based services for eligible individuals under this paragraph. The home- and community-based services under this paragraph and the activities performed by certified case management agencies under this paragraph shall be funded using state funds that are provided from the appropriation to the Division of Medicaid and used to match federal funds.

(16) Mental health services. Approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility which is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior approval of the division to be reimbursable under this

section * * *. From and after July 1, 2000, the division is authorized to contract with a 134-bed specialty hospital located on Highway 39 North in Lauderdale County for the use of not more than sixty (60) beds at the facility to provide mental health services for children and adolescents and for crisis intervention services for emotionally disturbed children with behavioral problems, with priority to be given to children in the custody of the Department of Human Services who are, or otherwise will be, receiving such services out-of-state.

(17) Durable medical equipment services and medical supplies. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997.

(18) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals which serve a disproportionate share of low-income patients and which meet the federal requirements for such payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. However, from and after January 1, 2000, no public hospital shall participate in the Medicaid disproportionate share program unless the public hospital participates in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations. Administration and support for participating hospitals shall be provided by the Mississippi Hospital Association.

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed

include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education. The division shall set reimbursement rates for providers in conjunction with the State Department of Health.

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, pursuant to Part H of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the director of the division the dollar amount of state early intervention funds available which shall be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the United States Department of Health and Human Services for home- and community-based services for physically disabled people using state funds which are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

(21) Nurse practitioner services. Services furnished by a registered nurse who is licensed and certified by the Mississippi Board of Nursing as a nurse practitioner including, but not limited to, nurse anesthetists, nurse midwives, family

nurse practitioners, family planning nurse practitioners, pediatric nurse practitioners, obstetrics-gynecology nurse practitioners and neonatal nurse practitioners, under regulations adopted by the division. Reimbursement for such services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

(22) Ambulatory services delivered in federally qualified health centers and in clinics of the local health departments of the State Department of Health for individuals eligible for medical assistance under this article based on reasonable costs as determined by the division.

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) which are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he reached age twenty-one (21), before the earlier of the date he no longer requires the services or the date he reaches age twenty-two (22), as provided by federal regulations. Recipients shall be allowed forty-five (45) days per year of psychiatric services provided in acute care psychiatric facilities, and shall be allowed unlimited days of psychiatric services provided in licensed psychiatric residential treatment facilities. The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

* * *

(24) Birthing center services.

(25) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in federal regulations.

(26) Group health plan premiums and cost sharing if it is cost effective as defined by the Secretary of Health and Human Services.

(27) Other health insurance premiums which are cost effective as defined by the Secretary of Health and Human Services. Medicare eligible must have Medicare Part B before other insurance premiums can be paid.

(28) The Division of Medicaid may apply for a waiver from the Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department,

provided that funds for these services are specifically appropriated to the Department of Mental Health.

(29) Pediatric skilled nursing services for eligible persons under twenty-one (21) years of age.

(30) Targeted case management services for children with special needs, under waivers from the United States Department of Health and Human Services, using state funds that are provided from the appropriation to the Mississippi Department of Human Services and used to match federal funds under a cooperative agreement between the division and the department.

(31) Care and services provided in Christian Science Sanatoria operated by or listed and certified by The First Church of Christ Scientist, Boston, Massachusetts, rendered in connection with treatment by prayer or spiritual means to the extent that such services are subject to reimbursement under Section 1903 of the Social Security Act.

(32) Podiatrist services.

(33) The division shall make application to the United States Health Care Financing Administration for a waiver to develop a program of services to personal care and assisted living homes in Mississippi. This waiver shall be completed by December 1, 1999.

(34) Services and activities authorized in Sections 43-27-101 and 43-27-103, using state funds that are provided from the appropriation to the State Department of Human Services and used to match federal funds under a cooperative agreement between the division and the department.

(35) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Division of Medicaid. The division may contract with additional entities to administer nonemergency transportation services as it deems necessary. All providers shall have a valid driver's license,

vehicle inspection sticker, valid vehicle license tags and a standard liability insurance policy covering the vehicle.

(36) Targeted case management services for individuals with chronic diseases, with expanded eligibility to cover services to uninsured recipients, on a pilot program basis. This paragraph (36) shall be contingent upon continued receipt of special funds from the Health Care Financing Authority and private foundations who have granted funds for planning these services. No funding for these services shall be provided from state general funds.

(37) Chiropractic services: a chiropractor's manual manipulation of the spine to correct a subluxation, if x-ray demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment. Reimbursement for chiropractic services shall not exceed Seven Hundred Dollars ($700.00) per year per recipient.

(38) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and ten percent (10%) coinsurance amounts for services available under Medicare for the duration and scope of services otherwise available under the Medicaid program.

(39) The division shall prepare an application for a waiver to provide prescription drug benefits to as many Mississippians as permitted under Title XIX of the Social Security Act.

(40) Services provided by the State Department of Rehabilitation Services for the care and rehabilitation of persons with spinal cord injuries or traumatic brain injuries, as allowed under waivers from the United States Department of Health and Human Services, using up to seventy-five percent (75%) of the funds that are appropriated to the Department of Rehabilitation Services from the Spinal Cord and Head Injury Trust Fund established under Section 37-33-261 and used to match federal

funds under a cooperative agreement between the division and the department.

(41) Notwithstanding any other provision in this article to the contrary, the division is hereby authorized to develop a population health management program for women and children health services through the age of two (2). This program is primarily for obstetrical care associated with low birth weight and pre-term babies. In order to effect cost savings, the division may develop a revised payment methodology which may include at-risk capitated payments.

(42) The division shall provide reimbursement, according to a payment schedule developed by the division, for smoking cessation medications for pregnant women during their pregnancy and other Medicaid-eligible women who are of child-bearing age.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless such is authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever such changes are required by federal law or regulation, or whenever such changes are necessary to correct administrative errors or omissions in calculating such payments or rates of reimbursement.

Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may

be added without enabling legislation from the Mississippi Legislature, except that the division may authorize such changes without enabling legislation when such addition of recipients or services is ordered by a court of proper authority. The director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. In the event current or projected expenditures can be reasonably anticipated to exceed the amounts appropriated for any fiscal year, the Governor, after consultation with the director, shall discontinue any or all of the payment of the types of care and services as provided herein which are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, for any period necessary to not exceed appropriated funds, and when necessary shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing such program or programs, it being the intent of the Legislature that expenditures during any fiscal year shall not exceed the amounts appropriated for such fiscal year.

SECTION 20. Section 43-13-303, Mississippi Code of 1972, is amended as follows:

43-13-303. (1) The Department of Human Services, in administering its child support enforcement program on behalf of Medicaid and non-Medicaid recipients, or any other attorney representing a Medicaid recipient, shall include a prayer for medical support in complaints and other pleadings in obtaining a child support order whenever health care coverage is available to the absent parent at a reasonable cost.

(2) Health insurers, including, but not limited to, ERISA plans, * * * shall not have contracts that limit or exclude payments if the individual is eligible for Medicaid, is not claimed as a dependent on the federal income tax return, or does not reside with the parent or in the insurer's service area.

Health insurers and employers shall honor court or administrative orders by permitting enrollment of a child or children at any time and by allowing enrollment by the custodial parent, the Division of Medicaid, or the Child Support Enforcement Agency if the absent parent fails to enroll the child(ren).

The health insurer and the employer shall not disenroll a child unless written documentation substantiates that the court order is no longer in effect, the child will be enrolled through another insurer, or the employer has eliminated family health coverage for all of its employees.

The employer shall allow payroll deduction for the insurance premium from the absent parent's wages and pay the insurer. The health insurer and the employer shall not impose requirements on the Medicaid recipient that are different from those applicable to any other individual. The health insurer shall provide pertinent information to the custodial parent to allow the child to obtain benefits and shall permit custodial parents to submit claims to the insurer.

The health insurer and employer shall notify the Division of Medicaid and the Department of Human Services when lapses in coverage occur in court-ordered insurance. If the noncustodial parent has provided such coverage and has changed employment, and the new employer provides health care coverage, the Department of Human Services shall transfer notice of the provision to the employer, which notice shall operate to enroll the child in the noncustodial parent's health plan, unless the noncustodial parent contests the notice. The health insurer and employer shall allow payments to the provider of medical services, shall honor the assignment of rights to third-party sources by the Medicaid recipient and the subrogation rights of the Division of Medicaid as set forth in Section 43-13-305, Mississippi Code of 1972, and shall permit payment to the custodial parent.

The employer shall allow the Division of Medicaid to garnish wages of the absent parent when such parent has received payment from the third party for medical services rendered to the insured child and such parent has failed to reimburse the Division of Medicaid to the extent of the medical service payment.

Any insurer or the employer who fails to comply with the provisions of this subsection shall be liable to the Division of Medicaid to the extent of payments made to the provider of medical services rendered to a recipient to which the third party or parties, is, are, or may be liable.

(3) The Division of Medicaid shall report to the Mississippi State Tax Commission an absent parent who has received third-party payment(s) for medical services rendered to the insured child and who has not reimbursed the Division of Medicaid for the related medical service payment(s). The Mississippi State Tax Commission shall withhold from the absent parent's state tax refund, and pay to the Division of Medicaid, the amount of the third-party payment(s) for medical services rendered to the insured child and not reimbursed to the Division of Medicaid for the related medical service payment(s).

SECTION 21. Section 71-3-217, Mississippi Code of 1972, is amended as follows:

71-3-217. In order to qualify as a private sector drug-free workplace and to qualify for the provisions of Section 71-3-207, and in addition to the educational program provided in Section 71-3-215, an employer must provide all supervisory personnel a minimum of two (2) hours of training prior to the institution of a drug-free workplace program under Sections 71-3-201 through 71-3-225, and each year thereafter which should include, but is not limited to, the following:

(a) Recognition of evidence of employee alcohol and other drug abuse;

(b) Documentation and corroboration of employee alcohol and other drug abuse;

(c) Referral of alcohol and other drug abusing employees to the proper treatment providers;

(d) Recognition of the benefits of referring alcohol and other drug abusing employees to treatment programs, in terms of employee health and safety and company savings; and

(e) Explanation of any employee health insurance * * * coverage for alcohol and other drug problems.

SECTION 22. Section 73-15-18, Mississippi Code of 1972, is amended as follows:

73-15-18. (1) The Mississippi Board of Nursing is designated as the state agency responsible for the administration and supervision of the Nursing Workforce Redevelopment Program as an educational curriculum in the State of Mississippi. It is the intent of the Legislature to develop a nursing workforce able to carry out the scope of service and leadership tasks required of the profession by promoting a strong educational infrastructure between nursing practice and nursing education.

(2) The Mississippi Board of Nursing is authorized to establish an Office of Nursing Workforce Redevelopment within the administrative framework of the board for the purpose of providing coordination and consultation to nursing education and practice. The Nursing Workforce Redevelopment Program shall encompass three (3) interdependent components:

* * *

(a) Determine the continuing education needs of the nursing workforce in an environment of restructuring from the hospital-bed-side setting to the home health and community practice settings, and implement such continuing education coursework through the university/college schools of nursing in the state and the community/junior college nursing programs in the state.

(b) Promote and coordinate through the schools of nursing opportunities for nurses prepared at the associate degree and bachelor degree levels to obtain higher degrees.

(c) Apply for and administer grants from public and private sources for the development of the Nursing Workforce Redevelopment Program prescribed herein.

(3) Pursuant to the provisions of subsections (1) and (2), the Board of Nursing is authorized to provide for the services of a Nursing Workforce Redevelopment Director and such other professional and nonprofessional staff as may be needed and as funds are available to the Board of Nursing to implement the Nursing Workforce Redevelopment Program prescribed herein. It shall be the responsibility of such professional staff to coordinate efforts of the bachelor degree schools of nursing, the associate degree schools of nursing and other appropriate agencies in the State of Mississippi to implement the Nursing Workforce Redevelopment Program.

(4) The Board of Nursing shall appoint a Nursing Workforce Redevelopment Advisory Committee composed of health care professionals, health agency administrators, nursing educators and other appropriate individuals to provide technical advice to the Office of Nursing Workforce Redevelopment created herein. The members of the committee shall be appointed by the Board of Nursing from a list of nominees submitted by appropriate nursing and health care organizations in the State of Mississippi. The members of the committee shall receive no compensation for their services, but may be reimbursed for actual travel expenses and mileage authorized by law for necessary committee business.

(5) All funds made available to the Board of Nursing for the purpose of nursing workforce redevelopment shall be administered by the board office for that purpose. The Board of Nursing is authorized to enter into contract with any private person,

organization or entity capable of contracting for the purpose of administering this section.

SECTION 23. Section 83-1-151, Mississippi Code of 1972, is amended as follows:

83-1-151. As used in Sections 83-1-151 through 83-1-169, the following items shall have the meanings ascribed herein unless the context indicates otherwise:

(a) "Insurer" means and includes every person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance or of annuities as limited to:

(i) Any insurer who is doing an insurer business, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future.

(ii) Any fraternal benefit society which is subject to the provisions of Section 83-29-1 et seq.

(iii) All corporate bodies organized for the purpose of carrying on the business of mutual insurance subject to the provisions of Section 83-31-1 et seq.

* * *

(b) "Exceeded its powers" means the following conditions:

(i) The insurer has refused to permit examination of its books, papers, accounts, records or affairs by the commissioner, his deputies, employees or duly commissioned examiners;

(ii) A domestic insurer has unlawfully removed from this state books, papers, accounts or records necessary for an examination of the insurer;

(iii) The insurer has failed to promptly comply with the applicable financial reporting statutes or rules and departmental requests relating thereto;

(iv) The insurer has neglected or refused to comply with an order of the commissioner to make good, within the

time prescribed by law, any prohibited deficiency in its capital, capital stock or surplus;

(v) The insurer is continuing to transact insurance or write business after its license has been revoked or suspended by the commissioner;

(vi) The insurer, by contract or otherwise, has unlawfully or has in violation of an order of the commissioner or has without first having obtained written approval of the commissioner if approval is required by law:

(A) Totally reinsured its entire outstanding business, or

(B) Merged or consolidated substantially its entire property or business with another insurer;

(vii) The insurer engaged in any transaction in which it is not authorized to engage under the laws of this state;

(viii) The insurer refused to comply with a lawful order of the commissioner.

(c) "Consent" means agreement to administrative supervision by the insurer.

(d) "Commissioner" means the Commissioner of Insurance.

(e) "Department" means the Department of Insurance.

SECTION 24. Section 83-5-1, Mississippi Code of 1972, is amended as follows:

83-5-1. All indemnity or guaranty companies, all companies, * * * corporations, partnerships, associations, individuals and fraternal orders, whether domestic or foreign, transacting, or to be admitted to transact, the business of insurance in this state are insurance companies within the meaning of this chapter, and shall be subject to the inspection and supervision of the commissioner.

SECTION 25. Section 83-5-72, Mississippi Code of 1972, is amended as follows:

83-5-72. All life, health and accident insurance companies * * * doing business in this state shall contribute annually, at such times as the Insurance Commissioner shall determine, in proportion to their gross premiums collected within the State of Mississippi during the preceding year, to a special fund in the State Treasury to be known as the "Insurance Department Fund" to be expended by the Insurance Commissioner in the payment of the expenses of the Department of Insurance as the commissioner may deem necessary. The commissioner is hereby authorized to employ such actuarial and other assistance as shall be necessary to carry out the duties of the department; and the employees shall be under the authority and direction of the Insurance Commissioner. The amount to be contributed annually to the fund shall be fixed each year by the Insurance Commissioner at a percentage of the gross premiums so collected during the preceding year. However, a minimum assessment of One Hundred Dollars ($100.00) shall be charged each licensed life, health and accident insurance company regardless of the gross premium amount collected during the preceding year.

The total contributions collected for the Insurance Department Fund shall not exceed the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00) in each fiscal year.

SECTION 26. Section 83-9-6, Mississippi Code of 1972, is amended as follows:

83-9-6. (1) This section shall apply to all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of Mississippi. This section shall also apply to insurance companies * * * that provide or administer coverages and benefits for prescription drugs. This section shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and dependents enrolled in

its health benefit plan; but this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services.

(2) As used in this section:

(a) "Copayment" means a type of cost sharing whereby insured or covered persons pay a specified predetermined amount per unit of service with their insurer paying the remainder of the charge. The copayment is incurred at the time the service is used. The copayment may be a fixed or variable amount.

(b) "Contract provider" means a pharmacy granted the right to provide prescription drugs and pharmacy services according to the terms of the insurer.

(c) "Health benefit plan" means any entity or program that provides reimbursement for pharmaceutical services.

(d) "Insurer" means any entity that provides or offers a health benefit plan.

(e) "Pharmacist" means a pharmacist licensed by the Mississippi State Board of Pharmacy.

(f) "Pharmacy" means a place licensed by the Mississippi State Board of Pharmacy.

(3) A health insurance plan, policy, or employee benefit plan * * * may not:

(a) Prohibit or limit any person who is a participant or beneficiary of the policy or plan from selecting a pharmacy or pharmacist of his choice who has agreed to participate in the plan according to the terms offered by the insurer;

(b) Deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services, including but not limited to prescription drugs, that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer;

(c) Impose upon a beneficiary of pharmacy services under a health benefit plan any copayment, fee or condition that is not equally imposed upon all beneficiaries in the same benefit category, class or copayment level under the health benefit plan when receiving services from a contract provider;

(d) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those pharmacies or pharmacists who have agreed to participate in the plan according to the terms offered by the insurer. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods;

(e) Reduce allowable reimbursement for pharmacy services to a beneficiary under a health benefit plan because the beneficiary selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area;

(f) Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy; or

(g) Impose upon a beneficiary any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to purchasing pharmacy services from any pharmacy, including prescription drugs, that is more costly or more restrictive than that which would be imposed upon the beneficiary if such services were purchased from a mail-order pharmacy or any other pharmacy that is willing to provide the same services or products for the same cost and copayment as any mail order service.

(4) A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent or owner, may not waive, discount, rebate or distort a copayment of any insurer, policy or plan or a

beneficiary's coinsurance portion of a prescription drug coverage or reimbursement and if a pharmacy, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of the insurer under a health benefit plan, the pharmacy shall provide its pharmacy services to all enrollees of that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the State Board of Pharmacy.

(5) If a health benefit plan providing reimbursement to Mississippi residents for prescription drugs restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan at least sixty (60) days before the effective date of the plan or before July 1, 1995, whichever comes first. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis and on regular intervals, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the state.

(6) A violation of this section creates a civil cause of action for injunctive relief in favor of any person or pharmacy aggrieved by the violation.

(7) The Commissioner of Insurance shall not approve any health benefit plan providing pharmaceutical services which does not conform to this section.

(8) Any provision in a health benefit plan which is executed, delivered or renewed, or otherwise contracted for in this state that is contrary to this section shall, to the extent of the conflict, be void.

(9) It is a violation of this section for any insurer or any person to provide any health benefit plan providing for pharmaceutical services to residents of this state that does not conform to this section.

SECTION 27. Section 83-9-32, Mississippi Code of 1972, is amended as follows:

83-9-32. Every hospital, health or medical expenses insurance policy, and hospital or medical service contract * * * that is delivered or issued for delivery in this state and otherwise provides anesthesia benefits shall offer benefits for anesthesia and for associated facility charges when the mental or physical condition of the child or mentally handicapped adult requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. This coverage shall be offered on an optional basis, and each primary insured must accept or reject such coverage in writing and accept responsibility for premium payment.

An insurer may require prior authorization for the anesthesia and associated facility charges for dental care procedures in the same manner that prior authorization is required for treatment of other medical conditions under general anesthesia. An insurer may require review for medical necessity and may limit payment of

facility charges to certified facilities in the same manner that medical review is required and payment of facility charges is limited for other services. The benefit provided by this coverage shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given policy, plan or contract. Private third party payers may not reduce or eliminate coverage due to these requirements.

A dentist shall consider the Indications for General Anesthesia as published in the reference manual of the American Academy of Pediatric Dentistry as utilization standards for determining whether performing dental procedures necessary to treat the particular condition or conditions of the patient under general anesthesia constitutes appropriate treatment.

The provisions of this section shall apply to anesthesia services provided by oral and maxillofacial surgeons as permitted by the Mississippi State Board of Dental Examiners.

The provisions of this section shall not apply to treatment rendered for temporal mandibular joint (TMJ) disorders.

SECTION 28. Section 83-9-34, Mississippi Code of 1972, is amended as follows:

83-9-34. (1) In this section, "health benefit plan" means a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident or sickness and that is offered by any insurance company or group hospital service corporation * * * that delivers or issues for delivery an individual, group, blanket or franchise insurance policy or insurance agreement, a group hospital service contract or an evidence of coverage or, to the extent permitted, by the Employee Retirement Income Security Act of 1974 (29 USCS Section 1001 et seq.), by a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 USCS Section 1002) or any other analogous benefit arrangement. The term does not include:

(a) A plan that provides coverage:

(i) Only for a specified disease;

(ii) Only for accidental death or dismemberment;

(iii) For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(iv) As a supplement to liability insurance;

(b) A Medicare supplemental policy as defined by Section 1882 (g)(1), Social Security Act (42 USCS Section 1395ss);

(c) Workers' compensation insurance coverage;

(d) Medical payment insurance issued as part of a motor vehicle insurance policy;

(e) A long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan; or

(f) A hospital indemnity only policy.

(2) A health benefit plan that provides benefits for a family member of the insured shall provide an option for the insured to elect coverage for each newly born child of the insured, from birth through the date the child is twenty-four (24) months of age, for:

(a) Immunization against:

(i) Diphtheria;

(ii) Hepatitis B;

(iii) Measles;

(iv) Mumps;

(v) Pertussis;

(vi) Polio;

(vii) Rubella;

(viii) Tetanus;

(ix) Varicella; and

(x) Hemophilus Influenza B (HIB).

(b) Any other immunization that the Commissioner of Insurance determines to be required by law for the child.

(c) The coverage shall be offered on an optional basis, and each primary insured must accept or reject such coverage in writing and accept responsibility for premium payment.

(3) The benefits required to be offered under subsection (2) of this section may not be made subject to a deductible, copayment or coinsurance requirement.

(4) This section applies only to a health benefit plan that is delivered, issued for delivery or renewed on or after January 1, 1999. A health benefit plan that is delivered, issued for delivery or renewed before January 1, 1999, is governed by the law as it existed immediately before January 1, 1999, and that law is continued in effect for this purpose.

SECTION 29. Section 83-9-35, Mississippi Code of 1972, is amended as follows:

83-9-35. (1) This section shall apply to any health benefit plan that provides coverage to two (2) or more employees of an employer in this state if any of the following conditions are satisfied:

(a) Any portion of the premium or benefits is paid by or on behalf of the employer;

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium; or

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Sections 162, 125 or 106 of the United States Internal Revenue Code.

(2) This section shall not apply to a health benefit plan which is issued in good faith with no knowledge or intent that the plan will, at the time of issuance or thereafter, satisfy one or more of the conditions set forth in subsection (1), and the

insurer has certified to the Department of Insurance that the policy form:

(a) Is not designed to be an employer-provided insurance.

(b) Is not intended to be an employer-provided insurance.

(c) Will not be advertised or marketed as employer-provided insurance.

(d) Will not be issued if the insurer knows that the policy will meet one (1) or more of the conditions set forth in subsection (1).

(3) This section shall not apply to an employer whose only role is collecting through payroll deductions the premiums of individual policies on behalf of employees.

(4) "Health benefit plan" means any group hospital or medical policy or group certificate delivered or issued for delivery in this state by an insurer; a nonprofit hospital, medical and surgical service corporation; * * * a fully insured multiple employer welfare arrangement; or any combination of these, except hospital daily indemnity plans, specified disease only policies, or other limited, supplemental benefit insurance policies.

(5) Whenever a health benefit plan of one carrier replaces a health benefit plan of similar benefits of another carrier:

(a) The prior carrier shall remain liable only to the extent of its accrued liabilities. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, or a self-insurer, or foregoes the provision of coverage.

(b) Each person who was validly covered under the prior health plan, who is eligible for coverage in accordance with the succeeding carrier's plan of benefits, with respect to classes eligible, shall be covered by that carrier's plan of benefits. No

previously covered person shall be considered ineligible for coverage solely because of his health condition or claims experience.

(c) The succeeding carrier, in determining whether a preexisting condition provision applies to an eligible employee or dependent, shall credit the time the person was covered under the prior plan if the previous coverage was continuous to a date not more than thirty (30) days prior to the effective date of the new coverage.

(d) The succeeding carrier, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the ninety (90) days preceding the effective date of the succeeding carrier's plan, but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible provision.

(e) Whenever a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this paragraph, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage was not replaced by the succeeding carrier.

(f) This section shall be applicable to any coverage offered and maintained as a result of membership or connection with any association or organization which exists for the purpose of offering health insurance to its members, and shall further be applicable to any health insurance policy or plan which is not made available to the general public on an individual basis with the exception of any State of Mississippi comprehensive health association.

SECTION 30. Section 83-9-37, Mississippi Code of 1972, is amended 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 * * * any * * * 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 31. Section 83-9-45, Mississippi Code of 1972, is amended as follows:

83-9-45. Except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies, no policy or certificate of health, medical, hospitalization or accident and sickness insurance and no subscriber contract provided by a nonprofit health service plan corporation * * * shall be issued, renewed, continued, issued for delivery or executed in this state after July 1, 1991, unless the policy, plan or contract specifically offers coverage for diagnostic and surgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage for diagnostic

services and surgery shall be the same as that for treatment to any other joint in the body and shall apply if the treatment is administered or prescribed by a physician or dentist. The minimum lifetime coverage for temporomandibular joint disorder and craniomandibular treatment shall be no less than Five Thousand Dollars ($5,000.00).

SECTION 32. Section 83-9-46, Mississippi Code of 1972, is amended as follows:

83-9-46. (1) Except as otherwise provided herein, from and after January 1, 1999, all individual and group health insurance policies or plans and pooled risk policies * * * shall offer coverage for diabetes treatments, including, but not limited to, equipment, supplies used in connection with the monitoring of blood glucose and insulin administration and self-management training/education and medical nutrition therapy in an outpatient, inpatient or home health setting. An amount of coverage not to exceed Two Hundred Fifty Dollars ($250.00) shall be offered annually for self-management training/education and medical nutrition therapy under this section. The coverage shall be offered on an optional basis, and each primary insured must accept or reject such coverage in writing and accept responsibility for premium payment. The coverage shall include treatment of all forms of diabetes, including, but not limited to, Type I, Type II, Gestational and all secondary forms of diabetes regardless of mode of treatment if such treatment is prescribed by a health care professional legally authorized to prescribe such treatment and regardless of the age of onset or duration of the disease. Such health insurance plans and policies shall not reduce, eliminate or delay coverage due to the requirements of this section.

(2) The services provided in an outpatient, inpatient or home health setting shall be provided by a Certified Diabetes Educator (CDE), who is appropriately certified, licensed or registered to practice in the State of Mississippi. Medical

nutrition therapy shall be provided by a Registered Dietician (RD) appropriately licensed to practice in the State of Mississippi. All services shall be based on nationally recognized standards including, but not limited to, the American Diabetes Association Practice Guidelines.

(3) The benefits provided in this section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given policy.

(4) The Commissioner of Insurance shall enforce the provisions of this section.

(5) Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

SECTION 33. Section 83-9-47, Mississippi Code of 1972, is amended as follows:

83-9-47. (1) As used in this section, the following terms shall be defined as follows:

(a) "Third-party payor" means any insurer, nonprofit hospital service plan, health care service plan, * * * self-insurer or any person or other entity which provides payment for medical and related services.

(b) "Health care provider" means a physician, optometrist, chiropractor, dentist, podiatrist, pharmacist, psychologist or hospital licensed by the State of Mississippi.

(c) "Patient" means any natural person who has received medical care or services from any medical care provider within the State of Mississippi.

(2) Any third-party payor who pays a patient or policyholder on behalf of a patient directly for medical care or services rendered by a health care provider shall provide information concerning the amount, date and nature of any such payment to the provider of services. The information may be provided by telephone, facsimile or by mailing a copy of the "explanation of

benefits" to the provider. If the information is provided by sending a copy of the "explanation of benefits" to the provider, then the third-party payor may require that the reasonable cost of producing and mailing the information be paid by the provider. The requirements of this subsection shall not apply to the following: a fixed-indemnity policy, a limited benefit health insurance policy, medical payment coverage or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance or workers' compensation.

SECTION 34. Section 83-9-51, Mississippi Code of 1972, is amended as follows:

83-9-51. (1) "Group policy" means a group accident and health insurance policy or group certificate delivered or issued for delivery in this state by an insurer; a nonprofit hospital, medical and surgical service corporation; * * * a fully insured multiple employer welfare arrangement; or any combination thereof.

(2) A group policy delivered or issued for delivery in this state which insures employees or members, and their eligible dependents, if they have elected to include them, for hospital, surgical or major medical insurance on an expense incurred or service basis, other than hospital daily indemnity plans, specified disease only policies, or other limited, supplemental benefit insurance policies, shall provide that employees or members whose insurance for these types of coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to continue their hospital, surgical and medical insurance under that group policy, for themselves and their eligible dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the conditions specified in this section. The terms and conditions set forth in

this section are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical or major medical plans already in force, or hereafter placed into effect, that provide continuation benefits equal to or better than those required in this section.

(3) Continuation shall only be available to an employee or member or an eligible dependent who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three (3) consecutive months immediately before the date of termination. The continued policy must cover all dependents covered under the group policy. A dependent spouse of an employee or member may elect continuation of dependent spouse and dependent child coverage for a period of coverage not to exceed twelve (12) months after: (a) the date of the death of the employee or member; (b) the date of the spouse's divorce from the employee or member; or (c) the date that the employee or member becomes entitled to Medicare benefits as provided under Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

A dependent child of an employee or member may elect continuation of his or her coverage for a period not to exceed twelve (12) months after the child ceases to be an eligible dependent of the employee or member.

(4) Continuation shall not be available for any person who is or could be covered by any other arrangement of hospital, surgical or medical coverage for individuals in a group, whether insured or uninsured, within thirty-one (31) days immediately following the date of termination, or whose insurance terminated because of fraud or because he failed to pay any required contribution for the insurance, or who is eligible for continuation under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) or who becomes entitled to Medicare benefits.

(5) Continuation shall not include dental, vision care or any other benefits provided under the group policy in addition to its hospital, surgical or major medical benefits.

(6) An employee or member or an eligible dependent electing continuation shall pay to the insurer, in advance, the amount of contribution required, which shall not be more than the full group rate for the instance applicable to the employee or member or an eligible dependent under the group policy on the due date of each payment. The employee or member or an eligible dependent shall not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member or an eligible dependent shall make a written election of continuation on a form furnished by the insurer and pay the first contribution, in advance, to the insurer on or before the date on which the employee's or member's or eligible dependent's insurance would otherwise terminate except as provided herein.

(7) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(a) The date twelve (12) months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.

(b) The date ending the period for which the employee or member or dependent last makes his required contribution, if he discontinues his contributions.

(c) The date the employee or member or dependent becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured.

(d) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy.

* * *

(e) The date the surviving spouse or former spouse of the employee or member remarries and becomes covered under a group health plan that does not exclude coverage for preexisting conditions.

(f) The date the employee or member or dependent becomes entitled to benefits under Medicare.

(8) A notification of the continuation privilege shall be included in each certificate of coverage.

(9) In the event of the employee's or member's death, the insurer shall provide notice of the continuation privilege within fourteen (14) days of the death to the person who is eligible to elect continuation. Such person has thirty (30) days after the notice to elect continuation.

(10) In the event that a dependent child of the employee or member ceases to be an eligible dependent, the insurer shall provide notice of the continuation privilege to the child within fourteen (14) days after the employee or member notifies the insurer of the child's ineligibility. The child has thirty (30) days after the notice to elect continuation of coverage.

(11) In the event of the employee's or member's divorce from his or her dependent spouse, the insurer shall provide notice of the continuation privilege to the spouse within fourteen (14) days after the employee or member notifies the insurer of the divorce. The spouse has thirty (30) days after the notice to elect continuation of coverage.

SECTION 35. Section 83-9-101, Mississippi Code of 1972, is amended as follows:

83-9-101. As used in Sections 83-9-101 through 83-9-113:

(a) "Applicant" means:

(i) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(ii) In the case of a group Medicare supplement policy, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplemental policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Commissioner" means the Commissioner of Insurance of this state.

(e) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, * * * and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(f) "Medicare supplement policy" means a group or individual policy of accident and health insurance, or a subscriber contract of hospital and medical service associations * * *, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, or an issued policy under a demonstration project specified in 42 USCS 1395(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(g) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(h) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

SECTION 36. Section 83-9-107, Mississippi Code of 1972, is amended as follows:

83-9-107. Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable

regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience * * * and earned premiums in accordance with accepted actuarial principles and practices.

SECTION 37. Section 83-9-205, Mississippi Code of 1972, is amended as follows:

83-9-205. As used in Sections 83-9-201 through 83-9-222, the following words shall have the meaning ascribed herein unless the context clearly requires otherwise:

(a) "Association" means the Comprehensive Health Insurance Risk Pool Association.

(b) "Board" means the board of directors of the association.

(c) "Dependent" means a resident spouse or resident unmarried child under the age of nineteen (19) years, a child who is a student under the age of twenty-three (23) years and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

(d) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care services plan contract, * * * or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, whether sold as an individual or group policy. The term does not include short-term, accident, dental-only, vision-only, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

* * *

(e) "Insurer" means any entity that is authorized in this state to write health insurance or that provides health insurance in this state or any third party administrator. For the purposes of Sections 83-9-201 through 83-9-222, insurer includes an insurance company, nonprofit health care services plan, or fraternal benefit society, * * * to the extent consistent with federal law any self-insurance arrangement covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state, any other entity providing a plan of health insurance or health benefits subject to state insurance regulation and any reinsurer reinsuring health insurance in this state.

(f) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 USC, Section 1395 et seq., as amended.

(g) "Plan" means the health insurance plan adopted by the board under Sections 83-9-201 through 83-9-222.

(h) "Resident" means an individual who is legally located in the United States and has been legally domiciled in this state for a period to be established by the board and subject to the approval of the commissioner but in no event shall such residency requirement be greater than one (1) year.

(i) "Agent" means a person who is licensed to sell health insurance in this state or a third party administrator.

(j) "Covered person" means any individual resident of this state (excluding dependents) who is eligible to receive benefits from any insurer.

(k) "Third party administrator" means any entity who is paying or processing health insurance claims for any Mississippi resident.

(l) "Reinsurer" means any insurer from whom any person providing health insurance for any Mississippi resident procures

insurance for itself in the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 38. Section 83-9-213, Mississippi Code of 1972, is amended as follows:

83-9-213. (1) The association shall:

(a) Establish administrative and accounting procedures for the operation of the association.

(b) Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board.

(c) Select an administering insurer in accordance with Section 83-9-215.

(d) Collect the assessments provided in Section 83-9-217 from insurers and third party administrators for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board. Assessments shall be collected pursuant to the plan of operation approved by the board. In addition to the collection of such assessments, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments shall be equal in amount for all insurers, but shall not exceed One Hundred Dollars ($100.00) per insurer for all such assessments. Assessments are due and payable within thirty (30) days of receipt of the assessment notice by the insurer.

(e) Require that all policy forms issued by the association conform to standard forms developed by the association. The forms shall be approved by the State Department of Insurance.

(f) Develop and implement a program to publicize the existence of the plan, the eligibility requirements for the plan, and the procedures for enrollment in the plan and to maintain public awareness of the plan.

(2) The association may:

(a) Exercise powers granted to insurers under the laws of this state.

(b) Take any legal actions necessary or proper for the recovery of any monies due the association under Sections 83-9-201 through 83-9-222. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner of Insurance or any of his staff, the administrator, the board or its directors, agents or employees, or against any participating insurer for any actions performed in accordance with Sections 83-9-201 through 83-9-222.

(c) Enter into contracts as are necessary or proper to carry out the provisions and purposes of Sections 83-9-201 through 83-9-222, including the authority, with the approval of the commissioner, to enter into contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(d) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the association.

(e) Take any legal actions necessary to:

(i) Avoid the payment of improper claims against the association or the coverage provided by or through the association.

(ii) Recover any amounts erroneously or improperly paid by the association.

(iii) Recover any amounts paid by the association as a result of mistake of fact or law.

(iv) Recover other amounts due the association.

(f) Establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the association. Rates and rate schedules may be adjusted for appropriate factors such as age, sex and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(g) Issue policies of insurance in accordance with the requirements of Sections 83-9-201 through 83-9-222.

(h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the association.

(i) Borrow money to effect the purposes of the association. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for insurers and may be carried as admitted assets.

(j) Establish rules, conditions and procedures for reinsuring risks of member insurers desiring to issue plan coverages to individuals otherwise eligible for plan coverages in their own name. Provision of reinsurance shall not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(k) Prepare and distribute application forms and enrollment instruction forms to insurance producers and to the general public.

(l) Provide for reinsurance of risks incurred by the association.

(m) Issue additional types of health insurance policies to provide optional coverages, including Medicare supplement health insurance.

(n) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review and individual case management for the purpose of making the benefit plan more cost effective.

(o) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services * * *.

(3) The commissioner may, by rule, establish additional powers and duties of the board and may adopt such rules as are necessary and proper to implement Sections 83-9-201 through 83-9-222.

(4) The State Department of Insurance shall examine and investigate the association and make an annual report to the Legislature thereon. Upon such investigation, the Commissioner of Insurance, if he deems necessary, shall require the board: (a) to contract with an outside independent actuarial firm to assess the solvency of the association and for consultation as to the sufficiency and means of the funding of the association, and the enrollment in and the eligibility, benefits and rate structure of the benefits plan to ensure the solvency of the association; and (b) to close enrollment in the benefits plan at any time upon a determination by the outside independent actuarial firm that funds of the association are insufficient to support the enrollment of additional persons. In no case shall the commissioner require such actuarial study any less than once every two (2) years.

SECTION 39. Section 83-18-1, Mississippi Code of 1972, is amended as follows:

83-18-1. As used in this chapter unless the context otherwise requires:

(a) "Administrator" or "third party administrator" or "TPA" means a person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, or residents of another state from offices in this state, in connection with life or health insurance coverage or annuities, except any of the following:

(i) An employer on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of such employer;

(ii) A union on behalf of its members;

(iii) An insurer which is authorized to transact insurance in this state with respect to a policy lawfully issued and delivered in and pursuant to the laws of this state or another state;

(iv) An agent or broker licensed to sell life or health insurance in this state, whose activities are limited exclusively to the sale of insurance;

(v) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vi) A trust and its trustees, agents and employees acting pursuant to such trust established in conformity with 29 USCS Section 186;

(vii) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to such trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(viii) A credit union or a financial institution which is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent they

collect and remit premiums to licensed insurance agents or authorized insurers in connection with loan payments;

(ix) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized collection if the company does not adjust or settle claims;

(x) A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life or health insurance coverage or annuities;

(xi) An adjuster licensed by this state whose activities are limited to adjustment of claims;

(xii) A person who acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization; or

(xiii) A person licensed as a managing general agent in this state, whose activities are limited exclusively to the scope of activities conveyed under such license.

(b) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Insurance" or "insurance coverage" means any coverage offered or provided by an insurer.

(e) "Insurer" means any person undertaking to provide life or health insurance coverage in this state. For the purposes of this chapter, insurer includes a licensed insurance company, a prepaid hospital or medical care plan, * * * a multiple employer welfare arrangement, or any other person providing a plan of insurance subject to state insurance regulation. Insurer does not include a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the

insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974.

(f) "Underwrites" or "underwriting" means, but is not limited to, the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer; the overall planning and coordinating of an insurance program; and the ability to procure bonds and excess insurance.

SECTION 40. Section 83-23-209, Mississippi Code of 1972, is amended as follows:

83-23-209. As used in this article:

(a) "Account" means either of the two (2) accounts created under Section 83-23-211.

(b) "Association" means the Mississippi Life and Health Insurance Guaranty Association created under Section 83-23-211.

(c) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(d) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(e) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) "Commissioner" means the Commissioner of Insurance of this state.

(g) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or

contract, or portion thereof for which coverage is provided under Section 83-23-205.

(h) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 83-23-205.

(i) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney's fees and costs.

(j) "Impaired insurer" means a member insurer which, after the effective date of this article, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(k) "Insolvent insurer" means a member insurer which after the effective date of this article, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(l) "Member insurer" means an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Section 83-23-205, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(i) A hospital or medical service organization whether profit or nonprofit;

*** * ***

(ii) A fraternal benefit society;

(iii) A mandatory state pooling plan;

(iv) A mutual assessment company or other person that operates on an assessment basis;

(v) An insurance exchange; or

(vi) Any entity similar to any of the above.

(m) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(n) "Owner" of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(o) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(p) "Plan sponsor" means:

(i) The employer in the case of a benefit plan established or maintained by a single employer;

(ii) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(iii) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(q) "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits, and less dividends and experience credits. "Premiums" does not include any amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is

not provided under Section 83-23-205(2), except that assessable premium shall not be reduced on account of Sections 83-23-205(2)(b)(iii) relating to interest limitations and 83-23-205(3)(b) relating to limitations with respect to one (1) individual, one (1) participant and one (1) contract owner. "Premiums" shall not include:

(i) Premiums in excess of Five Million Dollars ($5,000,000.00) on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code; or

(ii) With respect to multiple nongroup policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of Five Million Dollars ($5,000,000.00) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(r) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

The principal place of business of a plan sponsor of a benefit plan described in paragraph (p)(iii) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(s) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

(t) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may

be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this article, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(u) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(v) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(w) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(x) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

SECTION 41. Section 83-24-5, Mississippi Code of 1972, is amended as follows:

83-24-5. The proceedings authorized by this chapter may be applied to:

(a) All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future.

(b) All insurers who purport to do an insurance business in this state.

(c) All insurers who have insureds residing in this state.

(d) All other persons organized or in the process of organizing with the intent to do an insurance business in this state.

(e) All nonprofit service plans and all fraternal benefit societies and beneficial societies.

(f) All title insurance companies.

(g) All prepaid health care delivery plans.

(h) All corporate bodies organized for the purpose of carrying on the business of mutual insurance subject to the provisions of Section 83-31-1 et seq.

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SECTION 42. Section 83-41-214, Mississippi Code of 1972, is amended as follows:

83-41-214. A policy or contract providing for third-party payment or prepayment of health or medical expenses shall include a provision for the payment of necessary medical or surgical care and treatment provided by a duly certified nurse practitioner and performed within the scope of the license of the certified nurse practitioner if the policy or contract would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery. The policy or contract shall provide that policyholders and subscribers under the policy or contract may reject the coverage for services which may be provided by a certified nurse practitioner if the coverage is rejected for all providers of similar services. A policy or contract subject to this section shall not impose a practice or supervision restriction which is inconsistent with or more restrictive than the restriction already imposed by law. This section applies to services provided under a policy or contract delivered, issued for delivery, continued, or renewed in this on or after July 1, 1999,

and to an existing policy or contract, on the policy's or contract's anniversary or renewal date, whichever is later. This section does not apply to policyholders or subscribers eligible for coverage under Title XVIII of the federal Social Security Act or any similar coverage under a state or federal government plan. For the purposes of this section, third-party payment or prepayment includes an individual or group health care service contract * * *.

SECTION 43. Section 83-47-3, Mississippi Code of 1972, is amended as follows:

83-47-3. Any seven (7) or more physicians licensed to practice in Mississippi who are residents of this state, may form a nonprofit corporation under this chapter for the purpose of providing medical, professional, general and other liability insurance to health care providers and health care facilities * * * in Mississippi and any other state or jurisdiction. The term "health care provider," when used in this chapter, shall mean a physician, dentist, pharmacist, osteopath, psychologist, podiatrist, optometrist, chiropractor, nurse, medical technician or other health care provider licensed by the State of Mississippi or any other state or jurisdiction. * * * Members of the corporation shall consist of only individuals under contracts which entitle such individuals to medical liability insurance. Health care facilities * * * need not be owned by or comprised of members of the corporation in order to be insured by the corporation. All such corporations shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state, unless otherwise specifically provided herein. Such a corporation may be formed under this chapter in the following manner:

(a) The proposed incorporators shall subscribe articles of incorporation in which shall be stated:

(i) The proposed corporate name of the corporation, which shall not so closely resemble the name of any other corporation already transacting business in this state as to mislead the public or lead to confusion;

(ii) The domicile of the proposed corporation;

(iii) The names and post office addresses of the incorporators;

(iv) The fact that application for charter is being made under this chapter and the corporation proposed to operate under and subject to the provisions of this chapter;

(v) The purposes of the corporation.

(b) Such articles of incorporation shall be filed with the Commissioner of Insurance, who shall refer the same to the Attorney General for his opinion as to whether the same meet the requirements of this chapter and are not otherwise violative of the Constitution or laws of this state or of the United States. The Attorney General shall examine the same and endorse his opinion thereon and return the same to the Commissioner of Insurance for approval. The Commissioner of Insurance shall (if the same be approved by the Attorney General) thereupon endorse his certificate of approval upon such articles of incorporation, record the same in his office, and refer the same to the office of the Secretary of State to be there recorded, whereupon the corporation shall become and be considered an existing entity. The articles of incorporation as thus approved and recorded shall be and constitute the charter of incorporation of such corporation. It shall not be necessary that such charter be published, nor shall it be necessary that it be recorded in the office of the chancery clerk.

SECTION 44. Section 83-63-3, Mississippi Code of 1972, is amended as follows:

83-63-3. For purposes of this chapter, the following terms are defined as follows:

(a) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or other individual acceptable to the commissioner, that a small employer carrier is in compliance with Section 83-63-7, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(b) "Base premium rate" means for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(c) "Carrier" means any entity that provides health insurance in this state such as an insurance company; a prepaid hospital or medical service plan; a nonprofit hospital, medical and surgical service corporation; * * * a fully insured multiple employer welfare arrangement; or any other entity providing a plan of health insurance subject to state insurance regulation.

(d) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, but claim experience, health status and duration of coverage are not case characteristics for the purposes of this chapter.

(e) "Class of business" means all or a separate grouping of small employers established pursuant to Section 83-63-5.

(f) "Commissioner" means the Commissioner of Insurance.

(g) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty-two (32) or more hours. The term includes a sole proprietor, a partner of a

partnership and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis.

(h) "Established geographic service area" means a geographical area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(i) "Health benefit plan" or "plan" means any hospital or medical policy or certificate or hospital or medical service plan contract * * *. Health benefit plan does not include accident-only, specified disease, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(j) "Index rate" means for each class of business for small employees with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(k) "New business premium rate" means for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(l) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(m) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business which, on at least fifty percent (50%) of its working days during the preceding year, employed no more than fifty (50)

eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one (1) employer.

(n) "Small employer carrier" means any carrier which offers health benefit plans covering eligible employees of one or more small employers in this state.

SECTION 45. This act shall take effect and be in force from and after July 1, 2001.