## ~~Chapter 18 Mississippi Medical Malpractice Availability Plan Rates and Rating Rules Manual~~ REPEAL

~~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. Tile 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 lot 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

| | Industry Class Code | | |
|---|---|---|---|
| **Specialties** | **No Surgery** | **Minor Surgery** | **Major Surgery** |
| 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<br>This classification applies to any general practitioner or specialist primarily engaged | | 80102(C) | |

| | | | |
|---|---|---|---|
| ~~in emergency practice at a clinic, hospital 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~~ | | |
| ~~**Specialties**~~ | ~~**No Surgery**~~ | ~~**Minor Surgery**~~ | ~~**Major Surgery**~~ |
| ~~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)~~ |

| Specialties | No Surgery | Minor Surgery | Major Surgery |
|---|---|---|---|
| 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 |
| 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.

| | Based on % of 80420 | |
|---|---|---|
| Employee | 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 |

| | Based on % of 80151 | |
|---|---|---|
| Employee | 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 | NA | 0.25 |

~~CRNA employed by an insured group-~~
~~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 — 0.075 — NA~~
~~(If the ratio of employed CRNA's to Anesthesiologists exceeds 4: 1, the insured will be individually underwritten)~~

| | | Based on % of 80266 |
|---|---|---|
| ~~Employee~~ | ~~Shared Limits Factor~~ | ~~Separate Limits Factor~~ |
| ~~Cytotechnologist~~ | ~~0.1~~ | ~~NA~~ |

| | | Based on % of 80114 |
|---|---|---|
| ~~Employee~~ | ~~Shared Limits Factor~~ | ~~Separate Limits Factor~~ |
| ~~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.

| Years Since Training | Premium Credit |
|---|---|
| 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.

| Years Claim Free | Factor |
|---|---|
| 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.

| Number of Physicians in Group | Factor |
|---|---|
| 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:

| | Number of Losses | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 heath 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.