

Underlining and overstrikes show changes from the last draft of the model. Comments should be sent by email to Joe Bieniek.

MEDICAL MALPRACTICE CLOSED CLAIM REPORTING MODEL LAW

Table of Contents

Section 1.	Statement of Purpose
Section 2.	Definitions
Section 3.	Applicability and Scope
Section 4.	Reporting Requirements
Section 5.	Required Data Elements
Section 6.	Confidentiality of Data
Section 7.	Authority to Adopt Rules
Section 8.	Effective Date

Section 1. Statement of Purpose

This Act is intended to ensure the availability of closed claim data necessary for thorough analysis and understanding of issues associated with medical malpractice claims, in order to support the establishment and maintenance of sound public policy.

Section 2. Definitions

As used in this Act:

- A. "Claim" means:
 - (1) A demand for monetary damages for injury or death caused by medical malpractice; or
 - (2) A voluntary indemnity payment for injury or death caused by medical malpractice.
- B. "Claimant" means a person, including a decedent's estate, who is seeking or has sought monetary damages for injury or death caused by medical malpractice.
- C. "Closed claim" means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility or provider. A claim may be closed with or without an indemnity payment to a claimant.
- D. "Commissioner" means the commissioner of insurance.
- E. "Companion claims" means separate claims involving the same incident of medical malpractice made against other providers or facilities.
- F. "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, and loss of business or employment opportunities.
- G. "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients.
- H. "Health care provider" or "provider" means:

- (1) A person licensed to provide health care or related services, including an acupuncturist, a physician, a surgeon, an osteopathic physician, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician's assistant, a midwife, an osteopathic physician's assistant, a nurse practitioner, or a physician's trained mobile intensive care paramedic. If the person is deceased, this includes his or her estate or personal representative; or
 - (2) An employee or agent of a person described in paragraph (1) of this subsection, acting in the course and scope of his or her employment. If the employee or agent is deceased, this includes his or her estate or personal representative.
- I. "Insuring entity" means:
- (1) An authorized insurer;
 - (2) A captive insurer;
 - (3) A joint underwriting association;
 - (4) A patient compensation fund;
 - (5) A risk retention group; or
 - (6) An unauthorized insurer that provides surplus lines coverage.
- J. "Medical malpractice" means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services.
- K. "Noneconomic damages" means subjective, nonmonetary losses, including pain, suffering, inconvenience, mental anguish, disability, or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation, and destruction of the parent-child relationship.
- L. "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical malpractice.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears.

Drafting Note: If some of these terms are already defined elsewhere in this State's statutes, references to those statutes may be substituted for the definitions above. If some types of insuring entities are defined elsewhere in this State's statutes, those definitions may be cited.

Section 3. Applicability and Scope

This Act shall apply to all medical malpractice claims in this State, regardless of whether or how they are covered by medical professional liability insurance.

Section 4. Reporting Requirements

- A. For claims closed on or after January 1, [insert year]:
- (1) Every insuring entity or self-insurer that provides medical malpractice insurance to any facility or provider in this State must report each medical malpractice closed claim to the commissioner.
 - (2) A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that issued the primary policy shall report the total amount, if any, paid with respect to the closed claim,

including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider.

- (3) If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include situations in which:
 - (a) The facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;
 - (b) The claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or
 - (c) The annual aggregate coverage limits had been exhausted by other claim payments.
- (4) ~~(a) If a court of competent jurisdiction determines that any self-insurer, risk retention group, or unauthorized insurer is exempt from this Act due to a Federal preemption or other cause, the facility or provider named in a medical malpractice claim must report all data required by this Act.~~
 - ~~(b) If any self-insurer, risk retention group or unauthorized insurer fails to report information required by this Act or asserts a Federal exemption or other jurisdictional preemption, the commissioner may, at his or her sole discretion, grant a waiver from the reporting requirements of this Act.~~
 - ~~(c) In the event that a waiver is granted under subsection A(4)(b) of this section, the facility or provider named in a medical malpractice claim must report all data required by this Act on behalf of the self-insurer, risk retention group or unauthorized insurer. If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the commissioner, the facility or provider named in the claim must report it to the commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.~~
 - ~~(a) If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal liability risk retention act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider must report all data required by this Act on behalf of the risk retention group.~~
 - ~~(b) If a facility or provider is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider must report all data required by this Act on behalf of the unauthorized insurer.~~
- B. Beginning in [insert year], reports required under subsection A of this section must be filed by March 1. These reports must include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years.
- C. The commissioner may adopt rules that require insuring entities, self-insurers, facilities and providers to submit all required closed claim data electronically.

Drafting Note: Many State insurance codes specify penalties for failure to timely file statutorily required reports or for submitting materially incorrect data. Each State should determine the applicability of such penalties to this Act. If it is determined that the State does not possess an adequate means to enforce this Act, the State may wish to consider inserting additional enforcement wording in this section.

Drafting Note: The year inserted in subsection B should be the year following the year inserted in subsection A.

Section 5. Required Data Elements

Reports required under Section 4 of this Act must contain the following information in a format and coding protocol prescribed by the commissioner. To the greatest extent possible while still fulfilling the purposes of this Act, the format and coding protocol shall be consistent with the format and coding protocol for data reported to the National Practitioner Data Bank.

- A. Claim and incident identifiers, including:
 - (1) A claim identifier assigned to the claim by the insuring entity, self-insurer, facility or provider; and
 - (2) An incident identifier if companion claims have been made by a claimant;
- B. The policy limits of the medical professional liability insurance policy covering the claim;
- C. The medical specialty of the provider who was primarily responsible for the medical malpractice incident that led to the claim;
- D. The type of health care facility where the medical malpractice incident occurred;
- E. The primary location within a facility where the medical malpractice incident occurred;
- F. The geographic location, by city and county, where the medical malpractice incident occurred;
- G. The injured person's sex and age on the incident date;
- H. The severity of malpractice injury using the National Practitioner Data Bank severity scale;
- I. The dates of:
 - (1) The incident that was the proximate cause of the claim;
 - (2) Notice to the insuring entity, self-insurer, facility or provider;
 - (3) Suit, if a suit was filed;
 - (4) Final indemnity payment, if any; and
 - (5) Final action by the insuring entity, self-insurer, facility or provider to close the claim;
- J. Settlement information that identifies the timing and final method of claim disposition, including:
 - (1) Claims settled by the parties;
 - (2) Claims disposed of by a court, including the date disposed;
 - (3) Claims disposed of by alternative dispute resolution, such as arbitration, mediation, private trial and other common dispute resolution methods; and
 - (4) Whether the settlement occurred before or after trial, if a trial occurred;
- K. Specific information about the indemnity payments and defense and cost containment expenses, including:
 - (1) For claims disposed of by a court that result in a verdict or judgment that itemizes damages:

- (a) The total verdict or judgment;
 - (b) If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;
 - (c) Economic damages;
 - (d) Noneconomic damages;
 - (e) Punitive damages, if applicable; and
 - (f) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses; and
- (2) For claims that do not result in a verdict or judgment that itemizes damages:
- (a) The total amount of the settlement;
 - (b) If there is more than one defendant, the total indemnity paid by or on behalf of this facility or provider;
 - (c) The insuring entity's or self-insurer's best estimate of economic damages included in the settlement;
 - (d) The insuring entity's or self-insurer's best estimate of noneconomic damages included in the settlement; and
 - (e) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses;
- L. The reason for the medical malpractice claim. The reporting entity must use the same allegation group and specific allegation codes that are used for mandatory reporting to the National Practitioner Data Bank; and
- M. Any other closed claim data the commissioner determines to be necessary to accomplish the purpose of this Act and requires by adopting a rule.

Section 6. Confidentiality of Data

- ~~A. Documents, materials or other information in the possession or control of the commissioner that are provided pursuant to Section 4 of this Act shall be confidential by law and privileged, shall not be subject to [insert open records, freedom of information, sunshine or other appropriate phrase], shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.~~
- ~~B. Any report produced using the data reported to the commissioner under this Act shall not be so detailed that it permits readers to discern information about any particular insuring entity, self insurer, facility, provider, claim or claimant.~~

~~**Drafting Note:** If it is desirable and feasible in this state to provide for public access to some or all of the data reported to the commissioner pursuant to Section 4 of this Act, appropriate substitute wording may be used for Section 6.~~

~~**Note:** This topic is deferred to the Property and Casualty Insurance (C) Committee.~~

Section 7. Authority to Adopt Rules

The commissioner shall adopt any rules needed for implementing the provisions of this Act.

Section 8. Effective Date

This Act shall take effect on [insert date].