MISSISSIPPI LEGISLATURE REGULAR SESSION 2018

By: Representative Dortch

To: Insurance

HOUSE BILL NO. 76

1 AN ACT TO REQUIRE CERTAIN CONSUMER INFORMATION CONCERNING
2 FACILITY-BASED PHYSICIANS AND NOTICE AND AVAILABILITY OF MEDIATION
3 FOR BALANCE BILLING BY A FACILITY-BASED PHYSICIAN IN AN AMOUNT
4 GREATER THAN TWO HUNDRED FIFTY DOLLARS; TO BRING FORWARD SECTION
5 25-15-17, MISSISSIPPI CODE OF 1972, FOR PURPOSES OF POSSIBLE
6 AMENDMENT; TO AMEND SECTION 83-9-5, MISSISSIPPI CODE OF 1972, TO
7 MAKE SOME MINOR NONSUBSTANTIVE CHANGES; AND FOR RELATED PURPOSES.

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

9 **SECTION 1.** (1) "Facility-based physician" means a
10 radiologist, anesthesiologist, pathologist, emergency department
11 physician, neonatologist or assistant surgeon to whom the facility
12 has granted clinical privileges and who provides services to
13 patients of the facility under those clinical privileges.

14 (2) A facility-based physician who bills a patient covered
15 by a preferred provider benefit plan or a health benefit plan that
16 does not have a contract with the facility-based physician shall
17 send a billing statement to the patient that contains a
18 conspicuous, plain-language explanation of the mandatory mediation
19 process available under subsection (3) of this section if the
20 amount for which the enrollee is responsible to the physician,

21 after copayments, deductibles, and coinsurance, including the
22 amount unpaid by the administrator or insurer, is greater than Two
23 Hundred Fifty Dollars ($250.00).

24 (3) An enrollee may request mediation of a settlement of an
25 out-of-network health benefit claim if:

26 (a) The amount for which the enrollee is responsible to
27 a facility-based physician, after copayments, deductibles and
28 coinsurance, including the amount unpaid by the administrator or
29 insurer, is greater than Two Hundred Fifty Dollars ($250.00); and

30 (b) The health benefit claim is for a medical service
31 or supply provided by a facility-based physician in a hospital
32 that is a preferred provider or that has a contract with the
33 administrator.

34 (4) This section applies only to charges for a medical
35 service or supply provided on or after July 1, 2018. Charges for
36 a medical service or supply provided before July 1, 2018, are
37 governed by the law as it existed immediately before that date.

38 **SECTION 2.** Section 25-15-17, Mississippi Code of 1972, is
39 brought forward as follows:

40 25-15-17. (1) Any benefits payable under the plan may be
41 made either directly to the attending physicians, hospitals,
42 medical groups, or others furnishing the services upon which a
43 claim is based, or to the covered employee, upon presentation of
44 valid bills for such services, subject to subsection (3) of this
45 section and such provisions to facilitate payment as may be made

46 by the board. All benefits payable under this plan shall be
47 payable directly to the covered employee unless such covered
48 employee shall make a valid assignment in accordance with
49 subsection (3) of this section.
50 (2) The plan may not, by its terms, limit or restrict the
51 covered employee's ability to assign the covered employee's
52 benefits under the policy to a licensed health care provider that
53 provides health care services to the covered employee. Any such
54 plan provision in violation of this subsection shall be invalid.
55 (3) If the covered employee provides the board with written
56 direction that all or a portion of any indemnities or benefits
57 provided by the plan be paid to a licensed health care provider
58 rendering hospital, nursing, medical or surgical services, then
59 the plan shall pay directly the licensed health care provider
60 rendering such services. That payment shall be considered payment
61 in full to the provider, who may not bill or collect from the
62 covered employee any amount above that payment, other than the
63 deductible, coinsurance, copayment or other charges for equipment
64 or services requested by the covered employee that are noncovered
65 benefits after the signing of an explanatory document about the
66 noncovered benefit by the covered employee.
67 **SECTION 3.** Section 83-9-5, Mississippi Code of 1972, is
68 amended as follows:
69 83-9-5. (1) **Required provisions.** Except as provided in
70 subsection (3) of this section, each such policy delivered or

71 issued for delivery to any person in this state shall contain the
72 provisions specified in this subsection in the words in which the
73 same appear in this section. However, the insurer may, at its
74 option, substitute for one or more of such provisions,
75 corresponding provisions of different wording approved by the
76 commissioner which are in each instance not less favorable in any
77 respect to the insured or the beneficiary. Such provisions shall
78 be preceded individually by the caption appearing in this
79 subsection or, at the option of the insurer, by such appropriate
80 individual or group captions or subcaptions as the commissioner
81 may approve.

82 As used in this section, the term "insurer" means a health
83 maintenance organization, an insurance company or any other entity
84 responsible for the payment of benefits under a policy or contract
85 of accident and sickness insurance; however, the term "insurer"
86 shall not mean a liquidator, rehabilitator, conservator or
87 receiver or third-party administrator of any health maintenance
88 organization, insurance company or other entity responsible for
89 the payment of benefits which is in liquidation, rehabilitation or
90 conservation proceedings, nor shall it mean any responsible
91 guaranty association. Further, no cause of action shall accrue
92 against a liquidator, rehabilitator, conservator or receiver or
93 third-party administrator of any health maintenance organization,
94 insurance company or other entity responsible for the payment of
95 benefits which is in liquidation, rehabilitation or conservation

96 proceedings or any responsible guaranty association under
97 paragraph (h)3 of this subsection or any policy provision in
98 accordance therewith.

99 (a) A provision as follows:

100 Entire contract; changes: This policy, including the
101 endorsements and the attached papers, if any, constitutes the
102 entire contract of insurance. No change in this policy shall be
103 valid until approved by an executive officer of the insurer and
104 unless such approval be endorsed hereon or attached hereto. No
105 agent has authority to change this policy or to waive any of its
106 provisions.

107 (b) A provision as follows:

108 Time limit on certain defenses:

109 1. After two (2) years from the date of issue of
110 this policy, no misstatements, except fraudulent misstatements,
111 made by the applicant in the application for such policy shall be
112 used to void the policy or to deny a claim for loss incurred or
113 disability (as defined in the policy) commencing after the
114 expiration of such two-year period.

115 (The foregoing policy provision shall not be so construed as
116 to effect any legal requirement for avoidance of a policy or
117 denial of a claim during such initial two-year period, nor to
118 limit the application of subsection (2)(a) and (2)(b) of this
119 section in the event of misstatement with respect to age or
120 occupation.)

121 (A policy which the insured has the right to continue in
122 force subject to its terms by the timely payment of premium (1)
123 until at least age fifty (50) or, (2) in the case of a policy
124 issued after age forty-four (44), for at least five (5) years from
125 its date of issue, may contain in lieu of the foregoing the
126 following provision (from which the clause in parentheses may be
127 omitted at the insurer's option) under the caption
128 "INCONTESTABLE":
129 After this policy has been in force for a period of two (2)
130 years during the lifetime of the insured (excluding any period
131 during which the insured is disabled), it shall become
132 incontestable as to the statements in the application.)
133 2. No claim for loss incurred or disability (as
134 defined in the policy) commencing after two (2) years from the
135 date of issue of this policy shall be reduced or denied on the
136 ground that a disease or physical condition not excluded from
137 coverage by name or specific description effective on the date of
138 loss had existed prior to the effective date of coverage of this
139 policy.
140 (c) A provision as follows:
141 Grace period:
142 A grace period of seven (7) days for weekly premium policies,
143 ten (10) days for monthly premium policies and thirty-one (31)
144 days for all other policies will be granted for the payment of

145 each premium falling due after the first premium, during which
146 grace period the policy shall continue in force.
147 (A policy which contains a cancellation provision may add, at
148 the end of the above provision, "subject to the right of the
149 insurer to cancel in accordance with the cancellation provision
150 hereof."
151 A policy in which the insurer reserves the right to refuse
152 any renewal shall have, at the beginning of the above provision,
153 "unless not less than five (5) days prior to the premium due date
154 the insurer has delivered to the insured or has mailed to his last
155 address as shown by the records of the insurer written notice of
156 its intention not to renew this policy beyond the period for which
157 the premium has been accepted.")
158 (d) A provision as follows:
159 Reinstatement:
160 If any renewal premium be not paid within the time granted
161 the insured for payment, a subsequent acceptance of premium by the
162 insurer or by any agent duly authorized by the insurer to accept
163 such premium, without requiring in connection therewith an
164 application for reinstatement, shall reinstate the policy.
165 However, if the insurer or such agent requires an application for
166 reinstatement and issues a conditional receipt for the premium
167 tendered, the policy will be reinstated upon approval of such
168 application by the insurer or, lacking such approval, upon the
169 forty-fifth day following the date of such conditional receipt

170 unless the insurer has previously notified the insured in writing
171 of its disapproval of such application. The reinstated policy
172 shall cover only loss resulting from such accidental injury as may
173 be sustained after the date of reinstatement and loss due to such
174 sickness as may begin more than ten (10) days after such date. In
175 all other respects the insured and insurer shall have the same
176 rights thereunder as they had under the policy immediately before
177 the due date of the defaulted premium, subject to any provisions
178 endorsed hereon or attached hereto in connection with the
179 reinstatement. Any premium accepted in connection with a
180 reinstatement shall be applied to a period for which premium has
181 not been previously paid, but not to any period more than sixty
182 (60) days prior to the date of reinstatement. (The last sentence
183 of the above provision may be omitted from any policy which the
184 insured has the right to continue in force subject to its terms by
185 the timely payment of premiums (1) until at least age fifty (50)
186 or, (2) in the case of a policy issued after age forty-four (44),
187 for at least five (5) years from its date of issue.)

188 (e) A provision as follows:

189 Notice of claim:

190 Written notice of claim must be given to the insurer within
191 thirty (30) days after the occurrence or commencement of any loss
192 covered by the policy, or as soon thereafter as is reasonably
193 possible. Notice given by or on behalf of the insured or the
194 beneficiary to the insurer at ________________ (insert the

195 location of such office as the insurer may designate for the
196 purpose), or to any authorized agent of the insurer, with
197 information sufficient to identify the insured, shall be deemed
198 notice to the insurer.
199 (In a policy providing a loss of time benefit which may be
200 payable for at least two (2) years, an insurer may, at its option,
201 insert the following between the first and second sentences of the
202 above provision: "Subject to the qualifications set forth below,
203 if the insured suffers loss of time on account of disability for
204 which indemnity may be payable for at least two (2) years, he
205 shall, at least once in every six (6) months after having given
206 notice of claim, give to the insurer notice of continuance of said
207 disability, except in the event of legal incapacity. The period
208 of six (6) months following any filing of proof by the insured or
209 any payment by the insurer on account of such claim or any denial
210 of liability, in whole or in part, by the insurer shall be
211 excluded in applying this provision. Delay in the giving of such
212 notice shall not impair the insured's right to any indemnity which
213 would otherwise have accrued during the period of six (6) months
214 preceding the date on which such notice is actually given.")
215 (f) A provision as follows:
216 Claim forms:
217 The insurer, upon receipt of a notice of claim, will furnish
218 to the claimant such forms as are usually furnished by it for
219 filing proofs of loss. If such forms are not furnished within

220 fifteen (15) days after the giving of such notice, the claimant
221 shall be deemed to have complied with the requirements of this
222 policy as to proof of loss upon submitting, within the time fixed
223 in the policy for filing proofs of loss, written proof covering
224 the occurrence, the character and the extent of the loss for which
225 claim is made.

226 (g) A provision as follows:

227 Proofs of loss:

228 Written proof of loss must be furnished to the insurer at its
229 said office, in case of claim for loss for which this policy
230 provides any periodic payment contingent upon continuing loss,
231 within ninety (90) days after the termination of the period for
232 which the insurer is liable, and in case of claim for any other
233 loss, within ninety (90) days after the date of such loss.
234 Failure to furnish such proof within the time required shall not
235 invalidate or reduce any claim if it was not reasonably possible
236 to give proof within such time, provided such proof is furnished
237 as soon as reasonably possible and in no event, except in the
238 absence of legal capacity, later than one (1) year from the time
239 proof is otherwise required.

240 (h) A provision as follows:

241 Time of payment of claims:

242 1. All benefits payable under this policy for any
243 loss, other than loss for which this policy provides any periodic
244 payment, will be paid within twenty-five (25) days after receipt

245 of due written proof of such loss in the form of a clean claim
246 where claims are submitted electronically, and will be paid within
247 thirty-five (35) days after receipt of due written proof of such
248 loss in the form of clean claim where claims are submitted in
249 paper format. Benefits due under the policies and claims are
250 overdue if not paid within twenty-five (25) days or thirty-five
251 (35) days, whichever is applicable, after the insurer receives a
252 clean claim containing necessary medical information and other
253 information essential for the insurer to administer preexisting
254 condition, coordination of benefits and subrogation provisions. A
255 "clean claim" means a claim received by an insurer for
256 adjudication and which requires no further information, adjustment
257 or alteration by the provider of the services or the insured in
258 order to be processed and paid by the insurer. A claim is clean
259 if it has no defect or impropriety, including any lack of
260 substantiating documentation, or particular circumstance requiring
261 special treatment that prevents timely payment from being made on
262 the claim under this provision. A clean claim includes
263 resubmitted claims with previously identified deficiencies
264 corrected.

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

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

269 b. Claims which are submitted fraudulently or
270 that are based upon material misrepresentations;
271 c. Claims that require information essential
272 for the insurer to administer preexisting condition, coordination
273 of benefits or subrogation provisions; or
274 d. Claims submitted by a provider more than
275 thirty (30) days after the date of service; if the provider does
276 not submit the claim on behalf of the insured, then a claim is not
277 clean when submitted more than thirty (30) days after the date of
278 billing by the provider to the insured.
279 Not later than twenty-five (25) days after the date the
280 insurer actually receives an electronic claim, the insurer shall
281 pay the appropriate benefit in full, or any portion of the claim
282 that is clean, and notify the provider (where the claim is owed to
283 the provider) or the insured (where the claim is owed to the
284 insured) of the reasons why the claim or portion thereof is not
285 clean and will not be paid and what substantiating documentation
286 and information is required to adjudicate the claim as clean. Not
287 later than thirty-five (35) days after the date the insurer
288 actually receives a paper claim, the insurer shall pay the
289 appropriate benefit in full, or any portion of the claim that is
290 clean, and notify the provider (where the claim is owed to the
291 provider) or the insured (where the claim is owed to the insured)
292 of the reasons why the claim or portion thereof is not clean and
293 will not be paid and what substantiating documentation and

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

298 For purposes of this provision, the term "pay" means that the
299 insurer shall either send cash or a cash equivalent by United
300 States mail, or send cash or a cash equivalent by other means such
301 as electronic transfer, in full satisfaction of the appropriate
302 benefit due the provider (where the claim is owed to the provider)
303 or the insured (where the claim is owed to the insured). To
304 calculate the extent to which any benefits are overdue, payment
305 shall be treated as made on the date a draft or other valid
306 instrument was placed in the United States mail to the last known
307 address of the provider (where the claim is owed to the provider)
308 or the insured (where the claim is owed to the insured) in a
309 properly addressed, postpaid envelope, or, if not so posted, or
310 not sent by United States mail, on the date of delivery of payment
311 to the provider or insured.

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

318 3. If the claim is not denied for valid and proper
319 reasons by the end of the applicable time period prescribed in
320 this provision, the insurer must pay the provider (where the claim
321 is owed to the provider) or the insured (where the claim is owed
322 to the insured) interest on accrued benefits at the rate of one
323 and one-half percent (1-1/2%) per month accruing from the day
324 after payment was due on the amount of the benefits that remain
325 unpaid until the claim is finally settled or adjudicated.
326 Whenever interest due pursuant to this provision is less than One
327 Dollar ($1.00), such amount shall be credited to the account of
328 the person or entity to whom such amount is owed.
329 4. In the event the insurer fails to pay benefits
330 when due, the person entitled to such benefits may bring action to
331 recover such benefits, any interest which may accrue as provided
332 in *** * *** item 3 of this *** * *** paragraph (h) and any other damages
333 as may be allowable by law.
334 (i) A provision as follows:
335 Payment of claims:
336 Indemnity for loss of life will be payable in accordance with
337 the beneficiary designation and the provisions respecting such
338 payment which may be prescribed herein and effective at the time
339 of payment. If no such designation or provision is then
340 effective, such indemnity shall be payable to the estate of the
341 insured. Any other accrued indemnities unpaid at the insured's
342 death may, at the option of the insurer, be paid either to such

343 beneficiary or to such estate. All other indemnities will be
344 payable to the insured. When payments of benefits are made to an
345 insured directly for medical care or services rendered by a health
346 care provider, the health care provider shall be notified of such
347 payment. The notification requirement shall not apply to a
348 fixed-indemnity policy, a limited benefit health insurance policy,
349 medical payment coverage or personal injury protection coverage in
350 a motor vehicle policy, coverage issued as a supplement to
351 liability insurance or workers' compensation. If the insured
352 provides the insurer with written direction that all or a portion
353 of any indemnities or benefits provided by the policy be paid to a
354 licensed health care provider rendering hospital, nursing, medical
355 or surgical services, then the insurer shall pay directly the
356 licensed health care provider rendering such services. That
357 payment shall be considered payment in full to the provider, who
358 may not bill or collect from the insured any amount above that
359 payment, other than the deductible, coinsurance, copayment or
360 other charges for equipment or services requested by the insured
361 that are noncovered benefits.

362 (The following provision may be included with the foregoing
363 provision at the option of the insurer: "If any indemnity of this
364 policy shall be payable to the estate of the insured, or to an
365 insured or beneficiary who is a minor or otherwise not competent
366 to give a valid release, the insurer may pay such indemnity, up to
367 an amount not exceeding $______________ (insert an amount which

368 must not exceed One Thousand Dollars ($1,000.00)), to any relative
369 by blood or connection by marriage of the insured or beneficiary
370 who is deemed by the insurer to be equitably entitled thereto.
371 Any payment made by the insurer in good faith pursuant to this
372 provision shall fully discharge the insurer to the extent of such
373 payment."
374 (j) A provision as follows:
375 Physical examinations:
376 The insurer at his own expense shall have the right and
377 opportunity to examine the person of the insured when and as often
378 as it may reasonably require during the pendency of a claim
379 hereunder.
380 (k) A provision as follows:
381 Legal actions:
382 No action at law or in equity shall be brought to recover on
383 this policy prior to the expiration of sixty (60) days after
384 written proof of loss has been furnished in accordance with the
385 requirements of this policy. No such action shall be brought
386 after the expiration of three (3) years after the time written
387 proof of loss is required to be furnished.
388 (l) A provision as follows:
389 Change of beneficiary:
390 Unless the insured makes an irrevocable designation of
391 beneficiary, the right to change the beneficiary is reserved to
392 the insured, and the consent of the beneficiary or beneficiaries

393 shall not be requisite to surrender or assignment of this policy,
394 or to any change of beneficiary or beneficiaries, or to any other
395 changes in this policy.

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

399 (2) **Other provisions.** Except as provided in subsection (3)
400 of this section, no such policy delivered or issued for delivery
401 to any person in this state shall contain provisions respecting
402 the matters set forth below unless such provisions are in the
403 words in which the same appear in this section. However, the
404 insurer may, at its option, use in lieu of any such provision a
405 corresponding provision of different wording approved by the
406 commissioner which is not less favorable in any respect to the
407 insured or the beneficiary. Any such provision contained in the
408 policy shall be preceded individually by the appropriate caption
409 appearing in this subsection or, at the option of the insurer, by
410 such appropriate individual or group captions or subcaptions as
411 the commissioner may approve.

412 (a) A provision as follows:

413 Change of occupation:

414 If the insured be injured or contract sickness after having
415 changed his occupation to one classified by the insurer as more
416 hazardous than that stated in this policy or while doing for
417 compensation anything pertaining to an occupation so classified,

418 the insurer will pay only such portion of the indemnities provided
419 in this policy as the premium paid would have purchased at the
420 rates and within the limits fixed by the insurer for such more
421 hazardous occupation. If the insured changes his occupation to
422 one classified by the insurer as less hazardous than that stated
423 in this policy, the insurer, upon receipt of proof of such change
424 of occupation, will reduce the premium rate accordingly, and will
425 return the excess pro rata unearned premium from the date of
426 change of occupation or from the policy anniversary date
427 immediately preceding receipt of such proof, whichever is the most
428 recent. In applying this provision, the classification of
429 occupational risk and the premium rates shall be such as have been
430 last filed by the insurer prior to the occurrence of the loss for
431 which the insurer is liable, or prior to date of proof of change
432 in occupation, with the state official having supervision of
433 insurance in the state where the insured resided at the time this
434 policy was issued; but if such filing was not required, then the
435 classification of occupational risk and the premium rates shall be
436 those last made effective by the insurer in such state prior to
437 the occurrence of the loss or prior to the date of proof of change
438 in occupation.
439 (b) A provision as follows:
440 Misstatement of age:

441 If the age of the insured has been misstated, all amounts
442 payable under this policy shall be such as the premium paid would
443 have purchased at the correct age.
444 (c) A provision as follows:
445 Relation of earnings to issuance:
446 If the total monthly amount of loss of time benefits promised
447 for the same loss under all valid loss of time coverage upon the
448 insured, whether payable on a weekly or monthly basis, shall
449 exceed the monthly earnings of the insured at the time disability
450 commenced or his average monthly earnings for the period of two
451 (2) years immediately preceding a disability for which claim is
452 made, whichever is the greater, the insurer will be liable only
453 for such proportionate amount of such benefits under this policy
454 as the amount of such monthly earnings or such average monthly
455 earnings of the insured bears to the total amount of monthly
456 benefits for the same loss under all such coverage upon the
457 insured at the time such disability commences and for the return
458 of such part of the premiums paid during such two (2) years as
459 shall exceed the pro rata amount of the premiums for the benefits
460 actually paid hereunder; but this shall not operate to reduce the
461 total monthly amount of benefits payable under all such coverage
462 upon the insured below the sum of Two Hundred Dollars ($200.00) or
463 the sum of the monthly benefits specified in such coverages,
464 whichever is the lesser, nor shall it operate to reduce benefits
465 other than those payable for loss of time.

466 (The foregoing policy provision may be inserted only in a
467 policy which the insured has the right to continue in force
468 subject to its terms by the timely payment of premiums (1) until
469 at least age fifty (50) or, (2) in the case of a policy issued
470 after age forty-four (44), for at least five (5) years from its
471 date of issue. The insurer may, at its option, include in this
472 provision a definition of "valid loss of time coverage," approved
473 as to form by the commissioner, which definition shall be limited
474 in subject matter to coverage provided by governmental agencies or
475 by organizations subject to regulations by insurance law or by
476 insurance authorities of this or any other state of the United
477 States or any province of Canada, or to any other coverage the
478 inclusion of which may be approved by the commissioner, or any
479 combination of such coverages. In the absence of such definition,
480 such term shall not include any coverage provided for such insured
481 pursuant to any compulsory benefit statute (including any workers'
482 compensation or employer's liability statute), or benefits
483 provided by union welfare plans or by employer or employee benefit
484 organizations.)
485 (d) A provision as follows:
486 Unpaid premium:
487 Upon the payment of a claim under this policy, any premium
488 then due and unpaid or covered by any note or written order may be
489 deducted therefrom.
490 (e) A provision as follows:

491 Cancellation:

492 The insurer may cancel this policy at any time by written
493 notice delivered to the insured, or mailed to his last address as
494 shown by the records of the insurer, stating when, not less than
495 five (5) days thereafter, such cancellation shall be effective;
496 and after the policy has been continued beyond its original term,
497 the insured may cancel this policy at any time by written notice
498 delivered or mailed to the insurer, effective upon receipt or on
499 such later date as may be specified in such notice. In the event
500 of cancellation, the insurer will return promptly the unearned
501 portion of any premium paid. If the insured cancels, the earned
502 premium shall be computed by the use of the short-rate table last
503 filed with the state official having supervision of insurance in
504 the state where the insured resided when the policy was issued.
505 If the insurer cancels, the earned premium shall be computed pro
506 rata. Cancellation shall be without prejudice to any claim
507 originating prior to the effective date of cancellation.

508 (f) A provision as follows:

509 Conformity with state statutes:

510 Any provision of this policy which, on its effective date, is
511 in conflict with the statutes of the state in which the insured
512 resides on such date is hereby amended to conform to the minimum
513 requirements of such statutes.

514 (g) A provision as follows:

515 Illegal occupation:

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

520 (h) A provision as follows:

521 Intoxicants and narcotics:

522 The insurer shall not be liable for any loss sustained or
523 contracted in consequence of the insured's being intoxicated or
524 under the influence of any narcotic unless administered on the
525 advice of a physician.

526 (3) **Inapplicable or inconsistent provisions.** If any
527 provision of this section is, in whole or in part, inapplicable to
528 or inconsistent with the coverage provided by a particular form of
529 policy, the insurer, with the approval of the commissioner, shall
530 omit from such policy any inapplicable provision or part of a
531 provision, and shall modify any inconsistent provision or part of
532 the provision in such manner as to make the provision as contained
533 in the policy consistent with the coverage provided by the policy.

534 (4) **Order of certain policy provisions.** The provisions
535 which are the subject of subsections (1) and (2) of this section,
536 or any corresponding provisions which are used in lieu thereof in
537 accordance with such subsections, shall be printed in the
538 consecutive order of the provisions in such subsections or, at the
539 option of the insurer, any such provision may appear as a unit in
540 any part of the policy, with other provisions to which it may be

541 logically related, provided the resulting policy shall not be, in
542 whole or in part, unintelligible, uncertain, ambiguous, abstruse
543 or likely to mislead a person to whom the policy is offered,
544 delivered or issued.

545 (5) **Third-party ownership.** The word "insured," as used in
546 Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, shall
547 not be construed as preventing a person other than the insured
548 with a proper insurable interest from making application for and
549 owning a policy covering the insured, or from being entitled under
550 such a policy to any indemnities, benefits and rights provided
551 therein.

552 (6) **Requirements of other jurisdictions.**

553 (a) Any policy of a foreign or alien insurer, when
554 delivered or issued for delivery to any person in this state, may
555 contain any provision which is not less favorable to the insured
556 or the beneficiary than the provisions of Sections 83-9-1 through
557 83-9-21, Mississippi Code of 1972, and which is prescribed or
558 required by the law of the state under which the insurer is
559 organized.

560 (b) Any policy of a domestic insurer may, when issued
561 for delivery in any other state or country, contain any provision
562 permitted or required by the laws of such other state or country.

563 (7) **Filing procedure.** The commissioner may make such
564 reasonable rules and regulations concerning the procedure for the
565 filing or submission of policies subject to the cited sections as

566 are necessary, proper or advisable to the administration of said
567 sections. This provision shall not abridge any other authority
568 granted the commissioner by law.

569 (8) **Administrative penalties.**

570 (a) If the commissioner finds that an insurer, during
571 any calendar year, has paid at least eighty-five percent (85%),
572 but less than ninety-five percent (95%), of all clean claims
573 received from all providers during that year in accordance with
574 the provisions of subsection (1)(h) of this section, the
575 commissioner may levy an aggregate penalty in an amount not to
576 exceed Ten Thousand Dollars ($10,000.00). If the commissioner
577 finds that an insurer, during any calendar year, has paid at least
578 fifty percent (50%), but less than eighty-five percent (85%), of
579 all clean claims received from all providers during that year in
580 accordance with the provisions of subsection (1)(h) of this
581 section, the commissioner may levy an aggregate penalty in an
582 amount of not less than Ten Thousand Dollars ($10,000.00) nor more
583 than One Hundred Thousand Dollars ($100,000.00). If the
584 commissioner finds that an insurer, during any calendar year, has
585 paid less than fifty percent (50%) of all clean claims received
586 from all providers during that year in accordance with the
587 provisions of subsection (1)(h) of this section, the commissioner
588 may levy an aggregate penalty in an amount not less than One
589 Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred
590 Thousand Dollars ($200,000.00). In determining the amount of any

591 fine, the commissioner shall take into account whether the failure
592 to achieve the standards in subsection (1)(h) of this section were
593 due to circumstances beyond the control of the insurer. The
594 insurer may request an administrative hearing to contest the
595 assessment of any administrative penalty imposed by the
596 commissioner pursuant to this subsection within thirty (30) days
597 after receipt of the notice of assessment.

598 (b) Examinations to determine compliance with
599 subsection (1)(h) of this section may be conducted by the
600 commissioner or any of his examiners. The commissioner may
601 contract with qualified impartial outside sources to assist in
602 examinations to determine compliance. The expenses of any such
603 examinations shall be paid by the insurer examined.

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

608 (d) An insurer and a provider may enter into an express
609 written agreement containing timely claim payment provisions which
610 differ from, but are at least as stringent as, the provisions set
611 forth under subsection (1)(h) of this section, and in such case,
612 the provisions of the written agreement shall govern the timely
613 payment of claims by the insurer to the provider. If the express
614 written agreement is silent as to any interest penalty where
615 claims are not paid in accordance with the agreement, the interest

616 penalty provision of subsection (1)(h)3 of this section shall
617 apply.
618 (e) The commissioner may adopt rules and regulations
619 necessary to ensure compliance with this subsection.
620 **SECTION 4.** This act shall take effect and be in force from
621 and after July 1, 2018.

ST: Insurance; require certain consumer information and notice and availability of mediation regarding balance billing.