

TITLE 21 LAW AND JUSTICE
MISSISSIPPI TORT CLAIMS BOARD
REGULATIONS AND GUIDELINES

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TITLE 21 LAW AND JUSTICE MISSISSIPPI TORT CLAIMS BOARD

Chapter 01 Mississippi Tort Claims Board Rules to Comply with the Administrative Procedures Act

Section 100 The purpose of this rule is to describe the organization of the Mississippi Tort State Board (hereafter referred to as MTCB) and how the public may obtain information from the Board as required by Section 25-43-2.104 (a) of the Mississippi Code of 1972, as amended.

200 This rule establishes a description of the MTCB'S organization which states the general course and method of its operations, including how the public may obtain information or make submissions/requests to the MTCB.

300 The public may obtain a description of the MTCB'S organization from the Guidelines and Regulations of the MTCB currently on file with the Secretary of State. Additionally, the public may access information relevant to the MTCB at their website www.dfa.state.ms.us, or by reviewing Sections 11-46-1 et seq., of the Mississippi Code of 1972, as amended, which may be accessed at www.state.ms.us. The public may also request information, make submissions or requests including Mississippi Open Records Act requests by contacting the MTCB Administrator at Post Office Box 267, Jackson, MS, 39205. See also Chapter 07 Public Access to Records.

Chapter 02 Informal Proceedings Available to the Public

Section 100 The Purpose of this rule is to inform the public of all informal proceedings available to the public as required by Section 25-43-2.104 (b) of the Mississippi Code of 1972, as amended.

200 This rule establishes information on all MTCB proceedings.

300 All information as to the rules of practice concerning all formal and informal proceedings are available by reviewing the rules and regulations of the MTCB currently on file with the Secretary of State. Further information may be obtained by reviewing the MTCB website at www.dfa.state.ms.us, or by reviewing Sections 11-46-1 et seq., of the Mississippi Code of 1972, as amended, which may be accessed at www.state.ms.us.

301 The MTCB generally meets the 2nd Thursday of every other month at 1:30 P.M. at the Woolfolk State Office Building, 501 North West Street, Jackson, MS 39201. Other meetings may be called by the Board as necessary.

Chapter 03 Public Hearings

Purpose

Section 100 These sections set forth MTCB'S procedures for involving the public in the development of rules through public meetings and/or public hearings as required by Mississippi Code § 25-43-3.104.

Requirements for Public Hearings

200 At the time a Rule is filed with Secretary of State, the Administrator must also publish where written submissions or written requests for an opportunity to make oral presentations on the proposed rule may be inspected or submitted.

201 A public hearing is required if, during the first 20 business days of the rule notice, a written request for a public hearing is received from one of the following:

- 201.01** a political subdivision
- 201.02** an agency, or
- 201.03** 10 persons

202 If a public hearing is required, the Administrator will establish the time, date and location for the public hearing. The Administrator shall then:

- 202.01** Ensure that the public hearing is not scheduled earlier than 23 business days after filing notice of oral proceeding with SOS.
- 202.02** File notice of the time, date, and location of the public hearing with the Secretary of State.
- 202.03** Within three (3) days of filing notice with SOS, Administrator must mail or electronically transmit a copy of the notice to those who are on the notification list (their preference); MTCB can charge for mail but not electronic transmissions.

Location of Public Hearings

300 Public hearings shall be held at a place and time generally convenient for persons affected by the rule.

Conducting Public Hearings

400 Public Hearings must be open to the public.

401 The Administrator will preside at the proceeding.

402 The Administrator may issue rules for conduct of oral proceedings.

Public Availability of Public Hearings

- 500** A verbatim written transcript of the oral proceedings at each public hearing shall be produced by the Administrator.
- 501** This material will be available for public inspection and copying as part of the Rule-Making Record.

Chapter 04 Declaratory Opinions

Purpose

Section 100 These sections set forth the MTCB'S procedures regarding the requests for Declaratory Opinions, as required by § 25-43-2.103 of the Mississippi Code of 1972, as amended.

General

200 Declaratory Opinions will be prepared by the Administrator and approved by the Tort Claims Board.

Persons Who May Request Declaratory Opinions

300 Any person with a substantial interest in the subject matter may request the MTCB for a declaratory opinion by following the specified procedures:

Subjects Which May be Addressed in Declaratory Opinions

400 The MTCB will issue declaratory opinions regarding the applicability to specified facts of:

400.01 A statute administered or enforceable by the MTCB,

400.02 A rule promulgated by the MTCB, or

400.03 An order issued by the MTCB.

401 The MCTB will not issue a declaratory opinion regarding a statute, rule or order which is beyond the primary jurisdiction of the MTCB.

402 "Primary jurisdiction of the agency" means:

402.01 The agency has a constitutional grant of authority in the subject matter,

402.02 The agency has a statutory grant of authority in the subject matter,

402.03 The agency has issued specific regulations impacting on the subject matter, or

402.04 The agency has issued a specific order or orders impacting on the subject matter.

Circumstances In Which Declaratory Opinions Will Not Be Issued

500 The MTCB may, for good cause, refuse to issue a declaratory opinion. Without limiting the generality of the foregoing, the circumstances in which declaratory opinions will not be issued include, but are not necessarily limited to:

- 500.01** The matter is outside the jurisdiction of the MTCB;
- 500.02** Lack of clarity concerning the question presented;
- 500.03** There is pending or anticipated litigation, administrative action, or other adjudication;
- 500.04** The statute, rule, or order on which a declaratory opinion is sought is clear and not in need of interpretation to answer the question presented by the request;
- 500.05** The facts presented in the request are not sufficient to answer the question presented;
- 500.06** The request fails to contain information required by these rules or the requestor failed to follow the procedure set forth in these rules;
- 500.07** The request seeks to resolve issues which have become moot, or are abstract or hypothetical such that the requestor is not substantially affected by the rule, statute or order on which a declaratory opinion is sought;
- 500.08** No controversy exists concerning the issue as the requestor is not faced with existing facts or those certain to arise which raise a question concerning the application of the statute, rule, or order;
- 500.09** The question presented by the request concerns the legal or constitutional validity of a statute, rule or order;
- 500.10** The requestor has not suffered an injury or threatened injury fairly traceable to the application of the statute, rule or order;
- 500.11** No clear answer is determinable;
- 500.12** The question presented by the request involves the application of a criminal statute or sets for facts which may constitute a crime;
- 500.13** The answer to the question presented would require the disclosure of information which is privileged or otherwise protected by law from disclosure;
- 500.14** The question is currently the subject of an Attorney General's opinion request;
- 500.15** The question has been answered by an Attorney General's opinion;
- 500.16** The request is not made in good faith; or
- 500.17** The request is harassing in nature or for any other unlawful purposes.

501 A declaratory opinion will not be issued where a similar request is pending before this agency or any other agency or a proceeding is pending on the same subject matter before any agency, administrative or judicial tribunal, or where such an opinion would constitute the unauthorized practice of law.

502 A declaratory opinion will not be issued if it may adversely affect the interests of the State, the MTCB or any of their officers or employees in any litigation which is pending or may reasonably be expected to arise.

503 A declaratory opinion shall not be binding or effective for any third party or person other than the MTCB and the person to whom the opinion is issued and

shall not be used as precedent for any other transaction or occurrence beyond that set forth by the requesting person.

- 504** Where a request for a declaratory opinion involves a question of law, the MTCB may refer the matter to the State Attorney General.

Form of the Request for a Declaratory Opinion

- 600** Written Requests Required. Each request must be printed or typewritten, or must be in legible handwriting. Each request must be submitted on standard business letter-size paper (8-1/2 inches by 11 inches). Requests may be in the form of a letter addressed to the MTCB or in the form of a pleading as might be addressed to a court.
- 601** Where to Send Request. All requests must be mailed or delivered to the MTCB Administrator. The request and its envelope shall clearly state that it is a request for a declaratory opinion. Oral and telephone requests are unacceptable.
- 602** Name, Address and Signature of Requestor. Each request must include the full name, telephone number, and mailing address of the requestor. All requests shall be signed by the person filing the request, unless represented by an attorney, in which case the attorney may sign the request. The signing party shall attest that the request complies with the requirements set forth in these rules, including but not limited to a full, complete, and accurate statement of relevant facts and that there are no related proceedings pending before any agency, administrative or judicial tribunal.
- 603** Single transaction. A request must be limited to a single transaction or occurrence.
- 604** Question Presented. Each request shall contain the following:
- 604.01** A clear identification of the statute, rule, or order at issue;
 - 604.02** A concise statement of the issue or question presented for the declaratory opinion;
 - 604.03** A full, complete, and accurate statement of all facts relevant to a resolution of the question presented;
 - 604.04** The identity of all other known persons involved in or impacted by the factual situation causing the request including their relationship to the facts; their name, mailing address and telephone number;
 - 604.05** A statement sufficient to show that the person seeking relief is substantially affected by the rule.
- 605** The terms of the proposed opinion suggested by the requestor may be submitted

with the request or may be requested by the agency;

- 606** Memorandum of Authorities. A request may contain an argument by the requestor in support terms of the proposed opinion suggested by the requestor. The argument may be submitted in the *form* of a memorandum of authorities, containing a full discussion of the reasons, including any legal authorities, in support of such position of the requestor. The agency may request that argument and memorandum of authorities be submitted by any interested party.

Time for MTCB'S Response

- 700** MTCB'S Response. Within forty-five (45) days after the receipt of a request for a declaratory opinion which complies with the requirements of these rules, the MTCB shall in writing:
- 700.01.** Issue an opinion declaring the applicability of the specified statute, rule, or order to the specified circumstances;
 - 700.02** Decline to issue a declaratory opinion, stating the reasons for its action; or
 - 700.03** Agree to issue a declaratory opinion or a written statement declining to issue a declaratory opinion by a specified time but no later than ninety (90) days after receipt of the written request.
- 701** When Period Begins to Run. The forty-five (45) day period shall begin running on the first State of Mississippi business day that the request is received in the offices of the MTCB.

Public Availability of Requests and Declaratory Opinions

- 800** The Administrator will make declaratory opinions and requests for declaratory opinions available for public inspection and copying at the expense of the viewer during normal business hours. All declaratory opinions and requests shall be indexed by name and subject. Declaratory opinions and requests which contain information which is exempted from disclosure under the Mississippi Public Records Act or is otherwise confidential by law shall be exempt from this requirement.

Chapter 05 Availability of MTCB Orders

- Section 100** These sections set forth the procedures for making the MTCB Orders available to the public as required by § 25-42-2.102 of the Mississippi Code of 1972, as amended.
- 200** The Administrator shall be responsible for making them available for public inspection and copying indexed by name and subject. This is subject to any confidentiality

provisions established by law.

300 The written final order can't be precedent to the detriment of any person by the MTCB until it has been made available for public inspection & indexed.

300.01 This is inapplicable to any person who has actual timely knowledge of the order;

300.02 The burden of proof is on the MTCB.

Chapter 06 By-Laws of Mississippi Tort Claims Board

Section 100 Officers and Meetings

Section 101 Officers and Authority: The presiding officer of the Board shall be a Chairman appointed by the Governor subject to the advice and consent of the Senate to serve at the will and pleasure of the Governor. A Vice-Chairman shall be elected by the membership of the board by majority vote at the annual meeting of the board to serve for a term of one year. The Chairman shall preside at all meetings and shall have such authority and shall perform such duties as provided by, or may be reasonably inferred from, statutory provision, these by-laws or as may be determined and conferred by a resolution of the board not inconsistent with the laws of this state or these by-laws. The Vice-Chairman shall be authorized to preside in the absence or incapacity of the Chairman.

The six (6) ex officio members of the Board are: the Director of the Department of Environmental Quality, the Commissioner of Insurance; the Director of the Department of Finance and Administration; the Attorney General; the Commissioner of Public Safety; and the State Treasurer.

Section 102 Annual Meetings: There shall be an annual meeting of the Board held each year in the offices of the Department of Finance and Administration on the first Thursday of June, unless notice of the meeting to be held shall designate another place and time.

Section 103 Regular Meetings: The Board may authorize such other regular meetings as may be desired by resolution upon its minutes designating the time, date, and place of such regular meetings.

Section 104 Special Meetings: Extraordinary meetings of the Board may be held upon call of the Chairman or upon petition of any four (4) members of the Board should the Chairman refuse to call a meeting. Such meetings may be held at any time or place upon five (5) days written notice preceding the date of such meeting. The written notice shall state the place, date, and hour of said meeting and the purpose for which the meeting is called. Said notice shall be delivered or mailed to each member of the Board at his or her regular mailing address.

Section 105 Quorum: A quorum for the transaction of any business of the Board shall consist of an absolute majority of all the members of record of the Board. A quorum is necessary for any annual, regular or special meeting of the Board, and when a quorum is not present at any such

meeting, a majority of the members present may adjourn the meeting to a time and place without the necessity of further notice to the members.

Section 106 Executive Director: The Director of the Department of Finance and Administration shall serve as the Executive Director of the Board and shall be authorized to conduct the administrative affairs of the Board. The Board is authorized to employ on a fulltime basis a staff attorney who shall possess at a minimum the qualifications required to be a member of the Mississippi Bar, and such other staff as it may deem necessary to carry out the purposes of the tort claims statutes; the employees in the positions approved by the Board shall be hired by the Executive Director, shall be employees of the Department of Finance and Administration, and shall be compensated from the Tort Claims Fund. Upon recommendation of the Executive Director the Board shall define the duties and fix the compensation of such employees. The Executive Director shall execute all contracts and other instruments in writing on behalf of the Board which have been duly authorized by the Board. The Executive Director shall be charged with the duty of taking and preserving the official minutes of the meetings of the Board and shall provide copies of the proposed minutes to the members in advance of the next regular meeting. In addition, the Executive Director shall perform such other duties and functions as are incident to the office and not inconsistent with these by-laws.

Section 107 Rules of Order: The most recent edition of Robert's Rules of Order shall serve as the rules of order for the Board.

Section 108 Proxies: To the extent allowed under Mississippi law, a member of the Board may designate a proxy representative to act for such member in such member's absence, and the vote of such proxy representative shall be counted as the vote of such absent member.

Section 200 Article II: Committees.

Section 201 Standing and Special Committees: The Board shall authorize such committees as it may desire and shall designate whether the same are standing or special. The Authority shall specify the jurisdiction and scope of such standing committees by resolution upon the minutes. Special committees may be created by resolution which shall specify the special purpose and function of said committees.

Section 202 Appointments: Standing committees will continue to function from year to year. The Chairman shall make appointments to all standing committees at the annual meeting of the Board. Upon the creation of special committees or standing committees, initial appointments to committees shall be made by the Chairman as soon thereafter as may be convenient.

Section 203 Committee Minutes: All committees shall keep minutes of their proceedings which shall be submitted to the Board at its next regular or special meeting.

Section 300 Amendments.

These by-laws may be amended at any regular annual meeting of the Board without previous notice of any kind whatsoever, or at any regular or special meeting provided that notice is given setting out the subject matter and substance of the proposed amendments, such notice to be given

in the manner provided herein for notice of special meetings. Amendments shall require the approval of an absolute majority of the entire member of the Board.

Chapter 07 Public Access to Records.

Section 100 The Board shall collect fees for searching, reviewing and/or duplicating public records, together with the cost of mailing, if applicable. The amount charged shall be determined by estimating to the nearest quarter hour the time required for the Administrative Secretary to search, review and/or duplicate the public records and applying the rate of \$4 per quarter hour to such estimated time. The actual estimated cost of reproducing (\$.45 per page), and the expense of mailing, if any, shall be added to the time charge. The total estimated cost shall be paid in advance of complying with the request for public records.

Section 101 After payment of the cost has been made, the Tort Claims Board shall mail or deliver the records to the applying person no later than 10 working days from the date of such payment.

Section 102 The Tort Claims Board shall notify any applicant in writing if the request to be denied due to exemption of the records from disclosure by virtue of state law. The notification of denial shall be mailed or delivered to the applicant no later than 10 working days after tender of the cost has been made. The cost paid to the Board shall be returned to the applicant.

Chapter 08 Regulations for Political Subdivisions.

Section 100 Pursuant to Section 11-46-17(3), Mississippi Code of 1972, as amended, the Tort Claims Board adopts the following regulations respecting the policy or policies of insurance, the requirements for self-insurance reserves, the requirements for pooling agreements and contracts between and among political subdivisions, or combinations of such insurance, reserves and pooling agreements. Approval of the Board shall be conditioned upon fulfilling the requirements of those regulations.

Section 101 Statutory Exclusions: The insurance plan may contain any or all of the exclusions, exemptions or defenses set forth in Section 11-46-9, Mississippi Code of 1972, as amended, or in any other provision of state law. If the plan intends to incorporate such exclusions, etc., it shall specifically do so.

Section 102 Additional Exclusions: The Board determines that the following additional exclusions or limitations may be incorporated into the plan or policies of insurance for political subdivisions:

Insofar as they are applicable to the state and political subdivisions and are not contrary to Mississippi state statutes or case law, the Board adopts and approves the exclusions and limitations contained in the current version of the ISO Commercial General Liability Form (1988), and the Business Auto Liability Policy CA0001, 11/88 Edition.

Section 103 Reserves and Retentions: Self-insurance reserves and/or aggregate retentions may be approved by the Board, but must comply with the following requirements:

103.01 Amount: Amount of reserve or retention shall be established based on actuarial estimates for a self-insured or pool of similar size and risk exposure.

103.02 Trust Indenture: The political subdivision shall enter into an agreement with the Tort Claims Board that a Trust Account shall be established with a state depository. The agreement shall provide that only tort claim settlements or judgments, cost of legal defense, third party administrator fees and expenses, and the costs of regulation as determined by the Board shall be paid from the fund. All other related expenses, including liability claims not subject to the tort claims limitations of Section 11-46-1, et seq. of the Mississippi Code of 1972, as amended, shall not be expended from the trust account.

103.03 Audit by Independent Certified Public Accountancy Firm: An annual compliance audit on the operations and transactions affecting the trust account shall be required. The audit shall be conducted by a certified public accountancy firm and the cost paid by the self-insuring entity.

103.04 Actuarial Review: An annual actuarial review of reserve adequacy, claim patterns and loss history, with recommendations regarding the initial and annual contribution to the reserve, must be contracted for with an insurance consulting or actuarial firm. Such contract and the initial report and recommendations must accompany the application for approval. Such reports must be furnished to the Tort Claims Board annually.

103.05 Insurance Policies: All insurance policies constituting all or a portion of the insurance plan must name the Tort Claims Board as additional insured in order that the Board receives direct notification by the carrier of any policy cancellations or changes prior to annual renewal.

103.06 Annual Reapplication for Approval: The political subdivision shall annually reapply for approval of its self-insured plan or plan of aggregate retention. The information required shall be submitted 60 days before the end of the fiscal year. In the event the application is denied, the political subdivision shall be given 30 days to reapply.

Section 104 Pooling Agreements: Pooling of liabilities between and among political subdivisions is authorized by Section 11-46-17(5), of the Mississippi Code of 1972, as amended, subject to the approval of the Board. The Board may require a pooling agreement to provide for adequate excess insurance coverage and umbrella insurance coverage. Pooling agreements shall also be subject to the requirements of Section 103 above.

Section 105 The following categories of political subdivisions shall provide coverage for these types of tort risks:

- 105.01** Counties:
Auto, general, public officials', and law enforcement liability,
- 105.02** Municipalities:
Auto, general, public officials', and law enforcement liability.
- 105.03** School Districts:
Auto, general, public officials' or directors and officers' (depending on whether the trustees are elected or appointed), athletic participation, and professional liability.
- 105.04** Community Hospitals:
Auto, general, directors and officers', law enforcement, and professional liability.
- 105.05** Airport Authorities:
Auto, general, hangar-keeper's, and directors and officers' liability.
- 105.06** Community Colleges:
Auto, general, law enforcement, directors and officers', professional, athletic participation, and student nurses' professional liability.
- 105.07** Housing Authorities:
Auto, general, and directors and officers' liability.
- 105.08** Library Systems:
Auto, general, and directors and officers' liability.
- 105.09** Mental Health Services:
Auto, general, directors and officers', and professional liability.
- 105.10** Soil and Water Conservation Districts:
Auto and general liability.
- 105.11** Utility Districts, Gas Districts, and Sewer Districts:
Auto, general, and directors and officers' liability.
- 105.12** Drainage Districts:
Auto and general liability.
- 105.13** Economic Development Districts:
Auto, general, and directors and officers' liability.
- 105.14** Fire Protection Districts:
Auto and general liability.
- 105.15** Miscellaneous Political Subdivisions:

Auto, general, and other liabilities depending on the specific political subdivision's function, authority, etc.

Chapter 09 **Mississippi Tort Claims Board Application Regulations for Political Subdivisions.**

Section 100 The Mississippi Tort Claims Board (the Board) was established pursuant to HB 417, Regular Session 1993, and Section 11-46-1 et seq. of the Mississippi Code of 1972, as amended. Section 11-46-17(3) requires that "All political subdivisions shall, from and after October 1, 1993, obtain such policy or policies of insurance, establish such self insurance reserves, or provide a combination of such insurance and reserves as necessary to cover all risks of claims and suits for which political subdivisions may be liable under this chapter; provided, except any political subdivision shall not be required to obtain pollution liability insurance. However, this shall not limit any cause of action against such political subdivision relative to limits of liability under the Tort Claims Act. Such policy or policies of insurance or such self insurance may contain any reasonable limitations or exclusions not contrary to Mississippi state statutes or case law as are normally included in commercial liability insurance policies generally available to political subdivisions. All such plans of insurance and/or reserves shall be submitted for approval to the Board. The Board shall issue a Certificate of Coverage to each political subdivision whose plan of insurance and/or reserves it approves in the same manner as provided in subsection (2) of this section. Whenever any political subdivision fails to obtain the Board's approval of any plan of insurance and/or reserves, the political subdivision shall act in accordance with the rules and regulations of the Board and obtain a satisfactory plan of insurance and/or reserves to be approved by the board."

Section 101 Purchase of Liability Insurance:

Section 101.01 Any political subdivision purchasing a liability policy or policies shall purchase such policy only from an insurance company with a minimum Best rating of B+, or with a certification from the Department of Insurance, or a determination by the Tort Claims Board, that such insurance company has a sound financial condition. This paragraph shall not be construed as a delegation of authority by the Tort Claims Board to any person or entity, and the Tort Claims Board specifically reserves unto itself the authority to approve or disapprove such insurance company based on other appropriate criteria.

Section 101.02 Minimum limits of such liability policies must meet or exceed the statutory limitations of liability as established by the Tort Claims Act.

Section 101.03 All such policies must be presented to the board in the form of a copy of the declaration page of such policy or policies.

Section 101.04 Each subdivision shall purchase such insurance and shall present same to the board for approval and issuance of a Certificate of Coverage.

Section 102 Pooling of Two (2) or More Political Subdivisions:

Section 102.01 For the purpose of purchasing one or more liability policies of insurance, all purchases shall be made only from an insurance company with a minimum Best rating of B+ or with a certification from the Department of Insurance that such insurance company has the financial condition equivalent to a minimum Best rating of B+. This paragraph shall not be construed as a delegation of authority by the Tort Claims Board to any person or entity, and the Tort Claims Board specifically reserves unto itself the authority to approve or disapprove such insurance company based on other appropriate criteria.

Section 102.02 Minimum limits of liability purchased must meet or exceed the limitations of liability as established in the Tort Claims Act.

Section 102.03 Any two (2) or more political subdivisions agreeing to form a pool and self-insure must submit to the Board plans for establishing adequate amounts to be reserved for payment of claims, amounts reserved to be allocated toward any expenses of the pool, and what funds shall be used to establish said reserves. Each political subdivision participating in said pool shall reveal any and all funds it plans to use to participate in the pool.

Section 102.04 The Board must be furnished with an executed copy of the pooling agreement supported by appropriate resolutions or orders of the participating political subdivisions. The pooling agreement shall reflect the rights and responsibilities of the participants. The agreement shall provide for insurance over and above the aggregate of the pool assets to minimize further risk to pool participants for additional contributions during the plan year. The first layer of coverage above the pool aggregate shall extend from the pool amount to Five Million Dollars (\$5,000,000). If an umbrella coverage is deemed necessary by the Board, an additional amount of such coverage may be required.

Section 103 A Political Subdivision Self-Insuring Alone:

Section 103.01 A political subdivision choosing to self-insure must submit to the Board a plan to establish adequate amounts to be reserved for payment of claims against the political subdivision. Such plan shall reveal those funds to be used to establish reserves, how the self-insurance program shall be administered and how claims against the self-insured shall be paid, as well as expenses for administration, investigation, defense, etc., shall be paid. Any and all funds to be used to establish reserves for payment of claims and expenses must be revealed.

Section 103.02 In addition to the reserves identified by the applicant, the self-insuring political subdivisions shall be required to obtain a first layer of insurance coverage above the aggregate amount of the reserve. Additional umbrella coverage may also be required in some cases. The amounts and types of such coverages shall be determined by the Board upon submission of application by the political subdivision on a case by case determination.

Section 104 Submission of Plans for Approval:

Section 104.01 All plans for purchasing insurance, formation of a pool by two (2) or more political subdivisions or a political subdivision choosing to self-insure must be submitted to "the Board for approval or rejection. If approved, a Certificate of Coverage shall be issued for the political subdivisions.

Section 104.02 If a plan is rejected by the Board, or if any political subdivision fails to obtain approval of the Board of any plan of insurance and/or reserves, the political subdivision shall act in accordance with the rules and regulations of the Board and obtain a satisfactory plan of insurance and/or reserves to be approved by the Board.

Section 104.03 The Board shall have the authority to pursue judicial enforcement of the requirements of Section 11-46-1 et seq. of the Mississippi Code of 1972, as amended and these regulations in any court of competent jurisdiction; and, take all other reasonable and necessary actions to carry out the powers and duties of the Board under Section 11-46-1 et seq. of the Mississippi Code of 1972, as amended and these regulations.

Section 105 Combinations of Insurance Policies and Reserves: Any pool or self-insurance plan may contain a combination of insurance policies purchased and adequate reserves established for payment of claims. The plan must be submitted to the Board for approval and any such plan must comply with applicable of Sections 100 through 104 above.

Section 106 Subrogation Rights: The Department of Finance and Administration shall have such subrogation rights as prescribed by the Act and Amendments thereof against third parties.

Section 107 Address: All applications and communications should be submitted to:

Greg Hardy, Administrator
Mississippi Tort Claims Board
P. O. Box 267
Jackson, MS 39205

Chapter 10 Guidelines for the Purchase of Excess Liability Insurance by a State Agency.

Section 100 Section 11-46-17(4), Mississippi Code of 1972, as amended, provides: "Any governmental entity of the state may purchase liability insurance to cover claims in excess of the amounts provided for in Section 11-46-15 and may be sued by anyone in excess of the amounts provided for in Section 11-46-15 to the extent of such excess insurance carried; provided, however, that the immunity from suit above the amounts provided for in Section 11-46-15 shall be waived only to the extent of such excess liability insurance carried."

Section 101 Every state agency is protected to the extent of the limitations of liability as provided in the Tort Claims Act. The decision to purchase excess coverage above the statutory limitations of liability is a policy decision of each individual agency. Approval of the Tort

Claims Board is not required for purchase of excess coverage; however, the Tort Claims Board does suggest the following guidelines in purchasing any such excess coverage:

Section 101.01 The statutory limitations of liability as provided in the Tort constitute primary coverage and are mandatory for every state agency.

Section 101.02 The purchase of any excess coverage should be from an insurance company with a minimum Best rating of B+.

Section 101.03 A copy of the declaration page of any excess policy should be provided to the Tort Claims Board as the Board must notify the Third Party Administrator of such excess coverage. The Third Party Administrator will notify any excess carrier of any claim that may exceed the statutory limitations of liability.

Section 101.04 Each agency electing to purchase excess coverage shall submit to the Tort Claims Board, in writing, the reasons the agency believes it is necessary to have a greater amount of protection than that provided in the Tort Claims Act. All such reasons are to be submitted to the legislature annually.

Chapter 11 Additional Exclusions for State Plan.

Section 100 The Board adopts the exclusions and limitations contained in the current version of ISO Commercial General Liability Form (1988), and the Business Auto Liability Policy CA0001, 11/88 Edition, to be applicable to the Tort Claims Fund operated by the Board for state agencies.

Chapter 12 Hearings.

Section 100 These regulations shall govern hearings before the Board on the adequacy of a plan of coverage or any other issue.

Section 101 The Board, in its discretion, may hold a hearing upon its own motion or upon the timely written request for a hearing by a state agency, political subdivision, or any other interested person.

Section 102 The Board may hold, a hearing at any state of its deliberations, including:

Section 102.01 As part of the initial consideration by the Board of a plan or other issue.

Section 102.02 After such initial consideration, to receive supplemental information to aid the Board in making a determination.

Section 102.03 After an adverse decision by the Board, to permit the aggrieved political subdivision or other interested person to submit additional information for use

by the Board in reconsidering the adverse decision. Any such request for this type of hearing shall be made within twenty days after the adverse decision by the Board.

Section 103 The Board shall fix the time and place of such hearing and shall notify all parties thereto.

Section 104 The technical rules of evidence shall not be strictly followed. Any relevant evidence may be admitted, but the Chairman may limit or exclude testimony or documents that are redundant or irrelevant. All objections must be timely made or shall be waived.

Section 105 The Board anticipates that in most hearings the party involved shall be a state agency, political subdivision, or an entity, such as a liability pool, representing one or more political subdivisions. The Board recognizes, however, that other persons may from time to time request to appear at the hearings in opposition to the request of a political subdivision. The Board, in its discretion, may allow such a person to participate in the hearing, if the Board determines that the person has a substantial interest in the matter before the Board and that the person's participation would aid the Board in making a decision.

Section 106 All witnesses shall testify under oath.

Section 107 The hearing shall be recorded by a court reporter or other means capable of producing a record that may be used in any judicial appeal of a Board decision.

Section 108 To expedite a hearing, the Chairman may:

Section 108.01 Require each party to submit to the Board and to exchange with all other parties to the hearing, at least seven days prior to the hearing, a list of all witnesses the party plans to call at the hearing, a brief summary of each witness' expected testimony, and a copy of each document the party plans to introduce.

Section 108.02 Place time limits on the length of the hearing and vary the amount of time provided in Sections 111 and 115 of this chapter for opening or closing statements.

Section 109 Any party may be represented by counsel.

Section 110 The Chairman shall conduct a fair, impartial, and orderly hearing. After opening the hearing, the Chairman shall:

Section 110.01 State the matter to be considered.

Section 110.02 Request all persons present at the hearing (other than Board members and staff), to identify themselves and their interest in the matter under consideration in the hearing.

Section 110.03 Inform each party that any request that a Board member recuse

himself or herself must be made at this point in the hearing or shall be waived.

Section 110.04 Inform each party that any objection to the manner in which the hearing shall be recorded or to the person recording the hearing must be made at this point in the hearing or shall be waived.

Section 110.05 If parties with adverse interest are present, inquire as to whether the parties wish to invoke the rule of sequestration.

Section 110.06 Summarize the procedures to be followed in the hearing.

Section 111 After the announcements by the Chairman, the Board may request the staff to state briefly its recommendation as to the action the Board should take.

Section 112 Then the state agency, political subdivision, or other interested person requesting approval of a plan, reconsideration of a Board decision, or other action may make a brief opening statement not to exceed ten minutes. In addition, any interested person permitted to appear in opposition to the request may make a brief opening statement not to exceed ten minutes.

Section 113 Following the opening statements, the state agency, political subdivision, or other interested person requesting an action by the Board may present evidence through direct testimony of witnesses and introduction of documents. Any interested person permitted to appear in opposition to the request may cross-examine such witnesses. The Chairman may allow redirect examination if he determines that such would be helpful to the Board Members of the Board may question witnesses at any time.

Section 114 Any interested person permitted to appear in opposition to the request may present witnesses and introduce documents in the same procedure set forth in Section 112 of this chapter.

Section 115 At the conclusion of the testimony and introduction of documents, the state agency, political subdivision, or other interested person requesting the action may make a brief closing statement not to exceed fifteen minutes. In addition, any interested person permitted to appear in opposition to the request may make a brief closing statement not to exceed twenty minutes. If an interested person appearing in opposition to the request makes a closing statement, the state agency, political subdivision, or other interested person requesting the action may offer a rebuttal not to exceed five minutes.

Section 116 The Board may issue its decision after the closing statements or take the matter under advisement until a subsequent Board meeting. The Board shall spread its decision upon the minutes and shall notify the parties in writing of the decision.

Section 117 Notwithstanding any provision contained herein to the contrary, the Board, in its discretion, may appoint a hearing officer to preside at any hearing in the place and stead of the Chairman. In addition, the Board, in its discretion, may authorize the hearing officer to conduct any hearing without the Board being present and to submit to the Board findings of fact, conclusions of law, and recommendations. If the Board should appoint a hearing officer, then in

that event every reference to "Chairman" in Chapter 12 Hearings shall refer instead to the hearing officer, and, pursuant to Section 110 of this chapter, each party shall have the opportunity to object to the hearing officer.

Chapter 13 Exemptions and Exceptions

Section 100 Upon good cause shown, the Board shall have the authority to grant such exemptions and exceptions to these regulations as needed in the opinion of the Board to implement Section 11-46-1 et seq. of the Mississippi Code of 1972, as amended, effectively and efficiently in the best interests of the political subdivisions or the state.

Chapter 14 Disposal of Salvage.

Section 100 The Board hereby delegates to the Claims Manager the authority to dispose of all salvage obtained in the settlement or payment of any tort claim at fair market value by such means and upon such terms as the Claims Manager may think best. Provided, however, that prior to any sale of such salvage the Claims Manager shall ascertain the fair market value of such salvage by requesting offers from at least three salvage yards and shall then sell such salvage to the highest and best offer. All proceeds from the sale of such salvage shall be deposited in the Tort Claims Fund.

Chapter 15. Mediation.

Section 100 The Board shall have the discretionary authority to participate with willing claimants in voluntary non-binding mediation of tort claims against state agencies. The Board shall participate in any mediation ordered by a court pursuant to the mediation rules adopted by the Mississippi Supreme Court.

Chapter 16 Position Statement on Single Occurrence Jurisdiction.

Section 100 It is the stated position of the Mississippi Tort Claims Board as spread upon its minutes of the March 10th, 2005, Board meeting that Mississippi is and has always been, since the beginning effective date of the Tort Claims Act, a "single occurrence" jurisdiction and that notwithstanding the number of parties, recovery is limited to the maximum amount allowed bylaw.

Chapter 17 Board's Authority to Seek Judicial Enforcement

Section 100 The Board shall have the authority to pursue judicial enforcement of the requirements of Section 11-46-1 et seq. of the Mississippi Code of 1972, as amended, and these regulations in any court of competent jurisdiction; and, take all other reasonable and necessary actions to carry out the powers and duties of the board under Section 11-46-1 et seq. of the Mississippi Code of 1972, as amended and these regulations.

Chapter 18 **Mississippi Medical Malpractice Availability Plan Rates and Rating Rules Manual**

Section 100 **Plan Overview**

Section 101 **Coverage Availability**

Coverage is made available to provide a temporary market of last resort for medical malpractice insurance for hospitals, institutions for the aged or infirm, or other health care facilities licensed by the State of Mississippi, physicians, nurses and other personnel who are duly licensed to practice in a hospital or other health care facility licensed by the State of Mississippi. In order to be eligible for coverage the applicant shall:

Section 101.01 Maintain a policy of not excluding patients whose health care coverage is provided through the Mississippi State and School Employees Health Insurance Plan, Mississippi Medicaid, or the Mississippi Children's Health Insurance Program based solely on the fact that the person's health care coverage is provided by any of the aforementioned entities;

Section 101.02 Attend annually a sponsored Loss Prevention Seminar and/or participate in an Office Risk Assessment, as required by the Mississippi Medical Malpractice Availability Plan, at the insureds' expense and,

Section 101.03 Maintain an active Mississippi Medical License and have at least 75% of their practice in the State of Mississippi. The remaining 25% of practice must be located in a contiguous state.

Section 101.04 Professional Liability coverage is available on a claims-made basis only. The limits offered are on a per incident and annual aggregate basis. The limits of liability for insureds who are political subdivisions or employees of political subdivisions are \$500,000 per single occurrence; and \$2,000,000 annual aggregate. The limits of liability for all other insureds are either \$500,000 per single occurrence and \$2,000,000 annual aggregate or \$1,000,000 per single occurrence and \$3,000,000 annual aggregate. Defense is at 100% and is outside the limit of liability.

Section 102 **Assessable Policy Provision**

The Mississippi Medical Malpractice Availability Plan provides and the named insured agrees that in the event of an underwriting deficit at the end of any fiscal year the Plan is in effect, the board of directors of the Plan may make a premium contingency assessment against all policyholders; during such year, and that the named insured shall pay to the Plan the named insured's part of the premium contingency assessment based upon the policy premium payment paid by the named insured to the Plan with respect to that year. The Plan further provides that the company shall cancel the policy of any policyholder who fails to pay the premium contingency assessment.

Effective April 27, 2004, the assessable policy provision was changed to read as follows: The Mississippi Medical Malpractice Availability Plan provides, and the named insured(s) agrees, that for any plan year the plan's actuary may determine an assessment is needed to insure the solvency of the plan, every insured in the plan, that is charged a premium, shall pay a premium assessment. Each insured's assessment shall be based on the percentage his/her premium is to the whole premium for the plan year an assessment is required. Failure to pay an assessment as required by the plan shall result in the termination of coverage and refusal to pay any claim or claim expense from the inception date of the insured's entry into the plan.

Section 200 Operations Overview

Section 201 Servicing Company's Authority

The Plan grants operational and underwriting authority to the Servicing Company. The Rating Rules Manual provides a consistent and structured framework for the Servicing Company to equitably manage the Plan. The guidelines established are subject to change as the Plan evolves. Upon approval by the Plan, the Manual will be amended to incorporate changes. The commemoration of changes in this manual is not required for the changes to take effect.

Section 201 Policy Forms

The Plan will provide professional liability insurance and general liability insurance under policy forms and applications as approved by the Plan.

Approved Policy Forms

Physicians and Surgeons Professional Liability Claims-Made Declarations
Physicians and Surgeons Professional Liability Policy
Amendatory Endorsement
Exclusionary Endorsement
Extended Reporting Endorsement
Named Insured - Separate Limit of Liability Amendatory Endorsement
Named Insured - Shared Limit of Liability Amendatory Endorsement
Part-Time Endorsement
Cancellation Endorsement
HealthCare Professional Liability Claims-Made Declarations
Miscellaneous Healthcare Facilities Common Conditions
Miscellaneous Healthcare Facilities Professional Liability Coverage Part - Claims Made
Miscellaneous Healthcare Facilities General Liability Coverage Part – Occurrence
Exclusion of Certified Acts of Terrorism or Chemical Acts of Terrorism
Exclusion of Fungi or Bacteria
Exclusion of Employment Related Practices
Exclusion of Year 2000 Computer Related and Other Electronic Problems
Exclusion of Nuclear Energy Liability
Exclusion of War Liability

Approved Applications

Physicians and Surgeons Professional Liability Application
Physicians and Surgeons Professional Liability Renewal Application
Hospital, Institution, Healthcare Facility Professional Liability Application
Hospital, Institution, Healthcare Facility Professional Liability Renewal Application
Paramedical Provider Professional Liability Application
Paramedical Provider Professional Liability Renewal Application
Locum Tenens Application

Effective September 15, 2004, a Plan approved HIPAA Business Associate Agreement and Cover Letter will accompany all new and renewals policies issued (and for all future renewals issued thereafter).

Section 203 Manual Rules

Coverage will be underwritten in accordance with the rules, specialty classifications, and base rates as set forth by the Plan and outlined in this manual.

Health care providers applying for coverage may have characteristics that indicate a different exposure that presented by others in the same rating classifications. These differences in exposure shall be recognized through the application of credits/debits as set forth in this manual or at the direction of the Plan.

Section 204 Disputes Subsequent to Classification

The applicant may object to the selection of classification which was based on the application and rating procedure. All disputes should be referred to the Servicing Company. If a dispute cannot be resolved to the satisfaction of the insured, it may be referred to the Mississippi Medical Malpractice Availability Plan for review. Any insured may claim the right to review. All requests for such review must be submitted to the Servicing Company in writing. In the interim period prior to the Mississippi Medical Malpractice Availability Plan deliberation and findings, the original quoted premium must be paid to bind coverage. Should the Mississippi Medical Malpractice Practice Availability Plan subsequently rule in the insured's favor, the premium will be modified retroactive to the effective date of the policy term and a refund issued for overpayment, if appropriate.

Section 205 Distribution System

Commission of 5% of all premiums will be paid to licensed resident Mississippi agents. Commissions will be paid semi-annually on paid premiums. Premiums will not be reduced if a policy is purchased without an agent. Agents are not authorized to withhold their commission from payments made to the Plan.

The Plan will not contract or have agent or broker representation. The Servicing Company will not recommend insurance agents to health care providers. If the Plan provides the Servicing Company with a list of agents for recommendation to applicants who request assistance in

obtaining agent representation, the Servicing Company will provide the list of agents to such applicants. If the Servicing Company determines that an agent has made material misrepresentations with respect to any applicant or insured or that such agent has acted in any way to deceive or defraud the Plan, it will report this information to the Plan.

For any premium financing company approved by the Plan, the Servicing Company will remit return premiums to the finance company in accordance with the provisions of the approved finance agreements at the direction of the Plan. If the Servicing Company returns the entire unearned premium, including agent's commissions, to the finance company, the Servicing Company will have the right to offset any amount of commission paid by the Servicing Company from any other amounts due to the agent, or bill the agent directly for such unearned commission.

Requests to change agents received, in writing from an insured, will be honored immediately, in regard to servicing of their account. The agent who submitted the application will receive commissions through the end of the policy term.

Section 300 Processing Procedures

Section 301 Application and Quoting Process

Each Health Care Provider is required to submit the appropriate application(s) in order to be considered for coverage with the Plan. Applications can be obtained from the Servicing Company, licensed agent or from the Plans' web-site at www.dfa.state.ms.us.

New Applications should be returned to the Plan at least 60 days prior to the requested effective date of coverage to ensure ample time to complete the underwriting review process. Applicants with active coverage for an existing Mississippi practice will be considered for coverage only upon the expiration of active coverage. Requests for mid-term coverage when active coverage exists will not be honored without approval from the Plan.

The Servicing Company will endeavor to provide a firm quotation at least 30 days prior to the requested effective date when complete submissions are received, at least 60 days prior to the requested effective date. Complete submissions received less than 60 days prior to the requested effective date of coverage will receive a firm quotation upon completion of the underwriting review.

Applicants with incomplete submissions will receive a letter summarizing the items necessary to make the submission complete. Premium indications, which are subject to change, may be released if the underwriting information needed to release a premium indication has been provided. No firm premium quotation may be given before a fully completed application has been submitted.

A complete health care provider submission includes the following:

- Every question completed (use N/A, when applicable) and detailed explanations

- provided, when requested;
- Copy of most current Professional Liability Declarations Page
- Five-year Company Loss History
- Copy of Mississippi Medical License
- Curriculum Vitae
- Copy of Business Letterhead
- Supplemental Loss Information for each loss
- Signature and Date on Application
- Paramedical Provider Application for each provider, if applicable
- Verification of Extended Reporting Coverage, if applicable
- Copy of American Board Certification, if applicable
- Copy of Education Council for FMG or Fifth Pathway Program Certification, if applicable

In addition, a complete facility submission includes the following:

- Individual Application for each Professional Employee
- Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies
- Current audited financial statement
- Copy of medical staff by-laws
- AHA Survey of hospitals
- Risk Management and quality improvement plan
- Verification of professional liability coverage for all contracted services
- All hold harmless agreements

Renewal Applications will be mailed to insureds 120 days prior to their expiration date/renewal date. Renewal Applications should be returned to the Plan at least 90 days prior to the expiration date/renewal date.

Firm Quotations and Premium Indications expire 10 days after the requested effective date or 30 days from the release date, whichever is less.

Section 302 Binding of Coverage

The Plan shall rely on the information developed from the application and underwriting review process for the purposes of determining eligibility and required premium. Coverage may not be bound (made effective) until the submission is complete, including any additional information requested by the Servicing Company, the necessary investigation is completed, and the required premium is paid. The Servicing Company will issue a Certificate of Insurance based upon the applicant's request in accordance with a proposal made to the applicant after the appropriate premium has been received per the premium payment guidelines of the Plan.

Section 303 Premium Payment

Premium payments are expected in advance of binding of coverage. Coverage can not be bound until payment is received by the Plan. Payment is considered received on the date payment is sent to the Plan, as evidenced by the post-mark date or date shown as received by delivery service for items sent by overnight mail service.

A premium payment plan is available for active policy premiums when an insured's total annual premium is at least \$25,000. Annual premiums under \$25,000 are due in full at the time coverage is bound. The premium payment plan requires a deposit of 50% of the annual premium at binding with 25% due within 90 days of the effective date and the remaining 25% due within 180 days of the effective date. A non-refundable service fee equal to 1.5 % of the total financed premium will be due at binding along with the deposit. The premium payment plan is not available for Reporting Coverage premiums or mid-term endorsements.

At their June 10, 2004 meeting, the Board made the decision to change the premium payment plan. A premium payment plan remains available for active policy premiums when an insured's total annual premium is at least \$15,000. Annual premiums under \$15,000 are due in full at the time coverage is bound. The premium payment plan requires a deposit of 33.33% of the annual premium at binding with 33.33% due with 60 days of the effective date and the remaining 33.34% due with 120 days of the effective date. A non-refundable service fee remains equal to 1.5% of the total financed premium will be due at binding along with the deposit. The premium payment plan is not available for Reporting Coverage premiums or mid-term endorsements.

The Mississippi Medical Malpractice Plan reserves the right to not accept late payments or to accept late payment subject to restrictions and/or late fees equal to 10% of the premium due capped at \$2,000.

For all policies issued on an installment premium basis, installment billing notices will be mailed at least 30 days in advance of the premium due date. A Cancellation Warning Notice will be sent immediately, providing a 5 day grace period, if payment is not received by the due date. If payment is not received within the grace period a Notice of Cancellation for Non-Payment of Premium is issued providing 10 days plus 2 days mailing, within which payment must be received in order to continue coverage without a lapse.

All premium payments shall be made by check payable to Mississippi Medical Malpractice Availability Plan. Agency checks are discouraged. Checks will be accepted by Plan approved financing companies.

Section 304 Misrepresentations or Fraud

The application completed by the applicant is made part of the policy. Any concealment, misrepresentation or fraud on the part of any insured, whether before or after a loss, may result in the policy being voided as of inception, cancelled, or appropriate adjustment to the coverage premium.

Section 305 Certificates of Insurance

The Servicing Company will issue certificates evidencing insurance coverage, to interested parties upon request of the insured. An interested party is considered to be a hospital, nursing home, HMO, PPO, or other practice or managed care program that the Plan deems to have a legitimate interest in the coverage of the insured. Agents or brokers are not authorized to issue certificates.

Requests to add an Additional Insured to a policy will not be honored. A Certificate of Insurance may be issued for General Liability Coverage for leased equipment with the leasing company as the certificate holder, upon receipt of a written request, a copy of the contract, and specific leasing terms.

Section 306 Termination of Coverage

The insured may terminate coverage at any time. Termination will be effective no earlier than the date that the Plan receives written notice of the requested termination from the insured.

The Plan may cancel coverage if based on one or more of the following reasons cited in the policy. Cancellation notice will be sent to the insured in writing no less than thirty days prior to the effective date of cancellation (except when termination is due to non-payment of premium). In case of cancellation due to non-payment of premium, ten days written notice must be given. Notices will be mailed to the Policyholder at the last mailing address known by the Plan.

Subject to Mississippi's cancellation requirements, the following provisions apply:

- **Pro Rata Cancellation:** When a policy is cancelled at the request of the plan, pro-rata return premium will be computed and rounded to the next higher whole dollar.

At their November 13, 2003 meeting, the Board made the decision to pro-rate all cancellations. Cancellations are no longer subject to short rate.

If notice is mailed, proof of mailing will be sufficient proof of notice.

Minimum premium will be retained, unless the policy is cancelled flat as of the inception date stated in the declaration page.

Section 400 General Rating Rules

Section 401 Claims-Made Coverage

Professional Liability coverage will be offered on a Claims-Made Form. Prior Acts Coverage for an exposure with a previous carrier or uninsured period will not be offered. Coverage will not extend to any medical incident: 1) which has been reported to another carrier prior to the first date of coverage, 2) which occurred prior to the first date coverage is provided, 3) which occurred prior to the first date coverage is provided if such date, the insured knew or believed, or had reason to know or believe that such medical incident had occurred, or 4) that occurred during

a period in which the insured was not covered under a policy of professional liability insurance per the policy terms and conditions.

The Year/Step 1 (base) premium at the applicable rating class and limit of liability (including applicable debits and credits) will apply at the Inception Date (first date of coverage) coverage in the Plan. The Inception Date will become the Prior Acts Date for future renewals.

The Year/Step 2, Year/Step 3, Year/Step 4 or Year/Step 5 base premium at the applicable rating class and limit of liability (including applicable debits and credits) will be determined by counting the number of years from the Prior Acts Date (inception date) in the Plan. The proper step into which the insured is placed for rating purposes when claims-made coverage has been provided for less than annual periods is determined as follows:

- If claims made coverage has been in effect for less than 6 months, Step 1 applies
- If claims made coverage has been in effect for x years but less than x years, 6 months, step x plus 1 applies.
- If claims made coverage has been in effect for x years plus 6 months or more, Step x plus 2 applies.

When a claims-made renewal policy is issued, the assigned Prior Acts Date is maintained, but the effective date is changed to reflect the renewal policy period.

Section 402 Multiple Classifications

Health care providers will be classified in accordance with the classification schedule included with in the rate schedule developed by the Plan. If more than one classification applies, the classification with the highest base rate will apply.

Section 403 Coverage Terms

All policies will be written for a 12- month term to be effective on or after April 27, 2003, unless approved otherwise by the Medical Malpractice Availability Plan. Rates for periods shorter than one year will be pro rated from the annual rates. Reporting Coverage will be written for all unlimited term.

Section 404 Physicians and Surgeons

Rates apply on a per doctor basis and are based on the ISO Specialty Code listing below, rating class, and applicable limit of liability.

Attachment 1	Schedule of Rating Classes
Attachment 2	Annual Claims-Made Rates at Limits of \$500,000/\$2,000,000
Attachment 3	Annual Claims-Made Rates at Limits of \$1,000,000/\$3,000,000

The following definitions of "no surgery", "minor surgery" or "assist in surgery", and "all other surgery" apply to the classification of physicians for specialties where a distinction is made in the classification plan.

- The term "no surgery" applies to physicians who:
 - do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), and
 - do not assist other physicians during the performance of surgical procedures.
- The term "minor surgery" or "assist in surgery" applies to physicians who:
 - perform minor surgery, or
 - assist in major surgery on their own patients.
- The term "all other surgery" applies to physicians and surgeons who:
 - perform major surgical procedures on their own patients, or
 - assist in major surgery on other than their own patients.

PHYSICIANS' & SURGEONS' SPECIAL TV CODES

<u>Specialties</u>	<u>Industry Class Code</u>		
	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>Major Surgery</u>
Administrative Medicine	80178	-	-
Allergy	80254	-	-
Anesthesiology-including Spinal Caudal and General	-	-	80151
Bariatrics-Including but not limited to Gastric Bubble and Gastric Stapling	-	-	80476
Cardiovascular Disease	80255	80281	80150
Colon & Rectal	-	-	80155
Dermatopathology	-	-	80474
Dermatology	80256	80282	80472
Emergency Medicine This classification applies to any general practitioner or specialist primarily engaged in emergency practice at a clinic, hospital	-	80102(C)	-

or rescue facility

Family Practitioner or General Practitioner with Obstetrics	-	-	80117
Family Practitioner or General Practitioner with No Obstetrics	80420	80421	80117
Forensic/Legal Medicine	80240	-	-
Gastroenterology	80241	80274	-
General-N.O.C. This classification does not apply to any family or general practitioners or specialist who occasionally perform surgery	-	-	80143
General Preventative Medicine	80231	-	-
<u>Specialties</u>	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>Major Surgery</u>
Gynecology	80244	80277	80167
Hand	-	-	80169
Hematology	80245	80278	-
Intensive Care Medicine/Hospital	-	80283	-
Internal Medicine	80257	80284	-
Nephrology	80260	80287	-
Neurology	80261	80288	80152
Obstetrics/Gynecology	-	-	80153
Occupational Medicine	80233	-	-
Oncology	80473	80286	-
Ophthalmology	80263	80289	80114
Orthopedic-No Spinal Surgery	-	-	80154(A)
Orthopedic-Including Spinal Surgery	-	-	80154(B)

Otorhinolaryngology-No plastic Surgery	80265	80291	80159
Otorhinolaryngology-Including Plastic	-	-	80155
Pain Management	80475(A)	-	80475(B)
Pathology	80266	-	80475(C)
Pediatrics	80267	80293**	-
Physical Medicine & Rehabilitation	80235	-	-
Physicians-N.O.C.	80268	80294	-
Plastic-Including Breast Implants	-	-	80156
<u>Specialties</u>	<u>No Surgery</u>	<u>Minor Surgery</u>	<u>Major Surgery</u>
Podiatrist	80620	-	80621
Psychiatry	80249	-	-
Psychiatry-Including Shock Therapy	80431	-	-
Public Health	80236	-	-
Pulmonary Diseases	80269	-	-
Radiology-Diagnostic	80253	80280	-
Radiology-Including Radiation Therapy	-	80425	-
Rheumatology	80252	***	-
Thoracic	-	-	80144
Traumatic	-	-	80171
Urology	80145	80145	80145
Vascular	-	-	80146

*** See Internal Medicine-Minor Surgery

Section 405 Hospitals, Facilities and Nursing Homes

Hospitals, facilities and Nursing Homes shall be rated based on the number of beds, outpatient and inpatient visits per year, providers, and procedures/services provided, at the applicable limit of liability. A debit equal to 10% of the calculated rate will apply to all hospitals as directed by the Plan. Additional debits may be applied based on losses and underwriting experience as determined by the Servicing Company and/or the Plan.

A Vicarious Liability Charge equal to 15% of the base premium (no debits or credits) at the appropriate step and limits of liability for each (employed or contracted) physician, surgeon, and paramedical provider that is not individually insured by the Plan, will be added to the Hospital, Facility, and/or Nursing Home premium.

Employees, of governmental entities insured by the Plan (coverage per Section 11-46-7 of the Mississippi Code of 1972) are required to complete a New Business Application at inception of coverage or employment term. Renewal applications are not required for employees; however, an updated list of employees is required from the insured entity at each renewal. Employees of governmental entities insured by the Plan will not be included as a named insured on the insured entity's policy. 03/07/05

Employees of governmental entities not insured by the Plan (coverage per Section 11-46-7 of the Mississippi Code of 1972) may be offered coverage upon receipt of a letter from the insurer of the governmental entity refusing to insure the employee. If the employee can obtain coverage from its employer or employer's insurer, the Plan will not offer individual coverage to the employee. Employees of governmental entities not insured by the Plan are required to complete a New Business Application at inception of coverage and a renewal application for each renewal thereafter. If coverage is approved an individual physician policy will be issued and the governmental entity (public hospital of which they are employed) will be named as an additional insured on a shared limit of liability basis. A full-time physician premium, with applicable debits and credits, will be charged with an additional 25% debit for the vicarious liability exposure of the governmental entity. An Exclusion Endorsement will be issued which limits the coverage of the governmental entity to the exposure of the individual employed physician. Coverage will be limited to the employment term. Extended Reporting Coverage must be obtained to have reporting coverage after termination of the policy/employment term.

Certain forms of general liability insurance can be added to the professional liability policy for Hospitals, Facilities and Nursing Homes, as long as there is an insurable interest. General Liability is offered on occurrence form only (no claims made.) The general liability premium is calculated at 10% of the mature professional liability premium at the same limit of liability.

Attachment 5 Annual Claims-Made Rates at Limits of \$500,000/\$2,000,000 for Hospitals

Attachment 6 Annual Claims-Made Rates at Limits of \$1,000,000/\$3,000,000 for Hospitals

Attachment 7 Annual Claims-Made Rates at Limits of \$500,000/\$2,000,000 for Nursing Homes

Attachment 8 Annual Claims-Made Rates at Limits of \$1,000,000/\$3,000,000 for Nursing Homes

Section 406 Employed Paramedical (Other Than Physicians)

Professional employees (other than cytotechnologists, dentists, emergency medical technicians, certified (graduate) registered nurse anesthetists, nurse midwives, nurse practitioners, optometrists, perfusionists, physicians, physicians' assistants, psychologists, surgeons' assistants, Chiropractor, Podiatrists) are automatically included, at no additional charge, under policies issued to their employers while acting within the scope of their duties as an employee. The limits of liability are provided on a shared basis with the employer.

The following paramedical employees may be individually covered by the plan by payment of an additional premium or covered elsewhere through a program deemed acceptable to the plan with minimum limits of liability equal to or greater than those of the insured employer. Coverage is available through the Plan on a shared limits basis or with separate individual limits of liability. If coverage is obtained elsewhere a Vicarious Liability Charge equal to 10% of the calculated premium based on shared limits of liability, will apply to the Employers' premium. To determine the additional premium for the coverage selected, apply the appropriate factor from the premium assigned to Specialty Class Codes 80420, 80151, 80266 or 80114, as specified, for the applicable claims made year and limits of liability:

Paramedical employees written on a shared limits basis will be charged a fourth year claims made premium regardless of retroactive date and the shared limits factors stated above will always be applied to fourth year claims made premium.

A Vicarious Liability Charge equal to 15% of the calculated premium based on shared limits of liability, will apply to the Insured's premium for each non-employed paramedical for whom the Insured supervises.

Employee	Based on % of 80420	
	Shared Limits Factor	Separate Limits Factor
Physician's Assistants	0.132	0.400
Surgeon's Assistants	0.132	0.400
Certified Nurse Midwives	0.578	1.750
Certified Nurse Practitioner	0.132	0.400
Psychologists	0.008	0.111
Emergency Medical Technician	0.003	0.010
Perfusionist	0.132	0.496
Chiropractor	0.264	0.750

Employee	Based on % of 80151	
	Shared Limits Factor	Separate Limits Factor
Certified Nurse Anesthetists (CRNA) Not part of insured group	NA	0.35
CRNA employed by an insured group – Separate limits basis CRNA employed by an insured group-	NA	0.25

Shared limits basis; ratio of CRNA to Anesthesiologist between 2:1 and 4:1	0.15	NA
CRNA employed by an insured group- Shared limits basis; ratio of CRNA to Anesthesiologist no more than 2: 1 (If the ratio of employed CRNA's to Anesthesiologists exceeds 4: 1, the insured will be individually underwritten)	0.075	NA

<u>Employee</u>	<u>Based on % of 80266</u>	
	<u>Shared Limits Factor</u>	<u>Separate Limits Factor</u>
Cytotechnologist	0.1	NA

<u>Employee</u>	<u>Based on % of 80114</u>	
	<u>Shared Limits Factor</u>	<u>Separate Limits Factor</u>
Optometrist	0.025	0.032

Section 407 Business Entity Coverage

Coverage for partnerships, corporations, limited liability corporations, professional associations or other similar entities owned by more than one insured physician or surgeon may be written with a separate limit of liability equal to the limit of liability purchased by the insureds. The premium charge will be 15% of the sum of the individual premium of all physicians or surgeons who own, are employed by, or contract to the business entity. For each physician or surgeon who owns, is employed by, or whom contracts to the business, but not individually insured by the Plan, a Vicarious Liability Charge equal to 30% of that member's rate as it would otherwise be calculated if insured by the plan, will apply. All members of the business entity must be insured by the Plan or another professional liability program acceptable to the Plan before a separate coverage limit for the business entity will be provided. The Plan will require evidence of medical malpractice insurance maintained by such providers with limits equal to or greater than the limits provided by the Plan. Such other insurance must be primary coverage. If coverage for a business entity is provided on a separate limit of liability basis, a single policy will be issued for all insureds who own or are employed by the entity and who are insured through the Plan. Each insured who is separately scheduled will have separate limit of liability. The business entity will have a single limit of liability for all claims under the coverage document regardless of the number of providers covered or number of claims made against the organization.

A separate limit is not available for sole proprietor physicians or surgeons that form a corporation or limited liability corporation.

No charge will be made for partnerships, corporations, limited liability corporations, or professional associations sharing in the available limits of liability of the insured physicians or surgeons, providing the Plan insures each physician or surgeon member and the risk is otherwise

acceptable. Coverage for a business entity provided on a shared limit of liability will be limited to the exposure of the members insured by the Plan.

Coverage may be afforded to business entity, on a shared limit of liability basis, which is not owned by an insured physician or surgeon, at the direction of the Plan. A Vicarious Liability Charge equal to a 15% debit of the insured physician or surgeons' individual premium will apply.

Section 408 Unknown Classification

If there is no classification included in the class plan for operations applicable to a health care provider a classification will be assigned by the Plan that most closely reflects the type of work and relative exposure to loss of the applicant's activities compared to activities contemplated by the class plan. The Plan has made the following determinations in regard to the class plan:

A 10% credit will apply to the Orthopedic Surgery classification (80154), Class 6, if spinal surgery is not performed.

A Class 7, Bariatric Surgery classification (80476) will apply for surgeons whom perform any Bariatric Surgery. 1/24/05

A Class 2, Minor Surgery classification (80283) will apply for any practice as a Hospitalist.

A Class 1, No Surgery classification (80420) will apply for practice devoted to Urgent Care Medicine.

A Class 2, Minor Surgery classification (80293) will apply for any practice devoted to the practice of Neonatology.

A Class 2, Minor Surgery classification (80421) will apply for Family Practitioners whom perform minor surgery or assist in major surgery on patients of their own.

A Class 1 A, No Surgery classification (80178) will apply for the practice of Administrative Medicine. 1/24/05

A Class 1, No Surgery classification (80267) will apply for the practice of Pediatrics.

A Class 1, No Surgery classification (80431) will apply for the practice of Psychiatry including Shock Therapy. 1/24/05

A Class 1, No Surgery classification (80620) will apply for the practice of Podiatry with no surgery. 1/24/05

A Class 3, Major Surgery classification (80621) will apply for the practice of Podiatry with major surgery. 1/24/05

Pain Management classifications will apply based on the following procedures: 1/24/05

Class 5A	(80475A)	Medicine Only
Class 5B	(804756)	Dorsal Root Ganglotomies, Epidural Injections, Thoracic Sympathextomies, Spinal Cord Stimulators, Drug Infused Pumps, Sphenopalatine Lesioning
Class 8	(80475C)	Cordotomies, Trigeminal Lesioning

Section 409 Premium Computation

Premiums will be computed using the rules and rates in effect on the effective date of the current coverage term. This rule applies to all endorsements, including Reporting Coverage. All changes requiring a change in premium are to be pro rated for the remaining term. Whenever factors or multipliers are used to compute the premium, they will be applied consecutively and do not add together. Rating Credits are first applied to the base premium followed by Rating Debits. Debits and Credits are applied from lowest percentage to highest percentage.

The Plan reserves the right to adjust an insured's premium effective at coverage inception if information is developed during the policy term that differs from the information the applicant supplied in the application.

Minimum Premium: The minimum premium per policy period is \$500 regardless of the term.

Rounding Rule: Rates, factors and multipliers will be rounded to two decimal places. Round premiums to the nearest whole dollar. Round premiums involving \$0.50 or over to the next highest dollar.

Additional Premium Charges: All changes requiring additional or return premiums will be pro-rated. Additional or return premiums of \$15.00 or less will be waived. Return premiums requested by the insured will be granted. Retain the policy minimum premium.

Section 410 Deductibles

Deductibles are not available.

Section 411 Premium Adjustment for Risk Change

Health Care Providers, who change their practice to a lower rated classification, rating territory, reduce to part-time, or other changes that would affect a calculated rate continue to have an exposure to loss from their previous practice. An additional premium charge is calculated for the previous exposure and added to the insured's new rating unless; the current medical specialty falls within the same class as the previous specialty, the insured's changed rating five or more years ago while insured under claims-made coverage, the insured changed rating at any time while insured under an occurrence form of coverage, or the insured meets the requirements for the reporting coverage at no additional charge if they retired from the practice of medicine.

If an exposure changes on the renewal date, use the previous term's reporting endorsement premiums and pro-rate any periods of less than 12 months. If installment billings have been satisfied at the time of the change, additional monies are due and are not carried forward into the next policy term. While the retroactive date of the policy would remain the same as before the rating change, reporting endorsement ultimately charged would be based upon the insured's risk class at the point of termination.

The calculations for changes in exposure are performed by taking the difference between claims-made rates for each period of differing exposures. This method can be generalized by using the following formula to calculate a rate for the upcoming year.

1. Rate for current practice, determined using a retroactive date equal to the date that the current practice patterns began,
2. plus rate for prior practice, determined using a retroactive date equal to the date that the previous practice patterns began,
3. less rate for prior practice, determined using a retroactive date equal to the date that the current practice patterns began.

This method is applied in a similar manner if more than one practice change occurred during the previous four years, and the components are pro-rated if the change occurred at a date other than the policy anniversary date.

Section 412 Locum Tenens Coverage

Coverage for a physician or surgeon who is temporarily serving as a relief or substitute may be provided on a shared limit of liability basis with the insured physician or surgeon. Coverage will be provided for a period not to exceed 90 days per coverage term at no additional charge. Locum Tenens are defined as physicians or surgeons who provide temporary coverage for an insured who is regularly scheduled to work but is unable to do so for reasons including but not limited to vacation, maternity leave, hospitalization, attendance at a professional meeting/seminar, illness, continuing education, family emergency. Locum Tenens coverage is not available for Paramedical providers.

In order to obtain coverage, the insured and substitute provider must complete an application and receive underwriting approval prior to the dates for which the Locum Tenens will provide coverage. A log will be maintained as part of the coverage documents to track Locum Tenens providers and their specific coverage dates.

Section 413 Extended Reporting Coverage and Rates

If coverage is terminated through either cancellation or non-renewal by either the insured or the Plan or if the policy expires and is not renewed, the Servicing Company will provide written notice to the insured, upon request, of the cost of buying an unlimited Extended Reporting Coverage. An additional limit of liability will not be provided. This coverage extends the reporting period for claims, which may have occurred between the Prior Acts Date (inception

date) and the termination of coverage with the Plan, and which are first reported to the Plan after the termination date of coverage.

The cost of the Reporting Coverage will be based on 1) the rules and rates in effect at the effective date of the current coverage term, 2) the number of years of prior coverage included, based on the retroactive date of the policy, and 3) any surcharge premium adjustments applicable during the current coverage term (e.g. experience debit applied to the premium will also apply to the Reporting Coverage rates). Premiums are pro-rated based on terms less than 12 months. Credits applied to the premium do not apply to the Reporting Coverage rates. The cost of the Reporting Coverage may be waived upon death or total disability, or after five continuous years of coverage with the Plan and complete and total retirement from the practice of medicine.

The Reporting Coverage premium and any earned premium due as a result of cancellation are due in full before the endorsement will be issued.

Attachment 9	Single Reporting Endorsement Rates of \$500,000/\$2,000,000 for Physicians
Attachment 10	Single Reporting Endorsement Rates of \$1,000,000/\$3,000,000 for Physicians
Attachment 11	Single Reporting Endorsement Rates of \$500,000/\$2,000,000 for Hospitals
Attachment 12	Single Reporting Endorsement Rates of \$1,000,000/\$3,000,000 for Hospitals
Attachment 13	Single Reporting Endorsement Rates of \$500,000/\$2,000,000 for Nursing Homes
Attachment 14	Single Reporting Endorsement Rates of \$1,000,000/\$3,000,000 for Nursing Homes

Section 500 Rating Credits

Section 501 Moonlighting Physicians

Physicians and surgeons who perform covered "moonlighting" activities may be eligible to be insured at 50% of the rate applicable to the specialty in which the physician or surgeon is "moonlighting." This credit is not available to residents in training.

Covered "moonlighting" activities include:

- Physicians and surgeons in active, full-time military service requesting coverage for outside activities.

- Full-time Federal Government employed physicians and surgeons (such as VA Hospital employees) requesting coverage for outside activities.
- Physicians and surgeons employed full-time by the State or County Health Department requesting coverage for outside activities.

Section 502 Part-Time and Semi-Retired Physicians

A 50% Part-Time Discount may be available, for non-surgical specialties, for those insureds whose practice is limited to no more than 20 hours per week. Discounts for surgical specialties may also be granted by the Mississippi Medical Malpractice Availability Plan at less than 50%.

Practice hours are defined as:

- Hospital rounds,
- Charting,
- On call hours involving patient contact, whether direct or by telephone,
- Consultation with other physicians, and
- Patient visits/consultations.

Practice hours of physicians receiving the Part-Time Discount are subject to random audit by the Plan.

Applicants that reside in contiguous states may be eligible for a 25% Discount if they practice in Mississippi on a part-time basis (no more than 20 hours per week) and their current carrier will not extend coverage for their limited Mississippi practice. If provided, coverage is limited, by endorsement, to practice performed in the State of Mississippi. Coverage will not extend to services provided in the State which they reside and verification of coverage for this practice is required.

Section 503 New Practitioner

This discount applies to physicians who have never been in practice and proceed directly into practice from training. The discount is based on the date training was completed and will follow the policy term.

<u>Years Since Training</u>	<u>Premium Credit</u>
Year 1	25%
Year 2	10%

Section 504 Practice Interruption Discount

Individual Health Care Providers whose practice is interrupted are eligible for a one-time practice interruption discount. The purpose of this discount is to "freeze" coverage while allowing the claims-made policy to remain in force. Coverage for services rendered during the "frozen" period will cease. Eligible reasons for practice interruption include, but are not limited to, the situations of sabbatical, maternity leave, disability or volunteer charitable medical assignments.

This discount is not intended for absence due to vacation, illness, leaves of less than 90 days or that extend longer than one year.

A 30% premium credit will be applied to the period of practice interruption. The discount will be applied upon return to the practice of medicine.

Section 505 Loss Free Credit

The Loss Free Credit will be evaluated based on the preceding 10 years of loss history provided by the expiring carrier's loss run. The credit will apply only to the active individual premium. The credit does not apply to Reporting Coverage premiums.

"Loss" is defined as the sum of the reserve and paid indemnity losses and includes allocated loss adjustment expenses as determined by the expiring carrier. When allocated loss expense is unknown, multiply total incurred indemnity by 1.25. Class action and individual drug litigation (i.e. Lotronex, Fen-Phen, Propulsid, Ruzulin) will be forgiven and not considered when granting this credit.

<u>Years Claim Free</u>	<u>Factor</u>
5	.95
6	.94
7	.93
8	.92
9	.91
10	.90

Section 506 Group Practice

Group Practice credits are available for three (3) or more individual insureds when practicing as a partnership or professional corporation or are independently employed by the same Healthcare System.

<u>Number of Physicians in Group</u>	<u>Factor</u>
0-2	1.0
3-6	.96
7-10	.94
11-15	.92
16 +	.90

Section 600 Rating Debits

Section 601 Loss Evaluation Debit Factors

The Loss Evaluation Debit will be evaluated based on the preceding 5 years of loss history provided by the expiring carrier's loss run. The debit will apply to all premiums including Reporting Coverage premiums.

"Loss" is defined as the sum of the reserve and paid indemnity losses and includes allocated loss adjustment expenses as determined by the expiring carrier. When allocated loss expense is unknown, multiply total incurred indemnity by 1.25. A total of two separate losses which equal no more than the total reserve and paid indemnity and allocated loss adjustment expenses \$10,000 each will be forgiven. In addition, class action and individual drug litigation (i.e. Lotronex, Fen-Phen, Propulsid, Rezulin) will be forgiven and not considered when granting this credit.

The debit schedule considers both frequency and severity of cases as outlined below:

Losses	Number of Losses						
	1	2	3	4	5	6	7
Up to and including \$100,000	1.00	1.15	1.30	1.45	1.85	2.05	2.20
\$100,001 to \$250,000	1.15	1.30	1.45	1.60	2.05	2.20	2.35
\$250,001 to \$500,000	1.30	1.45	1.60	1.70	2.20	2.35	2.45
Greater than \$500,000	1.45	1.60	1.70	2.20	2.35	2.45	2.60

Section 602 Scheduled Evaluation Debit Criteria

A health care provider who reports to the Plan in their application for coverage, a history of any of the following criteria may receive a debit equal to 10% of the annual premium, for each offense occurring within the last five (5) years. If the offense occurred between five (5) and fifteen (15) years ago a debit equal to 5% of the annual premium for each offense, will apply. No debit will apply if the offense occurred more than fifteen (15) years ago, unless otherwise determined by the Mississippi Medical Malpractice Availability Plan. 11/1/04 The debits are applied with the understanding that more than one debit may be applied for the same occurrence. No maximum debit applies:

- 602.01** A health care provider who reports that a claim for sexual misconduct has been made against them.
- 602.02** A health care provider who reports that a hospital denied, restricted, suspended, or revoked their privileges or invoked probation or reprimand.
- 602.03** A health care provider who reports having appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee.
- 602.04** A health care provider who reports having their medical or narcotics license denied, suspended, restricted or revoked or has invoked probation or reprimand.
- 602.05** A health care provider who reports having been evaluated or recommended for treatment for, diagnosed with, or treated for received medication for alcohol, narcotics or any other substance abuse, sexual addiction or mental health, physical or emotional condition.
- 602.06** A health care provider who reports having relapsed following alcohol or chemical dependency treatment.

- 602.07** A health care provider who reports having been indicted for, charged with, convicted of, plead guilty to, or entered into a plea agreement for a felony and/or misdemeanor including but not limited to mail fraud, and perjury.
- 602.08** A health care provider who has admitted to altering medical records.
- 602.09** A health care provider who has practiced without medical malpractice insurance.
- 602.10** A health care provider whose type/nature of practice presents an increased risk including but not limited to prescribing substances that are not FDA approved, performing procedures that are considered experimental, practicing a specialty for which that have not received appropriate training.
- 602.11** A health care provider who expiring coverage is with a non-standard, non-admitted carrier for cause. Not intended for use due to lack of availability of insurance markets.
- 602.12** A health care provider who reports having been asked to participate in or have volunteered to participate in an impaired physician program.
- 602.13** A health care provider who reports having had an injury, illness, or other event occur that may impair, lessen or diminish their physical or mental ability to practice medicine.
- 602.14** A health care provider who reports having a patient or his representative file a complaint or grievance against them with a hospital committee, state licensing or regulatory agency or other medical review committee (other than complaints determined that no probable cause existed and file closed).
- 602.15** A health care provider who was non-renewed or cancelled by insurance carrier with cause.
- 602.16** A health care provider who Medicare/Medicaid has brought documented charges against it for alleged fraud or inappropriate fees or has whose ability to participate has been revoked, suspended, placed on probation or voluntarily surrendered,
11/01/04
- 602.17** A health care provider who fails to cooperate with Risk Management and/or attend a sponsored Loss Prevention Seminar.