

**NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT
EXCESS LIABILITY FUND**



**ANNUAL REPORT
as of December 31, 2011**

INTRODUCTION

The Excess Liability Fund (the Fund) is one of several Enterprise Funds maintained by Nebraska to account for operations that are financed and operated in a manner similar to private business enterprises—where the costs of providing goods and services to the general public are financed primarily through user charges.

The Fund is administered by the Nebraska Department of Insurance, due to implementation of the Nebraska Hospital-Medical Liability Act (adopted in 1976). Revenues are primarily a surcharge levied on Nebraska health care providers participating (voluntarily) in the Excess Liability plan, plus a small revenue stream from Nebraska health care providers unable to purchase such coverage from a licensed insurer. The Fund’s Expenses include administrative costs but are mostly to pay judgments against participating health care providers, up to an occurrence limit of \$1,750,000 per plaintiff.

Most Nebraska physicians purchase excess medical professional liability coverage from the Fund, paying a premium (“the surcharge”) and submitting proof of financial responsibility in the form of an underlying professional liability policy with specified coverage limits.

The body of the report will focus on the Fund’s 2011 assets, operating results, liabilities and operating reserve. This year most supporting commentary and history are moved to Appendices A (on the Fund’s Reserves and Risks), B (the Fund’s limits and underlying coverage requirements) and C (historical surcharge rates).

FINANCIAL POSITION- Assets and Operations

The Fund began the year with assets of \$86.24 Million, added \$3.64 Million during the year, to end the year with \$89.87 Million. On a cash basis, the Fund received \$5.31 Million revenue, paid \$4.36 Million loss and loss adjustment expense, and paid \$0.19 Million administrative expenses. Revenue minus the sum of paid losses and expenses equals \$769 Thousand in underwriting cash flow. Of the \$3.64 Million increase to assets, \$2.87 Million was from investment activity.

Table 1. Assets and Operations of the Fund – Cash Basis

	(1)	(2)	(3)	(4)	(5) = (2) - (3) - (4)	(6)	(7) = (5) + (6)	(8) = (1) + (7)
Cal- endar Year	Beginning Fund Assets	Direct Written Premium	Paid Loss and Loss Expense	Admin- istrative Expense	Direct Underwriting Cash Flow	Invest- ment Activity	Annual Change in Assets	Year End Fund Assets
2002	56,093,231	6,444,233	10,848,482	124,500	(4,528,749)	3,223,109	(1,305,639)	54,787,592
2003	54,787,592	10,041,551	11,118,182	122,869	(1,199,499)	3,464,168	2,264,669	57,052,261
2004	57,052,261	11,418,984	11,305,525	236,352	(122,892)	1,180,401	1,057,508	58,109,769
2005	58,109,769	12,799,247	14,126,368	133,643	(1,460,765)	3,699,006	2,238,241	60,348,010
2006	60,348,010	12,466,351	11,394,986	188,193	883,172	2,593,113	3,476,285	63,824,295
2007	63,824,295	10,407,093	8,491,084	171,892	1,744,117	2,581,239	4,325,356	68,149,651
2008	68,149,651	9,495,284	14,808,033	165,652	(5,478,401)	(497,649)	(5,976,050)	62,173,601
2009	62,173,601	9,298,293	5,857,305	185,933	3,255,054	9,681,857	12,936,912	75,110,513
2010	75,110,513	8,485,764	5,483,546	218,014	2,784,204	8,340,686	11,124,890	86,235,403
2011	86,235,403	5,313,025	4,355,554	188,727	768,744	2,868,206	3,636,951	89,872,354

“Investment Activity” includes income received (mainly interest from bonds) and gains/losses whether realized or unrealized. The Fund’s 10-year growth in assets is primarily due to investment activity.

FINANCIAL POSITION- Liabilities and Operating Reserve

Table 4 at the end of this section shows the Fund's Operating Reserve, which equals the Fund's Assets minus the Fund's Liabilities. Before subtracting we must estimate the Fund's 2011 liabilities for 1) claims known to the Fund, 2) claims incurred but not reported to the Fund and 3) unearned premiums.

Claims Known to the Fund at 12/31/2011

As of 12/31/2011, the actuarially estimated unpaid liability for claims presented to the Fund in years up to 2011 is \$19.886 Million. Adjusters' case estimates for the same claims add up to \$25.675 Million. For report years 2009-2011, we expect actuarially estimated reserves to predict future ultimate payout more accurately than the sums of adjusters' estimates. For report years 2008 and prior, we conservatively selected the greater of actuarial or adjusters' estimates. Table 2, column (6) below shows 10 report years' contributed to the Department's best estimate, which is the \$20.994 Million total of column (6). The supporting actuarial analysis is not attached to this report, but Appendix A includes an outline of the analysis and its uncertainties.

Table 2. Actuarial, Adjusters' and Selected Reserve Estimates (000's)
Claims Made Coverage as of 12/31/2011 for Indemnity and Claims Expenses

Report Year	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Nebraska Excess Liability Fund Revenue (000's)	Actuarial Ultimate Claims-Made Incurred	Cum. RY Paid Indemnity and Expense	= (2) - (3) Actuarial Estimated Claims Made Reserve	Adjusters' Estimated Case Reserves	Best Estimate Claims-Made Reserve	= (3) + (6) Best Estimate Ultimate Claims-Made Incurred	= (7) / (1) Estimated Ultimate Indemnity and Claims Expense Ratio
1998	610	3,581	3,581	-	-	-	3,581	586.8%
1999	629	8,163	8,163	-	-	-	8,163	1297.9%
2000	901	9,377	9,377	-	-	-	9,377	1040.2%
2001	3,867	7,756	7,756	-	-	-	7,756	200.6%
2002	6,444	16,888	16,836	52	-	52	16,888	262.1%
2003	10,042	10,947	10,897	50	-	50	10,947	109.0%
2004	11,419	9,596	8,594	1,001	1,050	1,050	9,644	84.5%
2005	12,799	15,502	14,913	589	700	700	15,613	122.0%
2006	12,466	12,031	10,774	1,257	600	1,257	12,031	96.5%
2007	10,407	9,373	8,546	826	250	826	9,373	90.1%
2008	9,495	3,636	2,634	1,003	1,900	1,900	4,534	47.7%
2009	9,298	5,935	2,757	3,178	4,625	3,178	5,935	63.8%
2010	8,486	6,888	2,001	4,887	7,700	4,887	6,888	81.2%
2011	5,313	7,444	400	7,044	8,850	7,044	7,444	140.1%
10 Yrs	96,170	98,238	78,352	19,886	25,675	20,944	99,296	103.3%

Column (8) shows loss ratios for 14 years (i.e. ratios of ultimate claims-made paid loss and claims expense to the Fund's annual revenue). High loss ratios in 1998-2000 reflect the Fund's surcharge percentage, which was

just 5% from 1997-2000. 2002 includes about \$9.3 Million for numerous claims from a Hepatitis “C” outbreak that arose at a clinic in Fremont. The 10-year loss ratio is 103.3%, which means the Fund’s revenue was about 3% short of funding the decade’s incurred claims and claims expenses. However, the Fund’s loss ratio has increased three years in a row and the 140.1 loss ratio for 2011 is almost triple the 47.7% loss ratio for 2008.

Claims Incurred but Not Reported (IBNR) to the Fund

Table 2 addresses the Fund’s liability for claims already presented to the Fund through 12/31/2011. The Fund also bears liability for certain claims reported to the Fund at later dates:

- 1) The Fund’s Excess coverage follows fund participants’ primary coverage, which is generally on a claims-made basis. When written by a primary insurer, claims-made coverage by definition should generate no IBNR claims. The Fund, however, will wait – while the primary carrier records a claim, investigates it, prepares to defend its policyholder, and in setting case reserves identified it as one of the few likely to exceed the Fund threshold.
- 2) The Fund also expects IBNR claims due to occurrence coverage underwritten by primary insurers, occurrence coverage issued by the Fund’s Residual Authority and “tail” coverage provided by primary insurers when a physician switches insurers, retires, dies or is disabled.

As of 12/31/2011, we actuarially estimate the IBNR liability to be \$2.305 Million, of which \$1.678 Million is for the claim reporting lag described in 1) above, and \$727 Thousand is for occurrence coverage described in 2) above. The supporting actuarial analysis is not attached to this report, but Appendix A includes discussion of the IBNR analysis and its uncertainties.

Unearned Premiums

At any given time, approximately half of the premiums (surcharges) received in the past year will be for excess and primary coverage not yet provided. In estimating that half of written premium is unearned at yearend, underlying assumptions are that all policies are written on annual terms with premiums written evenly though the year. Last year, for 2010 only, a more precise formula reflecting seasonal premium writing was used. We returned to the simpler formula at 2011.

Table 3. Written and Unearned Premium

Calendar Year	(1)	(2)	Calendar Year	(1)	(2)
	Direct Written Premium	Direct Unearned Premium		Direct Written Premium	Direct Unearned Premium
2002	6,444,233	3,222,117	2007	10,407,093	5,203,546
2003	10,041,551	5,020,776	2008	9,495,284	4,747,642
2004	11,418,984	5,709,492	2009	9,298,293	4,649,146
2005	12,799,247	6,399,623	2010	8,485,764	4,734,385
2006	12,466,351	6,233,175	2011	5,313,025	2,656,512

The Fund's Operating Reserve

The operating reserve equals year-end assets minus estimated year-end liabilities. Maintaining a strong operating reserve is one prudent method of addressing future uncertainties such as unanticipated fluctuations in claim costs, operational expenses or reductions in investment income. In 2011, the Fund's operating reserve declined by \$1.15 Million. This outcome is attributable to the year's 140.1% loss ratio (see Table 2) and modest investment activity compared to 2009-2010 (see Table 1).

Table 4. The Fund's Operating Reserve

	(1)	(2)	(3)	(4)	(5) = (1) - (2) - (3) - (4)	(6)
Calendar Year	Year End Fund Assets	Unpaid Reported Loss & LAE	IBNR	Unearned Premiums	Operating Reserve	Annual Change
2002	54,787,592	29,571,749	1,410,118	3,222,117	20,583,608	-13,122,592
2003	57,052,261	26,373,233	1,527,373	5,020,776	24,130,879	3,547,270
2004	58,109,769	23,870,768	1,836,800	5,709,492	26,692,708	2,561,829
2005	60,348,010	23,908,903	1,890,476	6,399,623	28,149,007	1,456,300
2006	63,824,295	23,730,729	1,362,560	6,233,175	32,497,830	4,348,822
2007	68,149,651	26,035,559	1,027,209	5,203,546	35,883,336	3,385,506
2008	62,173,601	15,346,197	977,241	4,747,642	41,102,521	5,219,185
2009	75,110,513	14,637,643	978,127	4,649,146	54,845,596	13,743,076
2010	86,235,403	14,772,762	1,000,000	4,734,385	65,728,256	10,882,660
2011	89,872,354	20,327,494	2,305,362	2,656,512	64,582,985	-1,145,271

The ideal operating reserve for the Fund can be debated, but it clearly must be a significant amount. The Department's pricing position has been 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. The operating reserve has been above that range since 2007, having increased a total of \$36.4 Million since 2005.

Two identified forces, neither of which is continuing, drove the Fund's operating reserve to this height. First, the Fund's investment activity in Table 1, column (6) reflects the fact that bond pricing recovered in 2009-2010 after losses in 2008. Bonds now typically produce low yields, and their value in the market is vulnerable to any increase in prevailing interest rates. Second, the Fund's loss ratios on Table 2 improved over 2005-2008 after LB 998 raised the required underlying occurrence limit by 150%. The loss ratio has deteriorated in 2009-2011 due in part to reductions in the surcharge rate. See Appendix B for the legislative history and Appendix C for the surcharge rate history.

At 2011, the Fund's \$65.6 Million operating reserve remains 87% stronger than the maximum that historically guided the Department's surcharge rate review.

Questions? – Contact Gordon Hay, Gordon.Hay@nebraska.gov, mailing address: Nebraska Department of Insurance, PO Box 82089, Lincoln, NE 68501-2089.

Appendix A. COMMENTARY – Reserves and Risks

This appendix covers three topics. First, periodic legislative action has indirectly impacted the Fund's surcharge rates, revenues and loss ratios, giving rise to certain opportunities. The second topic is actuarial methods and risks in estimating the Fund's liability for known claims. The third topic is actuarial reserving for IBNR claims.

The Department's actuarial work was performed by Gordon Hay, Senior Casualty Actuarial Examiner within the Department, who is a Fellow of the Casualty Actuarial Society, Member of the American Academy of Actuaries, and Chartered Property and Casualty Underwriter.

Legislative Action and Surcharge Rates

Five times in the Fund's history, legislation updated the Excess Fund's underlying coverage requirements and coverage limits. In response to the Fund's changing financial position and coverage grant, the Fund's surcharge rate has been reviewed annually (see Appendices B and C for historical details).

Logically, when the legislature increases underlying requirements (e.g. from \$200,000 per occurrence to \$500,000 per 2004 LB 998), the "layer" of Fund expected excess losses between \$200,000 and \$500,000 should shift to the primary carriers, who should obtain additional primary premium for their new exposure to their increased limit. So, primary premium should go up, and the Fund's surcharge rate should go down. Historically, the Fund's surcharge rate response has lagged years behind legislative changes. There is also evidence (see Appendix C) that voluntary provider participation in the Fund has been sensitive to the Department's selected surcharge rate, in context with the market, primary underlying limits, and excess coverage to be provided by the Fund in the coming year. An effort to more precisely evaluate the shift in expected losses from the Fund to the primary carriers at the next legislative update should reward the Fund with a more understandable post-legislation surcharge rate. The actuary could also hope to mitigate fluctuations in participants' total medical professional insurance costs, participation rates, Fund revenue, Fund loss ratios and Fund operating reserve changes.

Known Claims

The estimates in Column (2) summarize results of applying multiple actuarial methods to Fund data accumulated since July, 1976.

This year's \$20.327 Million reserve for known claims is a \$5.554 Million increase from \$14.773 Million at 2010. About \$4.3 Million of the change is due to selecting conservatively among multiple actuarial methods in 2011, and the remaining \$1.25 Million is because unpaid costs on report year 2011 are greater than unpaid report year 2010 costs a year ago.

Statistical and predictive challenges are inherent in actuarial analysis of claims data, and estimates of future payouts may turn out to be insufficient. The Fund may suffer from years of bad experience, and has done so in the past – see underwriting cash flows on Table 1 and loss ratios on Table 2. The Fund's most obvious viability concern is one or more many-defendant/many-plaintiff cases – for a historical example, see 2002 reported losses on Table 2 and operating reserve decline on Table 4, which reflect about \$9.3 Million from a Hepatitis "C" outbreak that arose at a clinic in Fremont.

A stable environment contributes to certainty in actuarial estimates, but the medical malpractice insurance environment has been dynamic and at times very challenging actuarially. During the Fund's history, claims-made coverage has almost replaced occurrence coverage, reducing the Fund's exposure to IBNR.

Insurance markets are not always healthy, but in recent years Nebraska medical malpractice insurance has been profitable. Ever-changing health care provider practices including risk management improvements should help contain insurance costs. Reversals on any of these fronts could cause increases in cost that erode the adequacy of an actuarial estimate.

Alternative estimates of each report year's future ultimate payout for known claims appear on Table 2 below. Both actuarial and adjusters' estimates are reasonable, but their reasonableness differs as a report year matures. The estimates vary more widely in report years 2009-2011, reflecting greater uncertainty in less mature report years. In earlier years, it is prudent to rely on adjusters' estimates for the few cases still pending, but for the least mature report years (2009-2011) the actuary recommends reliance on the (lower) actuarial central estimates.

Four actuarial methods support this year's actuarial known claims estimates:

- 1) Traditional paid loss and ALAE development method: This is similar to what the Nebraska actuary has used in the past, and assumes that over time, future payout as a report year matures will be similar to historical payouts as previous report years matured.
- 2) Traditional reported loss and ALAE development method: Adjusters' case reserves are added to cumulative paid-to-date data prior to measuring development. This assumes that adjusters' case reserving practices and estimates have been consistent over time. Case reserving was not consistent over the Fund's early history, but appears to have been consistent since at least 2006.
- 3) Least-squares regression method – primary premium basis: Least-squares estimation (LSE) uses a weighted average of two measures: first an estimated ultimate amount from a traditional paid-loss-and-ALAE development method, and second, an average ultimate amount from previous report years. In our "primary premium basis" variation, both measures are taken in units of paid loss and ALAE per dollar of Fund participants' primary written premium. The actuary avoided dividing losses by the Fund's revenue because that revenue reflects the surcharge rates. The actuary expects to partially predict the Fund's ultimate payout by report year by including participants' primary annual written premium in the calculation. The Least-Squares-Estimate of the report year's ultimate amount is a weighted average of the two measures, with the weight on the first measure being great when there was high correlation between historical report years' paid-to-date amount at a given age and historical ultimate amounts.
- 4) Least-squares regression method – report year loss and ALAE basis: This is identical to the first LSE method, but the actuary has substituted a different denominator in the two measures. In place of participants' primary annual written premium, the actuary expects the sum of adjusters' case estimates for each report year (evaluated at report year age 12 months) to partially predict the Fund's ultimate payout by report year.

In all cases, the actual ultimate payouts will differ from the estimates. For any given report year, or for all report years combined, it is possible that actual ultimate payouts will exceed, even significantly exceed actuarial estimates, adjusters' case estimates, or both.

IBNR

We have considered the Fund's actual loss and ALAE experience since 1976 on both a report year and accident year basis. The report year basis is appropriate for analysis of claims known to the Fund at each historical year end (including 2011), and the four supporting actuarial methods are described above. The accident year basis would be appropriate for analysis of claims, if they were insured on an occurrence basis.

The supporting actuarial methods are numbered 1) to 3) above. The denominator for method 4) is not applicable to accident year analysis. If the coverage were 100% on an occurrence basis, the accident year analysis should logically produce ultimate loss and ALAE estimates greater than the report year analysis, and the difference between them should be for claims that have occurred, but have not yet been reported (i.e. excluding expected future development on known claims). At 2011, this difference happens to be \$5.595 Million.

But the Fund's situation is not typical of reserving for purely Claims Made or purely Occurrence coverage. First, the Fund waits for claim reports while the primary carriers record, investigate, and at some point determine which few cases to present as claims to the Fund. The Fund does not know primary claims-made dates, but the actuary has roughly estimated the average delay to be 3 months and the amount to be 30% of the \$5.595 Million, or \$1.679 Million. Second, the actuary thinks only 16% of the remaining 70% is for Occurrence coverage, leading him to an IBNR estimate equal to 70% of 16% of \$5.595 Million, or \$626.7 Thousand. The combined IBNR estimate from the two situations is \$2.305 Million.

The 2011 change in IBNR is \$1.305 Million. The \$1.679 Million for primary claims-made reporting lag is new, partially offset by a \$373.3 Thousand decrease to IBNR for occurrence coverage.

This IBNR analysis is subject to uncertainties, including the usual statistical and predictive challenges inherent in actuarial analysis of claims data, dynamic factors in medical malpractice insurance outlined above, plus one specific unknown: primary claim report dates are not captured in the Fund actuarial data, so the Fund cannot measure delays between primary insurers' report dates and the Fund's report dates.

Appendix B. 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. Following widespread practice in general liability insurance, the underlying required limits are expressed in two amounts separated by a “slash mark.” The first applies under a provider’s policy “per occurrence” and the second is a “total liability” for two or more occurrences. The act also establishes a “cap” on the damages any single 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.

Appendix C. History of Surcharge Rates

<u>Hospital Surcharge</u>	<u>Time Period</u>	<u>Surcharge for Physicians & Others</u>
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% (corrected from 2010 Rep't)	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, increased the underlying coverage requirement to \$500,000 per occurrence from \$200,000 on a phased-in basis during 2005, resulted in successive reductions to the Fund’s surcharge rate to the current 20%, after having risen to the maximum 50% between 2000 and 2003.

Table 5. Surcharge Rates and Voluntary Participation

Calendar Year	(1) Medical Professional Direct Premiums Written	(2) Nebraska Excess Liability Fund Surcharge Rate	(3) = (1) X (2) Fund Revenue at 100% Participation Would Be:	(4) Actual Nebraska Excess Fund Revenue	(5) = (4) / (3) Actual Market Participation (Premium Volume)
1998	23,010,742	5%	1,150,537	610,325	53.0%
1999	18,732,040	5%	936,602	628,943	67.2%
2000	20,093,240	5%	1,004,662	901,435	89.7%
2001	24,110,258	20%	4,822,052	3,866,753	80.2%
2002	26,540,646	35%	9,289,226	6,444,233	69.4%
2003	32,008,670	50%	16,004,335	10,041,551	62.7%
2004	34,071,147	50%	17,035,574	11,418,984	67.0%
2005	36,804,243	50%	18,402,122	12,799,247	69.6%
2006	37,643,926	45%	16,939,767	12,466,351	73.6%
2007	36,964,825	40%	14,785,930	10,407,093	70.4%
2008	35,935,098	35%	12,577,284	9,495,284	75.5%
2009	36,400,709	35%	12,740,248	9,298,293	73.0%
2010	36,885,608	35%	12,909,963	8,485,764	65.7%
2011	36,321,600	20%	7,264,320	5,313,025	73.1%
5 Years	182,507,840	33%	60,277,745	42,999,459	71.3%
14 Years	453,003,221	32%	146,736,644	102,177,281	69.6%

In comparing the Surcharge Rates in column (2) with the Actual Market Participation rates in column (5), it stands to reason that very low surcharge rates (from 1998 to 2000) encouraged market participation (peaking in 2000). Maximum surcharge rates (2003 to 2005) prompted a mixed market participation response. After the 2005 implementation of LB 998, the Fund’s losses and ALAE decreased faster than the surcharge rate, and participation slipped in 2010 before rebounding in 2011. So there is evidence that participation, which is voluntary, has been sensitive to the Department’s selected surcharge rate, in context with the market, primary underlying limits, and excess coverage to be provided by the Fund in the coming year.