

By: Representatives Steverson, Currie, Bain, Baria, Barnett, Barton, Cockerham, Crawford, Dixon, Evans (45th), Hale, Holland, Hughes, Lamar, Massengill, Miles, Morgan, Powell, Roberson, Rogers (14th), Sanford, Touchstone, White, Willis To: Insurance

HOUSE BILL NO. 507

1 AN ACT TO REQUIRE HEALTH INSURANCE POLICIES WHICH PROVIDE
2 PREGNANCY RELATED BENEFITS TO PROVIDE COVERAGE FOR MEDICALLY
3 NECESSARY EXPENSES OF DIAGNOSIS AND TREATMENT OF INFERTILITY; TO
4 REQUIRE THAT CERTAIN INSURANCE POLICIES AND CONTRACTS SHALL
5 PROVIDE COVERAGE FOR ANNUAL PAP SMEARS AND BIENNIAL BONE DENSITY
6 TESTS; TO AMEND SECTION 25-15-9, MISSISSIPPI CODE OF 1972, TO
7 REQUIRE THE STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE PLAN TO
8 INCLUDE COVERAGE FOR ANNUAL PAP SMEARS AND BIENNIAL BONE DENSITY
9 TESTS; AND FOR RELATED PURPOSES.

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

11 SECTION 1. (1) Except as otherwise provided in this
12 section, a health insurance policy covering persons residing in
13 Mississippi which provides pregnancy related benefits must provide
14 coverage to the same extent for which pregnancy-related
15 procedures, coverage for medically necessary expenses of diagnosis
16 and treatment of infertility including the following: artificial
17 insemination; in vitro fertilization; sperm, egg and/or
18 inseminated egg procurement and processing and banking of sperm or
19 eggs, to the extent such costs are not covered by the patient's
20 insurer, if any; intra-cytoplasmic sperm injection; assisted



21 hatching and cryopreservation of eggs, sperm or embryo; and fresh  
22 and/or subsequent frozen embryo transfers.

23 (2) Coverage under this section shall be included in health  
24 insurance policies that are delivered, executed, issued, amended,  
25 adjusted, or renewed in this state, or outside this state if  
26 insuring residents of this state, on or after July 1, 2017. No  
27 insurer can terminate coverage, or refuse to deliver, execute,  
28 issue, amend, adjust or renew coverage to an individual solely  
29 because the individual is diagnosed with or has received treatment  
30 for infertility.

31 (3) Coverage of assisted reproductive technology procedures  
32 under this section include coverage of three (3) cycles of  
33 intrauterine insemination and three (3) cycles of in vitro  
34 fertilization.

35 (4) The benefits of coverage for infertility treatment shall  
36 be subject to the same deductibles, coinsurance and out-of-pocket  
37 limitations as under maternity benefit coverage.

38 (5) Coverage shall be provided to married females and males.

39 (6) Policies must provide diagnostic tests and procedures  
40 that include, but are not limited to, the following:

41 (a) Hysterosalpingogram;

42 (b) Hysteroscopy;

43 (c) Endometrial biopsy;

44 (d) Laparoscopy;

45 (e) Laparotomy;



- 46 (f) Sono-hysteroqram;
- 47 (g) Surigical sperm retrieval including testis biopsy;
- 48 (h) Semen analysis;
- 49 (i) Blood tests/hormonal analysis laboratory tests; and
- 50 (j) Ultrasounds.

51 Diagnostic and exploratory procedures shall be covered, including  
52 surgical procedures to correct the medically diagnosed disease or  
53 condition of the reproductive organs, including but not limited  
54 to: endometriosis, disorders affecting the function of the  
55 fallopian tubes, testicular failure, uterine anomalies and pelvic  
56 adhesive disease.

57 (7) Every policy that provides for prescription drug  
58 coverage shall also include drugs (approved by the FDA in the  
59 treatment of infertility) for use in the diagnosis and treatment  
60 of fertility. Insurers shall not impose any exclusions,  
61 limitations or other restrictions on coverage of infertility drugs  
62 that are different from those imposed on any other prescription  
63 drugs, nor shall they impose deductibles, copayment, coinsurance,  
64 benefit maximums, waiting periods or any other limitations on  
65 coverage for required infertility benefits which are different  
66 from those imposed upon benefits for services not related to  
67 infertility.

68 (8) Coverage shall include medically necessary expenses for  
69 standard fertility preservation services when a necessary medical  
70 treatment may directly or indirectly cause iatrogenic infertility



71 to a covered person. As used in this section, "iatrogenic  
72 infertility" means an impairment of fertility by surgery,  
73 radiation, chemotherapy or other medical treatment affecting  
74 reproductive organs or processes.

75 (9) As used in this section, "infertility" means a disease,  
76 defined by the failure to achieve a successful pregnancy after  
77 twelve (12) months or more appropriate, unprotected intercourse or  
78 therapeutic donor insemination. Earlier evaluation and treatment  
79 may be justified based on medical history and physical findings  
80 and is warranted after six (6) months for women over thirty-five  
81 (35) years of age.

82 (10) As used in this section, "health insurance policy"  
83 includes all individual and group health insurance policies  
84 providing coverage on an expense-incurred basis, individual and  
85 group service or indemnity type contracts issued by a nonprofit  
86 corporation, and individual and group service contracts issued by  
87 a health maintenance organization or preferred provider  
88 organization.

89 (11) This section does not apply to self-insured group  
90 arrangements, including the State Health Insurance Plan for  
91 employees of the State of Mississippi.

92 (12) Coverage required under this section must be for the  
93 policyholder and the spouse of the policyholder if the spouse is a  
94 covered person under the policy.



95 (13) Fertilization covered under this section shall only  
96 include fertilization of the covered person's eggs with the  
97 spouse's sperm.

98 **SECTION 2.** Procedures under Section 1 of this act must be  
99 performed at a facility certified by the College of American  
100 Pathologists and/or American Association of Bioanalysis and must  
101 conform with the American College of Obstetricians and  
102 Gynecologists and the American Society of Reproductive Medicine  
103 guidelines.

104 **SECTION 3.** (1) All individual and group health insurance  
105 policies providing coverage on an expense-incurred basis,  
106 individual and group service or indemnity type contracts issued by  
107 a nonprofit corporation, individual and group service contracts  
108 issued by a health maintenance organization, all self-insured  
109 group arrangements to the extent not preempted by federal law and  
110 all managed health care delivery entities of any type or  
111 description that are delivered, issued for delivery, continued or  
112 renewed on or after July 1, 2017, and providing coverage to any  
113 resident of this state shall provide coverage or benefits for  
114 annual pap smears and biennial bone density tests. The coverage  
115 required under this section shall meet the requirements set forth  
116 in subsection (2) of this section.

117 (2) An individual shall not be required to pay an additional  
118 deductible or coinsurance for screening or testing that is greater  
119 than an annual deductible or coinsurance established for similar



120 benefits. If the program or contract does not cover a similar  
121 benefit, a deductible or coinsurance may not be set at a level  
122 that materially diminishes the value of the pap smear or bone  
123 density test required. Reimbursement to health care providers for  
124 pap smear or bone density test provided under this section shall  
125 be equal to or greater than reimbursement to health care providers  
126 provided under Title XVII of the Social Security Act (Medicare).

127 (3) A group health plan or health insurance issuer is not  
128 required under this section to provide for a referral to a  
129 nonparticipating health care provider unless the plan or issuer  
130 does not have an appropriate health care provider that is  
131 available and accessible to administer the screening or testing  
132 exam and that is a participating health care provider with respect  
133 to that treatment.

134 (4) If a plan or issuer refers an individual to a  
135 nonparticipating health care provider in accordance with this  
136 section, services provided according to the approved screening or  
137 testing exam and resulting treatment, if any, shall be provided at  
138 no additional cost to the individual beyond what the individual  
139 would otherwise pay for services received by a participating  
140 health care provider.

141 **SECTION 4.** Section 25-15-9, Mississippi Code of 1972, is  
142 amended as follows:

143 25-15-9. (1) (a) The board shall design a plan of health  
144 insurance for state employees that provides benefits for



145 semiprivate rooms in addition to other incidental coverages that  
146 the board deems necessary. The amount of the coverages shall be  
147 in such reasonable amount as may be determined by the board to be  
148 adequate, after due consideration of current health costs in  
149 Mississippi. The plan shall also include major medical benefits  
150 in such amounts as the board determines. The plan shall provide  
151 for coverage for telemedicine services as provided in Section  
152 83-9-351. The plan shall also include coverage for annual pap  
153 smears and biennial bone density tests. The board is also  
154 authorized to accept bids for such alternate coverage and optional  
155 benefits as the board deems proper. The board is authorized to  
156 accept bids for surgical services that include assistance in  
157 locating a surgeon, setting up initial consultation, travel, a  
158 negotiated single case rate bundle and payment for orthopedic,  
159 spine, bariatric, cardiovascular and general surgeries. The  
160 surgical services may only utilize surgeons and facilities located  
161 in the State of Mississippi unless otherwise provided by the  
162 board. Any contract for alternative coverage and optional  
163 benefits shall be awarded by the board after it has carefully  
164 studied and evaluated the bids and selected the best and most  
165 cost-effective bid. The board may reject all of the bids;  
166 however, the board shall notify all bidders of the rejection and  
167 shall actively solicit new bids if all bids are rejected. The  
168 board may employ or contract for such consulting or actuarial  
169 services as may be necessary to formulate the plan, and to assist



170 the board in the preparation of specifications and in the process  
171 of advertising for the bids for the plan. Those contracts shall  
172 be solicited and entered into in accordance with Section 25-15-5.  
173 The board shall keep a record of all persons, agents and  
174 corporations who contract with or assist the board in preparing  
175 and developing the plan. The board in a timely manner shall  
176 provide copies of this record to the members of the advisory  
177 council created in this section and those legislators, or their  
178 designees, who may attend meetings of the advisory council. The  
179 board shall provide copies of this record in the solicitation of  
180 bids for the administration or servicing of the self-insured  
181 program. Each person, agent or corporation that, during the  
182 previous fiscal year, has assisted in the development of the plan  
183 or employed or compensated any person who assisted in the  
184 development of the plan, and that bids on the administration or  
185 servicing of the plan, shall submit to the board a statement  
186 accompanying the bid explaining in detail its participation with  
187 the development of the plan. This statement shall include the  
188 amount of compensation paid by the bidder to any such employee  
189 during the previous fiscal year. The board shall make all such  
190 information available to the members of the advisory council and  
191 those legislators, or their designees, who may attend meetings of  
192 the advisory council before any action is taken by the board on  
193 the bids submitted. The failure of any bidder to fully and  
194 accurately comply with this paragraph shall result in the





195 rejection of any bid submitted by that bidder or the cancellation  
196 of any contract executed when the failure is discovered after the  
197 acceptance of that bid. The board is authorized to promulgate  
198 rules and regulations to implement the provisions of this  
199 subsection.

200 The board shall develop plans for the insurance plan  
201 authorized by this section in accordance with the provisions of  
202 Section 25-15-5.

203 Any corporation, association, company or individual that  
204 contracts with the board for the third-party claims administration  
205 of the self-insured plan shall prepare and keep on file an  
206 explanation of benefits for each claim processed. The explanation  
207 of benefits shall contain such information relative to each  
208 processed claim that the board deems necessary, and, at a minimum,  
209 each explanation shall provide the claimant's name, claim number,  
210 provider number, provider name, service dates, type of services,  
211 amount of charges, amount allowed to the claimant and reason  
212 codes. The information contained in the explanation of benefits  
213 shall be available for inspection upon request by the board. The  
214 board shall have access to all claims information utilized in the  
215 issuance of payments to employees and providers.

216 (b) There is created an advisory council to advise the  
217 board in the formulation of the State and School Employees Health  
218 Insurance Plan. The council shall be composed of the State  
219 Insurance Commissioner, or his designee, an



220 employee-representative of the institutions of higher learning  
221 appointed by the board of trustees thereof, an  
222 employee-representative of the Department of Transportation  
223 appointed by the director thereof, an employee-representative of  
224 the Department of Revenue appointed by the Commissioner of  
225 Revenue, an employee-representative of the Mississippi Department  
226 of Health appointed by the State Health Officer, an  
227 employee-representative of the Mississippi Department of  
228 Corrections appointed by the Commissioner of Corrections, and an  
229 employee-representative of the Department of Human Services  
230 appointed by the Executive Director of Human Services, two (2)  
231 certificated public school administrators appointed by the State  
232 Board of Education, two (2) certificated classroom teachers  
233 appointed by the State Board of Education, a noncertificated  
234 school employee appointed by the State Board of Education and a  
235 community/junior college employee appointed by the Mississippi  
236 Community College Board.

237         The Lieutenant Governor may designate the Secretary of the  
238 Senate, the Chairman of the Senate Appropriations Committee, the  
239 Chairman of the Senate Education Committee and the Chairman of the  
240 Senate Insurance Committee, and the Speaker of the House of  
241 Representatives may designate the Clerk of the House, the Chairman  
242 of the House Appropriations Committee, the Chairman of the House  
243 Education Committee and the Chairman of the House Insurance  
244 Committee, to attend any meeting of the State and School Employees



245 Insurance Advisory Council. The appointing authorities may  
246 designate an alternate member from their respective houses to  
247 serve when the regular designee is unable to attend the meetings  
248 of the council. Those designees shall have no jurisdiction or  
249 vote on any matter within the jurisdiction of the council. For  
250 attending meetings of the council, the legislators shall receive  
251 per diem and expenses, which shall be paid from the contingent  
252 expense funds of their respective houses in the same amounts as  
253 provided for committee meetings when the Legislature is not in  
254 session; however, no per diem and expenses for attending meetings  
255 of the council will be paid while the Legislature is in session.  
256 No per diem and expenses will be paid except for attending  
257 meetings of the council without prior approval of the proper  
258 committee in their respective houses.

259 (c) No change in the terms of the State and School  
260 Employees Health Insurance Plan may be made effective unless the  
261 board, or its designee, has provided notice to the State and  
262 School Employees Health Insurance Advisory Council and has called  
263 a meeting of the council at least fifteen (15) days before the  
264 effective date of the change. If the State and School Employees  
265 Health Insurance Advisory Council does not meet to advise the  
266 board on the proposed changes, the changes to the plan shall  
267 become effective at such time as the board has informed the  
268 council that the changes shall become effective.



269                   (d) **Medical benefits for retired employees and**  
270 **dependents under age sixty-five (65) years and not eligible for**  
271 **Medicare benefits.** For employees who retire before July 1, 2005,  
272 and for employees retiring due to work-related disability under  
273 the Public Employees' Retirement System, the same health insurance  
274 coverage as for all other active employees and their dependents  
275 shall be available to retired employees and all dependents under  
276 age sixty-five (65) years who are not eligible for Medicare  
277 benefits, the level of benefits to be the same level as for all  
278 other active participants. For employees who retire on or after  
279 July 1, 2005, and not retiring due to work-related disability  
280 under the Public Employees' Retirement System, the same health  
281 insurance coverage as for all other active employees and their  
282 dependents shall be available to those retiring employees and all  
283 dependents under age sixty-five (65) years who are not eligible  
284 for Medicare benefits only if the retiring employees were  
285 participants in the State and School Employees Health Insurance  
286 Plan for four (4) years or more before their retirement, the level  
287 of benefits to be the same level as for all other active  
288 participants. This section will apply to those employees who  
289 retire due to one hundred percent (100%) medical disability as  
290 well as those employees electing early retirement.

291                   (e) **Medical benefits for retired employees and**  
292 **dependents over age sixty-five (65) years or otherwise eligible**  
293 **for Medicare benefits.** For employees who retire before July 1,



294 2005, and for employees retiring due to work-related disability  
295 under the Public Employees' Retirement System, the health  
296 insurance coverage available to retired employees over age  
297 sixty-five (65) years or otherwise eligible for Medicare benefits,  
298 and all dependents over age sixty-five (65) years or otherwise  
299 eligible for Medicare benefits, shall be the major medical  
300 coverage. For employees retiring on or after July 1, 2005, and  
301 not retiring due to work-related disability under the Public  
302 Employees' Retirement System, the health insurance coverage  
303 described in this paragraph (e) shall be available to those  
304 retiring employees only if they were participants in the State and  
305 School Employees Health Insurance Plan for four (4) years or more  
306 and are over age sixty-five (65) years or otherwise eligible for  
307 Medicare benefits, and to all dependents over age sixty-five (65)  
308 years or otherwise eligible for Medicare benefits. Benefits shall  
309 be reduced by Medicare benefits as though the Medicare benefits  
310 were the base plan.

311 All covered individuals shall be assumed to have full  
312 Medicare coverage, Parts A and B; and any Medicare payments under  
313 both Parts A and B shall be computed to reduce benefits payable  
314 under this plan.

315 (f) Lifetime maximum: The lifetime maximum amount of  
316 benefits payable under the health insurance plan for each  
317 participant is Two Million Dollars (\$2,000,000.00).



318           (2) Nonduplication of benefits – reduction of benefits by  
319 Title XIX benefits: When benefits would be payable under more  
320 than one (1) group plan, benefits under those plans will be  
321 coordinated to the extent that the total benefits under all plans  
322 will not exceed the total expenses incurred.

323           Benefits for hospital or surgical or medical benefits shall  
324 be reduced by any similar benefits payable in accordance with  
325 Title XIX of the Social Security Act or under any amendments  
326 thereto, or any implementing legislation.

327           Benefits for hospital or surgical or medical benefits shall  
328 be reduced by any similar benefits payable by workers'  
329 compensation.

330           No health care benefits under the state plan shall restrict  
331 coverage for medically appropriate treatment prescribed by a  
332 physician and agreed to by a fully informed insured, or if the  
333 insured lacks legal capacity to consent by a person who has legal  
334 authority to consent on his or her behalf, based on an insured's  
335 diagnosis with a terminal condition. As used in this paragraph,  
336 "terminal condition" means any aggressive malignancy, chronic  
337 end-stage cardiovascular or cerebral vascular disease, or any  
338 other disease, illness or condition which physician diagnoses as  
339 terminal.

340           Not later than January 1, 2016, the state health plan shall  
341 not require a higher co-payment, deductible or coinsurance amount  
342 for patient-administered anti-cancer medications, including, but



343 not limited to, those orally administered or self-injected, than  
344 it requires for anti-cancer medications that are injected or  
345 intravenously administered by a health care provider, regardless  
346 of the formulation or benefit category determination by the plan.  
347 For the purposes of this paragraph, the term "anti-cancer  
348 medications" has the meaning as defined in Section 83-9-24.

349 (3) (a) Schedule of life insurance benefits – group term:  
350 The amount of term life insurance for each active employee of a  
351 department, agency or institution of the state government shall  
352 not be in excess of One Hundred Thousand Dollars (\$100,000.00), or  
353 twice the amount of the employee's annual wage to the next highest  
354 One Thousand Dollars (\$1,000.00), whichever may be less, but in no  
355 case less than Thirty Thousand Dollars (\$30,000.00), with a like  
356 amount for accidental death and dismemberment on a  
357 twenty-four-hour basis. The plan will further contain a premium  
358 waiver provision if a covered employee becomes totally and  
359 permanently disabled before age sixty-five (65) years. Employees  
360 retiring after June 30, 1999, shall be eligible to continue life  
361 insurance coverage in an amount of Five Thousand Dollars  
362 (\$5,000.00), Ten Thousand Dollars (\$10,000.00) or Twenty Thousand  
363 Dollars (\$20,000.00) into retirement.

364 (b) Effective October 1, 1999, schedule of life  
365 insurance benefits – group term: The amount of term life  
366 insurance for each active employee of any school district,  
367 community/junior college, public library or university-based



368 program authorized under Section 37-23-31 for deaf, aphasic and  
369 emotionally disturbed children or any regular nonstudent bus  
370 driver shall not be in excess of One Hundred Thousand Dollars  
371 (\$100,000.00), or twice the amount of the employee's annual wage  
372 to the next highest One Thousand Dollars (\$1,000.00), whichever  
373 may be less, but in no case less than Thirty Thousand Dollars  
374 (\$30,000.00), with a like amount for accidental death and  
375 dismemberment on a twenty-four-hour basis. The plan will further  
376 contain a premium waiver provision if a covered employee of any  
377 school district, community/junior college, public library or  
378 university-based program authorized under Section 37-23-31 for  
379 deaf, aphasic and emotionally disturbed children or any regular  
380 nonstudent bus driver becomes totally and permanently disabled  
381 before age sixty-five (65) years. Employees of any school  
382 district, community/junior college, public library or  
383 university-based program authorized under Section 37-23-31 for  
384 deaf, aphasic and emotionally disturbed children or any regular  
385 nonstudent bus driver retiring after September 30, 1999, shall be  
386 eligible to continue life insurance coverage in an amount of Five  
387 Thousand Dollars (\$5,000.00), Ten Thousand Dollars (\$10,000.00) or  
388 Twenty Thousand Dollars (\$20,000.00) into retirement.

389 (4) Any eligible employee who on March 1, 1971, was  
390 participating in a group life insurance program that has  
391 provisions different from those included in this article and for  
392 which the State of Mississippi was paying a part of the premium





393 may, at his discretion, continue to participate in that plan. The  
394 employee shall pay in full all additional costs, if any, above the  
395 minimum program established by this article. Under no  
396 circumstances shall any individual who begins employment with the  
397 state after March 1, 1971, be eligible for the provisions of this  
398 subsection.

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

401 (6) Any premium differentials, differences in coverages,  
402 discounts determined by risk or by any other factors shall be  
403 uniformly applied to all active employees participating in the  
404 insurance plan. It is the intent of the Legislature that the  
405 state contribution to the plan be the same for each employee  
406 throughout the state.

407 (7) On October 1, 1999, any school district,  
408 community/junior college district or public library may elect to  
409 remain with an existing policy or policies of group life insurance  
410 with an insurance company approved by the State and School  
411 Employees Health Insurance Management Board, in lieu of  
412 participation in the State and School Life Insurance Plan. On or  
413 after July 1, 2004, until October 1, 2004, any school district,  
414 community/junior college district or public library may elect to  
415 choose a policy or policies of group life insurance existing on  
416 October 1, 1999, with an insurance company approved by the State  
417 and School Employees Health Insurance Management Board in lieu of



418 participation in the State and School Life Insurance Plan. The  
419 state's contribution of up to fifty percent (50%) of the active  
420 employee's premium under the State and School Life Insurance Plan  
421 may be applied toward the cost of coverage for full-time employees  
422 participating in the approved life insurance company group plan.  
423 For purposes of this subsection (7), "life insurance company group  
424 plan" means a plan administered or sold by a private insurance  
425 company. After October 1, 1999, the board may assess charges in  
426 addition to the existing State and School Life Insurance Plan  
427 rates to such employees as a condition of enrollment in the State  
428 and School Life Insurance Plan. In order for any life insurance  
429 company group plan to be approved by the State and School  
430 Employees Health Insurance Management Board under this subsection  
431 (7), it shall meet the following criteria:

432 (a) The insurance company offering the group life  
433 insurance plan shall be rated "A-" or better by A.M. Best state  
434 insurance rating service and be licensed as an admitted carrier in  
435 the State of Mississippi by the Mississippi Department of  
436 Insurance.

437 (b) The insurance company group life insurance plan  
438 shall provide the same life insurance, accidental death and  
439 dismemberment insurance and waiver of premium benefits as provided  
440 in the State and School Life Insurance Plan.



441 (c) The insurance company group life insurance plan  
442 shall be fully insured, and no form of self-funding life insurance  
443 by the company shall be approved.

444 (d) The insurance company group life insurance plan  
445 shall have one (1) composite rate per One Thousand Dollars  
446 (\$1,000.00) of coverage for active employees regardless of age and  
447 one (1) composite rate per One Thousand Dollars (\$1,000.00) of  
448 coverage for all retirees regardless of age or type of retiree.

449 (e) The insurance company and its group life insurance  
450 plan shall comply with any administrative requirements of the  
451 State and School Employees Health Insurance Management Board. If  
452 any insurance company providing group life insurance benefits to  
453 employees under this subsection (7) fails to comply with any  
454 requirements specified in this subsection or any administrative  
455 requirements of the board, the state shall discontinue providing  
456 funding for the cost of that insurance.

457 **SECTION 5.** This act shall take effect and be in force from  
458 and after July 1, 2017.

