

Wyoming Insurance Department
Annual Report, 2006

WYOMING QUALITY OF LIFE RESULTS:

Wyoming residents have affordable and accessible health care and insurance.

Our Contribution to Wyoming Quality of Life:

Department staff members help Wyoming citizens deal with insurance issues and complaints by working with insurers, producers (agents) and providers to solve problems.

A well-regulated insurance market provides Wyoming citizens, their families and their children with important protections through life, health, homeowner, auto and other types of insurance. The Department staff helps assure the competency and financial solvency of the insurance industry serving Wyoming citizens.

Wyoming state government is a responsible steward of state assets and effectively responds to the needs of residents and guests.

Our Contribution to Wyoming Quality of Life:

The Wyoming Department of Insurance regulates the business of insurance in Wyoming in a fair and consistent manner for the protection and benefit of Wyoming citizens, their families and their children.

BASIC FACTS:

The Wyoming Department of Insurance has 27 staff members dedicated to serving Wyoming citizens, their families and their children. The Department consists of five sections: Administrative (8); Financial Services and Finance Accounting (6); Education and Licensing (4); Consumer Affairs (5); and Policy Review (4).

The 2007-2008 biennium administrative budget of the Department is \$4,473,663. No state general funds (tax monies) are used to fund the Department's budget. The 1,100+ insurance companies licensed to do business in Wyoming are each assessed annually an equal amount to fund the Department's budget. The Department also oversees the budgets of the Board of Insurance Agent Examiners (\$15,773 for the 2007-2008 biennium) and the Wyoming Health Insurance Pool (\$23,362,277 for the 2007-2008 biennium).

Primary functions of the Department:

1. Consumer assistance, protection and outreach with regard to insurance issues.

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2. Collection of premium taxes, fees and assessments due the state of Wyoming. In calendar year 2005, net premium taxes alone equaled \$15,405,868.

3. Provision of fair and consistent regulation of insurance producers (agents), adjusters and companies operating in Wyoming.

4. Provision of administrative oversight to the following programs: Wyoming State Health Insurance Information Program, Wyoming Small Employer Health Reinsurance Program, Wyoming Health Insurance Pool, State of Wyoming Employees' and Officials' Group Insurance Plan, Wyoming Life and Health Insurance Guaranty Association, Wyoming Insurance Guaranty Association, Wyoming Health Benefit Plan Committee, State Board of Insurance Agent Examiners and the Wyoming Insurance Producer Continuing Education Program.

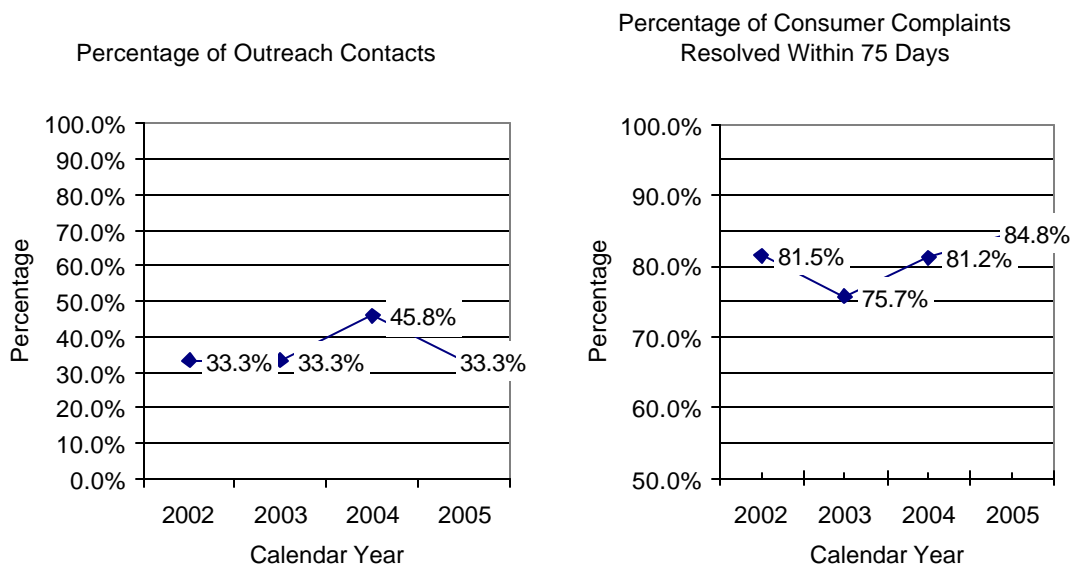
5. Maintenance of the Department's accreditation for financial solvency standards with the National Association of Insurance Commissioners.

PERFORMANCE:

The following three performance measures and the related graphs show the Department's performance over the last year. These performance measures will be the focus of the Wyoming Department of Insurance during the 2007-2008 biennium.

PERFORMANCE MEASURE 1

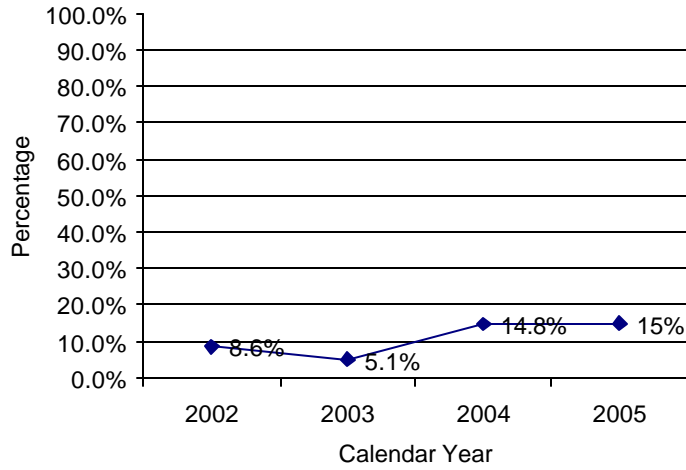
Increased Consumer Contact/Assistance



PERFORMANCE MEASURE 2

Creation of a Market Conduct Section

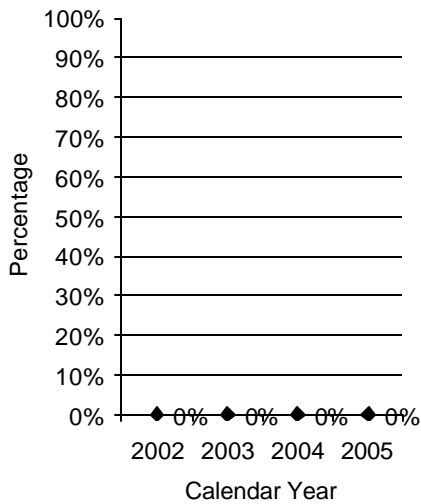
Percentage of Issues Subject to Market Conduct Review



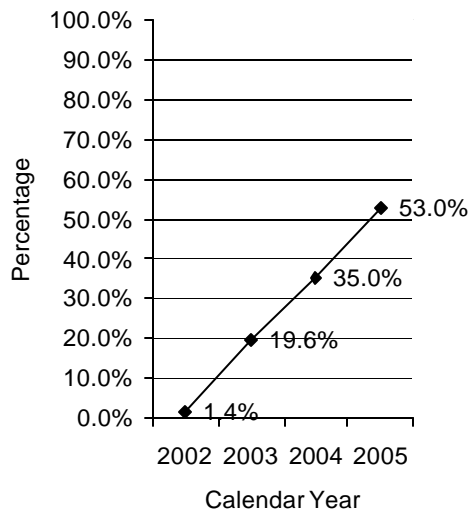
PERFORMANCE MEASURE 3

Increased Departmental Electronic Operations

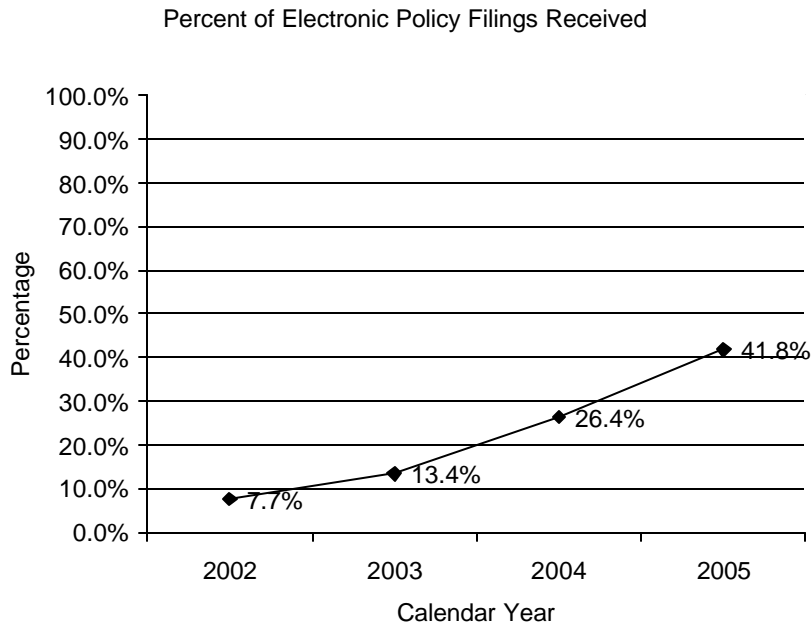
Percentage of Electronic Consumer Complaints Received



Percentage of Electronic Applications Filed



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STORY BEHIND THE LAST YEAR OF PERFORMANCE AND WHAT HAS BEEN ACCOMPLISHED:

The Department's new Agency Strategic Plan covers the period of July 1, 2006 to June 30, 2008. The data and information reported here is based upon the new plan's performance measures, but is compiled from the period prior to the plan being in effect. Therefore, some of the proposals set forth in the new plan have not yet been implemented and complete data may not be available.

The percentage of outreach contacts under Performance Measure 1, Increased Consumer Contact/Assistance, declined from 45.8 percent in 2004 to 33.3 percent in 2005. The Department has determined that it should have a minimum of 24 outreach contacts per year with Wyoming citizens. Beginning with July 1, 2006, the start date of the strategic plan, the Department must, and will, assure that outreach contacts are increased to meet the 24 per year goal.

The percentage of consumer complaints resolved within 75 days under Performance Measure 1, Increased Consumer Contact/Assistance, increased from 81.2 percent in 2004 to 84.80 percent in 2005. The Department needs to assure that this percentage continues to rise.

The Department was able to add an additional consumer advocate staff position with the approval of its most recent budget by the legislature. This position, when hired, should aid the Department in resolving consumer complaints in a faster manner. The increase in the consumer complaints resolved percentage shows the Department is, even with current staff, moving in the right direction in order to resolve complaints in a timely manner.

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Further, in 2005 the Department assisted Wyoming citizens in obtaining monies due them from insurance companies. The total collected in 2005 was \$831,721. This is an increase from \$621,381 in 2004.

The Department is beginning to track more closely its contacts with Wyoming consumers. For instance, from December 2005 to June 2006, the Department had 4,623 calls involving consumer insurance issues with 2,382 of those calls taking place directly with consumers. The remainder of the calls were made to insurers, agents and others in an effort to resolve consumer issues. The Department intends to track other consumer contacts such as web site hits.

The Department also intends to create an electronic newsletter, issue press releases, provide Wyoming consumers the ability to fill out and file complaints electronically, and to use consumer questionnaires to determine concerns and needs of Wyoming citizens. These are ongoing projects under the strategic plan which will help the Department better address consumer needs

The percentage of issues subject to market conduct review under Performance Measure 2, Creation of a Market Conduct Section, increased from 14.8 percent in 2004 to 15 percent in 2005.

The Department was successful in getting approval in its most recent budget for a market contact staff position. Once this position is hired, it should increase the percentage of issues subject to a market conduct review. The Department has not yet filled this position, or the new client advocate position, because of office space needs and the fact that the Department is in the process of locating new office space and moving out of the Herschler Building. The Department intends to build a market conduct section around the market conduct position which should lead to additional help for Wyoming citizens with current insurance problems.

The percentage of electronic applications filed under Performance Measure 3, Increased Departmental Electronic Operations, increased from 35 percent in 2004 to 53 percent in 2005. The Department staff is continuing to encourage applicants to file licensing applications and renewal forms electronically.

The percent of electronic policy filings received under Performance Measure 3, Increased Departmental Electronic Operations, increased from 26.40 percent in 2004 to 41.80 percent in 2005. The Department staff is continuing to encourage insurers to file policy forms electronically.

The increase in both of the above percentages indicates that the Department has been successful in becoming less reliant on paper files and, therefore, more efficient in providing services to its customers.

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The percentage of electronic consumer complaints received under Performance Measure 3, Increased Departmental Electronic Operations, remains at 0percent. The Department is continuing to develop a method to give consumers the ability to fill out and file consumer complaints electronically with the Department through its website. Consumers can already email, fax or mail the complaint form to the Department. Further, consumers can go to the National Association of Insurance Commissioners' (NAIC) website and complete a complaint form which can then be emailed to the Department. The Department staff anticipates that a method to fill out and file a complaint form on its website will be completed within the near future.

The Department, as part of its strategic plan, will also create an electronic newsletter as indicated above, and work to place continuing education course information and compliance status on the Department's website.

The Department, during the past year, changed from a server-based database to a web-based database. This gives licensees and applicants the ability to access on line licensing services connected to the Department. This has the effect of encouraging the use of electronic methods in dealing with the Department.

In summary, the Department has had good results over the past year in meeting some of its new performance measures. However, the Department is just beginning to implement its new strategic plan proposals which should improve the Department's effectiveness in reaching out to Wyoming citizens even more. The Department's goal is to meet all of its performance measures in full.

SUMMARY OF CLAIMS AGAINST WYOMING HEALTH CARE PROVIDERS AS REQUIRED BY WYO. STAT. § 26-3-124

Introduction

Wyoming Statute § 26-3-124 requires any insurer writing coverage for health care malpractice in Wyoming to file with the Insurance Commissioner a report of all claims against a health care provider and a report of all awards or settlements given in cases against health care providers. The statute lists specific items that must be reported.

The law was originally adopted in 1976, but was significantly amended and expanded in 2005, to add additional reporting requirements. These requirements related to specific information for each claim against health care providers. The original law only required aggregate information regarding all claims.

The first reports from insurers under the amended law were due on March 1, 2006, and the information contained in the reports is to be included in the Department's annual report to the Governor. The statute requires that any information provided the Commissioner under the law shall be confidential including the names of health care providers and any records pertaining thereto. The Commissioner is to prepare a summary

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of the information, in the aggregate if necessary to protect the identity of the health care provider or claimant.

The compilation of the information provided under this law is a work in progress. This is the first year that many of the insurers were required to report and insurers that did report in the past were now required to report additional and more detailed information. The Department created reporting forms which were used for the first time this year. Although follow-up requests were made of some insurers, some of the information required remains incomplete, missing or inconsistent. The Department will continue to pursue this information and may file an amended summary if additional significant information is obtained.

Because of the interest in professional liability insurance for physicians and surgeons over the past several years, this summary contains specific information on the results for the three insurers covering the bulk of the doctors in the state for malpractice.

Aggregate

Forty-four companies reported in their annual financial statements premium for coverage of health care providers for professional liability in 2005. Although reminder notices were sent out, aggregate reports were received from only 38 of those insurers. Thirty-eight companies reported insuring 3126 health care providers covering 42 different categories of health care providers, such as nurses, doctors, surgeons, dentists, chiropractors, hospitals and clinics. There were some discrepancies between what was reported in the aggregate reports and what was reported in the individual claims reports. Thirteen companies reported 154 claims on the aggregate reports, while 20 companies reported 165 claims on the individual reports. Likewise, the aggregate reports showed total claims of \$9,865,282 while the individual reports showed \$7,628,804.05 in total claims.

Specialty Coverages

While there were some inconsistencies in the way the various insurers described specialty coverage for the claims, the Department can summarize the claims in the following categories: 2 acute care hospitals; 1 ambulance service; 6 anesthesiology related; 5 cardiology; 3 chiropractic; 20 related to clinics/corporate-group practices/entities; 1 county health department; 4 dentists; 1 dermatology; 4 emergency medicine; 10 family practice; 14 general surgery; 18 gynecology/obstetrics; 33 hospitals; 9 internal medicine; 1 laboratory; 1 neurology; 1 neurosurgeon; 14 orthopedic surgery; 1 otolaryngology; 3 pathology; 2 pediatrics; 1 pharmacist; 1 plastic surgery; 1 podiatrist; 2 radiology; 1 rheumatology; 1 supplemental provider; 1 thoracic-cardiovascular surgery; 2 urological surgery; and 1 urologist.

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Nature and Substance of Claims

The following malpractice codes were reported: 11 delayed treatment; 20 failures to diagnose; 2 failure to inform/lack of informed consent; 66 mistake in performance/improperly performed; 1 not performed; 6 other procedural errors, including mis-prescription of medication; 12 failure to prevent harm; 8 lack of supervision; 3 wrong procedure/procedure not indicated; 34 other causes not listed; and 2 were not identified. The following injury codes were reported: 14 bone damage; 4 birth injuries; 6 circulatory injuries; 1 disease; 5 diminished life expectancy; 9 diminished use/loss of use; 2 dental injury; 1 dermal injury; 2 disfigurement; 42 deaths; 2 foreign body; 19 infections; 2 infection/loss or limb/organ; 4 loss of limb/organ; 14 non-physical; 10 nervous system; 5 organ injuries; 1 failure to prevent inmate suicide; 7 pain; 9 prolonged recovery/care; 3 side effects; 1 reproductive system; and 2 not identified.

Ages of Claimants

Claimants fell into the following age ranges: Six infants or newborns; 7 between 1 and 10; 11 between 11 and 20; 11 between 21 and 30; 18 between 31 and 40; 31 between 41 and 50; 39 between 51 and 60; 14 between 61 and 70; 9 between 71 and 80; 4 between 81 and 90; and age not specified on 15 claims.

Manner of Disposition

Insurers report that claims were disposed of in the following manner: Four judgments in the amount of \$1,699,280; 31 settlements in the amount of \$5,422,661; 6 by arbitration in the amount of \$502,000; 4 in favor of health care providers at trial; 6 denied; 7 closed due to inactivity; 7 claims withdrawn; 23 were closed for other unspecified reasons in the amount of \$4,863; and 77 claims remain pending.

Amounts Paid to Claimants

The following amounts were reported in the individual report forms as paid to claimants. (Please note that the aggregate reports showed total claims of \$9,865,282).

\$7,628,804.05	Total Claims – comprised of:
2,121,901.66	Economic damages
3,894,241.49	Non-economic damages
1,612,660.90	Not broken down between economic and non-economic damages

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In addition, the following were reported:

945,523	Medical and prescription costs (Some insurers included the medical and prescription costs in their total claims, while other insurers reported these separately and in addition to their total claims)
2,197,064	Attorney fees
1,491,615	Costs and expenses

Major Insurers:

The following three companies insure the largest number of physicians in Wyoming for professional liability:

The Doctors Company (TDC) reported insuring 293 health care providers, mostly physicians and surgeons. There were 56 claims filed against TDC, 10 of which resulted in payments to the claimant (all by settlement without trial) in the total amount of \$2,571,000 (\$986,000 economic; \$1,585,000 noneconomic). Medical and prescription costs were reported at \$624,000; attorneys fees at \$530,438 and general expenses at \$276,791.

OHIC Insurance Company (OHIC) reported insuring 23 hospitals and 39 physicians. There were 51 claims filed against OHIC, 16 of which resulted in payments to claimants. Two of these claims related to the same matter and a jury trial awarded \$1,175,000 (\$230,000 economic and \$945,000 noneconomic) for the two claims. The remainder of the claims resulted in claims paid of \$2,257,161 (\$663,377 economic; \$1,318,123 noneconomic; and \$275,661 was not broken down between economic and noneconomic damages). Medical and prescription costs were reported at \$319,345; attorneys fees at \$1,212,177; and costs and expenses at \$557,006.

Utah Medical Insurance Association (UMIA) reported insuring 352 health care providers. There were 10 claims filed against UMIA, 2 of which resulted in payments to the claimant in the total amount of \$600,000, 1 by settlement and the other by arbitration. UMIA reported \$48,599 for attorney fees and \$605,607 in general costs and expenses.

Notes:

There is some duplication or overlapping of reporting due to the fact that a claimant may have filed claims against more than one health care provider who may or may not have been covered by the same carrier.

Some risk retention groups, which are generally subject to federal and not state law, did not provide the information requested by the Department.