MISSISSIPPI LEGISLATURE REGULAR SESSION 2020

By: Representative Dortch

To: Insurance

HOUSE BILL NO. 374

AN ACT TO REQUIRE CERTAIN CONSUMER INFORMATION CONCERNING FACILITY-BASED PHYSICIANS AND NOTICE AND AVAILABILITY OF MEDIATION FOR BALANCE BILLING BY A FACILITY-BASED PHYSICIAN IN AN AMOUNT GREATER THAN TWO HUNDRED FIFTY DOLLARS; TO BRING FORWARD SECTIONS 25-15-17 AND 83-9-5, MISSISSIPPI CODE OF 1972, FOR PURPOSES OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

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

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

amount unpaid by the administrator or insurer, is greater than Two Hundred Fifty Dollars ($250.00).

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

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

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

(4) This section applies only to charges for a medical service or supply provided on or after July 1, 2020. Charges for a medical service or supply provided before July 1, 2020, are governed by the law as it existed immediately before that date.

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

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

payable directly to the covered employee unless such covered employee shall make a valid assignment in accordance with subsection (3) of this section.

(2) The plan may not, by its terms, limit or restrict the covered employee's ability to assign the covered employee's benefits under the policy to a licensed health care provider that provides health care services to the covered employee. Any such plan provision in violation of this subsection shall be invalid.

(3) If the covered employee provides the board with written direction that all or a portion of any indemnities or benefits provided by the plan be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the plan shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the covered employee any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the covered employee that are noncovered benefits after the signing of an explanatory document about the noncovered benefit by the covered employee.

SECTION 3. Section 83-9-5, Mississippi Code of 1972, is brought forward as follows:

83-9-5. (1) **Required provisions.** Except as provided in subsection (3) of this section, each such policy delivered or issued for delivery to any person in this state shall contain the

provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one or more of such provisions, corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

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

paragraph (h)3 of this subsection or any policy provision in accordance therewith.

(a) A provision as follows:

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

(b) A provision as follows:

Time limit on certain defenses:

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

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

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

After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements in the application.)

2. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) A provision as follows:

Grace period:

A grace period of seven (7) days for weekly premium policies, ten (10) days for monthly premium policies and thirty-one (31) days for all other policies will be granted for the payment of

each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "unless not less than five (5) days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.")

(d) A provision as follows:

Reinstatement:

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. However, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt

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

(e) A provision as follows:

Notice of claim:

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

location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss of time benefit which may be payable for at least two (2) years, an insurer may, at its option, insert the following between the first and second sentences of the above provision: "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, he shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability, in whole or in part, by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.")

(f) A provision as follows:

Claim forms:

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within

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

(g) A provision as follows:

Proofs of loss:

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

(h) A provision as follows:

Time of payment of claims:

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

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

A clean claim does not include any of the following:

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

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

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

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

Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and

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

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

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

3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed. The provisions of this subparagraph 3 shall not apply to any claims or benefits owed under Medicare Advantage plans or Medicare Advantage Prescription Drug plans.

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

(i) A provision as follows:

Payment of claims:

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. The notification requirement shall not apply to a fixed-indemnity policy, a limited benefit health insurance policy, medical payment coverage or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance or workers' compensation. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or

other charges for equipment or services requested by the insured that are noncovered benefits.

(The following provision may be included with the foregoing provision at the option of the insurer: "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $_____ (insert an amount which must not exceed One Thousand Dollars ($1,000.00)), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.")

(j) A provision as follows:

Physical examinations:

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

(k) A provision as follows:

Legal actions:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the

requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(l) A provision as follows:

Change of beneficiary:

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

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

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

such appropriate individual or group captions or subcaptions as the commissioner may approve.

(a) A provision as follows:

Change of occupation:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the most recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable, or prior to date of proof of change in occupation, with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the

classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(b) A provision as follows:

Misstatement of age:

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

(c) A provision as follows:

Relation of earnings to issuance:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits

actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of Two Hundred Dollars ($200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulations by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner, or any combination of such coverages. In the absence of such definition, such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

(d) A provision as follows:

Unpaid premium:

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

(e) A provision as follows:

Cancellation:

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

(f) A provision as follows:

Conformity with state statutes:

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

(g) A provision as follows:

Illegal occupation:

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

(h) A provision as follows:

Intoxicants and narcotics:

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

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

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

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

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

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, and which is prescribed or

required by the law of the state under which the insurer is organized.

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

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

(8) **Administrative penalties.**

(a) If the commissioner finds that an insurer, during any calendar year, has paid at least eighty-five percent (85%), but less than ninety-five percent (95%), of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not to exceed Ten Thousand Dollars ($10,000.00). If the commissioner finds that an insurer, during any calendar year, has paid at least fifty percent (50%), but less than eighty-five percent (85%), of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount of not less than Ten Thousand Dollars ($10,000.00) nor more

than One Hundred Thousand Dollars ($100,000.00). If the commissioner finds that an insurer, during any calendar year, has paid less than fifty percent (50%) of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not less than One Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred Thousand Dollars ($200,000.00). In determining the amount of any fine, the commissioner shall take into account whether the failure to achieve the standards in subsection (1)(h) of this section were due to circumstances beyond the control of the insurer. The insurer may request an administrative hearing to contest the assessment of any administrative penalty imposed by the commissioner pursuant to this subsection within thirty (30) days after receipt of the notice of assessment.

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

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

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

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

SECTION 4. This act shall take effect and be in force from and after July 1, 2020.