

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



**ANNUAL REPORT
As of December 31, 2012**

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, as required by the Nebraska Hospital-Medical Liability Act (adopted in 1976). Revenues primarily consist of a surcharge levied on Nebraska health care providers participating voluntarily in the Excess Liability Fund, 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 mostly include payments for 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 focuses on the Fund’s 2012 assets, operating results, liabilities and operating reserve. In this report, the terms “estimated” or “expected” refer to actuarially derived averages of possible future outcomes. In effect, the actual future may turn out to be significantly better or worse than our best current estimates and expectations. Supporting commentary and history are in 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 2012 with assets of \$89.87 Million, and added \$1.46 Million to end the year with \$91.33 Million. On a cash basis, the Fund received \$4.77 Million revenue, paid \$9.10 Million loss and loss adjustment expense, and paid \$0.17 Million administrative expenses. Underwriting cash flow (revenue minus the sum of paid losses and expenses) was minus \$4.50 Million. Since investment activity added \$5.96 Million, the Fund’s assets increased this year by \$1.46 Million.

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

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Calendar Year	Beginning Cash & Invested Assets	Direct Written Premium	Paid Loss and Loss Expense	Administrative Expenses	Direct Underwriting Cash Flow	Investment Activity	Annual Change in Assets	Year End Cash & Invested Assets
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
2012	89,872,354	4,769,655	9,100,443	173,464	(4,504,251)	5,960,884	1,456,632	91,328,986

“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 2012 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 12/31/2012

As of 12/31/2012, the actuarially estimated unpaid liability for claims that have been presented to the Fund is \$17.551 Million. Adjusters’ case estimates for the same claims add up to \$21.000 Million. Our best estimate reserve for claims presented to the fund as of 12/31/2012 is \$19.275 Million (see Table 2, Column (6) below). This is the average of our \$17.551 Million actuarial best estimate shown in Column (4) and the \$21.000 Million sum of adjusters’ case estimates shown in Column (5). The difference between Columns (5) and (6) means we expect case reserves to fund all claims reported to the Fund as of 12/31/2012, with \$1.72 Million left to partially provide for the Fund’s IBNR. The supporting actuarial analysis is not attached to this report, but Appendix A includes an outline of the actuarial analysis and its uncertainties.

Table 2. Actuarial, Adjusters' and Selected Reserve Estimates (000's)
Claims Made Coverage as of 12/31/2012 for Indemnity and Claims Expenses

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
				= (2) - (3)			= (3) + (6)	= (7) / (1)
Report Year	Nebraska Excess Liability Fund Revenue (000's)	Actuarial Ultimate Claims-Made Incurred	Cum. RY Paid Indemnity and Expense	Actuarial Estimated Claims Made Reserve	Adjusters' Estimated Case Reserves	Best Estimate Claims-Made Reserve	Best Estimate Ultimate Claims-Made Incurred	Estimated Ultimate Indemnity and Claims Expense Ratio
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	16,836	16,836	-	-	-	16,836	261.3%
2003	10,042	10,934	10,897	38	-	19	10,915	108.7%
2004	11,419	8,790	8,744	46	-	23	8,767	76.8%
2005	12,799	15,012	14,913	99	-	50	14,963	116.9%
2006	12,466	11,581	11,374	207	-	104	11,477	92.1%
2007	10,407	8,965	8,546	419	-	209	8,756	84.1%
2008	9,495	4,866	3,884	982	-	491	4,375	46.1%
2009	9,298	6,437	4,661	1,776	2,650	2,213	6,874	73.9%
2010	8,486	7,109	3,871	3,238	5,600	4,419	8,290	97.7%
2011	5,313	8,296	3,445	4,851	8,150	6,501	9,946	187.2%
2012	4,770	7,169	1,275	5,894	4,600	5,247	6,522	136.7%
10 Yrs	94,495	89,161	71,610	17,551	21,000	19,275	90,885	96.2%

Table 2, Column (8) shows 14 years’ ratios of ultimate claims-made paid loss and claims expense to the Fund’s annual revenue, with a ten year total. High loss ratios in 1999-2000 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 96.2%, which means the Fund’s revenue was about 4% more than the decade’s incurred claims and claims expenses. However, our estimates of the Fund’s 2011 and 2012 loss ratios are respectively 187% and 137%, and since yearend 2011 our estimate for the 2011 report year developed adversely from 140%. Such elevated ratios mean those years’ surcharge rates produced revenue considerably below the Fund’s underwriting costs.

Claims Incurred but Not Reported (IBNR) to the Fund

Table 2 addresses the Fund’s liability for claims already presented to the Fund through 12/31/2012. The Fund also bears liability for certain claims expected to emerge at later dates:

- 1) The Fund’s Excess coverage follows 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 identifies it as one of the few likely to exceed the Fund threshold. At 2012 we estimate this waiting time to average three months, and this portion of the Fund’s IBNR to be \$1.69 Million.
- 2) The Fund also receives IBNR claims due to occurrence coverage underwritten by primary insurers including the Fund’s Residual Authority and “tail” coverage provided by primary insurers when a physician switches insurers, retires, dies or is disabled. As of 2012, we estimate the Fund’s coverage to be 16% occurrence-basis, and this portion of the Fund’s IBNR to be \$1.66 Million.
- 3) At 2012 as stated above, we expect adjusters’ case reserves to fund all claims reported to the Fund as of 12/31/2012, with \$1.72 Million extra to partially provide for the Fund’s IBNR.

Adding 1) and 2), then subtracting 3), our estimate of the Fund’s 2012 IBNR liability are \$1.63 Million. 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. Underlying assumptions are that all policies are written on annual terms with premiums written evenly though the year. For 2010 only, a potentially more precise formula was used that depended on estimated policy effective dates. Having not captured actual effective dates, and being uncomfortable estimating them, 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
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
2007	10,407,093	5,203,546	2012	4,769,655	2,384,828

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 2012, the Fund's operating reserve increased by \$3.46 Million, to \$68.0 Million. The 2012 outcome reflects investment activity improved over 2011 (see Table 1, Column (6)), partially offset by loss ratio adversity (see Table 2, Column (8) for Report Years 2011-2012).

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
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
2012	91,328,986	19,275,299	1,630,000	2,384,828	68,038,860	3,455,875

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 \$37.6 Million from 2005-2010.

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 2009-2012 due in part to reductions in the surcharge rate. See Appendix B for the legislative history and Appendix C for the surcharge rate history.

From 2010 to 2012 the operating reserve has held fairly steady at \$65-68 Million. At 2012, the Fund's \$68.0 Million operating reserve is 94% stronger than the maximum that historically guided the Department's surcharge rate review. If 2013 investment activity, losses and expenses emerge at expected levels, we expect the 18% current surcharge rate to produce a modest operating reserve decrease in 2013.

Questions? – Contact Gordon Hay, Gordon.Hay@nebraska.gov, 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) of Table 2, in the body of the report above, summarize results of applying multiple actuarial methods to Fund data accumulated since July, 1976.

The \$19.275 Million reserve for known claims is down \$1.052 Million from \$20.327 Million at 2011.

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 did so in 2002. See Report Year 2002 on Table 2 above (loss ratios) or Table 5 below (Col. (8) cumulative paid loss and expense), which include about \$9.3 Million from a Hepatitis "C" outbreak that arose at a clinic in Fremont. The Fund's most obvious viability concern is one or more many-defendant/many-plaintiff cases.

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 5 below. Four actuarial methods shown in Columns (1) to (6) support this year's actuarial known claims estimates, with Column (7) showing the actuary's selection based on results from the six methods:

- 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. This method's estimated ultimate loss and expense ('000's) by report year are shown in Column (1) of Table 5.
- 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. This method's estimated ultimate loss and expense (000's) by report year are shown in Column (2) of Table 5.
- 3) 5 Years 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. This method is applied to five-year histories of the Fund's paid versus reported loss ratios to primary premium. This method's estimated ultimate loss and expense (000's) by report year are shown in Column (3) for paid data and Column (4) for reported data.
- 4) 15 Year 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. The actuary used 15 year averages because this denominator is less stable than the primary premium volume used for the fourth method. This method's estimated ultimate loss and expense (000's) by report year are shown in Column (5) for paid data and Column (6) for reported data. Column (6) for 2012 is blank because this method using this denominator is mathematically inapplicable to the current 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.

Both actuarial and adjusters' estimated reserves, shown in Columns (9) and (10), are reasonable. However, actuarial estimates vary most for report years 2010-2012, reflecting uncertainty when using low-volume data from the least mature report years. In earlier years, it is prudent to give some credence to adjusters' estimates for any cases still pending. For the least mature report years (2010-2012) adjusters' case estimates have historically been a bit conservative so some credence is due to the (often lower) actuarial

central estimates for recent years. At 2012, an effective balance is achieved in Column (11) of Table 5, by selecting the average of actuarial and adjusters' estimates for each historical report year.

**Table 5. Actuarial, Adjusters' and Selected Reserve Estimates (000's)
Known Claims as of 12/31/2012**

Report Year	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	Reported LDF Ult. Dollars	Paid LDF Ult. Dollars	5 Year Paid LSE Method Ult. - Primary Revenue Base	5 Year Reported LSE Method Ult. - Primary Revenue Base	15 Year Paid LSE Method Ult. - RY Case Incurred Base	15 Year Reported LSE Method Ult. - RY Case Incurred Base	Selected Incurred Indemnity & Expense	Cumulative Report Year Paid Indemnity and Expense	Actuarially Estimated Known Claims Reserve	Adjusters' Estimated Case Reserves	Selected Best Estimate Known Claims Reserve
							** See Note.		= (5) - (6)		*** See Note.
1992	4,178	4,178			4,178	4,178	4,178	4,178	-	-	-
1993	3,510	3,510			3,510	3,510	3,510	3,510	-	-	-
1994	3,610	3,610			3,610	3,610	3,610	3,610	-	-	-
1995	4,149	4,149			4,149	4,149	4,149	4,149	-	-	-
1996	7,881	7,881			7,881	7,881	7,881	7,881	-	-	-
1997	4,751	4,751			4,751	4,751	4,751	4,751	-	-	-
1998	3,581	3,581			3,581	3,581	3,581	3,581	-	-	-
1999	8,163	8,163	8,163	8,163	8,163	8,163	8,163	8,163	-	-	-
2000	9,377	9,377	9,377	9,377	9,377	9,377	9,377	9,377	-	-	-
2001	7,756	7,756	7,756	7,756	7,756	7,756	7,756	7,756	-	-	-
2002	16,836	16,836	16,836	16,836	16,836	16,836	16,836	16,836	-	-	-
2003	10,897	10,934	10,934	10,897	10,934	10,897	10,934	10,897	38	-	19
2004	8,744	8,790	8,790	8,744	8,790	8,744	8,790	8,744	46	-	23
2005	14,895	15,012	15,012	14,895	15,012	14,895	15,012	14,913	99	-	50
2006	11,095	11,581	11,581	11,095	11,581	11,095	11,581	11,374	207	-	104
2007	8,196	8,950	8,965	8,016	8,872	8,120	8,965	8,546	419	-	209
2008	3,603	4,152	4,866	3,477	3,444	3,451	4,866	3,884	982	-	491
2009	6,166	5,403	6,313	5,965	6,437	6,158	6,437	4,661	1,776	2,650	2,213
2010	8,245	5,855	6,757	7,963	6,608	7,625	7,109	3,871	3,238	5,600	4,419
2011	10,048	8,513	8,356	8,418	8,114	8,539	8,296	3,445	4,851	8,150	6,501
2012	5,673	21,046	11,638	5,462	4,407		7,169	1,275	5,894	4,600	5,247
10 Years	87,563	100,237	93,213		84,200		89,161	71,610	17,551	21,000	19,275

Note: The current case reserves total 21 Million compared to an estimated ultimate 19.28 Million required. I expect this estimated case reserve redundancy to fund 1.72 Million of the Fund's IBNR liabilities.

** Selected = max (1) to (6) except Report Year 2010-2012 selected = average (3) to (5).

*** Selected = average (9) and (10)

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 2012), 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 2012, this difference is \$12.06 Million (up from \$5.595 Million at 2011).

But Claims Made reports reach the Fund later than the primary carriers' report dates, and we believe the Fund responds to a coverage mix that was last estimated as of 2009 to be 84% Claims Made and 16% Occurrence.

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 roughly estimates the average delay to be 3 months. At 2012, this implies about 14% of the \$12.06 Million, or \$1.69 Million provides for claims reported to primary carriers that are not yet reported to the Fund.

Second, we think only 16% of the coverage provided is on an Occurrence basis, so our occurrence IBNR estimate is 86% of 16% of \$12.06 Million, or \$1.66 Million. Combined with the \$1.69 Million above, the Fund's liability for unreported claims from the two sources is \$3.35 Million.

Third, please note that in Tables 2 and 5, we expect adjusters' estimates at \$21.00 Million to be \$1.72 Million more than needed for our known claims' ultimate cost. We expect this \$1.72 Million to fund some of the \$3.35 Million liability for unreported claims. The remaining \$1.63 Million is the Fund's 2012 IBNR, which appears in Table 4 Column (3).

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%	1/1/1981	25%
1%	1-1-82 - 12-31-84	1%
50%	1-1-85 - 12-31-87	50%
50%	1/1/1988	45%
45%	1/1/1989	45%
40%	1/1/1990	40%
35%	1/1/1991	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 Report)	1-1-11 – 12-31-2012	20%
18%	1-1-13 – until revised	18%

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. The surcharge rate was reduced in succeeding years as experience was favorable and the total assets of the Fund increased. Starting with January 1, 2001 surcharge rates increased as the Fund’s losses were increasing significantly, and past loss reserves were developing unfavorably. The surcharge rate rose to the maximum 50% between 2000 and 2003.

LB 998, passed in 2004, increased the underlying coverage requirement to \$500,000 per occurrence from \$200,000 on a phased-in basis during 2005. Reductions to the surcharge rate followed. The current 18% rate is below the actuarially recommended 20%.

Table 6. Surcharge Rates and Voluntary Participation

	(1)	(2)	(3) = (1) X (2)	(4)	(5) = (4) / (3)
Calendar Year	Medical Professional Direct Premiums Written	Nebraska Excess Liability Fund Surcharge Rate	Fund Revenue at 100% Participation Would Be:	Actual Nebraska Excess Fund Revenue	Actual Market Participation (Premium Volume)
1998	23,010,742	5%	1,150,537	610,325	53.05%
1999	18,732,040	5%	936,602	628,943	67.15%
2000	20,093,240	5%	1,004,662	901,435	89.73%
2001	24,110,258	20%	4,822,052	3,866,753	80.19%
2002	26,540,646	35%	9,289,226	6,444,233	69.37%
2003	32,008,670	50%	16,004,335	10,041,551	62.74%
2004	34,071,147	50%	17,035,574	11,418,984	67.03%
2005	36,804,243	50%	18,402,122	12,799,247	69.55%
2006	37,643,926	45%	16,939,767	12,466,351	73.59%
2007	36,964,825	40%	14,785,930	10,407,093	70.39%
2008	35,935,098	35%	12,577,284	9,495,284	75.50%
2009	36,400,709	35%	12,740,248	9,298,293	72.98%
2010	36,885,608	35%	12,909,963	8,485,764	65.73%
2011	36,321,600	20%	7,264,320	5,313,025	73.14%
2012	35,474,134	20%	7,094,827	4,769,655	67.23%
5 Years	181,017,149	33%	52,586,642	37,362,021	71.05%
15 Years	470,996,886	32%	152,957,448	106,946,936	69.92%

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 and slipping again in 2012. So the Surcharge Rates have responded (but not instantaneously) to changes in the coverage provided. Participation, which is voluntary among the eligible disciplines, has at times 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. For some reason in 2012, despite no change in Fund coverage or surcharge rate, participation on a premium volume basis declined 5%.