

August 14, 2007

The Honorable Mike Kreidler, Chair
NAIC Statistical Information Task Force
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504

SUBJECT: Comments Regarding June 11, 2007 Draft Medical Malpractice
Closed Claim Reporting Model Law

Dear Commissioner Kreidler:

Thank you for the opportunity to provide further comments regarding the subject model law. At its meeting held on August 6, 2007, the PIAA Board of Directors reviewed the draft model law, and we submit the following comments. The comments in the body of this letter pertain to overall relevance of the data to be captured by the model law. We have also submitted specific comments regarding the data elements in previous correspondence, and we are resubmitting them at this time, as suggested during the June 19, 2007 teleconference meeting of the Statistical Information Task Force (SITF). These are attached as an addendum.

Development of a National Standard

The recently adopted NAIC “Procedures for Model Law Development,” contain criteria that stipulate model laws must address an issue which “...*necessitates a national standard and requires uniformity amongst all states;...*” While we agree with this criteria, we respectfully submit that the proposed MPLI closed claim model law will not achieve this result.

Many individual states (such as Washington) have already implemented their own unique closed claim data reporting requirement, and this is already placing an undue burden on insurers to comply with the specific and unique data reporting requirements of multiple states. As the SITF draft model law does not provide for a uniform data collection plan to be adopted by all states, it does nothing to resolve this serious issue, and indeed, does not implement a national standard or provide for uniformity amongst all states.

While the SITF draft identifies broadly defined elements of data to be collected, it leaves it up to the individual states to determine how those data elements are defined and reported¹ – and even this most general guidance is subject to change and interpretation by each state during the legislative process. By its lack of definition, the SITF draft virtually guarantees that there will not be uniformity amongst the states. And in fact, it is very possible that those states already having data collection plans in place will continue to use those plans, feeling that they are substantially in compliance with the NAIC model law requirements. This provides a nightmare for compliance by medical liability insurers, and greatly affects issues pertaining to accuracy and compliance. It also guarantees the inability to easily or accurately combine data from multiple states for desirable research purposes.

The PIAA strongly urges the NAIC to augment the current draft model law by defining a uniform national data set. While individual state legislatures could still produce variances, this would at least provide a common starting point – a starting point which should be strongly encouraged by the NAIC.

One way to guarantee uniformity amongst the states would be to collect the desired data on a national basis, with each claim being identified by state of origin. This could be accomplished as an in-house effort of the NAIC, or through an independent contractor. As a second method, all medical liability insurers in the United States are already required to report closed claim indemnity payment data to the National Practitioner Data Bank. While collecting data on a national basis would require the passage of pre-emptive federal legislation and also brings with it many other important considerations, it could be an easier and more cost-effective method to gather uniform data. Reporting to the NPDB could be mandatory for all MPLI insurers and indemnification mechanisms, regardless of individual state regulatory authority. While we recognize that both of these suggestions are different from the current direction of the Task Force and will require considerable deliberation, we offer them for consideration by the SITF.

Commissioner Kreidler, the PIAA has been involved in the collection of medical cause-of-loss claim data for over twenty years, and we are committed to providing timely and accurate MPLI data for patient safety and other research. We also recognize regulators' needs for increased financial and demographic information, and support the NAIC's efforts in this regard. However, the nature of MPLI claim data is very complex, and accurate coding and amalgamation is key to the provision of useful information. We agree that much of the scant data now available to regulators is less than ideal, and we cannot fail to note that this information is often converted and manipulated by

¹ The definition and codification of something as basic as the medical specialty of the doctor, for example.

researchers to prove their point of view. **The PIAA strongly feels that putting accurate information in the hands of regulators through the development of a national data set is the right thing to do.**

Thank you for the opportunity to comment. Additional comments regarding specific provisions of the model law are attached hereto.

Sincerely,

Lawrence E. Smarr
President

cc: Lee Barclay, Washington OIC
Joe Bieniek, NAIC Statistical Information Manager
PIAA Regulatory Affairs Committee
PIAA Board of Directors

ADDENDUM

General Comments

(1) Terminology Used to Identify Line of Insurance

The term “medical malpractice” is used throughout the model law to describe claims arising from the provision of medical care. We suggest that this be replaced by “medical professional liability insurance (MPLI)” to be consistent with current practices.

(2) Public Access

The PIAA does not support the public release of data as might be reported by the adoption of this model law. While we recognize the importance of research regarding the nature of medical professional liability claims, our appreciation in this regard is overshadowed by the spectre of identification of individual claims, defendants, and/or plaintiffs. The NAIC SITF and individual state insurance departments will surely aim to adopt language intended to prevent this, however, the small data cells created by parameters such as geographic location, medical specialty, and various dates will allow individual claims to be identified. This is clearly illustrated by the series of articles published by the Hartford Courant regarding the identity of physicians gleaned from the National Practitioner Data Bank public use file (previously provided). The NPDB goes to great lengths to protect the identity of the practitioners reported, however, it appears that “the smallness of the data” defeats these good intentions.

In addition, Attorney Black and his colleagues have suggested the capture of identifiers for individual insurers, defendants, and dates of trial and court judgment. If enacted, this will greatly enhance the ability to identify specific defendants and plaintiffs, and no supporting rationale for the reporting of this information is provided. For example, of what relevance is the date of trial, if not to identify the trial?

We feel that the best use of this data lies within the confines of state insurance departments, which are capable of providing useful aggregate information to policymakers, the public, and the research community. Our concern lies not only for the sake of insurers and defendants, but for plaintiffs as well. Medical liability actions are very stressful and consuming events for all involved, and facilitating the dissemination of information regarding these very personal events is not warranted. This may, in addition, substantially increase the risk of non-compliance with the adopted law. It must be noted that the

NPDB feels that there is substantial non-compliance with its federally mandated reporting requirements.

(3) Claim vs. Case Basis

MPLI claims are commonly identified on a “claim” basis or a “case” basis. In general parlance, a claim is an action taken against an individual defendant, and a case comprises claims against multiple defendants involved in the same medical incident or injury. We are unsure if the intent of the model law is to capture data on a claim or case basis, and suggest that the former format be utilized, with the provision of certain optional data fields that would allow the reporting of aggregate data for all defendants when this information is known to the reporting entity. This greatly simplifies the reporting process and enhances accuracy, as most required claim data should be known to the primary insurer, however, data regarding other non-insured defendants is often not known and impossible to obtain. In addition, if multiple insurers involved in any case each must report aggregate data for the case, many items of information, such as payment values, will be greatly overstated in the aggregate with no efficient means to avoid duplication. As the reporting of information on a claim basis does better define the parameters of individual claims, the confidentiality provisions of the model act are of heightened importance.

(4) Population of Claims to Be Reported

As written, the model act does not address the situation where an insurer subject to regulation in any state also does business in another state(s). Is that insurer required to report claims to the subject state insurance department for claims happening in each state in which it does business? For example, is an insurer subject to regulation in Washington required to report claims which may result from its Oregon business, or is this reporting the purview of the Oregon regulators? Our suggestion is that each state should limit the population of claims to be reported to those claims which happen in the state. The matter of risk retention groups, which are only regulated by the state of domicile, further complicates this issue, and should be addressed.

Specific Comments

(1) Section 2 (H) Definition of Health Care Provider.

We suggest that language found in subsection 1 stating “a physician, a surgeon, an osteopathic physician” be replaced with “an allopathic or osteopathic physician or surgeon.” This provides a more concise and complete description of the covered professions. We also suggest that the words “other health care professional” be added at the end of the list of entities.

(2) Section 4 (A) Reporting Requirements.

Reporting Total Amounts Subsection 2 states that the insurer “shall report the total amount, if any, paid with respect to the closed claim.” This does not distinguish between indemnity and loss adjustment expenses, and should be clarified. If case-based data is to be reported, then individual primary insurers are not going to have access to the loss adjustment expense data of other insurers involved, and may not have indemnity information in instances where defendants are settled out or dismissed prior to final disposition.

(3) Section 4 (B) Reporting Timeframe

Section 4 (B) stipulates that insurers must report all prior year data no later than March 1 of each year. Insurers are already overwhelmed by meeting March 1 deadlines in many other areas, including the reporting of annual statement data. As the data anticipated by the model law is not of a critical time-sensitive nature, we suggest making July 1 the reporting deadline.

(4) Section 5 (A) Required Data Elements

Incident Identifier Subsection 2 requires the reporting of an “incident identifier” where multiple claims are involved. The term “incident” is not defined in Section 2, and we suggest doing so. However, we also suggest replacing the term “incident” with the term “case.” The term “incident” is utilized by some insurers to index files for situations reported by their insured which they feel might develop into a future claim. This is also referred to as event reporting. To avoid confusion, we suggest that the term “case” be utilized to refer to claims against multiple defendants arising from a single treatment.

(5) Section 5 (C) Required Data Elements - Medical Specialty

This section requires the reporting of the medical specialty for “the provider who was primarily responsible for the medical malpractice incident that led to the claim.” This is stated in terms of reporting on a case basis. However, it is constructed in a manner that could be interpreted as the reporting of the specialty of an individual who is different from that insured by the company. For example, say the insurer insures a defendant anesthesiologist, but the primary defendant is a surgeon insured by another company. Should the insurer report general surgery as the specialty, or anesthesiology? This example speaks to the clarity of reporting on a claim basis, as discussed earlier.

(6) Section 5 (I) Required Data Elements – Dates

Final Action Subsection 5 requires the reporting of the “Final action by the reporting entity...” We do not know what is meant, and request clarification.

Issues Raised in February 26, 2007 Comments Submitted by Bernard S. Black, David A. Hyman, William M. Sage, Charles Silver, and Kathryn Zeiler.

The PIAA Regulatory Affairs Committee has also reviewed the comments submitted by Professor Black and his colleagues (hereinafter “Black”), and offers the following:

“Claims” versus “Open Files”

The PIAA is already on record with the SITF in opposition of the reporting of detailed open file data. Black suggests that “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 payments are made.” First of all, the reporting of claim data will not provide any indication of frequency, as this would also require the reporting of some measure of exposure. Secondly, claim count data is already provided by insurers in aggregate in the Annual Statement Blank, both for closed files and those remaining open at the end of the year. Thus, reporting such as in this instance would be a duplication of the current process and add unnecessary expense.

Use of NPDB Reporting Format

The PIAA supports the concept of using data field definitions and formats currently utilized by our members when reporting to the NPDB, and as applicable to the new model law. For example, it is reasonable to use the same format for the reporting of similar date fields found in both data plans. However, we urge the SITF to evaluate each of the fields in the NPDB data record before advising their use. As an example of where problems can occur, the model law currently suggests using the NPDB “Nature of Allegation-Act or Omission Code” to describe the nature of the medical injury or event. While this code may be useful for identifying individual claims and practitioners (the purpose of the NPDB), this scheme of codification is not sufficiently precise for the quantification of claims as to elements of medical cause-of-loss. As another example, the NPDB requires the reporting of the first payment made on any claim within 30 days of payment. Insurers may make more than one

indemnity payment (check) to a plaintiff, however, all subsequent payments are not included in the payment field submitted to the NPDB².

Defense Costs – Other Missing Cost Elements

Black suggests the reporting of costs for inside counsel. These costs may not be broken down in a retrievable format by insurers for statistical reporting. As most insurers largely rely on outside counsel for claim defense, we do not feel that this limited information will be worth the cost of collection.

However, major elements of the cost of the adjudication of MPLI claims are missing – those of the plaintiff side. We are not aware of any source of even the most basic information regarding the costs of claim prosecution borne by the plaintiff, and suggest that the same categories of expense provided in the model law for defendant also be required for plaintiffs in Section 5(E). Furthermore, we have previously noted the difficulty of insurers providing information on a case basis. However, the plaintiff does have this information relative to indemnity amounts paid/received, and we suggest that this also be added as additional reporting elements. A suggested mechanism for the reporting of this information would be to require plaintiff attorneys to provide the necessary data to insurers within a reasonable time after the closing of a claim and consistent with the reporting timeframe placed upon insurers.

Dates to Be Reported

Black comments that “The date when a file is opened may differ from the date when a claim is made...”, and suggests the reporting of both. For most claims, any difference in dates is an artifact of administrative process and not likely to be so long in length as to be of any importance. The only exception is in the case of the reporting of medical incidents (a/k/a events), where an actual claim has not been made. Some insurers open a file when the incident is reported, and others do not open a file until an actual claim is made. In any instance, this is an administrative process and not relevant for research purposes. We suggest that the date the actual claim is reported to the insurer be the required data element. That is also very likely to be the date the claim file is opened.

² Black also discusses the understanding of NPDB data, with reference to the reporting of payment values in ranges. As a point of clarification, the NPDB requires the reporting of the actual payment value, which is available to the NPDB for its own purposes. However, the public use file made available to the research community assigns a median bogie value to each payment within predetermined ranges as part of the de-identification process.

Initial Reserve Amounts

Black suggests that initial reserve amounts should be collected. We do not believe that the reporting of the initial reserve amount placed on individual claims is useful and it would add unnecessary expense. Very little is known about a claim on the day the claim is opened by the insurer, and the initial reserve amount for a claim is likely to be an average amount developed from historical data for similar claims. It is not meant to be an estimation of the value of the specific claim, but rather, a place holder, which in aggregate for all claims, represents an estimation of the liability of the insurer for all incurred claims. When more information is known about a specific claim, the reserve amount is adjusted to more appropriately reflect the potential cost of that claim.

Auditing of Totals

The discussion in this section of the Black memorandum concerns several suggestions for the “auditing” of the data reported by insurers. While we will not comment on actual auditing ramifications for insurance departments, we do agree in principle that all data reported should be subject to post-submission editing and correction. Tests of reasonableness as suggested by Black are, indeed, reasonable. However, we do not understand the usefulness of the report suggested where insurers would be required to provide a year-end summary of the data they have previously reported in the year. This is intended to measure the “completeness of reporting,” however, as the model law appears to require reporting on annual basis, we do not understand how this report would differ from the data submission due to insurance departments as of March 1 of each year (Section 4(B)).