

Long Term Care

2006 General Liability and Professional Liability Actuarial Analysis

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Actuarial & Analytics Practice

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Introduction

Purpose

At the request of the American Health Care Association (AHCA), Aon Risk Consultants (Aon) conducted an updated actuarial analysis of the cost of general liability and professional liability (GL/PL) claims to the long term care industry operating in the United States.

Scope

The specific objectives of this study are to:

1. **Identify the national trends in the cost of GL/PL claims for the long term care industry.** These trends are measured by monitoring the change in the number of claims reported (frequency), the size of claims (severity) and the overall cost per exposure (loss cost). These trends are measured on three levels: All states (Countrywide), tort reform states (Florida, Georgia, Louisiana, Mississippi, Ohio, Texas and West Virginia)¹, and excluding tort states (all states excluding the seven listed tort reform states).
2. **Identify state specific trends and their correlation to currently observed and future expected national trends.** Specific areas of the country for which a separate analysis is included in this study are the states of Alabama, Arizona, Arkansas, California, Mississippi, Tennessee, Texas, West Virginia and Wisconsin. All other states are analyzed as a group and labeled accordingly in the exhibits contained in this report.
3. **Identify trends in commercial insurance affordability and availability.** These trends are measured by monitoring the most recent policy year changes in premium levels, deductibles, per occurrence limits of liability, annual aggregate limits of liability, and policy form for commercially insured long term care operators.
4. **Estimate the portion of GL/PL loss costs paid as indemnification to claimants versus the portion paid for litigation costs.** Defense costs

¹ The criteria used to determine a tort reform state is 1) the state legislature passed a statute within the time period included in this study that included caps on non-economic damages of \$500,000 or less, and/or tightened the rules for filing allegations of patient care liability to such an extent that is anticipated to reduce the frequency of claims, and 2) there was sufficient data reported in the state to measure the changes in liability over the time period under review.

are easily identified in the claim detail files used to perform this study. The estimated portion of total claim costs attributed to defense costs, including investigation and attorney fees, is based on the average of the claim data provided to us. Plaintiff attorney costs are estimated as a portion of the indemnity payment to the plaintiff.

5. **Identify the distribution of losses by size of loss.** A histogram depicting the number of reported losses in incremental size of loss bands provides an indication of the variance of loss sizes, the magnitude of the large losses and the number of claims excess of \$1 Million.

In an effort to present a comprehensive analysis from the perspective of all long term care providers, the AHCA, through its various constituencies disseminated a request for data to independent providers, regional multi-facility providers, non-for-profit providers, national multi-facility providers, and the National Center for Assisted Living. In addition, AHCA contacted state executives of long term care associations and other stake holders and encouraged them to share the data request with their membership in order to encourage greater participation by independently owned facilities.

Using a web-based data survey instrument, long term care providers were given a list of data requirements and instructed to submit their data directly to Aon Risk Consultants. Among the data elements requested were detailed individual general and professional liability claim information for all claims occurring over the past five to ten years, corresponding historical exposure estimates in the form of occupied beds, and specifics regarding insurance coverage terms during the latest three policy years. Data was collected and compiled between the beginning of July 2006 and the end of September 2006. In order to ensure the quality of each data submission, there was extensive correspondence with providers via email, telephone, fax, and written correspondence during this period.

The results presented in this study are based on the ensuing comprehensive database of long term care general/professional liability losses and allocated loss adjustment expenses (ALAE) as reported to us by 60 long term care providers operating around the country. Approximately 20,000 individual non-zero claims from long term care facilities were aggregated to perform this study. The facilities included in this database combined currently operate approximately 290,000 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 15% of the beds in the United States.

Differences in participation rates between this year's study and prior studies are driven by two key industry trends. The first is the trend in ownership changes of long term care providers. A few of the larger prior participants to this study have come under new ownership and have chosen not to participate. The second is the trend towards reducing exposure in highly litigious states. Several of the annual participants to this study have sold facilities in selected states to reduce their overall exposure to volatile long term care liability costs and the new owners are not participating.

An executive summary containing our conclusions and recommendations can be found in this report. It is provided to give an overview of our national and state findings. More detailed benchmarks highlighting the national trends and identifying the specifics of the state trends are provided after the executive summary. Following the presentation of national and state specific loss trends is a section on the effects these trends are having on commercial insurance premium and coverage terms. Sections describing the data sources, defining common actuarial terms, and detailing state specific tort reform provisions follow.

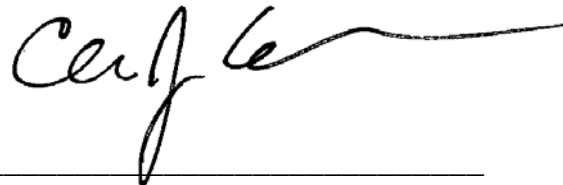
Should there be any questions regarding this report, we will be available to discuss them with you.

Respectfully submitted,

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Executive Summary

The landscape of the long term care liability picture has never been more varied. The explosion of litigation that started in a number of states in the mid to late 1990's and began expanding across the country has intersected with a range of largely industry driven strategic initiatives that are having a measurable effect on liability trends. These initiatives include legislative, operational and structural changes;

- A number of states have enacted tort reform legislation.
- Providers have made operational changes including stronger defenses and quality of care initiatives.
- Structural changes are evident as larger providers exit high cost states, leaving the market to smaller providers and limited liability corporations that typically have less capacity to indemnify claimants.

The results in this study show a wide range of impacts from these changes, dependent on the degree to which they have been successfully implemented by the long term care providers and policymakers in the various states included in this report.

GL/PL Trends

Based on our actuarial analysis of the long term care industry data provided to us, which represents 15% of the beds in the U.S., we find the following:

Countrywide Trends

- Countrywide, GL/PL loss costs are stabilizing at approximately \$1,610 per bed after peaking at \$2,030 per bed in 1999.
- Countrywide trends are driven by reductions in the average severity from a high of \$261,000 in 1998 to \$146,000 in 2006.
- Frequency of claims continues to climb. Countrywide, the number of claims incurred per 1,000 occupied beds has doubled from 5.6 in 1995 to 11.1 in 2006.

Tort Reform States

- Liability costs are dramatically dropping in states that have passed tort reform in the past several years. As a group, the average loss cost of Florida, Georgia, Louisiana, Mississippi, Ohio, Texas, and West Virginia has dropped from \$5,110 in 1998 to \$1,240 in 2006.
- For the providers represented in this study, tort reform has produced approximately \$200,000,000 in annual savings in the cost of care.
- Both frequency and severity are down in states that have passed tort reform. The number of claims per 1,000 occupied beds for this group peaked at 18.7 in 2001 and has since dropped to 12.3 in 2006. The average size of a claim has plummeted from \$358,000 in 1998 to \$101,000 in 2006.
- Texas is leading the charge in post tort-reform reductions in liability costs. Texas frequency levels have dropped almost 60% from 18.3 claims per 1,000 occupied beds to 7.5 claims in the years since tort reform was passed. Texas severity has dropped from \$410,000 in 1998 to \$149,000 in 2006. The Texas loss cost peaked at \$6,080 in 2002, the year before tort reform, and dropped 80% to \$1,260 in 2004, the year after reform.

States Without Tort Reform

- Increases in frequency remain problematic in states without tort reform. Excluding the seven tort reform states, frequency is increasing at an annual rate of 9%, having grown from 5.5 claims per 1,000 occupied beds in 1995 to 10.7 in 2006.
- The 2006 average severity of the states excluding tort reform is 60% greater than the tort reform states (\$160,000 versus \$101,000).
- Numerous states continue to experience dramatically high or increasing GL/PL loss costs. Topping the list is Arkansas, which reports the highest estimated 2006 loss cost of \$9,880. The steepest jumps in loss costs over the past five years have been incurred in Arizona (rising from \$1,240 in 2001 to \$4,300 in 2006) and Tennessee (rising from \$1,380 in 2001 to \$4,880 in 2006).

Attorney Fees

- The average amount spent to defend a GL/PL claim has almost quadrupled in the past seven years from approximately \$13,600 to \$52,800.
- Currently, more than half of the total amount of claims costs paid for GL/PL claims in the long term care industry is going directly to attorneys. This means that less than half of the dollars spent on liability is actually going to the patient and their families.

Insurance

- Annual commercial insurance premium increases are waning. The average reported increase is 3% between 2005 and 2006. This follows average reported increases of 16% in 2005, 18% in 2004, 51% in 2003, 143% in 2002, and 131% in 2001.

More detailed benchmarks highlighting the national trends and identifying the specifics of the state trends are provided in the following sections of this report.

Countrywide Long Term Care GL/PL Trends

Key Factors Affecting Trends

The factors affecting the countrywide trends are highly correlated to the states in which facilities are located. Material changes are occurring in the industry, including legislative, operational and structural, that are directly impacting the number and size of GL/PL claims. The cumulative effect of these changes is lower loss costs in a number of states. However, not all states are reporting improving trends because not all operators are equally benefiting from the industry driven initiatives.

Legislative Changes

Legislative changes in the form of state and federal patient rights and elder abuse laws have been a precursor in many states to increases in long term care litigation. Nearly two decades after Congress passed the Federal Omnibus Budget Reconciliation Act (OBRA 1987), expanding patients' rights, the nursing home industry continues to be a key target of litigation. There is a correlation between the presence of law firms specializing in long term care litigation in a given state and the number and size of claims. States demonstrating this phenomenon include Arkansas, California, Tennessee, and Arizona.

In direct response to this increase in litigation, tort reform has been passed in a number of states, including Florida, Georgia, Louisiana, Mississippi, Ohio, Texas, and West Virginia. Prior to tort reform, these states accounted for 50% of total GL/PL reported losses and only 21% of the beds in this study. Post tort reform they now represent only 16% of the countrywide losses. Dramatic reductions in the average severity in these states are driving this reduction in losses. As a group, these states are also reporting decreases in the number of claims per occupied bed.

However, most states have not had tort reform passed to address the rising GL/PL claim activity. Based on the participants reporting data in this study, 79% of the beds in the country are not benefiting from tort reform. Countrywide, excluding the seven tort reform states, claim frequency continues to increase and the average severity is 60% higher than in states with tort reform.

Operational Changes

In addition to tort reform, operational changes, strategically executed by providers to address the rising cost of GL/PL claims, are making a difference. Stronger defense strategies, evident by the dramatic increase in the average amount spent to defend claims, appear to be effectively stabilizing the average indemnification paid to plaintiffs. The increased use of arbitration has been cited by participants in this report as a key factor in reducing average severity. Many

additional operational changes have been implemented that focus on quality of care initiatives, including patient safety programs, family education plans, increased staffing ratios and investment in homes and equipment. Most providers have introduced at least some of these operational changes, and many in the industry have executed on robust strategic plans that address all segments of their operations. In comparing the trend lines in this study to those observed just a few years ago, it appears that, collectively, these changes are helping to control liability costs by improving the quality of care.

Structural Changes

Structural changes are also having a large impact. Large multi-state providers, who have historically incurred the greatest number of claims and the largest value claims, have aggressively exited historically high cost states such as Florida, Mississippi, and Arkansas. The new owners of these facilities have tended to be smaller operators or private equity funded investors who create limited liability corporations with reduced need or access to commercial or self insurance capacity, resulting in lower amounts of coverage to indemnify residents alleging patient care liability. This has contributed to the reduction in the average frequency, severity and loss cost in the states in which these facilities are located, particularly Florida. As with tort reform, not all providers are benefiting from a reduction in liability resulting from the structural changes occurring in the industry. Large publicly traded corporations continue to provide a fair amount of the long term care in this country and they have a responsibility to stockholders to maintain insurance limits that protect the financial integrity of the company. Additionally, the lower limits of liability maintained by some private operators do not provide full immunity from lawsuits that could put the assets of the company at risk.

Of all the changes occurring in the industry, tort reform appears to be having the greatest effect on reducing GL/PL losses. Therefore, a comparison of GL/PL loss costs between states with tort reform versus all other states provides the clearest picture of the trends across the country.

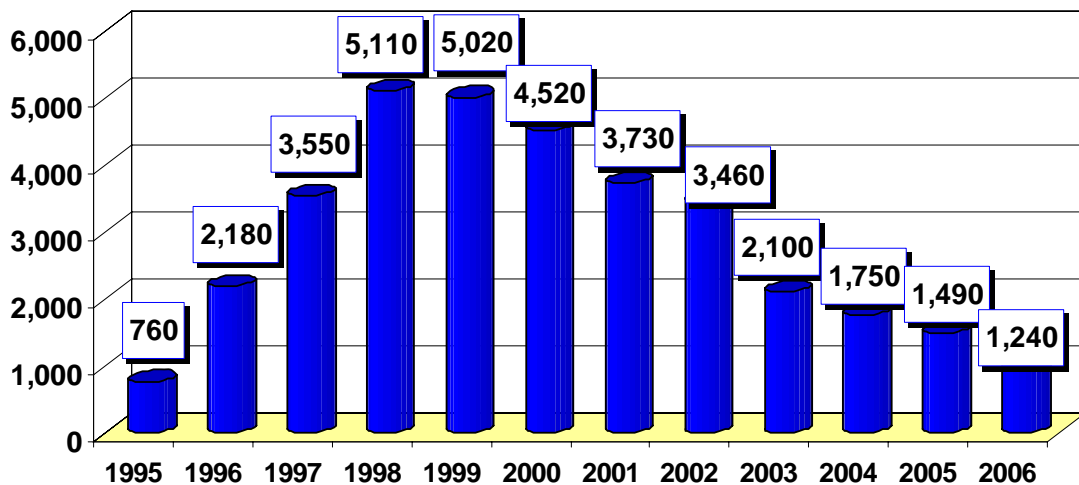
States With Tort Reform Report Dramatic Reductions in GL/PL Loss Costs

Several state legislatures have passed tort reform within the last five years to address the rising cost of patient care liability and medical malpractice claims. The impact of these reforms is now evident in the claim data of those states that historically incurred the highest GL/PL loss costs, and the results are profound. In this report we have analyzed the liability trends of seven states that passed tort reform between 2001 and 2005 that included caps on non-economic damages and/or tightened the rules for filing allegations of patient care liability. These states include Florida, Georgia, Louisiana, Mississippi, Ohio, Texas and West Virginia. (See page 1 for the criteria used to determine a tort reform state for this analysis.)

At the time these laws were passed, most of these states were experiencing unprecedented increases in the number and size of lawsuits alleging patient care liability. The litigation explosion was triggering an exodus of nursing home operators from the state and severely restricting the availability and affordability of commercial insurance to cover this liability.

Based on the data reported in this study, is it now apparent that the impact of the various tort reforms passed in these states is a reduction in both the number and size of GL/PL claims. On a combined basis, the loss cost for this group of states has been reduced approximately 76% from a peak level of \$5,110 in 1998 to an estimated \$1,240 for 2006, as shown in the following graph:

Tort Reform States (FL, GA, LA, MS, OH, TX, WV) Loss Cost per Occupied Bed²

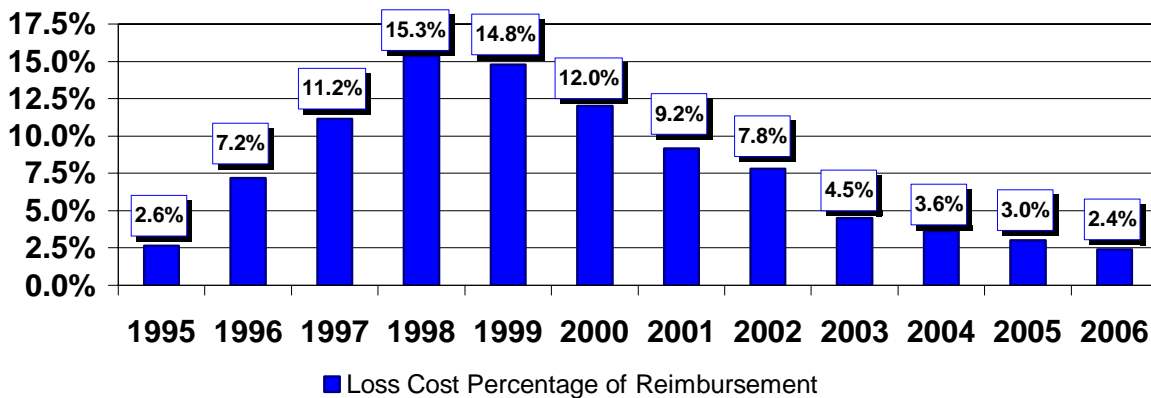


As a group, the 2006 loss cost for these states is now below the average countrywide loss cost of \$1,610 and the average non-tort group loss cost of \$1,710 (see the following sections for comparative loss costs).

² It should be noted that not all states that have passed some tort reform in recent years are represented in this “Tort Reform States” analysis. This is due to the limited amount of data available on these states to measure the impact of the specific provisions. California has been excluded from the “Tort Reform States” analysis due to the prevailing use of the 1982 Elderly Abuse and Dependent Adult Civil Protection Act (EADACPA) to circumvent the non-economic damage caps contained in the 1975 Medical Injury Compensation Reform Act (MICRA).

Because the majority of nursing home beds are funded by either Medicaid or Medicare (82% based on CMS OSCAR Survey data as of June, 2006), the cost of patient care liability is largely being funded by taxpayer dollars. The decrease in liability costs for the tort reform states translates to an approximate \$200,000,000 annual savings in the cost of care for the providers represented in this study. On a per diem basis, the loss cost decreased as a percent of Medicaid reimbursements, from 15.3% in 1998 to 2.4% in 2005 as shown in the graph below.

7 Tort Reform States Loss Cost as a Percentage of Medicaid Reimbursement

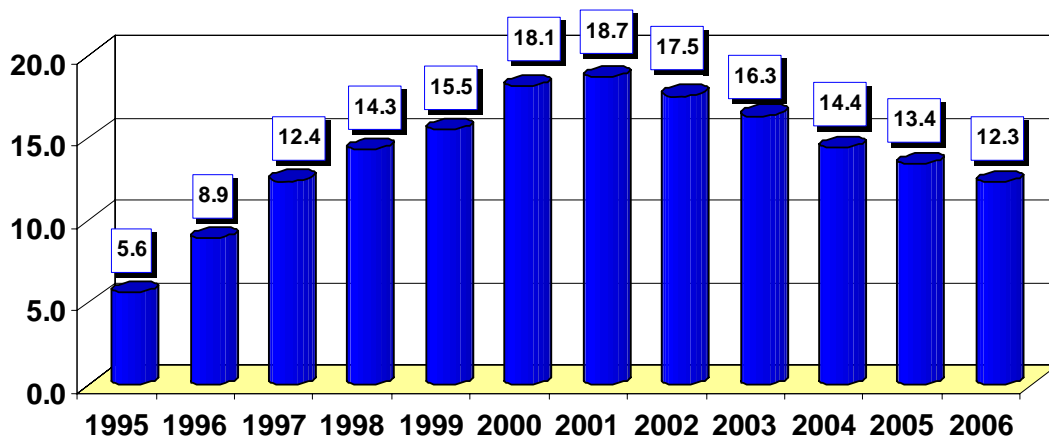


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	78.5	83.1	87.2	91.3	93.2	103.1	111.7	121.2	128.1	131.9	136.3	141.1
Per Diem Loss Cost Per Bed	2.1	6.0	9.7	14.0	13.8	12.4	10.2	9.5	5.8	4.8	4.1	3.4

*2005 Estimated

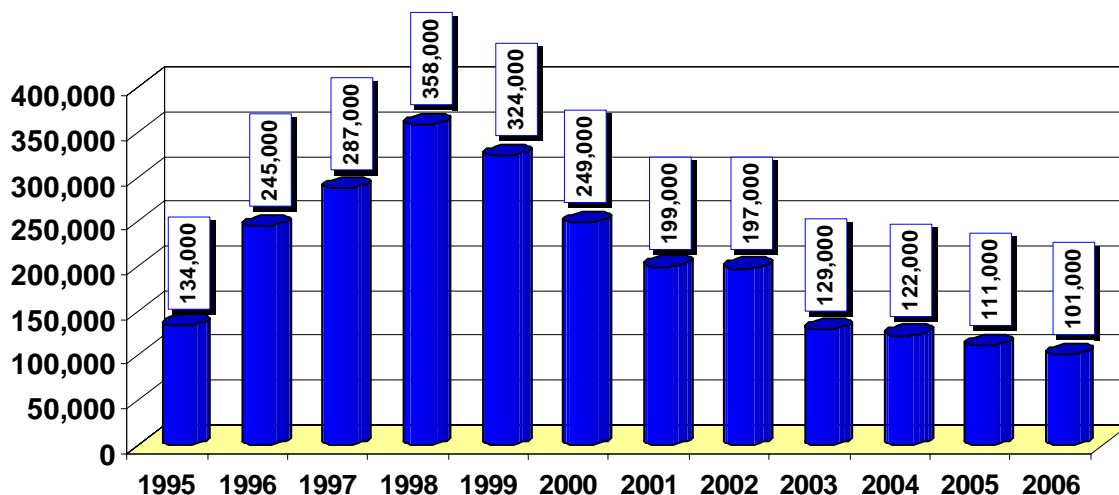
The drop in loss costs is the combination of a reduction in both the number of claims and the average size of claim. The frequency of claims per 1,000 occupied beds has dropped from a high of 18.7 claims in 2001 to only 12.3 claims in 2006. This compares to an estimated 11.1 claims per 1,000 occupied beds in 2006 for all states combined. Of note, however, is that the trend is decreasing for tort reform states and still strongly increasing for all other states combined.

Tort Reform States Annual Number of Claims per 1,000 Occupied Beds



Similarly, the average size of claim has dramatically reduced from a high of over \$350,000 in 1998 to an estimated \$101,000 in 2006. The average severity for the seven tort reform states is 31% lower than the countrywide average severity of \$146,000 and 37% lower than the average severity of \$160,000 for all other (i.e. excluding tort reform) states combined.

Tort Reform States Severity per Claim

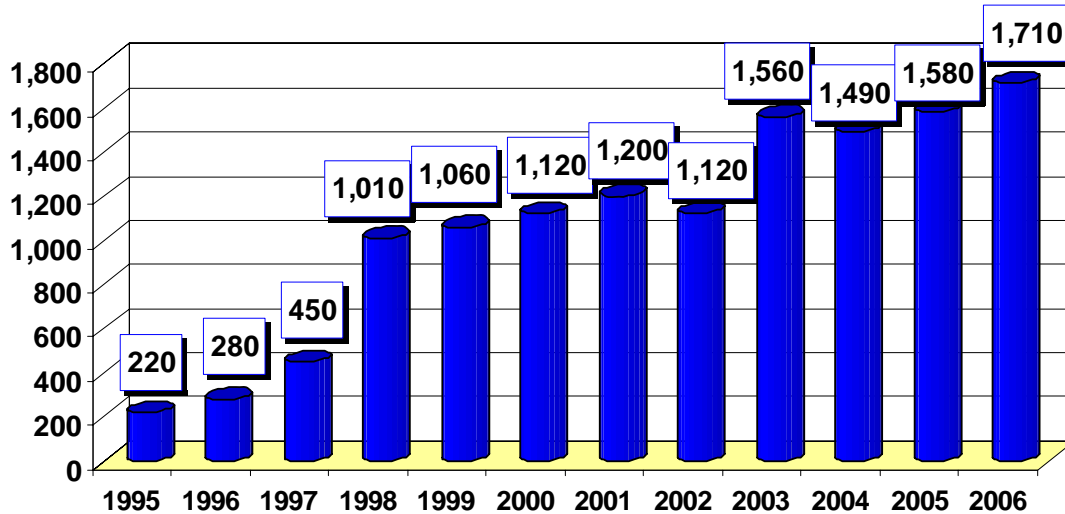


When reviewing the above graph it is important to understand that these are accident year results. In many states, a decline in severity on an accident year basis is observed preceding the date of legislative reform. This is a result of the lag time in patient care liability between the accident date and report date. As a result, a legislative reform that becomes effective for claims filed on or after a specific date will affect the claim severities for accident years preceding the reform date. The same phenomenon also may apply to claim frequency. However, an anticipated drop in frequency is often offset by an increase in claim filing activity prior to the passage or enactment date of tort reform.

Tort reform alone is not entirely responsible for the reduction in liability costs in the states presented above. Other factors that have contributed to the decrease include the investment in more effective defense strategies, the increased use of arbitration, the focus on quality of care, the exodus of the larger, deep pocket providers from the more litigious states, and the reduction in available limits of liability (particularly in Florida) .

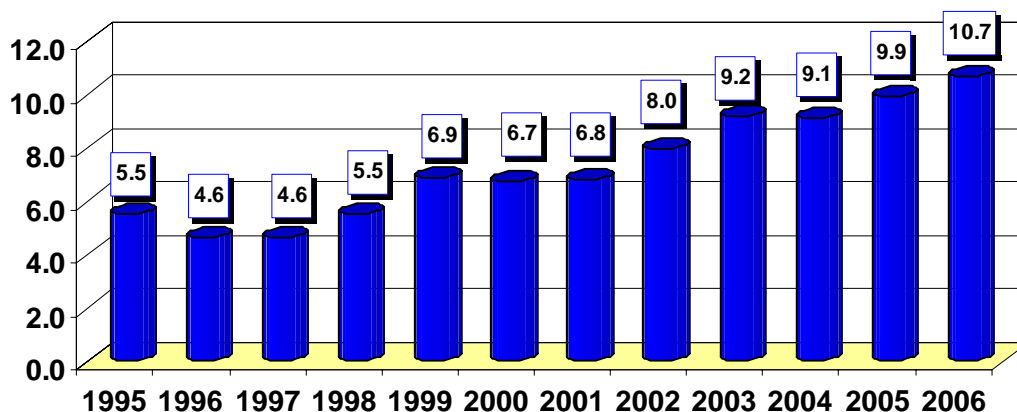
However, non-tort reform strategies for lowering liability costs are also being applied in other states, and the impact, while evident, is hardly as dramatic as the decreases observed in tort reform states. For comparison, below is a graph of the GL/PL loss cost trend for all states combined excluding Florida, Georgia, Louisiana, Mississippi, Ohio, Texas, and West Virginia.

All States Excluding Tort Reform States Loss Cost per Occupied Bed



As a group, these states are continuing to trend upward in total liability loss cost per occupied bed. This trend is driven entirely by frequency as the number of claims per 1,000 occupied beds has grown from 5.5 in 1995 to 10.7 in 2006, indicating a 9% average annual increase.

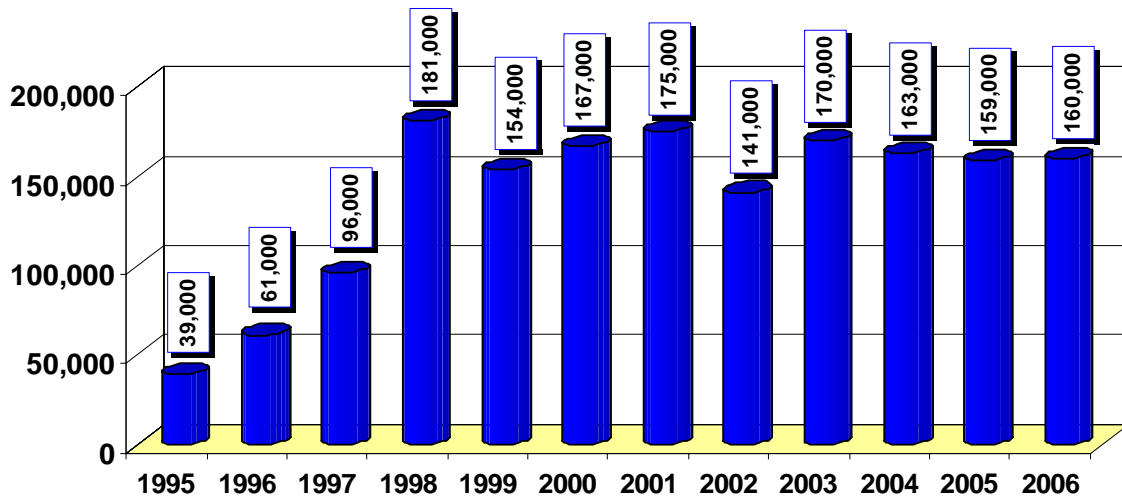
All States Excluding Tort Reform States Annual Number of Claims per 1,000 Occupied Beds



Severity, on the other hand, appears to be stabilizing, which demonstrates the impact of non-tort reform strategies being implemented around the country. However, the

average severity, at \$160,000, remains 60% higher than the current average severity of states with tort reform.

All States Excluding Tort Reform States Severity per Claim



Comparing the trends between the tort reform state group and the excluding tort reform group it becomes evident that tort reform has helped to bring the most litigious states back in line with the rest of the country as respects liability costs. Looking ahead, it appears that states with tort reform are trending towards lower liability costs than the rest of the country.

It is also important when comparing the two groups to be cognizant of the differences among states within each grouping. In particular, the “All States Excluding Tort Reform” group includes a wide range of loss costs and trends. At one extreme this group includes Arkansas, which has the highest loss cost in the country at \$9,880 per occupied bed, but is not trending up at this time. Alabama, on the other hand, has seen its loss cost drop from a high of \$1,810 per bed in 2001 to only \$980 per bed in 2006, without the benefit of tort reform. But then there is Arizona, trending up almost 40% annually in the last seven years from \$700 per bed back in 2000 to \$4,300 per bed in 2006.

The tort reform group is similarly varied. Ohio and West Virginia are included in this group along with the historically litigious states of Texas, Florida and Mississippi. Both Ohio and West Virginia passed tort reform within the past few years. However, at the time the tort reforms were passed both states were below countrywide average loss cost levels and the impact of their reforms is not as material to the historical results presented in this study as is the impact of reforms in the other tort states. It is expected

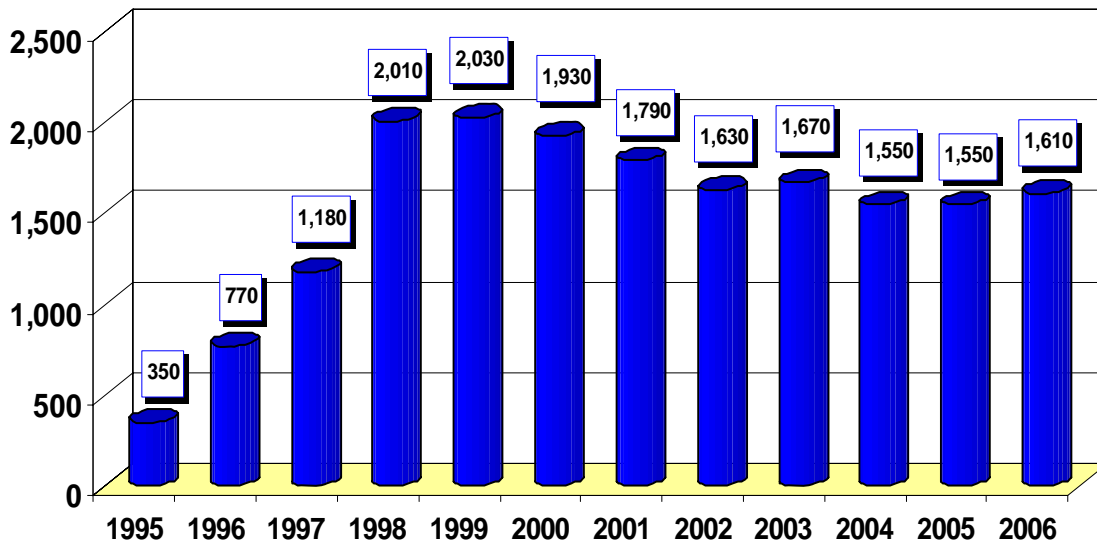
that the reforms will help mitigate future increases in both the frequency and severity of claims.

To assist in assessing the components of reform that have contributed to the results presented above, a state by state description of the tort reform provisions and their observed impact is provided at the end of the study.

Tort Reform, Operational Changes and Structural Changes are Stabilizing GL/PL Loss Costs in the United States

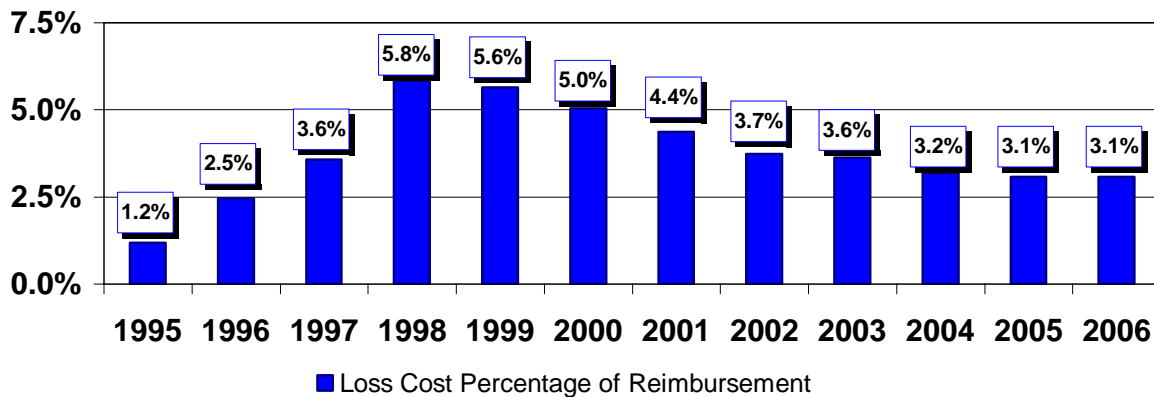
The impact of tort reform, operational changes and structural changes, combined, indicate relative stability in countrywide liability trends. After rising dramatically from the mid to late 1990's the countrywide average GL/PL cost per occupied long term care bed appears to have peaked in 1999 at \$2,030 per bed and since stabilized over the past five years at approximately \$1,600 per bed as the following graph shows.

Countrywide Loss Cost Per Occupied Bed



On a per diem basis, the loss cost increased as a percent of Medicaid reimbursements, from 1.2% in 1995 to a high of 5.8% in 1998, and has since leveled off at 3.1% in 2006 as shown in the following graph.

Countrywide Loss Cost as a Percentage of Medicaid Reimbursement



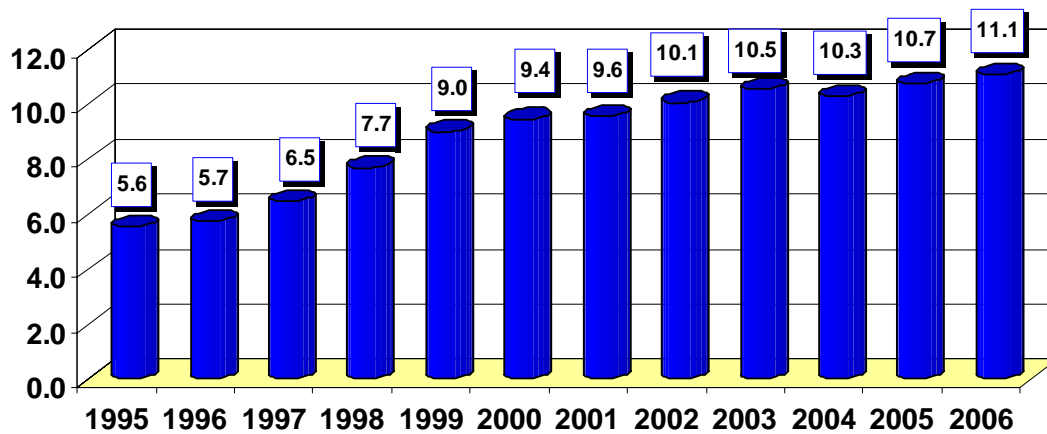
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	81.4	85.7	90.3	94.3	98.6	105.1	112.1	119.8	126.4	133.5	137.9	143.4
Per Diem Loss Cost Per Bed	1.0	2.1	3.2	5.5	5.6	5.3	4.9	4.5	4.6	4.3	4.3	4.4

*2005 Estimated

The Number of GL/PL Claims Continues to Increase

Despite the recent stability in the countrywide average GL/PL cost per bed, the annual number of GL/PL claims per 1,000 occupied beds has been increasing over the last eleven years and is currently about double the 1995 frequency per bed. Since 1995, the number of claims per occupied bed has been increasing at an annual rate of 6.6%. In the more recent five year period, however, frequency has been increasing at only 2.1% per year.

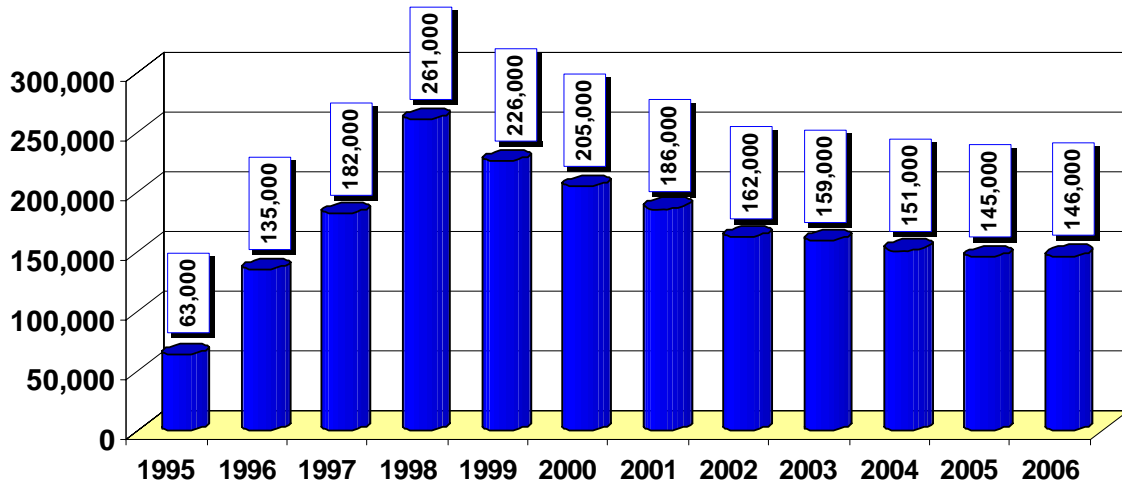
Countrywide Annual Number of Claims per 1,000 Occupied Beds



The Average Severity of GL/PL Claims Has Dropped

The countrywide average GL/PL claim size peaked at just over \$250,000 in 1998 and has been gradually coming down since.

Countrywide Severity per Claim



One of the key drivers in the reduction of the countrywide average size of loss is the passage of tort reform statutes in a handful of states with large numbers of patient care liability claims. Other factors that appear to be affecting the trend in the countrywide average severity include stronger defense strategies, increased use of arbitration, increased focus on quality of care, reduced operations in highly litigious jurisdictions, and reduced limits of liability.

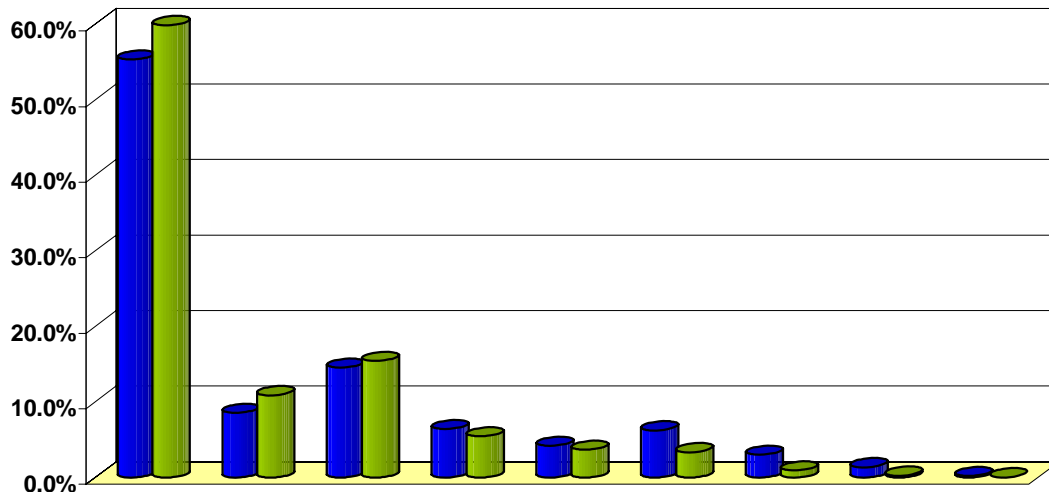
Consistent with the reduction in the overall average severity on a countrywide basis is a slight decrease in the number of large claims. The distribution of GL/PL losses by size indicates that approximately 16.4% of the claims reported from 1998 to 2004 are greater than \$250,000. When Aon reported on this topic in our prior study (looking at similarly aged years for the same group of providers), this ratio was 16.7%.

However, the percentage of claims above \$1 Million continues to grow. A total of 431 claims, or 2.2%, reported in our survey are greater than or equal to \$1 Million. This compares to only 2.0% in our prior report (looking at similarly aged years for the same group of providers). Of these, 20 claims are in excess of \$5 million and 3 claims are in excess of \$10 million. These counts represent only currently reported claims at company estimated case reserve levels. By the time many of these claims are taken to trial and/or settled, the number expected to exceed \$1 Million will increase.

This apparent contradiction of a decreasing average severity and an increasing percentage of claims excess of \$1 Million may be explained by two factors. First, the industry continues to work through an inventory of claims from older years of operation that do not reflect tort reform or current investments in operational and structural changes. Second, despite the positive effect of claim control strategies, there continues to be an expansion in the litigation of long term care liability. While the litigation crises of Florida and Texas appear to be mitigated, new and expanding crises continue in numerous other states such as Arkansas, Tennessee, and Arizona.

These differences are apparent in the following graph. For the nine states individually reviewed in this report (Alabama, Arizona, Arkansas, California, Mississippi, Tennessee, Texas, West Virginia and Wisconsin), the percentage of claims greater than \$250,000 is 21.5%. This compares to only 13.8% for all other states combined.

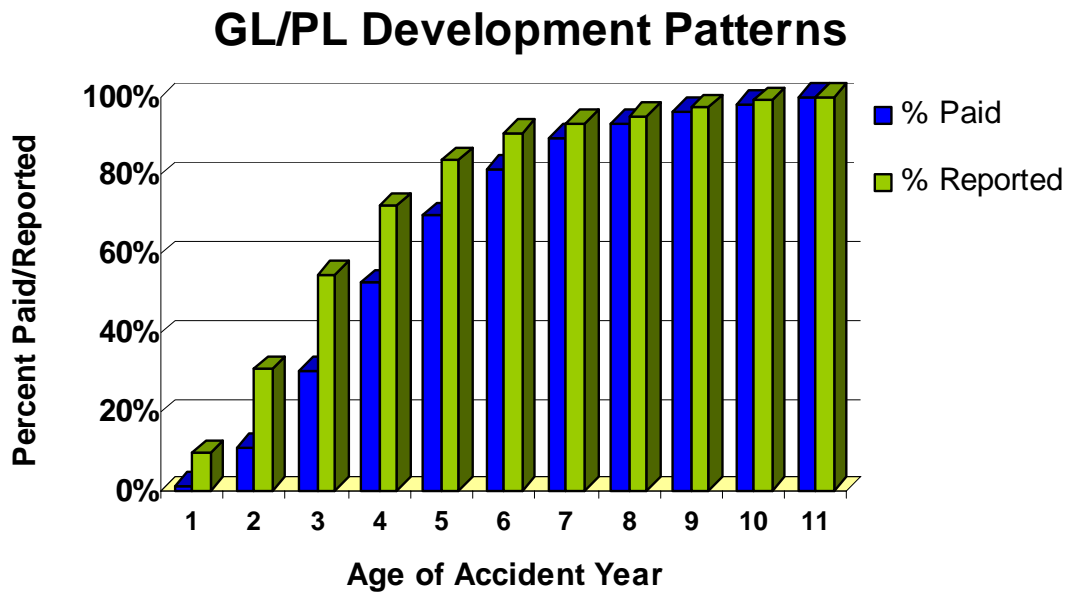
Percentage of Claims Reported by Size of Loss
AY 1998 - 2004 Reported Claims



	0 - 50K	50K - 100K	100K - 250K	250K - 350K	350K - 500K	500K - 1M	1M - 2M	2M - 5M	5M & Up
AL, AZ, AR, CA, MS, TN, TX, WI & WV	55.4%	8.6%	14.5%	6.4%	4.2%	6.2%	3.0%	1.4%	0.2%
Remaining States	59.9%	10.9%	15.5%	5.5%	3.7%	3.4%	0.9%	0.3%	0.0%
Total	58.4%	10.1%	15.2%	5.8%	3.9%	4.3%	1.6%	0.6%	0.1%

GL/PL Loss Development

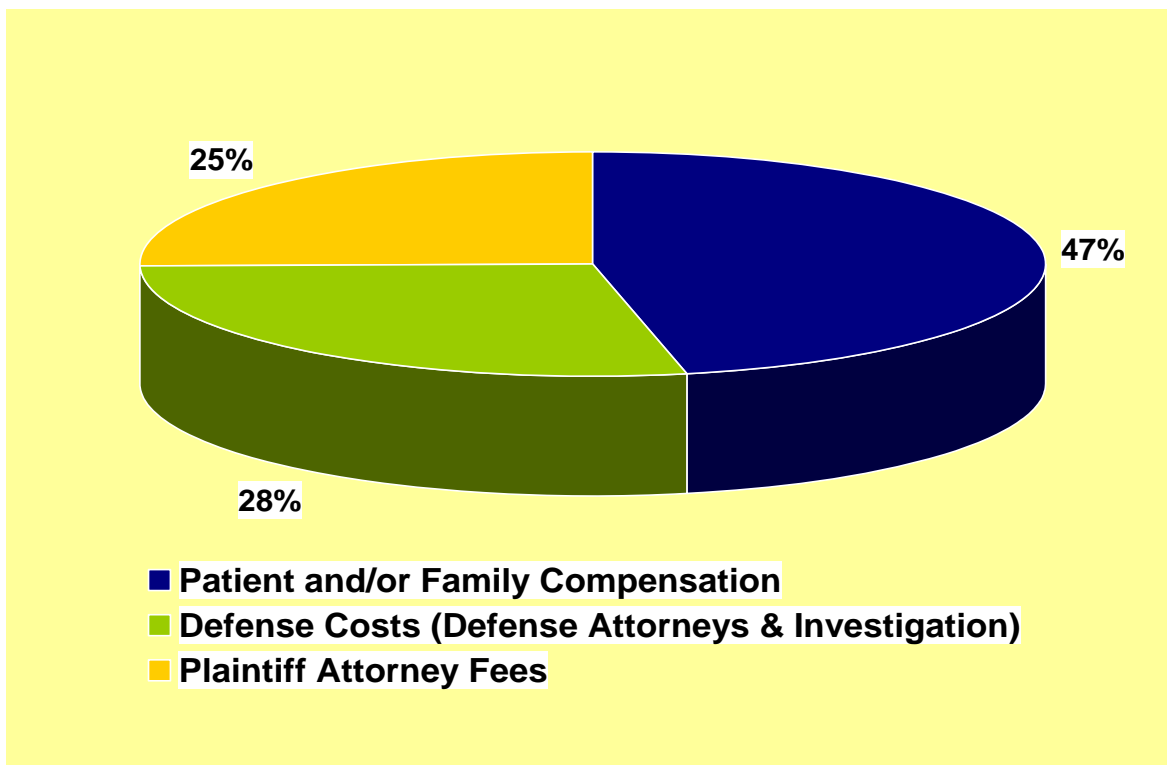
For the long term care industry, it takes approximately eleven years before all claim cost estimates related to incidents from a particular period of time are reported. Similarly, it takes approximately eleven years before all claims from incidents occurring during a year of operations are closed and the actual costs are known. The following graph shows the percentage reported and paid at each age until all claims are closed:



An Increasing Portion (53%) of Total Claim Dollars is Litigation Costs

It is estimated that 53% of the total amount of claim costs paid for GL/PL claims of the long term care industry are covering litigation costs, and this ratio has been increasing over the past several years. Based on the database of claims used in this study, 28% of total losses are allocated loss adjustment expenses (ALAE), which represent defense costs such as investigation and attorney fees. The remaining 72% represent the amount paid in total to the plaintiff, including amounts retained by the plaintiff's attorneys. Of this amount, based on state Bar standards for contingency fees*, it is estimated that the plaintiff's attorneys retain approximately 35%. Of the total loss dollars, this represents 25%. Consequently, 53%, or more than half, of total long term care industry GL/PL losses are litigation costs.

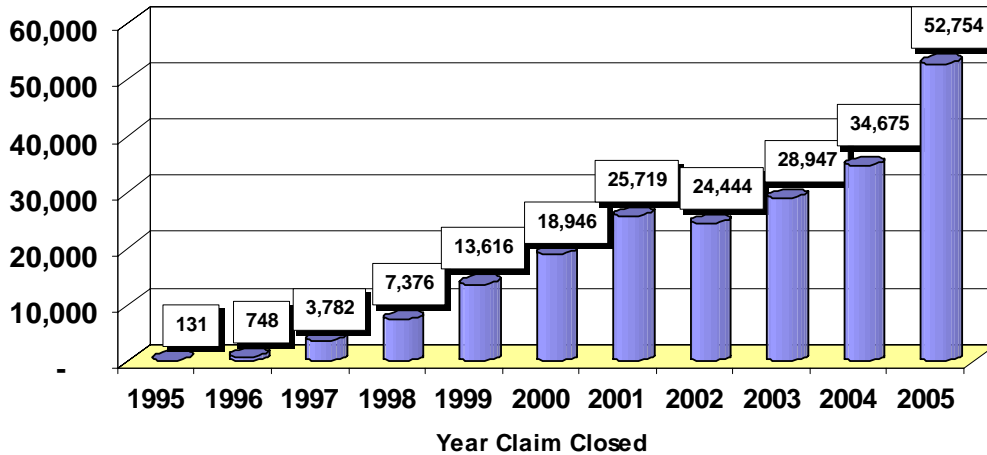
Distribution of Compensation



* Insurance claim data does not break down the indemnity component of loss between plaintiff and attorney because this is privileged information. However, state Bar rules provide some guidelines. For example, the Florida Bar Rules of Professional Conduct, Section 4.1, Client – Lawyer Relationship, provides a standard of contingency fees that, if exceeded, would be considered to be clearly excessive. The fee schedule shown in this section varies depending on the timing of filing for arbitration or the entry of judgment, but generally ranges from 33 1/3% to 40% for any recovery up to \$1 Million. Lower contingency fees are recommended for the portion of recoveries above \$1 Million.

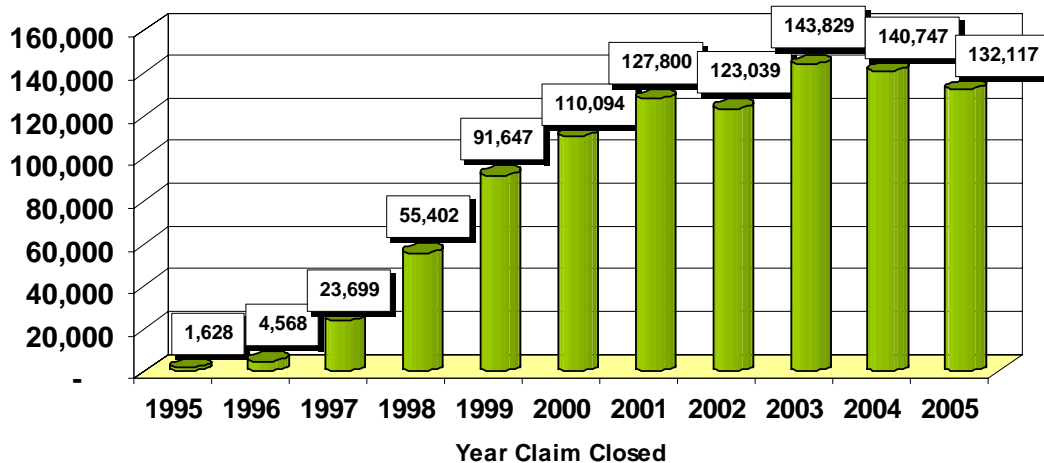
This ratio has been climbing in recent years. Grouping claims by year of closure, it becomes evident that the average amount spent to defend a GL/PL claim has doubled in the past five years as the following graph shows.

Average ALAE (Defense Cost) Paid



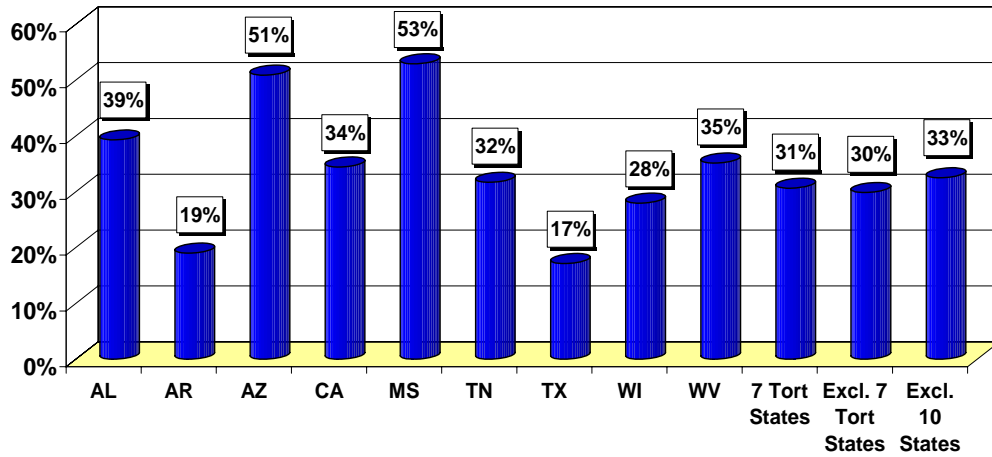
The average amount spent to indemnify patients has recently started to decrease, likely due in some part to the increased amount spent on defense.

Average Indemnity Paid



The component of total claim dollars used to defend claims (ALAE) varies by state as follows:

Percentage of Paid ALAE to Total Paid



7 Tort States are: FL, GA, LA, MS, OH, TX, and WV

Excl. 10 States excludes: AL, AR, AZ, CA, FL, MS, TN, TX, WI and WV

The Impact of Patient Rights Laws

Lawsuits against nursing homes often include allegations beyond the traditional causes of action against acute care providers. Patient care lawsuits filed against hospitals and physicians typically are based on allegations of medical malpractice and fall under the corresponding state statutes. Allegations against nursing homes may include causes of action based upon nursing home patient protection laws or elder abuse laws.

Independent of state laws, all nursing homes that receive Medicaid and Medicare funds to care for patients are subject to federal standards regarding quality of care and patient rights. In 1974 Congress passed the Nursing Home Bill of Rights (NHBR), which conditioned reimbursement on meeting federal standards. NHBR focused on quality of care and stated that every resident has the right “to a dignified existence in the home.” The federal regulation of nursing homes was further expanded in 1987 when Congress passed the Federal Omnibus Budget Reconciliation Act (OBRA 1987). OBRA 1987 expanded on the patients’ rights, for example, by providing that each patient has a right to be free from abuse and restraint, a right to privacy and a right to grievances.

OBRA 1987 did not preclude individual states from regulating patient rights and several state governments have supplemented the federal regulations either through legislation or case law. Based upon a review of the patient protection laws applicable to long term care residents in each of the 50 states, we note the following:

Six of the nine states individually profiled in this study have some form of state specific elder abuse or patients’ rights law or case ruling regulating the quality of care in nursing homes receiving Medicaid and Medicare funding. States with specific laws protecting the rights of nursing home residents include Arkansas, Arizona, California, Tennessee and Texas. In addition, Alabama’s Supreme Court has upheld a common law right of action against nursing homes even where a statutory cause of action is not supplied.⁴

Despite the correlation in these states, not all states with patient rights statutes have experienced the same trends in the cost of GL/PL claims. More than half of the states in the United States have some form of a patients’ bill of rights. However, states vary on issues such as enforcement by lawsuit, reimbursement of attorney’s fees, limits of liability, statute of limitations and damage caps.

Similarly, not all states identified as having higher than expected loss costs have patients’ bill of rights. For example, Mississippi does not currently have a long term care specific patients’ rights statute.

⁴ R. Patrick Bedell, *The Next Frontier in Tort Reform, Promoting the Financial Solvency of Nursing Homes*, *The Elder Law Journal* 364 (2004)

State Specific Long Term Care GL/PL Trends

The following sections highlight the range of litigation activity across the country on a state by state basis for select states with a credible percentage of nursing homes participating from the state. These states include, in order of highest to lowest 2006 loss cost, Arkansas, Mississippi, Tennessee, Arizona, California, West Virginia, Texas, Alabama, and Wisconsin. It should be recognized that these states do not represent the nine worst states with respect to patient care liability costs. While several of the most costly states are included, there may be states with higher loss costs that we have not included in our sampling.

A review of these nine states shows a wide variety in the trends of GL/PL claim activity over the past twelve years. As the long term care litigation crisis spread from a handful of states to a broader geographical area, a disturbing pattern began emerging. This pattern was a combination of increases in the number of claims and increases in the average claim size. In the early stages of this litigation crisis, this pattern continued, with few exceptions, until claim sizes reach an average level of between \$200,000 to \$300,000. But, the frequency rate generally kept trending up, creating no cap to the rising cost per bed. As providers have implemented strategies to control liability costs, the trend in severity has been curtailed in many states. Sizable reductions in claim sizes are evident where tort reform has been part of the strategy and average severities had exceeded \$300,000. In other states, average severity is stabilizing as the cumulative effects of all other cost control strategies make their impact.

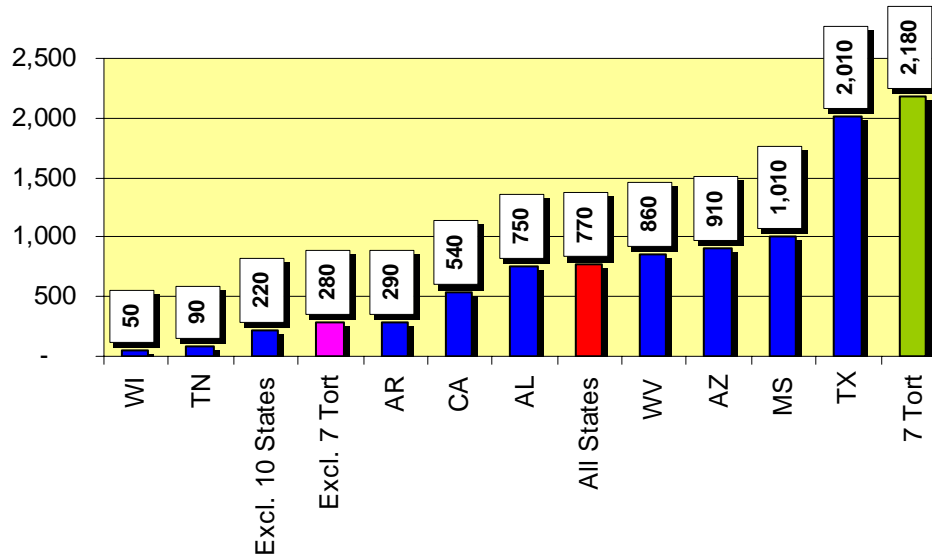
State differences continue, however. Among the individual states analyzed, current estimated loss costs range from \$550 per bed in Wisconsin to \$9,880 in Arkansas.

The impact of tort reform varies by state. Texas experienced a drop in loss cost from over \$6,000 to just over \$1,000 following its reform, which included a \$250,000 cap on non-economic damages per dependent, subject to a \$750,000 maximum. West Virginia, on the other hand, continues to experience increasing trends, despite a similar cap, and is now projecting a \$2,600 per bed loss cost. However, at the time the tort reform was passed, the West Virginia average loss cost was below the countrywide average and the impact of its reform was not anticipated to be as material as the impact of reforms in the other tort states. It is expected that the West Virginia reform will help mitigate future increases in both the frequency and severity of claims.

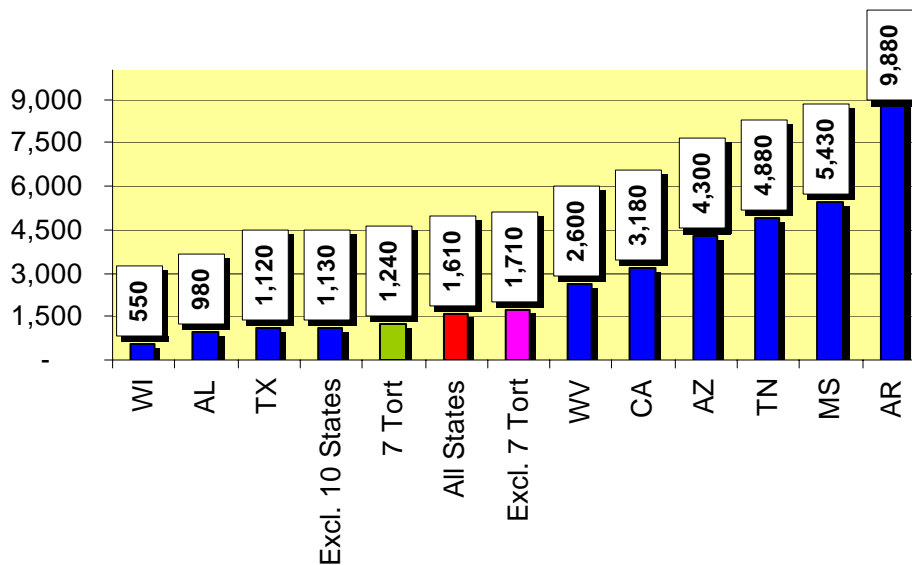
Setting aside the early crisis states that have benefited from tort reform and focused risk management strategies, the underlying trend is still upward. An analysis at the end of this section presents the loss cost trends for all other states combined, which excludes the nine states separately analyzed as well as Florida. This analysis indicates that the average loss cost per bed is increasing well in excess of normal tort liability inflation.

A summary of the 1996 and 2006 loss costs for the twelve analyses provided in this report is shown in the graphs below. Individual state sections follow.

1996 GL/PL Loss Cost by State



2006 GL/PL Loss Cost by State

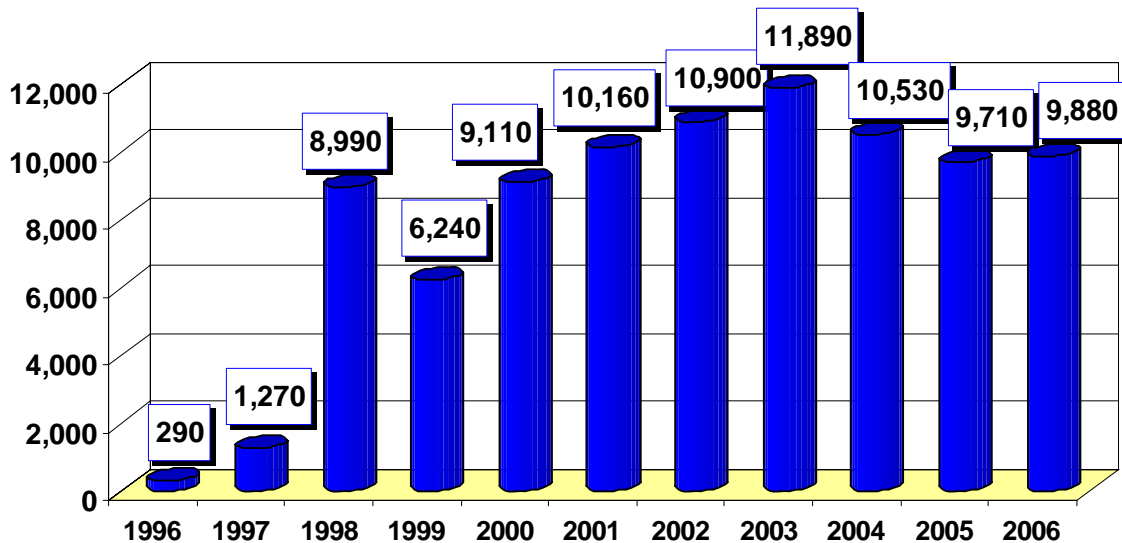


Arkansas

The participants in this study represent approximately 5,200 licensed beds in the state of Arkansas. This is approximately 19% of Arkansas nursing home beds.

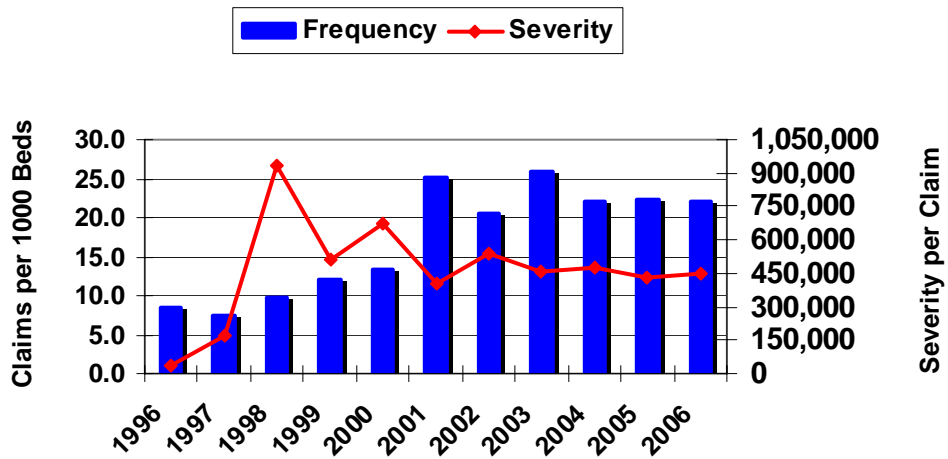
Arkansas GL/PL costs are now the highest in the country due to an extraordinary number of extremely large losses. Five of the twenty claims reported in this study to be over \$5 Million occurred in Arkansas. Prior to 1998 Arkansas long term care providers incurred an average GL/PL cost per bed of around \$290 - \$1,270. In 1998 loss costs jumped to \$8,990 and have since remained high.

Arkansas Loss Cost per Occupied Bed



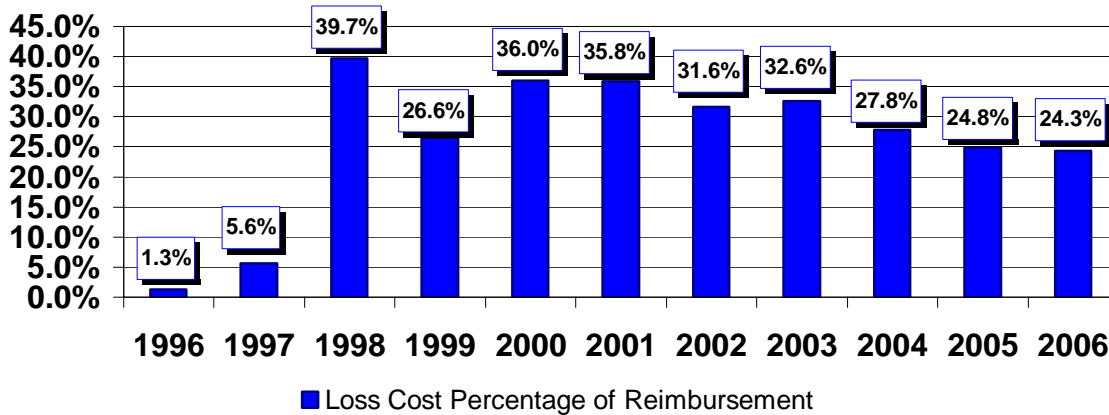
In 1998 the number of claims incurred started increasing dramatically over prior years and several resulted in multi-million dollar payments and an unprecedented average claim size of over \$930,000. From 1998 through 2003 the number of claims continued to climb and the average severity remained high. More recently, the number and size of claims appear to be stabilizing, but at very high levels relative to the rest of the country.

Arkansas Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the average loss cost increased as a percent of Arkansas Medicaid reimbursements, from 1.3% in 1996 to 39.7% in 1998, and has since leveled off at 24.3%, the highest ratio in the country.

Arkansas Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	62.0	62.0	62.0	64.3	69.4	77.7	94.5	99.9	103.7	107.1	111.4
Per Diem Loss Cost Per Bed	0.8	3.5	24.6	17.1	25.0	27.8	29.9	32.6	28.9	26.6	27.1

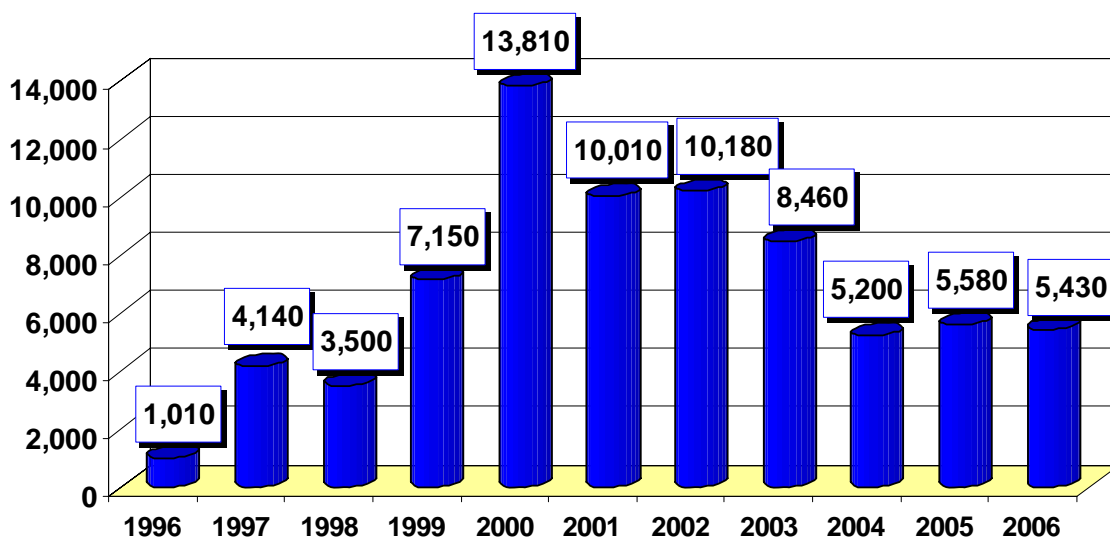
*2005 Estimated

Mississippi

The participants in this study represent approximately 2,100 licensed beds in the state of Mississippi. This is approximately 11% of Mississippi nursing home beds.

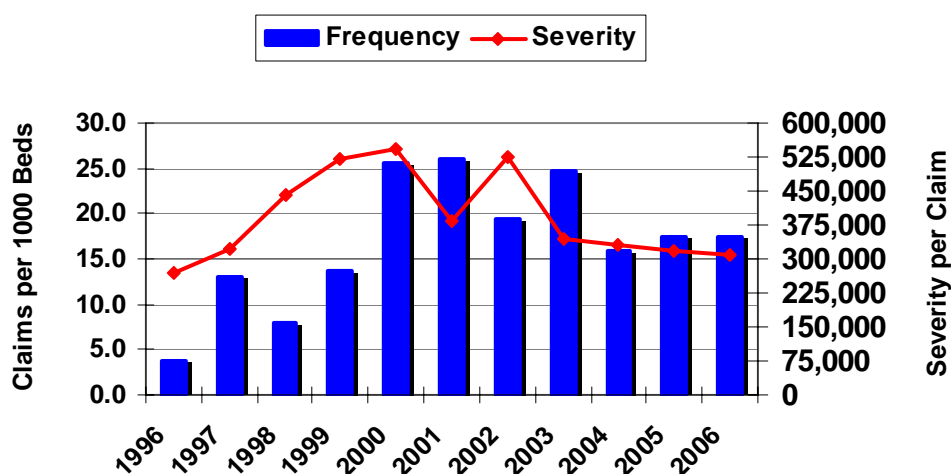
While currently the second highest in the country, Mississippi loss costs are down dramatically from 2000, likely due to the passage of tort reform in 2002. Prior to 1999, Mississippi long term care providers incurred an average GL/PL cost per bed of around \$1,010 - \$3,500. Loss costs jumped up to \$7,150 in 1999, peaked at \$13,810 in 2000, and have dropped over 50% since 2002. In the past three years, it appears that costs are leveling off to approximately \$5,500 per bed.

Mississippi Loss Cost per Occupied Bed



Fueling the rise in Mississippi loss costs is a huge spike in the frequency rate between 1996 and 2001 from 4 to 27 claims per 1,000 occupied beds. Prior to the passage of tort reform in 2003, Mississippi severity grew to over \$500,000 per claim.

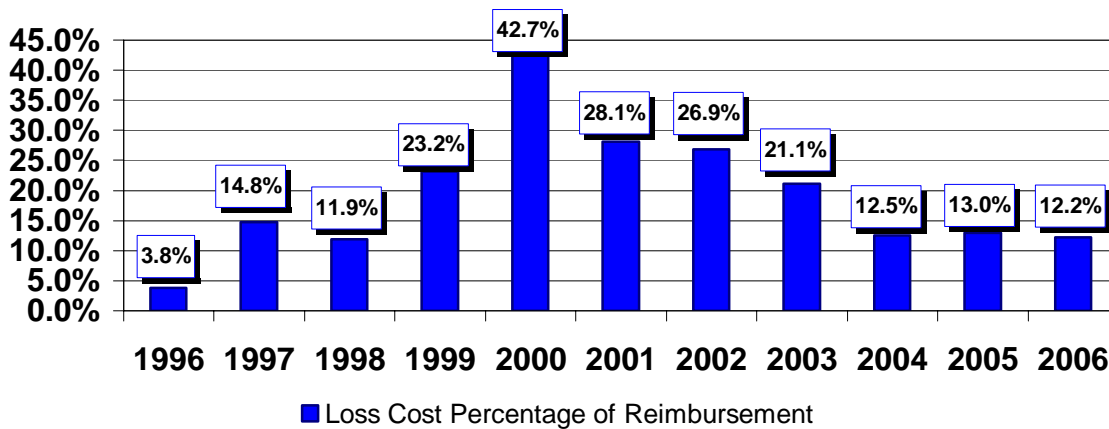
Mississippi Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



Mississippi passed legislation during its 2002 session with the intent of curbing the rising cost of patient care liability claims. House Bill No. 2 became effective January 1, 2003 and included revisions to the Mississippi medical malpractice code that, among other things, brought long term care providers under the act and limited non-economic damages to \$500,000 (increasing to \$750,000 on July 1, 2011 and \$1,000,000 on July 1, 2017). As has occurred in other states, the passage of this reform initially caused a significant spike in the number of claims, most alleging events in years 2000, 2001, and, to a lesser extent, 2002. Based on the data reported in this study, it appears that the tort reform is reducing both frequency and severity of Mississippi claims. The number of claims per 1,000 beds is down from 25 in 2003 to 17 in 2006. Additionally, an analysis of the large losses in Mississippi pre and post tort reform indicates that the caps are achieving their intended purpose. In the years prior to tort reform, the respondents to this survey reported 47 claims greater than \$1M in Mississippi. Since tort reform became effective 2003, the largest claim reported to date is \$850,000 and the largest indemnity payment made to date is \$700,000. This reduction in extremely large losses indicates that the average severity is coming down from the pre-reform levels that exceeded \$500,000. Currently, it is estimated that average severity is now closer to \$300,000.

The savings from tort reform has a direct impact on the total cost of care. On a per diem basis, the average loss cost in Mississippi increased as a percent of Medicaid reimbursements, from 3.8% in 1996 to 42.7% in 2000. Since 2000 this ratio has decreased but remains at a relatively high level of 12.2% in 2006 as shown in the graph below.

Mississippi Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	72.9	76.8	80.6	84.6	88.7	97.4	103.8	109.7	113.9	117.6	122.3
Per Diem Loss Cost Per Bed	2.8	11.3	9.6	19.6	37.8	27.4	27.9	23.2	14.3	15.3	14.9

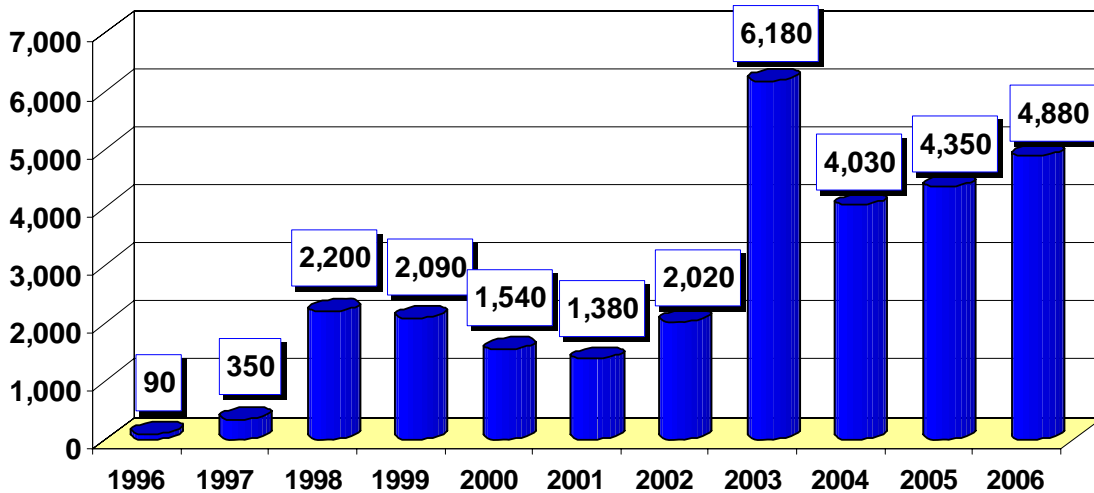
*2005 Estimated

Tennessee

The participants in this study represent approximately 8,900 licensed beds in the state of Tennessee. This is approximately 22% of Tennessee nursing home beds.

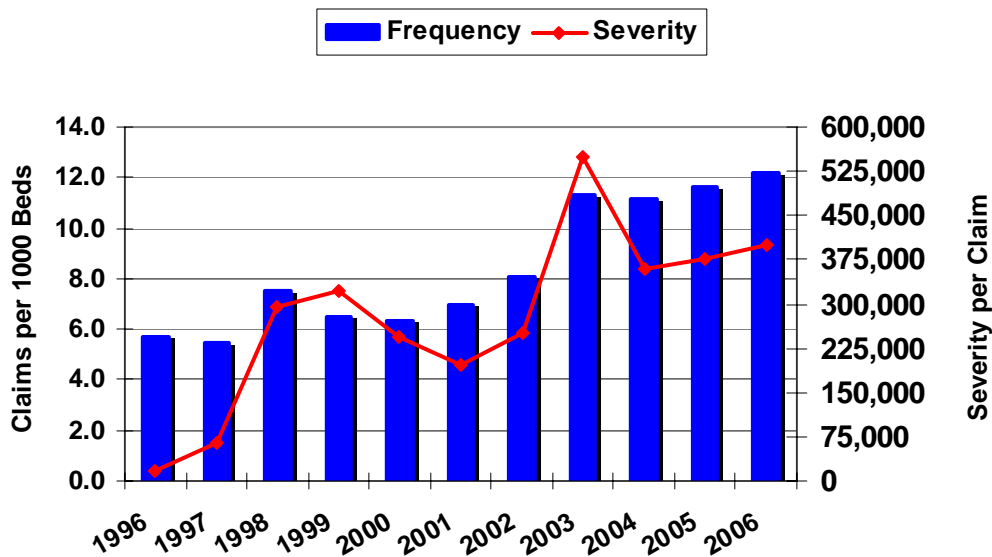
Tennessee loss costs, after jumping to over \$2,000 per bed in 1998, have continued to increase and are now the third highest in the country. The Tennessee average cost per bed was less than \$100 in 1996 and is now estimated at \$4,880 in 2006 as the following graph shows.

Tennessee Loss Cost per Occupied Bed



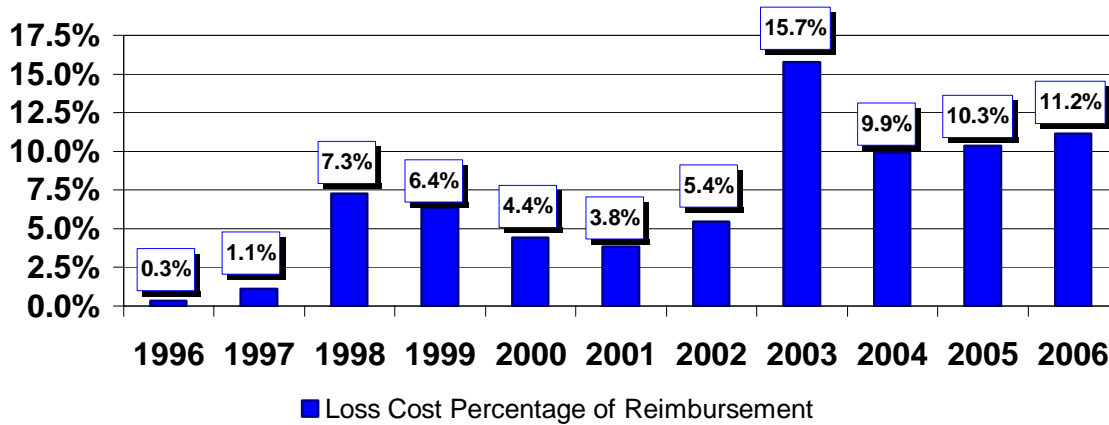
An increase in the number of claims per 1,000 occupied beds per year is contributing to the Tennessee loss cost increase. The number of claims has doubled from 6 claims per 1,000 occupied beds in 1996 to 12 in 2006. In addition, the average size of a PL/GL claim in Tennessee dramatically increased in 1998 to \$295,000 from an approximate average size of less than \$50,000 in prior years. Severity peaked at an average level of \$548,000 in 2003, a year with an unprecedented number of claims above \$1 Million, and has continued at an average of close to \$400,000. Tennessee average claim severities are now the second highest in the country, following Arkansas.

Tennessee Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the average loss cost is increasing as a percent of Tennessee Medicaid reimbursements, from 0.3% in 1996 to 11.2% in 2006 as shown in the graph below.

Tennessee Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	77.9	87.7	83.2	90.1	95.7	98.8	101.7	107.5	111.6	115.3	119.9
Per Diem Loss Cost Per Bed	0.3	1.0	6.0	5.7	4.2	3.8	5.5	16.9	11.0	11.9	13.4

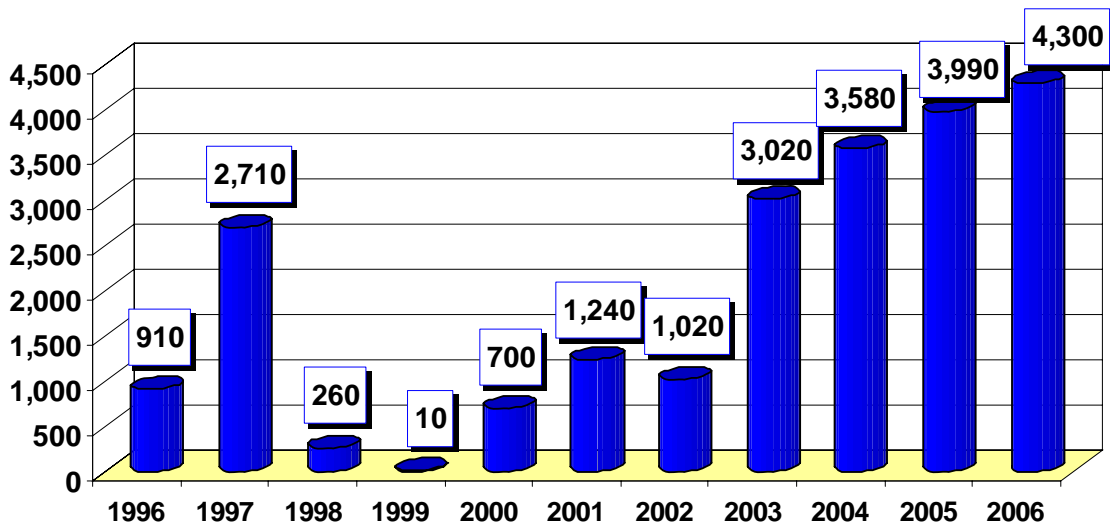
*2005 Estimated

Arizona

The participants in this study represent approximately 4,700 licensed beds in the state of Arizona. This is approximately 20% of Arizona nursing home beds.

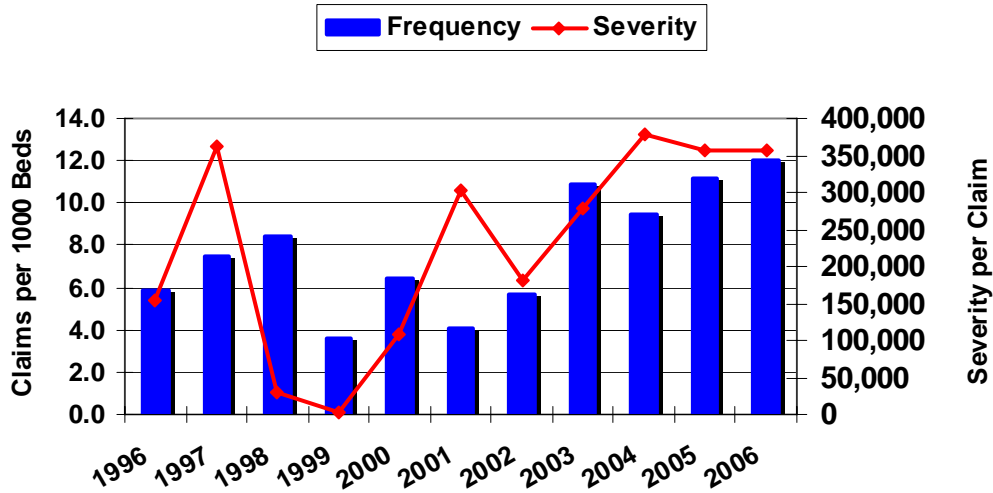
Arizona loss costs have increased from \$910 in 1996 to a projected \$4,300 in 2006. The spike seen in 1997, due to both an increase in the number of claims and the average claim size, seemed to be a sign of things to come in this state.

Arizona Loss Cost per Occupied Bed



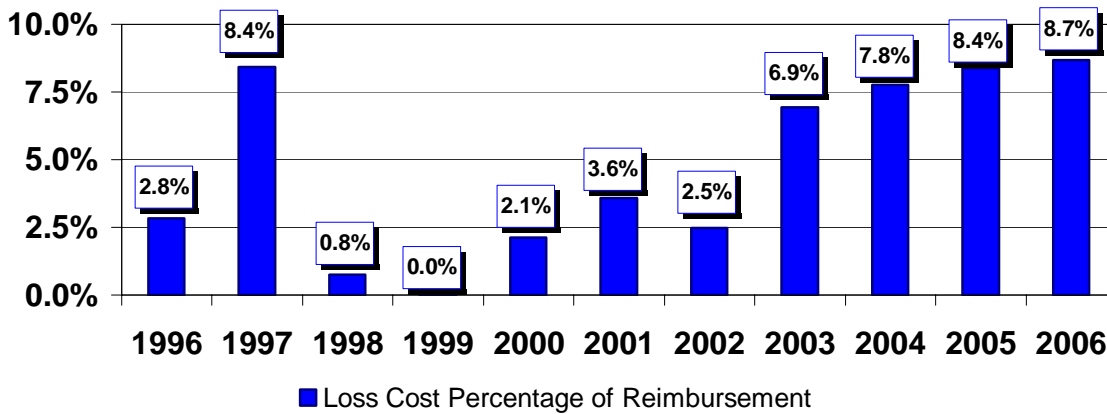
The number of claims per 1,000 occupied beds has doubled from 6 in 1996 to 12 in 2006. Severity has also climbed to an average of over \$350,000 per claim.

**Arizona Annual Number of Claims per 1,000 Occupied Beds
/ Severity per Claim**



On a per diem basis, the average loss cost has notably increased as a percent of Arizona Medicaid reimbursements, from 2.8% in 1996 to 8.7% in 2006 as shown in the graph below.

Arizona Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	88.2	88.2	93.8	97.4	90.2	94.7	112.4	119.2	126.5	130.6	135.9
Per Diem Loss Cost Per Bed	2.5	7.4	0.7	0.0	1.9	3.4	2.8	8.3	9.8	10.9	11.8

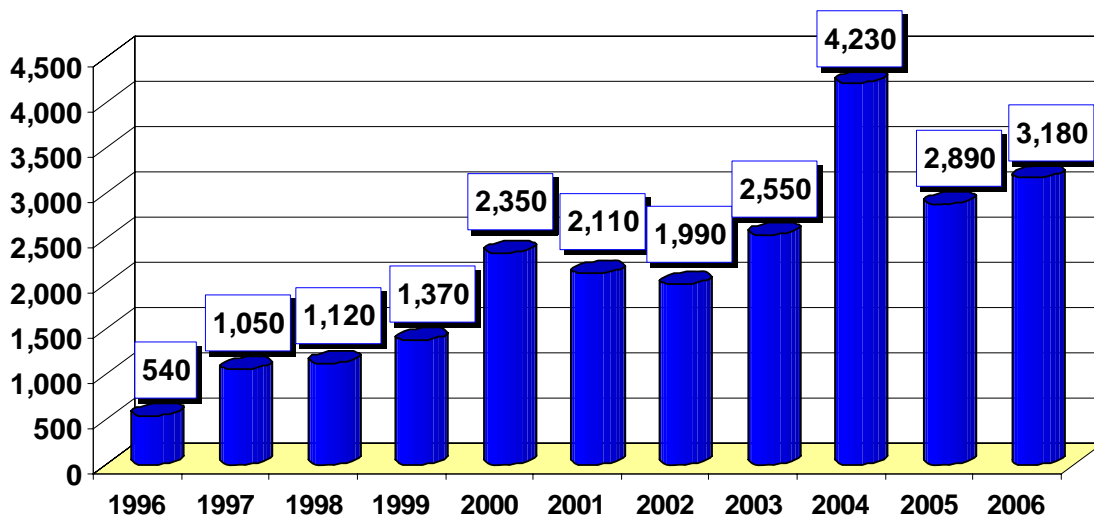
*2005 Estimated

California

The participants in this study represent approximately 12,700 licensed beds in the state of California. This is approximately 10% of California nursing home beds.

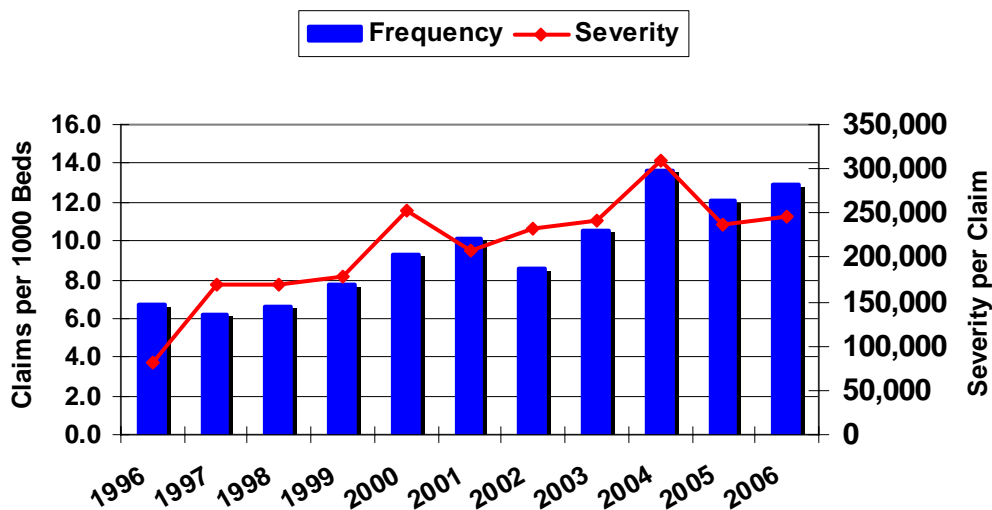
California loss costs have been increasing steadily since the early part of the last decade. Since 1996 California claims costs have increased on average 18% a year. Loss costs are now projected to be \$3,180.

California Loss Cost per Occupied Bed



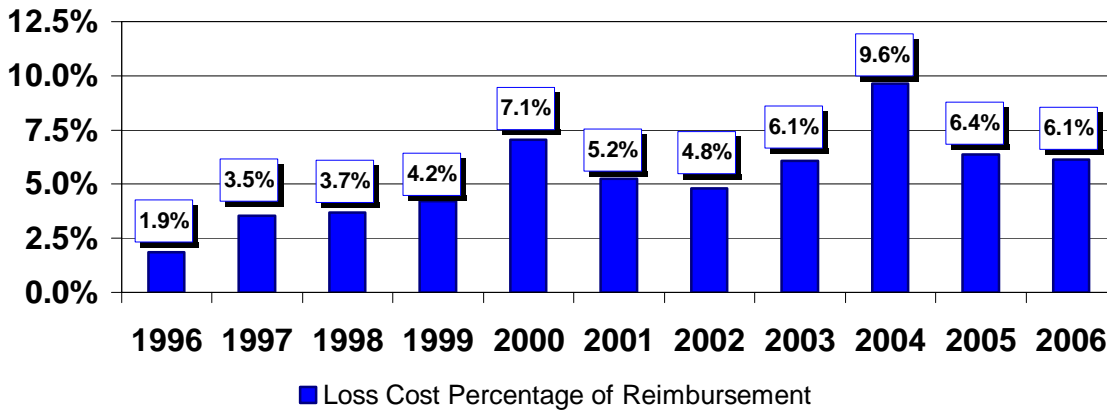
In California, frequency has more than doubled from just over 6 claims per 1,000 occupied beds in 1996 to 13 in 2006. Severity increased dramatically during the 1990's, but since then appears to be leveling off at around \$250,000 per claim. Long term care operators in California may not be benefiting to the same extent as hospitals and physicians from the \$250,000 cap on non-economic damages provided to healthcare providers in California under the provisions of The Medical Injury Compensation Reform Act of 1975 (MICRA). A second statute implemented in California in 1982, The Elderly Abuse and Dependent Adult Civil Protection Act (EADACPA), circumvents the MICRA caps on damages in cases of abuse or negligence to nursing home residents.

**California Annual Number of Claims per 1,000 Occupied Beds
/ Severity per Claim**



On a per diem basis, the average loss cost increased as a percent of California Medicaid reimbursements from 1.9% in 1996 to 9.6% in 2004. More recently, the ratio has been approximately 6% as shown in the graph below.

California Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	79.8	81.5	83.1	88.7	91.3	110.3	113.2	115.1	120.2	124.1	142.1
Per Diem Loss Cost Per Bed	1.5	2.9	3.1	3.8	6.4	5.8	5.5	7.0	11.6	7.9	8.7

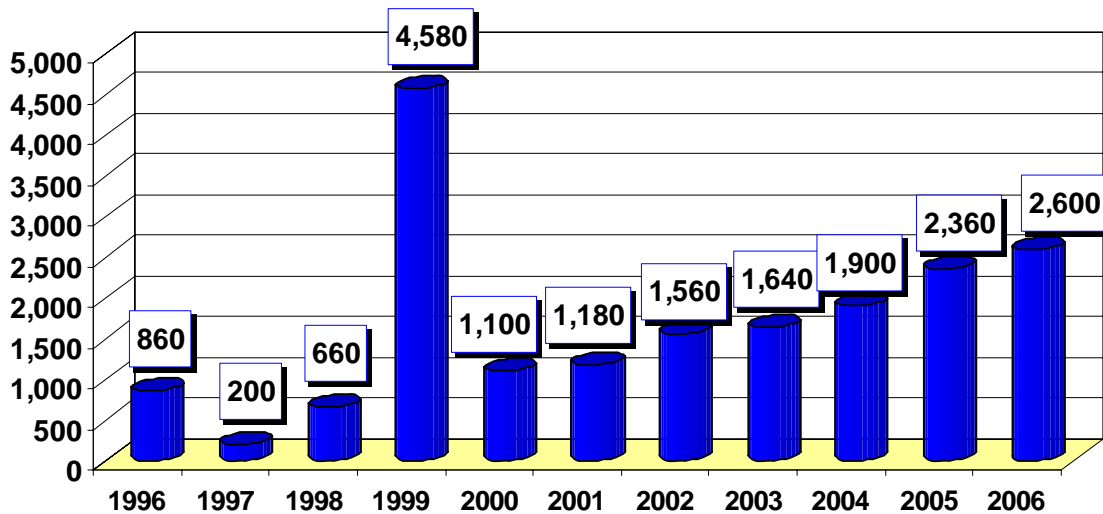
*2005 Estimated

West Virginia

The participants in this study represent approximately 4,200 licensed beds in the state of West Virginia. This is approximately 34% of West Virginia nursing home beds.

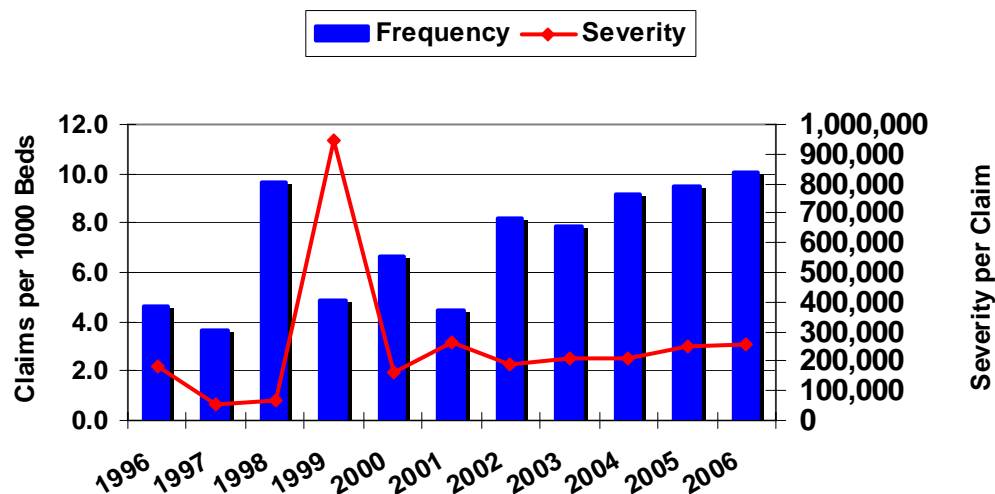
West Virginia loss costs have increased in the last ten years from \$200 in 1997 to \$2,600 in 2006. A \$5.3 Million claim in 1999 caused a sharp spike in the loss cost that year. Excluding this spike, loss costs in West Virginia appear to be on a steady upward trend.

West Virginia Loss Cost per Occupied Bed



Fueling the rise in West Virginia loss costs is the dramatic increase in the frequency rates between 1996 and 2006. The number of claims has increased from just over 4 claims per 1,000 occupied beds in 1996 to 10 claims in 2006. The average claim severity rose to an all time high in 1999 due to the inclusion of a \$5.3 Million claim. Since 2000, the average claim severity has hovered in the range of \$200,000 to \$250,000.

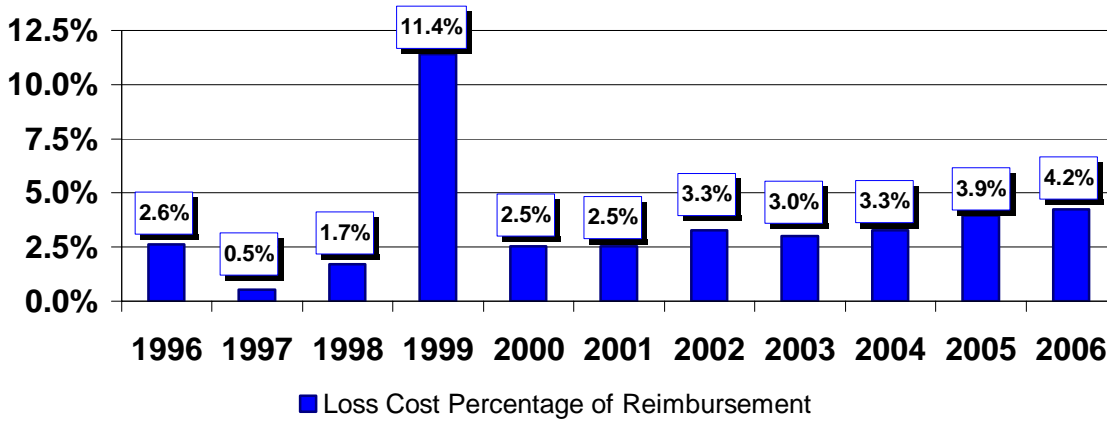
West Virginia Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



In March 2003 legislators in West Virginia enacted House Bill 2122 that contains caps on non-economic damages and other provisions intended to address the increase in patient care and medical malpractice liability. Under the new law the maximum award for non-economic loss is \$250,000 per occurrence. However, the maximum increases to \$500,000 per occurrence for wrongful death, permanent and substantial deformity, and loss of limb or bodily function. In addition, there is an inflation adjustment that began January 1, 2004 with an eventual maximum of \$1,000,000. These provisions have likely been a contributor to the relative stability in average severity the last few years and should help mitigate future increases in both severity and average loss cost.

On a per diem basis, the average loss cost increased as a percent of West Virginia Medicaid reimbursements, from 2.6% in 1996 to 4.2% in 2006 as shown in the graph below.

West Virginia Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	89.9	101.9	106.3	109.9	118.9	127.4	131.1	149.2	158.6	163.9	168.1
Per Diem Loss Cost Per Bed	2.4	0.6	1.8	12.6	3.0	3.2	4.3	4.5	5.2	6.5	7.1

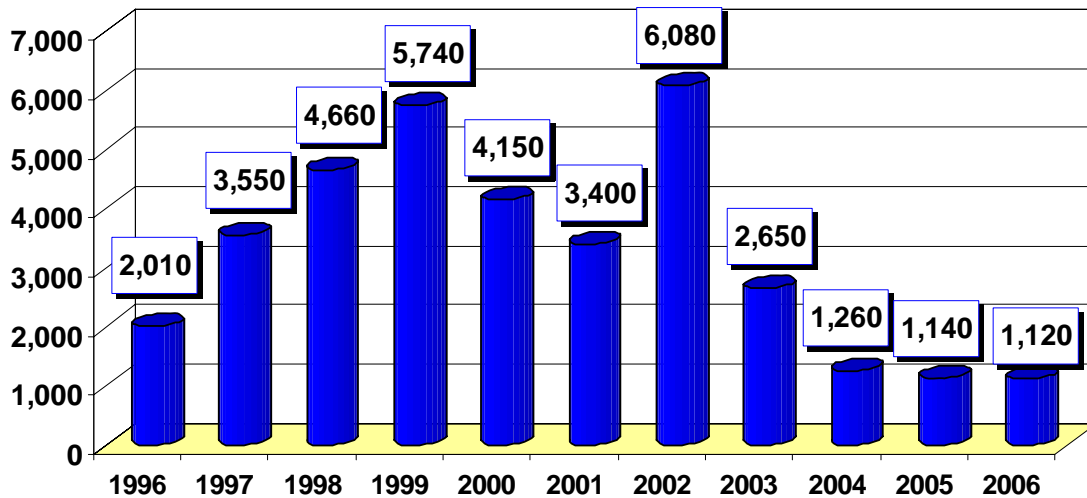
*2005 Estimated

Texas

The participants in this study represent approximately 13,300 licensed beds in the state of Texas. This is approximately 9% of Texas nursing home beds.

Texas GL/PL loss costs have dramatically improved following the passage of tort reform in 2003. Texas loss costs are now lower than the countrywide average. The Texas average cost per bed in 2006 has returned to the levels of the early 1990's, after climbing from \$2,010 in 1996 to a high of \$6,080 in 2002 as the following graph shows.

Texas Loss Cost per Occupied Bed

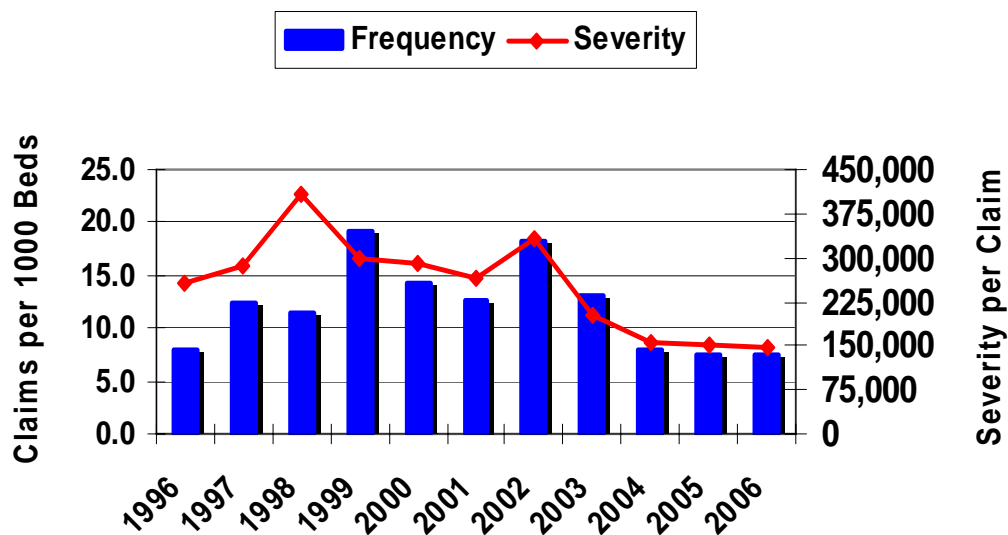


From 1996 through 2002 an increase in the number of claims per bed per year was the driving force behind the Texas loss cost increases. The number of claims Texas long term care providers incur per year grew from 8 per 1,000 occupied beds in 1996 to 18 per 1,000 occupied beds in 2002. Since 2002, claim frequency has declined to levels not seen since 1996. The average size of claims in Texas in the years leading up to the 2003 tort reform was in the range of \$300,000 to \$400,000. In the years following the Texas tort reform, average severity has dropped over 50% to an estimated \$150,000.

The favorable trends in Texas offer the most dramatic results of meaningful tort reform. Texas passed comprehensive tort reform for the healthcare industry with House Bill 4, which became effective September 1, 2003 and applies to all cases filed on or after this date.

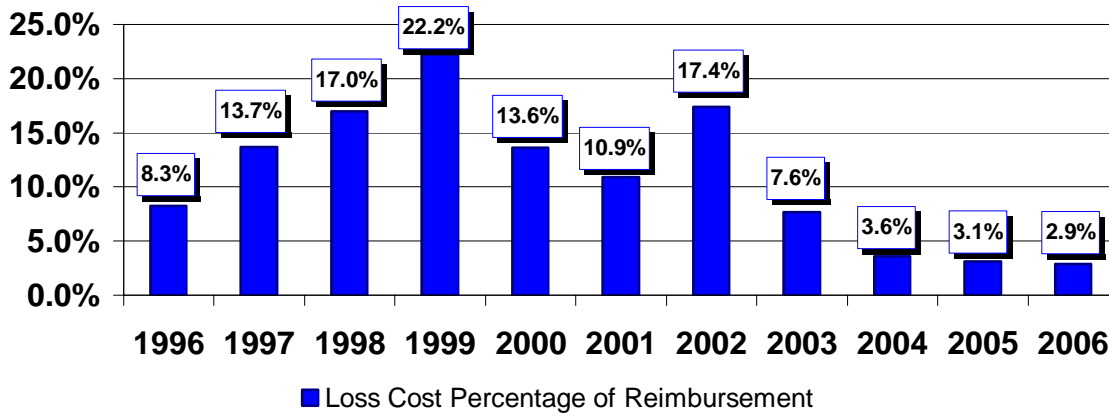
This reform brings nursing homes under the Texas punitive damage cap of \$750,000 and imposes a \$250,000 cap on non-economic damages for any single healthcare institution sued. This legislation also provides a total limit on all damages in a wrongful death claim of approximately \$1.4 million (\$500,000 indexed for inflation since 1977). Further strengthening the Texas reform was the passage in September 2003 of a Texas medical malpractice ballot initiative, called Proposition 12, which amends the Texas Constitution to allow caps on non-economic damages in medical malpractice lawsuits. Even before the evidence began emerging in the Texas claim data, the impact of House Bill 4 was expected to be significant due to the strong language defining the provisions for caps on non-economic damages, punitive damages and wrongful death claims.

Texas Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the average loss cost increased as a percent of Texas Medicaid reimbursements, from 8.3% in 1996 to a high of 22.2% in 1999. Since 1999 the ratio is decreasing and is projected to be 2.9% in 2006.

Texas Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	66.5	71.1	75.2	70.8	83.6	85.5	95.7	94.9	96.0	99.2	107.3
Per Diem Loss Cost Per Bed	5.5	9.7	12.8	15.7	11.4	9.3	16.7	7.3	3.5	3.1	3.1

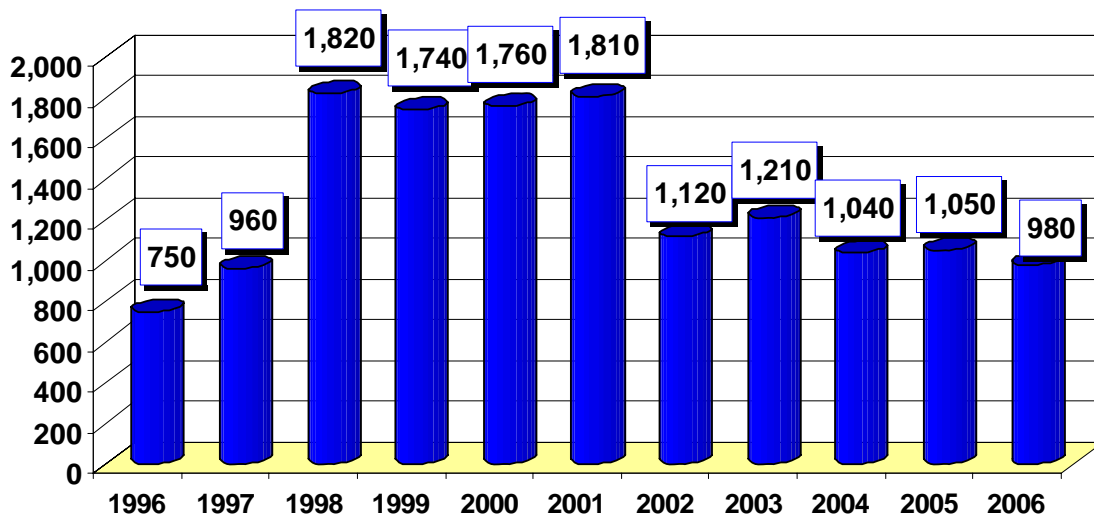
*2005 Estimated

Alabama

The participants in this study represent approximately 18,000 licensed beds in the state of Alabama. This is approximately 66% of Alabama nursing home beds.

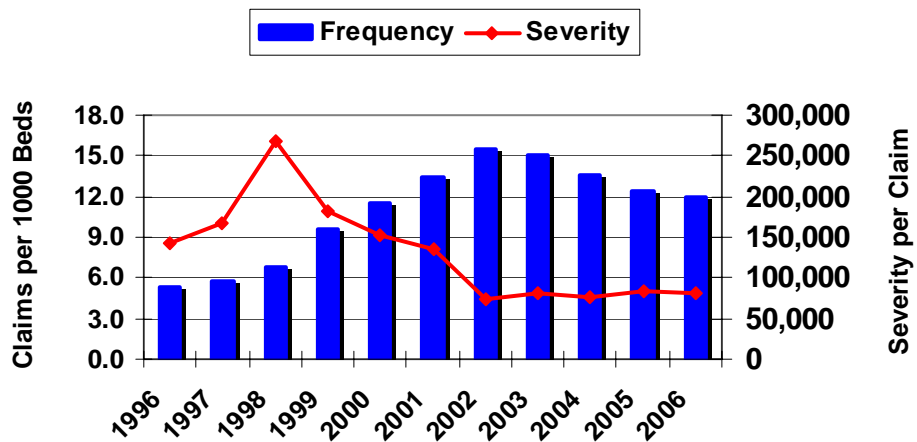
Alabama loss costs increased dramatically from the mid 1990's to 1998. Based on data reported in this study, costs have reset to a lower plateau of about \$1,000 since 2002.

Alabama Loss Cost per Occupied Bed



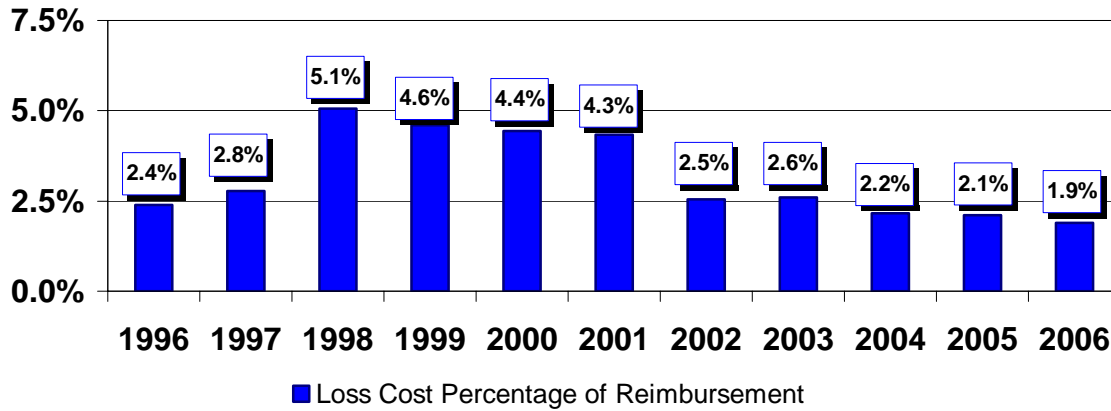
The decrease in average loss cost is a combination of lower frequency and reduced severity. The total number of claims peaked at 15 per 1,000 beds in 2002 and have since decreased to 12 claims in 2006. The average severity has dramatically dropped from a high of \$268,000 in 1998 to an estimated \$82,000 in 2006. Providers operating in Alabama report an increased use of arbitration, following case law earlier this decade supporting this form of claim resolution.

**Alabama Annual Number of Claims per 1,000 Occupied Beds
/ Severity per Claim**



On a per diem basis, the average loss cost is decreasing as a percent of Alabama Medicaid reimbursements, from a high of 5.1% in 1998 to 1.9% in 2006 as shown in the graph below.

Alabama Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	85.6	94.7	98.7	103.5	108.5	114.3	120.7	127.6	132.4	136.8	142.3
Per Diem Loss Cost Per Bed	2.1	2.6	5.0	4.8	4.8	5.0	3.1	3.3	2.9	2.9	2.7

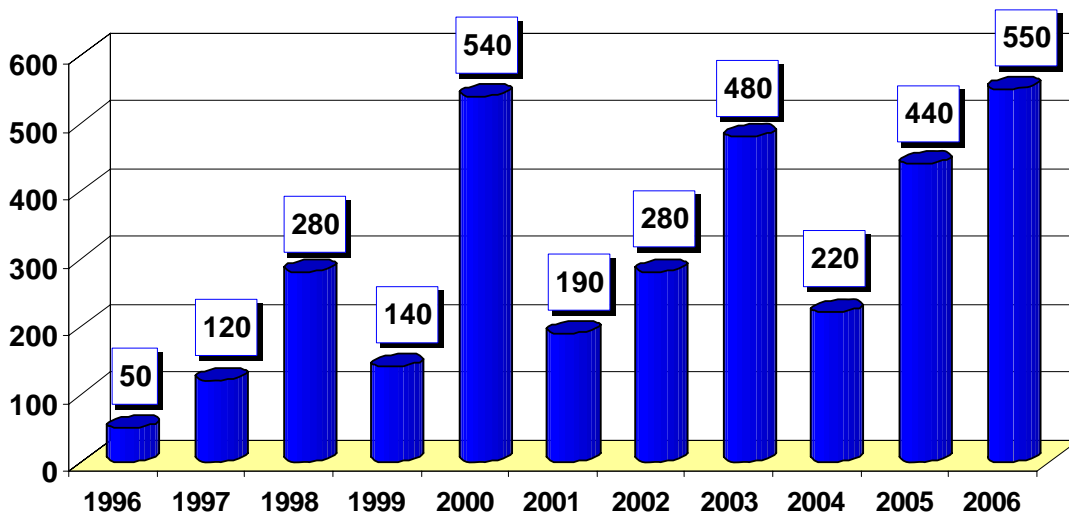
*2005 Estimated

Wisconsin

The participants in this study represent approximately 6,300 licensed beds in the state of Wisconsin. This is approximately 16% of Wisconsin nursing home beds.

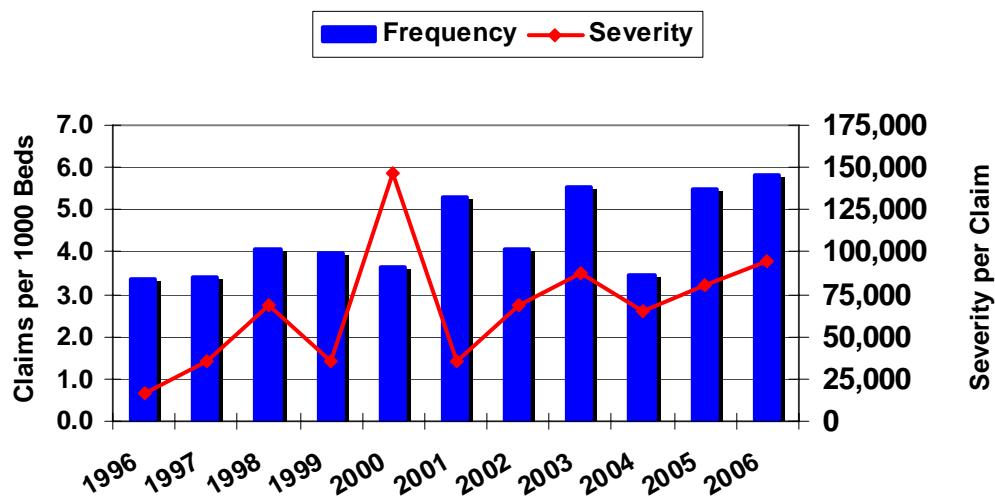
Wisconsin loss costs have increased ten-fold over the past decade from \$50 in 1996 to \$550 in 2006, but are still below the countrywide average.

Wisconsin Loss Cost per Occupied Bed



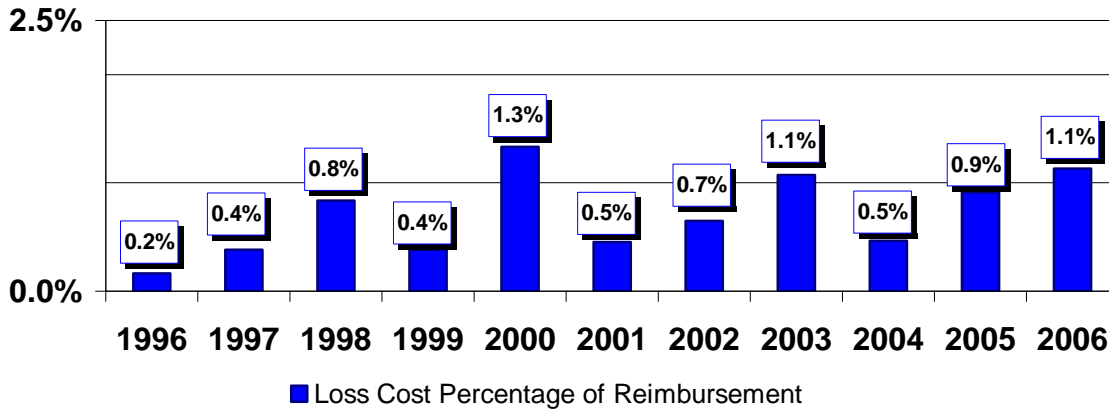
Fueling the rise in Wisconsin loss costs is an increase in both the frequency and severity of claims between 1996 and 2006. The number of claims has doubled from 3 claims per 1,000 beds in 1996 to 6 claims per 1,000 beds in 2006. The average claim severity has climbed from \$16,000 in 1996 to \$95,000 in 2006.

Wisconsin Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the average loss cost increased as a percent of Wisconsin Medicaid reimbursements, from 0.2% in 1996 to 1.1% in 2006 as shown in the graph below.

Wisconsin Loss Cost as a Percentage of Medicaid Reimbursement



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005*	2006
Average Medicaid Per Diem Reimbursement	85.9	85.9	91.7	99.0	111.2	113.8	118.3	122.7	128.2	132.5	133.2
Per Diem Loss Cost Per Bed	0.1	0.3	0.8	0.4	1.5	0.5	0.8	1.3	0.6	1.2	1.5

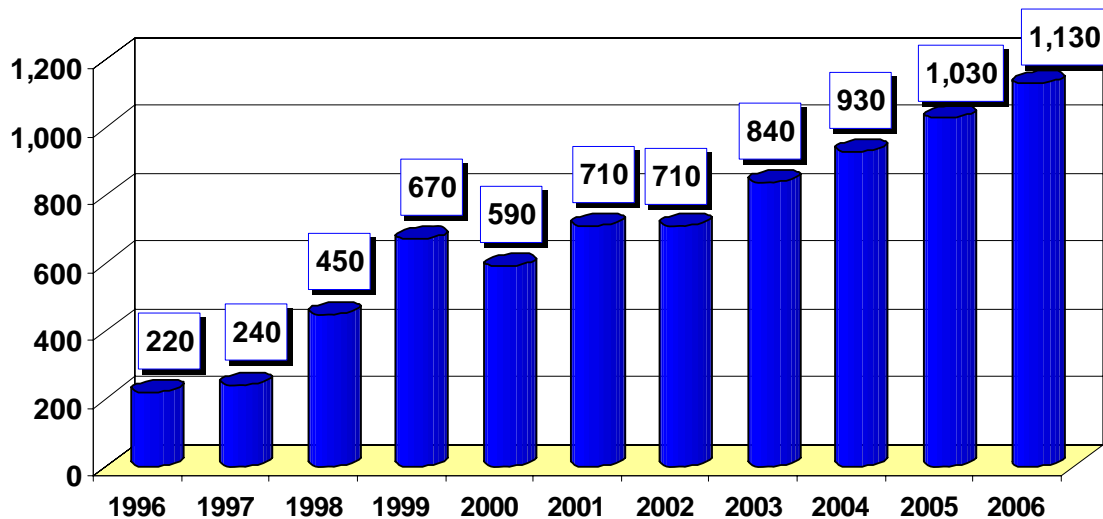
*2005 Estimated

All Other States Combined

The participants in this study represent approximately 195,000 licensed beds in the remainder of the country (that is, in descending 2006 loss cost order, excluding Arkansas, Mississippi, Tennessee, Arizona, California, West Virginia, Texas, Alabama, and Wisconsin, and also excluding Florida). This is approximately 14.5% of all nursing home beds in the remaining states.

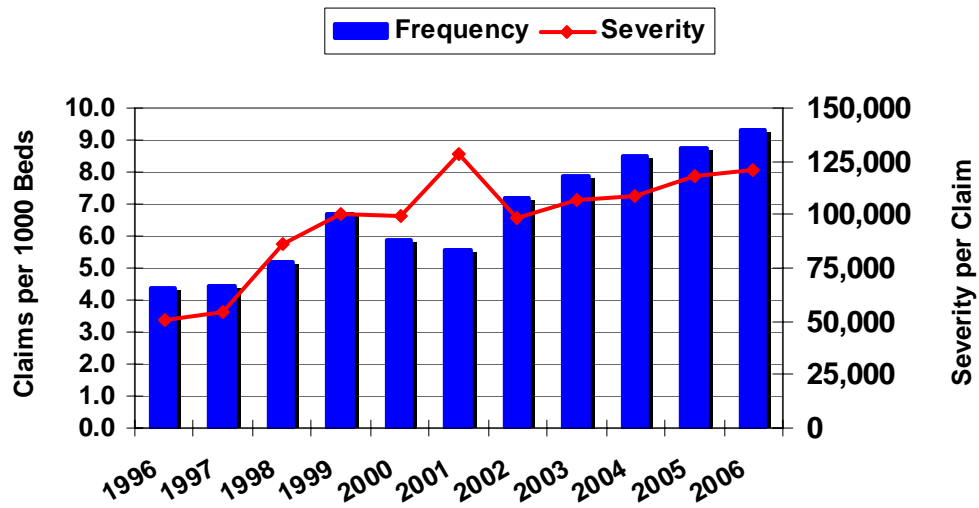
Even excluding the ten states noted above, which include some of the historically highest cost states in the country, GL/PL loss costs are increasing at an annual rate of 16.5% a year. This is well ahead of inflation and much higher than typical GL/PL claim cost increases for other industries, which tend to be in the 5% to 15% range a year. Our analysis of claims in all other states indicates that loss costs have risen from \$220 in 1996 to \$1,130 in 2006.

All Other States Loss Cost per Occupied Bed



The 16.5% annual loss cost increase is the result of an 8% annual increase in the number of claims, combined with an 8% annual increase in the average size of a claim.

All Other States Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



Insurance Premium and Coverage Analysis

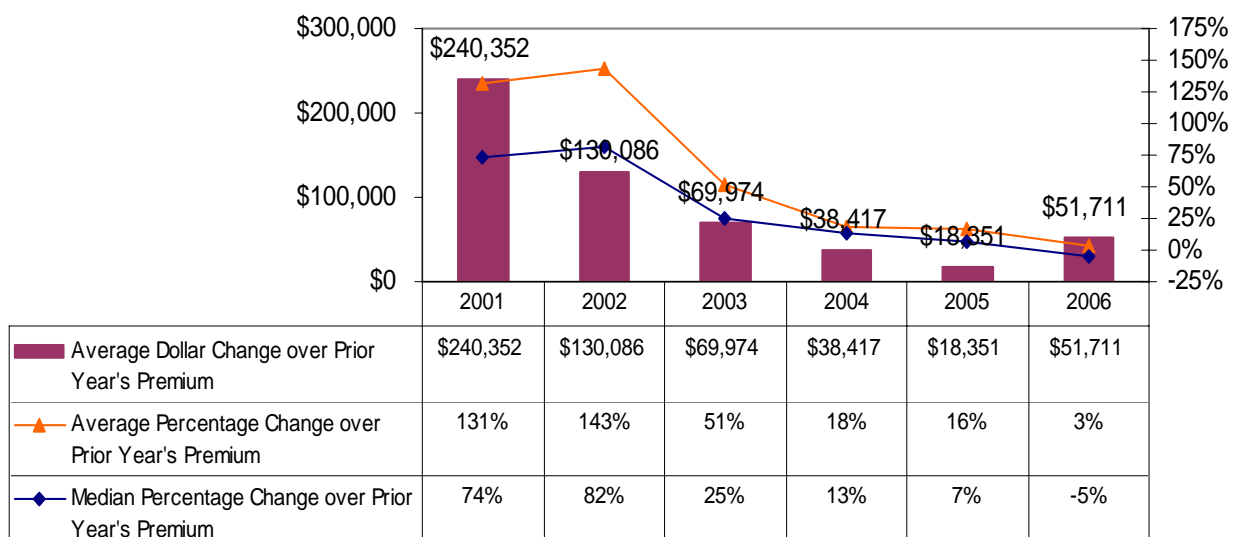
The rate of increase in insurance premiums continues to decline while coverage terms have slightly broadened for those survey respondents who have been commercially insured for their GL/PL exposure. With this finding, it appears that insurance capacity is increasing for this exposure.

Of the 60 total participants in this study, 47 (representing 64 facilities) provided insurance premium and coverage terms for policy years 2004, 2005 and 2006. These respondents are primarily comprised of the smaller, independent and regional providers. Respondents varied on whether they respond for each facility individually or for the company as a whole. On average, the respondents to this section of the survey operate approximately 2,100 licensed beds. The median size of respondents is closer to 150 beds. In total, they operate approximately 118,000 beds, or 40% of the total beds included in this study. The large national chains are, for the most part, self-insured and did not report commercial insurance coverage information. The following sections provide details on the impact of premium and coverage changes to the survey respondents.

Annual Premium Change

On average, the participants to this study reported a \$51,711 increase in their annual commercial GL/PL insurance premium over the prior year. For participants who were able to give a comparison of 2005 to 2006 coverage terms, the average percentage increase was 2.7%. As shown in the graph below, the average percentage change over the prior year has continued to decline.

Historical Premium Change – 2001 to 2006⁵



These historical increases reflect the trends underlying the countrywide loss cost increases presented in the first section of this report, when viewed in the context of how insurance is priced.

Premium is the amount paid to an insurance entity to cover costs associated with claims arising from a specifically defined risk. In the context of this report, premium refers to the premium paid for GL/PL insurance. Premium generally is developed as the expected loss cost for the period of coverage plus other underwriting expenses including commission, premium taxes, and general expenses incurred operating an insurance company.

But by far, the largest component (approximately 70%) is the loss cost. After years of relative stability in the early 1990's, GL/PL loss costs started climbing dramatically.

⁵ A slightly different mix of respondents to this section of our survey, including a higher number of providers operating greater than 10,000 beds and paying higher average premium, is causing the apparent incongruity between the jump in the average dollar change and the average percentage change between 2005 and 2006.

Because of the time lag between claim reporting and claim payment, the magnitude of the increase was not fully realized by insurance companies until early in this decade. At this time there was a bit of a “catch up” period to raise insurance premium to adequate levels, hence the large increases in 2001 and 2002, and to a lesser extent, 2003. Most carriers writing GL/PL insurance are now fully aware of the underlying trends as reflected in 2004 and subsequent year’s smaller increases.

Unlike in past years, medium to large sized providers, those with greater than 1,000 beds, incurred higher percentage increases than the smaller providers as shown in the table below.

In a striking change from the findings in past Aon studies, the smaller providers are now showing a decrease in the average percentage premium change. The amount of premium change varied; with nearly 60% of respondents having reported decreases and 25% reporting premium increases of less than \$50,000.

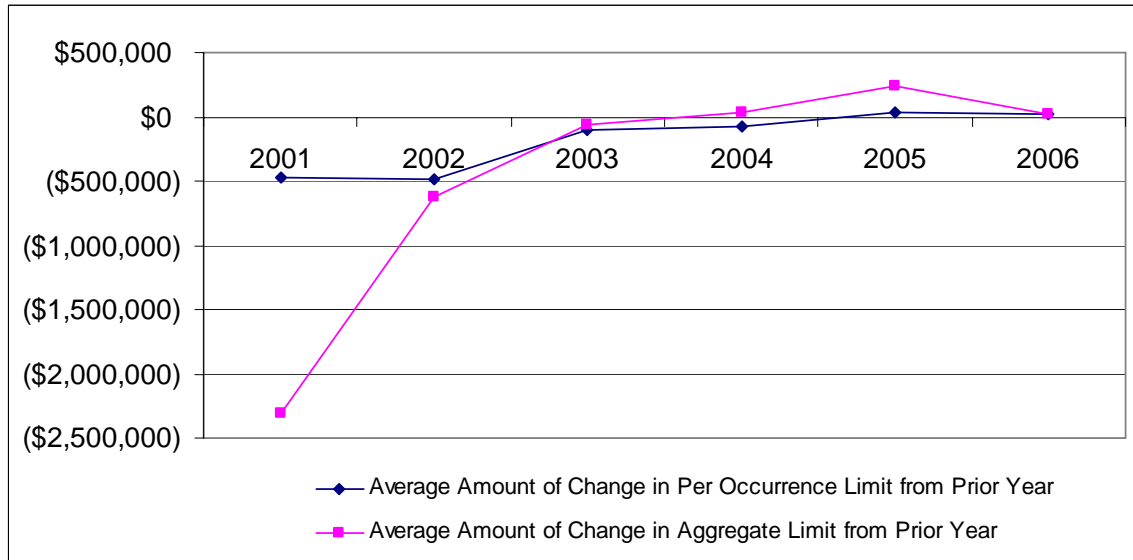
Change in Annual Premium by Provider Size – Policy Year 2005 to 2006

Provider Bed Count	Number of Respondents	Total Percentage Premium Change	Median Percentage Premium Change	Average Percentage Premium Change	Total Dollar Amount of Change	Average Dollar Amount
0-100	19	-3.5%	-6.9%	-3.7%	(\$34,268)	(\$1,804)
100-250	15	7.6%	-6.9%	3.6%	\$153,381	\$10,225
250-500	6	4.7%	-2.5%	9.5%	\$71,003	\$11,834
500-1000	2	1.0%	1.0%	1.0%	\$10,585	\$5,293
1000-5000	10	8.3%	2.8%	12.6%	\$782,414	\$78,241
5000-10,000	0	0.0%	0.0%	0.0%	\$0	\$0
>10,000	4	6.4%	-16.5%	-8.5%	\$1,912,701	\$478,175
Total	56	6.4%	-5.1%	2.7%	\$2,895,817	\$51,711

Limits of Liability

On average, survey respondents reported a slight increase in available limits between 2005 and 2006. As summarized below, the recent increases in available limits is a material change from the substantial decreases experienced in 2001 and 2002.

Historical Change in Limits of Liability – 2001 to 2006



Between 2005 and 2006, 95% of respondents reported no change or an increase in both their annual per occurrence limits of liability and their annual aggregate limits of liability. As shown in the table below, the majority of respondents reported a per occurrence limit between \$500,000 and \$1,000,000.

Five respondents reported increases in their per occurrence limits of liability and three reported decreases. Overall, the commercial insurance industry provided \$975,000 more capacity to the 61 providers responding to this section of our survey.

Change in Occurrence Limits – Policy Year 2005 to 2006

2006 Per Occurrence Limit	Number of Respondents	Total Dollar Amount of Change	Average Dollar Amount
\$0 - \$250,000	3	(225,000)	(75,000)
\$250,001 - \$500,000	2	200,000	100,000
\$500,001 - \$1,000,000	45	1,000,000	22,222
\$1,000,001 - \$2,000,000	3	1,000,000	333,333
\$2,000,001 - \$5,000,000	3	1,000,000	333,333
Greater than \$5,000,000	5	(2,000,000)	(400,000)
Total	61	\$975,000	\$15,984

Annual aggregate limits of liability decreased for two respondents while five respondents reported increases. For the 61 providers responding to this section of our survey, the commercial insurance industry provided \$1.6 million more capacity as shown in the above table. The majority of respondents reported an annual aggregate limit of between \$2,000,000 and \$3,000,000.

Change in Annual Aggregate Limits – Policy Year 2005 to 2006

2006 Annual Aggregate Limit	Number of Respondents	Total Dollar Amount of Change	Average Dollar Amount
\$0 - \$250,000	1	0	0
\$250,001 - \$500,000	2	(700,000)	(350,000)
\$500,001 - \$1,000,000	2	300,000	150,000
\$1,000,001 - \$2,000,000	3	0	0
\$2,000,001 - \$3,000,000	42	3,000,000	71,429
\$3,000,001 - \$4,000,000	3	1,000,000	333,333
\$4,000,001 - \$5,000,000	1	0	0
Greater than \$5,000,000	7	(2,000,000)	(285,714)
Total	61	\$1,600,000	\$26,230

Deductible Changes

Contradictory to findings in Aon's prior study, the majority of providers responding to this section of the survey reported no change in their deductible or a decrease in their deductible between the 2004-2005 and 2005-2006 policy years. This indicates a potential broadening of coverage, as deductibles (or retentions) are amounts insureds are required to pay out of pocket prior to accessing policy limits of liability.

On average, deductibles decreased \$82,869 between 2005 and 2006, although this is skewed by one respondent that reported a \$5 million decrease in their deductible. Similarly, between 2004 and 2005, deductibles decreased, on average, \$17,667. This is a departure from prior studies' findings that, on average, deductibles increased \$108,150 between 2002 and 2003, and \$97,748 between 2001 and 2002. As shown in the table below, the majority of respondents reported a per claim deductible of less than \$100,000.

Change in Per Claim Deductible – Policy Year 2005 to 2006

2006 Per Claim Deductible	Number of Respondents	Total Dollar Amount of Change	Average Dollar Amount
\$0 - \$25,000	33	(55,000)	(1,667)
\$25,001 - \$50,000	3	0	0
\$50,001 - \$100,000	19	0	0
\$100,001 - \$250,000	1	0	0
\$250,001 - \$500,000	1	0	0
\$500,001 - \$1,000,000	1	0	0
Greater than \$1,000,000	3	(5,000,000)	(1,666,667)
Total	61	(\$5,055,000)	(\$82,869)

Of the 61 respondents who reported annual aggregate deductible information, the majority reported very little change in their deductibles between policy year 2005 and 2006. Similar results were found in prior Aon Long Term Care Studies. Three respondents reported an increase in their aggregate deductible in the 2003 study, no respondent reported a decrease. On average, aggregate deductibles increased \$50,820. The majority of respondents reported no annual aggregate deductible.

Change in Annual Aggregate Deductible – Policy Year 2005 to 2006

2006 Annual Aggregate Deductible	Number of Respondents	Total Dollar Amount of Change	Average Dollar Amount
No Annual Aggregate Deductible	55	(200,000)	(3,636)
\$0 - \$25,000	1	0	0
\$25,001 - \$50,000	1	0	0
\$50,001 - \$100,000	0	0	0
\$100,001 - \$250,000	0	0	0
\$250,001 - \$500,000	1	300,000	300,000
\$500,001 - \$1,000,000	0	0	0
Greater than \$1,000,000	3	3,000,000	1,000,000
Total	61	\$3,100,000	\$50,820

Policy Form Changes

For the 56 respondents to this section of our survey, the findings show there is continued movement away from occurrence form coverage to the more restrictive claims-made coverage⁶.

Change in Policy Form – Policy Year 2004 to 2006

Policy Form	2004	2005	2006
Occurrence	12	10	9
Claims-Made	44	46	47

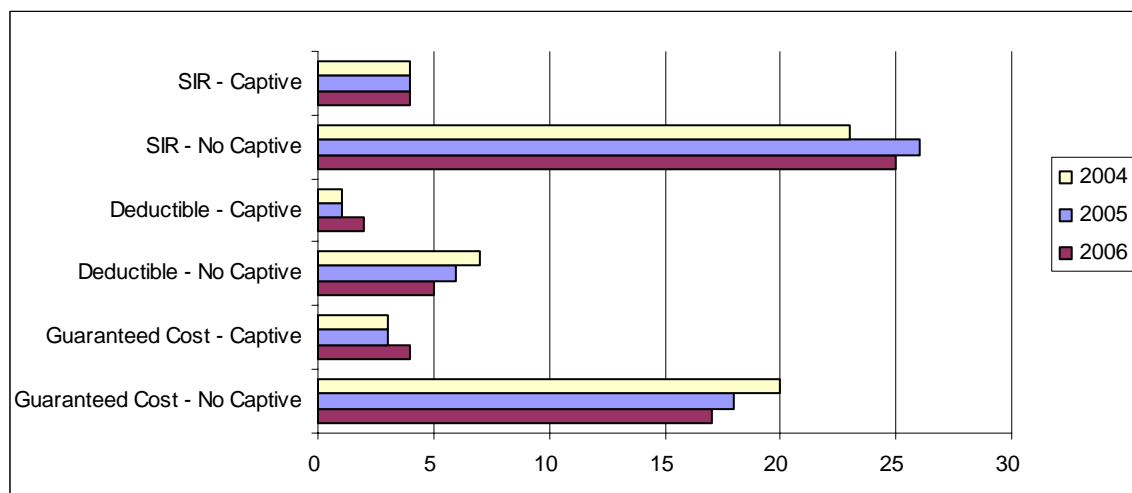
⁶ Occurrence form coverage provides insurance coverage for any incident occurring during a policy period, regardless of when it is reported. Claims-made coverage provides reimbursement only for claims reported during the policy period and occurring after a specified retroactive date. While retroactive dates may vary, a first year claims-made policy, where the retroactive date is the beginning of the policy period, only provides a fraction (less than 50% for professional liability coverage) of the coverage of an occurrence policy. A fully mature claims-made policy, where the retroactive date is at least five years prior to the inception of the policy year, typically only provides 90% to 95% of the coverage of an occurrence policy.

Policy Type

A new section of the survey, policy type, provides greater insight into respondents risk financing arrangements whether choosing to retain losses, transfer losses or some hybrid thereof.

Interestingly, between policy years 2005 and 2006, it appears the use of captive insurers increased for those providers responding to this section the survey. And, between 2004 and 2005, there was an increased movement towards self-insurance. These actions are often the result of a contraction in commercial insurance capacity as was experienced by the LTC industry early in this decade.

Policy Type – Policy Year 2004 to 2006⁷



⁷ A Captive is an insurance company subsidiary designed to cover the risks of its parent organization(s). Captives usually retain substantial portions of each loss, and purchase reinsurance above these levels. Captives provide an alternative funding mechanism when coverage breadth or capacity in traditional insurance is lacking. Captives can also provide cost savings, cash flow benefits, and specialized loss prevention and claims services not otherwise available.

A Self Insured Retention (SIR) is a dollar amount specified in an insurance policy (usually a liability policy) that must be paid by the insured before the insurance policy will respond to a loss. SIRs typically apply to both the amount of the loss and related costs, such as defense costs, but some apply only to amounts payable in damages, e.g., settlements, awards, and judgments.

An SIR differs from a true deductible in at least two important ways. Most importantly, a liability policy's limit stacks on top of an SIR, while the amount of a liability insurance deductible is subtracted from the policy's limit. As contrasted with its responsibility under a deductible, the insurer is not obligated to pay the SIR amount and then seek reimbursement from the insured. The insured pays the SIR directly to the claimant.

Guaranteed cost premiums are those charged on a prospective basis without adjustment for loss experience during the policy period. An agreed rate at the beginning of the policy term is charged against the applicable exposure base (payroll, sales, number of vehicles or square feet) to provide the premium.

Conditions and Limitations

Actuarial Estimates

We assumed that losses reported to us in the aggregate develop to higher ultimate amounts by the time all claims arising from incidents that have occurred in the historical period under study are reported and eventually closed. This assumption is based on the historical reporting patterns of the long term care industry and is in accordance with standard actuarial practice. Individual claims will likely develop more or less than the percentage of aggregate development. The adjustments we have made to past experience reflect the average effects of changes in the cost of claims.

Inherent Uncertainty

Actuarial calculations produce estimates of inherently uncertain future contingent events. We believe that the estimates provided represent reasonable provisions based on the appropriate application of actuarial techniques to the available data. However, there is no guarantee that actual future payments will not differ from estimates included herein.

Extraordinary Future Emergence

Our projections make no provision for the extraordinary future emergence of losses or types of losses not sufficiently represented in the historical data or which are not yet quantifiable.

Data Reliance

In conducting this analysis, we relied upon the provided data without audit or independent verification; however, we reviewed it for reasonableness and consistency. Any inaccuracies in quantitative data or qualitative representations could have a significant effect on the results of our review and analysis.

Data Composition

The loss projections presented in this report are based strictly on the claim detail provided to us and, therefore, are a function of the exposure characteristics of the long term care providers who responded to the data call. Fifteen of these long term care providers, representing a significant portion of exposure, are predominantly multi-facility, for-profit operations providing primarily skilled nursing care. The remaining operators are comprised of regional, state or independent long term care providers, both for-profit and not-for-profit. The large majority of the providers who responded are primarily skilled nursing care operators, although there is some representation by operators of exclusively assisted living facilities. The analyses contained in this report represent a blend of the experience of this varied group of participants. Individual nursing home operators around the country or in the states or state groupings presented in this report

may have different loss costs depending on their level of nursing care, profit status, and independence.

Use and Distribution

Use of this report is limited to the American Health Care Association and its members for the specific purpose described in the Introduction section. Other uses are prohibited without an executed release with Aon Risk Consultants.

Distribution by AHCA is unrestricted. We recognize that this report may be distributed to regulators and legislators. We request that Aon Risk Consultants be notified of further distribution of this report. The report should only be distributed in its entirety including all supporting exhibits.

Data Sources

The analyses contained in this report are entirely based on an industry wide call to long term care operators for data on GL/PL claims incurred during the last five to twelve years.

In an effort to present a comprehensive analysis from the perspective of all long term care providers, the American Health Care Association, through its various constituencies disseminated a request for data to independent providers, regional multi-facility providers, non-for-profit providers, national multi-facility providers, and the National Center for Assisted Living. In addition, AHCA contacted state executives of long term care associations and other stake holders and encouraged them to share the data request with their membership in order to encourage greater participation by independently owned facilities.

Using a web-based data survey instrument, long term care providers were given a list of data requirements and instructed to submit their data directly to Aon Risk Consultants, Inc. Among the data elements requested were detailed individual general and professional liability claim information for all claims occurring over the past five to ten years, corresponding historical exposure estimates in the form of occupied beds, and specifics regarding insurance coverage terms during the latest two policy years. Data was collected and compiled between the beginning of July 2006 and the end of September 2006. In order to ensure the quality of each data submission, there was extensive correspondence with providers via email, telephone, fax, and written correspondence during this period.

Sixty long term care providers responded to our call in whole or in part. The respondents range in size from independent single facility operators to large national multi-facility companies. Operators responded from forty-nine states (all except Alaska) and the District of Columbia. Fifteen of the respondents are for-profit, multi-facility long term care providers with facilities in numerous states. Twelve of the respondents are regional operators with facilities in at least two but no more than five states. The remaining thirty-three respondents are small independent operators concentrated in one state with one or more facilities. Most of the respondents provide primarily skilled nursing care, although five of the respondents are strictly assisted or independent living facility operators.

In developing the benchmarks presented in this report we have relied on the following data.

- **Individual claim detail** – This database is a compilation of 20,000 non-zero long term care general/professional liability claims occurring over the past twelve years. The information included by individual claim is status, accident date, report date, close date, accident state, indemnity paid, allocated loss adjustment expense paid, total paid, indemnity incurred, allocated loss adjustment expense incurred, and total incurred. The losses reported to us represent the unlimited amount of indemnity, ALAE and punitive damages paid and reserved as of the report date. To the extent losses have been limited and/or punitive damages not reported our loss projections might be understated.
- **Historical Loss Development Triangles** – Incurred and paid loss development factors and claim count development factors are derived from a consolidation of the reporting patterns of ten of the largest long term care providers. These ten providers represent approximately 77% of the loss data reported to us. Historical reporting patterns are not available from the other long term care providers. However, the similarity of the patterns for the seven reporting providers and the credibility of the consolidated development pattern justify the use of these patterns to estimate ultimate development for the group of providers as a whole.
- **Occupied Beds** – Annual occupied bed counts corresponding to the years for which loss experience is provided are utilized in this analysis to develop the relative loss cost per bed. Annual licensed bed counts are multiplied by average occupancy rates to derive annual occupied beds. For long term care providers who could not provide average occupancy rates, an occupancy rate of 89% is assumed. For all states combined, there are approximately 290,000 licensed beds of which approximately 255,000 are occupied.
- **Industry Bed Counts** – For purposes of determining the percentage of nursing home beds in a particular state, our study utilized the Centers for Medicare & Medicaid Services OSCAR Data Current Surveys, June 2006. Actual percentages shown are calculated by dividing our skilled equivalent beds to this industry source. However, the number of licensed beds stated in any individual state section reflects the total number of beds (including independent living, assisted living and other levels of care) obtained for the purpose of this study.
- **Medicaid Reimbursement Rates** – Average Medicaid per diem reimbursement rates by state are based on rates provided by the following sources: 1) the testimony of Thomas A. Scully, Administrator, Centers for Medicare & Medicaid Services on nursing home quality before the Senate Finance Committee on Thursday, July 17, 2003 and 2) A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care by BDO Seidman, LLP (*Annual Reports - Posted on www.ahca.org website*). The 2005 year is projected by Aon based on prior year trends.

Countrywide average rates and tort group rates are derived by weighting state rates by the occupied beds by state from the study participants.

Definitions

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 contained 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 our report and exhibits include ALAE except where noted otherwise.

Accident Year

An accident year is the year the claim is reported to have occurred. All of the loss cost, frequency and severity analyses presented in this report group 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.

Deductible

A deductible is a layer of loss retained by an insured entity. The insured pays amounts below the deductible and the insurance company pays amounts above the deductible. The higher the deductible the lower the commercial insurance premium. However, this is largely offset by the cost of the portion of claims below the deductible.

Retention is another word commonly used to refer to a deductible. Companies with high deductibles, or retentions, are commonly referred to as self-insured.

A deductible can apply on a per occurrence basis, that is for each individual loss, and/or on an aggregate basis for a given period of time. A typical GL/PL deductible for the health care industry may be expressed as \$1,000,000/\$3,000,000, meaning \$1 Million per occurrence and \$3 million in the aggregate for the year. With this deductible the insured is responsible for paying the first \$1 Million of each claim, subject to a maximum total of \$3 million for the year.

Deductibles can apply to the indemnity portion of losses only or the combined cost of indemnity and ALAE.

The losses included in this report are prior to the application of any deductible or retention. That is, they represent the total amount of loss from first dollar to the unlimited reported amount.

Defense Costs

In the context of this report, defense costs include attorneys' fees and other directly allocable costs associated with defending a company against GL/PL claims.

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 we use an exposure base of 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. We have adjusted all beds in this study to the equivalent of a skilled nursing care bed.

By dividing losses by exposures we develop comparative estimates of the long term care industry GL/PL loss costs between states, types of facilities (multi-chain vs. independent) and years of operation.

Frequency

Frequency is the ratio of the number of claims divided by exposures. In this report we measure frequency 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 our summary exhibits we present frequency as the number of claims a year for every 1,000 beds.

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.

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 not limited.

Loss Cost

Loss cost is the cost per exposure of settling and defending claims. Loss cost 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 cost 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 costs, 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.

Premium

Premium is the amount paid to an insurance entity to cover costs associated with claims arising from a specifically defined risk. In the context of this report, premium refers to the premium paid for GL/PL insurance. Premium generally is developed as the expected loss cost for the period of coverage plus other underwriting expenses including commission, premium taxes, and general expenses incurred operating an insurance company.

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 we measure the average severity for a given year by dividing the total dollars of losses for all claims incurred in the year by the total number of claims.

Underwriting Expenses

Underwriting expenses are expenses incurred in writing commercial insurance in addition to claim (indemnity and ALAE) expenses. Underwriting expenses generally include commission paid to agents and brokers, premium taxes and other general expenses incurred operating an insurance company. Underwriting expenses, when added to claim expenses, represent the total cost underlying commercial insurance premium. In this study we present only the loss costs associated with GL/PL claims. Underwriting expenses are in addition to these costs where GL/PL exposure is commercially insured.

Tort Reform States – A Description of Provisions and Their Impact

Florida

Effective with claims that occur on or after May 15, 2001, Florida resident's rights claims fall exclusively under Senate bills 1200 and 1202. These bills were passed with the intention of providing some tort reform to the nursing home patient care liability crisis. Based on our current study it remains inconclusive to what extent the bills have had an effect on reducing claim frequency in Florida. First of all, an increase in Florida claim frequency for incidents occurring prior to May 15, 2001 is evident, possibly triggered by the October 4, 2001 cut-off for filing claims under the old Statute 400 punitive damage provisions. Secondly, the frequency levels for 2002 through 2006 appear to be higher than the average level of the three years leading up to the tort reform. This is particularly evident if the jump in claims caused by the tort reform is removed from the comparison.

Current data provides stronger evidence that the passage of Senate bills 1200 and 1202 may have had some effect on reducing claim severity. Although, the average severity of Florida GL/PL claims appears to have peaked in 1998, three years before tort reform, and then steadily decreased up to the point of the tort reform. Post reform, the downward trend has continued, dropping from \$196,000 per claim in 2001 to an estimated \$100,000 per claim in 2006. However, it is difficult to differentiate the impact of tort reform from the impact of large providers leaving Florida and the reduced availability of insurance. Most operators in Florida today insure to a much lower limit of liability than before tort reform was passed. Another reason to suspect that the tort reform in Florida is not a key driver in the lower severity is that it did not provide a cap on non-economic damages, which actuarially is the most effective tort reform policy provision for reducing patient care liability claim severity.

Georgia

On February 16, 2005, Georgia's governor Sonny Perdue signed Senate Bill 3 into law. This legislation imposed a cap of \$350,000 on non-economic damages. A \$250,000 cap on punitive damages unless the plaintiff can show specific intent to harm was already in place prior to this legislation. One of the most significant aspects of the reform package is the elimination of joint and several liability. Also, a health care provider's statements of apology, sympathy, regret, etc. are no longer admissible in court.

Based on the data reported in this study, the Georgia tort reform is having its greatest impact on severity. The number of claims reported in Georgia continue rise. Prior to tort reform Georgia frequency of claims per 1,000 occupied beds had increased from 3 to 10 between 1995 and 2005. Post reform frequency is estimated at 12 claims per 1,000 beds. However, the average size of a claim in Georgia has dropped from over

\$300,000 prior to reform to an estimated \$150,000 post reform. As a result of the severity reductions, the annual loss cost per bed in Georgia has dropped to from a high of \$3,250 in 2002 to an estimated \$1,830 in 2006. Whether or not the loss cost can continue to decrease remains to be seen. Severity has already dropped 50% and frequency continues to trend upward. Yet, a significant number of post reform claims from years 2005 and 2006 are still open. As these claims close over the next two to four years, a clearer picture of the impact of the Georgia tort reform will emerge.

Louisiana

The Louisiana legislature passed Senate Bill 748 in 2003. This statute contained several provisions for reducing the number and size of patient care liability claims including shortening the statute of limitations to two years and imposing a \$500,000 limit on non-economic damages. Louisiana also has a state regulated patient compensation fund (PCF), which includes the liability exposures of state licensed nursing homes and effectively creates financial responsibility guidelines for healthcare providers that comply with the PCF rules and regulations. An independent actuarial analysis of Louisiana liability trends is not within the scope of this report, however, a cursory review of the Louisiana claim data reported for this study indicates that total loss costs have been dropping similarly to the pattern observed in the tort group analysis.

Mississippi

Mississippi passed legislation during its 2002 session with the intent of curbing the rising cost of patient care liability claims. House Bill No. 2 became effective January 1, 2003 and included revisions to the Mississippi medical malpractice code that, among other things, brought long term care providers under the act and limited non-economic damages to \$500,000 (stepping up to \$750,000 on July 1, 2011 and \$1,000,000 on July 1, 2017).

As has occurred in other states, the passage of this reform initially caused a significant spike in the number of claims, most alleging events in years 2000, 2001, and, to a lesser extent, 2002. Based on the data reported in this study, it appears that the tort reform is reducing both frequency and severity of Mississippi claims. The number of claims per 1,000 beds is down from 25 in 2003 to 17 in 2006. Additionally, an analysis of the large losses in Mississippi pre and post tort reform indicates that the caps are achieving their intended purpose. In the years prior to tort reform, the respondents to this survey reported 47 claims greater than \$1M in Mississippi. Since tort reform became effective 2003, the largest claim reported to date is \$850,000 and the largest indemnity payment made to date is \$700,000. This reduction in extremely large losses indicates that the average severity is coming down from the pre-reform levels that exceeded \$500,000. Currently, it is estimated that average severity is now closer to \$300,000.

Ohio

Ohio passed tort reform in January of 2003 that included a cap on non-economic damages of \$250,000 or 3 times economic loss to a maximum of \$350,000 per plaintiff or \$500,000 per occurrence. However, the exceptions are so broad that its potential impact on reducing long term care patient care liability is uncertain at this time. These exceptions include permanent and substantial physical deformity, loss of limb or bodily function, and permanent physical functional injury limiting activities of daily living. In the case of exceptions, the caps increase to \$500,000 per plaintiff or \$1,000,000 per occurrence. Based on data reported in this study, it appears that the Ohio tort reform is not having a material effect on the trend in patient care liability. However, although Ohio has experienced sharp increases in the number of claims reported over the past decade, it has been spared the dramatic jump in severity plaguing so many of the other states that resorted to tort reform. Over the past decade, the frequency of claims in Ohio has increased from 4 to 12 per 1,000 beds. The severity has remained fairly constant at an average level of only approximately \$70,000. This low level of severity is the primary reason the tort reform has not had a major impact on the cost of liability in the state. Longer term, however, the non-economic caps should be effective in curtailing future severity inflation.

Texas

Texas passed comprehensive tort reform for the healthcare industry with House Bill 4, which became effective September 1, 2003 and applies to all cases filed on or after this date. This reform brings nursing homes under the Texas punitive damage cap of \$750,000 and imposes a \$250,000 cap on non-economic damages for any single healthcare institution sued, subject to a \$500,000 total cap regardless of the number of defendants. This bill also provides a total limit on all damages in a wrongful death claim of approximately \$1.4 million (\$500,000 indexed for inflation since 1977). Further strengthening the Texas reform was the passage in September 2003 of a Texas medical malpractice ballot initiative, called Proposition 12, which amends the Texas Constitution to allow caps on non-economic damages in medical malpractice lawsuits. Even before the evidence began emerging in the Texas claim data, the impact of House Bill 4 was expected to be significant due to the strong language defining the provisions for caps on non-economic damages, punitive damages and wrongful death claims. Based on the data reported in this study, the Texas GL/PL loss cost has dropped from \$6,080 in 2002 to an estimated \$1,120 for 2006. The frequency of claims and the average severity are each down more than 50% from pre-tort reform levels.

West Virginia

In March 2003 legislators in West Virginia enacted House Bill 2122 that contains caps on non-economic damages and other provisions intended to address the increase in patient care and medical malpractice liability. Under the new law the maximum award for non-economic loss is \$250,000 per occurrence. However, the maximum increases to \$500,000 per occurrence for wrongful death, permanent and substantial deformity, and

loss of limb or bodily function. In addition, there is an inflation adjustment that began January 1, 2004 with an eventual maximum of \$1,000,000. These provisions have likely been a contributor to the relative stability in average severity the last few years and should help mitigate future increases in claims severity and average loss cost.