

By: Representative Turner

To: Insurance

HOUSE BILL NO. 1079

1 AN ACT TO AMEND SECTION 83-9-5, MISSISSIPPI CODE OF 1972, TO  
2 CLARIFY REQUIREMENTS FOR A CLEAN CLAIM; TO PROVIDE THAT THE  
3 COMMISSIONER OF INSURANCE MAY ADOPT RULES AND REGULATIONS  
4 NECESSARY TO ENSURE COMPLIANCE WITH THIS SECTION; 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. Upon request, the insurer shall provide to the insured  
205 or the provider submitting a claim a written list of the  
206 information required and the documentation required for the  
207 insurer to deem a claim to be clean, and the insurer shall then be  
208 bound to such list. Errors, such as system errors, attributable  
209 to the insurer, do not change the clean claim status.

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

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

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



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

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

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



241 documentation and information requested by the insurer shall be  
242 paid within twenty (20) days after receipt.

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

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

263 3. If the claim is not denied for valid and proper  
264 reasons by the end of the applicable time period prescribed in  
265 this provision, the insurer must pay the provider (where the claim



266 is owed to the provider) or the insured (where the claim is owed  
267 to the insured) interest on accrued benefits at the rate of three  
268 percent (3%) per month accruing from the day after payment was due  
269 on the amount of the benefits that remain unpaid until the claim  
270 is finally settled or adjudicated. Whenever interest due pursuant  
271 to this provision is less than One Dollar (\$1.00), such amount  
272 shall be credited to the account of the person or entity to whom  
273 such amount is owed. The provisions of this subparagraph 3 shall  
274 not apply to any claims or benefits owed under Medicare Advantage  
275 plans or Medicare Advantage Prescription Drug plans.

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

287 (i) A provision as follows:

288 Payment of claims:

289 Indemnity for loss of life will be payable in accordance with  
290 the beneficiary designation and the provisions respecting such



291 payment which may be prescribed herein and effective at the time  
292 of payment. If no such designation or provision is then  
293 effective, such indemnity shall be payable to the estate of the  
294 insured. Any other accrued indemnities unpaid at the insured's  
295 death may, at the option of the insurer, be paid either to such  
296 beneficiary or to such estate. All other indemnities will be  
297 payable to the insured. When payments of benefits are made to an  
298 insured directly for medical care or services rendered by a health  
299 care provider, the health care provider shall be notified of such  
300 payment. The notification requirement shall not apply to a  
301 fixed-indemnity policy, a limited benefit health insurance policy,  
302 medical payment coverage or personal injury protection coverage in  
303 a motor vehicle policy, coverage issued as a supplement to  
304 liability insurance or workers' compensation. If the insured  
305 provides the insurer with written direction that all or a portion  
306 of any indemnities or benefits provided by the policy be paid to a  
307 licensed health care provider rendering hospital, nursing, medical  
308 or surgical services, then the insurer shall pay directly the  
309 licensed health care provider rendering such services. That  
310 payment shall be considered payment in full to the provider, who  
311 may not bill or collect from the insured any amount above that  
312 payment, other than the deductible, coinsurance, copayment or  
313 other charges for equipment or services requested by the insured  
314 that are noncovered benefits. Any dispute between a provider and  
315 the insured arising under these provisions regarding assignment of



316 benefits and billing may be resolved by the Commissioner of  
317 Insurance. The Commissioner of Insurance shall adopt any rules  
318 and regulations necessary to enforce these provisions regarding  
319 assignment of benefits and billing.

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

332 (j) A provision as follows:

333 Physical examinations:

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

338 (k) A provision as follows:

339 Legal actions:



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

346 (1) A provision as follows:

347 Change of beneficiary:

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

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

357 (2) **Other provisions.** Except as provided in subsection (3)  
358 of this section, no such policy delivered or issued for delivery  
359 to any person in this state shall contain provisions respecting  
360 the matters set forth below unless such provisions are in the  
361 words in which the same appear in this section. However, the  
362 insurer may, at its option, use in lieu of any such provision a  
363 corresponding provision of different wording approved by the  
364 commissioner which is not less favorable in any respect to the



365 insured or the beneficiary. Any such provision contained in the  
366 policy shall be preceded individually by the appropriate caption  
367 appearing in this subsection or, at the option of the insurer, by  
368 such appropriate individual or group captions or subcaptions as  
369 the commissioner may approve.

370 (a) A provision as follows:

371 Change of occupation:

372 If the insured be injured or contract sickness after having  
373 changed his occupation to one classified by the insurer as more  
374 hazardous than that stated in this policy or while doing for  
375 compensation anything pertaining to an occupation so classified,  
376 the insurer will pay only such portion of the indemnities provided  
377 in this policy as the premium paid would have purchased at the  
378 rates and within the limits fixed by the insurer for such more  
379 hazardous occupation. If the insured changes his occupation to  
380 one classified by the insurer as less hazardous than that stated  
381 in this policy, the insurer, upon receipt of proof of such change  
382 of occupation, will reduce the premium rate accordingly, and will  
383 return the excess pro rata unearned premium from the date of  
384 change of occupation or from the policy anniversary date  
385 immediately preceding receipt of such proof, whichever is the most  
386 recent. In applying this provision, the classification of  
387 occupational risk and the premium rates shall be such as have been  
388 last filed by the insurer prior to the occurrence of the loss for  
389 which the insurer is liable, or prior to date of proof of change





390 in occupation, with the state official having supervision of  
391 insurance in the state where the insured resided at the time this  
392 policy was issued; but if such filing was not required, then the  
393 classification of occupational risk and the premium rates shall be  
394 those last made effective by the insurer in such state prior to  
395 the occurrence of the loss or prior to the date of proof of change  
396 in occupation.

397 (b) A provision as follows:

398 Misstatement of age:

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

402 (c) A provision as follows:

403 Relation of earnings to issuance:

404 If the total monthly amount of loss of time benefits promised  
405 for the same loss under all valid loss of time coverage upon the  
406 insured, whether payable on a weekly or monthly basis, shall  
407 exceed the monthly earnings of the insured at the time disability  
408 commenced or his average monthly earnings for the period of two  
409 (2) years immediately preceding a disability for which claim is  
410 made, whichever is the greater, the insurer will be liable only  
411 for such proportionate amount of such benefits under this policy  
412 as the amount of such monthly earnings or such average monthly  
413 earnings of the insured bears to the total amount of monthly  
414 benefits for the same loss under all such coverage upon the



415 insured at the time such disability commences and for the return  
416 of such part of the premiums paid during such two (2) years as  
417 shall exceed the pro rata amount of the premiums for the benefits  
418 actually paid hereunder; but this shall not operate to reduce the  
419 total monthly amount of benefits payable under all such coverage  
420 upon the insured below the sum of Two Hundred Dollars (\$200.00) or  
421 the sum of the monthly benefits specified in such coverages,  
422 whichever is the lesser, nor shall it operate to reduce benefits  
423 other than those payable for loss of time.

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



440 compensation or employer's liability statute), or benefits  
441 provided by union welfare plans or by employer or employee benefit  
442 organizations.)

443 (d) A provision as follows:

444 Unpaid premium:

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

448 (e) A provision as follows:

449 Cancellation:

450 The insurer may cancel this policy at any time by written  
451 notice delivered to the insured, or mailed to his last address as  
452 shown by the records of the insurer, stating when, not less than  
453 five (5) days thereafter, such cancellation shall be effective;  
454 and after the policy has been continued beyond its original term,  
455 the insured may cancel this policy at any time by written notice  
456 delivered or mailed to the insurer, effective upon receipt or on  
457 such later date as may be specified in such notice. In the event  
458 of cancellation, the insurer will return promptly the unearned  
459 portion of any premium paid. If the insured cancels, the earned  
460 premium shall be computed by the use of the short-rate table last  
461 filed with the state official having supervision of insurance in  
462 the state where the insured resided when the policy was issued.  
463 If the insurer cancels, the earned premium shall be computed pro



464 rata. Cancellation shall be without prejudice to any claim  
465 originating prior to the effective date of cancellation.

466 (f) A provision as follows:

467 Conformity with state statutes:

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

472 (g) A provision as follows:

473 Illegal occupation:

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

478 (h) A provision as follows:

479 Intoxicants and narcotics:

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

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



489 provision, and shall modify any inconsistent provision or part of  
490 the provision in such manner as to make the provision as contained  
491 in the policy consistent with the coverage provided by the policy.

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

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

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

511           (a) Any policy of a foreign or alien insurer, when  
512 delivered or issued for delivery to any person in this state, may  
513 contain any provision which is not less favorable to the insured



514 or the beneficiary than the provisions of Sections 83-9-1 through  
515 83-9-21, Mississippi Code of 1972, and which is prescribed or  
516 required by the law of the state under which the insurer is  
517 organized.

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

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

527 (8) **Administrative penalties.**

528 (a) If the commissioner finds that an insurer, during  
529 any calendar year, has paid at least eighty-five percent (85%),  
530 but less than ninety-five percent (95%), of all clean claims  
531 received from all providers during that year in accordance with  
532 the provisions of subsection (1)(h) of this section, the  
533 commissioner may levy an aggregate penalty in an amount not to  
534 exceed Ten Thousand Dollars (\$10,000.00). If the commissioner  
535 finds that an insurer, during any calendar year, has paid at least  
536 fifty percent (50%), but less than eighty-five percent (85%), of  
537 all clean claims received from all providers during that year in  
538 accordance with the provisions of subsection (1)(h) of this



539 section, the commissioner may levy an aggregate penalty in an  
540 amount of not less than Ten Thousand Dollars (\$10,000.00) nor more  
541 than One Hundred Thousand Dollars (\$100,000.00). If the  
542 commissioner finds that an insurer, during any calendar year, has  
543 paid less than fifty percent (50%) of all clean claims received  
544 from all providers during that year in accordance with the  
545 provisions of subsection (1)(h) of this section, the commissioner  
546 may levy an aggregate penalty in an amount not less than One  
547 Hundred Thousand Dollars (\$100,000.00) nor more than Two Hundred  
548 Thousand Dollars (\$200,000.00). In determining the amount of any  
549 fine, the commissioner shall take into account whether the failure  
550 to achieve the standards in subsection (1)(h) of this section were  
551 due to circumstances beyond the control of the insurer. The  
552 insurer may request an administrative hearing to contest the  
553 assessment of any administrative penalty imposed by the  
554 commissioner pursuant to this subsection within thirty (30) days  
555 after receipt of the notice of assessment.

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

562 (c) Nothing in the provisions of subsection (1)(h) of  
563 this section shall require an insurer to pay claims that are not



564 covered under the terms of a contract or policy of accident and  
565 sickness insurance.

566 (d) An insurer and a provider may enter into an express  
567 written agreement containing timely claim payment provisions which  
568 differ from, but are at least as stringent as, the provisions set  
569 forth under subsection (1)(h) of this section, and in such case,  
570 the provisions of the written agreement shall govern the timely  
571 payment of claims by the insurer to the provider. Any such  
572 written agreement shall contain a provision that the insurer shall  
573 provide to the insured or the provider submitting a claim a  
574 written list of the information required and the documentation  
575 required for the insurer to deem a claim to be clean, and the  
576 insurer shall then be bound to such list. If the express written  
577 agreement is silent as to any interest penalty where claims are  
578 not paid in accordance with the agreement, the interest penalty  
579 provision of subsection (1)(h)3 of this section shall apply. The  
580 commissioner shall have jurisdiction and authority to ensure any  
581 written agreement complies with the foregoing requirements.  
582 Further, the commissioner shall have jurisdiction and authority to  
583 apply the Administrative Penalties set forth in subsection (8) of  
584 this section to the written agreement.

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





587           (9) The commissioner may adopt rules and regulations  
588 necessary to ensure compliance with the provisions of this  
589 section.

590           **SECTION 2.** This act shall take effect and be in force from  
591 and after its passage.

