MISSISSIPPI LEGISLATURE REGULAR SESSION 2019

By: Representatives Chism, Hines, Paden To: Insurance

HOUSE BILL NO. 628
(As Passed the House)

1 AN ACT TO AMEND SECTION 83-9-5, MISSISSIPPI CODE OF 1972, TO
2 REQUIRE ACCIDENT AND HEALTH INSURANCE POLICIES TO INCLUDE
3 ADDITIONAL PROVISIONS THAT PENALIZE LATE PAYMENT OF CLAIMS BY
4 INSURER TO HEALTH CARE PROVIDER OR INSURED; AND FOR RELATED
5 PURPOSES.

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

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

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

20 individual or group captions or subcaptions as the commissioner
21 may approve.
22 As used in this section, the term "insurer" means a health
23 maintenance organization, an insurance company or any other entity
24 responsible for the payment of benefits under a policy or contract
25 of accident and sickness insurance; however, the term "insurer"
26 shall not mean a liquidator, rehabilitator, conservator or
27 receiver or third-party administrator of any health maintenance
28 organization, insurance company or other entity responsible for
29 the payment of benefits which is in liquidation, rehabilitation or
30 conservation proceedings, nor shall it mean any responsible
31 guaranty association. Further, no cause of action shall accrue
32 against a liquidator, rehabilitator, conservator or receiver or
33 third-party administrator of any health maintenance organization,
34 insurance company or other entity responsible for the payment of
35 benefits which is in liquidation, rehabilitation or conservation
36 proceedings or any responsible guaranty association under
37 paragraph (h)3 of this subsection or any policy provision in
38 accordance therewith.
39 (a) A provision as follows:
40 Entire contract; changes: This policy, including the
41 endorsements and the attached papers, if any, constitutes the
42 entire contract of insurance. No change in this policy shall be
43 valid until approved by an executive officer of the insurer and
44 unless such approval be endorsed hereon or attached hereto. No

45 agent has authority to change this policy or to waive any of its
46 provisions.
47 (b) A provision as follows:
48 Time limit on certain defenses:
49 1. After two (2) years from the date of issue of
50 this policy, no misstatements, except fraudulent misstatements,
51 made by the applicant in the application for such policy shall be
52 used to void the policy or to deny a claim for loss incurred or
53 disability (as defined in the policy) commencing after the
54 expiration of such two-year period.
55 (The foregoing policy provision shall not be so construed as
56 to effect any legal requirement for avoidance of a policy or
57 denial of a claim during such initial two-year period, nor to
58 limit the application of subsection (2)(a) and (2)(b) of this
59 section in the event of misstatement with respect to age or
60 occupation.)
61 (A policy which the insured has the right to continue in
62 force subject to its terms by the timely payment of premium (1)
63 until at least age fifty (50) or, (2) in the case of a policy
64 issued after age forty-four (44), for at least five (5) years from
65 its date of issue, may contain in lieu of the foregoing the
66 following provision (from which the clause in parentheses may be
67 omitted at the insurer's option) under the caption
68 "INCONTESTABLE":

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

94 the insurer has delivered to the insured or has mailed to his last
95 address as shown by the records of the insurer written notice of
96 its intention not to renew this policy beyond the period for which
97 the premium has been accepted.")

98 (d) A provision as follows:

99 Reinstatement:

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

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

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

168 Written proof of loss must be furnished to the insurer at its
169 said office, in case of claim for loss for which this policy
170 provides any periodic payment contingent upon continuing loss,
171 within ninety (90) days after the termination of the period for
172 which the insurer is liable, and in case of claim for any other
173 loss, within ninety (90) days after the date of such loss.
174 Failure to furnish such proof within the time required shall not
175 invalidate or reduce any claim if it was not reasonably possible
176 to give proof within such time, provided such proof is furnished
177 as soon as reasonably possible and in no event, except in the
178 absence of legal capacity, later than one (1) year from the time
179 proof is otherwise required.
180 (h) A provision as follows:
181 Time of payment of claims:
182 1. All benefits payable under this policy for any
183 loss, other than loss for which this policy provides any periodic
184 payment, will be paid within twenty-five (25) days after receipt
185 of due written proof of such loss in the form of a clean claim
186 where claims are submitted electronically, and will be paid within
187 thirty-five (35) days after receipt of due written proof of such
188 loss in the form of clean claim where claims are submitted in
189 paper format. Benefits due under the policies and claims are
190 overdue if not paid within twenty-five (25) days or thirty-five
191 (35) days, whichever is applicable, after the insurer receives a
192 clean claim containing necessary medical information and other

193 information essential for the insurer to administer preexisting
194 condition, coordination of benefits and subrogation provisions. A
195 "clean claim" means a claim received by an insurer for
196 adjudication and which requires no further information, adjustment
197 or alteration by the provider of the services or the insured in
198 order to be processed and paid by the insurer. A claim is clean
199 if it has no defect or impropriety, including any lack of
200 substantiating documentation, or particular circumstance requiring
201 special treatment that prevents timely payment from being made on
202 the claim under this provision. A clean claim includes
203 resubmitted claims with previously identified deficiencies
204 corrected. <u>Errors, such as system errors, attributable to the
205 insurer, do not change the clean claim status.</u>
206 A clean claim does not include any of the following:
207 a. A duplicate claim, which means an original
208 claim and its duplicate when the duplicate is filed within thirty
209 (30) days of the original claim;
210 b. Claims which are submitted fraudulently or
211 that are based upon material misrepresentations;
212 c. Claims that require information essential
213 for the insurer to administer preexisting condition, coordination
214 of benefits or subrogation provisions; or
215 d. Claims submitted by a provider more than
216 thirty (30) days after the date of service; if the provider does
217 not submit the claim on behalf of the insured, then a claim is not

218 clean when submitted more than thirty (30) days after the date of
219 billing by the provider to the insured.
220 Not later than twenty-five (25) days after the date the
221 insurer actually receives an electronic claim, the insurer shall
222 pay the appropriate benefit in full, or any portion of the claim
223 that is clean, and notify the provider (where the claim is owed to
224 the provider) or the insured (where the claim is owed to the
225 insured) of the reasons why the claim or portion thereof is not
226 clean and will not be paid and what substantiating documentation
227 and information is required to adjudicate the claim as clean. Not
228 later than thirty-five (35) days after the date the insurer
229 actually receives a paper claim, the insurer shall pay the
230 appropriate benefit in full, or any portion of the claim that is
231 clean, and notify the provider (where the claim is owed to the
232 provider) or the insured (where the claim is owed to the insured)
233 of the reasons why the claim or portion thereof is not clean and
234 will not be paid and what substantiating documentation and
235 information is required to adjudicate the claim as clean. Any
236 claim or portion thereof resubmitted with the supporting
237 documentation and information requested by the insurer shall be
238 paid within twenty (20) days after receipt.
239 For purposes of this provision, the term "pay" means that the
240 insurer shall either send cash or a cash equivalent by United
241 States mail, or send cash or a cash equivalent by other means such
242 as electronic transfer, in full satisfaction of the appropriate

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

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

259 3. If the claim is not denied for valid and proper
260 reasons by the end of the applicable time period prescribed in
261 this provision, the insurer must pay the provider (where the claim
262 is owed to the provider) or the insured (where the claim is owed
263 to the insured) interest on accrued benefits at the rate of *** * ***
264 three percent (3%) per month accruing from the day after payment
265 was due on the amount of the benefits that remain unpaid until the
266 claim is finally settled or adjudicated. Whenever interest due
267 pursuant to this provision is less than One Dollar ($1.00), such

268 amount shall be credited to the account of the person or entity to
269 whom such amount is owed.

270 4. In the event the insurer fails to pay benefits
271 when due, the person entitled to such benefits may bring action to
272 recover such benefits, any interest which may accrue as provided
273 in * * * item 3 of this * * * paragraph (h) and any other damages
274 as may be allowable by law. If it is determined in such action
275 that the insurer acted in bad faith as evidenced by a repeated or
276 deliberate pattern of failing to pay benefits and/or claims when
277 due, the person entitled to such benefits (healthcare provider or
278 insured) shall be entitled to recover damages in an amount equal
279 to three (3) times the amount of the unpaid claims.

280 (i) A provision as follows:

281 Payment of claims:

282 Indemnity for loss of life will be payable in accordance with
283 the beneficiary designation and the provisions respecting such
284 payment which may be prescribed herein and effective at the time
285 of payment. If no such designation or provision is then
286 effective, such indemnity shall be payable to the estate of the
287 insured. Any other accrued indemnities unpaid at the insured's
288 death may, at the option of the insurer, be paid either to such
289 beneficiary or to such estate. All other indemnities will be
290 payable to the insured. When payments of benefits are made to an
291 insured directly for medical care or services rendered by a health
292 care provider, the health care provider shall be notified of such

293 payment. The notification requirement shall not apply to a
294 fixed-indemnity policy, a limited benefit health insurance policy,
295 medical payment coverage or personal injury protection coverage in
296 a motor vehicle policy, coverage issued as a supplement to
297 liability insurance or workers' compensation. If the insured
298 provides the insurer with written direction that all or a portion
299 of any indemnities or benefits provided by the policy be paid to a
300 licensed health care provider rendering hospital, nursing, medical
301 or surgical services, then the insurer shall pay directly the
302 licensed health care provider rendering such services. That
303 payment shall be considered payment in full to the provider, who
304 may not bill or collect from the insured any amount above that
305 payment, other than the deductible, coinsurance, copayment or
306 other charges for equipment or services requested by the insured
307 that are noncovered benefits.
308 (The following provision may be included with the foregoing
309 provision at the option of the insurer: "If any indemnity of this
310 policy shall be payable to the estate of the insured, or to an
311 insured or beneficiary who is a minor or otherwise not competent
312 to give a valid release, the insurer may pay such indemnity, up to
313 an amount not exceeding $______________ (insert an amount which
314 must not exceed One Thousand Dollars ($1,000.00)), to any relative
315 by blood or connection by marriage of the insured or beneficiary
316 who is deemed by the insurer to be equitably entitled thereto.
317 Any payment made by the insurer in good faith pursuant to this

318 provision shall fully discharge the insurer to the extent of such
319 payment."
320 (j) A provision as follows:
321 Physical examinations:
322 The insurer at his own expense shall have the right and
323 opportunity to examine the person of the insured when and as often
324 as it may reasonably require during the pendency of a claim
325 hereunder.
326 (k) A provision as follows:
327 Legal actions:
328 No action at law or in equity shall be brought to recover on
329 this policy prior to the expiration of sixty (60) days after
330 written proof of loss has been furnished in accordance with the
331 requirements of this policy. No such action shall be brought
332 after the expiration of three (3) years after the time written
333 proof of loss is required to be furnished.
334 (l) A provision as follows:
335 Change of beneficiary:
336 Unless the insured makes an irrevocable designation of
337 beneficiary, the right to change the beneficiary is reserved to
338 the insured, and the consent of the beneficiary or beneficiaries
339 shall not be requisite to surrender or assignment of this policy,
340 or to any change of beneficiary or beneficiaries, or to any other
341 changes in this policy.

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

345 (2) **Other provisions.** Except as provided in subsection (3)
346 of this section, no such policy delivered or issued for delivery
347 to any person in this state shall contain provisions respecting
348 the matters set forth below unless such provisions are in the
349 words in which the same appear in this section. However, the
350 insurer may, at its option, use in lieu of any such provision a
351 corresponding provision of different wording approved by the
352 commissioner which is not less favorable in any respect to the
353 insured or the beneficiary. Any such provision contained in the
354 policy shall be preceded individually by the appropriate caption
355 appearing in this subsection or, at the option of the insurer, by
356 such appropriate individual or group captions or subcaptions as
357 the commissioner may approve.

358 (a) A provision as follows:

359 Change of occupation:

360 If the insured be injured or contract sickness after having
361 changed his occupation to one classified by the insurer as more
362 hazardous than that stated in this policy or while doing for
363 compensation anything pertaining to an occupation so classified,
364 the insurer will pay only such portion of the indemnities provided
365 in this policy as the premium paid would have purchased at the
366 rates and within the limits fixed by the insurer for such more

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

385 (b) A provision as follows:

386 Misstatement of age:

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

390 (c) A provision as follows:

391 Relation of earnings to issuance:

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

417 date of issue. The insurer may, at its option, include in this
418 provision a definition of "valid loss of time coverage," approved
419 as to form by the commissioner, which definition shall be limited
420 in subject matter to coverage provided by governmental agencies or
421 by organizations subject to regulations by insurance law or by
422 insurance authorities of this or any other state of the United
423 States or any province of Canada, or to any other coverage the
424 inclusion of which may be approved by the commissioner, or any
425 combination of such coverages. In the absence of such definition,
426 such term shall not include any coverage provided for such insured
427 pursuant to any compulsory benefit statute (including any workers'
428 compensation or employer's liability statute), or benefits
429 provided by union welfare plans or by employer or employee benefit
430 organizations.)

431 (d) A provision as follows:

432 Unpaid premium:

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

436 (e) A provision as follows:

437 Cancellation:

438 The insurer may cancel this policy at any time by written
439 notice delivered to the insured, or mailed to his last address as
440 shown by the records of the insurer, stating when, not less than
441 five (5) days thereafter, such cancellation shall be effective;

442 and after the policy has been continued beyond its original term,
443 the insured may cancel this policy at any time by written notice
444 delivered or mailed to the insurer, effective upon receipt or on
445 such later date as may be specified in such notice. In the event
446 of cancellation, the insurer will return promptly the unearned
447 portion of any premium paid. If the insured cancels, the earned
448 premium shall be computed by the use of the short-rate table last
449 filed with the state official having supervision of insurance in
450 the state where the insured resided when the policy was issued.
451 If the insurer cancels, the earned premium shall be computed pro
452 rata. Cancellation shall be without prejudice to any claim
453 originating prior to the effective date of cancellation.
454 (f) A provision as follows:
455 Conformity with state statutes:
456 Any provision of this policy which, on its effective date, is
457 in conflict with the statutes of the state in which the insured
458 resides on such date is hereby amended to conform to the minimum
459 requirements of such statutes.
460 (g) A provision as follows:
461 Illegal occupation:
462 The insurer shall not be liable for any loss to which a
463 contributing cause was the insured's commission of or attempt to
464 commit a felony or to which a contributing cause was the insured's
465 being engaged in an illegal occupation.
466 (h) A provision as follows:

467 Intoxicants and narcotics:

468 The insurer shall not be liable for any loss sustained or
469 contracted in consequence of the insured's being intoxicated or
470 under the influence of any narcotic unless administered on the
471 advice of a physician.

472 (3) **Inapplicable or inconsistent provisions.** If any
473 provision of this section is, in whole or in part, inapplicable to
474 or inconsistent with the coverage provided by a particular form of
475 policy, the insurer, with the approval of the commissioner, shall
476 omit from such policy any inapplicable provision or part of a
477 provision, and shall modify any inconsistent provision or part of
478 the provision in such manner as to make the provision as contained
479 in the policy consistent with the coverage provided by the policy.

480 (4) **Order of certain policy provisions.** The provisions
481 which are the subject of subsections (1) and (2) of this section,
482 or any corresponding provisions which are used in lieu thereof in
483 accordance with such subsections, shall be printed in the
484 consecutive order of the provisions in such subsections or, at the
485 option of the insurer, any such provision may appear as a unit in
486 any part of the policy, with other provisions to which it may be
487 logically related, provided the resulting policy shall not be, in
488 whole or in part, unintelligible, uncertain, ambiguous, abstruse
489 or likely to mislead a person to whom the policy is offered,
490 delivered or issued.

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

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

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

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

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

515 (8) **Administrative penalties.**

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

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

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

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

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

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

566 **SECTION 2.** This act shall take effect and be in force from
567 and after July 1, 2019.

ST: Health insurance; revise mandatory policy provisions to penalize late payments of claims.