By: Representative Holland

To: Insurance; Appropriations

HOUSE BILL NO. 595

1 AN ACT TO AMEND SECTION 25-15-9, MISSISSIPPI CODE OF 1972, TO
2 PROVIDE THAT THE STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE PLAN
3 SHALL BE CONSIDERED THE EMPLOYEE'S PRIMARY COVERAGE UNLESS THE
4 EMPLOYEE DESIGNATES THAT THE STATE AND SCHOOL EMPLOYEES HEALTH
5 INSURANCE PLAN IS HIS SECONDARY COVERAGE; TO AMEND SECTION 83-9-5,
6 MISSISSIPPI CODE OF 1972, TO PROVIDE REGULATIONS CONCERNING
7 INSURANCE POLICIES THAT COORDINATE BENEFITS WITH OTHER HEALTH
8 PLANS; AND FOR RELATED PURPOSES.

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

10 **SECTION 1.** Section 25-15-9, Mississippi Code of 1972, is
11 amended as follows:

12 **[Through June 30 of the year in which Section 25-11-143**
13 **becomes effective as provided in subsection (1) of Section**
14 **25-11-143, this section shall read as follows:]**

15 25-15-9. (1) (a) The board shall design a plan of health
16 insurance for state employees which provides benefits for
17 semiprivate rooms in addition to other incidental coverages which
18 the board deems necessary. The amount of the coverages shall be
19 in such reasonable amount as may be determined by the board to be
20 adequate, after due consideration of current health costs in
21 Mississippi. The plan shall also include major medical benefits
22 in such amounts as the board shall determine. The board is also
23 authorized to accept bids for such alternate coverage and optional
24 benefits as the board shall deem proper. Any contract for
25 alternative coverage and optional benefits shall be awarded by the
26 board after it has carefully studied and evaluated the bids and
27 selected the best and most cost-effective bid. The board may
28 reject all such bids; however, the board shall notify all bidders
29 of the rejection and shall actively solicit new bids if all bids
30 are rejected. The board may employ or contract for such

31 consulting or actuarial services as may be necessary to formulate
32 the plan, and to assist the board in the preparation of
33 specifications and in the process of advertising for the bids for
34 the plan. Such contracts shall be solicited and entered into in
35 accordance with Section 25-15-5. The board shall keep a record of
36 all persons, agents and corporations who contract with or assist
37 the board in preparing and developing the plan. The board in a
38 timely manner shall provide copies of this record to the members
39 of the advisory council created in this section and those
40 legislators, or their designees, who may attend meetings of the
41 advisory council. The board shall provide copies of this record
42 in the solicitation of bids for the administration or servicing of
43 the self-insured program. Each person, agent or corporation
44 which, during the previous fiscal year, has assisted in the
45 development of the plan or employed or compensated any person who
46 assisted in the development of the plan, and which bids on the
47 administration or servicing of the plan, shall submit to the board
48 a statement accompanying the bid explaining in detail its
49 participation with the development of the plan. This statement
50 shall include the amount of compensation paid by the bidder to any
51 such employee during the previous fiscal year. The board shall
52 make all such information available to the members of the advisory
53 council and those legislators, or their designees, who may attend
54 meetings of the advisory council before any action is taken by the
55 board on the bids submitted. The failure of any bidder to fully
56 and accurately comply with this paragraph shall result in the
57 rejection of any bid submitted by that bidder or the cancellation
58 of any contract executed when the failure is discovered after the
59 acceptance of that bid. The board is authorized to promulgate
60 rules and regulations to implement the provisions of this
61 subsection.

62 The board shall develop plans for the insurance plan
63 authorized by this section in accordance with the provisions of
64 Section 25-15-5.
65 Any corporation, association, company or individual that
66 contracts with the board for the third-party claims administration
67 of the self-insured plan shall prepare and keep on file an
68 explanation of benefits for each claim processed. The explanation
69 of benefits shall contain such information relative to each
70 processed claim which the board deems necessary, and, at a
71 minimum, each explanation shall provide the claimant's name, claim
72 number, provider number, provider name, service dates, type of
73 services, amount of charges, amount allowed to the claimant and
74 reason codes. The information contained in the explanation of
75 benefits shall be available for inspection upon request by the
76 board. The board shall have access to all claims information
77 utilized in the issuance of payments to employees and providers.
78 (b) There is created an advisory council to advise the
79 board in the formulation of the State and School Employees Health
80 Insurance Plan. The council shall be composed of the State
81 Insurance Commissioner or his designee, an employee-representative
82 of the institutions of higher learning appointed by the board of
83 trustees thereof, an employee-representative of the Department of
84 Transportation appointed by the director thereof, an
85 employee-representative of the State Tax Commission appointed by
86 the Commissioner of Revenue, an employee-representative of the
87 Mississippi Department of Health appointed by the State Health
88 Officer, an employee-representative of the Mississippi Department
89 of Corrections appointed by the Commissioner of Corrections, and
90 an employee-representative of the Department of Human Services
91 appointed by the Executive Director of Human Services, two (2)
92 certificated public school administrators appointed by the State
93 Board of Education, two (2) certificated classroom teachers
94 appointed by the State Board of Education, a noncertificated

95 school employee appointed by the State Board of Education and a
96 community/junior college employee appointed by the State Board for
97 Community and Junior Colleges.

98 The Lieutenant Governor may designate the Secretary of the
99 Senate, the Chairman of the Senate Appropriations Committee, the
100 Chairman of the Senate Education Committee and the Chairman of the
101 Senate Insurance Committee, and the Speaker of the House of
102 Representatives may designate the Clerk of the House, the Chairman
103 of the House Appropriations Committee, the Chairman of the House
104 Education Committee and the Chairman of the House Insurance
105 Committee, to attend any meeting of the State and School Employees
106 Insurance Advisory Council. The appointing authorities may
107 designate an alternate member from their respective houses to
108 serve when the regular designee is unable to attend such meetings
109 of the council. Such designees shall have no jurisdiction or vote
110 on any matter within the jurisdiction of the council. For
111 attending meetings of the council, such legislators shall receive
112 per diem and expenses which shall be paid from the contingent
113 expense funds of their respective houses in the same amounts as
114 provided for committee meetings when the Legislature is not in
115 session; however, no per diem and expenses for attending meetings
116 of the council will be paid while the Legislature is in session.
117 No per diem and expenses will be paid except for attending
118 meetings of the council without prior approval of the proper
119 committee in their respective houses.

120 (c) No change in the terms of the State and School
121 Employees Health Insurance Plan may be made effective unless the
122 board, or its designee, has provided notice to the State and
123 School Employees Health Insurance Advisory Council and has called
124 a meeting of the council at least fifteen (15) days before the
125 effective date of such change. In the event that the State and
126 School Employees Health Insurance Advisory Council does not meet
127 to advise the board on the proposed changes, the changes to the

128 plan shall become effective at such time as the board has informed
129 the council that the changes shall become effective.
130 (d) **Medical benefits for retired employees and**
131 **dependents under age sixty-five (65) years and not eligible for**
132 **Medicare benefits.** The same health insurance coverage as for all
133 other active employees and their dependents shall be available to
134 retired employees and all dependents under age sixty-five (65)
135 years who are not eligible for Medicare benefits, the level of
136 benefits to be the same level as for all other active
137 participants. This section will apply to those employees who
138 retire due to one hundred percent (100%) medical disability as
139 well as those employees electing early retirement.
140 (e) **Medical benefits for retired employees and**
141 **dependents over age sixty-five (65) years or otherwise eligible**
142 **for Medicare benefits.** The health insurance coverage available to
143 retired employees over age sixty-five (65) years or otherwise
144 eligible for Medicare benefits, and all dependents over age
145 sixty-five (65) years or otherwise eligible for Medicare benefits,
146 shall be the major medical coverage with the lifetime maximum of
147 One Million Dollars ($1,000,000.00). Benefits shall be reduced by
148 Medicare benefits as though such Medicare benefits were the base
149 plan.
150 All covered individuals shall be assumed to have full
151 Medicare coverage, Parts A and B; and any Medicare payments under
152 both Parts A and B shall be computed to reduce benefits payable
153 under this plan.
154 (2) Nonduplication of benefits--reduction of benefits by
155 Title XIX benefits: When benefits would be payable under more
156 than one (1) group plan, benefits under those plans will be
157 coordinated to the extent that the total benefits under all plans
158 will not exceed the total expenses incurred.
159 Benefits for hospital or surgical or medical benefits shall
160 be reduced by any similar benefits payable in accordance with

161 Title XIX of the Social Security Act or under any amendments
162 thereto, or any implementing legislation.
163 Benefits for hospital or surgical or medical benefits shall
164 be reduced by any similar benefits payable by workers'
165 compensation.
166 (3) (a) Schedule of life insurance benefits--group term:
167 The amount of term life insurance for each active employee of a
168 department, agency or institution of the state government shall
169 not be in excess of One Hundred Thousand Dollars ($100,000.00), or
170 twice the amount of the employee's annual wage to the next highest
171 One Thousand Dollars ($1,000.00), whichever may be less, but in no
172 case less than Thirty Thousand Dollars ($30,000.00), with a like
173 amount for accidental death and dismemberment on a
174 twenty-four-hour basis. The plan will further contain a premium
175 waiver provision if a covered employee becomes totally and
176 permanently disabled prior to age sixty-five (65) years.
177 Employees retiring after June 30, 1999, shall be eligible to
178 continue life insurance coverage in an amount of Five Thousand
179 Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty
180 Thousand Dollars ($20,000.00) into retirement.
181 (b) Effective October 1, 1999, schedule of life
182 insurance benefits--group term: The amount of term life insurance
183 for each active employee of any school district, community/junior
184 college, public library or university-based program authorized
185 under Section 37-23-31 for deaf, aphasic and emotionally disturbed
186 children or any regular nonstudent bus driver shall not be in
187 excess of One Hundred Thousand Dollars ($100,000.00), or twice the
188 amount of the employee's annual wage to the next highest One
189 Thousand Dollars ($1,000.00), whichever may be less, but in no
190 case less than Thirty Thousand Dollars ($30,000.00), with a like
191 amount for accidental death and dismemberment on a
192 twenty-four-hour basis. The plan will further contain a premium
193 waiver provision if a covered employee of any school district,

194 community/junior college, public library or university-based
195 program authorized under Section 37-23-31 for deaf, aphasic and
196 emotionally disturbed children or any regular nonstudent bus
197 driver becomes totally and permanently disabled prior to age
198 sixty-five (65) years. Employees of any school district,
199 community/junior college, public library or university-based
200 program authorized under Section 37-23-31 for deaf, aphasic and
201 emotionally disturbed children or any regular nonstudent bus
202 driver retiring after September 30, 1999, shall be eligible to
203 continue life insurance coverage in an amount of Five Thousand
204 Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty
205 Thousand Dollars ($20,000.00) into retirement.

206 (4) Any eligible employee who on March 1, 1971, was
207 participating in a group life insurance program which has
208 provisions different from those included herein and for which the
209 State of Mississippi was paying a part of the premium may, at his
210 discretion, continue to participate in such plan. Such employee
211 shall pay in full all additional costs, if any, above the minimum
212 program established by this article. Under no circumstances shall
213 any individual who begins employment with the state after March 1,
214 1971, be eligible for the provisions of this paragraph.

215 (5) The board may offer medical savings accounts as defined
216 in Section 71-9-3 as a plan option.

217 (6) Any premium differentials, differences in coverages,
218 discounts determined by risk or by any other factors shall be
219 uniformly applied to all active employees participating in the
220 insurance plan. It is the intent of the Legislature that the
221 state contribution to the plan be the same for each employee
222 throughout the state.

223 (7) On October 1, 1999, any school district,
224 community/junior college district or public library may elect to
225 remain with an existing policy or policies of group life insurance
226 with an insurance company approved by the State and School

227 Employees Health Insurance Management Board, in lieu of
228 participation in the State and School Life Insurance Plan. The
229 state's contribution of up to fifty percent (50%) of the active
230 employee's premium under the State and School Life Insurance Plan
231 may be applied toward the cost of coverage for full-time employees
232 participating in the approved life insurance company group plan.
233 For purposes of this subsection (7), "life insurance company group
234 plan" means a plan administered or sold by a private insurance
235 company. After October 1, 1999, the board may assess charges in
236 addition to the existing State and School Life Insurance Plan
237 rates to such employees as a condition of enrollment in the State
238 and School Life Insurance Plan. In order for any life insurance
239 company group plan existing as of October 1, 1999, to be approved
240 by the State and School Employees Health Insurance Management
241 Board under this subsection (7), it shall meet the following
242 criteria:

243 (a) The insurance company offering the group life
244 insurance plan shall be rated "A-" or better by A.M. Best state
245 insurance rating service and be licensed as an admitted carrier in
246 the State of Mississippi by the Mississippi Department of
247 Insurance.

248 (b) The insurance company group life insurance plan
249 shall provide the same life insurance, accidental death and
250 dismemberment insurance and waiver of premium benefits as provided
251 in the State and School Life Insurance Plan.

252 (c) The insurance company group life insurance plan
253 shall be fully insured, and no form of self-funding life insurance
254 by such company shall be approved.

255 (d) The insurance company group life insurance plan
256 shall have one (1) composite rate per One Thousand Dollars
257 ($1,000.00) of coverage for active employees regardless of age and
258 one (1) composite rate per One Thousand Dollars ($1,000.00) of
259 coverage for all retirees regardless of age or type of retiree.

260 (e) The insurance company and its group life insurance
261 plan shall comply with any administrative requirements of the
262 State and School Employees Health Insurance Management Board. In
263 the event any insurance company providing group life insurance
264 benefits to employees under this subsection (7) fails to comply
265 with any requirements specified herein or any administrative
266 requirements of the board, the state shall discontinue providing
267 funding for the cost of such insurance.

268 (8) The State and School Employees Health Insurance Plan
269 shall be considered the employee's primary health insurance
270 coverage unless the employee designates in writing that the State
271 and School Employees Health Insurance Plan is his secondary health
272 insurance coverage.

273 **[From and after July 1 of the year in which Section 25-11-143**
274 **becomes effective as provided in subsection (1) of Section**
275 **25-11-143, this section shall read as follows:]**

276 25-15-9. (1) (a) The board shall design a plan of health
277 insurance for state employees that provides benefits for
278 semiprivate rooms in addition to other incidental coverages that
279 the board deems necessary. The amount of the coverages shall be
280 in such reasonable amount as may be determined by the board to be
281 adequate, after due consideration of current health costs in
282 Mississippi. The plan shall also include major medical benefits
283 in such amounts as the board shall determine. The board is also
284 authorized to accept bids for such alternate coverage and optional
285 benefits as the board deems proper. Any contract for alternative
286 coverage and optional benefits shall be awarded by the board after
287 it has carefully studied and evaluated the bids and selected the
288 best and most cost-effective bid. The board may reject all such
289 bids; however, the board shall notify all bidders of the rejection
290 and shall actively solicit new bids if all bids are rejected. The
291 board may employ or contract for such consulting or actuarial
292 services as may be necessary to formulate the plan, and to assist

293 the board in the preparation of specifications and in the process
294 of advertising for the bids for the plan. Those contracts shall
295 be solicited and entered into in accordance with Section 25-15-5.
296 The board shall keep a record of all persons, agents and
297 corporations who contract with or assist the board in preparing
298 and developing the plan. The board in a timely manner shall
299 provide copies of this record to the members of the advisory
300 council created in this section and those legislators, or their
301 designees, who may attend meetings of the advisory council. The
302 board shall provide copies of this record in the solicitation of
303 bids for the administration or servicing of the self-insured
304 program. Each person, agent or corporation that, during the
305 previous fiscal year, has assisted in the development of the plan
306 or employed or compensated any person who assisted in the
307 development of the plan, and that bids on the administration or
308 servicing of the plan, shall submit to the board a statement
309 accompanying the bid explaining in detail its participation with
310 the development of the plan. This statement shall include the
311 amount of compensation paid by the bidder to any such employee
312 during the previous fiscal year. The board shall make all such
313 information available to the members of the advisory council and
314 those legislators, or their designees, who may attend meetings of
315 the advisory council before any action is taken by the board on
316 the bids submitted. The failure of any bidder to fully and
317 accurately comply with this paragraph shall result in the
318 rejection of any bid submitted by that bidder or the cancellation
319 of any contract executed when the failure is discovered after the
320 acceptance of that bid. The board is authorized to promulgate
321 rules and regulations to implement the provisions of this
322 subsection.
323 The board shall develop plans for the insurance plan
324 authorized by this section in accordance with the provisions of
325 Section 25-15-5.

326 Any corporation, association, company or individual that
327 contracts with the board for the third-party claims administration
328 of the self-insured plan shall prepare and keep on file an
329 explanation of benefits for each claim processed. The explanation
330 of benefits shall contain such information relative to each
331 processed claim which the board deems necessary, and, at a
332 minimum, each explanation shall provide the claimant's name, claim
333 number, provider number, provider name, service dates, type of
334 services, amount of charges, amount allowed to the claimant and
335 reason codes. The information contained in the explanation of
336 benefits shall be available for inspection upon request by the
337 board. The board shall have access to all claims information
338 utilized in the issuance of payments to employees and providers.
339 (b) There is created an advisory council to advise the
340 board in the formulation of the State and School Employees Health
341 Insurance Plan. The council shall be composed of the State
342 Insurance Commissioner or his designee, an employee-representative
343 of the state institutions of higher learning appointed by the
344 board of trustees thereof, an employee-representative of the
345 Mississippi Department of Transportation appointed by the director
346 thereof, an employee-representative of the State Tax Commission
347 appointed by the Commissioner of Revenue, an
348 employee-representative of the State Department of Health
349 appointed by the State Health Officer, an employee-representative
350 of the Mississippi Department of Corrections appointed by the
351 Commissioner of Corrections, and an employee-representative of the
352 Mississippi Department of Human Services appointed by the
353 Executive Director of Human Services, two (2) certificated public
354 school administrators appointed by the State Board of Education,
355 two (2) certificated classroom teachers appointed by the State
356 Board of Education, a noncertificated school employee appointed by
357 the State Board of Education and a community/junior college

358 employee appointed by the State Board for Community and Junior
359 Colleges.
360 The Lieutenant Governor may designate the Secretary of the
361 Senate, the Chairman of the Senate Appropriations Committee, the
362 Chairman of the Senate Education Committee and the Chairman of the
363 Senate Insurance Committee, and the Speaker of the House of
364 Representatives may designate the Clerk of the House, the Chairman
365 of the House Appropriations Committee, the Chairman of the House
366 Education Committee and the Chairman of the House Insurance
367 Committee, to attend any meeting of the State and School Employees
368 Insurance Advisory Council. The appointing authorities may
369 designate an alternate member from their respective houses to
370 serve when the regular designee is unable to attend such meetings
371 of the council. Those designees shall have no jurisdiction or
372 vote on any matter within the jurisdiction of the council. For
373 attending meetings of the council, those legislators shall receive
374 per diem and expenses, which shall be paid from the contingent
375 expense funds of their respective houses in the same amounts as
376 provided for committee meetings when the Legislature is not in
377 session; however, no per diem and expenses for attending meetings
378 of the council will be paid while the Legislature is in session.
379 No per diem and expenses will be paid except for attending
380 meetings of the council without prior approval of the proper
381 committee in their respective houses.
382 (c) No change in the terms of the State and School
383 Employees Health Insurance Plan may be made effective unless the
384 board, or its designee, has provided notice to the State and
385 School Employees Health Insurance Advisory Council and has called
386 a meeting of the council at least fifteen (15) days before the
387 effective date of the change. If the State and School Employees
388 Health Insurance Advisory Council does not meet to advise the
389 board on the proposed changes, the changes to the plan will become

390 effective at such time as the board has informed the council that
391 the changes will become effective.
392 (2) Nonduplication of benefits--reduction of benefits by
393 Title XIX benefits: When benefits would be payable under more
394 than one (1) group plan, benefits under those plans will be
395 coordinated to the extent that the total benefits under all plans
396 will not exceed the total expenses incurred.
397 Benefits for hospital or surgical or medical benefits shall
398 be reduced by any similar benefits payable in accordance with
399 Title XIX of the Social Security Act or under any amendments
400 thereto, or any implementing legislation.
401 Benefits for hospital or surgical or medical benefits shall
402 be reduced by any similar benefits payable by workers'
403 compensation.
404 (3) (a) Schedule of life insurance benefits--group term:
405 The amount of term life insurance for each active employee of a
406 department, agency or institution of the state government shall
407 not be in excess of One Hundred Thousand Dollars ($100,000.00), or
408 twice the amount of the employee's annual wage to the next highest
409 One Thousand Dollars ($1,000.00), whichever may be less, but in no
410 case less than Thirty Thousand Dollars ($30,000.00), with a like
411 amount for accidental death and dismemberment on a
412 twenty-four-hour basis.
413 (b) Effective October 1, 1999, schedule of life
414 insurance benefits--group term: The amount of term life insurance
415 for each active employee of any school district, community/junior
416 college, public library, university-based program authorized under
417 Section 37-23-31 for deaf, aphasic and emotionally disturbed
418 children, or any regular nonstudent bus driver shall not be in
419 excess of One Hundred Thousand Dollars ($100,000.00), or twice the
420 amount of the employee's annual wage to the next highest One
421 Thousand Dollars ($1,000.00), whichever may be less, but in no
422 case less than Thirty Thousand Dollars ($30,000.00), with a like

423 amount for accidental death and dismemberment on a
424 twenty-four-hour basis. The plan will further contain a premium
425 waiver provision if a covered employee of any school district,
426 community/junior college, public library, university-based program
427 authorized under Section 37-23-31 for deaf, aphasic and
428 emotionally disturbed children, or any regular nonstudent bus
429 driver becomes totally and permanently disabled before age
430 sixty-five (65) years.

431 (4) Any eligible employee who on March 1, 1971, was
432 participating in a group life insurance program that has
433 provisions different from those included in this section and for
434 which the State of Mississippi was paying a part of the premium
435 may, at his discretion, continue to participate in that plan. The
436 employee shall pay in full all additional costs, if any, above the
437 minimum program established by this article. Under no
438 circumstances shall any individual who begins employment with the
439 state after March 1, 1971, be eligible for the provisions of this
440 paragraph.

441 (5) The board may offer medical savings accounts as defined
442 in Section 71-9-3 as a plan option.

443 (6) Any premium differentials, differences in coverages,
444 discounts determined by risk or by any other factors shall be
445 uniformly applied to all active employees participating in the
446 insurance plan. It is the intent of the Legislature that the
447 state contribution to the plan be the same for each employee
448 throughout the state.

449 (7) On October 1, 1999, any school district,
450 community/junior college district or public library may elect to
451 remain with an existing policy or policies of group life insurance
452 with an insurance company approved by the State and School
453 Employees Health Insurance Management Board, in lieu of
454 participation in the State and School Life Insurance Plan. The
455 state's contribution of up to fifty percent (50%) of the active

456 employee's premium under the State and School Life Insurance Plan
457 may be applied toward the cost of coverage for full-time employees
458 participating in the approved life insurance company group plan.
459 For purposes of this subsection (7), "life insurance company group
460 plan" means a plan administered or sold by a private insurance
461 company. After October 1, 1999, the board may assess charges in
462 addition to the existing State and School Life Insurance Plan
463 rates to those employees as a condition of enrollment in the State
464 and School Life Insurance Plan. In order for any life insurance
465 company group plan existing as of October 1, 1999, to be approved
466 by the State and School Employees Health Insurance Management
467 Board under this subsection (7), it shall meet the following
468 criteria:
469 (a) The insurance company offering the group life
470 insurance plan shall be rated "A-" or better by A.M. Best state
471 insurance rating service and be licensed as an admitted carrier in
472 the State of Mississippi by the Mississippi Department of
473 Insurance.
474 (b) The insurance company group life insurance plan
475 shall provide the same life insurance, accidental death and
476 dismemberment insurance and waiver of premium benefits as provided
477 in the State and School Life Insurance Plan.
478 (c) The insurance company group life insurance plan
479 shall be fully insured, and no form of self-funding life insurance
480 by such company shall be approved.
481 (d) The insurance company group life insurance plan
482 shall have one (1) composite rate per One Thousand Dollars
483 ($1,000.00) of coverage for active employees regardless of age.
484 (e) The insurance company and its group life insurance
485 plan shall comply with any administrative requirements of the
486 State and School Employees Health Insurance Management Board. If
487 any insurance company providing group life insurance benefits to
488 employees under this subsection (7) fails to comply with any

489 requirements specified in this subsection or any administrative
490 requirements of the board, the state shall discontinue providing
491 funding for the cost of that insurance.

492 (8) The State and School Employees Health Insurance Plan
493 shall be considered the employee's primary health insurance
494 coverage unless the employee designates in writing that the State
495 and School Employees Health Insurance Plan is his secondary health
496 insurance coverage.

497 **SECTION 2.** Section 83-9-5, Mississippi Code of 1972, is
498 amended as follows:

499 83-9-5. (1) **Required provisions.** Except as provided in
500 subsection (3) of this section, each such policy delivered or
501 issued for delivery to any person in this state shall contain the
502 provisions specified in this subsection in the words in which the
503 same appear in this section. However, the insurer may, at its
504 option, substitute for one or more of such provisions,
505 corresponding provisions of different wording approved by the
506 commissioner which are in each instance not less favorable in any
507 respect to the insured or the beneficiary. Such provisions shall
508 be preceded individually by the caption appearing in this
509 subsection or, at the option of the insurer, by such appropriate
510 individual or group captions or subcaptions as the commissioner
511 may approve.

512 As used in this section, the term "insurer" means a health
513 maintenance organization, an insurance company or any other entity
514 responsible for the payment of benefits under a policy or contract
515 of accident and sickness insurance; however, the term "insurer"
516 shall not mean a liquidator, rehabilitator, conservator or
517 receiver or third party administrator of any health maintenance
518 organization, insurance company or other entity responsible for
519 the payment of benefits which is in liquidation, rehabilitation or
520 conservation proceedings, nor shall it mean any responsible
521 guaranty association. Further, no cause of action shall accrue

522 against a liquidator, rehabilitator, conservator or receiver or
523 third-party administrator of any health maintenance organization,
524 insurance company or other entity responsible for the payment of
525 benefits which is in liquidation, rehabilitation or conservation
526 proceedings or any responsible guaranty association under
527 subsection (1)(h)3 of this section or any policy provision in
528 accordance therewith.

529 (a) A provision as follows:

530 Entire contract; changes: This policy, including the
531 endorsements and the attached papers, if any, constitutes the
532 entire contract of insurance. No change in this policy shall be
533 valid until approved by an executive officer of the insurer and
534 unless such approval be endorsed hereon or attached hereto. No
535 agent has authority to change this policy or to waive any of its
536 provisions.

537 (b) A provision as follows:

538 Time limit on certain defenses:

539 1. After two (2) years from the date of issue of
540 this policy, no misstatements, except fraudulent misstatements,
541 made by the applicant in the application for such policy shall be
542 used to void the policy or to deny a claim for loss incurred or
543 disability (as defined in the policy) commencing after the
544 expiration of such two-year period.

545 (The foregoing policy provision shall not be so construed as
546 to effect any legal requirement for avoidance of a policy or
547 denial of a claim during such initial two-year period, nor to
548 limit the application of subparagraphs (2)(a) and (2)(b) of this
549 section in the event of misstatement with respect to age or
550 occupation.)

551 (A policy which the insured has the right to continue in
552 force subject to its terms by the timely payment of premium (1)
553 until at least age fifty (50) or, (2) in the case of a policy
554 issued after age forty-four (44), for at least five (5) years from

555 its date of issue, may contain in lieu of the foregoing the
556 following provision (from which the clause in parentheses may be
557 omitted at the insurer's option) under the caption
558 "INCONTESTABLE":
559 After this policy has been in force for a period of two (2)
560 years during the lifetime of the insured (excluding any period
561 during which the insured is disabled), it shall become
562 incontestable as to the statements in the application.)
563 2. No claim for loss incurred or disability (as
564 defined in the policy) commencing after two (2) years from the
565 date of issue of this policy shall be reduced or denied on the
566 ground that a disease or physical condition not excluded from
567 coverage by name or specific description effective on the date of
568 loss had existed prior to the effective date of coverage of this
569 policy.
570 (c) A provision as follows:
571 Grace period:
572 A grace period of seven (7) days for weekly premium policies,
573 ten (10) days for monthly premium policies and thirty-one (31)
574 days for all other policies will be granted for the payment of
575 each premium falling due after the first premium, during which
576 grace period the policy shall continue in force.
577 (A policy which contains a cancellation provision may add, at
578 the end of the above provision, "subject to the right of the
579 insurer to cancel in accordance with the cancellation provision
580 hereof."
581 A policy in which the insurer reserves the right to refuse
582 any renewal shall have, at the beginning of the above provision,
583 "unless not less than five (5) days prior to the premium due date
584 the insurer has delivered to the insured or has mailed to his last
585 address as shown by the records of the insurer written notice of
586 its intention not to renew this policy beyond the period for which
587 the premium has been accepted.")

588 (d) A provision as follows:

589 Reinstatement:

590 If any renewal premium be not paid within the time granted
591 the insured for payment, a subsequent acceptance of premium by the
592 insurer or by any agent duly authorized by the insurer to accept
593 such premium, without requiring in connection therewith an
594 application for reinstatement, shall reinstate the policy.
595 However, if the insurer or such agent requires an application for
596 reinstatement and issues a conditional receipt for the premium
597 tendered, the policy will be reinstated upon approval of such
598 application by the insurer or, lacking such approval, upon the
599 forty-fifth day following the date of such conditional receipt
600 unless the insurer has previously notified the insured in writing
601 of its disapproval of such application. The reinstated policy
602 shall cover only loss resulting from such accidental injury as may
603 be sustained after the date of reinstatement and loss due to such
604 sickness as may begin more than ten (10) days after such date. In
605 all other respects the insured and insurer shall have the same
606 rights thereunder as they had under the policy immediately before
607 the due date of the defaulted premium, subject to any provisions
608 endorsed hereon or attached hereto in connection with the
609 reinstatement. Any premium accepted in connection with a
610 reinstatement shall be applied to a period for which premium has
611 not been previously paid, but not to any period more than sixty
612 (60) days prior to the date of reinstatement. (The last sentence
613 of the above provision may be omitted from any policy which the
614 insured has the right to continue in force subject to its terms by
615 the timely payment of premiums (1) until at least age fifty (50)
616 or, (2) in the case of a policy issued after age forty-four (44),
617 for at least five (5) years from its date of issue.)

618 (e) A provision as follows:

619 Notice of claim:

620 Written notice of claim must be given to the insurer within
621 thirty (30) days after the occurrence or commencement of any loss
622 covered by the policy, or as soon thereafter as is reasonably
623 possible. Notice given by or on behalf of the insured or the
624 beneficiary to the insurer at ________________ (insert the
625 location of such office as the insurer may designate for the
626 purpose), or to any authorized agent of the insurer, with
627 information sufficient to identify the insured, shall be deemed
628 notice to the insurer.
629 (In a policy providing a loss-of-time benefit which may be
630 payable for at least two (2) years, an insurer may, at its option,
631 insert the following between the first and second sentences of the
632 above provision: "Subject to the qualifications set forth below,
633 if the insured suffers loss of time on account of disability for
634 which indemnity may be payable for at least two (2) years, he
635 shall, at least once in every six (6) months after having given
636 notice of claim, give to the insurer notice of continuance of said
637 disability, except in the event of legal incapacity. The period
638 of six (6) months following any filing of proof by the insured or
639 any payment by the insurer on account of such claim or any denial
640 of liability in whole or in part by the insurer shall be excluded
641 in applying this provision. Delay in the giving of such notice
642 shall not impair the insured's right to any indemnity which would
643 otherwise have accrued during the period of six (6) months
644 preceding the date on which such notice is actually given.")
645 (f) A provision as follows:
646 Claim forms:
647 The insurer, upon receipt of a notice of claim, will furnish
648 to the claimant such forms as are usually furnished by it for
649 filing proofs of loss. If such forms are not furnished within
650 fifteen (15) days after the giving of such notice, the claimant
651 shall be deemed to have complied with the requirements of this
652 policy as to proof of loss upon submitting, within the time fixed

653 in the policy for filing proofs of loss, written proof covering
654 the occurrence, the character and the extent of the loss for which
655 claim is made.

656 (g) A provision as follows:

657 Proofs of loss:

658 Written proof of loss must be furnished to the insurer at its
659 said office, in case of claim for loss for which this policy
660 provides any periodic payment contingent upon continuing loss,
661 within ninety (90) days after the termination of the period for
662 which the insurer is liable, and in case of claim for any other
663 loss, within ninety (90) days after the date of such loss.
664 Failure to furnish such proof within the time required shall not
665 invalidate or reduce any claim if it was not reasonably possible
666 to give proof within such time, provided such proof is furnished
667 as soon as reasonably possible and in no event, except in the
668 absence of legal capacity, later than one (1) year from the time
669 proof is otherwise required.

670 (h) A provision as follows:

671 Time of payment of claims:

672 1. All benefits payable under this policy for any
673 loss, other than loss for which this policy provides any periodic
674 payment, will be paid within twenty-five (25) days after receipt
675 of due written proof of such loss in the form of a clean claim
676 where claims are submitted electronically, and will be paid within
677 thirty-five (35) days after receipt of due written proof of such
678 loss in the form of clean claim where claims are submitted in
679 paper format. Benefits due under the policies and claims are
680 overdue if not paid within twenty-five (25) days or thirty-five
681 (35) days, whichever is applicable, after the insurer receives a
682 clean claim containing necessary medical information and other
683 information essential for the insurer to administer preexisting
684 condition, coordination of benefits and subrogation provisions. A
685 "clean claim" means a claim received by an insurer for

686 adjudication and which requires no further information, adjustment
687 or alteration by the provider of the services or the insured in
688 order to be processed and paid by the insurer. A claim is clean
689 if it has no defect or impropriety, including any lack of
690 substantiating documentation, or particular circumstance requiring
691 special treatment that prevents timely payment from being made on
692 the claim under this provision. A clean claim includes
693 resubmitted claims with previously identified deficiencies
694 corrected.

695 A clean claim does not include any of the following:

696 a. A duplicate claim, which means an original
697 claim and its duplicate when the duplicate is filed within thirty
698 (30) days of the original claim;

699 b. Claims which are submitted fraudulently or
700 that are based upon material misrepresentations;

701 c. Claims that require information essential
702 for the insurer to administer preexisting condition, coordination
703 of benefits or subrogation provisions; or

704 d. Claims submitted by a provider more than
705 thirty (30) days after the date of service; if the provider does
706 not submit the claim on behalf of the insured, then a claim is not
707 clean when submitted more than thirty (30) days after the date of
708 billing by the provider to the insured.

709 Not later than twenty-five (25) days after the date the
710 insurer actually receives an electronic claim, the insurer shall
711 pay the appropriate benefit in full, or any portion of the claim
712 that is clean, and notify the provider (where the claim is owed to
713 the provider) or the insured (where the claim is owed to the
714 insured) of the reasons why the claim or portion thereof is not
715 clean and will not be paid and what substantiating documentation
716 and information is required to adjudicate the claim as clean. Not
717 later than thirty-five (35) days after the date the insurer
718 actually receives a paper claim, the insurer shall pay the

719 appropriate benefit in full, or any portion of the claim that is
720 clean, and notify the provider (where the claim is owed to the
721 provider) or the insured (where the claim is owed to the insured)
722 of the reasons why the claim or portion thereof is not clean and
723 will not be paid and what substantiating documentation and
724 information is required to adjudicate the claim as clean. Any
725 claim or portion thereof resubmitted with the supporting
726 documentation and information requested by the insurer shall be
727 paid within twenty (20) days after receipt.

728 For purposes of this provision, the term "pay" means that the
729 insurer shall either send cash or a cash equivalent by United
730 States mail, or send cash or a cash equivalent by other means such
731 as electronic transfer, in full satisfaction of the appropriate
732 benefit due the provider (where the claim is owed to the provider)
733 or the insured (where the claim is owed to the insured). To
734 calculate the extent to which any benefits are overdue, payment
735 shall be treated as made on the date a draft or other valid
736 instrument was placed in the United States mail to the last known
737 address of the provider (where the claim is owed to the provider)
738 or the insured (where the claim is owed to the insured) in a
739 properly addressed, postpaid envelope, or, if not so posted, or
740 not sent by United States mail, on the date of delivery of payment
741 to the provider or insured.

742 2. Subject to due written proof of loss, all
743 accrued benefits for loss for which this policy provides periodic
744 payment will be paid _______________ (insert period for payment
745 which must not be less frequently than monthly), and any balance
746 remaining unpaid upon the termination of liability will be paid
747 within thirty (30) days after receipt of due written proof.

748 3. If the claim is not denied for valid and proper
749 reasons by the end of the applicable time period prescribed in
750 this provision, the insurer must pay the provider (where the claim
751 is owed to the provider) or the insured (where the claim is owed

752 to the insured) interest on accrued benefits at the rate of one
753 and one-half percent (1-1/2%) per month accruing from the day
754 after payment was due on the amount of the benefits that remain
755 unpaid until the claim is finally settled or adjudicated.
756 Whenever interest due pursuant to this provision is less than One
757 Dollar ($1.00), such amount shall be credited to the account of
758 the person or entity to whom such amount is owed.

759 4. In the event the insurer fails to pay benefits
760 when due, the person entitled to such benefits may bring action to
761 recover such benefits, any interest which may accrue as provided
762 in subsection (1)(h)3 of this section and any other damages as may
763 be allowable by law.

764 (i) A provision as follows:

765 Payment of claims:

766 Indemnity for loss of life will be payable in accordance with
767 the beneficiary designation and the provisions respecting such
768 payment which may be prescribed herein and effective at the time
769 of payment. If no such designation or provision is then
770 effective, such indemnity shall be payable to the estate of the
771 insured. Any other accrued indemnities unpaid at the insured's
772 death may, at the option of the insurer, be paid either to such
773 beneficiary or to such estate. All other indemnities will be
774 payable to the insured. When payments of benefits are made to an
775 insured directly for medical care or services rendered by a health
776 care provider, the health care provider shall be notified of such
777 payment. The notification requirement shall not apply to a
778 fixed-indemnity policy, a limited benefit health insurance policy,
779 medical payment coverage or personal injury protection coverage in
780 a motor vehicle policy, coverage issued as a supplement to
781 liability insurance or workers' compensation.

782 (The following provisions, or either of them, may be included
783 with the foregoing provision at the option of the insurer: "If
784 any indemnity of this policy shall be payable to the estate of the

785 insured, or to an insured or beneficiary who is a minor or
786 otherwise not competent to give a valid release, the insurer may
787 pay such indemnity, up to an amount not exceeding $______________
788 (insert an amount which must not exceed One Thousand Dollars
789 ($1,000.00)), to any relative by blood or connection by marriage
790 of the insured or beneficiary who is deemed by the insurer to be
791 equitably entitled thereto. Any payment made by the insurer in
792 good faith pursuant to this provision shall fully discharge the
793 insurer to the extent of such payment."

794 "Subject to any written direction of the insured in the
795 application or otherwise, all or a portion of any indemnities
796 provided by this policy on account of hospital, nursing, medical
797 or surgical services may, at the insurer's option and unless the
798 insured requests otherwise in writing not later than the time of
799 filing proofs of such loss, be paid directly to the hospital or
800 person rendering such services; but it is not required that the
801 service be rendered by a particular hospital or person.")

802 (j) A provision as follows:

803 Physical examinations:

804 The insurer at his own expense shall have the right and
805 opportunity to examine the person of the insured when and as often
806 as it may reasonably require during the pendency of a claim
807 hereunder.

808 (k) A provision as follows:

809 Legal actions:

810 No action at law or in equity shall be brought to recover on
811 this policy prior to the expiration of sixty (60) days after
812 written proof of loss has been furnished in accordance with the
813 requirements of this policy. No such action shall be brought
814 after the expiration of three (3) years after the time written
815 proof of loss is required to be furnished.

816 (l) A provision as follows:

817 Change of beneficiary:

818 Unless the insured makes an irrevocable designation of
819 beneficiary, the right to change the beneficiary is reserved to
820 the insured, and the consent of the beneficiary or beneficiaries
821 shall not be requisite to surrender or assignment of this policy,
822 or to any change of beneficiary or beneficiaries, or to any other
823 changes in this policy.

824 (The first clause of this provision, relating to the
825 irrevocable designation of beneficiary, may be omitted at the
826 insurer's option.)

827 (2) **Other provisions.** Except as provided in subsection (3)
828 of this section, no such policy delivered or issued for delivery
829 to any person in this state shall contain provisions respecting
830 the matters set forth below unless such provisions are in the
831 words in which the same appear in this section. However, the
832 insurer may, at its option, use in lieu of any such provision a
833 corresponding provision of different wording approved by the
834 commissioner which is not less favorable in any respect to the
835 insured or the beneficiary. Any such provision contained in the
836 policy shall be preceded individually by the appropriate caption
837 appearing in this subsection or, at the option of the insurer, by
838 such appropriate individual or group captions or subcaptions as
839 the commissioner may approve.

840 (a) A provision as follows:

841 Change of occupation:

842 If the insured be injured or contract sickness after having
843 changed his occupation to one classified by the insurer as more
844 hazardous than that stated in this policy or while doing for
845 compensation anything pertaining to an occupation so classified,
846 the insurer will pay only such portion of the indemnities provided
847 in this policy as the premium paid would have purchased at the
848 rates and within the limits fixed by the insurer for such more
849 hazardous occupation. If the insured changes his occupation to
850 one classified by the insurer as less hazardous than that stated

851 in this policy, the insurer, upon receipt of proof of such change
852 of occupation, will reduce the premium rate accordingly, and will
853 return the excess pro rata unearned premium from the date of
854 change of occupation or from the policy anniversary date
855 immediately preceding receipt of such proof, whichever is the most
856 recent. In applying this provision, the classification of
857 occupational risk and the premium rates shall be such as have been
858 last filed by the insurer prior to the occurrence of the loss for
859 which the insurer is liable, or prior to date of proof of change
860 in occupation, with the state official having supervision of
861 insurance in the state where the insured resided at the time this
862 policy was issued; but if such filing was not required, then the
863 classification of occupational risk and the premium rates shall be
864 those last made effective by the insurer in such state prior to
865 the occurrence of the loss or prior to the date of proof of change
866 in occupation.

867 (b) A provision as follows:

868 Misstatement of age:

869 If the age of the insured has been misstated, all amounts
870 payable under this policy shall be such as the premium paid would
871 have purchased at the correct age.

872 (c) A provision as follows:

873 Relation of earnings to issuance:

874 If the total monthly amount of loss of time benefits promised
875 for the same loss under all valid loss of time coverage upon the
876 insured, whether payable on a weekly or monthly basis, shall
877 exceed the monthly earnings of the insured at the time disability
878 commenced or his average monthly earnings for the period of two
879 (2) years immediately preceding a disability for which claim is
880 made, whichever is the greater, the insurer will be liable only
881 for such proportionate amount of such benefits under this policy
882 as the amount of such monthly earnings or such average monthly
883 earnings of the insured bears to the total amount of monthly

884 benefits for the same loss under all such coverage upon the
885 insured at the time such disability commences and for the return
886 of such part of the premiums paid during such two (2) years as
887 shall exceed the pro rata amount of the premiums for the benefits
888 actually paid hereunder; but this shall not operate to reduce the
889 total monthly amount of benefits payable under all such coverage
890 upon the insured below the sum of Two Hundred Dollars ($200.00) or
891 the sum of the monthly benefits specified in such coverages,
892 whichever is the lesser, nor shall it operate to reduce benefits
893 other than those payable for loss of time.

894 (The foregoing policy provision may be inserted only in a
895 policy which the insured has the right to continue in force
896 subject to its terms by the timely payment of premiums (1) until
897 at least age fifty (50) or, (2) in the case of a policy issued
898 after age forty-four (44), for at least five (5) years from its
899 date of issue. The insurer may, at its option, include in this
900 provision a definition of "valid loss of time coverage," approved
901 as to form by the commissioner, which definition shall be limited
902 in subject matter to coverage provided by governmental agencies or
903 by organizations subject to regulations by insurance law or by
904 insurance authorities of this or any other state of the United
905 States or any province of Canada, or to any other coverage the
906 inclusion of which may be approved by the commissioner, or any
907 combination of such coverages. In the absence of such definition,
908 such term shall not include any coverage provided for such insured
909 pursuant to any compulsory benefit statute (including any workers'
910 compensation or employer's liability statute), or benefits
911 provided by union welfare plans or by employer or employee benefit
912 organizations.)

913 (d) A provision as follows:

914 Unpaid premium:

915 Upon the payment of a claim under this policy, any premium
916 then due and unpaid or covered by any note or written order may be
917 deducted therefrom.

918 (e) A provision as follows:

919 Cancellation:

920 The insurer may cancel this policy at any time by written
921 notice delivered to the insured, or mailed to his last address as
922 shown by the records of the insurer, stating when, not less than
923 five (5) days thereafter, such cancellation shall be effective;
924 and after the policy has been continued beyond its original term,
925 the insured may cancel this policy at any time by written notice
926 delivered or mailed to the insurer, effective upon receipt or on
927 such later date as may be specified in such notice. In the event
928 of cancellation, the insurer will return promptly the unearned
929 portion of any premium paid. If the insured cancels, the earned
930 premium shall be computed by the use of the short-rate table last
931 filed with the state official having supervision of insurance in
932 the state where the insured resided when the policy was issued.
933 If the insurer cancels, the earned premium shall be computed pro
934 rata. Cancellation shall be without prejudice to any claim
935 originating prior to the effective date of cancellation.

936 (f) A provision as follows:

937 Conformity with state statutes:

938 Any provision of this policy which, on its effective date, is
939 in conflict with the statutes of the state in which the insured
940 resides on such date is hereby amended to conform to the minimum
941 requirements of such statutes.

942 (g) A provision as follows:

943 Illegal occupation:

944 The insurer shall not be liable for any loss to which a
945 contributing cause was the insured's commission of or attempt to
946 commit a felony or to which a contributing cause was the insured's
947 being engaged in an illegal occupation.

948 (h) A provision as follows:

949 Intoxicants and narcotics:

950 The insurer shall not be liable for any loss sustained or
951 contracted in consequence of the insured's being intoxicated or
952 under the influence of any narcotic unless administered on the
953 advice of a physician.

954 (i) A provision as follows:

955 Coordination of benefits:

956 The insured shall designate whether this insurance policy
957 shall be considered as primary or secondary coverage and shall so
958 indicate to the insurer in writing at the point of sale of the
959 policy and at any time that the insured changes the designation of
960 primary or secondary coverage for the policy.

961 (3) **Inapplicable or inconsistent provisions.** If any
962 provision of this section is in whole or in part inapplicable to
963 or inconsistent with the coverage provided by a particular form of
964 policy, the insurer, with the approval of the commissioner, shall
965 omit from such policy any inapplicable provision or part of a
966 provision, and shall modify any inconsistent provision or part of
967 the provision in such manner as to make the provision as contained
968 in the policy consistent with the coverage provided by the policy.

969 (4) **Order of certain policy provisions.** The provisions
970 which are the subject of subsections (1) and (2) of this section,
971 or any corresponding provisions which are used in lieu thereof in
972 accordance with such subsections, shall be printed in the
973 consecutive order of the provisions in such subsections or, at the
974 option of the insurer, any such provision may appear as a unit in
975 any part of the policy, with other provisions to which it may be
976 logically related, provided the resulting policy shall not be in
977 whole or in part unintelligible, uncertain, ambiguous, abstruse or
978 likely to mislead a person to whom the policy is offered,
979 delivered or issued.

980 (5) **Third-party ownership.** The word "insured," as used in
981 Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, shall
982 not be construed as preventing a person other than the insured
983 with a proper insurable interest from making application for and
984 owning a policy covering the insured, or from being entitled under
985 such a policy to any indemnities, benefits and rights provided
986 therein.
987 (6) **Requirements of other jurisdictions.**
988 (a) Any policy of a foreign or alien insurer, when
989 delivered or issued for delivery to any person in this state, may
990 contain any provision which is not less favorable to the insured
991 or the beneficiary than the provisions of Sections 83-9-1 through
992 83-9-21, Mississippi Code of 1972, and which is prescribed or
993 required by the law of the state under which the insurer is
994 organized.
995 (b) Any policy of a domestic insurer may, when issued
996 for delivery in any other state or country, contain any provision
997 permitted or required by the laws of such other state or country.
998 (7) **Filing procedure.** The commissioner may make such
999 reasonable rules and regulations concerning the procedure for the
1000 filing or submission of policies subject to the cited sections as
1001 are necessary, proper or advisable to the administration of said
1002 sections. This provision shall not abridge any other authority
1003 granted the commissioner by law.
1004 (8) **Administrative penalties.**
1005 (a) If the commissioner finds that an insurer, during
1006 any calendar year, has paid at least eighty-five percent (85%),
1007 but less than ninety-five percent (95%), of all clean claims
1008 received from all providers during that year in accordance with
1009 the provisions of subsection (1)(h) of this section, the
1010 commissioner may levy an aggregate penalty in an amount not to
1011 exceed Ten Thousand Dollars ($10,000.00). If the commissioner
1012 finds that an insurer, during any calendar year, has paid at least

1013 fifty percent (50%), but less than eighty-five percent (85%), of
1014 all clean claims received from all providers during that year in
1015 accordance with the provisions of subsection (1)(h) of this
1016 section, the commissioner may levy an aggregate penalty in an
1017 amount of not less than Ten Thousand Dollars ($10,000.00) nor more
1018 than One Hundred Thousand Dollars ($100,000.00). If the
1019 commissioner finds that an insurer, during any calendar year, has
1020 paid less than fifty percent (50%) of all clean claims received
1021 from all providers during that year in accordance with the
1022 provisions of subsection (1)(h) of this section, the commissioner
1023 may levy an aggregate penalty in an amount not less than One
1024 Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred
1025 Thousand Dollars ($200,000.00). In determining the amount of any
1026 fine, the commissioner shall take into account whether the failure
1027 to achieve the standards in subsection (1)(h) of this section were
1028 due to circumstances beyond the control of the insurer. The
1029 insurer may request an administrative hearing to contest the
1030 assessment of any administrative penalty imposed by the
1031 commissioner pursuant to this subsection within thirty (30) days
1032 after receipt of the notice of assessment.

1033 (b) Examinations to determine compliance with
1034 subsection (1)(h) of this section may be conducted by the
1035 commissioner or any of his examiners. The commissioner may
1036 contract with qualified impartial outside sources to assist in
1037 examinations to determine compliance. The expenses of any such
1038 examinations shall be paid by the insurer examined.

1039 (c) Nothing in the provisions of subsection (1)(h) of
1040 this section shall require an insurer to pay claims that are not
1041 covered under the terms of a contract or policy of accident and
1042 sickness insurance.

1043 (d) An insurer and a provider may enter into an express
1044 written agreement containing timely claim payment provisions which
1045 differ from, but are at least as stringent as, the provisions set

1046 forth under subsection (1)(h) of this section, and in such case,
1047 the provisions of the written agreement shall govern the timely
1048 payment of claims by the insurer to the provider. If the express
1049 written agreement is silent as to any interest penalty where
1050 claims are not paid in accordance with the agreement, the interest
1051 penalty provision of subsection (1)(h)3 of this section shall
1052 apply.

1053 (e) The commissioner may adopt rules and regulations
1054 necessary to ensure compliance with this subsection.

1055 **SECTION 3.** This act shall take effect and be in force from
1056 and after July 1, 2004.