2011 Long Term Care
General Liability and Professional Liability Actuarial Analysis
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Introduction

Purpose

With the support of the American Health Care Association (AHCA), the Actuarial and Analytics Practice of Aon Global Risk Consulting (Aon) conducted an actuarial analysis of general liability and professional liability (GL/PL) claim costs incurred by the long term care operators in the United States.

Scope

The specific objectives of this study are to:

• Identify the overall trends in the cost of GL/PL claims for long term care
• Identify state specific trends in the cost of GL/PL claims for long term care
• Examine trends in frequency and severity overall and on a state by state basis
• Compare liability costs in jurisdictions that do or do not have substantive tort reform
• Explore the impact of Alternative Dispute Resolution (ADR) on GL/PL claims for long term care

An overview of the findings can be found in the Executive Summary section of this report.

Please contact us if you have any questions regarding this report.

Respectfully submitted,

Christian Coleianne, FCAS, MAAA
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Executive Summary

Key Findings

Overall Loss Rates and Trends
Based on the actuarial analysis of GL/PL claims data collected from long term care providers on a national level:

- Long term care liability costs, or loss rates, are increasing by 3% annually.
- The 2012 forecast accident year long term care GL/PL loss rate is $1,470 per bed.
- The frequency of long term care liability claims is decreasing at a 1% annual rate.
- The frequency of long term care GL/PL claims is forecast to be 0.89% for the 2012 accident year, or about one claim per 112 occupied beds.
- The severity of long term care liability claims is increasing at a 4% annual rate overall.
- The severity of long term care GL/PL claims will grow to $165,000 per claim for accident year 2012.

Tort Reform and Loss Rates
In the late 1990s and early 2000s, tort reform legislation was enacted in a number of states as a way to combat and control escalating liability costs. These tort reform efforts generally included limits on non-economic damage awards.

Nearly ten years later, states with substantive tort reform continue to experience lower loss rates than those that do not have substantive tort reform. However, the presence of limits on non-economic damages alone does not determine the effectiveness of tort legislation. West Virginia and California, two states with $250,000 limits on non-economic damages, are among the highest cost states profiled in this report. In contrast, Texas tort limits, combined with constitutional protections, have resulted in one of the lowest cost levels in this report.

Arbitration
In recent years, operators have increasingly cited arbitration (also called Alternative Dispute Resolution, or ADR) as an effective tool to resolve claims. This report supports that the use of ADR is associated with lower liability costs.

While claims are rarely actually arbitrated, when a valid ADR agreement is in place, the claims are 25% less costly than claims that are closed without a valid ADR agreement in place. When the validity of ADR agreements is challenged, ADR agreements are found unenforceable less than 15% of the time.

Causes of Loss
Long term care providers can gain insight into clinical practices by understanding the types of allegations that give rise to liability costs. Understanding the leading contributors to liability costs can support clinical efforts to reduce the incidence or severity of common claim allegations.

“Falls with Injury” is the most common claim allegation in the database. “Pressure Ulcer/Wounds” is the costliest type of injury in the database.
Advisory Benchmarks

The following table presents a summary of our findings for long term care GL/PL.

**LTC Benchmarks and Annual Trends for Losses Limited to $1 million per Occurrence**

<table>
<thead>
<tr>
<th>Advisory Benchmark</th>
<th>Projected 2012 Benchmark</th>
<th>Selected Annual Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Frequency*</td>
<td>0.89%</td>
<td>-1.00%</td>
</tr>
<tr>
<td>Indemnity Frequency*</td>
<td>0.72%</td>
<td>-1.00%</td>
</tr>
<tr>
<td>Severity</td>
<td>$165,000</td>
<td>4.00%</td>
</tr>
<tr>
<td>Loss Rate*</td>
<td>$1,470</td>
<td>3.00%</td>
</tr>
</tbody>
</table>

*per occupied bed

The 2012 loss rate is $1,470 and is projected to grow by 3% annually.

State Findings

The following chart shows loss rate levels for the states that are profiled in this study. The states were profiled based on the volume of data we received, the stability of the results compared to prior years, and the number of providers represented in the data.

**Projected LTC Loss Rates for Losses Limited to $1 Million per Occurrence**

<table>
<thead>
<tr>
<th>State/Group</th>
<th>Aon Database ¹</th>
<th>Projected 2012 Loss Rate ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>4.8%</td>
<td>$2,080</td>
</tr>
<tr>
<td>Indiana</td>
<td>5.1%</td>
<td>$500</td>
</tr>
<tr>
<td>Kentucky</td>
<td>3.9%</td>
<td>$3,330</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>5.1%</td>
<td>$430</td>
</tr>
<tr>
<td>Minnesota</td>
<td>2.8%</td>
<td>$790</td>
</tr>
<tr>
<td>Ohio</td>
<td>7.1%</td>
<td>$630</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>12.3%</td>
<td>$870</td>
</tr>
<tr>
<td>Tennessee</td>
<td>4.3%</td>
<td>$2,690</td>
</tr>
<tr>
<td>Texas</td>
<td>3.9%</td>
<td>$340</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>3.1%</td>
<td>$680</td>
</tr>
<tr>
<td>West Virginia</td>
<td>2.4%</td>
<td>$4,020</td>
</tr>
<tr>
<td>All Other States</td>
<td>45.3%</td>
<td>$1,720</td>
</tr>
<tr>
<td>Tort Reform States</td>
<td>42.6%</td>
<td>$1,280</td>
</tr>
<tr>
<td>Non-Tort Reform States</td>
<td>57.4%</td>
<td>$1,640</td>
</tr>
</tbody>
</table>

¹ Percent of Exposures
² per occupied bed
Database

In an effort to present a comprehensive analysis from the perspective of all long term care providers, Aon disseminated a request for data to for-profit and not-for-profit providers including independent providers, regional multi-facility providers and national multi-facility providers.

The results presented in this study are based on the ensuing database of long term care GL/PL losses and allocated loss adjustment expenses (ALAE) as reported to us by 28 long term care providers. Approximately 17,000 individual non-zero claims from long term care facilities were aggregated. The facilities represented in the national study operate approximately 260,000 long term care beds, consisting primarily of skilled nursing facility beds but also including a number of independent living, assisted living, home health care and rehabilitation beds. They represent approximately 14% of the beds in the United States.

For the results presented on arbitration and the disposition of claims, a closed claim database from a subset of providers was used. These providers have robust claims coding and a history of using arbitration since the early 2000s.

The results found in this study are representative of the participants. Providers that did not participate may have different results, either higher or lower. This may be due to any number of reasons, including levels of effectiveness in quality of care initiatives and the attractiveness of the provider for tort actions. Based on standard actuarial techniques, the number of claims, number of participants and bed representation ensure significant credibility of the results at the national level. The proportion of statewide bed representation assures significant credibility of the results at the state level. To increase credibility, a higher response rate among providers would be required.

All long term care benchmark results published in this report are based on losses (indemnity plus allocated adjustment expense) limited to $1 million per occurrence unless otherwise noted. The $1 million per occurrence limitation was selected to limit the impact of large claims on the results. The inclusion of amounts excess of $1 million per occurrence can increase volatility in the results and mask trends.

Statutory limitations were based on National Conference of State Legislatures research updated September 23, 2010, accessed May 6, 2011 from http://www.ncsl.org/?tabid=18516. Referenced statutory limitations were cross referenced by reviewing the individual state codes online.

The loss rates are presented relative to the Medicaid per diem reimbursement rate. The Medicaid per diem reimbursement rate is based on data from “A Report on Shortfalls in Medicaid Funding for Nursing Home Care” produced by Eljay LLC for the AHCA and dated December 2010. The Overall Medicaid per diem reimbursement rate is based on the state exposure distribution inherent in this study.

Actuarial Analysis

The statistics presented in this report are based on an actuarial analysis of the aggregated long term care GL/PL claim database and related exposure data. The analysis applies standard actuarial methods to the data to develop ultimate losses and claim counts by accident year. These projections are used to calculate the following statistics presented in this report:

- Loss Rate—ultimate loss projection per occupied bed equivalent
- Overall Frequency—annual number of non-zero claims per occupied bed equivalent; a frequency of 1.0% represents 1 non-zero claim per 100 occupied bed equivalents
- Indemnity Frequency—annual number of claims with indemnity payments per occupied bed equivalent
- Severity—average ultimate size of each claim, where each claim is limited to $1 million per occurrence

The loss rates are presented relative to the Medicaid per diem reimbursement rate. The Medicaid per diem reimbursement rate is based on data from “A Report on Shortfalls in Medicaid Funding for Nursing Home Care” produced by Eljay LLC for the AHCA and dated December 2010. The Overall Medicaid per diem reimbursement rate is based on the state exposure distribution inherent in this study.
Countrywide Benchmark Statistics

This section presents an analysis of the countrywide loss rate per occupied long term care bed, claim frequency per bed and claim severity. The darker bar, labeled 2011, represents a forecast based on trending of 2010 estimates. Claim frequency statistics are presented for indemnity claims and expense only claims.
Loss Rate Trends

The following graph shows the loss rate per occupied long term care bed. The annual loss rate has been between $1,300 and $1,400 from 2003 to 2010, except for 2005, where the loss rate dipped to $1,190.

Frequency Trends

The following graph shows the claim frequency per occupied long term care bed. The stacked bar chart below provides frequency benchmarks for both claims closed with indemnity (indemnity claims) and claims closed without indemnity (expense only claims).

Frequency exhibits a slightly decreasing trend since 2007.

The indemnification rate represents how often a claim results in indemnity. This is the ratio of claims with indemnity to total non-zero claims. The indemnity ratio over the past ten years has been stable around 82%. This means that about eight claims out every ten result in indemnification to the claimant.
Severity Trends

The following graph shows the average size per long term care claim (severity).

From a low of $125,000 in 2005, severity has been increasing steadily.

![Severity per Claim Limited to $1M per Occurrence Graph]

Liability Costs and Medicaid Reimbursement Rates

Medicaid is a significant source of revenue for long term care providers.

The following graph shows the per diem loss rate per bed charted against the Overall Medicaid per diem reimbursement rate. The Overall Medicaid reimbursement rate shown here is a state rate weighted by the exposure distribution underlying the benchmark. As a percent of the Overall Medicaid per diem reimbursement rate, liability costs have decreased since 2003 and appear stable around 2.20%.

![Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence Graph]

<table>
<thead>
<tr>
<th>Accident Year</th>
<th>Average Medicaid per Diem Reimbursement</th>
<th>Per Diem Loss Rate per Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>$128.50</td>
<td>$3.86</td>
</tr>
<tr>
<td>2004</td>
<td>$137.74</td>
<td>$3.70</td>
</tr>
<tr>
<td>2005</td>
<td>$143.68</td>
<td>$3.26</td>
</tr>
<tr>
<td>2006</td>
<td>$148.29</td>
<td>$3.64</td>
</tr>
<tr>
<td>2007</td>
<td>$156.60</td>
<td>$3.81</td>
</tr>
<tr>
<td>2008</td>
<td>$163.84</td>
<td>$3.64</td>
</tr>
<tr>
<td>2009</td>
<td>$167.28</td>
<td>$3.67</td>
</tr>
<tr>
<td>2010</td>
<td>$171.87</td>
<td>$3.81</td>
</tr>
</tbody>
</table>
Countrywide Benchmark Statistics

Closed Claim Analysis

To further investigate trends in claim severity, a closed claim analysis is presented below. Payments are organized by the closing year for each claim in the database. To ensure that the mix of claim ages is consistent by closing year, only claims aged five years less are included.

The following graph presents the counts for claims closed with an indemnity payment and expense only claims. The lower portion of each bar is the number of claims that closed with an indemnity payment. The upper portion of each bar represents the number of claims that closed, but with an expense amount only. The graph illustrates a declining volume of claims, which supports lower frequency projections.

The following graph presents the average paid indemnity for claims closed with an indemnity payment. The number above each bar is the total average paid indemnity for all claims. Decreases in closed claim severity from 2005 through 2008 have been replaced by higher severity for claims closing in 2009 and 2010.
The following graph presents the average paid loss adjustment expense on claims closed with an indemnity payment. After decreasing from 2005 through 2008, the average paid expense has bulged to $47,000 in 2010.

![Average Paid Expense on Claims Closed with an Indemnity Payment—Unlimited Expense](image1)

The following graph presents the average paid loss adjustment expense on claims closed with expense only. With the exception of 2007, the average expense paid on expense only claims has been under $20,000.

![Average Paid Expense on Claims Closed with Expense Only—Unlimited Expense](image2)
Claim Costs Increase with the Age of the Claim

The size of a claim tends to increase with age. This reflects that claims that are less complicated and claims with lower financial stakes tend to be resolved more quickly. Claims with more complicated allegations or higher damages take longer to resolve.

The following chart shows the size of indemnity payments on claims closed in 2010, segmented by their age when closed. 

Average Paid Indemnity on Claims Closed with an Indemnity Payment—Limited to $1M per Occurrence

<table>
<thead>
<tr>
<th>Age</th>
<th>Paid Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 Year</td>
<td>$22,000</td>
</tr>
<tr>
<td>1 Year</td>
<td>$84,000</td>
</tr>
<tr>
<td>2 Years</td>
<td>$121,000</td>
</tr>
<tr>
<td>3 Years</td>
<td>$179,000</td>
</tr>
<tr>
<td>4 Years</td>
<td>$216,000</td>
</tr>
<tr>
<td>5 or More Yrs</td>
<td>$245,000</td>
</tr>
</tbody>
</table>

Claims expense shows a similar increasing pattern for claims closed with indemnity. 

Average Paid Expense on Claims Closed with an Indemnity Payment—Unlimited Expense

<table>
<thead>
<tr>
<th>Age</th>
<th>Paid Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 Year</td>
<td>$1,000</td>
</tr>
<tr>
<td>1 Year</td>
<td>$13,000</td>
</tr>
<tr>
<td>2 Years</td>
<td>$34,000</td>
</tr>
<tr>
<td>3 Years</td>
<td>$63,000</td>
</tr>
<tr>
<td>4 Years</td>
<td>$89,000</td>
</tr>
<tr>
<td>5 or More Yrs</td>
<td>$168,000</td>
</tr>
</tbody>
</table>
For claims closed without indemnity, the cost curve is flatter for claims aged less than 4 years. Claims that close without indemnity tend to close more quickly than those that close with indemnity.

<table>
<thead>
<tr>
<th>Age</th>
<th>Average Paid Expense (in $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 Year</td>
<td>$8,500</td>
</tr>
<tr>
<td>1 Year</td>
<td>$5,000</td>
</tr>
<tr>
<td>2 Years</td>
<td>$11,000</td>
</tr>
<tr>
<td>3 Years</td>
<td>$12,300</td>
</tr>
<tr>
<td>4 Years</td>
<td>$32,100</td>
</tr>
<tr>
<td>5 or More Yrs</td>
<td>$63,900</td>
</tr>
</tbody>
</table>

**Average Paid Expense on Claims Closed with Expense Only—Unlimited Expense**
Causes of Loss

Long term care providers have the opportunity to use claims data for more than insurance purposes. By using consistent coding to identify the causes of loss, they can make inferences about clinical practices that impact liability and the quality of patient care.

Using a framework suggested by a participant, Aon solicited claim descriptions using ten specific claim descriptions. These were:

- AAN (Assault/Abuse/Neglect)
- Pressure Ulcer/Wound
- Airway/Respiratory
- Medication Variance/Adverse Drug Reaction
- Elopement
- Treatment/Procedure – Adverse Outcome
- Fall with Injury
- Tube Displacement/Non-airway
- Injury – Not Fall Related
- Unspecified/Unknown

For participants that could not provide these standard claim descriptions, the existing claim descriptions were assigned to the standard groupings.

The resulting claim distributions are intended to comparatively show the frequency and severity by causes of loss. Operators that track this coding internally may find a correlation between clinical issues and causes of loss.

The following chart shows the distribution of closed claim counts by claim description. The most common claim description is Fall with Injury, and the top four claim descriptions comprised 78% of closed claims.
The following chart shows the distribution of closed claim dollars by claim description. The top dollar contributor is Pressure Ulcer/Wound.

The average size of a closed claim varies by claim type. Pressure Ulcer/Wound claims are the highest cost. Within the All Other category, only Elopement had a higher per claim cost, at about $300,000, but the incidence of Elopement was extremely low with only 39 claims out of the total 6,300 with coded claim descriptions.
Comparing Cost by Tort Environment

Aon’s 2008 Long Term Care Liability Report compared costs in states with and without substantive tort reform. Since that report, Oklahoma passed tort limits and Illinois and Georgia tort legislation has been found unconstitutional. In the prior report, the impact of tort reform was evident as liability costs dropped after the implementation of tort reforms. It is nearly seven years since the last major wave of tort reform legislation was enacted in 2004. The analysis suggests that the tort reforms are still effective, but that the cost gap between tort reform and non-tort reform jurisdictions is narrowing.

Using a compilation of state laws found on the National Conference of State Legislatures website, state data was compiled into states with substantive tort reform and those without. A substantive tort reform state was defined as a state with legislated limits on non-economic damages of $500,000 or lower.

States with Substantive Tort Reform

The table below shows the tort reform states that are profiled in this report, along with their contribution to the Tort Reform results. The All Other category includes data from fifteen other states, the largest of which are Florida and Michigan.

<table>
<thead>
<tr>
<th>State/Group</th>
<th>Tort Reform Distribution*</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>11.2%</td>
</tr>
<tr>
<td>Indiana</td>
<td>12.0%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>12.0%</td>
</tr>
<tr>
<td>Ohio</td>
<td>16.6%</td>
</tr>
<tr>
<td>Texas</td>
<td>9.2%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>5.6%</td>
</tr>
<tr>
<td>All Other States</td>
<td>33.3%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Percent of Exposures

While all of these states have limits on non-economic damage awards of $500,000 or lower, there is a wide range in liability costs. The high loss rates in California and West Virginia, when compared to the low loss rates in Texas, demonstrate that damage caps alone are not sufficient to reduce and control liability costs.

The following graphs present the loss rate per occupied bed, claim frequency per occupied bed, claim severity and loss rates relative to the Medicaid per diem reimbursement rate. Frequency is shown for claims with indemnity payments and expense only claims.
The impact of tort reforms can be seen after 2004, when the last of the major legislation was enacted. Seven years later, liability costs are projected below pre-tort reform levels.

In states with tort reform, claim frequency has been steadily decreasing since 2003. The initial decreases in frequency may be attributable to tort reform, but subsequent declines may be related to patient safety initiatives, increased focus on defense strategies in these states or other factors.
The loss rate as a percent of the Medicaid per diem reimbursement rate dropped after 2004, and has remained stable at about 2%.

After 2004, the severity of claims dropped for two years. Since that time, severity has increased steadily.

The loss rate as a percent of the Medicaid per diem reimbursement rate dropped after 2004, and has remained stable at about 2%.
States without Substantive Tort Reform

The list below shows the states without substantive tort reform that are profiled in this report, along with their contribution to the Non Tort Reform results. The All Other category includes data from twenty-three other states, the largest of which are Maryland, New Jersey, Arkansas and Virginia. Both Illinois and Georgia, which were previously tort reform states, have been included in the Non Tort Reform analysis.

<table>
<thead>
<tr>
<th>State/Group</th>
<th>Non Tort Reform Distribution*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kentucky</td>
<td>6.7%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>4.8%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>21.4%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>7.6%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>5.4%</td>
</tr>
<tr>
<td>All Other States</td>
<td>54.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

*Percent of Exposures
The loss rate in the states without substantive tort reform has been higher than the loss rate in the tort reform states throughout the experience period. Similar to the tort reform states, there is a decrease in the loss rate in 2005. Since that time, liability costs have fluctuated between $1,470 and $1,590 per occupied bed.

While dropping slightly in 2005, claim frequency in Non Tort Reform states has been fairly level through the experience period and may be decreasing slightly in recent years.
Severity in the non-tort reform states increased after 2005, and has been slightly increasing since 2008.

The loss rate as a percent of the Medicaid per diem reimbursement rate decreased from 2003 to a low in 2005. In the recent past, the percent has been around 2.4%.
Impact of Arbitration

Claims that close under valid ADR agreements are 25% less costly than claims that closed without a valid ADR agreement in place. But very few claims actually resolve through arbitration proceedings; the great majority are settled during trial.
The arbitration analysis consisted of 1,173 closed claims with coding related to the applicability of arbitration (ADR). Coded settlements are from closure years 2004 to 2010, providing a substantial basis for analysis.

These respondents also provided coding for the disposition of claims, discussed in the next section.

Organization of Data

The respondents provided data on closed claims, coded for arbitration outcomes. The claims were categorized claims as Arbitration Agreement Not Challenged (ADR), Arbitration Agreement Contested and Found Valid (Upheld ADR), No ADR—Unenforceable ADR (Invalid ADR) and No ADR. In the tables that follow, the first two categories are combined into Arbitration and the second two categories are combined into Non-Arbitration. It is important to recognize that claims in the ADR category are rarely resolved through arbitration proceedings, but are more often settled during trial.

The results were examined by state, by provider, by ADR category, by occurrence year and by year of closure. The data is presented for claims occurring between 2004 and 2009, and closed between 2004 and 2010. Claims occurring in 2010 were excluded due to the immaturity of the occurrence period.

Claim Distribution

The claims are grouped by the size of the indemnity award. This grouping was intended to show differences between claims with and without substantiated damages.

Just fewer than 40% of the claims in the database were closed with a valid or unchallenged ADR agreement in place.

<table>
<thead>
<tr>
<th>Indemnity Amount</th>
<th>Non-Arbitration</th>
<th>Arbitration</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Payment</td>
<td>149</td>
<td>137</td>
</tr>
<tr>
<td>$0 to $25,000</td>
<td>165</td>
<td>74</td>
</tr>
<tr>
<td>$25,000 to $250,000</td>
<td>308</td>
<td>221</td>
</tr>
<tr>
<td>$250,000 to $1,000,000</td>
<td>72</td>
<td>33</td>
</tr>
<tr>
<td>Greater than $1,000,000</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>706</strong></td>
<td><strong>467</strong></td>
</tr>
</tbody>
</table>

Claims with Payment

<table>
<thead>
<tr>
<th></th>
<th>Non-Arbitration</th>
<th>Arbitration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>557</td>
<td>330</td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>78.9%</td>
<td>70.7%</td>
</tr>
</tbody>
</table>
Total Cost

The average total cost of an outcome subject to an arbitration agreement is about $141,000, while the average cost of a non-arbitrated outcome is about $187,000, making arbitrated outcomes about 25% less costly.

<table>
<thead>
<tr>
<th>Indemnity Amount</th>
<th>Non-Arbitration</th>
<th>Arbitration</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Payment</td>
<td>$17,815</td>
<td>$10,358</td>
</tr>
<tr>
<td>With Payment</td>
<td>$232,129</td>
<td>$194,811</td>
</tr>
<tr>
<td>Total</td>
<td>$186,898</td>
<td>$140,700</td>
</tr>
</tbody>
</table>

Similar to the breakouts above, unchallenged ADR claims have the lowest total cost. Challenged (Invalid ADR and Upheld ADR) ADR claims are the highest cost claims.

<table>
<thead>
<tr>
<th>Indemnity Amount</th>
<th>Non-Arbitration</th>
<th>Arbitration</th>
</tr>
</thead>
<tbody>
<tr>
<td>No ADR</td>
<td>$17,020</td>
<td>$9,330</td>
</tr>
<tr>
<td>Invalid ADR</td>
<td>$46,617</td>
<td>$29,454</td>
</tr>
<tr>
<td>ADR</td>
<td>$184,702</td>
<td>$169,553</td>
</tr>
<tr>
<td>Upheld ADR</td>
<td>$610,777</td>
<td>$272,457</td>
</tr>
<tr>
<td>Total</td>
<td>$146,712</td>
<td>$253,128</td>
</tr>
</tbody>
</table>

Challenge Rates

Of the 533 closed claims that involved ADR, 154, or about 29%, were challenged. Of these, 66, or less than half, were found unenforceable. As noted above, the challenged claims were associated with higher overall costs.

<table>
<thead>
<tr>
<th>Indemnity Amount</th>
<th>Counts</th>
<th>Percent of ADR Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims with ADR Agreements</td>
<td>533</td>
<td>100.0%</td>
</tr>
<tr>
<td>Challenged</td>
<td>154</td>
<td>28.9%</td>
</tr>
<tr>
<td>Challenged and Unenforceable</td>
<td>66</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Time to Closure

More recent closure years have a higher concentration of resolutions subject to an arbitration agreement, while older closure years have a higher concentration of non-arbitrated resolutions. This may distort time to closure results, and so the time to closure is stratified by occurrence year in the following table.

From the table, there is not a consistent difference in the time to closure between outcomes subject to arbitration and not subject to arbitration. However, for five of the seven periods, outcomes subject to arbitration are resolved in less time than outcomes that are not subject to arbitration.
### How Claims Are Closed

The disposition of claims refers to the way a claim is closed. The respondents that provided arbitration data also provided useful data around the disposition of those claims. All of the 1,173 claims used for the arbitration analysis had Disposition codes. Providers were asked to classify how the claim was closed using six descriptions.

This sample represents a small portion of our database. It is difficult to extend the results to the profession, but the data may be useful to develop relative comparisons.

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Claim Count</th>
<th>Avg Days</th>
<th>Avg Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Arbitrated Decision</td>
<td>6</td>
<td>1,002</td>
<td>$365,282</td>
</tr>
<tr>
<td>C: Court Decision for Claimant</td>
<td>9</td>
<td>1,021</td>
<td>$360,103</td>
</tr>
<tr>
<td>D: Court Decision for Defense</td>
<td>67</td>
<td>799</td>
<td>$25,786</td>
</tr>
<tr>
<td>M: Mediated Decision</td>
<td>39</td>
<td>983</td>
<td>$298,641</td>
</tr>
<tr>
<td>N: Closed Other Reason</td>
<td>196</td>
<td>627</td>
<td>$8,579</td>
</tr>
<tr>
<td>T: Settled during trial</td>
<td>856</td>
<td>696</td>
<td>$206,972</td>
</tr>
<tr>
<td><strong>All Years Combined</strong></td>
<td><strong>1,173</strong></td>
<td><strong>704</strong></td>
<td><strong>$168,505</strong></td>
</tr>
</tbody>
</table>

The great majority of claims (73%) are settled during trial, with an average age at settlement of about two years (696 days).

Closed Other Reason makes up the next largest population. The claims are exclusively closed without indemnity, and have a much smaller average size than other claims. This claim group may include notice-only type claims with expenses entirely related to creating a claim file.

Other dispositions are a substantially smaller part of the database, making up only 121 of the 1,173 coded claims, or about 10%. This underscores that mediated and arbitrated outcomes are very rare.
State Specific Results

The remainder of the report profiles states where credible results were produced based on the volume of data, the stability of the results compared to prior years, and the number of providers represented in the data. The graphs for each state present the loss rate per occupied bed, claim frequency per occupied bed, claim severity and loss rates relative to the Medicaid per diem reimbursement rate. Frequency is shown for claims with indemnity payments and expense only claims. The darker bar, labeled 2011, represents a forecast based on trending of 2010 estimates.
The participants in this study represent approximately 10,100 occupied long term care beds in the state. This is approximately 10% of the state total long term care beds.

**Loss Rate**

The projected 2011 loss rate per occupied long term care bed is $2,020, which is the fourth highest loss rate in the study. Loss rates have been hovering around this loss rate since 2007.

California has legislation capping non-economic damages at $250,000 under The Medical Injury Compensation Reform Act of 1975 (MICRA). However, these caps can be circumvented in cases of abuse or negligence to nursing home residents through The Elder Abuse and Dependent Civil Protection Act (EADACPA) of 1982.

**Frequency**

Claim frequency peaked in 2007 but has been around its current level of 1.05% since 2008.
Severity

Claim severity decreased from a high of $210,000 in 2004 to $150,000 in 2007. From 2008 forward, claim severity is near $190,000.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has been under 4.00% since 2005.
Indiana

The participants in this study represent approximately 11,000 occupied long term care beds in the state. This is approximately 22% of the state total long term care beds.

Loss Rate

The projected 2011 loss rate per occupied long term care bed is $500. Of the eleven profiled states, Indiana has the second lowest projected loss rate.

Frequency

Indiana’s claim frequency is projected to be 0.59% in 2011, or just over one claim per two hundred occupied beds. This is the lowest frequency since 2004.
Severity

Indiana’s severity reflects volatility, but, over time, appears to be increasing. The $84,000 projected 2011 severity is the second lowest of the profiled states.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate fluctuates over the experience period. The current rate is 0.88%.
Kentucky

The participants in this study represent approximately 7,700 occupied long term care beds in the state. This is approximately 32% of the state total long term care beds.

**Loss Rate**

The loss rate in Kentucky has increased over the past eight years and has been over $3,000 per occupied bed in four of the past five years. The projected loss rate in 2010 is $3,230, second highest of the profiled states.

Kentucky has no legislated damage caps.

**Frequency**

Claim frequency increased from lows in 2003 and 2004 has been near one claim per one hundred occupied beds since 2005. The projected 2011 frequency of 1.15% is second highest of the profiled states.
Severity

Claim severity in Kentucky has been volatile, but shows a generally increasing trend since 2005.

![Severity Chart]

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate is currently at 5.82%, the highest of the profiled states.

![Medicaid Per Diem Reimbursement Chart]
The participants in this study represent approximately 10,400 occupied long term care beds in the state. This is approximately 23% of the state total long term care beds.

Loss Rate

After an increasing trend from 2003 through 2007, the loss rate per occupied bed dropped substantially in 2008. At $410 per occupied bed, the 2011 forecast is the second lowest of the profiled states.

Frequency

Except for a spike in 2007, the frequency in Massachusetts has been consistently near 0.35%. The 2011 forecast frequency at 0.36% is the lowest of the profiled states.
Severity

Claim severity reached a peak in 2005 at $157,000 before decreasing to a low of $98,000 in 2008. Since 2008, severity has been increasing steadily. The 2011 projected severity of $114,000 is sixth highest among the profiled states.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate showed an increasing trend through 2007 before dropping to 0.49% in 2008. Since 2008, the loss rate as a percent of the Medicaid per diem has increased to 0.56%, but is the lowest of the profiled states.
Minnesota

The participants in this study represent approximately 6,200 occupied long term care beds in the state. This is approximately 18% of the state total long term care beds.

Loss Rate

The loss rate per occupied long term care bed is has increased from a low of $240 per occupied bed in 2004 to $750 per occupied bed in 2010. The forecast loss rate of $770 per occupied bed is the sixth highest of the eleven profiled states.

Frequency

The projected claim frequency in Minnesota, at 0.51%, is the third lowest of the profiled states.
Severity

Except for a spike in 2005, severity was relatively flat from 2003 to 2006. Since 2006, severity has increased to about $150,000. The 2011 projection is the fifth highest among the profiled states.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has increased from less than 1% in 2003 to 1.26% in 2010, the fifth highest among the eleven profiled states.
Ohio

The participants in this study represent approximately 15,600 occupied long term care beds in the state. This is approximately 18% of the state total long term care beds.

Loss Rate

The loss rate per occupied bed in Ohio has been under $1,000 for the entire experience period. The projected 2011 loss rate is $610, the fourth lowest of the profiled states.

Frequency

Claim frequency in Ohio was increasing from 2003 through 2006. Since 2006, claim frequency appears to be decreasing to a forecast 2011 frequency of 0.64%, the sixth highest among the profiled states.
Severity

Severity in Ohio has increased substantially during the experience period, from a low of $23,000 to a projected $96,000 in 2011. Despite this increase, the severity ranks as the third lowest among the profiled states.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has varied over the experience period to 0.92%, the fourth lowest among the profiled states.
Pennsylvania

The participants in this study represent approximately 28,900 occupied long term care beds in the state. This is approximately 30% of the state total long term care beds.

Loss Rate

Pennsylvania’s loss rate per occupied bed has decreased from a high of $1,270 in 2004. Since 2007, the loss rate has been relatively stable just above $800 per occupied bed. The projected 2011 loss rate of $811 is the fifth highest among the profiled states.

Frequency

Claim frequency shows a decreasing trend from a high in 2004 of 1.37%. The projected frequency of 0.87% ranks as the fourth highest among the profiled states.
Severity

Claim severity in Pennsylvania exhibits stability over the experience period, hovering just under $100,000 per claim. The projected severity at $97,000 is the fourth lowest among the profiled states.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has been generally declining since peaking at 2.00% in 2004. The current rate of 1.09% is the fifth lowest among the profiled states.
Tennessee

The participants in this study represent approximately 9,100 occupied long term care beds in the state. This is approximately 27% of the state total long term care beds.

**Loss Rate**

The loss rate in Tennessee dropped from a high of $3,370 in 2003 to a low of $1,500 in 2005. Since that time, the loss rate has been above $2,000 per occupied bed, with a forecast of $2,620 for 2011, the third highest loss rate of the profiled states.

Despite numerous attempts over the years, Tennessee has no legislated damage caps.

**Frequency**

Claim frequency in Tennessee has been under 0.90% since 2007. The 2011 forecast of 0.84% is the fifth highest among the profiled states.
Severity

Claim severity drives Tennessee’s loss rates relative to other states. Tennessee’s 2011 forecast severity ranks the highest among the profiled states.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has dropped from a high of 8.46% in 2003 to 4.83% in 2010. Despite dropping by nearly half, this rate stands out as the third highest of the profiled states.
Texas

The participants in this study represent approximately 9,600 occupied long term care beds in the state. This is approximately 10% of the state total long term care beds.

Loss Rate

For years, the Aon study has cited Texas as the example for effective tort reform. Texas enacted tort reform in 2003 and shortly thereafter saw incredible reductions in loss rates. These reductions have persisted to this day.

The 2011 forecast loss rate in Texas is $330, the lowest loss rate of the profiled states.

Frequency

Tort reform impacted claim frequency dramatically and quickly in Texas. Within the first year of tort reform, frequency dropped more than 50% and has remained low since. The forecast 2011 frequency is 0.45%, the second lowest of the profiled states.
Severity

Claim severity also decreased after tort limits were enacted in 2003, dropping 20% in the first year. Severity continued to decline through 2007. The 2011 forecast severity of $73,000 is the lowest of the profiled states.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate tracks the tort reform gains. The current rate of 0.70% is the second lowest of the profiled states.
The participants in this study represent approximately 6,400 occupied long term care beds in the state. This is approximately 21% of the state total long term care beds.

### Loss Rate

Wisconsin's loss rate has been above $600 since 2005, but appears stable with a projected 2011 loss rate of $660, fifth lowest among the profiled states.

### Frequency

Claim frequency in Wisconsin exhibits stability since 2006, hovering around 0.61%.
Severity

Claim severity has been stable in Wisconsin since 2004 with the exception of 2007.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate peaked in 2007 at 1.53%, but has since dropped to 1.15% in 2010.
West Virginia

The participants in this study represent approximately 4,900 occupied long term care beds in the state. This is approximately 49% of the state total long term care beds.

Loss Rate

West Virginia’s loss rate exhibits a strong upward trend over the experience period. The 2011 forecast of $3,900 per occupied bed is the highest of the profiled states.

The high loss rate is contrary to expectations. West Virginia enacted a $250,000 limit on non-economic damages in 2003. Despite this legislation, loss rates have tripled from 2003 levels.

Frequency

West Virginia has the highest frequency of claims among the profiled states, with a 2011 forecast of 1.29%.
Severity

West Virginia has the second highest projected severity (behind Tennessee). The severity chart shows persistent growth since 2003.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has been increasing over the experience period. At 5.34%, West Virginia’s rate is the second highest among the profiled states.
All Other States

The participants in this study represent approximately 95,000 occupied long term care beds in the remaining states. This is approximately 10% of the state total long term care beds in the remaining states.

Loss Rate

The loss rate chart shows a peak in 2007 followed by a new increasing loss rate pattern.

Frequency

Claim frequency declined from 2003 to 2005 before increasing to a high of 1.21% in 2007. Since 2007, frequency has been level around 1.09%.
Severity

Severity has been relatively stable over the experience period, with low points around $130,000 in 2005 and 2008. The forecast 2011 severity is $153,000, the highest point on the chart and in line with recent severity growth.

Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate for All Other States has been over 2.00% for the entire experience period.
The following definitions are provided to help the users of this report fully understand the analyses presented and the resulting conclusions.

ALAE
ALAE is an abbreviation for allocated loss adjustment expense. ALAE refers to costs, in addition to indemnity payments and reserves, which are incurred in handling claims. Typically, these costs are comprised of legal fees paid by the insured entity in investigating and defending claims. In the context of this study ALAE represents defense costs. The majority of claim data used in this study contains a separate field to identify ALAE costs separately from indemnity costs. Whether separately identified or not, allocated loss adjustment expenses are included in the reported loss information, loss reserving methodologies and loss projections contained in this report. All references to losses throughout the report and exhibits include ALAE except where noted otherwise.

Accident Year
An accident year is the year in which an incident giving rise to a claim occurred. All of the loss rate, frequency and severity analyses use grouped data by accident year, unless specifically noted otherwise.

Claim
A claim is a demand by an individual or other entity to recover for a loss. It may involve a formal lawsuit but not necessarily, especially in the case of a general liability claim.

Exposure
Actuaries select an exposure base such that the incidence of claims will tend to vary directly with the exposure of the entity at risk. The actuary must consider both the historical loss level and the corresponding exposures in evaluating historical claim liabilities and expected future costs. It is important to choose an exposure measure that is relevant to the unique situation of each risk group.

In this study the exposure base is occupied beds. Occupied beds are calculated by multiplying the number of licensed beds by the average annual occupancy rate. There is a strong correlation between the number of occupied beds and the total amount of losses incurred by a long term care facility. Not all beds are equal in terms of their risk exposure, however. An assisted living bed generates fewer dollars of GL/PL claim activity than a skilled care bed. All beds in this study have been adjusted to the equivalent of a skilled nursing care bed.

By dividing losses by exposures, comparative estimates of the long term care industry GL/PL loss rates are developed.

Frequency
Frequency is the ratio of the number of claims divided by exposures. In this report, frequency is measured on an annual basis as the number of claims projected for the given time period divided by the number of occupied beds during that same period. In the summary exhibits, frequency is the number of claims a year per occupied bed.

General Liability (GL)
General liability exposure generally relates to those sums an entity becomes legally obligated to pay as damages because of a bodily injury (typically including personal and advertising injury) or property damage.

Indemnity
Indemnity refers to the component of claim costs actually paid or reserved to be paid to the plaintiff. Indemnity costs include both the amount provided for the plaintiff, either as a jury award or a settlement, and the amount retained by the plaintiff’s attorney. However, in most claim files, including those used to do this study, the split between plaintiff award and plaintiff attorney is not provided. Indemnity may also include punitive damages, although this is not consistently treated among companies.
Indemnification Rate

This is the ratio of claims that result in indemnity to all claims (claims with indemnity and claims with expense only). This reflects the likelihood that a claimant will receive indemnification.

Limit of Liability

A limit of liability is a maximum amount of coverage provided by an insurance transaction. Above the limit of liability, the insured is responsible for all losses. Limits of liability may be expressed on a per occurrence basis or an aggregate basis, similar to deductibles. The losses included in this study are limited to $1,000,000 per occurrence.

Loss Rate

Loss rate is the cost per exposure of settling and defending claims. Loss rate is calculated as the ratio of total dollars of losses (indemnity and ALAE) to total exposures for a given period of time. In this report exposures are selected to be occupied beds and the time period is one year. Consequently, a loss rate represents the annual amount per occupied bed expected to be paid to defend, settle and/or litigate GL/PL claims arising from incidents occurring during the respective year.

Loss Development

Loss development refers to the change in the estimated value of losses attributable to a body of claims or to a time period until all the claims are closed.

Generally, the reported losses will increase over time for several reasons. First, it is impossible to estimate precisely the ultimate losses and legal expenses for claims when they are initially reported. The estimated unpaid loss for a claim, called a case reserve, is adjusted up or down as more information is obtained. In the aggregate, the upward adjustments tend to be greater than the downward ones. Second, it takes a period of time for some claims to be discovered, reported, and recorded. Claims that have been incurred but have not been reported are called “pure” IBNR claims. Third, closed claims are sometimes reopened. This may be due to legislation, which applies retroactively to claims that have closed. In this report, except where specifically noted, projected loss rates, frequencies and severities by state and by year are all inclusive of actuarially indicated expected loss development.

Loss development also refers to the increase in paid losses as claims are reported, paid to their ultimate values, and closed.

Loss Trend

Loss trend is the change in claim frequency and/or severity from one time period to the next. Factors that affect the frequency and severity of claims are constantly changing over time. Examples of causes include inflation, societal attitudes toward legal action, and changes in laws. Actuaries use trend factors to adjust historical loss experience to comparable levels.

Professional Liability (PL)

Professional liability exposure relates to those sums an entity becomes legally obligated to pay as damages and associated claims and defense expenses because of a negligent act, error or omission in the rendering or failure to render professional services.

Severity

Severity refers to the total dollar amount of a claim including indemnity and ALAE. In this report, the average severity for a given year is measured by dividing the total dollars of losses for all claims incurred in the year by the total number of claims.