Aon Risk Solutions

2012 Long Term Care

General Liability and Professional Liability Actuarial Analysis

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Introduction

Purpose

The Actuarial and Analytics Practice of Aon Global Risk Consulting (Aon) conducted an actuarial analysis of general liability and professional liability (GL/PL) claim costs for the long term care profession in the United States.

Scope

The specific objectives of this study are to:

- Identify the overall trends in the cost of GL/PL claims for long term care
- Identify state specific trends in the cost of GL/PL claims for long term care
- Identify trends in frequency and severity overall and on a state by state basis
- Explore the impact of Alternative Dispute Resolution (ADR) on GL/PL claims

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

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

Respectfully submitted,

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Executive Summary

Key Findings

Based on the actuarial analysis of GL/PL claims data from long term care providers on a national level:

- Long term care loss rates are increasing by 4% annually.
- The overall forecasted 2013 accident year long term care GL/PL loss rate is $1,540 per bed.
- Long term care frequency is neither increasing nor decreasing.
- The 2013 accident year long term care GL/PL frequency is 0.88% per bed.
- Long term care severity is increasing by 4% annually on an overall basis.
- The forecasted 2013 accident year long term care GL/PL severity is $175,000 per claim.

Liability and the Long Term Care Profession

The long term care profession as a whole struggled with the cost of liability in the late 1990s and early 2000s. In response, it developed liability defenses, reinvested in patient safety, advocated for limits on tort damages and implemented arbitration.

Over the years, our studies have documented that tort limits can be effective in reducing costs. Our recent work shows a cost difference associated with the presence of valid arbitration agreements, also called Alternative Dispute Resolution (ADR) agreements.

Providers have challenges that are not directly related to liability, but will influence their liability costs nonetheless. In October 2011, Medicare reimbursement rates were implemented at a level 11.1% lower than the Centers for Medicare and Medicaid Services (CMS) had initially budgeted in April 2011. Providers derive a significant proportion of their income from Medicare reimbursement and this reduction will impact operating budgets. With reduced revenue, providers will find it more difficult to fund in expansion and improvements, maintain existing facilities, and hire and train qualified caregivers. These competing priorities have the potential to impact liability costs, especially if the investment in caregivers is reduced.

The passage of the Patient Protection and Affordable Care Act (PPACA) casts uncertainty into the operations of long term care providers. Provisions of PPACA are intended to encourage the coordination of care givers and to reduce costs, which may give rise to new avenues of liability. PPACA also promotes alternatives to residential skilled nursing care.[1] Competition from these alternatives will increase pressures on already strained revenue.

State laws and the state judiciary have a tremendous influence on liability costs. The state laws set limits on damages that can be awarded in torts. They determine which health care providers have limited liability and which do not. The state judiciary interprets the laws. A judiciary that is plaintiff friendly can reduce the effectiveness of laws intended to reduce liability costs.

1 See Patient Protection and Affordable Care Act, Section 10202. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

Loss Rates by State

Because state laws and the state judiciaries establish and interpret the rules on torts, state loss rates vary considerably. Kentucky has the highest loss rate in this study at $5,350 per bed while Texas has the lowest at $330 per bed.

Kentucky's constitution prevents the enactment of limits on tort damages. This presents a fertile ground for torts. With the specter of an unlimited judgment looming, providers may be willing to settle for higher amounts to avoid a trial. In 2010, a Kentucky jury awarded nearly $43 million in a nursing home liability case.[2] Of that, $41 million of the judgment were punitive and non-economic damages. These are the type of damages that are typically restricted by tort reform legislation. Such an award can be influential, encouraging plaintiff's attorneys to increase their demands and forcing providers to weigh the stakes of defending a claim. With this backdrop, it is no surprise that liability costs in Kentucky continue to increase.

West Virginia implemented non-economic damage caps of $250,000 to $500,000 in 2003. These caps seem to have had little impact in reducing costs. A recent nursing home case shows the challenge providers face in West Virginia. In August 2011, a jury returned a verdict for $91.5 million in damages.[3] The damages included compensatory damages, punitive damages and non-economic damages. The jury award was reduced several months later by $0.4 million to reflect the state's limitations on non-economic damages. As part of the jury verdict, the jurors were asked to assign a percentage to medical negligence versus ordinary negligence. Their assessment was that 20% of the negligence was medical. The cap was then applied to 20% of the $5 million in non-economic damages, resulting in a reduction of $0.4 million.[4] This case is still being litigated through appeals, but it illustrates that the tort limits in West Virginia can be circumvented.

Since tort reform was declared unconstitutional in Georgia in 2010, both the frequency and severity of claims have increased. The removal of the $350,000 limit on damages appears to have encouraged claimants and their attorneys to file claims. Without an upper bound on the amount the judicial system can award, settlement values are no longer constrained.

Tort limits were recently enacted in North Carolina and Tennessee. In both these states, we observe an increase in claim frequency as claimants move to assert their claims before the tort limits become effective. From our observation of tort limit implementation in other states, this pattern is typically followed by a decrease in claim frequency as the caps reduce the upper bound of claim sizes and lessen the incentive to pursue claims.

Texas has had limits on tort awards since 2003. A key aspect of the tort limits in Texas is that the state constitution was amended to allow the limits. Subsequently, the limits have survived challenges over the years, most recently in March 2012. Shortly after the limits were enacted, loss rates plummeted and have remained level for the past seven years.

2 Thompson Reuters News and Insight, *Kentucky jury awards $43 million for nursing home neglect*, http://newsandinsight.thomsonreuters.com/Legal/insight/2010/12_-_december/kentucky_jury_awards_$43_million_for_nursing_home_neglect/ (May 2012).

3 Laurence Viele Davidson, *Carlyle Nursing Unit to Appeal $91.5 Million Medical Negligence Verdict*, http://www.bloomberg.com/news/2011-08-08/carlyle-nursing-home-subsidiary-to-appeal-91-5-million-jury-verdict.html (May 2012) and Zac Taylor, Lawyers gear up for appeal in $91.5 million Charleston nursing home case, http://www.wvgazette.com/News/201108211245?page=1 (May 2012)

4 Zac Taylor, *Judge affirms $90 million Charleston nursing home verdict*, http://www.wvgazette.com/News/201110200203 (May 2012). Kyla Asbury, *Kanawha judge reduces jury award in nursing home case*, http://www.wvrecord.com/news/239177-kanawha-judge-reduces-jury-award-in-nursing-home-case (May 2012)

Arbitration Results

Arbitration continues to be an effective cost limiting tool for long term care providers. In our study of 1,449 closed claims, we found that claims settled under valid ADR agreements are 21% less costly than other claims.

We first examined arbitration in the wake of efforts on the national stage to outlaw the use of pre-dispute arbitration agreements in long term care settings. Congress has considered this legislation each year since 2008, but no laws have been enacted.

At the state level, citing "public policy," West Virginia's Supreme Court ruled in 2011 that pre-dispute arbitration agreements could not be enforced in cases of personal injury or wrongful death.[5] The decision was appealed to the US Supreme Court, which found the West Virginia court's ruling to be "incorrect and inconsistent [with] precedents," and sent the case back to the West Virginia court for reconsideration.[6] The case underscores that the environment in West Virginia is difficult for defendants in liability cases, but also shows that arbitration is being challenged both nationally and at the state level.

A more general challenge to arbitration came in the form a case before the US Supreme Court, AT&T Mobility v. Concepcion, No. 09-893. In this case, the Supreme Court affirmed that the Federal Arbitration Act preempts state laws, and allowed AT&T's contracts to require individual arbitration, as opposed to class action lawsuits or class-wide arbitration.[7]

Although the plaintiff's advocates continue to look for ways to limit their use, arbitration appears to have the support of the Supreme Court of the United States.

5 The Associated Press, Supreme Court: Nursing homes can't use arbitration, http://www.wvgazette.com/News/201107010703 (May 2012).

6 UPI, Supreme Court: Arbitration law applies in W.Va., http://www.upi.com/Top_News/US/2012/02/21/Supreme-Court-Arbitration-law-applies-in-WVa/UPI-73061329844533/ (May 2012).

7 Reuters, Supreme Court rules for AT&T in arbitration case, http://www.reuters.com/article/2011/04/27/us-att-arbitration-idUSTRE73Q4N520110427 (May 2012)

Advisory Benchmarks

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

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

Advisory Benchmark	Projected 2013 Benchmark	Selected Annual Trend
Overall Frequency*	0.88%	0.00%
Indemnity Frequency*	0.69%	0.00%
Severity	$175,000	4.00%
Loss Rate*	$1,540	4.00%

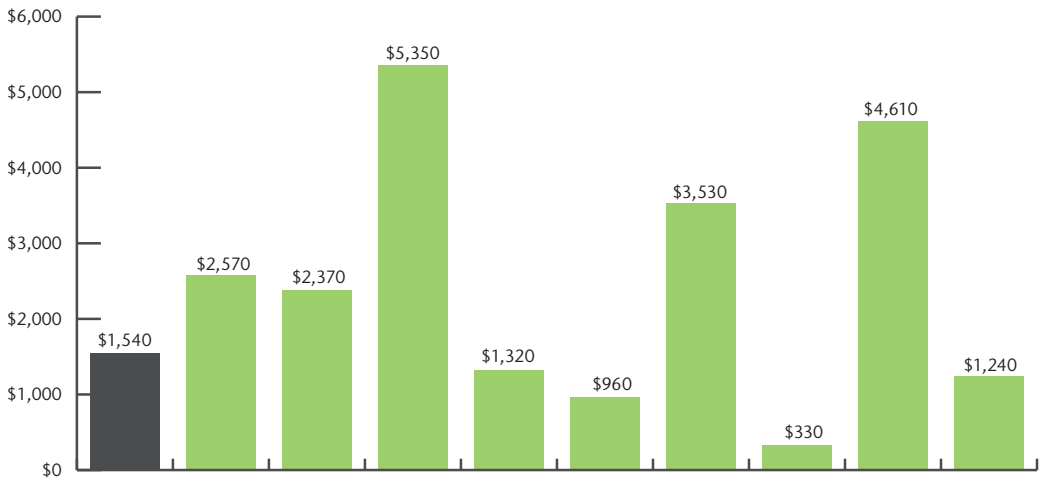
*per occupied bed

The projected 2013 benchmark loss rate is $1,540 and is projected to grow by 4% annually.

State Findings

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

Comparison of Projected 2013 Loss Rates Limited to $1 Million per Occurrence



	Countrywide	California	Georgia	Kentucky	North Carolina	Pennsylvania	Tennessee	Texas	West Virginia	All Other States
Loss Rate	$1,540	$2,570	$2,370	$5,350	$1,320	$960	$3,530	$330	$4,610	$1,240
% of Database	100.0%	4.2%	2.5%	3.3%	5.3%	10.8%	3.8%	5.1%	2.2%	62.8%

Loss Rates are relative to occupied beds.
The % of Database is measured by occupied beds.

Database

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

The results presented in this study are based on the ensuing database of long term care GL/PL losses and allocated loss adjustment expenses (ALAE) as reported to us by 37 long term care providers. Approximately 19,500 individual non-zero claims from long term care facilities were aggregated. The facilities represented in the national study operate approximately 280,000 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 16% of the beds in the United States, and eight of the ten largest providers in the country.

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

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

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

Statutory limitations were based on National Conference of State Legislatures research updated September 23, 2010, accessed April 27, 2012 from http://www.ncsl.org/issues-research/banking/medical-liability-medical-malpractice-laws.aspx. Referenced statutory limitations were confirmed by retrieving the individual state codes online.

The loss rates are presented relative to the Medicaid per diem reimbursement rate. The Medicaid per diem reimbursement rate is based on data from “A Report on Shortfalls in Medicaid Funding for Nursing Home Care” produced by Eljay LLC for the AHCA and dated December 2011.The Overall Medicaid per diem reimbursement rate is based on the state exposure distribution inherent in this study.

Actuarial Analysis

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

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

Countrywide Benchmark Statistics

This section presents an analysis of countrywide loss rate per occupied bed, claim frequency per bed and claim severity. The darker bar, labeled 2012, represents a forecast based on trending of 2011 estimates. Claim frequency statistics are presented for indemnity claims and expense only claims.

Countrywide Loss Rate Trends

The following graph shows the loss rate per occupied bed. The annual loss rate has been growing since 2009.

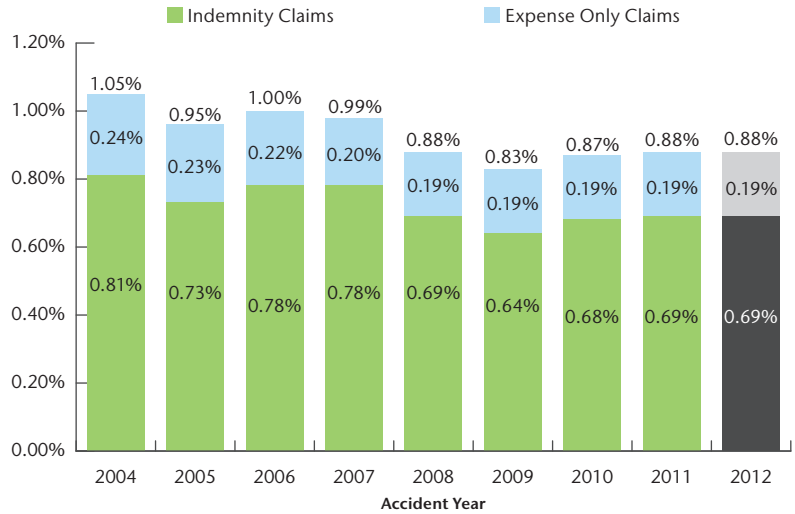
Loss Rate per Occupied Bed Limited to $1M per Occurrence

Countrywide Frequency Trends

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

Frequency has been stable since 2008.

Claim Frequency per Occupied Bed

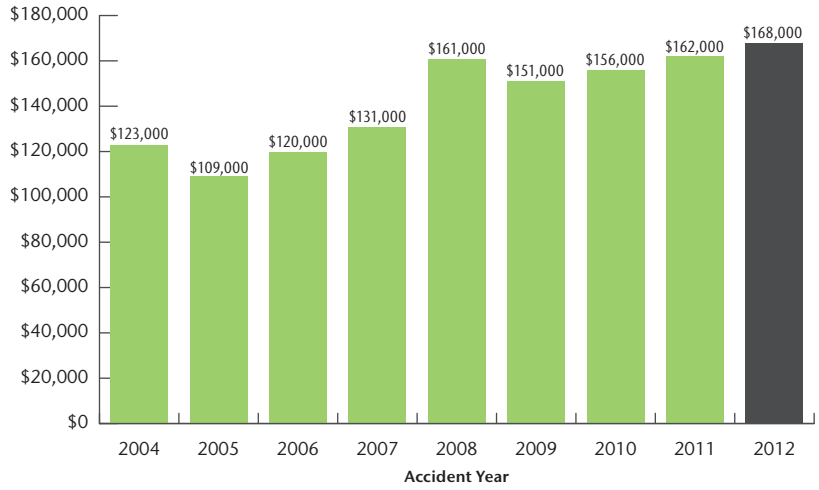


Countrywide Severity Trends

The following graph shows the average size per claim, also called claim severity.

From a low of $109,000 in 2005, severity has been increasing steadily.

Severity per Claim Limited to $1M per Occurrence

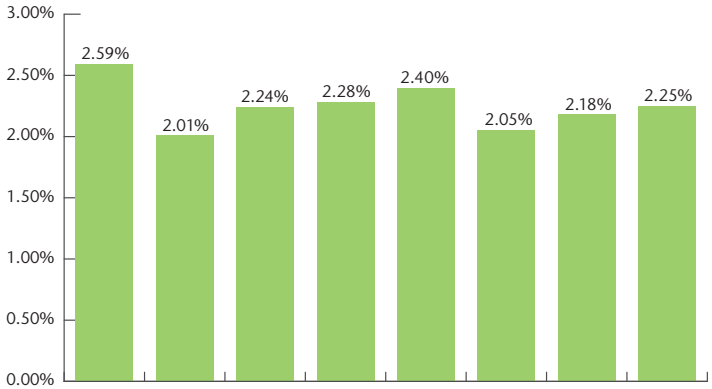


Countrywide Liability Costs and Medicaid Reimbursement Rates

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

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

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$136.20	$141.86	$146.61	$154.71	$162.00	$167.09	$170.32	$174.03
Per Diem Loss Rate per Bed	$3.53	$2.85	$3.29	$3.53	$3.89	$3.42	$3.72	$3.92

Impact of Arbitration

Aon has analyzed arbitration results for a number of years. The results consistently show a lower claim cost for claims that are settled with arbitration agreements in place. Claims settled under valid ADR agreements are 21% less costly than other claims.

Organization of Data

The arbitration analysis consisted of 1,449 closed claims with coding related to applicability of arbitration (ADR). These claims were closed between 2004 and 2012 and are related to occurrences between 2003 and 2011.

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

Claim Distribution

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

About 40% of the claims in the database were closed with a valid or unchallenged ADR agreement in place. This percentage is higher than prior years and indicates the growing influence of ADR.

The Arbitration category is slightly more concentrated in claims without indemnity.

Indemnity Amount	Non-Arbitration		Arbitration	
No Payment	168	19.2%	170	29.7%
$0 to $25,000	241	27.5%	85	14.8%
$25,000 to $250,000	364	41.6%	269	46.9%
$250,000 to $1,000,000	87	9.9%	47	8.2%
Greater than $1,000,000	16	1.8%	2	0.3%
Total	**876**	**100.0%**	**573**	**100.0%**
Claims with Payment	708	80.8%	403	70.3%

Total Cost

The average total cost of an outcome subject to an arbitration agreement is about $140,000, while the average cost of a non-arbitrated outcome is about $180,000, making arbitrated outcomes about 21% less costly.

Indemnity Amount	Non-Arbitration	Arbitration
No Payment	$17,832	$13,439
With Payment	$219,496	$196,235
Total	**$180,820**	**$142,003**

Unchallenged ADR claims have the lowest total cost. Challenged ADR claims are the highest cost claims.

Indemnity Amount	Non-Arbitration		Arbitration	
	No ADR	Invalid ADR	ADR	Upheld ADR
No Payment	$17,130	$46,617	$10,807	$48,098
With Payment	$167,652	$644,340	$167,710	$290,005
Total	**$136,601**	**$614,823**	**$114,625**	**$262,619**
Number of Claims	795	81	467	106

Challenge Rates

Of the 654 closed claims that involved ADR, 187, or about 29%, were challenged. Of these, 91, or fewer than half, were found unenforceable. As noted above, the challenged claims were associated with higher overall costs.

Indemnity Amount	Counts	Percent of ADR Claims
Claims with ADR Agreements	654	100.0%
Challenged	187	28.6%
Challenged and Unenforceable	81	12.4%

State Specific Results

The remainder of the report profiles states where credible results were produced based on the volume of data, the stability of the results compared to prior years, and the number of providers represented in the data. The graphs for each state present the loss rate per occupied bed, claim frequency per occupied bed, claim severity and loss rates relative to the Medicaid per diem reimbursement rate. Frequency is shown for claims with indemnity payments and expense only claims. The darker bar, labeled 2012, represents a forecast based on trending of 2011 estimates.

California

The participants in this study represent approximately 10,000 licensed beds in the state. This is approximately 10% of the state total beds.

Loss Rate

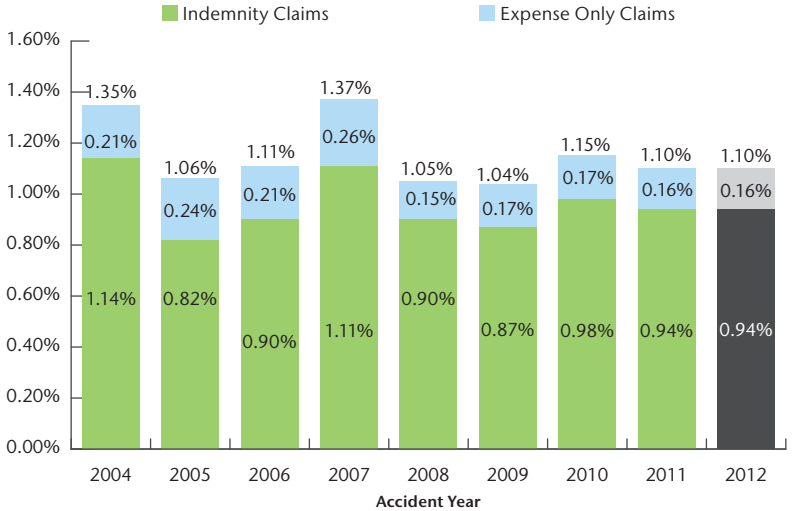
The projected 2012 loss rate per occupied long term care bed is $2,480. Loss rates have been increasing since 2006.

Loss Rate per Occupied Bed Limited to $1M per Occurrence

Frequency

Claim frequency peaked in 2007. Since then, frequency has been stable around 1.10%.

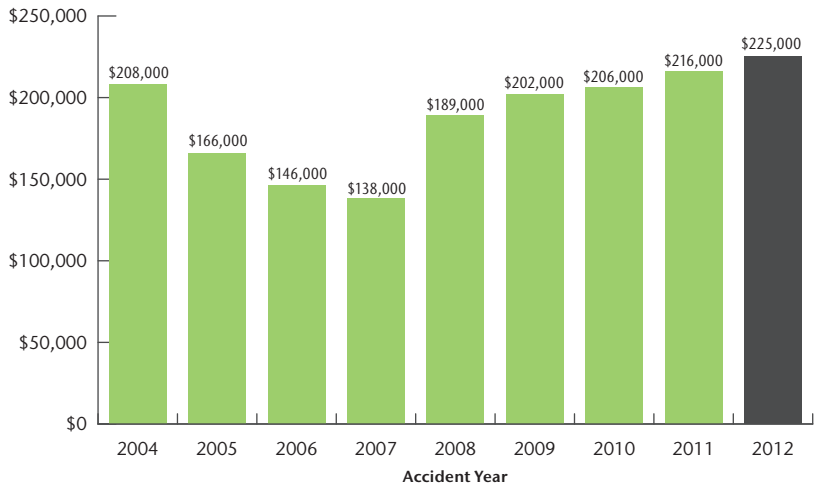
Claim Frequency per Occupied Bed



Severity

Claim severity increased between 2007 and 2008 and has been growing since.

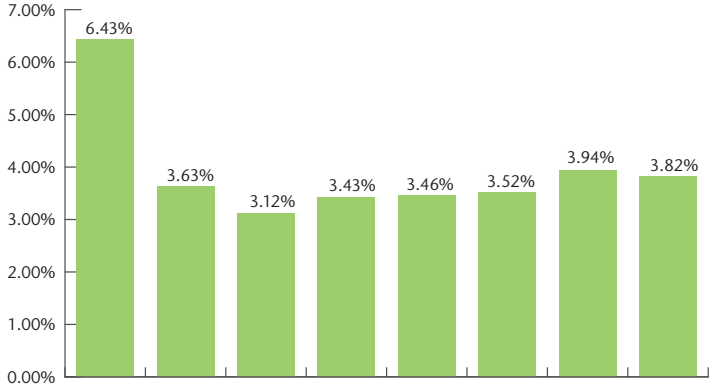
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem reimbursement

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

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$120.15	$132.83	$142.14	$150.69	$156.56	$163.40	$164.65	$170.64
Per Diem Loss Rate per Bed	$7.72	$4.82	$4.44	$5.17	$5.42	$5.75	$6.49	$6.52

Georgia

The participants in this study represent approximately 4,900 licensed beds in the state. This is approximately 14% of the state total long term care beds.

Loss Rate

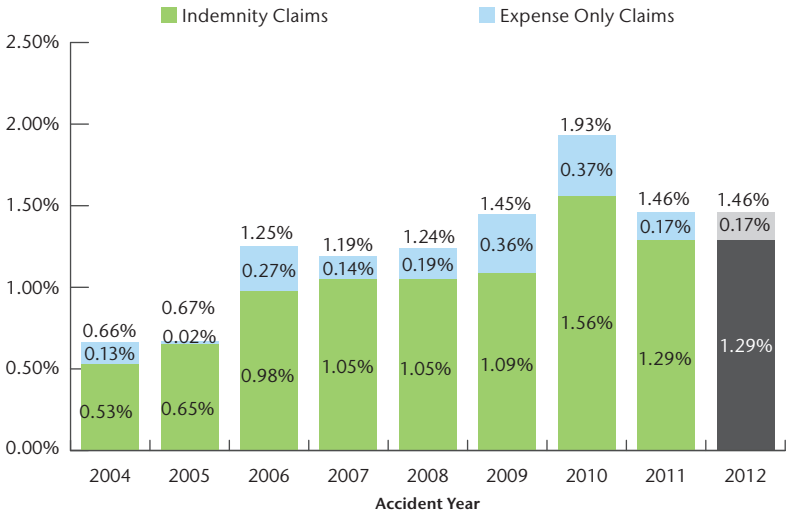
The projected 2012 loss rate per occupied long term care bed is $2,280. Tort limits were enacted in Georgia in 2005. These limits capped non-economic damages at $350,000 per defendant. Thereafter, the frequency of claims actually increased. When the limits were ruled unconstitutional by the Georgia Supreme Court in 2010, frequency spiked again. Since the ruling, the loss rate is comparable to levels prior to the ruling. Over this entire period, claim severity has increased moderately.

Loss Rate per Occupied Bed Limited to $1M per Occurrence

Frequency

Georgia's claim frequency is projected to be 1.46% in 2012, or just about 1.5 claims per hundred occupied beds. This is a lower rate than the frequency spike in 2010, but higher than other historical frequency rates. It ranks second highest among the profiled states.

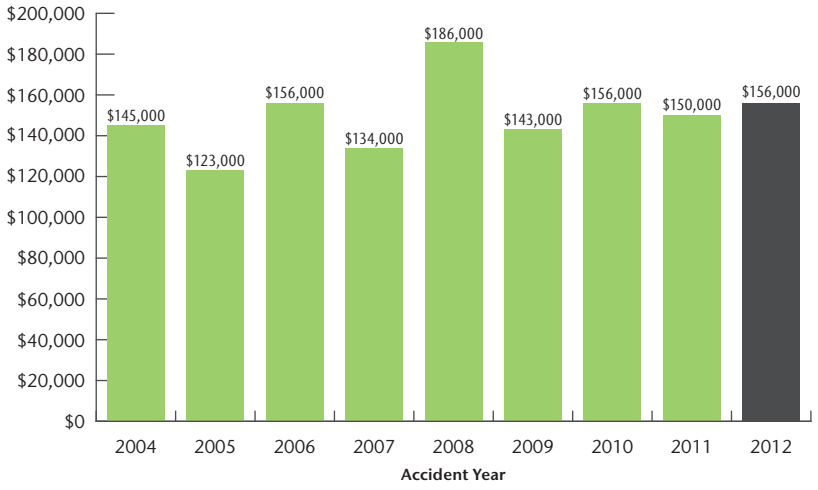
Claim Frequency per Occupied Bed



Severity

Georgia's severity reflects volatility, but, over time, is increasing moderately.

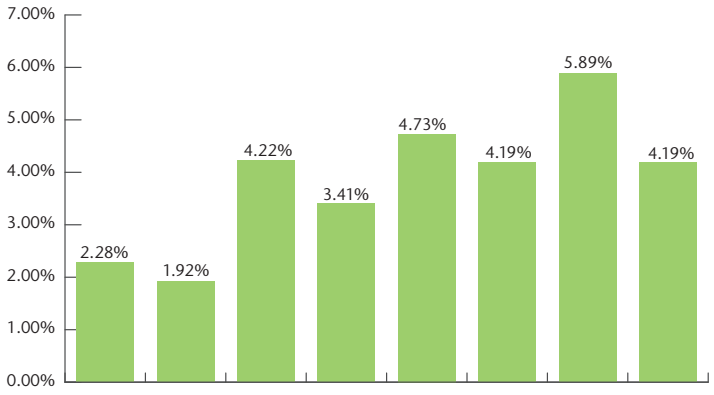
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate fluctuates over the past eight years. The current rate is 4.19%.

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$114.16	$117.25	$126.61	$127.43	$133.48	$135.22	$139.84	$143.03
Per Diem Loss Rate per Bed	$2.60	$2.25	$5.34	$4.35	$6.32	$5.67	$8.24	$6.00

Kentucky

The participants in this study represent approximately 7,600 licensed beds in the state. This is approximately 32% of the state total long term care beds.

Loss Rate

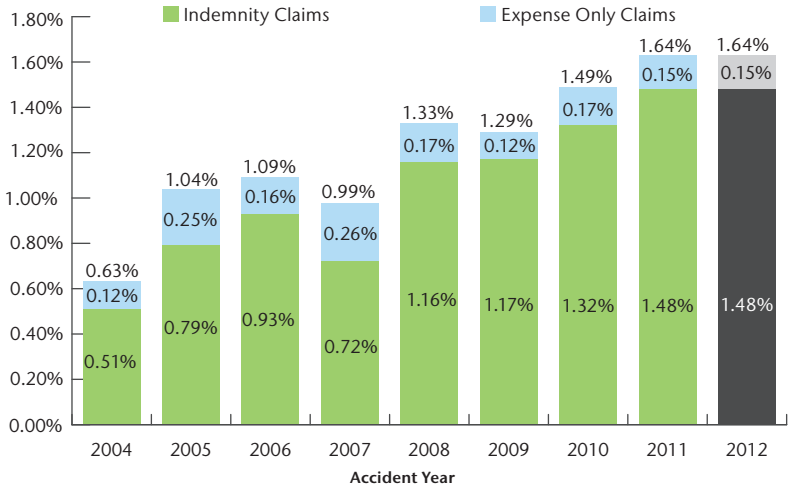
The loss rate in Kentucky has increased dramatically over the past eight years. The 2012 projected loss rate is $5,120 and is the highest of the profiled states. Kentucky's constitution prevents limitations on tort awards, and so providers in the state are unable to use this approach to limit the size of claims. A recent multimillion dollar jury award highlights this situation and may promote Kentucky as an attractive venue for litigation.

Loss Rate per Occupied Bed Limited to $1M per Occurrence

Frequency

While claim frequency was around one claim per one hundred occupied beds from 2005 through 2007, the claim frequency has been increasing since 2007. The projected 2012 frequency of 1.64% is the highest of the profiled states.

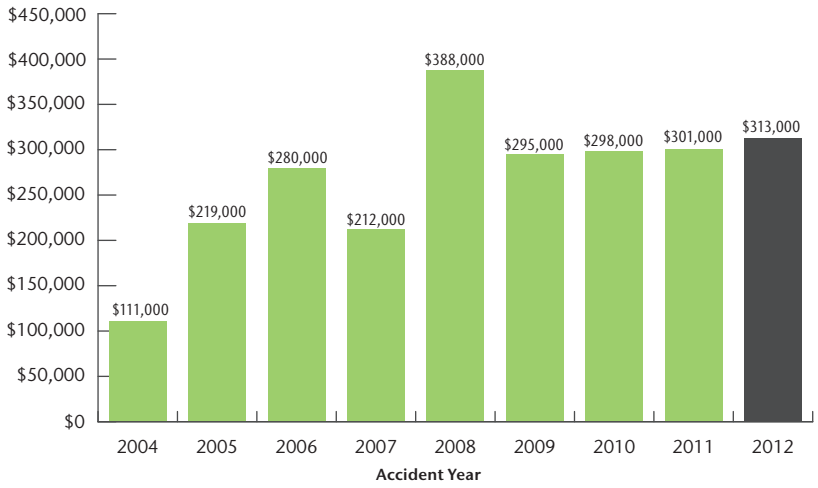
Claim Frequency per Occupied Bed



Severity

Claim severity in Kentucky is generally twice the overall average severity in this study and is the second highest severity of the profiled states.

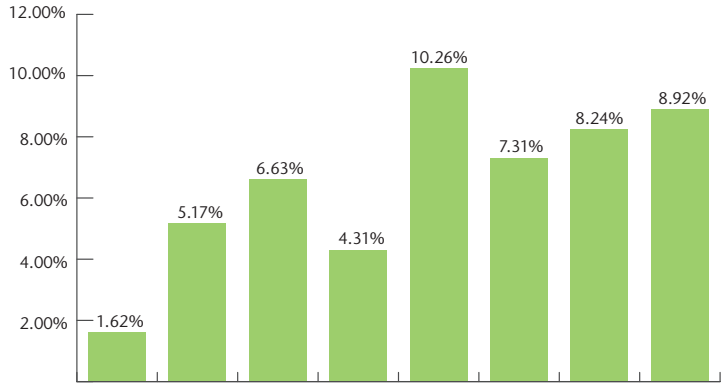
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate is currently at 8.92%, the highest of the profiled states.

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$116.76	$120.61	$125.56	$132.72	$137.49	$142.72	$147.14	$151.41
Per Diem Loss Rate per Bed	$1.89	$6.24	$8.32	$5.72	$14.10	$10.43	$12.13	$13.50

North Carolina

The participants in this study represent approximately 12,400 licensed beds in the state. This is approximately 33% of the state total long term care beds.

Loss Rate

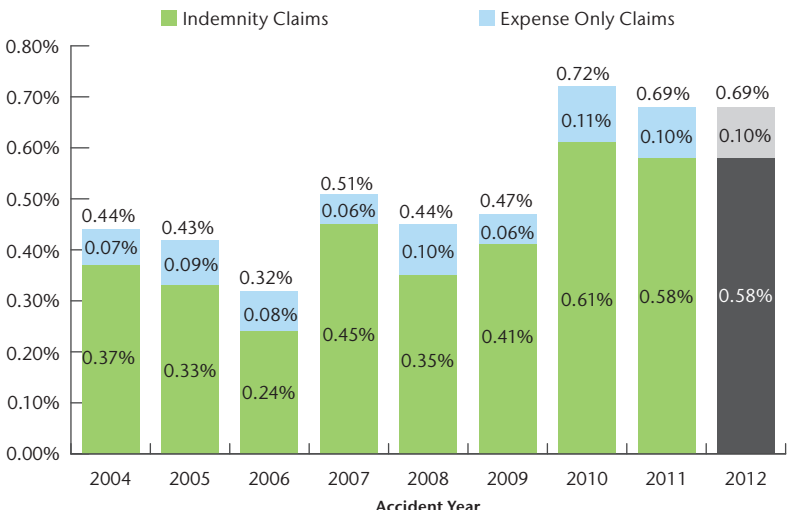
Loss rates in North Carolina have increased from lows under $500 per bed to a forecasted loss rate of $1,260 in 2012. North Carolina enacted limits on tort damages effective in October 2011. Under the new law, punitive damages will be limited to the greater of $250,000 or three times compensatory damages. Non-economic damages will be limited to $500,000 per plaintiff, except in cases that include certain significant injuries and where the defendant's conduct is especially egregious.

Loss Rate per Occupied Bed Limited to $1M per Occurrence

Frequency

Claims frequency has been historically under 1 claim in about 200 beds until 2010. The recent increase in claims frequency may be due to the enactment of tort reform legislation in North Carolina. This legislation was effective in late 2011. We often observe increased claims assertions in states where tort limits are enacted as claimants and their attorneys wish to litigate without the limits on awards.

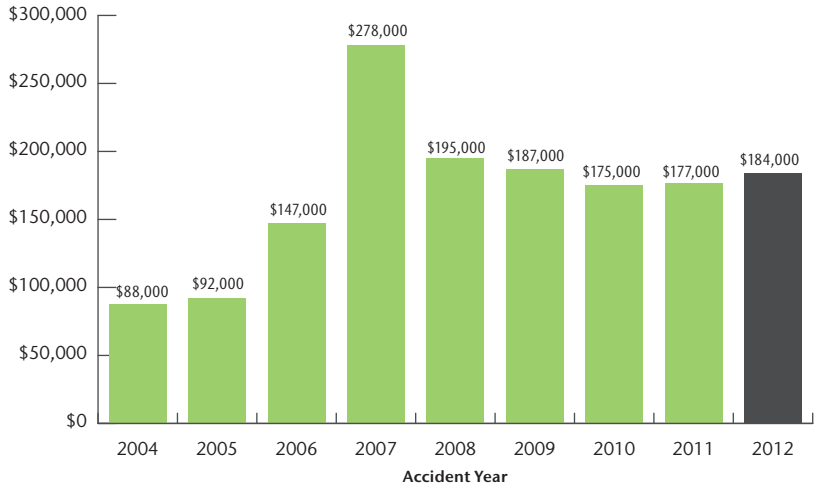
Claim Frequency per Occupied Bed



Severity

Claim severity spiked in 2007 at $278,000. Since then severity has been relatively stable at just under $200,000.

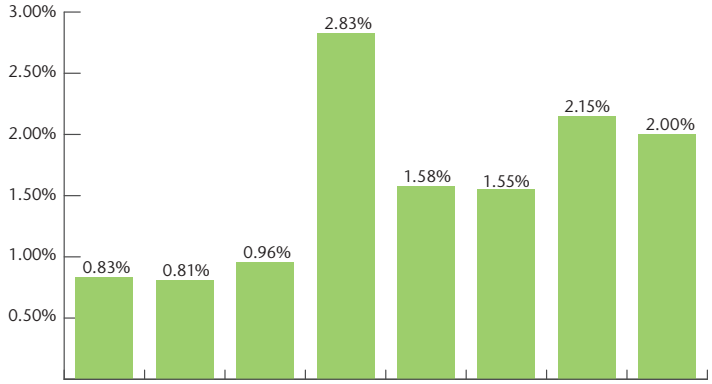
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has increased from levels before 2007. The 2011 loss rate as a percent of the Medicaid per diem reimbursement rate is 2.00%.

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$129.67	$132.87	$134.18	$136.54	$150.33	$155.69	$160.52	$165.17
Per Diem Loss Rate per Bed	$1.07	$1.07	$1.29	$3.86	$2.38	$2.41	$3.45	$3.31

Pennsylvania

The participants in this study represent approximately 24,400 licensed beds in the state. This is approximately 30% of the state total long term care beds.

Loss Rate

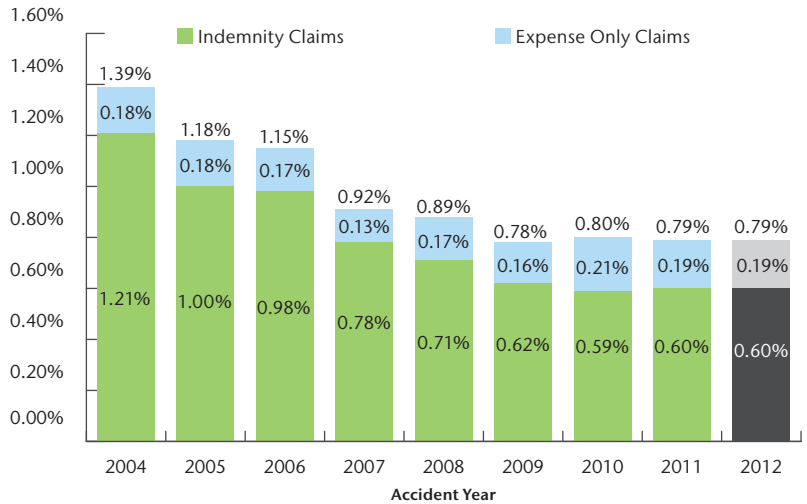
Pennsylvania's loss rate per occupied bed has decreased from a high of $1,290 in 2004. Since 2007, the loss rate has increased from $820 per occupied bed to a projected $920 per occupied bed in 2012.

Loss Rate per Occupied Bed Limited to $1M per Occurrence

Frequency

Claim frequency has dropped from a high in 2004 of 1.39% to a projected frequency of 0.79% in 2012.

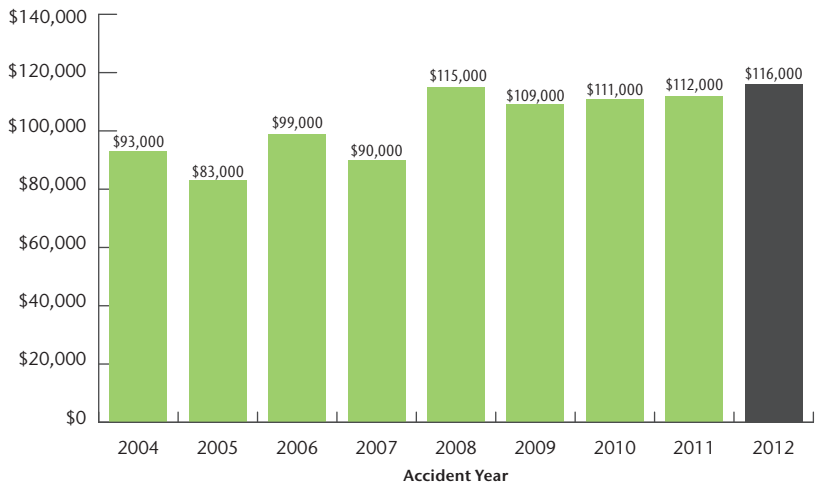
Claim Frequency per Occupied Bed



Severity

Claim severity in Pennsylvania shows a moderately increasing pattern over the experience period. The projected severity in 2012 is $116,000.

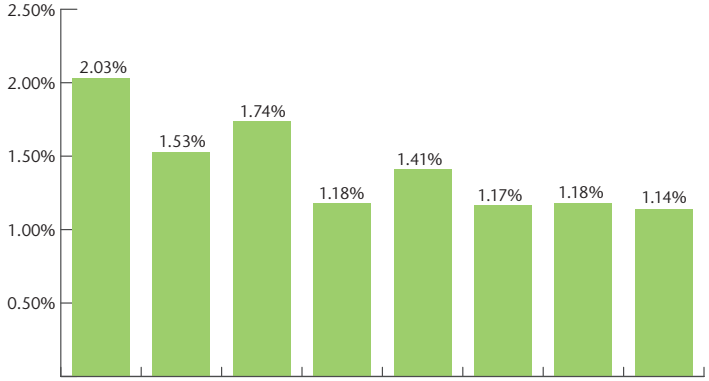
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has been steadily declining since peaking at 2.03% in 2004. The current rate is 1.14%.

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$173.97	$175.08	$179.17	$190.83	$197.61	$199.42	$205.96	$211.58
Per Diem Loss Rate per Bed	$3.53	$2.68	$3.12	$2.25	$2.79	$2.33	$2.44	$2.41

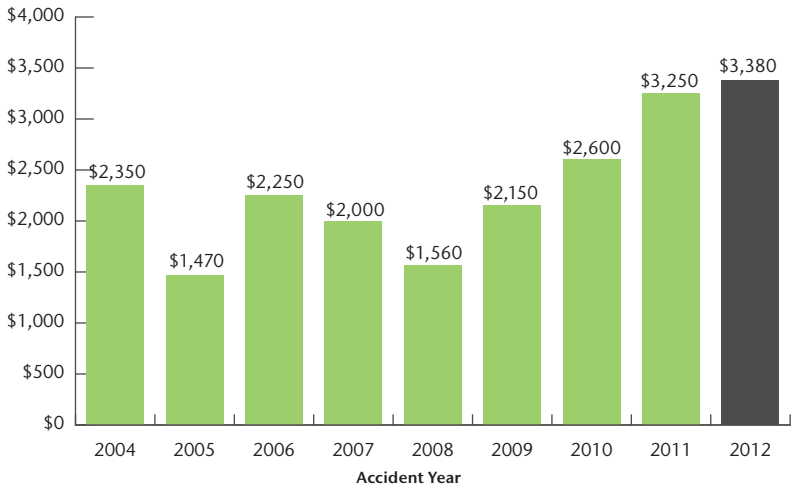
Tennessee

The participants in this study represent approximately 8,900 licensed beds in the state. This is approximately 28% of the state total long term care beds.

Loss Rate

Loss rates in Tennessee have increased in recent years from $1,560 in 2008 to a projected $3,380 in 2012. Tort limits on claims became effective in October 2011. The legislation caps punitive damages at the greater of twice compensatory damages or $500,000. Awards on non-economic damages are limited to $750,000 per claim, and $1 million in cases of catastrophic injury. The non-economic caps are removed if there is intent to harm, if the defendant acts to unlawfully evade liability or if the defendant was under the influence of intoxicants when the alleged harm occurred.

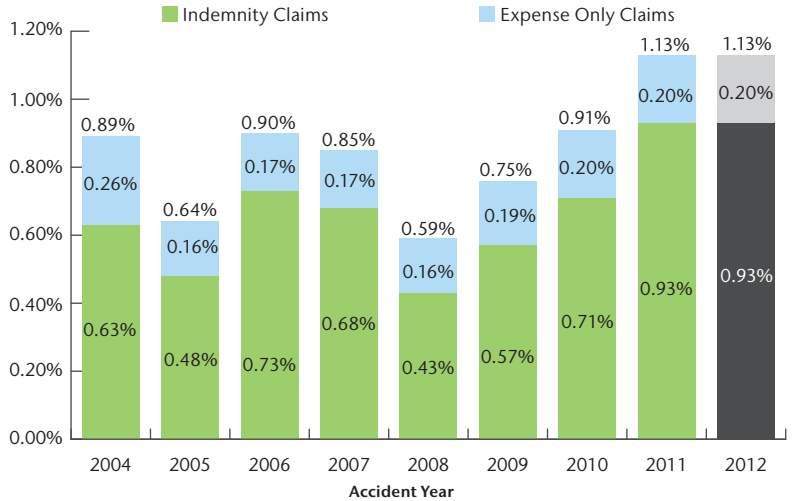
Loss Rate per Occupied Bed Limited to $1M per Occurrence



Frequency

Claim frequency in Tennessee has been under 0.91% from 2004 through 2009. The bulge in claim frequency in 2010 and 2011 may reflect an increase due to upcoming tort limits. Claimants will attempt to make claims before tort limits become effective, and these claims may have occurred in prior years.

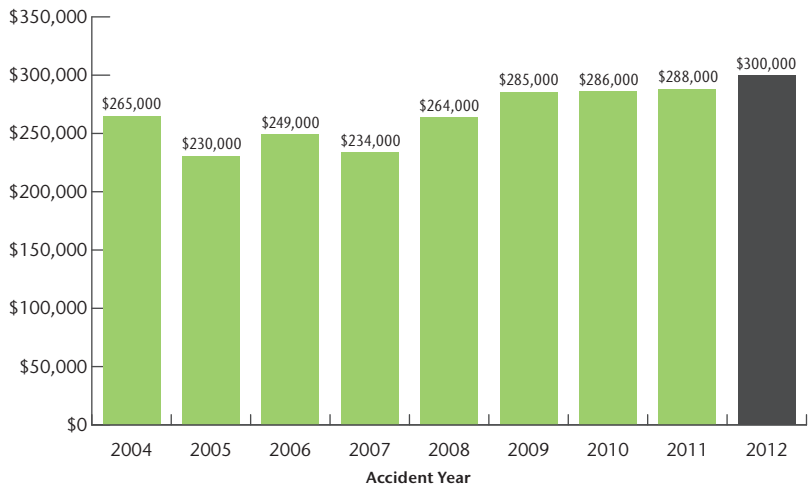
Claim Frequency per Occupied Bed



Severity

Claim severity drives Tennessee's loss rates relative to other states. In this study, Tennessee's 2012 forecast severity is third highest among the profiled states at $300,000.

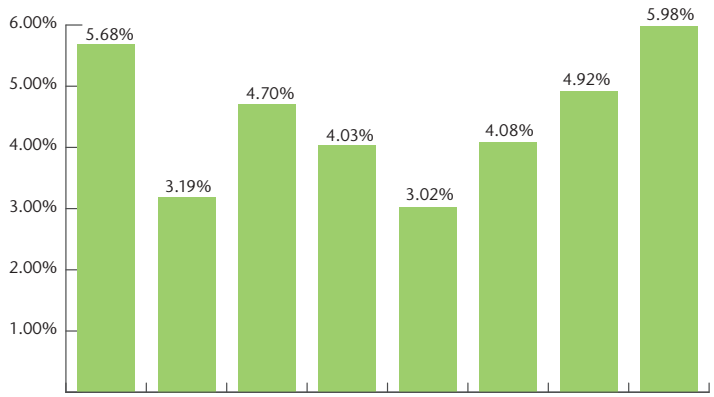
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has been as low as 3.02% in 2008, but has since increased to an eight year high at 5.98%.

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$113.22	$126.05	$131.05	$136.12	$141.56	$144.30	$144.63	$148.82
Per Diem Loss Rate per Bed	$6.43	$4.02	$6.16	$5.48	$4.27	$5.89	$7.12	$8.90

Texas

The participants in this study represent approximately 12,900 licensed beds in the state. This is approximately 14% of the state total long term care beds.

Loss Rate

For years, the Aon study has cited Texas as the example for effective tort reform. Texas enacted tort reform in 2003 and shortly thereafter saw remarkable reductions in loss rates. In prior studies, we have estimated pre-refom loss rates in Texas above $5,500 per occupied bed.[8] In 2005, just two years after tort reform became effective, the loss rate was $460 per occupied bed, This reduced rate level has persisted.

Periodically, the tort law has been challenged. It was recently affirmed by a court ruling in March 2012, maintaining Texas's tort environment. The tort limits have survived challenges in part due to constitutional amendments that allow for limits on tort damages in state law.

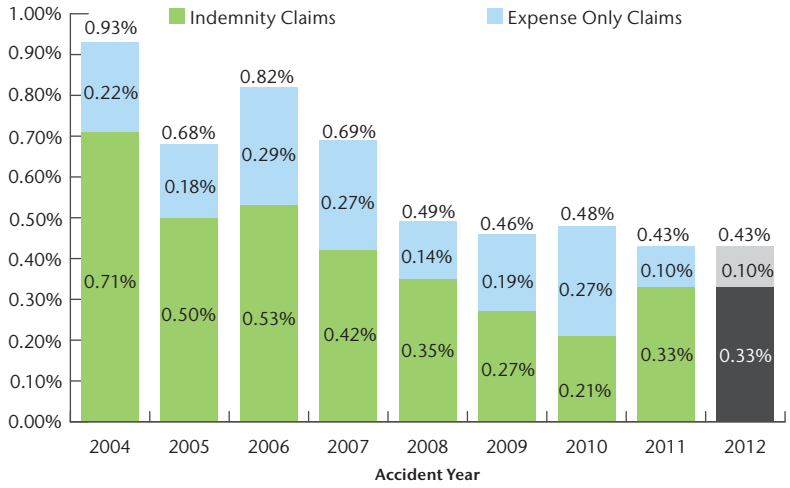
The 2012 forecast loss rate in Texas is $320, the lowest loss rate of the profiled states.

Loss Rate per Occupied Bed Limited to $1M per Occurrence

Frequency

Shortly after tort reform was enacted, loss frequency in Texas began a precipitous drop. The forecast 2011 frequency is 0.43%, the lowest of the profiled states.

Claim Frequency per Occupied Bed

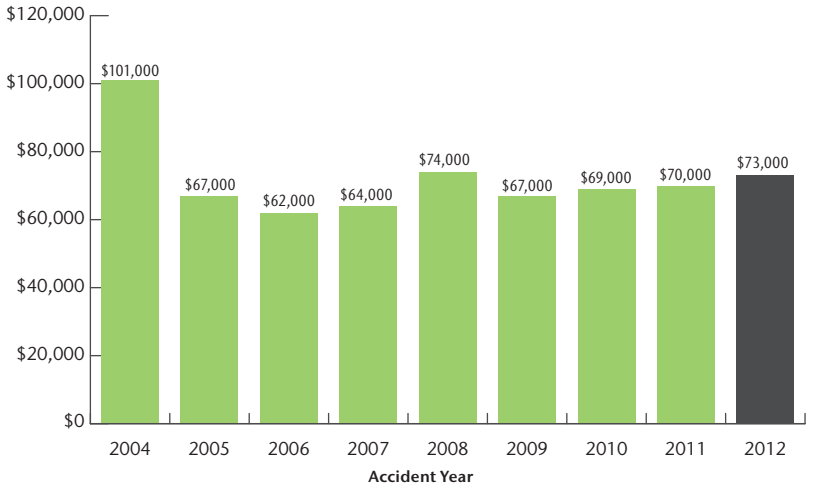


8 Christian Coleianne and Donald Riggins, *Long Term Care 2010 General Liability and Professional Liability Actuarial Analysis August 2010, 36*.

Severity

Claim severity also decreased after tort limits were enacted. Since 2005, severity has grown a slow pace. The 2012 forecast severity of $73,000 is the lowest of the profiled states.

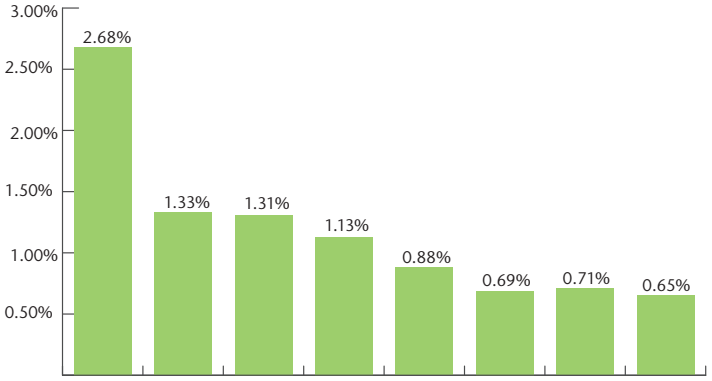
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate tracks the tort reform gains. The current rate of 0.65% is the lowest of the profiled states. The pre-tort reform rate was as high as 15.80%.[9]

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$95.99	$94.67	$107.26	$106.48	$111.89	$123.20	$126.29	$125.96
Per Diem Loss Rate per Bed	$2.57	$1.26	$1.40	$1.20	$0.99	$0.85	$0.90	$0.82

9 Christian Coleianne and Donald Riggins, *Long Term Care 2010 General Liability and Professional Liability Actuarial Analysis August 2010, 38.*

West Virginia

The participants in this study represent approximately 5,100 licensed beds in the state. This is approximately 54% of the state total long term care beds.

Loss Rate

West Virginia's loss rate exhibits a strong upward trend over the experience period. The 2012 forecast of $4,430 per occupied bed is the second highest of the profiled states.

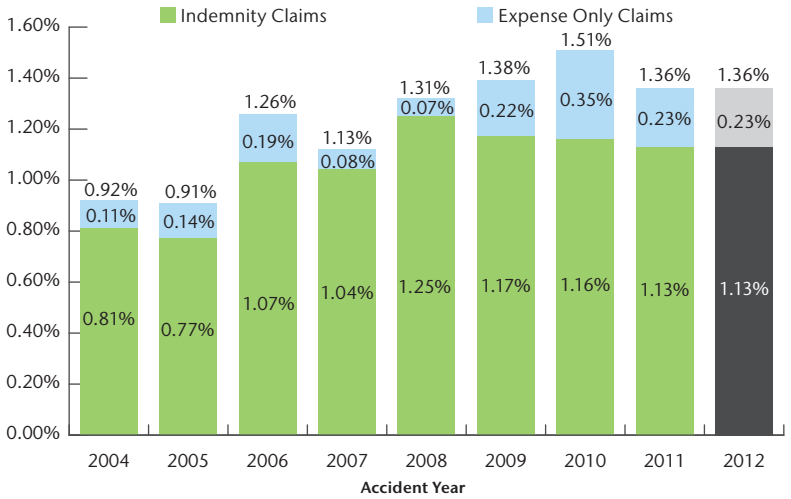
West Virginia enacted limits on non-economic damages in 2003. Despite this legislation, loss rates are high relative to other states and continue to grow. As discussed in the executive summary, judiciary interpretation of the state's laws may be a factor.

Loss Rate per Occupied Bed Limited to $1M per Occurrence

Frequency

West Virginia has the third highest frequency of claims among the profiled states, with a 2012 forecast of 1.36%.

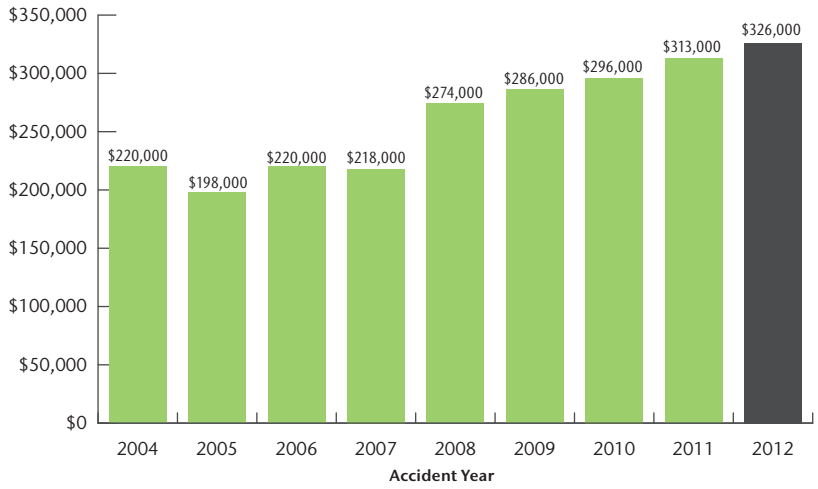
Claim Frequency per Occupied Bed



Severity

West Virginia has the highest projected severity at $326,000. The severity chart shows persistent growth since 2005.

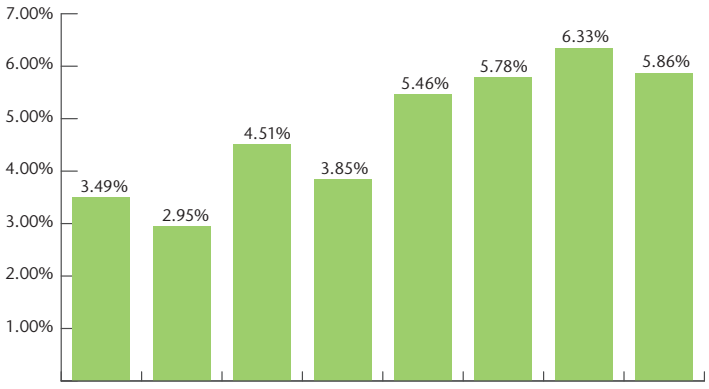
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate has been increasing over the past eight years. At 5.86%, West Virginia's rate is the third highest among the profiled states.

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$158.64	$168.02	$168.11	$174.36	$180.64	$187.50	$193.31	$198.92
Per Diem Loss Rate per Bed	$5.53	$4.96	$7.58	$6.71	$9.86	$10.84	$12.24	$11.66

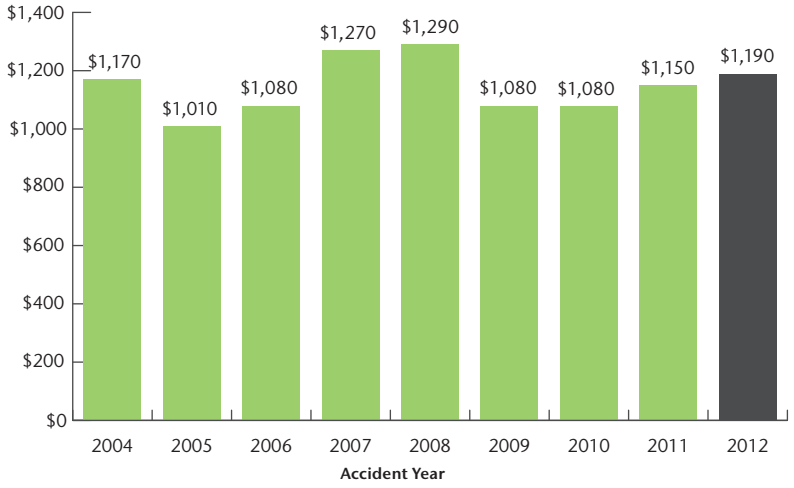
All Other States

The participants in this study represent approximately 146,000 occupied long term care beds in the remaining states. This is approximately 15% of the state total long term care beds in the remaining states.

Loss Rate

The loss rate chart shows a peak in 2008 followed by a new increasing loss rate pattern.

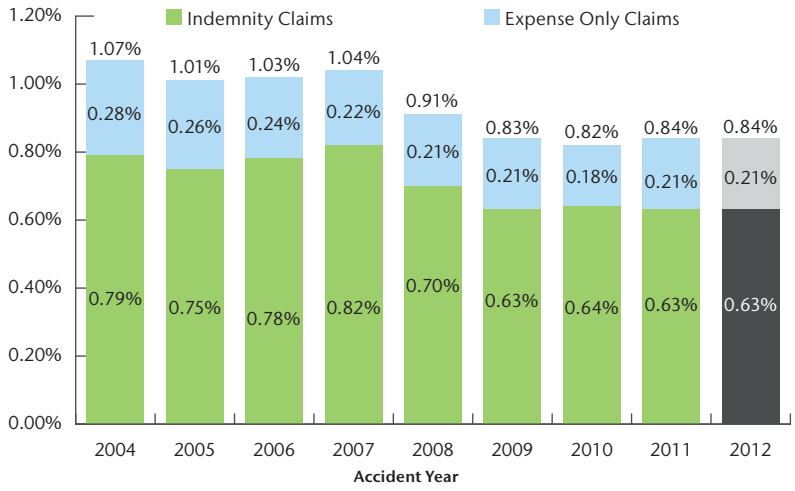
Loss Rate per Occupied Bed Limited to $1M per Occurrence



Frequency

Claim frequency hovered at just over one claim per 100 occupied beds from 2004 through 2007. Since 2007, frequency has decreased and is projected to be 0.84%.

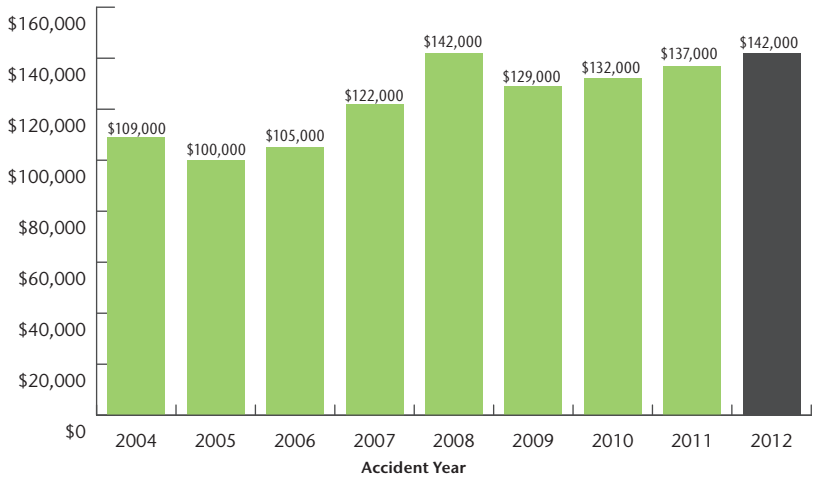
Claim Frequency per Occupied Bed



Severity

Severity has been increasing steadily over the experience period, with a low point $100,000 in 2005. The forecast 2012 severity is $142,000, the highest point on the chart and in line with recent severity growth.

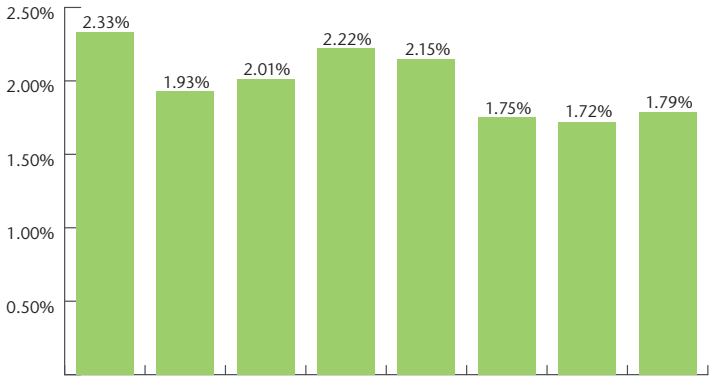
Severity per Claim Limited to $1M per Occurrence



Medicaid Per Diem Reimbursement

The loss rate as a percent of the Medicaid per diem reimbursement rate for All Other States has decreased from 2.33% in 2004 to 1.79% in 2011.

Loss Rate as a Percentage of Medicaid Reimbursement Limited to $1M per Occurrence



Accident Year	2004	2005	2006	2007	2008	2009	2010	2011
Average Medicaid per Diem Reimbursement	$137.07	$143.45	$147.61	$156.87	$164.27	$169.48	$172.12	$175.49
Per Diem Loss Rate per Bed	$3.20	$2.77	$2.96	$3.48	$3.53	$2.96	$2.96	$3.15

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 the report and exhibits include ALAE except where noted otherwise.

Accident Year

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

Claim

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

Exposure

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

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

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

Frequency

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

General Liability (GL)

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

Indemnity

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

Indemnification Rate

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

Limit of Liability

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

Loss Rate

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

Loss Development

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

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

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

Loss Trend

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

Profesional Liability (PL)

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

Severity

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

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