SUBSMISSION REQUIREMENTS FOR ACCIDENT AND HEALTH POLICIES

All accident and health policies must comply with the following provisions. Medicare supplement policies, long term care policies and credit life and disability policies must comply with the appropriate provisions for those types of policies, except where differences are noted. Where used, the term policy also includes any riders and/or endorsements. These requirements apply to all policies and/or certificates delivered in or issued for delivery in Mississippi.

All accident and health insurance policies delivered in or issued for delivery in Mississippi must comply with all Federal heath insurance requirements, including those required in the Health Insurance Portability and Accountability Act of 1996, the Newborn's and Mother's Health Protection Act of 1996, the Mental Health Parity Act of 1996 and the Women's Health and Cancer Rights Act of 1998.

At the time of initial filing of all policies and/or certificates, the premium rates must be filed, along with an actuarial memorandum, showing the derivation of the premiums. The actuarial memorandum must specifically state all actuarial assumptions and the expected lifetime loss ratio. All rate increases must be filed, along with an actuarial memorandum justifying the rate increase. All rate increases must use an amendment to implement the rate increase, in accordance with Regulation 73-4. The amendment must be filed for approval prior to use. For the specific information to be included in the actuarial memorandum justifying the rate increase, refer to attachments, MSRATE and Form RII 7/02.

Section 83-9-3 contains the following requirements that must be included in the policy and/or certificate:

The policy, attached application and any riders or endorsements constitute the entire policy.
The effective date and termination date of the policy must be shown.
Any exceptions and/or reductions must be stated in the policy.
The form number must be specified in the lower left hand corner of the policy.

Section 83-9-5 contains the following required and optional provisions:

Required Provisions that must be included in the policy and/or certificate:

Entire contract. The policy, including any attached papers, constitutes the entire contract. No agent may waive or alter any provisions.
Time Limit on Certain Defenses. There is a two year limit.
Grace Period. The minimum grace period is 31 days (7 days for weekly premium policies and 10 days for monthly premium policies).
Reinstatement.
Notice of Claim. 30 days
Claim Forms. Must be provided within 15 days.
Proofs of Loss. Must be provided within 90 days.
Time of Payment of Claims. Claims must be paid within 25 days of completed proof of loss in the form of a clean claim where claims are submitted electronically, and within 35 days of completed proof of loss in the form of a clean claim submitted in paper format; if not paid within applicable time period, interest is due at the rate of 1 ½% per month accruing from day after payment was due until paid; insured must have the right to bring action. All three points must be included in the policy.
Payment of Claims
Physical Examination. Insurer has the right to examine the insured. There can be no mention of autopsy in the policy.
Legal Actions. Time specified cannot be less than 3 years.
Change of Beneficiary.

Optional Provisions that may be included in the policy and/or certificate:

Change of Occupation.
Misstatement of Age.
Relation of Earnings to Insurance.

Unpaid Premiums.
Cancellations.
Conformity with State Statutes.
Illegal Occupation.
Intoxicants and Narcotics.

Other Miscellaneous Requirements:

Section 83-9-6. Requires freedom of choice for consumer on pharmacy when health plan provides for pharmaceutical services benefits.
Section 83-9-8. Cannot exclude drugs used for treatment of cancer even if drug not approved by FDA.
Section 83-9-11. Insured is not bound by any statement unless application is attached to and made a part of the policy.
Section 83-9-25. Insured has 10 days to examine policy.
Section 83-9-27. Alcoholism to be treated as any other illness under group policies and does not need to exceed $1,000 per calendar year.
Section 83-9-32. Optional mandate that insurer must provide anesthesia benefits for dental treatment of children or mentally handicapped adult insureds.
Section 83-9-33. Must provide coverage for newly born children.
Section 83-9-34. Optional mandate to provide coverage for child immunizations.
Sections 83-9-39 and 83-9-41. Optional mandate for mental illness coverage. Insured must decline the coverage.
Section 83-9-45. Required mandate to cover TMJ, up to $5,000 lifetime maximum.
Section 83-9-46. Optional mandate to provide coverage for diabetes.
Section 83-9-49. Pre-existing conditions exclusion. Group health insurance policies must contain a pre-existing condition period prior to the effective date of not more than 6 months and after the effective date of not more than 12 months. Individual health insurance polices must have a pre-existing condition period prior to the effective date of not more than 12 months and after the effective date of not more than 12 months. Limited benefit policies and specified disease policies are exempt from these requirements.
Departmental Requirement. Individual limited benefit policies and specified disease policies must have a pre-existing condition period prior to the effective date of not more than 60 months and after the effective date of not more than 24 months. Group limited benefit policies and specified disease policies must have a pre-existing condition period prior to the effective date of not more than 12 months and after the effective date of not more than 12 months.
Medicare Supplement and Long Term Care Policies and/or Certificates. Medicare Supplement and long term care policies must contain a pre-existing condition period prior to the effective date of not more than 6 months and after the effective date of not more than 6 months.
Section 83-9-108. Optional mandate to provide mammography coverage.
Section 83-41-203. Benefits for optometrists are required to be covered, if policy provides for reimbursement.
Section 83-41-205. Individual medical policies shall provide for continuation of coverage for physically handicapped and mentally retarded persons.
Section 83-41-207. Group medical policies shall provide for continuation of coverage for physically handicapped and mentally retarded persons.
Section 83-41-209. Provides for beneficiaries' freedom of choice of practitioners in performance of dental services. Cannot be any difference for reimbursement for services from non-network providers and network providers.
Section 83-41-211. Provides for beneficiaries' freedom of choice of practitioners in treatment of mental, nervous or emotional disorders.
Section 83-41-213. The definition of physician is required to include nurse practitioners.
Section 83-41-217. Provides for direct access to obstetricians/gynecologists as primary care physicians.
Accidental Death Benefits. No aggregate limit may be placed on accidental death benefits.
Section 83-9-33. Coverage for children must be from birth.
Handicapped Children. Handicapped children must be covered.
Regulation 88-101. Individual policies may not coordinate against other insurance policies.

Return of Premium Benefit. All return of premium benefits must provide for values prior to the end of the period for which 100% of the premiums will be returned. Insurer must provide an actuarial memorandum detailing the calculation of the values.

Subrogation. No policy may subrogate until the insured has been made whole for the loss.

Mental Illness. Mental illness must be covered on an optional basis, subject to Federal mandates. Applicable policies and/or certificates must comply with the Mental Health Parity Act of 1996.

Section 83-41-215 and Regulation 88-103. The definition of physicians must include chiropractors. Benefits for chiropractors may not be limited, unless benefits for all other specialties are also limited.

Binding Arbitration. Requirements contained in the Departmental Guidelines and Requirements for Approval of Binding Arbitration Provisions in Insurance Policies.

Rate Increases. All health insurance rate increases (group and individual) are subject to Bulletin 94-1 and Regulation 73-4. An endorsement must be used to implement all rate increases subject to Bulletin 94-1. All rate increases must be accompanied by a signed actuarial memorandum.

Section 83-51-11. Payment or reimbursement for a non-participating dentist shall be the same as payment or reimbursement for a participating dentist. Insured must have freedom of choice of dentist. Company may not prevent any dentist from becoming a participating dentist.

Section 83-1-101. Policies Issued to Non-Mississippi Domiciled Trusts or Associations. All policies and/or certificates delivered in or issued for delivery in Mississippi must be filed for review and must comply with all Mississippi laws and regulations.

Regulation 2000-2. All health insurance policies and/or certificates delivered in or issued for delivery in Mississippi must comply with the Federal Newborn's and Mother's Health Protection Act of 1996.

Regulation 2000-3. All health insurance policies and/or certificates delivered in or issued for delivery in Mississippi must comply with the Federal Women's Health and Cancer Rights Act of 1998.

Regulation 2000-5. All applicable health insurance policies and/or certificates delivered in or issued for delivery in Mississippi must comply with the Federal Health Insurance Portability and Accountability Act of 1996. All major medical and comprehensive policies must be guaranteed renewable as required by HIPAA.

Regulation 99-3. All health insurance policies and/or certificates issued or delivered in Mississippi must provide at time of delivery of the policy and/or certificate a Summary Document in the form prescribed outlining the general purposes and current limitations of the Guaranty Association.

Section 83-9-101 and Regulation 96-103, as Amended. Initial premiums on all health insurance policies and/or certificates are required to be filed. Individual Medicare Supplement policies must have at least a lifetime loss ratio of 65%. Group Medicare Supplement policies must have at least a lifetime loss ratio of 75%. Individual long term care policies must have at least a lifetime loss ratio of 60%. All rates filed must be accompanied by a signed actuarial memorandum.

Conditional Receipts. If an insurance company uses a conditional receipt, it must comply with Regulation 79-001.

Long Term Care. All long term care insurance coverage must comply with Mississippi long term care insurance policy minimum standards as found in Regulation 90-102.

Medicare Supplement Insurance. All Medicare Supplement insurance policies must comply with Mississippi Medicare Supplement minimum standards as found in Section 83-9-101, et seq and Regulation 96-103, as amended.