MISSISSIPPI LEGISLATURE REGULAR SESSION 2006

By: Representative Flaggs To: Insurance

HOUSE BILL NO. 1230

1 AN ACT TO AMEND SECTION 83-9-3, MISSISSIPPI CODE OF 1972, TO
2 PROHIBIT THE ISSUANCE OF HEALTH INSURANCE POLICIES THAT RESTRICT
3 THE INSURER FROM ASSIGNING BENEFITS TO THE HEALTH PROVIDER; TO
4 AMEND SECTION 83-9-5, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT IF
5 THE INSURED PROVIDES THE INSURER WITH WRITTEN DIRECTIONS THAT THE
6 BENEFITS PROVIDED BY A HEALTH INSURANCE POLICY SHALL BE PAID TO A
7 HEALTH CARE PROVIDER RENDERING SERVICES, THEN THE INSURER SHALL
8 PAY DIRECTLY THE HEALTH CARE PROVIDER; AND FOR RELATED PURPOSES.

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

10 **SECTION 1.** Section 83-9-3, Mississippi Code of 1972, is
11 amended as follows:

12 83-9-3. (1) No policy of accident and sickness insurance
13 shall be delivered or issued for delivery to any person in this
14 state unless:

15 (a) The entire money and other considerations therefor
16 are expressed therein; and

17 (b) The time at which the insurance takes effect and
18 terminates is expressed therein; and

19 (c) It purports to insure only one (1) person, except
20 that a policy may insure, originally or by subsequent amendment,
21 upon the application of an adult member of a family who shall be
22 deemed the policyholder, any two (2) or more eligible members of
23 that family, including husband, wife, dependent children or any
24 children under a specified age which shall not exceed nineteen
25 (19) years, and any other person dependent upon the policyholder;
26 and

27 (d) The style, arrangement and overall appearance of
28 the policy give no undue prominence to any portion of the text,
29 and unless every printed portion of the text of the policy and of
30 any endorsements or attached papers is plainly printed in

31 lightfaced type of a style in general use, the size of which shall
32 be uniform and not less than ten-point with a lowercase unspaced
33 alphabet length not less than one hundred and twenty-point (the
34 "text" shall include all printed matter except the name and
35 address of the insurer, name or title of the policy, the brief
36 description if any, and captions and subcaptions); and

37 (e) The exceptions and reductions of indemnity are set
38 forth in the policy and, except those which are set forth in
39 Section 83-9-5, are printed, at the insurer's option, either with
40 the benefit provision to which they apply, or under an appropriate
41 caption such as "Exceptions," or "Exceptions and Reductions,"
42 provided that if an exception or reduction specifically applies
43 only to a particular benefit of the policy, a statement of such
44 exception or reduction shall be included with the benefit
45 provision to which it applies; and

46 (f) Each such form, including riders and endorsements,
47 shall be identified by a form number in the lower left-hand corner
48 of the first page thereof; and

49 (g) It contains no provision purporting to make any
50 portion of the charter, rules, constitution or bylaws of the
51 insurer a part of the policy unless such portion is set forth in
52 full in the policy, except in the case of the incorporation of, or
53 reference to, a statement of rates or classification of risks, or
54 short-rate table filed with the commissioner.

55 (2) No individual or group policy covering health and
56 accident insurance (including experience-rated insurance
57 contracts, indemnity contracts, self-insured plans and self-funded
58 plans), or any group combinations of these coverages, shall be
59 issued by any commercial insurer doing business in this state
60 which, by the terms of such policy, limits or excludes payment
61 because the individual or group insured is eligible for or is
62 being provided medical assistance under the Mississippi Medicaid

63 Law. Any such policy provision in violation of this section shall
64 be invalid.
65 (3) No individual or group policy covering health and
66 accident insurance, including experience-rated insurance
67 contracts, indemnity contracts, self-insured plans and self-funded
68 plans, or any group combinations of these coverages, shall be
69 issued by any commercial insurer doing business in this state
70 which, by the terms of such policy, limits or restricts the
71 insured's ability to assign the insured's benefits under the
72 policy to a health care provider that provides health care
73 services to the insured. Any such policy provision in violation
74 of this subsection shall be invalid.
75 (4) If any policy is issued by an insurer domiciled in this
76 state for delivery to a person residing in another state, and if
77 the official having responsibility for the administration of the
78 insurance laws of such other state shall have advised the
79 commissioner that any such policy is not subject to approval or
80 disapproval by such official, the commissioner may, by ruling,
81 require that such policy meet the standards set forth in
82 subsection (1) of this subsection and in Section 83-9-5.
83 (5) The commissioner shall collect and pay into the Special
84 Fund in the State Treasury designated as the "Insurance Department
85 Fund" the following fees for services provided under this section:

	FORM	FEE
86		
87–88	Each individual policy contract, including revisions	$15.00
89–90	Each group master policy or contract including revisions	15.00
91	Each rider, endorsement or amendment, etc.	10.00
92–94	Each insurance application where written application is required and is to be made a part of the policy or contract	10.00
95	Each questionnaire	7.00

96 Charge for resubmission where payment is
97 not included with original submission............ 5.00
98 Additional charge for tentative approval same as above.
99 **SECTION 2.** Section 83-9-5, Mississippi Code of 1972, is
100 amended as follows:
101 83-9-5. (1) **Required provisions.** Except as provided in
102 subsection (3) of this section, each such policy delivered or
103 issued for delivery to any person in this state shall contain the
104 provisions specified in this subsection in the words in which the
105 same appear in this section. However, the insurer may, at its
106 option, substitute for one or more of such provisions,
107 corresponding provisions of different wording approved by the
108 commissioner which are in each instance not less favorable in any
109 respect to the insured or the beneficiary. Such provisions shall
110 be preceded individually by the caption appearing in this
111 subsection or, at the option of the insurer, by such appropriate
112 individual or group captions or subcaptions as the commissioner
113 may approve.
114 As used in this section, the term "insurer" means a health
115 maintenance organization, an insurance company or any other entity
116 responsible for the payment of benefits under a policy or contract
117 of accident and sickness insurance; however, the term "insurer"
118 shall not mean a liquidator, rehabilitator, conservator or
119 receiver or third party administrator of any health maintenance
120 organization, insurance company or other entity responsible for
121 the payment of benefits which is in liquidation, rehabilitation or
122 conservation proceedings, nor shall it mean any responsible
123 guaranty association. Further, no cause of action shall accrue
124 against a liquidator, rehabilitator, conservator or receiver or
125 third-party administrator of any health maintenance organization,
126 insurance company or other entity responsible for the payment of
127 benefits which is in liquidation, rehabilitation or conservation
128 proceedings or any responsible guaranty association under

129 subsection (1)(h)3 of this section or any policy provision in
130 accordance therewith.
131 (a) A provision as follows:
132 Entire contract; changes: This policy, including the
133 endorsements and the attached papers, if any, constitutes the
134 entire contract of insurance. No change in this policy shall be
135 valid until approved by an executive officer of the insurer and
136 unless such approval be endorsed hereon or attached hereto. No
137 agent has authority to change this policy or to waive any of its
138 provisions.
139 (b) A provision as follows:
140 Time limit on certain defenses:
141 1. After two (2) years from the date of issue of
142 this policy, no misstatements, except fraudulent misstatements,
143 made by the applicant in the application for such policy shall be
144 used to void the policy or to deny a claim for loss incurred or
145 disability (as defined in the policy) commencing after the
146 expiration of such two-year period.
147 (The foregoing policy provision shall not be so construed as
148 to effect any legal requirement for avoidance of a policy or
149 denial of a claim during such initial two-year period, nor to
150 limit the application of <u>subsection</u> (2)(a) and (2)(b) of this
151 section in the event of misstatement with respect to age or
152 occupation.)
153 (A policy which the insured has the right to continue in
154 force subject to its terms by the timely payment of premium (1)
155 until at least age fifty (50) or, (2) in the case of a policy
156 issued after age forty-four (44), for at least five (5) years from
157 its date of issue, may contain in lieu of the foregoing the
158 following provision (from which the clause in parentheses may be
159 omitted at the insurer's option) under the caption
160 "INCONTESTABLE":

161 After this policy has been in force for a period of two (2)
162 years during the lifetime of the insured (excluding any period
163 during which the insured is disabled), it shall become
164 incontestable as to the statements in the application.)
165 2. No claim for loss incurred or disability (as
166 defined in the policy) commencing after two (2) years from the
167 date of issue of this policy shall be reduced or denied on the
168 ground that a disease or physical condition not excluded from
169 coverage by name or specific description effective on the date of
170 loss had existed prior to the effective date of coverage of this
171 policy.
172 (c) A provision as follows:
173 Grace period:
174 A grace period of seven (7) days for weekly premium policies,
175 ten (10) days for monthly premium policies and thirty-one (31)
176 days for all other policies will be granted for the payment of
177 each premium falling due after the first premium, during which
178 grace period the policy shall continue in force.
179 (A policy which contains a cancellation provision may add, at
180 the end of the above provision, "subject to the right of the
181 insurer to cancel in accordance with the cancellation provision
182 hereof."
183 A policy in which the insurer reserves the right to refuse
184 any renewal shall have, at the beginning of the above provision,
185 "unless not less than five (5) days prior to the premium due date
186 the insurer has delivered to the insured or has mailed to his last
187 address as shown by the records of the insurer written notice of
188 its intention not to renew this policy beyond the period for which
189 the premium has been accepted.")
190 (d) A provision as follows:
191 Reinstatement:
192 If any renewal premium be not paid within the time granted
193 the insured for payment, a subsequent acceptance of premium by the

194 insurer or by any agent duly authorized by the insurer to accept
195 such premium, without requiring in connection therewith an
196 application for reinstatement, shall reinstate the policy.
197 However, if the insurer or such agent requires an application for
198 reinstatement and issues a conditional receipt for the premium
199 tendered, the policy will be reinstated upon approval of such
200 application by the insurer or, lacking such approval, upon the
201 forty-fifth day following the date of such conditional receipt
202 unless the insurer has previously notified the insured in writing
203 of its disapproval of such application. The reinstated policy
204 shall cover only loss resulting from such accidental injury as may
205 be sustained after the date of reinstatement and loss due to such
206 sickness as may begin more than ten (10) days after such date. In
207 all other respects the insured and insurer shall have the same
208 rights thereunder as they had under the policy immediately before
209 the due date of the defaulted premium, subject to any provisions
210 endorsed hereon or attached hereto in connection with the
211 reinstatement. Any premium accepted in connection with a
212 reinstatement shall be applied to a period for which premium has
213 not been previously paid, but not to any period more than sixty
214 (60) days prior to the date of reinstatement. (The last sentence
215 of the above provision may be omitted from any policy which the
216 insured has the right to continue in force subject to its terms by
217 the timely payment of premiums (1) until at least age fifty (50)
218 or, (2) in the case of a policy issued after age forty-four (44),
219 for at least five (5) years from its date of issue.)
220 (e) A provision as follows:
221 Notice of claim:
222 Written notice of claim must be given to the insurer within
223 thirty (30) days after the occurrence or commencement of any loss
224 covered by the policy, or as soon thereafter as is reasonably
225 possible. Notice given by or on behalf of the insured or the
226 beneficiary to the insurer at ________________ (insert the

227 location of such office as the insurer may designate for the
228 purpose), or to any authorized agent of the insurer, with
229 information sufficient to identify the insured, shall be deemed
230 notice to the insurer.

231 (In a policy providing a loss-of-time benefit which may be
232 payable for at least two (2) years, an insurer may, at its option,
233 insert the following between the first and second sentences of the
234 above provision: "Subject to the qualifications set forth below,
235 if the insured suffers loss of time on account of disability for
236 which indemnity may be payable for at least two (2) years, he
237 shall, at least once in every six (6) months after having given
238 notice of claim, give to the insurer notice of continuance of said
239 disability, except in the event of legal incapacity. The period
240 of six (6) months following any filing of proof by the insured or
241 any payment by the insurer on account of such claim or any denial
242 of liability in whole or in part by the insurer shall be excluded
243 in applying this provision. Delay in the giving of such notice
244 shall not impair the insured's right to any indemnity which would
245 otherwise have accrued during the period of six (6) months
246 preceding the date on which such notice is actually given.")

247 (f) A provision as follows:

248 Claim forms:

249 The insurer, upon receipt of a notice of claim, will furnish
250 to the claimant such forms as are usually furnished by it for
251 filing proofs of loss. If such forms are not furnished within
252 fifteen (15) days after the giving of such notice, the claimant
253 shall be deemed to have complied with the requirements of this
254 policy as to proof of loss upon submitting, within the time fixed
255 in the policy for filing proofs of loss, written proof covering
256 the occurrence, the character and the extent of the loss for which
257 claim is made.

258 (g) A provision as follows:

259 Proofs of loss:

260 Written proof of loss must be furnished to the insurer at its
261 said office, in case of claim for loss for which this policy
262 provides any periodic payment contingent upon continuing loss,
263 within ninety (90) days after the termination of the period for
264 which the insurer is liable, and in case of claim for any other
265 loss, within ninety (90) days after the date of such loss.
266 Failure to furnish such proof within the time required shall not
267 invalidate or reduce any claim if it was not reasonably possible
268 to give proof within such time, provided such proof is furnished
269 as soon as reasonably possible and in no event, except in the
270 absence of legal capacity, later than one (1) year from the time
271 proof is otherwise required.

272 (h) A provision as follows:

273 Time of payment of claims:

274 1. All benefits payable under this policy for any
275 loss, other than loss for which this policy provides any periodic
276 payment, will be paid within twenty-five (25) days after receipt
277 of due written proof of such loss in the form of a clean claim
278 where claims are submitted electronically, and will be paid within
279 thirty-five (35) days after receipt of due written proof of such
280 loss in the form of clean claim where claims are submitted in
281 paper format. Benefits due under the policies and claims are
282 overdue if not paid within twenty-five (25) days or thirty-five
283 (35) days, whichever is applicable, after the insurer receives a
284 clean claim containing necessary medical information and other
285 information essential for the insurer to administer preexisting
286 condition, coordination of benefits and subrogation provisions. A
287 "clean claim" means a claim received by an insurer for
288 adjudication and which requires no further information, adjustment
289 or alteration by the provider of the services or the insured in
290 order to be processed and paid by the insurer. A claim is clean
291 if it has no defect or impropriety, including any lack of
292 substantiating documentation, or particular circumstance requiring

293 special treatment that prevents timely payment from being made on
294 the claim under this provision. A clean claim includes
295 resubmitted claims with previously identified deficiencies
296 corrected.
297 A clean claim does not include any of the following:
298 a. A duplicate claim, which means an original
299 claim and its duplicate when the duplicate is filed within thirty
300 (30) days of the original claim;
301 b. Claims which are submitted fraudulently or
302 that are based upon material misrepresentations;
303 c. Claims that require information essential
304 for the insurer to administer preexisting condition, coordination
305 of benefits or subrogation provisions; or
306 d. Claims submitted by a provider more than
307 thirty (30) days after the date of service; if the provider does
308 not submit the claim on behalf of the insured, then a claim is not
309 clean when submitted more than thirty (30) days after the date of
310 billing by the provider to the insured.
311 Not later than twenty-five (25) days after the date the
312 insurer actually receives an electronic claim, the insurer shall
313 pay the appropriate benefit in full, or any portion of the claim
314 that is clean, and notify the provider (where the claim is owed to
315 the provider) or the insured (where the claim is owed to the
316 insured) of the reasons why the claim or portion thereof is not
317 clean and will not be paid and what substantiating documentation
318 and information is required to adjudicate the claim as clean. Not
319 later than thirty-five (35) days after the date the insurer
320 actually receives a paper claim, the insurer shall pay the
321 appropriate benefit in full, or any portion of the claim that is
322 clean, and notify the provider (where the claim is owed to the
323 provider) or the insured (where the claim is owed to the insured)
324 of the reasons why the claim or portion thereof is not clean and
325 will not be paid and what substantiating documentation and

326 information is required to adjudicate the claim as clean. Any
327 claim or portion thereof resubmitted with the supporting
328 documentation and information requested by the insurer shall be
329 paid within twenty (20) days after receipt.

330 For purposes of this provision, the term "pay" means that the
331 insurer shall either send cash or a cash equivalent by United
332 States mail, or send cash or a cash equivalent by other means such
333 as electronic transfer, in full satisfaction of the appropriate
334 benefit due the provider (where the claim is owed to the provider)
335 or the insured (where the claim is owed to the insured). To
336 calculate the extent to which any benefits are overdue, payment
337 shall be treated as made on the date a draft or other valid
338 instrument was placed in the United States mail to the last known
339 address of the provider (where the claim is owed to the provider)
340 or the insured (where the claim is owed to the insured) in a
341 properly addressed, postpaid envelope, or, if not so posted, or
342 not sent by United States mail, on the date of delivery of payment
343 to the provider or insured.

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

350 3. If the claim is not denied for valid and proper
351 reasons by the end of the applicable time period prescribed in
352 this provision, the insurer must pay the provider (where the claim
353 is owed to the provider) or the insured (where the claim is owed
354 to the insured) interest on accrued benefits at the rate of one
355 and one-half percent (1-1/2%) per month accruing from the day
356 after payment was due on the amount of the benefits that remain
357 unpaid until the claim is finally settled or adjudicated.
358 Whenever interest due pursuant to this provision is less than One

359 Dollar ($1.00), such amount shall be credited to the account of
360 the person or entity to whom such amount is owed.
361 4. In the event the insurer fails to pay benefits
362 when due, the person entitled to such benefits may bring action to
363 recover such benefits, any interest which may accrue as provided
364 in subsection (1)(h)3 of this section and any other damages as may
365 be allowable by law.
366 (i) A provision as follows:
367 Payment of claims:
368 Indemnity for loss of life will be payable in accordance with
369 the beneficiary designation and the provisions respecting such
370 payment which may be prescribed herein and effective at the time
371 of payment. If no such designation or provision is then
372 effective, such indemnity shall be payable to the estate of the
373 insured. Any other accrued indemnities unpaid at the insured's
374 death may, at the option of the insurer, be paid either to such
375 beneficiary or to such estate. All other indemnities will be
376 payable to the insured. When payments of benefits are made to an
377 insured directly for medical care or services rendered by a health
378 care provider, the health care provider shall be notified of such
379 payment. The notification requirement shall not apply to a
380 fixed-indemnity policy, a limited benefit health insurance policy,
381 medical payment coverage or personal injury protection coverage in
382 a motor vehicle policy, coverage issued as a supplement to
383 liability insurance or workers' compensation. If the insured
384 provides the insurer with written direction that all or a portion
385 of any indemnities or benefits provided by the policy shall be
386 paid to a health care provider rendering hospital, nursing,
387 medical or surgical services, then the insurer shall pay directly
388 the health care provider rendering such services.
389 (The following provision * * * may be included with the
390 foregoing provision at the option of the insurer: "If any
391 indemnity of this policy shall be payable to the estate of the

392 insured, or to an insured or beneficiary who is a minor or
393 otherwise not competent to give a valid release, the insurer may
394 pay such indemnity, up to an amount not exceeding $______________
395 (insert an amount which must not exceed One Thousand Dollars
396 ($1,000.00)), to any relative by blood or connection by marriage
397 of the insured or beneficiary who is deemed by the insurer to be
398 equitably entitled thereto. Any payment made by the insurer in
399 good faith pursuant to this provision shall fully discharge the
400 insurer to the extent of such payment."

401 * * *

402 (j) A provision as follows:

403 Physical examinations:

404 The insurer at his own expense shall have the right and
405 opportunity to examine the person of the insured when and as often
406 as it may reasonably require during the pendency of a claim
407 hereunder.

408 (k) A provision as follows:

409 Legal actions:

410 No action at law or in equity shall be brought to recover on
411 this policy prior to the expiration of sixty (60) days after
412 written proof of loss has been furnished in accordance with the
413 requirements of this policy. No such action shall be brought
414 after the expiration of three (3) years after the time written
415 proof of loss is required to be furnished.

416 (l) A provision as follows:

417 Change of beneficiary:

418 Unless the insured makes an irrevocable designation of
419 beneficiary, the right to change the beneficiary is reserved to
420 the insured, and the consent of the beneficiary or beneficiaries
421 shall not be requisite to surrender or assignment of this policy,
422 or to any change of beneficiary or beneficiaries, or to any other
423 changes in this policy.

424 (The first clause of this provision, relating to the
425 irrevocable designation of beneficiary, may be omitted at the
426 insurer's option.)
427 (2) **Other provisions.** Except as provided in subsection (3)
428 of this section, no such policy delivered or issued for delivery
429 to any person in this state shall contain provisions respecting
430 the matters set forth below unless such provisions are in the
431 words in which the same appear in this section. However, the
432 insurer may, at its option, use in lieu of any such provision a
433 corresponding provision of different wording approved by the
434 commissioner which is not less favorable in any respect to the
435 insured or the beneficiary. Any such provision contained in the
436 policy shall be preceded individually by the appropriate caption
437 appearing in this subsection or, at the option of the insurer, by
438 such appropriate individual or group captions or subcaptions as
439 the commissioner may approve.
440 (a) A provision as follows:
441 Change of occupation:
442 If the insured be injured or contract sickness after having
443 changed his occupation to one classified by the insurer as more
444 hazardous than that stated in this policy or while doing for
445 compensation anything pertaining to an occupation so classified,
446 the insurer will pay only such portion of the indemnities provided
447 in this policy as the premium paid would have purchased at the
448 rates and within the limits fixed by the insurer for such more
449 hazardous occupation. If the insured changes his occupation to
450 one classified by the insurer as less hazardous than that stated
451 in this policy, the insurer, upon receipt of proof of such change
452 of occupation, will reduce the premium rate accordingly, and will
453 return the excess pro rata unearned premium from the date of
454 change of occupation or from the policy anniversary date
455 immediately preceding receipt of such proof, whichever is the most
456 recent. In applying this provision, the classification of

457 occupational risk and the premium rates shall be such as have been
458 last filed by the insurer prior to the occurrence of the loss for
459 which the insurer is liable, or prior to date of proof of change
460 in occupation, with the state official having supervision of
461 insurance in the state where the insured resided at the time this
462 policy was issued; but if such filing was not required, then the
463 classification of occupational risk and the premium rates shall be
464 those last made effective by the insurer in such state prior to
465 the occurrence of the loss or prior to the date of proof of change
466 in occupation.

467 (b) A provision as follows:

468 Misstatement of age:

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

472 (c) A provision as follows:

473 Relation of earnings to issuance:

474 If the total monthly amount of loss of time benefits promised
475 for the same loss under all valid loss of time coverage upon the
476 insured, whether payable on a weekly or monthly basis, shall
477 exceed the monthly earnings of the insured at the time disability
478 commenced or his average monthly earnings for the period of two
479 (2) years immediately preceding a disability for which claim is
480 made, whichever is the greater, the insurer will be liable only
481 for such proportionate amount of such benefits under this policy
482 as the amount of such monthly earnings or such average monthly
483 earnings of the insured bears to the total amount of monthly
484 benefits for the same loss under all such coverage upon the
485 insured at the time such disability commences and for the return
486 of such part of the premiums paid during such two (2) years as
487 shall exceed the pro rata amount of the premiums for the benefits
488 actually paid hereunder; but this shall not operate to reduce the
489 total monthly amount of benefits payable under all such coverage

490 upon the insured below the sum of Two Hundred Dollars ($200.00) or
491 the sum of the monthly benefits specified in such coverages,
492 whichever is the lesser, nor shall it operate to reduce benefits
493 other than those payable for loss of time.

494 (The foregoing policy provision may be inserted only in a
495 policy which the insured has the right to continue in force
496 subject to its terms by the timely payment of premiums (1) until
497 at least age fifty (50) or, (2) in the case of a policy issued
498 after age forty-four (44), for at least five (5) years from its
499 date of issue. The insurer may, at its option, include in this
500 provision a definition of "valid loss of time coverage," approved
501 as to form by the commissioner, which definition shall be limited
502 in subject matter to coverage provided by governmental agencies or
503 by organizations subject to regulations by insurance law or by
504 insurance authorities of this or any other state of the United
505 States or any province of Canada, or to any other coverage the
506 inclusion of which may be approved by the commissioner, or any
507 combination of such coverages. In the absence of such definition,
508 such term shall not include any coverage provided for such insured
509 pursuant to any compulsory benefit statute (including any workers'
510 compensation or employer's liability statute), or benefits
511 provided by union welfare plans or by employer or employee benefit
512 organizations.)

513 (d) A provision as follows:

514 Unpaid premium:

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

518 (e) A provision as follows:

519 Cancellation:

520 The insurer may cancel this policy at any time by written
521 notice delivered to the insured, or mailed to his last address as
522 shown by the records of the insurer, stating when, not less than

523 five (5) days thereafter, such cancellation shall be effective;
524 and after the policy has been continued beyond its original term,
525 the insured may cancel this policy at any time by written notice
526 delivered or mailed to the insurer, effective upon receipt or on
527 such later date as may be specified in such notice. In the event
528 of cancellation, the insurer will return promptly the unearned
529 portion of any premium paid. If the insured cancels, the earned
530 premium shall be computed by the use of the short-rate table last
531 filed with the state official having supervision of insurance in
532 the state where the insured resided when the policy was issued.
533 If the insurer cancels, the earned premium shall be computed pro
534 rata. Cancellation shall be without prejudice to any claim
535 originating prior to the effective date of cancellation.

536 (f) A provision as follows:

537 Conformity with state statutes:

538 Any provision of this policy which, on its effective date, is
539 in conflict with the statutes of the state in which the insured
540 resides on such date is hereby amended to conform to the minimum
541 requirements of such statutes.

542 (g) A provision as follows:

543 Illegal occupation:

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

548 (h) A provision as follows:

549 Intoxicants and narcotics:

550 The insurer shall not be liable for any loss sustained or
551 contracted in consequence of the insured's being intoxicated or
552 under the influence of any narcotic unless administered on the
553 advice of a physician.

554 (3) **Inapplicable or inconsistent provisions.** If any
555 provision of this section is in whole or in part inapplicable to

556 or inconsistent with the coverage provided by a particular form of
557 policy, the insurer, with the approval of the commissioner, shall
558 omit from such policy any inapplicable provision or part of a
559 provision, and shall modify any inconsistent provision or part of
560 the provision in such manner as to make the provision as contained
561 in the policy consistent with the coverage provided by the policy.
562 (4) **Order of certain policy provisions.** The provisions
563 which are the subject of subsections (1) and (2) of this section,
564 or any corresponding provisions which are used in lieu thereof in
565 accordance with such subsections, shall be printed in the
566 consecutive order of the provisions in such subsections or, at the
567 option of the insurer, any such provision may appear as a unit in
568 any part of the policy, with other provisions to which it may be
569 logically related, provided the resulting policy shall not be in
570 whole or in part unintelligible, uncertain, ambiguous, abstruse or
571 likely to mislead a person to whom the policy is offered,
572 delivered or issued.
573 (5) **Third-party ownership.** The word "insured," as used in
574 Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, shall
575 not be construed as preventing a person other than the insured
576 with a proper insurable interest from making application for and
577 owning a policy covering the insured, or from being entitled under
578 such a policy to any indemnities, benefits and rights provided
579 therein.
580 (6) **Requirements of other jurisdictions.**
581 (a) Any policy of a foreign or alien insurer, when
582 delivered or issued for delivery to any person in this state, may
583 contain any provision which is not less favorable to the insured
584 or the beneficiary than the provisions of Sections 83-9-1 through
585 83-9-21, Mississippi Code of 1972, and which is prescribed or
586 required by the law of the state under which the insurer is
587 organized.

588 (b) Any policy of a domestic insurer may, when issued
589 for delivery in any other state or country, contain any provision
590 permitted or required by the laws of such other state or country.
591 (7) **Filing procedure.** The commissioner may make such
592 reasonable rules and regulations concerning the procedure for the
593 filing or submission of policies subject to the cited sections as
594 are necessary, proper or advisable to the administration of said
595 sections. This provision shall not abridge any other authority
596 granted the commissioner by law.
597 (8) **Administrative penalties.**
598 (a) If the commissioner finds that an insurer, during
599 any calendar year, has paid at least eighty-five percent (85%),
600 but less than ninety-five percent (95%), of all clean claims
601 received from all providers during that year in accordance with
602 the provisions of subsection (1)(h) of this section, the
603 commissioner may levy an aggregate penalty in an amount not to
604 exceed Ten Thousand Dollars ($10,000.00). If the commissioner
605 finds that an insurer, during any calendar year, has paid at least
606 fifty percent (50%), but less than eighty-five percent (85%), of
607 all clean claims received from all providers during that year in
608 accordance with the provisions of subsection (1)(h) of this
609 section, the commissioner may levy an aggregate penalty in an
610 amount of not less than Ten Thousand Dollars ($10,000.00) nor more
611 than One Hundred Thousand Dollars ($100,000.00). If the
612 commissioner finds that an insurer, during any calendar year, has
613 paid less than fifty percent (50%) of all clean claims received
614 from all providers during that year in accordance with the
615 provisions of subsection (1)(h) of this section, the commissioner
616 may levy an aggregate penalty in an amount not less than One
617 Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred
618 Thousand Dollars ($200,000.00). In determining the amount of any
619 fine, the commissioner shall take into account whether the failure
620 to achieve the standards in subsection (1)(h) of this section were

621 due to circumstances beyond the control of the insurer. The
622 insurer may request an administrative hearing to contest the
623 assessment of any administrative penalty imposed by the
624 commissioner pursuant to this subsection within thirty (30) days
625 after receipt of the notice of assessment.
626 (b) Examinations to determine compliance with
627 subsection (1)(h) of this section may be conducted by the
628 commissioner or any of his examiners. The commissioner may
629 contract with qualified impartial outside sources to assist in
630 examinations to determine compliance. The expenses of any such
631 examinations shall be paid by the insurer examined.
632 (c) Nothing in the provisions of subsection (1)(h) of
633 this section shall require an insurer to pay claims that are not
634 covered under the terms of a contract or policy of accident and
635 sickness insurance.
636 (d) An insurer and a provider may enter into an express
637 written agreement containing timely claim payment provisions which
638 differ from, but are at least as stringent as, the provisions set
639 forth under subsection (1)(h) of this section, and in such case,
640 the provisions of the written agreement shall govern the timely
641 payment of claims by the insurer to the provider. If the express
642 written agreement is silent as to any interest penalty where
643 claims are not paid in accordance with the agreement, the interest
644 penalty provision of subsection (1)(h)3 of this section shall
645 apply.
646 (e) The commissioner may adopt rules and regulations
647 necessary to ensure compliance with this subsection.
648 **SECTION 3.** This act shall take effect and be in force from
649 and after July 1, 2006.

ST: Health insurance; prohibit issuance of policy restricting insurer from assigning benefits to provider.