

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 (December 3, 2008 version).

Part A

Section 5.B(2) is written to require reporting only if the insurer decides to defend the claim. The meaning of “defend the claim” is not clear. The wording should be altered to require reporting of all claims for which the insurer either makes a payment or incurs defense and cost containment expenses. This would be consistent with Section 4.A.

Section 6.C: This subsection should read: “If a closed claim payment falls wholly within its self-insured retention,…”

Section 7.A: It would be valuable to know if the policy limits have been eroded by prior claims within the policy period. Consider adding a subsection (5) requesting “available policy limits, if less than the primary policy limit due to payments on prior claims.”

More importantly, the Codebook includes separate information for primary and excess insurers. The main part of the guidelines, however, requires reporting only of limits and payment by primary insurers. A separate section of Section 7 is needed for reporting of excess policy limits and a separate section is needed later for payouts by excess insurers.

Section 7.E: “City” is not a good term. Some incidents are not within cities. Perhaps “county” would be a better category.

Section 7.F. Severity should be coded on the standard 1-9 scale, as in item 21 of the Codebook. The nine items currently listed should be numbered from 1-9. This will match NPDB and NAIC coding.

Section 7.F(3): The term “principal injury” is not defined. The reporting entity should report severity based on the most severe injury.

Section 7.I: Resolution of a claim often occurs after the parties have engaged in more than one dispute resolution process. The data collection form should allow for accurate reporting of all processes that apply. The following is a suggestion for collecting information related to dispute resolution.

Dispute Processing and Resolution Stage		Check All that Apply	Check If Claim Resolved at this Stage
	Before a lawsuit is filed		
1	Negotiation prior to mediation, arbitration or formal commencement of litigation		
2	Mediation		
3	Non-binding arbitration		
4	Binding arbitration		
	After a lawsuit is filed		
5	Settlement without trial or formal mediation or arbitration		
	Screening panel (under state law)		
6	Mediation after suit filed		
7	Non-binding arbitration after suit filed		
8	Binding arbitration after suit filed		
9	Settlement without trial, after (but not directly as a result of) mediation or non-binding arbitration		
10	After start of trial but before verdict (during trial)		
11	After verdict but before appeal (after trial)		
12	After appeal filed but before appeal decided (during appeal)		
13	After appeal decided (after appeal)		

Section 7.J generally: This section should include a request for information regarding who paid how much to settle the claim. The categories can include:

- Payment by the insurer within policy limits
- Payment by the insurer above policy limits
- Payment by an excess insurer within the limits of the excess policy
- Payment by an excess insurer above the limits of the excess policy
- Payment by the insured due to a deductible or self-insured retention
- Payment by the insured above policy limits
- Payment by other insurers for other defendants
- Payment by other defendants (not covered by insurance)
- Total payment (should reconcile to the sum of individual payments)

Section 7.J(2). If the payment exceeds limits, the insurer should report separately the within-limits and above-limits amounts. See previous comment, which suggests this breakout of payments by the insurer.

Section 7.J(5)(a): Not all claims involve filed legal claims. Consider replacing “defendants” with “providers whom it represents.” Also, for cases that go to trial, there will often be an assessment by the trier of fact of the percentage responsibility of each defendant. Consider adding after “The reporting entity must allocate indemnity payments between defendants based on an assessment of comparative fault,” the following “or, for a case which reaches a trial verdict, using the apportionment resulting from the verdict.”

Section 7.J(6): It would be useful to report separately expenses for in-house counsel and outside counsel. Similarly, it would be useful to report separately expenses for in-house and outside experts.

Section 7.J(proposed new subsection 8): For cases with positive payment but zero defense and cost containment expenses, it would be useful to ask whether these costs were truly zero, or whether the defense costs were paid by another party, such as an insurer for another defendant.

Section 7.K: Refer to Zeiler comments submitted December 15, 2008. As researchers, we would probably not be able to employ any information on estimated damages in a rigorous analysis. The only information that might be useful is past medical expenses (derived from invoices), past lost earnings, and estimates of future medical expenses and future lost earnings. Thus, it would be useful to divide the categories of medical expenses and loss of earnings into past amounts, which are reasonably well known, and future amounts, which are only estimates. This is consistent with current reporting in Missouri.

It is important to distinguish between estimated damages and the amount paid by the insurer. Many claims are settled for less than the amount of damages, for various reasons, especially the probability that the defendants would win at trial. Thus, the estimate of damages should be made *assuming* the defendants are liable, and in some cases, perhaps many cases, will exceed the amount paid.

(Proposed new section 8): Trial outcome. There is no section in the guideline requiring reporting of the outcomes of trials. This needs to be added generally. The Texas Closed Claim Reporting Guide can provide a model. The reporting is quite detailed for cases that go to trial, but overall is not that burdensome because this is a small fraction of all cases.

(Proposed new section 9): Plaintiff settlement demand. If the plaintiff has made a demand for a specific settlement amount, the demand that is closest in time to the resolution of the claim should be reported. If the plaintiff has made a demand for settlement at the policy limits, this should be specifically reported.

Part D

Introduction (and general comments): The tone of this Part suggests that the risks of disclosure of provider identities are great. Yet, we know of no instance in which reporters or researchers have used closed claim databases to discover provider identities. Texas and Florida are large states, and have had claim-level reporting for an extended period of time. This risk, if it exists at all, is tiny. All examples included in this Part are hypothetical and should be clearly identified as such. Without such a disclaimer, this section creates a false impression that disclosure risks abound. More generally, Part D is written in a way that suggests disclosure would create serious risks, and it likely will mislead states when they decide whether to disclose the data to the public.

After “To the extent that data are confidential, the commissioner must protect the data in a manner consistent with provisions used in the state’s adoption of Section 6 of the Medical Professional Liability Closed Claim Reporting Model Law,” include another sentence: “If the data are not confidential, the department should make the data publicly available on a website in a standard format, within a reasonable period (not to exceed one year) after the year to which the claim report relates.”

Part D needs to include additional options that provide for release of claim-level data without the aggregation rules provided for under Option 1. The options listed in this Part should correspond to the four options provided in the model law. The current draft provides details only for the most restrictive release options. In addition, Option 1 goes far beyond any possible need in calling for aggregation of data. We provide specific examples below, but this entire discussion needs to be revisited, with a view to how the data is actually likely to be used.

The guidebook should also provide for “combined” options, such as limited release to the general public, but more complete release to researchers who sign a confidentiality agreement.

p. 13 (“This guide is intended to assist state regulators in compiling claims data pursuant to the Medical Professional Liability Closed Claim Reporting Model Law. It is designed to promote uniformity and to ensure that data can be seamlessly aggregated across states.”). These sentences seem misplaced. They might fit better in the introduction to the guidelines.

Section I:

The guidelines on completeness are vague. We recommend following Texas’ protocol for evaluating completeness and accuracy of reports. Texas requires insurers to submit reconciliation reports, which ensure that individual claim report totals equal annual aggregate reports. State insurance departments should also require insurers to verify, and then should check themselves, that numbers that should add up to a total (individual payments, individual elements of defense costs, and so on) in fact do so.

We agree that the example provided in the section titled “Internal Consistency” is problematic. An insurer might pay more than the per-occurrence limits to close a claim. A better example would be a series of individual payment components that does not sum to the total payment reported.

Section II: Confidentiality

Option 1:

p. 15: (“In general, demographic characteristics, such as age, should be released in general categories (such as ages 1-5, 6 -10, etc).”). Disclosing the plaintiff’s age does not create a confidentiality risk. It is useful for research purposes to have plaintiff age available. If groups are to be used, the categories should not be chosen randomly. For example, the ability to distinguish cases involving newborns from cases involving 1-year-old children is helpful in isolating perinatal cases. Thus, age < 1 should be a separate category. Also, other data sources often distinguish between children (age 1-17) and adults. And Medicare kicks in at age 65, so age 65 should be the start of an age category. But again, we think simply reporting age as <1, 1, 2, etc. should be fine.

p. 15: (“For example, a dataset containing only a single claim against a neurosurgeon for an injury occurring on a given date within a specified geographic location may allow one to easily identify the practitioner.”): We are not aware of any example in which this occurred. If such an example is to be included in the guidelines, it should be an actual example in which someone used a closed claim dataset to identify a provider.

In fact, this example shows why the concern with confidentiality is overstated. How would someone begin knowing the date of injury and the geographic location, yet not knowing the provider? A news reporter would almost have to speak to the plaintiff or the plaintiff’s family to know the date of injury, but a reporter who does so will know the neurosurgeon’s name already.

Under option 1(b), the guidelines suggest reporting “time to close” rather than open and close dates. Actual open and close dates **are critical** for any effort to study time trends related to any of the variables. Also, rather than suggesting the reporting of year as an alternative to the actual date, consider either quarter and year or month and year. These will allow for more nuanced time trend analyses. For example, as a practical matter, changes in the length of time it takes to resolve cases will be impossible to measure without data that includes at least month and year, not merely year.

Option 2

This option will severely limit usefulness of the data and will place a heavy burden on state insurance departments. At a minimum, states should be willing to provide data to researchers subject to a confidentiality agreement between states and researchers. This

method has worked well in the past and is used for data which are much more sensitive than medical malpractice claims – for example, for patient-level medical records.

The practical reality is that (i) many state insurance departments are not staffed to thoroughly research their own data; and (ii) cross-state comparison requires access to claim-level data.

Finally, the guidelines suggest that individuals might be able to discover undisclosed information using the closed claim data and court records. Court records and jury verdict reporters report much of the information available in the closed claim database. Jury verdict reporters report verdicts and settlement payments and include names of the parties. The hypothetical scenarios discussed in the guidelines exaggerate the potential risk of discovery. The hypothetical scenarios involving insurers and law firms are especially troublesome. First, why would insurers or law firms spend time to discover information about unrelated claims? Second, even if they did, why shouldn't we trust them with the information? To suggest otherwise contradicts the guideline's call for data sharing between insurers.

Part E

The second paragraph discusses the use of drop-down boxes. Consider including a word of caution to avoid setting defaults for drop-down boxes as “not reported” rather than a reportable value (e.g., 0). Failure to report should not be coded as a report of “zero,” due to the structure of the web form.

Item 20 (age of injured person): specify age on date of injury. Age should be in years, except that for babies less than one year old, age should be indicated as 0-1 month, or 2-11 months.

Item 27 (timing of disposition code): see table above for discussion of the usefulness of reporting the stage at which a claim is resolved.

Item 33: See discussion above of the additional detail it would be useful to have, some of which is already provided for in the first part of the Guidelines.

Finally, we attached a version of the guidelines with a few typographical errors highlighted.