Rule 1.7 Self-Insurers

(I) Individual Self-Insurance

A. Application for Individual Exemption from Insuring

(1) Any employer desiring to qualify as an individual exempt from insuring its liability for compensation (individual self-insurance) under the provisions of Miss. Code Ann. § 71-3-75 shall make application on a form provided by the Commission, and shall be required to reply fully to all inquiries made by the Commission and provide all necessary documents for the application to be properly considered.

(2) No record or any information concerning the solvency and financial ability of any applicant for individual self-insurance and no other information acquired by the Commission, which is deemed confidential by other provisions of law, shall be subject to public inspection.

(3) In no event shall an application for self-insurance be approved unless the applicant is willing and able to furnish adequate security for the payment of its obligations under the Act, and the type and amount of such security shall be determined by the Commission and in no event shall be less than $100,000.00. Upon approval of application by the Commission, security information shall be made available to the Mississippi Workers’ Compensation Individual Self-insurer Guaranty Association (IGA).

(4) Each applicant for individual self-insurance shall provide the Commission with one (1) point of contact information consisting of its mailing address, e-mail address, and telephone number.

(5) Upon approval of an application to be self-insured, the applicant must furnish the complete excess insurance policy in a form and in an amount acceptable to the Commission and that specifically names the Mississippi Workers' Compensation Individual Self-insurer Guaranty Association (IGA) as an additional insured in the event of the self-insurer’s insolvency or default.

B. Regulation of Approved Individual Self-Insurers

(1) The Commission shall continually monitor the financial status and claim liabilities of the individual self-insurer, and shall require, at the expense of the self-insurer, periodic financial, actuarial, or other such audits, statements, or reports as the Commission deems necessary to ensure that the financial status of the self-insurer remains satisfactory, that its liabilities remain adequately funded, and that its obligations under the compensation law are being promptly met.

(2) All individual self-insurers shall file with the Commission a statement of financial condition audited by an independent certified public accountant six months after the end of the individual self-insurer's fiscal year. All financial reports requested are required to be submitted electronically to the Commission. No record or any information concerning the solvency and financial ability of an individual self-insurer acquired by the Commission shall be subject to public inspection.

(3) At the same time the individual self-insurer files its required financial reports, each individual self-insurer shall provide the Commission with a current point of contact information consisting of its mailing address, e-mail address, telephone number. Failure to provide a current point of

contact for Commission regulation and the Commission's annual assessment may result in cancellation of an individual self-insured's certificate of authority.

(4) All individual self-insurers shall maintain specific and/or aggregate excess insurance coverage in an approved form providing statutory coverage with retention in an amount set by the Commission and naming the IGA as an additional insured in the event of the self-insurer's insolvency or default. A copy of the renewal policy shall be filed electronically with the Commission within thirty (30) days of the policy inception date.

(5) The security posted or the indemnity bond held by the Commission shall be for the benefit of the Commission and IGA as security for the payment of the individual self-insurer's covered claims and other obligations under the Law; for the expenses incurred by IGA in evaluating, adjusting, defending, or settling the self-insurer's covered claims; and for any assessment made against the self-insurer pursuant to the Mississippi Workers' Compensation Self-insurer Guaranty Association Law, Miss. Code Ann. §§ 71-3-151 through 181. The security posted or the indemnity bond held by the Commission shall also be for the benefit of the Commission to the extent of any assessment made against the self-insurer pursuant to the applicable provisions of the Act. Any bond or other security held by the Commission shall not be returned to a self-insurer or released any earlier than at least one (1) year after the last known claim, including medical only claims, against such self-insurer has been closed in accordance with the provisions of the Act.

(6) The Commission has the authority to require further or additional security from the individual self-insured to ensure that all outstanding liabilities are adequately secured. Additionally, the Commission has the authority to reduce the amount of security to a minimum held on behalf of the individual self-insured. The Commission shall not reduce the amount of security held on behalf of an individual self-insurer to below $100,000.00, until at least one (1) year after the last known claim, including medical only claims, against such individual self-insurer has been closed in accordance with the provisions of the Act. The Commission shall notify the IGA of the Commission's intent to release, reduce, or increase the security or bond.

(7) All individual self-insurers are required to furnish the Commission safety reports at least annually, according to the schedule or time fixed by the Commission. Such reports are to be made by a safety engineer or some other party competent to make safety surveys and reports, shall be submitted electronically, and shall be in the format prescribed by the Commission.

(8) At least every three years, unless relieved by the Commission, or more often if prescribed by the Commission, every individual self-insurer shall file an actuarial report with the Commission from a Member of the American Academy of Actuaries or other Commission approved qualified loss reserve specialist. The report shall include, but not be limited to, the amount of actuarially appropriate reserves for (i) known Mississippi claims and expenses associated therewith, and (ii) Mississippi claims incurred but not reported and expenses associated therewith, which reserves shall be shown as liabilities.

(9) All renewals of certificates of authority for the privilege of individual self-insurance shall automatically be granted upon the express condition that the individual self-insurer files promptly and completely by the prescribed due date all reports required of it by the Commission and that

the individual self-insurer complies with the plan of operation of the IGA, in accordance with Mississippi Code § 71-3-165(3).

(10) The Commission may institute proceedings requiring the individual self-insurer to show cause why its certificate of authority to act as an individual self-insurer pursuant to Miss. Code Ann. § 71-3-75 should not be terminated. The Commission shall notify the IGA of any such proceedings instituted against an individual self-insurer and of the basis for the Commission's decision to institute the proceedings.

(II) GROUP SELF-INSURERS.

A. Authority to Act as a Workers' Compensation Self-Insurance Group

The Commmission may permit two or more employers engaged in a common type of business activity or pursuit, or having other reasons to associate, to enter into agreements to pool their liabilities under Miss. Code Ann. § 71-3-75 for the purpose of qualifying as group self-insurers, and, in conjunction therewith, to enter into agreements to pool any other liabilities to their employees, and each employer member of such approved group shall be classified as a self-insurer. No person, association, or other entity shall act as a workers' compensation self-insurance group unless it has been issued an annual certificate of authority by the Commission. Such certificate of authority must be renewed annually on or before the anniversary date of the original certificate of authority of group self-insurance.

B. Qualifications for Initial Approval and Authority to Act as a Workers' Compensation Group

(1) A group of employers shall file an application with the Commission to act as a group self-insurer~~,~~demonstrating the need to form such a group. The proposed group self-insurer must show cause as to why a new group self-insurer should be approved. This may be through written presentation, oral, or both, at the direction of the Commission. The proposed self-insurance group shall file with the Commission its application for a certificate of approval accompanied by a non-refundable filing fee in the amount of Five Thousand Dollars ($5,000.00).

(2) In no event shall an application for group self-insurance be approved unless the applicant is willing and able to furnish adequate security for the payment of its obligations under the Act, and the type and amount of such security shall be determined by the Commission and in no event shall be less than $100,000.00. Upon approval of application to form a group self-insured by the Commission, security information shall be made available to the Mississippi Workers' Compensation Group Self-insurer Guaranty Association (GGA).

(3) After approval of the proposed group self-insurer, the self-insurance group shall file with the Commission the following:

(i) The applicant group self-insurer's name, location of its principal office, date of organization, and name and address of each member;

(ii) A copy of the articles of association, if any;

(iii) A copy of the bylaws of the proposed group self-insurer;

(iv) A copy of agreements with the administrator and with any and all service companies;

(v) A copy of the agreement between the group self-insurer and each member securing the payment of workers' compensation benefits, which shall include provisions for payment of assessments as provided by law;

(vi) Designation of the initial board of trustees and administrator;

(vii) The address in this State where the books and records of the group self-insurer will be maintained;

(viii) A pro-forma financial statement and any other documents required by the Commission on forms acceptable to the Commission showing the financial ability of the group self-insurer to pay workers' compensation obligations of its members;

(ix) Proof of payment to the group self-insurer by each member of not less than 25% of that member's first year of estimated annual premium as defined by the Commission on a date prescribed;

(x) Public group self-insurers must submit authorization from the governing authorities of each proposed member allowing participation in such a group self-insurance program with other political subdivisions or state agencies, boards, commissions or other public entities;

(xi) Rates, Rating Plans, (including all rating elements and formulas, e.g., experience rating factors, discounts, Schedule Rating Plans, etc.). Premium payment plans and classes of business to be written must be submitted for, and approved by the Commission, prior to a certificate of authority being issued.

C. Maintaining Authority to Act as a Group Self-Insurer

(1) In order to maintain the authority to act as a self-insurance group, the certificate of authority must be renewed annually on or before the anniversary date of the original certificate of authority of group self-insurance.

(2) To renew a group self-insurer certificate of authority, the group self-insurer must comply annually with the following provisions and supply the following items to the Commission:

(i) Demonstrate a combined net worth of all members of at minimum $1,000,000.00;

(ii) Each group self-insurer shall submit to the Commission a statement of financial condition audited by an independent certified public accountant, approved by the Commission, six months after the end of the group self-insurer's fiscal year. The financial statement shall include actuarially appropriate reserves for (a) known claims and expenses associated therewith, (b) claims incurred but not reported and expenses associated therewith, (c) unearned premiums, and (d) bad debt, which reserves shall be shown as liabilities;

(iii) An actuarial opinion regarding reserves for (a) claims and expenses associated therewith and (b) claims incurred but not reported and expense associated therewith shall be submitted to the Commission included in the audited financial statement;

(iv) Rates, Rating Plans, (including all rating elements and formulas, e.g., experience rating factors, discounts, Schedule Rating Plans, etc.) Premium payment plans and classes of business to be written must be submitted for, and approved by the Commission at least ninety (90) days prior to the renewal date in order for the group self-insurer's certificate of authority to be renewed.

(v) Unless relieved by the Commission, an actuarial rate analysis shall be performed annually and presented to the Commission in conjunction with the submission of the items mentioned in part (C)(2)(iv) above. This analysis shall include all classes to be written by the group self-insurer. The actuarial opinions and rate analysis shall be given by a Member of the American Academy of Actuaries or other Commission-approved qualified loss reserve specialist as defined in the annual statement adopted by the National Association of Insurance Commissioners, or any other qualified entity approved by the Commission.

(vi) Security against all unpaid claims and other liabilities in case of insolvency as prescribed by the Commission shall be provided by either a surety bond, financial security endorsement, guaranty agreement, or such other security as may be required by the Commission, payment into the self-insurance guaranty fund in an amount specified by the Commission, or any combination thereof. The Commission may adjust from time to time the requirements for the amount of security based on differences among group self-insurers in their size, types of employment, years in existence, financial status, or other relevant factors. The Commission shall notify the GGA of the Commission’s intent to release, reduce, or increase the security;

(vii) Specific and/or aggregate excess insurance in a form and in an amount by an insurance company acceptable to the Commission;

(viii) An indemnity agreement jointly and severally binding the group self-insurer and each member thereof to meet the workers' compensation obligations of each member. The indemnity agreement shall be in a form prescribed by the Commission;

(ix) A fidelity bond for the administrator in a form and amount acceptable to the Commission;

(x) Any changes in bylaws of the approved group self-insurer;

(xi) Any changes in agreement with the administrator and with any and all service companies;

(xii) Any changes in the board of trustees or administrator.

D. Examinations.

The Commission may examine the affairs, transactions, accounts, records, assets, and liabilities of each group self-insurer as often as the Commission deems advisable. The expenses of such examinations shall be assessed against the group self-insurer.

E. Board of Trustees: Membership, Powers, Duties, Prohibition.

(1) Each group self-insurer shall be operated by a board of trustees which shall consist of not less than five persons whom the members of a group self-insurer elect for stated terms of office. At least two-thirds of the trustees shall be employees, officers, or directors of members of the group self-insurer. The group self-insurer's administrator, service company, or any owner, officer, employee of, or any person affiliated with such administrator or service company shall not serve on the board of trustees of the group self-insurer. All trustees shall be residents of the state of Mississippi or officers of corporations authorized to do business in the state of Mississippi. The board of trustees of each group self-insurer shall ensure that all claims are paid promptly and shall take all necessary precautions to safeguard the assets of the group self-insurer.

(2) The board of trustees shall:

(i) Maintain responsibility for all monies collected or disbursed from the group self-insurer. Unless otherwise required by the Commission, at least 70% of the premium as determined by the Commission shall be for the sole purpose of paying claims, allocated claims expenses, reinsurance or excess insurance, and special fund contributions, including second injury and other loss related funds. The remaining premium shall be for the payment of taxes, general regulatory fees and assessments, and administrative costs. The Commission may approve an administrative fund account of more than 30% and a claims fund account of less than 70% only if the group self-insurer shows to the Commission's satisfaction that (a) more than 30% is needed for an effective safety and loss control program or (b) the group self-insurer's aggregate excess insurance attaches at less than 70%;

(ii) Maintain minutes of all board meetings and make such minutes available to the Commission;

(iii) Designate an administrator to carry out the policies established by the board of trustees, provide day to day management of the group self-insurer, and delineate in the written minutes of its meetings the areas of authority it delegates to the administrator;

(iv) Retain an independent certified public accountant to prepare the statement of financial condition as required by the Commission;

(v) Adopt and be responsible for maintaining an investment policy which will permit no more than 30% of investments in equities, unless otherwise approved by the Commission.

(3) The board of trustees shall not:

(i) Extend credit to individual members for payment of a premium except pursuant to payment plans approved by the Commission;

(ii) Borrow any monies from the group self-insurer or in the name of the group self-insurer except in the ordinary course of business, without first advising the Commission of the nature and purpose of the loan and obtaining prior approval from the Commission.

F. Individual Employer: Group Membership, Termination, and Liability

(1) An employer joining a workers' compensation self-insurance group after the group self-insurer has been issued a certificate of approval shall (i) submit an application for membership to the board

of trustees or its administrator and (ii) enter into the indemnity agreement required by this Rule. Membership takes effect no earlier than each member's date of approval. The application for membership and its approval shall be maintained as permanent records of the board of trustees.

(2) Individual members of a group self-insurer shall be subject to cancellation by the group self-insurer pursuant to the by-laws of the group. In addition, individual members may elect to terminate their participation in the group. The group self-insurer shall notify the Commission of the termination or cancellation of a member within ten (10) days and shall maintain coverage of each canceled or terminated member for thirty (30) days after such notice, at the terminating member's expense, unless the group self-insurer is notified sooner that the canceled or terminated member has procured workers' compensation insurance, has become an approved individual self-insurer, or has become a member of another group self-insurer. The Commission may terminate any member of a group self-insurer. Any member that owes undisputed premium or assessment to a group self-insurer shall be prohibited from joining any other self-insurance groups or becoming an individual self-insurer until such debt is paid.

(3) The group self-insurer shall pay all workers' compensation benefits for which each member incurs liability during its period of membership. A member that wishes to terminate its membership or is canceled by a group self-insurer remains jointly and severally liable for workers' compensation obligations of the group self-insurer and its members which were incurred during the canceled or terminated member's period of membership.

(4) A group self-insurer member is not relieved of its workers' compensation liabilities incurred during its period of membership except through payment by the group self-insurer or the member of required workers' compensation benefits and other assessments or liabilities.

(5) The insolvency or bankruptcy of a member does not relieve the group self-insurer or any other member of liability for the payment of any workers' compensation benefits or assessments and liabilities incurred during the insolvent or bankrupt member's period of membership.

G. Service Companies.

(1) No service company or its employees, officers, or directors shall be an employee, officer, or director of, or have either a direct or indirect financial interest in, an administrator. No administrator or its employees, officers, or directors shall be an employee, officer, or director of, or have either a direct or indirect financial interest in, a service company. All contracts shall be made available to the Commission upon request.

(2) The service contract shall state that, unless the Commission approves otherwise, the service company shall handle, to their conclusion, all claims and their obligations incurred during the contract period.

H. Other Reports.

(1) The Commission may prescribe the format and frequency of other reports which may include, but shall not be limited to, payroll audit reports, summary loss reports (loss runs), and quarterly financial statements.

(2) The Commission may also prescribe that information be submitted in a data form to the Commission so that the Commission may prepare its own reports and to satisfy oversight responsibility. In any case, non-cooperation, or incomplete or improper submissions may result in a show-cause hearing or a hearing for revocation.

I. Rates and Reporting of Rates.

(1) Each group member shall be audited by an auditor acceptable to the Commission at least annually, unless relieved by the Commission, to verify proper classification, experience rating, payroll, and rates.

(2) A group self-insurer or any member thereof may request a hearing and review by the Commission on any objections to the classifications, experience rating, payroll, or rates. The Commission may, in its discretion, convene a hearing for such purpose or consider the request without a formal hearing. If the Commission determines that as a result of an improper classification, a member's premium is insufficient, the Commission may order the group self-insurer to assess that member an amount equal to the deficiency. If the Commission determines that as a result of an improper classification a member's premium is excessive, the Commission may order the group self-insurer to refund to the member the excess collected. The Commission may grant such other relief as may be appropriate under the circumstances. The audit shall be at the expense of the group self-insurer.

J. Refunds.

(1)Any monies for a fund year in excess of the amount necessary to fund all obligations for that fund year may be declared to be refundable by the board of trustees with the approval of the Commission.

(2) Each member shall be given a written description of the refund plan at the time of application for membership. A refund for any year shall be paid only to those employers that remain participants in the group for the entire fund year for which such refund has been approved. However, payment of a refund based on a premium fund year shall not be contingent on continued membership in the group after that fund year for which such refund has been approved.

K. Payment of Premium.

(1) Each group self-insurer shall establish a premium payment plan which is filed with and approved by the Commission.

(2) Each group self-insurer shall establish and maintain bad debt reserves based on the historical experience of the group self-insurer or other group self-insurers.

L. Deficits and Insolvencies.

(1) If the assets of a group self-insurer are at any time found by the Commission to be insufficient to enable the group to discharge its legal liabilities and other obligations and to maintain the reserves required of it under the Mississippi Workers' Compensation Act and the provisions herein,

the group self-insurer shall immediately levy an assessment upon its members for the amount needed to make up the deficiency.

(2) In the event of a deficiency in any fund year, such deficiency shall be made up immediately, either from: (i) surplus from a fund year other than the current fund year, (ii) administrative funds, (iii) assessments of the membership, if ordered by the group self-insurer or the Commission, or (iv) such alternate method as the Commission may approve or direct. The Commission shall be notified prior to any transfer of surplus funds from one year to another.

(3) The Commission may deem a group self-insurer insolvent if:

(i) it fails to make and collect the assessments to overcome Commission recognized deficiencies; or

(ii) it is unable to pay its outstanding lawful obligations as they mature in the regular course of business, as may be shown either by an excess of its required reserves and other liabilities over its assets or by its not having sufficient assets to reinsure all of its outstanding liabilities after paying all accrued claims and assessments owed by it. The Commission shall levy an assessment upon the members of an insolvent group self-insurer sufficient to discharge all liabilities of the group, including the reasonable cost of liquidation.

(4) The Commission may replace the current board of directors and/or administrator of an insolvent group self-insurer if necessary to collect outstanding liabilities and assessments through rehabilitation or liquidation of the fund.

(5) The Commission shall notify the GGA of any proceedings instituted by the Commission against a group self-insurer and of the basis for the Commission's decision to institute the proceedings.

M. Revocation and Non-Renewal of Certificate of Authority.

(1) After notice and opportunity for a hearing, the Commission may revoke a group self-insurer's certificate of authority prior to annual renewal for the following reasons:

(i) the group self-insurer is found to be insolvent by the Commission,

(ii) the group self-insurer fails to pay assessments, fines, or other payments imposed upon it,

(iii) the group self-insurer fails to comply with any of the provisions of the Mississippi Workers' Compensation Act or Rules promulgated thereunder,

(iv) any certificate of approval that was issued to the group self-insurer was obtained by fraud,

(v) there was a material misrepresentation in the application for the certificate of approval,

(vi) the group self-insurer or its administrator has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any monies that belong to a member, or employee of a member, or a person otherwise entitled thereto and that may have been entrusted to the group self-insurer or its administrator in its fiduciary capacities, or

(vii) for other good cause.

(2) Non-renewal of the annual certificate of authority shall be at the discretion of the Commission and shall not require a hearing.

(3) Any group self-insurer that ceases to act as a self-insurer through non-renewal or revocation shall remain subject to regulation by the Commission until such time as all claims are paid and an appropriate amount of time, as determined by the Commission, has passed to insure that no additional liability under the Act will be incurred. During this time of continuing regulatory oversight by the Commission, all reports required by the Commission shall continue to be submitted by the former group self-insurer as shall any additional reports required by the Commission. The Commission maintains the ultimate responsibility for regulation throughout said process up to and including the installation of a new group self-insurer if the Commission so warrants, or final dissolution.

O. Definitions.

(1) "Administrator" means an individual, partnership, or corporation engaged by a workers' compensation group self-insurer's board of trustees to carry out the policies established by the group self-insurer's board of trustees and to provide day to day management of the group self-insurer.

(2) "Commission" means the Mississippi Workers' Compensation Commission.

(3) "Service Company" means a person or entity which provides services not provided by the administrator, including but not limited to, (1) claims adjustment, (2) safety engineering, (3) compilation of statistics and the preparation of premium, loss, and tax reports, (4) preparation of other required self-insurance reports, (5) development of members' assessments and fees, and (6) administration of a claim fund.

Source: Miss. Code Ann. § 71-3-85.

Rule 1.15 Inspection and Reproduction of Records.

1. Each person has a right to inspect and reproduce any public record on file in the offices of the Commission, except those records expressly exempted by a statute or a Commission Rule.

(a) To insure protection of Commission records and to prevent interference with the regular duties of the Commission, all Commission claim files shall be made available for inspection and copying only in the offices of the Commission during usual business hours, provided:

(1) A written request marked "Request for Public Records" is submitted to the Secretary of the Commission;

(2) The written request sufficiently identifies the claim file by referencing the names of parties and/or the Commission file number; and

(3) The written request states the desired time for inspection and/or the number of copies sought.

On the requesting party's compliance with (1), (2) and (3) above, the Commission shall respond in writing by granting or denying the request within ten (10) working days after receipt of the request. A Commission response denying a "Request for Public Records" shall specifically state the grounds for the denial and shall remain on file with the Commission for three (3) years.

The Commission shall attach an estimate of its actual copy costs to its response to the "Request for Public Records." Actual costs to the Commission shall be determined as follows:

(1) For copies of records not required to be certified by the Commission, $.50 per page;

(2) For certified copies of records, $1.00 per page and $3.50 for every certificate under seal affixed thereto;

(3) For copies of transcripts not required to be certified by the Commission, such cost per page shall be equal to the prevailing cost per page of transcripts in the trial courts of this state.

(4) For any staff time or contractual services required to respond to the request which shall be at the pay scale of the lowest level employee or contractor competent to respond to the request.

Within ten (10) business days after receiving payment of copy costs, the Commission shall supply machine copies of the material sought. The Commission may also elect to respond to a records request by making the requested records available for inspection in its offices or by electronically transmitting the records.

Any excess costs exceeding the previously paid estimated charges shall be due no later than ten (10) business days after Commission compliance with the request. Non-payment of estimated charges shall justify Commission denial of future requests.

(b) Notwithstanding any other provision contained herein, the Commission shall provide to any party to a claim a copy of any record in the file of such claim, including but not limited to, transcripts prepared for review by the Full Commission, at a charge of ten cents ($.10) per page, with a minimum charge of five dollars ($5.00).

2. As provided in Miss. Code Ann. § 71-3-66 (1972), the following records are exempt from public disclosure under the Mississippi Public Records Act of 1983 and shall not be available for public inspection: medical reports, rehabilitation counselor reports and psychological reports on file with the Commission in controverted and non-controverted cases, insofar as they refer to accidents, injuries and settlements.

(a) Such information contained in controverted and non-controverted case files shall be made available only to the claimant or to the employer or its insurance carrier which is called upon to pay claimant compensation in the same or any other workers' compensation claim. However, such information shall be subject to inspection by proper representatives of the Social Security Administration, Medicaid Commission, Employment Security Commission, or other state or federal agency which, in the opinion of the Commission, can show a compelling state interest requiring disclosure. The Commission may also issue statistical information where the individual claimants are not identified.

(b) The Commission may also make such information available to interested parties involved in proceedings or negotiations regarding the legal liability owing claimant from a third party. However, such request for disclosure, just as all other requests not specifically referred to in (a),

above, shall be accompanied by a statement of the requesting party's interest in disclosure of exempt materials. On Commission receipt of such request, the Secretary of the Commission, by certified mail, shall provide claimant a copy of the request and notify claimant of his right to file with the Commission an objection to such disclosure within ten (10) working days. Should claimant file an objection to the request, the parties shall be entitled to a hearing before the Commission. If claimant files no objection within ten (10) working days, such failure to respond shall be a waiver of any objection to the release of such requested information, and such information shall be provided upon payment of fees as set forth in section 1(a).

(c) To assure the right of individual privacy, any "Request for Public Records" referring to non-exempt information contained in a claim file shall be accompanied by a statement of the requesting party's interest in such records. Should the requesting party satisfy the Commission of its right to inspect records contained in a claim file, the Commission shall separate exempt material from non-exempt material and make the non-exempt material available after the requesting party's payment of costs.

Source: Miss. Code Ann. § 71-3-85.

Rule 1.16 Assessment Procedure

1. Every Carrier or Self-Insured shall report to the Commission all compensation and medical payments for the prior calendar year (January 1st through December 31st) on or before March 1st of each year on the Annual Assessment Report Form available on the Commission's website. The Carrier or Self-Insured shall include the six-digit Carrier Number at the time of submission. Additionally, each Carrier or Self-Insured shall certify that the form is a true and correct report of payments made by the Carrier or Self-Insured for the prescribed period. Failure to include all information required shall result in the Annual Assessment Report being returned to the Carrier or Self-Insured and may result in late penalties.

2. Failure of the Carrier or Self-Insured to submit the Annual Assessment Report on or before March 1st shall result in assessment of a twenty dollars ($20.00) per day penalty for each day the Carrier or Self-Insured fails to return the completed Annual Assessment Report to the Commission.

3. When calculating the percentage of gross claims for compensation and medical payments of Carriers and Self-Insureds to fund the administration of the Commission, the Commission shall utilize a percentage for the assessment that yields the closest total practical to the budget amount appropriated by the Legislature.

4. A Carrier or Self-Insured shall have 30 days from the date of the assessment invoice to tender payment to the Commission in the form and manner as directed by the assessment invoice.

5. Failure of the Carrier or Self-Insured to tender payment in the form and manner as directed by the assessment invoice within 30 days from the date of the assessment invoice shall result in notice to the Carrier or Self-Insured that payment is due and that a late penalty of ten percent

(10%) on the unpaid assessment amount is due at the same time payment of the outstanding assessment is tendered.

6. Failure of any Carrier or Self-Insured to pay an outstanding assessment within 60 days from the date of the assessment invoice shall result in the Commission entering an Order to demand payment of the outstanding assessment in full, including penalties. Further, failure to promptly issue payment may result in the Commission suspending or revoking the authorization to insure compensation or to be self-insured.

Source: Miss. Code Ann. § 71-3-99 (Rev. 2017)

Rule 2.2 Procedure to Controvert

A. Claimant Represented by an Attorney

An Employee's attorney may controvert a claim by filing with the Commission a properly executed Petition to Controvert, Form B-5,11. This document shall be filed electronically with the Commission through the Attorney Transmittal Online System (ATOS). In all claims in which no benefits, including disability, death, and medical benefits, have been paid, the Claimant shall file medical records in support of his claim for benefits within sixty days of filing a Petition to Controvert. Absent good cause shown, Claimant's failure to file medical records in support of his claim for benefits in accordance with this rule may result in dismissal of the claim or other sanctions.

A Claimant's attorney preparing to file a Petition to Controvert shall (a) locate the proper Commission claim file number by using Claimant's name/social security number to check the "First Report of Injury" portal on the Commission web site for a non-controverted file that appears to reference the same injury; (b) determine whether the Employer had workers' compensation insurance coverage on the date of the injury by checking the "Proof of Coverage" portal on the Commission web site; (c) list only one date of injury per Petition to Controvert; (d) correctly identify the Employer, county of injury, and date of injury to prevent filing delays due to misinformation; and (e) file an attorney employment/fee contract, if one is not already on file.

If the Employer is uninsured, the Claimant shall include on the Petition to Controvert the name and address of each owner of the Employer, or, in the case of an uninsured corporation, the names and addresses of the corporate president, secretary, and treasurer pursuant to Miss. Code Ann. § 71-3-83, so the owners/officers will be given notice of the claim when filed and afforded an opportunity to answer.

B. Unrepresented Claimant

An Employee may controvert a claim by filing with the Commission a properly executed Petition to Controvert, Form B-5,11. This document shall be mailed to the Commission. The Claimant shall file medical records in support of his claim for benefits within sixty days of filing a Petition to Controvert. Claimant's failure to file medical records in support of his claim for benefits may result in dismissal of the claim or other sanctions.

C. Employer or Carrier

An Employer or Carrier may controvert its liability to pay a claim by filing a Notice of Controversion, Form B-52, pursuant to Miss. Code Ann. § 71-3-37(4). Employer or Carrier shall simultaneously mail or personally deliver a copy of the Notice of Controversion to the Employee at the Employee's most current address which can be determined by diligent inquiry or, if the Employee is represented, to his or her attorney through ATOS or by mail. Commission Form B-18, Notice to Employee of Suspension of Payment, shall suffice as notice of controversion if the Employer or carrier has paid workers' compensation disability benefits.

Source: Miss. Code Ann. § 71-3-85.

Rule 2.3 Notice

Upon the filing of a Claimant's Petition to Controvert, Form B-5,11, the Commission shall immediately furnish a copy of the Petition to Controvert with any attachments to Employer and Carrier.

Source: Miss. Code Ann. § 71-3-85.

Rule 2.4 Response to Petition to Controvert

The Employer or Carrier shall file a properly executed Answer, Form B-5,22, with the Commission within twenty-three (23) days after the Commission mails an unrepresented Claimant's Petition to Controvert, Form B-5,11 to the Employer or Carrier. Employer or Carrier may attach a list of affirmative defenses to the Answer. No other copies of the Answer need be furnished to the Commission. The Employer or Carrier shall mail a copy of the completed Answer and any attachments to the Claimant or, if represented, provide notice to the Claimant's attorney.

Averments contained in Claimant's Petition to Controvert to which a responsive answer is required are admitted unless denied in the Answer. All affirmative defenses such as intoxication of the injured Employee, willful intent to injure himself or another, statute of limitations, lack of notice, etc., must be pleaded. Unless so pleaded, they shall be deemed waived.

The Administrative Judge may grant Employer or Carrier additional time to file an Answer, but the discovery period shall still begin twenty-three (23) days after the Commission mails the Petition to Controvert to Employer or Carrier. All requests for additional time shall note Claimant's agreement to the extension or be filed as a motion and noticed for hearing in the usual manner. An Employer may be sanctioned for failure to timely file an Answer without good cause.

Source: Miss. Code Ann. § 71-3-85.

Rule 2.5 Prehearing Statement; Setting of Hearings.

Before a matter can be set for hearing on the merits, each party must submit a complete Prehearing Statement with appropriate documents attached. The completed Prehearing Statement shall follow

the form prescribed by the Commission and be completed per its instructions. Attorneys shall file the Prehearing Statement electronically with the Commission through ATOS.

All depositions shall be taken or officially noticed before the hearing on the merits is set. If medical witnesses have not been deposed before the Prehearing Statement is filed, a copy of the notice of the deposition must be attached to the Prehearing Statement.

Except for depositions and exhibits to depositions, counsel shall secure the Administrative Judge's permission to attach to the Prehearing Statement any single, proposed exhibit that exceeds fifty (50) pages.

The written information submitted by the parties shall comprise the only prehearing conference to be held routinely before the hearing, unless the Administrative Judge or a party requests further conference for special needs in a particular claim. The granting of a prehearing conference shall be in the discretion of the Administrative Judge. After the parties file complete Prehearing Statements, the Administrative Judge shall advise the Commission docket room that the matter is ready to be set for hearing. The Administrative Judge may schedule the hearing, or the docket room shall notify the parties in writing that they may contact the Administrative Judge's legal assistant to request a setting. The hearing date shall follow the date of the last deposition. Both parties shall confirm a hearing date or dates with the Administrative Judge’s legal assistant within two (2) business days after a hearing date or dates are provided; failure to confirm a date for hearing without good cause may result in sanctions for unreasonable delay.

Within fifteen (15) days after the discovery deadline expires per Mississippi Workers' Compensation Commission Procedural Rule 2.7, the Claimant shall file a properly completed Prehearing Statement or a written request for an extension of time explaining the reasons for the request. The Employer and carrier shall have fifteen (15) days after the filing of the Claimant's properly completed Prehearing Statement to file a properly completed Prehearing Statement or written request for an extension of time. Claimant's failure to timely file the Prehearing Statement may result in the dismissal of the claim or other sanctions. Employer/Carrier's failure to timely file the Prehearing Statement may entitle Claimant to a unilateral setting or other sanctions.

Rule 2.6 Notice of Hearing

Absent agreement by the parties, the Commission shall give notice of an evidentiary hearing at least twenty (20) days before the hearing date. The notice shall contain the names of the parties and the date, time and place of the hearing. The hearing shall be limited solely to the issues reflected by the pleadings, requests for admissions, and prehearing statements.

Per Miss. Code Ann. § 71-3-55(3), the Commission may designate one or more central locations within the territory of each Administrative Judge, other than the county where the injury occurred, as the location for all hearings by the Administrative Judge in that territory. The hearing locations are listed on the Commission's website.

The parties shall contact each other fourteen (14) days prior to the hearing to discuss settlement. Counsel for the Employer/Carrier shall report the results of this discussion to the Administrative Judge and the Administrative Judge's legal assistant by email copied to opposing counsel.

Source: Miss. Code Ann. § 71-3-85.

Rule 2.7 Hearings; Discovery

All evidentiary hearings before an Administrative Judge or review hearings before the Commission, shall be docketed with the Commission at least twenty-three (23) days before the date set for hearing, except when the parties otherwise agree or when shorter notice is allowed by statute or rule, including but not limited to Miss. Code Ann. § 71-3-17(b) and Mississippi Workers' Compensation Commission General Rule 1.9. The Commission shall provide all parties written notice of the date, time and place of the hearing.

At each evidentiary hearing before an Administrative Judge, the Employer shall have the claims professional handling the claim present at the hearing or available to the Commission by telephone during the entirety of the hearing. Parties shall bring three (3) hard copies of all proposed exhibits to the hearing. Medical records must be paginated and presented in chronological order.

Twenty-three days after Claimant files a Petition to Controvert, the claim shall be assigned to an Administrative Judge and placed on the active docket. Discovery shall be completed and medical depositions scheduled within 120 days after the claim is placed on the active docket.

A party may request extension of the 120-day time limitation for discovery if there is credible medical evidence that the Claimant has not reached maximum medical improvement or if other good cause is shown in writing to the Administrative Judge. The discovery deadline may be shortened to as few as sixty (60) days if the Claimant files a complete Prehearing Statement indicating discovery is complete and the claim is ready for a hearing on the merits; in that event, Employer /carrier have fifteen (15) days after the filing of the Claimant's Prehearing Statement to file its completed Prehearing Statement or written request for additional time.

Unless the Administrative Judge finds a bifurcated hearing shall expedite resolution of a claim, all claims shall be completed at one hearing on the merits, and all lay, expert, and documentary evidence, including medical depositions, shall be introduced at the hearing. All issues ripe for determination at the time of the hearing shall be addressed at the hearing.

Absent the illness of a party or other extreme circumstances, no claim set for a hearing on the merits shall be continued. All requests for continuances shall be in writing and state with particularity the grounds for the request. An Administrative Judge or a Commissioner may grant a continuance by written order or hearing cancellation notice.

If a party fails to appear at a scheduled hearing, the Administrative Judge on the Administrative Judge's motion, or the motion of a party, may dismiss the claim or award compensation upon presentation of proper proof. If a justifiable reason for the party's absence is presented within fourteen (14) days after the date of the order dismissing or awarding compensation the

Commission or Administrative Judge may grant a motion to reopen or set aside the order of dismissal.

Each controverted claim not set for hearing shall be reviewed periodically. Failure of the party or the party's attorney to respond to the Commission status request form within fifteen (15) days may result in the dismissal of the claim, award of benefits, or other sanctions.

Source: Miss. Code Ann. § 71-3-85.

Rule 2.9 Introduction of Evidence and Discovery

All testimony and documentary evidence shall be presented at the evidentiary hearing before the Administrative Judge. The hearing shall be stenographically reported or recorded. The Commission has discretion to admit any additional evidence offered on review. A motion to introduce additional evidence must be made in writing at least five (5) days before the date of the Commission's review hearing. The motion shall state with particularity the nature and need for such evidence, and the reason it was not introduced at the evidentiary hearing. If additional evidence is admitted, it shall be stenographically reported or recorded and become a part of the record.

Depositions may be taken and discovery had by any party in accordance with the Mississippi Rules of Civil Procedure relating to depositions and discovery (Rules 26 - 37) except as specifically amended by the Commission Rules.

INTERROGATORIES; REQUESTS FOR PRODUCTION. Interrogatories to parties, responses to interrogatories, requests for production of documents and things, and the responses to requests for production shall be served upon other counsel or parties per Rules 33 and 34 of the Mississippi Rules of Civil Procedure, respectively. The interrogatories, requests for production, and responses shall not be filed with the Commission, but the party serving the discovery requests or responses shall file a copy of the transmittal letter with the Commission.

DEPOSITIONS. Medical deposition transcripts shall be filed with the Commission. Deposition transcripts other than medical depositions shall not be filed with the Commission.

REQUESTS FOR ADMISSION. Requests for admissions and responses to requests for admission (Rule 36 of the Mississippi Rules of Civil Procedure) shall be filed with the Commission.

MEDICAL RECORDS AND AFFIDAVITS. Parties in controverted claims shall exchange medical records upon receipt. They are encouraged to admit into evidence medical records of claimant's treatment for the injury alleged in the Petition to Controvert. Absent agreement, the medical records of examining or treating physicians, including narrative office notes, reports dictated by the physician in the ordinary course of his or her practice, CMS 1500 forms, and other records composed by the physician in his or her practice, may be introduced into evidence in lieu of direct testimony taken at the hearing or by deposition upon the following conditions. The records shall not contain narrative reports composed by attorneys which require only the signature of the medical providers.

All medical records filed with the Commission, whether attached to a Motion, Response to Motion, Prehearing Statement, or submitted at a hearing or otherwise, shall be paginated and arranged in chronological order. Failure to do so may constitute unreasonable delay in the proceedings and subject the party to sanctions by the Commission.

1. The party wishing to introduce such medical records shall notify opposing parties and the Commission in writing at least thirty (30) days before the scheduled hearing. The Prehearing Statement may suffice as notification under this Rule.

2. A copy of the medical records shall be attached to the written notice. Each set of medical records shall be presented in chronological order and paginated.

3. An attorney offering the medical records/reports shall attach to the records/reports his or her attested statement that

a. the records/reports are a true, correct, and complete copy of the records/reports received from the medical provider, or

b. opposing counsel agreed that only the attached excerpts from the medical provider's records/reports are needed to address the contested issues.

4. The contents of the medical reports shall be subject to the same objections as to relevancy and competency as the testimony of the reporting physician had he or she been personally present to testify at the hearing. Any objection to the use of an affidavit must be made within fifteen (15) days after receipt by the objecting party of a notice of intent to use such affidavit.

5. Any other party to the controversy may depose the physician and/or require the physician's presence at the hearing on the merits, at the sole expense of the party who requests the deposition or appearance at the hearing. Notice of the deposition must be made before setting the case for hearing on the merits, and the deposition must be taken before the evidentiary hearing on the merits. At the deposition or hearing, the physician shall be declared to be the witness of the party who introduced the medical records in lieu of testimony. The other party must cooperate in the taking of the deposition by agreeing to a deposition date within two (2) business days after dates are provided; failure to agree to a deposition date without good cause within two (2) business days may result in sanctions for unreasonable delay.

6. The affidavit used for the introduction of medical records shall be in the form prescribed by the Commission.

Source: Miss. Code Ann. § 71-3-85.

Rule 2.15 Settlements and Mediation

All matters pertaining to applications for lump sum payment of benefits pursuant to Miss. Code Ann. § 71-3-37(10); requests for lump sum payment of attorney's fees pursuant to Miss. Code Ann. § 71-3-63; requests for approval of compromise settlements pursuant to Miss. Code Ann. § 71-3-29; and requests for approval of third-party settlements pursuant to Miss. Code Ann. § 71-3-71 shall be considered at the offices of the Commission by the Commission. Proposed settlements

and all applications for lump sums shall be electronically filed through ATOS and shall be assigned to a Commissioner for review. Unrepresented Claimants may file an application for lump sum payment of benefits by mail.

At the Commission's discretion, the Commission may assign a settlement to be reviewed by an Administrative Judge as deemed appropriate. A settlement agreement or lump sum payment application approved by an Administrative Judge shall have the same force and effect as one approved by the Commission.

In all Miss. Code Ann. § 71-3-29 compromise settlements and Miss. Code Ann. § 71-3-71 third party settlements, where the Claimant is physically able, it shall be the responsibility of the Employer or insurer to make the Claimant available, along with the legal representative of the Employer or insurer, at the office of the Commission in Jackson, Mississippi, or at some other designated location, on a day set by the Commission or Administrative Judge if requested by the Commission or Administrative Judge; however, where minors and incompetents are concerned, or where the Claimant is represented by counsel, Claimant's presence shall not be required. All expenses incurred in transporting the Claimant from his home to the designated location shall be paid by the Employer or insurer.

Prior to appearing before the Commission with an unrepresented Claimant, counsel for Employer or insurer shall file the proposed settlement paperwork and supporting documentation with the Commission. After the Commission reviews the proposed settlement, the attorney shall be notified via e-mail that the Claimant shall be made available in the manner requested by the Commissioner to whom the settlement is assigned by the Commission for the settlement interview.

A Claimant making application for lump sum payment of benefits pursuant to Miss. Code Ann. § 71-3-37(10) shall, unless represented by an attorney or unless otherwise provided by the Commission or Administrative Judge, make himself or herself available for an interview with the Commission or one of its Administrative Judges prior to approval of the application. The purpose of this interview is to

a. explain to the applicant the nature and consequences of his or her actions in applying for a lump sum payment of benefits, and

b. determine whether payment in this manner is in the Claimant's best interest.

In every case of compromise settlement, the proposed settlement shall be explored and medical reports shall be examined to determine if the amount of the proposed settlement appears fair and reasonable. The Commission or Administrative Judge shall not approve the settlement if it is:

a. not accurately reported,

b. not completely understood by the Claimant, or

c. not in the best interest of the Claimant.

The Commission or Administrative Judge shall approve the settlement if:

a. the underlying facts, terms, and amount of the settlement are accurately reported,

b. Claimant understands the settlement's import and effect, and

c. the settlement is in Claimant's best interest.

MEDIATION.

The Commission encourages voluntary alternative dispute resolution and mediation by the parties on the terms they may choose. The Commission does not endorse or recommend any particular mediation procedures or lists of mediators. Names of mediators may be obtained from the Mississippi Bar's website, for which there is a link on the Commission's website. All settlement agreements reached through mediation must be submitted for consideration and review by the Commission pursuant to Miss. Code. Ann. § 71-3-29.

Source: Miss. Code Ann. § 71-3-85.

Rule 2.20 Filing of Pleadings and Other Documents

A. Attorneys of Record

Any document or pleading prepared by an attorney representing a party shall be electronically filed with the Commission through ATOS and contain the typed or printed name, official Mississippi Bar identification number, email address, mailing address and telephone number of the attorney. Once a claim is controverted, each party shall certify that he or she has sent a copy of the pleading or other document to each other party to the claim. Any document or pleading requiring a claimant's signature may be electronically signed using DocuSign.

All pleadings and other documents filed with the Commission, including any stenographically reported depositions, shall be typed or printed on letter size (8-1/2″ x 11″) paper to conform with the Mississippi Rules of Civil Procedure and the Mississippi Rules of Appellate Procedure and shall contain the style of the claim and Commission file number.

Any proposed order submitted to the Commission or Administrative Judge shall be signed by the party preparing the order, and where the proposed order is an agreed or joint order, such as an order approving settlement, it must be signed and approved by an attorney or other legal representative for each party.

B. Unrepresented Party

An unrepresented party shall file all pleadings and documents required by the Commission by mail addressed to the attention of the Administrative Judge assigned to the claim.

Source: Miss. Code Ann. § 71-3-85.

Rule 2.22 Prehearing Motions; Motion Days

(a) All motions shall be filed in the manner prescribed by Miss. Work. Comp. Comm. Rule 2.20. All documents to be considered as evidence by the Administrative Judge shall be attached to the motion or described with specificity if already filed. A proposed order must accompany each nondispositive motion. The movant shall serve a copy of the motion, attachments and proposed order on the opposite party.

(b) A party desiring oral argument on a motion shall:

1. notice the motion for motion day or other agreed time and place permitted by the Administrative Judge;

2. coordinate the date and time of the hearing with the opposing party and the Administrative Judge;

3. if the nonmoving party does not confirm a motion hearing date with the Administrative Judge's legal assistant within two (2) business days after dates are provided, movant may unilaterally select an open hearing date and notice the motion for hearing on that date;

4. allow at least five (5) calendar days before setting the motion hearing, unless the parties and Administrative Judge agree otherwise;

5. file the notice of hearing with the Commission; and

6. serve a copy of the notice of hearing on the opposing party.

(c) Respondent shall file a written response in the manner prescribed by Miss. Work. Comp. Comm. Rule 2.20 within fifteen (15) days after the date of service of the motion. All documents to be considered as evidence by the Administrative Judge shall be attached to the response or described with specificity if already filed. Any party who wants to present testimony before a court reporter in lieu of a telephonic hearing shall file a written motion for a hearing on the record at least five (5) days before the date set for the telephonic hearing. Otherwise said issue is moot and shall not be considered by the Commission on any appeal.

Before all telephonic motion hearings, counsel for the parties shall discuss and identify the documents they will offer as exhibits during the motion hearing (aside from attachments to the motion/response to the motion); after the telephonic motion hearing, a Commission court reporter shall mark into evidence any exhibits admitted by the Administrative Judge during the motion hearing.

Briefs or other memoranda of law will not routinely be required for motion hearings.

The Administrative Judge has the discretion to conduct a motion hearing by telephone conference and to waive oral argument on a motion.

(d) MOTION DAY. Each Administrative Judge shall hold at least one motion day a month on a date certain beginning at 10:00 a.m. and at a place central to the territory to which he or she travels. The dates and locations shall be published on the Commission website.

(e) SPECIAL MOTIONS. A party who files a motion for emergency hearing (e.g. motion for immediate hearing or five-day hearing under Mississippi Workers' Compensation Commission General Rule 1.9 or Miss. Code Ann. § 71-3-17(b)) or a motion to reopen shall first request a telephonic prehearing conference with the Administrative Judge and other parties to the claim so the parties may consult with the Administrative Judge about all necessary prehearing matters.

(f) PREHEARING STATEMENTS. The parties shall file Prehearing Statements if an evidentiary hearing is needed to resolve any motion.

Source: Miss. Code Ann. § 71-3-85.