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STATEMENT

INSURANCE ASSOCIATION OF CONNECTICUT

Insurance and Real Estate Committee

February 24, 2009

SB 961, An Act Concerning Medical Malpractice
Data Reporting

The Insurance Association of Connecticut has concerns with SB 961, An Act Concerning Medical Malpractice Data Reporting.

First, as drafted, SB 961 would apply to surplus lines insurers who are not an entity regulated by the Insurance Department. Surplus lines insurers are not in the state, and subjecting them to regulation runs contrary to the basic theory of surplus lines law. Given the perceived difficulties in the medical malpractice marketplace, it seems counterintuitive to impose extra legal burdens on entities that are willing to write the business.

Next, the definition of "health care provider" in Section 38a-395(a)(7) is overly broad and not targeted at specialties that have encountered difficulties. The definition would cover health care institutions, medicine and surgery, chiropractic, podiatry, physical therapists, midwifery, nursing, dentistry, optometry, and opticians. There are a relatively small number of specialties that have been, or are likely to be, distressed from a medical malpractice point of view (e.g., obstetrics/gynecology), and these specialties should be the focus of any reporting requirements. It is unnecessary to require insuring entities to report every closed claim, regardless of specialty or the type of provider involved – particularly in the absence of a market crisis. Data collection efforts should focus on claims in those areas or specialties that show signs of stress in order to

avoid the inefficiencies and costs associated with the unnecessary capture and reporting of information.

Inclusion of non-economic damage estimates is problematic. Current law in Connecticut requires insurers to report the amount of non-economic damages or the insurer's estimate of the amount in the event of a settlement. This has been a very controversial issue at the NAIC, with many stakeholders (and even some regulators) noting that it doesn't make sense to require estimates because the lack of uniformity involved in guesswork by different entities will result in data that is not useful for public policy purposes. Non-economic damages are not quantifiable and are awarded based on demands of the plaintiff and the subjectivity of a judge or jury, a process, which insurance employees cannot replicate for individual claims. Rather than force the manufacture of unreliable estimates of non-economic damage amounts of individual claim payments, insurers should only report the allocation of total indemnity data payments when such payments actually exist.

Finally, the late filing fee is potentially excessive. Section 38a-395(c)(5) would impose a late filing fee of \$100 per day for each day from the due date of a closed claim report to the date of filing. While this may not seem like a large sum, each closed claim is considered a separate report, so late fees may run into the thousands for each claim for simply being ten or more days late.