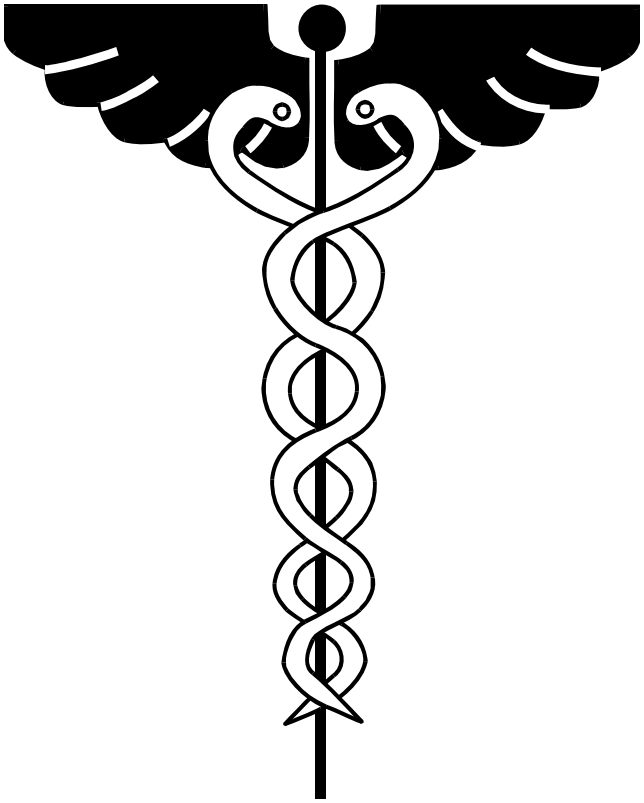
NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT

ANNUAL REPORT



AS OF

DECEMBER 31, 2005

GENERAL INFORMATION ABOUT EXCESS FUND COVERAGE LEVELS

The Act requires health care providers to submit proof of financial responsibility in the form of an underlying professional liability policy with specified coverage limits. When established in 1976, these limits were $100,000/300,000 for physicians or nurse anesthetists and $100,000/1,000,000 for hospitals. The Act also established a cap on the amount a plaintiff could recover from a qualified health care provider of $500,000. Subsequent legislation has changed this over the years:

- LB 692 passed by the 1984 Legislature raised the cap to $1,000,000 for incidents occurring after January 1, 1985.

- LB 1005 passed by the 1986 Legislature increased the amount of required underlying insurance to $200,000/600,000 for physicians or nurse anesthetists and $200,000/1,000,000 for hospitals effective January 1, 1987.

- LB 1006 passed by the 1992 Legislature then raised the cap to $1,250,000 for incidents occurring after January 1, 1993.

- LB 146 passed by the 2003 Legislature raised the cap to $1,750,000 for incidents occurring after January 1, 2004.

- LB 998 in 2004 raised the underlying coverage requirement to $500,000/$1,000,000 for all providers other than hospitals, and to $500,000/$3,000,000 for hospitals. The effective date of this change depended upon the provider's first qualification on or after January 2, 2005. For example, a provider renewing on July 1, 2005 had the increased coverage requirement applying on July 1, 2005, with $200,000 limits applying to medical incidents occurring before that date (even if the report of the incident may occur *after* that date). For providers with claims-made coverage, this meant that the premium impact of this change was phased in over a period of several years, as most claims in the couple of years immediately following this change will still have the prior $200,000 limits applying.

THE HISTORY OF SURCHARGE LEVELS

The Act became effective in 1976. As originally written, the Act placed a cap of $5 million on the assets of the Excess Fund. As this was approached, the surcharge for 1981 was reduced. A further reduction to the minimum surcharge of 1% was made for 1982 as the amount in the Excess Fund exceeded the cap. LB 692 passed during the 1984 Legislature modified the cap to allow for consideration of future claim costs. Following that, the surcharge was raised to 50% (the maximum allowed by the Act) for all categories effective January 1, 1985. This amount was reduced in succeeding years as experience was favorable and the total assets of the Excess Fund increased. This practice was reversed starting with January 1, 2001 as it became apparent that losses were increasing significantly and past loss reserves were developing upward. This trend changed again with the passage of LB 998 in 2004 (effective in 2005), which increased the underlying coverage requirement to $500,000 from $200,000. The current surcharge for 2006 is 45%.

Hospital Surcharge	Time Period	Surcharge for Physicians & Others
15%	Original	50%
10%	1-1-81	25%
1%	1-1-82 - 12-31-84	1%
50%	1-1-85 - 12-31-87	50%
50%	1-1-88	45%
45%	1-1-89	45%
40%	1-1-90	40%
35%	1-1-91	35%
40%	1-1-92 - 12-31-93	40%
30%	1-1-94 - 12-31-94	30%
15%	1-1-95 - 12-31-95	30%
10%	1-1-96 - 12-31-96	10%
5%	1-1-97 - 12-31-00	5%
20%	1-1-01 - 12-31-01	20%
35%	1-1-02 - 12-31-02	35%
50%	1-1-03 – 12-31-05	50%
45%	1-1-06 – Current	45%

Financial Status of the Excess Fund as of December 31, 2005

Balance January 1, 2005	$58,109,769
Excess Fund Surcharges (net refunds)	12,156,215
Residual Premiums (net refunds)	643,031
Interest/Dividends Earned	2,994,314
Investment Gain (Loss) less Investment Expense	704,692
Claims Payments during 2005	(13,861,619)
Claims Expenses during 2005	(264,749)
General Expenses during 2005	(133,643)
Balance December 31, 2005	$60,348,010

Liabilities of the Excess Fund

The aggregate liabilities of the Excess Fund are subject to significant uncertainty. Some of these sources of uncertainty are the same as those faced by insurers of medical professional liability – the long time to settlement and the uncertain outcome of cases. For the Excess Fund, the relatively small number of cases paid each year increases variability for purely statistical reasons. The Excess Fund has also faced uncertainties based on attempts to change the Excess Fund's coverage through litigation. Underscoring the potential variability of Fund results was a series of many claims that recently arose from Hepatitis "C" infections and a Fremont oncology clinic. While those cases are largely settled and no longer contribute to material uncertainty in the Fund's liabilities, they only underscore risks involved with the Fund.

The most recent evaluation of the Fund's liabilities was as of 6/30/2006, in which the Department's casualty actuary, Alan Wickman, estimated unpaid losses and unpaid loss adjustment expenses on a following-form basis, undiscounted for prospective investment income, of $41.5MM. Unearned premiums and surcharges as of 6/30/2006 were approximately $6.5MM, resulting in overall reserves of $48MM. These compared to overall reserves of $46MM that were estimated a year prior for 6/30/2005. With a bit of hindsight, the reserves as of 12/31/2005 are also estimated at $48MM. This implies an estimated cushion of approximately $12MM for unforeseen events and the possibility of under-reserving. As was demonstrated with the Hepatitis "C" cases, "events" can happen. In addition, about 5 years ago, it can now be seen (with hindsight) that we had been underestimating the liabilities of the Fund for a period of several years.

Over the course of the next few years, the impact of LB 998 will be felt. This raised the underlying coverage requirement to $500,000 on a phased-in basis starting on January 2, 2005. This will eventually have a substantial claims-related impact, but this will take several more years. On account of the phase in, the average effective date of the change was in the latter half of 2005. But this applied to occurrences, and not claim reports or payments. Owing to a two-year provision in the Act, a large percentage of claims are reported about two years following the medical incident. This means that it may not be until later in 2007 before most of the claims reported to the Excess Fund have a $500,000 underlying limit applying. Then, as a high percentage of cases involve litigation (or at least preparation for litigation), it is common for claims to take years before they are paid. As such, we can expect to see most of the claims paid for the Excess Fund involving the $200,000 underlying requirement until past 2010.

The more immediate effect of the change is that the underlying premiums paid by providers are now higher, which means that a given surcharge percentage will generate more income. This is a good thing for the Excess Fund, as previous projections of liabilities versus income at the $200,000 threshold with the maximum 50% surcharge showed that the Fund would steadily lose ground. Clearly, the increase was necessary.

SYNOPSIS OF RECEIPTS AND HEALTH CARE PROVIDERS PARTICIPATING UNDER THE NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT

Excess Fund

	Dec. 31, 2001	Dec. 31, 2002	Dec. 31, 2003	Dec. 31, 2004	Dec. 31, 2005
Physicians	3,078	3,248	3,389	3,474	3,533
Hospitals	81	89	93	102	104
CRNA	175	181	203	227	241
D.O.	52	59	63	72	87
Total	3,386	3,577	3,748	3,875	3,965
Excess Fund Surcharge Collected	$3,683,419	$5,901,357	$9,354,126	$10,796,758	$12,156,215

Please note that counts shown above are on a different basis than in prior years. The counts in prior years tended to identify how many providers were identified in some part of a year. The counts above can be viewed as provider-years.

Note also that the hospital counts are higher than what most people would consider the count of "hospitals" that we cover. Some hospitals own multiple entities, each of which are covered with us separately, and we code each such entity as a hospital. As such, when a person drives by the campus of a large Omaha or Lincoln hospital complex, they may be viewing several different entities – not just one – that we have individually coded as a "hospital."

Residual Fund

	Dec. 31, 2001	Dec. 31, 2002	Dec. 31, 2003	Dec. 31, 2004	Dec. 31, 2005
Physicians	8	22	21	17	33
Hospitals	0	1	0	0	0
CRNA	0	0	3	2	4
D.O.	0	0	0	0	0
Total	8	23	24	19	37
Premium Collected	$169,995	$542,876	$687,426	$622,226	$643,031

CLAIMS MADE AGAINST THE EXCESS AND RESIDUAL FUND

(see notes on the following pages)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Year	Unpaid Claim Counts -- Start of Year	New Claim Counts Reported	Development of Old Claim Counts	Net Claim Counts Incurred	Number of Claims Paid	Claim Counts Unpaid -- End of Year	Unpaid Claim $$$ -- Start of Year	$$$'s for New Claims Reported this Year	Development of Old Claim Reserves	Net $$$'s Incurred	Claims Paid	Claim $$$'s Unpaid End of Year
1976	0.00	0.00	0.00	0.00	0.00	0.00	0	0	0	0	0	0
1977	0.00	0.00	0.00	0.00	0.00	0.00	0	0	0	0	0	0
1978	0.00	0.00	0.00	0.00	0.00	0.00	0	0	0	0	0	0
1979	0.00	0.00	0.00	0.00	0.00	0.00	0	0	0	0	0	0
1980	0.00	2.00	0.00	2.00	0.00	2.00	0	305,000	0	305,000	0	305,000
1981	2.00	2.00	0.00	2.00	0.00	4.00	305,000	265,000	0	265,000	0	570,000
1982	4.00	3.00	0.00	3.00	0.00	7.00	570,000	625,000	0	625,000	0	1,195,000
1983	7.00	8.00	0.00	8.00	0.00	15.00	1,195,000	2,389,500	0	2,389,500	0	3,584,500
1984	15.00	12.00	0.00	12.00	6.00	21.00	3,584,500	1,865,957	0	1,865,957	1,293,231	4,157,226
1985	21.00	9.00	0.00	9.00	4.00	26.00	4,157,226	1,961,985	0	1,961,985	1,030,787	5,088,424
1986	26.00	10.00	0.00	10.00	9.00	27.00	5,088,424	2,181,887	0	2,181,887	1,840,844	5,429,467
1987	27.00	17.00	-1.00	16.00	5.00	38.00	5,429,467	2,373,161	(650,000)	1,723,161	953,117	6,199,511
1988	38.00	21.00	-6.00	15.00	6.00	47.00	6,199,511	3,075,000	181,385	3,256,385	1,460,896	7,995,000
1989	47.00	18.00	-9.00	9.00	8.00	48.00	7,995,000	2,275,000	(307,836)	1,967,164	1,867,164	8,095,000
1990	48.00	9.00	-13.00	-4.00	7.00	37.00	8,095,000	995,000	(684,931)	310,069	1,695,069	6,710,000
1991	37.00	22.00	-2.00	20.00	10.00	47.00	6,710,000	3,410,000	367,308	3,777,308	4,297,308	6,190,000
1992	47.00	39.00	-15.00	24.00	10.00	61.00	6,190,000	7,230,000	(161,903)	7,068,097	1,953,097	11,305,000
1993	61.00	34.00	-19.00	15.00	9.00	67.00	11,305,000	6,400,000	(2,653,999)	3,746,001	2,001,001	13,050,000
1994	67.00	29.00	-16.00	13.00	10.00	70.00	13,050,000	5,265,000	(3,648,459)	1,616,541	3,016,541	11,650,000
1995	70.00	27.00	-20.00	7.00	10.00	67.00	11,650,000	3,840,001	(893,221)	2,946,780	2,861,779	11,735,001
1996	67.00	32.00	-16.00	16.00	15.46	67.54	11,735,001	6,825,000	(2,116,802)	4,708,198	2,693,198	13,750,001
1997	67.54	41.00	-19.00	22.00	10.54	79.00	13,750,001	7,750,000	(450,403)	7,299,597	3,324,598	17,725,000
1998	79.00	28.00	-24.00	4.00	11.00	72.00	17,725,000	4,650,000	(2,589,572)	2,060,428	2,860,428	16,925,000
1999	72.00	52.00	-8.00	44.00	12.82	103.18	16,925,000	9,310,000	(275,178)	9,034,822	4,659,822	21,300,000
2000	103.18	66.00	-15.00	51.00	24.00	130.18	21,300,000	18,291,188	4,167,250	22,458,438	9,318,438	34,440,000
2001	130.18	45.00	-11.00	34.00	23.00	141.18	34,440,000	12,775,000	(1,155,000)	11,620,000	8,060,000	38,000,000
2002	141.18	66.00	-22.00	44.00	28.28	156.90	38,000,000	23,110,000	(3,902,600)	19,207,400	10,837,400	46,370,000
2003	156.90	49.00	-17.00	32.00	27.72	161.18	46,370,000	14,660,000	(4,478,500)	9,481,500	11,036,500	44,815,000
2004	161.18	58	-45.00	13.00	23.18	151.00	45,515,000	18,120,001	(6,940,348)	11,179,653	10,687,912	46,006,741
2005	151.00	58	-48.00	10.00	20.00	141.00	46,006,741	16,130,000	(10,342,500)	5,787,500	8,339,240	43,455,001

Notes to the Table showing Claims Made

The table shown on the preceding page contains different information than tables shown several years ago. The numbers that are comparable to the older figures are the number of claims paid and the dollars of claims paid. There were a couple of minor corrections to figures from old years.

The table shows claim counts only where we had a payment or had established a reserve. This will include a few Residual claims, but all but a few of these claims are purely Excess Fund claims.

The table shows Excess Fund results using undeveloped case-basis (i.e., "claims-made") reserves. Most of the coverage provided by the Excess Fund follows primary coverage written on a claims-made basis. Nevertheless, the existence of "tail" and occurrence coverages means that the liabilities of the Excess Fund are greater than those expressed on a claims-made basis. A small percentage of the medical professional liability coverage written by private insurers is on an occurrence basis; coverage written in the Residual Fund is on an occurrence basis, and we provide excess coverage for health care providers with "tail" coverage.

In the second half of 2003, we became aware of a situation involving Hepatitis "C" and many plaintiffs arising out of an oncology clinic in Fremont. None of our reserves or activities for that situation are reflected in this table. Their inclusion would skew the results. We'll provide total numbers for that entire set of cases when they are all closed, which may be relatively soon. With that exception, no other claims or payments have been omitted from this table.

The following comments explain the meaning of each of the columns in the table:

1. Year:

2. Unpaid Claim Counts – Start of Year: This column shows, according to our reserves at the start of the year shown, the number of claims for which we had established a reserve. For example, if we had a claim alleging chipped dental work on account of an anesthesiologist's miscue, we wouldn't show a reserve here, even though we might expect the plaintiff to win the case. The reason is that, on an excess claim, the Excess Fund won't contribute anything to a settlement unless the judgment is at least $200,001 (or $500,001 for a few very recent claims). In the past, tables that we published had shown all of the claims reported to us, regardless of whether we ever established a reserve for the claim.

3. New Claim Counts Reported: This column shows the number of claims reported during the year on which there was either an excess reserve at the end of the year or on which there had been a payment made during the year.

4. Development of Old Claim Counts: This column shows how the claim counts in column 2 developed during the year. This number is consistently negative, although a positive value would be perfectly valid. In practice, we get claims newly reported to us with a fairly good description by the plaintiff as to the nature of the alleged injury, but we don't have defense reports and we don't know the extent of negligence. As such, our initial reserves are often overestimates. There will be underestimates as well, but the number of overestimates will typically exceed the number of underestimates.

5. Net Claim Counts Incurred: These might be viewed as "incurred claim counts" on a "calendar year basis," which is a term familiar to those that engage in insurance accounting. It is to be distinguished from being on an "occurrence" basis. Nothing on this table is on an "occurrence" basis. This column can be calculated by summing the numbers from columns 3 and 4.

6. Number of Claims Paid: As also shows up in columns 2 and 7, some of these values are fractional because some claims were paid in more than one year.

7. Claim Counts Unpaid – End of Year: When figures for the next year are given, it will be seen that this is the same number as the unpaid claim counts at the start of the next year. It can be calculated by taking the prior year claim counts (column 2), adding the net claim counts incurred (column 5) and subtracting the number of claims paid (column 6).

Columns 8 through 13 are the dollar values that "mirror" the claim counts given in columns 2 through 7. Columns 4, 10 and 13 deserve a little extra explanation, however.

The column 4 and 10 values would make it appear that the Excess Fund had no loss development prior to 1987. One would get the impression that someone was very effective at establishing reserves back then. In fact, the Excess Fund didn't regularly reserve claims on a case basis until the mid-1980s, and reserves did not exist on all open claims until December 1987. The figures from prior to that time were entered into the computer database when the database was created in the late 1980s, but the claims were shown as being opened with case reserves exactly equal to the final settlement value. This makes it appear, prior to 1987, that we reserved claims with perfect foresight. Such was not the case

With regard to column 13, the reader will note that the last value in this column indicates case-basis reserves of $43,455,001, while our total loss reserves (indicated in the discussion on page 3 of this report) were estimate to be about $42MM. The difference occurs because:

- The case-basis reserves are undeveloped. That is, no adjustments are made to reflect reserving or settlement patterns that have been experienced in the past or are expected in the future.

- The $43,455,001 figure does not include IBNR for the Excess Fund (from tail coverages and underlying occurrence coverages). It also does not include IBNR for primary Residual policies, which are on an occurrence basis.

- These figures don't include anticipated loss adjustment expense. This is relatively negligible for most Excess Fund claims. Percentage-wise, it is material for Residual Fund claims, but that is not separately included here. (That may change with a future report, as we may begin to provide more Residual Fund detail.)

- The $43,455,001 figure does not include any of the remaining liabilities of the Excess Fund arising out of the Hepatitis "C" cases.

Questions?

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