NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT

ANNUAL REPORT

as of December 31, 2007

THE EXCESS LIABILITY FUND
(under the Nebraska Hospital-Medical Liability Act)

The Nebraska Hospital-Medical Liability Act was adopted in 1976. Its intent is, "to serve the public interest by providing an alternative method for determining malpractice claims in order to improve the availability of medical care, to improve its quality and to reduce the cost thereof, and to insure the availability of malpractice insurance coverage at reasonable rates." Pursuant to this law, the primary functions of the Fund are to provide excess liability insurance for health care providers and to provide assurance to persons receiving health care from these providers that medical professional liability insurance is in place. Another function of the Fund is to provide underlying ("first dollar") medical professional liability insurance for health care providers that are unable to purchase such coverage from a licensed insurer.

Participation by a health care provider in the Fund is voluntary, although most Nebraska physicians now take advantage of the Fund to purchase excess medical professional liability coverage. To participate in the Fund, a health care provider must submit proof of financial responsibility in the form of an underlying professional liability policy with specified coverage limits and pay a premium ("the surcharge") to the Fund. The act also establishes a "cap" on the amount a plaintiff can recover from all qualified health care providers.

The exhibits and discussions itemized below provide details.

– Exhibits & Discussions –

Number of Health Care Providers Participating in the Fund

Year	Average # of Physicians	Average # of DOs*	Average # of CRNAs*
1976**	188	0	0
1977	418	0	0
1978	717	0	3
1979	822	0	7
1980	882	0	11
1981	971	0	18
1982	1144	0	30
1983	1298	2	33
1984	1526	2	36
1985	1667	3	37
1986	1707	4	37
1987	1773	4	39
1988	1846	8	43
1989	1925	14	44
1990	1991	15	48
1991	2073	16	72
1992	2165	20	81
1993	2259	25	84
1994	2337	27	93
1995	2402	31	103
1996	2536	36	109
1997	2636	36	110
1998	2691	38	125
1999	2759	43	146
2000	2903	52	172
2001	3101	61	176
2002	3279	71	182
2003	3417	78	204
2004	3508	87	228
2005	3576	102	241
2006	3661	109	236
2007	3728	114	258

* A “DO” is a Doctor of Osteopathy and a “CRNA” is a Certified Registered Nurse Anesthetist.

** The Fund also covers hospitals and professional corporations (PCs). With a PC, it is typical for the PC as well as all of its member providers to opt to be covered by the Fund. With hospitals, participation has increased over the years, although not as rapidly as for physicians. The problem with showing numbers for hospitals is that large hospitals often own a number of entities that also provide health care, and these entities are also coded as “hospitals.” Thus, the number of entries that we have for “hospitals” would be a deceptively large number.

*** The first day of the Fund was 7/8/1976, and the averages shown for 1976 are for the part of a year that the Fund was in effect. The numbers for all other years are “provider-years”. That is, these numbers show average number of providers insured each day throughout the calendar year (except for 1976).

Residual Coverage Provided under the Act

Number of Covered Residual Providers by Year					
Year	**Physicians**	**Hospitals**	**CRNAs**	**DOs**	**PCs**
2000	1.00	0.00	0.00	0.00	0.00
2001	3.95	0.00	0.00	0.00	0.48
2002	17.44	0.25	0.00	0.42	4.01
2003	21.25	0.75	1.96	0.58	5.59
2004	25.31	0.00	1.90	0.00	5.26
2005	28.09	0.00	3.86	0.00	7.54
2006	30.18	0.00	3.00	0.00	10.05
2007	26.79	0.00	2.95	0.00	10.00

As with the exhibit showing the total numbers of providers covered, these numbers are on a provider-year basis. That is, these numbers show average number of providers insured each day throughout the calendar year. This can be less than one for year if only one provider is insured and that provider is insured for less than the full year.

The Residual Authority provides coverage for health care providers that are unable to purchase medical professional liability insurance in the private admitted market. The premiums charged by the Residual Authority are considerably higher than in the voluntary marketplace, as the expected exposure is greater for physicians that private insurers are unwilling to write.

In the 1980s and 1990s, there were periods of time where no providers purchased coverage through the Residual Authority, and never more than two doctors were insured with the Residual Authority at any one time. While insurers in the past decade have declined to write the providers noted in the table above, the number of physicians covered by the Residual Authority is still only a fraction of a percent of the total number of physicians in the state, which indicates a healthy market for medical professional liability insurance.

History of Underlying Coverage Requirements and the "Cap"

To participate in the Fund, a health care provider must submit proof of financial responsibility in the form of an underlying professional liability policy with specified coverage limits and pay a premium ("the surcharge") to the Fund. The act also establishes a "cap" on the amount a plaintiff could recover from all qualified health care providers. The Legislature has updated these limits and the cap over the years:

- When the Fund was established in 1976, these limits were set at $100,000/300,000 for physicians and nurse anesthetists and $100,000/1,000,000 for hospitals, with a $500,000 cap on the amount a plaintiff could recover from all qualified health care providers.

- 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 was the date of the provider's first qualification on or after January 2, 2005.

History of Surcharge Levels

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 – 12-31-06	45%
40%	1-1-07 – until revised	40%

A 50% surcharge, which is the maximum allowed by the Act, was instituted by the Department when the Act was first put into effect so that a fund could be established to pay claims. The Legislature did not provide any "seed money" for this purpose and there was a concern that the Fund would not have money to pay a claim made shortly after the Act's inception. (A loss payment was not made by the Fund until 1984, when it paid 6 claims.)

As originally written, the Act placed a statutory cap of $5 million on the assets of the Fund, without regard to the Fund's liabilities. As the Fund's assets approached $5 MM, the surcharge for 1981 was reduced. A further reduction to the minimum surcharge of 1% was made for 1982 as the amount in the Fund exceeded the statutory 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 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.

The passage of LB 998 in 2004, which increased the underlying coverage requirement to $500,000 from $200,000 on a phased-in basis during 2005, resulted in the surcharge for 2006 being lowered to 45%, to 40% effective 1/1/2007.

Assets and Operating Results of the Fund

Year	Fund Assets, 1/1/XXXX	Revenue	Investment Activity	Calendar Year Paid Loss & LAE	Admin Expenses	Net Annual Results (cash basis)	Fund Assets, 12/31/XXXX
1998	54,603,622	610,325	10,538,105*	2,916,649	210,329	8,021,452	62,625,074
1999	62,625,074	628,943	741,931	4,775,455	279,519	(3,684,100)	58,940,974
2000	58,940,974	901,435	3,754,219	9,531,986	231,320	(5,107,651)	53,833,323
2001	53,833,323	3,866,753	6,679,229	8,101,409	184,665	2,259,908	56,093,231
2002	56,093,231	6,444,233	3,223,109	10,848,482	124,500	(1,305,639)	54,787,592
2003	54,787,592	10,041,551	3,464,168	11,118,182	122,869	2,264,669	57,052,261
2004	57,052,261	11,418,984	1,180,401	11,305,525	236,352	1,057,508	58,109,769
2005	58,109,769	12,799,247	3,699,006	14,126,368	133,643	2,238,241	60,348,010
2006	60,348,010	12,466,351	2,593,113	11,394,986	188,193	3,476,285	63,824,295
2007	63,824,295	10,407,093	2,581,239	8,491,084	171,892	4,325,356	68,149,651

* The investment income results from 1998 are deceptive. In March of 1998, the method for recording investments was changed from book value to market value. This one-time change accounted for an increase of $5,308,855 in the value of the Fund's assets.

Liabilities of the Fund

The loss liabilities of the Fund are subject to significant uncertainty. Some of these sources of uncertainty are the same as those faced by insurers of medical professional liability – a long time to settlement and the uncertain outcome of cases. For the Fund, the relatively small number of cases paid each year increases variability for purely statistical reasons. Underscoring the potential variability of Fund results was a series of many claims that arose from Hepatitis "C" infections and a Fremont oncology clinic. While this set of claims no longer contributes to uncertainty in the Fund's liabilities, the Fund's experience with them only underscores the uncertain nature of the Fund's liabilities.

As of 12/31/2007, the Fund's liabilities are estimated at $33,573,524.36, which consists of $28,369,977.91 for unpaid losses and $5,203,546.45 for unearned premium. The reserves for unpaid losses arise primarily from claims that have already been reported, but are in various stages of litigation or negotiation. Persons familiar with medical professional liability realize that the eventual disposition of claims often requires a number of years. Also included in the claims reserves, however, are reserves for so-called "IBNR" claims – claims that have been "incurred" but have not yet been reported. On account of extended-reporting ("tail") endorsements, as well as a relatively small number of occurrence policies, the Fund is currently liable for some claims that will not be reported for a period of several years. Most coverage provided by the Fund is on a claims-made basis, where IBNR is typically not a consideration, but some coverage involves IBNR.

The estimated total liabilities of $33,573,524.36 as of 12/31/2007 versus assets of $68.1MM as of the same date imply an operating reserve of $34,576,126.42 for unforeseen events and the possibility of inadequate reserve estimations. As was demonstrated with the Hepatitis "C" cases, "unusual" events can happen. In addition, hindsight now shows that we have both underestimated as well as overestimated the liabilities of the Fund at times in the past.

Persons that compare this report with Annual Reports as of 12/31/2006 and prior will see that loss reserves have dropped substantially from those older reports. The primary reason for this drop was the impact of LB 998, which was passed in 2004. This raised the underlying coverage requirement to $500,000 on a phased-in basis starting on January 2, 2005 and with an average effective date in the latter half of 2005. This effective date applied to occurrences, not claim reports. A large percentage of claims are not reported until several years following the medical incident, which is then followed by legal processes involving litigation and/or negotiation. As a result, the effect of this legislation won't be strongly felt for a number of years after its passage.

The other reason for this sharp drop is because these loss reserve exhibits were calculated more than two years after the end of the period of time under examination. As such, an unusual amount of hindsight was available, and this hindsight revealed that previous reserve estimates were significantly higher than necessary. (The magnitude of this overestimation only reinforces comments about variability and difficulties with the estimation of future losses.) As a result, the loss reserves contained in this document are much more likely to prove accurate than with typical reserve calculations that are made only a few months following the end of the period under examination.

Loss experience of the Fund

(on a reported basis)

Year	Calendar Year Paid Loss & LAE	Report Year Incurred Loss & LAE	Unpaid Reported Loss & LAE, End of Year	Paid Claim Counts Excl. Mass Torts	Paid Claim Counts Incl. Mass Torts
1976	0	0	0	0	0
1977	0	0	0	0	0
1978	0	0	0	0	0
1979	0	0	0	0	0
1980	0	305,129.50	305,129.50	0	0
1981	0	326,368.51	631,498.01	0	0
1982	0	600,254.75	1,231,752.76	0	0
1983	0	1,690,217.34	2,921,970.10	0	0
1984	1,294,322.00	1,473,660.43	3,101,308.53	6	6
1985	1,031,917.83	1,827,658.67	3,897,049.38	4	4
1986	1,845,684.83	2,413,511.58	4,464,876.13	9	9
1987	1,282,502.25	2,036,836.45	5,219,210.33	6	6
1988	1,160,457.68	2,496,987.74	6,555,740.38	5	5
1989	1,927,508.62	1,640,986.45	6,269,218.21	8	8
1990	1,827,716.17	1,888,430.46	6,329,932.50	8	8
1991	4,305,512.25	2,170,941.36	4,195,361.61	8	9
1992	2,098,858.64	4,179,956.00	6,276,458.98	10	10
1993	2,147,007.22	3,511,126.15	7,640,577.90	9	9
1994	3,251,669.50	3,611,432.72	8,000,341.12	11	11
1995	2,855,918.71	4,150,285.41	9,294,707.82	9	9
1996	2,916,493.25	7,884,592.27	14,262,806.84	15	15
1997	3,421,227.66	4,753,051.23	15,594,630.40	11	11
1998	2,916,649.16	3,582,770.55	16,260,751.80	11	11
1999	4,775,454.51	8,166,224.80	19,651,522.09	13	13
2000	9,531,985.58	9,382,286.54	19,501,823.05	23	23
2001	8,101,409.04	7,765,236.58	19,165,650.59	23	23
2002	10,848,481.82	21,270,678.19*	29,587,846.95	28	28
2003	11,118,181.55	7,942,159.14	26,411,824.55	28	28
2004	11,305,525.30	8,842,167.91	23,948,467.15	24	34
2005	14,126,368.48	14,226,846.60	24,048,945.27	21	82
2006	11,394,985.64	11,354,211.95	24,008,171.58	27	36
2007	8,491,084.02	10,946,663.49	26,463,751.05	19	20
Totals	**123,976,921.71**	**150,440,672.76**		336	418

* The 2002 reported losses include about $9.3MM for cases arising out of a large number of claims made arising out of Hepatitis “C” infections and a clinic in Fremont.

Calendar Year Paid Loss & LAE – The paid loss and loss adjustment expense (LAE) numbers shown in the first data column of this table are taken directly from the Fund’s financial records and should be accurate to the penny. Please note that none of the loss & LAE numbers in these exhibits include loss & LAE incurred by the primary insurer unless the primary insurer is the Residual

Authority. Residual Authority losses are included, but are not a material part of the total losses, as the Authority only covers a small number of health care providers.

Report Year Incurred Loss & LAE – The report-year numbers are from individual claim files and actuarial estimates. For older years, where no reported claims remain open, these numbers should agree to the penny with numbers from the Fund's financial records, but they do not. In the last 10 years or so, the only differences between these two sets of records arise from rounding, because the dollars in the claim records are rounded to the nearest dollar. For older years, however, there was not the same rigorous balancing between financial and claim records that exists today. As a result, there were LAE amounts that were paid and thus included in the financial numbers that were not included in the claim file numbers. As a result, there was about $66,000 in LAE included in the financial numbers that was never included in the individual claim files. As the report-year numbers must be developed from claim files, the "solution" to this problem is that the total claim file numbers for all years combined were increased by a very small factor so that they total $150,440,672.76 instead of about $66,000 less. With this small caveat, the report-year numbers for older years can be viewed as being precise, while the numbers for recent years include a combination of known paid losses and estimated unpaid losses.

Unpaid Reported Loss & LAE, End of Year – The unpaid reported loss and LAE is the largest part of expected liabilities. The other material liabilities are unearned premiums (surcharges) and incurred but not reported (IBNR) losses. With regard to this column, the numbers are somewhat different than is typical for an exhibit of this sort. As this document was not prepared until following the middle of the 2010 calendar year, we have the advantage of a great deal of hindsight with these numbers. As such, while 100% of the $26,463,751.05 shown as unpaid reported losses as of 12/31/2007 would have been unpaid (and thus unknown) at that time, a number of these claims have since been closed and the reserves have been replaced by their actual settlement amounts. Thus, even though part of this number is still represented by actuarial estimates, it is subject to less uncertainty than is typical for unpaid losses as of the end of a year.

Paid Loss Counts – These counts represent the number of losses with an indemnity payment that were closed by the Fund in a given calendar year. Thus, this does *not* include claims that were closed without an indemnity payment by the Fund, even though the underlying insurer (other than the Residual Authority) may have made an indemnity payment. It also does not include claims where the Fund had LAE, but didn't pay indemnity. In this regard, if one divides calendar year loss & LAE for a year by the number of closed claims for a year, it is possible that this will include LAE for claims without indemnity payment and for claims that are ultimately closed in another year, but this "distortion" should be insignificant as the Fund's total LAE is typically only a percent or two of its total indemnity. Most LAE is incurred by the underlying carriers, which have LAE-to-indemnity ratios that are much higher.

Mass Torts (in Loss Counts & elsewhere) – The reference to "mass torts" includes two situations. The first relates to treatments that were administered by a physician in 1976, that were reported in 1986 and paid in 1991. The Fund made a single global payment of $1,500,000 as part of a total settlement of $4,500,000. There were ultimately 213 plaintiffs represented, but it was handled as a single large case by the Fund.

The second "mass tort" situation dealt with a clinic in Fremont and a number of cases of Hepatitis "C" that arose following patients' treatments by the clinic. The Fund opened a total of 92 cases out of this situation. The value of the Fund's share of paid and unpaid loss and LAE for these claims is $9,274,627.

The Fund's Operating Reserve

Year	Fund Assets, 12/31/XXXX	Unpaid Reported Loss & LAE	IBNR	Unearned Premiums	Operating Reserve
1997	54,603,622.37	15,594,630.40	1,344,052.44	388,740.00	37,276,199.53
1998	62,625,074.07	16,260,751.80	1,432,087.02	305,162.39	44,627,072.86
1999	58,940,974.10	19,651,522.09	1,522,497.75	314,471.61	37,452,482.65
2000	53,833,322.75	19,501,823.05	1,642,381.13	450,717.68	32,238,400.89
2001	56,093,231.00	19,165,650.59	1,794,763.85	1,933,376.27	33,199,440.29
2002	54,787,591.56	29,587,846.95	1,960,531.79	3,222,116.64	20,017,096.18
2003	57,052,260.61	26,411,824.55	2,125,717.60	5,020,775.70	23,493,942.76
2004	58,109,768.77	23,948,467.15	2,559,847.16	5,709,492.23	25,891,962.23
2005	60,348,009.67	24,048,945.27	2,710,676.25	6,399,623.26	27,188,764.89
2006	63,824,294.68	24,008,171.58	2,210,379.78	6,233,175.42	31,372,567.90
2007	68,149,650.78	26,463,751.05	1,906,226.86	5,203,546.45	34,576,126.42

Fund Assets – This is simply the estimated value of the Fund's assets as of the date specified.

Unpaid Reported Loss & LAE – As explained in previous exhibits, this represents the Fund's estimated liability for claims that have been reported to the Fund, but are in various stages of the dispute and/or settlement process.

IBNR – Incurred but not reported (IBNR) losses represent obligations of the Fund on account of medical incidents or treatments that had already occurred as of a specified date, but where the physical condition giving rise to a claim had not yet manifested itself, or where the condition was known to the plaintiff, but where a claim had not yet been made and/or communicated to the Fund. As most underlying medical professional liability coverage is claims-made, the amount of this liability is typically expected to be considerably less than liabilities on account of claims that have already been reported. For the Fund, the primary sources of IBNR are occurrence coverage written by the Residual Authority and so-called "tail" coverage provided by underlying insurers when a physician switches insurers, retires, dies or is disabled.

Unearned premiums – At any given time, approximately half of the premiums (surcharges) received in the past year will be for excess and primary coverage yet to be provided. The unearned premium number thus represents 50% of the premiums & surcharges collected by the Fund during the previous year.

Operating Reserve – The ideal operating reserve for the Fund can be debated, but it clearly must be a significant amount. The Fund may suffer from years of bad experience, as is clearly demonstrated by previous exhibits, and estimations of future losses may prove inadequate. The most obvious viability concern for the Fund's would be a many-defendant case. The Department's current pricing position is to set surcharge levels approximately equal to expected

future loss rates if the operating reserve is between $30MM and $35MM, and to set the surcharge levels somewhat higher or lower, respectively, if the operating reserve is below or above this range.

Questions?

Contact Alan Wickman, Al.Wickman@nebraska.gov, mailing address: Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089.