

By: Senator(s) Dawkins

To: Public Health and
Welfare; Insurance

SENATE BILL NO. 2752

1 AN ACT TO REQUIRE HEALTH CARE INSURANCE CONTRACTS WITH
2 PROVIDERS TO CONTAIN A PROVISION REQUIRING A DISPUTE RESOLUTION
3 MECHANISM UNDER WHICH PROVIDERS MAY SUBMIT DISPUTES TO THE PLAN;
4 TO REQUIRE EACH HEALTH CARE INSURANCE PLAN TO ANNUALLY SUBMIT A
5 REPORT TO THE COMMISSIONER OF INSURANCE REGARDING ITS DISPUTE
6 RESOLUTION MECHANISM; TO AMEND SECTION 83-9-5, MISSISSIPPI CODE OF
7 1972, TO REVISE THE INTEREST RATE AND ADMINISTRATIVE FINE FOR
8 FAILING TO TIMELY PAY CLEAN CLAIMS; AND FOR RELATED PURPOSES.

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

10 **SECTION 1.** (1) All health care insurance contracts with
11 providers shall contain provisions requiring a fast, fair and
12 cost-effective dispute resolution mechanism under which providers
13 may submit disputes to the plan, and requiring the plan to inform
14 its providers upon contracting with the plan or, upon change to
15 these provisions, of the procedures for processing and resolving
16 disputes, including the location and telephone number where
17 information regarding disputes may be submitted.

18 (2) Each health care insurance plan shall ensure that a
19 dispute resolution mechanism is accessible to noncontracting
20 providers for the purpose of resolving billing and claims
21 disputes.

22 (3) On and after January 1, 2008, each health care insurance
23 plan shall annually submit a report to the Commissioner of
24 Insurance regarding its dispute resolution mechanism. The report
25 shall include information of the number of providers who utilized
26 the dispute resolution mechanism and a summary of the disposition
27 of those disputes.

28 **SECTION 2.** Section 83-9-5, Mississippi Code of 1972, is
29 amended as follows:

30 83-9-5. (1) **Required provisions.** Except as provided in
31 subsection (3) of this section, each such policy delivered or
32 issued for delivery to any person in this state shall contain the
33 provisions specified in this subsection in the words in which the
34 same appear in this section. However, the insurer may, at its
35 option, substitute for one or more of such provisions,
36 corresponding provisions of different wording approved by the
37 commissioner which are in each instance not less favorable in any
38 respect to the insured or the beneficiary. Such provisions shall
39 be preceded individually by the caption appearing in this
40 subsection or, at the option of the insurer, by such appropriate
41 individual or group captions or subcaptions as the commissioner
42 may approve.

43 As used in this section, the term "insurer" means a health
44 maintenance organization, an insurance company or any other entity
45 responsible for the payment of benefits under a policy or contract
46 of accident and sickness insurance; however, the term "insurer"
47 shall not mean a liquidator, rehabilitator, conservator or
48 receiver or third-party administrator of any health maintenance
49 organization, insurance company or other entity responsible for
50 the payment of benefits which is in liquidation, rehabilitation or
51 conservation proceedings, nor shall it mean any responsible
52 guaranty association. Further, no cause of action shall accrue
53 against a liquidator, rehabilitator, conservator or receiver or
54 third-party administrator of any health maintenance organization,
55 insurance company or other entity responsible for the payment of
56 benefits which is in liquidation, rehabilitation or conservation
57 proceedings or any responsible guaranty association under
58 subsection (1)(h)3 of this section or any policy provision in
59 accordance therewith.

60 (a) A provision as follows:

61 Entire contract; changes: This policy, including the
62 endorsements and the attached papers, if any, constitutes the

63 entire contract of insurance. No change in this policy shall be
64 valid until approved by an executive officer of the insurer and
65 unless such approval be endorsed hereon or attached hereto. No
66 agent has authority to change this policy or to waive any of its
67 provisions.

68 (b) A provision as follows:

69 Time limit on certain defenses:

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

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

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

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

94 2. No claim for loss incurred or disability (as
95 defined in the policy) commencing after two (2) years from the

96 date of issue of this policy shall be reduced or denied on the
97 ground that a disease or physical condition not excluded from
98 coverage by name or specific description effective on the date of
99 loss had existed prior to the effective date of coverage of this
100 policy.

101 (c) A provision as follows:

102 Grace period:

103 A grace period of seven (7) days for weekly premium policies,
104 ten (10) days for monthly premium policies and thirty-one (31)
105 days for all other policies will be granted for the payment of
106 each premium falling due after the first premium, during which
107 grace period the policy shall continue in force.

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

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

119 (d) A provision as follows:

120 Reinstatement:

121 If any renewal premium be not paid within the time granted
122 the insured for payment, a subsequent acceptance of premium by the
123 insurer or by any agent duly authorized by the insurer to accept
124 such premium, without requiring in connection therewith an
125 application for reinstatement, shall reinstate the policy.

126 However, if the insurer or such agent requires an application for
127 reinstatement and issues a conditional receipt for the premium
128 tendered, the policy will be reinstated upon approval of such

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

149 (e) A provision as follows:

150 Notice of claim:

151 Written notice of claim must be given to the insurer within
152 thirty (30) days after the occurrence or commencement of any loss
153 covered by the policy, or as soon thereafter as is reasonably
154 possible. Notice given by or on behalf of the insured or the
155 beneficiary to the insurer at _____ (insert the
156 location of such office as the insurer may designate for the
157 purpose), or to any authorized agent of the insurer, with
158 information sufficient to identify the insured, shall be deemed
159 notice to the insurer.

160 (In a policy providing a loss of time benefit which may be
161 payable for at least two (2) years, an insurer may, at its option,

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

176 (f) A provision as follows:

177 Claim forms:

178 The insurer, upon receipt of a notice of claim, will furnish
179 to the claimant such forms as are usually furnished by it for
180 filing proofs of loss. If such forms are not furnished within
181 fifteen (15) days after the giving of such notice, the claimant
182 shall be deemed to have complied with the requirements of this
183 policy as to proof of loss upon submitting, within the time fixed
184 in the policy for filing proofs of loss, written proof covering
185 the occurrence, the character and the extent of the loss for which
186 claim is made.

187 (g) A provision as follows:

188 Proofs of loss:

189 Written proof of loss must be furnished to the insurer at its
190 said office, in case of claim for loss for which this policy
191 provides any periodic payment contingent upon continuing loss,
192 within ninety (90) days after the termination of the period for
193 which the insurer is liable, and in case of claim for any other
194 loss, within ninety (90) days after the date of such loss.

195 Failure to furnish such proof within the time required shall not
196 invalidate or reduce any claim if it was not reasonably possible
197 to give proof within such time, provided such proof is furnished
198 as soon as reasonably possible and in no event, except in the
199 absence of legal capacity, later than one (1) year from the time
200 proof is otherwise required.

201 (h) A provision as follows:

202 Time of payment of claims:

203 1. All benefits payable under this policy for any
204 loss, other than loss for which this policy provides any periodic
205 payment, will be paid within twenty-five (25) days after receipt
206 of due written proof of such loss in the form of a clean claim
207 where claims are submitted electronically, and will be paid within
208 thirty-five (35) days after receipt of due written proof of such
209 loss in the form of clean claim where claims are submitted in
210 paper format. Benefits due under the policies and claims are
211 overdue if not paid within twenty-five (25) days or thirty-five
212 (35) days, whichever is applicable, after the insurer receives a
213 clean claim containing necessary medical information and other
214 information essential for the insurer to administer preexisting
215 condition, coordination of benefits and subrogation provisions. A
216 "clean claim" means a claim received by an insurer for
217 adjudication and which requires no further information, adjustment
218 or alteration by the provider of the services or the insured in
219 order to be processed and paid by the insurer. A claim is clean
220 if it has no defect or impropriety, including any lack of
221 substantiating documentation, or particular circumstance requiring
222 special treatment that prevents timely payment from being made on
223 the claim under this provision. A clean claim includes
224 resubmitted claims with previously identified deficiencies
225 corrected.

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

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

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

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

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

240 Not later than twenty-five (25) days after the date the
241 insurer actually receives an electronic claim, the insurer shall
242 pay the appropriate benefit in full, or any portion of the claim
243 that is clean, and notify the provider (where the claim is owed to
244 the provider) or the insured (where the claim is owed to the
245 insured) of the reasons why the claim or portion thereof is not
246 clean and will not be paid and what substantiating documentation
247 and information is required to adjudicate the claim as clean. Not
248 later than thirty-five (35) days after the date the insurer
249 actually receives a paper claim, the insurer shall pay the
250 appropriate benefit in full, or any portion of the claim that is
251 clean, and notify the provider (where the claim is owed to the
252 provider) or the insured (where the claim is owed to the insured)
253 of the reasons why the claim or portion thereof is not clean and
254 will not be paid and what substantiating documentation and
255 information is required to adjudicate the claim as clean. Any
256 claim or portion thereof resubmitted with the supporting
257 documentation and information requested by the insurer shall be
258 paid within twenty (20) days after receipt.

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

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

279 3. If the claim is not denied for valid and proper
280 reasons by the end of the applicable time period prescribed in
281 this provision, the insurer must pay the provider (where the claim
282 is owed to the provider) or the insured (where the claim is owed
283 to the insured) interest on accrued benefits at the rate of two
284 and one-half percent (2-1/2%) per month accruing from the day
285 after payment was due on the amount of the benefits that remain
286 unpaid until the claim is finally settled or adjudicated.
287 Whenever interest due pursuant to this provision is less than One
288 Dollar (\$1.00), such amount shall be credited to the account of
289 the person or entity to whom such amount is owed.

290 4. In the event the insurer fails to pay benefits
291 when due, the person entitled to such benefits may bring action to

292 recover such benefits, any interest which may accrue as provided
293 in subsection (1)(h)3 of this section and any other damages as may
294 be allowable by law.

295 (i) A provision as follows:

296 Payment of claims:

297 Indemnity for loss of life will be payable in accordance with
298 the beneficiary designation and the provisions respecting such
299 payment which may be prescribed herein and effective at the time
300 of payment. If no such designation or provision is then
301 effective, such indemnity shall be payable to the estate of the
302 insured. Any other accrued indemnities unpaid at the insured's
303 death may, at the option of the insurer, be paid either to such
304 beneficiary or to such estate. All other indemnities will be
305 payable to the insured. When payments of benefits are made to an
306 insured directly for medical care or services rendered by a health
307 care provider, the health care provider shall be notified of such
308 payment. The notification requirement shall not apply to a
309 fixed-indemnity policy, a limited benefit health insurance policy,
310 medical payment coverage or personal injury protection coverage in
311 a motor vehicle policy, coverage issued as a supplement to
312 liability insurance or workers' compensation.

313 (The following provisions, or either of them, may be included
314 with the foregoing provision at the option of the insurer: "If
315 any indemnity of this policy shall be payable to the estate of the
316 insured, or to an insured or beneficiary who is a minor or
317 otherwise not competent to give a valid release, the insurer may
318 pay such indemnity, up to an amount not exceeding \$_____

319 (insert an amount which must not exceed One Thousand Dollars
320 (\$1,000.00)), to any relative by blood or connection by marriage
321 of the insured or beneficiary who is deemed by the insurer to be
322 equitably entitled thereto. Any payment made by the insurer in
323 good faith pursuant to this provision shall fully discharge the
324 insurer to the extent of such payment."

325 "Subject to any written direction of the insured in the
326 application or otherwise, all or a portion of any indemnities
327 provided by this policy on account of hospital, nursing, medical
328 or surgical services may, at the insurer's option and unless the
329 insured requests otherwise in writing not later than the time of
330 filing proofs of such loss, be paid directly to the hospital or
331 person rendering such services; but it is not required that the
332 service be rendered by a particular hospital or person.")

333 (j) A provision as follows:

334 Physical examinations:

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

339 (k) A provision as follows:

340 Legal actions:

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

347 (l) A provision as follows:

348 Change of beneficiary:

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

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

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

371 (a) A provision as follows:

372 Change of occupation:

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

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

398 (b) A provision as follows:

399 Misstatement of age:

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

403 (c) A provision as follows:

404 Relation of earnings to issuance:

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

423 whichever is the lesser, nor shall it operate to reduce benefits
424 other than those payable for loss of time.

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

444 (d) A provision as follows:

445 Unpaid premium:

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

449 (e) A provision as follows:

450 Cancellation:

451 The insurer may cancel this policy at any time by written
452 notice delivered to the insured, or mailed to his last address as
453 shown by the records of the insurer, stating when, not less than
454 five (5) days thereafter, such cancellation shall be effective;
455 and after the policy has been continued beyond its original term,

456 the insured may cancel this policy at any time by written notice
457 delivered or mailed to the insurer, effective upon receipt or on
458 such later date as may be specified in such notice. In the event
459 of cancellation, the insurer will return promptly the unearned
460 portion of any premium paid. If the insured cancels, the earned
461 premium shall be computed by the use of the short-rate table last
462 filed with the state official having supervision of insurance in
463 the state where the insured resided when the policy was issued.
464 If the insurer cancels, the earned premium shall be computed pro
465 rata. Cancellation shall be without prejudice to any claim
466 originating prior to the effective date of cancellation.

467 (f) A provision as follows:

468 Conformity with state statutes:

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

473 (g) A provision as follows:

474 Illegal occupation:

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

479 (h) A provision as follows:

480 Intoxicants and narcotics:

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

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

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

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

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

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

512 (a) Any policy of a foreign or alien insurer, when
513 delivered or issued for delivery to any person in this state, may
514 contain any provision which is not less favorable to the insured
515 or the beneficiary than the provisions of Sections 83-9-1 through
516 83-9-21, Mississippi Code of 1972, and which is prescribed or
517 required by the law of the state under which the insurer is
518 organized.

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

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

528 (8) **Administrative penalties.**

529 (a) If the commissioner finds that an insurer, during
530 any calendar year, has paid at least eighty-five percent (85%),
531 but less than ninety-five percent (95%), of all clean claims
532 received from all providers during that year in accordance with
533 the provisions of subsection (1)(h) of this section, the
534 commissioner may levy an aggregate penalty in an amount not to
535 exceed Twenty Thousand Dollars (\$20,000.00). If the commissioner
536 finds that an insurer, during any calendar year, has paid at least
537 fifty percent (50%), but less than eighty-five percent (85%), of
538 all clean claims received from all providers during that year in
539 accordance with the provisions of subsection (1)(h) of this
540 section, the commissioner may levy an aggregate penalty in an
541 amount of not less than Twenty Thousand Dollars (\$20,000.00) nor
542 more than One Hundred Thousand Dollars (\$100,000.00). If the
543 commissioner finds that an insurer, during any calendar year, has
544 paid less than fifty percent (50%) of all clean claims received
545 from all providers during that year in accordance with the
546 provisions of subsection (1)(h) of this section, the commissioner
547 may levy an aggregate penalty in an amount not less than One
548 Hundred Thousand Dollars (\$100,000.00) nor more than Two Hundred
549 Thousand Dollars (\$200,000.00). In determining the amount of any
550 fine, the commissioner shall take into account whether the failure
551 to achieve the standards in subsection (1)(h) of this section were
552 due to circumstances beyond the control of the insurer. The
553 insurer may request an administrative hearing to contest the
554 assessment of any administrative penalty imposed by the

555 commissioner pursuant to this subsection within thirty (30) days
556 after receipt of the notice of assessment.

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

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

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

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

579 **SECTION 3.** This act shall take effect and be in force from
580 and after July 1, 2007.