Insights from Claims

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Objectives

1. How Claims Can Help You
2. Trends
3. Case Studies and Lessons Learned

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1 How Claims Can Help You

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Copic's Claims Department

What matters do we handle?

- Questions related to Claims/Suits/Candor
- Questions related to Copic's attorney panel
- Cyber matters
- Covered Proceedings
- Care for the Caregiver
- Lawsuit stress
- Regulatory reporting
- Request for medical records
- Reputation management
- Subpoenas
- Settlement questions
- Claims Committee
- Trials

Copic's Claims Department

Matters we do not handle:

- Contract questions or review
- Employee/HR policies
- Most billing issues unless it relates to allegations of billing fraud (Covered Proceedings)
- Workers Compensation

2 Trends

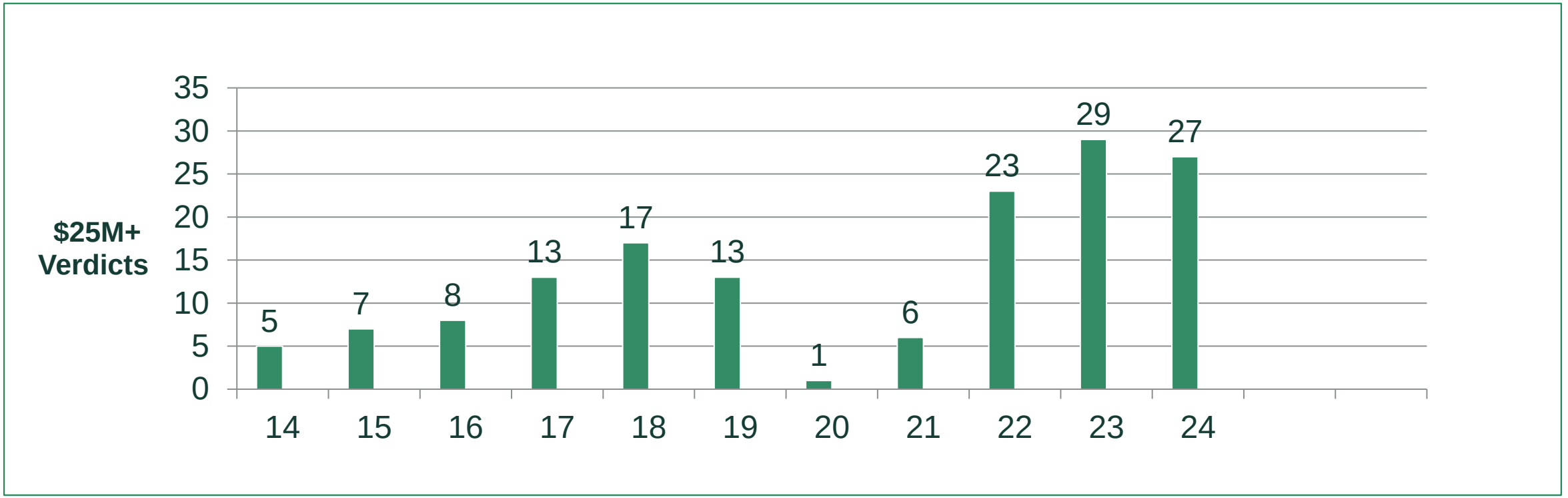
Trends

What's happening in the MPL market?

- Challenges to Tort Reform
- Multi-defendant matters
- Prolonged lifecycle of matters
- Early Resolution Programs
- Organized plaintiff's counsel bar
- Nuclear verdicts/High Damage Cases
- Changing Jury Pool
- Increase in Cyber matters
- Third-Party Litigation Funding
- Artificial Intelligence

$25M+ Verdicts, 2014-2024

Data as of 12/31/2024



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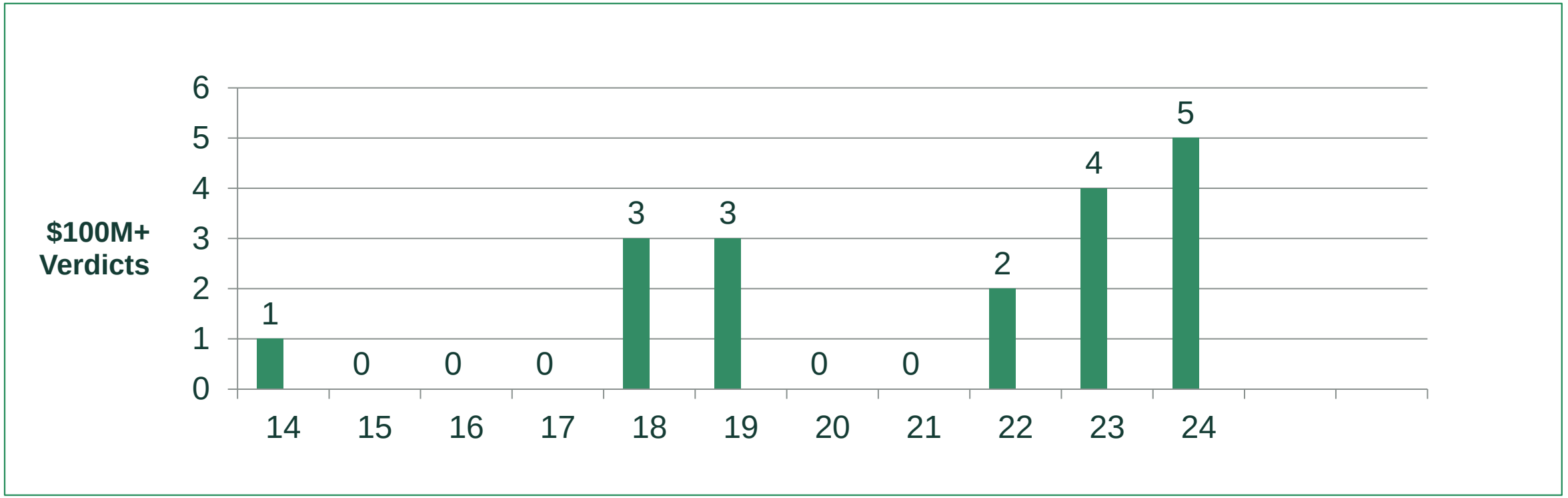
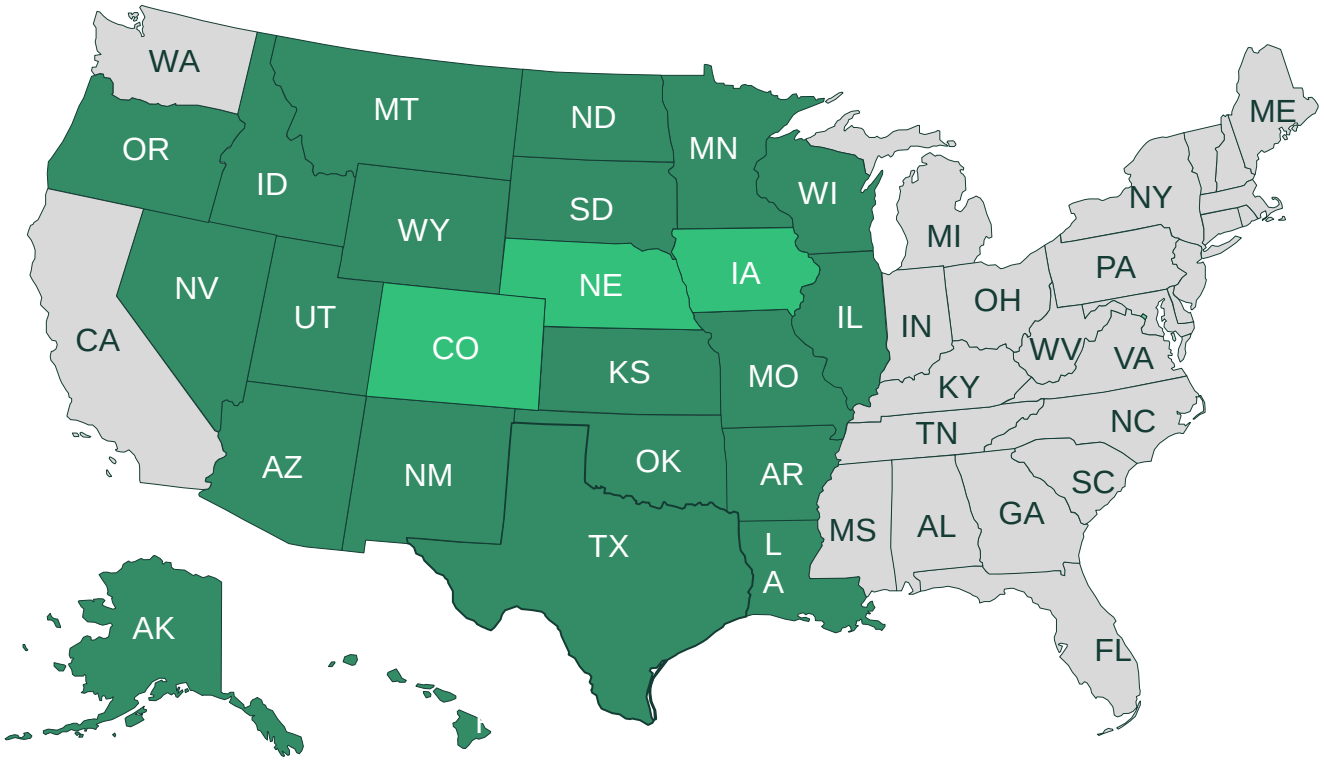
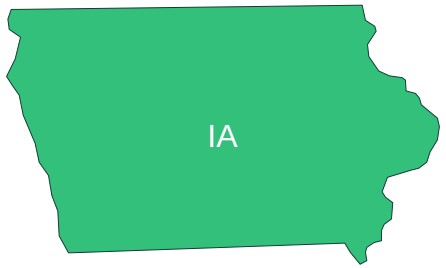


Tort Reform Changes in Our Coverage Area

- Iowa
- Nebraska
- Colorado





Changes in Iowa

Medical Malpractice Caps—Iowa Code 147.136A

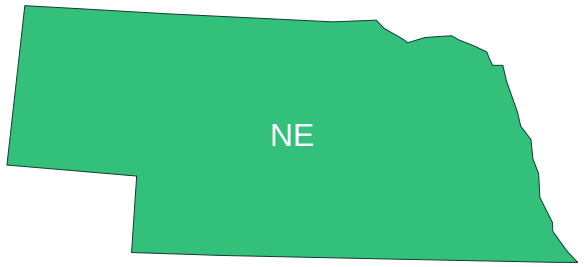
Previous "Soft Cap" on Noneconomic Damages:

The previous Iowa statute provided that noneconomic damages were limited to $250,000 "unless the jury determined that there was a substantial or permanent loss or impairment of a bodily function, substantial disfigurement, or death.

New "Hard" Cap on Noneconomic Damages:

The new legislation creates a two-part damage cap analysis.

- First, noneconomic damages are still limited to $250,000 (see above)
- If the jury makes a conclusion that an amount above $250,000 is warranted, noneconomic damages are capped at $1,000,000 or $2,000,000 if a hospital is involved in total regardless of the severity of the injury.



Changes in Nebraska

- Legislation in Nebraska effective January 1, 2025 increases the amount of liability coverage that must be carried by physicians, CRNAs, and hospitals in order to qualify for Excess Liability Fund coverage under the Nebraska Hospital-Medical Liability Act.
- What coverage amounts are required?

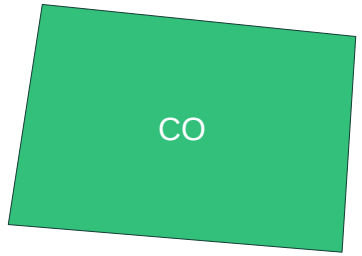
Until 12/31/24:

Physicians, qualified entities, and CRNAs	$500,000 per occurrence/$1,000,000 aggregate
Hospitals and surgery centers	$500,000 per occurrence/$3,000,000 aggregate

1/1/25 and after:

All Risks (physicians, CRNAs, and hospitals)	$800,000 per occurrence/$3,000,000 aggregate

- Effective 1/1/25 all renewals for NE policies with limits of $500k/$1M will be increased to $800k/$3M.
- All providers added mid-term to 2024 policies will be added at the $800k/3M limit after 1/1/25.
- All tails issued after 1/1/25 where the provider previously had a 500k/1M limit will be issued at the $800k/3M limit.



Changes in Colorado

Damage caps: The noneconomic damages cap inc from $300,000 for medical malpractice cases filed on or after Jan. 1, 2025, as follows:

	No Wrongful Death Claim	Wrongful Death Claim
Jan. 1, 2024 and before Jan. 1, 2026	$415,000	$555,000
Jan. 1, 2026 and before Jan. 1, 2027	$530,000	$810,000
Jan. 1, 2027 and before Jan. 1, 2028	$645,000	$1,065,000
Jan. 1, 2028 and before Jan. 1, 2029	$760,000	$1,320,000
Jan. 1, 2029 and before Jan. 1, 2030	$875,000	$1,575,000
January 1, 2030 and every two years thereafter	Cap multiplied by the U.S. Dept. of Labor Consumer Price Index for the Denver-Aurora-Lakewood area	

Other notable changes/challenges to existing tort reform

Montana – An increase in the non-economic damage cap from $250,000 to $500,000 over 4 years

Utah – There was an attempt at doubling the statute of limitations from two to four years, doubling the statute of repose from four to eight years, and more than doubling the cap on non-economic damages from $450k to $950k.

California and Nevada have also undergone attacks on tort reform and an increase in their respective caps on non-economic damages.

What do the changes mean?

Encourage	Encourage early reporting
Educate	Educate, educate, educate… on the impact when tort reform is challenged
Continue	Continue Copic's approach to early and thorough investigations and our philosophy of defending good medicine

3 Case Studies and Lessons Learned

Case Study #1

34-year-old male patient seen by APP 1 for skin lesion on medial left ankle and soft lump at base of neck.

Lesion removed with scissors and discarded. Documented as skin tag removal. Told to follow up as needed.

March 7

February 5

Eleven months later patient seen by APP 2 for left upper thigh and groin pain.

CT obtained and reported as enlarged left inguinal lymph node *“which may be reactive vs. malignant.”*

Antibiotic ordered and follow up with APP 3.

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Case Study #1 (continued)

Seen by APP 3 on February 10. Complaints of SOB at work with exertion. Continued taking antibiotic. No mention of groin lump.

February 10

June 15

Patient presents to APP 3 on June 15 with complaints of skin lesion of left ankle painful and increased in size, 2.4 cm x 2.5 cm.

MRI recommended and referred to a Podiatrist. MRI was not ordered or scheduled.

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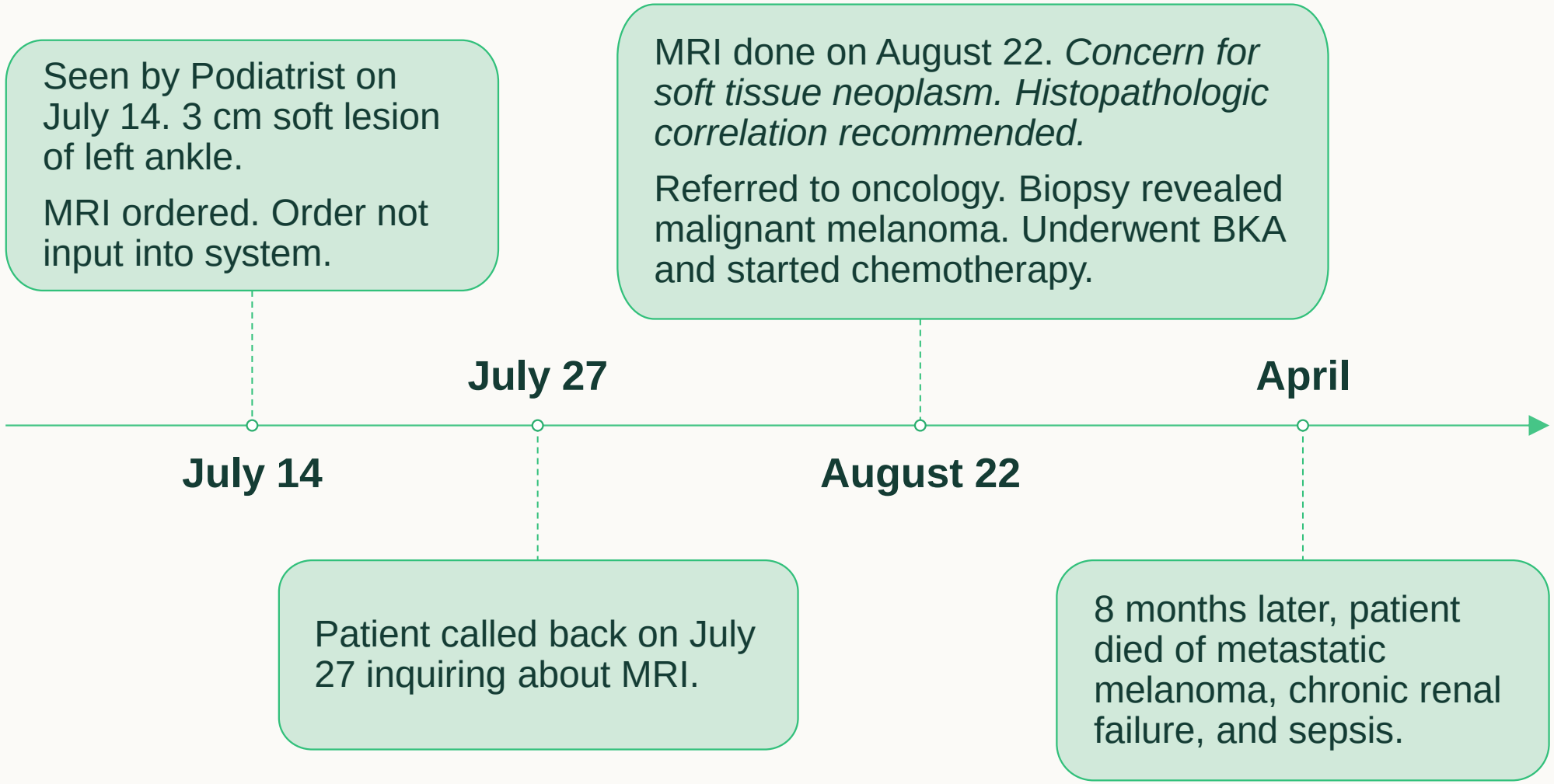
Case Study #1 (continued)



Lessons Learned

Challenges to Defense:

- Poor medical judgment—Standard of care concerns
- Poor documentation—Skin Tag??, no biopsy?, tissue discarded
- Poor communication—No follow up on lymph node following CT. No coordination of care. No one closed the loop.
- Wrong referral—Why Podiatry v. Dermatology?
- System failures—Delayed treatment, patient had to follow up on MRI

Defense experts could not support care.

Case settled for significant sum with allocation to multiple providers.

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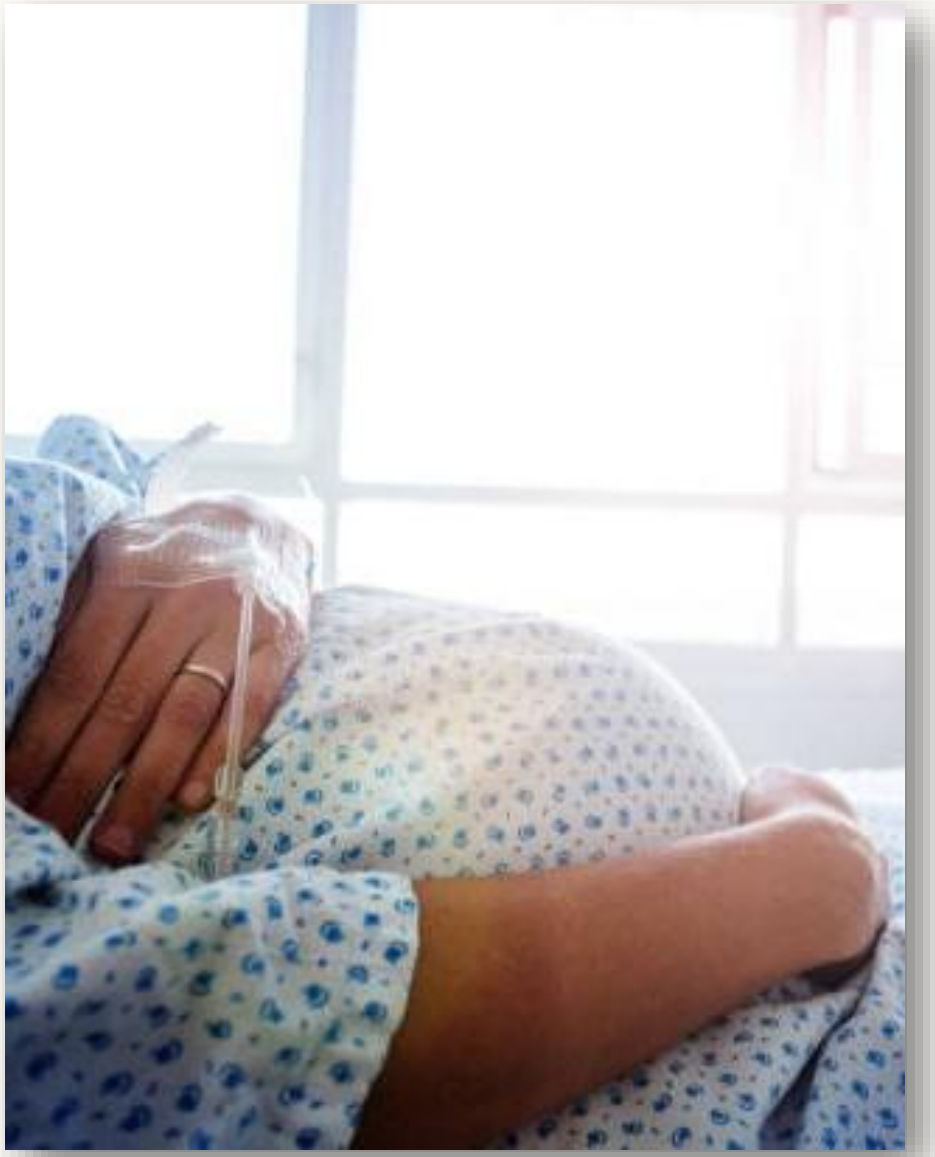
Case Study #2

38-year-old, (G6P5005), no history of shoulder dystocia delivery, admitted at 41 weeks 0 days, with membranes ruptured and there was meconium-stained fluid present. She was having contractions, and was 6 cm on arrival. Our Insured OB's delivery note:

> *"When the head was about 2/3 delivered, maternal effort became poor d/t pain. She was urged to push stronger, hips were flexed back. Suprapubic pressure applied but was not effective enough to aide delivery of anterior shoulder."*

This reads as if our insured "urged" [mom] to push stronger. There is no mention in the medical note that our insured instructed mom to stop pushing before the McRoberts position was attempted and suprapubic pressure was applied.



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Case Study #2 (continued)

After mom's hips were flexed back, mom stopped making progress. Our insured then did a vaginal exam and confirmed that baby's shoulders were wedged behind mom's pubic bone. Our insured told Mom not to push but this is not charted.

Our insured reduced the nuchal cord and charted the anterior shoulder was difficult to reach behind mom's pubic bone but there was quite a bit of room posteriorly.

Our insured OB's next note:

> *"I was then able to delivery the posterior arm & corkscrew the baby out."*

Case Study #2 (continued)

The baby was born at 9 lb., 2 oz, with Apgar's 2,6,8.

In total, this was a 1 minute 58 second shoulder dystocia.

No episiotomy was needed, nor the need to apply forceps or a vacuum.

The labor was not augmented in any way nor did mom have anesthesia—mom declined an epidural. She did receive IV pain medicine instead of an epidural. She was given IV fentanyl.

Baby has a left brachial plexus injury at C5/6 without avulsion.

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Lessons Learned

Challenges to Defense:

Documentation is vague and could be misconstrued

> ***"When the head was about 2/3 delivered, maternal effort became poor d/t pain. She was urged to push stronger, hips were flexed back. Suprapubic pressure applied but was not effective enough to aide delivery of anterior shoulder."***

Lack of chart note that insured told mom to stop pushing before McRoberts position attempted and suprapubic pressure applied.

- This note reads as if our insured "urged" [mom] to push stronger. No mention in the medical note that our insured instructed mom to stop pushing before the McRoberts position was attempted and suprapubic pressure was applied.

Lessons Learned (continued)

Challenges to Defense:

Documentation is vague and could be misconstrued

"I was then able to delivery the posterior arm & corkscrew the baby out."

- Plaintiff's expert opined our insured performed an "unknown maneuver" to deliver the child and referenced to "corkscrew".

Defense experts were supportive of our insured.

The case was tried and the jury returned a defense verdict in a short amount of time.

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QUESTIONS?

Thank you!