



Senate

General Assembly

File No. 294

January Session, 2009

Senate Bill No. 961

Senate, March 30, 2009

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING MEDICAL MALPRACTICE DATA REPORTING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-395 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2009*):

3 (a) As used in this section:

4 (1) "Claim" means a [request for indemnification filed by a medical
5 professional or hospital pursuant to a professional liability policy for a
6 loss for which a reserve amount has been established by an insurer]
7 demand for monetary compensation for injury or death caused by
8 medical malpractice or a voluntary indemnity payment for injury or
9 death caused by medical malpractice;

10 (2) "Claimant" means a person, including a decedent's estate, who is
11 seeking or has sought monetary compensation for injury or death
12 caused by medical malpractice;

13 [(2)] (3) "Closed claim" means a claim that has been settled [,] or
14 otherwise disposed of [, where the insurer has made all indemnity and
15 expense payments on the claim] by the insuring entity, self-insurer,
16 health care facility or health care provider, where all indemnity and
17 expense payments have been made. A claim may be closed with or
18 without an indemnity payment to a claimant;

19 [(3) "Insurer" means an insurer that insures a medical professional
20 or hospital against professional liability. "Insurer" includes, but is not
21 limited to, a captive insurer or a self-insured person; and

22 (4) "Medical professional" has the same meaning as provided in
23 section 38a-976.]

24 (4) "Commissioner" means the Insurance Commissioner;

25 (5) "Economic damages" means objectively verifiable monetary
26 losses, including, but not limited to, medical expenses, loss of earnings,
27 loss of use of property, burial costs, cost of replacement or repair, cost
28 of obtaining substitute domestic services and loss of business or
29 employment opportunities;

30 (6) "Health care facility" or "facility" means a clinic, diagnostic
31 center, hospital, laboratory, mental health care center, nursing home,
32 medical office, surgical facility, treatment facility or similar place
33 where a health care provider provides health care to patients;

34 (7) "Health care provider" or "provider" means (A) a person licensed
35 to provide health care services under chapters 368v, 370 to 372,
36 inclusive, 375, 376, 377 to 379, inclusive, 380 and 381, or (B) an
37 employee or agent of such provider acting in the scope of such
38 employee's or agent's employment, or if such employee or agent is
39 deceased, such employee's or agent's estate or personal representative;

40 (8) "Insuring entity" means (A) an authorized insurer, (B) a captive
41 insurer, (C) a risk retention group, or (D) an unauthorized insurer that
42 provides surplus lines coverage;

43 (9) "Medical malpractice" means an actual or alleged negligent act,
44 error or omission in providing health care services;

45 (10) "Noneconomic damages" means subjective, nonmonetary
46 losses, including, but not limited to, pain and suffering, mental
47 anguish, disability or disfigurement incurred by the injured party,
48 emotional distress, loss of society and companionship, loss of
49 consortium, inconvenience, humiliation and injury to reputation and
50 destruction of the parent-child relationship;

51 (11) "Person" means an individual, a corporation, a partnership, a
52 limited liability company, an association, a joint stock company, a
53 business trust, an unincorporated organization or other legal entity;
54 and

55 (12) "Self-insurer" means any health care facility, health care
56 provider or other entity or individual that assumes operational or
57 financial risks for health care providers' liability claims.

58 (b) [On and after January 1, 2006, each insurer] Each insuring entity
59 or self-insurer that provides professional liability insurance to any
60 health care facility or health care provider in this state shall provide to
61 the Insurance Commissioner a closed claim report, on such form as the
62 commissioner prescribes, in accordance with this section. The
63 requirements of this section shall apply to all professional liability
64 claims in this state, regardless of whether or how such claims are
65 covered by professional liability insurance. The [insurer] insuring
66 entity or self-insurer shall submit the report not later than ten days
67 after the last day of the calendar quarter in which a claim is closed.
68 [The report shall only include information about claims settled under
69 the laws of this state.]

70 (c) (1) A closed claim that is covered under a primary policy and one
71 or more excess policies shall be reported only by the insuring entity
72 that issued the primary policy. Such insuring entity shall report the
73 total amount paid, if any, with respect to such closed claim, including
74 any amount paid under an excess policy, any amount paid by the

75 facility or provider and any amount paid by any other entity or person
76 on behalf of the facility or provider.

77 (2) If a claim is not covered by an insuring entity or self-insurer, the
78 facility or provider named in such claim shall report the claim to the
79 commissioner after a final claim disposition has occurred by a court
80 proceeding or settlement by the parties. A claim that is not covered by
81 an insuring entity or self-insurer includes, but is not limited to,
82 situations in which: (A) The facility or provider did not purchase
83 professional liability insurance or maintained a self-insured retention
84 that was larger than the final judgment or settlement; (B) the claim was
85 denied by an insuring entity or self-insurer because such claim was not
86 within the scope of the coverage agreement; or (C) the annual
87 aggregate coverage limit was exhausted by other claims payments.

88 (3) (A) If a claim is covered by an insuring entity or self-insurer and
89 such insuring entity or self-insurer fails to report such claim to the
90 commissioner, the facility or provider named in such claim shall report
91 the claim to the commissioner after a final claim disposition has
92 occurred by a court proceeding or settlement by the parties.

93 (B) If a facility or provider is insured by (i) a risk retention group,
94 (ii) an unauthorized insurer, or (iii) a captive insurer, and such risk
95 retention group, unauthorized insurer or captive insurer refuses to
96 report closed claims to the commissioner on the basis of federal or
97 other jurisdictional preemption or exemption, the facility or provider
98 shall report all data required by this section on behalf of such risk
99 retention group, unauthorized insurer or captive insurer.

100 (4) The commissioner shall establish procedures by which a facility
101 or provider shall be notified when such facility or provider is obligated
102 to report closed claim data pursuant to this subsection.

103 (5) Any insuring entity or self-insurer doing business in this state
104 that fails to file any report required under this section shall pay a late
105 filing fee of one hundred dollars per day for each day from the due
106 date of such report to the date of filing.

107 (6) The commissioner may adopt regulations, in accordance with
108 chapter 54, to require insuring entities, self-insurers, facilities and
109 providers to submit all required closed claim reports electronically.

110 [(c)] (d) The closed claim report shall include:

111 (1) Details about the insured and [insurer] insuring entity,
112 including: (A) The name of the [insurer] insuring entity; (B) the
113 professional liability insurance policy limits and whether the policy
114 was an occurrence policy or was issued on a claims-made basis; (C) the
115 name, address, health care provider professional license number and
116 specialty coverage of the insured; and (D) the insured's policy number
117 and a unique claim number.

118 (2) Details about the injury or loss, including: (A) The date of the
119 injury or loss that was the basis of the claim; (B) the date the injury or
120 loss was reported to the [insurer] insuring entity; (C) the name of the
121 institution or location at which the injury or loss occurred; (D) the type
122 of injury or loss, including a severity of injury rating that corresponds
123 with the severity of injury scale that the [Insurance Commissioner]
124 commissioner shall establish based on the severity of injury scale
125 developed by the National Association of Insurance Commissioners;
126 and (E) the name, age and gender of any injured person covered by the
127 claim. Any individually identifiable health information, as defined in
128 45 CFR 160.103, as amended from time to time, [amended,] submitted
129 pursuant to this subdivision shall be confidential. [The reporting of the
130 information is required by law.] If necessary to comply with federal
131 privacy laws, including the Health Insurance Portability and
132 Accountability Act of 1996, (P.L. 104-191) (HIPAA), as amended from
133 time to time, [amended,] the insured shall arrange with the [insurer]
134 insuring entity to release the required information.

135 (3) Details about the claims process, including: (A) Whether a
136 lawsuit was filed and, if so, in which court; (B) the outcome of such
137 lawsuit; (C) the number of other defendants, if any; (D) the stage in the
138 process when the claim was closed; (E) the dates of the trial, if any; (F)
139 the date of the judgment or settlement, if any; (G) whether an appeal

140 was filed and, if so, the date filed; (H) the resolution of any appeal and
141 the date such appeal was decided; (I) the date the claim was closed; (J)
142 the initial indemnity and expense reserve for the claim; and (K) the
143 final indemnity and expense reserve for the claim.

144 (4) Details about the amount paid on the claim, including: (A) The
145 total amount of the initial judgment rendered by a jury or awarded by
146 the court; (B) the total amount of the settlement if there was no
147 judgment rendered or awarded; (C) the total amount of the settlement
148 if the claim was settled after judgment was rendered or awarded; (D)
149 the amount of economic damages [, as defined in section 52-572h,] or
150 the [insurer's] insuring entity's estimate of the amount in the event of a
151 settlement; (E) the amount of noneconomic damages [, as defined in
152 section 52-572h,] or the [insurer's] insuring entity's estimate of the
153 amount in the event of a settlement; (F) the amount of any interest
154 awarded due to the failure to accept an offer of judgment or
155 compromise; (G) the amount of any remittitur or additur; (H) the
156 amount of final judgment after remittitur or additur; (I) the amount of
157 punitive damages, if applicable; (J) the amount paid by the [insurer]
158 insuring entity; [(J)] (K) the amount paid by the defendant due to a
159 deductible or a judgment or settlement in excess of policy limits; [(K)]
160 (L) the amount paid by other [insurers] insuring entities; [(L)] (M) the
161 amount paid by other defendants; [(M)] (N) whether a structured
162 settlement was used; [(N)] (O) the expense assigned to and recorded
163 with the claim, including, but not limited to, defense and investigation
164 costs, but not including the actual claim payment; and [(O)] (P) any
165 other information the commissioner determines to be necessary to
166 regulate the professional liability insurance industry with respect to
167 [medical professionals or hospitals] health care providers, ensure the
168 industry's solvency and ensure that such liability insurance is available
169 and affordable.

170 [(d)] (e) (1) The commissioner shall establish an electronic database
171 composed of closed claim reports filed pursuant to this section.

172 (2) The commissioner shall compile the data included in individual

173 closed claim reports into an aggregated summary format and shall
174 prepare a written annual report of the summary data. The report shall
175 provide an analysis of closed claim information including (A) a
176 minimum of five years of comparative data, when available, (B) trends
177 in frequency and severity of claims, (C) itemization of damages, (D)
178 timeliness of the claims process, and (E) any other descriptive or
179 analytical information that would assist in interpreting the trends in
180 closed claims.

181 (3) The annual report shall include a summary of rate filings for
182 professional liability insurance for [medical professionals or] hospitals,
183 [which] physicians, surgeons, advanced practice registered nurses and
184 physician assistants that have been approved by the department for
185 the prior calendar year, including an analysis of the trend of direct
186 losses, incurred losses, earned premiums and investment income as
187 compared to prior years. The report shall include base premiums
188 charged by [insurers] insuring entities for each specialty and the
189 number of providers insured by specialty for each [insurer] insuring
190 entity.

191 (4) Not later than [March 15, 2007] May 15, 2010, and annually
192 thereafter, the commissioner shall submit the annual report to the joint
193 standing committee of the General Assembly having cognizance of
194 matters relating to insurance, in accordance with section 11-4a. The
195 commissioner shall also (A) make the report available to the public, (B)
196 post the report on its Internet site, and (C) provide public access to the
197 contents of the electronic database after the commissioner establishes
198 that the names and other individually identifiable information about
199 the claimant and [practitioner] provider have been removed.

200 [(e)] (5) The Insurance Commissioner shall provide the
201 Commissioner of Public Health with electronic access to all
202 information received pursuant to this section. The Commissioner of
203 Public Health shall maintain the confidentiality of such information in
204 the same manner and to the same extent as required for the Insurance
205 Commissioner.

206 (f) Documents, materials or other information submitted pursuant
207 to this section and in the possession or control of the Insurance
208 Commissioner shall be confidential by law and privileged, and shall
209 not be subject to subpoena or discovery or admissible in evidence in a
210 private civil action.

211 (g) The commissioner may adopt regulations, in accordance with
212 chapter 54, to implement the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2009	38a-395

INS *Joint Favorable*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 10 \$	FY 11 \$
Insurance Dept.	IF - Cost	\$150,000	\$50,000

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

This bill requires the Department of Insurance (DOI) to adopt regulations requiring insurers to submit closed claim reports to the agency electronically, resulting in a cost to DOI of \$150,000 in FY 10 and \$50,000 in FY 11. \$100,000 would be required to contract for the development of regulations in FY 10 and \$50,000 would be required in FY 10 and FY 11 for the automation of the reports.

The Out Years

The cost for automation of closed claims reports filing of \$50,000 would be on-going subject to inflation.

OLR Bill Analysis**SB 961*****AN ACT CONCERNING MEDICAL MALPRACTICE DATA REPORTING.*****SUMMARY:**

By law each insurer (including captive insurers and self-insured entities) must provide to the insurance commissioner a medical malpractice “closed claim” report for each medical malpractice case that has been settled or otherwise disposed of, where the insurer has paid all claims. This bill broadens the application of this law by imposing a reporting requirement on claims against additional health care related facilities, and by requiring the health care provider or facility to file a closed claim report with the commissioner if a claim is not covered by an insurer or self-insurer or if the insurer fails to file it. The bill requires the insurance commissioner to establish procedures by which facilities and providers must be notified when they are required to report closed claim data. The bill requires that punitive damages be included in closed claims reports.

It establishes a late filing fee of \$100 per day for each day a report is overdue, and authorizes the insurance commissioner to adopt regulations to require insuring entities, self-insurers, facilities, and providers to submit all required closed claim reports electronically. By law, the report must be filed within 10 days after the last day of the calendar quarter in which a claim is closed.

Current law requires the insurance commissioner to file an annual report with the legislature that summarizes rate filings for medical malpractice insurance for hospitals and any medical professional that the department approved for the prior calendar year. The bill instead requires the report to summarize rate filings for medical malpractice insurance for hospitals, physicians, surgeons, and advanced practice

registered nurses and that the department approved for the prior calendar year.

Finally, the bill alters several definitions used in current law, and defines some additional terms such as claimant and medical malpractice.

EFFECTIVE DATE: July 1, 2009

DEFINITIONS

Claim

Current law defines a “claim” as a request for indemnification filed by a medical professional or hospital pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer. The bill broadens the definition by defining it as a demand for monetary compensation for injury or death caused by medical malpractice or a voluntary indemnity payment for injury or death caused by medical malpractice.

Claimant

The bill defines a “claimant” as a person, including a decedent’s estate that is seeking or has sought monetary compensation for injury or death caused by medical malpractice. Under the bill a “person” can include an individual, corporation, partnership, limited liability company, association, joint stock company, business trust, unincorporated organization, or other legal entity

Closed Claim

Under current law, a “closed claim” means a claim that has been settled, or otherwise disposed of where the insurer has made all indemnity and expense payments on the claim. The bill expands this definition by including any claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, health care facility, or health care provider, where all indemnity and expense payments have been made. It specifies that a claim may be closed with or without an indemnity payment to a claimant.

Economic Damages

Current law requires the closed claim report to specify “economic damages,” which it defines as compensation determined by the trier of fact (i.e., judge or jury), for pecuniary losses including the cost of reasonable and necessary medical care, rehabilitative services, custodial care, and loss of earnings or earning capacity. The bill eliminates the requirement that economic damages be determined by a trier of fact but instead requires that they be “objectively verifiable.” Neither current law nor the bill provides an exhaustive list of what constitutes economic damages, but the bill does not specifically mention rehabilitative services, or custodial care, which current law does. On the other hand, the bill specifies loss of use of property, burial costs, cost of replacement or repair, cost of obtaining substitute domestic services, and loss of business or employment opportunities, which current law does not. Both current law and the bill specify loss of earnings as an example of economic damages.

Noneconomic Damages

The law also requires that the closed claim report specify the “noneconomic damages,” which it defines as compensation determined by the trier of fact for all non-pecuniary losses including, physical pain and suffering and mental and emotional suffering. The bill instead defines “noneconomic damages” as subjective, nonmonetary losses, including pain and suffering; mental anguish; disability or disfigurement incurred by the injured party; emotional distress; loss of society and companionship; loss of consortium; inconvenience, humiliation, and injury to reputation; and destruction of the parent-child relationship.

Health Care Providers and Facilities

Current law covers malpractice claims against any “medical professional,” which it defines as any person licensed or certified to provide health care services to individuals. It also lists certain health care providers such as a physician, chiropractor, and podiatrist. The bill instead defines a health care provider as a person who is licensed as a physician, chiropractor, podiatrist, physical therapist, midwife,

nurse, nurse's aide, dentist, optometrist, optician, or nursing home administrator. It excludes clinical dietitians, clinical psychologists, occupational and speech therapists, pharmacists, and psychiatric social workers, who are explicitly covered by current law.

Current law also covers malpractice claims against hospitals. The bill makes the law apply to a "health care facility" or "facility," which it defines as a licensed clinic, diagnostic center, hospital, laboratory, mental health care center, nursing home, medical office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients.

The bill also explicitly covers claims against their employees or agents acting in the scope of their employment, or if they are deceased, their estates or personal representatives.

Insurer

Current law imposes the reporting requirement on an insurer, which it defines as an insurer that insures a medical professional or hospital against professional liability, and specifies that it includes a captive insurer or a self-insured person. The bill instead applies the reporting requirement to any "insuring entity," which it defines as (1) an authorized insurer, (2) a captive insurer, (3) a risk retention group, or (4) an unauthorized insurer that provides surplus lines coverage.

The bill also, defines a "self-insurer" as any health care facility, health care provider, or other entity or individual that assumes operational or financial risks for health care providers' liability claims.

Medical Malpractice

The bill defines "medical malpractice" as an actual or alleged negligent act, error, or omission in providing health care services.

REPORTING OF CLOSED CLAIMS COVERED UNDER A PRIMARY POLICY AND EXCESS POLICY

The bill requires a closed claim that is covered under a primary policy and one or more excess policies to be reported only by the

insuring entity that issued the primary policy. It must report the total amount paid, if any, for the claim, including any amounts paid under an excess policy, by the facility or provider, and by any other entity or person on the provider's or facility's behalf.

REPORTING OF CLAIMS NOT COVERED BY INSURER OR SELF INSURER

For claims not covered by an insuring entity or self-insurer, the bill requires the facility or provider named in the claim to report the claim to the commissioner after a final claim disposition has occurred in a court proceeding or settlement. A claim that is not covered by an insuring entity or self-insurer includes situations in which the:

1. facility or provider did not purchase professional liability insurance or maintained a self-insured retention that was larger than the final judgment or settlement;
2. claim was denied by an insuring entity or self-insurer because it was not within the coverage agreement's scope; or
3. annual aggregate coverage limit was exhausted by other claims payments.

CLAIMS UNREPORTED BY INSURING ENTITY OR SELF-INSURER

The bill requires that, if a claim is covered by an insuring entity or self-insurer and the insuring entity or self-insurer fails to report the claim to the commissioner, the facility or provider named in the claim report it to the commissioner after a final claim disposition has occurred by a court proceeding or settlement.

The bill requires a facility or provider that is insured by (1) a risk retention group, (2) an unauthorized insurer, or (3) a captive insurer that refuses to report closed claims to the commissioner on the basis of federal or other jurisdictional preemption or exemption, to report all data the bill requires on behalf of the risk retention group, unauthorized insurer, or captive insurer.

PROCEDURES TO NOTIFY FACILITIES AND PROVIDERS TO REPORT CLOSED CLAIM DATA

The bill requires the commissioner to establish procedures by which a facility or provider must be notified when it or he or she is obligated to report closed claim data.

LATE FILING FEE

The bill requires any insuring entity or self-insurer doing business in this state that fails to file any required claims data report to pay a late filing fee of \$100 per day from the due date to the filing date.

REGULATIONS

The bill authorizes the insurance commissioner to adopt regulations to (1) require insuring entities, self-insurers, facilities, and providers to submit all required closed claim reports electronically and (2) implement other provisions of the bill.

ANNUAL DATA SUMMARY

The law requires the insurance commissioner to aggregate the individual closed claim report data into a summary and annual report. The report must analyze the closed claim information, including:

1. a minimum of five years of comparative data, when available;
2. trends in frequency and severity of claims;
3. itemization of damages;
4. timeliness of the claims process; and
5. any other descriptive or analytical information that would help interpret trends in closed claims.

Current law requires the annual report to summarize rate filings for medical malpractice insurance for hospitals and any medical professional that the department approved for the prior calendar year. The bill instead requires the report to summarize rate filings for medical malpractice insurance for hospitals, physicians, surgeons, and

advanced practice registered nurses and that the department approved for the prior calendar year. Thus, the bill eliminates the commissioner's duty to summarize filings for certain health care providers including chiropractors, podiatrists, physical therapists, nurses, dentists, optometrists, clinical dietitians, clinical psychologists, occupational and speech therapists, pharmacists, and psychiatric social workers that are explicitly covered by current law. The summary must include an analysis of the trend of direct losses, incurred losses, earned premiums, and investment income compared to prior years. The report must also include base premiums medical malpractice insurers charge for each specialty and the number of providers insured, by specialty, for each insurer.

The commissioner must annually submit the report to the Insurance and Real Estate Committee. He or she must also (1) make the report available to the public, (2) post it on the department's Internet site, and (3) provide public access to the contents of the electronic database after establishing that the names and other individually identifiable information about claimants and practitioners has been removed.

BACKGROUND

Closed Claim Report

By law, a closed claim report must include specific information about the insured and the insurer, the injury or loss, the claims process, and the amount paid on the claim.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 18 Nay 0 (03/12/2009)