NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT

ANNUAL REPORT

as of December 31, 2010

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**	186	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	2757	43	146
2000	2900	52	172
2001	3103	61	176
2002	3282	71	182
2003	3413	78	203
2004	3500	87	227
2005	3568	102	241
2006	3652	109	236
2007	3721	114	258
2008	3719	120	266
2009	3779	120	280
2010	3828	118	289

* 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
2008	25.89	0.00	2.81	0.00	9.61
2009	15.49	0.00	2.00	0.00	5.06
2010	12.75	0.00	1.00	0.00	3.43

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 – 12-31-07	40%
35%	1-1-08 – 12-31-10	35%
20%	1-1-11 – until revised	20%

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 million in 1980, 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, to 35% effective 1/1/2008, and to 20% effective 1/1/2011.

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
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
2008	68,149,651	9,495,284	(497,649)	14,808,033	165,652	(5,976,050)	62,173,601
2009	62,173,601	9,298,293	9,681,857	5,857,305	185,933	12,936,912	75,110,513
2010	75,110,513	8,485,764	8,340,686	5,483,546	218,014	11,124,890	86,235,403

Revenue: The Fund's revenue primarily consists of Excess Fund surcharges and is thus a function of the surcharge rate. It declined slightly during 2010, reflecting competition in the medical professional liability insurance market, a decline in the number of Residual providers written by the Fund, and reduced receipts in December of 2010 owing to the decreased surcharge level effective 1/1/2011. It can be expected that revenue will decline in 2011 owing to the surcharge rate being reduced from 35% to 20%. Revenues in 2011 are likely to be close to $5 million.

Investment Activity: The Excess Liability Fund is heavily invested in the bond market. As a result, while higher interest rates will result in higher returns over the long term, they will depress the book value of a bond portfolio in the short term (and vice versa). The negative results in 2008 were the result of very unsettled financial markets, while the unusually good results in 2009 (especially) and in 2010 were the result of stability returning to the bond market in combination with lower interest rates that increased the value of the Fund's bond portfolio. Looking to the future – especially as interest rates cannot reasonably be expected to fall much lower – it is not reasonable to assume that the investment results seen in 2009 and 2010 will continue into the future. Investment returns for at least the next several years are likely to be relatively low.

Loss Payments: It was reasonable to anticipate a gradual decline in paid losses starting in 2006 following the passage of LB 998 a few years before. This bill increased the underlying insurance requirement from $200,000 to $500,000 and correspondingly reduced the Fund's liability on most claims. In fact, this decline occurred, but 2008 was a serious aberration that – in retrospect – caused an underestimation of the favorable effect of LB 998 on Excess Fund losses. This decline has now largely ended as less than 20 unpaid claims remain with occurrence dates prior to 2005. While payments in the near future are expected to remain in the $5MM to $10MM range annually, individual years may exhibit significant variation, as a single claim can cost up to $1,750,000.

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 also 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 12/31/2010, the Fund's liabilities are estimated at $20,507,146.80, which consists of $15,772,762.15 for unpaid losses and $4,734,384.65 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. Claims reserves also include 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 $20,507,146.80 as of 12/31/2010 versus assets of $86,235,403.01 as of the same date imply an operating reserve of $65,728,256.21 for unforeseen events, variation in year-to-year results and the possibility of inadequate reserve estimations. As was demonstrated with the Hepatitis "C" cases, events with many defendants – which can produce losses far outside the range of normal statistical variation – are possible. While the current operating reserve is higher than recent targets and resulted in a significantly reduced surcharge rate for 2011, it should be stressed that large scale events with many plaintiffs (as with the Hepatitis "C" case in Nebraska) still have the potential to be larger than the Fund's current operating reserves.

The exhibit on the next page shows that incurred losses dropped substantially in 2008. The reason for this drop was the impact of LB 998, which 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. As the effective date applied to occurrences, not claim reports, it took several years before the higher underlying threshold applied to most of the new claim reports (which are thus "incurred" under claims-made policies).

The exhibits contained in this report allow one to see a very good picture of what losses were a few years ago, plus it shows our best estimates of most recent loss levels. That is, while losses and reserves for recent years are mostly just estimates, the losses and reserves shown for older years – particularly for more than 3 years ago – represent claims that are now mostly paid. All claims reported during the first 25 years of the Fund's existence are now entirely paid. For instance, the number shown in this exhibit for reported losses in 2000 is no longer is subjection to any estimation uncertainty, as all of the claims reported as of 12/31/2000 have since been paid.

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	305,122.65	305,122.65	0	0
1981	0	326,361.18	631,483.83	0	0
1982	0	600,241.27	1,231,725.11	0	0
1983	0	1,690,179.39	2,921,904.49	0	0
1984	1,294,322.00	1,473,627.34	3,101,209.83	6	6
1985	1,031,917.83	1,827,617.63	3,896,909.63	4	4
1986	1,845,684.83	2,414,100.37	4,465,325.18	9	9
1987	1,282,502.25	2,036,790.71	5,219,613.64	6	6
1988	1,160,457.68	2,496,931.67	6,556,087.63	5	5
1989	1,927,508.62	1,640,949.60	6,269,528.61	8	8
1990	1,827,716.17	1,888,388.06	6,330,200.49	8	8
1991	4,305,512.25	2,170,892.61	4,195,580.86	8	9
1992	2,098,858.64	4,179,862.14	6,276,584.36	10	10
1993	2,147,007.22	3,511,047.30	7,640,624.45	9	9
1994	3,251,669.50	3,611,351.62	8,000,306.57	11	11
1995	2,855,918.71	4,150,192.22	9,294,580.07	9	9
1996	2,916,493.25	7,884,415.23	14,262,502.05	15	15
1997	3,421,227.66	4,752,944.50	15,594,218.89	11	11
1998	2,916,649.16	3,582,690.10	16,260,259.83	11	11
1999	4,775,454.51	8,166,041.43	19,650,846.75	13	13
2000	9,531,985.58	9,380,812.72	19,499,673.90	23	23
2001	8,101,409.04	7,764,872.78	19,163,137.63	23	23
2002	10,848,481.82	21,257,093.07	29,571,748.88	28	28
2003	11,118,181.55	7,919,665.57	26,373,232.90	28	28
2004	11,305,525.30	8,803,060.83	23,870,768.43	24	34
2005	14,126,368.48	14,164,503.11	23,908,903.06	21	82
2006	11,394,985.64	11,216,811.77	23,730,729.19	27	36
2007	8,491,084.02	10,795,913.80	26,035,558.98	19	20
2008	14,808,032.62	4,118,671.14	15,346,197.49	26	27
2009	5,857,305.27	5,148,751.26	14,637,643.48	15	15
2010	5,483,546.21	5,618,664.88	14,772,762.15	10	11
Totals	150,125,805.81	164,898,567.96		387	471

* 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.

(See the next two pages for an additional discussion of these results.)

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 the loss & LAE numbers in these exhibits do not 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. This does not include IBNR reserves, which were estimated at $1,000,000 as of 12/31/2010. For claims that are still open, these numbers represent actuarial estimates. For closed claims, the numbers represent whatever was paid, which is usually different than the reserve that was set on the claim when it was open. Thus, 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 customarily 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. About $66,000 in LAE was included in the financial numbers that was never included in the individual claim files. As report-year numbers must be developed from claim files, the "solution" to this problem was that the total claim file numbers for all years combined were increased by a very small factor so that they total $164,898,567.96 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 numbers in this exhibit are somewhat different than is typical for an exhibit of this sort. The numbers for every year represent our estimation *as of 12/31/2010* of the reported losses that were unpaid as of the end of the corresponding year. For the most recent year – 2010 – that means that all of these losses were unpaid as of 12/31/2010. But with regard to another year – take 2005 as an example – there are only a small number of claims that were unpaid as of 12/31/2005 that are still open and potentially unpaid as of 12/31/2010. This gives us the advantage of 20-20 hindsight when it comes to selecting these numbers for older years, because we now know with certainty what happened with most (or all) of these claims. As such, while the most recent year's unpaid losses can be viewed as an actuarial estimate, we can compare this actuarial estimate to what we now know would have been the correct numbers or more likely estimates for previous years.

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 and ultimately paid $8,706,345 in indemnity costs and $568,282 in LAE with regard to these cases. (The total payments to all plaintiffs were considerably higher, as there were other parties that contributed to settlements.) As of 12/31/2010, the Fund participated in indemnity payments to close 83 of these cases and the other 9 cases were closed without a Fund payment (although other defendants may have paid).

The Fund's Operating Reserve

Year	Fund Assets, 12/31/XXXX	Unpaid Reported Loss & LAE	IBNR	Unearned Premiums	Operating Reserve
2001	56,093,231.00	19,163,137.63	1,290,517.17	1,933,376.27	33,706,199.93
2002	54,787,591.56	29,571,748.88	1,410,117.79	3,222,116.64	20,583,608.25
2003	57,052,260.61	26,373,232.90	1,527,373.45	5,020,775.70	24,130,878.56
2004	58,109,768.77	23,870,768.43	1,836,800.33	5,709,492.23	26,692,707.78
2005	60,348,009.67	23,908,903.06	1,890,475.96	6,399,623.26	28,149,007.39
2006	63,824,294.68	23,730,729.19	1,362,560.35	6,233,175.42	32,497,829.72
2007	68,149,650.78	26,035,558.98	1,027,209.42	5,203,546.45	35,883,335.93
2008	62,173,601.05	15,346,197.49	977,240.91	4,747,642.01	41,102,520.63
2009	75,110,512.66	14,637,643.48	978,126.70	4,649,146.31	54,845,596.16
2010	86,235,403.01	14,772,762.15	1,000,000.00	4,734,384.65	65,728,256.21

Fund Assets – Fund Assets represents the actual cash and investments in the bank and includes both the short-term pool that consists of cash and short term investments and the long-term pool that consists of bonds and similar instruments. It also includes a monthly booking of the gain or loss in the market value.

Unpaid Reported Loss & LAE – This represents the Fund's estimated liability for open claims that were reported to the Fund prior to 12/31 of the year shown.

IBNR – Incurred but not reported (IBNR) losses represent obligations of the Fund on account of medical incidents or treatments that had already occurred, but where a claim had not yet been made to the Fund. As most medical professional liability coverage is claims-made, IBNR liabilities are typically much smaller 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.

A person comparing this year's report to last year's will note that last year's report shows IBNR of $1,935,737.29 as of 12/31/2009, while this year's report only shows $978,126.70. In fact, all prior years' reserves – both for reported losses as well as for IBNR – were recalculated based on the most recent experience available, but the change in IBNR was the result of more than simply that recalculation. In some circumstances, the database used for these calculations automatically inserts tail coverage dates in records, even when no tail coverage is being provided. While Department staff using these coverage records for claim purposes were aware of this anomaly and there is no indication that this problem caused any errors with claim handling, these illusory tail coverage indications resulted in IBNR being overestimated in actuarial calculations. In fact, this same error has been made for perhaps 10 years, with calculations in past years (but not the ones shown for past years in this exhibit) subject to the same overestimation of IBNR.

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.

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 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 Gary Timm, Gary.Timm@nebraska.gov, mailing address: Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089.