Medical Malpractice Committee
Standard Operating Procedures

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Introduction

In every conversation we have, every initiative we explore, and every action we take, we must hold them up against PRISM's Mission, Vision and Core Values. Together, the Mission, Vision and Core Values are our strategic framework and clarify why PRISM exists and what we aim to be. As you review this document, please keep these in mind:

Mission:

Public Risk Innovation, Solutions and Management (PRISM) is a member-directed risk sharing pool of public agencies committed to providing risk coverage programs and risk management services, which drive member stability, efficiency, and best practices.

Vision:

PRISM will continue to be internationally recognized as a leading risk sharing pool for its member-directed operating philosophy and commitment to member fiscal sustainability. PRISM will continue to influence and shape the future of the risk management profession.

Core Values:

PRISM is dedicated to preserving a member-directed culture, defining standards for quality and performance throughout the industry, and ensuring programs and services are:

- **C**ompetitive in scope and price over the long term
- **A**daptable and customized to meet member needs, based on high-quality standards
- **R**esolute in delivering timely solutions that address present and emerging risks
- **E**quitable in allocating costs and services between various members in a fair and consistent manner
- **S**table in supporting cost-effective, fiscally prudent operations *and* long-term solvency, and in building long-term relationships with members and program/service partners.

Composition

The Committee is comprised of 9 members that participate in the Medical Malpractice Programs, of which 7 are voting members and 2 are alternates who are eligible to vote at any meeting where a voting member is absent. Designated positions have been established as follows:

- Four members from Program 1
- Two members from Program 2
- One Public Entity representative

- Two alternates

Reference: Committee Composition

Roles

Committee

The Medical Malpractice Committee is responsible for all matters pertaining to the Medical Malpractice Program, including but not limited to approval of funding mechanisms, reinsurance placements, new member applications, and settlement of claims.

From time to time, the Committee may consider contracting with outside parties for services. PRISM's Executive Committee has adopted a Service Provider Contracting Policy which outlines the process for competitive bidding as well as protocols and authorities for entering into such contracts. The Medical Malpractice Committee is responsible for determining whether a competitive selection process should be used for procurement of any new member service offerings or a new service provider for an existing member service in excess of $50,000. Any renewal contract must go to the Committee for approval of the vendor and the amount to be expended.

Reference: Service Provider Contracting Policy

Chair

- Call/Authorize meeting to be scheduled
  - Staff will contact Chair to arrange date, time, location (in-person or Web/Video Meeting)
  - Once authorized, staff will notify the Committee members via e-mail
- Call the meeting to order
- Orchestrate agenda items
- Recognize members to facilitate orderly debate
- Preside over voting
- Enforce rules of the group
- Expedite the business of the group
- Declare meeting adjournment

Vice Chair

The Vice Chair's role is to assume the responsibilities of the Chair in their absence.

Staff

- Assist Chair in facilitating meeting, prepare agenda, take minutes, summarize meeting for those not in attendance
- Advisory to the Committee

- Will make recommendations to assist Committee
- Sarah Bishop is the staff liaison for this Committee

Broker

- Advisory to the Committee
- Will make recommendations to assist Committee

Reference: Medical Malpractice Scope of Services from Alliant Contract

Consultants

PRISM utilizes consultants for various services, including but not limited to actuarial, legal advice, third party claims administration, and underwriting. Their role is:

- Advisory to the Committee
- May make recommendations to assist Committee

Responsibilities

Structure

In 2000, the Medical Malpractice Program combined Program 1, Mid Mal, and Program 2 into one Medical Malpractice Program. For administrative purposes going forward, the larger members with self-insured retentions were designated as Program 1 members. The smaller members with deductibles were designated as Program 2 members. Effective October 1, 2020 Program 2 member deductibles were increased to a minimum of $25,000.

Reference: 12/7/00 Med Mal Committee Minute Order
Reference: 7/27/2020 Med Mal Committee Minute Order

Memorandum of Understanding

The Committee oversees the provisions of the Medical Malpractice Program MOU and will approve changes from time to time.

Occassionally, the Medical Malpractice Committee has requested that members execute an Extended Particpation Agreement in order to secure multi-year agreement with our reinsurer. The Extended Particpiation Agreement is an addendum to the Program MOU.

Reference: Medical Malpractice Memorandum of Understanding

Underwriting & Claims Administration Standards

The Committee oversees the provisions of the Standards pertaining to the Medical Malpractice Program and may recommend changes to the Executive Committee and Board from time to time.

Reference: Underwriting and Claims Administration Standards

Premium Allocation Methodologies, Rate Setting, and Exposure Base Determination

Exposure Base Determination

The exposure base of a coverage program is the basis from which the Program's pool rates are applied to determine premium. The exposure base of the Medical Malpractice Program is Occupied Bed Equivalency (OBE), which applies a unique weighted value (or relativity) to a particular exposure category. The weighted value is based on the risk of the particular exposure category with higher relativities for riskier exposures. The Committee oversees the exposure categories included in the Program's OBE calculation and the weighted values they are assigned.

Historically, the OBE calculation and class relativities has been based on the more traditional practice of doctors providing primary medical care with the support of nurses and physician assistants. The medical environment continues to evolve and in response to the evolution, PRISM may update the class relativities and exposure categories with Committee approval. In FY 2018/19 nurses and physician assistants were included as a rated exposure category to account for an increase in exposure as a result of these providers providing more independent medical care with less oversight from physicians. In FY 2019/20, the committee voted and approved new exposure categories and corresponding class relativites for members with jail operations, as a way to manage the increased risk and loss activity resulting from jail healthcare and services.

Premium Allocation Methodologies and Rate Setting

The Committee oversees the provisions of the premium allocation methodologies and may approve changes from time to time. They also have authority to declare dividends and assessments, and approve deviations from the standard allocation methodologies. They have adopted a Target Funding Policy to assist them in making annual funding decisions.

Effective 10/1/14, four members (Alameda, Marin, Santa Barbara, and Stanislaus Counties) moved from Program 1 to Program 2. All claims occurring after that date will be at their new deductible levels. For all claims occurring prior to 10/1/14, the member's prior SIR will apply. The four members will pay a tail premium for the ongoing exposure for the prior claim periods. The members were given the ability to pay the tail premium over five years with no finance charges being applied (6/4/14 Meeting, Item 3.F. and 9/12/14 Meeting, Item 3.B.).

Effective 9/1/21, the Program's premium allocation methodology has been modified to allocate the Program's administrative costs based on a percentage of each members' premium. Historically, administrative costs allocation methodology was designed to address the larger makeup of Program 1 over Program 2 in Medical Malpractice. Since then, many Program 1 members have shifted into Program 2 and Program 2 members now make up a larger percentage of losses and premium. Instead, administrative costs will be allocated based on a percentage of the member's total premium in order to make the allocation more equitable and keep the allocation of admin consistent with other PRISM Property and Casualty programs.

Reference: Med Mal Target Funding Guidelines
Reference: Med Mal Allocation Methodology 09/01/21
Reference: 6/4/14 Med Mal Committee Minute Order
Reference: 9/12/14 Med Mal Committee Minute Order
Reference: 9/1/21 Med Mal Committee Minute Order

The Committee has adopted the following policies related to premium allocation:

- A two-year smoothing mechanism is incorporated to reduce the impact of large premium changes due to loss experience (5/1/02 Minutes, Item III.C.)
- When allocating premium based on exposure, the intent is to only count visits for actual medical treatment (5/29/03 Minutes, Item 3.C.)
- A $5,000 minimum premium has been established for new members joining the Program (5/30/07 Minutes, Item 4.F.)
- Deadlines and penalties have been established for late submission of renewal data (Renewal Timeline Policy)
- Monthly loss data submission policy outlines requirements for current and new members to report data on a monthly basis according to the loss specification.

Reference: 5/1/02 Med Mal Committee Minute Order
Reference: 5/29/03 Med Mal Committee Minute Order
Reference: 5/30/07 Med Mal Committee Minute Order
Reference: 6/10/21 Med Mal Renewal Timeline Policy
Reference: MM Loss Data Submission Policy

Actuarial Discount Assumption

The Committee annually approves the actuarial discount assumption to be used in evaluating outstanding losses and the rates for future funding. This decision is based on the long-term investment projections so the assumption rate does not change frequently. The current actuarial discount assumption is 2.50%

Approval of New Members

The Committee has full authority to approve new members for participation in the Program. Staff develops underwriting information for the Committee's review and consideration. It is the intent that coverage be provided for all operations. The Committee has determined that any member wanting to only cover parts of their exposures requires specific Committee approval.

Reference: 1/30/91 Med Mal Committee Minute Order

Risk Tolerance

Each PRISM program has determined its own appetite for risk, which generally ranges between very low to neutral (PRISM Risk Tolerance). A low tolerance for risk creates a bias towards transfer of risk. A high tolerance for risk is characterized by a bias toward retention of risk. The Medical Malpractice Committee has determined that the risk tolerance for the Medical Malpractice Program is neutral.

Reference: PRISM Risk Tolerance

Reinsurance Placements

The Committee is responsible for review and approval of the Program's reinsurance placements.

Reliance Years
Prior to 10/1/00, Reliance Insurance Company provided reinsurance and excess insurance for the Program. When Reliance went into liquidation, the placement was moved. At that time, the Medical Malpractice Committee took specific action to separate the years for purposes of assessment calculations. All years prior to 10/1/00 are deemed to be the "Reliance Program". The separation ensures that all members joining after 10/1/00 will not be liable for any Reliance Program assessments (12/7/00 Minutes, Item III.B.). The Committee has taken action to keep the Reliance Program years open until the Committee is comfortable there is no further need for an assessment (12/7/00 Minutes, Item III.B.). The Committee has also determined to treat any uncollectible reinsurance as a result of the Reliance liquidation, on a pooled basis, and from the Program to front any payments made by mthembers in the excess layers pending a determination as to whether the payments will be reimbursed by the Reliance estate (2/7/02 Minutes, Item IV.C). As of June 2014, the Committee was informed that legal pursuit of Reliance has been discontinued, as all recovery options have been exhausted and further recovery is not likely.

Lexington Years
Starting on 10/1/00, the Program began a partnership with Lexington Insurance Company. All years between 10/1/00 and 9/30/17 are deemed by the Committee to be the "Lexington Program." For the first two years (10/1/00-10/1/02), coverage was provided by Lexington on an occurrence basis. Beginning 10/1/02, coverage was converted to claims-made. Beginning 10/1/10, the Program began a transition to convert coverage back to occurrence-based. The transition took place over a three year period.

From time to time, the Committee may want to request members enter into multi-year commitments in Program 1 in order to achieve reinsurance savings. This occurred in 2015/16, with all but four members (El Dorado, Imperial and Modoc Counties, as well as City of Fremont) committing to remain in the Program through 10/1/16.

Reference: 12/7/00 Med Mal Committee Minute Order
Reference: 2/7/02 Med Mal Committee Minute Order
Reference: 10/21/10 Med Mal Committee Minute Order

ACE Years
Beginning 10/1/08, the Program expanded the limits provided by the Program by entering into an excess reinsurance placement with ACE. The relationship with ACE was terminated as of 10/1/10 because they were not able to provide occurrence based coverage. The coverage for the additional limits was placed back with Lexington.

Medical Protective Company (MedPro) Years
Beginning on 10/1/2017, the Medical Protective Company (MedPro) provided reinsurance coverage for the Program on an occurrence basis. When MedPro came on, coverage was broadened to remove the $50M annual program aggregate as well as increase the per member aggregates to $25M. All years after 10/1/17 are known as the "MedPro Program".

Current Program
Beginning in 2020/21, MedPro reduced their participation. In 2022/23 MedPro further reduced their participation and moved up their attachment in the program to $10M. Beta Heathcare Group provides coverage excess of the pool to $5M, including a pre-paid tail coverage option. Coverys is providing coverage excess of $15M to $20M.

Program Services and Administrative Costs

The Committee has authority for determining the services that will be provided by the Program. They are also responsible for overseeing the administrative expenses of the Program and determining how the costs will be allocated amongst the members. These are documented in the Program Budget Policies, which are reviewed by the Committee annually. The services and policies adopted by the Committee are:

- The Program will subsidize the cost of up to 3 people from each member to attend the annual Medical Malpractice Seminar (3/9/94 Minutes, Item IX.A.)
- Administrative fees are allocated based on the approved premium allocation methodology.
- The Program's premium allocation methodology has been modified to allocate the Program's administrative costs based on a percentage of each members' premium. The Program provides an annual actuarial subsidy of $2,000 for each Program 1 member (3/24/06 Minutes, Item 3.D.)
- The Program provides an annual risk management subsidy of $1,000 per member (6/9/10 Minutes, Item 3.F.)
- The Program has adopted a policy to provide pre and post Crisis Incident Management Services up to a $50,000 limit. These services will be funded from the program's surplus.

Reference: Med Mal Program Budget Policies
Reference: 3/9/94 Med Mal Committee Minute Order

Reference: 4/29/94 Med Mal Committee Minute Order
Reference: 3/24/06 Med Mal Committee Minute Order
Reference: 6/9/10 Med Mal Committee Minute Order
Reference: Med Mal Crisis Incident Management Policy

Coverage Matters

Memorandum of Coverage (MOC)

The Committee oversees the provisions of the MOC and will make amendments from time to time. When amendments are proposed, they are circulated to the members and County Counsels for review and comment prior to the Medical Malpractice Committee taking final action. The Medical Malpractice Committee usually seeks input from excess underwriters on proposed amendments as well.

Reference: Med Mal MOC Program 1 Members 10/1/10

MOC Endorsements

The Committee may from time to time approve various coverage endorsements. The Committee has delegated authority to staff to approve non-premium bearing endorsements including additional covered party endorsements, waiver of subrogation endorsements; and primary and non-contributory endorsements. They also have authority to reissue endorsements from the prior year if still applicable.

Reference: Med Mal Delegation of Underwriting Authority 8/11/05

Coverage Intentions

The Committee may from time to time make statements regarding their coverage intentions.

- Program 2 Deductible Payments – The Program will pay the Program 2 deductibles and invoice members quarterly.
- Coordination of Coverage with General Liability Programs – If a claim involves coverage in the Medical Malpractice Program and PRISM's GL1 or GL2 Programs, primary coverage will be provided by the Program where the gravamen of the claim or suit falls. If the gravamen of the claim or suit involves medical malpractice covered under the Medical Malpractice Memorandum of Coverage then the MM Program will provide primary coverage with the General Liability Program providing excess coverage, if necessary.
- Coverage Guidelines for Contract Physicians – Members can extend coverage in the Program to contract physicians for medical services via a written contract but it is not the intent of the Program to cover such physicians for their private practice. In the event a member has extended coverage to a medical provider for their private practice and a claim occurs, the coordination of coverage statement will be used to analyze coverage.
- Coverage extended to contractors is not limited to professional liability and includes general liability (5/29/03 Minutes, Item 4.D.)

- The application of excess limits in the event of a claim involving multiple members was clarified as respects the pool and excess carriers (6/9/10 Minutes, Item 3.K.)
- Coverage intention for consent decrees is clarified to exclude coverage for non-monetary relief (2/15/22 Minutes, Item 4.B.). The Committee confirmed its intent to exclude coverage for associated defense and plaintiff's fees/costs both retrospectively and prospectively for claims where only non-monetary relief is sought as well as claims where a consent decree is entered into in connection with a claim for damages. The Committee also confirmed its intent that a claim filed as a class action seeking only non-monetary relief or silent as to damages does not present a potential for coverage and does not trigger any duty to defend.

Reference: 9/3/92 Med Mal Committee Minute Order
Reference: Coordination of Coverage Statement
Reference: Coverage Guidelines for Contract Physicians 2/4/05
Reference: 5/29/03 Med Mal Committee Minute Order
Reference: 6/9/10 Med Mal Committee Minute Order
Reference: 02/15/22 Med Mal Committee Minute Order

Approval of Affiliated Non-Profit Named Insureds

The Committee has been delegated authority by the Board to approve the addition of non-profit entities as additional covered parties in the Program subject to:

- Receipt of a completed application including a governing board resolution or minute order;
- A determination that it is an acceptable risk;
- Willingness by the member to accept responsibility for the SIR, premium payment, and to act as a liaison for risk management and loss prevention issues;
- The member providing renewal information;
- The member agreeing to provide appropriate loss prevention services; and
- A written agreement must exist between the member and the non-profit.

Reference: NonProfits Policy Statement 5/31/12

Issuance of Coverage Alert Letter or a Denial Letter

The Committee established a process that occurs when a claim is presented which has coverage questions involved, in whole or in part, that will be carried out by PRISM staff and the Medical Malpractice Claims Administrator:

1. The Medical Malpractice Claims Administrator will review all reported potential excess claims for coverage issues. A Coverage Alert Letter (CAL) will be drafted for PRISM staff review prior to issuance. Upon approval, the Claims Administrator will notify members via a CAL when potential coverage problems exist.
2. Issuance of a CAL is a courtesy to members and is not intended to preclude PRISM from asserting any coverage theories not previously identified.

3. Upon PRISM staff review and approval, the Claims Administrator will issue denial letters when there is either an absolute exclusion or non-controversial coverage ssues.
4. If coverage is questionable, staff and the Claims Administrator will issue a CAL rather than a denial letter and will seek a coverage opinion. Staff is authorized to retain pre-approved counsel to obtain a legal opinion. The cost of obtaining a coverage opinion will be considered an administrative expense to the application Medical Malpractice Program the member participates in.

Where a coverage denial is sought on a controversial coverage issue, PRISM staff will bring the matter to the Committee along with the received coverage opinion for Committee action regarding the issuance of a denial letter. The Medical Malpractice Committee's decision on coverage shall be communicated in writing to the member by PRISM staff or legal counsel summarizing the significant issues discussed in the coverage opinion. PRISM staff and the Medical Malpractice Claims Administrator are authorized to release the coverage opinion to excess carriers or reinsurers following presentation to the Medical Malpractice Committee, unless otherwise directed by the Committee.

Reference: 9/20/21 Med Mal Committee Minute Order
Reference: Issuance of a Coverage Alert Letter or a Denial Letter

Claims Administration Matters

The Medical Malpractice Program provides claims administration services for Program 2 members. The Medical Malpractice Committee is responsible for selection and oversight of the claims administrator and ensures the claims are being administered properly and efficiently.

As part of the CAJPA Accreditation Standards and pursuant to the policy adopted by the Executive Committee, claims audits are required of the claims administrator every other year. The auditor is selected by the Medical Malpractice Committee. The audit report is presented to the Committee along with a response from the claims administrator, when necessary.

Program 1 members are responsible for their own claims administration. Some utilize a claims administrator and some handle the claims in-house. Pursuant to the Underwriting & Claims Administration Standards, Program 1 members are required to have a claims audit conducted once every 3 years (section VII.A.3.). The Program 1 claim audits are provided by the Medical Malpractice Program. Program 1 audits are conducted by PRISM's contracted auditor. The audit reports are presented to the Committee along with a response from the claim administrator or member if the claims are handled in-house. A response to the audit from the member is required, where recommendations are made, including a timeline where appropriate (6/21/02 Minutes, Item III.D.).

The Committee has also adopted a policy establishing a process for reimbursing, not paying on behalf of, members for claim payments.

Reference: Requirement for PRISM to have Audits & Actuarials 9/28/98
Reference: 6/21/02 Med Mal Committee Minute Order
Reference: Claim Reimbursement Policy 11/1/06
Reference: Underwriting & Claims Aministration Standards

Claims Settlement Authority

The Committee has extended authority to PRISM staff, with concurrence of the Chair, to approve settlements up to $50,000 above the SIR or deductible (11/2/09 Minutes, Item 3.A.). Staff has been directed by the Committee to report all settlements made since the last meeting.

Reference: 11/2/09 Med Mal Committee Minute Order

Meetings

Code of Conduct/Ethics Policy

The Board has adopted a Code of Conduct, which is applicable to all members, staff, committees, and the Board.

Reference: Code of Conduct

Scheduling

The Committee will meet as needed and at the call of the Chair. Below is generally when the Committee will meet to address certain matters:

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  - Actuarial results and determination of pool funding for upcoming year including excess and reinsurance renewal terms.

Quorum

Pursuant to the Bylaws, a quorum consisting of a majority of the Committee (at least 4 members) must be present in order to conduct a meeting.

Voting

Voting Requirements
Pursuant to the Bylaws, the voting requirement is a majority of the Committee (at least 4 members) for all actions of the Medical Malpractice Committee.

Conflicts
Pertinent PRISM Code of Conduct Provisions:

2. We are committed to the concepts of democratic, effective and efficient governance by responsible, knowledgeable members of the Board of Directors and Committees with an understanding that official decisions made and actions taken by the Authority are

always made in the best interests of the Authority's membership, as opposed to the interests of the Authority's staff, service providers, or other outside interests.

9. We are committed to the principle that conflicts of interest (defined as situations in which a person has a financial or other interest or the appearance of a conflicting interest that would call into question the person's ability to act in an impartial manner with respect to a matter affecting PRISM) should be avoided and where present shall be fully disclosed. This includes situations when a member of the Board, a Committee, staff, or vendor has personal interests (including those of his/her family) that are contrary to his/her loyalty to PRISM.

Vote on behalf of PRISM or the entity I represent?
Attorney General Opinion No. 00-708 dated 12/8/00 concluded that a member of the governing board (in this case the Medical Malpractice Committee) of a joint powers agency may cast a valid vote on a matter before the agency that is inconsistent with the position by the legislative body which appointed the member.

Reference: Attorney General Opinion No. 00-708

Voting When Conflict Arises:
According to FPPC:

- Disqualification
  - For financial interest (exception when action required)
- Abstention
  - Conflicting loyalties
  - Perception you can't be fair
  - Ethical dilemmas (exception for necessity to take action)

According to Roberts Rules of Order:

- Duty to vote if you have an opinion
- Right to abstain
- Personal interest - must abstain except
  - Vote for self in an election
  - Vote if other's interests are included in the motion

Closed Session

Closed sessions may be held in accordance with the provisions of state law and the Brown Act. Information discussed in closed session is confidential. In addition to the Medical Malpractice Committee and Legal Counsel, only individuals necessary for the discussion will be present. The Executive Committee has appointed PRISM's General Counsel, the Claims Review Committee's Legal Counsel, and the Claims Review Committee's Alternate Legal Counsel to serve as legal counsel to PRISM's Board of Directors and all PRISM Committees for purposes of obtaining legal advice during closed sessions in accordance with the Brown Act (2/2/12 Executive Committee Meeting, Item 5.B.).

Reference: 2/2/12 Executive Committee Minute Order

Members are able to be present and participate during a Closed Session discussion regarding a request for settlement and/or reimbursement authority from their entity only if the claim discussion will not be controversial, as determined by the Chair of the Medical Malpractice Committee. The member will vote to abstain when their name is called. If the claims discussion is deemed controversial by the Chair of the Medical Malpractice Committee, the member and/or representatative will be asked to speak about the claim, if they so choose, at the outset of the claim presentation. Once done providing information, there will be an opportunity for the Committee members to ask question. When the Committee is done asking questions, the Committee member shall then leave, so that PRISM staff can discuss the matter with the Committee. The member that has left may return to participate in other Closed Session matters after the voting on their entity's claim is complete.

If a claim being is being discussed with the Committee so a coverage determination can be made, representatives of the member entity will be allowed to provide information regarding the coverage issue at the beginning of the Closed Session discussion on their claim. After the member's presentation, the Committee will be able to ask questions. Once questions are done, the Committee member from that entity, and any other persons attending on behalf of the entity, shall leave so that PRISM staff and PRISM's coverage counsel can discuss the matter with the Committee. The Committee member may return to participate in other Closed Session matters after the voting on their entity's claim is complete.

Reference: 9/20/21 Medical Malpractice Committee Minute Order
Reference: Policy Discussing Member's Participation in Closed Session Discussion Regarding a Claim from that Member's Entity

Glossary of Terms

Aggregate: The term used to describe the cumulative amount of all losses for a period of time.

Attachment Point: The dollar amount of a loss where the next layer of insurance begins to pay for the loss.

CAJPA (California Association of Joint Powers Authorities): Association of insurance and risk management pools in California. CAJPA performs regulatory and legislative lobbying as well as accreditation of JPAs to promote financial stability and best management practices.

Claims Made: Method of determining whether or not coverage is available for a specific claim. A claims-made policy states that a claim must be made during the policy period or the extended reporting period, if applicable.

Confidence Level: The confidence level is a percentage estimate of the ultimate pool layer costs. The actuary's expected costs are shown at slightly more than average

(approximately 55%). About half the time, the actual costs will be lower than the actuary's estimates and the other half of the time the actual costs will be higher. To be more conservative, pools set aside additional sums of money to increase the chance that enough funds are available to pay claims. For example, if the actuary's estimate at the 70% confidence level is $1M, then there is a 30% chance that losses will exceed $1M.

Deductible: Amount of a loss that is the member's responsibility. The Program will pay the loss costs and invoice or charge the member after for the deductible amount.

Extended Reporting Period Endorsement: A claims made coverage feature that provides ongoing reporting rights after termination or cancellation of a claims made policy. This is a premium bearing endorsement issued after cancellation of a claims made policy. Also known as tail coverage or an ERP.

IBNR (Incurred But Not Reported): This is an actuarial term referring to the estimated future loss development as well as the estimated cost of claims that have happened but are not yet included in the claims data. A reserve for IBNR is established by the actuary as part of the Ultimate Loss Costs to contemplate for these future estimated costs.

Incurred Loss: This is the expected value of any claim. It includes the amount already paid plus the estimated amount yet to be paid (reserves).

Law of Large Numbers: A mathematical concept which postulates that the more times an event is repeated (in insurance, the larger the number of homogeneous exposure units), the more predictable the outcome becomes. In a classic example, the more times one flips a coin, the more likely that the results will be 50% heads, 50% tails.

Limit of Liability: The most that will be paid in a loss.

Loss Development: The process of change in amount of losses as a policy or accident year matures, as measured by the difference between paid losses and estimated outstanding losses at one point in time, and paid losses and estimated outstanding losses at some previous point in time. In common usage, it might refer to development on reported cases only, whereas a broader definition also would take into account the IBNR claims.

Mega Fund: An aggregated pool layer that caps the aggregate to a predetermined limit at which point the excess carrier would "drop down" and begin to reimburse for losses within the JPA's SIR or pooled layer.

MICRA: Medical Injury Compensation Reform Act is a statue adopted by the California Legilstature in 1975 which provides a cap/limit for non economic damages. The cap was originally set at $250k. Legislation passed in 2022, effective 1/1/2023 adjusted the cap for non-economic damages to account for inflation and the cap will increase incrementally over the next 10 years. The cap is dependent on the type of case and whether or not the case involves a death of patient.

MOC (Memorandum of Coverage): The policy or coverage document issued by the JPA outlining coverage to its members.

Occurrence: An accident or event, which results in personal injury or property damage, neither expected nor intended from the standpoint of the member.

Outstanding Reserve: The claims administrator's estimate of the ultimate expected value of each claim. As moneys are paid out for a claim, the outstanding reserve amount is decreased.

Policy Year: The year commencing with the effective date of the policy or with an anniversary of that date.

Pooled Loss: The portion of a loss that is allocated to, or paid by, the self-insured pool. For example, the Medical Malpractice Program pools, or self-insures $1.5M excess of the members' deductible or SIR. Loss costs exceeding this amount are reimbursed by excess insurance or reinsurance.

Retroactive Coverage: A claims made coverage feature that covers claims made on covered events that occurred prior to the policy period. Also known as retroactive coverage or nose coverage.

SIR (Self Insured Retention): This is the amount of each loss for which the member will be responsible. Once the value of the claim has exceeded their SIR, the member may seek reimbursement for those expenses in excess of their SIR.

Surplus: The excess of assets over liabilities of an insurance carrier. Surplus determines an insurer's or reinsurer's ability to write business. PRISM refers to its "surplus" as Net Equity.

Ultimate Net Loss: The total sum that the insured, or any company as his insurer, or both, become obligated to pay either through adjudication or compromise.

Wholesale Broker: A licensed broker providing specialized insurance products to retail insurance agents and brokers. A wholesale broker will utilize insurers who can consider accounts that the retail agent cannot place with their standard markets. These insurers underwrite specialized or hard to place insurance.