MISSISSIPPI LEGISLATURE REGULAR SESSION 2020

By: Representative Chism To: Insurance

HOUSE BILL NO. 95
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 83-9-5, MISSISSIPPI CODE OF 1972, TO
2 PROVIDE THAT THE COMMISSIONER OF INSURANCE MAY RESOLVE CERTAIN
3 DISPUTES BETWEEN HEALTH CARE PROVIDERS AND INSUREDS; TO PROVIDE
4 THAT THE COMMISSIONER OF INSURANCE SHALL ADOPT RULES AND
5 REGULATIONS NECESSARY TO ENFORCE CERTAIN PROVISIONS; TO BRING
6 FORWARD SECTION 83-9-3, MISSISSIPPI CODE OF 1972, FOR PURPOSES OF
7 POSSIBLE 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. Errors, such as system errors, attributable to the
207 insurer, do not change the clean claim status.
208 A clean claim does not include any of the following:
209 a. A duplicate claim, which means an original
210 claim and its duplicate when the duplicate is filed within thirty
211 (30) days of the original claim;
212 b. Claims which are submitted fraudulently or
213 that are based upon material misrepresentations;
214 c. Claims that require information essential
215 for the insurer to administer preexisting condition, coordination
216 of benefits or subrogation provisions; or
217 d. Claims submitted by a provider more than
218 thirty (30) days after the date of service; if the provider does
219 not submit the claim on behalf of the insured, then a claim is not

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

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

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

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

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

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

270 shall be credited to the account of the person or entity to whom
271 such amount is owed. The provisions of this subparagraph 3 shall
272 not apply to any claims or benefits owed under Medicare Advantage
273 plans or Medicare Advantage Prescription Drug plans.

274 4. In the event the insurer fails to pay benefits
275 when due, the person entitled to such benefits may bring action to
276 recover such benefits, any interest which may accrue as provided
277 in subparagraph 3 of this paragraph (h) and any other damages as
278 may be allowable by law. If it is determined in such action that
279 the insurer acted in bad faith as evidenced by a repeated or
280 deliberate pattern of failing to pay benefits and/or claims when
281 due, the person entitled to such benefits (health care provider or
282 insured) shall be entitled to recover damages in an amount up to
283 three (3) times the amount of the benefits that remain unpaid
284 until the claim is finally settled or adjudicated.

285 (i) A provision as follows:

286 Payment of claims:

287 Indemnity for loss of life will be payable in accordance with
288 the beneficiary designation and the provisions respecting such
289 payment which may be prescribed herein and effective at the time
290 of payment. If no such designation or provision is then
291 effective, such indemnity shall be payable to the estate of the
292 insured. Any other accrued indemnities unpaid at the insured's
293 death may, at the option of the insurer, be paid either to such
294 beneficiary or to such estate. All other indemnities will be

295 payable to the insured. When payments of benefits are made to an
296 insured directly for medical care or services rendered by a health
297 care provider, the health care provider shall be notified of such
298 payment. The notification requirement shall not apply to a
299 fixed-indemnity policy, a limited benefit health insurance policy,
300 medical payment coverage or personal injury protection coverage in
301 a motor vehicle policy, coverage issued as a supplement to
302 liability insurance or workers' compensation. If the insured
303 provides the insurer with written direction that all or a portion
304 of any indemnities or benefits provided by the policy be paid to a
305 licensed health care provider rendering hospital, nursing, medical
306 or surgical services, then the insurer shall pay directly the
307 licensed health care provider rendering such services. That
308 payment shall be considered payment in full to the provider, who
309 may not bill or collect from the insured any amount above that
310 payment, other than the deductible, coinsurance, copayment or
311 other charges for equipment or services requested by the insured
312 that are noncovered benefits. Any dispute between a provider and
313 the insured arising under these provisions regarding assignment of
314 benefits and billing may be resolved by the Commissioner of
315 Insurance. The Commissioner of Insurance shall adopt any rules
316 and regulations necessary to enforce these provisions regarding
317 assignment of benefits and billing.
318 (The following provision may be included with the foregoing
319 provision at the option of the insurer: "If any indemnity of this

320 policy shall be payable to the estate of the insured, or to an
321 insured or beneficiary who is a minor or otherwise not competent
322 to give a valid release, the insurer may pay such indemnity, up to
323 an amount not exceeding $______________ (insert an amount which
324 must not exceed One Thousand Dollars ($1,000.00)), to any relative
325 by blood or connection by marriage of the insured or beneficiary
326 who is deemed by the insurer to be equitably entitled thereto.
327 Any payment made by the insurer in good faith pursuant to this
328 provision shall fully discharge the insurer to the extent of such
329 payment.")

330 (j) A provision as follows:

331 Physical examinations:

332 The insurer at his own expense shall have the right and
333 opportunity to examine the person of the insured when and as often
334 as it may reasonably require during the pendency of a claim
335 hereunder.

336 (k) A provision as follows:

337 Legal actions:

338 No action at law or in equity shall be brought to recover on
339 this policy prior to the expiration of sixty (60) days after
340 written proof of loss has been furnished in accordance with the
341 requirements of this policy. No such action shall be brought
342 after the expiration of three (3) years after the time written
343 proof of loss is required to be furnished.

344 (l) A provision as follows:

345 Change of beneficiary:

346 Unless the insured makes an irrevocable designation of
347 beneficiary, the right to change the beneficiary is reserved to
348 the insured, and the consent of the beneficiary or beneficiaries
349 shall not be requisite to surrender or assignment of this policy,
350 or to any change of beneficiary or beneficiaries, or to any other
351 changes in this policy.

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

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

368 (a) A provision as follows:

369 Change of occupation:

370 If the insured be injured or contract sickness after having
371 changed his occupation to one classified by the insurer as more
372 hazardous than that stated in this policy or while doing for
373 compensation anything pertaining to an occupation so classified,
374 the insurer will pay only such portion of the indemnities provided
375 in this policy as the premium paid would have purchased at the
376 rates and within the limits fixed by the insurer for such more
377 hazardous occupation. If the insured changes his occupation to
378 one classified by the insurer as less hazardous than that stated
379 in this policy, the insurer, upon receipt of proof of such change
380 of occupation, will reduce the premium rate accordingly, and will
381 return the excess pro rata unearned premium from the date of
382 change of occupation or from the policy anniversary date
383 immediately preceding receipt of such proof, whichever is the most
384 recent. In applying this provision, the classification of
385 occupational risk and the premium rates shall be such as have been
386 last filed by the insurer prior to the occurrence of the loss for
387 which the insurer is liable, or prior to date of proof of change
388 in occupation, with the state official having supervision of
389 insurance in the state where the insured resided at the time this
390 policy was issued; but if such filing was not required, then the
391 classification of occupational risk and the premium rates shall be
392 those last made effective by the insurer in such state prior to
393 the occurrence of the loss or prior to the date of proof of change
394 in occupation.

395 (b) A provision as follows:

396 Misstatement of age:

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

400 (c) A provision as follows:

401 Relation of earnings to issuance:

402 If the total monthly amount of loss of time benefits promised
403 for the same loss under all valid loss of time coverage upon the
404 insured, whether payable on a weekly or monthly basis, shall
405 exceed the monthly earnings of the insured at the time disability
406 commenced or his average monthly earnings for the period of two
407 (2) years immediately preceding a disability for which claim is
408 made, whichever is the greater, the insurer will be liable only
409 for such proportionate amount of such benefits under this policy
410 as the amount of such monthly earnings or such average monthly
411 earnings of the insured bears to the total amount of monthly
412 benefits for the same loss under all such coverage upon the
413 insured at the time such disability commences and for the return
414 of such part of the premiums paid during such two (2) years as
415 shall exceed the pro rata amount of the premiums for the benefits
416 actually paid hereunder; but this shall not operate to reduce the
417 total monthly amount of benefits payable under all such coverage
418 upon the insured below the sum of Two Hundred Dollars ($200.00) or
419 the sum of the monthly benefits specified in such coverages,

420 whichever is the lesser, nor shall it operate to reduce benefits
421 other than those payable for loss of time.
422 (The foregoing policy provision may be inserted only in a
423 policy which the insured has the right to continue in force
424 subject to its terms by the timely payment of premiums (1) until
425 at least age fifty (50) or, (2) in the case of a policy issued
426 after age forty-four (44), for at least five (5) years from its
427 date of issue. The insurer may, at its option, include in this
428 provision a definition of "valid loss of time coverage," approved
429 as to form by the commissioner, which definition shall be limited
430 in subject matter to coverage provided by governmental agencies or
431 by organizations subject to regulations by insurance law or by
432 insurance authorities of this or any other state of the United
433 States or any province of Canada, or to any other coverage the
434 inclusion of which may be approved by the commissioner, or any
435 combination of such coverages. In the absence of such definition,
436 such term shall not include any coverage provided for such insured
437 pursuant to any compulsory benefit statute (including any workers'
438 compensation or employer's liability statute), or benefits
439 provided by union welfare plans or by employer or employee benefit
440 organizations.)
441 (d) A provision as follows:
442 Unpaid premium:

443 Upon the payment of a claim under this policy, any premium
444 then due and unpaid or covered by any note or written order may be
445 deducted therefrom.
446 (e) A provision as follows:
447 Cancellation:
448 The insurer may cancel this policy at any time by written
449 notice delivered to the insured, or mailed to his last address as
450 shown by the records of the insurer, stating when, not less than
451 five (5) days thereafter, such cancellation shall be effective;
452 and after the policy has been continued beyond its original term,
453 the insured may cancel this policy at any time by written notice
454 delivered or mailed to the insurer, effective upon receipt or on
455 such later date as may be specified in such notice. In the event
456 of cancellation, the insurer will return promptly the unearned
457 portion of any premium paid. If the insured cancels, the earned
458 premium shall be computed by the use of the short-rate table last
459 filed with the state official having supervision of insurance in
460 the state where the insured resided when the policy was issued.
461 If the insurer cancels, the earned premium shall be computed pro
462 rata. Cancellation shall be without prejudice to any claim
463 originating prior to the effective date of cancellation.
464 (f) A provision as follows:
465 Conformity with state statutes:
466 Any provision of this policy which, on its effective date, is
467 in conflict with the statutes of the state in which the insured

468 resides on such date is hereby amended to conform to the minimum
469 requirements of such statutes.

470 (g) A provision as follows:

471 Illegal occupation:

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

476 (h) A provision as follows:

477 Intoxicants and narcotics:

478 The insurer shall not be liable for any loss sustained or
479 contracted in consequence of the insured's being intoxicated or
480 under the influence of any narcotic unless administered on the
481 advice of a physician.

482 (3) **Inapplicable or inconsistent provisions.** If any
483 provision of this section is, in whole or in part, inapplicable to
484 or inconsistent with the coverage provided by a particular form of
485 policy, the insurer, with the approval of the commissioner, shall
486 omit from such policy any inapplicable provision or part of a
487 provision, and shall modify any inconsistent provision or part of
488 the provision in such manner as to make the provision as contained
489 in the policy consistent with the coverage provided by the policy.

490 (4) **Order of certain policy provisions.** The provisions
491 which are the subject of subsections (1) and (2) of this section,
492 or any corresponding provisions which are used in lieu thereof in

493 accordance with such subsections, shall be printed in the
494 consecutive order of the provisions in such subsections or, at the
495 option of the insurer, any such provision may appear as a unit in
496 any part of the policy, with other provisions to which it may be
497 logically related, provided the resulting policy shall not be, in
498 whole or in part, unintelligible, uncertain, ambiguous, abstruse
499 or likely to mislead a person to whom the policy is offered,
500 delivered or issued.

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

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

509 (a) Any policy of a foreign or alien insurer, when
510 delivered or issued for delivery to any person in this state, may
511 contain any provision which is not less favorable to the insured
512 or the beneficiary than the provisions of Sections 83-9-1 through
513 83-9-21, Mississippi Code of 1972, and which is prescribed or
514 required by the law of the state under which the insurer is
515 organized.

516 (b) Any policy of a domestic insurer may, when issued
517 for delivery in any other state or country, contain any provision
518 permitted or required by the laws of such other state or country.
519 (7) **Filing procedure.** The commissioner may make such
520 reasonable rules and regulations concerning the procedure for the
521 filing or submission of policies subject to the cited sections as
522 are necessary, proper or advisable to the administration of said
523 sections. This provision shall not abridge any other authority
524 granted the commissioner by law.
525 (8) **Administrative penalties.**
526 (a) If the commissioner finds that an insurer, during
527 any calendar year, has paid at least eighty-five percent (85%),
528 but less than ninety-five percent (95%), of all clean claims
529 received from all providers during that year in accordance with
530 the provisions of subsection (1)(h) of this section, the
531 commissioner may levy an aggregate penalty in an amount not to
532 exceed Ten Thousand Dollars ($10,000.00). If the commissioner
533 finds that an insurer, during any calendar year, has paid at least
534 fifty percent (50%), but less than eighty-five percent (85%), of
535 all clean claims received from all providers during that year in
536 accordance with the provisions of subsection (1)(h) of this
537 section, the commissioner may levy an aggregate penalty in an
538 amount of not less than Ten Thousand Dollars ($10,000.00) nor more
539 than One Hundred Thousand Dollars ($100,000.00). If the
540 commissioner finds that an insurer, during any calendar year, has

541 paid less than fifty percent (50%) of all clean claims received
542 from all providers during that year in accordance with the
543 provisions of subsection (1)(h) of this section, the commissioner
544 may levy an aggregate penalty in an amount not less than One
545 Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred
546 Thousand Dollars ($200,000.00). In determining the amount of any
547 fine, the commissioner shall take into account whether the failure
548 to achieve the standards in subsection (1)(h) of this section were
549 due to circumstances beyond the control of the insurer. The
550 insurer may request an administrative hearing to contest the
551 assessment of any administrative penalty imposed by the
552 commissioner pursuant to this subsection within thirty (30) days
553 after receipt of the notice of assessment.
554 (b) Examinations to determine compliance with
555 subsection (1)(h) of this section may be conducted by the
556 commissioner or any of his examiners. The commissioner may
557 contract with qualified impartial outside sources to assist in
558 examinations to determine compliance. The expenses of any such
559 examinations shall be paid by the insurer examined.
560 (c) Nothing in the provisions of subsection (1)(h) of
561 this section shall require an insurer to pay claims that are not
562 covered under the terms of a contract or policy of accident and
563 sickness insurance.
564 (d) An insurer and a provider may enter into an express
565 written agreement containing timely claim payment provisions which

566 differ from, but are at least as stringent as, the provisions set
567 forth under subsection (1)(h) of this section, and in such case,
568 the provisions of the written agreement shall govern the timely
569 payment of claims by the insurer to the provider. If the express
570 written agreement is silent as to any interest penalty where
571 claims are not paid in accordance with the agreement, the interest
572 penalty provision of subsection (1)(h)3 of this section shall
573 apply.

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

576 **SECTION 2.** Section 83-9-3, Mississippi Code of 1972, is
577 brought forward as follows:

578 83-9-3. (1) No policy of accident and sickness insurance
579 shall be delivered or issued for delivery to any person in this
580 state unless:

581 (a) The entire money and other considerations therefor
582 are expressed therein; and

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

585 (c) It purports to insure only one (1) person, except
586 that a policy may insure, originally or by subsequent amendment,
587 upon the application of an adult member of a family who shall be
588 deemed the policyholder, any two (2) or more eligible members of
589 that family, including husband, wife, dependent children or any
590 children under a specified age which shall not exceed nineteen

591 (19) years, and any other person dependent upon the policyholder;
592 and

593 (d) The style, arrangement and overall appearance of
594 the policy give no undue prominence to any portion of the text,
595 and unless every printed portion of the text of the policy and of
596 any endorsements or attached papers is plainly printed in
597 lightfaced type of a style in general use, the size of which shall
598 be uniform and not less than ten-point with a lowercase unspaced
599 alphabet length not less than one-hundred-twenty-point (the "text"
600 shall include all printed matter except the name and address of
601 the insurer, name or title of the policy, the brief description if
602 any, and captions and subcaptions); and

603 (e) The exceptions and reductions of indemnity are set
604 forth in the policy and, except those which are set forth in
605 Section 83-9-5, are printed, at the insurer's option, either with
606 the benefit provision to which they apply, or under an appropriate
607 caption such as "Exceptions" or "Exceptions and Reductions,"
608 provided that if an exception or reduction specifically applies
609 only to a particular benefit of the policy, a statement of such
610 exception or reduction shall be included with the benefit
611 provision to which it applies; and

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

615 (g) It contains no provision purporting to make any
616 portion of the charter, rules, constitution or bylaws of the
617 insurer a part of the policy unless such portion is set forth in
618 full in the policy, except in the case of the incorporation of, or
619 reference to, a statement of rates or classification of risks, or
620 short-rate table filed with the commissioner.

621 (2) No individual or group policy covering health and
622 accident insurance (including experience-rated insurance
623 contracts, indemnity contracts, self-insured plans and self-funded
624 plans), or any group combinations of these coverages, shall be
625 issued by any commercial insurer doing business in this state
626 which, by the terms of such policy, limits or excludes payment
627 because the individual or group insured is eligible for or is
628 being provided medical assistance under the Mississippi Medicaid
629 Law. Any such policy provision in violation of this section shall
630 be invalid.

631 (3) No individual or group policy covering health and
632 accident insurance (including experience-rated insurance
633 contracts, indemnity contracts, self-insured plans and self-funded
634 plans) or any group combinations of these coverages, shall be
635 issued by any commercial insurer doing business in this state,
636 which, by the terms of such policy, limits or restricts the
637 insured's ability to assign the insured's benefits under the
638 policy to a licensed health care provider that provides health
639 care services to the insured. Commercial insurers doing business

640 in this state shall honor an assignment for a period of one (1)
641 year starting from the initial date of an assignment. Any such
642 policy provision in violation of this subsection shall be invalid.
643 (4) If any policy is issued by an insurer domiciled in this
644 state for delivery to a person residing in another state, and if
645 the official having responsibility for the administration of the
646 insurance laws of such other state shall have advised the
647 commissioner that any such policy is not subject to approval or
648 disapproval by such official, the commissioner may, by ruling,
649 require that such policy meet the standards set forth in
650 subsection (1) of this section and in Section 83-9-5.
651 (5) The commissioner shall collect and pay into the special
652 fund in the State Treasury designated as the "Insurance Department
653 Fund" the following fees for services provided under this section:
654 FORM FEE
655 Each individual policy contract, including
656 revisions..$15.00
657 Each group master policy or contract, including
658 revisions.. 15.00
659 Each rider, endorsement or amendment, etc.............. 10.00
660 Each insurance application where written application
661 is required and is to be made a part of the policy or
662 contract.. 10.00
663 Each questionnaire..................................... 7.00
664 Charge for resubmission where payment is not included

665 with original submission.................................... 5.00

666 Additional charge for tentative approval same as above.

667 (6) In order to expedite and become more efficient in
668 reviewing and approving accident and health form and rate filings,
669 the commissioner may establish an expedited form and rate review
670 procedure whereby insurers may elect to pay reasonable actuarial
671 fees directly to a department-approved actuarial service in
672 exchange for an expedited review of form and rate filings by the
673 actuarial service. The commissioner may make such reasonable
674 rules and regulations concerning the expedited procedure, and may
675 set reasonable fees for the actuarial services provided. This
676 provision shall not abridge any other authority granted to the
677 commissioner by law, including the authority to collect the filing
678 fees prescribed by this section.

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

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

687 **SECTION 3.** This act shall take effect and be in force from
688 and after July 1, 2020.

ST: Commissioner of Insurance; provide shall resolve certain disputes between provider and insured regarding billing.