Adopted: June 1, 1988
Last Amended: 9/20/2018

MEMORANDUM OF UNDERSTANDING
MEDICAL MALPRACTICE PROGRAM

This Memorandum of Understanding is entered into by and between the Public Risk Innovation, Solutions, and Management (hereinafter referred to as "PRISM") 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 Public Risk Innovation, Solutions, and Management (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 (2) groups of members, Program 1 and Program 2. Program 1 members shall be those members that maintain a self-insured retention. Program 2 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 PRISM shall appoint the Committee members, to be selected from the members in the Program, consisting of four (4) members from Program 1, two (2) members from Program 2, 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 PRISM.

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.

5. **Member Deductibles and Self-Insured Retentions.** The self-insured retention amount of those members participating in Program 1 and the amount of the deductible of those members participating in Program 2 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 paragraph 9(a) 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 (3) 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" policy periods except as follows:

a. A dividend shall be declared at the time a policy 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 PRISM evidencing membership in the Medical Malpractice Program and setting forth terms and conditions of coverage.

11. **Claims Administration.** PRISM will be responsible for the handling of all claims affecting Program 2 members. The Committee will authorize the retention of the services of a claims administrator to provide such claims services for Program 2.

Subject to approval by the Medical Malpractice Committee, members of Program 1 will be responsible for the administration of their entity's claims or retaining the services of a claims administrator. Each participating member of Program 1 is required to comply with PRISM'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 PRISM 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.

10/1/2013
Dated

Public Risk Innovation, Solutions, and Management

6/22/2021
Dated

Member Entity

ATTEST:
BERNICE E. SEIDEL
Clerk of the Board of Supervisors
County of Fresno, State of California
By
Deputy

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 1 and Program 2.
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 2, losses will be limited at $100,000 per loss.
      iii) For Program 1, 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 two-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 1 and Program 2 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 five-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 two-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 two-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 2: 10% of premium

   Program 1: 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

Exhibit B

Adopted: December 6, 1985
Last Amended: March 6, 2009
Amend by BOD Policy Statement: October 4, 2013

PUBLIC RISK INNOVATION, SOLUTIONS, AND MANAGEMENT (PRISM)
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 PRISM 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 PRISM 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 PRISM's Workers' Compensation Claims Administration Guidelines (Addendum A) and shall advise its claims administrator that these guidelines are utilized in PRISM's workers' compensation claims audits.

B. The Member shall provide PRISM written notice of any potential excess workers' compensation claims in accordance with the requirements of PRISM's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of PRISM's Workers' Compensation Claims

Administration Guidelines (Addendum A) or as requested by PRISM and/or PRISM's excess carrier.

C. A claims administration audit utilizing PRISM'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 PRISM 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 PRISM 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 PRISM and shall provide such records to PRISM 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 1 or General Liability 2 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 PRISM's liability claims audits.

B. The Member shall provide PRISM written notice of any potential excess liability claim in accordance with the requirements of PRISM's Bylaws. Updates on such claims shall be provided pursuant to the reporting provisions of PRISM's Liability Claims Administration Guidelines (Addendum B) or as requested by PRISM and/or PRISM's excess carrier.

C. A claims administration audit utilizing PRISM's Liability Claims Administration Guidelines (Addendum B) 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 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 1 or General Liability 2 Program.

The claims audit shall be performed by a firm selected by PRISM 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 PRISM 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 PRISM and shall provide such records to PRISM 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 PRISM. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.

B. PRISM shall be responsible for ensuring qualified personnel administer claims in the Primary Workers' Compensation Program and that claims are administered in accordance with PRISM's Workers' Compensation Claims Administration Guidelines (Addendum A).

C. PRISM shall be responsible for ensuring a claims administration audit utilizing PRISM's Workers' Compensation Claims Administration Guidelines (Addendum A) is performed once every two (2) years.

D. PRISM 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 PRISM. Members must also cooperate with the third party administrator in providing all necessary information in order for claims to be administered appropriately.

B. PRISM shall be responsible for ensuring qualified personnel administer claims in the Primary General Liability Program and that claims are administered in accordance with PRISM's Liability Claims Administration Guidelines (Addendum B).

C. PRISM shall be responsible for ensuring a claims administration audit utilizing PRISM's Liability Claims Administration Guidelines (Addendum B) is performed once every two (2) years.

D. PRISM 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 PRISM 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 1

1. Members of Medical Malpractice Program 1 (hereinafter Program 1) 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 1 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 1 shall use the "Claims Reporting and Handling Guidelines" in the PRISM 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 PRISM's medical malpractice claims audits.

2. Members of Program 1 shall provide PRISM written notice of any potential excess claim or "major incident" in accordance with the requirements of PRISM 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 PRISM.

3. A claims administration audit utilizing PRISM'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 PRISM. 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 PRISM 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 PRISM and shall provide such records to PRISM 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 1 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 2

1. For Medical Malpractice Program 2 (hereinafter Program 2) Members, PRISM shall be responsible for the investigation, settlement, defense and appeal of any claim made, suit brought or proceeding instituted against the Member. PRISM may contract with a third party administrator for handling of such claims.

2. PRISM shall be responsible for ensuring the third party administrator uses qualified personnel to administer Program 2 claims.

3. PRISM shall be responsible for ensuring qualified defense counsel experienced in health facility law shall handle litigated claims.

4. PRISM shall be responsible for ensuring a claims administration audit utilizing PRISM's Claims Reporting and Handing 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 PRISM. 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 PRISM within sixty (60) days of receipt of the audit.

5. PRISM 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. PRISM 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 PRISM.

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