MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING MODEL LAW

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Drafting Introductory Note: This model law pertains to the collection of data necessary to accomplish the purpose stated in Section 1. It is not intended to discourage states from collecting additional data for other purposes.

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 professional liability 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, doctor of medicine or osteopathy, 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 professional liability.

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 professional liability 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 professional liability insurance to any facility or provider in this State must report each medical professional liability 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) 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.

(c) If a facility or provider is insured by a captive insurer and the captive 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 captive insurer.

Drafting Note: When subsection A(4) applies, the State needs to consider inserting wording regarding who is responsible for notification to facilities and providers. Notification by either the domiciliary state regulator or the insurer must be provided in advance to insureds that they must produce all data required by this act upon behalf of the 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 earliest act or omission by the defendant 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 indemnity payment made on behalf of the defendant;

(b) Economic damages;

(c) Non-economic damages;

(d) Punitive damages, if applicable; and

(e) 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 on behalf of the defendant;

(b) The insuring entity's or self-insurer's best estimate of economic damages included in the settlement;

(c) The insuring entity's or self-insurer's best estimate of noneconomic damages included in the settlement; and

(d) Defense and cost containment expenses, including court costs, attorneys' fees, and costs of expert witnesses;

L. The reason for the medical professional liability 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

Drafting Note: Each state should determine the extent to which the data collected may be made available to other parties and insert wording consistent with that determination. Options include:

- All data are available to the public.
- All data are subject to release under certain restricted conditions, such as to applicants submitting a research proposal and signing a confidentiality agreement.
- Only individual records that have been "anonymized" may be released. For example, the data can be anonymized to varying degrees by removing elements that may permit identification of the parties to a case, by removing place references such as counties, and by limiting the representation of dates to the corresponding year.
- All data are confidential except data released in summary or aggregate form. Data would be aggregated to a high enough level that readers would not be able to deduce information on any particular provider, facility, claimant, or claim.

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].

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2008 Proc. 3rd Quarter 3-323 to 3-330 (adopted). (Comment Letters-8-144 to 8-169).