NCCSIF
Northern California Cities Self Insurance Fund
A Joint Power Authority

NCCSIF
EXECUTIVE COMMITTEE
MEETING

A – Action
I – Information

1 – Attached
2 – Hand Out
3 – Separate Cover
4 – Verbal
5 – Previously Mailed

Date: Wednesday, January 09, 2013
Time: 10:30 a.m.

Location: Meeting via Web-Conference at the following locations:

1. City of Anderson, 1887 Howard Street, Anderson, CA 96007
2. City of Corning, 794 Third Street, Corning, CA 96021
3. City of Gridley, 685 Kentucky Street, Gridley, CA 95948
4. City of Oroville, 1735 Montgomery Street, Oroville, CA 95965
5. City of Red Bluff, 555 Washington Street, Red Bluff, CA 95988
6. City of Willows, 201 Lassen Street, Willows, CA 95988
7. City of Yuba City, 1201 Civic Center Boulevard, Yuba City, CA 95993
8. Town of Paradise, 5555 Skyway, Paradise, CA 95969
9. Alliant Insurance Services, Inc., 1792 Tribute Road, Ste. 450, Sacramento, CA 95815
10. James Marta & Company, 701 Howe Avenue, Ste. E3, Sacramento, CA 95825
11. York Risk Services Group, 1101 Creekside Ridge Drive, Suite 1101, Roseville, CA 95661

MISSION STATEMENT

The Northern California Cities Self Insurance Fund, or NCCSIF, is an association of municipalities joined to protect member resources by stabilizing risk costs in a reliable, economical and beneficial manner while providing members with broad coverage and quality services in risk management and claims management.

AGENDA

A. CALL TO ORDER

B. PUBLIC COMMENTS
This time is reserved for members of the public to address the Executive Committee on matters pertaining to NCCSIF that are of interest to them.

C. APPROVAL OF AGENDA AS POSTED **A** **1**

pg. 01 **D. CONSENT CALENDAR** **A** **1**
All matters listed under the consent calendar are considered routine with no separate discussion necessary. Any member of the public or the Executive Committee may request any item to be considered separately.

pg. 02 1. Executive Committee Teleconference Meeting Draft Minutes – November 15, 2012
pg. 07 2. Long Range Planning Draft Minutes – December 13, 2012

NCCSIF
Northern California Cities Self Insurance Fund
A Joint Power Authority

E. ADMINISTRATION REPORTS **I** **4**

1. President's Report
Liz Ehrenstrom will address the Committee on items pertaining to NCCSIF.

2. Program Administrator's Report
Susan Adams will address the Committee on items pertaining to NCCSIF.

F. JPA BUSINESS

pg. 14 **1. REVIEW OF ITEMS DISCUSSED DURING THE LONG RANGE PLANNING MEETING** **A** **1**
Staff will provide the Executive Committee with an update on the items discussed and direction given to staff at the Long Range Planning Session. The Committee will be asked to review and discuss the Action Plan and recommend any changes as necessary to be presented at the Board of Directors meeting for approval.

A. WORKERS' COMPENSATION PROGRAM

pg. 15 1. Workers' Compensation Claims Administration
pg. 68 2. Workers' Compensation Self Inured Retention (SIR) Analysis
3. Financial Impact of Confidence Levels and Discounting Rates used in Determining Funding of Losses
pg. 69 i. Confidence Levels
pg. 71 ii. Discount Rates
pg. 73 4. Excess Pooling Partners
pg. 74 5. Retrospective Rating Dividends Program

B. LIABILITY PROGRAM

pg. 95 1. Liability Self Inured Retention (SIR) Analysis
2. Financial Impact of Confidence Levels and Discounting Rates used in Determining Funding of Losses
pg. 95 i. Confidence Levels
pg. 101 ii. Discount Rates
pg. 104 3. Excess Pooling Partners
pg. 105 4. Retrospective Rating Dividends Program

pg. 126 **G. REVIEW OF JANUARY 24, 2013 BOARD MEETING "DRAFT"AGENDA** **A** **1**
The Executive Committee will be asked to review and discuss the "Draft" Agenda for the January 24, 2013 Board meeting and provide staff with direction if necessary.

H. ADJOURNMENT

NCCSIF
Northern California Cities Self Insurance Fund
A Joint Power Authority

UPCOMING MEETINGS

Police Risk Management Committee Meeting – January 10, 2013
Risk Management Committee Meeting – January 24, 2013
Board of Directors Meeting – January 24, 2013
Executive Committee Meeting – March 14, 2013
Board of Directors Meeting – April 25, 2013

Per Government Code 54954.2, persons requesting disability related modifications or accommodations, including auxiliary aids or services in order to participate in the meeting, are requested to contact Johnny Yang at Alliant Insurance at (916) 643-2712.

The Agenda packet will be posted on the NCCSIF website at www.nccsif.org. Documents and material relating to an open session agenda item that are provided to the NCCSIF Executive Committee less than 72 hours prior to a regular meeting will be available for public inspection and copying at 1792 Tribute Road, Suite 450, Sacramento, CA 95815.

Access to some buildings and offices may require routine provisions of identification to building security. However, NCCSIF does not require any member of the public to register his or her name, or to provide other information, as a condition to attendance at any public meeting and will not inquire of building security concerning information so provided. See Government Code section 54953.3

CONSENT CALENDAR

ACTION ITEM

ISSUE: Items on the Consent Calendar should be reviewed by the Executive Committee and, if there is any item requiring clarification or amendment, such item(s) should be pulled from the agenda for separate discussion.

RECOMMENDATION: The Program Administrator recommends adoption of the Consent Calendar after review by the Executive Committee. *Items pulled from the Consent Calendar by a member will be placed in order, back on the agenda,by the President.*

FISCAL IMPACT: None.

BACKGROUND: The Executive Committee places the following items on the Consent Calendar for adoption. The Executive Committee may accept the Consent Calendar as presented, or pull items for discussion and separate action while accepting the remaining items.

ATTACHMENT(S):

1. Executive Committee Teleconference Meeting Draft Minutes – November 15, 2012
2. Long Range Planning Meeting Draft Minutes – December 13, 2012

NCCSIF
Northern California Cities Self Insurance Fund
A Joint Power Authority

MINUTES OF THE
NCCSIF EXECUTIVE COMMITTEE MEETING
RESIDENCE INN, CHICO, CA
NOVEMBER 15, 2012

MEMBERS PRESENT
Karin Helvey, City of Gridley
Liz Ehrenstrom, City of Oroville
Tim Sailsbery, City of Willows
Steve Kroeger, City of Yuba City
Gina Will, Town of Paradise

MEMBERS ABSENT
Jeff Kiser, City of Anderson
John Brewer, City of Corning
Sandy Ryan, City of Red Bluff

GUESTS & CONSULTANTS
Michael Simmons, Alliant Insurance Services
Susan Adams, Alliant Insurance Services
Johnny Yang, Alliant Insurance Services
David Becker, James Marta & Company
Craig Wheaton, York Risk Services
Ben Burg, York Risk Services
Debra Yokota, York Risk Services

A. CALL TO ORDER

The meeting was called to order at 10:30 a.m.

B. PUBLIC COMMENTS

There were no public comments made.

C. APPROVAL OF AGENDA AS POSTED

A motion was made to approve the Agenda as posted.

MOTION: Tim Sailsbery **SECOND:** Steve Kroeger **MOTION CARRIED**

D. CONSENT CALENDAR

1. Executive Committee Teleconference Meeting Draft Minutes – September 13, 2012
2. Check Register at September 30, 2012
3. Investment Reports
   a. LAIF as of September 30, 2012
   b. Chandler Asset Management – Short/Long Term – October, 2012

A motion was made to approve the Consent Calendar.

MOTION: Karin Helvey **SECOND:** Tim Sailsbery **MOTION CARRIED**

E. MINUTES AND REPORTS

1. Risk Management Committee Draft Minutes – October 15, 2012
2. Board of Directors Meeting Draft Minutes – October 15, 2012
3. Claims Committee Teleconference Draft Minutes – September 13, 2012
4. CJPRMA Investment Report ending September 30, 2012
5. CSAC EIA Investment Report – Quarter ending September 30, 2012

These items are provided as information only.

F. ADMINISTRATION REPORTS

F1. President's Report

Ms. Liz Ehrenstrom had no items to address pertaining to NCCSIF.

F2. Program Administrator's Report

Ms. Susan Adams advised that members' have expressed concerns regarding Workers' Compensation Claims handling and that she was contacting the members directly to get specifics to address with York. Staff has been in contact with York Risk Services and a meeting has been scheduled for November 19th to address the issues.

Mr. Ben Burg explained that York is aware of these concerns and is working on improving their services and providing more prompt claims handling. Ms. Debra Yokota advised that York is working on obtaining new personnel in the near future which will be able to resolve members' concerns.

The Committee asked that the new claims adjusters reach out and update members on a quarterly basis. The Committee stated their concerns and is not interested in issuing a RFP for Claims Administration at this time, they want service to increase to the level it was previously at.

G. FINANCIAL REPORTS

G1. Quarterly Financial Report for Period Ending September 30, 2012

Mr. David Becker from James Marta & Company gave a report on the Quarterly Financials for period ending September 30, 2012.

MOTION: Steve Kroeger **SECOND:** Tim Sailsbery **MOTION CARRIED**

H. JPA BUSINESS

H1. 2013 Executive Committee Rotation Schedule

Ms. Adams explained that the Executive Committee members rotate on an annual basis. The members coming off of the Executive Committee are the Cities of Anderson, Corning, Red Bluff and Willows. The Cities of Auburn, Lincoln, Nevada City and Rocklin will be coming on to the Executive Committee as their replacements. Mr. Tim Sailsbery will remain on the Executive Committee as the NCCSIF Treasurer.

A motion was made to approve the 2013 Executive Committee Rotation Schedule.

MOTION: Steve Kroeger **SECOND:** Tim Sailsbery **MOTION CARRIED**

H2. 2013 Nominating Committee and Nomination of Officers

A motion was made to approve the 2013 Nominated Slate of Officers as follows:

President: Liz Ehrenstrom, City of Oroville
Vice President: Andy Heath, City of Auburn
Treasurer: Tim Sailsbery, City of Willows
Secretary: Gina Will, Town of Paradise

MOTION: Tim Sailsbery **SECOND:** Steve Kroeger **MOTION CARRIED**

H3. Resolution 13-01 Authorizing Investment of Monies in LAIF

Ms. Adams advised that on an annual basis, records are updated with the Local Agency Investment Fund (LAIF) to reflect the newly elected officers of NCCSIF.

A motion was made to recommend to the Board of Directors approval of Resolution 13-01, authorizing the newly elected President, Vice President and Treasurer, authority to order the deposits or withdrawal of monies in LAIF.

MOTION: Tim Sailsbery **SECOND:** Gina Will **MOTION CARRIED**

H4. 2013 NCCSIF Board and Committee Meeting Calendar

Ms. Adams presented the 2013 NCCSIF Meeting Calendar noting the addition of the January 17, 2013 Risk Management Committee and Board of Directors meetings. The meeting has been rescheduled from its original December 13, 2012 date due to the Long Range Planning Session scheduled for December 13th.

A motion was made to approve the 2013 NCCSIF Meeting Calendar as proposed.

MOTION: Steve Kroeger **SECOND:** Gina Will **MOTION CARRIED**

H5. 2013 NCCSIF Services Calendar

Ms. Adams explained that on an annual basis, a service calendar is provided to the Executive Committee showing a timeline of the annual activities to be completed on behalf of the organization.

H6. 2013/14 Insurance Market Update and Renewal Marketing Plan

Ms. Adams provided the Executive Committee with an Insurance Market Update and relevant recommendations.

With respects to Workers' Compensation, staff recommends to continue purchasing excess coverage through CSAC EIA. The Workers' Compensation program was marketed last year and staff did not find another program to match the advantages of participating in CSAC EIA. CSAC EIA advises to expect an increase of around 15%. Historically, increases have been less than the initial indications.

CJPRMA has not provided their preliminary calculations for the excess liability coverage at this time. Calculations are expected at their December Board of Directors meeting at which time staff will take note and present these figures at the next Executive Committee meeting in January of 2013.

With respects to Property, staff advised members to expect a rate increase due to insurance losses sustained by Hurricane Sandy. Final loss numbers from the Hurricane has not been confirmed.

H7. Long Range Planning Session

Ms. Adams advised that staff has asked Mr. Kevin Bibler from Alliant Insurance Services to facilitate the Long Range Planning Session. The meeting will be held at Le Rivage Hotel in Sacramento, California on December 13, 2012. Alliant will host a dinner for members traveling in the night prior to the meeting. Mr. Kroeger asked that Chandler Asset Management provide a presentation on expected economic conditions at the Long Range Planning meeting.

The Committee also discussed if the financial solvency of members should be an item of the Long Range Planning Session and whether or not the NCCSIF Bylaws need to be amended to protect to organization financially. Mr. Sailsbery and Mr. Kroeger feel that this item is more of a legal issue rather than a Board decision. Upon further discussion, staff was directed to remove this item from the Long Range Planning Session Agenda. The item will be brought to the next Board of Directors meeting for further discussion.

A motion was made to remove the Financial Solvency of Members Discussion Item off the Long Range Planning Session.

MOTION: Tim Sailsbery **SECOND:** Gina Will **MOTION CARRIED**

H8. January Executive Committee Meeting

Ms. Adams advised that staff is recommending holding a teleconference meeting the week of January 7, 2013 to review and discuss the Long Range Planning Action Plan to be approved at the January Board of Directors meeting.

A motion was made to approve an Executive Committee teleconference meeting on January 9th, 2013 scheduled for 10:00 a.m.

MOTION: Karin Helvey **SECOND:** Tim Sailsbery **MOTION CARRIED**

I. INFORMATION ITEMS
I1. NCCSIF Board Members and Alternates
I2. NCCSIF Meeting Calendar 2012
I3. NCCSIF Travel Reimbursement Form
I4. PARMA Annual Conference – February 3 – 6, 2013 at Rancho Mirage, CA
I5. NCCSIF Resource Contact Guide

These items were provided as information only.

I. ADJOURNMENT

The meeting was adjourned at 11:54 a.m.

NCCSIF
Northern California Cities Self Insurance Fund
A Joint Power Authority

MINUTES OF THE
LONG RANGE PLANNING SESSION
LE RIVAGE HOTEL, SACRAMENTO, CA
DECEMBER 13, 2012

MEMBERS PRESENT
Jeff Kiser, City of Anderson
Andy Heath, City of Auburn
Steve Johnson, City of Dixon
Bruce Kline, City of Folsom
Paula Islas, City of Galt
Karin Helvey, City of Gridley
Sheila Vanzandt, City of Lincoln
Liz Ehrenstrom, City of Oroville
Russell Hildebrand, City of Rocklin
Steve Kroeger, City of Yuba City
Gina Will, Town of Paradise

MEMBERS ABSENT
Shelly Kittle, City of Colusa
John Brewer, City of Corning
Jane Wright, City of Ione
Michael Daly, City of Jackson
Matt Michaelis, City of Marysville
Catrina Olson, City of Nevada City
Dave Warren, City of Placerville
Sandy Ryan, City of Red Bluff
Marni Rittburg, City of Rio Vista
Tim Sailsbery, City of Willows

GUESTS & CONSULTANTS
Kevin Bibler, Alliant Insurance Services, Inc.
Michael Simmons, Alliant Insurance Services, Inc.
Susan Adams, Alliant Insurance Services, Inc.
Johnny Yang, Alliant Insurance Services, Inc.
Laurence Voiculescu, Alliant Insurance Services, Inc.
Marcus Beverley, York Risk Services
Tom Baber, York Risk Services
Debra Yokota, York Risk Services
Kelli Vitale-Carson, York Risk Services
Michelle Bridges, York Risk Services
Lela Casey, York Risk Services
Ted Piorkowski, Chandler Asset Management
James Marta, James Marta & Company

I. INTRODUCTION / EXPECTATIONS OF LONG RANGE PLANNING SESSION

Ms. Susan Adams introduced Mr. Kevin Bibler, Alliant Insurance Services, who will be facilitating the Long Range Planning Session today.

Mr. Kevin Bibler gave a brief introduction and asked the attendees to then introduce themselves. He then explained how the Long Range Planning Session is set up today. Reports will be given in the morning and after lunch, the group will meet and discuss Action Items that will be brought to the Board of Directors for approval.

II. REPORTS

II.A. Financial Investment Update

Mr. Ted Piorkowski, Chandler Asset Management, provided a presentation on the current economic conditions and the effects on NCCSIF's investment portfolio.

II.B. Target Equity Ratio Trends

Ms. Adams and Mr. James Marta explained that annually NCCSIF reviews Target Equity Ratios which assists in evaluation and implementation of funding levels and shows any variances in either layer. There were 5 ratios which were focused on today. Change in Equity, Equity to SIR, Ultimate Reserves Development, Outstanding Reserve to Equity, and Contributions to Equity. NCCSIF's Net Assets totaled $13,163,942 as of 06/30/12 which is about $5 million less than what it was in 06/30/11 at $17,950,648. Ms. Adams noted the Workers' Compensation program remains healthy while the Liability program is experiencing a deficit in its Shared Risk Layer.

Ms. Adams went through the Target Equity Ratios for the Workers' Compensation program, which have all been met showing that the program is currently well funded.

She then went through the Target Equity Ratios for the General Liability program which were as follows:

The Liability Banking & Shared Risk Programs Combined only met the Net Contributions to Equity Goal.

EQUITY RATIO	TARGET	ACTUAL	
Net Contribution to Equity	< 2:1	1.4778	Met
Outstanding Reserves to Equity	< 3-5:1	1.4940	Not Met
Equity to Self-Insured Retention	> 3.5:1	1.8507	Not Met
2 Year Reserve Development	-20% <x <20%	-62%	Not Met
1 Year Reserve Development	-20% < x < 20%	-75%	Not Met
Change in Equity	> -10%	-70%	Not Met

The Liability Shared Risk Layer only met the Net Contribution to Equity Goal.

EQUITY RATIO	TARGET	ACTUAL	
Net Contribution to Equity	< 2:1	-1.4054	Met
Outstanding Reserves to Equity	< 3-5:1	-1.1587	Not Met
Equity to Self-Insured Retention	> 3.5:1	-0.9613	Not Met
Change in Equity	> -10%	-134%	Not Met

During the presentation Susan explained that in 2007 NCCSIF increased its Self Insured Retention from $500,000 to $1,000,000. Since then, NCCSIF has had 4 losses that have incurred over $1,000,000 which resulted in the Liability Shared Risk Layer deficit. Ms. Adams also advised that NCCSIF has incurred large losses dating back to 1987 and there are no specific trends, members or causes resulting in the losses.

II.C. Retrospective Rating Distributions

Ms. Adams explained that since dividends have been declared, NCCSIF members have received $6,942,114 from the Workers' Compensation Shared Risk program and $3,979,364 from the Liability Shared Risk program. No dividends were declared in 2012 for the Liability Shared Risk Layer due to the deficit calculations.

II.D. 10 year snapshot of NCCSIF Loss Trends

Ms. Adams provided members with a report on NCCSIF's losses for Liability and Workers' Compensation.

The Summary of Workers' Compensation Claims Analysis is as follows:

- Frequency:
  1. Strains
  2. Slips/Trips/Falls
- Severity:
  1. Strains
  2. Slips/Trips/Falls
- Department:
  1. Police
  2. Public Works
  3. Fire

The Summary of Liability Claims Analysis is as follows:

- Frequency:
  1. Automobile
  2. Property Damage
  3. Civil Rights
  4. Roads
  5. Sidewalks – Slip and Fall
- Severity:
  1. Civil Rights
  2. Employment Practices
  3. Sewers
  4. Roads
- Department:
  1. Public Works
  2. Police

Ms. Adams also advised members that NCCSIF will be hosting a Wastewater Treatment Plant Training in Yuba City and Redding which will be available to all NCCSIF members as well as

members of SCORE. This training is designed for senior level employees of the Wastewater and Public Works departments.

Ms. Paula Islas, City of Galt suggested providing Training to the Police Chiefs and Lieutenants regarding the claims process.

Mr. Kevin Bibler suggested Employment Practices Training as these types of losses can grow severe very quickly. There was further discussion of purchasing EPL through ERMA as EPL Training is provided through ERMA. Ms. Adams advised this will be an item to be discussed by the Risk Management Committee. She also advised that 2 sessions of Harassment Training is available through Bickmore and shared that the Hazard and Risk Assessments will be completed soon and show great information.

II.E. Best Practices for Your Workers' Compensation Program

Mr. Marcus Beverly and Kelli Vitale-Carson gave a presentation on Best Practices to Manage and/or reduce Workers' Compensation claims.

II.F. Emerging Risks

There was no discussion on this item due to the shortage of time and this presentation will be brought to the January Board of Directors Meeting.

III. LONG RANGE PLANNING DISCUSSION AND ACTION ITEMS

Ms. Liz Ehrenstrom called the meeting to order at 1:07 p.m.

III.A.1. Workers' Compensation Claims Administration

Ms. Adams explained that the goal is to get the Workers' Compensation Claims Administration back on track as there have been concerns with claims administration service and these concerns have been shared with York by staff.

Ms. Islas shared a couple of Workers' Compensation claims that did not get resolved in a timely fashion.

Ms. Ehrenstrom advised that familiarity with a claims adjuster is appreciate as the key to the concerns arise from a high employee turnover.

Mr. Andy Heath advised that he felt documentation being transferred between adjusters were not transmitted appropriately.

Mr. Bruce Cline expressed a very positive experience with the new Workers' Compensation claims adjusters.

Mr. Steve Kroeger noted that his concerns seem to have been addressed and the changes being taken seem to be a great resolution and he looks forward to the service being brought back to expected in the future.

Ms. Ehrenstrom then suggested quarterly meetings on open claims with the new claims adjusters would greatly assist in a smooth transition.

York Risk Services introduced two new Workers' Compensation claims adjusters who are in the process of visiting member cities for introductions and claims review. Members have expressed that they are happy with York Risk Services and will inquire on the issues at upcoming Board of Directors and Claims Committee meetings.

III.A.2. Workers' Compensation Self Insured Retention (SIR) Analysis

Ms. Adams gave a brief presentation on the options regarding different Workers' Compensation Self Retention options explaining that an increase to $750,000 would result in a $339,315 funding increase. Increasing the Self Insured Retention to $1,000,000 would result in a $516,315 funding increase. She advised that rate increases in the 15% range are expected in the insurance industry.

Upon further discussion Members decided not to consider increasing the Workers' Compensation Self-Insured Retention of $500,000.

III.A.3. Financial Impact of Confidence Levels and Discounting Rates used in Determining Funding of Losses

a. NCCSIF Discount Funding for Investment Income

Ms. Adams went over the funding impact at different discount rates advising that with respects to Workers' Compensation NCCSIF currently funds at a 60% Confidence Level and a 3% discount rate for funding for losses.

Mr. Marta explained that a discount rate is used to fund losses at a lower rate while expecting an estimated investment income rate of return.

Ms. Adams advised that staff will receive the new actuarial numbers in March which will determine possible dividend potential for further discussion.

Mr. Bibler recognized a consensus towards selecting a discount rate of 1.5% but upon further discussion members requested to wait for the actuarial numbers in March for determination at the April Board of Directors meeting.

b. NCCSIF Confidence Level Funding

Ms. Adams advised the in 2006 NCCSIF dropped their Confidence Level Funding rate to 60% to decrease the Workers' Compensation rate as the program was so well funded. She also advised that dividends are calculated once funding is at a 90% Confidence Level rate and 5 times the Self Insured Retention.

Upon further discussion staff was asked to bring the Workers' Compensation deposit calculations, using current year numbers, at various confidence levels back to the January Board of Directors meeting for review.

III.A.4. NCCSIF Workers' Compensation Excess Pooling Partners

Ms. Adams explained that this time has been allocated to allow members to discuss what is working well and what isn't with NCCSIF's Excess Pooling Partner CSAC EIA. She then explained that there are many services offered by CSAC EIA and also that through CSAC EIA NCCSIF receives discounted TargetSolution prices. She has also asked that CSAC EIA provide a presentation of the trainings offered at upcoming NCCSIF meetings.

Mr. Bibler also mentioned that NCCSIF receives a $7,500 discount in excess workers' compensation premium by being CAJPA accredited with excellence and CSAC EIA pays for the Workers' Compensation clams audit.

Members advised that they would like to receive a list of upcoming trainings and webinars available through CSAC EIA at no additional costs.

III.A.5. Retrospective Rating Dividends Program

Ms. Adams inquired as to whether members felt changes need to be made to Policies and Procedures A-1 and A-12 as members are allowed to take funds out of their banking layer funding and later receive assessments as needed.

Mr. Russell Hildebrand suggested including provisions which would restrict members from taking funds out of their banking layer if they are to receive an assessment and only allowing fund distributions upon Board approval.

Staff will review Policies and Procedures A-1 and A-12 to provide recommendations to the Board of Directors in January, 2013.

III.B.1. Liability Self Insured Retention (SIR) Analysis

Ms. Adams provided members with an analysis of decreasing NCCSIF's Liability Self Insured Retention from $1,000,000 to $500,000. She advised of a few options available to members. One would be going out to the market for the $500,000 xs $500,000 layer. Another option would be to purchase reinsurance for the $500,000 xs $500,000 layer. CJPRMA would have to approve any changes to NCCSIF Self Insured Retention limit. NCCSIF would also have to provide CJPRMA with a Notice to Change SIR prior to 12/31/12 should NCCSIF wish to consider a different SIR for the 7/1/13 policy year. Ms. Adams also touched on the option to join ERMA for EPL coverage.

Staff was directed to provide CJPRMA with a Notice to Change SIR and confirm the members that are currently in CJPRMA's Pool B layer. Staff was also advised to market the $500,000 xs $500,000

III.B.2. Financial Impact of Confidence Levels and Discounting Rates used in Determining Funding of Losses

Ms. Adams gave a presentation on the financial impacting of different Confidence Level Funding and Discounting Rates. Mr. Marta suggested an option of a dividend distribution from the Workers' Compensation being applied to the Liability program to help off-set the deficit. Upon further discussion staff was directed to bring back scenarios of member contributions at different discount rates, confidence levels, and dividend options.

III.B.3. Excess Pooling Partners

Ms. Adams explained that this time has been allocated to allow members to discuss what is working well and what isn't with NCCSIF's Excess Pooling Partner CJPRMA. She advised that NCCSIF has never marketed their Liability program as NCCSIF has acquired a large amount of Equity in the program.

Mr. Simmons suggested that NCCSIF address the Liability Shared Risk Layer deficit prior to making any changes the program and excess layer.

There was no discussion or action taken.

III.B.4. Retrospective Rating Dividends Program

Per direction in a prior item, staff will review Policies and Procedures A-1 and A-12 to provide recommendations to the Board of Directors in January 2013.

Ms. Adams advised that the next Board of Directors meeting is scheduled on January 17, 2013 and an Executive Committee Teleconference has been scheduled on January 9, 2013.

The meeting was adjourned at 3:34 p.m.

LONG RANGE PLANNING SESSION

ACTION ITEM

ISSUE: NCCSIF held their 2012 Long Range Planning Meeting on December 13, 2013 to discuss specific financial issues that may impact the JPA in the future. These key issues included things such as: the amount of risk NCCSIF is willing to retain, funding levels including confidence levels and discount rates used to pay losses funded in the future and membership issues. The Board took action on some of the items, however requested Staff to provide additional information on the other items before taking action. This information is now presented to the Executive Committee for their review prior to being presented to the Board at the January 24, 2013 meeting for further review, discussion and action.

FISCAL IMPACT: TBD

RECOMMENDATION: The Executive Committee should review and discuss the *Draft LRP Action Plans* provided for each of these items, including the additional information provided to assist in making a recommendation to the Board of Directors or give Staff direction.

BACKGROUND: NCCSIF held its 2012 Long Range Planning Session on December 13, 2012. The Board was presented with reports and information to assist them in making decisions on the items presented for the future of the JPA.

ATTACHMENT(S): *Draft LRP Action Plans* and supporting documents.

Worker's Compensation Claims Administration

TOPIC: York Risk Services, previously Bragg and Associates, has been NCCSIF's Workers' Compensation Claim Administer since 1990. This time has been allocated to allow members to discuss "What is Working Well and What Isn't" with the overall Workers' Compensation claims administration program. The Board will be presented an Improvement Plan from York that will assist with the following discussion points:

DISCUSSION POINTS:

- Are there any concerns with Workers' Compensation claims handling**?**
- What next steps should NCCSIF take if there are issues?
- What are programs/services that can assist NCCSIF members with reducing cost of claims?

OBJECTIVE: To address concerns expressed by NCCSIF members regarding the Workers' Compensation claims handling and improve the services provided by York Risk Services. Members have expressed concerns regarding communication issues, staffing issues and timely processing of claims regarding Workers' Compensation.

ACTION(s)/DELIVERABLE(s): Marcus Beverly and Kelli Vitali Carson provided the Board with a presentation on Best Risk Practices for Workers' Compensation claims handling. They also addressed the Board's concerns regarding the decline in claims handling services to members. They introduced the two new Workers' Compensation claims adjusters who were recently hired to replace the prior adjustors who left for personal reasons. Each of the new adjustors have made contact via phone with the members and are in the process of scheduling visits with member cities for introductions and claims review. Members expressed that they are currently satisfied with York Risk Services and will inquire on the issues at upcoming Board of Directors and Claims Committee meetings.

DEADLINE(s): Ongoing.

FINANCIAL IMPACT: None.

RESPONSIBILITY: Board of Directors and Claims Committee will request input from members at t future meetings to determine if any further action needs to be taken with respects Workers' Compensation Claims Administration.

ATTACHMENT: Workers' Compensation Claim Audit performed by North Bay Associates in November 2012.

NBA

NORTH BAY ASSOCIATES
WORKERS' COMPENSATION
AUDITORS • CONSULTANTS

November 2012

Workers' Compensation Claims Audit

for

EIA, COUNTY OF NAPA AND NORTHERN CALIFORNIA CITIES SELF INSURANCE FUND/ALLIANT INSURANCE

ADMINISTERED BY

YORK INSURANCE SERVICES

NORTH BAY ASSOCIATES
Salinas, California

NBA

Workers' Compensation Claims Audit

November 2012

EIA, County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance

Administered by

York Insurance Services

CONFIDENTIAL

North Bay Associates
1522 Constitution Blvd. #189 • Salinas, Ca. 93905 • (831) 449-4296

NBA
NORTH BAY ASSOCIATES
WORKERS' COMPENSATION
AUDITORS • CONSULTANTS

December 31, 2012

CSAC Excess Insurance Authority
Ms. Kathy McLean
Workers' Compensation Claims Manager

County of Napa
Mr. Kerry John Whitney

Northern California Cities Self Insurance Fund/Alliant Insurance
Ms. Susan Adams

The Workers' Compensation Claims Audit report for November 2012 for these EIA members: County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance administered by York Insurance Services is presented herewith.

We wish to acknowledge the cooperation of the administrator, York Insurance Services, and for providing us with a comfortable place to review the files in its office and by providing us with direct access to the claims data in its computer.

Quick Overview
- *Executive Summary & Audit Profile* ***(page 4)***
- *Summary of Recommendations* ***(page 6)***

This report has been simultaneously provided to the administrator. Although all the data had not yet been tabulated in the form seen here, the general findings and preliminary recommendations of this audit were discussed with TPA management during an exit interview.

Since this report deals with employees' injuries, reserves on the claim files, tactics for further handling, and so on, we suggest it be kept confidential.

We hope that this report is self-explanatory; any comments or questions the reader may have are welcome. It has been a pleasure once again to serve County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance and the Excess Insurance Authority.

Respectfully submitted,

NORTH BAY ASSOCIATES

Robert N. Hoyle
President

C:\NBA New Reports\Reports 2012\York Insurance Services November 2012.frm

1522 Constitution Blvd. #189 • Salinas, Ca. 93905 • **PHONE (831) 449-4296** or **(888) WC-AUDIT**
FAX (831) 449-1737 • e-mail northbayassociates@comcast.net

Table of Contents

A. INTRODUCTION. 1
1. Goals of the Claims Audit... 1
2. Report Organization.. 1
3. Audit Sample.. 3

B. EXECUTIVE SUMMARY. 4

C. SUMMARY OF RECOMMENDATIONS. 6

D. ORGANIZATIONAL INFORMATION. 7
1. Claims Examiner's Caseload.. 7
2. Claims Assistant's Duties.. 8
3. Findings, Summary and Recommendations. 8

E. AUDIT DETAIL. 9
1. Compensability Determination.. 9
1.1 Investigated If Necessary.. 9
1.2 Correct Compensability Decision.. 10
1.3 Basis of Decision Documented.. 10
1.4 Decision Timely.. 10
1.5 Employer Contact.. 11
1.6 Index Bureau. 11
1.7 Findings, Summary and Recommendations. 11
2. Employee Contact.. 12
2.1 Prompt Contact With Employee.. 12
2.2 Employee Contact Continued.. 13
2.3 Findings, Summary and Recommendations.. 13
3. Benefit Payments.. 14
3.1 Timeliness of First Payment.. 14
3.2 Subsequent Temporary Disability Biweekly... 14
3.3 Transportation Expense.. 15
3.4 Correct Permanent Disability Payments.. 15
3.5 Permanent Disability Rate Adjustment.. 17
3.6 Self-Imposed 10% Penalty Paid if Required... 17
3.7 Regular File Balancing.. 18
3.8 Findings, Summary and Recommendations.. 18
4. Case Planning & Correspondence... 20
4.1 Case Plan Appropriate.. 20
4.2 Apportionment Pursuit.. 21
4.3 Required Notices... 21

4.4 File Documentation... 22
4.5 Correspondence... 23
4.6 Findings, Summary and Recommendations. .. 23
5. Medical Administration.. 25
5.1 Physician Contact.. 25
5.2 Appropriate Medical Consultations Obtained.. 25
5.3 Findings, Summary and Recommendations. .. 25
6. Litigation... 26
6.1 Files Litigated.. 26
6.2 Use of Defense Attorney Appropriate... 26
6.3 Legal Issue Recognition.. 26
6.4 Litigation Expense Control.. 27
6.5 Litigation Plan Documented.. 27
6.6 Timely and Documented Referral to Counsel... 27
6.7 Findings, Summary and Recommendations. .. 28
7. Finalization.. 29
7.1 Continuous Finalization Efforts.. 29
7.2 Correct Settlement Valuation.. 30
7.3 Compromise and Release Offered if Appropriate... 30
7.4 Timely Closing.. 31
7.5 Findings, Summary and Recommendations. .. 31
8. Reserve Adequacy... 32
8.1 Reserve Calculation Work Sheets Complete.. 32
8.2 Initial Reserves Appropriate.. 33
8.3 Reserves Revised Appropriately.. 33
8.4 Findings, Summary and Recommendations.. 34
9. Excess Insurance.. 35
9.1 Prompt Excess Reporting.. 35
9.2 Sufficient Subsequent Reports.. 35
9.3 Regular Reimbursement Requested.. 36
9.4 Findings, Summary and Recommendations. .. 36
10. Subrogation.. 37
10.1 Prompt and Effective Subrogation.. 37
10.2 Appropriate Follow-Up... 37
10.3 Findings, Summary and Recommendations. .. 37
11. Penalty Summary.. 38
11.1 Labor Code § 5814 Penalty... 38
11.2 Labor Code § 4650 (Self-imposed 10% Penalty).. 38
11.3 Labor Code § 129.5 (DWC Audit Unit Fines).. 38
11.4 Findings, Summary and Recommendations. .. 39

Addendum

TABLE OF CONTENTS

Sample Lists. . . . . Tab One

Reserve Summary, Reserve Work Sheets, and Excess Reporting. . . . . Tab Two

Summary Memos. . . . . Tab Three

Audit Profile and Audit Data. . . . . Tab Four

A. INTRODUCTION

THIS is the Workers' Compensation Claims Audit report for November 2012 for these EIA members: County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance.

1. Goals of the Claims Audit.

- ❖ Gather and present statistical data relating to the administration of the members' workers' compensation claims from October 2010, to date.
- ❖ Focus on those claims constituting the bulk of the outstanding reserves, and claims involving key issues and a representative sample of each entity's files.
- ❖ Present and explain industry standards, Division of Workers' Compensation Audit Unit standards, and CSAC/EIA standards and goals.
- ❖ Compare audit findings to the standards, and to prior audits, noting strengths and weaknesses.
- ❖ Recommend ways to meet standards and to reach goals.

2. Report Organization.

This report contains eleven audit areas beginning at Section E, page 9. Each has an introduction, point-by-point discussion, and summary and recommendations. Data is presented in as many as four different ways for clarity and for different depths of detail.

First, for an overview, are the Executive Summary and Audit Profile on pages 4 and following. These summarize strengths and weaknesses in the major audit areas. The overall Audit Score is provided along with a comparison of results to the prior audit.

Second, for detailed data and explanation, each numbered paragraph delves into a

particular audit item. Each point is explained and audit findings are compared to standards. Comments about any particular claim file are often amplified by "Summary Memos." These can be found in the *Addendum* at Tab Three in order by NBA number.

Third, the Audit Data numerically restates the same data shown in the text. The Audit Data is the engine that drives this audit. It is located in the *Addendum* at Tab Four.

Fourth, the Audit Profile augments key audit areas with a graphical view of the data. The audit points are explained in the audit area to which each refers and the Audit Profile can be found in Tab Four of the *Addendum.*

The *Addendum* contains statistical and other essential data. In brief, the *Addendum* includes the following:

Tab One: Full list of claims audited, sorted by NBA#. These lists may be used to identify claimants; to maintain confidentiality, the body of this report refers only to NBA#'s. If a particular claimant is not on your list, it means that is not your employee.

Tab Two: The Reserve Summary reports on the dollar amounts of reserve changes recommended. Reserve Work Sheets provide the detail behind the Reserve Summary report and are located here. The Excess Report shows all excess cases in the sample.

Tab Three: Individual Summary Memos. These are left on certain files for the benefit of the examiner where some issue was pending or where guidance was appropriate. Some explain a definite shortcoming in a file and offer recommendations for further handling. Others offer suggestions on files that are being correctly handled. Not every file audited has a Memo. Since many Memos detail specific recommendations for further file handling, we recommend the EIA follow up to be certain the administrator acts on these Memos and recommendations. We always encourage the examiners to discuss these Memos with us. In this case, the supervisor chose to discuss some of the Memos and the points raised therein.

Tab Four: The Audit Profile and Audit Data are here. Included with the Audit Data is the composite audit score for the group as well as each entity's audit score.

3. Audit Sample.

The sample used to develop the data for this audit was taken from live data provided to us by York Insurance Services. The sample consisted of 94 files, or 15.0% of the total open inventory of indemnity files. The sample is a carefully selected and structured sample rather than a random sample. It is weighted in favor of claims with significant potential and claims containing certain key issues. This is called the "dollar value" sampling technique. But we also spread the sample to include the work of all the entities and examiners, to look at files newly opened since the last audit.

Not all audit queries apply to each case in the sample. Some points apply to the beginning stages of a file, while others pertain only to the end. Claims activity during this audit period is the determining factor. Except for historical comparisons, we read but do not consider for audit purposes activity prior to the last audit.

B. EXECUTIVE SUMMARY

The November 2012 workers' compensation audit for these EIA members: County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance was begun on 11/12/2012. It covers file activity from October 2010, the date of the last audit.

The Audit Data shows an overall composite score of 90.5% whereas the prior audit showed a composite score of 94.8%. A closer review reveals decreased scores in the majority of the audit groupings for the current audit.

The graph below entitled "Audit Profile," lists many of the most important audit points; this graph is printed full size at Tab Four, as is the Audit Data report showing a performance percentage for each audit point.

N O R T H   B A Y   A S S O C I A T E S

AUDIT PROFILE — Audit Date: November 2012

York Insurance Services (grp3)

Area	Audit Point	Files	%Yes	Percent Chart (60% 70% 80% 90%)
1.1	Investigated if Necessary	26	88.5%	>>
1.2	Correct Compensability Decision	25	100.0%	>>>
1.4	Decision Timely	25	92.0%	>>
2.1	Prompt Contact with Employee	60	66.7%	>>>
3.1	Timeliness of First Payment	46	97.8%	>>
3.4	Permanent Disability Payments	39	66.7%	>>>
3.7	File Balancing	60	60.0%	>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>
4.1	Case Plan Appropriate	94	91.5%	>>
4.2	Apportionment Pursuit	15	100.0%	>>>
6.2	Use of Defense Atty. Appropriate	32	100.0%	>>>
7.1	Continuous Finalization Efforts	90	95.6%	>>
7.2	Correct Settlement Valuation	21	95.2%	>>
8.3	Reserves Revised Appropriately	73	89.0%	>>
9.1	Prompt Excess Reporting	16	81.3%	>>
10.1	Prompt & Effective Subrogation	8	100.0%	>>>

Some important points that need improvement are:

Investigating and deciding on claim compensability. This is an examiner's prime function and a few cases lacked timely and adequate investigation.

Paying indemnity benefits accurately and timely. This occupies the most time and requires mastery of external rules and internal procedures.

Reserving sufficient funds to pay each case. This ensures the self-insured's financial viability and several cases lacked timely addressing of reserves or were not adequately reserved.

Documented case planning with timely follow up. This is crucial to keeping the current issues that need to be acted upon in focus. A number of cases lacked documentation of a current plan of action.

Communication with the injured employees. This helps ensure a large degree of control over the claims process.

Balancing file payments. This is a fiduciary responsibility and this area has shown a significant decrease from the prior audit.

Summarized recommendations for further improvement begin on the next page.

C. SUMMARY OF RECOMMENDATIONS

Recommendations are compiled here to provide a summary and to provide convenient reference. To be fully understood, the recommendations should be considered in the context of the audit detail.

- ❑ We recommend reviewing the AOE-COE investigation process to ensure adequate investigations and timely decisions on compensability. Please see pages 9 and following.

- ❑ We recommend review of the EIA employee contact standard and to ensure compliance. We also recommend an established and enforced ongoing employee contact standard. Please see pages 12 and 13.

- ❑ We recommend review of the indemnity payment process to improve upon the timeliness of these payments and more consistency and compliance with the EIA file balancing standard. Please see pages 14 and following.

- ❑ We recommend better documented and updated case planning with timely follow through. Please see pages 20 and following.

- ❑ We recommend reviewing reserving practices with examiners and closer supervisory review of reserves on diary. Please see pages 33 and 34.

- ❑ We recommend implementation of necessary steps be taken to ensure timely reporting to excess. Please see pages 35 and 36.

We suggest that the employers, the EIA and York Insurance Services set priorities and adopt a timetable for implementing these recommendations.

D. ORGANIZATIONAL INFORMATION

The workers' compensation claims of County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance continue to be handled by York Insurance Services. The supervisor/manager in immediate charge of these claims is Mr. Ben Burg.

1. Claims Examiner's Caseload.

The EIA has set a reasonable standard of 150 to175 open indemnity files based on "future medical" files counted at a ratio of 2:1 relative to other indemnity files. Examiners with a combination of too many files or too little support have no time for regular communication with their clients' injured employees, consulting with the client on significant cases and developments, and continuing their training. Therefore, the whole picture must be evaluated.

The following table shows the examiner's workload, experience, and certification as reported by York Insurance Services. Self Insurance Plans, a state agency, certifies workers' compensation examiners by a one-time test. The Insurance Education Association has an extensive certification program.

	Workload †		Experience ‡		Certification	
	This Account	All Accounts	This Account	Total	SIP	IEA
Teresa Underwood	36	161	12yrs	28yrs	Y	
Michelle Bridges	66	160	New	10yrs	Y	
Lela Casey	116	160	New	11yrs	Y	
Sara Marshall*	62	135	.5yrs	4yrs	Y	
Christine Stillwell (FM)	228	355	8yrs	10yrs	Y	
Federica Simpson (FM)*	69	327	1yr	10yrs	Y	
Sara Marshall*	73	135	.5yrs	4yrs	Y	
Federica Simpson*	66	327	1yr	10yrs	Y	
*On both accounts						

Total	716	† All Indemnity Files			‡ As an Examiner	

2. Claims Assistant's Duties.

The most common duties of the examiner's principal assistant, whatever the actual job title, may include: doing a triage to separate MO's from indemnity and urgent indemnity from normal indemnity files; controlling and paying ongoing temporary and permanent indemnity payments; calculating and paying Awards; paying medical bills on both indemnity and MO files; and data input.

Here, there is a separate pool of assistants; the assistants' duties include TD and PD payments, award payments, and data input.

3. Findings, Summary and Recommendations.

There has been some examiner personnel changes in the past several months but currently both programs are adequately staffed with experienced personnel. Recommendations are not felt to be warranted.

E. AUDIT DETAIL

This section contains the details of this audit for these EIA members: County of Napa and Northern California Cities Self Insurance Fund/Alliant Insurance. Each subsection discusses an important group of related points and the sub-subsections offer specifics of narrow points and, finally, findings, a summary and any needed recommendations are offered for the group.

1. Compensability Determination.

This audit area concerns the initial decision regarding compensability of the claim at the time it is reported. Usually simple, this issue is sometimes complicated at the outset. The initial decision to accept, delay, or deny a particular claim is an important milestone. Inquiries in this area are also made to see whether adequate background investigation is made, if necessary, and if communication with the relevant department of the employer is established and maintained.

1.1 Investigated If Necessary.

This inquiry detects whether a particular file requires an investigation: either an intensive field investigation, a simple phone investigation by the examiner, or a medical investigation by a consultant and, if so, whether this investigation was done. Conversely, we also look for unnecessary sub rosa or compensability investigations that would drive up costs needlessly.

Investigations needed: 26.
Investigations appropriately done: 23 (88.5%).

The exceptions are:

- #20841: Although claim denied without a response thereafter from EE, this claim nevertheless, should have been assigned to an outside investigator for EE and supervisor statements. Examiner's POA note indicating waiting for signed medical releases before assigning outside investigation is not appropriate for a claim of this nature. Further more there never was any direct contact by examiner with EE even though there is 3 documented attempts at the outset.

- #26551: Case was not timely assigned for outside investigation.

- #27173: Examiner had some concerns regarding delayed reporting but was never addressed with ER or EE.

1.2 Correct Compensability Decision.

The examiner's threshold function is to decide if a workers' compensation claim is to be accepted, delayed, or denied. This inquiry looks at the correctness of that decision.

Compensability decisions required: 25.
Compensability decisions correct: 25.

1.3 Basis of Decision Documented.

Any file other than those routinely accepted should be fully documented with evidence sufficient to justify the action taken, and should show a clear statement of the examiner's thought processes. If the self-insured, defense attorney, or any other source of information was relied upon, then these facts and sources need to be included in the documentation. The Office of Benefit Assistance and Enforcement Audit Unit fine, payable to the state, for an "unsupported" denial is as much as $5,000.

Cases that require documentation: 25.
Cases sufficiently documented: 25.

1.4 Decision Timely.

The timeliness standard is that the initial decision to accept, delay, or deny a claim be made within three days of receipt of all available information. If an investigation is necessary and meanwhile the claim is delayed, then a final decision whether to accept or deny must be made within three days of receipt of the investigation findings. In any case, the decision should be made within the state requirement of ninety days of the employer's date of knowledge.

Cases requiring a decision: 25.
Cases decided timely at each stage: 23 (92.0%).

The exceptions are:

- #17758: It does not appear that the decision to accept/deny claim was made within the 90 day determination period.

- #21100: Denial notice was issued 1 day late.

1.5 Employer Contact.

Critical compensability decisions should be made in consultation with the employer. This might include the employee's supervisor, the Risk Manager, or other pertinent parties to guarantee coordination of all facts.

Cases requiring contact: 63.
Cases with documented contact: 62 (98.4%).

1.6 Index Bureau.

Many claims administrators or self-insured entities use the Index Bureau. This is a private company that maintains a database of claimants with workers' compensation, bodily injury, and other types of claims. The claims person or an automated process completes a short form and sends it to the Index Bureau. If there is a match to other claims by the same person, a minimum amount of information is returned to the examiner, who then decides whether to make further use of it. Useful information is not always obtained but it is frequent enough to be cost effective.

York Insurance Services uses the Index Bureau.

1.7 Findings, Summary and Recommendations.

The exceptions noted in Section 1.1 show that there were a few cases that were not fully investigated or not timely referred for outside investigation. These should be reviewed with the examiner to ensure complete and timely investigation of questionable claims in the future. There were also 2 cases in which the decision to accept/deny was not made within the 90 day determination period. The individual claims need to be reviewed and necessary steps implemented to ensure that there are timely decisions made concerning compensability in the future.

2. Employee Contact.

The purpose of this area of inquiry is to learn if the claims examiner makes early telephone contact with each injured worker according to industry standards and whether this telephone contact continues as appropriate. Most good administrators do this as part of "three-point contact." The other two contact points are the treating doctor and the employer.

2.1 Prompt Contact With Employee.

It is a good standard claims practice for the examiner to personally contact every disabled claimant by telephone. Often the employee is simply the best source of information about the claim and we need to ask for his or her side of the facts. Contact is particularly critical with problematic claims or those in which information must be given to the employee that he or she may not want to hear, for instance, that his or her claim is being denied. It is generally believed that some litigation will be avoided by close telephone contact between the examiner and the injured workers. The EIA has established a reasonable standard of initial contact within 3 days of claim receipt with at least 2 additional attempts at contact if not previously established. This standard is now applicable on medical only claims in addition to lost time claims.

Files in need of initial contact: 60.
Files showing initial contact: 40 (66.7%).

Exceptions are:

- #10786: EE was never contacted on this subrogation case. Since there seems to be some difficulties recovering from the 3rd party insurer examiner should contact EE to find out whether he is actively pursuing a settlement with the insurer. Perhaps both EE and examiner together can put pressure on insurer to act a little more responsibly in settling this claim.

- #16064: There was only 1 documented contact attempt with the EE. In addition, according to the EE, there were a number of unreturned phone calls to the examiner.

- #18194: Only 2 documented attempts at EE contact and not documented as to dates of attempts.

2.2 Employee Contact Continued.

Maintaining employee contact on non litigated claims with ongoing temporary disability is a widely accepted industry standard. It is recommended that such contact occur at critical points in the claim such as just before/after surgery and at a frequency no greater than every 45 days. While assigned nurse case managers maintain employee contact on many cases their role is not a substitute for periodic contact by the examiner.

Cases needing continuing employee contact: 32.
Cases with continuing contact: 20 (62.5%).

An exception is:

- #26743: See comment under 3.2.

2.3 Findings, Summary and Recommendations.

Most of the exceptions regarding initial employee contact related to a lack of 3 documented attempts or the initial contact not occurring within 3 days of claim receipt. Ongoing employee contact was inconsistent. We recommend that the EIA's employee-contact standard be reviewed and more vigorously enforced. We also recommend that an ongoing employee contact standard be established and enforced.

3. Benefit Payments.

This area concerns itself with the timeliness and accuracy of benefit payments. Initial indemnity payments and the issuance of the first DWC notice are checked against the timeliness standards of the Administrative Director of the Division of Workers' Compensation. Subsequent indemnity payments and permanent disability payments are also reviewed for timeliness.

3.1 Timeliness of First Payment.

California administrative regulations require that initial indemnity payments (or notice, in the case of salary continuation) be issued within fourteen days of the first date of disability. Late claims are subject to a DWC Audit Unit fine of up to $100 each. In addition, if direct payment was made to the employee (as opposed to salary continuation) and this payment was twenty-eight or more days late, then an additional automatic penalty is payable to the employee. The goal is to accomplish 100% within this time limit.

Cases on which temporary disability was paid: 46.
Cases paid timely: 45 (97.8%).

The exception is:

- #26198: TD payments were mistakenly issued by voucher instead of directly to the EE. Once this was corrected the TD checks issued to EE should have included the 10% self imposed increase.

3.2 Subsequent Temporary Disability Biweekly.

Subsequent indemnity payments are required to be paid once every two weeks exactly.

Subsequent payments: 42.
Subsequent payments timely: 40 (95.2%).

The exceptions are:

- #14799: EE was determined unable to do the usual and customary occupation as of 5/7/12. LC 4850 up to the full year entitled should have continued or there should have been an IDR effective as of

that date. Also see comment in Section 3.4.

- #26743: The last documentation regarding EE's LT was on 10/10/12. There has been no examiner follow up nor has there been any contact with EE on this issue. Meanwhile, treating MD has EE on TTD for the ortho aspects of the claim.

3.3 Transportation Expense.

This inquiry looks at the speed with which employees are reimbursed upon requesting medical transportation expense and if mileage payment is provided in advance of a PQME evaluation. The CSAC/EIA standard calls for payment within five days.

Transportation expense requests: 38.
Transportation expense payments timely: 32 (84.2%).

The exceptions are:

- #13969: Mileage check for the 2nd PQME evaluation was not sent 10 days in advance.
- #14236: Mileage check was not sent for the PQME evaluation.
- #16064: A mileage check was not sent for the PQME evaluation.
- #20939: Mileage check for first PQME evaluation was not sent 10 days in advance.
- #22362: Mileage check was not issued 10 days in advance of PQME evaluation.
- #27584: Mileage check was not sent for the PQME evaluation.

3.4 Correct Permanent Disability Payments.

This inquiry is intended to discover whether permanent disability (and advances thereon) are paid correctly by law. This requires advance payment of permanent disability between the end of temporary disability and the date a permanent disability rating is determined. Without such advance of permanent disability payments, a penalty by the Workers'

Compensation Appeals Board is at risk. Further, there is an additional $100 penalty payable to the state and the 10% automatic penalty that is payable to the claimant with the administrator's own funds. Thus, on a late or absent permanent disability payment, as many as three penalties could apply. Conversely, permanent disability payments should not be made unnecessarily simply to avoid the risk of a penalty.

Cases on which PD (or advances) were required: 39.
Cases with correct PD payments: 26 (66.7%).

The exceptions are:

- #14799: EE was determined unable to do usual and customary occupation on 5/7/12. See comment in previous Section 3.2.

- #16064: PD was either payable upon the receipt of the PQME report or an additional denial notice should have been sent setting forth the basis of the continuing denial. In this case the only basis for a continuing denial would have been based on good faith personnel actions. That is a legal basis and would have needed to be resolved prior to dealing with the medical issues contained in the PQME's opinion. Alternatively, the filing of an application was required in order to continue discovery on the medical issues.

- #20678: PD advances were not timely resumed after receipt of the AME report. The 10% self imposed increase was not paid.

- #20947: PR4 report was received 7/5/12. PD advances were not timely resumed. The 10% self imposed increase was not paid.

- #22111: PD advance was not paid within 14 days of receiving the P&S report. The 10% self imposed increase was not paid.

- #22362: There was 1 underpayment of PD. The 10% self imposed increase was paid.

- #24378: There was 1 PD payment at an incorrect rate. The 10% self imposed increase was paid.

- #24682: Initial PD advance was not paid within 14 days of receiving the PR4 report. The 10 % self imposed increase was not paid.

- #26141: PD advances should have been resumed upon receipt of the P&S report from the psych PQME.

- #26989: There was 1 late PD payment. The 10% self imposed increase was paid.

- #27756: Initial PD advance was not timely. The 10% self imposed increase was not paid.

- #27973: Even though there is potential for some apportionment the EE underwent a surgical procedure with a scheduled PD rating. Some PD advances should have initiated at the termination of LC4850.

- #29475: EE RTW full duty 11/2/12. PD advances have not been initiated per scheduled rating.

3.5 Permanent Disability Rate Adjustment.

Beginning January 1, 2005, permanent disability benefit weekly payment amounts are affected up or down depending on the employer making work available to an employee with a disability. This query records whether this new section, LC§ 4658(d)(1), is applied correctly.

Cases involving a PD rate adjustment: 20.
Cases on which the adjustment was correctly applied: 20.

An observation is:

- #26989: It is noted that EE retired on a non industrial basis prior to P&S status. PD rate was increased as EE was ultimately determined to be unable to do his usual and customary occupation. Since ER was unable to conduct the interactive process it would seem that the correct rate under these circumstances would be at the neutral rate.

3.6 Self-Imposed 10% Penalty Paid if Required.

This query records whether the automatic penalty is paid when required. It is automatically triggered by any of several situations. The problem is circuitous because a late or absent penalty triggers yet another penalty.

Cases involving a self-imposed penalty: 9.
Cases on which such a penalty was properly paid: 3 (33.3%).

3.7 Regular File Balancing.

In this area we look at the fiscal safeguards or "prevent and detect" used by York Insurance Services. Specifically, we note whether cases are balanced at regular intervals. "Balancing" means the following: On the indemnity portion of the file, the term refers to the regular reconciliation of payment liability against payments issued as shown by the manual and the data processing records. In other words, is the administrator regularly checking what it intends to pay against what is being paid? On the medical and expense portion of the case, balancing consists of reconciling bills paid against the manual and data processing records and, more important, it requires verification by a second person that each bill is correct in every way.

Cases on which balancing was expected: 60.
Cases with regular balancing: 36 (60.0%).

Exceptions are:

- #10786: Ambulance bill was paid twice. Examiner needs to seek reimbursement and then submit corrected lien to 3rd party insurer.

- #11183: It is noted that there was an issue regarding verification of TD/LC4850 paid which delayed excess reimbursement for a period of time. This should have been verified long ago through effective file balancing and clearly was not.

- #27504: Amount of LC4850 left should be documented.

3.8 Findings, Summary and Recommendations.

Two cases lacked sufficient documentation concerning the employee's ongoing disability status and there were a number of cases involving permanent disability payments. We recommend review of the payment process and that these issues be reviewed with the examiners to effect improvement in these areas.

There were a number of instances in which a mileage check was not issued

for a PQME evaluation or not issued 10 days in advance of the evaluation. It is recommended examiners establish a routine of issuing these checks at the time the appointment notice is received or at the time the cover letter is sent to the PQME.

File balancing was inconsistent and/or not adequately documented. The EIA standard for this procedure should be reviewed with examiners to ensure it is being followed.

4. Case Planning & Correspondence.

Examining workers' compensation claims, like any other business activity, should include a plan of action to achieve an explicit result. Without a plan, the claims examiner merely reacts to outside stimuli and the claims administration process breaks down, to the detriment of everyone concerned. Ideally, a plan should be written and include contingencies. This is where tactics are evaluated.

4.1 Case Plan Appropriate.

The purpose of this inquiry is to learn whether initial case planning took place when the claim was reported to York Insurance Services from any source and if subsequent planning and tactics are appropriate to the case. In simple cases, action is a more than adequate substitute for a written plan.

Cases where planning should have been evident: 94.
Cases where appropriate planning was seen: 86 (91.5%).

The exceptions are:

- #16064: See comment under3.4.
- #22596: There is no current POA in place to resolve the dilemma created by the WCAB in refusing to approve Stips without FM. EE hasn't requested any further treatment in over 2 years. The least costly alternative would be to just amend the Stips to include FM. Then close the file once they are approved.
- #24682: EE was never temporarily disabled. PD was due from P&S date of 3/4/11 and not from the DOI.
- #25234: There is no current POA.
- #25401: The first PQME re-evaluation should have been scheduled sooner. This likely would have resulted in the eventual surgery having occurred sooner. Medical treatment was ineffective for several months.
- #26141: See comment under 6.5. No CSR since 2/12.
- #26397: There is no current POA.

- #27173: The issue regarding the ending of temporary employment and any subsequent employment was not timely pursued. EE is 57 years old and had worked for ER only 4 months before the injury. A detailed medical history is highly recommended to explore for potential apportionment. EE has been on TD for over a year. PQME process should have been initiated before this. Assigning a NCM would be a good idea as well.

4.2 Apportionment Pursuit.

The Labor Code has significantly changed as of April 19, 2004, in regards to apportionment of permanent disability. All cases are affected regardless of the date of injury. This major change is sharply in favor of employers but it will only be as effective as it is aggressively pursued. If the examiners do not develop information and effectively ask the doctors about this information, nothing will change. Exactly what form the examiner's efforts should take is problematic at this point. Therefore, to audit for this point we look for any efforts that seem appropriate and effective.

Cases on which apportionment is an issue: 15.
Cases on which apportionment is thoroughly addressed: 15.

An observation is:

- #24782: Seems like it would have been a good idea for a DA to review the apportionment issues given the prior awards for the knee and shoulder.

4.3 Required Notices.

The Division of Workers' Compensation requires that many separate notices be sent to claimants. There are well over one hundred such notices. The language is largely prescribed by the state and this language constantly prompts employees to hire attorneys and appeal even insignificant developments in their cases. The lack of notice or slightly incorrect language is a major source of Division of Workers' Compensation Audit Unit fines. Sending unnecessary notices should be avoided too as unnecessary litigation will result.

Cases with notices required: 81.
Cases with notices: 69 (85.2%).

Exceptions are:

- #14048: Beginning TD notice was not timely sent.
- #14236: Subsequent denial notice was not sent within 14 days of receiving the PQME report.
- #14799: Two LC4850 notices were sent late.
- #20678: The ending LC4850 notice was sent late.
- #20939: A delay of LC4850 notice should have been sent at the outset pending clarification of time lost.
- #22596: PD advice notice was not timely sent.
- #24379: Beginning LC4850 notice was sent late.
- #25234: The beginning/ending LC4850 notice was sent late.
- #26397: Discharge report was received 10/23/12. A no PD advice notice has not been sent.
- #26551: Delay notice was not timely sent.
- #27973: Ending LC4850 notice was sent late.
- #28995: The delay notice was not timely sent.

4.4 File Documentation.

Here, the depth and breadth of file documentation is reviewed. Each claim file, if documented well, stands on its own. A new examiner, a supervisor, the client, or an auditor should be able to read the file and determine how and why the file got to its current point.

Files sampled: 94.
Files with reasonably clear and complete documentation: 89 (94.7%).

The exceptions are:

- #12063: There was no DWC1 in file and no indication of follow up with ER to determine if EE had returned it.
- #14799: File does not contain any documentation as to whether EE is retired, if so if that is an IDR, or whether he is still on the books as an employee.
- #18194: No DWC1 in file and no documented follow up with ER to see if EE had returned it.
- #24682: PQME report for the evaluation occurring on 9/12/11 was not in file. If this is in the other claim a copy should be put in this file.
- #27353: It is not clear whether EE is currently working. If not then it would appear that LC4850 is owed.

4.5 Correspondence.

The EIA standard is that all incoming correspondence shall be date stamped and if a response is required, it shall be within five days.

Files with correspondence: 94.
Files with timely response: 93 (98.9%).

The exception is:

- #27756: Claim was not timely accepted after receipt of the AME report.

4.6 Findings, Summary and Recommendations.

Several claims lacked a current plan of action and current relative issues in some cases were not adequately addressed. These need to be addressed with the examiner to make sure the plan of action is current and issues are timely and adequately addressed. A consistent supervisory diary review is also needed to make sure current issues are addressed in a timely fashion.

Several of the required benefit notices were issued late. This needs review

to effect improvement in this area.

5. Medical Administration.

The Labor Code requires the treating physician periodically to report to the claims administrator during treatment of an injured worker. This allows the examiner to insist on a regular flow of chart notes, X-ray reports, etc., to keep treatment focused on the industrial injury. Without sufficient reports from the doctors, the treatment can drift from the actual industrial injury. We also look at the appropriate use (or lack thereof) of additional cost containment measures such as billing review, utilization review, and nurse case management services.

5.1 Physician Contact.

The CSAC/EIA standard is that the physician's office be contacted within five days and as needed thereafter.

Cases that required physician contact: 23.
Cases with regular contact: 23.

5.2 Appropriate Medical Consultations Obtained.

This inquiry looks for both treatment-oriented consultations and appropriate initiation of the PQME process or AME process if litigated. Many cases do not need medical opinions other than the treater's.

Cases needing medical consultations: 20.
Cases on which consultations were obtained: 20.

5.3 Findings, Summary and Recommendations.

There were a few instances that are noted elseware in which either a nurse case manager probably could have helped with the medical issues or the PQME process should have been initiated sooner. These would be part of a more aggressive plan of action when medical treatment stagnates or becomes ineffective.

6. Litigation.

Litigation has a major impact on any self-insured program. Although it affects only a minority of files, it uses a disproportionate amount of time and money. This audit area focuses on the efficient use of defense counsel.

6.1 Files Litigated.

This inquiry is quantitative rather than qualitative. It simply looks at the total number of files sampled with applications filed. Of the cases sampled, 37 were in litigation as of the date of the audit. That is 39.4% The sample used by North Bay Associates for this claims review is weighted toward the high-dollar indemnity claims that tend to be litigated.

6.2 Use of Defense Attorney Appropriate.

This inquiry records whether a defense attorney was assigned as needed or used unnecessarily. This is subjective but is based on the experience level of the examiner and standard practices of other examiners and administrators. It may seem appropriate for the claims examiner to hire an attorney if the injured worker has done so, but if this is done unnecessarily, it will drastically increase the cost of handling litigated claims. On the other hand, if the defense counsel is needed because of overriding legal issues or other reasons, then it is important that the claims examiner refer the file as soon as possible and then control counsel rather than the other way around. This is not to suggest that claims examiners go to the Workers' Compensation Appeals Board and try cases against applicants' attorneys. But many experienced examiners can handle a litigated case so that no WCAB hearing is necessary and the case is equitably and speedily settled.

Litigated cases where inquiry was applied: 32.
Cases where attorneys were used appropriately: 32.

6.3 Legal Issue Recognition.

Here we evaluate if the examiner recognizes all relevant legal issues and proceeds accordingly.

This inquiry was directed at each litigated file: 38.

Cases that showed good issue recognition: 37 (97.4%).

6.4 Litigation Expense Control.

This inquiry is directed to each case with counsel assigned: 32.
Cases that showed expected level of expense control: 32.

6.5 Litigation Plan Documented.

Litigated cases: 36.
Cases with documented plans: 34 (94.4%).

The exceptions are:

- #26141: Case contains no current litigated POA. P&S reports were received 6 months ago. Of major concern is the psych report rated at 92%. DA did not think a depo would be fruitful but that needs to be done with this level of PD. There are clearly issues that are potentially non industrial including financial issues, self medicating, and lack of motivation. It is highly recommended that a POA be developed surrounding PQME's depo.

- #26428: AA requested QME panel 9/7/12. Examiner needs to contact DA/Medical Unit to find out why the panel has not been received yet.

6.6 Timely and Documented Referral to Counsel.

This inquiry determines whether files requiring defense counsel are referred timely and if the referral is documented with all appropriate issues identified, as opposed to merely shipping the file to an attorney blindly without any guidance. It is this initial referral document by which the examiner takes the first steps to assert control of the file and not relinquish control to counsel. The purpose of this control is to save money.

Files assigned to counsel during this audit period: 32.
Files that were timely: 32.

6.7 Findings, Summary and Recommendations.

Case# 26141 has a high liability potential. Aggressive litigation management is necessary to minimize this liability as much as possible. Otherwise, litigation handling is generally acceptable but litigation plans need to be kept up to date and focused.

7. Finalization.

This area is probably the most important to any claims operation. It is essential to conclude every case at the earliest possible moment. This requires not only a high examiner energy level but also a case load appropriate to the claims examiner's experience and expertise to know what to do next and how to do it. It is in the interest of all parties to move cases toward resolution as quickly as possible. No case ever gets better by being aged or ignored.

Workers' compensation files that are not disposed of with all due speed can be ranked as follows: 1) those that are not being handled briskly but with no apparent ill effect by the time of this audit; 2) those in which the delays have resulted in an ill effect; and 3) those where the ill effect is workers' compensation benefits being paid needlessly.

7.1 Continuous Finalization Efforts.

The North Bay Associates standard for measuring constant finalization efforts is that there should be no time in the life of the file when these efforts lag for more than forty-five days, that is, if the file reaches a point where something needs to happen but for forty-five number of days it does not, then we consider that a finalization failing even if at some subsequent time appropriate activity on the file resumes. If at the time of the audit a file is inactive or stuck, then specific suggestions are made and left on the file for the benefit of the claims examiner. These are called Summary Memos, copies of which are found at Tab Three in the *Addendum* to this report.

Cases in which we expect constant finalization efforts: 90.
Cases with constant efforts to finalize: 86 (95.6%).

The exceptions and recommendation (#20148) are:

- #20148: Looks like claim can move forward to resolution based on prior PR4 as there has been no follow up treatment since the flareup event.

- #24378: Settlement authority was received 8/28/12. No activity to resolve claim since then.

- #25234: See no activity to bring case to resolution since the ending of LC4850.

- #26141: There has been no activity to move case to resolution for 6 months.

- #26198: EE failed a follow up appointment so the treating physician could complete an exam for the PR4 report. That was known nearly 3 months ago. Examiner should have contacted the EE and arranged a final evaluation for completion of the PR4 report.

7.2 Correct Settlement Valuation.

Here we measure the examiner's technical and tactical evaluation of the settlement value of each case that was or is in the finalization stages. Is the examiner correctly reading the medical reports on which compromise and release or stipulations are based? Is the examiner challenging the state's permanent disability rating if appropriate? Are cases undervalued for any reason?

Cases settled or in the process of being settled: 21.
Cases correctly valued: 20 (95.2%).

The exception is:

- #27001: This is a case where waiting for the DEU rating before settlement should have occurred. It is noted that the DEU rated lower then the examiner's rating.

7.3 Compromise and Release Offered if Appropriate.

Several methods are available to conclude a workers' compensation case. One important method is the compromise and release by which the employer is released from all further liability. This method, though, is not the preferred method in all cases. Most of the time a C&R is appropriate when the claimant is no longer an employee; conversely, a C&R is rarely a good strategy if the claimant continues to be an employee and may not be a preferred method of settlement in some cases that require a medicare set aside. The purpose in tracking this is to provide a baseline statistic. With it, one can track if there are too many files without total settlements where it would have been appropriate. If so, it probably suggests that not enough money is being offered or not enough effort is being made. Therefore, this

inquiry looks at whether a C&R is attempted if appropriate.

Compromise and release appropriate: 8.
Compromise and release offered: 6 (75.0%).

The exceptions are:

- #24782: Not sure why a C&R was not considered or offered.

- #26989: Examiner indicated it would not be cost effective to consider a C&R. Disagree with that. A reasonable estimation of FM should usually be offered by C&R when appropriate and it should also be pointed out that a C&R closes the right to new and further disability.

7.4 Timely Closing.

This inquiry is designed to catch any files that are open at the time of the audit but that should have been closed.

Cases that should have been closed: 7.
Cases closed: 7.

7.5 Findings, Summary and Recommendations.

A few cases lacked timely movement toward resolution. An effective diary and a current plan of action with follow through is needed to effect improvement in this area.

8. Reserve Adequacy.

Reserve adequacy is a key area. The self-insured entity wants to know and understand what its total liability is at any given time. Reserving may seem subjective but an experienced examiner can, during any given fiscal year, set case-based aggregate reserves that will still be adequate (within a few percentage points) years later. Most individual cases will close with total costs below the reserve, but many cases will need to have their reserves sharply increased from the initial amounts. Done correctly over the years, decreases in reserves and salvage on closing will offset the increases, leaving the original fiscal year aggregate accurate.

The underlying premise is that at the end of any given year the aggregate incurred reserve should be adequate for the life of all claims opened during that year. The governing regulation[1] states: "Each indemnity claim listed on the self insurer's annual report shall be estimated on the basis of computations which will develop the **probable total future cost** of the compensation and medical benefits due or potentially due. Future liabilities on the annual report must represent the total future cost of the claim based on the information available in the claim file at the cutoff date of the period of time covered by the annual report." In reality, the aggregate incurred for many claims administrators does not level off for two or even three years. This is not a major flaw if it is understood, anticipated, and supplemented with actuarial studies. The findings in this report regarding reserving should be shared with client's actuary and correlated with the actuarial reports. But inadequate reserves found by Self Insurance Plans, the state Agency that regulates workers' compensation self insurance will result in an audit and possible sanctions.

North Bay Associates looks at case-based reserves at several points: initial reserves at creation, revisions up and down that are constantly necessary as more information is received into the file, and finally, reserves at the time of the audit.

8.1 Reserve Calculation Work Sheets Complete.

This query checks for sufficiently complete use of the examiner's main reserving tool: a reserve calculation worksheet. A worksheet encourages the examiner to break down the reserves into component parts rather than quickly guessing at totals only. The California Code of Regulations

[1] §15300 (b) Rules and Regulations.

"recommends" the use of a worksheet.[2]

Cases that should have sufficiently complete worksheets: 89.
Cases with such worksheets: 89.

8.2 Initial Reserves Appropriate.

Reserves created at the time the case is first opened should be adequate based on the information then available in the file. If newly incurred losses are under reserved, then the aggregate of all losses will be constantly understated. A properly trained examiner will recognize the gravity of a loss as the file is created; he or she does not need to wait for actual costs to push up reserves.

Files opened during this audit period: 67.
Files with accurate initial reserves: 67.

8.3 Reserves Revised Appropriately.

New information is constantly received into the file and it often impacts the reserves. Here we see if the examiner reacted to the new information by addressing reserve adequacy in a timely fashion.

Files that needed their reserves revised: 73.
Files with properly revised reserves: 65 (89.0%).

The exceptions are:

- #13969: Do not see any reason not to calculate the FM reserve based on usage and PQME opinion regarding FM as condition is P&S. No need to delay this kind of calculation at this point pending final resolution.

- #14799: No PD reserve on this litigated case for an EE who also has been determined unable to do the usual and customary occupation on a permanent basis. Recommend 15% pending additional discovery.

[2] §15400 of the Rules and Regulations.

- #16064: Litigated case that lacks an indemnity reserve for settlement purposes. PD is rated at 10%.

- #20538: Looks like LC4850 reserve will run out unless EE RTW in the next couple of weeks.

- #21123: Do not believe the FM reserve is adequate based on medication cost. This appears to have settled into a long term pattern.

- #22700: Although this is a denied claim based on the PQME opinion it is noted this is a cancer presumption claim that will be very costly if the presumption is not overcome. For this reason the current reserves are not adequate. It is not too early to begin thinking about settlement by C&R with injury in issue despite a notoriously unreasonable AA.

- #24119: There is no LC4850 reserve left. Recommend an additional 10 weeks.

- #25705: PD reserve should have been added at the time EE became represented.

- #26141: PD and medical reserves are inadequate. Psych currently rated at 92% and costly medical treatment continues unabated including large amounts of medication.

- #26743: TD reserve is not adequate. All reserves need updated evaluation by examiner. See comment in 3.2.

8.4 Findings, Summary and Recommendations.

Reserves were inadequate on several cases. These should be brought to the examiner's attention and it is also recommended that closer supervisory review on diary occur to ensure reserves are timely adjusted and adequate.

9. Excess Insurance.

This area assesses proper reinsurance reporting to the Excess Insurance Authority or other excess carrier as required, including subsequent reporting as necessary and regular requests for reimbursement as applicable.

9.1 Prompt Excess Reporting.

The basis for this query is the common reinsurance reporting requirements; the actual excess insurance policies covering these claims were not examined.

Cases requiring reporting to the reinsurer: 16.
Cases reported: 13 (81.3%).

The exceptions and recommendation (#24782) are:

- #22147: Claim is reserved over 50% SIR and not yet reported to excess.
- #22893: Do not see documentation this case has actually been reported to excess or acknowledgement of such.
- #24782: The recent reserve increase now requires reporting to excess.
- #25705: Case was reportable to excess at the time of the reserve increases on 7/23/12. It has not yet been reported.

9.2 Sufficient Subsequent Reports.

Cases requiring subsequent reports: 11.
Cases with subsequent reports: 7 (63.6%).

The exceptions are:

- #11060: See no documentation that the more recent CMR's have been transmitted to excess.
- #11183: See comment in Section 9.3.

- #19227: See no documentation there has been any follow up report to excess since the initial report.

- #20874: Looks like the last report to excess was on 9/1/11

- #26141: There have been no reports to excess since 2/12.

9.3 Regular Reimbursement Requested.

Cases over retention, thus entitled to periodic reimbursement: 1.
Cases on which reimbursement regularly requested: 0 (.0%).

The exception is:

- #11183: Although the file documentation indicates quarterly claim status reports, clear documentation lacked showing these reports were being sent to excess. Clear documentation in these reports is needed that excess has been sent a copy and it is also recommended a file note be entered to that affect. It was also noted that there were no reimbursement requests made from from 5/09 until 11/22/11. In addition there was 1 reimbursement received that was not posted to the file at the time it was received. We would highly recommend that quarterly reports and reimbursement requests be made together and that received reimbursements are promptly posted to the file. Medical treatment remains highly active and there is no reason not to be making consistent quarterly reimbursement requests.

9.4 Findings, Summary and Recommendations.

Initial and follow up reporting to excess is not occurring at an acceptable level and needs improvement. Initial reports should be done concurrent with reserve increases that exceed 50% of the SIR. Follow up reports should be done every 90 days and it is recommended that occur concurrently with the examiners' 90 day diary. A listing of reportable cases in the audit sample—entitled “Excess Reporting”—is at Tab Two in the *Addendum*.

10. Subrogation.

Subrogation is an important issue. This area usually involves few files but is unique in that it allows the administrator to recover some of the clients' funds. It is another indicator of the depth of the claims examiner's knowledge and skills.

10.1 Prompt and Effective Subrogation.

Cases with at least a potential for subrogation: 8.
Cases identified and acted upon: 8.

10.2 Appropriate Follow-Up.

Actual subrogation cases: 8.
Subrogation cases handled appropriately: 7 (87.5%).

The exception is:

- #23950: See no follow up subrogation pursuit since 3/8/12.

10.3 Findings, Summary and Recommendations.

Subrogation cases were recognized and timely investigated. There was appropriate follow up excepting the 1 noted case above. No specific recommendations are offered.

11. Penalty Summary.

This audit area is a review of any claims that fall into the penalty provisions of the Labor Code or Division of Workers' Compensation Rules and Regulations. Penalties may prove to be more fair to employers and less of an issue after 2004. In other audit areas, the Tabular Summary generally records expected results under "Yes" against undesirable results under "No." In this area, neither a "Yes" nor a "No" is desirable. A "Yes" means one or more penalties were due and paid or at risk, while a "No" means one or more penalties were due but not paid. An ideal result is all zeros.

11.1 Labor Code § 5814 Penalty.

This inquiry lists any claims at risk for the 25% penalty. This penalty must be asserted by the employee, typically through his attorney, and awarded by a judge of the Appeals Board before it is due. The audit will not concern itself with every file where a remote possibility for penalty exists or where the issue is raised by an applicant's attorney as a negotiating tactic, but only those in which it has actually and properly been raised by the employee or his attorney.

Cases with potential or actual §5814 penalties: 0.

11.2 Labor Code § 4650 (Self-imposed 10% Penalty).

This inquiry is directed at those claims that may have had some benefit delayed. A delay requires that the administrator automatically penalize itself 10%, and pay that money to the claimant or medical provider.

Cases with self-imposed penalty due: 9.
Cases with self-imposed penalty paid: 3 (33.3%).

11.3 Labor Code § 129.5 (DWC Audit Unit Fines).

A DWC shortcoming on a claim will remain in the file for a state Audit to ultimately find and penalize. North Bay Associates does attempt to monitor the current practices of the DWC Audit Unit to gauge if any of the files sampled are at risk for such penalties.

Cases with at least one potential Audit Unit penalty: 25.

11.4 Findings, Summary and Recommendations.

There is some potential for penalties on late disability payments in which the 10% self imposed increase was not paid. There is a mechanism in place for providing the client with prompt reimbursement of self imposed penalties.

Addendum

Tab Four

Audit Profile

11/22/2012

94 Claims

York Insurance Services (grp3)

All Clients in Audit

Line	Audit Point	Files	Yes %
1.1	Investigated if Necessary	26	88 %
1.2	Correct Compensability Decision	25	100 %
1.4	Decision Timely	25	92 %
2.1	Prompt Contact with Employee	60	67 %
3.1	Timeliness of First Payment	46	98 %
3.4	Permanent Disability Payments	39	67 %
3.7	File Balancing	60	60 %
4.1	Case Plan Appropriate	94	91 %
4.2	Apportionment Pursuit	15	100 %
6.2	Use of Defense Atty. Appropriate	32	100 %
7.1	Continuous Finalization Efforts	90	96 %
7.2	Correct Settlement Valuation	21	95 %
8.3	Reserves Revised Appropriately	73	89 %
9.1	Prompt Excess Reporting	16	81 %
10.1	Prompt & Effective Subrogation	8	100 %

Audit Profile

11/22/2012

77 Claims

York Insurance Services (grp3)

Northern California Cities Self Insurance Fund/Alliant Insurance

Line	Audit Point	Files	Yes %
1.1	Investigated if Necessary	21	86 %
1.2	Correct Compensability Decision	20	100 %
1.4	Decision Timely	20	95 %
2.1	Prompt Contact with Employee	47	74 %
3.1	Timeliness of First Payment	39	97 %
3.4	Permanent Disability Payments	33	67 %
3.7	File Balancing	50	70 %
4.1	Case Plan Appropriate	77	91 %
4.2	Apportionment Pursuit	13	100 %
6.2	Use of Defense Atty. Appropriate	26	100 %
7.1	Continuous Finalization Efforts	75	95 %
7.2	Correct Settlement Valuation	17	94 %
8.3	Reserves Revised Appropriately	58	90 %
9.1	Prompt Excess Reporting	11	73 %
10.1	Prompt & Effective Subrogation	7	100 %

Audit Data

11/22/2012

Audit Score 90.5%

94 Claims

York Insurance Services (grp3)

All Clients in Audit

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
1.1	Investigated if Necessary	23	3	0	26	88.5	11.5	0.0
1.2	Correct Compensability Decision	25	0	0	25	100.0	0.0	0.0
1.3	Basis of Decision Documented	25	0	0	25	100.0	0.0	0.0
1.4	Decision Timely	23	2	0	25	92.0	8.0	0.0
1.5	Employer Contact	62	1	0	63	98.4	1.6	0.0
2.1	Prompt Contact with Employee	40	20	0	60	66.7	33.3	0.0
2.2	Employee Contact Continued	20	11	1	32	62.5	34.4	3.1
3.1	Timeliness of First Payment	45	1	0	46	97.8	2.2	0.0
3.2	Subsequent T.D. Biweekly	40	2	0	42	95.2	4.8	0.0
3.3	Transportation Expense	32	6	0	38	84.2	15.8	0.0
3.4	Permanent Disability Payments	26	13	0	39	66.7	33.3	0.0
3.5	PD Rate Adjustment	20	0	0	20	100.0	0.0	0.0
3.6	Self-Imposed 10% Penalty Paid	3	6	0	9	33.3	66.7	0.0
3.7	File Balancing	36	24	0	60	60.0	40.0	0.0
4.1	Case Plan Appropriate	86	8	0	94	91.5	8.5	0.0
4.2	Apportionment Pursuit	15	0	0	15	100.0	0.0	0.0
4.3	Required Notices	69	12	0	81	85.2	14.8	0.0
4.4	File Documentation	89	5	0	94	94.7	5.3	0.0
4.5	Correspondence	93	1	0	94	98.9	1.1	0.0
5.1	Physician Contact	23	0	0	23	100.0	0.0	0.0
5.2	Appropriate Consultations Obtained	20	0	0	20	100.0	0.0	0.0

Audit Data

11/22/2012

Audit Score 90.5%

94 Claims

York Insurance Services (grp3)

All Clients in Audit

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
6.1	File Litigated	37	0	0	37	100.0	0.0	0.0
6.2	Use of Defense Atty. Appropriate	32	0	0	32	100.0	0.0	0.0
6.3	Legal Issue Recognition	37	1	0	38	97.4	2.6	0.0
6.4	Litigation Expense Control	32	0	0	32	100.0	0.0	0.0
6.5	Litigation Plan Documented	34	2	0	36	94.4	5.6	0.0
6.6	Timely & Documented Atty Referral	32	0	0	32	100.0	0.0	0.0
7.1	Continuous Finalization Efforts	86	4	0	90	95.6	4.4	0.0
7.2	Correct Settlement Valuation	20	1	0	21	95.2	4.8	0.0
7.3	C&R Offered if Appropriate	6	2	0	8	75.0	25.0	0.0
7.4	Timely Closing	7	0	0	7	100.0	0.0	0.0
8.1	Reserve Work Sheets Complete	89	0	0	89	100.0	0.0	0.0
8.2	Initial Reserves Appropriate	67	0	0	67	100.0	0.0	0.0
8.3	Reserves Revised Appropriately	65	8	0	73	89.0	11.0	0.0
9.1	Prompt Excess Reporting	13	3	0	16	81.3	18.8	0.0
9.2	Sufficient Subsequent Reports	7	4	0	11	63.6	36.4	0.0
9.3	Regular Reimbursement Requested	0	1	0	1	0.0	100.0	0.0
10.1	Prompt & Effective Subrogation	8	0	0	8	100.0	0.0	0.0
10.2	Appropriate Follow Up	7	1	0	8	87.5	12.5	0.0
11.1	L.C. 5814 (Old 10% Penalty)	0	0	0	0	0.0	0.0	0.0
11.2	L.C. 4650 (Self-Imposed 10%)	3	6	0	9	33.3	66.7	0.0
11.3	L.C. 129.5 (DWC Audit Unit Fines)	25	0	0	25	100.0	0.0	0.0

Audit Points Composite	Yes	Yes + No	Audit Score (%Yes)
	1422	1571	90.5%

Audit Data

11/22/2012

Audit Score 91.6%

77 Claims

York Insurance Services (grp3)

Northern California Cities Self Insurance Fund/Alliant Insurance

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
1.1	Investigated if Necessary	18	3	0	21	85.7	14.3	0.0
1.2	Correct Compensability Decision	20	0	0	20	100.0	0.0	0.0
1.3	Basis of Decision Documented	20	0	0	20	100.0	0.0	0.0
1.4	Decision Timely	19	1	0	20	95.0	5.0	0.0
1.5	Employer Contact	49	1	0	50	98.0	2.0	0.0
2.1	Prompt Contact with Employee	35	12	0	47	74.5	25.5	0.0
2.2	Employee Contact Continued	18	7	1	26	69.2	26.9	3.8
3.1	Timeliness of First Payment	38	1	0	39	97.4	2.6	0.0
3.2	Subsequent T.D. Biweekly	36	1	0	37	97.3	2.7	0.0
3.3	Transportation Expense	31	3	0	34	91.2	8.8	0.0
3.4	Permanent Disability Payments	22	11	0	33	66.7	33.3	0.0
3.5	PD Rate Adjustment	17	0	0	17	100.0	0.0	0.0
3.6	Self-Imposed 10% Penalty Paid	3	6	0	9	33.3	66.7	0.0
3.7	File Balancing	35	15	0	50	70.0	30.0	0.0
4.1	Case Plan Appropriate	70	7	0	77	90.9	9.1	0.0
4.2	Apportionment Pursuit	13	0	0	13	100.0	0.0	0.0
4.3	Required Notices	60	9	0	69	87.0	13.0	0.0
4.4	File Documentation	75	2	0	77	97.4	2.6	0.0
4.5	Correspondence	76	1	0	77	98.7	1.3	0.0
5.1	Physician Contact	22	0	0	22	100.0	0.0	0.0
5.2	Appropriate Consultations Obtained	16	0	0	16	100.0	0.0	0.0

Audit Data

11/22/2012

Audit Score 91.6%

77 Claims

York Insurance Services (grp3)

Northern California Cities Self Insurance Fund/Alliant Insurance

Audit Point	Question	Yes	No	Unkn	Tot	%Yes	%No	%Unkn
6.1	File Litigated	30	0	0	30	100.0	0.0	0.0
6.2	Use of Defense Atty. Appropriate	26	0	0	26	100.0	0.0	0.0
6.3	Legal Issue Recognition	30	1	0	31	96.8	3.2	0.0
6.4	Litigation Expense Control	26	0	0	26	100.0	0.0	0.0
6.5	Litigation Plan Documented	27	2	0	29	93.1	6.9	0.0
6.6	Timely & Documented Atty Referral	26	0	0	26	100.0	0.0	0.0
7.1	Continuous Finalization Efforts	71	4	0	75	94.7	5.3	0.0
7.2	Correct Settlement Valuation	16	1	0	17	94.1	5.9	0.0
7.3	C&R Offered if Appropriate	4	2	0	6	66.7	33.3	0.0
7.4	Timely Closing	7	0	0	7	100.0	0.0	0.0
8.1	Reserve Work Sheets Complete	73	0	0	73	100.0	0.0	0.0
8.2	Initial Reserves Appropriate	53	0	0	53	100.0	0.0	0.0
8.3	Reserves Revised Appropriately	52	6	0	58	89.7	10.3	0.0
9.1	Prompt Excess Reporting	8	3	0	11	72.7	27.3	0.0
9.2	Sufficient Subsequent Reports	4	2	0	6	66.7	33.3	0.0
9.3	Regular Reimbursement Requested	0	0	0	0	0.0	0.0	0.0
10.1	Prompt & Effective Subrogation	7	0	0	7	100.0	0.0	0.0
10.2	Appropriate Follow Up	6	1	0	7	85.7	14.3	0.0
11.1	L.C. 5814 (Old 10% Penalty)	0	0	0	0	0.0	0.0	0.0
11.2	L.C. 4650 (Self-Imposed 10%)	3	6	0	9	33.3	66.7	0.0
11.3	L.C. 129.5 (DWC Audit Unit Fines)	21	0	0	21	100.0	0.0	0.0

Audit Points Composite	Yes	Yes + No	Audit Score (%Yes)
	1183	1292	91.6%

Worker's Compensation Self-Insured Retention (SIR) Analysis

TOPIC: NCCSIF has retained the first $500,000 of each Workers' Compensation claim since 2002. From 1992 to 2002 NCCSIF's SIR was $300,000 and $250,000 prior to 1991. NCCSIF has incurred $20,616,266 losses excess of $400,000 since inception. The Board will be presented with exhibits and information that will assist with the following discussion points:

DISCUSSION POINTS:

1. What will be the additional funding costs to increase the SIR from $500,000 to $1,000,000 SIR?
2. How will impact the premium to our excess carrier?
3. How will these impact members' contributions?
4. What have NCCSIF's actual losses been in the $500K xs $500K layer?
5. Is it in NCCSIF's best interest to increase the SIR?

OBJECTIVE: To determine if NCCSIF should considering increasing their Self Insured Retention from $500,000 to $1,000,000.

ACTION(s)/DELIVERABLE(s): Members reviewed the information provided and decided not to consider increasing the Workers' Compensation Self-Insured Retention of $500,000 at this time. The current pricing is more attractive to purchase excess coverage at the current SIR than to fund an additional $500,000 per occurrence of loss.

DEADLINE(s): None.

FINANCIAL IMPACT: None.

RESPONSIBILITY: None.

Workers' Compensation Confidence Level Funding

TOPIC: NCCSIF currently funds losses for future payments at the 60% confidence level for the Workers' Compensation program. What this means is that NCCSIF is confident that 6 out of 10 times those programs adequately. NCCSIF has funded their program at different confidence levels since inception. Most recently the confidence levels for the last 10 years have been:

- 2003/2007 = 70%
- 2008/2012 = 60%

DISCUSSION POINTS:

1. Review of Equity in Workers' Compensation Program
2. Review of actual expected losses to projected losses
3. How will the change in the confidence level impact members' contributions?

OBJECTIVE: To determine if NCCSIF should adjust the current 60% Confidence Level for future payments of Workers' Compensation losses.

ACTION(s)/DELIVERABLE(s):

1. The Board of Directors request Staff to provide estimated Funding Calculations at difference Confidence Levels at the January Board of Directors meeting based on the current Actuarial report used for 2012/13 funding.
2. The Board also request Staff to review the current Workers' Compensation Equity balance to determine if funds are available to offset the increased costs to fund the Workers' Compensation program at a higher confidence level.

DEADLINE(s):

1. January 24, 2013.
2. January 24, 2013.

FINANCIAL IMPACT:

1. Unknown.
2. Unknown

RESPONSIBILITY:

1. Program Administrator.
2. Program Administrator.

NCCSIF
Northern California Cities Self Insurance Fund

WORKERS' COMPENSATION CONFIDENCE LEVEL ANALYSIS

NCCSIF currently funds *current year* (2012/2013) expected losses at the 60% confidence level and discounts rates by 3%.

The following table shows the additional funding required at a 70% confidence level and at various discount rates.

	60%	70%	ADDITIONAL FUNDING @ Higher Confidence Level
3.0%	$6,463,000	$6,926,000	$463,000
2.5%	$6,539,000	$7,007,000	$468,000
2.0%	$6,617,000	$7,091,000	$474,000
1.5%	$6,699,000	$7,179,000	$480,000
1.0%	$6,784,000	$7,270,000	$486,000

Workers' Compensation Discount Funding for Investment Income

TOPIC: NCCSIF currently discounts Workers' Compensation expected losses as determined by our Actuary by 3% to offset investment income earned on our investments. With interest rates at an all time low, NCCSIF should review the discounting practices as they relate to actual investment income to determine appropriate discount levels for future funding. NCCSIF's actuary Mike Harrington from Bickmore and Ted Piorkowski from Chandler Asset Management will provide the Board with information that will assist with the discussion points below.

DISCUSSION POINTS:

1. Review of interest earned on investments for the past 5 years as compared with discount rate amounts NCCSIF has used for funding losses in the banking and shared risk layers.
2. Review the payout pattern for Workers' Compensation claim payments made or settled.
3. What are other primary JPAs using as discount factors?
4. How will the change in the discount funding impact members' contributions?

OBJECTIVE: To determine if NCCSIF should adjust the current Discount Funding percentage of 3% for Investment Income.

ACTION(s)/DELIVERABLE(s):

1. Staff will provide estimated Funding Deposit Calculations at difference Discount Funding percentages at the January Board of Directors meeting.
2. Staff will provide calculations that will show if funds from the Workers' Compensation Equity are available to offset the increased costs to fund the Workers' Compensation program at a lower discount rate.

DEADLINE(s):

1. January 24, 2013.
2. January 24, 2013.

FINANCIAL IMPACT: Unknown.

RESPONSIBILITY:

1. Program Administrator.
2. Program Administrator.

NCCSIF
Northern California Cities Self Insurance Fund

WORKERS' COMPENSATION DISCOUNT RATES ANALYSIS

NCCSIF currently discounts Current Year and Outstanding Year expected losses at 3%.

Future earnings estimate from Chandler Asset Management are 1.25%.

The following table shows Outstanding Liabilities and the additional funding that would reduce Net Assets if the discount rate were changed.

	OUTSTANDING LIABILITES	INCREASE IN FUNDING	CURRENT YEAR @ 60% CONFIDENCE LEVEL	INCREASE IN FUNDING	TOTAL ADDITIONAL FUNDING REQUIRED
3%	$22,847,000	$0	$6,463,000	$0	$0
2.5%	$23,257,000	$410,000	$6,539,000	$ 76,000	$ 486,000
2.0%	$23,693,000	$846,000	$6,617,000	$154,000	$1,000,000
1.5%	$24,155,000	$1,308,000	$6,699,000	$236,000	$1,544,000
1.0%	$24,616,000	$1,769,000	$6,784,000	$321,000	$2,090,000

Item F.1.A.4.

Excess Workers' Compensation Pooling Partners

TOPIC: NCCSIF has purchased Excess Workers' Compensation Insurance coverage from CSAC EIA since 2003. CSAC EIA provides Statutory limits excess of NCCSIF's $500,000 Self Insured Retention. This time has been allocated to allow members to discuss "What is Working Well and What Isn't" with CSAC EIA.

DISCUSSION POINTS:

- What will be the reduction in cost to increase the SIR from $500,000 to $1,000,000 SIR?
- Are there any concerns with CSAC EIA**?**
  - Financial?
  - Cost?
  - Claims Handling?
  - Coverage?
  - Service?
- What next steps should NCCSIF take if there are issues?
- What are programs/services that CSAC EIA can assist NCCSIF members as respects risk transfer, risk management, training or other services?

OBJECTIVE: To determine if there are any items that need to be address with respects to NCCSIF's Excess Workers' Compensation coverage purchased from CSAC EIA.

ACTION(s)/DELIVERABLE(s): Members expressed that they are currently satisfied with the coverage and services provided by CSAC EIA. NCCSIF receives a $7,500 credit annually from CSAC EIA due to CAJPA Accreditation with Excellence. CSAC EIA also provides a $1,000 annual loss control subsidiary for members to use for loss control services.

Members would like to receive a list of upcoming trainings and webinars available through CSAC EIA at no additional costs.

DEADLINE(s): Ongoing.

FINANCIAL IMPACT: None.

RESPONSIBILITY: Program Administrator will provide to the NCCSIF Risk Management Committee to distribute to members and provide information on accessing this information from the CSAC EIA website.

Workers' Compensation Retrospective Rating Program

TOPIC: NCCSIF has a retrospective rating program for both the Banking and Shared Risk Layers. P&P A-1 address the Banking Layer Fund adjustments and P&P A-12 details the Shared Risk Fund Adjustments.

DISCUSSION POINTS:

1. Review historical dividends declared.
2. Review dividends declared and equity available at the time dividends were declared.
3. Are any changes necessary to these plans?
4. Does the Assessment provision need any improvements?

OBJECTIVE: To determine if NCCSIF should considering revising Policy and Procedures A-1 and A-12 with respects to the Banking and Shared Risk Layers Retrospective Rating Program.

ACTION(s)/DELIVERABLE(s): The Board of Directors did not have any issues to discuss regarding this topic, and requested Staff to provide recommendations to the Board of Directors at the January 2013 meeting.

DEADLINE(s): January 24, 2013.

FINANCIAL IMPACT: Unknown.

RESPONSIBILITY: Program Administrator.

ATTACHMENT: Red-Line Strike out of Bylaws, P&P A-1 and P&P A-12

A Public Entity Joint Powers Authority
c/o Alliant Insurance Services, Inc. | 1792 Tribute Road, Ste 450, Sacramento, CA 95815 | Phone: 916.643.2700 | Fax: 916.643.2750

NCCSIF

BYLAWS

NCCSIF BYLAWS
Table of Contents

		Page
Preamble		1
Section 1	The Authority	1
Section 2	Definitions	1
Section 3	Meetings of the Board of Directors	2
Section 4	Executive Committee	3
Section 5	Officers of the Authority	5
Section 6	Committees	5
Section 7	Program Director and Other Staff	5
Section 8	Responsibilities of the Authority	6
Section 9	Insurance Coverage	6
Section 10	Accounts and Records	7
Section 11	Responsibilities for Funds and Property	7
Section 12	Development, Implementation & Funding of Coverage Program	8
Section 13	New Members	9
Section 14	Withdrawal	10
Section 15	Termination and Distribution	10
Section 16	Effect of Withdrawal or Termination	10
Section 17	Claims Administration	11
Section 18	Budget	11
Section 19	Disbursement of Funds	12
Section 20	Separation of Programs	12
Section 21	Program Deposits	12
Section 22	Program Year Adjustments	12
Section 23	Coverage Documents	13
Section 24	Amendments	13

BYLAWS
OF THE
NORTHERN CALIFORNIA CITIES SELF INSURANCE FUND
(RESTATED AS OF OCTOBER 5, 1999)
(AMENDED AS OF JUNE 16, 2000)
(AMENDED AS OF JANUARY 24, 2013)

PREAMBLE

These Bylaws are adopted pursuant to the "Joint Exercise of Powers Agreement of the Northern California Cities Self Insurance Fund (Restated as of October 5, 1999 "("the Agreement"). These Bylaws, supersede the Bylaws of the Northern California Cities Self Insurance Fund ("NCCSIF") which were adopted by a resolution of NCCSIF's Board of Directors on December 8, 1987, and which were subsequently amended as of April 22, 1988. Because of a contemporaneous restatement of the Agreement due to restructuring of the NCCSIF organization, the need to make additional amendments to NCCSIF's Bylaws and the desirability of incorporating all changes in a single instrument, NCCSIF's Bylaws are restated as of October 5, 1999.

SECTION 1
The Authority

A. - Name of Authority. The name of the Authority created by the Agreement shall be the Northern California Cities Self Insurance Fund (the "Authority").

B. - Office of Authority.

The principal office of the Authority shall be fixed and located at:

Alliant Insurance Services, Inc.
1792 Tribute Road, Ste 450
Sacramento, CA 95815

or at such other location as the Board of Directors may designate by resolution."

C. - Fiscal Year. The fiscal year for the Authority shall commence July 1 of each calendar year and end June 30 of the following calendar year.

SECTION 2
Definitions

A. "Agreement" shall mean the restated Joint Exercise of Powers Agreement creating the Northern California Cities Self Insurance Fund.

B. "Authority" shall mean the Northern California Cities Self Insurance Fund (sometimes also referred to in the Agreement as the "NCCSIF") created by and existing under the Agreement.

C. "Board of Directors" shall mean the principal governing body of the Authority.

D. "Bylaws" shall mean the adopted Bylaws of the Authority as amended and/or restated in their latest approved form.

E. "Deposit" shall mean all the components comprising the annual costs of each program including: banking fund deposits, Shared Risk Layer deposits, administrative costs, excess premiums, taxes and fees.

F. "Executive Committee" shall mean the Executive Committee of the Authority's Board of Directors.

G. "Coverage Program" shall mean any program of the Authority providing coverage against losses to Member Entities who are participants in the program whether the coverage is based upon purchased insurance, self-insurance, pooled funding or any other similar mechanism, instrument or facility.

H. "Member Entity" shall mean a city government which is party to the Agreement.

I. "Program Director" shall mean the individual or firm retained by the Board of Directors to administer the Authority.

SECTION 3
Meetings of the Board of Directors

A. A majority of the membership of the Board of Directors shall constitute a quorum for the transaction of business. Each member of the Board shall have one vote. Except as otherwise provided in these Bylaws or any other duly executed agreement of the members, action of the Board shall require the affirmative vote of a majority of the members present and voting.

B. The Board shall hold at least one regular meeting each year and shall provide for such other regular meetings and for such special meetings as it deems necessary.

C. The Secretary of the Authority shall provide for the keeping of minutes of regular and special meetings of the Board, and shall endeavor to provide a copy of the minutes to each member of the Board prior to the next scheduled meeting.

E. All meetings of the Board shall be called, noticed, held and conducted in accordance with the provisions of Ralph M. Brown Act (Government Code Section 54950 et seq.).

SECTION 4
Executive Committee

A. - Membership. The Executive Committee shall be composed of seven (7) *voting and* two (2) *non-voting* members of the Board of Directors or their alternates. The President, Vice President, immediate Past President and Secretary shall serve as *voting* members on the Executive Committee. The remaining three (3) *voting* members shall be elected by the Board of Directors on a member rotation basis, as established by the Board of Directors. The two (2) non-voting members shall be comprised of the Treasurer and the CJPRMA Board Representative. The President shall act as Chairman.

B. - Term. The terms of all members of the Executive Board shall be two (2) years, except for those of the President, Vice President, immediate Past President and Secretary, who shall all serve for one (1) year. A member may be reappointed to serve on the Executive Committee, except for the immediate Past President.

C. - Powers, Duties and Responsibilities.

1. The Executive Committee shall conduct, direct and supervise the day-to-day business of the Authority and in doing so shall exercise the powers expressly granted to it by the Agreement, these Bylaws and as otherwise delegated by the Board of Directors.

2. The following duties and responsibilities shall be assumed and carried out by the Executive Committee, which shall have all powers necessary for those purposes:

a. Provide general supervision and direction to the Program Director;

b. Authorize payment of claims against the Authority; provided, however, that with respect to claims arising under coverage programs operated by the Authority, claim settlement authority shall be in accordance with the policies and procedures governing the particular program;

c. Enter into contracts, within budget limits;

d. Make payments pursuant to previously authorized contracts, within budget limits; this Authority includes the power to authorize and reimburse expenses incurred for budgeted activities, within budget limits;

e. Review and recommend a budget to the Board no later than seventy-two (72) hours prior to the spring meeting of the Board;

f. Act as Program Director in the absence of the Program Director;

g. Recommend policies and procedures to the Board for implementation of the Agreement, the Bylaws and the operation of specific coverage programs; and

h. Appoint a nominating committee for each election of officers and members of the Executive Committee.

i. Amend annual budget in an amount not to exceed the contingency account.

3. Subject only to such limitations as are expressly stated in the Agreement, these Bylaws or a resolution of the Board of Directors, the Executive Committee shall have and be entitled to exercise all powers which may be reasonably implied from powers expressly granted and which are reasonably necessary to conduct, direct and supervise the business of the Authority.

D. - Meetings

1. Regular Meetings. Regular meetings shall be held at times, as the Executive Committee deems appropriate.

2. Special Meetings. Special meetings of the Executive Committee may be called by the Chairman or a majority of Executive Committee members, in accordance with the provisions of California Government Code Section 54956.

3. Public Meetings. All meetings of the Executive Committee shall be open to the public, except as provided by law.

4. Quorum. Four (4) members of the Executive Committee shall constitute a quorum for the transaction of business. Except as otherwise provided, no action may be taken by the Executive Committee except by affirmative vote of not less than a majority of those Executive Committee members present. A smaller number may adjourn a meeting.

5. Removal From Executive Committee. A member may be removed from the Executive Committee in the following ways:

a. Death of a Committee member;

b. Voluntary resignation;

c. Absence from three (3) consecutive meetings without a valid reason, in which case the Chair may recommend to the Executive Committee that member be terminated from Executive Committee membership. If the Executive Committee recommends to the Board of Directors that an Executive Committee member be terminated, the Board of Directors shall vote on the matter at its next regularly scheduled meeting.

d. When a vacancy occurs under the above provisions, a replacement shall be made from among the Board of Directors.

SECTION 5
Officers of the Authority

A. The officers of the Authority shall be a President, Vice President, Secretary, and Treasurer Officers so appointed shall serve at the pleasure of the Board of Directors. The president shall chair meetings to the Board of Directors and Executive Committee; the vice president shall act in the place of the president in the president's absence. The secretary shall keep and maintain minutes of the Board meetings and Executive Committee meetings, or to direct the keeping and maintaining of such minutes, and to promptly report minutes of meetings to all members as soon as practicable after the meeting has concluded. The treasurer's duties are as described in Sections 11 and 12 of the Bylaws. Other responsibilities may be set forth by the Board of Directors.

B. The President, Vice President and Secretary shall be elected by the Board of Directors and shall serve one (1) year terms. No officer shall serve for more than two (2) complete consecutive terms in his or her respective office. The terms of each office will ordinarily commence on January 1st of each calendar year, except that if an election has not been conducted by that date, the terms shall commence as soon as the election has been held. The terms of each office shall end on December 31st of the calendar year, except that if the election of the officers to serve the next succeeding term has not been conducted, the incumbent officers shall continue to hold their offices until the election has been conducted.

C. The Treasurer shall be appointed by the Board of Directors and, unless the Board of Directors determines otherwise, the Treasurer shall serve at the Board of Directors' pleasure. The Treasurer shall be an officer or employee of a Member Entity or a Certified Public Accountant.

D. The Board of Directors may create such other offices and appoint such other officers as it deems necessary and advisable.

SECTION 6
Committees

Committees may be formed as necessary by either the Board of Directors or the Executive Committee for the purposes of overseeing any functions that the Board or Executive Committee has authority to control, such as, but not limited to, administration and policy direction, claims administration, investments, safety/loss control, etc.

SECTION 7
Program Director and Other Staff

A. The Board of Directors shall appoint a Program Director who shall be responsible for the general administration of the business and activities of the Authority as directed by the Executive Committee.

B. Subject to the direction of the Board of Directors, the Executive Committee shall provide for the appointment of such other staff of the Authority as may be necessary for the administration of the Authority. Supervision of staff is delegated to the Executive Committee.

C. The Program Director and other staff of the Authority shall have such powers, duties and obligations as are established by the Agreement, these Bylaws, the policies, procedures and rules promulgated by the Authority and any contractual arrangements which may exist between the Authority and the respective party.

D. Subject to any applicable contractual arrangement which may take precedence, the Program Director shall serve at the will and pleasure of the Board of Directors.

SECTION 8
Responsibilities of the Authority

The Authority shall perform the following functions in discharging its responsibilities under this agreement:

A. Develop, implement and maintain coverage programs;

B. Assist each Member Entity's designated risk manager with the risk management functions including: loss control, risk transfer, and employee safety programs.

C. Provide loss prevention and safety services to the Member Entities;

D. Provide claims adjusting and claims management services as required;

E. Provide statistical reports to the Member Entities;

F. Recommended standard contract clauses relating to indemnity, hold harmless, insurance and other similar matters affecting Members Entities; and

G. Provide other services consistent with purposes of the Authority as may be deemed necessary, advisable and beneficial to the Member Entities.

SECTION 9
Insurance Coverage

The Authority shall maintain insurance coverage on its activities as determined by the Executive Committee to be necessary and adequate.

SECTION 10
Accounts and Records

A. Annual Budget - The Authority shall adopt an annual budget that shall include a separate budget for each separate coverage program under development or adopted and implemented by the Authority. The Executive Committee shall cause to be prepared, shall review and approve and shall recommend a proposed annual budget to the Board of Directors for its consideration. The recommended budget shall be submitted to the members of the Board of Directors not later than seventy-two (72) hours prior to the Board of Directors' spring meeting.

B. Funds and Accounts - As directed by the Executive Committee, the Treasurer of Authority shall establish and maintain such funds and accounts as may be required by law and generally accepted accounting principles. Separate accounts shall be established and maintained for each coverage program under development or adopted and implemented by the Authority. Books and records of the Authority in the hands of the Treasurer shall be open to inspection at all reasonable times by authorized representatives of Member Entities. A quarterly unaudited financial statement will be produced and distributed to all Member Entities. The Authority shall adhere to the standard of strict accountability for funds set forth in Government Code Section 6505 and Governmental Accounting Standards Board (GASB) Statement No. 10.

C. Treasurer's Report - The Treasurer, within one hundred and twenty (120) days after the close of each fiscal year, shall give a complete written report of all financial activities for such fiscal year to the Board and to each Member Entity.

D. Annual Audit - Pursuant to Government Code Section 6505, the Authority shall contract with an independent certified public accountant to make an annual fiscal year audit of all accounts and financial statements of the Authority, conforming in all respects with the requirements of that section. A report of the audit shall be filed as a public record with the County Auditor of each Member Entity within six (6) months of the end of the fiscal year under examination. Costs of the audit shall be considered a general expense of the Authority.

SECTION 11
Responsibilities for Funds and Property

A. The Treasurer shall have custody of and disburse the Authority's funds. The Treasurer may direct the activities of the accounting function.

B. Pursuant to Government Code Section 6505.5, the Treasurer shall:

1. Receive and acknowledge receipt for all funds of the Authority and place them in the treasury of the Treasurer to the credit of the Authority;

2. Be responsible upon his or her official bond for the safekeeping and disbursement of all Authority funds so held by him or her;

3. Pay any sums due from the Authority, as approved for payment by the Board of Directors or by any body or person to whom the Board has delegated approval authority, making such payments from Authority funds upon warrants drawn by the Treasurer and signed by persons designated in Section 20 of these Bylaws;

4. Verify and report in writing to the Authority and to Member Entities, as of the first day of each quarter of the fiscal year, the amount of money then held for the Authority, the amount of receipts since the last report, and the amount paid out since the last report.

C. Pursuant to Government Code Section 6505.1, the Program Director, the Treasurer and such other persons as the Board of Directors may designate shall have charge of, handle and have access to the property of the Authority.

D. The Authority shall secure and pay for a fidelity bond or bonds, in an amount or amounts and in form specified by the Board of Directors, covering the Treasurer and all other officers and staff of the Authority who are authorized to hold or disburse funds of the Authority, and all other officers and staff who are authorized to have charge of, handle, and have access to property of the Authority.

E. The Treasurer shall invest funds in accordance with the approved investment policy of the Authority.

SECTION 12
Development, Implementation and Funding of Coverage Program

A. Program Coverage - The Authority may develop and implement Coverage Programs, which the Authority deems necessary, advisable and beneficial to Member Entities. Subject to any Coverage Program's applicable underwriting rules and other qualifying conditions, each Member Entity shall be eligible to apply for membership and participation in any Coverage Program conducted by the Authority.

B. Coverage Program and Authority Funding - The Member Entities developing or participating in a Coverage Program shall fund all costs of that program, including administrative costs, as hereinafter provided. Costs of staffing and supporting the Authority, hereinafter called Authority general expenses, shall be equitably allocated among the various programs and shall be funded by the Member Entities developing or participating in such programs in accordance with such allocations, as hereinafter provided.

1. Development Charge. Development cost of a coverage program shall be funded by a development charge as fixed by the Executive Committee. The development charge shall be paid by each Member Entity which wishes to join in development of the program, after receipt of information as estimated on the cost and scope of the program and thereby reserve the option to participate in the program following its adoption by the Board of Directors. Development costs are those costs incurred by the Authority in developing a coverage program for review and adoption by the Board of Directors, including but not limited to: research, feasibility studies,

information and liaison work among Entities, preparation and review of documents, and actuarial and risk management consulting services. The development charge may also include an equitable share of Authority general expenses incurred in the development functions. Upon the conclusion of program development: any deficiency in development funds shall be billed to all Member Entities which have paid the development charge, on a pro-rata or other equitable basis, as determined by the Executive Committee; and any surplus in such funds shall be transferred into the loss reserve fund for the program, or, if the program is not implemented, into the Authority's general fund. Future Members may be charged a Fee for development as part of the Entry Fee determined by the Executive Committee.

2. Deposits. Except as provided in Item 3 below, all post development costs of a Coverage Program shall be funded by annual deposits charged to the Member Entities participating in the Coverage Program each policy year, and by interest earnings on the fund so accumulated. Deposits shall be determined annually by the Executive Committee and based upon policy and procedures developed by the Authority with the assistance of an actuary at least every other year, and risk management consultant or other qualified person. The deposit for each participating Member Entity shall include the Member Entity's share of expense program losses, program excess insurance or reinsurance costs, and program administrative costs for the year plus that Member Entity's share of Authority general expense allocated to the program. Deposits shall be billed by the Authority at the beginning of each policy year and shall be payable as set forth in Section 22 of these Bylaws. Any deficiency or surplus in the deposit paid by a participating Entity shall be adjusted pursuant to policy and procedures adopted by the Authority.

3. Assessability. For any program year, the Board of Directors may impose assessments on the program members for that year which, in total amount, will assure adequate funds to the Authority for the payment of all losses.

This applies whether a member has subsequently withdrawn or been expelled from the Authority.

SECTION 13
New Members

A city which is not a Member Entity may become a party to the Agreement only upon approval of two-thirds (2/3) of the Board of Directors and by paying an appropriate entry fee or charge as established by the Executive Committee. The Board of Directors may condition its approval upon the proposed new member's ability to satisfy the underwriting criteria and other qualifying conditions which may then be in effect for any coverage program in which the proposed new Member Entity wishes to participate. The Board may prorate deposits and/or the coverage period for entities entering any coverage program at other than the beginning of the Authority's program year.

SECTION 14
Withdrawal

A. An Entity which enters any coverage program shall not withdraw from that program or as a party to the Agreement or the Authority for a three-year period commencing with its entrance into said program.

B. After the initial three (3) year noncancellable commitment to any coverage program, a Member Entity may withdraw only at the end of the Program Year, provided it has given the Authority a six (6) month written notice of its intent to withdraw from the program. The written notice of its intent to withdraw from the program is non-revocable."

C. Any member Entity which withdraws as a participant of any coverage program pursuant to item B of this Section shall not be reconsidered for participation in the program until the expiration of three (3) years from the Member Entity's withdrawal.

D. Member Agencies that withdraw from NCCSIF's Liability and or Worker's Compensation plans, agree that any available funds' allocated to them in the Shared Risk Layer, will remain with NCCSIF until such time as the "Program Year" is closed. This includes funds allocated to them via the "Shared Risk Plan Layer Adjustment" or any other manner of distribution other than the declaration of a dividend by the Board or in accordance with distribution described in the Joint Powers Agreement upon the dissolution of NCCSIF. Funds available from the Banking Layer to these Members are available for distribution.

If a "Program Year" is not yet closed and the "Participating Member" would otherwise be eligible for a distribution, a Member that has withdrawn from the "Authority" may annually, in writing, request a early release of their funds for consideration by the Board of Directors. This action will require approval of the Board of Directors as specified in the JPA Bylaws, Section 3, paragraph A.

SECTION 15
Termination and Distribution

A. This Agreement may be terminated by the written consent of three-fourths (3/4) of the Member Entities; provided, however, that the Agreement and the Authority shall continue to exist for the purpose of disposing of all claims, distribution of assets and any other functions necessary to wind up the affairs of the Authority.

B. Upon termination of the Agreement, all assets of the Authority shall be distributed only among the parties which have been participants in its Coverage Programs, including any of those parties which previously withdrew pursuant to Section 15 of these Bylaws and in accordance with the terms and conditions of these Bylaws. Distribution will be made within six (6) months

after the last pending claims or covered loss subject to the Agreement has been finally resolved and will be in proportion to the contributions made.

C. The Board is vested with all powers of the Authority for the purpose of concluding and dissolving the business affairs of the Authority. These powers shall include the power to require Member Entities, including those which were program participants at the time the claims arose or at the time the covered loss was incurred, to pay their share of any cash assessment deemed necessary by the Board for final disposition of all such claims and covered losses subject to the Agreement.

SECTION 16
Effect of Withdrawal or Termination

A. The expulsion or withdrawal of any member Entity after the inception of its participation in any coverage program shall not terminate its responsibility to:

1. Cooperate fully with the Authority in determining the cause of losses and in the settlement of claims, as defined in the coverage Agreement;

2. Pay any Deposit increases or assessments determined by the Board to be due and payable for each coverage program to which it participated;

3. Provide the Authority with such statistical and loss experience data and other information as may be necessary for the Authority to carry out the purposes of the Agreement; and

4. Cooperate with and assist the Authority and any insurer, claims adjuster or legal counsel retained by the Authority, in all matters relating to the Agreement.

Withdrawal of a member shall not be considered as a completion of the purpose of this agreement and shall not require the repayment or return to the withdrawing member agency of all or any part of any contributions, payments or advances made by the parties unless the agreement is rescinded or terminated as to all parties; however, when funds earmarked for program years in which the member agency participated are returned, the member will be entitled to its pro rata share (as determined by the Board of Directors) for its years of participation.

SECTION 17
Claims Administration

A. All claims shall be reported to the Claims Administrator in accordance with the Coverage Program claims reporting procedures.

B. All claims with potential penetration into the risk sharing portion of the Authority's programs will be presented to the Board (or claims committee) by the Claims Administrator and updates provided at regularly scheduled Board (or committee) meetings. The Authority has the right and power to direct the adjustment and settlement of a claim(s) penetrating the risk sharing

layer which in the opinion of the Board or Claims Committee, have a reasonable probability of penetrating the risk sharing layer.

C. All claims with potential penetration into any excess coverage joint powers authority or excess insurance carrier shall be reported in accordance with their guidelines.

D. Claims administration shall be audited at least every other year.

E. Member entities shall be responsible to maintain the confidentiality of any records which are privileged from disclosure under California law. This shall include taking reasonable steps to prevent the inadvertent disclosure of confidential records.

SECTION 18
Budget

The budget shall be presented at the spring meeting and adopted by the Board on or before June 30 of each year and shall separately show the following:

A. General and administrative costs;
B. Loss Control/Risk Management costs;
C. Deposits, projected interest income, and other income; and
D. The estimated claims and allocated claims adjustment expense.

SECTION 19
Disbursement of Funds

All disbursements under $5,000 shall have approval and signature of the Treasurer, or the President in the Treasurer's absence. All disbursements over $5,000 shall require two (2) of the four (4) officers' signatures. A register of all checks issued since the last Board meeting shall be provided as a part of the Treasurer's report at the subsequent Board meeting and approved by the Board.

The Workers Compensation Claims Administrator shall have the responsibility and authority to issue checks from the Authority's trust account in satisfaction of legal requirements to pay benefits to industrially injured workers of the member cities. The Administrator will issue checks for state mandated benefits including Indemnity, Medical, Rehabilitation and Expense categories. For checks below $5,000, one authorized signature or stamp from the administrator is required. For checks above $5,000, two signatures are required.

The Liability Claims Administrator shall have the responsibility and authority to issue checks from the Authority's trust account to pay liability claims and defense costs as agreed upon and approved by the Member City and/or the Claims Committee, as appropriate. For checks below $5,000, one authorized signature or stamp from the administrator is required. For checks above $5,000, two signatures are required.

SECTION 20
Separation of Programs

Each coverage program of the Authority shall be autonomous. Members shall participate only in the coverage programs so authorized by City Council resolution.

SECTION 21
Program Deposits

Program deposits shall be sufficient to cover the budget for each fiscal year of the program. Program deposits for each fiscal year shall be calculated according to the deposit calculation formulas adopted by the Board.

Deposits are due and payable immediately upon commencement of the Liability Plan year and quarterly for the Workers' Compensation Plan. Deposits are considered delinquent if not received by the Treasurer within thirty (30) days.

SECTION 22
Program Year Adjustments

Prior to the beginning of each program year, adjustments shall be calculated in accordance with the policy and procedure adopted by the Board of Directors.

SECTION 23
Coverage Documents

Each Member Entity participating in a coverage program of the Authority shall be provided with either a Memorandum of Coverage or an insurance policy, as the case may be, which shall describe in detail the nature of the applicable coverage, including dollar amounts, together with any deductibles, exclusions, limitations or other provisions of the coverage.

SECTION 24
Amendments

A. These Bylaws may be amended by a two-thirds vote of the Board of Directors present and voting at a regular meeting provided that any amendment is compatible with the purposes of the Authority, is not in conflict with the Agreement and has been submitted to the Board at least 30 days in advance. Any such amendment shall be effective immediately, unless otherwise designated.

ADMINISTRATIVE POLICY AND PROCEDURE #A-1

SUBJECT: BANKING LAYER PLAN FUND ADJUSTMENTS

Policy Statement:

It shall be the policy of the Northern California Cities Self Insurance Fund to review annually each Plan's financial status and to evaluate the appropriateness for declaring either a refund or an assessment to Member Agencies.

When so determined to be fiscally responsible by the Board of Directors, the adjustments shall be in accordance with the provisions outlined in this policy and procedure.

Provisions:

1. The refund/assessment calculations shall be performed annually and presented to the Board of Directors at its meeting in April.

2. The "Total Equity" at December 31, "Gross Equity" at December 31, "Outstanding Claims Liabilities" at December 31, "Buffer Allocation" and "Net Equity" shall be used for purposes of calculating any adjustments.

The "Total Equity" shall be that figure in the Financial Consultants Financial Report representing total equity at December 31.

The "Outstanding Claims Liabilities" shall be that figure developed by the Financial Consultant based on the Actuarial Report and IBNR factors, which represents the total amount of reserves on open claims and Incurred But Not Reported (IBNR) at the 90% Confidence Level, at December 31.

The "Gross Equity" shall be the sum of the "Total Equity" minus the "Outstanding Claims Liability at the 90% Confidence Level."

The "Buffer Allocation" shall be the allocation among Members Agencies with a positive "Gross Equity" of the sum of the negative "Gross Equity" and 10 times the Banking Layer Limit.

The "Net Equity" shall be the sum of the "Gross Equity" minus the "Buffer Allocation"

Assessments:

1. A Member Agency reflecting a negative "Gross Equity" shall be required to pay to the Treasurer twenty percent (20%) of the negative amount in two installments due September 15 and December 15 in the year is which the Assessment is declared. If 20% of the negative "Gross

Equity" is less than $10,000, than the full amount will be paid to NCCSIF in the first installment of September 15 rather than two installments.

2. A Member Agency failing to meet the payment schedule above shall be charged interest in the manner and amount earned on funds deposited in LAIF.

Refunds:

1. A Member Agency shall be eligible for a refund by meeting the following conditions:

   A. Participation in the Plan for three years

   B. A positive Plan "Net Equity"

2. The Amount available to be refunded shall be the "Net Equity" as determined annually by the Board of Directors.

3. Member Agencies may decline the refund and leave such funds or a portion of the funds in their account.

4. Members Agencies may elect to allocate the remaining amount available as follows:

   A. If funds are not being retained in their Account, then a negative balance in the other Program must first be offset

   B. If not used for "5." or "6a." above, remaining available funds, or any portion thereof, may be used to offset the next fiscal year deposits, or may be requested in the form of a check

Effective Date:	May 26, 1989
First Revision Date:	June 14, 1996
Second Revision Date:	June 13, 1997
Third Revision Date:	December 17, 1999
Fourth Revision Date:	December 15, 2000
Fifth Revision Date:	March 16, 2007
Sixth Revision Date:	December 13, 2007
Seventh Revision Date:	April 25, 2008
Eighth Revision Date:	January 24, 2013

ADMINISTRATIVE POLICY AND PROCEDURE # A-12

SUBJECT: SHARED RISK LAYER PLAN FUND ADJUSTMENTS

Policy Statement:

It shall be the goal of the Northern California Cities Self Insurance Fund (NCCSIF) to retain funds in the Shared Risk Layer Programs sufficient to meet an expected discounted level of "outstanding liabilities" plus a reasonable contingency margin, for all program years combined NCCSIF shall annually review the financial position for each open program based on NCCSIF's actuarial study, and evaluate the claims payment pattern to determine if the current assets and projected payments are sufficient to maintain the program liquidity. The review will evaluate the appropriateness for declaring either a refund or an assessment to Members.

When determined to be fiscally responsible by the Board of Directors, the adjustments will be in accordance with the provisions outlined in this policy and procedure.

Procedure:

1. The evaluation shall be performed annually and presented to the Board of Directors at its meeting in the spring of each year.

2. The "total assets" at December 31, "outstanding claims liabilities" at December 31 and "adjustment balance" will be used for the purposes of calculating any adjustments.

   - "total assets" shall be that figure in the auditor's financial Report representing total assets at June 30, minus claims paid between June 30 and December 31.

   - "outstanding claims liabilities" shall be that figure in the actuarial Review which represents the total amount of reserves on open claims and Incurred But Not Reported (IBNR) claims stated at an expected confidence level and optionally at a 60% and 70% confidence level, discounted or at present value, for open shared risk layer program years, but based upon the December 31, loss statistics.

   - "adjustment balance" shall be the sum for each applicable shared risk layer program year of the "total assets" minus the chosen "outstanding liabilities".

3. Refunds:

   A Member shall be eligible for a refund by meeting the following conditions:

   a. Participation in the plan for three years;
   b. Applicable program years determined separately for liability and workers' compensation results in a positive adjustment balance.

c. The amount to be refunded shall be a certain percentage of the "adjustment balance" as determined annually by the Board of Directors.

4. Assessments:

A Member will be assessed if the "adjustment balance" for the open Shared Risk Layer Program Years (determined separately for liability and workers' compensation) is/are negative. The amount of the assessment declared will be 100% of the deficit "adjustment balance". The amount of the assessment will be collected over a period of seven (7) years. The member shall be required to pay their proportional share for each program year in a deficit position. The proportional share is the Members' % of total contributions for that program year. Payment will be made as part of the September 15 program billings.

5. A Member failing to meet the payment schedule above shall be charged interest in the manner and amount earned on funds deposited in LAIF, at the time they are delinquent.

6. ~~6.~~ Refunds from positive years will first go to offset negative years before being refunded to Members.

7. Refunds from positive years will first go to offset negative years in another program before being refunded to Members.

8. **Effective July 1, 2013, "Participants" that withdraw from NCCSIF's Workers' Compensation plan, agree that any available funds' allocated to them in the Shared Risk Layer, will remain with NCCSIF until such time as the "Program Year" is closed. This includes funds allocated to them via the "Shared Risk Layer Plan Adjustment" or any other manner of distribution other than the declaration of a dividend by the Board or in accordance with distribution described in the Joint Powers Agreement upon the dissolution of NCCSIF. If a "Program Year" is not closed and the "Participating Member" would be eligible for a distribution, they may annually send a written request for release of their funds to the Board of Directors. This action will require approval of the Board of Directors as specified in the JPA Bylaws, Section 3, paragraph A.**

Effective Date: June 16, 2000

First Revision Date: April 11, 2003

Second Revision Date: January 24, 2013

Liability Self-Insured Retention (SIR) Analysis

TOPIC: NCCSIF currently retains the first $1,000,000 of each Liability claim. NCCSIF increased their SIR from $500,000 to $1,000,000 in 2007 and has incurred four losses that exceed $1,000,000 that has eroded equity in that layer. From 1993 to 2006 NCCSIF's SIR was $500,000 and $250,000 in 1991 & 1992 coverage years. The Board will be presented with exhibits and information that will assist with the following discussion points:

DISCUSSION POINTS:

1. What will be the reduction in funding cost to decrease the SIR from $1,000,000 to $500,000 SIR?
2. How will these impact members' contributions?
3. What have NCCSIF's actual losses been in the $500K xs $500K layer?
4. Is it in NCCSIF's best interest to decrease the SIR?

OBJECTIVE: To determine if NCCSIF should consider decreasing their current Liability Self-Insured Retention of $1,000,000 to $500,000.

ACTION(s)/DELIVERABLE(s): The Board of Directors approved decreasing the SIR from $1,000,000 to $500,000 per occurrence effective July 1, 2013:

1. The Board directed Staff to provide notice to CJPRMA by 12/31/12, regarding reducing the current Self Insured Retention from $1,000,000 to $500,000. Though notice will be given to CJPRMA, any changes to the Self-Insured Retention layer will require final NCCSIF Board approval in addition to review and approval of a 2/3rd vote by the CJPRMA Board of Directors.
2. Staff will confirm members who currently participate in CJPRMA's Pool B layer at a $500,000 Self-Insured Retention layer to determine NCCSIF's percentage of membership in that Pool Layer.
3. Staff will market the $500,000 xs $500,000 Liability layer with other pools and carriers proposing quota/share programs and/or corridor deductible programs. Mr. Mike Simmons advised that NCCSIF should address the Liability Equity deficit prior to marketing the program.

DEADLINE(s): 1. Completed 2. Completed 3. 3/31/13

FINANCIAL IMPACT: 1. TBD. 2. TBD. 3. TBD.

RESPONSIBILITY: 1. Program Administrator 2. Program Administrator 3. Program Administrator

ATTACHMENT:
1. Notice to CJPRMA of intent to reduce SIR to $500,000.
2. CJPRMA Agenda Item regarding Buy Down of SIR

NCCSIF
Northern California Cities Self Insurance Fund

December 17, 2012

Mr. David Clovis
General Manager
CJPRMA
3252 Constitution Drive
Livermore, CA 94551

RE: NCCSIF Reducing SIR to $500,000

Dear David,

NCCSIF just held our Long Range Planning meeting and have decided that we will be looking at various options to reduce our SIR from $1,000,000 to $500,000. Obviously our first consideration is to inquire if CJPRMA is interested in providing coverage for this layer and what the cost would be.

Therefore, NCCSIF is formally requesting CJPRMA to review and consider approving allowing us to join Pool B, the $500,000 xs $500,000 layer. We understand that this takes Board approval. We also note that this item will be discussed at your December 20th Board meeting and both Paula Islas and Susan Adams will be in attendance if there are any questions from the Board.

Thank you for your consideration.

Sincerely,

Elizabeth Ehrenstrom

Elizabeth Ehrenstrom
NCCSIF President

Cc: Paula Islas
Susan Adams

CALIFORNIA JOINT POWERS
RISK MANAGEMENT AUTHORITY

AGENDA BILL

ITEM: 6	***TITLE:*** **CHANGE IN S.I.R FOR NCCSIF**
MEETING: 12/20/2012	
GENERAL MANAGER:	

Recommended Actions:

Approval of the NCCSIF request to change their S.I.R. from $1 million to $500,000.

Item Explanation:

The Northern California Cities Self Insurance Fund (NCCSIF) notified CJPRMA, that it was considering lowering its self insured retention level (SIR) to $500,000 effective July 1, 2013. NCCSIF will be taking formal action on this item at their December 13, 2012 Board of Directors meeting. Susan Adams administrator to the NCCSIF program submitted the request and will provide a formal notice of the action taken by their board immediately following their meeting.

Article XIX of the JPA Agreement provides member entities with the ability to determine, on a year to year basis, their own self-insured retention level.

Article XIX also provides that such a determination be communicated in writing at least 180 days prior to the commencement of the program year.

NCCSIF joined CJPRMA July 10, 1993 and at that time elected to participate in Pool B with a $500,000 SIR. NCCSIF remained in Pool B through program year 2006-2007. Effective program year 2007-2008 NCCSIF opted out of Pool B increasing their SIR to $1,000,000.

In order to calculate future liability premiums, CJPRMA bases losses on a rolling ten year average of actual claims expenses. The most current actuarial study used program years 1999/00–2008/09 for the rolling 10 year loss average. Since NCCSIF participated in Pool B through 2006-2007, their losses were included for eight years in the current actuarial study for Pool B.

Loss history for NCCSIF for these eight years reveals developed trended losses in Pool B of $2,066,404, for an average of $258,300 per year at expected. Increasing this to a 70% confidence level increases the annual loss average to $312,543. The proposed rate for CJPRMA for PY 2013/14 for Pool B is $0.127 per $100 of payroll. With payroll estimated at $154.7 million, this will generate approximately $196,469 of Pool B premium contribution from NCCSIF. The data also showed that NCCSIF has five incurred losses greater than $500,000 in years 2010 and 2011.

Given the adverse loss development, it is recommended that NCCSIF pay an additional premium contribution of $116,000 in Pool B. The overall impact to Pool B members would be mitigated by the increase in contribution. In addition, to lessen the negative claims experience for future years, staff recommends the additional contribution of $116,000 for Pool B be applied to their PY 2014-2015 and 2015-2016 premium. A three year term was chosen as this is the minimum requirement for a new member joining CJPRMA.

Staff recommends that the NCCSIF be permitted to change its retained limit to $500,000 for program year 2013-2014 and contribute an additional premium of approximately $116,000 making their total contribution to Pool B $312,543.

Fiscal Impact:

1. Additional deposit contribution in Pool B of approximately $312,543.

Exhibits:

None.

Liability Program Confidence Level Funding

TOPIC: NCCSIF currently funds losses for future payments at the 60% confidence level for the Liability programs. What this means is that NCCSIF is confident that 6 out of 10 times, we have funded those programs adequately. NCCSIF has funded their program at different confidence levels since inceptions. Most recently the confidence levels for the last 10 years have been:

- 2003/2007 = 70%
- 2008/2012 = 60%

DISCUSSION POINTS:

1. Review of Equity in Liability Program
2. Review of actual expected losses to projected losses
3. How will the change in the confidence level impact members' contributions?

OBJECTIVE: To determine if NCCSIF should adjust the current 60% Confidence Level for future payments of Liability losses.

ACTION(s)/DELIVERABLE(s):

1. The Board of Directors request Staff to provide estimated Funding Calculations at difference Confidence Levels at the January Board of Directors meeting based on the current Actuarial report used for 2012/13 funding.
2. The Board also request Staff to review the current Workers' Compensation Equity balance to determine if funds are available to offset the increased costs to fund the Workers' Compensation program at a higher confidence level.

DEADLINE(s):

1. January 24, 2013 2. January 24, 2013.

FINANCIAL IMPACT:

1. Unknown. 2. Unknown.

RESPONSIBILITY:

2. Program Administrator 2. Program Administrator.

ATTACHMENT: Funding Analysis

NCCSIF
Northern California Cities Self Insurance Fund

LIABILITY CONFIDENCE LEVEL ANALYSIS

NCCSIF currently funds *current year* (2012/2013) expected losses at the 60% confidence level and discounts rates by 2%.

The following table shows the additional funding required at a 70% confidence level and at various discount rates.

	60%	70%	ADDITIONAL FUNDING
3.0%	N/A	N/A	N/A
2.5%	N/A	N/A	N/A
2.0%	$2,851,000	$3,260,000	$409,000
1.5%	$2,881,000	$3,294,000	$413,000
1.0%	$2,911,000	$3,328,000	$417,000

	60%	75%	ADDITIONAL FUNDING
3.0%	N/A	N/A	N/A
2.5%	N/A	N/A	N/A
2.0%	$2,851,000	$3,506,000	$655,000
1.5%	$2,881,000	$3,543,000	$662,000
1.0%	$2,911,000	$3,580,000	$669,000

Liability Program Discount Funding for Investment Income

TOPIC: NCCSIF currently discounts Liability expected losses as determined by our Actuary by 2% to offset investment income earned on our investments. With interest rates at an all time low, NCCSIF should review the discounting practices as they relate to actual investment income to determine appropriate discount levels for future funding.

At today's meeting, NCCSIF's actuary Mike Harrington from Bickmore and Ted Piorkowski from Chandler Asset Management will provide the Board with information that will assist with the discussion points below.

DISCUSSION POINTS:

1. Review of interest earned on investments for the past 5 years as compared with discount rate amounts NCCSIF has used for funding losses in the banking and shared risk layers.
2. Review the payout pattern for Liability claim payments made or settled.
3. What are other primary JPAs using as discount factors?
4. How will the change in the discount funding impact members' contributions?

OBJECTIVE: To determine if NCCSIF should adjust the current Discount Funding percentage of 2% for Investment Income. NCCSIF reduced the discount rate from 3% to 2% for the 2012 coverage year.

ACTION(s)/DELIVERABLE(s):

1. Staff will provide estimated Funding Deposit Calculations at difference Discount Funding percentages at the January Board of Directors meeting.
2. Staff will provide calculations that will show if funds from the Workers' Compensation Equity are available to offset the increased costs to fund the liability program at a lower discount rate.

DEADLINE(s):

1. January 24, 2013 2.January 24, 2013.

FINANCIAL IMPACT: Unknown.

RESPONSIBILITY:

1. Program Administrator 2.Program Administrator.

ATTACHMENT: Funding Analysis

NCCSIF
Northern California Cities Self Insurance Fund

NCCSIF LIABILITY DISCOUNT RATES ANALYSIS

NCCSIF currently discounts Current Year and Outstanding Year expected losses at 3%.

Future earnings estimate from Chandler Asset Management are 1.25%.

The following table shows Outstanding Liabilities and the additional funding that would reduce Net Assets if the discount rate were changed.

	OUTSTANDING LIABILITES	INCREASE IN FUNDING	CURRENT YEAR @ 60% CONFIDENCE LEVEL	INCREASE IN FUNDING	ADDITIONAL FUNDING REQUIRED
3%	N/A	N/A	N/A	N/A	N/A
2.5%	N/A	N/A	N/A	N/A	N/A
2.0%	$8,072,000	N/A	$2,851,000	N.A	$0
1.5%	$8,140,000	$ 68,000	$2,881,000	$30,000	$ 98,000
1.0%	$8,206,000	$134,000	$2,911,000	$60,000	$194,000

	OUTSTANDING LIABILITES	INCREASE IN FUNDING	CURRENT YEAR @ 70% CONFIDENCE LEVEL	INCREASE IN FUNDING	ADDITIONAL FUNDING REQUIRED
3%	N/A	N/A	N/A	N/A	N/A
2.5%	N/A	N/A	N/A	N/A	N/A
2.0%	$8,072,000	N/A	$3,260,000	N.A	$0
1.5%	$8,140,000	$ 68,000	$3,294,000	$413,000	$481,000
1.0%	$8,206,000	$134,000	$3,328,000	$417,000	$551,000

	OUTSTANDING LIABILITES	INCREASE IN FUNDING	CURRENT YEAR @ 75% CONFIDENCE LEVEL	INCREASE IN FUNDING	ADDITIONAL FUNDING REQUIRED
3%	N/A	N/A	N/A	N/A	N/A
2.5%	N/A	N/A	N/A	N/A	N/A
2.0%	$8,072,000	N/A	$3,506,000	$655,000	$655,000
1.5%	$8,140,000	$ 68,000	$3,543,000	$692,000	$760,000
1.0%	$8,206,000	$134,000	$3,580,000	$729,000	$863,000

Excess Liability Pooling Partners

TOPIC: NCCSIF has purchased Excess Liability coverage from CJPRMA since 1993. CJPRMA provides $40,000,000 in limits excess of NCCSIF's $1,000,000 Self Insured Retention.

This time has been allocated to allow members to discuss "What is Working Well and What Isn't" with CJPRMA.

DISCUSSION POINTS:

- What will be the increase in cost to decrease the SIR from $1,000,000 to $500,000 SIR?
- Are there any concerns with CJPRMA**?**
  - Financial?
  - Cost?
  - Claims Handling?
  - Coverage?
  - Service?
- What next steps should NCCSIF take if there are issues?
- What are programs/services that CJPRMA can assist NCCSIF members as respects risk transfer, risk management, training or other services?

OBJECTIVE: To determine if there are any items that need to be address with respects to NCCSIF's Excess Liability coverage purchased from CJPRMA.

ACTION(s)/DELIVERABLE(s):

1. Staff to advise CJPRMA of intent to decrease SIR from $1,000,000 to $500,000.
2. Staff to obtain quotations for funding the $500 xs $500 layer from the insurance market.

DEADLINE(s):

1. 12/31/12 - completed
2. 4/1/13

FINANCIAL IMPACT:

1. None
2. Unknown – Estimated $350,000.

RESPONSIBILITY:

1. Program Administrator
2. Program Administrator

Liability Retrospective Rating Program

TOPIC: NCCSIF has a retrospective rating program for both the Banking and Shared Risk Layers. P&P A-1 address the Banking Layer Fund adjustments and P&P A-12 details the Shared Risk Fund Adjustments.

DISCUSSION POINTS:

1. Review historical dividends declared.
2. Review dividends declared and equity available at the time dividends were declared.
3. Are any changes necessary to these plans?
4. Does the Assessment provision need any improvements?

OBJECTIVE: To determine if NCCSIF should considering revising Policy and Procedures A-1 and A-12 with respects to the Banking and Shared Risk Layers Retrospective Rating Program.

ACTION(s)/DELIVERABLE(s): The Board of Directors did not have any issues to discuss regarding this topic, and requested Staff to provide recommendations to the Board of Directors at the January 2013 meeting.

DEADLINE(s): January 24, 2013.

FINANCIAL IMPACT: Unknown.

RESPONSIBILITY: Program Administrator.

ATTACHMENT: Red-Line Strike out of Bylaws, P&P A-1 and P&P A-12

NCCSIF

BYLAWS

NCCSIF BYLAWS
Table of Contents

		Page
Preamble		1
Section 1	The Authority	1
Section 2	Definitions	1
Section 3	Meetings of the Board of Directors	2
Section 4	Executive Committee	3
Section 5	Officers of the Authority	5
Section 6	Committees	5
Section 7	Program Director and Other Staff	5
Section 8	Responsibilities of the Authority	6
Section 9	Insurance Coverage	6
Section 10	Accounts and Records	7
Section 11	Responsibilities for Funds and Property	7
Section 12	Development, Implementation & Funding of Coverage Program	8
Section 13	New Members	9
Section 14	Withdrawal	10
Section 15	Termination and Distribution	10
Section 16	Effect of Withdrawal or Termination	10
Section 17	Claims Administration	11
Section 18	Budget	11
Section 19	Disbursement of Funds	12
Section 20	Separation of Programs	12
Section 21	Program Deposits	12
Section 22	Program Year Adjustments	12
Section 23	Coverage Documents	13
Section 24	Amendments	13

BYLAWS
OF THE
NORTHERN CALIFORNIA CITIES SELF INSURANCE FUND
(RESTATED AS OF OCTOBER 5, 1999)
(AMENDED AS OF JUNE 16, 2000)
(AMENDED AS OF JANUARY 24, 2013)

PREAMBLE

These Bylaws are adopted pursuant to the "Joint Exercise of Powers Agreement of the Northern California Cities Self Insurance Fund (Restated as of October 5, 1999 "("the Agreement"). These Bylaws, supersede the Bylaws of the Northern California Cities Self Insurance Fund ("NCCSIF") which were adopted by a resolution of NCCSIF's Board of Directors on December 8, 1987, and which were subsequently amended as of April 22, 1988. Because of a contemporaneous restatement of the Agreement due to restructuring of the NCCSIF organization, the need to make additional amendments to NCCSIF's Bylaws and the desirability of incorporating all changes in a single instrument, NCCSIF's Bylaws are restated as of October 5, 1999.

SECTION 1
The Authority

A. - Name of Authority. The name of the Authority created by the Agreement shall be the Northern California Cities Self Insurance Fund (the "Authority").

B. - Office of Authority.

The principal office of the Authority shall be fixed and located at:

Alliant Insurance Services, Inc.
1792 Tribute Road, Ste 450
Sacramento, CA 95815

or at such other location as the Board of Directors may designate by resolution."

C. - Fiscal Year. The fiscal year for the Authority shall commence July 1 of each calendar year and end June 30 of the following calendar year.

SECTION 2
Definitions

A. "Agreement" shall mean the restated Joint Exercise of Powers Agreement creating the Northern California Cities Self Insurance Fund.

B. "Authority" shall mean the Northern California Cities Self Insurance Fund (sometimes also referred to in the Agreement as the "NCCSIF") created by and existing under the Agreement.

C. "Board of Directors" shall mean the principal governing body of the Authority.

D. "Bylaws" shall mean the adopted Bylaws of the Authority as amended and/or restated in their latest approved form.

E. "Deposit" shall mean all the components comprising the annual costs of each program including: banking fund deposits, Shared Risk Layer deposits, administrative costs, excess premiums, taxes and fees.

F. "Executive Committee" shall mean the Executive Committee of the Authority's Board of Directors.

G. "Coverage Program" shall mean any program of the Authority providing coverage against losses to Member Entities who are participants in the program whether the coverage is based upon purchased insurance, self-insurance, pooled funding or any other similar mechanism, instrument or facility.

H. "Member Entity" shall mean a city government which is party to the Agreement.

I. "Program Director" shall mean the individual or firm retained by the Board of Directors to administer the Authority.

SECTION 3
Meetings of the Board of Directors

A. A majority of the membership of the Board of Directors shall constitute a quorum for the transaction of business. Each member of the Board shall have one vote. Except as otherwise provided in these Bylaws or any other duly executed agreement of the members, action of the Board shall require the affirmative vote of a majority of the members present and voting.

B. The Board shall hold at least one regular meeting each year and shall provide for such other regular meetings and for such special meetings as it deems necessary.

C. The Secretary of the Authority shall provide for the keeping of minutes of regular and special meetings of the Board, and shall endeavor to provide a copy of the minutes to each member of the Board prior to the next scheduled meeting.

E. All meetings of the Board shall be called, noticed, held and conducted in accordance with the provisions of Ralph M. Brown Act (Government Code Section 54950 et seq.).

SECTION 4
Executive Committee

A. - Membership. The Executive Committee shall be composed of seven (7) *voting and* two (2) *non-voting* members of the Board of Directors or their alternates. The President, Vice President, immediate Past President and Secretary shall serve as *voting* members on the Executive Committee. The remaining three (3) *voting* members shall be elected by the Board of Directors on a member rotation basis, as established by the Board of Directors. The two (2) non-voting members shall be comprised of the Treasurer and the CJPRMA Board Representative. The President shall act as Chairman.

B. - Term. The terms of all members of the Executive Board shall be two (2) years, except for those of the President, Vice President, immediate Past President and Secretary, who shall all serve for one (1) year. A member may be reappointed to serve on the Executive Committee, except for the immediate Past President.

C. - Powers, Duties and Responsibilities.

1. The Executive Committee shall conduct, direct and supervise the day-to-day business of the Authority and in doing so shall exercise the powers expressly granted to it by the Agreement, these Bylaws and as otherwise delegated by the Board of Directors.

2. The following duties and responsibilities shall be assumed and carried out by the Executive Committee, which shall have all powers necessary for those purposes:

a. Provide general supervision and direction to the Program Director;

b. Authorize payment of claims against the Authority; provided, however, that with respect to claims arising under coverage programs operated by the Authority, claim settlement authority shall be in accordance with the policies and procedures governing the particular program;

c. Enter into contracts, within budget limits;

d. Make payments pursuant to previously authorized contracts, within budget limits; this Authority includes the power to authorize and reimburse expenses incurred for budgeted activities, within budget limits;

e. Review and recommend a budget to the Board no later than seventy-two (72) hours prior to the spring meeting of the Board;

f. Act as Program Director in the absence of the Program Director;

g. Recommend policies and procedures to the Board for implementation of the Agreement, the Bylaws and the operation of specific coverage programs; and

h. Appoint a nominating committee for each election of officers and members of the Executive Committee.

i. Amend annual budget in an amount not to exceed the contingency account.

3. Subject only to such limitations as are expressly stated in the Agreement, these Bylaws or a resolution of the Board of Directors, the Executive Committee shall have and be entitled to exercise all powers which may be reasonably implied from powers expressly granted and which are reasonably necessary to conduct, direct and supervise the business of the Authority.

D. - Meetings

1. Regular Meetings. Regular meetings shall be held at times, as the Executive Committee deems appropriate.

2. Special Meetings. Special meetings of the Executive Committee may be called by the Chairman or a majority of Executive Committee members, in accordance with the provisions of California Government Code Section 54956.

3. Public Meetings. All meetings of the Executive Committee shall be open to the public, except as provided by law.

4. Quorum. Four (4) members of the Executive Committee shall constitute a quorum for the transaction of business. Except as otherwise provided, no action may be taken by the Executive Committee except by affirmative vote of not less than a majority of those Executive Committee members present. A smaller number may adjourn a meeting.

5. Removal From Executive Committee. A member may be removed from the Executive Committee in the following ways:

a. Death of a Committee member;

b. Voluntary resignation;

c. Absence from three (3) consecutive meetings without a valid reason, in which case the Chair may recommend to the Executive Committee that member be terminated from Executive Committee membership. If the Executive Committee recommends to the Board of Directors that an Executive Committee member be terminated, the Board of Directors shall vote on the matter at its next regularly scheduled meeting.

d. When a vacancy occurs under the above provisions, a replacement shall be made from among the Board of Directors.

SECTION 5
Officers of the Authority

A. The officers of the Authority shall be a President, Vice President, Secretary, and Treasurer Officers so appointed shall serve at the pleasure of the Board of Directors. The president shall chair meetings to the Board of Directors and Executive Committee; the vice president shall act in the place of the president in the president's absence. The secretary shall keep and maintain minutes of the Board meetings and Executive Committee meetings, or to direct the keeping and maintaining of such minutes, and to promptly report minutes of meetings to all members as soon as practicable after the meeting has concluded. The treasurer's duties are as described in Sections 11 and 12 of the Bylaws. Other responsibilities may be set forth by the Board of Directors.

B. The President, Vice President and Secretary shall be elected by the Board of Directors and shall serve one (1) year terms. No officer shall serve for more than two (2) complete consecutive terms in his or her respective office. The terms of each office will ordinarily commence on January 1st of each calendar year, except that if an election has not been conducted by that date, the terms shall commence as soon as the election has been held. The terms of each office shall end on December 31st of the calendar year, except that if the election of the officers to serve the next succeeding term has not been conducted, the incumbent officers shall continue to hold their offices until the election has been conducted.

C. The Treasurer shall be appointed by the Board of Directors and, unless the Board of Directors determines otherwise, the Treasurer shall serve at the Board of Directors' pleasure. The Treasurer shall be an officer or employee of a Member Entity or a Certified Public Accountant.

D. The Board of Directors may create such other offices and appoint such other officers as it deems necessary and advisable.

SECTION 6
Committees

Committees may be formed as necessary by either the Board of Directors or the Executive Committee for the purposes of overseeing any functions that the Board or Executive Committee has authority to control, such as, but not limited to, administration and policy direction, claims administration, investments, safety/loss control, etc.

SECTION 7
Program Director and Other Staff

A. The Board of Directors shall appoint a Program Director who shall be responsible for the general administration of the business and activities of the Authority as directed by the Executive Committee.

B. Subject to the direction of the Board of Directors, the Executive Committee shall provide for the appointment of such other staff of the Authority as may be necessary for the administration of the Authority. Supervision of staff is delegated to the Executive Committee.

C. The Program Director and other staff of the Authority shall have such powers, duties and obligations as are established by the Agreement, these Bylaws, the policies, procedures and rules promulgated by the Authority and any contractual arrangements which may exist between the Authority and the respective party.

D. Subject to any applicable contractual arrangement which may take precedence, the Program Director shall serve at the will and pleasure of the Board of Directors.

SECTION 8
Responsibilities of the Authority

The Authority shall perform the following functions in discharging its responsibilities under this agreement:

A. Develop, implement and maintain coverage programs;

B. Assist each Member Entity's designated risk manager with the risk management functions including: loss control, risk transfer, and employee safety programs.

C. Provide loss prevention and safety services to the Member Entities;

D. Provide claims adjusting and claims management services as required;

E. Provide statistical reports to the Member Entities;

F. Recommended standard contract clauses relating to indemnity, hold harmless, insurance and other similar matters affecting Members Entities; and

G. Provide other services consistent with purposes of the Authority as may be deemed necessary, advisable and beneficial to the Member Entities.

SECTION 9
Insurance Coverage

The Authority shall maintain insurance coverage on its activities as determined by the Executive Committee to be necessary and adequate.

SECTION 10
Accounts and Records

A. Annual Budget - The Authority shall adopt an annual budget that shall include a separate budget for each separate coverage program under development or adopted and implemented by the Authority. The Executive Committee shall cause to be prepared, shall review and approve and shall recommend a proposed annual budget to the Board of Directors for its consideration. The recommended budget shall be submitted to the members of the Board of Directors not later than seventy-two (72) hours prior to the Board of Directors' spring meeting.

B. Funds and Accounts - As directed by the Executive Committee, the Treasurer of Authority shall establish and maintain such funds and accounts as may be required by law and generally accepted accounting principles. Separate accounts shall be established and maintained for each coverage program under development or adopted and implemented by the Authority. Books and records of the Authority in the hands of the Treasurer shall be open to inspection at all reasonable times by authorized representatives of Member Entities. A quarterly unaudited financial statement will be produced and distributed to all Member Entities. The Authority shall adhere to the standard of strict accountability for funds set forth in Government Code Section 6505 and Governmental Accounting Standards Board (GASB) Statement No. 10.

C. Treasurer's Report - The Treasurer, within one hundred and twenty (120) days after the close of each fiscal year, shall give a complete written report of all financial activities for such fiscal year to the Board and to each Member Entity.

D. Annual Audit - Pursuant to Government Code Section 6505, the Authority shall contract with an independent certified public accountant to make an annual fiscal year audit of all accounts and financial statements of the Authority, conforming in all respects with the requirements of that section. A report of the audit shall be filed as a public record with the County Auditor of each Member Entity within six (6) months of the end of the fiscal year under examination. Costs of the audit shall be considered a general expense of the Authority.

SECTION 11
Responsibilities for Funds and Property

A. The Treasurer shall have custody of and disburse the Authority's funds. The Treasurer may direct the activities of the accounting function.

B. Pursuant to Government Code Section 6505.5, the Treasurer shall:

1. Receive and acknowledge receipt for all funds of the Authority and place them in the treasury of the Treasurer to the credit of the Authority;

2. Be responsible upon his or her official bond for the safekeeping and disbursement of all Authority funds so held by him or her;

3. Pay any sums due from the Authority, as approved for payment by the Board of Directors or by any body or person to whom the Board has delegated approval authority, making such payments from Authority funds upon warrants drawn by the Treasurer and signed by persons designated in Section 20 of these Bylaws;

4. Verify and report in writing to the Authority and to Member Entities, as of the first day of each quarter of the fiscal year, the amount of money then held for the Authority, the amount of receipts since the last report, and the amount paid out since the last report.

C. Pursuant to Government Code Section 6505.1, the Program Director, the Treasurer and such other persons as the Board of Directors may designate shall have charge of, handle and have access to the property of the Authority.

D. The Authority shall secure and pay for a fidelity bond or bonds, in an amount or amounts and in form specified by the Board of Directors, covering the Treasurer and all other officers and staff of the Authority who are authorized to hold or disburse funds of the Authority, and all other officers and staff who are authorized to have charge of, handle, and have access to property of the Authority.

E. The Treasurer shall invest funds in accordance with the approved investment policy of the Authority.

SECTION 12
Development, Implementation and Funding of Coverage Program

A. Program Coverage - The Authority may develop and implement Coverage Programs, which the Authority deems necessary, advisable and beneficial to Member Entities. Subject to any Coverage Program's applicable underwriting rules and other qualifying conditions, each Member Entity shall be eligible to apply for membership and participation in any Coverage Program conducted by the Authority.

B. Coverage Program and Authority Funding - The Member Entities developing or participating in a Coverage Program shall fund all costs of that program, including administrative costs, as hereinafter provided. Costs of staffing and supporting the Authority, hereinafter called Authority general expenses, shall be equitably allocated among the various programs and shall be funded by the Member Entities developing or participating in such programs in accordance with such allocations, as hereinafter provided.

1. Development Charge. Development cost of a coverage program shall be funded by a development charge as fixed by the Executive Committee. The development charge shall be paid by each Member Entity which wishes to join in development of the program, after receipt of information as estimated on the cost and scope of the program and thereby reserve the option to participate in the program following its adoption by the Board of Directors. Development costs are those costs incurred by the Authority in developing a coverage program for review and adoption by the Board of Directors, including but not limited to: research, feasibility studies,

information and liaison work among Entities, preparation and review of documents, and actuarial and risk management consulting services. The development charge may also include an equitable share of Authority general expenses incurred in the development functions. Upon the conclusion of program development: any deficiency in development funds shall be billed to all Member Entities which have paid the development charge, on a pro-rata or other equitable basis, as determined by the Executive Committee; and any surplus in such funds shall be transferred into the loss reserve fund for the program, or, if the program is not implemented, into the Authority's general fund. Future Members may be charged a Fee for development as part of the Entry Fee determined by the Executive Committee.

2. Deposits. Except as provided in Item 3 below, all post development costs of a Coverage Program shall be funded by annual deposits charged to the Member Entities participating in the Coverage Program each policy year, and by interest earnings on the fund so accumulated. Deposits shall be determined annually by the Executive Committee and based upon policy and procedures developed by the Authority with the assistance of an actuary at least every other year, and risk management consultant or other qualified person. The deposit for each participating Member Entity shall include the Member Entity's share of expense program losses, program excess insurance or reinsurance costs, and program administrative costs for the year plus that Member Entity's share of Authority general expense allocated to the program. Deposits shall be billed by the Authority at the beginning of each policy year and shall be payable as set forth in Section 22 of these Bylaws. Any deficiency or surplus in the deposit paid by a participating Entity shall be adjusted pursuant to policy and procedures adopted by the Authority.

3. Assessability. For any program year, the Board of Directors may impose assessments on the program members for that year which, in total amount, will assure adequate funds to the Authority for the payment of all losses.

This applies whether a member has subsequently withdrawn or been expelled from the Authority.

SECTION 13
New Members

A city which is not a Member Entity may become a party to the Agreement only upon approval of two-thirds (2/3) of the Board of Directors and by paying an appropriate entry fee or charge as established by the Executive Committee. The Board of Directors may condition its approval upon the proposed new member's ability to satisfy the underwriting criteria and other qualifying conditions which may then be in effect for any coverage program in which the proposed new Member Entity wishes to participate. The Board may prorate deposits and/or the coverage period for entities entering any coverage program at other than the beginning of the Authority's program year.

SECTION 14
Withdrawal

A. An Entity which enters any coverage program shall not withdraw from that program or as a party to the Agreement or the Authority for a three-year period commencing with its entrance into said program.

B. After the initial three (3) year noncancellable commitment to any coverage program, a Member Entity may withdraw only at the end of the Program Year, provided it has given the Authority a six (6) month written notice of its intent to withdraw from the program. The written notice of its intent to withdraw from the program is non-revocable."

C. Any member Entity which withdraws as a participant of any coverage program pursuant to item B of this Section shall not be reconsidered for participation in the program until the expiration of three (3) years from the Member Entity's withdrawal.

D. Member Agencies that withdraw from NCCSIF's Liability and or Worker's Compensation plans, agree that any available funds' allocated to them in the Shared Risk Layer, will remain with NCCSIF until such time as the "Program Year" is closed. This includes funds allocated to them via the "Shared Risk Plan Layer Adjustment" or any other manner of distribution other than the declaration of a dividend by the Board or in accordance with distribution described in the Joint Powers Agreement upon the dissolution of NCCSIF. Funds available from the Banking Layer to these Members are available for distribution.

If a "Program Year" is not yet closed and the "Participating Member" would otherwise be eligible for a distribution, a Member that has withdrawn from the "Authority" may annually, in writing, request a early release of their funds for consideration by the Board of Directors. This action will require approval of the Board of Directors as specified in the JPA Bylaws, Section 3, paragraph A.

SECTION 15
Termination and Distribution

A. This Agreement may be terminated by the written consent of three-fourths (3/4) of the Member Entities; provided, however, that the Agreement and the Authority shall continue to exist for the purpose of disposing of all claims, distribution of assets and any other functions necessary to wind up the affairs of the Authority.

B. Upon termination of the Agreement, all assets of the Authority shall be distributed only among the parties which have been participants in its Coverage Programs, including any of those parties which previously withdrew pursuant to Section 15 of these Bylaws and in accordance with the terms and conditions of these Bylaws. Distribution will be made within six (6) months

after the last pending claims or covered loss subject to the Agreement has been finally resolved and will be in proportion to the contributions made.

C. The Board is vested with all powers of the Authority for the purpose of concluding and dissolving the business affairs of the Authority. These powers shall include the power to require Member Entities, including those which were program participants at the time the claims arose or at the time the covered loss was incurred, to pay their share of any cash assessment deemed necessary by the Board for final disposition of all such claims and covered losses subject to the Agreement.

SECTION 16
Effect of Withdrawal or Termination

A. The expulsion or withdrawal of any member Entity after the inception of its participation in any coverage program shall not terminate its responsibility to:

1. Cooperate fully with the Authority in determining the cause of losses and in the settlement of claims, as defined in the coverage Agreement;

2. Pay any Deposit increases or assessments determined by the Board to be due and payable for each coverage program to which it participated;

3. Provide the Authority with such statistical and loss experience data and other information as may be necessary for the Authority to carry out the purposes of the Agreement; and

4. Cooperate with and assist the Authority and any insurer, claims adjuster or legal counsel retained by the Authority, in all matters relating to the Agreement.

Withdrawal of a member shall not be considered as a completion of the purpose of this agreement and shall not require the repayment or return to the withdrawing member agency of all or any part of any contributions, payments or advances made by the parties unless the agreement is rescinded or terminated as to all parties; however, when funds earmarked for program years in which the member agency participated are returned, the member will be entitled to its pro rata share (as determined by the Board of Directors) for its years of participation.

SECTION 17
Claims Administration

A. All claims shall be reported to the Claims Administrator in accordance with the Coverage Program claims reporting procedures.

B. All claims with potential penetration into the risk sharing portion of the Authority's programs will be presented to the Board (or claims committee) by the Claims Administrator and updates provided at regularly scheduled Board (or committee) meetings. The Authority has the right and power to direct the adjustment and settlement of a claim(s) penetrating the risk sharing

layer which in the opinion of the Board or Claims Committee, have a reasonable probability of penetrating the risk sharing layer.

C. All claims with potential penetration into any excess coverage joint powers authority or excess insurance carrier shall be reported in accordance with their guidelines.

D. Claims administration shall be audited at least every other year.

E. Member entities shall be responsible to maintain the confidentiality of any records which are privileged from disclosure under California law. This shall include taking reasonable steps to prevent the inadvertent disclosure of confidential records.

SECTION 18
Budget

The budget shall be presented at the spring meeting and adopted by the Board on or before June 30 of each year and shall separately show the following:

A. General and administrative costs;
B. Loss Control/Risk Management costs;
C. Deposits, projected interest income, and other income; and
D. The estimated claims and allocated claims adjustment expense.

SECTION 19
Disbursement of Funds

All disbursements under $5,000 shall have approval and signature of the Treasurer, or the President in the Treasurer's absence. All disbursements over $5,000 shall require two (2) of the four (4) officers' signatures. A register of all checks issued since the last Board meeting shall be provided as a part of the Treasurer's report at the subsequent Board meeting and approved by the Board.

The Workers Compensation Claims Administrator shall have the responsibility and authority to issue checks from the Authority's trust account in satisfaction of legal requirements to pay benefits to industrially injured workers of the member cities. The Administrator will issue checks for state mandated benefits including Indemnity, Medical, Rehabilitation and Expense categories. For checks below $5,000, one authorized signature or stamp from the administrator is required. For checks above $5,000, two signatures are required.

The Liability Claims Administrator shall have the responsibility and authority to issue checks from the Authority's trust account to pay liability claims and defense costs as agreed upon and approved by the Member City and/or the Claims Committee, as appropriate. For checks below $5,000, one authorized signature or stamp from the administrator is required. For checks above $5,000, two signatures are required.

SECTION 20
Separation of Programs

Each coverage program of the Authority shall be autonomous. Members shall participate only in the coverage programs so authorized by City Council resolution.

SECTION 21
Program Deposits

Program deposits shall be sufficient to cover the budget for each fiscal year of the program. Program deposits for each fiscal year shall be calculated according to the deposit calculation formulas adopted by the Board.

Deposits are due and payable immediately upon commencement of the Liability Plan year and quarterly for the Workers' Compensation Plan. Deposits are considered delinquent if not received by the Treasurer within thirty (30) days.

SECTION 22
Program Year Adjustments

Prior to the beginning of each program year, adjustments shall be calculated in accordance with the policy and procedure adopted by the Board of Directors.

SECTION 23
Coverage Documents

Each Member Entity participating in a coverage program of the Authority shall be provided with either a Memorandum of Coverage or an insurance policy, as the case may be, which shall describe in detail the nature of the applicable coverage, including dollar amounts, together with any deductibles, exclusions, limitations or other provisions of the coverage.

SECTION 24
Amendments

A. These Bylaws may be amended by a two-thirds vote of the Board of Directors present and voting at a regular meeting provided that any amendment is compatible with the purposes of the Authority, is not in conflict with the Agreement and has been submitted to the Board at least 30 days in advance. Any such amendment shall be effective immediately, unless otherwise designated.

ADMINISTRATIVE POLICY AND PROCEDURE #A-1

SUBJECT: BANKING LAYER PLAN FUND ADJUSTMENTS

Policy Statement:

It shall be the policy of the Northern California Cities Self Insurance Fund to review annually each Plan's financial status and to evaluate the appropriateness for declaring either a refund or an assessment to Member Agencies.

When so determined to be fiscally responsible by the Board of Directors, the adjustments shall be in accordance with the provisions outlined in this policy and procedure.

Provisions:

1. The refund/assessment calculations shall be performed annually and presented to the Board of Directors at its meeting in April.

2. The "Total Equity" at December 31, "Gross Equity" at December 31, "Outstanding Claims Liabilities" at December 31, "Buffer Allocation" and "Net Equity" shall be used for purposes of calculating any adjustments.

The "Total Equity" shall be that figure in the Financial Consultants Financial Report representing total equity at December 31.

The "Outstanding Claims Liabilities" shall be that figure developed by the Financial Consultant based on the Actuarial Report and IBNR factors, which represents the total amount of reserves on open claims and Incurred But Not Reported (IBNR) at the 90% Confidence Level, at December 31.

The "Gross Equity" shall be the sum of the "Total Equity" minus the "Outstanding Claims Liability at the 90% Confidence Level."

The "Buffer Allocation" shall be the allocation among Members Agencies with a positive "Gross Equity" of the sum of the negative "Gross Equity" and 10 times the Banking Layer Limit.

The "Net Equity" shall be the sum of the "Gross Equity" minus the "Buffer Allocation"

Assessments:

1. A Member Agency reflecting a negative "Gross Equity" shall be required to pay to the Treasurer twenty percent (20%) of the negative amount in two installments due September 15 and December 15 in the year is which the Assessment is declared. If 20% of the negative "Gross

Equity" is less than $10,000, than the full amount will be paid to NCCSIF in the first installment of September 15 rather than two installments.

2. A Member Agency failing to meet the payment schedule above shall be charged interest in the manner and amount earned on funds deposited in LAIF.

Refunds:

1. A Member Agency shall be eligible for a refund by meeting the following conditions:

   A. Participation in the Plan for three years

   B. A positive Plan "Net Equity"

2. The Amount available to be refunded shall be the "Net Equity" as determined annually by the Board of Directors.

3. Member Agencies may decline the refund and leave such funds or a portion of the funds in their account.

4. Members Agencies may elect to allocate the remaining amount available as follows:

   A. If funds are not being retained in their Account, then a negative balance in the other Program must first be offset

   B. If not used for "5." or "6a." above, remaining available funds, or any portion thereof, may be used to offset the next fiscal year deposits, or may be requested in the form of a check

Effective Date:	May 26, 1989
First Revision Date:	June 14, 1996
Second Revision Date:	June 13, 1997
Third Revision Date:	December 17, 1999
Fourth Revision Date:	December 15, 2000
Fifth Revision Date:	March 16, 2007
Sixth Revision Date:	December 13, 2007
Seventh Revision Date:	April 25, 2008
Eighth Revision Date:	January 24, 2013

ADMINISTRATIVE POLICY AND PROCEDURE # A-12

SUBJECT: SHARED RISK LAYER PLAN FUND ADJUSTMENTS

Policy Statement:

It shall be the goal of the Northern California Cities Self Insurance Fund (NCCSIF) to retain funds in the Shared Risk Layer Programs sufficient to meet an expected discounted level of "outstanding liabilities" plus a reasonable contingency margin, for all program years combined NCCSIF shall annually review the financial position for each open program based on NCCSIF's actuarial study, and evaluate the claims payment pattern to determine if the current assets and projected payments are sufficient to maintain the program liquidity. The review will evaluate the appropriateness for declaring either a refund or an assessment to Members.

When determined to be fiscally responsible by the Board of Directors, the adjustments will be in accordance with the provisions outlined in this policy and procedure.

Procedure:

1. The evaluation shall be performed annually and presented to the Board of Directors at its meeting in the spring of each year.

2. The "total assets" at December 31, "outstanding claims liabilities" at December 31 and "adjustment balance" will be used for the purposes of calculating any adjustments.

   - "total assets" shall be that figure in the auditor's financial Report representing total assets at June 30, minus claims paid between June 30 and December 31.

   - "outstanding claims liabilities" shall be that figure in the actuarial Review which represents the total amount of reserves on open claims and Incurred But Not Reported (IBNR) claims stated at an expected confidence level and optionally at a 60% and 70% confidence level, discounted or at present value, for open shared risk layer program years, but based upon the December 31, loss statistics.

   - "adjustment balance" shall be the sum for each applicable shared risk layer program year of the "total assets" minus the chosen "outstanding liabilities".

3. Refunds:

   A Member shall be eligible for a refund by meeting the following conditions:

   a. Participation in the plan for three years;
   b. Applicable program years determined separately for liability and workers' compensation results in a positive adjustment balance.

c. The amount to be refunded shall be a certain percentage of the "adjustment balance" as determined annually by the Board of Directors.

4. Assessments:

A Member will be assessed if the "adjustment balance" for the open Shared Risk Layer Program Years (determined separately for liability and workers' compensation) is/are negative. The amount of the assessment declared will be 100% of the deficit "adjustment balance". The amount of the assessment will be collected over a period of seven (7) years. The member shall be required to pay their proportional share for each program year in a deficit position. The proportional share is the Members' % of total contributions for that program year. Payment will be made as part of the September 15 program billings.

5. A Member failing to meet the payment schedule above shall be charged interest in the manner and amount earned on funds deposited in LAIF, at the time they are delinquent.

6. ~~6.~~ Refunds from positive years will first go to offset negative years before being refunded to Members.

7. Refunds from positive years will first go to offset negative years in another program before being refunded to Members.

8. **Effective July 1, 2013, "Participants" that withdraw from NCCSIF's Workers' Compensation plan, agree that any available funds' allocated to them in the Shared Risk Layer, will remain with NCCSIF until such time as the "Program Year" is closed. This includes funds allocated to them via the "Shared Risk Layer Plan Adjustment" or any other manner of distribution other than the declaration of a dividend by the Board or in accordance with distribution described in the Joint Powers Agreement upon the dissolution of NCCSIF. If a "Program Year" is not closed and the "Participating Member" would be eligible for a distribution, they may annually send a written request for release of their funds to the Board of Directors. This action will require approval of the Board of Directors as specified in the JPA Bylaws, Section 3, paragraph A.**

Effective Date: June 16, 2000

First Revision Date: April 11, 2003

Second Revision Date: January 24, 2013

"DRAFT" JANUARY 24, 2013 BOARD OF DIRECTORS AGENDA

ACTION ITEM

ISSUE: The Executive Committee is provided a copy of the "Draft" Agenda for the upcoming Board of Directors meeting for their review and discussion.

FISCAL IMPACT: TBD

RECOMMENDATION: The Executive Committee should review the attached "Draft" Agenda and provide staff with feedback.

BACKGROUND: Staff prepared a "Draft" of the agenda for the upcoming Board of Directors Meeting to be held on January 24, 2013. The meeting will be held at the Peach Tree Golf and Country Club in Marysville. We will be presenting these agendas to the Executive Committee for their review prior to finalizing for Board Meetings to incorporate issues the Executive Committee would like to add to the agendas.

ATTACHMENT(S): ***"****Draft"* Board of Directors Agenda.

NCCSIF
Northern California Cities Self Insurance Fund
A Joint Power Authority

NCCSIF
BOARD OF DIRECTORS
MEETING

Date: **Thursday, January 24, 2013**
Time: **12:00 p.m.**

Location: **Peach Tree Golf & Country Club**
2043 Simpson Dantoni Road
Marysville, CA 95901

A – Action
I – Information

1 – Attached
2 – Hand Out
3 – Separate Cover
4 – Verbal
5 – Previously Mailed

MISSION STATEMENT

The Northern California Cities Self Insurance Fund, or NCCSIF, is an association of municipalities joined to protect member resources by stabilizing risk costs in a reliable, economical and beneficial manner while providing members with broad coverage and quality services in risk management and claims management.

AGENDA

PRESENTATION

Time Certain 12:00 pm

1. Emerging Risks — I — 1
Michael Simmons will provide a presentation to the Board of Directors regarding Emerging Risks in the Insurance Industry.

A. CALL TO ORDER

B. PUBLIC COMMENTS
This time is reserved for members of the public to address the Board of Directors on matters pertaining to NCCSIF that are of interest to them.

C. APPROVAL OF AGENDA AS POSTED — A — 1

D. CONSENT CALENDAR — A — 1
All matters listed under the consent calendar are considered routine with no separate discussion necessary. Any member of the public or the Board of Directors may request any item to be considered separately.

1. Draft Minutes of the Board of Directors Meeting October 18, 2012
2. Check Register at December 31, 2012
3. Investment Reports
   a. Chandler Asset Management Report October, November, December 2012 Short/Long Term
4. Budget to Actual Report as of December 31, 2012

NCCSIF
Northern California Cities Self Insurance Fund
A Joint Power Authority

E. ACTION TAKEN BY THE EXECUTIVE COMMITTEE I 4

1. 2013 Executive Committee Rotation Schedule
The Committee approved the 2013 Executive Committee Rotation Schedule.

2. 2013 Nominating Committee and Nomination of Officers
The Committee appointed themselves as a Nominating Committee for election of officers and nominated officers for the 2013 Calendar Year.

3. Resolution 13-01 Authorizing Investment of Monies in LAIF
The Committee reviewed and recommends approval of Resolution 13-01 authorizing the new officers to deposit or withdraw monies in the Local Agency Investment Fund (LAIF).

4. Long Range Planning Session
The Committee reviewed and discussed the Long Range Planning Items and directed staff as necessary.

F. MINUTES AND REPORTS I 1

Minutes and/or summary reports are provided from the Committees noted below.

1. Risk Management Meeting January 24, 2013 – Verbal Report
2. Draft Minutes – Executive Committee Meeting January 9, 2013
3. Draft Minutes – Police Risk Management Committee Meeting January 10, 2013

G. ADMINISTRATION REPORTS I 4

1. President's Report
Liz Ehrenstrom will address the Board on items pertaining to NCCSIF.

2. Program Administrator's Report
Susan Adams will address the Board on items pertaining to NCCSIF.

H. FINANCIAL REPORTS

1. Quarterly Financial Report for Period Ending September 30, 2012 A 1
The Board of Directors will be asked to receive and file the report from James Marta and Company.

J. JPA BUSINESS

1. REVIEW OF ITEMS DISCUSSED DURING THE LONG RANGE PLANNING MEETING A 1
Staff will provide the Board with an update on the items discussed and direction given to staff at the Long Range Planning Session. The Board will be asked to review and discuss the Action Plan and recommend any changes as necessary.

A. WORKERS' COMPENSATION PROGRAM

1. Workers' Compensation Claims Administration
2. Workers' Compensation Self Inured Retention (SIR) Analysis
3. Financial Impact of Confidence Levels and Discounting Rates used in Determining Funding of Losses

i. Confidence Levels
ii. Discount Rates

4. Excess Pooling Partners
5. Retrospective Rating Dividends Program

B. LIABILITY PROGRAM

1. Liability Self Inured Retention (SIR) Analysis
2. Financial Impact of Confidence Levels and Discounting Rates used in Determining Funding of Losses

i. Confidence Levels
ii. Discount Rates

3. Excess Pooling Partners
4. Retrospective Rating Dividends Program

2. 2013 Governance

a. 2013 Executive Committee Rotation Schedule A 1
The Board of Directors will be asked to review and approve the 2013 Executive Committee Rotation Schedule.

b. 2013 Slate of Officers A 1
The Board of Directors will be asked to review and approve the 2013 Slate of Officers.

3. Resolution 13-01 Authorizing Investments of Monies in LAIF A 1
The Board of Directors will be asked to review and approve Resolution 13-01 authorizing the new officers to deposit or withdraw monies in the Local Agency Investment Fund (LAIF).

4. 2013/14 Insurance Market Update & Renewal Marketing Plan A 1
The Board of Directors will be asked to review and approve the 2013/14 Insurance Renewal Marketing Plan.

5. Governing Documents Amendments A 1

a. NCCSIF ByLaws Proposed Amendment
The Board of Directors will be asked to review and approve the recommendations to the NCCSIF Bylaws.

b. NCCSIF Target Equity Plan Amendment A 1
The Board of Directors will be asked to review and approve the recommended changes to NCCSIF Policies and Procedures A-1 and A-12.

6. Financial Solvency of Members A 1
The Board of Directors will be asked to discuss if any action needs to be taken to protect the organization against the Financial Solvency of members.

7. 2012/2013 NCCSIF Program Manual I 1
The 2012/2013 NCCSIF Program Manual will be distributed to members.

8. 2012 NCCSIF Annual Report I 1
The 2012 NCCSIF Annual Report will be distributed to members.

K. INFORMATION ITEMS

1. NCCSIF Board Members and Alternates
2. NCCSIF Meeting Calendar 2013
3. NCCSIF Travel Reimbursement Form
4. NCCSIF Resource Contact Guide
5. Annual PARMA Conference – Feb. 3-6, 2013 – Ranch Mirage, CA

L. ADJOURNMENT

UPCOMING MEETINGS
Executive Committee Meeting – March 14, 2013
Claims Committee Meeting – March 14, 2013
Board of Directors Meeting – April 25, 2013
Risk Management Meeting – April 25, 2013

NCCSIF
Northern California Cities Self Insurance Fund
A Joint Power Authority

Per Government Code 54954.2, persons requesting disability related modifications or accommodations, including auxiliary aids or services in order to participate in the meeting, are requested to contact Johnny Yang at Alliant Insurance at (916) 643-2712.

The Agenda packet will be posted on the NCCSIF website at www.nccsif.org. Documents and material relating to an open session agenda item that are provided to the NCCSIF Board of Directors less than 72 hours prior to a regular meeting will be available for public inspection and copying at 1792 Tribute Road, Suite 450, Sacramento, CA 95815.

Access to some buildings and offices may require routine provisions of identification to building security. However, NCCSIF does not require any member of the public to register his or her name, or to provide other information, as a condition to attendance at any public meeting and will not inquire of building security concerning information so provided. See Government Code section 54953.3