



June 28, 2013

TO: Members of the Medical Malpractice Program

FROM: Gina Dean, Chief Operating Officer

SUBJECT: Proposed Amendment to Medical Malpractice Program MOU

The EIA's Medical Malpractice Committee will be considering amendments to the Program MOU at their September meeting. Enclosed for your review are proposed amendments shown in **redline/strikeout** text. If you have **comments or concerns** about the proposed amendments, please **provide your feedback**, to my attention at the EIA office, by **August 30, 2013**.

The proposed amendments are for updating to current practice and, as more fully described below, would: 1) eliminate the provision for automatic dividends to be declared on amounts over the 90% confidence level upon closure of a policy period, and 2) require a member to be in the Program for a period of time to be eligible for a dividend.

Elimination of Automatic Dividend

When the Program was established in the mid-90's, it was structured so that, for purposes of dividends and assessments, the Program would be evaluated on a bottom-line basis and policy periods would be combined. After 10 years of maturity, a policy period would be deemed "closed" for dividend and assessment purposes, and any dividend or assessment calculations would be based upon the "open" policy periods. Two exceptions were made to the formula for calculating dividends to provide that, upon closure of a policy period, an automatic dividend on all amounts over the 90% confidence level or amounts over the 80% confidence level for supplemental assessments would be declared based upon contributions for the individual year being closed. The thought process at the time was that if funding was overly conservative in a particular year, those members that contributed in that year should be the only ones to benefit from a dividend. The same reasoning applied to the supplemental assessment: if we over-assessed, then those amounts should come back to the members that were assessed. We are not recommending a change to the provision for a dividend following a supplemental assessment. The MOU still retains the requirement to return amounts over the 80% confidence level as a result of supplemental assessments.

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EXECUTIVE COMMITTEE:

Barbara Lubben President Alameda County	Larry Hoos Vice President East Bay Regional Park District	Teri Enos-Guerrero City of Chula Vista	Peggy Scroggins Colusa County	Scott Schimke Golden State Risk Mgmt. Authority	Kristin McMenomy Mendocino County	James Brown Merced County	Maryellen Peters Placer County	Jim Sessions Riverdale County	Lance Sposito Santa Clara County	Peter W. Huebner Sierra County
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Chief Executive Officer: Michael Fleming

Legal Counsel: Stephen Underwood

The bottom-line/10-year mechanism was developed to maximize the value of the funding mechanism by leveraging the size of the pool. Effectively, we are able to net the “good” years together with the “bad” years to minimize the chance of an assessment being levied. This mechanism also allows the actuarial confidence levels to be thinner on a prospective basis, saving members real money up front. The Committee also has maximum flexibility in setting rates and declaring dividends. Elimination of the automatic dividend will provide greater flexibility and more transparency. The EIA’s funding philosophy has evolved since the Program’s inception, and there is a greater comfort level with the open years’ formula.

Dividend Eligibility

The addition of language to Paragraph 8(c) would require a member to be in the Program for a period of time to be eligible for a dividend. This sentence appears in other program MOUs, but was not previously included in the Medical Malpractice MOU. There is no reason why this Program should have different requirements. It is believed that it was an oversight to not include this provision in the Medical Malpractice MOU.

The last thorough review and amendment of the MOU took place in 2006. The proposed amendments have been reviewed by the EIA’s Legal Counsel, Steve Underwood, and he had no concerns with the items being suggested.

If you have questions or concerns about the proposed amendments, please contact me at (916) 850-7300 or gdean@csac-eia.org.

Enclosure



Adopted: June 1, 1988{PRIVATE }
Amended: March 2, 1990
Amended: January 1, 1991
Amended: October 1, 1993
Amended: October 2, 1998
Amended: December 18, 2006

Proposed Amendments: , 2013

MEMORANDUM OF UNDERSTANDING MEDICAL MALPRACTICE PROGRAM

This Memorandum of Understanding is entered into by and between the CSAC-EIA (hereinafter referred to as the "Authority") and the participating members of the Medical Malpractice Program, consisting of counties and other public entities (hereinafter "Public Entity") who are signatories to this Memorandum.

- 1. Joint Powers Agreement.** Except as otherwise provided herein, all terms used herein shall be as defined in Article 1 of the Joint Powers Agreement Creating the CSAC Excess Insurance Authority (hereinafter "Agreement"). Provisions of any applicable coverage agreement and all other provisions of the Agreement not in conflict with this Memorandum shall be applicable.
- 2. Program Participation.** The Medical Malpractice Program shall consist of two groups of members, Program I and Program II. Program I members shall be those members that maintain a self-insured retention. Program II members shall be those members which participate for primary coverage and in which a deductible applies.
- 3. Program Committee.** There is hereby established a Medical Malpractice Program Committee (hereinafter referred to as "Medical Malpractice Committee" or "Committee") comprised of seven (7) members. Except as otherwise provided herein, the Medical Malpractice Committee shall have full authority to determine all matters affecting the Medical Malpractice Program and its members, including, but not limited to, approval of new members, premium/rate setting, and review and settlement of claims. The Committee has authority to settle all claims affecting the Medical Malpractice Program, however, the Committee may delegate any or all of this authority as it deems appropriate.

The Executive Committee of the Authority shall appoint the Committee members, to be selected from the members in the Program, consisting of four (4) members from Program I, two (2) members from Program II, and one (1) Public Entity member. If there are no Public Entity nominees from the Program membership for the Public Entity seat, the Executive Committee shall appoint the Committee member from those counties participating in the Program.

The terms of the members of the Committee shall be for two (2) years, except for the Public Entity representative whose term shall be for one (1) year. The expiration dates of the two-year appointments shall be staggered so that terms of no more than four (4) members will expire at any one time. The Committee will annually, at its first meeting of the calendar year, select its officers, consisting of a Chair and Vice-Chair.

The Medical Malpractice Committee, when necessary to fulfill the purposes of this Memorandum, shall meet on the call of the Chair of the Committee as provided in Article 12 of the Agreement and Article VI of the Bylaws of the Authority.

A majority of the members of the Medical Malpractice Committee shall constitute a quorum for the transaction of business. All actions of the Committee shall require the affirmative vote of a majority of the members of the Committee. Any meeting of the Committee shall be subject to the applicable provisions of Government Code §54950 et seq., commonly known as the "Brown Act".

4. **Premiums.** The participating members, in accordance with the provisions of Article 14 of the Agreement, shall be assessed an annual premium for the purpose of funding the Medical Malpractice Program. Annual premium contributions, including administrative costs associated with the Program, shall be as established by the Committee. ~~However, the administrative costs for members of Program I shall be divided equally among the Program I members and the administrative costs for members of Program II shall be divided among the Program II members based upon their percent of premium in relation to the other Program II members.~~

5. **Member Deductibles and Self-Insured Retentions.** The self-insured retention amount of those members participating in Program I and the amount of the deductible of those members participating in Program II shall be established upon consultation with the underwriters and subject to approval by the Medical Malpractice Committee.

6. **Cost Allocation.** The method of allocating contributions to the Program shall be determined by the Medical Malpractice Committee. The Committee's approved Premium Allocation Methodology is attached hereto as Exhibit A and may be amended from time to time by an affirmative vote of the majority of the Committee.

7. **Dividends and Assessments.** In general, the annual premium, as determined by the Medical Malpractice Committee, will be established at a level which will provide adequate overall funding without the need for adjustment to past policy period(s) in the form of dividends and assessments. However, should the Program for any reason not be adequately funded, except as otherwise provided herein, pro-rata assessments to the participating members may be utilized to ensure the approved funding level for those policy periods individually or for a block of policy periods, in accordance with the provisions of Article 14(b)(3) of the Agreement. Pro-rata dividends may be declared as provided herein or as deemed appropriate by the Committee.

8. **Closure of Policy Periods.** Notwithstanding any other provision of this Memorandum, the following provisions are applicable:

- a. Upon reaching ten (10) years of maturity after the end of a policy period, that period shall be "closed" and there shall be no further dividends declared or assessments made with respect to those policy periods except as set forth in paragraphs 8(b) and 8(c), below.
- b. Notwithstanding subparagraph (a) above, the Committee may take action to leave a policy period "open" even if it may otherwise qualify for closure. In addition, the last ten (10) policy periods shall always remain "open" unless the Committee takes specific action to declare any of the last ten (10) policy periods closed.
- c. Dividends and assessments, other than as outlined in paragraphs 9(a) ~~and 9(b)~~ below shall be administered to the participating members based on the proportion of premiums paid to the Program in "open" periods only. For purposes of administering dividends and assessments pursuant to this sub-paragraph, all "open" policy periods shall be considered as one block. In accordance with the Agreement, all members currently participating in the Program at the time of distribution of a dividend shall receive their proportionate share of that dividend. New members to the Program shall become eligible for dividends and assessments upon participating in the Program for three consecutive policy periods (not less than 24 months). Any members that participated in the Program during the "open" periods in question shall be responsible for the payment of any assessment levied, whether or not they are participating in the Program at the time of assessment.

9. Declaration of Dividends. Dividends shall be payable from the Program to a participating member in accordance with its proportionate funding to the Program during all "open" the applicable policy periods except as follows:

- a. ~~A dividend shall be declared at the time a program period is closed on all amounts over the 90% confidence level;~~
- ~~b. A dividend shall be declared at the time a program period is closed on all amounts which represent premium surcharge amounts assessed pursuant to Article 14(b)(3) of the Agreement where the funding exceeds the 80% confidence level.~~
A dividend shall be declared at the time a program period is closed on all amounts which represent premium surcharge amounts assessed pursuant to Article 14(b)(3) of the Agreement where the funding exceeds the 80% confidence level. This dividend shall be distributed based upon each member's proportionate share of assessment paid and accrued to the policy period being closed.

10. Memorandum of Coverage. A Memorandum of Coverage will be issued by the Authority evidencing membership in the Medical Malpractice Program and setting forth terms and conditions of coverage.

11. Claims Administration. The Authority will be responsible for the handling of all claims affecting Program II members. The Committee will authorize the retention of the services of a claims administrator to provide such claims services for Program II.

Subject to approval by the Medical Malpractice Committee, members of Program I will be responsible for the administration of their entity's claims or retaining the services of a claims administrator. Each participating member of Program I is required to comply with the Authority's Underwriting and Claims Administration Standards, as amended from time to time, and which are attached hereto as Exhibit B and incorporated herein.

12. Application to the Program. All applications to join the Medical Malpractice Program will be evaluated and subject to approval by the Committee and the underwriter. Any entity which makes application to become a participating member of the Program who is not already a participating member in the Authority must also be approved in accordance with the provisions of Article 19 of the Agreement.

New participating members may be added to the Program during the term of the coverage year on a pro-rata basis. Notwithstanding late entry into the Program, the new member may be assessed additional sums pursuant to paragraph 7 herein, based upon all claims made against the Program during the entire coverage year.

13. Withdrawal and/or Cancellation from the Program. Withdrawal and/or cancellation of a member from the Program shall be in accordance with the provisions of Article 20 or 21 of the Agreement.

14. Late Payments. Notwithstanding any other provision to the contrary regarding late payment of invoices or cancellation from a program, at the discretion of the Executive Committee, any member that fails to pay an invoice when due may be given a ten (10) day written notice of cancellation.

15. Resolution of Disputes. Any question or dispute with respect to the rights, duties and obligations of the parties to this Memorandum regarding coverage shall be determined in accordance with Article 31 of the Agreement, and may also be subject to approval of the underwriter.

16. Amendment. This Memorandum may be amended by a majority vote of the Medical Malpractice Committee and signature on the Memorandum by the

member's designated representative who shall have authority to execute this Memorandum. Should a member of the Program fail to execute any amendment to this Memorandum within the time provided by the Committee, the member will be deemed to have withdrawn as of the end of the policy period.

17. Complete Agreement. Except as otherwise provided herein, this Memorandum constitutes the full and complete agreement of the members.

18. Severability. Should any provision of this Memorandum be judicially determined to be void or unenforceable, such determination shall not affect any remaining provision.

19. Effective Date. This Memorandum shall become effective on the date of coverage for the member and upon approval by the Committee of any amendment, whichever is later.

20. Execution in Counterparts. This Memorandum may be executed in several counterparts, each of which shall be an original, all of which shall constitute but one and the same instrument.

In witness whereof, the undersigned have executed this Memorandum as of the date set forth below.

Dated

CSAC Excess Insurance Authority

Dated

Member Entity



Medical Malpractice Program Premium Allocation Methodology MOU Exhibit A

Pool Contribution

- 1) Total pool funding is based on the actuarial study for the coverage year, at a confidence level determined by the Medical Malpractice Committee, discounted for investment income.
- 2) Pool funding is calculated separately for both Program I and Program II.
- 3) Each member's contribution will be calculated based partially on Exposure and partially on Experience.
 - a) Exposure is based on a five-year rolling average of the Occupied Bed Equivalent (OBE).
 - i) An OBE is a composite of the exposures reported annually by the members.
 - ii) For a list of the exposures used to calculate the OBEs, see Exhibit 1.
 - b) Experience is limited loss data for the last five years, excluding the current year.
 - i) Losses used will be Total Incurred on a claims-made basis.
 - ii) For Program II, losses will be limited at \$100,000 per loss.
 - iii) For Program I, losses will be Stratified Losses, which are based on the total incurred for each claim and are calculated from 25% below the SIR and are capped at \$1,000,000 per claim.
- 4) A credibility formula will be applied to determine how much of each member's premium will be based on exposure (OBE) and how much will be based on experience.
 - a) Smaller members (based on exposure) will be weighted more heavily on exposure and larger members will be weighted more heavily on experience.
 - b) No member will be weighted less than 5% or more than 50% on experience.
- 5) The needed pool funding will be distributed based on each member's credibility-weighted percentage of exposure and experience.
- 6) A calculation is made to determine the indicated rate for each member. That is averaged with the indicated rate from the prior year. That 2-year average rate is applied to the member's exposure (OBE) to determine their contribution of pool premium.
- 7) The pool premium contribution is prorated back to the needed pool funding based on each member's percentage of the 2-year average pool premium.
- 8) Notwithstanding the above, the minimum pool premium for new members joining the Medical Malpractice Program is \$5,000. The minimum premium will be prorated for members joining the Program mid-term.

Insurance Premium

- 1) The excess insurance premium is divided into two pieces. The total amount of premium to be split between Program I and Program II is determined based on each Program's percentage of total OBE.
- 2) The premium is allocated among the members based on their percentage of the total adjusted OBEs (OBEs calculated using the 5-year rolling average).
 - a) Adjusted OBEs are calculated by multiplying each member's OBE by their deductible or SIR excess discount factor (factors to be provided by the actuary).
- 3) A calculation is made to determine the indicated excess insurance rate for each member. That is averaged with the indicated excess insurance rate from the prior year. That 2-year average rate is applied to the member's exposure (OBE) to determine their contribution of excess insurance premium.
- 4) The excess insurance premium contribution is prorated back to the needed collection based on each member's percentage of the 2-year average excess insurance premium.

Administrative Costs

- 1) Administrative costs are generally allocated based on percentage of premium.
- 2) Because premium doesn't directly correlate to added administrative burden, a sliding scale is used to allocate the administrative costs as follows:

Program II: 10% of premium

Program I: 10% of first 250k premium, with the balance distributed on premiums over \$250k

- 3) The percentage that is applied to the premiums, in excess of \$250k, will be modified each year, based on the amount needed to fully fund the administrative costs.

**Exhibit 1
OBE Formula**

Category	Weighted Value
Occupied Daily Acute Care	2
Occupied Daily Long Term Care	1
Occupied Daily Psychiatric Care	1
Occupied Daily Cribs	5
Annual Emergency Room Visits	.001
Annual Mental Health Visits	.0001
Annual Outpatient Public Health Visits	.0001
Annual Home Health Visits	.0005
Annual Other Visits	.0005
Physician Group 1	1
Physician Group 2	2
Physician Group 3	2
Physician Group 4	3
Physician Group 5	3
Physician Group 6	4
Physician Group 7	4
Physician Group 8	5
Interns and Residents	1
CRNA's (Nurse Anesthetists)	3



Adopted: December 6, 1985
Amended: January 23, 1987
Amended: October 6, 1995
Amended: October 1, 1999
Amended: October 3, 2003
Amended: October 1, 2004
Amended: March 6, 2009

**CSAC EXCESS INSURANCE AUTHORITY
UNDERWRITING AND CLAIMS ADMINISTRATION STANDARDS
Medical Malpractice MOU Exhibit B**

I. GENERAL

- A. Each Member shall appoint an official or employee of the Member to be responsible for the risk management function and to serve as a liaison between the Member and the Authority for all matters relating to risk management.
- B. Each Member shall maintain a loss prevention program and shall consider and act upon all recommendations of the Authority concerning the reduction of unsafe conditions.

II. EXCESS WORKERS' COMPENSATION PROGRAM

- A. Members of the Excess Workers' Compensation Program, except those members of the Primary Workers' Compensation Program whose responsibilities are outlined in Section IV below, shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.
 - 1. The Member shall use only qualified personnel to administer its workers' compensation claims. At least one person in the claims office (whether in-house or outside administrator) shall be certified by the State of California as a qualified administrator of self-insured workers' compensation plans.
 - 2. Qualified defense counsel experienced in workers' compensation law and practice shall handle litigated claims. Members are encouraged to utilize attorneys who have the designation "Certified Workers' Compensation Specialist, the State Bar of California, Board of Legal Specialization".
 - 3. The Member shall use the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) and shall advise its claims administrator that these guidelines are utilized in the Authority's workers' compensation claims audits.
- B. The Member shall provide the Authority written notice of any potential excess workers' compensation claims in accordance with the requirements of the Authority's Bylaws. Updates on such claims shall be provided

pursuant to the reporting provisions of the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) or as requested by the Authority and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) shall be performed once every two (2) years. In addition, an audit will be performed within twelve (12) months of any of the following events:

1. There is an unusual fluctuation in the Member's claim experience or number of large claims, or
2. There is a change of workers' compensation claims administration firms, or
3. The Member is a new member of the Excess Workers' Compensation Program.

The claims audit shall be performed by a firm selected by the Authority unless an exception is approved. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

D. Each Member shall maintain records of claims in each category of coverage (i.e. indemnity, medical, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors, Claims Review Committee, Underwriting Committee, or Executive Committee. Such records shall include both open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.

E. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

III. GENERAL LIABILITY PROGRAMS

A. Members of the General Liability I or General Liability II Programs, except those members of the Primary General Liability Program whose responsibilities are outlined in Section V below, shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.

1. The Member shall use only qualified personnel to administer its liability claims.

2. Qualified defense counsel experienced in tort liability law shall handle litigated claims. Members are encouraged to utilize defense counsel experienced in the subject at issue in the litigation.
 3. The Member shall use the Liability Claims Administration Guidelines (Addendum B) and shall advise its claims administrator that these guidelines are utilized in the Authority's liability claims audits.
- B. The Member shall provide the Authority written notice of any potential excess liability claim in accordance with the requirements of the Authority's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of the Authority's Liability Claims Administration Guidelines (Addendum B) or as requested by the Authority and/or the Authority's excess carrier.
- C. A claims administration audit utilizing the Authority's Liability Claims Administration Guidelines (Addendum B) shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:
1. There is an unusual fluctuation in the Member's claims experience or number of large claims, or
 2. There is a change of liability claims administration firms, or
 3. The Member is a new member of the General Liability I or General Liability II Program.

The claims audit shall be performed by a firm selected by the Authority unless an exception is approved. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

- D. Each Member shall maintain records of claims in each category of coverage (i.e. bodily injury, property damage, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors or applicable committee. Such records shall include open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.
- E. The Member shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.

IV. PRIMARY WORKERS' COMPENSATION PROGRAM

- A. Members of the Primary Workers' Compensation Program shall provide the third party administrator written notice of any claim in accordance with the requirements of the Authority. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.
- B. The Authority shall be responsible for ensuring qualified personnel administer claims in the Primary Workers' Compensation Program and that claims are administered in accordance with the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A).
- C. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Workers' Compensation Claims Administration Guidelines (Addendum A) is performed once every two (2) years.
- D. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

V. PRIMARY GENERAL LIABILITY PROGRAM

- A. Members of the Primary General Liability Program shall provide the third party administrator written notice of any claim or incident in accordance with the requirements of the Authority. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.
- B. The Authority shall be responsible for ensuring qualified personnel administer claims in the Primary General Liability Program and that claims are administered in accordance with the Authority's Liability Claims Administration Guidelines (Addendum B).
- C. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Liability Claims Administration Guidelines (Addendum B) is performed once every two (2) years.
- D. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.

VI. PROPERTY PROGRAM

- A. Members of the Property Program shall maintain appropriate records including a complete list of insured locations and schedule of values pertaining to all real property. Such records shall be provided to the Authority or its brokers as requested by the Executive or Property Committees.

- B. Each Member shall perform a real property replacement valuation for all locations over \$250,000. Valuations shall be equivalent to the Marshall Swift system and shall be performed at least once every five (5) years. New members shall have an appraisal or valuation performed within one year from entry into the Program.

VII. MEDICAL MALPRACTICE PROGRAM

A. Program I

1. Members of Medical Malpractice Program I (hereinafter Program I) shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member.
 - a. Members of Program I shall use only qualified personnel to administer its health facility claims.
 - b. Qualified defense counsel experienced in health facility law shall handle litigated claims.
 - c. Members of Program I shall use the "Claims Reporting and Handling Guidelines" in the CSAC Excess Insurance Authority Medical Malpractice Program Operating and Guidelines Manual (hereinafter Operating and Guidelines Manual), and shall advise its claims administrator that these claims handling guidelines are utilized in the Authority's medical malpractice claims audits.
2. Members of Program I shall provide the Authority written notice of any potential excess claim or "major incident" in accordance with the requirements of the Authority and of the excess carrier as stated in the Operating and Guidelines Manual. Updates on such claims or major incidents shall be provided as requested by the Authority.
3. A claims administration audit utilizing the Authority's Claims Reporting and Handling Guidelines in the Operating and Guidelines Manual shall be performed once every three (3) years. In addition, an audit will be performed within twelve (12) months of any of the following events:
 - a. There is an unusual fluctuation in the Member's claims experience or number of large claims, or
 - b. There is a change of health facility claims administration firms, or
 - c. The Member is a new member of the Medical Malpractice Program, or

- d. The Medical Malpractice Committee requests an audit. The claims audit shall be performed by a firm(s) selected by the Authority. Recommendations made in the claims audit shall be addressed by the Member and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.
4. Each Member shall maintain records of claims in each category of coverage (i.e. bodily injury, property damage, expense) or as defined by the Authority and shall provide such records to the Authority as directed by the Board of Directors or applicable committee. Such records shall include open and closed claims, allocated expenses, and shall not be capped by the Member's self-insured retention.
5. Members of Program I shall obtain an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) at least once every three (3) years. Based upon the actuarial recommendations, the Member should maintain reserves and make funding contributions equal to or exceeding the present value of expected losses and a reasonable margin for contingencies.
6. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as stated in the Operating and Guidelines Manual.

B. Program II

1. For Medical Malpractice Program II (hereinafter Program II) Members, the Authority shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member. The Authority may contract with a third party administrator for handling of such claims.
2. The Authority shall be responsible for ensuring the third party administrator uses qualified personnel to administer Program II claims.
3. The Authority shall be responsible for ensuring qualified defense counsel experienced in health facility law shall handle litigated claims.
4. The Authority shall be responsible for ensuring a claims administration audit utilizing the Authority's Claims Reporting and Handling Guidelines in the Operating and Guidelines Manual shall be performed once every two (2) years.

The claims audit shall be performed by a firm(s) selected by the Authority. Recommendations made in the claims audit shall be

addressed by the third party administrator and a written response outlining a program for corrective action shall be provided to the Authority within sixty (60) days of receipt of the audit.

5. The Authority shall be responsible for obtaining an actuarial study performed by a Fellow of the Casualty Actuarial Society (FCAS) annually.
6. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as stated in the Operating and Guidelines Manual.

VIII. SANCTIONS

- A. The Authority shall provide the Member written notification of the Member's failure to meet any of the above-mentioned standards or of other concerns, which affect or could affect the Authority.
- B. The Member shall provide a written response outlining a program for corrective action within sixty (60) days of receipt of the Authority's notification.
- C. After approval by the Executive or applicable Program Committee of the Member's corrective program, the Member shall implement the approved program within ninety (90) days. The Member may request an additional sixty (60) days from the Executive or applicable Program Committee. Further requests for extensions shall be referred to the Board of Directors.
- D. Failure to comply with subsections B or C may result in cancellation of the Member from the affected Authority Program in accordance with the provisions in the Joint Powers Agreement.
- E. Notwithstanding any other provision herein, any Member may be canceled pursuant to the provision of the Joint Powers Agreement.



**CSAC Excess Insurance Authority
Medical Malpractice Program
Extended Participation Agreement**

This Extended Participation Agreement (“Agreement”) is entered into by and between the CSAC-EIA (“EIA”) and the participating members of the Medical Malpractice Program (“Program”), consisting of counties and other public entities (“Public Entity”).

WHEREAS, on September 26, 2012, the EIA’s Medical Malpractice Committee (“Committee”) approved an extended participation requirement for participating members covering the period from October 1, 2012 to October 1, 2014 (two-years); and

WHEREAS, the Program’s excess carrier, Lexington Insurance, has agreed to extend their coverage commitment to October 1, 2014 and have agreed to provide a discount in their premium to the Program if a minimum number of participating members individually commit to not withdraw from the Program for two years; and


WHEREAS, the Committee has approved a plan in which participating members will be given the choice of executing this Agreement in exchange for a premium reduction. If a participating member fails to execute this Agreement the participating member will not receive this reduction.

NOW, THEREFORE, in consideration of the mutual promises and agreements made herein, the parties hereby agree as follows:

1. **Premium Discount.** Participating members who execute this Agreement shall receive a discount in premium as approved by the Committee, subject to paragraph 3.
2. **Term of Agreement.** The term of this Agreement is two years beginning October 1, 2012 until October 1, 2014 and each participating member hereby agrees not to withdraw from this Agreement prior to October 1, 2014.
3. **Minimum Participation.** In order for the Program to receive the agreed discount a certain minimum number of participating members has been agreed to by the Committee and Lexington Insurance. If an insufficient number of participating members fail to execute this Agreement as set forth in paragraph 4, the Program will not receive the agreed discount. If the minimum participation is not met, individual participating members that executed this Agreement will not receive the agreed discount and will be released from the terms of this Agreement.
4. **Time for Execution of Agreement.** Participating members shall have until December 1, 2012, to execute this Agreement.

5. **Future Commitments.** Participating members agree that the Committee may consider such two-year commitments in the future.
6. **Agreement and Amendment.** This Agreement contains the entire understanding and agreement of the parties and there have been no promises, representations or agreements by any of the parties, either oral or written, of any character or nature hereafter binding except as set forth herein. This Agreement may be altered, amended or modified only by an instrument in writing, executed by the parties to this Agreement and by no other means.

10/1/2012
Dated



CSAC Excess Insurance Authority
Chief Executive Officer/Secretary

Dated

Authorized Representative
Of (Member Name): _____
Please Print Name: _____