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Ohio 2007 Medical Professional Liability Closed Claim Report

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Ohio Medical Professional Liability Closed Claim Report - 2007

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 third annual report to the General Assembly summarizing the Ohio medical professional liability closed claim data received by the Department for calendar year 2007. This report also includes comparisons of calendar year 2007 data with the data from the prior two calendar years. Copies of the prior annual reports are available on the Department's web site www.ohioinsurance.gov.

II. Overview

ORC §3929.302 requires all entities that provide medical professional liability 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 professional liability claims that close during the year. In addition, each entity must report the costs of defending medical professional 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 of any sort, including a trial verdict, settlement or the passing of the statute of limitations. 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 professional liability insurance rates.

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

VI. Key Findings for 2007 Closed Claims

- **Total Claims:** For 2007, a total of 3,451 claims were reported by 93 entities. Authorized insurers[1] reported the majority of the claims, 2,144. Self-insured entities reported 1,096 claims; surplus lines insurers[2] reported 157 claims; and risk retention groups[3] reported 54 claims.

[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.
[2] 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.
[3] 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 professional liability claims resulted in no payment to a claimant. Nearly 80% of the claims or 2,705, had no indemnity payments, while a little over 20% of the claims or 746, closed with an indemnity payment. The total amount paid to claimants was $235,463,393, an average of $315,635 per claim in which an indemnity payment was made.

- **ALAE:** While most 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 2,894. These expenses totaled $103,033,668, an average of $35,603 per claim.

- **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, 186 closed within one year of being reported and had average paid indemnity of $67,146. That figure rose to $297,935 for 202 claims closing in their second year. Nine claims closed seven or more years after being reported, having average paid indemnity of $2,785,326.

- **ALAE and Age of Claim:** Allocated loss adjustment expense also increased with the age of the claim, starting with an average of $5,356 for claims that closed in the first year, and rising to $17,961 for claims that closed in the second year. For claims closing seven or more years after being reported, average ALAE was $114,042.

- **Regional Comparisons:** Nearly half of the claims, 1,607, came from Northeast Ohio. Of these, one-fourth or 379, resulted in indemnity payments totaling $108,875,627. Almost half of the total dollar amount paid to claimants statewide in 2007 arose from Northeast Ohio claims. However, Central Ohio had the highest average paid indemnity of $607,151. The breakdown of average paid indemnity for the remainder of Ohio, in descending order, is: Southeast-$384,070; Northeast-$287,271; Southwest- $267,507; and Northwest-$217,844.

- **Specialty Comparisons:** When claims were broken down by medical specialty, Internal Medicine had the most claims at 195 with 14 resulting in paid indemnity averaging $265,867. However, for those specialties that are broken out, Anesthesiology had the highest average paid indemnity of $1,693,402 for 10 claims with payments, out of 73 reported claims.

- **Treatment Comparisons:** Diagnosis-related incidents, such as failure to diagnose, delay in diagnosis, or misdiagnosis produced the highest number of claims, 916 with 152 resulting in paid indemnity. Anesthesia-related claims totaled 44. Of these, 9 resulted in indemnity payments averaging $1,827,222, the highest average payment for any type of injury.

VII. Detailed Findings and Comparison With Prior Years

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 3,451 claims that were closed in 2007, 78.4% closed with no indemnity payment. Included in this figure are five categories:
  - 65.3% of the claims closed when the claim or suit was abandoned or was dismissed without prejudice;
  - 7.6% were dismissed by summary judgment or a directed verdict;
  - 4.1% ended with a verdict for the defendant;
  - 1.2% ended through a settlement;
  - 0.1% ended with alternative dispute resolution.
- The remaining 21.6% of the claims closed with paid indemnity. Four categories of claims are included here:
  - 19.1% reached a settlement;
  - 1.4% used alternative dispute resolution;
  - 0.9% had a verdict for the plaintiff;
  - 0.2%[4] 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, 65.3%.
- Claims resulting in settlement are the next largest group, 20.3%. Of these, most resulted in an indemnity payment.
- Claims with a summary judgment or a directed verdict comprise 7.8% of the total, with a large majority of these resulting in no indemnity payment.
- Claims that closed following alternative dispute resolution comprise 1.5% of the total, the majority of which resulted in indemnity payments.
- Finally, of the 5% of the claims that ended with a verdict, most ended without indemnity payments.

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 disposed of by a settlement agreement without an indemnity payment had average ALAE of $8,288. The 30 claims that were disposed of by a trial or jury verdict which resulted in an indemnity payment had the highest average ALAE of $221,964.

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

The following table provides a comparison of the three years of data collected. While the number of claims has decreased each year, the percentage of claims that resulted in an indemnity payment has remained at approximately 20%.

Closed Claim Year	2005	2006	2007	Total
Total # of Claims	5,051	4,004	3,451	12,506
% of Claims With Indemnity	20.7%	19.8%	21.6%	20.7%
% of Claims Without Indemnity	79.3%	80.2%	78.4%	79.3%
Total Indemnity	$281,764,938	$228,735,572	$235,463,393	$745,963,902
Average Indemnity	$269,374	$288,080	$315,635	$288,463
Total ALAE	$113,194,565	$88,131,139	$103,033,668	$304,359,342
Average ALAE	$24,443	$25,672	$35,603	$27,775

Age of Claim (Appendix C, Exhibit 3)

This exhibit displays claims by age at the time of closing, and shows that in nearly all age groupings average indemnity and average ALAE increased with the age of the claim. Claims that closed in their first year represent 26% of the total and had the lowest average indemnity of $67,136, and ALAE of $5,356. Costs grew significantly as the claims aged. The oldest category, claims that closed after seven or more years, had average indemnity payments of $2,785,326, and average ALAE of $114,042.

Claims by Size (Appendix C, Exhibit 4)

Of the 3,451 claims reported closed in 2007, almost 22%, or 746, generated an indemnity payment. Of these 746 claims, 47 claims or 6% generated an indemnity payment greater than $1 million. The 47 claims in total generated indemnity payments of $127.1 million or 54% of the total indemnity payments for all claims. Another 67 claims, or 9%, generated an indemnity payment below $1 million but at least $500,000. The 67 claims in total generated indemnity payments of $46.6 million or 20% of the total indemnity payments for all claims. So for 2007, 74% of the total paid indemnity was generated by only 15% of the claims that closed with an indemnity payment. In comparison, for 2006, 72% of the total paid indemnity was generated by 15% of the claims that closed with an indemnity payment. For

2005, 65% of the total paid indemnity was generated by 15% of the claims that closed with 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 3,451 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. These percentages were identical in 2006 and very comparable in 2005.

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 2007, 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 2007 were from the Northeast region. The Central region had the largest average indemnity payment. The Southwest region incurred the largest average allocated loss adjustment expense. Conversely, with the exception of the Unknown category, the Northwest region had the smallest average indemnity payment, while the Central region incurred the smallest average allocated loss adjustment expense. The table below provides the regional data for all three years combined.

Region	Central	Northeast	Northwest	Southeast	Southwest
Total # of Claims	1,565	6,064	1,970	637	2,237
% With Indemnity	18.7%	20.6%	19.2%	22.1%	22.9%
% Without Indemnity	81.3%	79.4%	80.8%	77.9%	77.1%
Average Indemnity	$357,469	$288,224	$267,373	$307,671	$264,596
Average ALAE	$21,651	$25,876	$26,605	$23,684	$39,395

Claims by Physician Specialty (Appendix C, Exhibit 8)

This exhibit shows eleven physician and surgeon specialties. All other specialties are grouped together as "Other" to maintain confidentiality. Internal Medicine had the most closed claims in 2007 followed by Family Physicians/General Practitioners. An average of 14% of the claims against a physician or surgeon resulted in an indemnity payment.

Of the physician specialties shown, Anesthesiology had the highest average paid indemnity of $1,693,402. The table below provides the physician & surgeons' data for all three years combined for the five specialties with the greatest number of claims.

Specialty	Internal Medicine	Family Physician/ General Practitioner	Surgery-General	Emergency Medicine	Obstetrics/ Gynecology	All P&S Specialties
Total # of Claims	727	628	572	536	467	6,120
% With Indemnity	10.2%	18.0%	13.5%	11.4%	24.6%	13.9%
% Without Indemnity	89.8%	82.0%	86.5%	88.6%	75.4%	86.1%
Average Indemnity	$247,807	$277,240	$289,903	$342,219	$361,432	$339,193
Average ALAE	$23,107	$24,888	$30,768	$24,939	$37,417	$24,483

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

The reporting entities identified the primary complaint or injury that led to the medical professional liability claim. Of the 3,451 claims reported as closed in 2007, 52% 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. Anesthesia-Related claims, including improper choice and improper administration, had the highest average paid indemnity of $1,827,722. Obstetrics-Related claims, including improper delivery method, improper management of pregnancy, and delay in delivery, had the highest average ALAE of $213,571. These figures include all medical providers, including hospitals. The following table provides the data for all three years combined for the three injury descriptions with the greatest number of claims.

Injury Description	Diagnosis-Related	Medical Treatment, Non-Obstetrical	Surgery-Related	All Claims 2005-2007
Total # of Claims	3,498	3,377	2,445	12,506
% With Indemnity	16.2%	16.4%	15.6%	20.7%
% Without Indemnity	83.8%	83.6%	84.4%	79.3%
Average Indemnity	$347,044	$233,938	$260,646	$288,463
Average ALAE	$27,263	$20,537	$23,759	$27,775

Birth Injury Claims (Appendix C, Exhibit 10)

Reporting entities identified whether the closed claim was due to a birth injury. Of the 3,451 reported, 146, or 4%, were identified as birth injury claims. Of these 146 birth injury claims, 37% resulted in an indemnity payment. The average indemnity payment of a birth injury claim was $1,187,018- over three times the overall average indemnity payment of $315,635.

Of the 12,506 closed claims reported for calendar years 2005 through 2007, 546 or 4% were identified as birth injury. Of these 546 birth injury claims, 34% resulted in an indemnity payment. The average indemnity payment of the combined data for a birth injury claim was $819,882 which is nearly three times the overall average indemnity payment of $288,463.

Severity of Injury (Appendix C, Exhibit 11)

Of the 3,451 claims reported as closed in 2007, 1,137 or 33% of the claims were due to the death of the injured party, with an average paid indemnity of $411,227. Injuries identified as “permanent grave” had an average paid indemnity of $1,684,371, more than five times the overall average indemnity payment. The injuries include quadriplegia and brain damage, requiring lifelong dependent care.

Of the 12,506 reported as closed for calendar years 2005 through 2007, 4,339 or 35% were due to the death of the injury party. Of these 18% closed with an indemnity payment which averaged $337,037. Injuries identified as “permanent grave” totaled 292 for the three years. Of these 25% closed with an indemnity payment which averaged $1,340,752.

Age of Injured Person (Appendix C, Exhibit 12)

Of the 3,451 claims reported as closed, 69% of the claims identified the injured party as an adult, age 18 to 64. Adults ages 65 or older represented 20% of the claims. Minors and infants represented 6% and 5% of the claims, respectively. The average indemnity payment for infants was the highest at $1,436,731. The table below provides the data for all three years combined for the various age groupings.

Age	Adult 18-64	Senior 65+	Minor 1-7	Infant
Total # of Claims	8,808	2,420	553	661
% With Indemnity	17.6%	27.1%	26.0%	33.3%
% Without Indemnity	82.4%	72.9%	74.0%	66.7%
Average Indemnity	$262,948	$132,591	$362,797	$875,460
Average ALAE	$22,631	$22,778	$36,650	$37,238

Gender of Injured Person (Appendix C, Exhibit 13)

For the 3,451 claims reported as closed, 57% of the claims reported the injured party as female and 43% of the claims reported the injured party as male. When the injured party was a female, the average indemnity payment was $277,848. When the injured party was a male, the average indemnity payment was $375,388.

Of the 12,506 reported as closed for calendar years 2005 through 2007, 57% of the claims reported the injured party as female and 43% of the claims reported the injured party as male. When the injured party was a female, the average indemnity payment was $249,966. When the injured party was a male, the average indemnity payment was $343,972. For both sexes, nearly 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 professional 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 47% of the claims. The largest average allocated loss adjustment expenses and the largest average indemnity payments were due to

injuries that occurred in the Obstetrics Department. The table below provides the data for all three years combined for various locations.

Location	Operating Room	Medical Professional Office	Emergency Department	Obstetrics Department	All Claims 2005-2007
Total # of Claims	3,024	2,786	1,840	583	12,506
% With Indemnity	16.9%	17.3%	15.5%	33.1%	20.7%
% Without Indemnity	83.1%	82.6%	84.5%	66.9%	79.3%
Average Indemnity	$308,859	$223,024	$242,217	$792,757	$288,463
Average ALAE	$24,828	$20,940	$25,303	$106,010	$27,775

VII. Impact of Tort Reform (S.B. 281)

Effective April 11, 2003, the 124th General Assembly enacted Senate Bill 281 which included a comprehensive set of tort reforms aimed at reducing the costs of litigation and stabilizing the Ohio medical professional liability insurance market. At present, there is insufficient data to draw any supportable conclusions regarding the impact of these measures for many reasons. First, as noted above, the typical average indemnity payment increases with the age of the claim. For example, for 2007, the "oldest" closed claims that subject to SB 281 would have been less than five years old. Second, few claims have reached a trial or jury verdict that required separate detail of economic and non-economic damages and the potential for capping. The Department is sensitive to issues of confidentiality; therefore it cannot release any specific information regarding these claims. Lastly, the Department is not capturing any data regarding risk management efforts that would possibly impact the number of, or cost of, medical professional liability claims, as such data would be beyond the scope of the General Assembly's request in Senate Bill 281. Such information would include, but not be limited to, better communications between providers and patients, patient safety and improved treatment protocols or procedures. Any analysis of trends in claims should include information on risk management efforts along with changes in the law.

Although conclusions cannot be drawn, the following table does provide a comparison of the data for each year and in total.

Closed Claim Year	2005	2006	2007	Total
Total # of Claims	5,051	4,004	3,451	12,506
# Claims with injury pre- SB 281	3,864	1,939	1,058	6,861
Avg Indemnity pre-SB 281 claims	$307,899	$342,091	$556,191	$358,257
Avg ALAE pre- SB 281 claims	$28,265	$34,470	$67,898	$35,981
# Claims with injury post- SB 281	1,187	2,065	2,393	5,645
Avg Indemnity post-SB 281 claims	$171,299	$235,677	$213,065	$210,437
Avg ALAE post-SB 281 claims	$9,044	$15,768	$18,990	$15,760
# Claims where verdict could have been subject to capping	0	2	3	5

VIII. Conclusion

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

- Most of the claims closed without a payment to the plaintiff. For all three years, 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.

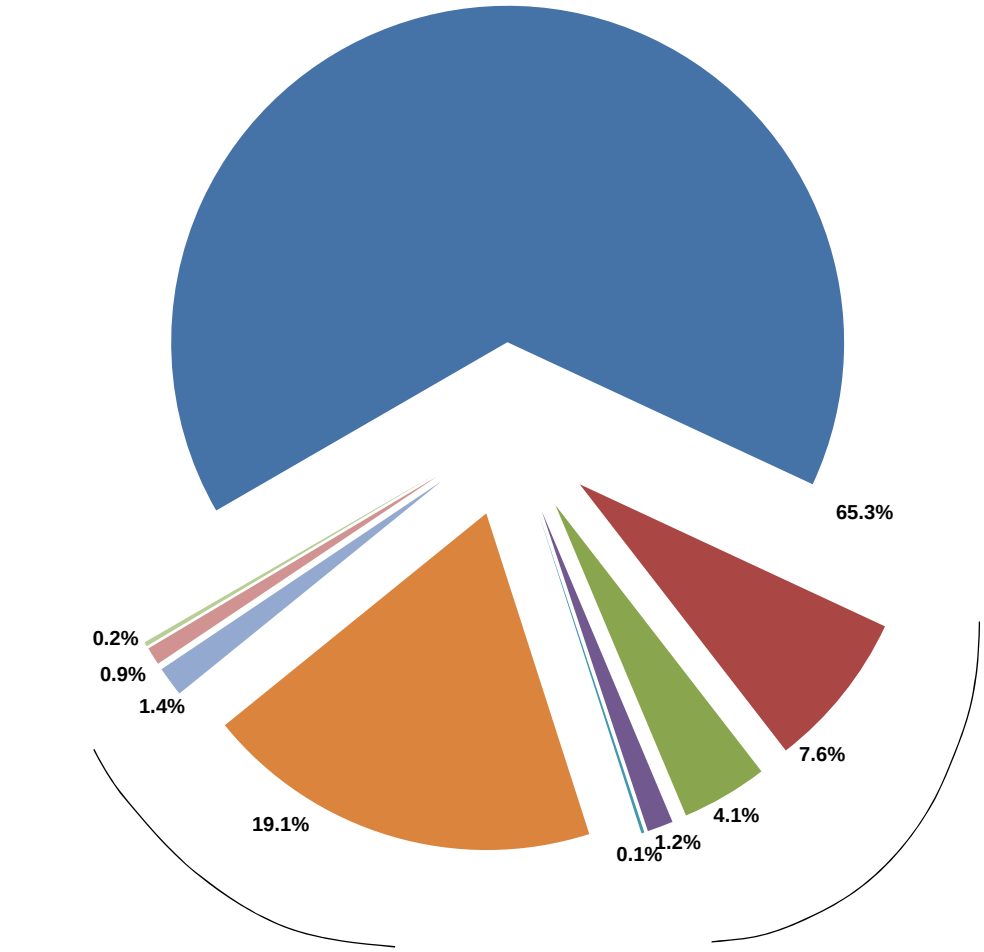
(I) The requirements of this rule do not apply to reinsurers, reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

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

OHIO
Closed Claims in 2007
Outcome of Malpractice Claims

Appendix C, Exhibit 1

3451 Closed Claims



- 65.3% Claim/Suit Abandoned Without Indemnity Payment, Including Dismissed Without Prejudice
- 7.6% Dismissed by Court -Summary Judgment/Directed Verdict -- Without Indemnity
- 4.1% Disposed of by Trial Verdict/Jury Verdict -- Without Indemnity
- 1.2% Disposed of by Settlement Agreement -- Without Indemnity
- 0.1% Disposed of by Alternative Dispute Resolution -- Without Indemnity
- 19.1% Disposed of by Settlement Agreement -- With Indemnity
- 1.4% Disposed of by Alternative Dispute Resolution -- With Indemnity
- 0.9% Disposed of by Trial Verdict/Jury Verdict -- With Indemnity
- 0.2% Dismissed by Court -Summary Judgment/Directed Verdict -- With Indemnity

21.6% - Claims With Indemnity Payment

78.4% - Claims Without Indemnity Payment

OHIO
2007 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	2252	65.3%	1894	$33,158,538	$17,507	0	$0	$0
Dismissed by Court -Summary Judgment/Directed Verdict -- Without Indemnity	262	7.6%	241	$6,102,736	$25,323	0	$0	$0
Disposed of by Trial Verdict/Jury Verdict -- Without Indemnity	143	4.1%	141	$13,090,692	$92,842	0	$0	$0
Disposed of by Settlement Agreement -- Without Indemnity	43	1.2%	29	$434,594	$14,986	0	$0	$0
Disposed of by Alternative Dispute Resolution -- Without Indemnity	5	0.1%	4	$32,910	$8,228	0	$0	$0

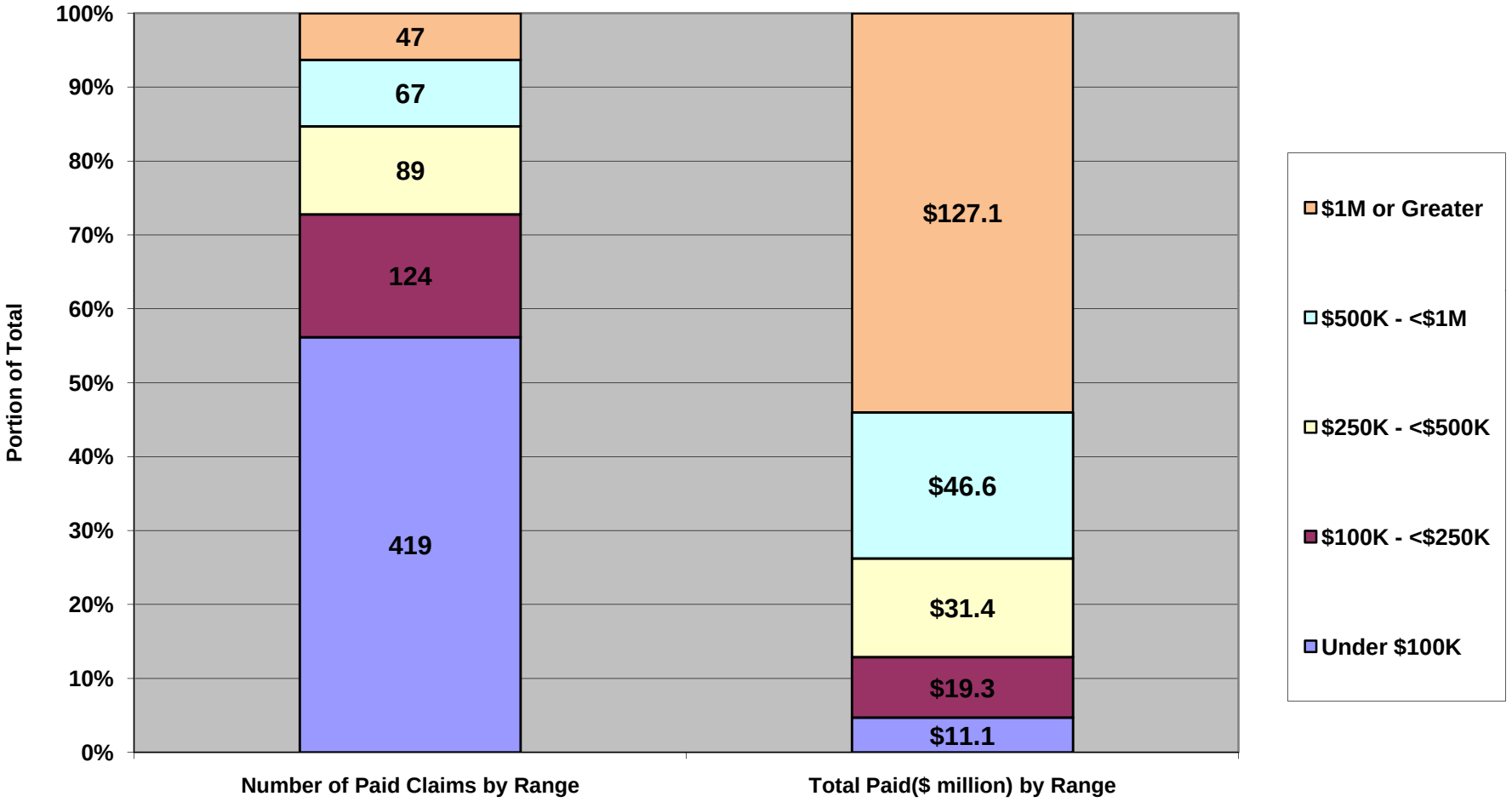
FINAL DISPOSITION DESCRIPTION	TOTAL CLAIMS	AVG	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Disposed of by Settlement Agreement -- With Indemnity	660	19.1%	502	$40,303,946	$80,287	660	$175,145,787	$265,372
Disposed of by Alternative Dispute Resolution -- With Indemnity	49	1.4%	47	$2,756,634	$58,652	49	$20,701,936	$422,488
Disposed of by Trial Verdict/Jury Verdict -- With Indemnity	30	0.9%	30	$6,658,911	$221,964	30	$38,513,890	$1,283,796
Dismissed by Court -Summary Judgment/Directed Verdict -- With Indemnity	7	0.2%	6	$494,707	$82,451	7	$1,101,780	$157,397
TOTALS and AVERAGES:	3451	100.0%	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

OHIO
2007 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	899	553	$2,961,877	$5,356	186	$12,489,072	$67,146
1 But Less Than 2	1007	883	$15,859,421	$17,961	202	$60,182,882	$297,935
2 But Less Than 3	757	719	$25,374,929	$35,292	161	$56,555,760	$351,278
3 But Less Than 4	353	324	$17,273,619	$53,314	98	$31,974,881	$326,274
4 But Less Than 5	216	204	$12,258,582	$60,091	48	$29,403,571	$612,574
5 But Less Than 7	172	164	$23,945,250	$146,008	42	$19,789,291	$471,174
7 or Greater	47	47	$5,359,991	$114,042	9	$25,067,936	$2,785,326
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

Appendix C, Exhibit 4

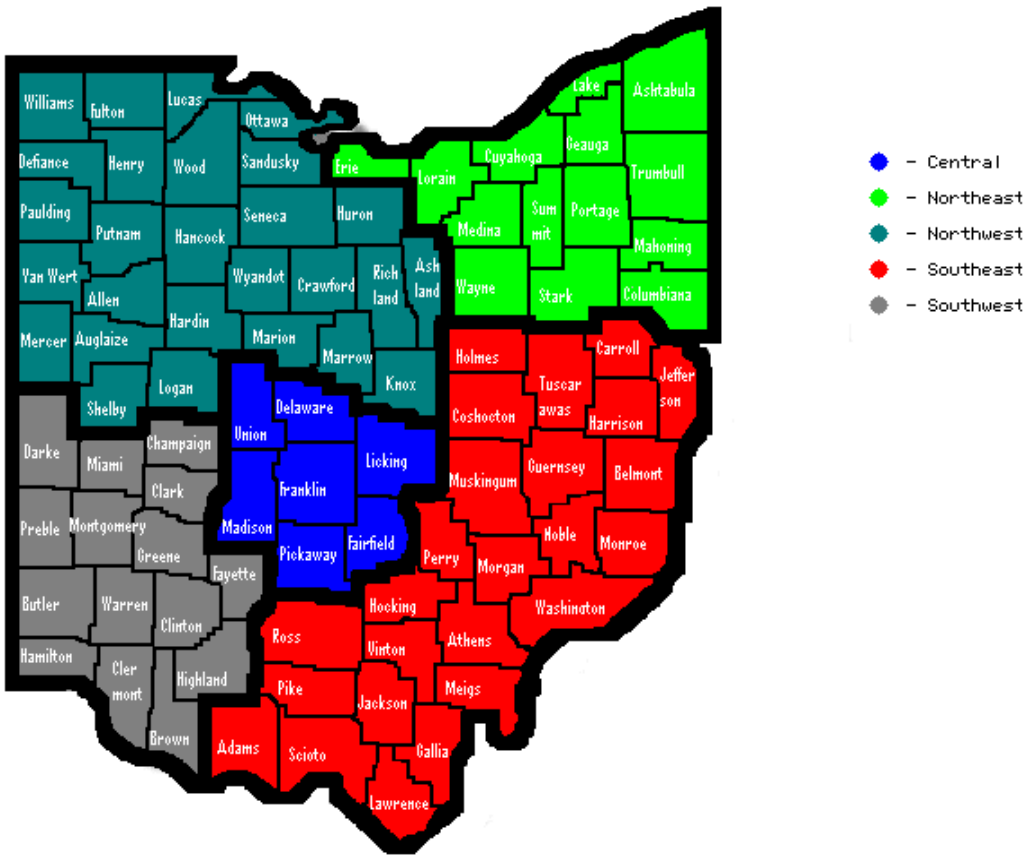
OHIO
2007 Closed Claims
By Size of Payment



OHIO
2007 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	2144	1875	$72,240,717	$38,528	365	$134,304,583	$367,958
Insurance Company - Surplus Lines	157	127	$2,912,682	$22,935	26	$3,382,776	$130,107
Risk Retention Group	54	37	$532,602	$14,395	8	$352,518	$44,065
Self Insurers (Captives)	1096	855	$27,347,667	$31,986	347	$97,423,516	$280,759
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

Closed Claims 2007
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
2007 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	442	371	$9,581,432	$25,826	81	$49,179,139	$607,150
Northeast	1607	1352	$41,675,902	$30,825	379	$108,875,627	$287,271
Northwest	537	465	$14,528,783	$31,245	85	$18,516,755	$217,844
Southeast	204	174	$5,012,429	$28,807	52	$19,971,661	$384,070
Southwest	644	517	$31,748,242	$61,409	143	$38,253,544	$267,507
Unknown	17	15	$486,879	$32,459	6	$666,667	$111,111
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

OHIO
2007 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	195	175	$4,755,835	$27,176	14	$3,722,131	$265,867
Family Physicians\General Practitioners	175	157	$4,393,000	$27,981	33	$9,742,749	$295,235
Surgery - General	167	149	$6,227,380	$41,794	24	$7,948,493	$331,187
Surgery - Orthopedic	148	128	$2,616,211	$20,439	16	$4,903,775	$306,486
Emergency Medicine	130	109	$3,643,812	$33,429	21	$9,807,794	$467,038
Radiology	120	108	$3,062,174	$28,353	15	$5,689,361	$379,291
Obstetrics/Gynecology	108	99	$4,774,695	$48,229	24	$10,355,541	$431,481
Anesthesiology	73	59	$1,679,128	$28,460	10	$16,934,016	$1,693,402
Cardiovascular Disease	66	60	$1,036,824	$17,280	12	$4,083,225	$340,269
Neurology	43	41	$1,379,955	$33,657	7	$2,770,607	$395,801

PHYSICIAN SPECIALTY	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Pediatrics	41	30	$1,198,611	$39,954	8	$1,975,500	$246,938
Other	411	350	$7,158,612	$20,453	44	$14,978,642	$340,424
TOTALS and AVERAGES:	1677	1465	$41,926,236	$28,619	228	$92,911,834	$407,508

OHIO
2007 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.)	916	813	$24,399,863	$30,012	152	$52,186,322	$343,331
Medical Treatment, Non-Obstetrical (Failure to Treat, Delay in Treatment, Improper Treatment, etc.)	884	731	$18,330,706	$25,076	150	$38,449,956	$256,333
Surgery-Related (Delay in Surgery, Improper Performance of Surgery, etc.)	726	614	$18,047,666	$29,394	133	$31,565,077	$237,331
Other (No Listed Category Applies)	191	152	$2,453,791	$16,143	34	$4,688,585	$137,900

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.)	157	125	$3,242,055	$25,936	52	$10,606,597	$203,973
Safety & Security-Related (Falls, Failure To Ensure Safety, Failure to Protect From Assault)	146	98	$2,544,695	$25,966	83	$4,181,395	$50,378
Obstetrics-Related (Improper Delivery Method, Improper Management of Pregnancy, Delay in Delivery, etc.)	134	126	$26,909,959	$213,571	45	$62,178,250	$1,381,739
Patient Monitoring-Related (Failure to Monitor, etc.)	111	94	$2,997,903	$31,893	38	$10,972,242	$288,743
Breach of Confidentiality/Communication-Related (Failure To Instruct, Failure to Obtain Consent, etc.)	66	55	$1,158,089	$21,056	17	$1,070,350	$62,962

INJURY DESCRIPTION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Anesthesia-Related (Improper Choice, Improper Administration, etc.)	44	31	$1,322,344	$42,656	9	$16,449,500	$1,827,722
Equipment-Related (Improper Use of Equipment, Improper Maintenance, Equipment Failure/Malfunction, etc.)	41	27	$242,201	$8,970	17	$259,126	$15,243
Policies & Procedures-Related (Failure To Follow, Negligent Credentialing, etc.)/Supervision-Related (Supervision of Residents, Nurses, etc.)	35	28	$1,384,396	$49,443	16	$2,855,993	$178,500
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

OHIO
2007 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	3305	2756	$76,006,603	$27,579	692	$171,364,403	$247,636
Yes	146	138	$27,027,065	$195,848	54	$64,098,990	$1,187,018
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

OHIO
2007 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	1137	1040	$31,413,346	$30,205	203	$83,479,029	$411,227
Emotional	106	88	$2,717,910	$30,885	27	$2,303,930	$85,331
Permanent Grave	67	61	$5,282,412	$86,597	20	$33,687,410	$1,684,371
Permanent Major	368	321	$13,933,186	$43,406	92	$76,856,698	$835,399
Permanent Minor	272	225	$8,501,342	$37,784	52	$3,482,530	$66,972
Permanent Significant	396	353	$27,563,302	$78,083	61	$21,824,941	$357,786
Temporary Low Significance	170	84	$892,455	$10,624	57	$387,901	$6,805
Temporary Major	448	366	$8,204,914	$22,418	115	$10,256,753	$89,189
Temporary Minor	487	356	$4,524,802	$12,710	119	$3,184,201	$26,758
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

OHIO
2007 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)	2387	2023	$54,289,156	$26,836	448	$109,879,141	$245,266
Senior (Age 65+)	681	562	$14,297,497	$25,440	185	$25,588,289	$138,315
Minor (Ages 1 to 17)	190	140	$5,426,329	$38,759	50	$15,776,464	$315,529
Infant (Less than 1 year old)	173	150	$28,317,543	$188,784	58	$83,330,408	$1,436,731
Unknown	20	19	$703,142	$37,007	5	$889,090	$177,818
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

OHIO
2007 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	1959	1653	$67,546,483	$40,863	457	$126,976,337	$277,848
Male	1492	1241	$35,487,184	$28,596	289	$108,487,055	$375,388
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635

OHIO
2007 Closed Claims
ALAE and Indemnity Payments by Location

Appendix C, Exhibit 14

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Operating Suite (Includes Pre-Op & Operating Rooms)	864	730	$22,048,945	$30,204	156	$52,556,204	$336,899
Medical Professional's Office	765	662	$17,026,914	$25,720	151	$30,794,895	$203,940
Emergency Room/Emergency Department	456	356	$10,939,396	$30,729	80	$26,553,286	$331,916
Patient's Room, Including Patient Bathroom for Inpatient Areas Not Otherwise Specified	426	367	$9,821,040	$26,760	113	$26,155,431	$231,464

LOCATION	TOTAL CLAIMS	CLAIMS With ALAE	TOTAL ALAE	AVERAGE ALAE	CLAIMS With INDEMNITY	TOTAL INDEMNITY	AVERAGE INDEMNITY
Other	228	162	$3,502,256	$21,619	54	$7,836,456	$145,120
Radiology (Includes Mammograpy, CT, MRI, Radiation Therapy & Nuclear Medicine)	142	128	$3,069,633	$23,982	28	$8,312,622	$296,879
Obstetrics Department (Labor & Delivery, Recovery & Post-Partum)	141	134	$27,046,226	$201,838	46	$62,058,250	$1,349,092
Nursing Home (Includes Assisted Living, Extended Care & Long-Term Care)	99	88	$2,050,186	$23,298	36	$3,297,586	$91,600
Outpatient/Ambulatory Care Areas or Facilities	93	71	$1,814,341	$25,554	23	$4,704,683	$204,551
Critical Care Unit (ICU/CCU/NICU)	64	53	$2,203,795	$41,581	13	$5,450,056	$419,235

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.)	54	40	$640,671	$16,017	9	$532,019	$59,113
Patient's Home	44	38	$1,533,659	$40,359	17	$5,566,254	$327,427
Ancillary Services (Includes Laboratory, Pharmacy, and Blood Bank)	32	28	$782,242	$27,937	6	$717,910	$119,652
Mental Health (Includes Psychiatric and Drug & Alcohol Addiction)	28	27	$431,688	$15,988	7	$398,542	$56,935
Physical Therapy Dept.	15	10	$122,677	$12,268	7	$529,198	$75,600
TOTALS and AVERAGES:	3451	2894	$103,033,668	$35,603	746	$235,463,393	$315,635