Long Term Care

General Liability and Professional Liability

2004 Actuarial Analysis

Submitted by:

Aon Risk Consultants, Inc.

Theresa W. Bourdon, FCAS, MAAA

Sharon C. Dubin, ACAS, MAAA

June 2004

Table of Contents

Introduction 1

Executive Summary 4

- **Claim Cost Trends** 4
- **Key Factors Affecting Trends** 5
- **Insurance Coverage Trends** 6

Countrywide Long Term Care GL/PL Trends 8

- **GL/PL Loss Costs in the United States are Significantly Increasing** 8
- **The Long Term Care Industry is Incurring More Claims Per Bed Every Year** 9
- **Larger Jury Verdicts and Claim Settlements are Driving Up the Average Size of Losses** 10
- **GL/PL Loss Development Extends Eleven Years** 11
- **Almost Half of the Total Claim Dollars are Litigation Costs** 12
- **The Impact of Patient Rights Laws** 13
- **The Impact of Tort Reform Laws** 14
  - Florida 15
  - Mississippi 15
  - Ohio 16
  - Texas 16
  - West Virginia 16

State Specific Long Term Care GL/PL Trends 18

- **Florida** 19
- **Arkansas** 22
- **Texas** 24

Mississippi 27
Alabama 30
Tennessee 32
California 34
Georgia 36
Ohio 38
Kentucky 40
West Virginia 42
North Carolina 44
Arizona 46
All Other States Combined 48
ALAE 50
Insurance Premium and Coverage Analysis 51
Premium Increases 51
Limits of Liability Reductions 53
Deductible Changes 55
Policy Form Changes 56
Conditions and Limitations 57
Data Sources 59
Definitions 61

Introduction

At the request of the American Health Care Association (AHCA), Aon Risk Consultants, Inc. (Aon) has 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.

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).

2. **Identify state specific trends and their correlation to currently observed and future expected national trends.** Specific areas of the country for which separate analysis is included in this study are the states of Alabama, Arizona, Arkansas, California, Florida, Georgia, Kentucky, Mississippi, North Carolina, Ohio, Tennessee, Texas, and West Virginia. 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 and annual aggregate limits of liability 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 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 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 end of September 2003 and early December 2003. 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 108 long term care providers operating around the country. Approximately 28,000 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 470,000 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 24% of the beds in the United States.

An executive summary containing our conclusions and recommendations can be found in this report. It is provided to give an overview of our national findings. More detailed benchmarks highlighting the national trends and identifying the state trends underlying the national increases 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 and defining common actuarial terms follow.

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

Respectfully Submitted,

Theresa W. Bourdon, FCAS, MAAA
Managing Director and Actuary

Sharon C. Dubin, ACAS, MAAA
Assistant Director and Actuary

Executive Summary

National trends in GL/PL losses continue to increase at rates well ahead of average inflation. The rate of claim cost inflation varies dramatically by state and there are some signs that costs are no longer increasing in some areas. States with the highest average GL/PL cost per bed are showing signs of flattening trend, and in some cases, reduced cost levels. However, many states with historically low GL/PL costs per bed are experiencing dramatic annual increases in the number and size of claims.

Claim Cost Trends

Based on our actuarial analysis of the long term care industry data provided to us, which represents 24% of the U.S., we find the following:

- The average long term care GL/PL cost per annual occupied skilled nursing bed has increased from $310 in 1992 to $2,290 in 2003. National costs are now seven times higher than they were in the early 1990's. On a cost of care basis this means $6.27 per day needs to be set aside per long term care resident to cover the cost of patient care litigation.
- The long term care operators represented in this study report $3.1 billion in GL/PL liability claims incurred from 1992 to 2003. The expected ultimate cost of claims incurred in this period is $5.2 billion, taking into consideration the claims in the pipeline and the as yet to be determined outcomes of open cases.
- These same providers, which represent only 24% of the providers in the United States, are projected to incur $1 billion in GL/PL claims in 2004 alone. Extrapolated to a national basis this exposure is a multi-billion dollar a year cost to the nursing home industry.
- The average size of a GL/PL claim has more than doubled from $65,000 in 1992 to just under $150,000 in 2003.
- Countrywide, long term care operators now incur 15.3 claims per year for every 1,000 occupied skilled nursing care beds. This is three times higher than the 1992 frequency rate of 4.8 claims per 1000 beds.
- Florida and Texas were leaders in driving the increase in GL/PL costs for the long term care industry. With trends during the 1990's in the range of 25% to 35% a year, costs in Florida appear to have peaked at $11,000 per bed in 2000 and have since dropped to $8,200. Texas loss costs are projected to have peaked at $5,500 in 2003 and are expected to decrease following the significant tort reform (most notable the $250,000 cap on non-economic damages) that was passed in 2003.
- Numerous states across the country are still experiencing increasing trends and are seeing their loss cost per bed head towards levels similar to those in Florida and Texas. Most notable are Arkansas ($5,760), Mississippi ($4,070), Alabama ($3,310), Tennessee ($2,980), and California ($2,790).

- In 2003 GL/PL claim costs are projected to absorb 5% of the countrywide average Medicaid reimbursement rate for long term care providers.
- Almost half of the total amount of claim costs paid for GL/PL claims in the long term care industry is going directly to attorneys.

Key Factors Affecting Trends

The factors affecting the above trends are multiple and highly correlated to the states in which facilities are located. In the opinion of the authors of this study, the following general observations may have an impact on these trends.

- The nursing home industry continues to be a key target of professional liability 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.
- Large multi-state providers, who have historically incurred the greatest number of claims and the largest value claims, are aggressively exiting high cost states such as Florida, thereby reducing the average frequency, severity and loss cost of these states.
- These same providers are implementing improved claims management processes, including faster investigation and claim resolution, and more effective litigation strategies, which in turn are lowering the average severity of claims. These strategies are being targeted first and foremost in the highest cost states such as Florida and Texas.
- Small to medium sized providers are carrying lower limits of liability, due to the lack of insurance availability. This has the effect of lowering average severity and its impact is strongest in states like Florida where capacity is most restricted.
- All providers are reporting an increase in the number of smaller value claims than in past years. This increase appears to be driven by greater interest in early tracking of any event or incident that may evolve into a lawsuit. Such early tracking and reporting can help mitigate large awards. In addition, under claims-made policy forms, which are the only forms generally being offered to the long term care industry these days, early reporting of claims is critical to triggering coverage for the appropriate policy period. The impact of this increase in event reporting is an increase in claim frequency and a corresponding decrease in the indicated average claim severity.
- Tort reform has been passed in a handful of states over the last few years, which for some states (Florida, Mississippi and Texas) triggered a higher than expected frequency level in the years just prior to the reform. However, while it is still too early to determine from the data reported in this study, it is anticipated that post reform severity will be lower in those states that included strongly worded non-economic caps of $500,000 or less.

The effect of these factors on a state by state basis is presented in the state analyses contained in this report.

Insurance Coverage Trends

Insurance markets have continued to offer only limited capacity to write long term care GL/PL insurance. As with the trends in claim costs, the availability varies by state. In some states, such as Florida, insurance capacity continues to be essentially non-existent for long term care patient care liability. In other states, only a very limited number of insurance companies are writing policies and doing so on a very selective underwriting basis. Where coverage has been available, based on the commercially insured respondents to our study, the following trends are indicated:

- Annual commercial insurance premium levels increased dramatically for the third straight year in a row. The average reported increase is 51% between 2002 and 2003. This follows average reported increases of 143% in 2002 and 131% in 2001. A comparison of the average reported increase and the median reported increase over the last three years is shown in the following table.

Historical Premium Increases – 2001 to 2003

	2001	2002	2003
Median Increase over Prior Year's Premium	74%	82%	25%
Average Increase over Prior Year's Premium	131%	143%	51%

- Smaller providers were the hardest hit by the premium increases in 2003. A comparison of premium changes by provider size (based on number of licensed beds) is provided in the chart below.

Change in Annual Premium by Provider Size – Policy Year 2002 to 2003

Provider Bed Count	Number of Respondents	Total Percentage Premium Change	Median Percentage Premium Change	Average Percentage Premium Change
0-100	27	33.9%	37.1%	73.7%
100-250	18	46.4%	30.4%	77.2%
250-500	6	27.9%	34.5%	61.6%
500-1000	4	-42.6%	-28.4%	-29.4%
1000-5000	22	8.1%	26.5%	32.6%
5000-10,000	8	24.5%	10.4%	21.4%
>10,000	1	-9.4%	-9.4%	-9.4%

- Both per occurrence and annual aggregate limits of liability available from the commercial insurance marketplace were reduced in 2003, following two years of severe capacity restrictions. The average reductions were $108,537 and $68,452, respectively. Overall, the commercial insurance industry provided $8.9 million less capacity to the 96 providers responding to this section of our survey.

Historical Limits of Liability Reductions – 2001 to 2003

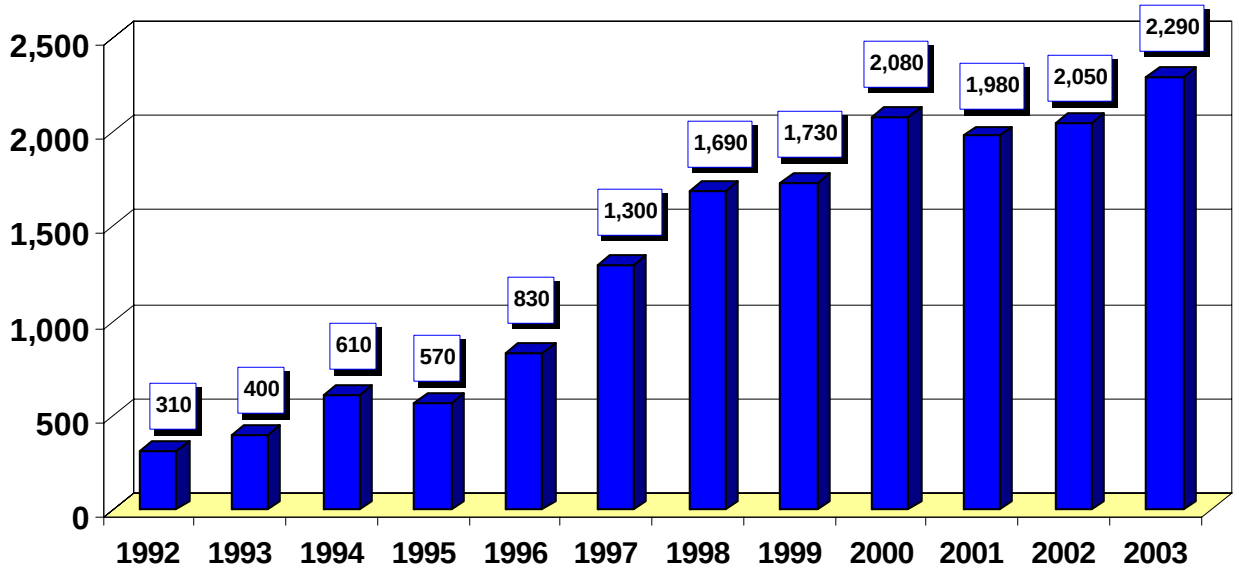
	2001	2002	2003
Average Decrease in Per Occurrence Limit from Prior Year	($474,074)	($488,679)	($108,537)
Average Decrease in Aggregate Limit from Prior Year	($2,311,111)	($624,000)	($68,452)

Countrywide Long Term Care GL/PL Trends

GL/PL Loss Costs in the United States are Significantly Increasing

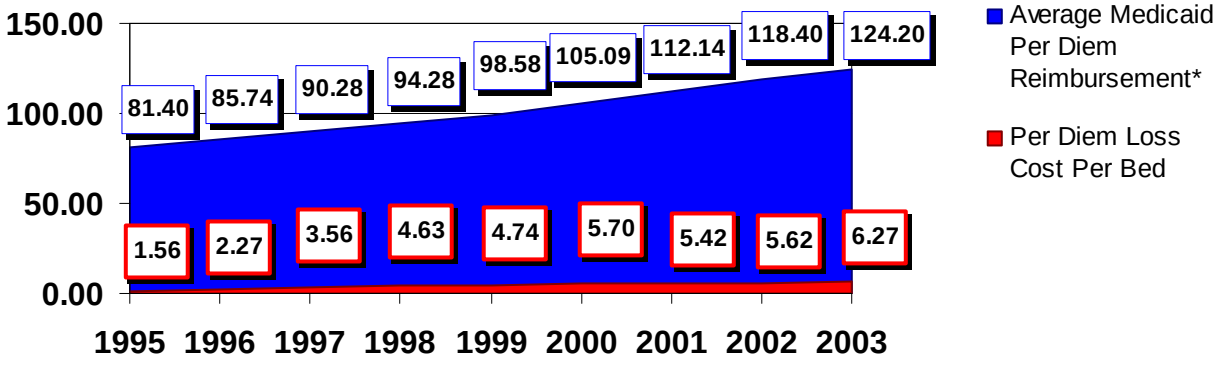
The cost per occupied long term care bed of GL/PL losses has increased 600% in the last decade, growing from $310 in 1992 to $2,290 in 2003, as the following graph shows:

Countrywide Loss Cost Per Occupied Bed



Because the majority of nursing home beds are funded by either Medicaid or Medicare (77% based on CMS OSCAR Survey data as of June, 2003: split 11% Medicare, 66% Medicaid), the increases in patient care liability are largely being funded by taxpayer dollars. On a per diem basis, the loss cost is increasing as a percent of Medicaid reimbursements, from 2% in 1995 to 5% in 2003 as shown in the graph below.

Countrywide Per Diem Loss Cost Versus Medicaid Reimbursement

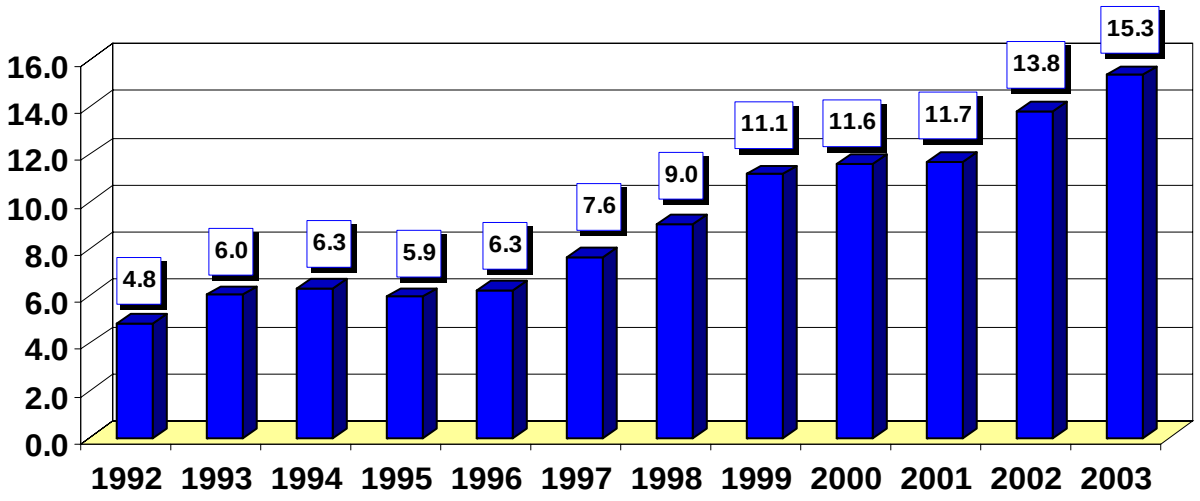


*2003 Projected

The Long Term Care Industry is Incurring More Claims Per Bed Every Year

The annual number of GL/PL claims per 1,000 beds in this country has been increasing over the last twelve years and currently is more than 3 times higher than the 1992 frequency per bed. Since 1995, the number of claims per bed has been increasing at an annual rate of 13%.

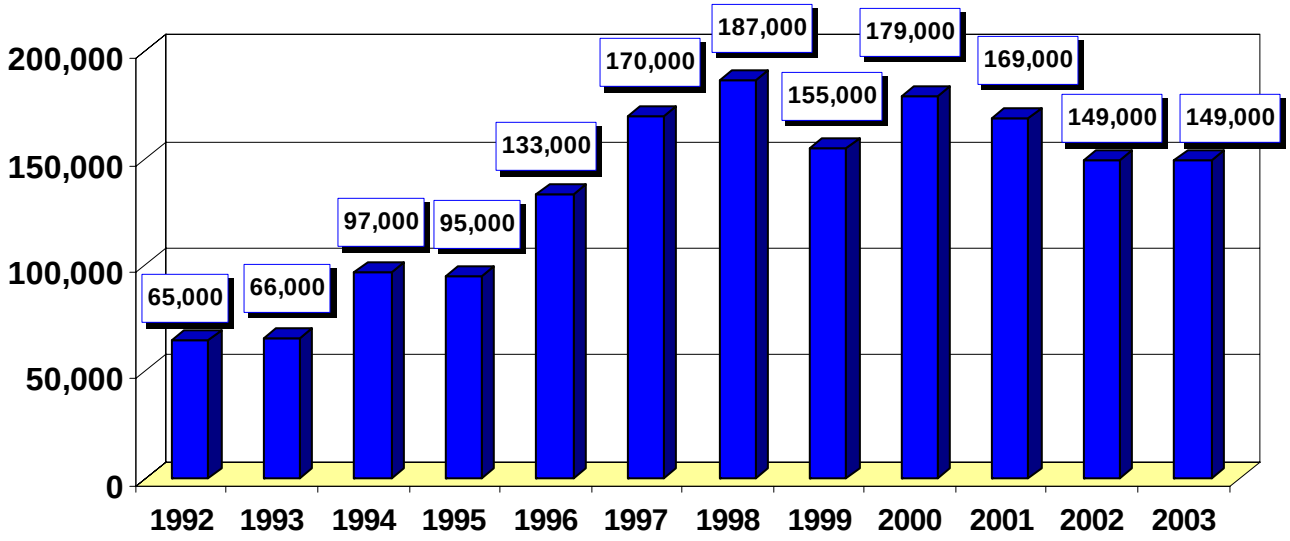
Countrywide Annual Number of Claims per 1,000 Occupied Beds



Larger Jury Verdicts and Claim Settlements are Driving Up the Average Size of Losses

Current average GL/PL claim sizes are more than double the average size at the beginning of the last decade. The majority of this increase occurred from 1992 through 1998. Stabilization in the average severity in the states with the greatest amount of patient care litigation has directly affected the national average trends:

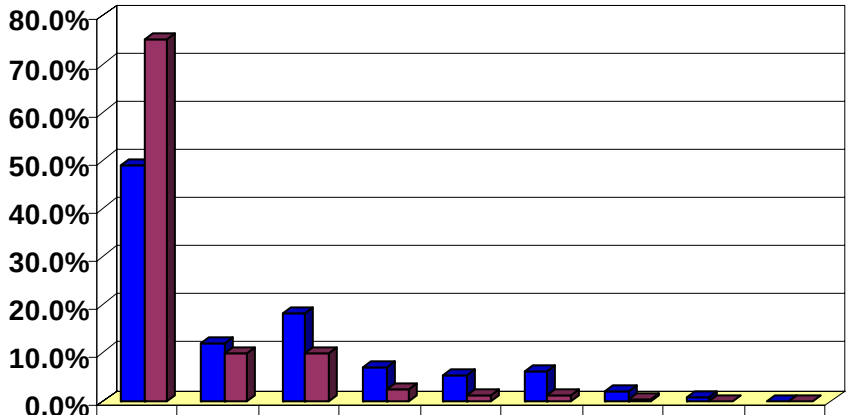
Countrywide Severity per Claim



A key factor affecting average severity is the number of extremely large claims. The distribution of GL/PL losses by size indicates that approximately 42% of the claims reported from 1995 to 2001 are greater than $50,000.

This distribution differs dramatically by state as the following graph demonstrates. For the thirteen states individually reviewed in this report (Alabama, Arizona, Arkansas, California, Florida, Georgia, Kentucky, Mississippi, North Carolina, Ohio, Tennessee, Texas and West Virginia), the percentage of claims greater than $50,000 is 50.9%. This compares to only 24.8% for all other states combined.

Percentage of Claims Reported by Size of Loss

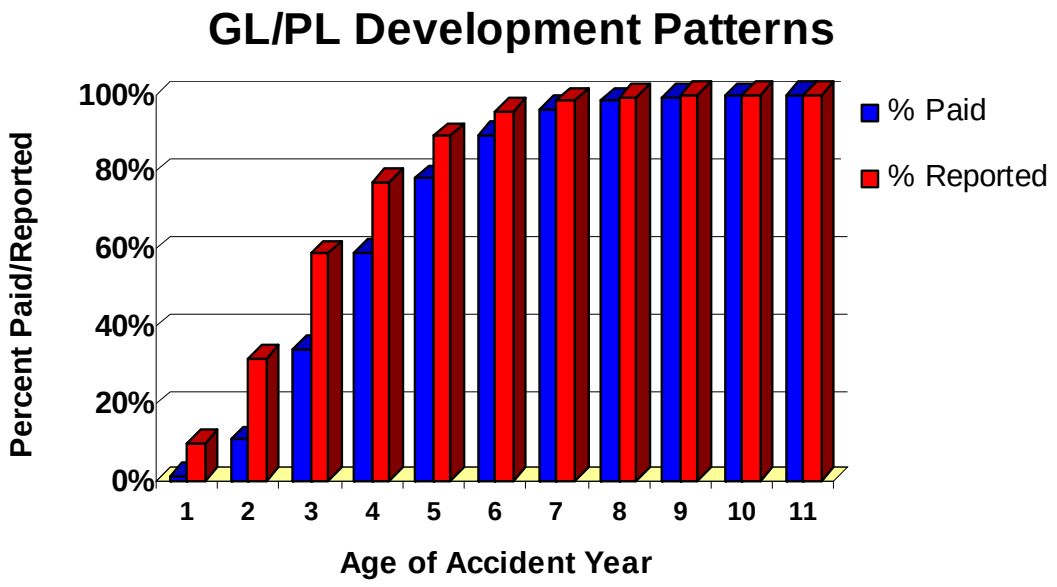


	0 - 50K	50K - 100K	100K - 250K	250K - 350K	350K - 500K	500K - 1M	1M - 2M	2M - 5M	5M & Up
AL, AZ, AR, CA, FL, GA, KY, MS, NC, OH, TN, TX & WV	49.1%	11.9%	18.1%	6.9%	5.2%	6.2%	2.0%	0.5%	0.1%
Remaining States	75.2%	10.0%	10.0%	2.3%	1.3%	1.0%	0.3%	0.1%	0.0%

Including all years (1992 through 2003), a total of 403 claims reported in our survey are greater than or equal to $1 million. Of these, 15 claims are in excess of $5 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 significantly.

GL/PL Loss Development Extends Eleven Years

For the long term care industry, it takes approximately ten years before all claim cost estimates related to incidents from a particular period of time are reported. 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:

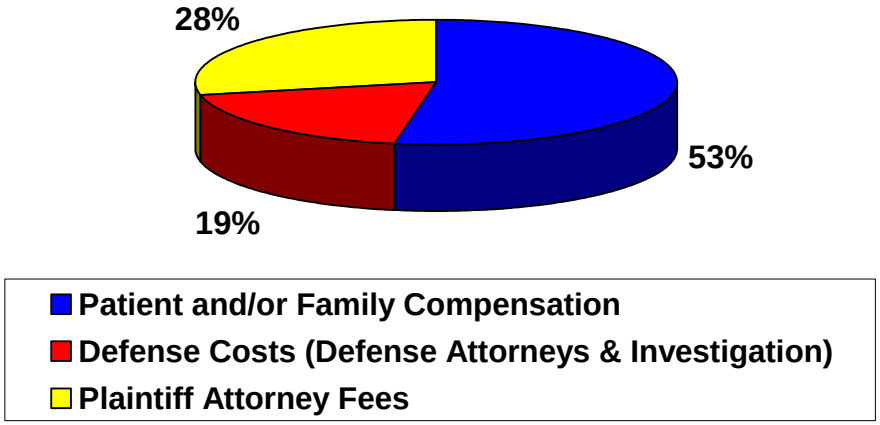


Almost Half of the Total Claim Dollars are Litigation Costs

It is estimated that 47% of the total amount of claim costs paid for GL/PL claims of the long term care industry are covering litigation costs. Based on the database of claims used in this study, 19% of total losses are allocated loss adjustment expenses, which represent defense costs such as investigation and attorney fees. The remaining 81% 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 28%. Consequently, 47%, or almost half, of total long term care industry GL/PL losses are litigation costs.

* 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.

Distribution of Compensation



The Impact of Patient Rights Laws

Depending on individual state 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. Based upon a review of the patient protection laws applicable to long term care residents in each of the 50 states, we find the following:

The two states with notably high per bed loss costs both have had strong patient rights statutes for a significant portion of the period under review in this study. Florida's Patient's Bill of Rights (Statute 400.002), which applied to Florida resident care liability claims up until May 15, 2001, guaranteed the patient's right to be informed, provided adequate care, and treated with dignity, among many other rights. The violation remedies provided under this statute include actual damages, punitive damages and attorney's fees.

Texas' Patients' Bill of Rights (Chapter 247 of the Texas Health and Safety Code)

itemizes 14 rights including, "the right to … a safe and decent living environment and considerate and respectful care that recognizes the dignity and individuality of the resident." While the Texas statute does not specifically provide for punitive damages as a remedy for violations, cases involving injury to the elderly were specifically exempt from the 1995 Texas tort reform punitive damage cap. (This exemption was repealed when Texas passed significant healthcare tort reform effective September 1, 2003.)

In addition to Florida and Texas, several other states we have identified as having higher than average loss cost trends have patients' bill of rights statutes specific to the long term care industry. These include Arkansas and California.

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, neither Alabama nor Mississippi currently has a long term care specific patients' rights statute.

The Impact of Tort Reform Laws

Several state legislatures have recently passed tort reform to address the rising cost of patient care liability and medical malpractice claims. The impact of these reforms will be dependent upon the specific provisions of each and can only be fully measured once the applicable statute's effect has worked its way through an entire year of reported claims from incident date to the closure of all claims, whether settled or taken to trial. However, there are some early indications that can be gleaned from the post reform reported data or estimated based on how specific provisions would have affected past claims.

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 appears that the bills have had little to no 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, most likely 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 and 2003 appear to be higher than the average level of the three years leading up to the tort reform. The impact of Senate bills 1200 and 1202 on claim severity is inconclusive at this time. The average severity of Florida GL/PL claims appears to have peaked in 1998 (three years before tort reform) and has been steadily decreasing at about 2% a year since then. While the decrease has continued post reform, 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 importantly, the Florida tort reform did not provide any caps on non-economic damages, which actuarially are the most effective tort reform policy provision for reducing long term care patient care liability claim severity.

Mississippi

Like Florida, Mississippi passed legislation recently 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. The impact of the tort reform on severity is not yet evident, due to the fact that the law has only been in effect a year and most post reform claims are still open. However, the $500,000 cap on non-economic damages is expected to have some affect on reducing average severity in years 2003 and later.

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.

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. 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, that amends the Texas Constitution to allow caps on non-economic damages in medical malpractice lawsuits. As has occurred in other states, the passage of this bill had no immediate effect on reducing frequency, and likely is a reason the indicated Texas frequency for years 2001 through 2003 continues to be increasing at an annual rate of close to 20%. However, the impact on severity, while several years from being evident in the data, is expected to be significant due to the strong language defining the provisions for caps on non-economic damages, punitive damages and wrongful death claims.

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 will begin January 1, 2004 with an eventual maximum of $1,000,000. Due to the fact that the current average severity of West Virginia GL/PL claims is below the countrywide average, the impact of these caps is not expected to have a significant effect on reducing severity. However, these provisions should help mitigate future increases in claims severity and average loss cost.

State Specific Long Term Care GL/PL Trends

The countrywide increases in long term care GL/PL costs are the result of an explosion in litigation that started in a handful of states and is spreading to a multitude of regions throughout the country. This increase in litigation is raising the number of claims individual long term care operators are incurring each year. In addition, the average size of each claim is going up in many states across the country at annual increases well ahead of inflation. In many states, the increase in liability costs is largely offsetting annual increases in Medicaid reimbursements.

The following sections highlight the range of litigation activity across the country on a state by state basis for all states for which there were a credible percentage of nursing homes participating from the state. These states include, in order of highest to lowest loss cost, Florida, Arkansas, Texas, Mississippi, Alabama, Tennessee, California, Georgia, Ohio, Kentucky, West Virginia, North Carolina and Arizona. Due to the credibility criterion, it should be recognized that these states do not represent the thirteen 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 due to lack of data.

A review of these thirteen states shows a disturbing pattern that is repeating itself throughout the country. This pattern is a combination of increases in the number of claims and increases in the average claim size. This pattern continues until claim sizes reach an average level of between $200,000 to $300,000. At these levels it appears there is some tapering off of the average claim size. But, the frequency rate keeps trending up, creating no cap to the rising cost per bed.

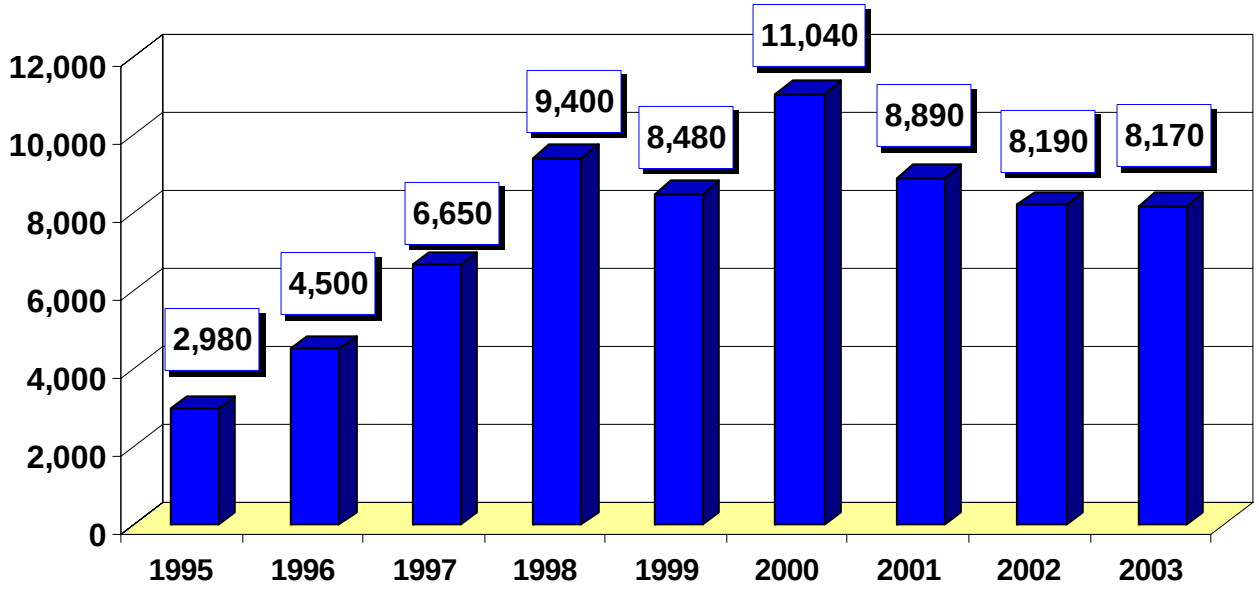
An analysis at the end of this section presents the loss cost trends for all other states combined, which indicates trends well in excess of normal tort liability inflation.

Florida

The participants in this study represent approximately 44,000 licensed beds in the state of Florida. This is approximately 47% of Florida nursing home beds.

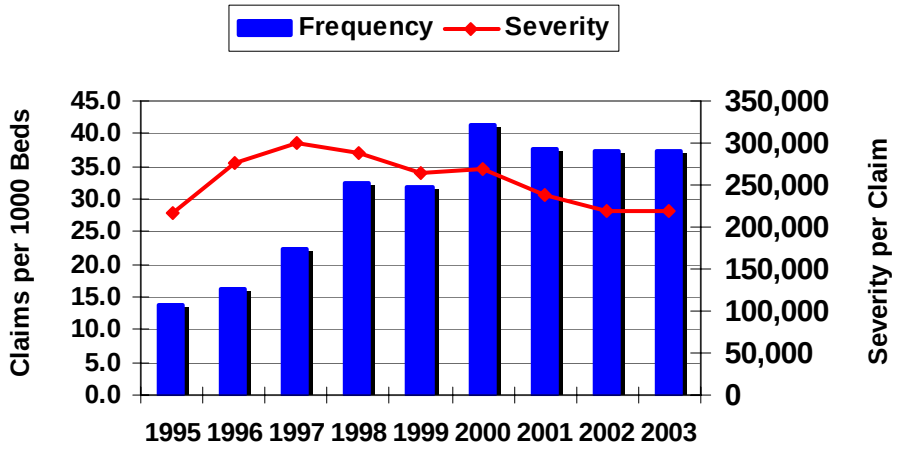
The cost per bed of GL/PL losses is materially higher in Florida than the rest of the United States as the following graph shows:

Florida Loss Cost per Occupied Bed



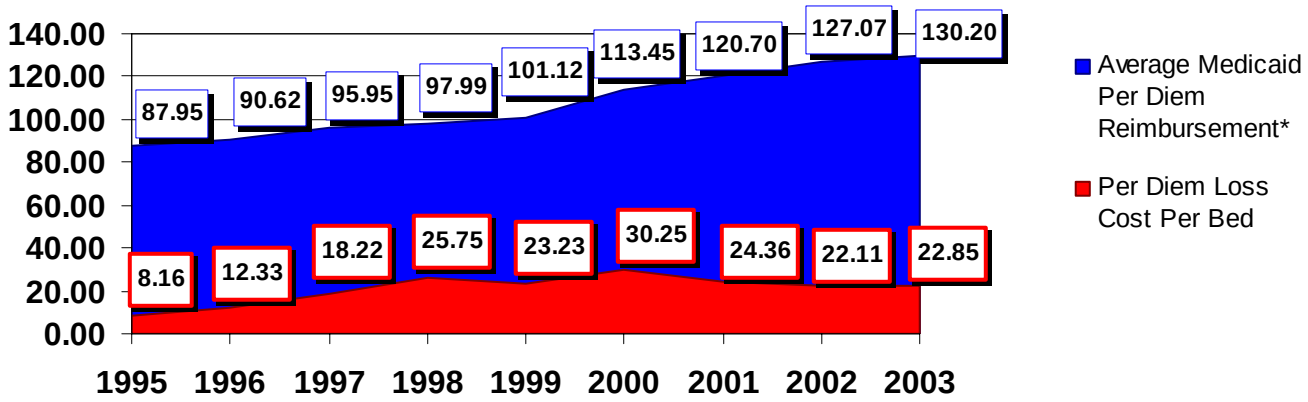
Underlying the loss cost increases are higher than average numbers of claims filed and significantly higher than average sizes of claims. For incidents occurring during 2003, Florida facilities will report approximately 38 claims for every 1,000 occupied beds. The average size of these claims is projected to be $218,000.

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



On a per diem basis, the loss cost is increasing as a percent of Florida Medicaid reimbursements, from 9% in 1995 to 17% in 2003 as shown in the graph below.

Florida Per Diem Loss Cost Versus Medicaid Reimbursement



*2003 Projected

A strong patient rights statute was in effect from the late 1980's until May 15, 2001. Effective with claims that occur on or after May 15, 2001, Florida resident's rights claims fall exclusively under recently enacted Senate bills 1200 and 1202. Based on our

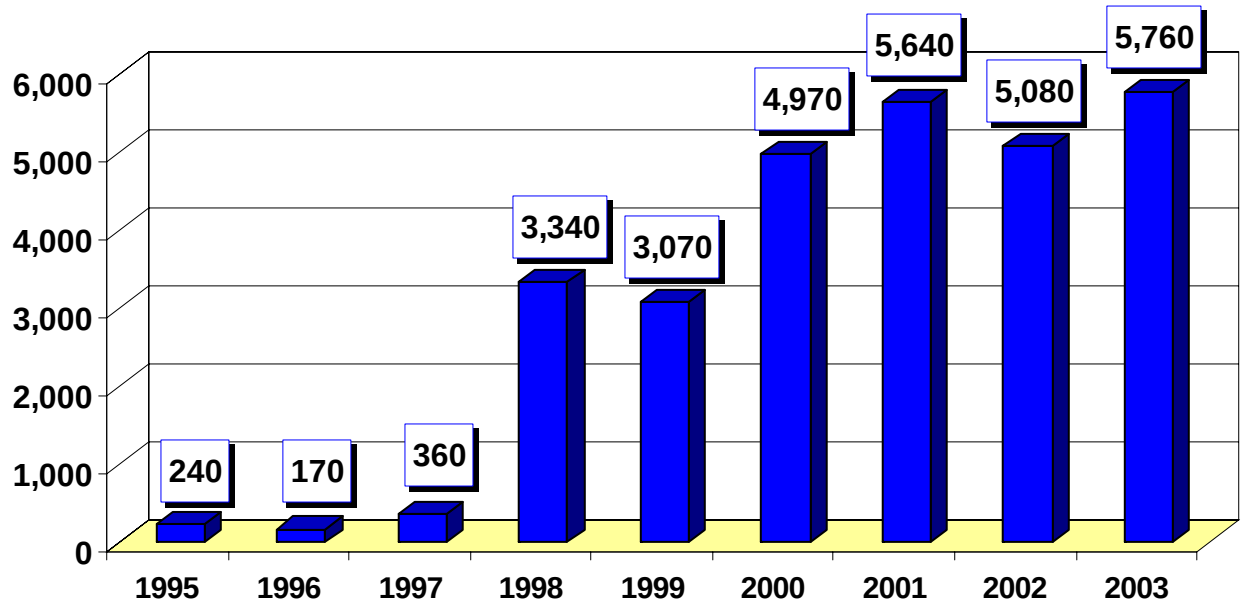
current study it appears that the bills have had no effect on reducing claim frequency in Florida. First of all, an increase in Florida claim frequency for incidents occurring prior to May 15, 2001 is evident, possibly triggered by the October 4, 2001 cut-off for filing claims under the old Statute 400 punitive damage provisions. Secondly, the frequency levels for 2002 and 2003 appear to be higher than the average level of the three years leading up to the tort reform. The impact of Senate bills 1200 and 1202 on claim severity is inconclusive at this time. The average severity of Florida GL/PL claims appears to have peaked in 1998 (three years before tort reform) and has been steadily decreasing at about 2% a year since then. While the decrease has continued post reform, 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 importantly, the Florida tort reform did not provide any caps on non-economic damages, which actuarially are the most effective tort reform policy provision for reducing long term care patient care liability claim severity.

Arkansas

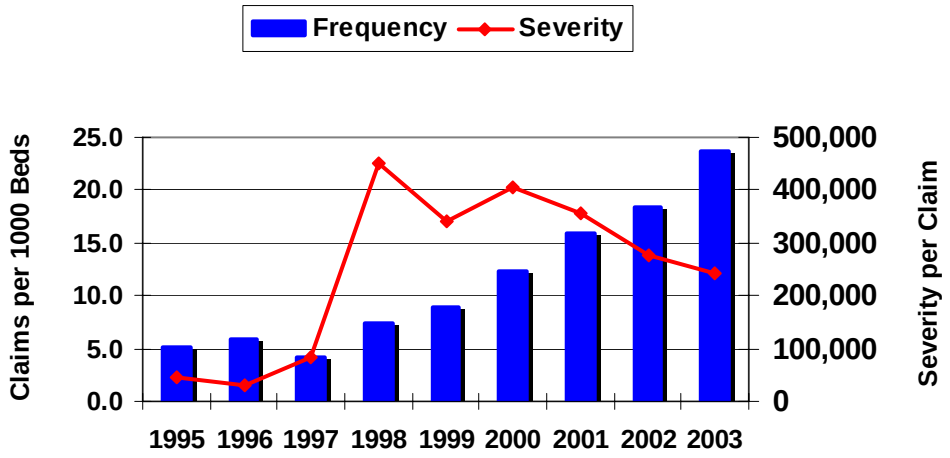
The participants in this study represent approximately 6,100 licensed beds in the state of Arkansas. This is approximately 20% of Arkansas nursing home beds.

Arkansas GL/PL costs are the second highest in the country due to significant increases in the last six years. Prior to 1998 Arkansas long term care providers incurred an average GL/PL cost per bed of around $120 - $360. In 1998 the number of claims incurred started increasing dramatically over prior years and several resulted in multi-million dollar payments. Since 1998 the number of claims has continued to climb and the average size is expected to continue at post 1998 levels. Of particular concern is that Arkansas appears to have the highest average severity in the country, with average per claim costs in the $250,000 to $450,000 range.

Arkansas Loss Cost per Occupied Bed

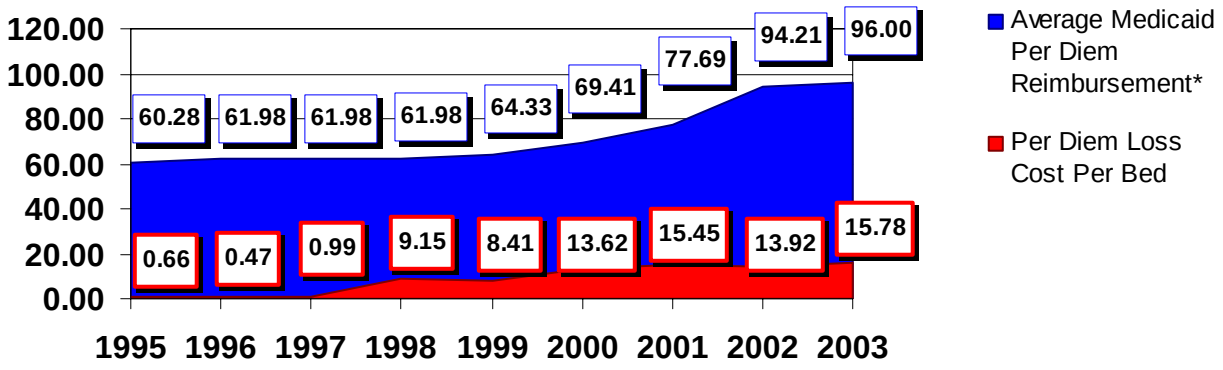


Arkansas Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Arkansas Medicaid reimbursements, from 1% in 1995 to 16% in 2003 as shown in the graph below.

Arkansas Per Diem Loss Cost Versus Medicaid Reimbursement

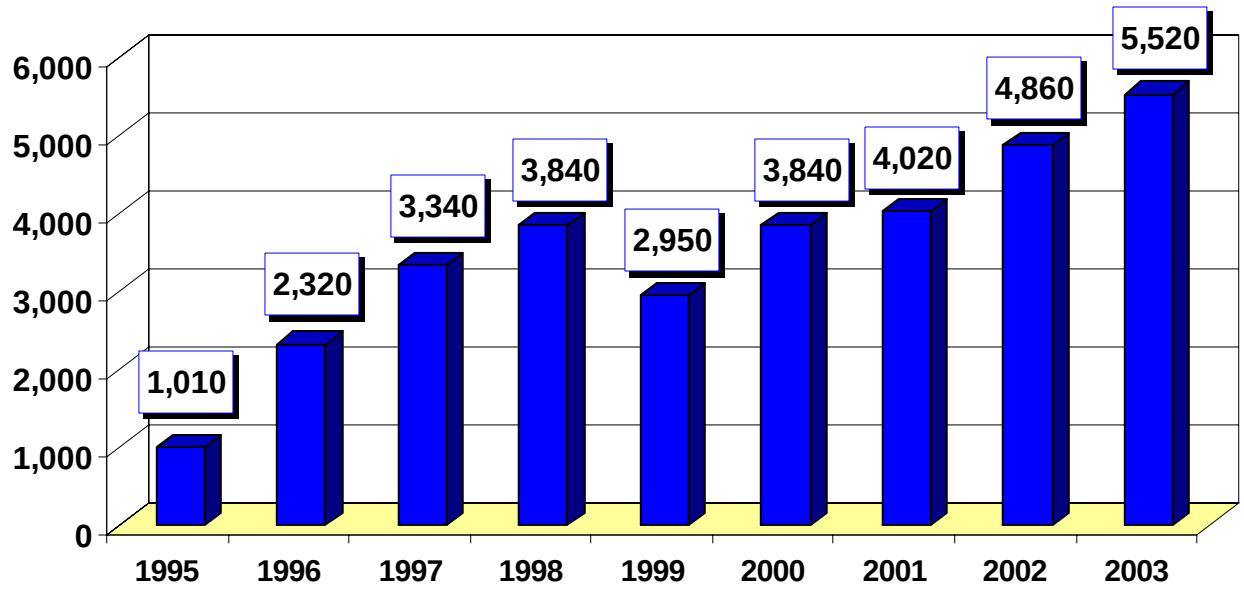


*2003 Projected

Texas

The participants in this study represent approximately 29,000 licensed beds in the state of Texas. This is approximately 21% of Texas nursing home beds.

Texas GL/PL loss costs are the third highest in the country. The Texas average cost per bed has increased from $1,010 in 1995 to $5,520 in 2003 as the following graph shows:

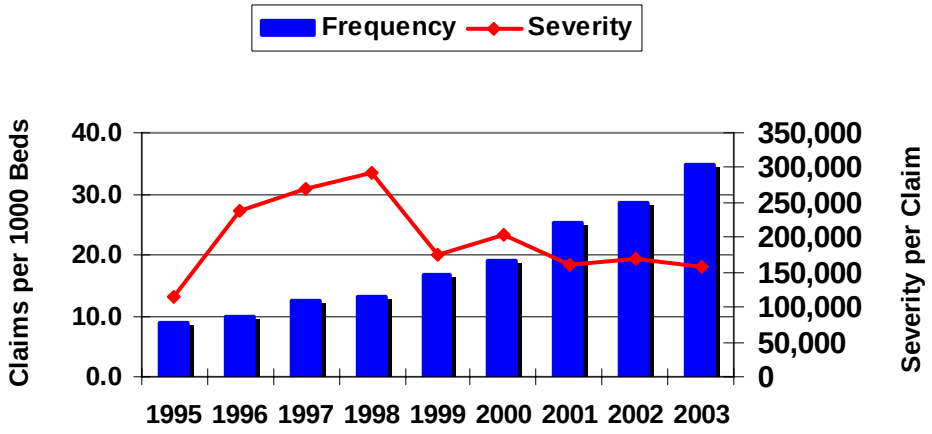


Like Florida, an increase in the number of claims per bed per year is a driving force behind the Texas loss cost increases. The number of claims Texas long term care providers incur per year has shot up to 35 per 1,000 occupied beds. The average size of claims in Texas, however, has been trending downward at approximately 2% since 1995, and noticeably reduced from a high of close to $300,000 in 1998.

Recent tort reform in Texas is likely to have an impact on future trends. 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

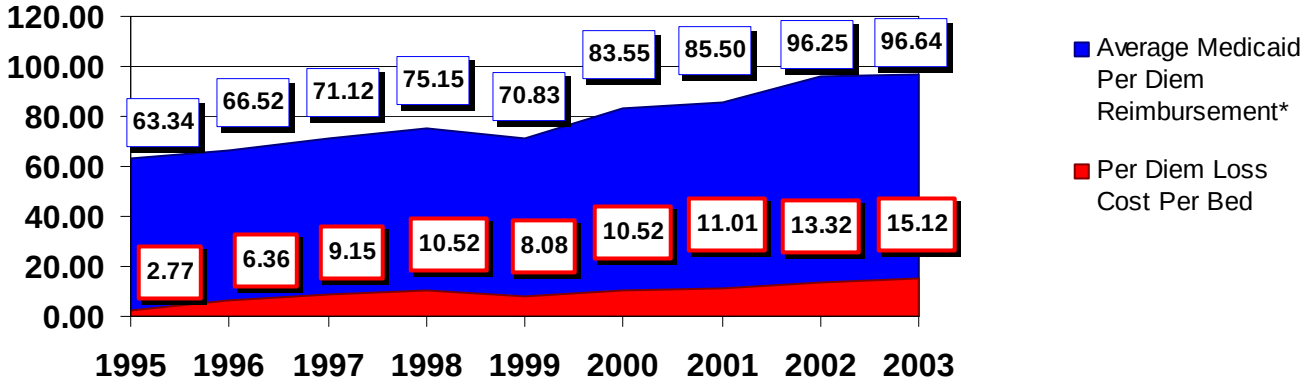
imposes a $250,000 cap on non-economic damages for any single healthcare institution sued. This bill also provides a total limit on all damages in a wrongful death claim of approximately $1.4 million ($500,000 indexed for inflation since 1977). Further strengthening the Texas reform was the passage in September 2003 of a Texas medical malpractice ballot initiative, called Proposition 12, that amends the Texas Constitution to allow caps on non-economic damages in medical malpractice lawsuits. As has occurred in other states, the passage of this bill had no immediate effect on reducing frequency, and likely is a reason the indicated Texas frequency for years 2001 through 2003 continues to be increasing at an annual rate of close to 20%. However, the impact on severity, while several years from being evident in the data, is 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 loss cost is increasing as a percent of Texas Medicaid reimbursements, from 4% in 1995 to 16% in 2003 as shown in the graph below.

Texas Per Diem Loss Cost Versus Medicaid Reimbursement



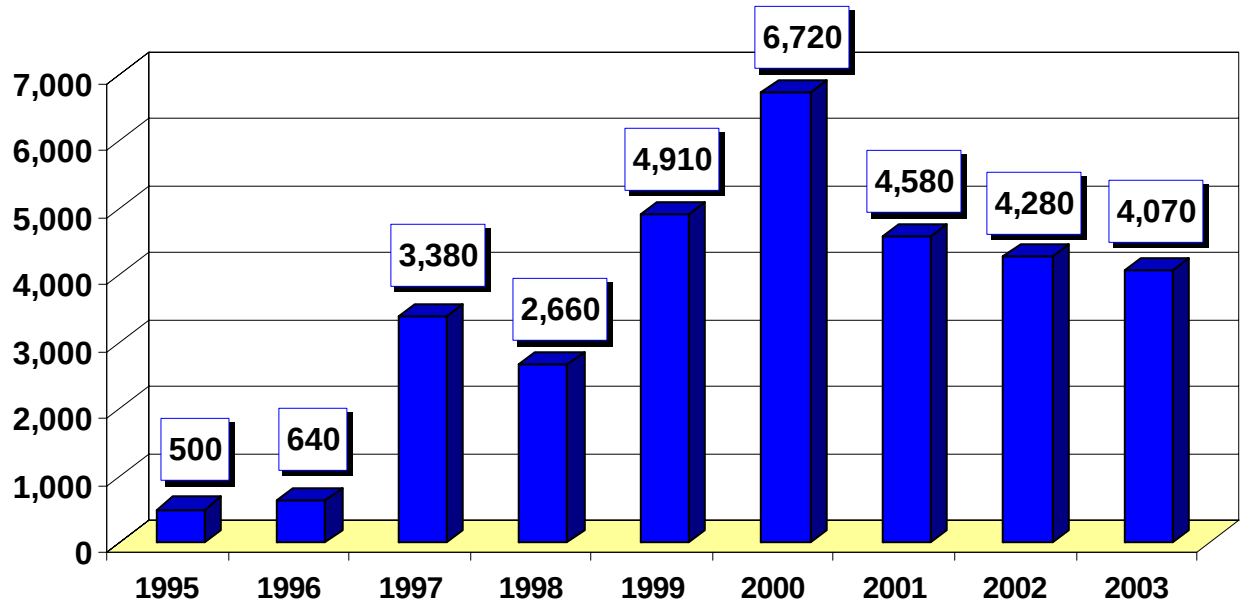
*2003 Projected

Mississippi

The participants in this study represent approximately 9,200 licensed beds in the state of Mississippi. This is approximately 50% of Mississippi nursing home beds.

While currently the fourth highest state in the country, Mississippi loss costs have recently shown some stabilization. Prior to 1997, Mississippi long term care providers incurred an average GL/PL cost per bed of around $400 - $600. But costs jumped up to $3,400 in 1997, peaked at $6,720 in 2000 and are now just over $4,000 per bed for 2003 occurrences.

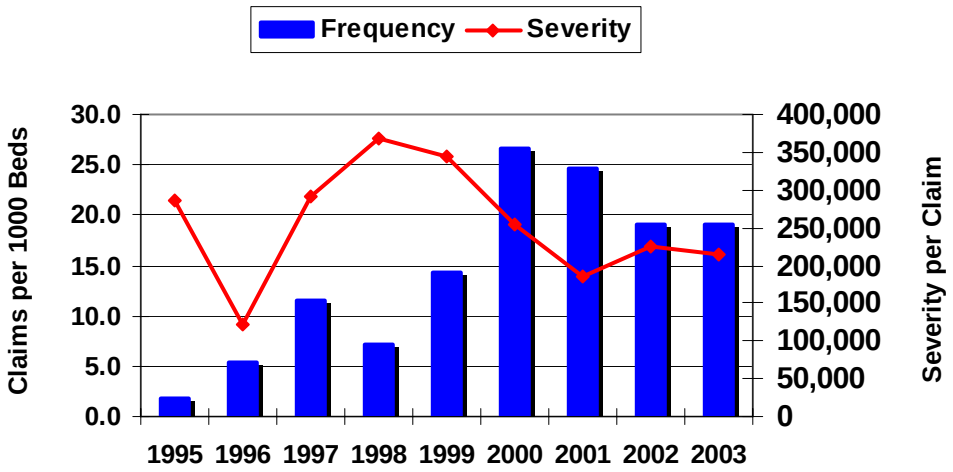
Mississippi Loss Cost per Occupied Bed



Fueling the rise in Mississippi loss costs is a huge spike in the frequency rate between 1995 and 2000 from 2 claims per 1,000 beds to 27 claims per 1,000 beds. Mississippi severity during this period also peaked at approximately $380,000 per claim and seems to be leveling off at approximately $215,000 per claim in 2003.

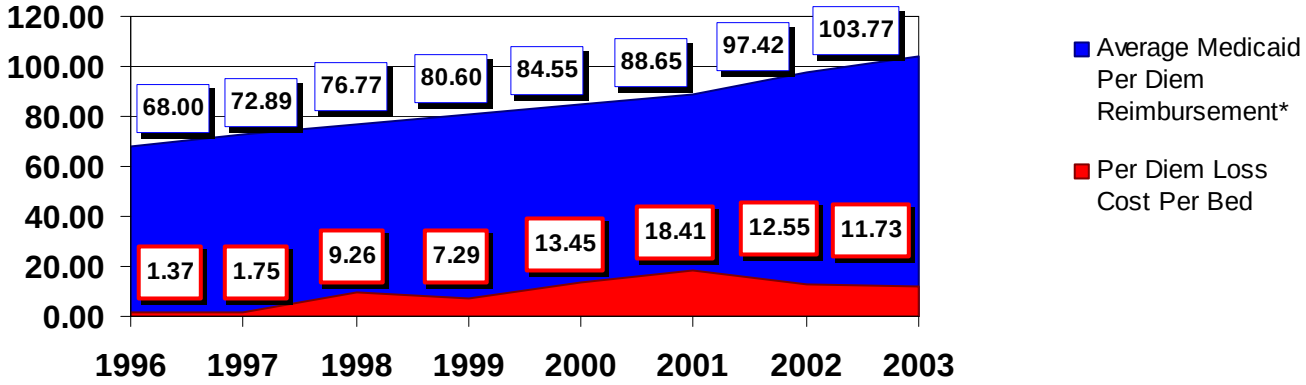
Like Florida, Mississippi passed legislation recently with the intent of curbing the rising cost of patient care liability claims. House Bill No. 2 became effective January 1, 2003 and included revisions to the Mississippi medical malpractice code that, among other things, brought long term care providers 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. The impact of the tort reform on severity is not yet evident, due to the fact that the law has only been in effect a year and most post reform claims are still open. However, the $500,000 cap on non-economic damages is expected to have some affect on reducing average severity in years 2003 and later.

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



On a per diem basis, the loss cost is increasing as a percent of Mississippi Medicaid reimbursements, from 2% in 1996 to 11% in 2003 as shown in the graph below.

Mississippi Per Diem Loss Cost Versus Medicaid Reimbursement



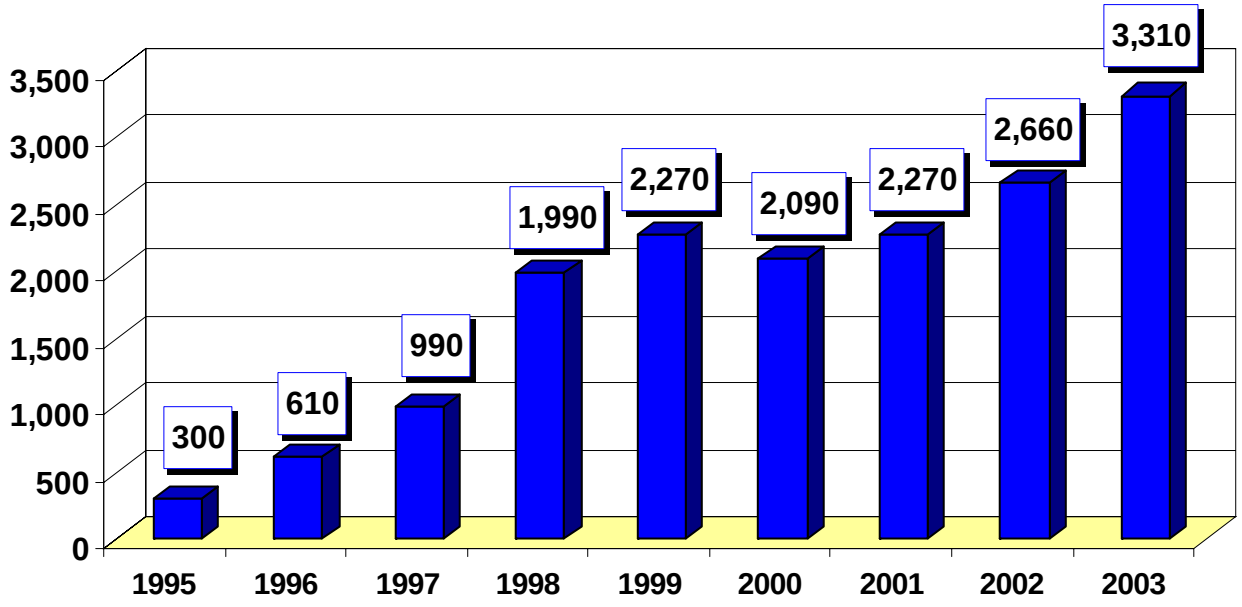
*2003 Projected

Alabama

The participants in this study represent approximately 19,700 licensed beds in the state of Alabama. This is approximately 72% of Alabama nursing home beds.

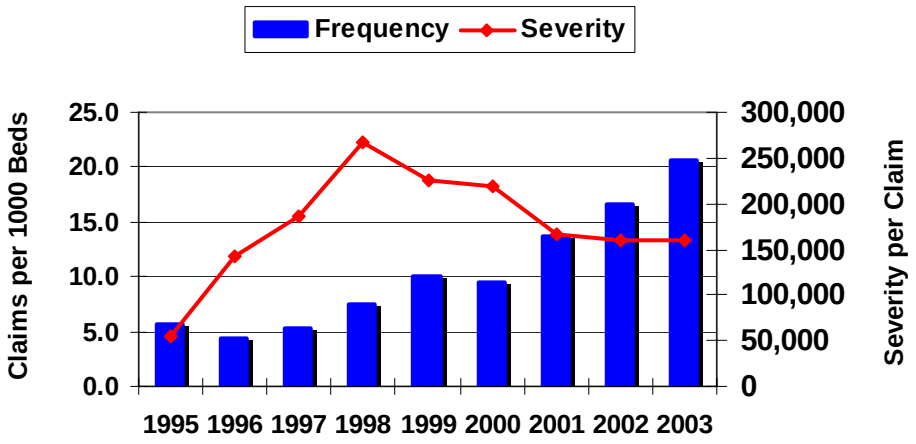
Like Arkansas, Alabama loss costs took a dramatic increase in 1998, although the increasing trends started a few years earlier. Alabama loss costs have steadily increased from $300 per bed in 1995 to an estimated $3,310 in 2003, resulting in an average annual increase of 29% per year.

Alabama Loss Cost per Occupied Bed



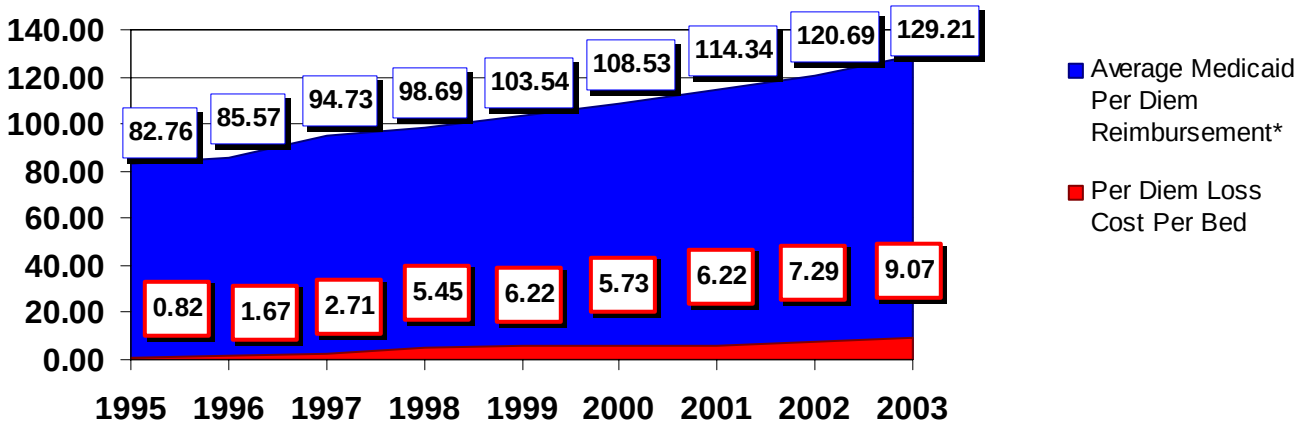
Frequency, while steadily increasing at an annual increase of 22% a year, is not yet as high as Florida, Arkansas or Texas. However, the average size of a PL/GL claim in Alabama is comparable to Texas, having increased dramatically between 1995 and 1998.

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



On a per diem basis, the loss cost is increasing as a percent of Alabama Medicaid reimbursements, from 1% in 1995 to 7% in 2003 as shown in the graph below.

Alabama Per Diem Loss Cost Versus Medicaid Reimbursement

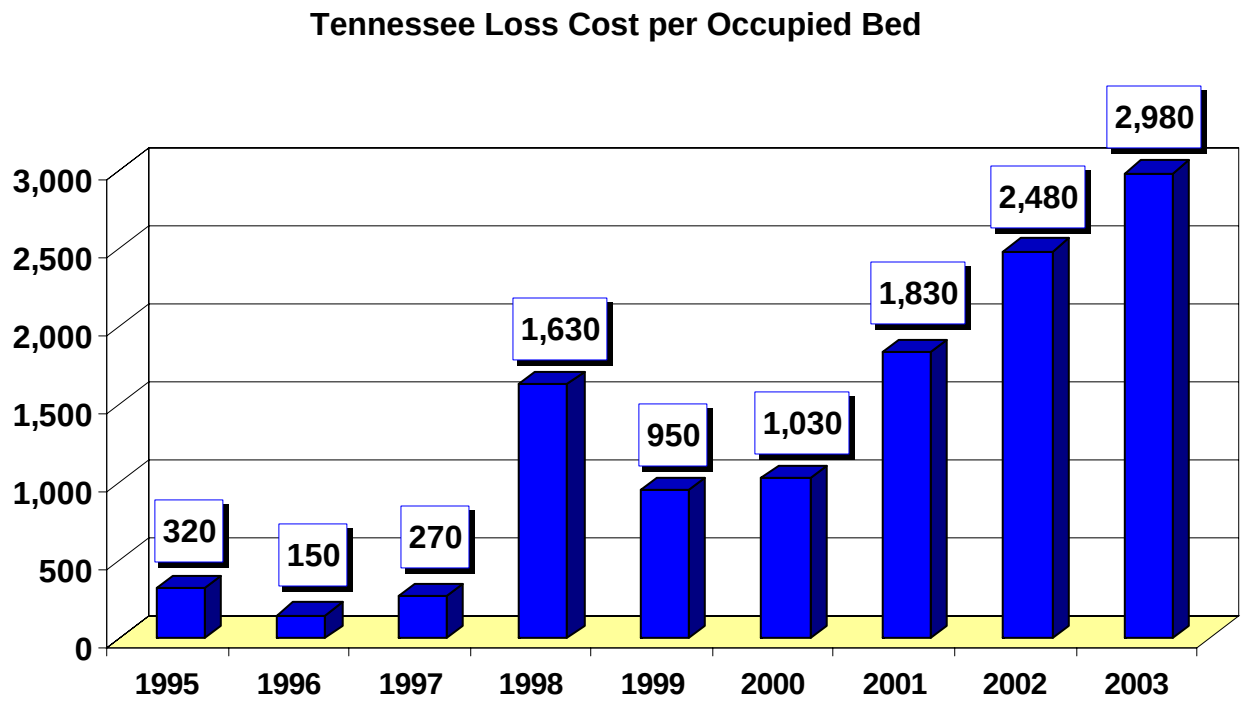


*2003 Projected

Tennessee

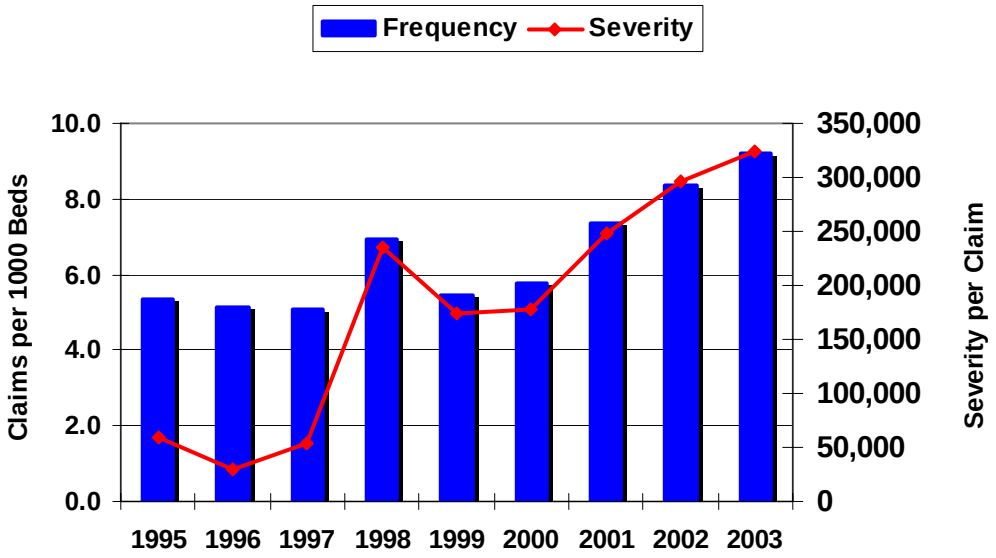
The participants in this study represent approximately 11,500 licensed beds in the state of Tennessee. This is approximately 29% of Tennessee nursing home beds.

Tennessee loss costs also took a dramatic increase in 1998. The Tennessee average cost per bed has increased from $320 per bed in 1995 to an estimated $2,980 in 2003 as the following graph shows:



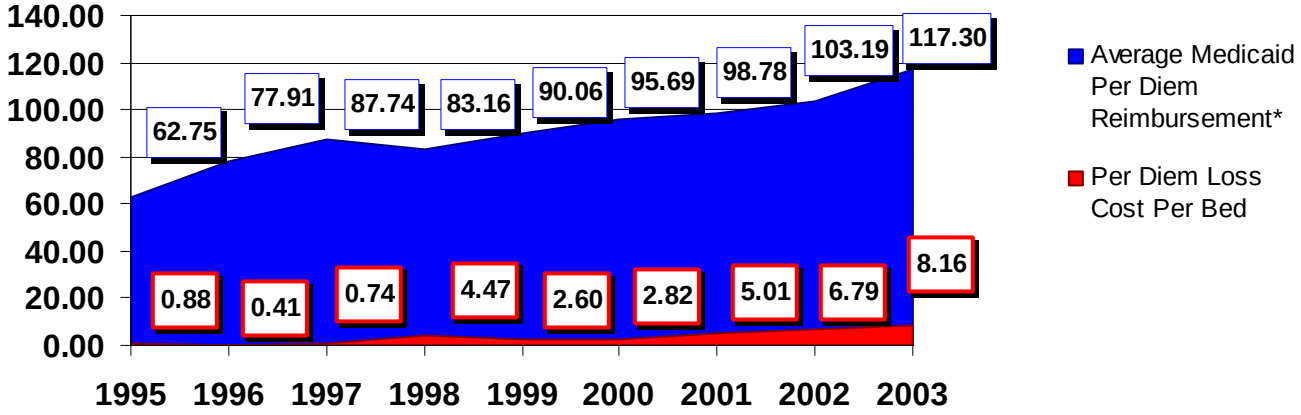
Like Florida and Texas, an increase in the number of claims per bed per year is contributing toward the Tennessee loss cost increase. The number of claims has increased from 5 claims per 1,000 occupied beds in 1995 to 9 in 2003. However, the average size of a PL/GL claim in Tennessee dramatically increased in 1998 to approximately $235,000 from an approximate average size of $50,000 in prior years. Unlike other states, where severity seems to be leveling off, the Tennessee average severity is increasing 32% a year and is projected to reach $325,000 for claims occurring in 2003.

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



On a per diem basis, the loss cost is increasing as a percent of Tennessee Medicaid reimbursements, from 1% in 1995 to 7% in 2003 as shown in the graph below.

Tennessee Per Diem Loss Cost Versus Medicaid Reimbursement



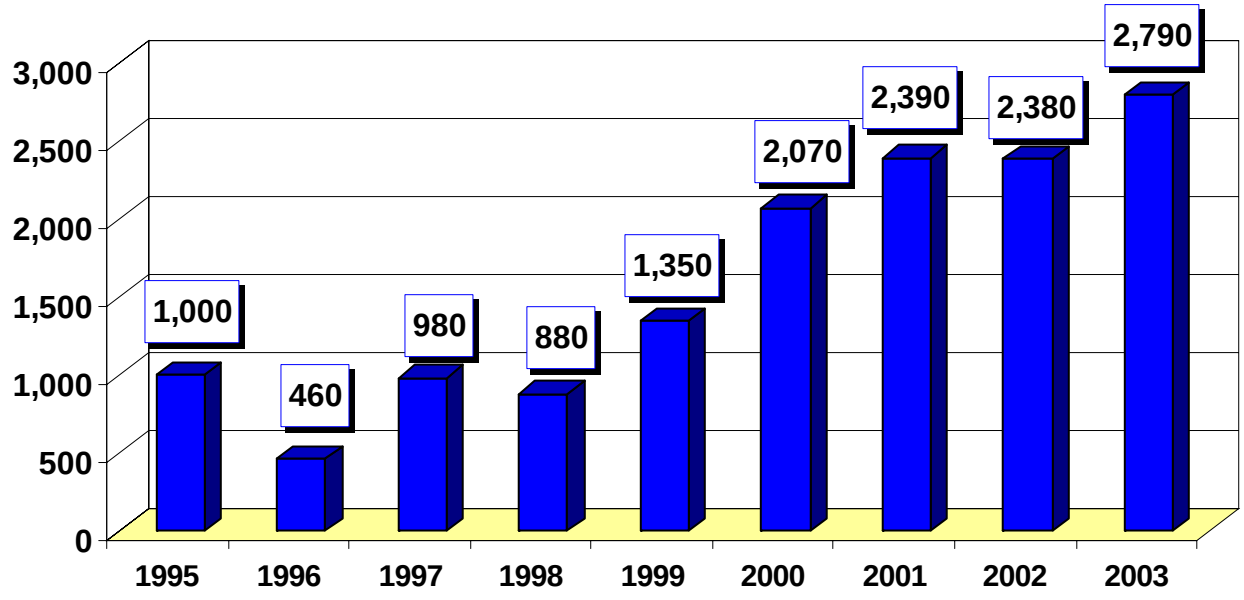
*2003 Projected

California

The participants in this study represent approximately 30,000 licensed beds in the state of California. This is approximately 21% of California nursing home beds.

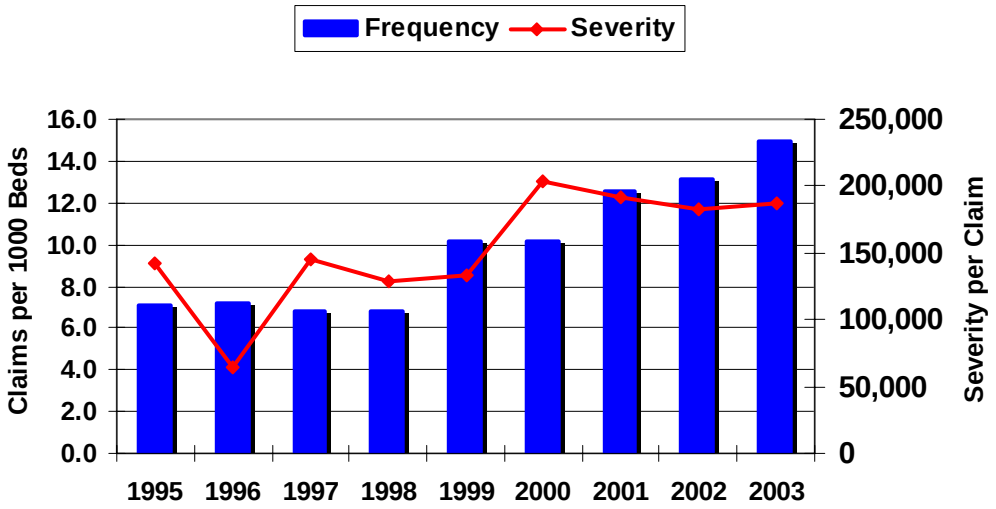
Similar to many of the southern states presented above, California loss costs in the early part of the last decade hovered in the $100 to $300 range per bed. In 1994 the number of claims per bed started creeping up and in 1995 the average size of California patient liability claims jumped dramatically. Since 1995 California claims costs have increased on average 29% a year. Loss costs are now projected to be $2,790.

California Loss Cost per Occupied Bed



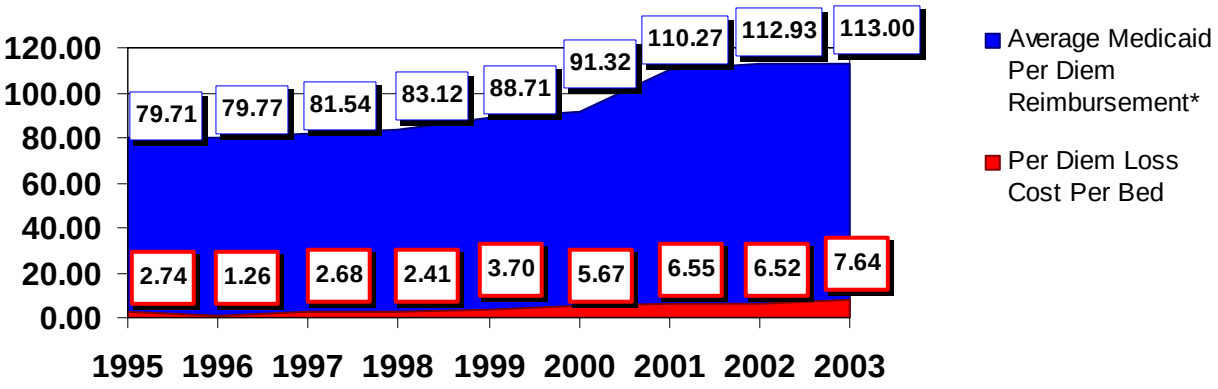
In California, while frequency continues to increase at an average rate of 13% a year, severity appears to be leveling off in recent years at a level just under $200,000.

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



On a per diem basis, the loss cost is increasing as a percent of California Medicaid reimbursements, from 3% in 1995 to 7% in 2003 as shown in the graph below.

California Per Diem Loss Cost Versus Medicaid Reimbursement



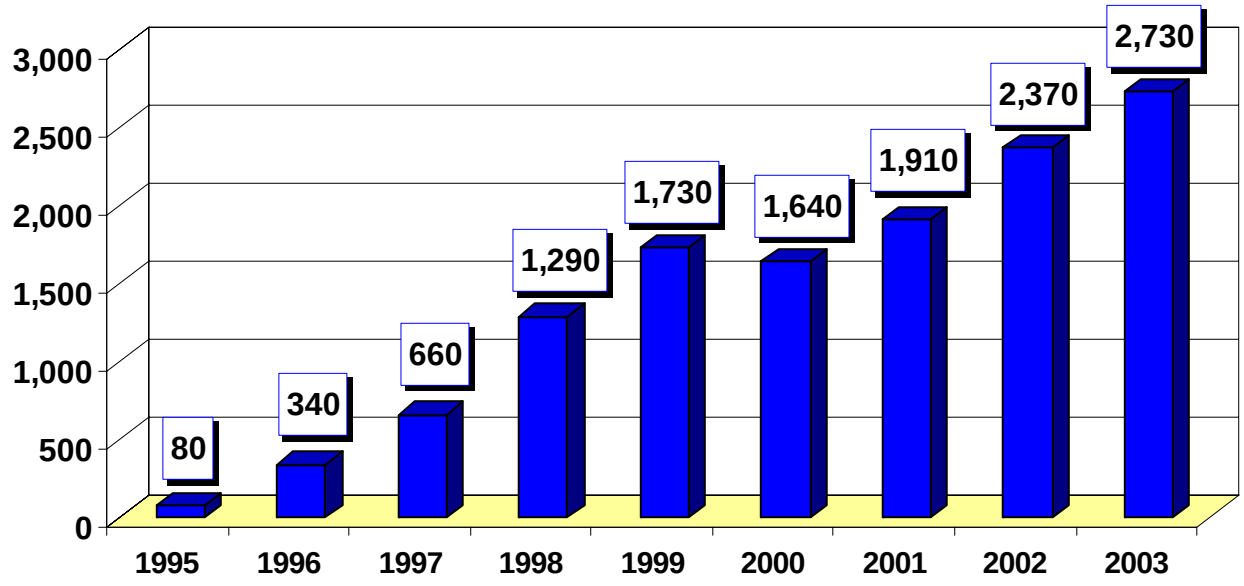
*2003 Projected

Georgia

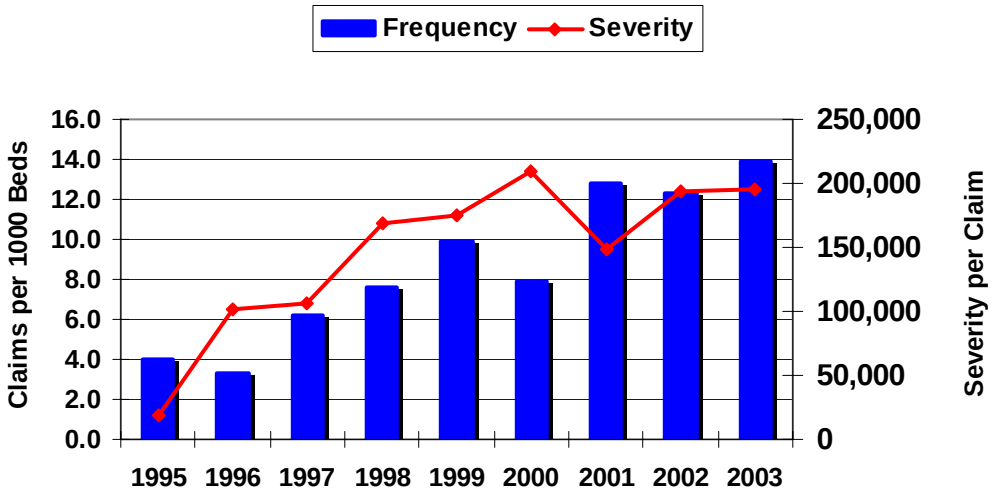
The participants in this study represent approximately 10,700 licensed beds in the state of Georgia. This is approximately 26% of Georgia nursing home beds.

Georgia loss costs have increased dramatically in the last five years from $80 in 1995 to $2,730 in 2003 at an annual trend rate of approximately 46%. Fueling the rise in Georgia loss costs is the dramatic increase in the frequency rate between 1995 and 2003 from 4 claims to 14 claims per 1,000 beds. The average claim severity in the same period has also grown from $20,000 to almost $200,000.

Georgia Loss Cost per Occupied Bed

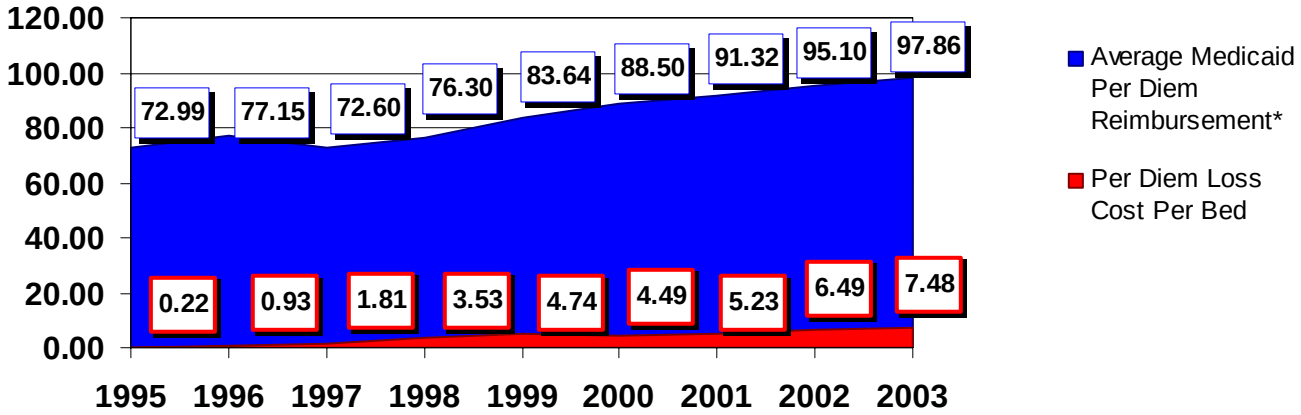


Georgia Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Georgia Medicaid reimbursements, from 0.3% in 1995 to 8% in 2003 as shown in the graph below.

Georgia Per Diem Loss Cost Versus Medicaid Reimbursement



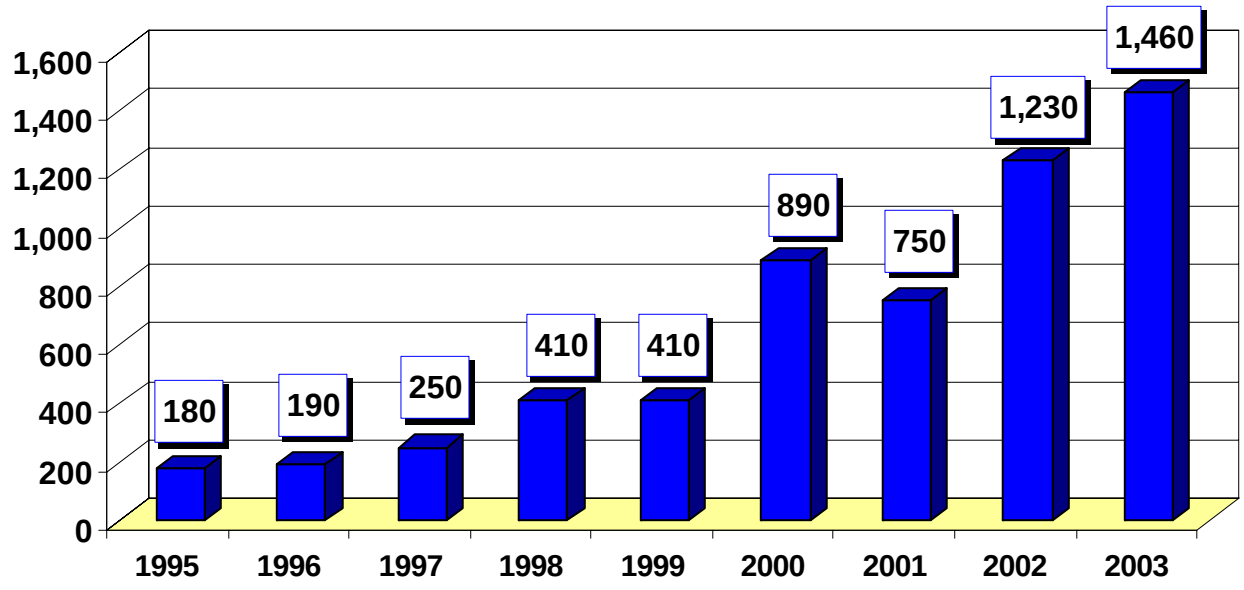
*2003 Projected

Ohio

The participants in this study represent approximately 26,000 licensed beds in the state of Ohio. This is approximately 20% of Ohio nursing home beds.

Prior to 2000, Ohio long term care providers incurred an average GL/PL cost per bed of around $100 - $400. But costs started climbing in 2000 and are projected to reach almost $1,500 per bed for 2003 occurrences. While frequency rates have been increasing, the noteworthy increase has been in severity. The average claim size has steadily grown from approximately $50,000 in 1995 to a projected $192,000 in 2003.

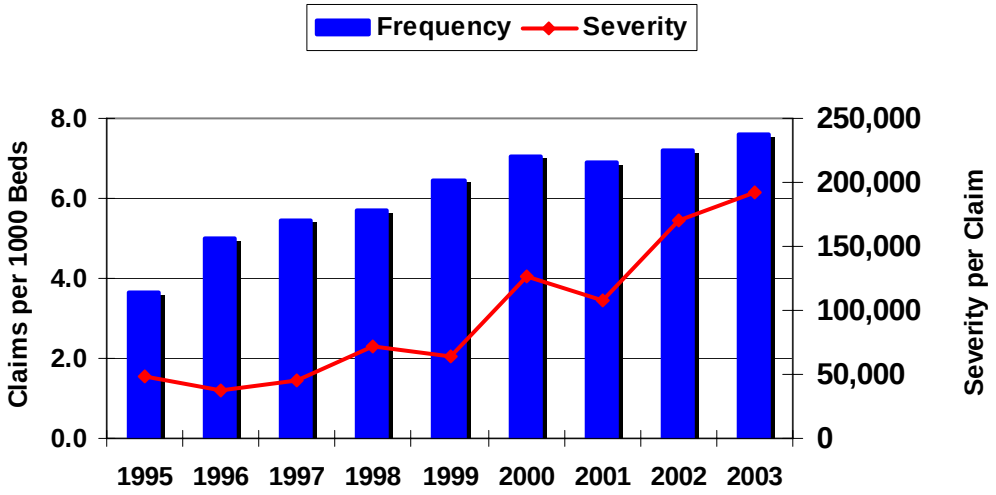
Ohio Loss Cost per Occupied Bed



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

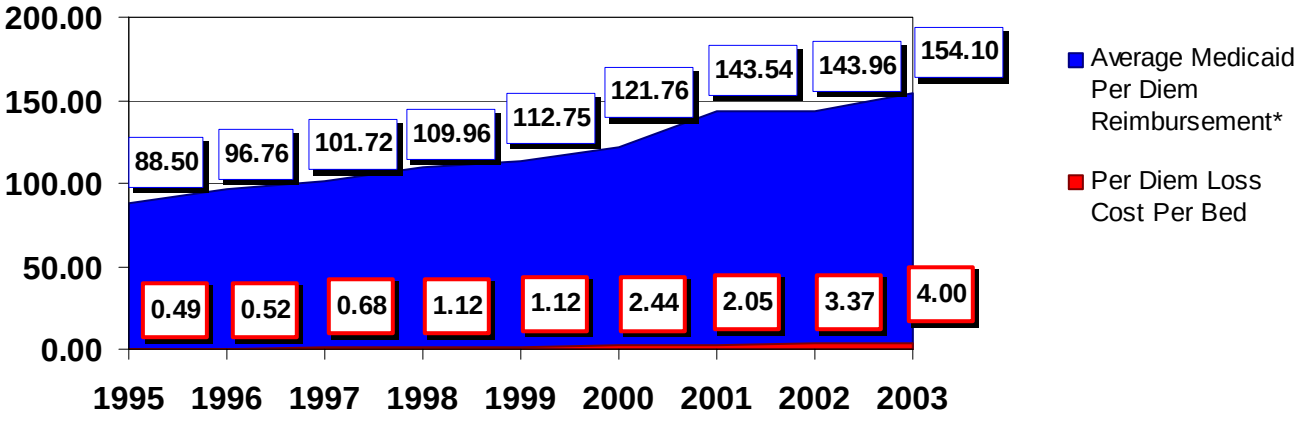
function, and permanent physical functional injury limiting activities of daily living. In the case of exceptions, the caps increase to $500,000 per plaintiff or $1,000,000 per occurrence.

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



On a per diem basis, the loss cost is increasing as a percent of Ohio Medicaid reimbursements, from 1% in 1995 to 3% in 2003 as shown in the graph below.

Ohio Per Diem Loss Cost Versus Medicaid Reimbursement



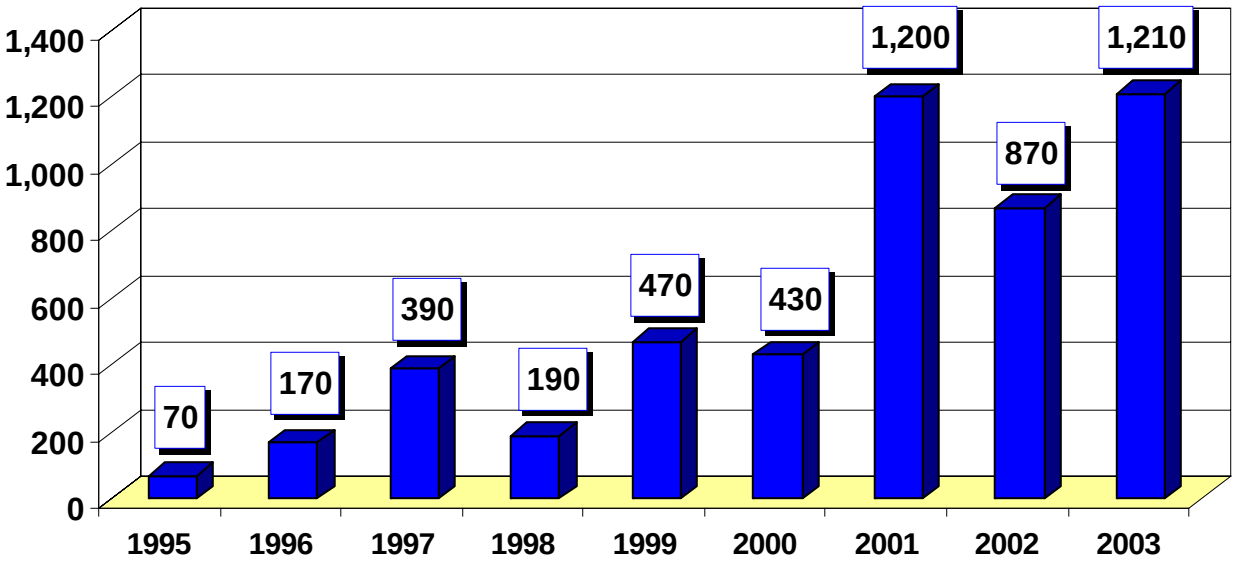
*2003 Projected

Kentucky

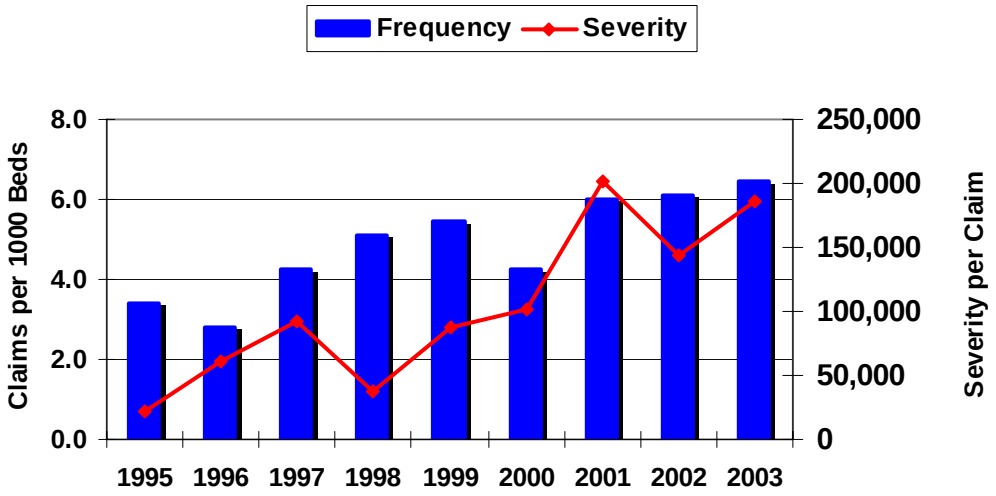
The participants in this study represent approximately 8,100 licensed beds in the state of Kentucky. This is approximately 31% of Kentucky nursing home beds.

Like Ohio, Kentucky seems to be a more recent victim to the increased trends we have seen countrywide. Prior to 2001, Kentucky long term care providers incurred an average GL/PL cost per bed of around $50 - $400. But costs started climbing in 2001 and are projected to reach $1,210 per bed for 2003 occurrences. While frequency rates have been increasing, the noteworthy increase has been in severity. The average claim size has steadily grown at an annual trend rate of 25% from approximately $22,000 in 1995 to a projected $186,000 in 2003.

Kentucky Loss Cost per Occupied Bed

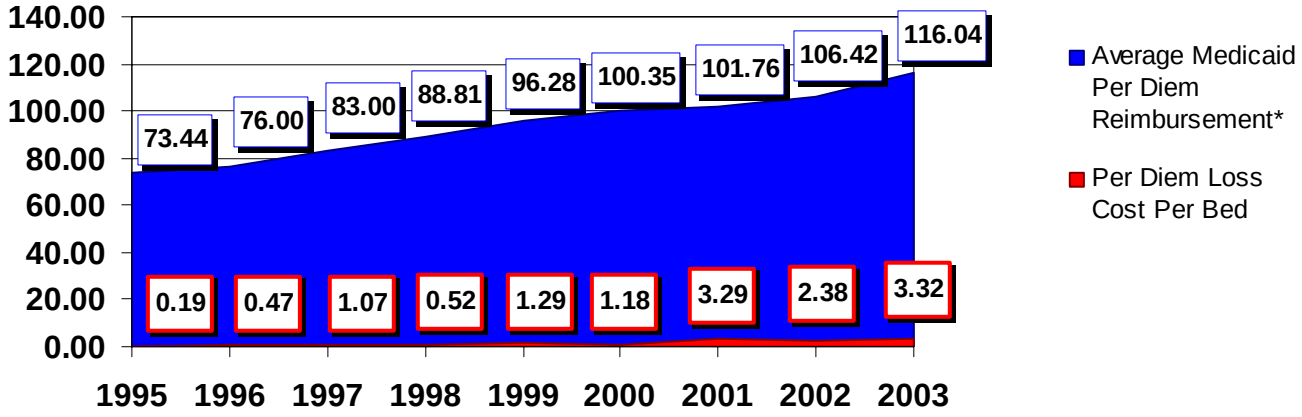


Kentucky Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of Kentucky Medicaid reimbursements, from 0.3% in 1995 to 3% in 2003 as shown in the graph below.

Kentucky Per Diem Loss Cost Versus Medicaid Reimbursement



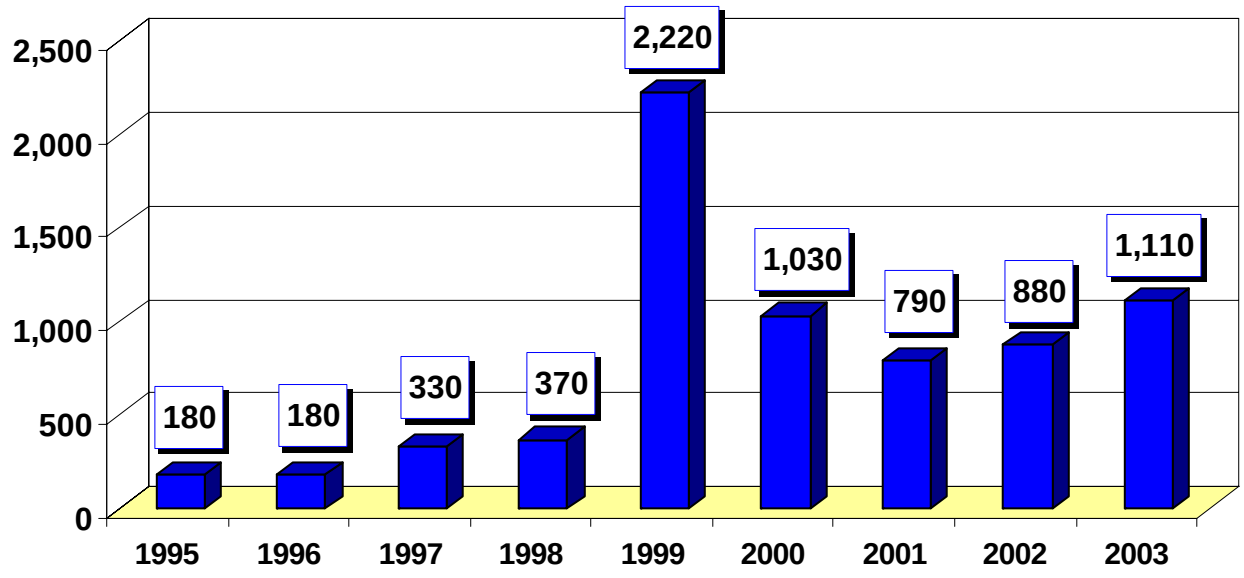
*2003 Projected

West Virginia

The participants in this study represent approximately 5,300 licensed beds in the state of West Virginia. This is approximately 46% of West Virginia nursing home beds.

West Virginia loss costs have increased in the last five years from $180 in 1995 to $1,110 in 2003. Fueling the rise in West Virginia loss cost is the dramatic, yet highly volatile, increase in the frequency rates between 1995 and 2003. The number of claims has ranged from 1 claim per 1,000 beds in 1995 to a high of 14 in 1999 and leveling off at approximately 8 claims per 1,000 beds in 2003. The average claim severity in the same period has hovered around $150,000.

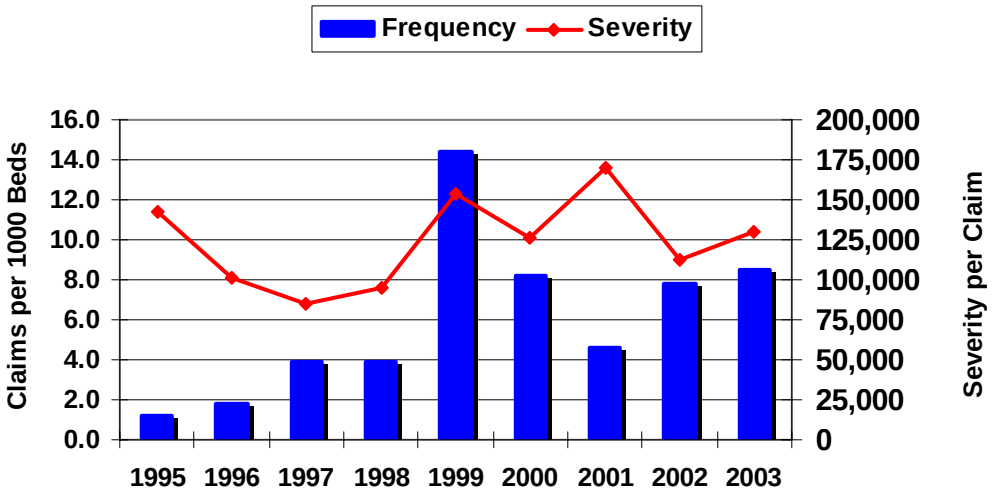
West Virginia Loss Cost per Occupied Bed



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 will

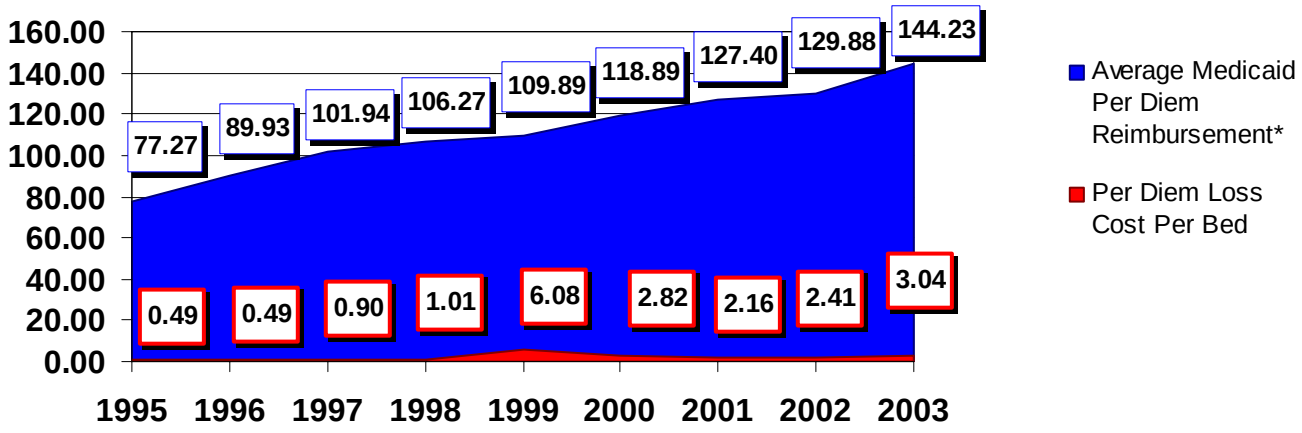
begin January 1, 2004 with an eventual maximum of $1,000,000. Due to the fact that the current average severity of West Virginia GL/PL claims is below the countrywide average, the impact of these caps is not expected to have a significant effect on reducing severity. However, these provisions should help mitigate future increases in claims severity and average loss cost.

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



On a per diem basis, the loss cost as a percent of West Virginia Medicaid reimbursements, from 1% in 1995 to 2% in 2003 as shown in the graph below.

West Virginia Per Diem Loss Cost Versus Medicaid Reimbursement



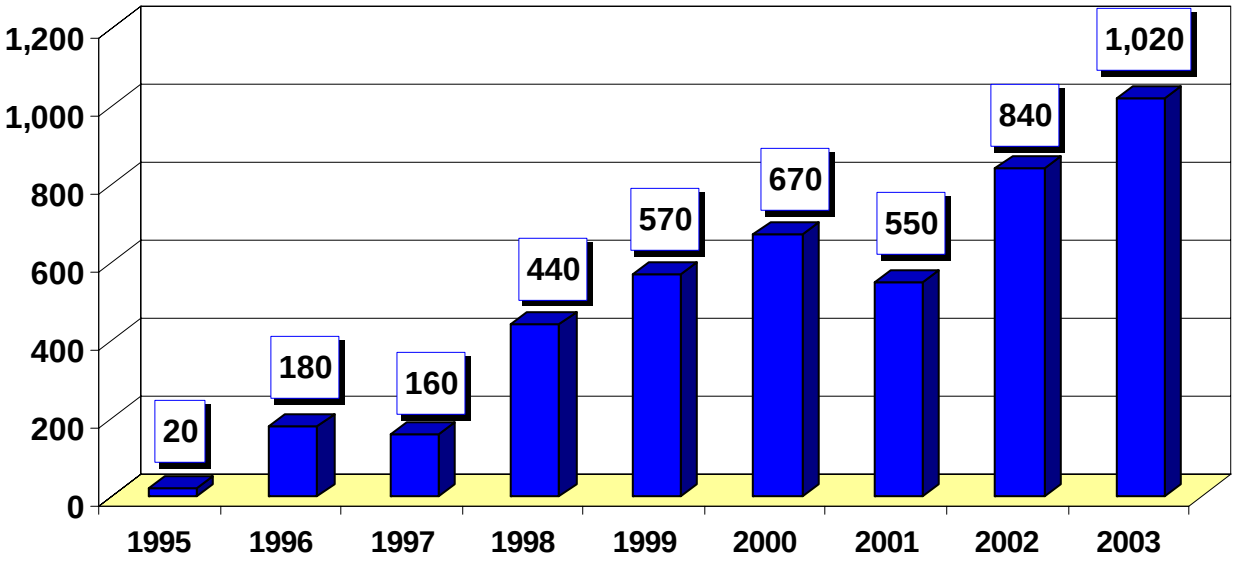
*2003 Projected

North Carolina

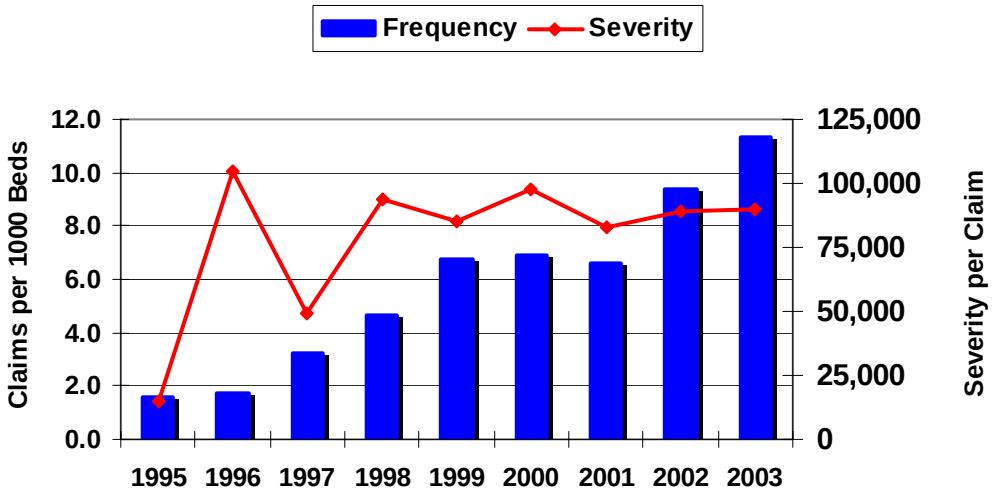
The participants in this study represent approximately 23,200 licensed beds in the state of North Carolina. This is approximately 51% of North Carolina nursing home beds.

North Carolina loss costs have steadily increased since 1995 at an annual trend rate of approximately 29%. While the projected average loss cost in 2003 of $1,020 does not rival the likes of Florida, Arkansas and Texas, the number of claims incurred has increased dramatically since 1996. The number of claims was 2 per 1,000 beds in 1995 and is now projected to be 11 per 1,000 beds in 2003. Also in 1996, the average claim size jumped considerably to an unprecedented $105,000 per claim. However, the average claim size has remained relatively stable at approximately $90,000 since 1996.

North Carolina Loss Cost per Occupied Bed

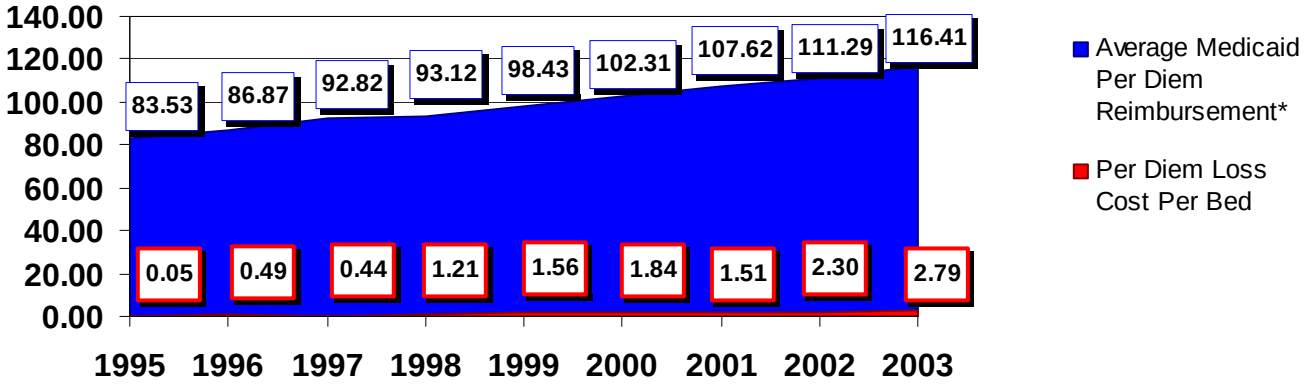


North Carolina Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost is increasing as a percent of North Carolina Medicaid reimbursements, from 0.1% in 1995 to 2% in 2003 as shown in the graph below.

North Carolina Per Diem Loss Cost Versus Medicaid Reimbursement



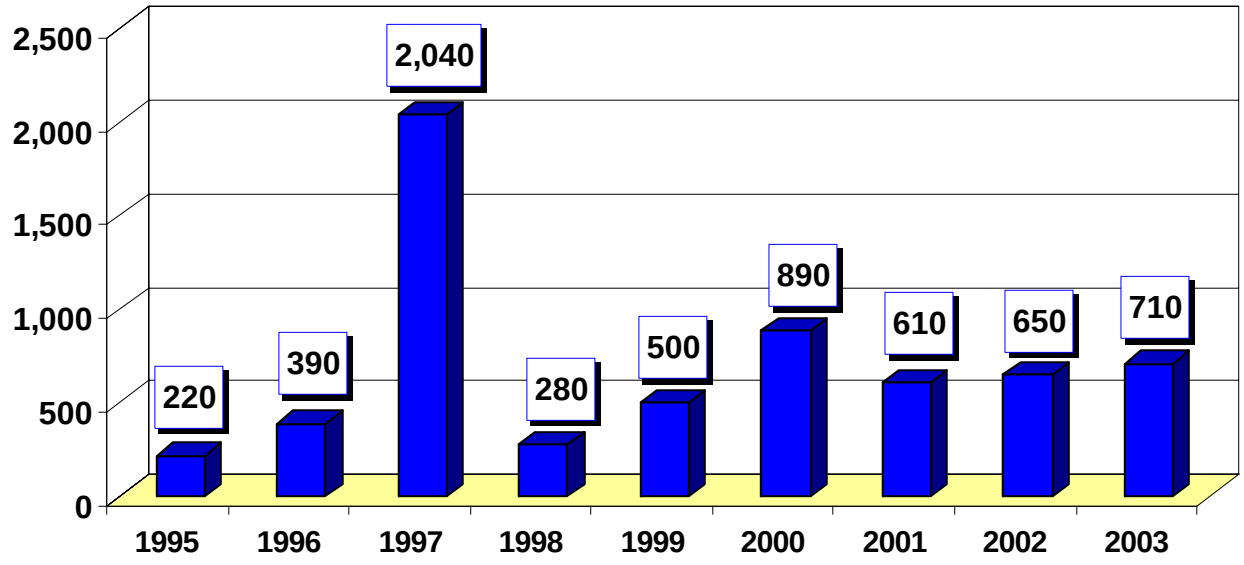
*2003 Projected

Arizona

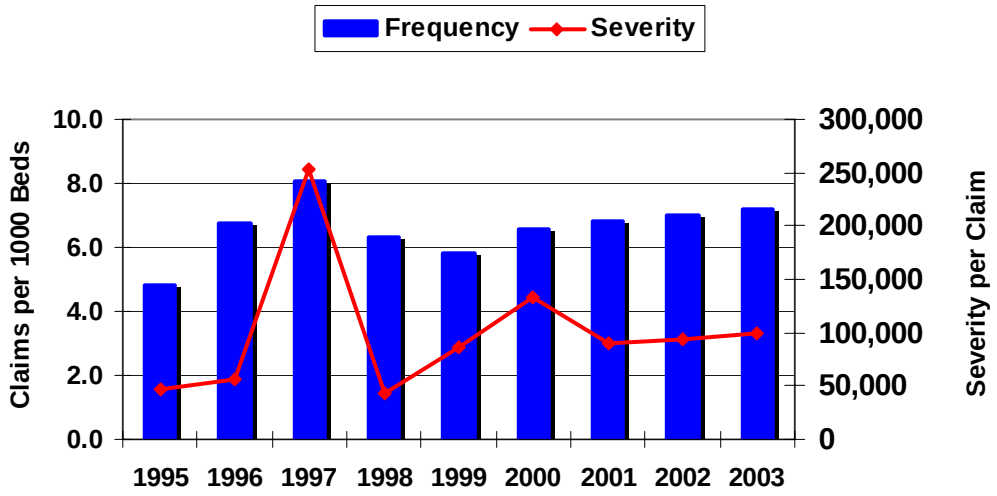
The participants in this study represent approximately 6,400 licensed beds in the state of Arizona. This is approximately 30% of Arizona nursing home beds.

Arizona loss costs have increased from $220 in 1995 to a projected $710 in 2003. The spike seen in 1997, due to both an increase in the number of claims and the average claim size did not have a continuing effect in this state. Overlooking this spike, the number of claims per 1,000 occupied beds has gone from 5 in 1995 to only 7 in 2003. Severity, on the other hand, has doubled from $47,000 in 1995 to $100,000 in 2003.

Arizona Loss Cost per Occupied Bed

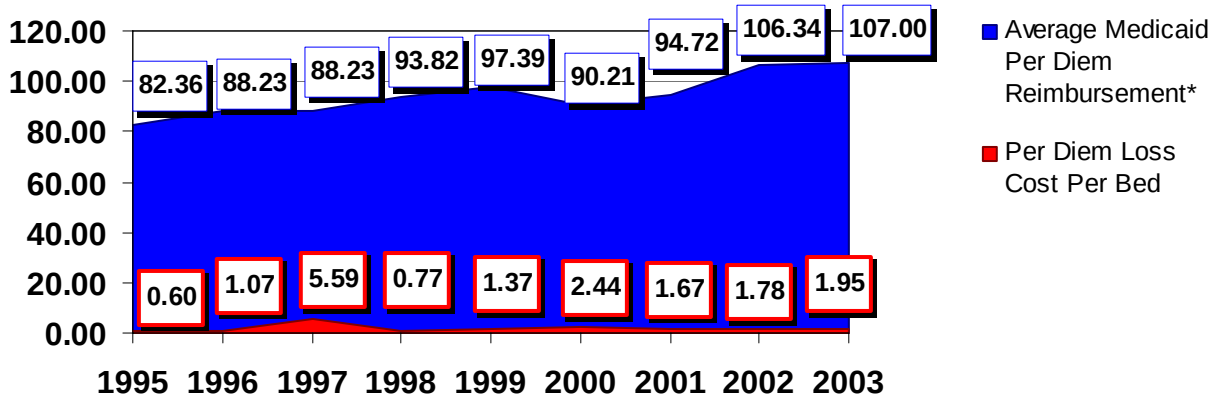


Arizona Annual Number of Claims per 1,000 Occupied Beds / Severity per Claim



On a per diem basis, the loss cost has doubled as a percent of Arizona Medicaid reimbursements, from 1% in 1995 to 2% in 2003 as shown in the graph below.

Arizona Per Diem Loss Cost Versus Medicaid Reimbursement



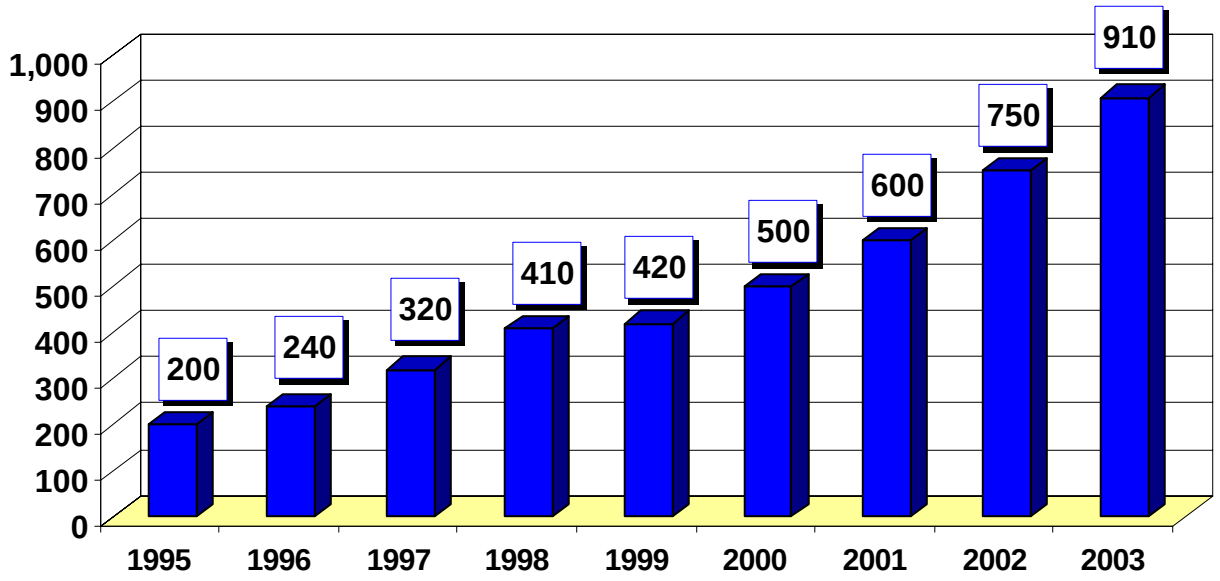
*2003 Projected

All Other States Combined

The participants in this study represent approximately 240,000 licensed beds in the remainder of the country (that is, excluding Florida, Arkansas, Texas, Mississippi, Alabama, Tennessee, California, Georgia, Ohio, Kentucky, West Virginia, North Carolina and Arizona). This is approximately 20% of all nursing home beds in the remaining states.

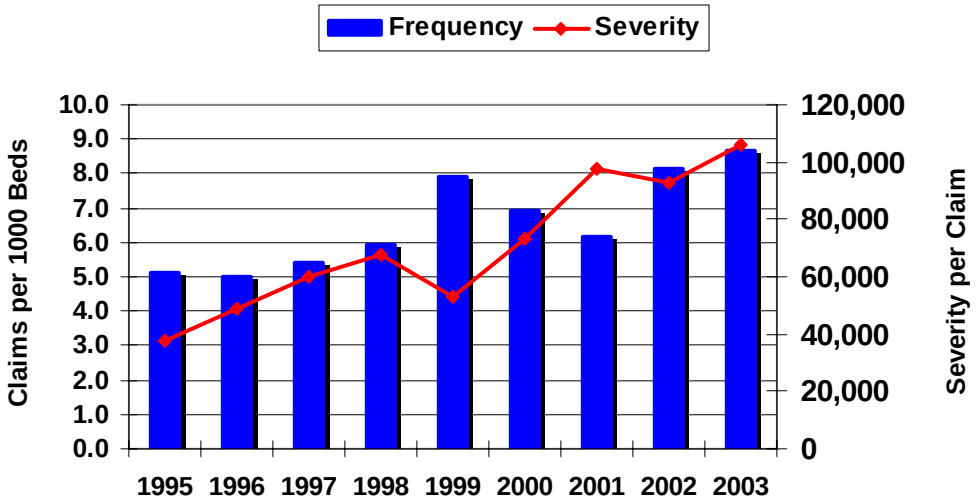
Even excluding the thirteen states noted above, which include some of the highest cost states in the country, GL/PL loss costs are increasing at an annual rate of 20% a year. This is well ahead of inflation and much higher than typical GL/PL claim cost increases for other industries, which tend to be in the 5% to 15% range a year. Our analysis of claims in all other states indicates that loss costs have risen from $200 in 1995 to $910 in 2003.

All Other States Loss Cost per Occupied Bed



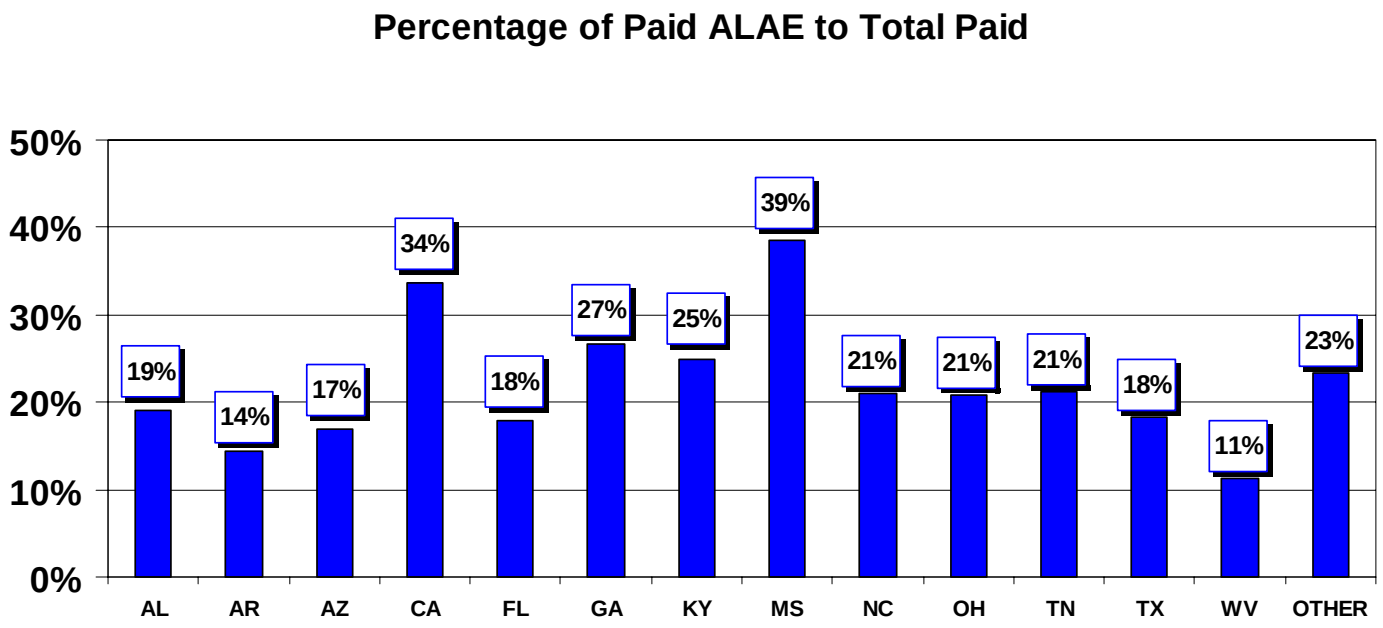
The 20% annual loss cost increase is the result of a 7% annual increase in the number of claims, combined with a 12% annual increase in the average size of a claim.

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



ALAE

The component of total claim dollars used to defend claims, referred to as allocated loss adjustment expenses or ALAE varies by state as follows:



Insurance Premium and Coverage Analysis

Insurance premium has continued to increase and coverage terms have been further restricted for those survey respondents who have been commercially insured for their GL/PL exposure. Of the 108 total participants in this study (a 37% increase over last year's participation rate), 96 provided insurance premium and coverage terms for policy years 2002 and 2003 (a 71% increase over last year). These respondents are primarily comprised of the smaller, independent and regional providers. On average, the respondents to this section of the survey operate approximately 1,984 licensed beds. The median size of respondents is closer to 253 beds. In total, they operate approximately 120,000 beds, or one quarter 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 to the survey respondents of premium and coverage changes. The key findings in this year's survey are continued premium increases, higher deductibles (insured retentions), and a shift from occurrence based policy forms to the more restrictive claims-made form.

Premium Increases

On average, annual commercial GL/PL insurance premiums increased $70,000 over the past year. For participants who were able to give a comparison of 2002 to 2003 coverage terms, the average percentage increase was 51%. This follows two years of substantial increases in GL/PL insurance premiums, as documented in prior Aon studies and summarized in the below chart.

Historical Premium Increases – 2001 to 2003

	2001	2002	2003
Median Increase over Prior Year's Premium	74%	82%	25%
Average Increase over Prior Year's Premium	131%	143%	51%

Smaller providers, those with less than 500 beds, incurred higher percentage increases than larger providers.

Change in Annual Premium by Provider Size – Policy Year 2002 to 2003

Provider Bed Count	Number of Respondents	Total Percentage Premium Change	Median Percentage Premium Change	Average Percentage Premium Change
0-100	27	33.9%	37.1%	73.7%
100-250	18	46.4%	30.4%	77.2%
250-500	6	27.9%	34.5%	61.6%
500-1000	4	-42.6%	-28.4%	-29.4%
1000-5000	22	8.1%	26.5%	32.6%
5000-10,000	8	24.5%	10.4%	21.4%
>10,000	1	-9.4%	-9.4%	-9.4%

The amount of premium change varied widely, however, the majority (74 of 85 respondents) reported increases. The maximum percentage premium increase was incurred by a 129 bed independent facility whose premium increased from under $100,000 to over $500,000, and whose coverage was reduced from occurrence based with no deductible to claims-made with a $50,000 deductible.

Change in Annual Premium - Policy Year 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount of Change	Average Dollar Amount
Less than $0	11	($3,376,988)	($306,999)
$0 - $50,000	45	$846,754	$18,817
$50,001 - $100,000	10	$719,892	$71,989
$100,001 - $500,000	17	$4,885,352	$287,374
$500,001 - $1,000,000	1	$650,000	$650,000
Greater than $1,000,000	1	$2,222,800	$2,222,800
Total	85	$5,947,811	$69,974

Limits of Liability Reductions

On average, survey respondents continued to report a reduction in available limits, although the contraction in capacity is materially reduced from prior years, as reported in previous Aon studies and summarized below.

Historical Limits of Liability Reductions – 2001 to 2003

	2001	2002	2003
Average Decrease in Per Occurrence Limit from Prior Year	($474,074)	($488,679)	($108,537)
Average Decrease in Aggregate Limit from Prior Year	($2,311,111)	($624,000)	($68,452)

Between 2002 and 2003 the majority of respondents (69 of 82 providing limits of liability comparisons) reported no change in their annual limits of liability. Five respondents reported increases in their limits of liability and eight reported decreases. Overall, the commercial insurance industry provided $8.9 million less capacity to the 82 providers responding to this section of our survey.

Change in Occurrence Limits - Policy Year 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Decreased more than $1,000,000	2	($12,000,000)	($6,000,000)
Decreased $500,001 - $1,000,000	3	($2,500,000)	($833,333)
Decreased $100,001 - $500,000	3	($1,150,000)	($383,333)
Decreased $50,001 - $100,000	0	$0	$0
Decreased $1 - $50,000	0	$0	$0
Increased $0 - $50,000	69	$0	$0
Increased $50,001 - $100,000	0	$0	$0
Increased $100,001 - $500,000	2	$750,000	$375,000
Increased $500,001 - $1,000,000	2	$2,000,000	$1,000,000
Increased more than $1,000,000	1	$4,000,000	$4,000,000
Total	82	($8,900,000)	($108,537)

Similar to per occurrence reductions, annual aggregate limits of liability on average declined, but to a much lesser extent than prior years. However, the decreases continued to outnumber the increases this year (14 to 8) and the cumulative effect of restrictions on aggregate limits between 2000 and 2004 is an average restriction in capacity of approximately $3,000,000.

Change in Annual Aggregate Limits - Policy Years 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Decreased more than $1,000,000	8	($30,500,000)	($3,812,500)
Decreased $500,001 - $1,000,000	6	($6,000,000)	($1,000,000)
Decreased $100,001 - $500,000	0	$0	$0
Decreased $50,001 - $100,000	0	$0	$0
Decreased $1 - $50,000	0	$0	$0
Increased $0 - $50,000	62	$0	$0
Increased $50,001 - $100,000	0	$0	$0
Increased $100,001 - $500,000	0	$0	$0
Increased $500,001 - $1,000,000	3	$3,000,000	$1,000,000
Increased more than $1,000,000	5	$27,750,000	$5,550,000
Total	84	($5,750,000)	($68,452)

Deductible Changes

Contrary to findings in prior years, the majority of respondents (65 of 70 who provided deductible comparisons) reported deductible increases between 2002 and 2003 policy years. These increases represent a restriction in 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 increased $180,150, although this is skewed by one respondent that reported an $8 million increase in their deductible. This compares to prior studies' findings that, on average, deductibles increased $97,748 between 2001 and 2002, mostly due to three respondents reporting deductible increases ranging from $175,000 to $4 million. Only one respondent reported a material increase in deductibles between 2000 and 2001 in Aon's February 2002 Long Term Care study.

Change in Per Claim Deductible - Policy Year 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Less than $0	5	($355,000)	($71,000)
$0 - $50,000	53	$140,500	$2,651
$50,001 - $100,000	1	$100,000	$100,000
$100,001 - $500,000	6	$1,025,000	$170,833
$500,001 - $1,000,000	4	$3,700,000	$925,000
Greater than $1,000,000	1	$8,000,000	$8,000,000
Total	70	$12,610,500	$180,150

Of the 29 respondents who reported annual aggregate deductible information, the majority reported very little change in their deductibles between policy year 2002 and 2003. Similar results were found in prior Aon Long Term Care Studies. Four respondents reported an increase in their aggregate deductible since last year; three reported a decrease. On average, aggregate deductibles decreased $379,828.

Change in Annual Aggregate Deductible – Policy Year 2002 to 2003

Amount of Change	Number of Respondents	Total Dollar Amount	Average Dollar Amount
Less than $0	3	($15,515,000)	($5,171,667)
$0 - $50,000	22	$50,000	$2,273
$50,001 - $100,000	0	$0	$0
$100,001 - $500,000	0	$0	$0
$500,001 - $1,000,000	3	$2,450,000	$816,667
Greater than $1,000,000	1	$2,000,000	$2,000,000
Total	29	($11,015,000)	($379,828)

Policy Form Changes

Restrictions in coverage are also evident this year by the increase in the number of respondents who reported converting from occurrence form coverage to the more restrictive claims-made coverage*.

Change in Policy Form – Policy Year 2002 to 2003

Policy Form	2002	2003
Occurrence	40	33
Claims-Made	42	49

*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 coverages) 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.

Conditions and Limitations

The projections contained in our analysis rely on methods and assumptions that are in accordance with standard actuarial practice. Except where specifically noted, the results of this analysis are based entirely on the loss, exposure and insurance coverage data provided to us by the long term care facilities that responded to the AHCA data call. Readers of this report should keep the following observations in mind:

1. We have relied on this loss, exposure and insurance coverage information without detailed verification or audit other than checks for reasonableness. We do not assume any responsibility for errors or omissions in the data or material provided to us.

2. We have assumed that losses reported to us in the aggregate will 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.

3. We have assumed that 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.

4. The losses presented in this report are on a nominal, undiscounted basis. They represent the actual dollars paid on an ultimate basis by the time all claims are closed. No recognition of the time value of money or the cost of capital has been included in our projections.

5. Except where specifically noted, 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 108 long term care providers who responded to the data call. Seventeen 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.

6. The report is strictly for the use of the American Health Care Association and its members. In addition, this report is being made available to all long term care providers who participated in the data request. This report may also be released to regulatory authorities. If this report is distributed, the report should be distributed in its entirety. All recipients of this report should be aware that the Aon actuaries who signed the report are available to answer questions about it.

The above notwithstanding, we believe that the projections in this report are reasonable, and are based on sound actuarial methods and assumptions. Our conclusions are subject to the ordinary limitations involved in any actuarial analysis, and must not be viewed as absolute or guaranteed results.

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 end of September 2003 and early December 2003. 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.

108 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. Seventeen of the respondents are for-profit, multi-facility long term care providers with facilities in numerous states. Twenty of the respondents are regional operators with facilities in at least two but no more than five states. The remaining seventy-one respondents are small independent operators concentrated in one state with one or more facilities. Most of the respondents provide primarily skilled nursing care, although twelve 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 28,441 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.

- **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 eight of the largest long term care providers. These eight 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 eight 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 470,000 licensed beds of which approximately 420,000 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 2003. 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 reflect 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 in 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. This is a different and more current source than that used in prior Aon studies. This change may contribute to slightly different average Medicaid reimbursement rates. The 2003 year is projected by Aon based on prior year trends. Countrywide average 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.

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.