

## **Comments on NAIC Medical Malpractice Closed Claim Reporting Guidelines**

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We respectfully submit the comments below on the NAIC malpractice closed claims reporting guidelines. Our comments relate to two documents: (1) Guide and Codebook dated July 17, 2008 (“Codebook”), and (2) Guideline for Implementation of Medical Professional Liability Closed Claim Reporting dated July 10, 2008 (“Guideline”). We would welcome an opportunity to discuss these comments with you, at your convenience, or with the authors of these documents.

The draft Codebook is a better starting place for further development than the draft Guideline, in our opinion, largely because it is more detailed. But the Guideline covers much material that is not in the Codebook. The two can usefully be combined into a single document.

### **1. Consistency with model law**

To increase the likelihood that insurers will comply with the reporting requirements, the reporting guidelines document should be organized similarly to the model law. In addition, the guidelines should include a comprehensive list of the required data fields. Neither the Guideline nor the Codebook includes all fields required by the model law. The “Table of Data Fields” (Codebook, p. 7-8) is useful, but it should include all required fields, and an explanation of each.

### **2. Codebook**

a. *Verification*. Including guidance on data verification will be helpful for regulators. Consider adding a note to the “Missing Data Elements” section (p. 1-2) to warn regulators not to use “0” as the default entry. Doing this will make it impossible to

identify true zeros. If pull-down menus are used in the reporting application, the default should be “missing” or “not applicable” to avoid this problem.

b. *Verification details.* For verification, it would be useful to specify in detail which fields should be verified and how. For example, fields a+b+c should equal field d; field f should be completed only if field e is completed, and so on. The verification should include:

- 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. This has been valuable in Texas in catching incomplete reporting of individual claims.
- 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).

c. *Confidentiality options.* The “Confidentiality” section (p. 2) should include all options presented in the model law and should provide specific examples of possible licensing/confidentiality agreements with researchers, to make it easier to implement this option. Also, states should be encouraged to report dollar amounts rather than ranges (e.g., Department of Education: National Center for Education Statistics reporting of income, see p. 5). This will substantially increase data quality without harming confidentiality.

d. *County reporting.* Part a. of Option 1 on p. 2 suggests using regions larger than counties to protect confidentiality. This would prevent county-level analysis without gaining much on the confidentiality front. A better approach might be to disclose county information for claims filed in larger counties and treat smaller counties as a single “aggregate” county; perhaps with a rural, suburban, or urban identifier.

e. *Date opened and closed.* Part b. of Option 1 on p. 2 suggests reporting time-to-close instead of the year claims open and close. This would prevent any analysis of trends over time, and make the data virtuously useless for studying changes in market conditions. We strongly urge you to remove this suggestion, and instead provide for reporting of the date the claim was opened, and the date it was closed. This information should be readily available to insurers.

f. *Other defendants.* Insurers should be asked to report the number and type of other defendants, and payments already made by other defendants. 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. This information should generally be available, and Texas currently requires this information, without apparent difficulty. Also, the insurer should be asked to report whether a claim has been closed as to all defendants, or whether it remains open as to other defendants. Both of these pieces of information should normally be available to insurers.

g. Item 27 of the “Table of Data Fields” needs a description.

h. *Details on payout.* The total payment made to the claimant should be broken out according to payer. The insurer should report the amount it paid, the amount the insured paid in the form of a deductible, the amount paid by any excess carrier, the amount paid by the insured in excess of the policy limits, and the amounts paid by other insurers (if known).

i. *Eroded limits.* In addition to the field for policy limits, the insurer should be asked to indicate whether the limits have been eroded by prior claims within the policy period and, if so, the remaining limits prior to payment of the current claim.

j. *Age at date of injury.* p. 17, item 20: specify age of injured person at date of injury.

k. *Breakdown of payout by type of damages.* p. 18, items 30-31: We understand that these items are controversial. Texas currently asks the insurer to estimate the components of settlements that represent economic, non-economic, and punitive damages. We found this data to be virtually useless for analysis. Even when the settlement followed a jury verdict, the insurers often reported breakdowns that were inconsistent with the verdict. In addition, settlements often involve discounts for the time value of money, and for the probability of plaintiff success at trial. It’s not clear how insurers are supposed to adjust for these factors when estimating the breakdown. Instead of asking insurers to estimate the amount paid for economic and non-economic damages, we recommend asking insurers to report the insurer’s estimates of economic damages (the damages that would be awarded if the plaintiff were to win at trial). This is objective information that should be available to insurers. This estimate should be subdivided into past and future lost wages, past and future medical expenses, and other costs (see list in Guideline, Section 7(J)(2)).

l. *Tried cases.* Verdicts and court judgments should be reported for tried cases, as well as the amount paid after the verdict. The post-verdict payment is generally not the same as the verdict. The verdicts should be broken down by damages type: economic damages, non-economic damages, and punitive damages. Pre-judgment interest and the total court award (economic damages + noneconomic damages + punitive damages + prejudgment interest) should also be reported. If the court judgment differs from the verdict, this should be explained (e.g., damages not allowed due to statutory caps (by damages type), remittiturs, additurs, award reduced due to plaintiff share of fault, etc.).

m. *Trial dates.* For cases in which trial is begun, the date trial began should be reported. For cases in which a complete trial is held, the date of trial completion should be reported. For cases in which a court judgment is delivered, the date of the judgment should be reported.

n. *Expenses.* p. 19, items 33-34: A finer breakdown of expenses is desirable. We propose separate entries for inside lawyer fees, outside lawyer fees, fees paid to experts and other defense costs, plus a total.

### **3. Guideline**

a. *Which claims are reported.* Section 4 (A): We strongly recommend reporting of claims without indemnity payments and without paid defense and cost containment expenses. This will allow counts of non-meritorious claims that are quickly closed without much effort.

b. *Provider types.* Section 7(A): The second sentence is confusing, because all the provider types listed in this section as optional additional specialties are already included in the NPDB list.

c. *Amounts paid by other insurers.* Section 7(I): add amounts paid by other insurers to this list.

d. *Content of annual reports.* Section 9: consider including more detail regarding the analysis that should be included in annual reports. Of all reports currently being produced, Missouri's are of the highest quality and can be used as a template for this Section.

e. *Appeals.* If a case is appealed, the outcome of the appeal should be provided, including affirm verdict for plaintiff, affirm verdict for defendant, reduce verdict for plaintiff, remand for new trial, etc.

f. *Stage of resolution.* The data fields should clearly ask whether ADR was attempted, and whether it was successful in resolving the dispute. They should also indicate whether trial was started, since many cases settle during trial. More generally, one needs to treat trial as distinct from arbitration or mediation, and not lump them together.

g. *Type of ADR.* If ADR is used, the type should be specified, and also whether ADR was voluntarily chosen or was required by local rules, and the sponsor of the ADR (e.g., independent sponsor, hospital dispute resolution program).

g. *Allocation of fault.* For tried cases, the allocation of fault among defendants and plaintiff should be indicated.

### **4. Reserves**

It would be useful to require reporting of initial reserve amounts for indemnity and expenses, as well as the date that the reserves were set. The best number to report would be the first reserve estimate on the claim. This will allow researchers to study important questions related to insurer expectations and the adequacy and reasonableness of reserves and insurance rates.

### **5. Sample Closed Claim Reporting Form**

The guideline should include a model claim reporting form. This will increase the odds of uniformity of reporting across states. The Texas form offers a good place to start.