MISSISSIPPI LEGISLATURE REGULAR SESSION 2019

By: Representative Chism To: Insurance; Judiciary A

HOUSE BILL NO. 278

1 AN ACT TO AMEND SECTION 83-9-5, MISSISSIPPI CODE OF 1972, TO
2 PROVIDE THAT BINDING ARBITRATION SHALL BE THE METHOD TO RESOLVE
3 CERTAIN DISPUTES BETWEEN HEALTH CARE PROVIDERS AND INSUREDS; TO
4 PROVIDE THAT THE OFFICE OF ATTORNEY GENERAL, CONSUMER PROTECTION
5 DIVISION, SHALL ENFORCE CERTAIN PROVISIONS; TO BRING FORWARD
6 SECTION 83-9-3, MISSISSIPPI CODE OF 1972, FOR PURPOSES OF POSSIBLE
7 AMENDMENT; AND FOR RELATED PURPOSES.

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

9 **SECTION 1.** Section 83-9-5, Mississippi Code of 1972, is
10 amended as follows:

11 83-9-5. (1) **Required provisions.** Except as provided in
12 subsection (3) of this section, each such policy delivered or
13 issued for delivery to any person in this state shall contain the
14 provisions specified in this subsection in the words in which the
15 same appear in this section. However, the insurer may, at its
16 option, substitute for one or more of such provisions,
17 corresponding provisions of different wording approved by the
18 commissioner which are in each instance not less favorable in any
19 respect to the insured or the beneficiary. Such provisions shall
20 be preceded individually by the caption appearing in this

21 subsection or, at the option of the insurer, by such appropriate
22 individual or group captions or subcaptions as the commissioner
23 may approve.

24 As used in this section, the term "insurer" means a health
25 maintenance organization, an insurance company or any other entity
26 responsible for the payment of benefits under a policy or contract
27 of accident and sickness insurance; however, the term "insurer"
28 shall not mean a liquidator, rehabilitator, conservator or
29 receiver or third-party administrator of any health maintenance
30 organization, insurance company or other entity responsible for
31 the payment of benefits which is in liquidation, rehabilitation or
32 conservation proceedings, nor shall it mean any responsible
33 guaranty association. Further, no cause of action shall accrue
34 against a liquidator, rehabilitator, conservator or receiver or
35 third-party administrator of any health maintenance organization,
36 insurance company or other entity responsible for the payment of
37 benefits which is in liquidation, rehabilitation or conservation
38 proceedings or any responsible guaranty association under
39 paragraph (h)3 of this subsection or any policy provision in
40 accordance therewith.

41 (a) A provision as follows:

42 Entire contract; changes: This policy, including the
43 endorsements and the attached papers, if any, constitutes the
44 entire contract of insurance. No change in this policy shall be
45 valid until approved by an executive officer of the insurer and

46 unless such approval be endorsed hereon or attached hereto. No
47 agent has authority to change this policy or to waive any of its
48 provisions.

49 (b) A provision as follows:

50 Time limit on certain defenses:

51 1. After two (2) years from the date of issue of
52 this policy, no misstatements, except fraudulent misstatements,
53 made by the applicant in the application for such policy shall be
54 used to void the policy or to deny a claim for loss incurred or
55 disability (as defined in the policy) commencing after the
56 expiration of such two-year period.

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

63 (A policy which the insured has the right to continue in
64 force subject to its terms by the timely payment of premium (1)
65 until at least age fifty (50) or, (2) in the case of a policy
66 issued after age forty-four (44), for at least five (5) years from
67 its date of issue, may contain in lieu of the foregoing the
68 following provision (from which the clause in parentheses may be
69 omitted at the insurer's option) under the caption
70 "INCONTESTABLE":

71 After this policy has been in force for a period of two (2)
72 years during the lifetime of the insured (excluding any period
73 during which the insured is disabled), it shall become
74 incontestable as to the statements in the application.)
75 2. No claim for loss incurred or disability (as
76 defined in the policy) commencing after two (2) years from the
77 date of issue of this policy shall be reduced or denied on the
78 ground that a disease or physical condition not excluded from
79 coverage by name or specific description effective on the date of
80 loss had existed prior to the effective date of coverage of this
81 policy.
82 (c) A provision as follows:
83 Grace period:
84 A grace period of seven (7) days for weekly premium policies,
85 ten (10) days for monthly premium policies and thirty-one (31)
86 days for all other policies will be granted for the payment of
87 each premium falling due after the first premium, during which
88 grace period the policy shall continue in force.
89 (A policy which contains a cancellation provision may add, at
90 the end of the above provision, "subject to the right of the
91 insurer to cancel in accordance with the cancellation provision
92 hereof."
93 A policy in which the insurer reserves the right to refuse
94 any renewal shall have, at the beginning of the above provision,
95 "unless not less than five (5) days prior to the premium due date

96 the insurer has delivered to the insured or has mailed to his last
97 address as shown by the records of the insurer written notice of
98 its intention not to renew this policy beyond the period for which
99 the premium has been accepted.")
100 (d) A provision as follows:
101 Reinstatement:
102 If any renewal premium be not paid within the time granted
103 the insured for payment, a subsequent acceptance of premium by the
104 insurer or by any agent duly authorized by the insurer to accept
105 such premium, without requiring in connection therewith an
106 application for reinstatement, shall reinstate the policy.
107 However, if the insurer or such agent requires an application for
108 reinstatement and issues a conditional receipt for the premium
109 tendered, the policy will be reinstated upon approval of such
110 application by the insurer or, lacking such approval, upon the
111 forty-fifth day following the date of such conditional receipt
112 unless the insurer has previously notified the insured in writing
113 of its disapproval of such application. The reinstated policy
114 shall cover only loss resulting from such accidental injury as may
115 be sustained after the date of reinstatement and loss due to such
116 sickness as may begin more than ten (10) days after such date. In
117 all other respects the insured and insurer shall have the same
118 rights thereunder as they had under the policy immediately before
119 the due date of the defaulted premium, subject to any provisions
120 endorsed hereon or attached hereto in connection with the

121 reinstatement. Any premium accepted in connection with a
122 reinstatement shall be applied to a period for which premium has
123 not been previously paid, but not to any period more than sixty
124 (60) days prior to the date of reinstatement. (The last sentence
125 of the above provision may be omitted from any policy which the
126 insured has the right to continue in force subject to its terms by
127 the timely payment of premiums (1) until at least age fifty (50)
128 or, (2) in the case of a policy issued after age forty-four (44),
129 for at least five (5) years from its date of issue.)
130 (e) A provision as follows:
131 Notice of claim:
132 Written notice of claim must be given to the insurer within
133 thirty (30) days after the occurrence or commencement of any loss
134 covered by the policy, or as soon thereafter as is reasonably
135 possible. Notice given by or on behalf of the insured or the
136 beneficiary to the insurer at ________________ (insert the
137 location of such office as the insurer may designate for the
138 purpose), or to any authorized agent of the insurer, with
139 information sufficient to identify the insured, shall be deemed
140 notice to the insurer.
141 (In a policy providing a loss of time benefit which may be
142 payable for at least two (2) years, an insurer may, at its option,
143 insert the following between the first and second sentences of the
144 above provision: "Subject to the qualifications set forth below,
145 if the insured suffers loss of time on account of disability for

146 which indemnity may be payable for at least two (2) years, he
147 shall, at least once in every six (6) months after having given
148 notice of claim, give to the insurer notice of continuance of said
149 disability, except in the event of legal incapacity. The period
150 of six (6) months following any filing of proof by the insured or
151 any payment by the insurer on account of such claim or any denial
152 of liability, in whole or in part, by the insurer shall be
153 excluded in applying this provision. Delay in the giving of such
154 notice shall not impair the insured's right to any indemnity which
155 would otherwise have accrued during the period of six (6) months
156 preceding the date on which such notice is actually given.")
157 (f) A provision as follows:
158 Claim forms:
159 The insurer, upon receipt of a notice of claim, will furnish
160 to the claimant such forms as are usually furnished by it for
161 filing proofs of loss. If such forms are not furnished within
162 fifteen (15) days after the giving of such notice, the claimant
163 shall be deemed to have complied with the requirements of this
164 policy as to proof of loss upon submitting, within the time fixed
165 in the policy for filing proofs of loss, written proof covering
166 the occurrence, the character and the extent of the loss for which
167 claim is made.
168 (g) A provision as follows:
169 Proofs of loss:

170 Written proof of loss must be furnished to the insurer at its
171 said office, in case of claim for loss for which this policy
172 provides any periodic payment contingent upon continuing loss,
173 within ninety (90) days after the termination of the period for
174 which the insurer is liable, and in case of claim for any other
175 loss, within ninety (90) days after the date of such loss.
176 Failure to furnish such proof within the time required shall not
177 invalidate or reduce any claim if it was not reasonably possible
178 to give proof within such time, provided such proof is furnished
179 as soon as reasonably possible and in no event, except in the
180 absence of legal capacity, later than one (1) year from the time
181 proof is otherwise required.

182 (h) A provision as follows:

183 Time of payment of claims:

184 1. All benefits payable under this policy for any
185 loss, other than loss for which this policy provides any periodic
186 payment, will be paid within twenty-five (25) days after receipt
187 of due written proof of such loss in the form of a clean claim
188 where claims are submitted electronically, and will be paid within
189 thirty-five (35) days after receipt of due written proof of such
190 loss in the form of clean claim where claims are submitted in
191 paper format. Benefits due under the policies and claims are
192 overdue if not paid within twenty-five (25) days or thirty-five
193 (35) days, whichever is applicable, after the insurer receives a
194 clean claim containing necessary medical information and other

195 information essential for the insurer to administer preexisting
196 condition, coordination of benefits and subrogation provisions. A
197 "clean claim" means a claim received by an insurer for
198 adjudication and which requires no further information, adjustment
199 or alteration by the provider of the services or the insured in
200 order to be processed and paid by the insurer. A claim is clean
201 if it has no defect or impropriety, including any lack of
202 substantiating documentation, or particular circumstance requiring
203 special treatment that prevents timely payment from being made on
204 the claim under this provision. A clean claim includes
205 resubmitted claims with previously identified deficiencies
206 corrected.

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

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

211 b. Claims which are submitted fraudulently or
212 that are based upon material misrepresentations;

213 c. Claims that require information essential
214 for the insurer to administer preexisting condition, coordination
215 of benefits or subrogation provisions; or

216 d. Claims submitted by a provider more than
217 thirty (30) days after the date of service; if the provider does
218 not submit the claim on behalf of the insured, then a claim is not

219 clean when submitted more than thirty (30) days after the date of
220 billing by the provider to the insured.

221 Not later than twenty-five (25) days after the date the
222 insurer actually receives an electronic claim, the insurer shall
223 pay the appropriate benefit in full, or any portion of the claim
224 that is clean, and notify the provider (where the claim is owed to
225 the provider) or the insured (where the claim is owed to the
226 insured) of the reasons why the claim or portion thereof is not
227 clean and will not be paid and what substantiating documentation
228 and information is required to adjudicate the claim as clean. Not
229 later than thirty-five (35) days after the date the insurer
230 actually receives a paper claim, the insurer shall pay the
231 appropriate benefit in full, or any portion of the claim that is
232 clean, and notify the provider (where the claim is owed to the
233 provider) or the insured (where the claim is owed to the insured)
234 of the reasons why the claim or portion thereof is not clean and
235 will not be paid and what substantiating documentation and
236 information is required to adjudicate the claim as clean. Any
237 claim or portion thereof resubmitted with the supporting
238 documentation and information requested by the insurer shall be
239 paid within twenty (20) days after receipt.

240 For purposes of this provision, the term "pay" means that the
241 insurer shall either send cash or a cash equivalent by United
242 States mail, or send cash or a cash equivalent by other means such
243 as electronic transfer, in full satisfaction of the appropriate

244 benefit due the provider (where the claim is owed to the provider)
245 or the insured (where the claim is owed to the insured). To
246 calculate the extent to which any benefits are overdue, payment
247 shall be treated as made on the date a draft or other valid
248 instrument was placed in the United States mail to the last known
249 address of the provider (where the claim is owed to the provider)
250 or the insured (where the claim is owed to the insured) in a
251 properly addressed, postpaid envelope, or, if not so posted, or
252 not sent by United States mail, on the date of delivery of payment
253 to the provider or insured.

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

260 3. If the claim is not denied for valid and proper
261 reasons by the end of the applicable time period prescribed in
262 this provision, the insurer must pay the provider (where the claim
263 is owed to the provider) or the insured (where the claim is owed
264 to the insured) interest on accrued benefits at the rate of one
265 and one-half percent (1-1/2%) per month accruing from the day
266 after payment was due on the amount of the benefits that remain
267 unpaid until the claim is finally settled or adjudicated.
268 Whenever interest due pursuant to this provision is less than One

269 Dollar ($1.00), such amount shall be credited to the account of
270 the person or entity to whom such amount is owed.
271 4. In the event the insurer fails to pay benefits
272 when due, the person entitled to such benefits may bring action to
273 recover such benefits, any interest which may accrue as provided
274 in *** * *** item 3 of this *** * *** paragraph (h) and any other damages
275 as may be allowable by law.
276 (i) A provision as follows:
277 Payment of claims:
278 Indemnity for loss of life will be payable in accordance with
279 the beneficiary designation and the provisions respecting such
280 payment which may be prescribed herein and effective at the time
281 of payment. If no such designation or provision is then
282 effective, such indemnity shall be payable to the estate of the
283 insured. Any other accrued indemnities unpaid at the insured's
284 death may, at the option of the insurer, be paid either to such
285 beneficiary or to such estate. All other indemnities will be
286 payable to the insured. When payments of benefits are made to an
287 insured directly for medical care or services rendered by a health
288 care provider, the health care provider shall be notified of such
289 payment. The notification requirement shall not apply to a
290 fixed-indemnity policy, a limited benefit health insurance policy,
291 medical payment coverage or personal injury protection coverage in
292 a motor vehicle policy, coverage issued as a supplement to
293 liability insurance or workers' compensation. If the insured

294 provides the insurer with written direction that all or a portion
295 of any indemnities or benefits provided by the policy be paid to a
296 licensed health care provider rendering hospital, nursing, medical
297 or surgical services, then the insurer shall pay directly the
298 licensed health care provider rendering such services. That
299 payment shall be considered payment in full to the provider, who
300 may not bill or collect from the insured any amount above that
301 payment, other than the deductible, coinsurance, copayment or
302 other charges for equipment or services requested by the insured
303 that are noncovered benefits. Any dispute between a provider and
304 the insured arising under these provisions regarding assignment of
305 benefits and billing shall be resolved through binding
306 arbitration. The Office of Attorney General, Consumer Protection
307 Division, shall enforce these provisions regarding assignment of
308 benefits and billing.
309 (The following provision may be included with the foregoing
310 provision at the option of the insurer: "If any indemnity of this
311 policy shall be payable to the estate of the insured, or to an
312 insured or beneficiary who is a minor or otherwise not competent
313 to give a valid release, the insurer may pay such indemnity, up to
314 an amount not exceeding $______________ (insert an amount which
315 must not exceed One Thousand Dollars ($1,000.00)), to any relative
316 by blood or connection by marriage of the insured or beneficiary
317 who is deemed by the insurer to be equitably entitled thereto.
318 Any payment made by the insurer in good faith pursuant to this

319 provision shall fully discharge the insurer to the extent of such
320 payment."

321 (j) A provision as follows:

322 Physical examinations:

323 The insurer at his own expense shall have the right and
324 opportunity to examine the person of the insured when and as often
325 as it may reasonably require during the pendency of a claim
326 hereunder.

327 (k) A provision as follows:

328 Legal actions:

329 No action at law or in equity shall be brought to recover on
330 this policy prior to the expiration of sixty (60) days after
331 written proof of loss has been furnished in accordance with the
332 requirements of this policy. No such action shall be brought
333 after the expiration of three (3) years after the time written
334 proof of loss is required to be furnished.

335 (l) A provision as follows:

336 Change of beneficiary:

337 Unless the insured makes an irrevocable designation of
338 beneficiary, the right to change the beneficiary is reserved to
339 the insured, and the consent of the beneficiary or beneficiaries
340 shall not be requisite to surrender or assignment of this policy,
341 or to any change of beneficiary or beneficiaries, or to any other
342 changes in this policy.

343 (The first clause of this provision, relating to the
344 irrevocable designation of beneficiary, may be omitted at the
345 insurer's option.)
346 (2) **Other provisions**. Except as provided in subsection (3)
347 of this section, no such policy delivered or issued for delivery
348 to any person in this state shall contain provisions respecting
349 the matters set forth below unless such provisions are in the
350 words in which the same appear in this section. However, the
351 insurer may, at its option, use in lieu of any such provision a
352 corresponding provision of different wording approved by the
353 commissioner which is not less favorable in any respect to the
354 insured or the beneficiary. Any such provision contained in the
355 policy shall be preceded individually by the appropriate caption
356 appearing in this subsection or, at the option of the insurer, by
357 such appropriate individual or group captions or subcaptions as
358 the commissioner may approve.
359 (a) A provision as follows:
360 Change of occupation:
361 If the insured be injured or contract sickness after having
362 changed his occupation to one classified by the insurer as more
363 hazardous than that stated in this policy or while doing for
364 compensation anything pertaining to an occupation so classified,
365 the insurer will pay only such portion of the indemnities provided
366 in this policy as the premium paid would have purchased at the
367 rates and within the limits fixed by the insurer for such more

368 hazardous occupation. If the insured changes his occupation to
369 one classified by the insurer as less hazardous than that stated
370 in this policy, the insurer, upon receipt of proof of such change
371 of occupation, will reduce the premium rate accordingly, and will
372 return the excess pro rata unearned premium from the date of
373 change of occupation or from the policy anniversary date
374 immediately preceding receipt of such proof, whichever is the most
375 recent. In applying this provision, the classification of
376 occupational risk and the premium rates shall be such as have been
377 last filed by the insurer prior to the occurrence of the loss for
378 which the insurer is liable, or prior to date of proof of change
379 in occupation, with the state official having supervision of
380 insurance in the state where the insured resided at the time this
381 policy was issued; but if such filing was not required, then the
382 classification of occupational risk and the premium rates shall be
383 those last made effective by the insurer in such state prior to
384 the occurrence of the loss or prior to the date of proof of change
385 in occupation.

386 (b) A provision as follows:

387 Misstatement of age:

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

391 (c) A provision as follows:

392 Relation of earnings to issuance:

393 If the total monthly amount of loss of time benefits promised
394 for the same loss under all valid loss of time coverage upon the
395 insured, whether payable on a weekly or monthly basis, shall
396 exceed the monthly earnings of the insured at the time disability
397 commenced or his average monthly earnings for the period of two
398 (2) years immediately preceding a disability for which claim is
399 made, whichever is the greater, the insurer will be liable only
400 for such proportionate amount of such benefits under this policy
401 as the amount of such monthly earnings or such average monthly
402 earnings of the insured bears to the total amount of monthly
403 benefits for the same loss under all such coverage upon the
404 insured at the time such disability commences and for the return
405 of such part of the premiums paid during such two (2) years as
406 shall exceed the pro rata amount of the premiums for the benefits
407 actually paid hereunder; but this shall not operate to reduce the
408 total monthly amount of benefits payable under all such coverage
409 upon the insured below the sum of Two Hundred Dollars ($200.00) or
410 the sum of the monthly benefits specified in such coverages,
411 whichever is the lesser, nor shall it operate to reduce benefits
412 other than those payable for loss of time.
413 (The foregoing policy provision may be inserted only in a
414 policy which the insured has the right to continue in force
415 subject to its terms by the timely payment of premiums (1) until
416 at least age fifty (50) or, (2) in the case of a policy issued
417 after age forty-four (44), for at least five (5) years from its

418 date of issue. The insurer may, at its option, include in this
419 provision a definition of "valid loss of time coverage," approved
420 as to form by the commissioner, which definition shall be limited
421 in subject matter to coverage provided by governmental agencies or
422 by organizations subject to regulations by insurance law or by
423 insurance authorities of this or any other state of the United
424 States or any province of Canada, or to any other coverage the
425 inclusion of which may be approved by the commissioner, or any
426 combination of such coverages. In the absence of such definition,
427 such term shall not include any coverage provided for such insured
428 pursuant to any compulsory benefit statute (including any workers'
429 compensation or employer's liability statute), or benefits
430 provided by union welfare plans or by employer or employee benefit
431 organizations.)
432 (d) A provision as follows:
433 Unpaid premium:
434 Upon the payment of a claim under this policy, any premium
435 then due and unpaid or covered by any note or written order may be
436 deducted therefrom.
437 (e) A provision as follows:
438 Cancellation:
439 The insurer may cancel this policy at any time by written
440 notice delivered to the insured, or mailed to his last address as
441 shown by the records of the insurer, stating when, not less than
442 five (5) days thereafter, such cancellation shall be effective;

443 and after the policy has been continued beyond its original term,
444 the insured may cancel this policy at any time by written notice
445 delivered or mailed to the insurer, effective upon receipt or on
446 such later date as may be specified in such notice. In the event
447 of cancellation, the insurer will return promptly the unearned
448 portion of any premium paid. If the insured cancels, the earned
449 premium shall be computed by the use of the short-rate table last
450 filed with the state official having supervision of insurance in
451 the state where the insured resided when the policy was issued.
452 If the insurer cancels, the earned premium shall be computed pro
453 rata. Cancellation shall be without prejudice to any claim
454 originating prior to the effective date of cancellation.

455 (f) A provision as follows:

456 Conformity with state statutes:

457 Any provision of this policy which, on its effective date, is
458 in conflict with the statutes of the state in which the insured
459 resides on such date is hereby amended to conform to the minimum
460 requirements of such statutes.

461 (g) A provision as follows:

462 Illegal occupation:

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

467 (h) A provision as follows:

468 Intoxicants and narcotics:
469 The insurer shall not be liable for any loss sustained or
470 contracted in consequence of the insured's being intoxicated or
471 under the influence of any narcotic unless administered on the
472 advice of a physician.
473 (3) **Inapplicable or inconsistent provisions.** If any
474 provision of this section is, in whole or in part, inapplicable to
475 or inconsistent with the coverage provided by a particular form of
476 policy, the insurer, with the approval of the commissioner, shall
477 omit from such policy any inapplicable provision or part of a
478 provision, and shall modify any inconsistent provision or part of
479 the provision in such manner as to make the provision as contained
480 in the policy consistent with the coverage provided by the policy.
481 (4) **Order of certain policy provisions.** The provisions
482 which are the subject of subsections (1) and (2) of this section,
483 or any corresponding provisions which are used in lieu thereof in
484 accordance with such subsections, shall be printed in the
485 consecutive order of the provisions in such subsections or, at the
486 option of the insurer, any such provision may appear as a unit in
487 any part of the policy, with other provisions to which it may be
488 logically related, provided the resulting policy shall not be, in
489 whole or in part, unintelligible, uncertain, ambiguous, abstruse
490 or likely to mislead a person to whom the policy is offered,
491 delivered or issued.

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

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

500 (a) Any policy of a foreign or alien insurer, when
501 delivered or issued for delivery to any person in this state, may
502 contain any provision which is not less favorable to the insured
503 or the beneficiary than the provisions of Sections 83-9-1 through
504 83-9-21, Mississippi Code of 1972, and which is prescribed or
505 required by the law of the state under which the insurer is
506 organized.

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

510 (7) **Filing procedure.** The commissioner may make such
511 reasonable rules and regulations concerning the procedure for the
512 filing or submission of policies subject to the cited sections as
513 are necessary, proper or advisable to the administration of said
514 sections. This provision shall not abridge any other authority
515 granted the commissioner by law.

516 (8) **Administrative penalties.**

517 (a) If the commissioner finds that an insurer, during
518 any calendar year, has paid at least eighty-five percent (85%),
519 but less than ninety-five percent (95%), of all clean claims
520 received from all providers during that year in accordance with
521 the provisions of subsection (1)(h) of this section, the
522 commissioner may levy an aggregate penalty in an amount not to
523 exceed Ten Thousand Dollars ($10,000.00). If the commissioner
524 finds that an insurer, during any calendar year, has paid at least
525 fifty percent (50%), but less than eighty-five percent (85%), of
526 all clean claims received from all providers during that year in
527 accordance with the provisions of subsection (1)(h) of this
528 section, the commissioner may levy an aggregate penalty in an
529 amount of not less than Ten Thousand Dollars ($10,000.00) nor more
530 than One Hundred Thousand Dollars ($100,000.00). If the
531 commissioner finds that an insurer, during any calendar year, has
532 paid less than fifty percent (50%) of all clean claims received
533 from all providers during that year in accordance with the
534 provisions of subsection (1)(h) of this section, the commissioner
535 may levy an aggregate penalty in an amount not less than One
536 Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred
537 Thousand Dollars ($200,000.00). In determining the amount of any
538 fine, the commissioner shall take into account whether the failure
539 to achieve the standards in subsection (1)(h) of this section were
540 due to circumstances beyond the control of the insurer. The
541 insurer may request an administrative hearing to contest the

542 assessment of any administrative penalty imposed by the
543 commissioner pursuant to this subsection within thirty (30) days
544 after receipt of the notice of assessment.

545 (b) Examinations to determine compliance with
546 subsection (1)(h) of this section may be conducted by the
547 commissioner or any of his examiners. The commissioner may
548 contract with qualified impartial outside sources to assist in
549 examinations to determine compliance. The expenses of any such
550 examinations shall be paid by the insurer examined.

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

555 (d) An insurer and a provider may enter into an express
556 written agreement containing timely claim payment provisions which
557 differ from, but are at least as stringent as, the provisions set
558 forth under subsection (1)(h) of this section, and in such case,
559 the provisions of the written agreement shall govern the timely
560 payment of claims by the insurer to the provider. If the express
561 written agreement is silent as to any interest penalty where
562 claims are not paid in accordance with the agreement, the interest
563 penalty provision of subsection (1)(h)3 of this section shall
564 apply.

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

567 **SECTION 2.** Section 83-9-3, Mississippi Code of 1972, is
568 brought forward as follows:
569 83-9-3. (1) No policy of accident and sickness insurance
570 shall be delivered or issued for delivery to any person in this
571 state unless:
572 (a) The entire money and other considerations therefor
573 are expressed therein; and
574 (b) The time at which the insurance takes effect and
575 terminates is expressed therein; and
576 (c) It purports to insure only one (1) person, except
577 that a policy may insure, originally or by subsequent amendment,
578 upon the application of an adult member of a family who shall be
579 deemed the policyholder, any two (2) or more eligible members of
580 that family, including husband, wife, dependent children or any
581 children under a specified age which shall not exceed nineteen
582 (19) years, and any other person dependent upon the policyholder;
583 and
584 (d) The style, arrangement and overall appearance of
585 the policy give no undue prominence to any portion of the text,
586 and unless every printed portion of the text of the policy and of
587 any endorsements or attached papers is plainly printed in
588 lightfaced type of a style in general use, the size of which shall
589 be uniform and not less than ten-point with a lowercase unspaced
590 alphabet length not less than one-hundred-twenty-point (the "text"
591 shall include all printed matter except the name and address of

592 the insurer, name or title of the policy, the brief description if
593 any, and captions and subcaptions); and
594 (e) The exceptions and reductions of indemnity are set
595 forth in the policy and, except those which are set forth in
596 Section 83-9-5, are printed, at the insurer's option, either with
597 the benefit provision to which they apply, or under an appropriate
598 caption such as "Exceptions" or "Exceptions and Reductions,"
599 provided that if an exception or reduction specifically applies
600 only to a particular benefit of the policy, a statement of such
601 exception or reduction shall be included with the benefit
602 provision to which it applies; and
603 (f) Each such form, including riders and endorsements,
604 shall be identified by a form number in the lower left-hand corner
605 of the first page thereof; and
606 (g) It contains no provision purporting to make any
607 portion of the charter, rules, constitution or bylaws of the
608 insurer a part of the policy unless such portion is set forth in
609 full in the policy, except in the case of the incorporation of, or
610 reference to, a statement of rates or classification of risks, or
611 short-rate table filed with the commissioner.
612 (2) No individual or group policy covering health and
613 accident insurance (including experience-rated insurance
614 contracts, indemnity contracts, self-insured plans and self-funded
615 plans), or any group combinations of these coverages, shall be
616 issued by any commercial insurer doing business in this state

617 which, by the terms of such policy, limits or excludes payment
618 because the individual or group insured is eligible for or is
619 being provided medical assistance under the Mississippi Medicaid
620 Law. Any such policy provision in violation of this section shall
621 be invalid.

622 (3) No individual or group policy covering health and
623 accident insurance (including experience-rated insurance
624 contracts, indemnity contracts, self-insured plans and self-funded
625 plans) or any group combinations of these coverages, shall be
626 issued by any commercial insurer doing business in this state,
627 which, by the terms of such policy, limits or restricts the
628 insured's ability to assign the insured's benefits under the
629 policy to a licensed health care provider that provides health
630 care services to the insured. Commercial insurers doing business
631 in this state shall honor an assignment for a period of one (1)
632 year starting from the initial date of an assignment. Any such
633 policy provision in violation of this subsection shall be invalid.

634 (4) If any policy is issued by an insurer domiciled in this
635 state for delivery to a person residing in another state, and if
636 the official having responsibility for the administration of the
637 insurance laws of such other state shall have advised the
638 commissioner that any such policy is not subject to approval or
639 disapproval by such official, the commissioner may, by ruling,
640 require that such policy meet the standards set forth in
641 subsection (1) of this section and in Section 83-9-5.

642 (5) The commissioner shall collect and pay into the special
643 fund in the State Treasury designated as the "Insurance Department
644 Fund" the following fees for services provided under this section:

	FORM	FEE
645		
646	Each individual policy contract, including	
647	revisions..	$15.00
648	Each group master policy or contract, including	
649	revisions..	15.00
650	Each rider, endorsement or amendment, etc..............	10.00
651	Each insurance application where written application	
652	is required and is to be made a part of the policy or	
653	contract...	10.00
654	Each questionnaire.......................................	7.00
655	Charge for resubmission where payment is not included	
656	with original submission.................................	5.00
657	Additional charge for tentative approval same as above.	

658 (6) In order to expedite and become more efficient in
659 reviewing and approving accident and health form and rate filings,
660 the commissioner may establish an expedited form and rate review
661 procedure whereby insurers may elect to pay reasonable actuarial
662 fees directly to a department-approved actuarial service in
663 exchange for an expedited review of form and rate filings by the
664 actuarial service. The commissioner may make such reasonable
665 rules and regulations concerning the expedited procedure, and may
666 set reasonable fees for the actuarial services provided. This

667 provision shall not abridge any other authority granted to the
668 commissioner by law, including the authority to collect the filing
669 fees prescribed by this section.

670 (7) From and after July 1, 2016, the expenses of this agency
671 shall be defrayed by appropriation from the State General Fund and
672 all user charges and fees authorized under this section shall be
673 deposited into the State General Fund as authorized by law.

674 (8) From and after July 1, 2016, no state agency shall
675 charge another state agency a fee, assessment, rent or other
676 charge for services or resources received by authority of this
677 section.

678 **SECTION 3.** This act shall take effect and be in force from
679 and after July 1, 2019.

ST: Health insurance; provide AG regulation and arbitration of disputes regarding billing between provider and insured.