Injured Patients and Families Compensation Fund

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Injured Patients and Families Compensation Fund

The Injured Patients and Families Compensation Fund provides payments to injured patients for malpractice claims that exceed a health care provider's primary malpractice coverage. State statutes require most full-time Wisconsin physicians to participate in the fund and pay fees to finance the payment of claims and the fund's operation. All fund participants receive unlimited medical malpractice insurance coverage for claims that exceed a mandatory level of primary coverage purchased separately by participating providers. The fund was created in 1975, and is codified under Chapter 655 of the Wisconsin Statutes, and Insurance Administrative Rule 17.

This paper provides an overview of the fund's management, participation, provider fees, and the process by which patients make claims against the fund. Finally, the paper provides information about the fund's finances, including a discussion of the transfer from the fund under the 2007-09 biennial budget, and the subsequent Wisconsin Supreme Court decision reversing that transfer.

Provider Participation

Wisconsin law requires certain health care providers to participate in the fund, makes participation optional for other providers, and exempts others from participation. In order to participate, the provider must hold a primary layer of medical malpractice coverage, and pay an annual fee to the fund.

Participating Providers. Statutes require certain health care providers to participate in the fund, including physicians, certified registered nurse anesthetists (CRNAs), hospitals, corporations, and other organizations based in Wisconsin. Most of the health care providers who have the option of participating in the fund are either part-time providers, or providers not based in Wisconsin. Appendix I lists the groups of providers for whom participation in the fund is mandatory, optional, or not required.

For participating providers, the fund's excess medical malpractice insurance covers the health care provider and their employees acting within the scope of their employment, with some exceptions. For exempted providers, the exemptions apply only to professional activities covered by the exemption, and not to activities performed outside the scope of that employment. Fund participation is required for all non-exempt activities that meet the mandatory participation criteria. In such cases, the fund's coverage applies only to malpractice claims arising from the provider's non-exempt activities.

Table 1 provides the number of health care providers actively participating in the fund, and Wisconsin providers who were exempted from participation, at the end of 2011. The number of health care providers participating in the fund has steadily increased over the past fifteen years, growing from 11,485 participants in 1996, to 15,124 participants in 2011. The majority of participating providers are physicians or surgeons.

At the end of 2011, 10,208 health care providers were exempt from fund participation. Most of those exemptions arose either because the provider did not practice mainly in Wisconsin, or because the provider practiced less than 240 hours during the year.

Primary Malpractice Insurance. To benefit from the fund's excess medical malpractice insurance, providers must maintain the minimum level of primary medical malpractice insurance re-

Table 1: Participating and Exempted Providers, as of December 31, 2011

Participating Providers			Exempted Providers		
Provider Category	Number	% of Total Participants	Basis for Exemption	Number	% of Total Exemptions
Physicians	13,003	86.0%	Practicing Outside of Wisconsin	2,693	26.4%
Corporations	1,210	8.0	Practicing less than 240 hours	2,641	25.9
Certified Registered Nurse Anesthetists	648	4.3	Not Yet Practicing or Never Practiced	1,507	14.8
Hospitals	137	0.9	State, County or Municipal Employees	1,487	14.6
Ambulatory Surgery Centers	52	0.3	Retired	1,200	11.8
Partnerships	33	0.2	Federal Employees	534	5.2
Hospital-affiliated Nursing Homes	20	0.1	Temporarily Ceased Practice	146	1.4
Hospital-owned or -controlled Entities	20	0.1			
Cooperatives	1	<0.1	Total	10,208	100%
Total	15,124	100%			

quired by law. Currently, those minimum coverage amounts are $1 million per occurrence or claim, and $3 million for all occurrences or claims in any policy or reporting year. If the provider's primary coverage exceeds the statutory minimum, the fund's excess coverage triggers when the provider's primary layer of coverage is exhausted.

Administrative rules require an insurance policy to contain certain provisions to satisfy a provider's insurance obligations under Chapter 655. A provider can satisfy the primary insurance requirement by purchasing coverage from an insurer licensed to do business in Wisconsin, or by qualifying as a self-insurer. While most providers buy primary coverage from a private insurer, some purchase coverage from the Wisconsin Health Care Liability Plan, a separately-licensed health care liability insurer created by statute and governed by the fund's Board of Governors. As of June 30, 2012, the plan provided primary medical malpractice coverage to 267 providers.

Annual Fee. Health care providers must pay an annual assessment to participate in the fund. The Board of Governors sets the assessment amount, and the Commissioner of Insurance promulgates the associated administrative rule. The provider's fee amount depends on factors such as the risk level of a participating physician's area of practice, and the past and prospective loss experience of the fund. Pinnacle Actuarial Resources Inc., the fund's actuary, analyzes estimated liabilities and financial position to help determine the assessment amounts.

The fund's fee schedule establishes four physician payment classes, grouped by types of practice with similar exposure to loss. For example, practices with lower exposure to loss such as family or general practitioners are in Class 1, while providers with higher exposure to losses such as OB/GYN surgeons are in Class 4. Chapter 655 states that no more than four payment categories can exist based on the amount of surgery performed and the risk of services provided by the physician. Within these four payment classes, fees vary based on factors such as the number of hours the physician practices during the fiscal year, and primary place of residence.

The Board also sets fees for participating organizations, based on the size of the organization and the types of health care professionals it employs. A participating corporation is subject to a base assessment, plus per-provider fees for each health care provider employed.

Appendix II provides major annual fees for

fiscal year 2012-13. Table 2 shows fees for physicians and CRNAs for whom Wisconsin was a principal place of practice, for fiscal years 2003-04 through 2012-13. For all of the fees charged by the fund, see Insurance Chapter 17 of the Wisconsin Administrative Code.

Table 2: Fees for Physicians/Surgeons, FY 2003-04 to FY 2012-13

Year	Class 1	Class 2	Class 3	Class 4
2003-04	$1,534	$2,761	$6,366	$9,204
2004-05	1,227	2,209	5,092	7,362
2005-06	859	1,546	3,565	5,154
2006-07	1,074	1,933	4,457	6,444
2007-08	1,128	2,030	4,681	6,768
2008-09	1,128	2,030	4,681	6,768
2009-10	1,240	2,231	5,144	7,438
2010-11	1,347	2,423	5,387	8,888
2011-12	1,461	2,629	5,844	9,643
2012-13	1,534	2,760	6,165	10,125

In addition to these base fees, the provider's medical malpractice loss and expense experience may affect the provider's assessment level. Statutes require every insurer that writes medical malpractice insurance in Wisconsin and every self-insurer to report to the fund all claims paid for damages from the rendering of health care services. The Board of Governors, along with a board-appointed five-member peer review council, reviews those claims to determine if a surcharge should be added to that provider's annual fund assessment. Since the peer review council was established in 1986, through December 31, 2011, 65 providers have been reviewed for possible surcharge, with two providers assessed a surcharge.

Claims

Chapter 655 establishes the process for individuals to pursue medical malpractice claims, including claims against the fund. These provisions apply to any patient, or a patient's representative, spouse, parent, minor sibling or child who has a derivative claim for injury or death on account of medical malpractice.

While state law allows health care providers to obtain either occurrence coverage or claims-made coverage to satisfy their statutory obligations, the fund itself provides occurrence coverage. That means the fund offers coverage for incidents that occur during a year in which the participating health care provider has coverage under the fund, regardless of when the patient or family makes the claim.

A total of 5,806 medical malpractice claims have named the fund as a party from the fund's inception through December 31, 2011, with the fund paying a total of $810.3 million for 662 claims. Of the remaining claims, 5,003 resulted in no payment, and 141 cases were pending.

Mediation Process. Before seeking damages for medical malpractice through court action, claimants may participate in the mediation system created in Chapter 655. The legislative intent behind this mediation process is to provide an informal, inexpensive, and expedient means for resolving disputes without litigation. While Chapter 655 initially established mediation as mandatory, subsequent court cases have ruled that the mediation process be voluntary.

To initiate mediation, the claimant submits a written request for mediation to the Director of State Courts identifying the claimant and patient, and the allegedly negligent health care provider. The mediation request must also describe the condition or disease that was treated and the injury allegedly caused by provider negligence. The Director of State Courts sends a copy of the mediation request to all health care providers identified in the request, and to the fund. The Director of State Courts then appoints a three-person me-

diation panel comprised of a health care provider, a lawyer, and a member of the public who is neither a health care provider nor a lawyer, to hear the dispute. The mediation period generally expires 90 days after the Director of State Courts receives the request for mediation if the request is delivered in person, unless the parties agree to extend these periods.

The mediation process is designed to be relatively informal and inexpensive, and is conducted without a stenographic record, other transcript, or the administration of any oaths. Statutes also prohibit the order of physical examinations, the production of records, the subpoena of witnesses, and the use of expert witnesses, opinions or reports. However, mediation participants must provide to each other and to the mediation panel all patient health records of the claimant. The statute also allows participants, including the fund, to be represented by a lawyer.

Court Actions. A person filing a malpractice claim can recover from the fund only if the provider has coverage under the fund, the fund is named as a party in the court action, and the action against the fund commences within the same time limit in which the action against the provider must commence. The fund retains and pays for its own legal counsel to represent the fund on each claim.

Chapter 655 generally limits the contingency fees a claimant's legal counsel can collect to no more than one-third of the first $1 million recovered, and no more than 20% of any portion of a recovery that exceeds $1 million. A court may approve contingency fees in excess of these amounts under exceptional circumstances. In addition, an attorney can charge the client on an hourly or per diem basis, in which case the fees are not subject to these limitations.

Chapter 655 also defines the manner and timing in which certain claimants receive money from the fund. First, if a settlement or judgment provides for more than $100,000 in future medical expenses, the portion of such damages in excess of $100,000 is paid into the fund and disbursed for those expenses until the money is exhausted or the patient dies. Second, if a settlement or judgment causes the fund to incur liability for future payments in excess of $1 million to any person under a single claim, the fund pays the full medical expenses each year, plus an amount not to exceed $500,000 per year that will pay the remaining liability over the person's anticipated lifetime, or until the liability is paid in full.

Economic and Non-economic Damages. Plaintiffs in medical malpractice cases often seek both economic and non-economic damages. Economic damages can include past and future medical costs and lost income. Chapter 655 does not place any explicit limits on the amount of economic damages plaintiffs can recover in a medical malpractice case. As a result, there is no statutory limit to the liability the fund may incur for economic damages if a participating health care provider commits medical malpractice.

Chapter 655 defines noneconomic damages as compensation for pain and suffering, humiliation, embarrassment, worry, mental distress, loss of consortium, society and companionship, or loss of love and affection. Non-economic effects of disability include the loss of enjoyment of the normal activities, benefits and pleasures of life and the loss of mental or physical health, well-being, or bodily functions.

Prior to 2005, Wisconsin law limited the recovery of non-economic damages for certain types of claims in medical malpractice cases to $350,000, adjusted annually for inflation. As a result of the Wisconsin Supreme Court decision under *Ferdon v. Wisconsin Patients Compensation Fund*, and subsequent action by the Legislature, noneconomic damages for medical malprac-

tice claims arising from occurrences after April 6, 2006 are limited to $750,000, but no limit applies to the recovery of such damages for claims arising from occurrences before that date. Wisconsin law also limits non-economic damages for wrongful death claims in cases of medical malpractice -- those limits of $500,000 per occurrence in the case of a deceased minor and $350,000 per occurrence in the case of a deceased adult were not addressed in *Ferdon* and remain in effect.

Fund Management

A 13-member Board of Governors ("the Board") manages the fund, and is comprised of the following representatives:

- The Commissioner of Insurance (or his or her delegate) who serves as Chairperson of the Board;

- Three representatives of the insurance industry appointed by the Commissioner of Insurance;

- One person named by the State Bar Association, and one person named by the Wisconsin Association for Justice (formerly the Wisconsin Academy of Trial Lawyers);

- Two people named by the Wisconsin Medical Society, and one person named by the Wisconsin Hospital Association; and

- Four members of the public appointed by the Governor, at least two of whom are not lawyers, doctors, or professionally associated with any hospital or insurance company.

The Board's duties include approving the annual provider fee schedule and contracting for services provided to the fund, such as actuarial services. The Board receives support from staff in the Office of the Commissioner of Insurance (OCI), various Board committees, and outside entities. By March 1 of each year, the Board must present fund members and the standing committees on insurance in each house of the Legislature with a summary of fund activities in the previous calendar year. The State of Wisconsin Investment Board manages the fund's investments.

Financial Operations

This section reviews the fund's recent financial operations and financial position. The appendices to this paper provide the statement of net equity, showing the fund's assets and liabilities at the end of a given fiscal year, and the statement of revenues and expenses, showing the total income or loss over the course of a given fiscal year. Additional information and explanatory notes regarding these statements are available in the fund's annual Functional and Progress Report.

Fund Condition. The annual statement of net equity shows the fund's total assets, total liabilities, and total net equity as of the end of each fiscal year. Appendix III provides full statements of net equity as of June 30 for fiscal years 2009-10, 2010-11, and 2011-12, and Table 3 summarizes the fund's statement of net equity at the end of 2011-12. Appendix IV provides the statement of revenues, expenses, and change in net equity for those fiscal years 2009-10, 2010-11, and 2011-12.

As of June 30, 2012, the fund reported total assets of $1,028.5 million (comprised of current, or short-term, and non-current, or long-term, assets) and total liabilities of $667.2 million, resulting in a surplus of $361.3 million. Most of the fund's assets are invested in fixed-income securi-

ties, with a substantially smaller percentage invested in equities (limited to no more than 20% of the total portfolio by Board investment policy).

Table 3: Statement of Net Equity, as of June 30, 2012 ($ in Millions)

Assets	
Total Current Assets	$119.3
Total Non-Current Assets	909.2
Total Assets	*$1,028.5*
Liabilities	
Total Current Liabilities	$83.6
Total Non-Current Liabilities	583.6
Total Liabilities	*$667.2*
Total Net Equity	**$361.3**

The statement of net equity includes liabilities incurred by the fund that do not result in claims until some point in the future. In any given year, the fund makes payments to injured patients and families who have filed successful claims against the fund. However, in that same year incidents of medical malpractice occur that will not result in losses to the fund until the malpractice is discovered, a claim is filed, and the case is resolved. These are referred to as losses "incurred but not reported" (IBNR), and comprise the largest source of liabilities for the fund. The majority of the total liabilities shown in the statement of net equity reflect an actuarial estimate of these IBNR liabilities.

Estimating the fund's total liabilities is an important function, both for financial reporting purposes, and for establishing the level of annual assessments. Accurately estimating IBNR liabilities is difficult. The fund's estimated liabilities are continually reviewed and adjusted based on a number of factors such as the fund's evolving loss experience, changes in interest rates, and other economic and legal changes.

The fund's primary sources of income include the assessments collected from fund participants and the investment income earned on assets held by the fund. The fund's main expenses are underwriting and administrative expenses. Appendix IV provides a statement of revenues, expenses and change in net assets for fiscal years 2009-10, 2010-11 and 2011-12. The transfers to the MA trust fund in the 2007-09 biennium, and the amount due to the fund after the reversal of these transfers are shown in these statements.

Transfer from the Fund. The Governor's 2007-09 biennial budget bill proposed a transfer from the fund to a health care quality fund (HCQF). The Assembly deleted this provision. However, the Conference Committee on the budget restored the provision, but allocated the transfer of funds to the Medical Assistance (MA) trust fund and deleted provisions in the bill that would have created the HCQF. These Conference Committee provisions were included in the final 2007-09 biennial budget act (2007 Wisconsin Act 20), transferring $200 million over the biennium ($71.5 million in 2007-08, and $128.5 million in 2008-09) to the MA trust fund. Act 20 also established a sum sufficient general fund appropriation, limited to $100 million, to fund any claim that the fund must pay but has insufficient monies for the payment.

In October, 2007, the Wisconsin Medical Society (WMS) filed suit in Dane County Circuit Court, challenging the legality of this transfer. WMS asserted that the transfer constituted an "unconstitutional taking without just compensation" from health care providers and injured patients and families, represented an unconstitutional impairment of contract, violated equal protection under the law, violated statute, deprived constitutional rights outside the authority of state law, and was an invalid tax.

The Circuit Court dismissed the WMS lawsuit in December, 2008, ruling that the transfer from the fund was legal. All of the claims made by

WMS with the exception of the unconstitutional takings claim were found to be barred by the doctrine of sovereign immunity, which prevents the state from being sued in certain circumstances. The judge also dismissed the unconstitutional takings claim on the basis that the plaintiffs did not have a "protectable property interest in the Fund," even though the doctrine of sovereign immunity did not apply to that claim.

In March, 2009, WMS appealed the Circuit Court decision, and the Wisconsin Supreme Court accepted the appeal for consideration. Following oral arguments, the Supreme Court reversed the Circuit Court ruling by a vote of 5 to 2 on July 20, 2010. In the majority opinion, the Court ruled that participating health care providers have a protected property interest in the fund, and that the Act 20 transfer was an unconstitutional taking of private property without just compensation.

The Court ordered that the state replace the $200 million removed from the fund, as well as lost earnings and interest charged to the fund. Additionally, the Court issued a permanent injunction prohibiting the transfer of money out of the fund under the provisions of Act 20. The case was sent back to the Circuit Court to determine the final amount of interest and lost earnings due to the fund.

Following this decision, the Legislature passed 2011 Wisconsin Act 27, authorizing a transfer of up to $235 million from the state's general fund to the injured patients and families compensation fund by June 30, 2012, to satisfy the terms of the pending settlement amount. In July, the Dane County Circuit Court issued a final order in which the state was required to transfer a total of $233,747,081.35 to the injured patients and families compensation fund by October 1, 2011. The final order and injunction from the circuit court specified that $691,106.46 be paid to the Wisconsin Medical Society for legal expenses incurred. The state made this payment to the fund on August 1, 2011, and this repayment is reflected in the most recent financial statements.

Additional Information

Additional information on the Injured Patients and Families Compensation Fund can be found through the following sources.

Injured Patients and Families Compensation Fund Website, Office of the Commissioner of Insurance:
www.oci.wi.gov/pcf.htm

2011 Functional and Progress Report:
www.oci.wi.gov/ipfcf/progrpt2011.pdf

Wisconsin Legislative Audit Bureau, 2010 Audit Report:
w*ww.legis.wisconsin.gov/lab/reports/10-4full.pdf*

APPENDIX I

Mandatory, Optional, and Exempted Participation in the Fund

Mandatory Participation	Optional Participation	Exempt from Participation
A physician or certified registered nurse anesthetist (CRNA) whose principal place of practice is Wisconsin, and who practices in Wisconsin for more than 240 hours per year.	A physician or CRNA whose principal place of practice is Wisconsin, but who practices for less than 241 hours in a fiscal year.	A physician or CRNA employed by the state, county, municipal, or federal government, or contractor covered under the federal tort claims act, who is acting within the scope of his or her employment or contractual duties.
A physician or CRNA whose principal place of practice is Michigan, and who meets all the following criteria: (a) is a Wisconsin resident; (b) practices in Wisconsin, Michigan, or both for at least a combined 240 hours; and (c) performs most of his or her procedures in a Michigan hospital that is an affiliate of a Wisconsin corporation.	A physician or CRNA whose principal place of practice is not Wisconsin (except as provided for certain providers whose principal place of practice is Michigan). Only activities performed in this state are covered by the fund.	A physician or a CRNA who provides professional health care services under the state's volunteer health care provider program, with respect to those professional services for which the provider covered by s. 165.25 of the statutes (regarding legal defense by the Attorney General) and considered an agent of the Department of Health Services.
A corporation or other organization operating in Wisconsin for the primary purpose of providing the medical services of physicians or CRNAs.	A graduate medical education program in Wisconsin.	A facility such as a county hospital, juvenile correctional facility, county home and infirmary, or public health dispensary that is exempt from certain hospital regulations under s. 50.39(3) of the statutes, or operated by any governmental agency.
A partnership of physicians or CRNAs organized and operated in Wisconsin for the primary purpose of providing the medical services of physicians or CRNAs.		
A hospital operating in Wisconsin.		
A hospital-affiliated entity operating in Wisconsin that diagnoses, treats or cares for patients of the hospital.		
An ambulatory surgery center operating in Wisconsin.		
A nursing home whose operations are combined with a hospital, whether or not the nursing home is physically separate from the hospital.		

APPENDIX II

Selected Provider Fees, Fiscal Year 2012-13*

Provider Fees

	Class 1	Class 2	Class 3	Class 4
Physician/Surgeon	$1,534	$2,760	$6,165	$10,125
Resident Physician/Surgeon	767	1,380	3,083	5,063
Full-time Faculty, Medical College of Wisconsin	617	1,104	2,470	4,075
Out-of-state Physician/Surgeon	767	1,380	3,083	5,063
Half-time Physician/Surgeon (1,040 hours or less per year)	920	1,656	3,699	6,075

Resident Practicing Outside Scope of Residency ("Moonlighter")	$921
Part-time Physician/Surgeon (Fewer than 500 hours per year)	383

Nurse Anesthetist	$376
Out-of-state Nurse Anesthetist	188

Facility/Organization Fees

Partnership/Corporation Size	Flat Fee
2 to 10 Partners, Physicians and Nurse Anesthetists	$54
11 to 100 Partners, Physicians and Nurse Anesthetists	529
Over 100 Partners, Physicians and Nurse Anesthetists	1,318

Fee Per Employed Professional, Charged to a Facility/Organization
(in addition to Flat Fee)

Podiatrist - Surgical	$6,519
Advanced Nurse Midwife	3,527
Nurse Midwife	3,375
Oral Surgeon	2,302
Chiropractor	613
Advanced Nurse Practitioner	537
Advanced Practice Nurse Prescriber	537
Nurse Practitioner	383
Dentist	307
Optometrist	307
Physician Assistant	307

* See Insurance Chapter 17 of the Wisconsin Administrative Code for a complete fee schedule.

APPENDIX III

Statement of Net Equity*
As of June 30, Fiscal Years 2009-10, 2010-11, and 2011-12

Assets

	2009-10	2010-11	2011-12
Current Assets			
Cash	$88,481	$290,011	$90,622
State Investment Fund (SIF) Shares	18,267,861	9,439,625	39,887,604
SIF Shares Interest Receivable	8,908	5,077	9,296
Short-term Investments	35,682,131	30,806,972	69,593,881
Investment Income Receivable	7,146,038	7,116,504	9,452,522
Assessments Receivable	4,550	250,024	245,847
MA Trust Fund Advance**	0	233,747,081	0
Other Supplies, Receivables and Current Assets	46,783	27,349	26,739
Total Current Assets	*$61,244,752*	*$281,682,643*	*$119,306,511*
Noncurrent Assets			
Long-term Investments	$555,906,309	$615,282,693	$874,699,029
Estimate of Amount Due From MA Trust Fund**	202,587,765	0	0
Restricted Assets -- Future Medical Expenses	35,059,139	37,190,375	34,010,396
Software (in use and in progress)	327,561	377,700	467,351
Total Noncurrent Assets	*$793,880,774*	*$652,850,768*	*$909,176,776*
Total Assets	*$855,125,526*	*$934,533,411*	*$1,028,483,287*

Liabilities

Current Liabilities			
Loss Liabilities	$86,334,986	$79,816,675	$82,214,231
Advance Assessments	718,971	2,463,069	208,982
Provider Refunds Payable	370,658	732,653	1,059,192
General/Administrative Expenses Payable	80,639	892,131	54,662
Medical Mediation Fees Payable	159	37,834	12,420
Compensated Employee Absences	690	23,525	17,946
Total Current Liabilities	*$87,506,103*	*$83,965,887*	*$83,567,433*
Noncurrent Liabilities			
Losses Incurred But Not Reported	$655,652,804	$610,453,190	$619,211,193
Losses Reported	56,028,392	7,149,424	20,146,674
Loss Adjustment Expense	124,918,894	109,580,634	112,230,853
Estimated Loss Liabilities	*$836,600,090*	*$727,183,248*	*$751,588,720*
Minus Amount Representing Interest	-150,588,016	-127,870,547	-119,821,247
Discounted Loss Liabilities	*$686,012,074*	*$599,312,701*	*$631,767,473*
Future Medical Expense Liabilities	35,059,139	37,190,375	34,010,396
Total Loss Liabilities	*$721,071,213*	*$636,503,076*	*$665,777,869*
Minus Current Portion	-86,334,986	-79,816,675	-82,214,231
Total Noncurrent Loss Liabilities	*$634,736,227*	*$556,686,401*	*$583,563,638*
Compensated Absence and Retirement Liabilities	80,352	82,704	90,602
Total Noncurrent Liabilities	*$634,816,579*	*$556,769,105*	*$583,654,240*
Total Liabilities	*$722,322,682*	*$640,734,992*	*$667,221,673*
Total Net Equity (Assets minus Liabilities)	**$132,802,844**	**$293,798,419**	**$361,261,614**

* Unaudited financial statements are obtained from Fund Functional and Progress Reports and financial information provided by fund staff. See Functional and Progress Reports for additional information and notes on these asset and liability categories.
** "Estimate of Amount due from the MA Trust Fund" in 2009-10 represented the estimated amount at the time that the Statement of Net Equity was prepared, and was included as a non-current asset. In 2010-11, the full amount was accounted for as a current asset.

APPENDIX IV

Revenues, Expenses and Change in Net Equity*
Fiscal Years 2009-10, 2010-11, and 2011-12

Operating Revenues/Expenses

	2009-10	2010-11	2011-12
Operating Revenues			
Assessments	$29,627,550	$33,191,145	$36,371,756
Assessment Interest	51,350	331	-40
Assessment Administrative Fee	34,691	35,553	35,684
Total Operating Revenues	*$29,713,591*	*$33,227,029*	*$36,407,400*
Operating Expenses			
Net Losses	$3,879,618	$33,587,316	$1,211,182
Loss Adjustment Expenses (LAE)	4,585,068	4,874,519	3,867,772
Risk Management Expenses	90,072	46,280	57,390
Medical Expenses Paid	2,472,169	1,787,542	1,472,998
Change in Liability for Losses Incurred but not Reported	26,106,944	-45,199,615	8,758,003
Change in Liability for Reported Losses	22,988,180	-48,878,968	12,997,250
Change in Liability for LAE	22,266	-15,338,260	2,650,219
Change in Amount Representing Interest	-2,541,269	22,717,469	8,049,300
Change in Liability for Future Medical Expenses	88,691	2,131,236	-3,179,979
Total Underwriting Expenses	*$57,691,739*	*-$44,272,481*	*$35,884,135*
General, Administrative and Other Expenses	$745,320	$1,013,410	$532,255
Depreciation	0	27,290	35,643
Total Operating Expenses	*$58,437,059*	*-$43,231,781*	*$36,452,033*
Total Operating Income/Loss	*-$28,723,468*	*$76,458,810*	*-$44,633*

Nonoperating Revenues/Expenses

Investment Income	$67,999,399	$54,074,633	$67,517,498
Interest Expense	-68,440	0	0
Miscellaneous Revenue	3,730	-681,858	6,854
Total Nonoperating Income/Loss	*$67,934,689*	*$53,392,775*	*$67,524,352*
Operating and Nonoperating Income/Loss (Before Transfers)	**$39,211,221**	**$129,851,585**	**$67,479,719**
Court-ordered Transfer from MA Trust Fund**	$202,573,719	$31,159,316	$0
Other Transfers from Fund	0	-15,323	-16,525
Net Assets -- Beginning of Year	**-$108,982,094**	**$132,802,846**	**$293,798,424**
Net Assets -- End of Year	**$132,802,846**	**$293,798,424**	**$361,261,618**

* Unaudited financial statements are obtained from Fund Functional and Progress Reports and financial information provided by fund staff. See Functional and Progress Reports for additional information and notes on these asset and liability categories.
** 2009-10 amount is the estimated amount due from the MA Trust Fund at the time that the Statement of Net Equity was prepared, with the balance of the $233 million accounted for in 2010-11.