EL DORADO COUNTY BOARD OF SUPERVISORS
AGENDA ITEM TRANSMITTAL
Meeting of December 5, 2006

AGENDA TITLE: CSAC EIA Excess Workers Compensation Program – Revised Memorandum of Understanding (MOU)

DEPARTMENT: Human Resources	**DEPT SIGNOFF:**	**CAO USE ONLY:**
CONTACT: Laura S. Gill		
DATE: 11/7/2006 **PHONE:** 5592		11/17/06

DEPARTMENT SUMMARY AND REQUESTED BOARD ACTION:

Human Resources is recommending that the Board direct the Chief Administrative Officer, or designee, to sign the Excess Workers Compensation - Memorandum of Understanding with CSAC EIA. A copy of the contract is on file with the Clerk of the Board.

The redlined version of the MOU is presented first, followed by the "clean" version. The accompanying exhibits have remained the same.

CAO RECOMMENDATIONS: Recommend approval. Laura A. Gill 11/27/06

Financial impact? ( ) Yes (X) No	Funding Source: ( ) Gen Fund ( ) Other
BUDGET SUMMARY:	Other:
Total Est. Cost _____	**CAO Office Use Only:**
Funding	4/5's Vote Required ( ) Yes (~~X~~) No
Budgeted _____	Change in Policy ( ) Yes (~~X~~) No
New Funding _____	New Personnel ( ) Yes (~~X~~) No
Savings _____	CONCURRENCES:
Other _____	Risk Management (YES)
Total Funding _____	County Counsel (YES)
Change in Net County Cost	Other _____

***Explain**

BOARD ACTIONS:

Vote: Unanimous _____ **Or**	**I hereby certify that this is a true and correct copy of an action taken and entered into the minutes of the Board of Supervisors**
Ayes:	**Date:** _____
Noes:	**Attest: Cindy Keck, Board of Supervisors Clerk**
Abstentions:	**By:** _____
Absent:	

Rev. 04/05

Contract #: _____

CONTRACT ROUTING SHEET

Date Prepared: 10-27-6 **Need Date:** 11/10/6

PROCESSING DEPARTMENT:
Department: Human Resources
Dept. Contact: Sherril Jodar
Phone #: 5597
Department Authorization: Human Resources

CONTRACTOR:
Name: CSAC EIA
Address:
Phone: 5597

2006 OCT 27 PM 1:44 EL DORADO COUNTY COUNSEL

CONTRACTING DEPARTMENT: Human Resources
Service Requested: Review and approval of MOU amendments to the EWC Program
Contract Term: _____ Contract/Amendment Value: _____
Compliance with Human Resources requirements? Yes: NA No: _____
Compliance verified by:

COUNTY COUNSEL: (Must approve all contracts and MOU's)
Approved: ✓ Disapproved: _____ Date: 11/1/06 By:
Approved: _____ Disapproved: _____ Date: _____ By: _____

ASSIGNMENT
DATE 10/30/2006
ATTORNEY Mike T.
DEPT./INDEX NO. 0240
BY: DLD

PLEASE FORWARD TO Sherril Jodar at RISK MANAGEMENT. THANKS!

RISK MANAGEMENT: (All contracts and MOU's except boilerplate grant funding agreements)
Approved: Yes Disapproved: _____ Date: 10-27-6 By: S. Jodar
Approved: _____ Disapproved: _____ Date: _____ By: _____

NOV 01 2006

OTHER APPROVAL: (Specify department(s) participating or directly affected by this contract).
Departments: _____
Approved: _____ Disapproved: _____ Date: _____ Bv: _____
Approved: _____ Disapproved: _____ Date: _____ By: _____

County of El Dorado
Chief Administrative Office
Interdepartmental Memorandum

DATE: November 7, 2006

TO: Board of Supervisors

FROM: Laura S. Gill, Chief Administrative Officer

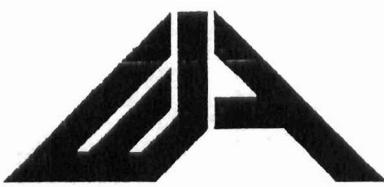
SUBJECT: Amendment to the CSAC EIA Excess Workers Compensation Program - Memorandum of Understanding (MOU)

Recommendation: Human Resources is recommending that the Board direct the Chief Administrative Officer, or designee, to sign the Excess Workers Compensation - Memorandum of Understanding with CSAC EIA.

Reason for Recommendation: The CSAC EIA was recently restructured in order to incorporate public entities (school districts, cities, public agencies, etc.) into its membership. This new MOU revised language to include the new public entities, along with other minor grammatical and non-substantive changes.

Fiscal Impact: There is no fiscal impact relating to the MOU amendment.

Action to be Taken Following Approval: Following the Board's approval, the CAO, or designee, will sign the MOU and forward to CSAC EIA.



Adopted: March 5, 1993
Amended: October 4, 1996
Amended: _____, 2006

MEMORANDUM OF UNDERSTANDING
EXCESS WORKERS' COMPENSATION PROGRAM

This Memorandum of Understanding is entered into by and between the CSAC Excess Insurance Authority (hereinafter referred to as the "Authority") and the participating ~~counties~~members 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 referred to as "Agreement"), and all other provisions of the Agreement not in conflict with this Memorandum shall be applicable.

2. **Annual Premium.** The participating ~~counties~~members, in accordance with the provisions of Article 14(b)(2) of the Agreement, shall be assessed an annual premium for the purpose of funding the Excess Workers' Compensation Program (hereinafter referred to as the "Program"). Annual premiums shall include expected losses for the policy period, including incurred but not reported losses (IBNR), as well as a margin for contingencies based upon a confidence level as determined by the Board of Directors of the Authority (hereinafter Board), and adjustments, if any, for a surplus or deficit from all program policy periods. In addition, the premium shall include program reinsurance costs and program administrative costs, plus the Authority's general expense allocated to the Program by the Board for the next policy period.

3. **Cost Allocation.** Each participating ~~county's~~member's share of annual premium shall be determined pursuant to a cost allocation plan as described in Article 14(b)(2) of the Agreement. The Board approved cost allocation plan is attached hereto as Exhibit A and may be amended from time to time by an affirmative vote of the majority of the Board representing the ~~counties~~members participating in the Program.

4. **Dividends and Assessments.** The Program shall be funded in accordance with paragraph 2 above. In general, the annual premium, as determined by the Board, will be established at a level which will provide adequate overall funding without the need for adjustments 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 ~~counties~~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 will be declared as provided herein. Dividends may also be declared as deemed appropriate by the Board.

5. **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 program period, that period shall be "closed" and there shall be no further dividends declared or assessments made with respect to those program periods except as set forth in paragraphs 6(a) and 6(b), below;

(b) Notwithstanding sub-paragraph (a) above, the Board may take action to leave a policy period "open" even though it may otherwise qualify for closure. In addition, the last ten (10) policy periods shall always remain "open" unless the Board takes specific action to declare any of the last ten (10) policy periods closed.

(c) Dividends and assessments (other than as outlined in paragraphs 6(a) and 6(b), below) shall be administered to the participating ~~counties~~members based upon 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.

6. **Declaration of Dividends.** Dividends shall be payable from the Program to a participating ~~county~~ member in accordance with its proportionate funding to the Program during the applicable program period 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.

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

8. **Claims Administration.** Each participating member is required to comply with the Authority's Underwriting and Claims Administration Standards (including Addendum A—W.C. Claims Administration Guidelines) as amended from time to time, and which are attached hereto as Exhibit B and incorporated herein.

9. **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.

~~8~~10. **Disputes.** Any question or dispute with respect to the rights and obligations of the parties to this ~~memorandum~~ Memorandum regarding coverage shall be determined ~~by a majority vote of the Board~~ in accordance with the Joint Powers Agreement Article 31, Dispute Resolution.

~~9~~11. **Amendment.** This Memorandum may be amended by two-thirds of the CSAC Excess Insurance Authority's Board of Directors ~~upon ninety (90) days' advance written notice to the Member Counties and their respective counsels specifying the proposed amendments.~~ 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 Board, the member will be deemed to have withdrawn as of the end of the policy period.

~~10~~12. **Complete Agreement.** Except as otherwise provided herein, this Memorandum constitutes the full and complete agreement of the members.

~~11~~13. **Severability.** Should any provision of this Memorandum be judicially determined to be void or unenforceable, such determination shall not affect any remaining provision.

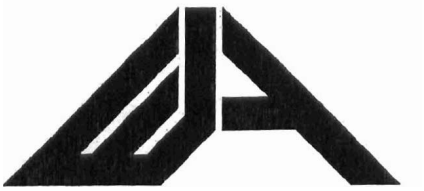
~~12~~14. **Effective Date.** This Memorandum ~~became effective on July 1, 1993 as it relates to participating counties and shall be effective on the first day of coverage as it relates to the County of _____~~shall become effective on the effective date of coverage for the member and upon approval by the Board of any amendment, whichever is later.

~~13~~15. **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: _____ _____
~~County of~~ Member Entity: _____



Adopted: March 5, 1993
Amended: October 4, 1996
Amended: October 6, 2006

MEMORANDUM OF UNDERSTANDING
EXCESS WORKERS' COMPENSATION PROGRAM

This Memorandum of Understanding is entered into by and between the CSAC Excess Insurance Authority (hereinafter referred to as the "Authority") and the participating members 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 referred to as "Agreement"), and all other provisions of the Agreement not in conflict with this Memorandum shall be applicable.

2. **Annual Premium.** The participating members, in accordance with the provisions of Article 14(b)(2) of the Agreement, shall be assessed an annual premium for the purpose of funding the Excess Workers' Compensation Program (hereinafter referred to as the "Program"). Annual premiums shall include expected losses for the policy period, including incurred but not reported losses (IBNR), as well as a margin for contingencies based upon a confidence level as determined by the Board of Directors of the Authority (hereinafter Board), and adjustments, if any, for a surplus or deficit from all program policy periods. In addition, the premium shall include program reinsurance costs and program administrative costs, plus the Authority's general expense allocated to the Program by the Board for the next policy period.

3. **Cost Allocation.** Each participating member's share of annual premium shall be determined pursuant to a cost allocation plan as described in Article 14(b)(2) of the Agreement. The Board approved cost allocation plan is attached hereto as Exhibit A and may be amended from time to time by an affirmative vote of the majority of the Board representing the members participating in the Program.

4. **Dividends and Assessments.** The Program shall be funded in accordance with paragraph 2 above. In general, the annual premium, as determined by the Board, will be established at a level which will provide adequate overall funding without the need for adjustments 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 will be declared as provided herein. Dividends may also be declared as deemed appropriate by the Board.

5. **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 program period, that period shall be "closed" and there shall be no further dividends declared or assessments made with respect to those program periods except as set forth in paragraphs 6(a) and 6(b), below;

(b) Notwithstanding sub-paragraph (a) above, the Board may take action to leave a policy period "open" even though it may otherwise qualify for closure. In addition, the last ten (10) policy periods shall always remain "open" unless the Board takes specific action to declare any of the last ten (10) policy periods closed.

(c) Dividends and assessments (other than as outlined in paragraphs 6(a) and 6(b), below) shall be administered to the participating members based upon 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.

6. **Declaration of Dividends.** Dividends shall be payable from the Program to a participating member in accordance with its proportionate funding to the Program during the applicable program period 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.

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

8. **Claims Administration.** Each participating member is required to comply with the Authority's Underwriting and Claims Administration Standards (including Addendum A - W.C. Claims Administration Guidelines) as amended from time to time, and which are attached hereto as Exhibit B and incorporated herein.

9. **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.

10. **Disputes.** Any question or dispute with respect to the rights and obligations of the parties to this Memorandum regarding coverage shall be determined in accordance with the Joint Powers Agreement Article 31, Dispute Resolution.

11. **Amendment.** This Memorandum may be amended by two-thirds of the CSAC Excess Insurance Authority's Board of Directors 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 Board, the member will be deemed to have withdrawn as of the end of the policy period.

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

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

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

15. **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: _____

EXHIBIT A

EXCESS WORKERS' COMPENSATION PROGRAM
COST ALLOCATION PLAN

As delegated by the Board of Directors, the Executive Committee will determine the specific allocation of all costs among the members subject to the following parameters:

Actuarial Analysis

An annual actuarial analysis will be performed using loss data and payroll collected from the members. The analysis will determine the necessary funding rates at various confidence levels and using various discount assumptions. Different rates may be developed for different groups or classes of business as is deemed necessary or appropriate by the Executive Committee. At the March Board meeting, the Board of Directors will select the funding level rates and discount factors to be used based upon the actuarial analysis and recommendations from the actuary, the Underwriting Committee and the Executive Committee.

Pool Contributions

The total needed deposit pool contribution will be determined by multiplying the rates described above by the payroll for all of the members participating in the pool. Estimated payroll for the year being funded will be used. The Executive Committee may break the pool into different layers for allocation purposes, and may apply a different loss experience modification for each layer as is deemed appropriate based on loss frequency. In general, the lower layers will be subject to greater experience modification and the higher layers will be subject to lower experience modification or no experience modification. Within the layers, the larger members will be subject to greater experience modification than the smaller members. After the experience modification has been applied for each layer, there will be a pro-rata adjustment back to the total needed deposit pool contribution. This amount will be collected from the members at the beginning of the policy period. The actual payroll for the period will be determined after the completion of the policy period and an adjustment to each member's pool contribution will be made to account for the difference between the estimated and actual payroll. Additional contributions will be collected or return contributions will be refunded as appropriate.

Reinsurance Premiums

The reinsurance premium will be determined through negotiations with the reinsurer(s) and approved by the Board upon recommendation of the

Underwriting and Executive Committees. This premium will then be allocated among the members based upon their estimated payroll. Adjustments will be made based on the actual payroll upon completion of the policy period in the same manner as described in the Pool Contribution section above.

EIA Administration Fees

The total EIA Administration Fees will be determined through the annual budgeting process with an appropriate amount allocated to the Excess Workers' Compensation Program. These fees will be allocated among the members as determined by the Executive Committee. In general, the basis for this allocation will be each member's percentage of the total pool contributions and reinsurance premium.

Deviation From the Standard

The Executive Committee may establish policies to deviate from the standard allocation methodology selected for each year on a case-by-case basis, if necessary. They may also elect to further delegate some or all of the decision-making authority described herein to the Underwriting Committee.

EXHIBIT B

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

CSAC EXCESS INSURANCE AUTHORITY

UNDERWRITING AND CLAIMS ADMINISTRATION STANDARDS

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.

C. Each Member shall maintain records of claims in each category of insurance covered by a program of the Authority and shall provide copies of such records to the Authority as directed by the Executive, Underwriting or Claims Review Committees.

Such records shall provide the following information by fiscal year: number of claims (open and closed); amounts paid, amounts reserved and total incurred. Allocated expenses shall be included. If losses are capped, the excess amount shall be indicated.

II. EXCESS WORKERS' COMPENSATION PROGRAM

A. The Member 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 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 Insurance Authority.

The claims audit shall be performed by a firm 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.

D. 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. EXCESS LIABILITY PROGRAMS

A. The Member 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 be 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 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 Excess Insurance Authority.

The claims audit shall be performed by a firm 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.

D. 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. PROPERTY PROGRAMS

A. The Member shall maintain appropriate records including a complete list of insured locations and schedule of values pertaining to all real property. Copies of 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 one million dollars. 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.

V. MEDICAL MALPRACTICE PROGRAM

A. The Member, if a member of Medical Malpractice Program I (hereinafter Program I), or Mid Mal Program; or the third party administrator for Medical Malpractice Program II (hereinafter Program II); 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 (Program I and Mid Mal Program) or third party administrator (Program II) shall use only qualified personnel to administer its health facility claims.

2. Qualified defense counsel experienced in health facility law shall handle litigated claims.

3. The Member (Program I and Mid Mal Program) or third party administrator (Program II) shall use the "Claims Reporting And Handling Guidelines" in the CSAC Excess Insurance Authority Medical Malpractice Excess Insurance 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.

B. The Member (Program I and Mid Mal Program) or third party administrator (Program II) shall provide the Authority and its excess carrier 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 and/or the Authority's excess carrier.

C. A claims administration audit utilizing the Authority's Claims Reporting and Handing 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:

1. There is an unusual fluctuation in the Member's claims experience or number of large claims or

2. There is a change of health facility claims administration firms or

3. The Member is a new member of the Excess Insurance Authority or

4. The Medical Malpractice Committee requests an audit.

The claims audit shall be performed by a firm 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.

D. If a Member of Program I or the Mid Mal Program, 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.

E. The Member shall have an effective risk management program in accordance with the "Risk Management Guidelines" as states in the OPERATING AND GUIDELINES MANUAL.

VI. 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.

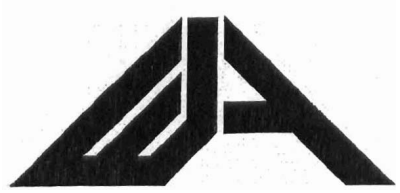
B. The Member shall provide a written response outlining a program for corrective action within sixty (60) days of receipt of the Authority's notification.

C. After approval by the Executive 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 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 insurance 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.

ADDENDUM TO EXHIBIT B



Adopted:	December 6, 1985
Amended:	March 4, 1988
Amended:	October 7, 1988
Amended:	October 6, 1995
Amended:	October 1, 1999
Amended:	June 6, 2003

ADDENDUM A
WORKERS' COMPENSATION
CLAIMS ADMINISTRATION GUIDELINES

The following Guidelines have been adopted by the CSAC Excess Insurance Authority in accordance with Article 18(b) of the March 1993 Amended Joint Powers Agreement Creating the CSAC Excess Insurance Authority.

I. CASE LOAD

A. On or after 07/01/2004, the claims examiner assigned to the Member shall handle a caseload not to exceed 175 indemnity claims. This caseload will include future medical cases with every 4 future medical cases counted as 1 indemnity case.

B. Supervisory personnel should not handle a caseload, although they may handle specific issues.

II. CASE REVIEW AND DOCUMENTATION

A. Documentation should reflect any significant developments in the file and include a plan of action. The examiner should review the file every 45 days. The supervisor shall monitor any significant activity on the file every 120 days. An accomplishment level of 95% shall be considered acceptable.

III. COMPENSABILITY

A. The initial compensability determination (accept claim, deny claim or delay acceptance pending the results of additional investigation) and the reasons for such a determination will be made and documented in the file within fourteen (14) calendar days of the filing of the claim with the employer. An accomplishment level of 100% shall be considered acceptable.

B. Delay of benefit letters shall be mailed in compliance with Department of Industrial Relations' guidelines. An accomplishment level of 100% shall be considered acceptable.

C. The final compensability determination shall be made by the claims examiner or supervisor within 90 days of employer receipt of the claim form. An accomplishment level of 100% shall be considered acceptable.

IV. THREE POINT CONTACT

A. The claims examiner shall conduct the three (3) point contact with the injured worker, employer representative and treating physician within five (5) working days of receipt of the notice of the claim. An accomplishment level of 95% shall be considered acceptable.

V. INITIAL INDEMNITY PAYMENT

A. The initial indemnity payment will be issued and mailed to the injured employee within fourteen (14) days of the first day of disability. This shall not apply with salary continuation. An accomplishment level of 100% shall be considered acceptable.

B. The properly completed DWC Benefit Notice shall be mailed to the employee within fourteen (14) days. An accomplishment level of 100% shall be considered acceptable.

C. Late payments due directly to the injured worker must include the self imposed 10% penalty in accordance with Labor Code Section 4650. An accomplishment level of 100% shall be considered acceptable.

VI. SUBSEQUENT INDEMNITY PAYMENTS

A. All indemnity payments subsequent to the first payment will be verified, except for obvious long-term disability, and issued in compliance with Labor Code Section 4651. An accomplishment level of 100% shall be considered acceptable.

B. Late payments must include the self-imposed 10% penalty in accordance with Labor Code Section 4650. An accomplishment level of 100% shall be considered acceptable.

VII. FINAL INDEMNITY PAYMENTS

A. All final payments will be issued with the appropriate DWC benefit notices.

VIII. TRANSPORTATION EXPENSE

A. Transportation reimbursement will be mailed within fifteen (15) working days of the receipt of the claim for reimbursement. Advance travel expense payments will be mailed to the injured employee ten (10) days prior to the anticipated date of travel. An accomplishment level of 100% shall be considered acceptable.

IX. MEDICAL PAYMENTS

A. Medical treatment billings (physician, pharmacy, hospital, physiotherapist, etc.) will be matched to the file, reviewed for correctness, approved for

payment and paid within sixty (60) calendar days of receipt. An accomplishment level of 100% shall be considered acceptable.

B. The medical provider must be notified in writing within 30 working days if a medical bill is contested, denied or incomplete.

C. A bill review process should be utilized wherever possible. There should be participation in a PPO whenever possible.

X. PHYSICIAN CONTACT

A. In cases involving loss of time from work, the attending physician's office will be contacted within five (5) working days of notice of claim. Such contact will continue as needed during the continuation of temporary disability to assure that treatment is related to a compensable injury or illness.

XI. LITIGATED CASES

The claims administrator and Member shall establish written guidelines for the handling of litigated cases. The guidelines should, at a minimum, include the points below, which may be adopted and incorporated by reference as "the guidelines".

A. Defense of Litigated Claims

1. The claims administrator shall promptly initiate investigation of issues identified as material to potential litigation. The Member shall be alerted to the need for in-house investigation, or the need for a contract investigator who is acceptable to the Member. The Member shall be kept informed on the scope and results of investigations.

2. The claims administrator shall, in consultation with the Member, assign defense counsel from a list approved by the Member. (Note: To comply with Government Code Section 25203, the Member's list should be approved by a two-thirds vote of the board of supervisors.)

3. Settlement proposals directed to the Member shall be forwarded by the claims administrator or defense counsel in a concise and clear written form with a reasoned recommendation. Settlement proposals shall be presented to the Member as directed so as to insure receipt in sufficient time to process the proposal.

4. Knowledgeable Member personnel shall be involved in the preparation for medical examinations and trial, when appropriate or deemed necessary by the Member so that all material evidence and witnesses are utilized to obtain a favorable result for the defense.

5. The claims administrator shall comply with any reporting requirement of the Member.

B. Subrogation

1. In all cases where a third party (other than a Member employee or agent) is responsible for the injury to the employee, the third party shall be contacted within 10 days with notification of the Member's right to subrogation and the recovery of certain claim expenses. If the third party is a governmental entity, a claim shall be filed with the governing board (or State Board of Control as to State entities) within 6 months of the injury or notice of the injury.

2. Periodic contact shall be made with the responsible party and/or insurer to provide notification of the amount of the estimated recovery to which the Member will be entitled.

3. The file will be monitored to determine the need to file a complaint in civil court in order to preserve the statute of limitations.

4. If the injured worker brings a civil action against the party responsible for the injury, the claims administrator shall consult with the Member about the value of the subrogation claim and other considerations. Upon Member authorization, subrogation counsel shall be assigned to file a Lien or a Complaint in Intervention in the civil action.

5. Whenever practical, the claims administrator will aggressively pursue recovery in any subrogation claim. They should attempt to maximize the recovery for benefits paid, and assert a credit against the injured workers' net recovery for future benefit payments.

XII. VOCATIONAL REHABILITATION

A. Adjusting personnel will notify the injured worker of their potential rights to rehabilitation benefits per Labor Code Section 4636 after 90 days of aggregate temporary disability and get the treating doctor to determine if injured worker is a Qualified Injured Worker.

B. Determination of the Qualified Injured Worker/Non-Qualified Injured Worker status shall be made in accordance with Labor Code Section 4637. The adjusting personnel shall advise the injured worker of his/her rehabilitation benefits in accordance with the Rules of the Division of Workers' Compensation, within ten (10) days of knowledge of medical eligibility. The claims administrator will:

1. Notify the employer of the employee's permanent work restrictions so that the employer can determine the availability of permanent modified or alternate work.

2. Make timely referral to a Qualified Rehabilitation Representative in accordance with Labor Code Section 4637

3. Control rehabilitation costs.

4. Attempt to secure the prompt conclusion of vocational rehabilitation benefits, and settle rehabilitation where appropriate.

XIII. FISCAL HANDLING

A. Active indemnity cases will be balanced with appropriate file documentation on a semi-annual basis to verify that statutory benefits are paid, and medical, legal and vocational rehabilitation charges are appropriate. An accomplishment level of 100% shall be considered acceptable.

XIV. EXCESS INSURANCE

A. Potential Workers' Compensation excess cases shall be reported in accordance with the reporting criteria established by The Bylaws of the CSAC Excess Insurance Authority.

All cases which meet the established reporting criteria are to be reported within five (5) working days of the day on which it is known the criterion is met. An accomplishment level of 100% shall be considered acceptable.

XV. AWARD PAYMENT

A. Payments on undisputed Awards, Commutations, or Compromise and Releases will be issued within ten (10) days following receipt of the appropriate document. An accomplishment level of 100% shall be considered acceptable.

XVI. PENALTIES

A. If the Member utilizes a third party administrator, the Member will be advised of the assessment of any penalty for delayed payment and the reason thereof, and the administrators plans for payment of such penalty within five (5) days of assessment. An accomplishment level of 100% shall be considered acceptable.

B. If the Member utilizes a third party administrator, the Member, in their contract with the administrator, shall specify who is responsible for specific penalties.

XVII. RESERVES

A. Using the information available at the time, an initial reserve will be established at the most probable case value. Claim reserves shall be reviewed on a regular basis and updated as case values increase or decrease.

XVIII. RESOLUTION OF CLAIM

A. Within ten (10) days of receiving medical information indicating that a claim be finalized, the claims examiner shall take appropriate action to finalize the claim. An accomplishment level of 95% shall be considered acceptable.

XIX. CASE CLOSURE

A. All indemnity cases will be closed within sixty (60) days of the final financial transaction or final correspondence to the injured worker as required by law. An accomplishment level of 95% shall be considered acceptable.

B. All medical only cases will be closed or transferred to an indemnity status by the ninetieth (90) day following incurral. An accomplishment level of 95% shall be considered acceptable.

XX. TELEPHONE INQUIRIES

A. Return calls will be made within one working day of the original telephone inquiry. An accomplishment level of 90% shall be considered acceptable.

XXI. INCOMING CORRESPONDENCE

A. All correspondence received will have the date of receipt clearly stamped on the front side. An accomplishment level of 100% shall be considered acceptable.

XXII. RETURN CORRESPONDENCE

A. All correspondence requiring a written answer will have such answer completed and transmitted within five (5)working days of receipt. An accomplishment level of 95% is acceptable.

XXIII. SETTLEMENTS

A. The third party administrator shall obtain the Member's authorization on all settlements or stipulations in excess of the settlement authority provided in any provision of the individual contract between the Member and the claims administrator.

B. No agreement shall be authorized involving liability, or potential liability, of the Authority without the advance written consent of the Authority.