MAINE BUREAU OF INSURANCE

Recommendations for Improving the Database Collected to Evaluate the Effectiveness of Medical Professional Liability Prescreening Panels

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Purpose

The Maine Bureau of Insurance (the Bureau) engaged the services of AMI Risk Consultants, Inc. (AMI) to perform a review of the effectiveness of medical professional liability prescreening panels in the state of Maine. In addition the Bureau requested that AMI make recommendations for improving the content or quality of the data collected for the express purpose of evaluating the effectiveness of prescreening panels. This report details AMI's recommendations.

Conclusions

While evaluating the effectiveness of prescreening panels, AMI relied heavily on data collected from insurers and compiled in the Maine Health Security Act Database. Based on our observations of the information collected, we have the following recommendations:

- Give insurers written instructions describing data items to be reported. In particular the date fields need to be clearly defined.

- Edit the date fields, when input to the Bureau's database, to assure they fall in a logical sequence, e.g. Date of Occurrence <= Date of Claim <= Date of Award. In fact, cross-edit fields wherever possible. Claims with an Award Amount should also have a Date of Award and vice versa.

- Require insurers to indicate which claims are settled informally outside the Panel/Court process, and capture this information.

- Edit to require docket number from insurers at time of claim closure, except on claims settled informally. Edit for valid docket number, if possible.

- Encode Reason Final and Reopen Reason fields. Both are currently text fields. Define "claim abandoned" and "claim dismissed" as two separate codes. Let insurers pick from a list of valid codes the entry that best describes each claim.

- If not available from other sources such as statistical agents, capture written exposure so you can track how claim frequency is behaving. You will need a code to identify the type of exposure base, such as number of doctors or number of beds. Also capture policy effective year, policy term, calendar year and exposure units written.

- If there is any way to verify that the Bureau receives every claim from the insurance companies, that verification process should be pursued.

Conclusions (continued)

- For open claims, "notice only" cases should be identified separately from claims where the claimant has taken some action.

- The Bureau should contact insurers about any claims that stay open indefinitely on its files. Those claims may have closed without report to the Bureau.

The question arose during discussions with the Bureau as to what additional information should be collected to help identify claims with and without merit. We do not have any suggestions along this line. It seems to us that if claims with merit could be easily identified by some simple, measurable criterion, then legal proceedings would not be necessary to decide such matters.

The Bureau could ask insurers to identify any claim that, in their opinion lacked merit, but a settlement was paid to avoid suit. Similarly, insurers could identify any claim abandoned by the claimant that probably had merit. This is asking for judgement calls on the insurance company's part, but their attorneys and claim examiners may at least know enough about each claim to have a reasonable opinion. Insurance companies, though, may be reluctant to identify claims with merit that were abandoned by the claimant.