



General Assembly

January Session, 2009

**Raised Bill No. 961**

LCO No. 3703

\*03703\_\_\_\_\_INS\*

Referred to Committee on Insurance and Real Estate

Introduced by:  
(INS)

***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 Section 38a-395 of the general statutes is repealed and the  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	<i>July 1, 2009</i>	38a-395

**Statement of Purpose:**

To add clarifying definitions, to expand closed claim reporting requirements to risk retention groups, captive insurers, unauthorized insurers and facilities and providers named in such claims, to grant the Insurance Commissioner the authority to fine entities that fail to submit reports as required, and to add confidentiality provisions.

*[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]*