



District of Columbia Medical Liability Captive Insurance Company

Plan of Operation

In accordance with D.C. Official Code § 1-307.87(a), the District of Columbia Medical Liability Captive Insurance Company Establishment Act ('Act'), the captive manager of the District of Columbia Medical Liability Captive Insurance Company ('Company') hereby submits for approval by the Commissioner of the Department of Insurance, Securities and Banking ('Commissioner') a plan of operation ('Plan') designed to assure the fair, reasonable and equitable administration of the Company. Upon approval by the Commissioner the Plan shall be submitted to the Risk Officer of the Company for approval.

(B.2) Procedures for the operation of the Company

The company shall operate under the control and guidance of the Risk Officer, Advisory Council, and the captive manager. Experts in the fields of actuarial analysis, insurance and reinsurance, clinical loss prevention, and other expertise have been and will continue to be engaged as necessary to provide advice and recommendations. The captive manager shall oversee the operations of the Company and report its status and financial condition to the Risk Officer and the Commissioner in accordance with all governing laws and regulations.

(B.3) Procedures for health centers to qualify to purchase medical malpractice insurance

The health centers must comply with all the requirements of the Act and those informational requests of the Risk Officer and the captive manager related to risk assessment. Once the level of risk has been assessed based using the captive's underwriting guidelines, an appropriate premium will be charged to the health center assuming the health center meets the underwriting criteria. The health center may also have to comply with certain loss prevention, procedural and training requirements in order to qualify to purchase medical malpractice insurance.

(B.4) Procedures for offering gap coverage

The Risk Officer, using the services of insurance and actuarial experts to measure the exposure associated with gap coverage, will price and offer insurance, if warranted, to the District's Federally Qualified Health Centers.

(B.5) Procedures for the payment of administrative expenses

The Office of Risk Management will receive and review all invoices for all administrative expenses of the Company. Once verified as being appropriate for payment, they will be forwarded to the Risk Officer for approval and payment following the established procedures of the Office of Risk Management.

(B.6) Procedures for adjustment and payment of claims

Claims will first be reviewed by the Risk Officer and Advisory Council. Depending upon the circumstances outside legal counsel will be selected and engaged to defend the claim and the claim will be reported to the third party claims administrator, if necessary, for assistance with claims administration. The hourly rate of counsel and support staff will be approved by the Risk Officer. All invoices from legal counsel will be sent to the captive manager and will be subject to the same payment procedures as for administrative expenses. Claims will be monitored by the Advisory Council on a frequency of at least once a quarter. The settlement and payment of a claim must receive the approval of the Risk Officer.

(B.7) Procedures for tail coverage to health centers purchasing medical malpractice coverage

The tail coverage risk of the health centers prior to the inception of the Company was evaluated by an actuarial consultant. It was determined that the exposure was small and therefore the Company gave retro coverage to the health centers for no additional premium. If a health center were to cancel or not renew its insurance purchased from the Company then the risk associated with the tail coverage going forward will be evaluated by an actuary and either 1) a premium will be charged for the tail coverage, 2) it will be provided for no additional premium or 3) the coverage will be cancelled.

(B.8) Development of standards for the level of subsidies that shall be provided to health centers to offset premiums due the Company

The Risk Officer will take under advisement the recommendations of an actuary as regards the premium to be charged to the health centers. The Risk Officer will also consider the capital and surplus in the Company, the claims that have been reported to date, and the budgetary constraints faced by the health centers. After considering all of these factors the Risk Officer will determine the level of subsidy.

(B.9) Establish rules, conditions and procedures for facilitating the reinsurance of risks of participating health centers

Prior to the issuance of the first policy by the Company the cost of reinsuring a layer of risk from the Company to commercial markets was evaluated. Using the results of an actuarial study it was determined that the cost to purchase the reinsurance was not cost effective and that the Company had enough financial strength to retain the risk.

On an annual basis and with the assistance of actuarial and insurance brokerage professionals, the Risk Officer will evaluate the risk retained by the Company. Based upon that evaluation, if the risk is deemed to warrant consideration of the purchase of reinsurance quotes will be obtained and the decision to retain or transfer risk will be reevaluated.

(B.10) Establish risk management standards to which the health centers shall adhere and auditing procedures for compliance

Prior to the issuance of the first policy by the Company an evaluation of the risk management standards in effect at the health centers was conducted. Based upon the results of this study, the Risk Officer established risk management standards together with auditing procedures for compliance. These procedures will be evaluated by the Advisory Council on an annual basis and updated as necessary.

(B.11) Establish underwriting guidelines for policyholders

Underwriting guidelines for policyholders have been established and are based upon the medical services provided by each health center, the number of physicians and their specialties, the hours worked by the physicians, the number of persons who visit the health center, and the number and type of medical procedures undertaken each year. This data is reviewed by a qualified actuary on an annual basis in arriving at the premium rating and underwriting guidelines.

(B.12) Provide for other matters as may be necessary and proper for the execution of the Risk Officer's and captive manager's respective powers, duties and obligations under the Act.

To date none have been identified.

Assuming you find the responses to be in order, we will forward to you supporting documentation related to the operations of the company and the points described with the intention of securing written confirmation of the Commissioner's approval.

Please let us know if you have questions.

Sincerely,