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June 16, 2008

National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

Re: Medical Professional Liability Closed Claim Reporting Model Law ("Model Law")

Dear Sir or Madam:

I am writing to offer comments with respect to the Model Law in furtherance of the discussions related to the Model Law that occurred at the NAIC 2008 summer meeting. A copy of the draft Model Law is enclosed for your reference.

Vermont is the largest on-shore domicile for captive insurers, with over 500 currently active licensed captives. Certain of these captives (some of which are organized as risk retention groups) provide a method of self-insurance for medical malpractice liability for health care providers located throughout the US.

Vermont is proud of its reputation as the "gold standard" for captive formation and regulation, and supports the development of reporting processes to facilitate the confidential and privileged reporting of adverse events that pose risks to patient safety.

To that end, I would propose that Section 4(A)4 of the Model Law be amended to reduce possible litigation regarding the authority of the enacting state to obtain information regarding closed claims from captive insurers and risk retention groups domiciled in other states.

Most captive insurance entities that provide medical liability insurance and that are not organized as risk retention groups are so-called "pure captives" that each insure only the liability risks of a single entity. These pure captives maintain their offices, issue their policies and administer their businesses entirely within the state of their domicile, even if the risks covered may be located elsewhere, and are recognized by the NAIC as not having a multi-state impact for purposes of accreditation. As a result, to the extent a state attempts to require a captive domiciled elsewhere to conform to its regulations, the captive will most likely argue that under the US Supreme Court's ruling in State Board of Insurance et al. v. Todd Shipyards Corporation, 370 U.S. 451 (U.S. 1962), which held

that the Due Process clause of the 14th Amendment to the US Constitution prevented state of Texas from charging premium tax on an insurance policy negotiated, paid for and administered entirely outside the state of Texas simply because the property insured was located in Texas, the captive should not be required to comply. See, Domino Oil, Inc. v. Phoenix Assurance Co. of New York, 1998 WL 34170721 (D. V.I. 1998) (the location of certain insured properties covered under a policy negotiated and issued elsewhere in and of itself "is not a proper nexus for assertion of taxation or regulation even [under] the most restrictive reading of due process").

To the extent that a captive is organized as a risk retention group, the entity will argue that under the terms of the federal Liability Risk Retention Act (15 USCA 3901, et seq.) ("LRRA"), risk retention groups are exempt from any attempt by a non-chartering state to regulate, directly or indirectly, their operation beyond certain very specific requirements set forth in the LRRA, none of which would include providing the kind of information outlined in the Model Law. See, National Risk Retention Association v. Brown, 927 F. Supp. 195 (M.D. La. 1996) (risk retention group was exempt from complying with statute that would require submission to a non-domicile state of documentation beyond what is required in LRRA Section 3902(d)). In fact, when the predecessor statute to the LRRA was amended to expand the scope of risks that could be covered by risk retention groups beyond products liability, the provision permitting non-domicile states to obtain information on products liability or completed operations liability losses or expenses was deleted rather than expanded. See, Risk Retention Amendments of 1986, Pub. L. No. 99-563 § 5(b)(1), 100 Stat. 3172 (1986).

In light of the foregoing, we suggest that Section 4(A)4 of the Model Law be amended to add the following sub-paragraph (d):

> (d) Notwithstanding any other provision of this Act, to the extent data required by this Act may be held by a captive insurer or risk retention group domiciled outside of this state, the commissioner shall obtain such data solely from the facility or provider named in a medical professional liability claim.

Thank you for the opportunity to comment on this worthwhile endeavor to promote the confidential and privileged reporting of closed claims, which we believe will enhance efforts to promote patient safety and control medical costs.

Respectfully submitted,

Paulette Thabault
Commissioner
Vermont Department of Banking, Insurance,
Securities and Health Care Administration

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) (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 professional liability claim must report all data required by this Act.

(b) In the absence of a ruling from a court of competent jurisdiction, 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 professional liability claim must report all data required by this Act on behalf of the self-insurer, risk retention group or 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 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) Noneconomic 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].