OMIC Members Report 2013

IN DEFENSE OF GOOD MEDICINE

OPHTHALMIC MUTUAL INSURANCE COMPANY
(a Risk Retention Group)


2013
HIGHLIGHTS

Policyholder Dividend
OMIC declares a 25% dividend for all physician-insureds as of December 31, 2013, to be applied as a credit to 2014 premiums.

Admitted Assets
OMIC surpasses a quarter billion dollars in assets after 3% growth of more than $7 million.

Policyholder Surplus
OMIC maintains a better than 25% premium to surplus ratio. Surplus increases 6%, or nearly $9 million, since year-end 2012.

Underwriting Profit
OMIC posts an underwriting profit of $7.5 million through June 30, 2013. OMIC has shown an underwriting profit for 9 consecutive years.

OMIC is the largest insurer of ophthalmologists in America and one of the most financially sound carriers, earning an "Excellent" rating from A.M. Best for the 17th consecutive year in 2013.

MESSAGE FROM THE Chairman

During the late summer months of 1991, an OMIC colleague performed surgery to repair a bullous retinal detachment in a patient's right eye. Postoperative choroidal detachments unfortunately developed, and despite close monitoring and an appropriate treatment plan, the patient's vision deteriorated and was ultimately lost. The patient sued, launching a two-decade legal odyssey for both OMIC and our insured. A few months ago, we were finally able to bring this case, the longest open claim in the history of our company, to a close once and for all—and with no payment to the plaintiff. A closer look at the trials and tribulations faced by our legal team clearly illustrates what we often refer to as the "OMIC advantage" over the traditional malpractice insurance industry.

After careful review of this case by retinal experts, it was OMIC's contention that the insured's treatment both pre- and postoperatively met the standard of care. Our determination was that the patient's preexisting chronic uveitis was the cause of the poor outcome rather than any negligence on behalf of the ophthalmologist. Our legal team mounted a vigorous defense of our colleague.

The case went to trial several times, always resulting in defense verdicts, and yet the patient appealed each decision. Local media outlets chronicled the plaintiff's story, highlighting not only the poor outcome but also the contention that justice was being denied.

The state Supreme Court heard the case on four separate occasions, most recently after our successful defense in a lower court in 2010. The final hope for the plaintiff was to appeal to the United States Supreme Court. Thankfully, the plaintiff did not pursue this avenue and the deadline for such action has now passed.

OMIC spent more than $1 million defending this claim. And this is the quandary we find ourselves in while navigating the legal system in America: litigation, even in very defensible cases, can drag on for years. The financial and emotional tolls are immeasurable.

Clearly, we could not remain viable as a company if the cost to defend every claim reached these heights. But this difficult, seemingly never-ending claim highlights a commitment to both our insured and our specialty.

Many of our competitors would refuse to pursue such a costly legal journey, arguing that it does not make good business sense. I disagree. You can be sure that plaintiff attorneys in future cases will think twice before questioning OMIC's resolve in defending good medicine. In this respect, our money was well spent.

From the day I became a policyholder in 1995, I realized that OMIC would play an integral part in protecting my practice and my career. For nearly 15 years, I have served as an OMIC Board and Committee member, an experience that has filled me with optimism for our specialty's future and gratitude for the opportunity to help shape its destiny.

As I prepare to step down as your chairman at year's end, I wish to express my profound appreciation for the honor of leading this exceptional company over the past three years. I leave the company in the capable hands of a fellow oculoplastic surgeon and trusted colleague, Tamara R. Fountain, MD, of Deerfield, IL. Please join me in welcoming Dr. Fountain, who served as an OMIC Committee member from 2001 to 2006 before being elected to the Board in 2007 and who has distinguished herself as a leader for OMIC during its most successful and prolific years.

JOHN W. SHORE, MD

MESSAGE FROM THE President & CEO

The defense of malpractice claims could be described as both a marathon and a sprint, at times requiring long stretches of hard work and diligence punctuated by brief moments in which we are presented with the opportunity to perform at our best.

In this year's *Members Report*, we describe one claim where legal maneuverings required endurance lasting decades and another in which bold action by our defense team caused a plaintiff-friendly state panel member to switch sides, providing an opening that culminated in a surprising win at trial.

OMIC's superior claim performance is highlighted in this report because the financial health of your company is directly related to our successful management of ophthalmic claims and lawsuits.

I am happy to report that OMIC's 2012 and 2013 operating performance once again places us among the most financially sound carriers in America. For the first time, admitted assets surpassed a quarter billion dollars. In just 18 months, we strengthened surplus by $18 million and are on track to return nearly $10 million in policyholder dividends. Since 2008, the total dividend credits declared equals a full year's premium per physician-insured. During this same six-year period, OMIC paid 10% more in dividends than our competitors.

We are able to achieve these impressive results for several reasons. Our underwriters and Board and Committee ophthalmologists select only the most favorable risk profiles and review changes in exposure upon policy renewal and disposition of claims. Our risk managers provide ophthalmic loss prevention training and pre-claim assistance that is unparalleled in our industry. It is no coincidence that with risk management participation consistently above 50%—a figure many competitors envy—our policyholders' claims experience is markedly improved.

Finally, our claims team, with access to the best experts in each ophthalmic subspecialty, is able to quickly isolate key issues related to a claim's defensibility. Whereas opposing counsel may never have tried an ophthalmic case, OMIC's attorneys are experienced in ophthalmic litigation. The claim described on page 8 of this report illustrates how expertise in the field can push us toward the finish line while the other side falters practically from the start.

Our efforts paid off in 2012 results. OMIC's loss and loss expense ratio of 52% was significantly better than the 62% average of our peers. We have outperformed our peer group in loss and loss expense ratio every year during the past decade. (An explanation of this measure of losses in relation to premium is on page 12 of this report.)

As a result of our positive claims results, OMIC is pleased to announce the continuation of our competitive 2013 rates through year-end 2014. OMIC's Board has also approved a 25% dividend for all active physician-insureds as of December 31, 2013, to be applied as a credit to your 2014 renewal premium. Upon application of these dividend credits, OMIC will have returned more than $30 million to policyholders over the past five years. This figure is even more impressive considering that base rates for ophthalmology are lower than many other specialties, largely due to OMIC's presence in the marketplace.

In closing, I would like to take this opportunity to recognize and thank Dr. John Shore for his exemplary stewardship of OMIC. It has been a pleasure working with him and he will be missed. Thankfully, we are fortunate to have a wealth of talent ready to lead us forward toward 2020.

TIMOTHY J. PADOVESE

THE RISK MANAGEMENT LIFELINE

By Ellen Adams

In 2002, I was hired as the Compliance Officer for Ophthalmic Consultants of Boston. With the ink barely dry on my MBA and over 16 years' experience as an ophthalmic technician/scrub assistant, I felt ready to handle HIPAA, coding, and OSHA issues. After all, that is what a compliance officer does, right?

How wrong I was.

Almost immediately, I found myself in the cross hairs. Patients with complaints were transferred to me. I answered calls from lawyers asking for copies of medical records. And our satellite office managers called me whenever problems arose, such as when a patient fell in the parking lot. In most of these situations, no one really knew what to do and panic was often coloring the event. After one especially concerning situation, I met with OCB's then-president, Dr. Tom Hutchinson, to ask for help. Without hesitation, his response was to call the OMIC hotline. At the time, I didn't realize there was such a thing, but over the past 11 years this service has become one of my most valuable tools. Most importantly, I have found that there is no need to panic. I have objective, highly knowledgeable experts when I need them; a lifeline that is just an email or phone call away.

One recent typical day at OCB found me working at my desk when the phone rang. It was a patient who at first seemed reasonable. We were about six months into using electronic health records, and she was upset that a note by one of our physicians included an unflattering comment about how demanding she was. She was particularly concerned that her primary care physician would be able to see the comment and wanted it removed. What the patient did not realize was that the note she had seen during her previous visit had not been finalized; the draft version had been subsequently reviewed by our physician and this particular comment had been removed. While speaking with her, I reiterated several times that the final version of the note in her record did not contain the comment, but that was not good enough for her and the conversation continued to escalate into a highly charged tirade. As the call approached 45 minutes, I realized this patient was not as she had first presented on the phone—in fact, I was beginning to suspect that our physician's now removed comment was closer to the truth. She was unreasonable, demanding, and unpredictably volatile. Time for a lifeline!

I emailed OMIC and asked for help. Not only did OMIC's risk manager, Anne Menke, assure me that neither I nor our practice was the problem, she also guided me through a reasonable response to the patient. When that didn't work (a subsequent hour and twenty-five minute phone call with the patient days later progressed in a similar fashion as the previous encounter), OMIC helped me draft a letter to discharge the patient from our practice. Clearly, this was in the best interest of both the patient and OCB. OMIC's help was exactly what I needed in order to facilitate a solution to a difficult practice-patient relationship while also protecting our practice.

Incredibly, when the patient called back a full year later wishing to be seen again by OCB, I was back on the phone with Anne, who recalled the entire incident and helped me compose a "discharge means discharge" letter to the patient.

This is what I value most about OCB's relationship with OMIC. The risk managers are there to help me. They treat my calls as completely confidential. No one, not even other employees within OMIC, have access to risk management files and they keep detailed notes so anyone can pick up the tale if things escalate; they are calm and rational when patients pull me into an abyss. They are my lifeline.

The OMIC risk management team has given me the confidence and tools to now handle most situations on my own. They use hotline calls like mine to develop recommendations, protocols, sample letters, and consent forms, which are posted on the OMIC website so they are available when I need them. When I call the hotline now, my OMIC team lets me know if my new problem is indeed unique or scarily interesting. I feel like OMIC is not just another malpractice insurance company but an integral part of my compliance and risk management team.

CASE STUDY

OMIC legal team convinces pre-litigation panel member to join defense

By Ryan Bucsi

An elderly patient, with a history of glaucoma and cataract surgery in the left eye, was informed by our insured that there was a significant cataract in the right eye. Over the next four years, the patient continued to come in for regular examinations yet refused to have surgery despite consistent recommendations by the insured.

By the time the patient agreed to surgery, the cataract was brunescent and too advanced to be removed by phacoemulsification. The insured performed a large incision extracapsular cataract extraction with insertion of an anterior chamber multiflex lens. At the first postoperative examination, the insured was not available to see the patient, so another ophthalmologist covered for him. A hyphema was present, which prevented visualization of the retina; vision was hand motion.

Following this exam and throughout the postoperative course, the insured attributed the patient's poor vision to the hyphema. After a slight improvement in visual acuity to 20/400, the insured assumed that the hyphema was gradually being absorbed and the patient would continue to recover visual acuity. When the patient's vision did not improve after a month, the insured suspected a retinal detachment. A same day referral was made to a retina specialist, who diagnosed a small hyphema on the anterior chamber lens. A B-scan confirmed the retinal detachment. A posterior vitrectomy with membrane peel and panretinal endolaser photocoagulation was performed but the retina re-detached. Following the placement of silicone oil, the retina was reattached but visual acuity remained hand motion.

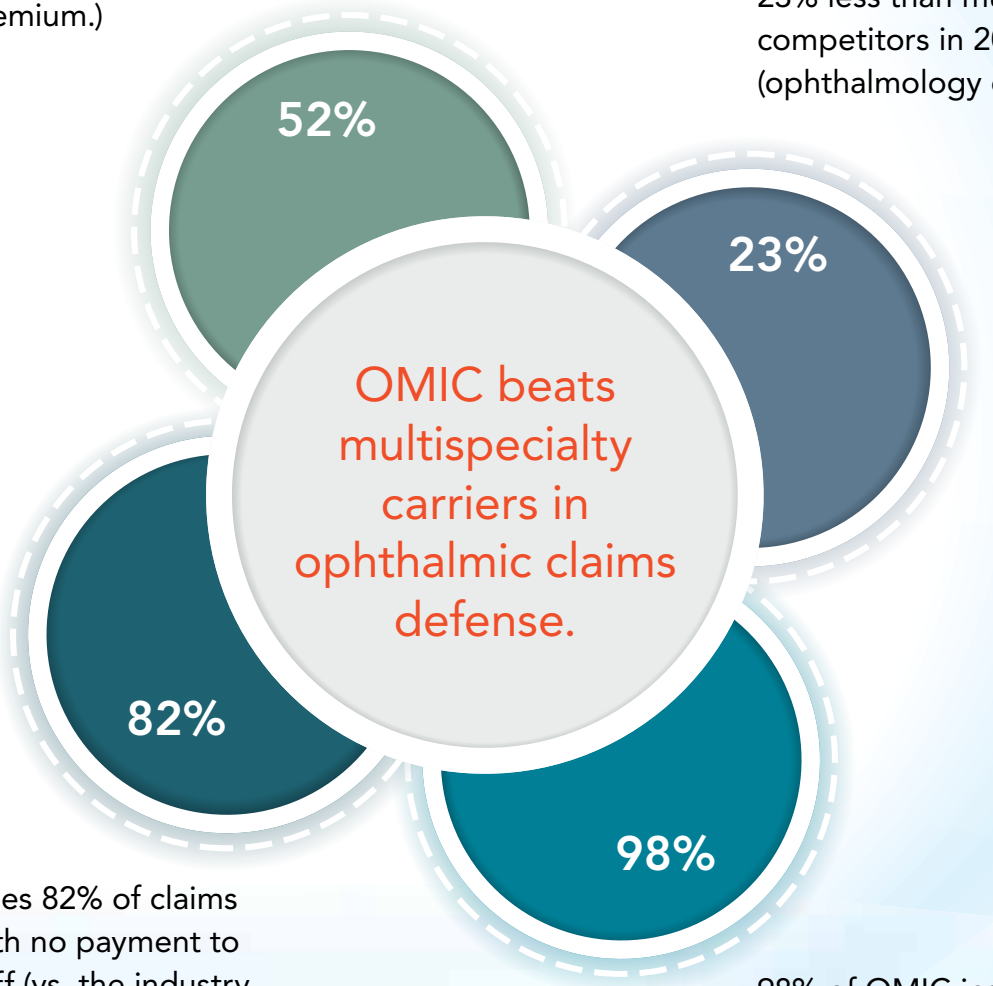
This case occurred in a state where medical malpractice complaints are presented to a pre-litigation panel, in this instance consisting of two ophthalmologists and an optometrist. OMIC had the case reviewed by a retina expert and a cataract expert. The retinal expert concluded that the decrease in vision postoperatively could be explained by a hyphema. He opined that as the hyphema decreased but vision did not improve, the insured appropriately referred to a retinal specialist. The cataract expert also felt the insured's treatment was well within the standard of care.

The state's panel, however, unanimously found that "in view of the patient's persistent hyphema and the inability to examine the retina, our insured should have referred to a retinal specialist sooner." Based on our experts' opinions, we moved forward despite counsel's caution that it would be difficult to defend since all panel members would testify for the plaintiff. OMIC retained a well respected local retina specialist, who echoed the opinions of our first retina expert, and we prepared for trial. Meanwhile, plaintiff's counsel retained out-of-state "hired guns."

During discovery, our counsel and retina expert's testimony were so impressive that we convinced a panel member that the insured had met the standard of care. Bolstered by superior attorneys and experts, and a sudden flip within the panel to the defense, we proceeded to trial. After six days of testimony, the jury deliberated for a brief period before returning a 12-0 defense verdict.

OMIC's loss and loss expense ratio of 52% in 2012 is 10 points better than the peer average. (Loss and loss expense ratio measures losses in relation to earned premium.)

OMIC's average indemnity is 23% less than multispecialty competitors in 2012 (ophthalmology claims only).



OMIC closes 82% of claims in 2012 with no payment to the plaintiff (vs. the industry average of 70%).

98% of OMIC insureds rate their defense attorney and claims staff "Excellent" or "Good."

COOPERATIVE VENTURES

OMIC partners with 44 ophthalmic societies nationwide

Twenty years ago, OMIC entered into a trial venture with the Colorado Ophthalmological Society to provide financial incentives for risk management education. OMIC's 1993 *Members Report* described the initiative as a way to "help COS members pay their society dues" by providing a risk management discount on our insurance premium for policyholders who attend a jointly sponsored course. It was hoped the benefit would serve as a recruitment and retention tool for both organizations and increase participation in OMIC's risk management program. In early 1995, we presented a *Risk Management Fundamentals* seminar to a small group of COS members, launching what would grow into a multimillion dollar initiative, with 44 society partners serving thousands of ophthalmologists from every state in America.

From our perspective, we recognized that OMIC and ophthalmic societies share similar marketing goals and membership concerns. Beginning in 1992, OMIC's Board committed to collaborate with state, regional, subspecialty, and specialized interest societies to encourage membership and attendance at ophthalmic meetings and events.

Convinced that OMIC's risk management information, combined with financial support for organizations advocating for ophthalmology, would lower the risk of lawsuits and promote patient safety, we devoted significant resources to create educational alliances. Early on, we were encouraged as these alliances helped us "sell" OMIC to ophthalmologists who were not already insured by us.

Cumulative premium credits applied through Cooperative Venture Program

Our experience in defending ophthalmology claims helped us identify trends in plaintiff litigation tactics and use this information to develop risk management recommendations that dramatically improved our defense of subsequent claims. The challenge was to get this information in the hands of those on the "front lines" of ophthalmic practice.

This is where our cooperative ventures played a critical role. Since that first venture with COS, participation in our risk management program has nearly doubled, and more than 10,000 premium discounts totaling over $13 million have been awarded to OMIC insureds who are members of cooperative venture societies. The average credit earned in 2012 was $1,100, which paid the society dues for many insureds.

It is truly a win-win-win partnership. Societies report that OMIC benefits have helped to maintain, and even increase, their membership numbers. Society members themselves have earned millions of dollars in premium discounts, and OMIC has nearly tripled in size. In 2012, OMIC was ranked #1 among our peers in claim performance, which we believe is largely the result of the high participation rate of our insureds in risk management programs.

OMIC partners with the following ophthalmic societies across the nation to conduct joint educational seminars and disseminate the latest ophthalmic case studies and loss prevention recommendations.

Alabama Academy of Ophthalmology
American Association for Pediatric Ophthalmology and Strabismus
American Eye Study Club
American Society of Ophthalmic Plastic and Reconstructive Surgery
Arizona Ophthalmological Society
Arkansas Ophthalmological Society
Association of University Professors of Ophthalmology
California Academy of Eye Physicians and Surgeons
Colorado Society of Eye Physicians and Surgeons
Connecticut Society of Eye Physicians
Contact Lens Association of Ophthalmologists
Delaware Academy of Ophthalmology
Florida Society of Ophthalmology
Georgia Society of Ophthalmology
Hawaii Ophthalmological Society
Idaho Society of Ophthalmology
Illinois Association of Ophthalmology
Indiana Academy of Ophthalmology
Iowa Academy of Ophthalmology
Kansas Society of Eye Physicians and Surgeons
Kentucky Academy of Eye Physicians and Surgeons
Louisiana Ophthalmology Association
Maine Society of Eye Physicians and Surgeons
Maryland Society of Eye Physicians and Surgeons
Michigan Society of Eye Physicians and Surgeons
Mississippi Academy of Eye Physicians and Surgeons
Missouri Society of Eye Physicians and Surgeons
Nevada Academy of Ophthalmology
New England Ophthalmological Society
North Carolina Society of Eye Physicians and Surgeons
Ohio Ophthalmological Society
Oklahoma Academy of Ophthalmology
Pennsylvania Academy of Ophthalmology
South Carolina Society of Ophthalmology
Tennessee Academy of Ophthalmology
Texas Ophthalmological Association
Utah Ophthalmology Society
Vermont Ophthalmological Society
Virginia Society of Eye Physicians and Surgeons
Washington Academy of Eye Physicians and Surgeons
Washington DC Metropolitan Ophthalmological Society
West Virginia Academy of Eye Physicians and Surgeons
Women In Ophthalmology
Wyoming Ophthalmological Society

A PARTNERSHIP THAT WORKS

We are fortunate in Utah to have an active and engaged community of ophthalmologists with a very high percentage of membership in the Utah Ophthalmolgy Society (UOS). Our mission to support our members with state-specific education, legislative advocacy, and coding and regulatory resources is vital to protect their interests and promote patient safety. Our venture with OMIC has been a good way to help achieve some of our goals. The OMIC premium discount provides a significant UOS-specific incentive. Our members have earned nearly $100,000 in credits since we formed the educational alliance in 2008. We consider our partnership with OMIC to be a valuable member benefit.

ANNETTE MAHLER
Executive Director
Utah Ophthalmology Society

CLAIM MANAGEMENT 101

Understanding claim reserves, losses, and related expenses

As of August 2013, OMIC had managed 4,000 claims and lawsuits, and paid more than $200 million in related losses and loss expenses. The quarter century of experience we've gained from handling such a volume and variety of ophthalmic claims gives OMIC a strategic advantage over multispecialty carriers. This is because the two major predictors for successful management of a malpractice claim are (1) the competent analysis of risk to both the insured and the company and (2) a prompt response to and vigorous defense of demands for damages. In this report, we present several statistics that show OMIC's superior claim performance in relation to our peers. Here we discuss two important measurements related to claim and loss management.

LOSS AND LAE RESERVES

Allocating money to pay for expected loss payments and loss expenses is one of the most difficult aspects of claim management. Setting loss and loss adjustment expense reserves involves an educated "guess" of what a reported claim might cost the company in both losses and related expenses. To make matters worse, we often must make decisions based on the limited or inadequate facts available during the early stages of a claim. Setting reserves too conservatively could inhibit our operating performance. Inadequate reserves could place us in a dangerous position of lacking sufficient funds to pay claims. Ideally, a carrier hopes to set reserves for claims that are as close as possible to the actual loss or expense incurred.

Fortunately, OMIC's claims staff has more than 75 years of combined experience in handling ophthalmic claims and, with assistance from the ophthalmologists on OMIC's Claims Committee and an attorney panel with an unmatched ophthalmic defense record, is able to quickly assess the merits of a claim and the potential for damages.

LOSS AND LAE RATIO

Managing losses and loss adjustment expenses (LAEs) is perhaps the most important function of a malpractice carrier. The loss and loss adjustment expense ratio reflects the proportion of each premium dollar that is used to pay for losses and related costs, such as claim investigations, medical examinations, attorney fees, and other expenses. OMIC retains a profitability advantage over multispecialty carriers largely because of our favorable loss and LAE ratio. In a 2012 actuarial review of claims, OMIC ranked #1 among our peers in key measurements, suggesting we are well prepared for the future. Moreover, OMIC's 52% loss and LAE ratio was significantly better than the average of 62% for multispecialty carriers. In other words, OMIC paid out 52 cents for every dollar we collected to cover losses while our competitors paid out 62 cents. Carriers that pay out a higher portion of each dollar in losses must rely more heavily on investments to remain profitable, a recipe for trouble during turbulent market conditions.

OMIC's superior management of losses and expenses also has a direct impact on the cost of your insurance. Our base rates have remained 15% lower on average than multispecialty carriers and OMIC's policyholder dividends in 2011 and 2012 were 28% higher than those of our multispecialty competitors.

Looking forward, OMIC has been able to manage surplus better as well. Our premium to surplus ratio of 26% is significantly better than our competitors' average of 32%. Therefore, should market conditions change or unforeseen losses develop, OMIC is well positioned for the future.

FINANCIAL HIGHLIGHTS

Ophthalmic Mutual Insurance Company

Statutory Basis—12 Months Ending December 31	2012	2011	2010	2009	2008
Net Admitted Assets	$245,951,335	$232,983,213	$221,950,157	$202,098,252	$199,132,351
Loss & LAE Reserves	$55,791,199	$50,863,000	$52,601,072	$48,354,933	$62,047,295
Total Open Claims	471	456	455	448	489
Policyholders' Surplus	$149,533,498	$140,377,848	$132,886,012	$115,207,419	$91,984,680
Net Written Premium to Surplus Ratio[1]	25.9%	23.7%	32.9%	30.6%	41.3%
Direct Premium Written	$42,790,167	$41,507,606	$43,028,754	$42,442,092	$44,682,363
Net Premiums Earned	$37,376,077	$33,648,518	$43,238,206	$35,674,850	$37,569,201
Net Income	$7,548,044	$8,080,526	$15,908,899	$21,658,982	$16,327,731
Loss & Loss Expense Ratio[2]	52.3%	46.2%	37.6%	11.9%	19.7%
Combined Ratio[3]	97.2%	94.7%	67.2%	39.2%	63.2%
Operating Ratio[4]	77.9%	73.8%	50.4%	18.8%	43.2%
Number of Insured Physicians	4,477	4,411	4,253	4,107	3,939

[1] Net written premium to surplus ratio measures the adequacy of an insurer's surplus. A ratio of less than 100% indicates acceptable financial health.

[2] Loss & loss expense ratio measures a company's loss experience in relation to its earned premium.

[3] Combined ratio measures overall underwriting profitability. A ratio of less than 100% indicates an underwriting profit.

[4] Operating ratio measures a company's overall profitability from underwriting and investment activity (pretax).

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2013 MEMBERS REPORT

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