

**From:** Spitzer, Robert  
**Sent:** Tuesday, December 05, 2006 3:01 PM  
**To:** Bieniek, Joe  
**Cc:** william.rader@dobi.state.nj.us; Sackey, Sam  
**Subject:** Comments on Model Law on Med Mal Closed Claim Reporting Draft of November 13, 2006

Joe,

First, we want to compliment the Washington State gang for doing a great job of writing up the draft. Our comments are mostly editorial, not fundamental.

1. In the Explanatory Notes, we are asked if we think "Defense and Cost Containment Expenses" is a better choice than "Allocated Loss Adjustment Expenses." Yes, it is the better term, as it corresponds to the current financial reporting definition.
2. On Page 1 of the Draft, in Section 2,A, the definition of a Claim: Shouldn't the "demand for monetary damages" be from a specific source, i.e., shouldn't the injured party be a part of the definition?
3. On Page 2, Section 2,H,(1), we recommend adding "surgeon" as a provider, especially as the podiatric surgeon is already mentioned separately. As the SITF discussed, each state will likely have its own "list."
4. On Page 2, Section 4,A,(2), the primary insurer is responsible for reporting the entire payment, including the amount paid under an excess policy, or any other person on behalf of the facility or provider. If a different company wrote the excess policy, or more than one primary insurer was involved in the claim, is it likely that each insurer will know what each of the others paid? Is it likely that the insurers will agree on which one reports the claim? Do the existing closed claim reporting rules out there already cover these issues?
5. On Page 3, Section 4,A,(4), the providers named in the claim have to report it to the commissioner if the insurance company does not. This has similar issues as in (4) above. How would the provider know if the insurer reported the claim, and if there were multiple providers, does each know how much the others were paid, and which one is supposed to report? In addition, asking the providers to report on themselves could be a hard sell. Again, do the existing closed claim reporting rules in the states already cover this?
6. Under Section 5, the Required Data Elements, we recommend the following additional items, as it is likely that we will not get a second chance to expand on the list for a long time:
  1. Age of Insured - with the average age of practicing doctors rising, this factor is growing in importance.
  2. Sub-allegation - in addition to the "Reason for the medical malpractice claim, in (L)" which tends to be very general (diagnosis, procedure), the sub-allegations (as coded in the NPDB data base) provide a more specific description, from which some form of action can be taken.
  3. Adverse Action - this data shows what happened to the insured as a result of the claim, such as "loss of license," "reprimand," etc. This addresses the question of whether, and how often the doctors are disciplined.
  4. Doctor's ID - this would be either the license or social security number of the doctor, that can be used to find out how many claims, and how many dollars of payment, are caused by the same doctors.