# Medical Malpractice Claims Study

# 1984

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# MEDICAL MALPRACTICE CLAIMS STUDY

Prepared by Staff Members of the
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## INTRODUCTION

Section 155.19 of the Illinois Insurance Code requires the Director of Insurance to release from time to time statistical reports based on Medical Liability Claim reports filed with the Department of Insurance. This reporting statute evolved in 1976 to assist the Department of Insurance in monitoring this very volatile line of insurance and in heading off future market problems or irregularities.

The following study is based on malpractice claims closed in Illinois from January 1, 1980 through December 31, 1983. Of the 3,763 claims closed in this period and reported to the Department, 1,218 had a loss payment and 2,545 did not. "Indemnity Paid" refers to pure dollars of loss settlement, while "Claim Expense Paid" means defense attorneys' fees and miscellaneous loss adjustment expenses.

The reporting form used by companies is included in Appendix A. It is the same form utilized by the National Association of Insurance Commissioners in their September, 1980 study of countrywide claims closed during the years 1975 through 1978. The majority of the graphs and charts presented here closely parallel the material in the NAIC study. Direct comparisons of the studies, however, should not be made. A number of NAIC charts were compiled on an incident basis. That is, if two or more physicians or nurses were named as defendants as a result of one operation allegedly involving malpractice, the entire incident was combined into a single claim count. In the Illinois report all of the charts treat each defendant separately and include only physicians and surgeons. Each claim count, therefore, represents only one defendant doctor. We did this, first, to keep the data base as uniform and as unbiased as possible. Secondly, in assigning report and disposition dates to an incident, we quite often had to decide between two or more dates. The disposition is therefore tracked for each doctor. Thirdly, since there were often two or more insurance companies involved, it was possible that some claim reports stemming from one incident were either short on information or not submitted at all. A defendant doctor claim basis isolates the one area with which there is most concern at the present time.

There are other differences between the Illinois and NAIC studies. We did not collect any information on economic loss, such as the injured person's medical expense, wage loss, and other miscellaneous expense. The information collected was very spotty, and since it is not necessarily a well-defined item within a settlement, economic loss, both past and future, becomes too nebulous to use.

The claim survey contained 27 different codes under the category "Other Contributing to Injury" and 51 different codes under the category "Associated Issues." There were a significant number of claims where two or more codes were

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entered under one category or the other. In 1982, for example, the 1,013 reported claim count would have been expanded to a 1,263 code count. The coding is subjective in the first place. Capturing multiple codes tends to reinforce such subjectivity. These categories were thus excluded from this report but will be reviewed in some detail when a follow-up report is prepared in the future.

The survey only includes claims involving physicians and excludes hospital claims. The hospital claim data was not included for several reasons. Hospital malpractice policies account for less than 25% of the total written malpractice premiums in Illinois. A large percentage of the hospitals are either self insured or have coverage through surplus lines writers and religious trusts. The Department only receives closed claim reports from admitted insurance writers. Finally, there were less than 500 closed claim reports filed with the Department for 1980-83, which constituted too small a sample to have meaning.

Although closed claim data has been collected since 1977, we did not include 1977-79 data because by statute, claims filed with the company prior to 1977 did not have to be reported to the Department. These first three years would therefore be biased toward quickly settled claims. A big part of malpractice insurance is the "tail" which only becomes evident four or more years after an injury occurs. A further discussion of the subject of late reported claims can be found in Appendix B.

In addition, the first nine graphs and charts show only 1980 through 1983 consolidated figures. Individual years are not presented because of a lack of credibility. The three closure years in the NAIC study produced 12,000 claims (closed with and without payments) in 1975; 18,000 in 1976; 16,000 in 1977; and 17,000 in 1978, for a total of 62,097 claims. In Illinois the highest number of closed claims reported to the Department in any one year was only 1,375 in 1983, as shown in Chart 10. Even on a combined four year basis the reported claim count of 3,763 is often stretched so thin that extreme care must be taken in drawing conclusions from these reports.

In the way of background, the Annual Statement Page 14 data for Medical Malpractice is shown for 1978-1983 in Appendix B. Prior to 1978 these direct figures did not show "incurred but not reported" or late reported loss reserves and would therefore not be appropriate to use.

This study is our first attempt at presenting malpractice loss data as required by statute. We're hopeful that the information will be of help to all those affected by the issue of medical malpractice insurance. If any of the physicians,

attorneys, insurance companies, or consumers using this study find a need for additional information as coded on the reporting form or changes in the charts and graphs, they should contact Robert Gossrow, Casualty Actuary, Illinois Department of Insurance. Future studies can be modified accordingly.

## 1. TIME FROM INJURY TO REPORT

Charts 1A - 1C display the time patterns of injury reporting, from the date of injury to the date that it was reported to the insurance company.

Chart 1A lists the number of claims reported (claims closed with and without loss payment), number of claims paid (claims closed with loss payment), and the total indemnity paid in 6 month intervals, for minors (under 18) and all ages combined. For example, of the claims reported 19 to 24 months after the injury, 46 involved minors. Out of these, only 16 resulted in any indemnity paid with the total amounting to $965,788. For all ages including minors, 850 claims were initially reported with 273 claims paying $20,008,572. Overall, minors accounted for slightly over 10% of claims reported and paid.

Chart 1B reflects the same data stated in percentages. For minors, 10.6% of all claims were reported 19-24 months after the injury (46/430 from Chart 1A). Of the total number of paid claims for minors, 9.8% were reported 19-24 months after the injury (16/163), and eventually resulted in 4.6% of the total indemnity paid. For claims reported 19-24 months after the injury for all ages, the corresponding figures are 22.5%, 22.4%, and 22.6%.

Chart 1C shows the cumulative percents. Interpretating the same line, 19-24 months for minors, 54.4% of all claims were reported within 24 months of the injury. The line 55-60 shows that for minors, 88.1% of all claims were reported within 60 months of the injury. The same interpretation is used for the other columns (e.g., for all ages, 66.8% of the total indemnity paid resulted from claims reported within 24 months of the injury).

Observations:

Chart 1A shows that over 11% (430/3763) of all claims reported involved minors. This number includes 13% (163/1218) of the paid claims involving 23% (20,659,416/88,157,167) of the total indemnity paid. These percentages are probably understated since 713 of the reported claims in the All Ages category did not report any age. (This data is not available from Charts 1A - 1C.)

By comparing the cumulative percents of claims reported and claims paid in Chart 1C, it is apparent that there is little variation in the development pattern of the two. Regardless of age (minor or all ages) the cumulative percent of claims paid never varies more than 5% from the claims reported.

Graph 1 illustrates that injuries involving minors show a more prolonged reporting pattern than injuries involving all ages. Of the total indemnity paid for all ages, 83.5% is generated by claims reported within 36 months. Minors have a comparable figure of 60.8%. The same general trend is true concerning reported or paid claims. Using Chart 1C, 76.0% of the claims involving minors were reported within 36 months compared to 86.2% for all ages. The paid claim figures are 73.6% and 86.4% respectively.

Charts 1A - 1C are for claims closed in a four year period. These results may differ significantly from a study using claims opened or reported in a four year period. This distinction should be noted before any attempt is made to develop pricing or reserving techniques.

CHART 1A
TIME FROM INJURY TO REPORT
CLAIMS CLOSED IN 1980-83

| MONTHS FROM INJ TO REP (2A - 2B) | MINORS (UNDER AGE 18) CLAIMS REPORTED | CLAIMS PAID | INDEMNITY PAID (22+23) | ALL AGES CLAIMS REPORTED | CLAIMS PAID | INDEMNITY PAID (22+23) |
|---|---|---|---|---|---|---|
| 0 - 6 | 75 | 32 | $3,458,562 | 458 | 149 | $11,401,250 |
| 7 - 12 | 54 | 18 | $2,144,024 | 439 | 169 | $14,423,098 |
| 13 - 18 | 59 | 21 | $2,421,851 | 435 | 154 | $13,099,156 |
| 19 - 24 | 46 | 16 | $965,788 | 850 | 273 | $20,008,572 |
| 25 - 30 | 66 | 25 | $1,145,661 | 844 | 252 | $10,036,645 |
| 31 - 36 | 27 | 8 | $2,429,500 | 218 | 56 | $4,700,034 |
| 37 - 42 | 20 | 5 | $1,626,500 | 121 | 44 | $3,874,883 |
| 43 - 48 | 13 | 5 | $1,742,019 | 81 | 23 | $2,602,269 |
| 49 - 54 | 11 | 3 | $112,400 | 91 | 25 | $937,400 |
| 55 - 60 | 8 | 4 | $512,000 | 37 | 11 | $1,158,499 |
| 61 - 72 | 10 | 6 | $332,000 | 52 | 14 | $1,269,500 |
| 73 - 84 | 12 | 3 | $585,611 | 44 | 9 | $1,016,611 |
| 85 - 96 | 5 | 3 | $2,295,000 | 15 | 9 | $2,482,500 |
| 97 - 108 | 3 | 1 | $10,000 | 25 | 7 | $46,000 |
| 109 - 120 | 4 | 2 | $135,000 | 10 | 3 | $138,000 |
| 121 - 180 | 13 | 8 | $703,500 | 33 | 14 | $792,750 |
| OVER 181 | 4 | 3 | $40,080 | 10 | 6 | $170,000 |
| TOTAL | 430 | 163 | $20,659,416 | 3,763 | 1,218 | $88,157,167 |

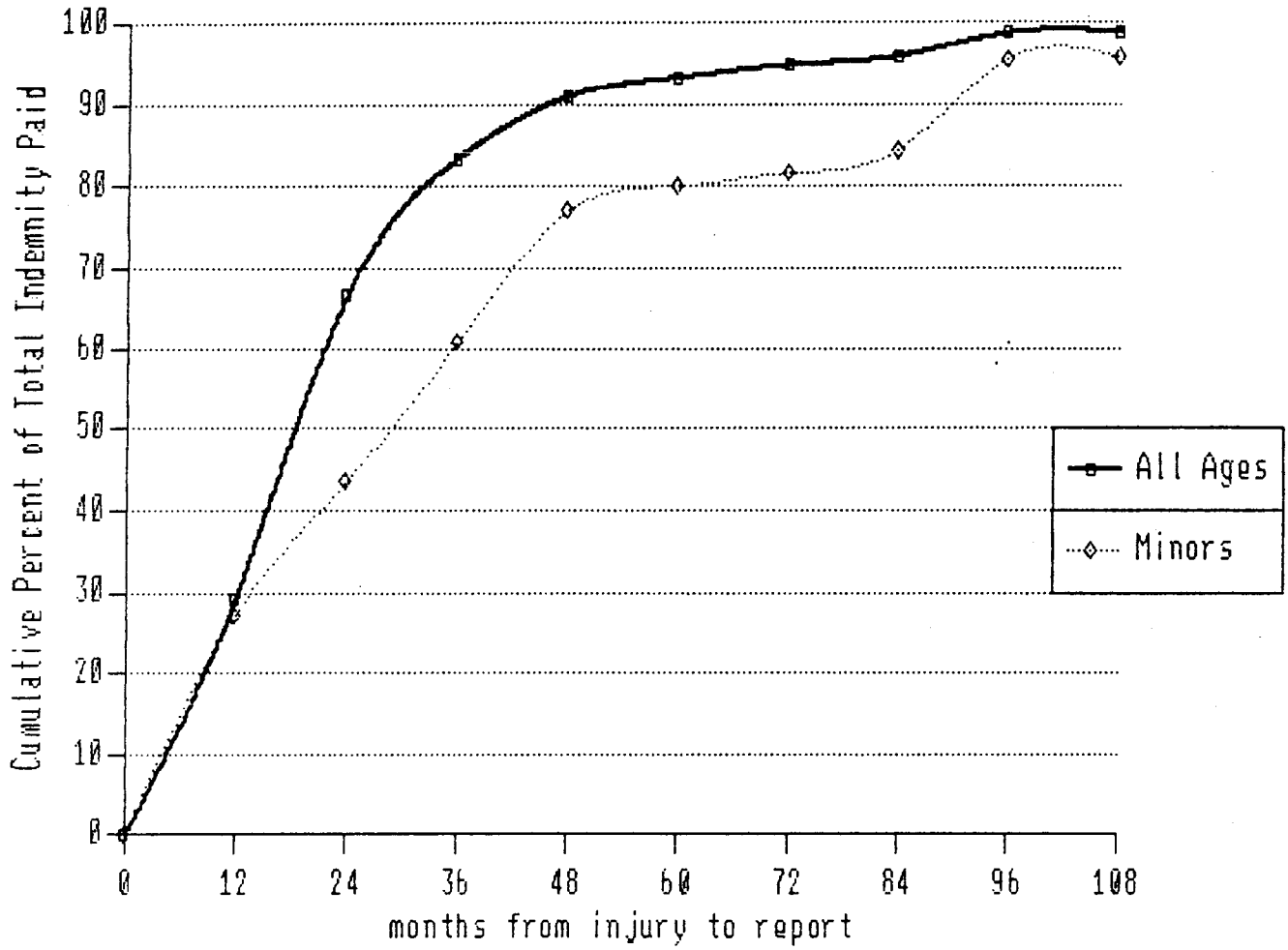
CHART 1B
TIME FROM INJURY TO REPORT
CLAIMS CLOSED IN 1980-83

| MONTHS FROM INJ TO REP (2A - 2B) | MINORS (UNDER AGE 18) PERCENT OF CLAIMS REPORTED | MINORS (UNDER AGE 18) PERCENT OF CLAIMS PAID | MINORS (UNDER AGE 18) INDEMNITY PAID (22+23) | ALL AGES PERCENT OF CLAIMS REPORTED | ALL AGES PERCENT OF CLAIMS PAID | ALL AGES INDEMNITY PAID (22+23) |
|---|---|---|---|---|---|---|
| 0 - 6 | 17.4% | 19.6% | 16.7% | 12.1% | 12.2% | 12.9% |
| 7 - 12 | 12.5% | 11.0% | 10.3% | 11.6% | 13.8% | 16.3% |
| 13 - 18 | 13.7% | 12.8% | 11.7% | 11.5% | 12.6% | 14.8% |
| 19 - 24 | 10.6% | 9.8% | 4.6% | 22.5% | 22.4% | 22.6% |
| 25 - 30 | 15.3% | 15.3% | 5.5% | 22.4% | 20.6% | 11.3% |
| 31 - 36 | 6.2% | 4.9% | 11.7% | 5.7% | 4.5% | 5.3% |
| 37 - 42 | 4.6% | 3.0% | 7.8% | 3.2% | 3.6% | 4.3% |
| 43 - 48 | 3.0% | 3.0% | 8.4% | 2.1% | 1.8% | 2.9% |
| 49 - 54 | 2.5% | 1.8% | 0.5% | 2.4% | 2.0% | 1.0% |
| 55 - 60 | 1.8% | 2.4% | 2.4% | 0.9% | 0.9% | 1.3% |
| 61 - 72 | 2.3% | 3.6% | 1.6% | 1.3% | 1.1% | 1.4% |
| 73 - 84 | 2.7% | 1.8% | 2.8% | 1.1% | 0.7% | 1.1% |
| 85 - 96 | 1.1% | 1.8% | 11.1% | 0.3% | 0.7% | 2.8% |
| 97 - 108 | 0.6% | 0.6% | 0.0% | 0.6% | 0.5% | 0.0% |
| 109 - 120 | 0.9% | 1.2% | 0.6% | 0.2% | 0.2% | 0.1% |
| 121 - 180 | 3.0% | 4.9% | 3.4% | 0.8% | 1.1% | 0.8% |
| OVER 181 | 0.9% | 1.8% | 0.1% | 0.2% | 0.4% | 0.1% |

CHART 1C
TIME FROM INJURY TO REPORT
CLAIMS CLOSED IN 1980-83

| MONTHS FROM INJ TO REP (2A - 2B) | MINORS (UNDER AGE 18) CUM % OF CLAIMS REPORTED | MINORS (UNDER AGE 18) CUM % OF CLAIMS PAID | MINORS (UNDER AGE 18) INDEMNITY PAID (22+23) | ALL AGES CUM % OF CLAIMS REPORTED | ALL AGES CUM % OF CLAIMS PAID | ALL AGES INDEMNITY PAID (22+23) |
|---|---|---|---|---|---|---|
| 0 - 6 | 17.4% | 19.6% | 16.7% | 12.1% | 12.2% | 12.9% |
| 7 - 12 | 30.0% | 30.6% | 27.1% | 23.8% | 26.1% | 29.2% |
| 13 - 18 | 43.7% | 43.5% | 38.8% | 35.3% | 38.7% | 44.1% |
| 19 - 24 | 54.4% | 53.3% | 43.5% | 57.9% | 61.1% | 66.8% |
| 25 - 30 | 69.7% | 68.7% | 49.0% | 80.4% | 81.8% | 78.2% |
| 31 - 36 | 76.0% | 73.6% | 60.8% | 86.2% | 86.4% | 83.5% |
| 37 - 42 | 80.6% | 76.6% | 68.6% | 89.4% | 90.0% | 87.9% |
| 43 - 48 | 83.7% | 79.7% | 77.1% | 91.5% | 91.9% | 90.9% |
| 49 - 54 | 86.2% | 81.5% | 77.6% | 93.9% | 94.0% | 91.9% |
| 55 - 60 | 88.1% | 84.0% | 80.1% | 94.9% | 94.9% | 93.2% |
| 61 - 72 | 90.4% | 87.7% | 81.7% | 96.3% | 96.0% | 94.7% |
| 73 - 84 | 93.2% | 89.5% | 84.5% | 97.5% | 96.7% | 95.8% |
| 85 - 96 | 94.4% | 91.4% | 95.6% | 97.9% | 97.5% | 98.6% |
| 97 - 108 | 95.1% | 92.0% | 95.7% | 98.5% | 98.1% | 98.7% |
| 109 - 120 | 96.0% | 93.2% | 96.4% | 98.8% | 98.3% | 98.9% |
| 121 - 180 | 99.0% | 98.1% | 99.8% | 99.7% | 99.5% | 99.8% |
| OVER 181 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Graph 1
Time From Injury to Report
Claims Closed in 1980-83




For example, claims reported within 36 months from injury accounted for 83.5% of the total indemnity paid for all ages. For minors that figure was only 60.8%.

## 2. TIME FROM REPORT TO DISPOSITION AND INJURY TO DISPOSITION

Charts 2A - 2C simultaneously display time patterns of closed claims from injury and report dates. They also show how variations in length of time relate to the amount of indemnity and expense paid per claim.

Chart 2A lists the number of claims reported, number of claims paid, total indemnity paid, and claim expense paid in six month increments. The left half measures the time from the report date to the date of disposition or closure, while the other measures the time from the injury date to the closure date. For example, there were 213 reported claims that were closed 43 to 48 months after they were reported. One hundred of these claims resulted in $6,263,657 indemnity paid. The total claim expense for all 213 claims was $1,550,986. In addition, Chart 2A shows that there were 437 reported claims that were closed 43 to 48 months after the injury occurred. The equality of the corresponding totals emphasizes that both halves of the chart are summarizing the identical data.

Chart 2B shows the percentages. For example, 5.6% (213/3,763 from Chart 2A) of the reported claims were closed 43-48 months after they were reported. Of the paid claims, 8.2% (100/1218) had similar report to disposition times; 7.1% of the total indemnity paid and 10.7% of the claim expense paid were from claims in this interval. Of the total reported claims, 11.6% (437/3,763) were closed 43-48 months after the injury had occurred.

Chart 2C shows the cumulative percents. For example, 86.7% of all reported claims were closed within 48 months after they were reported, while 52.5% of the reported claims were closed within 48 months after the injury occurred.

Any time the term "Claims Reported" is used, it includes both claims with indemnity paid and claims closed without indemnity paid.

Observations:

In Chart 2C, the cumulative percents measured by report to disposition are always greater than the corresponding injury to disposition percents. This is true because the time from injury to disposition is the sum of the injury to report time and the report to disposition time. About 50% of all reported claims were closed 24 months after they were reported, while it took almost 48 months from injury to close 50%.

Graph 2 illustrates that large claims take longer to close than small claims. For example, 80.2% of all claims paid were

closed within 48 months of the report date. The graph shows that the remaining 19.8% of paid claims accounted for 31% of the total indemnity paid. Since less claims account for a higher percent of the dollars, they must be larger. So because the indemnity paid line is below the paid claim line, the larger claims are toward the end of the graph. The graph also shows that the claims with higher expenses take longer.

CHART 2A
TIME FROM REPORT TO DISPOSITION AND TIME FROM INJURY TO DISPOSITION
CLAIMS CLOSED IN 1980-83

| TIME IN MONTHS | REPORT TO DISPOSITION | | | | INJURY TO DISPOSITION | | | |
|---|---|---|---|---|---|---|---|---|
| | CLAIMS REPORTED | CLAIMS PAID | INDEMNITY PAID (22+23) | CLAIM EXPENSE PAID (25+26) | CLAIMS REPORTED | CLAIMS PAID | INDEMNITY PAID (22+23) | CLAIM EXPENSE PAID (25+26) |
| 0 - 6 | 317 | 96 | 1,318,593 | 162,633 | 19 | 9 | 23,078 | 5,264 |
| 7 - 12 | 511 | 80 | 6,621,425 | 686,955 | 71 | 31 | 339,730 | 10,834 |
| 13 - 18 | 592 | 114 | 4,784,744 | 986,316 | 104 | 30 | 1,024,875 | 63,941 |
| 19 - 24 | 514 | 134 | 8,667,552 | 1,556,347 | 160 | 54 | 2,773,852 | 165,732 |
| 25 - 30 | 482 | 168 | 15,276,743 | 2,090,157 | 376 | 76 | 5,120,143 | 557,275 |
| 31 - 36 | 351 | 162 | 11,470,655 | 1,885,535 | 381 | 74 | 7,221,228 | 831,301 |
| 37 - 42 | 283 | 123 | 6,472,791 | 1,436,800 | 430 | 111 | 6,928,334 | 1,119,954 |
| 43 - 48 | 213 | 100 | 6,263,657 | 1,550,986 | 437 | 125 | 7,458,927 | 1,716,348 |
| 49 - 54 | 139 | 68 | 5,477,612 | 935,014 | 354 | 108 | 5,534,163 | 1,390,144 |
| 55 - 60 | 130 | 51 | 3,146,650 | 737,014 | 284 | 100 | 7,117,266 | 1,289,365 |
| 61 - 72 | 127 | 72 | 12,235,887 | 1,363,489 | 468 | 170 | 10,404,728 | 2,481,538 |
| 73 - 84 | 58 | 24 | 4,676,358 | 561,335 | 272 | 147 | 16,870,859 | 1,901,155 |
| 85 - 96 | 21 | 12 | 612,000 | 316,407 | 162 | 80 | 7,688,431 | 1,118,148 |
| 97 - 108 | 14 | 6 | 545,000 | 116,778 | 73 | 35 | 4,334,172 | 628,482 |
| 109 - 120 | 8 | 5 | 400,000 | 66,262 | 64 | 21 | 2,362,631 | 531,738 |
| 121 - 180 | 3 | 3 | 187,500 | 20,909 | 79 | 33 | 2,383,250 | 521,915 |
| OVER 181 | . | 0 | . | . | 29 | 14 | 571,500 | 139,803 |
| TOTAL | 3,763 | 1,218 | 88,157,167 | 14,472,937 | 3,763 | 1,218 | 88,157,167 | 14,472,937 |

CHART 2B

TIME FROM REPORT TO DISPOSITION AND TIME FROM INJURY TO DISPOSITION

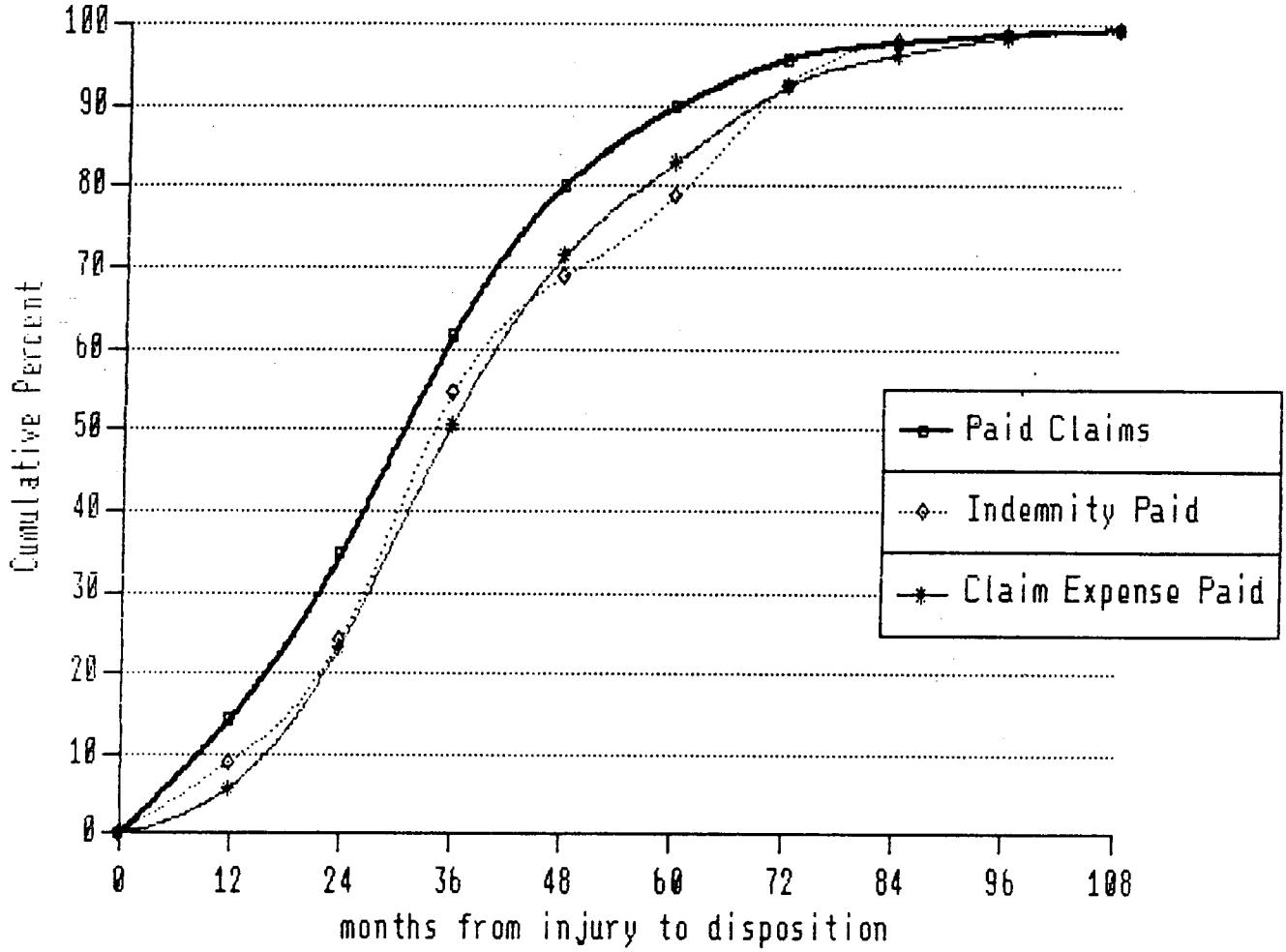
CLAIMS CLOSED IN 1980-83

| TIME IN MONTHS | REPORT TO DISPOSITION | | | | INJURY TO DISPOSITION | | | |
|---|---|---|---|---|---|---|---|---|
| | PERCENT OF CLAIMS REPORTED | PERCENT OF CLAIMS PAID | INDEMNITY PAID (22+23) | CLAIM EXPENSE PAID (25+26) | PERCENT OF CLAIMS REPORTED | PERCENT OF CLAIMS PAID | INDEMNITY PAID (22+23) | CLAIM EXPENSE PAID (25+26) |
| 0 - 6 | 8.4% | 7.8% | 1.4% | 1.1% | 0.5% | 0.7% | 0.0% | 0.0% |
| 7 - 12 | 13.5% | 6.5% | 7.5% | 4.7% | 1.8% | 2.5% | 0.3% | 0.0% |
| 13 - 18 | 15.7% | 9.3% | 5.4% | 6.8% | 2.7% | 2.4% | 1.1% | 0.4% |
| 19 - 24 | 13.6% | 11.0% | 9.8% | 10.7% | 4.2% | 4.4% | 3.1% | 1.1% |
| 25 - 30 | 12.8% | 13.7% | 17.3% | 14.4% | 9.9% | 6.2% | 5.8% | 3.8% |
| 31 - 36 | 9.3% | 13.3% | 13.0% | 13.0% | 10.1% | 6.0% | 8.1% | 5.7% |
| 37 - 42 | 7.5% | 10.0% | 7.3% | 9.9% | 11.4% | 9.1% | 7.8% | 7.7% |
| 43 - 48 | 5.6% | 8.2% | 7.1% | 10.7% | 11.6% | 10.2% | 8.4% | 11.8% |
| 49 - 54 | 3.6% | 5.5% | 6.2% | 6.4% | 9.4% | 8.8% | 6.2% | 9.6% |
| 55 - 60 | 3.4% | 4.1% | 3.5% | 5.0% | 7.5% | 8.2% | 8.0% | 8.9% |
| 61 - 72 | 3.3% | 5.9% | 13.8% | 9.4% | 12.4% | 13.9% | 11.8% | 17.1% |
| 73 - 84 | 1.5% | 1.9% | 5.3% | 3.8% | 7.2% | 12.0% | 19.1% | 13.1% |
| 85 - 96 | 0.5% | 0.9% | 0.6% | 2.1% | 4.3% | 6.5% | 8.7% | 7.7% |
| 97 - 108 | 0.3% | 0.4% | 0.6% | 0.8% | 1.9% | 2.8% | 4.9% | 4.3% |
| 109 - 120 | 0.2% | 0.4% | 0.4% | 0.4% | 1.7% | 1.7% | 2.6% | 3.6% |
| 121 - 180 | 0.0% | 0.2% | 0.2% | 0.1% | 2.0% | 2.7% | 2.7% | 3.6% |
| OVER 181 | . | 0.0% | . | . | 0.7% | 1.1% | 0.6% | 0.9% |

CHART 2C
TIME FROM REPORT TO DISPOSITION AND TIME FROM INJURY TO DISPOSITION
CLAIMS CLOSED IN 1980-83

| TIME IN MONTHS | REPORT TO DISPOSITION | | | | INJURY TO DISPOSITION | | | |
|---|---|---|---|---|---|---|---|---|
| | CUM % OF CLAIMS REPORTED | CUM % OF CLAIMS PAID | INDEMNITY PAID (22+23) | CLAIM EXPENSE PAID (25+26) | CUM % OF CLAIMS REPORTED | CUM % OF CLAIMS PAID | INDEMNITY PAID (22+23) | CLAIM EXPENSE PAID (25+26) |
| 0 - 6 | 8.4% | 7.8% | 1.4% | 1.1% | 0.5% | 0.7% | 0.0% | 0.0% |
| 7 - 12 | 22.0% | 14.4% | 9.0% | 5.8% | 2.3% | 3.2% | 0.4% | 0.1% |
| 3 - 18 | 37.7% | 23.8% | 14.4% | 12.6% | 5.1% | 5.7% | 1.5% | 0.5% |
| 9 - 24 | 51.3% | 34.8% | 24.2% | 23.4% | 9.4% | 10.1% | 4.7% | 1.6% |
| 5 - 30 | 64.2% | 48.6% | 41.5% | 37.8% | 19.3% | 16.4% | 10.5% | 5.5% |
| 1 - 36 | 73.5% | 61.9% | 54.6% | 50.9% | 29.5% | 22.4% | 18.7% | 11.2% |
| 7 - 42 | 81.0% | 72.0% | 61.9% | 60.8% | 40.9% | 31.6% | 26.5% | 19.0% |
| 3 - 48 | 86.7% | 80.2% | 69.0% | 71.5% | 52.5% | 41.8% | 35.0% | 30.8% |
| 9 - 54 | 90.4% | 85.7% | 75.2% | 78.0% | 61.9% | 50.7% | 41.3% | 40.4% |
| 5 - 60 | 93.8% | 89.9% | 78.8% | 83.1% | 69.5% | 58.9% | 49.3% | 49.4% |
| 1 - 72 | 97.2% | 95.8% | 92.7% | 92.5% | 81.9% | 72.9% | 61.1% | 66.5% |
| 3 - 84 | 98.7% | 97.8% | 98.0% | 96.4% | 89.1% | 84.9% | 80.3% | 79.6% |
| 5 - 96 | 99.3% | 98.8% | 98.7% | 98.5% | 93.4% | 91.5% | 89.0% | 87.4% |
| 7 - 108 | 99.7% | 99.3% | 99.3% | 99.3% | 95.4% | 94.4% | 93.9% | 91.7% |
| 9 - 120 | 99.9% | 99.7% | 99.7% | 99.8% | 97.1% | 96.1% | 96.6% | 95.4% |
| 1 - 180 | 100.0% | 100.0% | 100.0% | 100.0% | 99.2% | 98.8% | 99.3% | 99.0% |
| ER 181 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Graph 2
Time From Report to Disposition
Claims Closed in 1980-83




For example, 80.2% of all claims paid were closed within 48 months of the report date. These claims only accounted for 69.0% of the total indemnity paid and 71.5% of the claim expense paid.

## 3. TIME BETWEEN INJURY, REPORT, AND DISPOSITION, BY SEVERITY

Chart 3 displays, by degree of severity of injury, the average number of months between: (1) injury and report date; (2) report and closure date; and (3) injury and closure date. The three patterns are shown separately for claims with and without indemnity paid.

For example, there were 644 closed claims with a severity code of 5 (permanent minor). The 246 claims with indemnity paid took an average of 28.4 months from injury date to report date and 34.6 months from report to disposition (closure) date. This totals to 63.0 months from injury to closure date. The 398 claims without payment took 54.4 months from injury to closure date.

Observations:

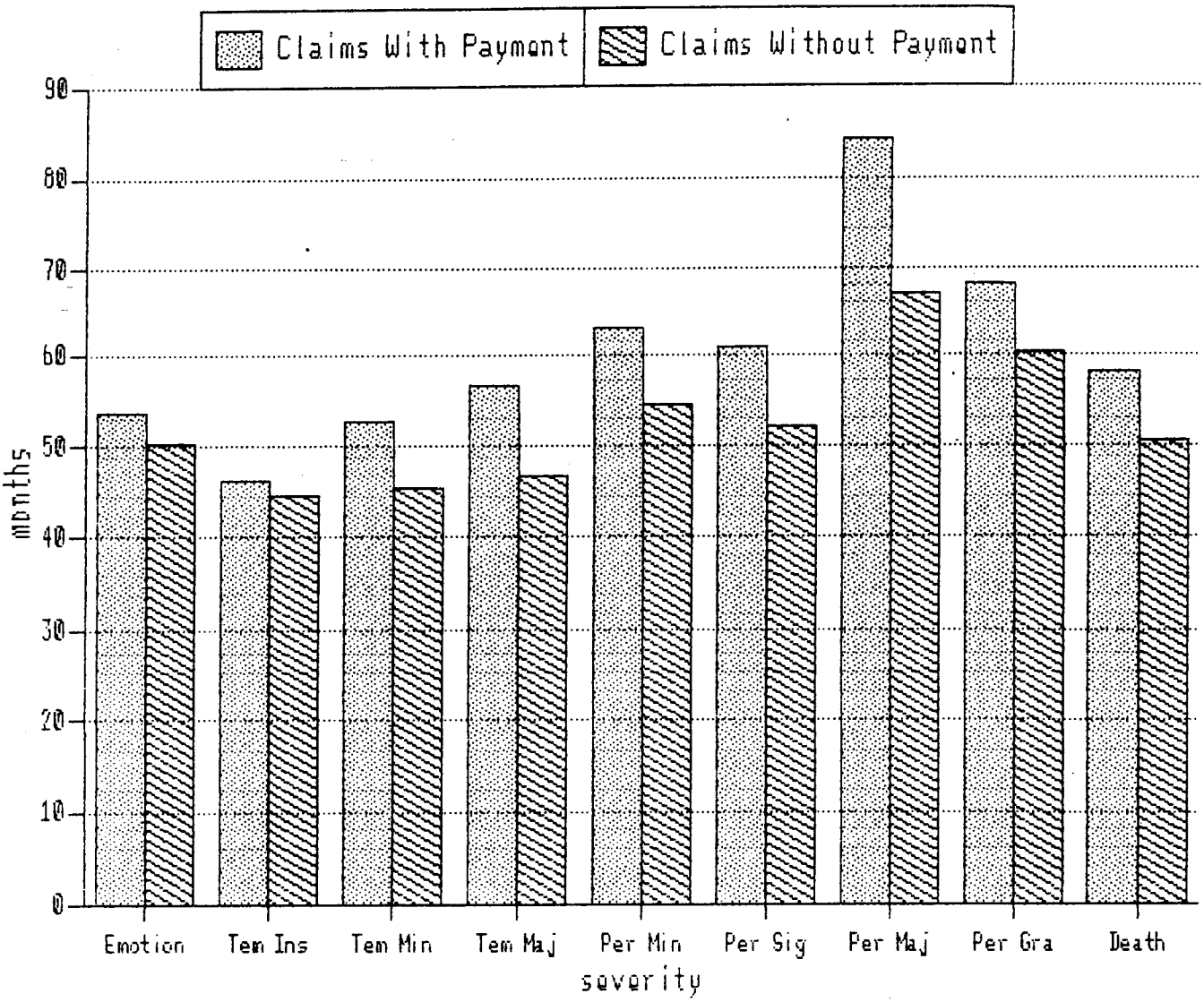
There were twice as many claims closed without payment (2,545) as were closed with payment (1,218). Claims with and without payment had the same average report time (25.2 and 25.4 months), but once reported, claims that eventually ended in payment took an average of 8.7 months longer to close (33.5 - 24.8 months).

Graph 3 shows that regardless of severity, claims with payments had larger injury to closure times than claims without payments. Permanent major severity claims took the longest time to close with permanent grave being second. The lowest closure time is exhibited by temporary insignificant claims. It is interesting to note that overall average time from incident to settlement is in excess of 4 years.

CHART 3
TIME BETWEEN INJURY, REPORT AND DISPOSITION, BY SEVERITY
CLAIMS CLOSED IN 1980-83

| SEVERITY | CLAIMS WITH PAYMENTS | CLAIMS WITHOUT PAYMENTS | CLAIMS WITH PAYMENT: INJ / REP AV MONTHS (2B-2A) | CLAIMS WITH PAYMENT: REP / DISP AV MONTHS (20A-2B) | CLAIMS WITH PAYMENT: INJ / DISP AV MONTHS (20A-2A) | CLAIMS WITHOUT PAYMENTS: INJ / REP AV MONTHS (2B-2A) | CLAIMS WITHOUT PAYMENTS: REP / DISP AV MONTHS (20A-2B) | CLAIMS WITHOUT PAYMENTS: INJ / DISP AV MONTHS (20A-2A) |
|---|---|---|---|---|---|---|---|---|
| NOT CODED | 1 | 42 | 39.0 | 45.0 | 84.0 | 26.7 | 14.7 | 41.4 |
| 1 EMOTIONAL ONLY | 40 | 109 | 32.9 | 20.8 | 53.7 | 29.3 | 20.8 | 50.1 |
| 2 TEMPORARY INSIGNIFICANT | 98 | 222 | 23.7 | 22.4 | 46.1 | 20.4 | 24.0 | 44.5 |
| 3 TEMPORARY MINOR | 198 | 513 | 24.0 | 28.5 | 52.5 | 21.7 | 23.8 | 45.5 |
| 4 TEMPORARY MAJOR | 124 | 340 | 25.1 | 31.6 | 56.7 | 23.6 | 23.1 | 46.7 |
| 5 PERMANENT MINOR | 246 | 398 | 28.4 | 34.6 | 63.0 | 29.2 | 25.2 | 54.4 |
| 6 PERMANENT SIGNIFICANT | 130 | 212 | 23.0 | 37.8 | 60.8 | 27.1 | 25.0 | 52.2 |
| 7 PERMANENT MAJOR | 49 | 111 | 37.5 | 46.6 | 84.1 | 35.6 | 31.1 | 66.7 |
| 8 PERMANENT GRAVE | 57 | 113 | 31.1 | 36.8 | 67.9 | 32.8 | 27.6 | 60.4 |
| 9 DEATH | 275 | 485 | 20.4 | 37.8 | 58.2 | 23.8 | 26.7 | 50.5 |
| TOTAL | 1,218 | 2,545 | 25.2 | 33.5 | 58.8 | 25.4 | 24.8 | 50.2 |

Graph 3
Time Between Injury amd Disposition by Severity
Claims Closed in 1980-83



## 4. AMOUNT OF INDEMNITY PAID FOR EACH CLAIM

Chart 4 reflects the distribution of claims according to size of loss and analyzes the relationship between indemnity and expense.

For example, there were 41 claims reported with indemnity paid of $5,000 to $5,999. The average time from injury to report date for these 41 claims was 31 months and it took 57 months from injury to disposition (closure). These 41 claims had an average indemnity paid of $5,036. Thirty six (36) of these 41 claims had expenses paid that averaged $4,338. (This means there were 5 claims with indemnity paid of $5,000 to $5,999 that had no claim expense paid.) Of all claims reported, 75.0% were under $5,999 (including claims closed with 0 indemnity paid). Claims under $5,999 accounted for only 0.7% of the total loss dollars paid.

It is important to note that the average indemnity column is for reported claims. The total average indemnity of $23,427 includes the 2,545 that were closed without any payment. The comparable average on a per paid claim basis would be $72,379.

Observations:

There were 874 (3,763 minus 2,889) reported claims that had zero claim expense paid. The majority of these were claims that were closed without any indemnity paid.

Two-thirds of all claims reported (2,545 or 68%) are closed without any indemnity paid. On 1,817 of these claims, insurers spent an average of $3,686 successfully defending the claim.

Large claims constitute the majority of the total indemnity paid. Only 5.8% of all reported claims were over $100,000 (94.2% were below $99,999), but this 5.8% accounted for 73.8% of the total indemnity paid. The 8 claims over $1,000,000 accounted for 15.8% of the total.

There is no readily identifiable pattern for average months either from injury to report or from injury to disposition. It does appear, however, that large claims take about the same time to emerge or be reported as small claims. This might be related to the Illinois statute of limitations. Also, as the average loss increases so does the average claim expense. As is to be expected, more attention is given the larger claims.

CHART 4
AMOUNT OF INDEMNITY PAID FOR EACH CLAIM
CLAIMS CLOSED IN 1980-83

| AL INDEMNITY PAID (22&23) | AV MONTHS INJ/REP (2B-2A) | AV MONTHS INJ/DIS (20A-2A) | # OF REPORTED CLAIMS | CUMULATIVE PERCENT OF CLAIMS | INDEMNITY PAID (22+23) | CUMULATIVE PERCENT OF DOLLARS PAID | AV IND PER REPORTED CLAIM | NUMBER OF CLAIMS WITH EXPENSES PAID | EXPENSE PAID (25+26) | AVERAGE EXPENSE PAID |
|---|---|---|---|---|---|---|---|---|---|---|
| NONE | 25 | 50 | 2,545 | 67.6% | 0 | 0.0% | 0 | 1,817 | 6,697,696 | 3,686 |
| 1 - 999 | 20 | 36 | 49 | 68.9% | 23,062 | 0.0% | 471 | 19 | 34,272 | 1,804 |
| ,000 - 1,999 | 22 | 49 | 59 | 70.5% | 78,348 | 0.1% | 1,328 | 45 | 92,936 | 2,065 |
| ,000 - 2,999 | 25 | 53 | 65 | 72.2% | 148,728 | 0.2% | 2,288 | 56 | 209,074 | 3,733 |
| ,000 - 3,999 | 24 | 53 | 45 | 73.4% | 147,278 | 0.4% | 3,273 | 38 | 116,859 | 3,075 |
| ,000 - 4,999 | 17 | 40 | 22 | 74.0% | 92,900 | 0.5% | 4,223 | 14 | 55,688 | 3,978 |
| ,000 - 5,999 | 31 | 57 | 41 | 75.0% | 206,483 | 0.7% | 5,036 | 36 | 156,174 | 4,338 |
| ,000 - 6,999 | 41 | 63 | 28 | 75.8% | 171,450 | 0.9% | 6,123 | 21 | 52,309 | 2,491 |
| ,000 - 7,999 | 23 | 52 | 46 | 77.0% | 341,076 | 1.3% | 7,415 | 41 | 141,351 | 3,448 |
| ,000 - 8,999 | 36 | 68 | 20 | 77.5% | 162,834 | 1.5% | 8,142 | 16 | 60,731 | 3,796 |
| ,000 - 9,999 | 28 | 65 | 20 | 78.1% | 182,700 | 1.7% | 9,135 | 19 | 80,291 | 4,226 |
| ,000 - 19,999 | 24 | 58 | 202 | 83.4% | 2,663,588 | 4.7% | 13,186 | 181 | 1,190,410 | 6,577 |
| ,000 - 29,999 | 27 | 61 | 113 | 86.5% | 2,596,450 | 7.7% | 22,977 | 99 | 570,136 | 5,759 |
| ,000 - 39,999 | 22 | 58 | 76 | 88.5% | 2,511,488 | 10.5% | 33,046 | 72 | 543,963 | 7,555 |
| ,000 - 49,999 | 28 | 67 | 46 | 89.7% | 2,023,166 | 12.8% | 43,982 | 42 | 262,474 | 6,249 |
| ,000 - 59,999 | 25 | 64 | 53 | 91.1% | 2,759,334 | 16.0% | 52,063 | 52 | 394,020 | 7,577 |
| ,000 - 69,999 | 23 | 59 | 32 | 92.0% | 2,016,810 | 18.2% | 63,025 | 32 | 241,814 | 7,557 |
| ,000 - 79,999 | 19 | 58 | 30 | 92.7% | 2,221,000 | 20.8% | 74,033 | 29 | 202,062 | 6,968 |
| ,000 - 89,999 | 29 | 72 | 30 | 93.5% | 2,502,038 | 23.6% | 83,401 | 29 | 292,911 | 10,100 |
| ,000 - 99,999 | 23 | 60 | 25 | 94.2% | 2,310,479 | 26.2% | 92,419 | 24 | 239,516 | 9,980 |
| ,000 - 199,999 | 31 | 71 | 107 | 97.1% | 14,471,219 | 42.6% | 135,245 | 100 | 1,060,770 | 10,608 |
| ,000 - 299,999 | 25 | 67 | 46 | 98.3% | 10,141,408 | 54.1% | 220,465 | 45 | 744,919 | 16,554 |
| ,000 - 399,999 | 12 | 42 | 16 | 98.7% | 5,307,132 | 60.2% | 331,696 | 16 | 268,060 | 16,754 |
| ,000 - 499,999 | 22 | 51 | 21 | 99.3% | 9,055,011 | 70.4% | 431,191 | 21 | 273,257 | 13,012 |
| ,000 - 999,999 | 21 | 59 | 18 | 99.7% | 12,173,185 | 84.2% | 676,288 | 18 | 244,042 | 13,558 |
| 00,000 & OVER | 32 | 90 | 8 | 100.0% | 13,850,000 | 100.0% | 1,731,250 | 7 | 247,202 | 35,315 |
| TOTAL | 25 | 53 | 3,763 | 100.0% | 88,157,167 | 100.0% | 23,427 | 2,889 | 14,472,937 | 5,010 |

## 5. AMOUNT OF COMBINED INDEMNITY AND CLAIM EXPENSE PAID

Chart 5 determines the distribution of claim costs, which is the sum of indemnity paid and claim expense paid on behalf of a defendant. Plaintiffs' expenses and expenses which could not be allocated to a particular defendant are excluded.

For example, there were 51 reported claims with a claim cost of $8,000-8,999. These claims had an average indemnity paid of $3,010 per reported claim and an average claim expense of $5,473 per reported claim. The average includes 24 claims which had zero indemnity paid (51 reported claims minus 27 paid claims) and just an expense of $8,000-8,999; and some claims with an indemnity paid of $8,000-8,999 and zero claim expense paid. Notice that the sum of average indemnity and expense always falls in the proper range. Of all reported claims, 71.5% have a claim cost of less than $8,999. These claims account for only 0.9% of the total indemnity paid.

Observations:

Over one half (53.1%) of the reported claims are closed with a total claim cost of under $2,999. Of these, 728 claims are closed without any indemnity or expense paid. In contrast, claims with a total claim cost over $50,000 constitute only 11.2% (100-88.8) of the reported claims, but 88.3% of the indemnity paid.

CHART 5
AMOUNT OF COMBINED INDEMNITY AND CLAIM EXPENSE PAID
CLAIMS CLOSED IN 1980-83

| CLAIM COST (22+23+25+26) | # OF PAID CLAIMS | # OF REPORTED CLAIMS | CUM % OF REPORTED OF CLAIMS | AV IND PER REPORTED CLAIM (22+23) | CUMULATIVE PERCENT OF IND PAID | AV EXP PER REPORTED CLAIM (25+26) |
|---|---|---|---|---|---|---|
| NONE | 0 | 728 | 19.3% | 0 | 0.0% | 0 |
| 1 - 999 | 34 | 566 | 34.3% | 27 | 0.0% | 476 |
| 1,000 - 1,999 | 31 | 421 | 45.5% | 81 | 0.0% | 1,373 |
| 2,000 - 2,999 | 30 | 285 | 53.1% | 175 | 0.1% | 2,291 |
| 3,000 - 3,999 | 27 | 228 | 59.2% | 272 | 0.1% | 3,175 |
| 4,000 - 4,999 | 39 | 149 | 63.1% | 665 | 0.2% | 3,820 |
| 5,000 - 5,999 | 33 | 106 | 65.9% | 1,100 | 0.4% | 4,363 |
| 6,000 - 6,999 | 37 | 87 | 68.2% | 1,770 | 0.6% | 4,695 |
| 7,000 - 7,999 | 34 | 72 | 70.2% | 2,284 | 0.7% | 5,205 |
| 8,000 - 8,999 | 27 | 51 | 71.5% | 3,010 | 0.9% | 5,473 |
| 9,000 - 9,999 | 22 | 43 | 72.7% | 3,217 | 1.1% | 6,240 |
| 10,000 - 19,999 | 217 | 294 | 80.5% | 7,857 | 3.7% | 6,392 |
| 20,000 - 29,999 | 140 | 165 | 84.9% | 16,088 | 6.7% | 8,312 |
| 30,000 - 39,999 | 78 | 87 | 87.2% | 24,977 | 9.2% | 9,342 |
| 40,000 - 49,999 | 56 | 60 | 88.8% | 36,529 | 11.7% | 7,984 |
| 50,000 - 59,999 | 47 | 51 | 90.1% | 44,583 | 14.2% | 10,262 |
| 60,000 - 69,999 | 43 | 45 | 91.3% | 50,881 | 16.8% | 12,895 |
| 70,000 - 79,999 | 33 | 34 | 92.2% | 64,166 | 19.3% | 10,964 |
| 80,000 - 89,999 | 27 | 27 | 92.9% | 77,759 | 21.7% | 7,318 |
| 90,000 - 99,999 | 31 | 32 | 93.8% | 82,977 | 24.7% | 11,386 |
| 100,000 - 199,999 | 120 | 120 | 97.0% | 127,342 | 42.0% | 11,973 |
| 200,000 - 299,999 | 49 | 49 | 98.3% | 217,864 | 54.1% | 17,064 |
| 300,000 - 399,999 | 14 | 14 | 98.6% | 322,923 | 59.3% | 14,033 |
| 400,000 - 499,999 | 23 | 23 | 99.3% | 427,879 | 70.4% | 14,994 |
| 500,000 - 999,999 | 18 | 18 | 99.7% | 676,288 | 84.2% | 13,558 |
| 1,000,000 & OVER | 8 | 8 | 100.0% | 1,731,250 | 100.0% | 30,900 |
| TOTAL | 1,218 | 3,763 | 100.0% | 23,427 | 100.0% | 3,846 |

## 6. AGE OF INJURED PERSON AND SEVERITY OF INJURY

Chart 6 shows the distribution of claims by severity and age at injury. The chart divided age into: (1) under 18 at time of injury; (2) over 18 at time of injury; and (3) age not coded. It then gives the total for all ages including claims with no age coded. Only claims closed with an indemnity paid are included, contrary to the use of both paid and reported claims in Chart 3.

For example, there were 8 paid claims with a severity of temporary major that involved minors (under age 18). These claims had an average indemnity paid of $71,625. Adults (18 and over) had 99 claims with an average of $38,098 indemnity paid for the same severity. There were 124 total paid claims with severity 4 including 17 claims that did not have a code age.

It is important to remember that this chart only includes paid claims. Claims closed without payment are excluded.

Observations:

A total of 13.4% (163/1,218) of all claims involved minors, while 67.6% (823/1,218) involved adults. There are 232 claims or 19% without any age code. On the total, minors claims had a higher average indemnity paid than adult claims, $126,745 versus $72,637.

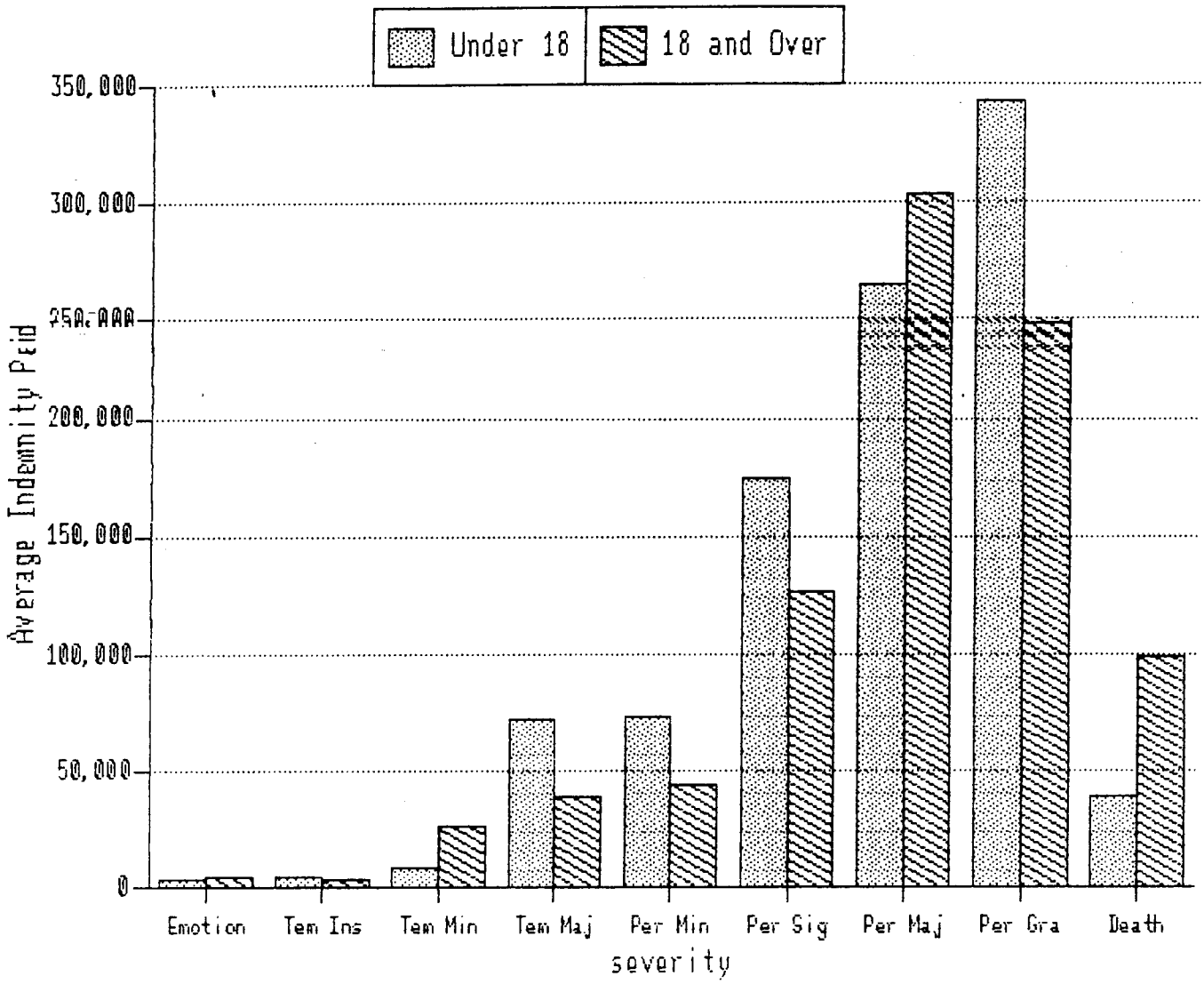
Graph 6A shows that regardless of age, paid claims with permanent major or permanent grave severities had the highest average indemnity. As a general rule the average indemnity increases with the severity, except for death. Death claims are much less than permanent major or grave.

Graph 6B shows that minors have relatively more claims in the high severity codes. A total of 16% (26/163) of all paid claims involving minors result in a permanent grave injury, while only 3% (25/823) of the adult claims do. One reason for the difference in death claim percentages for minors versus adults is infant mortality.

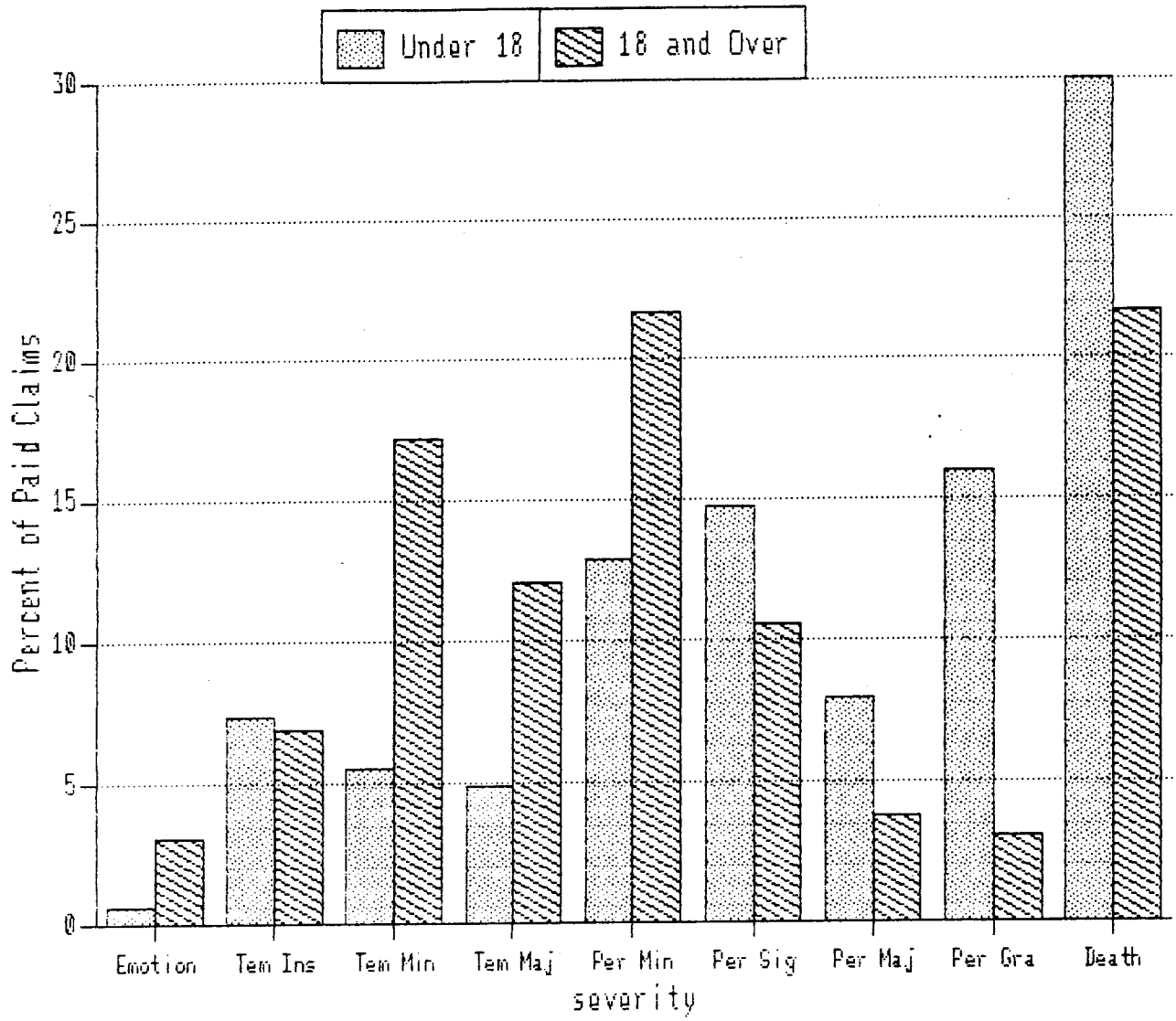
CHART 6
AGE OF INJURED PERSON AND SEVERITY OF INJURY
ONLY CLAIMS CLOSED WITH PAYMENT
CLAIMS CLOSED IN 1980-83

| | AGE | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | UNDER 18 | | 18 AND OVER | | AGE NOT CODED | | TOTAL | |
| | PAID CLAIMS | | PAID CLAIMS | | PAID CLAIMS | | PAID CLAIMS | |
| | CLAIMS | AV IND (22+23) | CLAIMS | AV IND (22+23) | CLAIMS | AV IND (22+23) | CLAIMS | AV IND (22+23) |
| TOTAL | 163 | 126745 | 823 | 72637 | 232 | 33265 | 1218 | 72379 |
| SEVERITY | | | | | | | | |
| NOT CODED | . | . | 1 | 32500 | . | . | 1 | 32500 |
| 1 EMOTIONAL ONLY | 1 | 3500 | 25 | 4405 | 14 | 6925 | 40 | 5264 |
| 2 TEMPORARY INSIGNIFICANT | 12 | 3711 | 57 | 3447 | 29 | 2752 | 98 | 3274 |
| 3 TEMPORARY MINOR | 9 | 8148 | 142 | 26476 | 47 | 13745 | 198 | 22621 |
| 4 TEMPORARY MAJOR | 8 | 71625 | 99 | 38098 | 17 | 27868 | 124 | 38858 |
| 5 PERMANENT MINOR | 21 | 72703 | 178 | 43387 | 47 | 49196 | 246 | 46999 |
| 6 PERMANENT SIGNIFICANT | 24 | 175008 | 87 | 125961 | 19 | 62027 | 130 | 125672 |
| 7 PERMANENT MAJOR | 13 | 265383 | 31 | 303574 | 5 | 30667 | 49 | 265594 |
| 8 PERMANENT GRAVE | 26 | 343132 | 25 | 248664 | 6 | 84000 | 57 | 274422 |
| 9 DEATH | 49 | 38095 | 178 | 98882 | 48 | 47355 | 275 | 79057 |

Graph 6A - Average Indemnity Paid
Age of Injured Person and Severity of Injury
Only Paid Claims Closed in 1980-83



Graph 6B - Percentage of Paid Claims
Age of Injured Person and Severity of Injury
Only Paid Claims Closed in 1980-83



## 7. DISPOSITION OF CLAIMS

Chart 7 summarizes the reported method used for closure or disposition. The table shows many statistics such as average time from report to disposition and average indemnity. It is divided into two sections: claims closed in favor of the plaintiff (claims closed with indemnity paid); and claims closed in favor of the defendant (claims closed without indemnity payment). Each claim can be closed in two main ways: by settlement by parties; or by court disposition. Each category has 9 specific codes for disposition. If a claim did not have these fields coded, it was termed "Unspecified." If a claim had a sequence of codes that did not make sense, it was termed "Coding Errors." For example, if a claim said it was closed by court disposition, but still had a code for settlement by parties, it was termed a "Coding Error."

For example, 49 claims were settled by parties in favor of the plaintiff during trial or hearing.

These 49 claims represented 4.0% of the total 1,218 claims and 5.5% of the total indemnity paid for claims closed in favor of the plaintiff. They had an average time from report to close (disposition) of 41 months, average severity code of 6, and an average indemnity of $99,108. Forty seven (47) of the 49 claims had claim expense paid with an average of $12,444. Twenty seven (27) of the 49 claims were settled by parties, but also had a court disposition code.

Observations:

Almost all claims closed in favor of the plaintiff were settled by parties (95.7%). One fourth (303) of these 1,166 claims had some form of court involvement but the final report was closed by settlement by parties. A total of 90% of the claims were settled before filing suit or before the hearing. These 1,102 (135 + 967) claims involved most (85.6%) of the total indemnity paid. Only 3 out of 1,218 claims were reported to be closed by court disposition.

Less than half (43.5%) of the claims closed in favor of the defendant were settled by parties. One fourth (283) of these 1,109 claims had some form of court involvement but the final closure was by settlement by parties. A total of 20.4% of the claims were decided by court disposition. Over one third (35.9%) of the claims were either "unspecified" or "coding errors." All claims closed in favor of the defendant had zero indemnity paid.

Two thirds (2,545 vs 3,763) of all claims reported were closed in favor of the defendant. If a claim was closed by court disposition it almost always was in favor of the defendant

CHART 7
DISPOSITION OF CLAIM
CLAIMS CLOSED IN 1980-83
FAVOR OF PLAINTIFF (ONLY CLAIMS CLOSED WITH PAYMENT)

CLAIM=SETTLEMENT BY PARTIES

| DISPOSITION (20B/20C/21A) | NUMBER OF CLAIMS | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| (1) BEFORE FILING SUIT OR HEARING | 135 | 11.0% | 10 | 4 | 3.0% | 19,882 | 40 | 1,651 | 12 |
| (2) BEFORE TRIAL OR HEARING | 967 | 79.3% | 36 | 6 | 82.6% | 75,364 | 926 | 6,633 | 257 |
| (3) DURING TRIAL OR HEARING | 49 | 4.0% | 41 | 6 | 5.5% | 99,108 | 47 | 12,444 | 27 |
| (4) AFTER TRIAL/HEARING BEFORE DECISION | 3 | 0.2% | 39 | 8 | 0.0% | 27,500 | 3 | 24,331 | 1 |
| (5) AFTER DECISION BUT BEFORE APPEAL | 7 | 0.5% | 69 | 5 | 0.8% | 108,857 | 7 | 32,513 | 6 |
| (6) DURING APPEAL | 4 | 0.3% | 30 | 3 | 0.0% | 10,188 | 3 | 5,298 | . |
| (7) AFTER APPEAL | 1 | 0.0% | 77 | 6 | 0.0% | 50,000 | 1 | 8,274 | . |
| TOTAL | 1,166 | 95.7% | 33 | 5 | 92.2% | 69,771 | 1,027 | 6,931 | 303 |

CLAIM=COURT DISPOSITION

| DISPOSITION (20B/20C/21A) | NUMBER OF CLAIMS | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| (5) JUDGEMENT FOR PLAINTIFF | 3 | 0.2% | 30 | 6 | 0.4% | 133,333 | 3 | 31,457 | . |
| TOTAL | 3 | 0.2% | 30 | 6 | 0.4% | 133,333 | 3 | 31,457 | . |

CLAIM=DISPOSITION UNSPECIFIED

| DISPOSITION (20B/20C/21A) | NUMBER OF CLAIMS | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 13 | 1.0% | 32 | 7 | 1.2% | 84,099 | 9 | 7,877 | . |

CLAIM=CODING ERRORS

| DISPOSITION (20B/20C/21A) | NUMBER OF CLAIMS | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 36 | 2.9% | 45 | 6 | 6.0% | 147,540 | 33 | 14,918 | . |

CLAIM=TOTAL PAID CLAIM DISPOSITIONS

| DISPOSITION (20B/20C/21A) | NUMBER OF CLAIMS | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 1,218 | 100.0% | 34 | 5 | 100.0% | 72,379 | 1,072 | 7,253 | 303 |

(521 vs 3). Claims in favor of the plaintiff took longer from report to close (34 vs 25 months) and cost insurers almost twice as much in expenses ($7,253 vs $3,686). A total of 88% of plaintiff claims involved claims expenses, while 71% of defendant claims involved such.

CHART 7 (CONTINUED)
DISPOSITION OF CLAIM
CLAIMS CLOSED IN 1980-83
IN FAVOR OF DEFENDANT (ONLY CLAIMS CLOSED WITHOUT PAYMENT)

CLAIM=SETTLEMENT BY PARTIES

| TYPE | DISPOSITION (20B/20C/21A) | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| (1) BEFORE FILING SUIT OR HEARING | 154 | 6.0% | 16 | 4 | . | . | 87 | 1,710 | 16 |
| (2) BEFORE TRIAL OR HEARING | 550 | 21.6% | 32 | 6 | . | . | 383 | 4,345 | 171 |
| (3) DURING TRIAL OR HEARING | 9 | 0.3% | 36 | 7 | . | . | 7 | 14,025 | 7 |
| (4) AFTER TRIAL/HEARING BEFORE DECISION | 1 | 0.0% | 29 | 2 | . | . | 1 | 718 | 1 |
| (5) AFTER DECISION BUT BEFORE APPEAL | 2 | 0.0% | 47 | 7 | . | . | 1 | 4,142 | 1 |
| (7) AFTER APPEAL | 1 | 0.0% | 77 | 2 | . | . | 1 | 3,581 | 1 |
| (8) CLAIM OR SUIT ABANDONED | 391 | 15.3% | 22 | 5 | . | . | 203 | 2,685 | 86 |
| (9) DURING REVIEW PANEL OR NON BIND ARB | 1 | 0.0% | 9 | 2 | . | . | 1 | 597 | . |
| TOTAL | 1,109 | 43.5% | 26 | 5 | . | . | 684 | 3,604 | 283 |

CLAIM=COURT DISPOSITION

| TYPE | DISPOSITION (20B/20C/21A) | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| (1) DIRECTED VERDICT FOR PLAINTIFF | 4 | 0.1% | 16 | 5 | . | . | 4 | 554 | . |
| (2) DIRECTED VERDICT FOR DEFENDANT | 42 | 1.6% | 26 | 4 | . | . | 40 | 5,897 | . |
| (3) JUDGEMENT NWS VERDICT FOR PLAINTIFF | 3 | 0.1% | 28 | 8 | . | . | 3 | 2,536 | . |
| (4) JUDGEMENT NWS VERDICT FOR DEFENDANT | 4 | 0.1% | 18 | 6 | . | . | 4 | 2,091 | . |
| (6) JUDGEMENT FOR DEFENDANT | 88 | 3.4% | 38 | 5 | . | . | 80 | 11,813 | . |
| (8) FOR DEFENDANT AFTER APPEAL | 29 | 1.1% | 48 | 6 | . | . | 23 | 13,446 | . |
| (9) ALL OTHER | 351 | 13.7% | 22 | 6 | . | . | 325 | 2,810 | . |
| TOTAL | 521 | 20.4% | 26 | 5 | . | . | 479 | 5,056 | . |

CLAIM=DISPOSITION UNSPECIFIED

| TYPE | DISPOSITION (20B/20C/21A) | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 578 | 22.7% | 19 | 5 | . | . | 360 | 1,953 | . |

CLAIM=CODING ERRORS

| TYPE | DISPOSITION (20B/20C/21A) | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 337 | 13.2% | 27 | 5 | . | . | 294 | 3,768 | . |

CHART 7 (CONTINUED)
DISPOSITION OF CLAIM
CLAIMS CLOSED IN 1980-83
IN FAVOR OF DEFENDANT (ONLY CLAIMS CLOSED WITHOUT PAYMENT)

CLAIM=TOTAL UNPAID CLAIM DISPOSITIONS

| TYPE | DISPOSITION (20B/20C/21A) | PERCENT OF CLAIMS | AV MONTH REP/DIS (20A-2B) | AV SEV | PERCENT OF TOT IND | AV IND PER PAID CLAIM (22+23) | NUMBER OF CLAIMS WITH EXP PAID | AV EXP PAID (25+26) | CLAIMS WITH COURT CODES |
|---|---|---|---|---|---|---|---|---|---|
| TOTAL | 2,545 | 100.0% | 25 | 5 | 100.0% | | 1,817 | 3,686 | 283 |

## 8. PROFESSIONS BY SPECIALTY CODE

Chart 8 displays the distribution of paid claims by the various specialties of the doctors. The specialty code is defined by the Insurance Services Office.

For example, Pediatrics No Surgery (code 80267) had 30 claims closed with payment. They constituted 2.4% of the total number of claims and 2.5% of the total indemnity paid. They were reported on the average of 50 months after the injury and were closed 84 months after the injury. They had an average indemnity of $73,339. Twenty three (23) out of these 30 claims had expenses paid with an average of $9,291. The 30 claims had an average severity code of 6.

The Total Line is the total for all specialties, not just the 25 largest listed.

Only claims closed with indemnity paid are included. All claims closed without payment are excluded.

Observations:

Doctors with specialty codes Surgery General, Surgery Orthopedic, and Surgery Obstetric Gynecology had the highest number of paid claims. The top 25 specialties accounted for 85% of all paid claims and 84% of the total indemnity paid. There are over 120 doctor specialty codes in total.

Anesthesiology had the shortest report time (11 months) and closure time (39 months). Pediatrics No Surgery had the longest (50 and 84 months). Both varied far from the averages of 25 and 59 months.

Anesthesiology ($152,879) and Neurology Surgery Including Children ($148,331) were both over double the average indemnity paid of $72,383. Opthamology Surgery ($24,495), Orthopedic No Spinal Surgery ($27,708), and General Practice No Surgery ($27,739) had the smallest average indemnities.

Orthopedics No Spinal Surgery ($3,892), Plastic Surgery ($4,423), and Family Practice No Surgery ($4,610) were well below the average claim expense paid of $7,254. Neurology Surgery Including Children ($10,060) had the highest average expenses.

Fourteen (14) claims did not have any specialty code but accounted for 4.7% of the indemnity paid. This group also had the highest average indemnity paid and the second highest average claim expense paid.

CHART 8
PROFESSIONS BY SPECIALTY CODE
TOP 25 SPECIALTIES BY NUMBER OF CLAIMS
ONLY CLAIMS CLOSED WITH PAYMENT
CLAIMS CLOSED IN 1980-1983

| SPECIALTY CODE | | NUMBER OF CLAIMS | PERCENT OF TOTAL CLAIMS | AV MONTHS INJ/REP (2B-2A) | AV MONTHS INJ/DIS (20A-2A) | % OF INDEMNITY PAID | AVERAGE INDEMNITY PER CLAIM | NUMBER OF CLAIMS WITH EXPENSES PAID | AVERAGE EXPENSE PAID (25+26) | AV SEV |
|---|---|---|---|---|---|---|---|---|---|---|
| 80143 | SGY GENERAL | 160 | 13.1% | 25 | 57 | 12.0% | 66,487 | 136 | 7,198 | 5 |
| 80154 | SGY ORTHOPEDIC | 129 | 10.6% | 26 | 63 | 10.6% | 72,842 | 125 | 6,573 | 5 |
| 80153 | SGY OBSTETRICS GYNECOLOGY | 124 | 10.2% | 23 | 61 | 6.8% | 48,443 | 101 | 8,157 | 5 |
| 80275 | GEN PRACTICE MIN SGY | 88 | 7.2% | 33 | 68 | 4.9% | 49,313 | 79 | 6,042 | 6 |
| 80257 | INTERNAL MEDICINE NO SGY | 86 | 7.0% | 27 | 61 | 7.0% | 71,972 | 78 | 8,925 | 6 |
| 80273 | FAMILY PRACTICE MIN SGY | 49 | 4.0% | 20 | 49 | 3.2% | 58,196 | 42 | 5,712 | 6 |
| 80151 | ANESTHESIOLOGY | 35 | 2.8% | 11 | 39 | 6.0% | 152,879 | 29 | 7,538 | 7 |
| 80114 | SGY OPTHAMOLOGY | 33 | 2.7% | 22 | 42 | 0.9% | 24,495 | 22 | 6,404 | 5 |
| 80145 | SGY UROLOGICAL | 32 | 2.6% | 23 | 53 | 4.9% | 136,025 | 29 | 6,891 | 5 |
| 80242 | GEN PRACTICE NO SGY | 31 | 2.5% | 33 | 61 | 0.9% | 27,739 | 26 | 5,277 | 6 |
| 80267 | PEDIATRICS NO SGY | 30 | 2.4% | 50 | 84 | 2.5% | 73,339 | 23 | 9,291 | 6 |
| 80253 | RADIOLOGY DIAGNOSTIC NO SGY | 27 | 2.2% | 22 | 55 | 4.3% | 143,148 | 24 | 6,611 | 6 |
| 80117 | GEN PRACTICE SGY | 23 | 1.8% | 27 | 56 | 0.7% | 30,538 | 21 | 6,509 | 5 |
| 80152 | SGY NEUROLOGY INCL CHILD | 23 | 1.8% | 18 | 54 | 3.8% | 148,331 | 21 | 10,060 | 7 |
| 80284 | INTERNAL MEDICINE MIN SGY | 20 | 1.6% | 20 | 58 | 2.0% | 89,715 | 19 | 5,596 | 7 |
| 80159 | SGY OTOLARYNGOLOGY | 19 | 1.5% | 16 | 50 | 1.7% | 81,002 | 18 | 5,970 | 6 |
| 80109 | PHYSICIAN NO MAJOR SGY | 17 | 1.3% | 24 | 60 | 0.5% | 29,525 | 16 | 5,871 | 7 |
| 80293 | PEDIATRICS MIN SGY | 16 | 1.3% | 35 | 71 | 2.1% | 117,583 | 12 | 9,915 | 5 |
| 80239 | FAMILY PRACTICE NO SGY | 15 | 1.2% | 20 | 59 | 0.9% | 55,699 | 15 | 4,610 | 6 |
| | NOT CODED | 14 | 1.1% | 24 | 66 | 4.7% | 297,172 | 12 | 10,056 | 5 |
| 80144 | SGY THORACIC | 13 | 1.0% | 20 | 54 | 1.5% | 103,455 | 13 | 7,698 | 5 |
| 80156 | SGY PLASTIC | 12 | 0.9% | 22 | 51 | 0.7% | 55,896 | 10 | 4,423 | 5 |
| 86026 | ORTHOPEDIC NO SPINAL SGY | 12 | 0.9% | 17 | 43 | 0.3% | 27,708 | 12 | 3,892 | 5 |
| 80102 | EMERGENCY MED NO MAJOR SGY | 11 | 0.9% | 18 | 43 | 0.4% | 37,697 | 8 | 6,464 | 5 |
| 80146 | SGY VASCULAR | 11 | 0.9% | 22 | 47 | 0.8% | 63,962 | 9 | 7,686 | 6 |
| TOTAL | OF ALL SPECIALTIES | 1,215 | 100.0% | 25 | 59 | 100.0% | 72,383 | 1,069 | 7,254 | 5 |

## 9. SEVERITY OF INJURY

Charts 9A and 9B display the distribution of claims by severity. Chart 9A is made up of claims closed with payment, while Chart 9B shows claims closed without payment. These charts differ from previous severity exhibits in that claim expense has been added.

For example, the 275 death claims closed with payment represented 22.5% of the total number of paid claims and 24.6% of the total indemnity paid. They took an average of 58.2 months from injury to closure and had an average indemnity of $79,057. A total of 251 out of the 275 claims had expenses paid, with an average $8,402.

Observations:

Charts 9A and 9B show that generally the higher the severity, the more total indemnity paid with death claims accounting for the highest amount. The same was true with average claim expenses, but with the exception that death claims had close to average expense. Average claim expense on the claims with payments ($7,253) was almost twice the expense of claims without payments ($3,686).

Graph 9 shows the distribution of reported claims by severity for claims closed with and without payment. The death claims accounted for 22.5% of all paid claims. A close second were permanent minor claims. The paid claims with the highest average indemnity, permanent grave and permanent major, had very low incidence rates.

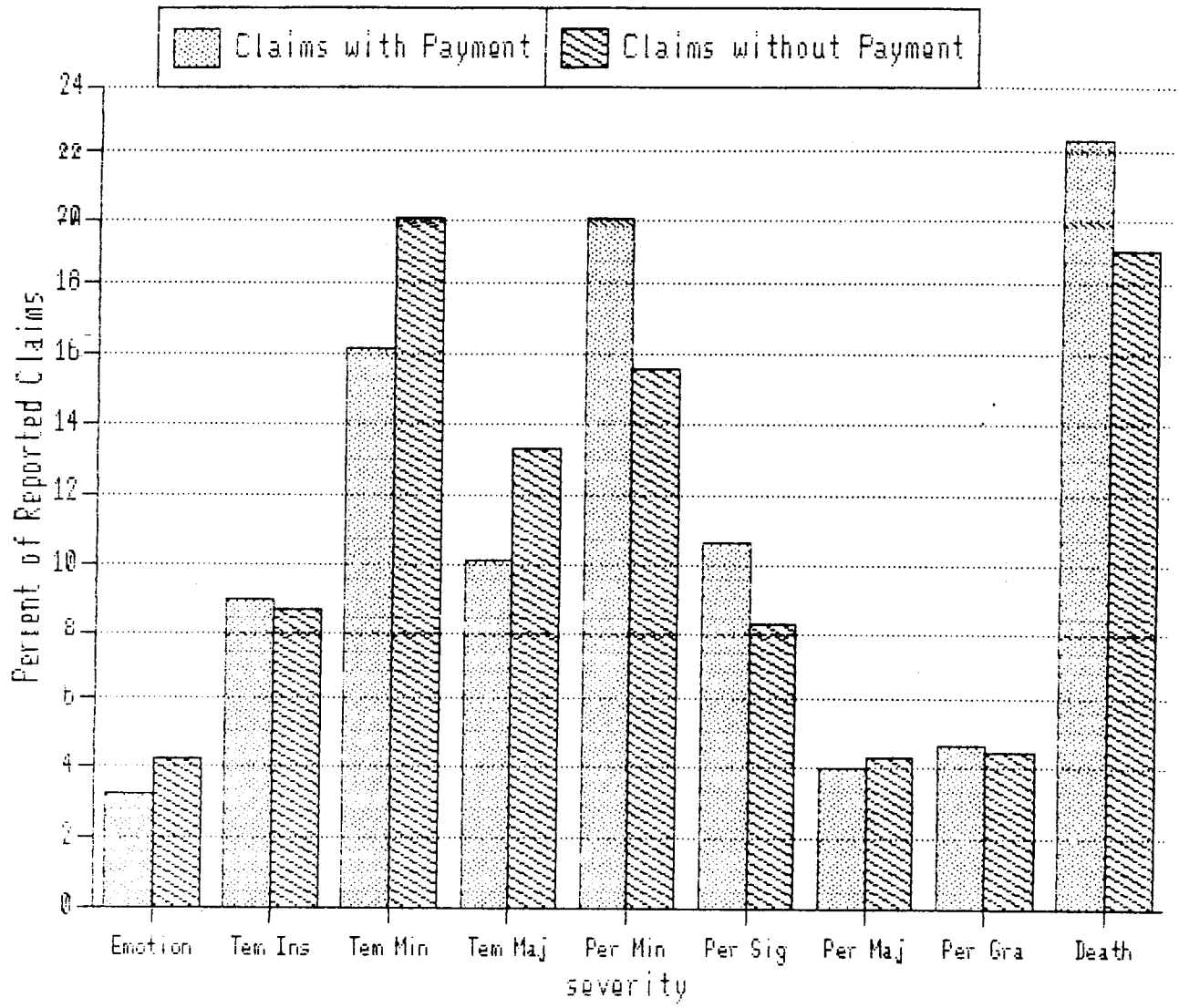
CHART 9A
SEVERITY OF INJURY
CLAIMS CLOSED IN 1980-83
ONLY CLAIMS CLOSED WITHOUT PAYMENT

| SEVERITY (16B) | INJ TO DISP AVG (20A-2A) | NUMBER OF CLAIMS | PERCENT OF CLAIMS | NUMBER OF CLAIMS WITH EXPENSES PAID | AVERAGE EXPENSE PAID (25+26) |
|---|---|---|---|---|---|
| NOT CODED | 41.4 | 42 | 1.6% | 27 | 1,503 |
| 1 EMOTIONAL ONLY | 50.1 | 109 | 4.2% | 64 | 2,697 |
| 2 TEMPORARY INSIGNIFICANT | 44.5 | 222 | 8.7% | 131 | 2,813 |
| 3 TEMPORARY MINOR | 45.5 | 513 | 20.1% | 361 | 3,080 |
| 4 TEMPORARY MAJOR | 46.7 | 340 | 13.3% | 255 | 2,980 |
| 5 PERMANENT MINOR | 54.4 | 398 | 15.6% | 293 | 3,456 |
| 6 PERMANENT SIGNIFICANT | 52.2 | 212 | 8.3% | 167 | 4,186 |
| 7 PERMANENT MAJOR | 66.7 | 111 | 4.3% | 79 | 4,902 |
| 8 PERMANENT GRAVE | 60.4 | 113 | 4.4% | 91 | 9,983 |
| 9 DEATH | 50.5 | 485 | 19.0% | 349 | 3,544 |
| TOTAL | 50.2 | 2,545 | 100.0% | 1,817 | 3,686 |

CHART 9B
SEVERITY OF INJURY
CLAIMS CLOSED IN 1980-83
ONLY CLAIMS CLOSED WITH PAYMENT

| SEVERITY (16B) | INJ TO DISP AVG (20A-2A) | NUMBER OF PAID CLAIMS | PERCENT OF CLAIMS | PERCENT OF DOLLARS PAID | AVERAGE INDEMNITY PAID (22+23) | NUMBER OF CLAIMS WITH EXPENSES PAID | AVERAGE EXPENSE PAID (25+26) |
|---|---|---|---|---|---|---|---|
| NOT CODED | 84.0 | 1 | 0.0% | 0.0% | 32,500 | 1 | 16,893 |
| 1 EMOTIONAL ONLY | 53.7 | 40 | 3.2% | 0.2% | 5,264 | 28 | 3,456 |
| 2 TEMPORARY INSIGNIFICANT | 46.1 | 98 | 8.0% | 0.3% | 3,274 | 67 | 3,241 |
| 3 TEMPORARY MINOR | 52.5 | 198 | 16.2% | 5.0% | 22,621 | 164 | 4,148 |
| 4 TEMPORARY MAJOR | 56.7 | 124 | 10.1% | 5.4% | 38,858 | 111 | 6,157 |
| 5 PERMANENT MINOR | 63.0 | 246 | 20.1% | 13.1% | 46,999 | 227 | 5,434 |
| 6 PERMANENT SIGNIFICANT | 60.8 | 130 | 10.6% | 18.5% | 125,672 | 121 | 10,038 |
| 7 PERMANENT MAJOR | 84.1 | 49 | 4.0% | 14.7% | 265,594 | 45 | 13,613 |
| 8 PERMANENT GRAVE | 67.9 | 57 | 4.6% | 17.7% | 274,422 | 57 | 15,989 |
| 9 DEATH | 58.2 | 275 | 22.5% | 24.6% | 79,057 | 251 | 8,402 |
| TOTAL | 58.8 | 1,218 | 100.0% | 100.0% | 72,379 | 1,072 | 7,253 |

Graph 9
Severity of Injury
Claims Closed in 1980-83



## 10. YEARLY COMPARISON

The Yearly Comparison segregates the total data into its closure years. By studying this chart, any basic trends can be observed.

For example, in 1980 there were 630 claims reported. Of these, 243 claims had a total indemnity of $10,755,167. The average indemnity for the 243 paid claims was $44,260. The average indemnity of the 630 reported claims was $17,072. A total of 433 of the 630 reported claims had claim expenses. These 433 claims had a total expense of $1,969,515. The average expense for these 433 claims was $4,549. The average expense for the 630 reported claims was $3,846.

The term "Reported Claims" includes claims closed with indemnity paid and without indemnity paid.

Observations:

The number of closed claims reported to the Department more than doubled from 1980 (630) to 1983 (1,375). The total indemnity paid tripled from $10,755,167 in 1980 to $31,792,181 in 1983. The average indemnity per paid claim almost doubled from 1980 ($44,260) to 1983 ($86,392). The total expenses paid increased 274% from 1980 to 1983 ($1,969,515 to $5,408,162).

The percentage of paid claims to reported claims dropped from 39% in 1980 (243/630) to 27% in 1983 (368/1,375). This means that there was a higher percent of claims closed without payment in 1983 than in 1980.

It is speculated that the increased workload due to a rise in filed claims might have slowed the closing of files, which in turn would make the 1983 data understated. This would explain any questionable trends in comparing 1982 to 1983. For this fact, it is important not to use the 1983 data for any specific yearly comparisons or to think that it depicts any future trends.

The total indemnity paid in Chart 10 does not correspond to the losses paid in Appendix B. Chart 10 is closed claim data submitted by insurance company claim departments, while Appendix B is financial data from the annual statements. Chart 10 is for closed claims involving physicians only (no hospital claims) and Appendix B is for all medical malpractice claims. By statute, claims filed with the insurance companies before 1977 do not have to be reported to the Department. The annual statement data includes all claims regardless of time of filing. Also, there is an inherent lag time from when insurance companies closed claims and when the Department receives the closed claim report. For these reasons, Chart 10 differs from Appendix B.

CHART 10
YEARLY COMPARISON
CLAIMS CLOSED IN 1980-1983

| CLOSURE YEAR | # OF REPORTED CLAIMS | # OF PAID CLAIMS | INDEMNITY PAID (22+23) | AV IND PER REPORTED CLAIM | AV IND PER PAID CLAIM | NUMBER OF CLAIMS WITH EXP PAID | EXPENSE PAID (25+26) | AV EXP PER REPORTED CLAIM | AV EXP PER PAID CLAIM |
|---|---|---|---|---|---|---|---|---|---|
| 1980 | 630 | 243 | 10,755,167 | 17,072 | 44,260 | 433 | 1,969,515 | 3,126 | 4,549 |
| 1981 | 745 | 258 | 15,649,143 | 21,006 | 60,656 | 541 | 2,636,162 | 3,538 | 4,873 |
| 1982 | 1,013 | 349 | 29,960,676 | 29,576 | 85,847 | 790 | 4,459,098 | 4,402 | 5,644 |
| 1983* | 1,375 | 368 | 31,792,181 | 23,122 | 86,392 | 1,125 | 5,408,162 | 3,933 | 4,807 |
| TOTAL | 3,763 | 1,218 | 88,157,167 | 23,427 | 72,379 | 2,889 | 14,472,937 | 3,846 | 5,010 |

* 1983 DATA IS TENTATIVE BECAUSE OF REPORTING IRREGULARITIES.

# NAIC MEDICAL PROFESSIONAL LIABILITY INSURANCE UNIFORM CLAIMS REPORT

Report each claim closed on or after July 1, 1976. Submit a report for each defendant insured by filing insurer, including claims closed without payment. Complete all blocks on the form. If information is unknown, enter "UNK," if not applicable, enter "NA." When an item calls for a dollar amount and no amount is involved, enter 0 in the space after the $ sign. When you prepare a report on a reopened case on which a previous report has been made, mark "Previously Reported" at the top of the report. Record all amounts in whole dollars only, all dates as MM YY and all ages (on date of occurrence) as YY.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1a. | Name of insurer | | | 1b. | Claim file identification | | |
| 2a. | Date of injury | | 2b. | Date reported to insurer | | 2c. | Date reopened |
| 3a. | Insured's name | 3b. Age | 3c. | City | 3d. State | 3e. | Zip |
| 4a. | Profession or business (CODE) | | 4b. | Specialty (CODE) | 4c. | Type of practice (CODE) | |
| 5a. | Board certification (CODE) | | 5b. | Foreign medical graduate? | 5c. | Country | |
| 6a. | Place where injury occurred (CODE) | | 6b. | City | 6c. State | 6d. | Zip |
| 7a. | Name of institution (if injury occurred in institution) | | 7b. | Location in institution (CODE) | 7c. | Hospital identification (Leave Blank) | |
| 8a. | Injured person's name | | | | 8b. Age | 8c. | Sex |
| 9a. | Total defendants involved in claim | | | 9b. | Derivative claim (CODE) | | |
| 10. | Amount of reserve for indemnity if still outstanding $ | | | 11. | Amount of reserve for expense if still outstanding $ | | |
| 12a. | Plaintiff attorney's name | | 12b. | City | 12c. State | 12d. | Zip |

| | | |
|---|---|---|
| 13. | Describe action which caused claim to be made | (Leave Blank) 14a. |
| | | 14b. |
| 14a. | Final diagnosis for which treatment was sought or rendered (patient's actual condition) | 15. |
| 14b. | Describe misdiagnosis made, if any, of patient's actual condition | 15. |
| 15. | Operation, diagnostic or treatment procedure causing the injury | 16a. |
| 16a. | Describe principal injury giving rise to the claim | 16a. |

| | | | | | |
|---|---|---|---|---|---|
| 16b. | Severity of injury (CODE) | | | | |
| 17a. | Misadventures in procedures (CODE) | | 17b. | Misadventures in diagnosis (CODE) | |
| 18a. | Others contributing to injury (CODE) | | 18b. | Associated issues (CODE) | 18c. Coverage (CODE) |
| 19 | Companion claim file identification | 1. 2. | | 3. | 4. |
| 20a. | Date of this payment or closure | | 20b. | Claim disposition (CODE) | 20c. Settlement (CODE) |
| 21a. | Court (CODE) | | 21b. | Binding arbitration (CODE) | 21c. Review panel (CODE) |
| 22. | Indemnity paid by you on behalf of this defendant | | | | $ |
| 23. | Other indemnity paid by or on behalf of this defendant | | | | $ D ☐ E ☐ |
| 24. | Indemnity paid by all parties (for all defendants) | | | | $ |
| 25. | Loss adjustment expense paid to defense counsel | | | | $ |
| 26. | All other allocated loss adjustment expense paid by you | | | | $ |
| 27. | Injured person's incurred medical expense | | | | $ |
| 28. | Injured person's anticipated future medical expense | | | | $ |
| 29. | Injured person's incurred wage loss | | | | $ |
| 30. | Injured person's anticipated wage loss | | | | $ |
| 31. | Injured person's other expense | | | | $ |
| 32. | Total amount allocated for future periodic payments (for all defendants) | | | | $ |

Contact Person and Telephone Number

Address

Person Responsible for Report

4a. Profession or Business Code: 1) physicians and surgeons, 2) hospitals, 3) other medical professionals, 4) other health care facilities. (When 3 is entered, specify type of professional in addition.)

4b. Specialty Code: (five digits) from ISO Common Statistical Base classifications.

4c. Type of Practice Code: 1) institutional (academic), 2) professional corporation or partnership (group), 3) self-employed, 4) employed physician, 5) employed nurse, 6) all other employees, 7) intern or resident.

5a. Enter appropriate code if insured physician is Board Certified in 1) specialty coded in 4b, 2) a different specialty, 3) both specialty coded in 4b and another specialty 4) insured physician is not board-certified. If 2 or 3 is entered, also enter the additional specialty code (5 digits) in this line.

5b. Indicate yes or no if insured physician is a Foreign Medical Graduate.

5c. Enter Country in which primary medical education was received if other than U.S.

6a. Enter the appropriate code of the Place Where the principal Injury Occurred: 1) hospital inpatient facility, 2) emergency room, 3) hospital outpatient facility, 4) nursing home, 5) physician's office, 6) patient's home, 7) other outpatient facility, 8) other. Use only one code. If code 8, other, is used enter description of the place.

7b. Enter appropriate code if Location of Institutional Injury was: 1) patient's room, 2) labor and delivery room, 3) operating suite, 4) recovery room, 5) critical care unit, 6) special procedure room, 7) nursery, 8) radiology, 9) physical therapy department.

9a. Enter the Total Number of Defendants (persons and institutions other than John Does) Involved in Claim.

9b. Enter the appropriate code(s) if a Derivative Claim (on behalf of someone other than the medically injured) was made by: 1) spouse, 2) children, 3) parent, 4) personal representative.

14a. Use nomenclature and/or descriptions to enter the Final Diagnosis for which Treatment was Sought or Rendered (actual abnormal condition), and also 14b. the Misdiagnosis, if any, of the Patient's Actual Condition.

15. Use nomenclature and/or descriptions of the procedure used. Include method of anesthesia, or name of drug used for treatment, with detail of administration.

16a. Use nomenclature and/or descriptions of the injury. Include type of adverse effect from drugs where applicable.

16b. Enter one digit code for Severity of Injury from scale provided below. Enter the code for the most serious injury if several are involved.

| | Severity of Injury Scale | Examples |
|---|---|---|
| | 1) Emotional only | Fright, no physical damage. |
| Temporary | 2) Insignificant | Lacerations, contusions, minor scars, rash. No delay. |
| | 3) Minor | Infections, misset fracture, fall in hospital. Recovery delayed. |
| | 4) Major | Burns, surgical material left, drug side effect, brain damage. Recovery delayed. |
| Permanent | 5) Minor | Loss of fingers, loss or damage to organs. Includes nondisabling injuries. |
| | 6) Significant | Deafness, loss of limb, loss of eye, loss of one kidney or lung. |
| | 7) Major | Paraplegia, blindness, loss of two limbs, brain damage. |
| | 8) Grave | Quadraplegia, severe brain damage, lifelong care or fatal prognosis. |
| | 9) Death | |

17a. Enter the appropriate Misadventure Code(s) if the Procedure was: 1) not adequately indicated, 2) contraindicated, 3) there was a more appropriate alternative, 4) delayed, 5) improperly performed, 6) not performed, 7) occasioned by misdiagnosis, 8) inadequate assessment, 9) mis-identification of the patient, 10) delay in notifying physician, 11) failure to notice an improper order, 12) failure to obtain a proper order, 13) failure to instruct patient.

17b. Enter the appropriate code if the following Misadventures in Diagnosis caused or aggravated the injury: 1) delay in diagnosis, 2) misdiagnosis of the abnormal condition, 3) misdiagnosis in the absence of an abnormal condition.

18a. Enter the appropriate code(s) if any Other person(s) caused or Contributed to the Injury: 1) attending physician, 2) house staff, 3) consultant, 4) nurse R.N., 5) nurse L.P.N. or L.V.N., 6) aide, 7) orderly, 8) pharmacist, 9) radiologist, 10) radiology technician, 11) anesthesiologist, 12) anesthetist, 13) pathologist, 14) laboratory technician, 15) physician's assistant, 16) O.R. technician, 17) physical therapist, 18) inhalation therapist, 19) other therapists, 20) other technicians, 21) dietitian, 22) maintenance personnel, 23) engineer, 24) administrator, 25) other personnel, 26) patient, 27) another patient.

18b. Enter the appropriate code(s) if one or more of the following factors were Associated Issues in the claim: 1) abandonment, 2) premature discharge from institution, 3) false imprisonment, 4) lack or delay of consultation, 5) lack of supervision, 6) breach of confidentiality, 7) failure to prevent an abnormal condition, 8) failure to accomplish intended result, 9) failure to conform with regulation or statutory rule, 10) lack of adequate facilities or equipment, 11) laboratory error, 12) pharmacy error, 13) products liability, 14) failure to timely disclose, 15) failure to provide warning instructions, 16) lack of consent from proper person, 17) inadequate information for informed consent, 18) procedure exceeded consensual understanding, 19) breach of contract, 20) warranty, 21) assault and battery, 22) res ipsa loquitur, 23) emergency equipment, 24) cooling devices, 25) heating devices, 26) cautery equipment, 27) x-ray equipment, 28) radiation therapy equipment, 29) traction equipment, 30) anesthesia equipment, 31) operative equipment, 32) surgical instruments and materials, 33) food preparation equipment, 34) laboratory equipment, 35) laboratory mislabeling, 36) laboratory computation error, 37) inadequate laboratory specimen, 38) lost laboratory specimen, 39) laboratory interpretation, 40) laboratory reporting error, 41) laboratory delay in reporting, 42) sterilization of equipment, 43) skin preparation, 44) aseptic technique, 45) isolation for infection control, 46) records, 47) billing and collection, 48) inter-professional relations, 49) vicarious liability, 50) statute of limitations, 51) punitive damages.

18c. Enter the appropriate Coverage Code for the type of policy covering the claim: 1) policy covers all claims made during the term of the policy, 2) policy covers all claims made during the policy term for events which occurred during a designated previous policy term, 3) policy covers all claims whenever presented for events which occur during the policy term.

20b. Enter final method of Claim Disposition: 1) settled by parties, 2) disposed of by a court, 3) disposed of by binding arbitration.

20c. If settled by agreement of parties, enter appropriate Settlement Code: 1) before filing suit or demanding hearing, 2) before trial or hearing, 3) during trial or hearing, 4) after trial or hearing, but before judgment or decision (award), 5) after judgment or decision, but before appeal, 6) during appeal, 7) after appeal, 8) claim or suit abandoned, 9) during review panel or non-binding arbitration .

21a. Enter the appropriate Court Code: 0) no court proceedings, 1) directed verdict for plaintiff, 2) directed verdict for defendant, 3) judgment notwithstanding the verdict for the plaintiff, 4) judgment notwithstanding the verdict for the defendant, 5) judgment for the plaintiff, 6) judgment for the defendant. 7) for plaintiff after appeal, 8) for defendant after appeal, 9) all other.

21b. Enter appropriate Binding Arbitration Code: 0) claim not subject to arbitration, 1) claim subject to arbitration, but previously coded disposition reached in lieu of award, 2) award for plaintiff, 3) award for defendant.

21c. If a review panel or non-binding arbitration was used in disposition, enter appropriate code: 1) finding for plaintiff, 2) finding for defendant.

23. Mark appropriate box if this amount was a deductible paid by the insured or indemnity paid under an excess limits policy by another insurer.

25. Enter fees paid to your defense counsel for this defendant.

26. Enter filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.

28. Enter best estimate of future medical expense if it appears the claimant will incur expenses in the future.

30. Enter best estimate of future wage loss if it appears the claimant will incur wage loss in the future.

32. If a reserve, annuity, trust fund or similar mechanism was established to provide future periodic payments, enter total amount thereof.

APPENDIX B

A major portion of losses incurred for the medical malpractice line of insurance stems from reserves for pending and not yet reported (IBNR) claims. For example, the incurred losses for 1982 were $196,873,914. Of this, only $59,389,369 was actually paid out in 1982. The loss reserve at year end 1982 for both pending and not yet reported claims was $619,452,987. The comparable reserve at year end 1981 was $481,968,442. Therefore, the reserve change incurred in 1982 was $137,484,545. This reserve change of $137,484,545 added to the paid losses of $59,389,369 produced a total incurred figure of $196,873,914.

This relationship between paid losses and incurred losses is further illustrated using annual statement data for the major malpractice insurance company covering doctors. The following chart shows the number of claims paid during the last three calendar years. It also shows the number of claims still pending as of December 31 of each year. The pending count does not include IBNR claims not yet reported.

| | Claims Paid | Reported Claims Pending @ 12/31 |
|---|---|---|
| 1981 | 135 | 3,899 |
| 1982 | 193 | 5,022 |
| 1983 | 212 | 6,337 |
| Total | 540 | NA |

Only 540 claims with loss payments were processed. Without even considering not yet reported claims, over 10 times that amount or 6,337 claims were still pending at last report. This is the source of the "tail" of medical malpractice insurance. It takes an extensive period of time both for the emergence of a claim and for its disposition. At any given point in time, especially with companies new in the business, the "tail" thus wags the "dog."

Calendar Year losses are strongly affected by old losses settled by companies that are no longer active in the business of writing malpractice insurance. They report large losses with almost no premium income. Following are examples:

| | 1982 | |
|---|---|---|
| | Written Premiums | Paid Losses |
| Co. A | $476,000 | $8,703,000 |
| B | 0 | 7,260,000 |
| C | 0 | 2,725,000 |
| D | 0 | 1,040,000 |
| Total | $476,000 | $19,728,000 |

This is a good illustration of the "tail" concept.

# APPENDIX B
## MEDICAL MALPRACTICE ANNUAL STATEMENT DATA (PAGE 14)
## ILLINOIS DIRECT BUSINESS ONLY
## TOTAL ALL COMPANIES

| Year | Premiums Written | Premiums Earned | Losses Paid | Losses Incurred | Incurred Loss Ratio |
|---|---|---|---|---|---|
| 1978 | $108,867,585 | $106,684,650 | $19,361,046 | $ 84,514,283 | .792 |
| 1979 | $ 92,776,647 | $ 97,489,450 | $16,839,920 | $ 91,109,064 | .935 |
| 1980 | $100,226,921 | $ 97,303,261 | $25,856,858 | $102,461,279 | 1.053 |
| 1981 | $100,068,605 | $ 99,006,466 | $45,292,990 | $130,441,334 | 1.317 |
| 1982 | $109,650,876 | $106,583,712 | $59,389,369 | $196,873,914 | 1.847 |
| *1983 | $118,720,000 | $112,620,000 | $70,340,000 | $150,240,000 | 1.334 |

* 1983 is preliminary data.