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Ohio 2006 Medical Liability Closed Claim Report

January 2008

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Ohio Medical Malpractice Closed Claim Report - 2006

I. Introduction

Pursuant to Ohio Revised Code ("ORC") §3929.302 and Ohio Administrative Code ("OAC") 3901-1-64, the Department of Insurance ("Department") hereby submits its second annual report to the General Assembly summarizing the Ohio medical liability closed claim data received by the Department for calendar year 2006. A copy of the first annual report is available on the Department's web site www.ohioinsurance.gov.

II. Overview

ORC §3929.302 requires all entities that provide medical malpractice insurance to health care providers located in Ohio, including authorized insurers, surplus lines insurers, risk retention groups and self-insurers, to report data to the Department regarding medical malpractice claims that close during the year. In addition, each entity must report the costs of defending medical liability claims and paying judgments and/or settlements on behalf of health care providers and health care facilities.

The Department is required to prepare an annual report to the General Assembly summarizing the closed claim data on a statewide basis. The data is summarized in this report in order to maintain the confidentiality of the specific data filed by each reporting entity.

Copies of ORC §3929.302 and OAC 3901-1-64 are attached to this report as Appendices A and B.

III. Data Collection

A secured application on the Department's web site has been set up in order to capture the data elements required by OAC 3901-1-64, Medical Liability Data Collection. Companies must submit data by May 1 for each medical, dental, optometric or chiropractic claim closed in the prior calendar year.

IV. Description of Analysis

For the purposes of this report, and based on general practice, when an insurer or other insuring entity opens a file and begins to investigate the circumstances of a demand for compensation due to alleged malpractice of a health care provider or facility, a claim has occurred, whether or not a lawsuit is ever filed. When the file is closed for one of the many reasons detailed in this report, even when the claimant receives no payment, the claim is considered closed. Multiple closed claim records can be generated from one incident, since a closed claim record must be entered for each health care provider and/or facility from which a demand for compensation is sought.

In this report, two primary pieces of data are analyzed:

- **Paid Indemnity:** The amount of compensation paid on behalf of each defendant to a claimant.

- **Allocated Loss Adjustment Expense (ALAE):** The expenses incurred by a reporting entity, other than paid indemnity, which relate to a specific claim, such as the costs of investigation and defense counsel fees and expenses. As a business practice, some of the reporting entities do not allocate loss adjustment expenses to a specific claim.

This report organizes and summarizes the data to reflect the types of medical malpractice claims, the age and size of these claims, differences among regions of the state, differences among medical professionals, and several other categories.

V. Limitations of Analysis

The analysis is based entirely on historical closed claim data. That is, claims are reported to us and included in this analysis based on the year in which they reach a final outcome. Some arose from recent medical incidents, but most arose from incidents that occurred several years ago.

This report is not intended to be used to evaluate past or current medical liability insurance rates.

In addition, this data does not reflect plaintiffs' attorney fees, which are not separately collected and cannot be broken out from this data or from any data available to the Department.

VI. Key Findings

- **Total Claims:** For 2006, a total of 4,004 claims were reported by 93 entities. Authorized insurers[1] reported the majority of the claims, 2,495. Self-insured entities reported 1,283 claims; surplus lines insurers reported 169 claims; and risk retention groups reported 57 claims. For 2005, a total of 5,051 claims were reported by 91 entities. Total claims reported for 2006 were approximately 20% less than the number reported for 2005.

[1] Authorized (admitted) insurers are licensed to write business in the state; are subject to the Department's rate, policy form and solvency regulation; and are backed by the Ohio Insurance Guaranty Fund. Surplus lines insurers are not authorized and do not have guaranty fund backing, but are allowed to write policies for those doctors and hospitals that cannot obtain coverage from an authorized insurer. These companies must be on a list of accepted surplus lines insurers and are regulated for financial strength by their domiciliary state or country. Risk retention groups are permitted by federal law to cover the liability insurance risk of the group's members. These groups are not backed by the guaranty fund.

- **Indemnity Payments:** A large majority of medical malpractice claims resulted in no payment to a claimant. Four-fifths of the claims, 3,210, had no indemnity payments, while one-fifth of the claims, 794, closed with an indemnity payment. The total amount paid to claimants was $228,735,572, an average of $288,080 per claim in which an indemnity payment was made. Similarly, in 2005, one-fifth of the claims closed with an indemnity payment, averaging $269,374 per paid claim.

- **ALAE:** While most medical malpractice claims closed with no payments to claimants, almost all claims generated expenses for investigation and defense. The number of claims reported to have ALAE was 3,433. These expenses totaled $88,131,139, an average of $25,672 per claim. In 2005, the average ALAE was $24,443.

- **Indemnity Payments and Age of Claim:** The amount paid to claimants increased with the age of the claim. Of the claims that closed with an indemnity payment, 168 closed within one year of being reported and had average paid indemnity of $111,806. That figure rose to $299,520 for 221 claims closing in their second year. Thirteen claims closed seven or more years after being reported, having average paid indemnity of $595,067. Similar results were seen in 2005.

- **ALAE and Age of Claim:** Allocated loss adjustment expense also increased with the age of the claim, starting with an average of $8,143 for claims that closed in the first year, and rising to $16,878 for claims that closed in the second year. For claims closing seven or more years after being reported, average ALAE was $74,419. Similar results were seen in 2005.

- **Regional Comparisons:** Nearly half of the claims,1,896, came from Northeast Ohio. Of these, one-fifth or 377, resulted in indemnity payments totaling $101,699,092. Almost half of the total dollar amount paid to claimants statewide in 2006 arose from Northeast Ohio claims. However, Northwest Ohio had the highest average paid indemnity of $365,007. The breakdown of average paid indemnity for the remainder of the Ohio, in descending order, is: Southwest-$288,988; Central-$285,147; Northeast-$269,759; and Southeast-$256,266.

- **Specialty Comparisons:** When claims were broken down by medical specialty, Internal Medicine had the most claims at 245 with 19 resulting in paid indemnity averaging $170,237. However, for those specialties that are broken out, Pathology had the highest average paid indemnity of $663,000 for 5 claims with payments, out of 12 reported claims.

- **Treatment Comparisons:** Diagnosis-related incidents, such as failure to diagnose, delay in diagnosis, or misdiagnosis produced the highest number

of claims, 1,129 with 181 resulting in paid indemnity. Obstetrics-related claims totaled 167. Of these, 53 resulted in indemnity payments averaging $726,506, the highest average payment for any type of injury.

VII. Detailed Findings

Claims by Outcome (Appendix C, Exhibits 1 and 2)

Reporting entities were asked to indicate the method of final disposition for each closed claim:

- Of the 4,004 claims that were closed in 2006, 80% closed with no indemnity payment. Included in this figure are five categories:
  - 65.5% of the claims closed when the claim or suit was abandoned or was dismissed without prejudice;
  - 8.5% were dismissed by summary judgment or a directed verdict;
  - 5% ended with a verdict for the defendant;
  - 1% ended through a settlement;
  - 0.2% ended with alternative dispute resolution.
- The remaining 20% of the claims closed with paid indemnity. Four categories of claims are included here:
  - 18% reached a settlement;
  - 1% used alternative dispute resolution;
  - 1% had a verdict for the plaintiff;
  - 0.2%[2] ended with a summary judgment or directed verdict for the plaintiff.

Another perspective is gained by grouping these outcomes together as follows:

- Claims that were dropped or dismissed without prejudice, and without an indemnity payment, form the largest group, 65.5%.
- Claims resulting in settlement are the next largest group, 19%. Of these, most resulted in an indemnity payment.
- Claims with a summary judgment or a directed verdict comprise 9% of the total, with a large majority of these resulting in no indemnity payment.
- Claims that closed following alternative dispute resolution comprise 2% of the total, the majority of which resulted in indemnity payments.
- Finally, of the 5% of the claims that went to trial, most ended without indemnity payments.

Claims ending in a settlement or through alternative dispute resolution were more likely to result in indemnity payments to the plaintiff. Claims ending in a trial or jury verdict were more likely to resolve in favor of the defendant.

[2] Some of these breakdowns do not add up to 100% due to rounding. See Appendix C, Exhibits 1 and 2 for actual figures.

Regardless of outcome, all categories of claims had expenses in the form of ALAE. That is, even though a claim may have closed without an indemnity payment, the claim was likely to generate investigation and legal expense. Exhibit 2 contains the details. Claims dropped or dismissed without prejudice had average ALAE of $13,266. The 26 claims that were disposed of by a trial or jury verdict which resulted in an indemnity payment had the highest average ALAE of $95,809.

Age of Claim (Appendix C, Exhibit 3)

This exhibit displays claims by age at the time of closing, and shows that average indemnity and average ALAE increased with the age of the claim. Claims that closed in their first year represent 24% of the total and had the lowest average indemnity of $111,806, and ALAE of $8,143. Costs grew significantly as the claims aged. The oldest category, claims that closed after seven or more years, had average indemnity payments of $595,067, and average ALAE of $74,419.

While some age categories have values lower than younger age categories, this is likely due to the number of claims for just one year of data. Statistical tests for growth indicate that ALAE grew by approximately $7,400 per claim per year, and paid indemnity grew by approximately $48,000 per claim per year.

Claims by Size (Appendix C, Exhibit 4)

Of the 4,004 claims reported closed in 2006, only 20%, or 794, generated an indemnity payment. Of these 794 claims, 57 claims or 7% generated an indemnity payment greater than $1 million. The 57 claims in total generated indemnity payments of $121.3 million or 53% of the total indemnity payments for all claims. Another 64 claims, or 8%, generated an indemnity payment below $1 million but at least $500,000. The 64 claims in total generated indemnity payments of $42.7 million or 19% of the total indemnity payments for all claims. For 2006, 72% of the total paid indemnity was generated by only 15% of the claims that had an indemnity payment.

Claims by Insurer Type (Appendix C, Exhibit 5)

A total of 93 entities reported closed claim information to the Department. The reporting entities are categorized as authorized (admitted) insurance companies, surplus lines insurance companies, risk retention groups and self-insurers/captives. Of the 4,004 closed claims that were reported, 62% were reported by admitted insurance companies and 32% were reported by self-insurers/captives. Very few claims were reported as closed by surplus lines insurance companies or risk retention groups.

Claims by Region (Appendix C, Exhibits 6 & 7)

Claims were reported by county. However, an exhibit showing details by county would allow for identification of the specific claims in counties with very few claims reported in 2006, violating the requirement of confidentiality. In order to provide meaningful information regarding differences by location, we divided the state into five regions: Central, Northeast, Northwest, Southeast and Southwest. The counties within each region are shown in Exhibit 6, while Exhibit 7 displays claim data for the regions.

Nearly half of the closed claims reported for 2006 were from the Northeast region. The Northwest region had the largest average indemnity payment. With the exception of the claims labeled Unknown, the Northwest region also incurred the largest average allocated loss adjustment expense. Conversely, the Southeast region had the smallest average indemnity payment, while the Central region incurred the smallest average allocated loss adjustment expense.

Claims by Physician Specialty (Appendix C, Exhibit 8)

This exhibit shows fifteen physician and surgeon specialties. All other specialties are grouped together as "Other" to maintain confidentiality. Internal Medicine had the most closed claims followed by General Surgery. An average of 12% of the claims against a physician or surgeon resulted in an indemnity payment.

Pathology had the highest average paid indemnity, $663,000, followed closely by Anesthesiology with an average paid indemnity of $617,222.

Claims by Type of Injury (Appendix C, Exhibit 9)

The reporting entities identified the primary complaint or injury that led to the medical liability claim. Of the 4,004 claims reported as closed, 54% of the claims were closely split between two categories, Diagnosis-Related and Non-Obstetrical Medical Treatment. Diagnosis-Related includes failure to diagnose, misdiagnosis, and delay in diagnosis. Non-Obstetrical Medical Treatment includes failure to treat, delay in treatment, and improper treatment. Obstetrics-Related claims, including improper delivery method, improper management of pregnancy, and delay in delivery, had the highest average paid indemnity, $726,506, and the highest average ALAE, $49,810. These figures include all medical providers, including hospitals.

Birth Injury Claims (Appendix C, Exhibit 10)

Reporting entities identified whether the closed claim was due to a birth injury. Of the 4,004 claims reported, 161, or 4%, were identified as birth injury claims. Of these 161 birth injury claims, 34% resulted in an indemnity payment. The average

indemnity payment of a birth injury claim was $817,117- almost three times the overall average indemnity payment of $288,080.

Severity of Injury (Appendix C, Exhibit 11)

Of the 4,004 claims reported as closed, 1,373 or 34% of the claims were due to the death of the injured party, with average paid indemnity of $295,664. Injuries identified as "permanent grave" had average paid indemnity of $1,475,966, more than five times the overall average indemnity payment. The injuries include quadriplegia and brain damage, requiring lifelong dependent care.

Age of Injured Person (Appendix C, Exhibit 12)

Of the 4,004 claims reported as closed, 71% of the claims identified the injured party as an adult, ages 18 to 64. Adults ages 65 or greater represented 19% of the claims. Infants and minors represented 5% and 4% of the claims, respectively. The average indemnity payment for infants was the highest at $824,076.

Gender of Injured Person (Appendix C, Exhibit 13)

For the 4,004 claims reported as closed, 56% of the claims reported the injured party as female and 44% reported the injured party as male. For both genders, approximately 20% of the claims resulted in an indemnity payment.

Location of Injury (Appendix C, Exhibit 14)

Reporting entities identified the location where the primary injury or complaint occurred that led to the medical liability claim. The greatest number of claims was generated by incidents that occurred in the operating suite, followed closely by incidents that occurred in the medical professional's office. These two locations represent 45% of the claims. The largest average allocated loss adjustment expenses and the largest average indemnity payments were due to injuries that occurred in the Nursery/Pediatric Ward.

VII. Conclusion

This second annual report provides insight into the details of Ohio medical malpractice claims. Trends will continue to emerge as data for additional years are gathered. However, based on only two years of data the following conclusions can be drawn:

- Most of the claims closed without a payment to the plaintiff. For both 2005 and 2006, approximately 80% of the claims closed without an indemnity payment.
- Almost all of the claims had costs in the form of ALAE.
- Higher value claims tended to be older. Conversely, smaller claims closed faster.

- Claims that went to trial were more likely to close with no indemnity payment, while those that settled or went through alternative dispute resolution were more likely to close with paid indemnity.

§ 3929.302. Collection and disclosure of medical claims data.

(A) The superintendent of insurance, by rule adopted in accordance with Chapter 119. of the Revised Code, shall require each authorized insurer, surplus lines insurer, risk retention group, self-insurer, captive insurer, the medical liability underwriting association if created under section 3929.63 of the Revised Code, and any other entity that provides medical malpractice insurance to risks located in this state, to report information to the department of insurance at least annually regarding any medical, dental, optometric, or chiropractic claim asserted against a risk located in this state, if the claim resulted in any of the following results:

(1) A final judgment in any amount;

(2) A settlement in any amount;

(3) A final disposition of the claim resulting in no indemnity payment on behalf of the insured.

(B) The report required by division (A) of this section shall contain such information as the superintendent prescribes by rule adopted in accordance with Chapter 119. of the Revised Code, including, but not limited to, the following information:

(1) The name, address, and specialty coverage of the insured;

(2) The insured's policy number;

(3) The date of the occurrence that created the claim;

(4) The name and address of the injured person;

(5) The date and amount of the judgment, if any, including a description of the portion of the judgment that represents economic loss, noneconomic loss and, if applicable, punitive damages;

(6) In the case of a settlement, the date and amount of the settlement;

(7) Any allocated loss adjustment expenses;

(8) Any other information required by the superintendent pursuant to rules adopted in accordance with Chapter 119. of the Revised Code.

(C) The superintendent may prescribe the format and the manner in which the information described in division (B) of this section is reported. The superintendent may, by rule adopted in accordance with Chapter 119. of the Revised Code, prescribe the frequency that the information described in division (B) of this section is reported.

(D) The superintendent may designate one or more rating organizations licensed pursuant to section 3937.05 of the Revised Code or other agencies to assist the superintendent in gathering the information, and making compilations thereof, required by this section.

(E) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any person or entity reporting under this section or its agents or employees, or the department of insurance or its employees, for any action taken that is authorized under this section.

(F) The superintendent may impose a fine not to exceed five hundred dollars against any person designated in division (A) of this section that fails to timely submit the report required under this section. Fines imposed under this section shall be paid into the state treasury to the credit of the department of insurance operating fund created under section 3901.021 [3901.02.1] of the Revised Code.

(G) Except as specifically provided in division (H) of this section, the information required by this section shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information provided under this section is not subject to discovery or subpoena and shall not be made public by the superintendent or any other person.

(H) The department of insurance shall prepare an annual report that summarizes the closed claims reported under this section. The annual report shall summarize the closed claim reports on a statewide basis, and also by specialty and geographic region. Individual claims data shall not be released in the annual report. Copies of the report shall be provided to the members of the general assembly.

(I) (1) Except as specifically provided in division (I)(2) of this section, any information submitted to the department of insurance by an attorney, law firm, or legal professional association pursuant to rules promulgated by the Ohio supreme court shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information submitted is not subject to discovery or subpoena and shall not be made public by the department of insurance or any other person.

(2) The department of insurance shall summarize the information submitted by attorneys, law firms, and legal professional associations and include the information in the annual

report required by division (H) of this section. Individual claims data shall not be released in the annual report.

(J) As used in this section, medical, dental, optometric, and chiropractic claims include those claims asserted against a risk located in this state that either:

(1) Meet the definition of a "medical claim," "dental claim," "optometric claim," or "chiropractic claim" under section 2305.113 [2305.11.3] of the Revised Code;

(2) Have not been asserted in any civil action, but that otherwise meet the definition of a "medical claim," "dental claim," "optometric claim," or "chiropractic claim" under section 2305.113 [2305.11.3] of the Revised Code.

HISTORY: 150 v H 215, § 1, eff. 9-13-04; 150 v H 425, § 1, eff. 4-27-05.

The provisions of § 3 of H.B. 425 (150 v -) read as follows:
SECTION 3. The General Assembly hereby requests the Ohio Supreme Court adopt rules of professional conduct that require any attorney who provides representation to a person bringing a medical, dental, optometric, or chiropractic claim to file with the Department of Insurance or its designee under division (D) of section 3929.302 of the Revised Code a report describing the attorney fees and expenses received for such representation, as well as any other data necessary for the Department of Insurance to reconcile the attorney fee and expense data with other medical malpractice closed claim data received by the Department of Insurance pursuant to rules promulgated under section 3929.302 of the Revised Code. The General Assembly hereby requests that any rules adopted by the Ohio Supreme Court define medical, dental, optometric, and chiropractic claims in the same manner as section 3929.302 of the Revised Code and require the filing of a report with the Department of Insurance if the medical, dental, optometric, or chiropractic claim results in a final judgment or settlement in any amount or a final disposition of the claim resulting in no indemnity payment to the claimant.

Effect of Amendments

150 v H 425, effective April 27, 2005, inserted (I) and redesignated former (I) as (J).

3901-1-64 Medical liability data collection.

(A) Purpose The purpose of this rule is to establish procedures and requirements for the reporting of specific medical, dental, optometric and chiropractic claims data to the Ohio Department of Insurance.

(B) Authority This rule is promulgated pursuant to the authority vested in the superintendent under sections 3901.041 and 3929.302 of the Revised Code.

(C) Definitions

(1) "Medical, dental, optometric and chiropractic claims" include those claims asserted against a risk located in this state that either:

(a) Meet the definition of "medical claim," "dental claim," "optometric claim," or "chiropractic claim" in section 2305.113 of the Revised Code, or

(b) Have not been asserted in any civil action, but that otherwise meet the definition of "medical claim," "dental claim," "optometric claim," or "chiropractic claim" in section 2305.113 of the Revised Code.

(2) "Risk retention group" has the same meaning as in section 3960.02 of the Revised Code.

(3) "Surplus lines insurer" means an insurer that is not licensed to do business in this state, but is nonetheless approved by the department to offer insurance because coverage is not available through licensed insurers.

(4) "Self-insurer" means any person or persons who set aside funds to cover liability for future medical, dental, optometric or chiropractic claims or that otherwise assume their own risk or potential loss for such claims. "Self-insurer" includes captives.

(D) Each authorized insurer, surplus lines insurer, risk retention group, self-insurer, the medical liability underwriting association if created under section 3929.63 of the Revised Code, or any other entity that offers medical malpractice insurance to, or that otherwise assumes liability to pay medical, dental, optometric or chiropractic claims for, risks located in this state, shall report at least annually to the superintendent of insurance, or to the superintendent's designee, information regarding any medical, dental, optometric, or chiropractic claim asserted against a risk located in this state, if the claim resulted in:

(1) A final judgment in any amount,

(2) A settlement in any amount, or

(3) A final disposition of the claim resulting in no indemnity payment on behalf of the covered person or persons.

(E) The report required by division (D) shall include for each claim:

(1) The name, address and specialty coverage of each covered person;

(2) The insured's policy number, if applicable;

(3) The date of the occurrence that created the claim;

(4) The name and address of the injured person;

(5) The date the claim was reported and the claim number;

(6) The injured person's age and sex;

(7) If the medical, dental, optometric, or chiropractic claim was filed with the court, the case number and the name and location of the court;

(8) In the case of a judgment, the date and amount of the judgment and, if the judgment is subject to the itemization requirements in section 2323.43(B) of the Revised Code, a description of the portion of the judgment that represents economic loss, non-economic loss and punitive damages, if any;

(9) In the case of a settlement, the date and amount of the settlement and, if known, the injured person's incurred medical expense, wage loss, and other expenses;

(10) Any loss adjustment expenses allocated to the claim or, if known, the amount allocated to each covered person;

(11) The loss adjustment expense, broken down between fees and expenses, paid to defense counsel;

(12) The date and reason for final disposition, if no judgment or settlement, and the type of disposition;

(13) Unless disclosure is otherwise prohibited by state or federal law, a summary of the occurrence which created the claim which shall include:

(a) The name of the institution, if any, and the location at which the injury occurred;

(b) The operation, diagnosis, treatment, procedure or other medical event or incident giving rise to the alleged injury;

(c) A description of the principal injury giving rise to the claim.

(F) Frequency The report(s) required by this rule shall be filed with the superintendent, or the superintendent's designee, on or before May 1 of each year, and shall contain information for the previous calendar year.

(G) Noncompliance Any person listed in division (D) that fails to timely submit the report required under this section shall be subject to a fine not to exceed $ 500.00.

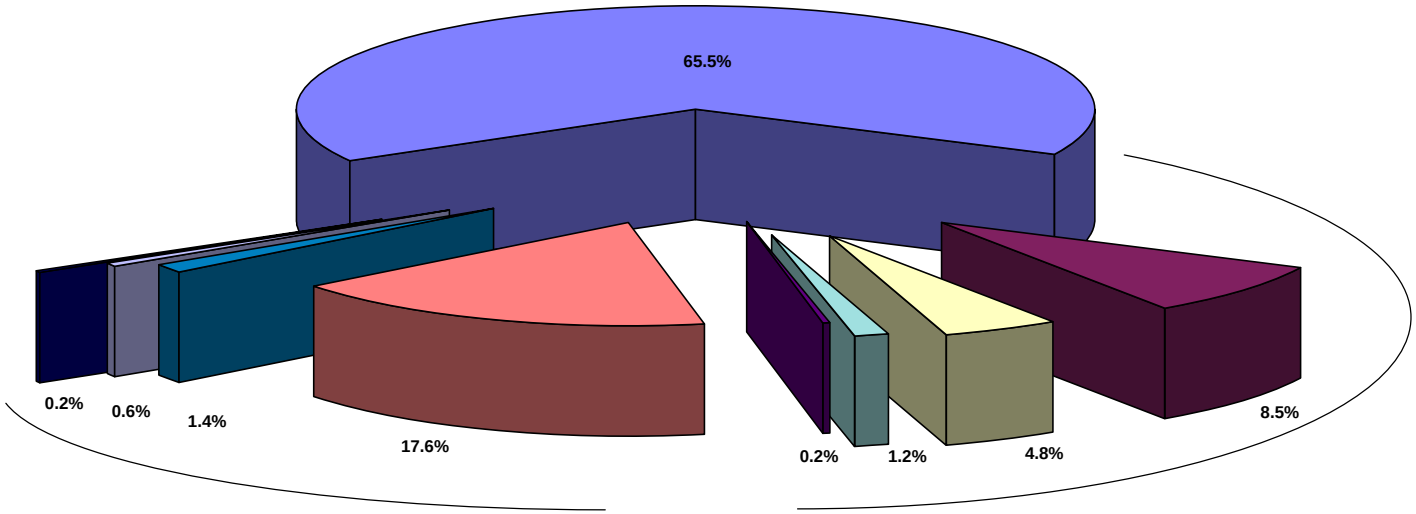
(H) Confidentiality Information reported to the superintendent or the superintendent's designee pursuant to this rule shall be confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information provided under this section is not subject to discovery or subpoena and shall not be made public by the superintendent or any other person, including any rating organizations or other agencies designated by the superintendent to gather and/or compile the information.

(I) The requirements of this rule do not apply to reinsurers, reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

HISTORY: Eff. 01/02/2005
Promulgated Under: 119.03
Statutory Authority: 3901.041, 3929.302
Rule Amplifies: 3929.302
R.C. 119.032 review dates: 12/30/2008

Appendix C, Exhibit 1

OHIO
Closed Claims in 2006
Outcome of Malpractice Claims
4004 Closed Claims



65.5% Claim/Suit Abandoned Without Indemnity Payment, Including Dismissed Without Prejudice

8.5% Dismissed by Court -Summary Judgment/Directed Verdict -- Without Indemnity

4.8% Disposed of by Trial Verdict/Jury Verdict -- Without Indemnity

1.2% Disposed of by Settlement Agreement -- Without Indemnity

0.2% Disposed of by Alternative Dispute Resolution -- Without Indemnity

17.6% Disposed of by Settlement Agreement -- With Indemnity

1.4% Disposed of by Alternative Dispute Resolution -- With Indemnity

0.6% Disposed of by Trial Verdict/Jury Verdict -- With Indemnity

0.2% Dismissed by Court -Summary Judgment/Directed Verdict -- With Indemnity

19.8% - Claims With Indemnity Payment

80.2% - Claims Without Indemnity Payment

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2006 Closed Claims
ALAE and Indemnity Payments by Final Disposition Description

FINAL DISPOSITION DESCRIPTION	TOTAL CLAIMS	AVG	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Claim/Suit Abandoned Without Indemnity Payment, Including Dismissed Without Prejudice -- Without Indemnity	2622	65.5%	2230	$29,582,626	$13,266	0	$0	$0
Dismissed by Court -Summary Judgment/Directed Verdict -- Without Indemnity	340	8.5%	313	$5,408,106	$17,278	0	$0	$0
Disposed of by Trial Verdict/Jury Verdict -- Without Indemnity	191	4.8%	187	$14,489,251	$77,483	0	$0	$0
Disposed of by Settlement Agreement -- Without Indemnity	49	1.2%	36	$1,121,810	$31,161	0	$0	$0
Disposed of by Alternative Dispute Resolution -- Without Indemnity	8	0.2%	6	$78,337	$13,056	0	$0	$0

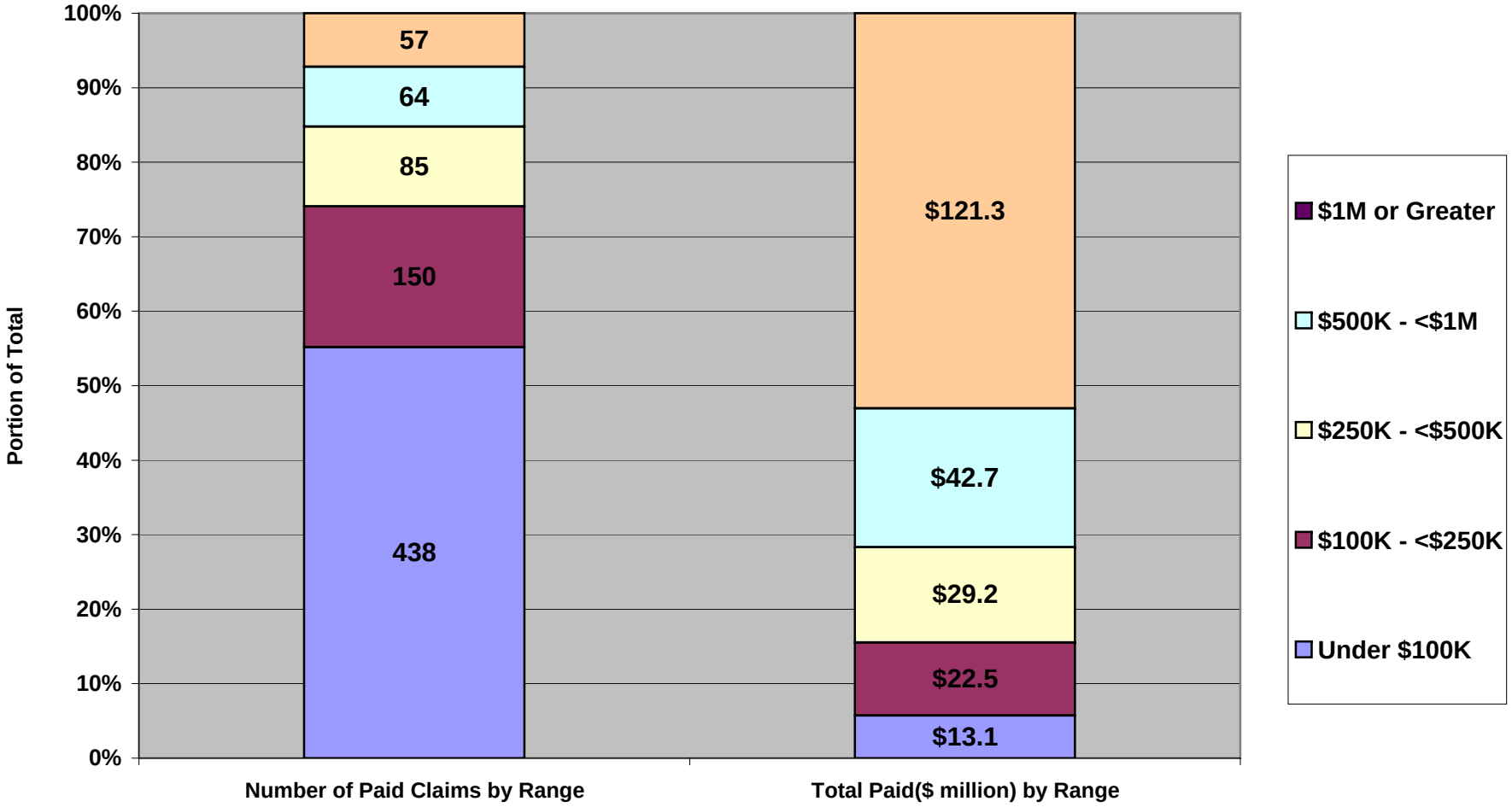
FINAL DISPOSITION DESCRIPTION	TOTAL CLAIMS	AVG	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Disposed of by Settlement Agreement -- With Indemnity	703	17.6%	571	$31,277,755	$54,777	703	$191,006,244	$271,702
Disposed of by Alternative Dispute Resolution -- With Indemnity	55	1.4%	55	$3,093,204	$56,240	55	$27,587,274	$501,587
Disposed of by Trial Verdict/Jury Verdict -- With Indemnity	26	0.6%	26	$2,491,045	$95,809	26	$9,086,934	$349,497
Dismissed by Court -Summary Judgment/Directed Verdict -- With Indemnity	10	0.2%	9	$589,006	$65,445	10	$1,055,120	$105,512
TOTALS and AVERAGES:	4004	100.0%	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Age of Claim

AGE IN YEARS	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Less Than 1	960	652	$5,309,555	$8,143	168	$18,783,476	$111,806
1 But Less Than 2	1271	1143	$19,291,406	$16,878	221	$66,193,837	$299,520
2 But Less Than 3	901	829	$21,752,192	$26,239	177	$53,041,712	$299,671
3 But Less Than 4	485	454	$20,494,436	$45,142	128	$51,019,061	$398,586
4 But Less Than 5	228	201	$10,796,004	$53,711	54	$11,465,370	$212,322
5 But Less Than 7	124	122	$8,106,144	$66,444	33	$20,496,242	$621,098
7 or Greater	35	32	$2,381,404	$74,419	13	$7,735,873	$595,067
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

Appendix C, Exhibit 4

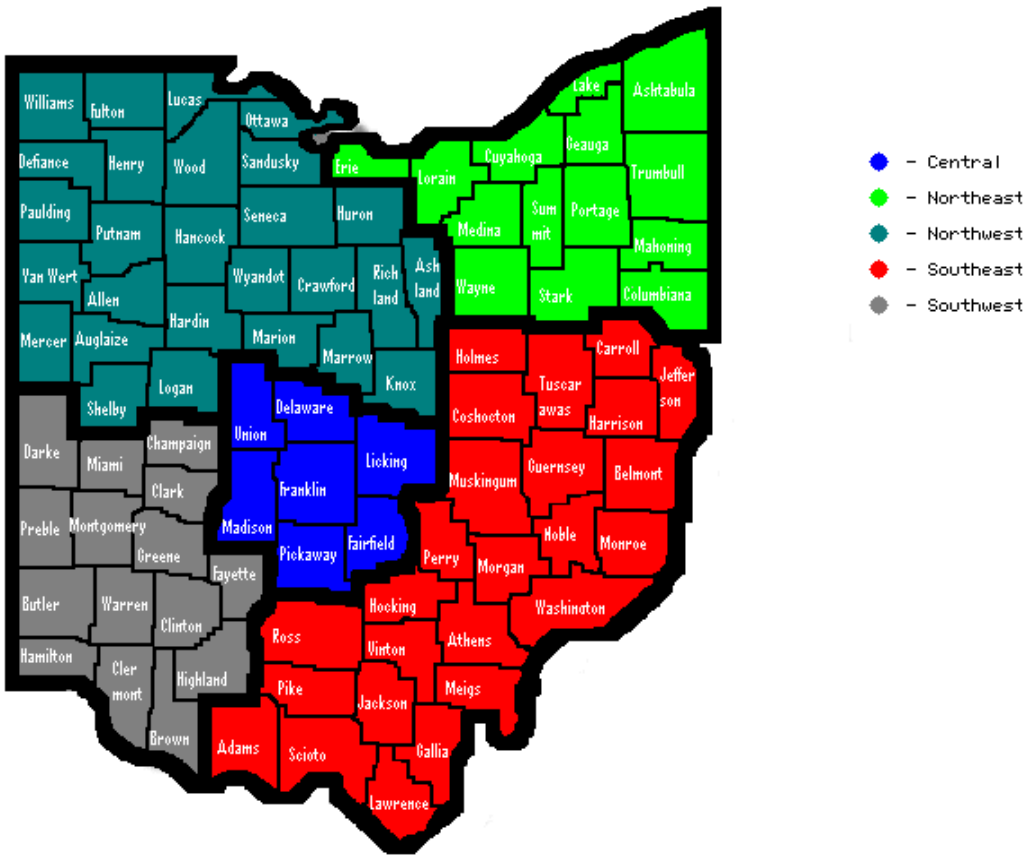
OHIO
2006 Closed Claims
By Size of Payment



OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Insurer Type

INSURING ENTITY TYPE	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Insurance Company - Authorized/Admitted	2495	2300	$56,100,028	$24,391	383	$103,648,677	$270,623
Insurance Company - Surplus Lines	169	115	$2,150,342	$18,699	28	$10,030,080	$358,217
Risk Retention Group	57	44	$545,530	$12,398	14	$1,997,200	$142,657
Self Insurers (Captives)	1283	974	$29,335,239	$30,118	369	$113,059,614	$306,395
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

Closed Claims 2006
Regions



The counties displayed on the map include the following:

Central:
Delaware, Fairfield, Franklin, Licking, Madison, Pickaway, Union

Northeast:
Ashtabula, Columbiana, Cuyahoga, Erie, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, Wayne

Northwest:
Allen, Ashland, Auglaize, Crawford, Defiance, Fulton, Hancock, Hardin, Henry, Huron, Knox, Logan, Lucas, Marion, Mercer, Morrow, Ottawa, Paulding, Putnam, Richland, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood, Wyandot

Southeast:
Adams, Athens, Belmont, Carroll, Coshocton, Gallia, Guernsey, Harrison, Hocking, Holmes, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Pike, Ross, Scioto, Tuscarawas, Vinton, Washington

Southwest:
Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble, Warren

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Region

STATE REGION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Central	507	418	$8,885,809	$21,258	95	$27,088,923	$285,147
Northeast	1896	1584	$42,691,478	$26,952	377	$101,699,092	$269,759
Northwest	662	613	$17,858,125	$29,132	120	$43,800,826	$365,007
Southeast	216	192	$4,297,812	$22,384	38	$9,738,125	$256,266
Southwest	715	620	$14,058,474	$22,675	158	$45,660,105	$288,988
Unknown	8	6	$339,441	$56,574	6	$748,500	$124,750
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Physician Specialty

PHYSICIAN SPECIALTY	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Internal Medicine	245	230	$4,770,056	$20,739	19	$3,234,500	$170,237
Surgery - General	193	175	$5,109,656	$29,198	19	$5,464,516	$287,606
Emergency Medicine	191	160	$3,728,321	$23,302	23	$4,577,070	$199,003
Family Physicians\General Practioners	189	177	$4,396,667	$24,840	32	$8,302,219	$259,444
Surgery - Orthopedic	149	136	$2,195,010	$16,140	19	$1,999,898	$105,258
Obstetrics/Gynecology	144	132	$5,513,254	$41,767	35	$15,636,443	$446,756
Radiology	117	102	$1,918,693	$18,811	15	$5,190,000	$346,000
Anesthesiology	73	61	$1,861,234	$30,512	9	$5,555,000	$617,222
Cardiovascular Disease	54	35	$914,694	$26,134	9	$3,771,440	$419,049
Surgery - Plastic	53	49	$815,675	$16,646	5	$134,997	$26,999

PHYSICIAN SPECIALTY	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Gynecology	23	21	$1,110,733	$52,892	7	$3,130,000	$447,143
Ophthalmology	22	16	$394,800	$24,675	6	$454,000	$75,667
Otorhinolaryngology	21	17	$600,297	$35,312	6	$1,505,000	$250,833
Pathology	12	12	$282,304	$23,525	5	$3,315,000	$663,000
Other	508	423	$10,876,113	$25,712	35	$13,375,300	$382,151
TOTALS and AVERAGES:	1994	1746	$44,487,506	$25,480	244	$75,645,383	$310,022

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Injury

INJURY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Diagnosis-Related (Failure To Diagnose, Misdiagnosis, Delay In Diagnosis, etc.)	1129	957	$29,195,630	$30,507	181	$68,117,412	$376,339
Medical Treatment, Non-Obstetrical (Failure to Treat, Delay in Treatment, Improper Treatment, etc.)	1021	916	$17,773,183	$19,403	172	$32,979,339	$191,740
Surgery-Related (Delay in Surgery, Improper Performance of Surgery, etc.)	816	721	$16,490,375	$22,872	100	$14,952,201	$149,522
Other (No Listed Category Applies)	213	162	$2,800,360	$17,286	42	$6,143,120	$146,265

INJURY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Blood-Related (Wrong Blood Type, Contaminated Blood, etc.)/Medication-Related (Failure to Order, Wrong Medication, Wrong Dosage, etc.)	184	159	$4,484,972	$28,207	58	$29,015,154	$500,261
Obstetrics-Related (Improper Delivery Method, Improper Management of Pregnancy, Delay in Delivery, etc.)	167	153	$7,620,896	$49,810	53	$38,504,811	$726,506
Patient Monitoring-Related (Failure to Monitor, etc.)	139	113	$4,239,553	$37,518	55	$19,980,210	$363,277
Safety & Security-Related (Falls, Failure To Ensure Safety, Failure to Protect From Assault)	131	91	$1,652,607	$18,161	82	$4,861,154	$59,282
Anesthesia-Related (Improper Choice, Improper Administration, etc.)	69	56	$1,200,245	$21,433	12	$5,753,227	$479,436

INJURY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Breach of Confidentiality/Communication-Related (Failure To Instruct, Failure to Obtain Consent, etc.)	53	45	$940,138	$20,892	10	$3,235,300	$323,530
Equipment-Related (Improper Use of Equipment, Improper Maintenance, Equipment Failure/Malfunction, etc.)	50	34	$528,523	$15,545	16	$3,876,229	$242,264
Policies & Procedures-Related (Failure To Follow, Negligent Credentialing, etc.)/Supervision-Related (Supervision of Residents, Nurses, etc.)	32	26	$1,204,658	$46,333	13	$1,317,415	$101,340
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Birth Injury

BIRTH INJURY	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
No	3843	3283	$79,723,347	$24,284	740	$184,611,236	$249,475
Yes	161	150	$8,407,793	$56,052	54	$44,124,335	$817,117
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Severity

SEVERITY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Death	1373	1267	$35,228,605	$27,805	244	$72,141,910	$295,664
Emotional	90	60	$1,127,418	$18,790	17	$721,181	$42,422
Permanent Grave	91	83	$4,449,176	$53,605	28	$41,327,060	$1,475,966
Permanent Major	473	419	$17,069,716	$40,739	88	$60,658,181	$689,298
Permanent Minor	274	231	$5,325,581	$23,054	57	$9,531,726	$167,223
Permanent Significant	464	415	$10,537,923	$25,393	74	$30,831,780	$416,646
Temporary Low Significance	138	90	$904,675	$10,052	26	$138,601	$5,331
Temporary Major	463	362	$6,453,782	$17,828	87	$7,355,157	$84,542
Temporary Minor	638	506	$7,034,264	$13,902	173	$6,029,976	$34,855
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Age

AGE RANGE	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Adult (Ages 18-64)	2855	2448	$57,530,152	$23,501	478	$133,934,490	$280,198
Senior (Age 65+)	753	641	$14,494,573	$22,612	211	$24,639,761	$116,776
Infant (Less than 1 year old)	217	191	$10,679,899	$55,916	66	$54,388,998	$824,076
Minor (Ages 1 to 17)	157	135	$4,539,620	$33,627	32	$12,436,255	$388,633
Unknown	22	18	$886,896	$49,272	7	$3,336,067	$476,581
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Gender

GENDER	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Female	2253	1938	$48,602,218	$25,079	465	$108,129,976	$232,538
Male	1751	1495	$39,528,922	$26,441	329	$120,605,596	$366,582
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080

OHIO
2006 Closed Claims
ALAE and Indemnity Payments by Location

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Operating Suite (Includes Pre-Op & Operating Rooms)	962	846	$21,791,839	$25,759	144	$33,927,198	$235,606
Medical Professional's Office	858	774	$16,732,065	$21,618	127	$26,632,067	$209,701
Emergency Room/Emergency Department	633	537	$12,490,087	$23,259	100	$17,186,090	$171,861
Patient's Room, Including Patient Bathroom for Inpatient Areas Not Otherwise Specified	449	392	$10,315,859	$26,316	135	$40,224,596	$297,960

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Radiology (Includes Mammograpy, CT, MRI, Radiation Therapy & Nuclear Medicine)	193	163	$4,202,482	$25,782	42	$12,224,446	$291,058
Obstetrics Department (Labor & Delivery, Recovery & Post-Partum)	172	157	$8,743,926	$55,694	60	$48,408,249	$806,804
Other (No Listed Location Applies)	135	103	$1,593,389	$15,470	37	$6,275,782	$169,616
Critical Care Unit (ICU/CCU/NICU)	100	81	$2,667,604	$32,933	20	$16,220,449	$811,022
Nursing Home (Includes Assisted Living, Extended Care & Long-Term Care)	99	90	$1,606,645	$17,852	33	$4,012,498	$121,591
Outpatient/Ambulatory Care Areas or Facilities	99	88	$1,685,098	$19,149	17	$3,050,113	$179,418

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Special Procedure Room (Includes Cardiac Cath Lab, EEG, Dialysis, Endoscopy, Sleep Lab, etc.)	83	42	$698,291	$16,626	11	$2,986,507	$271,501
Patient's Home	47	37	$1,087,572	$29,394	10	$740,571	$74,057
Nursery/Pediatric Ward	44	29	$1,870,037	$64,484	9	$7,934,621	$881,625
Ancillary Services (Includes Laboratory, Pharmacy, and Blood Bank)	39	28	$413,074	$14,753	14	$3,845,295	$274,664
Mental Health (Includes Psychiatric and Drug & Alchohol Addicition)	29	22	$1,149,263	$52,239	6	$1,845,598	$307,600
Physical Therapy Dept.	24	14	$408,823	$29,202	8	$286,779	$35,847

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Facility Support Areas (Including Administrative Areas, Hallways, Elevators, Cafeteria, Gift Shop & Public Restrooms)	21	15	$219,815	$14,654	13	$351,922	$27,071
Recovery Room (Post-Anesthesia Care Unit)	14	12	$325,483	$27,124	7	$2,562,789	$366,113
Hospice Area or Facility	3	3	$129,787	$43,262	1	$20,000	$20,000
TOTALS and AVERAGES:	4004	3433	$88,131,139	$25,672	794	$228,735,572	$288,080