

Comments on NAIC Model Medical Malpractice Closed Claim Reporting Law

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We respectfully submit the comments below on the Feb. 2007 NAIC model law on closed claim reporting. We would welcome an opportunity to discuss these comments with you, at your convenience

1. Researcher Access [Draft Law § 6(a)]

The critical flaw in the model law is its failure to provide for researcher access to the data that will be collected. Without this access, the value of the information will be dramatically reduced. We will, at best, have individual state reports, of mixed quality, that in most cases will not meet academic standards and will not provide cross-state comparisons.

The experiences of Texas and Florida show that it is possible to provide researcher access to closed claim data. The Texas Department of Insurance, for example, provides public access to closed claim reports, from which information that could identify individual physicians or insurers has been removed. This information has been available since 1988, yet we are aware of no complaints that confidentiality has been violated, or that the public reporting is not appropriate.

We propose that the Model Law should provide that:

"Within [six] months after the end of each year, the Department of Insurance will release publicly, in downloadable form, the information contained in closed claim reports, after removing information that would identify a particular insurer, facility, provider, or claimant. Each facility, provider, or claimant shall be identified with an identifying number, which will be unique to that facility, provider, or claimant. Multiple reports involving companion claims (claims involving the same claimant and incident) shall be identified as such."

Another approach would be to provide full access to closed claim reports to researchers who are willing to sign a confidentiality agreement, in which they promise not to publicly disclose information about particular insurers, defendants, or claimants.

2. Scope of Permitted Disclosure [Draft Law § 6(b)]

There are other ways in which the confidentiality provisions in Section 6 are written too broadly. In particular:

- state agencies other than the Department of Insurance should be explicitly permitted to have access to the closed claim reports. These reports will be of importance, in particular, to the Public Health Department or other agencies concerned with quality of health care or patient safety.
- It sweeps too broadly to forbid the preparation of reports that might "permit[] readers to discern information about any particular insuring entity . . ." [Draft law § 6(b)] For some specialized lines of malpractice insurance, there may be only a single provider in a state, or one provider may have a dominant market share, such that *any* information will provide information about a particular insurer. Nor is there any policy reason why insurers should have this level of protection. All they are doing is reporting claim outcomes. It is appropriate to require that insurers, or researchers, not disclose information that would permit the identification of a particular facility, provider, or claimant. Our draft researcher access provision, above, would limit information disclosure to ensure this outcome.
- As long as protection is provided for the identify of facilities, providers, and claimants, it should be possible, as the Texas and Florida experience shows, to publicly release information about particular claims. Thus, the reference to "claims" in § 6(b) should be removed.

3. Annual Reporting by Department of Insurance

The law should provide for annual reports by the Department of Insurance. For example:

"The Department of Insurance should complete annually a summary report based on the information collected through the closed claim reports. Comparisons of different years, within the summary report, should be based to the extent possible on inflation-adjusted amounts."

4. "Claims" versus "Open Files"

In many cases, a preliminary inquiry by a patient, such as a request for medical records, will lead to an insurer opening a file. It would be useful to collect information on the frequency with which files are opened, as well as the frequency with which formal demands for payment are made.

5. Required Data Elements: Scope of Reporting

Only the primary insurer is required to report information. This is appropriate in general. However, it is important to ensure that the primary insurer reports information about other insurance that was potentially available. Thus, reporting elements should include

- Was there an excess policy (policies)?
- If yes, what were the policy limits of the excess policy (policies)?

Additional data should also be provided on the nature of the policy:

- Is the policy claims made or occurrence based?
- If there are separate per-incident and annual limits, both should be reported.

One should be careful, in specifying a reporting format consistent with NPDB, not to reproduce some mistakes made in NPDB, such as reporting a payment range rather than a specific payment amount.

Reporting should include the nature of the insurance policy, for example, medical professional liability or other (if other, specify from a list to be provided in the reporting form)

Section 4.A.1 reads as if only providers of medical professional liability insurance are required to report. The reporting requirements should be explicitly extended to include all insurers, regardless of the nature of the policy. Many nursing homes are covered by a variety of insurance policies (other professional liability insurance is a common form).

If a claim is reported under § 4.A.3, even though it is not covered, the reason for non-coverage should be reported.

6. Total Payout

It is important, in assessing the overall nature of medical malpractice outcomes, to know the total amount paid to a claimant from all sources, *including other defendants*. In general, this information will be available to the primary insurer. Currently, § 5.K.1(b) and § 5.K.2(b) require reporting only as to a particular defendant.

Information should be required on both (i) the total amount paid by all defendants; and (ii) on the amount paid by each defendant to the extent known to the reporting insurer. We are not aware of problems in Texas, which requires similar detail on payments by each paying defendant.

7. Defense Costs

It would be valuable to have a further breakdown of defense costs, perhaps into:

- expense for inside counsel

- expense for outside counsel
- expense for expert witnesses
- other cost containment expenses

8. Information on Defendants

Details should be required on each defendant. Currently the form requires information (for example, on specialty) only on the provider who was "primarily responsible" for the incident.

Thus, if a claimant sues two physicians, one nurse, one hospital, and a nursing facility, all defendants should be identified, and each physician's specialty should be identified. Information on defendants who are not health care providers should also be provided.

9. Reporting of Trial Outcomes

For cases that go to trial, it would be valuable to report both the amounts awarded by the jury and, if different, the amounts reflected in the final court judgment, and the reasons for any differences. Such reasons could include remittitur and the application of statutory caps on damages.

Reporting of trial outcomes should also include the amount of any pre-judgment interest to which the claimant is entitled. This amount will usually be computed by the court and specified in the court judgment.

If a case is tried, the date of trial and the date of the court judgment should be reported. It appears, under §§ 5.I and 5.J. that if a case is tried, and then settled for an amount different than the court judgment after trial, that the date of trial will not be reported under either section.

If a case is tried, there may be an allocation of fault among defendants, and perhaps also a partial allocation of fault to the plaintiff. These allocations should be reported.

If a case is tried and then appealed, information on the appeal should be reported

- was the appeal heard, or was the case settled before the appeal was heard
- If the appeal was heard, what was the outcome

10. Alternative Dispute Resolution

In some cases, ADR will be attempted but will not succeed in resolving a claim. The reporting should indicate whether ADR was attempted. Right now, ADR appears to be reported only if it resolves the claim (§ 5.J.3).

If ADR is used, the type of ADR should be reported.

11. Dates to be reported

The date when a file is opened may differ from the date when a claim is made. Both dates should be reported under § 5.I.

12. Initial reserve amounts

It would be useful to require reporting of initial reserve amounts for indemnity and expenses.

In contrast, our experience, in working with the Texas data, is that insurers' estimates of the breakdown of damages between economic, noneconomic, and punitive damages are not particularly useful.

13. Auditing of Totals

The Department of Insurance should be required to audit claim reports for:

- internal consistency (do amounts that should add up, in fact add up)
- completeness of reporting (both completeness within each report and complete reporting of all claims): insurers should be required to file an annual report summarizing basic information on all claims, the information in this summary report can then be checked against individual reports.
- do the reported items make sense (for example, if a case goes to trial, and there is no expense reported for counsel, the Department should inquire as to whether there has been a reporting error)
- do the amounts reported make sense (for example, one would expect insurance policy limits to be reasonably round numbers).

The Texas experience indicates that this sort of auditing is important to ensure reporting accuracy and completeness

14. Sample Closed Claim Reporting Form

The draft law should be accompanied by a model closed claim reporting form. The Texas form offers a good place to start.