



Senate

General Assembly

File No. 431

February Session, 2004

Substitute Senate Bill No. 356

Senate, April 5, 2004

The Committee on Public Health reported through SEN. MURPHY of the 16th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAL MALPRACTICE AND HEALTH CARE QUALITY.

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

1 Section 1. Section 38a-32 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective from passage*):

3 There is established within the Insurance Department the "Medical
4 Malpractice Screening Panel" which shall consist of members whose
5 names shall be supplied by [the Connecticut State Medical Society]
6 professional societies or associations that represent health care
7 providers in this state and the Connecticut Bar Association. This panel
8 may be added to whenever the need arises by requesting further
9 names from [either the Connecticut State Medical Society or the
10 Connecticut Bar Association] any such society or association. Members
11 of the panel shall serve without compensation. The Insurance
12 Commissioner may designate [a member of his] an employee of the
13 department to administer the operation of and maintain the records for

14 such screening panel.

15 Sec. 2. Section 38a-33 of the general statutes is repealed and the
16 following is substituted in lieu thereof (*Effective from passage*):

17 (a) No civil action shall be tried with respect to a malpractice claim
18 until the proposed complaint in such action is filed with the Insurance
19 Commissioner and a hearing panel has made and recorded a finding
20 as to liability or dismissed the claim pursuant to sections 38a-32 to 38a-
21 36, inclusive, as amended by this act.

22 (b) The claimant shall personally deliver or cause to be delivered, or
23 send, by registered or certified mail, return receipt requested, the
24 proposed complaint to the Insurance Commissioner. Not later than ten
25 days after receipt of such proposed complaint, the commissioner shall
26 send by registered or certified mail, return receipt requested, a copy of
27 such proposed complaint to each health care provider named as a
28 defendant at such provider's last-known place of residence or business.
29 The filing of a proposed complaint with the Insurance Commissioner
30 shall toll the applicable statute of limitations until sixty days after the
31 date the claimant receives a copy of the hearing panel's finding
32 pursuant to section 38a-36, as amended by this act, or the hearing
33 panel's decision dismissing the claim.

34 (c) Whenever [all parties to a claim for malpractice agree, they may
35 request the Insurance Commissioner or his designee to] a complaint is
36 filed with the Insurance Commissioner pursuant to subsection (b) of
37 this section, the commissioner or the commissioner's designee shall,
38 not later than thirty days after such filing, select a hearing panel
39 composed of [two physicians] two health care providers and one
40 attorney from the Malpractice Screening Panel established under
41 section 38a-32, as amended by this act. None of the members of the
42 hearing panel, insofar as possible, shall be from the same community
43 of practice of either the [physician] health care provider involved or
44 the attorneys for the parties. [At least one of the physicians] One health
45 care provider member shall be from the same profession or specialty as
46 the [physician] health care provider against whom such claim is filed.

47 [and the] The attorney shall have experience in the trial of personal
48 injury cases and shall have experience representing both plaintiffs and
49 defendants in such actions. [The attorney so designated shall act as
50 chairman.] Upon the filing of such proposed complaint, the Insurance
51 Commissioner shall notify the Chief Court Administrator and the
52 Chief Court Administrator shall, not later than thirty days after such
53 notice, select a judge trial referee to be a member of the hearing panel
54 and serve as chairperson of the hearing panel. Whenever deemed
55 necessary due to the nature of the claim or the parties, the chairperson
56 may consult with a member of the Medical Malpractice Screening
57 Panel established under section 38a-32, as amended by this act.

58 (d) For the purposes of this section, "health care provider" means
59 any person, corporation, facility or institution licensed by this state to
60 provide health care or professional services, or an officer, employee or
61 agent thereof acting in the course and scope of his or her employment.

62 Sec. 3. Section 38a-34 of the general statutes is repealed and the
63 following is substituted in lieu thereof (*Effective from passage*):

64 The hearing panel so selected shall decide when and at what place it
65 will hold its hearings. A transcript of the proceedings may be taken at
66 the discretion of either or both parties and the expense of the same
67 shall be borne by the party ordering the same or desiring a copy
68 thereof. The original of [said] the transcript and all pertinent records of
69 [said] the panel shall be maintained by the Insurance Commissioner.

70 Sec. 4. Section 38a-35 of the general statutes is repealed and the
71 following is substituted in lieu thereof (*Effective from passage*):

72 (a) All proceedings, records, findings and deliberations of a hearing
73 panel shall be confidential and shall not be used in any other
74 proceedings, or otherwise publicized, except as provided in section
75 19a-17b and sections 38a-32 to 38a-36, inclusive, [nor] as amended by
76 this act, or disclosed by any party, witness, counsel, panel member or
77 other person, on penalty of being found in contempt of court.

78 (b) No person who provides testimony or information to a hearing
79 panel on any matter submitted to it shall, without a showing of malice,
80 be personally liable for any damages resulting from such testimony or
81 information.

82 (c) The manner in which a hearing panel and each member thereof
83 deliberates, decides and votes on any matter submitted to it, including
84 whether its final decision is unanimous or otherwise, shall not be
85 disclosed or made public by any person, except as provided in [said
86 sections] section 19a-17b and sections 38a-32 to 38a-36, inclusive, as
87 amended by this act.

88 Sec. 5. Section 38a-36 of the general statutes is repealed and the
89 following is substituted in lieu thereof (*Effective from passage*):

90 At the conclusion of its hearing and deliberation, the hearing panel
91 shall make a finding as to liability only signed by all members and
92 record the same with the Insurance Commissioner who shall forward a
93 copy of the same to the parties. The finding, [if unanimous] by a
94 majority vote, shall be admissible in evidence at any subsequent trial of
95 the issues. The trier, whether court or jury, shall determine what if any
96 weight should be afforded [said] the finding. The finding shall speak
97 for itself and no member of the panel shall be subject to subpoena or
98 required to testify regarding the same. Any explanation of the finding
99 [or] of the panel shall be at the discretion of the trial judge.

100 Sec. 6. Section 52-190a of the general statutes, as amended by section
101 14 of public act 03-202, is repealed and the following is substituted in
102 lieu thereof (*Effective from passage and applicable to actions filed on or after*
103 *said date*):

104 (a) No civil action shall be filed to recover damages resulting from
105 personal injury or wrongful death occurring on or after October 1,
106 1987, whether in tort or in contract, in which it is alleged that such
107 injury or death resulted from the negligence of a health care provider,
108 unless the attorney or party filing the action has made a reasonable
109 inquiry as permitted by the circumstances to determine that there are

110 grounds for a good faith belief that there has been negligence in the
111 care or treatment of the claimant. The complaint or initial pleading
112 shall contain a certificate of the attorney or party filing the action that
113 such reasonable inquiry gave rise to a good faith belief that grounds
114 exist for an action against each named defendant. [For the purposes of
115 this section, such good faith may be shown to exist if the claimant or
116 his attorney has received a written opinion, which shall not be subject
117 to discovery by any party except for questioning the validity of the
118 certificate,] To show the existence of such good faith, the claimant or
119 the claimant's attorney shall obtain a written and signed opinion of a
120 similar health care provider, as defined in section 52-184c, which
121 similar health care provider shall be selected pursuant to the
122 provisions of said section, that there appears to be evidence of medical
123 negligence and includes a detailed basis for the formation of such
124 opinion. Such written opinion shall not be subject to discovery by any
125 party except for questioning the validity of the certificate. The claimant
126 or the claimant's attorney shall retain the original written opinion and
127 shall attach a copy of such written opinion, with the name and
128 signature of the similar health care provider expunged, to such
129 certificate. In addition to such written opinion, the court may consider
130 other factors with regard to the existence of good faith. If the court
131 determines, after the completion of discovery, that such certificate was
132 not made in good faith and that no justiciable issue was presented
133 against a health care provider that fully cooperated in providing
134 informal discovery, the court upon motion or upon its own initiative
135 shall impose upon the person who signed such certificate or a
136 represented party, or both, an appropriate sanction which may include
137 an order to pay to the other party or parties the amount of the
138 reasonable expenses incurred because of the filing of the pleading,
139 motion or other paper, including a reasonable attorney's fee. The court
140 may also submit the matter to the appropriate authority for
141 disciplinary review of the attorney if the claimant's attorney submitted
142 the certificate.

143 (b) Upon petition to the clerk of the court where the action will be
144 filed, an automatic ninety-day extension of the statute of limitations

145 shall be granted to allow the reasonable inquiry required by subsection
146 (a) of this section. This period shall be in addition to other tolling
147 periods.

148 Sec. 7. Section 19a-17a of the general statutes is repealed and the
149 following is substituted in lieu thereof (*Effective from passage*):

150 (a) For purposes of this section, "terms of the award or settlement"
151 means the rights and obligations of the parties to a medical malpractice
152 claim, as determined by a court or by agreement of the parties, and
153 includes, but is not limited to, (1) for any individual licensed pursuant
154 to chapter 370 to 373, inclusive, 379 or 383 who is a party to the claim,
155 the type of healing art or other health care practice, and the specialty, if
156 any, in which such individual engages, (2) the amount of the award or
157 settlement, specifying the portion of the award or settlement
158 attributable to economic damages and the portion of the award or
159 settlement attributable to noneconomic damages, and (3) if there are
160 multiple defendants, the allocation for payment of the award between
161 or among such defendants.

162 (b) Upon the filing of any medical malpractice claim against an
163 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
164 383, the plaintiff shall mail a copy of the complaint to the Department
165 of Public Health.

166 (c) Upon entry of any medical malpractice award by any court or
167 upon the parties entering a settlement of a malpractice claim against an
168 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
169 383, the entity making payment on behalf of a party or, if no such
170 entity exists, the party, shall [notify] provide to the Department of
171 Public Health and the Insurance Department notice of the terms of the
172 award or settlement and shall provide to [the department] said
173 departments a copy of the award or settlement and the underlying
174 complaint and answer, if any. Such notices and copies provided to the
175 Insurance Department shall not identify the parties to the claim. The
176 Department of Public Health shall send the information received from
177 such entity or party to the state board of examiners having cognizance

178 over any individual licensed pursuant to chapter 370 to 373, inclusive,
179 379 or 383 who is a party to the claim. The [department] Department of
180 Public Health shall review all medical malpractice claims and awards
181 and all settlements to determine whether further investigation or
182 disciplinary action against the providers involved is warranted. On
183 and after July 1, 2004, such review shall be conducted in accordance
184 with guidelines adopted by the Department of Public Health, in
185 accordance with the provisions of section 20-13b, as amended by this
186 act, to determine the basis for such further investigation or disciplinary
187 action. Any document received pursuant to this section shall not be
188 considered a petition and shall not be subject to the provisions of
189 section 1-210 unless the [department] Department of Public Health
190 determines, following completion of its review, that further
191 investigation or disciplinary action is warranted.

192 (d) No release of liability executed by a party to which payment is to
193 be made under a settlement of a malpractice claim against an
194 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
195 383 shall be effective until the attorney for the entity making payment
196 on behalf of a party or, if no such entity exists, the attorney for the
197 party, files with the court an affidavit stating that such attorney has
198 provided the information required under subsection (c) of this section
199 to the Department of Public Health and the Insurance Department.

200 (e) The Commissioner of Public Health and the Insurance
201 Commissioner shall develop systems within their respective agencies
202 for collecting, storing, utilizing, interpreting, reporting and providing
203 public access to the information received under subsections (b) and (c)
204 of this section. Each commissioner shall report the details of such
205 systems within its agency to the joint standing committees of the
206 General Assembly having cognizance of matters relating to public
207 health and insurance on or before July 1, 2004, in accordance with
208 section 11-4a.

209 Sec. 8. Section 20-13b of the general statutes is repealed and the
210 following is substituted in lieu thereof (*Effective from passage*):

211 The Commissioner of Public Health, with advice and assistance
212 from the board, may establish such regulations in accordance with
213 chapter 54 as may be necessary to carry out the provisions of sections
214 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1,
215 2004, such regulations shall include, but need not be limited to: (1)
216 Guidelines for screening complaints received to determine which
217 complaints will be investigated; (2) a prioritization system for conduct
218 of investigations to ensure prompt action when it appears necessary;
219 and (3) guidelines to determine when an investigation should be
220 broadened beyond the initial complaint to include sampling patient
221 records to identify patterns of care, reviewing office practices and
222 procedures, reviewing performance and discharge data from hospitals
223 and managed care organizations and additional interviews of patients
224 and peers.

225 Sec. 9. Section 20-8a of the general statutes is repealed and the
226 following is substituted in lieu thereof (*Effective from passage*):

227 (a) There shall be within the Department of Public Health a
228 Connecticut Medical Examining Board. Said board shall consist of
229 fifteen members [appointed by the Governor, subject to the provisions
230 of section 4-9a, in the manner prescribed for department heads in
231 section 4-7, as follows: Five physicians practicing in the state;] as
232 follows: The Governor shall appoint three physicians practicing in the
233 state and three public members; the speaker of the House of
234 Representatives shall appoint one physician who shall be a full-time
235 member of the faculty of The University of Connecticut School of
236 Medicine; the president pro tempore of the Senate shall appoint one
237 physician who shall be a full-time chief of staff in a general-care
238 hospital in the state; the majority leader of the House of
239 Representatives shall appoint one physician who shall be registered as
240 a supervising physician for one or more physician assistants; the
241 majority leader of the Senate shall appoint one physician who shall be
242 a graduate of a medical education program accredited by the
243 American Osteopathic Association; the minority leader of the House of
244 Representatives shall appoint one physician assistant licensed

245 pursuant to section 20-12b and practicing in this state; [and five public
246 members] the minority leader of the Senate shall appoint one
247 physician practicing in the state; and a patient advocacy group selected
248 by the chairpersons of the joint standing committee of the General
249 Assembly having cognizance of matters relating to public health shall
250 appoint three members, one of whom shall be a physician practicing in
251 the state, one of whom shall be an attorney with expertise in the
252 practice of criminal law and one of whom shall be a public member.
253 No professional member of said board shall be an elected or appointed
254 officer of a professional society or association relating to such
255 member's profession at the time of appointment to the board or have
256 been such an officer during the year immediately preceding
257 appointment or serve for more than two consecutive terms.
258 Professional members shall be practitioners in good professional
259 standing and residents of this state.

260 (b) All vacancies shall be filled by the [Governor in the manner
261 prescribed for department heads in section 4-7] the appointing
262 authority, except the chairpersons of the joint standing committee of
263 the General Assembly having cognizance of matters relating to public
264 health may designate a different patient advocacy group for
265 subsequent appointments. Successors and appointments to fill a
266 vacancy shall fulfill the same qualifications as the member succeeded
267 or replaced. In addition to the requirements in sections 4-9a, as
268 amended, and 19a-8, no person whose spouse, parent, brother, sister,
269 child or spouse of a child is a physician, as defined in section 20-13a, or
270 a physician assistant, as defined in section 20-12a, shall be appointed
271 as a public member.

272 (c) The Commissioner of Public Health shall establish a list of
273 eighteen persons who may serve as members of medical hearing
274 panels established pursuant to subsection (g) of this section. Persons
275 appointed to the list shall serve as members of the medical hearing
276 panels and provide the same services as members of the Connecticut
277 Medical Examining Board. Members from the list serving on such
278 panels shall not be voting members of the Connecticut Medical

279 Examining Board. The list shall consist of eighteen members appointed
280 by the commissioner, eight of whom shall be physicians, as defined in
281 section 20-13a, with at least one of such physicians being a graduate of
282 a medical education program accredited by the American Osteopathic
283 Association, one of whom shall be a physician assistant licensed
284 pursuant to section 20-12b, and nine of whom shall be members of the
285 public. No professional member of the list shall be an elected or
286 appointed officer of a professional society or association relating to
287 such member's profession at the time of appointment to the list or have
288 been such an officer during the year immediately preceding such
289 appointment to the list. A licensed professional appointed to the list
290 shall be a practitioner in good professional standing and a resident of
291 this state. All vacancies shall be filled by the commissioner. Successors
292 and appointments to fill a vacancy on the list shall possess the same
293 qualifications as those required of the member succeeded or replaced.
294 No person whose spouse, parent, brother, sister, child or spouse of a
295 child is a physician, as defined in section 20-13a, or a physician
296 assistant, as defined in section 20-12a, shall be appointed to the list as a
297 member of the public. Each person appointed to the list shall serve
298 without compensation at the pleasure of the commissioner.

299 (d) The office of the board shall be in Hartford, in facilities to be
300 provided by the department.

301 (e) The board shall adopt and may amend a seal.

302 (f) The Governor shall appoint a chairperson from among the board
303 members. Said board shall meet at least once during each calendar
304 quarter and at such other times as the chairperson deems necessary.
305 Special meetings shall be held on the request of a majority of the board
306 after notice in accordance with the provisions of section 1-225. A
307 majority of the members of the board shall constitute a quorum.
308 Members shall not be compensated for their services. Any member
309 who fails to attend three consecutive meetings or who fails to attend
310 fifty per cent of all meetings held during any calendar year shall be
311 deemed to have resigned from office. Minutes of all meetings shall be

312 recorded by the board. No member shall participate in the affairs of
313 the board during the pendency of any disciplinary proceedings by the
314 board against such member. Said board shall (1) hear and decide
315 matters concerning suspension or revocation of licensure, (2)
316 adjudicate complaints against practitioners, and (3) impose sanctions
317 where appropriate. Said board shall inform the Chief State's Attorney
318 if it appears that an individual currently or formerly under
319 investigation violated any criminal statutes.

320 (g) (1) Not later than December 31, 2004, the board, with the
321 assistance of the department, shall adopt regulations, in accordance
322 with chapter 54, to establish guidelines for use in the disciplinary
323 process. Such guidelines shall include, but need not be limited to: (A)
324 Identification of each type of violation; (B) a minimum and maximum
325 penalty for each type of violation; (C) additional optional conditions
326 that may be imposed by the board for each violation; (D) identification
327 of factors the board shall consider in determining if the maximum or
328 minimum penalty should apply; (E) conditions, such as mitigating
329 factors or other facts, that may be considered in allowing deviations
330 from the guidelines; and (F) a provision that when a deviation from
331 the guidelines occurs, the reason for the deviation shall be identified.

332 (2) The board shall refer all statements of charges filed with the
333 board by the department pursuant to section 20-13e, as amended by
334 this act, to a medical hearing panel within sixty days of the receipt of
335 charges. This time period may be extended for good cause by the
336 board in a duly recorded vote. [The panel shall consist of three
337 members, at least one of whom shall be a member of the board and one
338 a member of the public. The public member may be a member of either
339 the board or of the list established pursuant to subsection (c) of this
340 section.] The panel shall conduct a hearing, in accordance with the
341 provisions of chapter 54, and the regulations established by the
342 Commissioner of Public Health concerning contested cases, except that
343 the panel shall file a proposed final decision with the board within one
344 hundred twenty days of the receipt of the issuance of the notice of
345 hearing by the board. The time period for filing such proposed final

346 decision with the board may be extended for good cause by the board
347 in a duly recorded vote. If the panel has not conducted a hearing
348 within sixty days of the date of referral of the statement of charges by
349 the board, such hearing shall be conducted by the commissioner, in
350 accordance with the provisions of chapter 54, and the regulations
351 established by the commissioner concerning contested cases. The
352 commissioner shall file a proposed final decision with the board not
353 later than sixty days after such hearing. The time period for filing such
354 proposed final decision with the board may be extended for good
355 cause by the board in a duly recorded vote.

356 (3) The board shall refer all findings of no probable cause filed with
357 the board by the department pursuant to section 20-13e, as amended
358 by this act, to a medical hearing panel within sixty days of the receipt
359 of charges. This time period may be extended for good cause by the
360 board in a duly recorded vote. The panel shall review the petition and
361 the entire record of the investigation and may request the department
362 for more information or for a reconsideration of such finding. If the
363 panel takes no action within ninety days of the submission to the
364 board of such finding, the department's finding of no probable cause
365 shall be considered final.

366 (4) For purposes of this section, a medical hearing panel shall consist
367 of three members, at least one of whom shall be a member of the board
368 and one a member of the public. The public member may be a member
369 of either the board or of the list established pursuant to subsection (c)
370 of this section.

371 (h) The board shall review the panel's proposed final decision in
372 accordance with the provisions of section 4-179, and adopt, modify or
373 remand said decision for further review or for the taking of additional
374 evidence. The board shall act on the proposed final decision within
375 ninety days of the filing of said decision by the panel. This time period
376 may be extended by the board for good cause in a duly recorded vote.

377 (i) Except in a case in which a license has been summarily
378 suspended, pursuant to subsection (c) of section 19a-17 or subsection

379 (c) of section 4-182, all three panel members shall be present to hear
380 any evidence and vote on a proposed final decision. The chairperson of
381 the Medical Examining Board may exempt a member from a meeting
382 of the panel if the chairperson finds that good cause exists for such an
383 exemption. Such an exemption may be granted orally but shall be
384 reduced to writing and included as part of the record of the panel
385 within two business days of the granting of the exemption or the
386 opening of the record and shall state the reason for the exemption.
387 Such exemption shall be granted to a member no more than once
388 during any contested case and shall not be granted for a meeting at
389 which the panel is acting on a proposed final decision on a statement
390 of charges. The board may appoint a member to the panel to replace
391 any member who resigns or otherwise fails to continue to serve on the
392 panel. Such replacement member shall review the record prior to the
393 next hearing.

394 (j) A determination of good cause shall not be reviewable and shall
395 not constitute a basis for appeal of the decision of the board pursuant
396 to section 4-183.

397 Sec. 10. Section 20-13i of the general statutes is repealed and the
398 following is substituted in lieu thereof (*Effective from passage*):

399 The department shall file with the Governor and the joint standing
400 committee on public health of the General Assembly on or before
401 January 1, 1986, and thereafter on or before January first of each
402 succeeding year, a report of the activities of the department and the
403 board conducted pursuant to sections 20-13d and 20-13e, as amended
404 by this act. Each such report shall include, but shall not be limited to,
405 the following information: The number of petitions received; the
406 number of petitions not investigated, and the reasons why; the number
407 of hearings held on such petitions; [and,] the outcome of such
408 hearings; the timeliness of action taken on any petition considered to
409 be a priority; without identifying the particular physician concerned, a
410 brief description of the impairment alleged in each such petition and
411 the actions taken with regard to each such petition by the department

412 and the board; the number of notifications received pursuant to section
413 19a-17a, as amended by this act; the number of such notifications with
414 no further action taken, and the reasons why; and the outcomes for
415 notifications where further action is taken.

416 Sec. 11. (NEW) (*Effective from passage*) (a) Each licensed hospital or
417 outpatient surgical facility shall establish protocols for screening
418 patients prior to any surgery. Such protocols shall require that: (1)
419 Prior to any surgery, members of the surgical team, including at least
420 one principal surgeon, but not exceeding five such members in total,
421 together (A) identify the patient and, where the patient is able to do so,
422 have the patient identify himself, and (B) identify the procedure to be
423 performed, and (2) no patient may be anesthetized and no surgery
424 may be performed unless the identifications specified in subdivision
425 (1) of this subsection have been confirmed by all such members, except
426 that such protocols may provide for alternative identification
427 procedures where the patient is unconscious or under emergency
428 circumstances. Each licensed hospital or outpatient surgical facility
429 shall annually submit to the Department of Public Health a copy of
430 such protocols and a report on their implementation.

431 (b) The Department of Public Health shall assist each hospital or
432 outpatient surgical facility with the development and implementation
433 of the screening protocols required under subsection (a) of this section.

434 Sec. 12. Section 52-192a of the general statutes is repealed and the
435 following is substituted in lieu thereof (*Effective from passage*):

436 (a) After commencement of any civil action based upon contract or
437 seeking the recovery of money damages, whether or not other relief is
438 sought, the plaintiff may, not later than thirty days before trial, file
439 with the clerk of the court a written "offer of judgment" signed by the
440 plaintiff or the plaintiff's attorney, directed to the defendant or the
441 defendant's attorney, offering to settle the claim underlying the action
442 and to stipulate to a judgment for a sum certain. The plaintiff shall give
443 notice of the offer of settlement to the defendant's attorney or, if the
444 defendant is not represented by an attorney, to the defendant himself

445 or herself. Within sixty days after being notified of the filing of the
446 "offer of judgment" or within any extension or extensions thereof, not
447 to exceed a total of one hundred twenty additional days, granted by
448 the court for good cause shown, and prior to the rendering of a verdict
449 by the jury or an award by the court, the defendant or the defendant's
450 attorney may file with the clerk of the court a written "acceptance of
451 offer of judgment" agreeing to a stipulation for judgment as contained
452 in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter
453 judgment immediately on the stipulation. If the "offer of judgment" is
454 not accepted within [sixty days] the sixty-day period or any extension
455 thereof, and prior to the rendering of a verdict by the jury or an award
456 by the court, the "offer of judgment" shall be considered rejected and
457 not subject to acceptance unless refiled. Any such "offer of judgment"
458 and any "acceptance of offer of judgment" shall be included by the
459 clerk in the record of the case.

460 (b) After trial the court shall examine the record to determine
461 whether the plaintiff made an "offer of judgment" which the defendant
462 failed to accept. If the court ascertains from the record that the plaintiff
463 has recovered an amount equal to or greater than the sum certain
464 stated in the plaintiff's "offer of judgment", the court shall add to the
465 amount so recovered twelve per cent annual interest on said amount,
466 [computed from the date such offer was filed in actions commenced
467 before October 1, 1981. In those actions commenced on or after October
468 1, 1981, the] with respect to an offer of judgment filed prior to the
469 effective date of this section, and interest at an annual rate of four
470 percentage points above the weekly average five-year constant
471 maturity yield of United States Treasury securities, as published by the
472 Board of Governors of the Federal Reserve System, for the calendar
473 week preceding the beginning of each year for which interest is owed,
474 with respect to an offer of judgment filed on or after the effective date
475 of this section. The interest shall be computed from the date the
476 complaint in the civil action was filed with the court if the "offer of
477 judgment" was filed not later than eighteen months from the filing of
478 such complaint. If such offer was filed later than eighteen months from
479 the date of filing of the complaint, the interest shall be computed from

480 the date the "offer of judgment" was filed. The court may award
481 reasonable attorney's fees in an amount not to exceed three hundred
482 fifty dollars, and shall render judgment accordingly. This section shall
483 not be interpreted to abrogate the contractual rights of any party
484 concerning the recovery of attorney's fees in accordance with the
485 provisions of any written contract between the parties to the action.

486 Sec. 13. Subsection (a) of section 20-13e of the general statutes is
487 repealed and the following is substituted in lieu thereof (*Effective from*
488 *passage*):

489 (a) (1) The department shall investigate each petition filed pursuant
490 to section 20-13d, in accordance with the provisions of subdivision (10)
491 of subsection (a) of section 19a-14, to determine if probable cause exists
492 to issue a statement of charges and to institute proceedings against the
493 physician under subsection (e) of this section. Such investigation shall
494 be concluded not later than eighteen months from the date the petition
495 is filed with the department and, unless otherwise specified by this
496 subsection, the record of such investigation shall be deemed a public
497 record, in accordance with section 1-210, as amended, at the conclusion
498 of such eighteen-month period. Any such investigation shall be
499 confidential and no person shall disclose his knowledge of such
500 investigation to a third party unless the physician requests that such
501 investigation and disclosure be open. If the department determines
502 that probable cause exists to issue a statement of charges, the entire
503 record of such proceeding shall be public unless the department
504 determines that the physician is an appropriate candidate for
505 participation in a rehabilitation program in accordance with subsection
506 (b) of this section and the physician agrees to participate in such
507 program in accordance with terms agreed upon by the department and
508 the physician. If at any time subsequent to the filing of a petition and
509 during the eighteen-month period, the department makes a finding of
510 no probable cause and the medical panel appointed pursuant to
511 subsection (g) of section 20-8a, as amended by this act, allows such
512 finding to stand, the petition and the entire record of such
513 investigation shall remain confidential unless the physician requests

514 that such petition and record be open.

515 (2) The department shall notify the person who filed the petition or
516 such person's legal representative at such time as the department
517 makes a finding of no probable cause, and include the reason for such
518 finding.

519 Sec. 14. Subsection (b) of section 19a-88 of the general statutes is
520 repealed and the following is substituted in lieu thereof (*Effective from*
521 *passage*):

522 (b) Each person holding a license to practice medicine, surgery,
523 podiatry, chiropractic or natureopathy shall, annually, during the
524 month of such person's birth, register with the Department of Public
525 Health, upon payment of the professional services fee for class I, as
526 defined in section 33-182l, on blanks to be furnished by the department
527 for such purpose, giving such person's name in full, such person's
528 residence and business address, the name of the insurance company
529 providing such person's professional liability insurance and the policy
530 number of such insurance, such person's area of specialization,
531 whether such person is actively involved in patient care, any
532 disciplinary action against such person, or malpractice payments made
533 on behalf of such person in any other state or jurisdiction, and such
534 other information as the department requests. The department may
535 compare information submitted pursuant to this subsection to
536 information contained in the National Practitioner Data Base.

537 Sec. 15. (NEW) (*Effective from passage*) On or before January 1, 2005,
538 and annually thereafter, the Department of Public Health shall report,
539 in accordance with section 11-4a of the general statutes, the number of
540 physicians by specialty who are actively providing patient care.

541 Sec. 16. (NEW) (*Effective July 1, 2004*) Each insurer that delivers,
542 issues for delivery or renews in this state a professional liability
543 insurance policy for a medical professional or entity shall offer a
544 premium discount on the policy to any insured who submits to the
545 insurer proof that the insured will use an electronic health record

546 system during the premium period to establish and maintain patient
547 records and verify patient treatment. Such discount shall be not less
548 than twenty per cent of the premium for a period of one year from the
549 effective date of the policy or renewal.

550 Sec. 17. (NEW) (*Effective July 1, 2004*) The Connecticut Health and
551 Educational Facilities Authority shall establish a program, within
552 available appropriations, to finance low interest loans to hospitals to
553 install or upgrade electronic health record systems for the
554 establishment and maintenance of patient records and verification of
555 patient treatment. The program shall be known as the Connecticut
556 Electronic Health Records Program. Loans shall be made for the
557 purpose of establishing or upgrading electronic health record systems
558 for use by hospitals in order to promote patient safety and eliminate
559 errors.

560 Sec. 18. Section 38a-676 of the general statutes is repealed and the
561 following is substituted in lieu thereof (*Effective from passage*):

562 (a) With respect to rates pertaining to commercial risk insurance,
563 and subject to the provisions of subsection (b) of this section with
564 respect to workers' compensation and employers' liability insurance
565 and certain professional liability insurance, on or before the effective
566 date [thereof, every] of such rates, each admitted insurer shall submit
567 to the Insurance Commissioner for the commissioner's information,
568 except as to inland marine risks which by general custom of the
569 business are not written according to manual rates or rating plans,
570 [every] each manual of classifications, rules and rates, and [every] each
571 minimum, class rate, rating plan, rating schedule and rating system
572 and any modification of the foregoing which it uses. Such submission
573 by a licensed rating organization of which an insurer is a member or
574 subscriber shall be sufficient compliance with this section for any
575 insurer maintaining membership or subscribership in such
576 organization, to the extent that the insurer uses the manuals,
577 minimums, class rates, rating plans, rating schedules, rating systems,
578 policy or bond forms of such organization. The information shall be

579 open to public inspection after its submission.

580 (b) (1) Each filing as described in subsection (a) of this section for
581 workers' compensation or employers' liability insurance shall be on file
582 with the Insurance Commissioner for a waiting period of thirty days
583 before it becomes effective, which period may be extended by the
584 commissioner for an additional period not to exceed thirty days if the
585 commissioner gives written notice within such waiting period to the
586 insurer or rating organization which made the filing that the
587 commissioner needs such additional time for the consideration of such
588 filing. Upon written application by such insurer or rating organization,
589 the commissioner may authorize a filing which the commissioner has
590 reviewed to become effective before the expiration of the waiting
591 period or any extension thereof. A filing shall be deemed to meet the
592 requirements of sections 38a-663 to 38a-696, inclusive, unless
593 disapproved by the commissioner within the waiting period or any
594 extension thereof. If, within the waiting period or any extension
595 thereof, the commissioner finds that a filing does not meet the
596 requirements of said sections, the commissioner shall send to the
597 insurer or rating organization which made such filing written notice of
598 disapproval of such filing, specifying therein in what respects the
599 commissioner finds such filing fails to meet the requirements of said
600 sections and stating that such filing shall not become effective. Such
601 finding of the commissioner shall be subject to review as provided in
602 section 38a-19.

603 (2) Each filing as described in subsection (a) of this section for
604 professional liability insurance for physicians and surgeons, hospitals
605 or advanced practice registered nurses shall be subject to prior rate
606 approval in accordance with this section. On and after the effective
607 date of this section, each insurer or rating organization seeking to
608 change its rates for such insurance shall (A) file a request for such
609 change with the Insurance Department, and (B) provide written notice
610 to its insureds with respect to any request for an increase in rates. Such
611 request shall be filed and such notice, if applicable, shall be sent at
612 least sixty days prior to the proposed effective date of the change. The

613 notice to insureds of a request for an increase in rates shall indicate
614 that a public hearing shall be held in accordance with this section. The
615 Insurance Department shall review the request and, with respect to a
616 request for an increase in rates, shall hold a public hearing on such
617 increase prior to approving or denying the request. The Insurance
618 Commissioner shall approve or deny the request no later than forty-
619 five days after its receipt. Such finding of the commissioner shall be
620 subject to review as provided in section 38a-19.

621 (c) The form of any insurance policy or contract the rates for which
622 are subject to the provisions of sections 38a-663 to 38a-696, inclusive,
623 other than fidelity, surety or guaranty bonds, and the form of any
624 endorsement modifying such insurance policy or contract, shall be
625 filed with the Insurance Commissioner prior to its issuance. The
626 commissioner shall adopt regulations, in accordance with the
627 provisions of chapter 54, establishing a procedure for review of such
628 policy or contract. If at any time the commissioner finds that any such
629 policy, contract or endorsement is not in accordance with such
630 provisions or any other provision of law, the commissioner shall issue
631 an order disapproving the issuance of such form and stating the
632 reasons for disapproval. The provisions of section 38a-19 shall apply to
633 any such order issued by the commissioner.

634 Sec. 19. (NEW) (*Effective October 1, 2004*) (a) On and after October 1,
635 2004, no captive insurer, as defined in section 38a-91 of the general
636 statutes, may insure a health care provider or entity in this state
637 against liability for medical malpractice unless the captive insurer has
638 obtained a certificate of authority from the Insurance Commissioner,
639 except that no certificate of authority shall be required for any captive
640 insurer that is duly licensed in this state to offer such insurance.

641 (b) Any captive insurer seeking to obtain a certificate of authority
642 shall make application to the commissioner, on such form as the
643 commissioner requires, setting forth the line or lines of business which
644 it is seeking authorization to write. The captive insurer shall file with
645 the commissioner a certified copy of its charter or articles of

646 association and evidence satisfactory to the commissioner that it has
647 complied with the laws of the jurisdiction under which it is organized,
648 a statement of its financial condition in such form as is required by the
649 commissioner, together with such evidence of its correctness as the
650 commissioner requires and evidence of good management in such
651 form as is required by the commissioner. The captive insurer shall
652 submit evidence of its ability to provide continuant and timely claims
653 settlement. If the information furnished is satisfactory to the
654 commissioner, and if all other requirements of law have been complied
655 with, the commissioner may issue to such insurer a certificate of
656 authority permitting it to do business in this state. Each such certificate
657 of authority shall expire on the first day of May succeeding the date of
658 its issuance, but may be renewed without any formalities except as
659 required by the commissioner. Failure of a captive insurer to exercise
660 its authority to write a particular line or lines of business in this state
661 for two consecutive calendar years may constitute sufficient cause for
662 revocation of the captive insurer's authority to write those lines of
663 business.

664 (c) The commissioner shall adopt regulations, in accordance with
665 chapter 54 of the general statutes, specifying the information and
666 evidence that a captive insurer seeking to obtain or renew a certificate
667 of authority shall submit and the requirements with which it shall
668 comply.

669 (d) The commissioner may, at any time, for cause, suspend, revoke
670 or reissue any such certificate of authority or in lieu of or in addition to
671 suspension or revocation of such certificate of authority the
672 commissioner, after reasonable notice to and hearing of any holder of
673 such certificate of authority, may impose a fine not to exceed ten
674 thousand dollars. Such hearings may be held by the commissioner or
675 any person designated by the commissioner. Whenever a person other
676 than the commissioner acts as the hearing officer, the person shall
677 submit to the commissioner a memorandum of findings and
678 recommendations upon which the commissioner may base a decision.
679 The commissioner may, if the commissioner deems it in the interest of

680 the public, publish in one or more newspapers of the state a statement
681 that, under the provisions of this section, the commissioner has
682 suspended or revoked the certificate of authority of any captive insurer
683 to do business in this state.

684 (e) Each application for a certificate of authority shall be
685 accompanied by a nonrefundable fee as set forth in section 38a-11 of
686 the general statutes, as amended by this act. All expenses incurred by
687 the commissioner in connection with proceedings under this section
688 shall be paid by the person filing the application.

689 (f) Any captive insurer aggrieved by the action of the commissioner
690 in revoking, suspending or refusing to reissue a certificate of authority
691 or in imposing a fine may appeal therefrom, in accordance with the
692 provisions of section 4-183 of the general statutes, except venue for
693 such appeal shall be in the judicial district of New Britain. Appeals
694 under this section shall be privileged in respect to the order of trial
695 assignment.

696 Sec. 20. Subsection (a) of section 38a-11 of the general statutes, as
697 amended by section 10 of public act 03-152 and section 9 of public act
698 03-169, is repealed and the following is substituted in lieu thereof
699 (*Effective October 1, 2004*):

700 (a) The commissioner shall demand and receive the following fees:
701 (1) For the annual fee for each license issued to a domestic insurance
702 company, one hundred dollars; (2) for receiving and filing annual
703 reports of domestic insurance companies, twenty-five dollars; (3) for
704 filing all documents prerequisite to the issuance of a license to an
705 insurance company, one hundred seventy-five dollars, except that the
706 fee for such filings by any health care center, as defined in section 38a-
707 175, shall be one thousand one hundred dollars; (4) for filing any
708 additional paper required by law, fifteen dollars; (5) for each certificate
709 of valuation, organization, reciprocity or compliance, twenty dollars;
710 (6) for each certified copy of a license to a company, twenty dollars; (7)
711 for each certified copy of a report or certificate of condition of a
712 company to be filed in any other state, twenty dollars; (8) for

713 amending a certificate of authority, one hundred dollars; (9) for each
714 license issued to a rating organization, one hundred dollars. In
715 addition, insurance companies shall pay any fees imposed under
716 section 12-211; (10) a filing fee of twenty-five dollars for each initial
717 application for a license made pursuant to section 38a-769; (11) with
718 respect to insurance agents' appointments: (A) A filing fee of twenty-
719 five dollars for each request for any agent appointment; (B) a fee of
720 forty dollars for each appointment issued to an agent of a domestic
721 insurance company or for each appointment continued; and (C) a fee
722 of twenty dollars for each appointment issued to an agent of any other
723 insurance company or for each appointment continued, except that no
724 fee shall be payable for an appointment issued to an agent of an
725 insurance company domiciled in a state or foreign country which does
726 not require any fee for an appointment issued to an agent of a
727 Connecticut insurance company; (12) with respect to insurance
728 producers: (A) An examination fee of seven dollars for each
729 examination taken, except when a testing service is used, the testing
730 service shall pay a fee of seven dollars to the commissioner for each
731 examination taken by an applicant; (B) a fee of forty dollars for each
732 license issued; and (C) a fee of forty dollars for each license renewed;
733 (13) with respect to public adjusters: (A) An examination fee of seven
734 dollars for each examination taken, except when a testing service is
735 used, the testing service shall pay a fee of seven dollars to the
736 commissioner for each examination taken by an applicant; and (B) a fee
737 of one hundred twenty-five dollars for each license issued or renewed;
738 (14) with respect to casualty adjusters: (A) An examination fee of ten
739 dollars for each examination taken, except when a testing service is
740 used, the testing service shall pay a fee of ten dollars to the
741 commissioner for each examination taken by an applicant; (B) a fee of
742 forty dollars for each license issued or renewed; and (C) the expense of
743 any examination administered outside the state shall be the
744 responsibility of the entity making the request and such entity shall
745 pay to the commissioner one hundred dollars for such examination
746 and the actual traveling expenses of the examination administrator to
747 administer such examination; (15) with respect to motor vehicle

748 physical damage appraisers: (A) An examination fee of forty dollars
749 for each examination taken, except when a testing service is used, the
750 testing service shall pay a fee of forty dollars to the commissioner for
751 each examination taken by an applicant; (B) a fee of forty dollars for
752 each license issued or renewed; and (C) the expense of any
753 examination administered outside the state shall be the responsibility
754 of the entity making the request and such entity shall pay to the
755 commissioner one hundred dollars for such examination and the
756 actual traveling expenses of the examination administrator to
757 administer such examination; (16) with respect to certified insurance
758 consultants: (A) An examination fee of thirteen dollars for each
759 examination taken, except when a testing service is used, the testing
760 service shall pay a fee of thirteen dollars to the commissioner for each
761 examination taken by an applicant; (B) a fee of two hundred dollars for
762 each license issued; and (C) a fee of one hundred twenty-five dollars
763 for each license renewed; (17) with respect to surplus lines brokers: (A)
764 An examination fee of ten dollars for each examination taken, except
765 when a testing service is used, the testing service shall pay a fee of ten
766 dollars to the commissioner for each examination taken by an
767 applicant; and (B) a fee of five hundred dollars for each license issued
768 or renewed; (18) with respect to fraternal agents, a fee of forty dollars
769 for each license issued or renewed; (19) a fee of thirteen dollars for
770 each license certificate requested, whether or not a license has been
771 issued; (20) with respect to domestic and foreign benefit societies shall
772 pay: (A) For service of process, twenty-five dollars for each person or
773 insurer to be served; (B) for filing a certified copy of its charter or
774 articles of association, five dollars; (C) for filing the annual report, ten
775 dollars; and (D) for filing any additional paper required by law, three
776 dollars; (21) with respect to foreign benefit societies: (A) For each
777 certificate of organization or compliance, four dollars; (B) for each
778 certified copy of permit, two dollars; and (C) for each copy of a report
779 or certificate of condition of a society to be filed in any other state, four
780 dollars; (22) with respect to reinsurance intermediaries: A fee of five
781 hundred dollars for each license issued or renewed; (23) with respect
782 to viatical settlement providers: (A) A filing fee of thirteen dollars for

783 each initial application for a license made pursuant to section 38a-465a;
784 and (B) a fee of twenty dollars for each license issued or renewed; (24)
785 with respect to viatical settlement brokers: (A) A filing fee of thirteen
786 dollars for each initial application for a license made pursuant to
787 section 38a-465a; and (B) a fee of twenty dollars for each license issued
788 or renewed; (25) with respect to viatical settlement investment agents:
789 (A) A filing fee of thirteen dollars for each initial application for a
790 license made pursuant to section 38a-465a; and (B) a fee of twenty
791 dollars for each license issued or renewed; (26) with respect to
792 preferred provider networks, a fee of two thousand five hundred
793 dollars for each license issued or renewed; (27) with respect to rental
794 companies, as defined in section 38a-799, a fee of forty dollars for each
795 permit issued or renewed; (28) with respect to a certificate of authority
796 for a captive insurer pursuant to section 19 of this act, a fee of one
797 hundred seventy-five dollars for each certificate issued or renewed;
798 and ~~[(28)]~~ (29) with respect to each duplicate license issued a fee of
799 twenty-five dollars for each license issued.

800 Sec. 21. (NEW) (*Effective from passage*) Any party to an action for
801 medical malpractice may file an application with the Superior Court
802 requesting that the case be designated as a complex litigation case and
803 be transferred by the Chief Court Administrator or any judge
804 designated by the Chief Court Administrator to the complex litigation
805 docket in a judicial district and court location determined by the Chief
806 Court Administrator or such designee.

807 Sec. 22. Section 52-251c of the general statutes is repealed and the
808 following is substituted in lieu thereof (*Effective from passage*):

809 (a) In any claim or civil action to recover damages resulting from
810 personal injury, wrongful death or damage to property occurring on or
811 after October 1, 1987, the attorney and the claimant may provide by
812 contract, which contract shall comply with all applicable provisions of
813 the rules of professional conduct governing attorneys adopted by the
814 judges of the Superior Court, that the fee for the attorney shall be paid
815 contingent upon, and as a percentage of: (1) Damages awarded and

816 received by the claimant; or (2) settlement amount pursuant to a
817 settlement agreement.

818 (b) In any such contingency fee arrangement such fee shall be the
819 exclusive method for payment of the attorney by the claimant and
820 shall not exceed an amount equal to a percentage of the damages
821 awarded and received by the claimant or of the settlement amount
822 received by the claimant as follows: (1) Thirty-three and one-third per
823 cent of the first three hundred thousand dollars; (2) twenty-five per
824 cent of the next three hundred thousand dollars; (3) twenty per cent of
825 the next three hundred thousand dollars; (4) fifteen per cent of the next
826 three hundred thousand dollars; and (5) ten per cent of any amount
827 which exceeds one million two hundred thousand dollars.

828 (c) Whenever a claimant in a medical malpractice case enters into a
829 contingency fee arrangement with an attorney which provides for a fee
830 that would exceed the percentage limitations set forth in subsection (b)
831 of this section, such arrangement shall not be valid unless the
832 claimant's attorney files an application with the court for approval of
833 such arrangement and the court, after a hearing, grants such
834 application. The claimant's attorney shall attach to such application a
835 copy of such fee arrangement and the proposed unsigned writ,
836 summons and complaint in the case. The court shall grant such
837 application if it finds that the case is sufficiently complex, unique or
838 different from other medical malpractice cases so as to warrant a
839 deviation from such percentage limitations. At such hearing, the
840 claimant's attorney shall have the burden of showing that such
841 deviation is warranted. If the court does not grant such application, it
842 shall advise the claimant of the claimant's right to seek representation
843 by another attorney willing to abide by the percentage limitations set
844 forth in subsection (b) of this section. The filing of such application
845 shall toll the applicable statute of limitations for a period of ninety
846 days.

847 [(c)] (d) For the purposes of this section, "damages awarded and
848 received" means in a civil action in which final judgment is entered,

849 that amount of the judgment or amended judgment entered by the
850 court that is received by the claimant after deduction for any
851 disbursements or costs incurred by the attorney in connection with the
852 prosecution or settlement of the civil action, other than ordinary office
853 overhead and expense, for which the claimant is liable, except that in a
854 civil action brought pursuant to section 38a-368 such amount shall be
855 further reduced by any basic reparations benefits paid to the claimant
856 pursuant to section 38a-365; and "settlement amount received" means
857 in a claim or civil action in which no final judgment is entered, the
858 amount received by the claimant pursuant to a settlement agreement
859 after deduction for any disbursements or costs incurred by the
860 attorney in connection with the prosecution or settlement of the claim
861 or civil action, other than ordinary office overhead and expense, for
862 which the claimant is liable, except that in a claim or civil action
863 brought pursuant to section 38a-368 such amount shall be further
864 reduced by any basic reparations benefits paid to the claimant
865 pursuant to section 38a-365. [; and "fee" shall not include
866 disbursements or costs incurred in connection with the prosecution or
867 settlement of the claim or civil action, other than ordinary office
868 overhead and expense.]

869 Sec. 23. Section 38a-395 of the general statutes is repealed and the
870 following is substituted in lieu thereof (*Effective January 1, 2005*):

871 [The Insurance Commissioner may require all insurance companies
872 writing medical malpractice insurance in this state to submit, in such
873 manner and at such times as he specifies, such information as he
874 deems necessary to establish a data base on medical malpractice,
875 including information on all incidents of medical malpractice, all
876 settlements, all awards, other information relative to procedures and
877 specialties involved and any other information relating to risk
878 management.]

879 (a) As used in this section:

880 (1) "Claim" means a request for indemnification filed by a medical
881 professional or entity pursuant to a professional liability policy for a

882 loss for which a reserve amount has been established by an insurer;

883 (2) "Closed claim" means a claim that has been settled, or otherwise
884 disposed of, where the insurer has made all indemnity and expense
885 payments on the claim; and

886 (3) "Insurer" means an insurer, as defined in section 38a-1, as
887 amended, that insures a medical professional or entity against
888 professional liability. Insurer includes, but is not limited to, a captive
889 insurer or a self-insured person.

890 (b) On and after January 1, 2005, each insurer shall provide to the
891 Insurance Commissioner a closed claim report, on such form as the
892 commissioner requires, in accordance with this section. The insurer
893 shall submit the report not later than ten days after the last day of the
894 calendar quarter in which a claim for recovery under a medical
895 liability policy is closed. The report shall only include information
896 about claims settled under the laws of this state.

897 (c) The closed claim report shall include:

898 (1) Details about the insured and insurer, including: (A) The name
899 of the insurer; (B) the professional liability insurance policy limits and
900 whether the policy was an occurrence policy or was issued on a claims-
901 made basis; (C) the name, address, health care provider professional
902 license number and specialty coverage of the insured; and (D) the
903 insured's policy number and a unique claim number.

904 (2) Details about the injury or loss, including: (A) The date of the
905 injury or loss that was the basis of the claim; (B) the date the injury or
906 loss was reported to the insurer; (C) the name of the institution or
907 location at which the injury or loss occurred; (D) the type of injury or
908 loss, including a severity of injury rating that corresponds with the
909 severity of injury scale that the Insurance Commissioner shall establish
910 based on the severity of injury scale developed by the National
911 Association of Insurance Commissioners; and (E) the name, age and
912 gender of any injured person covered by the claim. Any individually

913 identifiable information submitted pursuant to this subdivision shall
914 be confidential.

915 (3) Details about the claims process, including: (A) Whether a
916 lawsuit was filed, and if so, in which court; (B) the outcome of such
917 lawsuit; (C) the number of other defendants, if any; (D) the stage in the
918 process when the claim was closed; (E) the dates of the trial; (F) the
919 date of the judgment or settlement, if any; (G) whether an appeal was
920 filed, and if so, the date filed; (H) the resolution of the appeal and the
921 date such appeal was decided; (I) the date the claim was closed; (J) the
922 initial indemnity and expense reserve for the claim; and (K) the final
923 indemnity and expense reserve for the claim.

924 (4) Details about the amount paid on the claim, including: (A) The
925 total amount of the initial judgment rendered by a jury or awarded by
926 the court; (B) the total amount of the settlement if there was no
927 judgment rendered or awarded; (C) the total amount of the settlement
928 if the claim was settled after judgment was rendered or awarded; (D)
929 the amount of economic damages, as defined in section 52-572h, or the
930 insurer's estimate of the amount in the event of a settlement; (E) the
931 amount of noneconomic damages, as defined in section 52-572h, or the
932 insurer's estimate of the amount in the event of a settlement; (F) the
933 amount of any interest awarded due to failure to accept an offer of
934 judgment; (G) the amount of any remittitur or additur; (H) the amount
935 of final judgment after remittitur or additur; (I) the amount paid by the
936 insurer; (J) the amount paid by the defendant due to a deductible or a
937 judgment or settlement in excess of policy limits; (K) the amount paid
938 by other insurers; (L) the amount paid by other defendants; (M)
939 whether a structured settlement was used; (N) the expense assigned to
940 and recorded with the claim, including, but not limited to, defense and
941 investigation costs, but not including the actual claim payment; and
942 (O) any other information the commissioner determines to be
943 necessary to regulate the professional liability insurance industry with
944 respect to medical professionals and entities, ensure the industry's
945 solvency and ensure that such liability insurance is available and
946 affordable.

947 (d) (1) The commissioner shall establish an electronic database
948 composed of closed claim reports filed pursuant to this section.

949 (2) The commissioner shall compile the data included in individual
950 closed claim reports into an aggregated, summary format and shall
951 prepare a written annual report of the summary data. The report shall
952 provide an analysis of closed claim information including a minimum
953 of five years of comparative data, when available, trends in frequency
954 and severity of claims, itemization of damages, timeliness of the claims
955 process, and any other descriptive or analytical information that would
956 assist in interpreting the trends in closed claims.

957 (3) The annual report shall include a summary of rate filings for
958 professional liability insurance for medical professionals and entities
959 which have been approved by the department for the prior calendar
960 year, including an analysis of the trend of direct losses, incurred losses,
961 earned premiums and investment income as compared to prior years.
962 The report shall include base premiums charged by medical
963 malpractice insurers for each specialty and the number of providers
964 insured by specialty for each insurer.

965 (4) Not later than March 15, 2006, and annually thereafter, the
966 commissioner shall submit the annual report to the joint standing
967 committee of the General Assembly having cognizance of matters
968 relating to insurance in accordance with section 11-4a. The
969 commissioner shall also (A) make the report available to the public, (B)
970 post the report on its Internet site, and (C) provide public access to the
971 contents of the electronic database after the commissioner establishes
972 that the names and other individually identifiable information about
973 the claimant and practitioner have been removed.

974 (e) The Insurance Commissioner shall provide the Commissioner of
975 Public Health with electronic access to all information received
976 pursuant to this section.

977 Sec. 24. (NEW) (*Effective from passage*) (a) As used in this section and
978 sections 25 to 27, inclusive, of this act: (1) "Licensed health care

979 provider" or "provider" means a physician or surgeon; director, officer
980 or trustee of a hospital or nursing home; nurse; oral surgeon; dentist;
981 pharmacist; chiropractor; optometrist; podiatrist; hospital or nursing
982 home; (2) "fund" means the Healthy Connecticut Fund established in
983 subsection (b) of this section; and (3) "commissioner" means the
984 Insurance Commissioner.

985 (b) There is established a Healthy Connecticut Fund for the purpose
986 of reimbursing any portion of a medical malpractice claim, settlement
987 or judgment which represents the deductible applicable to a provider's
988 coverage. The fund shall be liable only for (1) payment of such
989 deductibles pursuant to claims, settlements or judgments against
990 licensed health care providers who comply with the provisions of this
991 section where the claim, settlement or judgment arises from an event
992 that occurs on or after the effective date of the first plan of operation
993 established pursuant to this section, and (2) reasonable and necessary
994 expenses incurred in payment of such deductibles and the fund's
995 administrative expenses. The fund may contain any moneys required
996 by law to be deposited in the fund and shall be held by the State
997 Treasurer separate and apart from all other moneys, funds and
998 accounts. The interest derived from the investment of the fund shall be
999 credited to the fund. Amounts in the fund may be expended only
1000 pursuant to the direction of the Insurance Commissioner in accordance
1001 with this section. Any balance remaining in the fund at the end of any
1002 fiscal year shall be carried forward in the fund for the fiscal year next
1003 succeeding.

1004 (c) Any Connecticut-licensed health care provider may participate
1005 in the fund.

1006 (d) Any deficit in the fund shall be paid by assessment pursuant to
1007 section 25 of this act. The state shall not be responsible for any costs,
1008 expenses, liabilities, judgments or other obligations of the fund.

1009 (e) All books, records and audits of the fund shall be public records,
1010 as defined in section 1-200 of the general statutes.

1011 (f) On or before December thirty-first of each year the Auditors of
1012 Public Accounts shall audit the records of the fund and shall furnish an
1013 audited financial report to the commissioner, State Treasurer and the
1014 General Assembly.

1015 (g) The Insurance Commissioner shall adopt regulations, in
1016 accordance with chapter 54 of the general statutes, to establish a plan
1017 of operation for the fund.

1018 Sec. 25. (NEW) (*Effective from passage*) (a) Not later than January 1,
1019 2005, and annually thereafter, the Insurance Commissioner shall
1020 determine the amount necessary to maintain solvency of the Healthy
1021 Connecticut Fund established in section 24 of this act.

1022 (b) Four per cent of each medical malpractice award or settlement
1023 under five hundred thousand dollars shall be paid into the fund. Six
1024 per cent of each medical malpractice award or settlement from five
1025 hundred thousand dollars to one million dollars shall be paid into the
1026 fund. Ten per cent of each medical malpractice award or settlement
1027 over one million dollars shall be paid into the fund. Not later than
1028 January 1, 2005, the commissioner shall establish procedures for
1029 collecting such amounts from medical malpractice insurers.

1030 (c) If the assessments set forth in subsection (b) of this section are
1031 not sufficient to meet the solvency amount determined by the
1032 commissioner pursuant to subsection (a) of this section, the
1033 commissioner may assess each licensed health care provider an annual
1034 amount to be determined by the commissioner, provided that the
1035 commissioner shall have the power to exempt from such assessment
1036 certain provider specialty groups with high medical malpractice
1037 premiums. Not later than January 1, 2005, and annually thereafter, the
1038 commissioner shall determine the assessment amount for the next
1039 fiscal year and determine which specialty groups will be exempt from
1040 the assessment. Not later than January 1, 2005, and annually thereafter,
1041 the commissioner shall submit a statement to each provider subject to
1042 assessment that includes the proposed assessment amount.

1043 (d) Any person aggrieved by an assessment levied under this
1044 section may appeal therefrom in the same manner as provided for
1045 appeals under section 38a-52 of the general statutes.

1046 Sec. 26. (NEW) (*Effective from passage*) (a) The Insurance
1047 Commissioner may approve professional liability insurance policies
1048 for providers who participate in the Healthy Connecticut Fund
1049 established pursuant to section 24 of this act that contain a deductible
1050 that does not exceed (1) fifty thousand dollars with respect to a
1051 medical professional, and (2) one hundred thousand dollars with
1052 respect to a medical entity, including, but not limited to, a hospital.
1053 Such policies shall be subject to title 38a of the general statutes.

1054 (b) In connection with any claim for award or settlement against a
1055 professional liability insurance policy that is approved by the
1056 commissioner in accordance with subsection (a) of this section, any
1057 professional liability insurer may make an application to the
1058 commissioner for a disbursement from the Healthy Connecticut Fund
1059 to such professional liability insurer in an amount equal to the
1060 deductible described in subsection (a) of this section. Such application
1061 shall be made in accordance with an application prepared by the
1062 commissioner. In no event shall a disbursement from the Healthy
1063 Connecticut Fund exceed (1) fifty thousand dollars with respect to a
1064 medical professional, and (2) one hundred thousand dollars with
1065 respect to a medical entity, including, but not limited to, a hospital,
1066 and in no event shall a disbursement exceed the total amount of such
1067 award or settlement. If the commissioner deems an application
1068 complete and sufficient funds exist in the Health Connecticut Fund to
1069 pay such deductible, the commissioner shall promptly make such
1070 disbursement to the applicant professional liability insurer.

1071 Sec. 27. (NEW) (*Effective July 1, 2004*) (a) For the purposes described
1072 in subsection (b) of this section, the State Bond Commission shall have
1073 the power, from time to time, to authorize the issuance of bonds of the
1074 state in one or more series and in principal amounts not exceeding in
1075 the aggregate ten million dollars.

1076 (b) The proceeds of the sale of said bonds, to the extent of the
 1077 amount stated in subsection (a) of this section, shall be deposited in the
 1078 Healthy Connecticut Fund established pursuant to section 24 of this act
 1079 and used by the Insurance Department for disbursements pursuant to
 1080 section 26 of this act.

1081 (c) All provisions of section 3-20 of the general statutes, or the
 1082 exercise of any right or power granted thereby, which are not
 1083 inconsistent with the provisions of this section are hereby adopted and
 1084 shall apply to all bonds authorized by the State Bond Commission
 1085 pursuant to this section, and temporary notes in anticipation of the
 1086 money to be derived from the sale of any such bonds so authorized
 1087 may be issued in accordance with said section 3-20 and from time to
 1088 time renewed. Such bonds shall mature at such time or times not
 1089 exceeding twenty years from their respective dates as may be provided
 1090 in or pursuant to the resolution or resolutions of the State Bond
 1091 Commission authorizing such bonds. None of said bonds shall be
 1092 authorized except upon a finding by the State Bond Commission that
 1093 there has been filed with it a request for such authorization which is
 1094 signed by or on behalf of the Secretary of the Office of Policy and
 1095 Management and states such terms and conditions as said commission,
 1096 in its discretion, may require. Said bonds issued pursuant to this
 1097 section shall be general obligations of the state and the full faith and
 1098 credit of the state of Connecticut are pledged for the payment of the
 1099 principal of and interest on said bonds as the same become due, and
 1100 accordingly and as part of the contract of the state with the holders of
 1101 said bonds, appropriation of all amounts necessary for punctual
 1102 payment of such principal and interest is hereby made, and the State
 1103 Treasurer shall pay such principal and interest as the same become
 1104 due.

| | |
|--|---------------------|
| This act shall take effect as follows: | |
| Section 1 | <i>from passage</i> |
| Sec. 2 | <i>from passage</i> |
| Sec. 3 | <i>from passage</i> |
| Sec. 4 | <i>from passage</i> |

| | |
|---------|---|
| Sec. 5 | <i>from passage</i> |
| Sec. 6 | <i>from passage and applicable to actions filed on or after said date</i> |
| Sec. 7 | <i>from passage</i> |
| Sec. 8 | <i>from passage</i> |
| Sec. 9 | <i>from passage</i> |
| Sec. 10 | <i>from passage</i> |
| Sec. 11 | <i>from passage</i> |
| Sec. 12 | <i>from passage</i> |
| Sec. 13 | <i>from passage</i> |
| Sec. 14 | <i>from passage</i> |
| Sec. 15 | <i>from passage</i> |
| Sec. 16 | <i>July 1, 2004</i> |
| Sec. 17 | <i>July 1, 2004</i> |
| Sec. 18 | <i>from passage</i> |
| Sec. 19 | <i>October 1, 2004</i> |
| Sec. 20 | <i>October 1, 2004</i> |
| Sec. 21 | <i>from passage</i> |
| Sec. 22 | <i>from passage</i> |
| Sec. 23 | <i>January 1, 2005</i> |
| Sec. 24 | <i>from passage</i> |
| Sec. 25 | <i>from passage</i> |
| Sec. 26 | <i>from passage</i> |
| Sec. 27 | <i>July 1, 2004</i> |

PH *Joint Favorable Subst.*

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 04\$ | FY 05\$ | FY 06\$ |
|---|--|-------------------|-------------------|-------------------|
| Public Health, Dept. | GF - Cost | 50,500 | 776,880 | 687,880 |
| Comptroller Misc. Accounts (Fringe Benefits) | GF - Cost | 10,100 | 131,000 | 296,920 |
| Insurance Dept.; Public Health, Dept. | Various - Revenue Gain | Potential Minimal | Potential Minimal | Potential Minimal |
| UConn Health Ctr. | Various - Savings | Potential | Potential | Potential |
| Connecticut Health and Educational Facilities Authority | CHEFA General Fund Balance - See Below | See Below | See Below | See Below |
| Insurance Dept. | IF - Cost | 9,100 | 55,000 | 55,000 |
| Judicial Dept. | GF - Cost | Less than 50,000 | Less than 300,000 | Less than 300,000 |
| Judicial Dept. | GF - Potential Savings | 0 | 175,000 | 175,000 |
| Insurance Dept. | Healthy CT Fund - See Below | See Below | See Below | See Below |

Note: GF=General Fund; IF=Insurance Fund

Municipal Impact: None

Explanation

Sections 1 - 5 make use of the Insurance Department's pre-trial Medical Malpractice Screening Panel (MMSP) mandatory unless both parties agree to go directly to court. The Commissioner of Insurance would choose from the MMSP one attorney and two health care providers to serve on a hearing panel for each claim. In addition, the Chief Court Administrator must assign a judge trial referee to be a member and serve as chairperson of the hearing panel. Members of the MMSP are not compensated. However, judge trial referees are

paid \$200 per day.

Up to 375 claims could be heard annually by these panels.¹ It is estimated that each of these additional cases could take up to four working days to dispose. The Judicial Department's annual cost to provide judge trial referees could therefore be as high as \$300,000. Since the bill is effective upon passage, the FY 04 cost is estimated to be \$50,000 (assuming May 1st enactment.) It is anticipated that hearing panel members will require transcripts of proceedings in order to make their findings of liability or dismiss claims. The associated, annual cost to the Department of Insurance is estimated to be \$55,000. The FY 04 pro rated cost is \$9,167. There is also a minimal cost to the Department related to sending notice by registered or certified mail to health care providers named as defendants.

The institution of pre-trial hearing panels could substantially reduce the number of medical malpractice cases brought before the court. Limited data from the state of Maine (which has a similar program) indicate that eighty per cent of panels yield a unanimous finding, which typically precludes a jury trial. If Connecticut were to experience a similar result, an estimated annual savings of \$175,000 could be achieved.

Section 6 requires a plaintiff or plaintiff's attorney to file a written and signed opinion by a similar health care provider in order to initiate a medical malpractice action. This additional requirement could reduce the number of medical malpractice cases brought before the Superior Court, and thereby decrease the workload of the Civil Division. Any such change would be small relative to the overall caseload since medical malpractice cases comprise less than one per cent of total civil cases added each year.² Consequently, there is no fiscal impact.

Implementation of **Sections 7-9 and 13** will result in a significant cost

¹ An average of 375 medical malpractice cases have been filed with the Superior Court in each of the last five (complete) fiscal years.

² In FY 03, there were 52,308 civil cases added: 383 of which were medical malpractice.

to the Department of Public Health (DPH). The predominant reason for this is a requirement that the agency review and investigate when warranted all medical malpractice claims filed against a licensed physician, chiropractor, dentist or psychologist. Under current law, the agency reviews about 500 complaints and malpractice payment notices annually. Of these, about fifty percent (or 250) progress to an investigation. Under the bill, an additional 380 - 400 filed claims would require agency review each year, prompting an additional 190 - 200 investigations. The agency's Practitioner Investigations Unit currently has nine investigators.

The department's workload would also be increased to the extent that: (a) filed claims involve cases in which multiple medical practitioners are named, (b) the scope of reviews/investigations is broadened following adoption of regulations, and (c) medical review panels convened by the Connecticut Medical Examining Board (CMEB) ask for reconsideration of findings of no probable cause. (The agency dismisses about 240 cases each year concerning physicians following an investigation.)

Additional work would be associated with: (a) developing regulations, (b) notifying parties who have filed a petition questioning a physician's ability to practice, or the person's legal representative, when the department makes a finding of no probable cause, and (c) developing systems for public access to information received about medical malpractice claims, awards and settlements and reporting on the same to the Public Health and Insurance Committees by July 1, 2004.

The DPH will incur FY 05 costs of \$613,340 to comply with **Sections 7-9 and 13**. This reflects the full-year salaries of: one Physician (at \$142,000 annually), one Supervising Nurse Consultant (at \$77,400 annually), two Health Program Associates (at \$55,280 annually), two Nurse Consultants (at \$66,640 annually), one Administrative Hearings Officer (at an annual salary of \$70,000), one Office Assistant (at an annual salary of \$34,870), and one half-time Systems Developer (at

\$31,230 annually). Also included are one-time equipment costs of \$8,000 and other expenses of \$5,000. In FY 06 this cost will decrease to \$604,340 as equipment costs will not recur. DPH costs will be supplemented by fringe benefit³ costs of \$121,250 in FY 05 and \$274,620 in FY 06. A potential minimal revenue gain would be expected should the enhanced investigation process lead to the collection of additional financial penalties from health care professionals. Since the bill is effective from passage, FY 04 costs of approximately \$50,500 (DPH) and \$10,100 (fringe benefits) would ensue given June 1, 2004 implementation. No funding has been included within sHB 5033 (the Revised FY 05 Appropriations Act, as favorably reported by the Appropriations Committee) for these purposes.

Section 10 requires the DPH to include additional information related to medical malpractice investigations in its annual report to the General Assembly. The department will incur FY 05 costs of \$92,940 to support the salary of one half-time Office Assistant (at an annual salary of \$17,440) needed to enter data not presently collected and/or entered into the agency's database, one-time associated equipment costs of \$3,000, and costs of one-time data processing services (approximately \$72,500) needed to revise the agency's computer database and develop reporting tools. In FY 06 this cost will fall to \$17,440, as the consultant services will no longer be required. DPH costs will be supplemented by fringe benefit costs of \$3,530 in FY 05 and \$7,990 in FY 06.

Section 11 requires each hospital or outpatient surgical facility to establish protocols for screening patients prior to any surgery, and submit copies of the same annually to the DPH with a report on their

³ The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The total fringe benefit reimbursement rate as a percentage of payroll is 45.82%, effective July 1, 2003. However, first year fringe benefit costs for new positions do not include pension costs - lowering the rate to 20.23% in FY 05. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System.

implementation. The development and implementation of these protocols will lead to additional costs for the John Dempsey Hospital at the University of Connecticut Health Center. However, given the required assistance of DPH in the development of these protocols as well as potential coordination with other hospitals in the state, these additional costs are expected to be minimal. To the extent that the measures in this bill lower medical malpractice and malpractice insurance costs, the John Dempsey Hospital may realize future savings. The extent of these savings cannot be determined at this time.

Section 12 changes the rate of interest applied to offers of judgment made by plaintiffs after the effective date of the bill. Specifically, it pegs the interest rate applicable to offers of judgment at four percentage points above the weekly average five-year constant maturity yield of United States Treasury Securities. This would effectively reduce the rate of interest on offers of judgment from 12 per cent under current law to 7 per cent, although that difference would diminish as US Treasury Securities yields and interest rates rise.

Section 14 requires each physician, podiatrist, chiropractor and naturopathic physician to report the name of the insurance company providing his or her professional liability insurance, the policy number, his or her area of specialization and whether he or she is actively involved in patient care. It also allows DPH to compare this information to that contained in the National Practitioner Data Base.

Section 15 requires the DPH to report, by January 1, 2005, and annually thereafter, on the number of physicians by specialty who are actively providing patient care.

The DPH will incur FY 05 costs of \$70,600 to support the salaries of one Office Assistant (at an annual salary of \$34,870), and one half-time Systems Developer (at an annual salary of \$31,230) needed to revise the agency's existing licensure database, enter information, follow-up with physicians who fail to supply the required data, and compile the

annual report. Also included in this sum are one-time costs for equipment (\$3,000) and reprinting the physician renewal card (\$1,500). In FY 06 this cost will fall to \$66,100 as one-time equipment and printing costs will not recur. DPH costs will be supplemented by fringe benefit costs of \$6,320 in FY 05 and \$14,310 in FY 06. It is anticipated that DPH will conduct few National Practitioner Data Bank checks, since each query costs \$4.25 and no funding has been appropriated to the department for this purpose within sHB 5033.

Section 16 requires medical malpractice insurance companies to offer a premium discount on the policy to any insured that qualifies. This does not result in a fiscal impact.

Section 17 requires the quasi-public, Connecticut Health and Educational Facilities Authority (CHEFA) to establish a program to finance low interest loans to hospitals to install or upgrade electronic health record systems for the establishment and maintenance of patient records and verification of patient treatment. It is anticipated that CHEFA will have sufficient reserves to finance the loan program.

Section 18 requires medical malpractice insurance companies to file a request for rate approval with the Insurance Commissioner 60 days prior to the effective date. This has no fiscal impact on the Department of Insurance.

Sections 19 & 20 require that captive insurers submit an application and a nonrefundable fee of \$175 to the Insurance Commissioner in order to obtain a certificate of authority. Furthermore, the captive insurer must pay all expenses incurred as a result of filing the application. Currently, it is unknown how many captive insurers are in the state, as it is not a regulated industry. The bill also authorizes the commissioner, upon determination, to impose a civil penalty, with a maximum fine of \$10,000. This will result in minimal revenue gain.

Section 21 permits any party to a medical malpractice civil action to request that the Chief Court Administrator designate the case as a complex litigation case. This conforms statute to current practice and,

thus, there is no fiscal impact.⁴

Section 22 requires the court to grant any waiver of attorneys' contingency fees in medical malpractice cases. There is no related fiscal impact.

Section 23 requires the Insurance Commissioner to create and maintain an information database. The department already collects much of the information that the bill requires. This does not result in a fiscal impact.

Sections 24-26 establish the Healthy Connecticut Fund and require it to reimburse any portion of a medical malpractice claim, settlement, or judgment, which represents the deductible applicable to a provider's coverage. The bill sets the maximum amount of reimbursement at \$50,000 for a medical professional and \$100,000 for a medical entity (such as a hospital). The cost of these reimbursements is estimated at \$29.3 million annually but would likely be higher⁵. In addition, the bill requires that any expenses associated with operating the fund by the Department of Insurance be borne by the Healthy Connecticut Fund. The expenses for fund management, claims review and disbursement is estimated at \$500,000 including fringe benefits for three staff.

In order to pay for these costs, the bill requires to be paid into the fund an assessment on each medical malpractice award or settlement of 4% for those under \$500,000, 6% for those from \$500,000 to \$1,000,000 and 10% for those over \$1,000,000. The revenue from these assessments is estimated to range from at least \$9.0 million up to \$15.0 million. The bill also allows, in the event that the settlement and

⁴ In calendar year 2003, nine per cent of the 423 cases added to the complex litigation docket were medical malpractice cases: thirteen per cent of the 359 cases disposed of were medical malpractice cases.

⁵ This figure is based on an analysis of hospital and doctor claims, settlements and awards. These make up the vast majority of all medical malpractice claims, settlements and awards but a portion of certain allied health profession claims, settlements and awards are not included in this estimate.

award assessments are not sufficient to maintain solvency of the fund, assessments on licensed health care providers but leaves the amounts for each provider to be determined by the Insurance Commissioner. There are over 90,000 individuals or entities that currently fall under the bill's definition (in section 24) of "licensed health care provider" or "provider."

Section 27 authorizes \$10 million in General Obligation (GO) bonds to the Insurance Department for the purposes of the Healthy Connecticut Fund. The interest cost to bond this amount for twenty years, assuming a 5.0% interest rate, is \$5.25 million.

OLR BILL ANALYSIS

sSB 356

AN ACT CONCERNING MEDICAL MALPRACTICE AND HEALTH CARE QUALITY**SUMMARY:**

This bill makes numerous changes to the laws dealing with civil litigation; insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors.

It also establishes a Healthy Connecticut Fund to help with malpractice costs.

Civil Litigation Reform (Sections 1-6, 12, 21 and 22)

The bill:

1. authorizes professional societies or associations that represent health care providers, instead of only the Connecticut State Medical Society, to recommend names for the Medical Malpractice Screening Panel;
2. mandates the use of the Medical Malpractice Screening Panel;
3. increases membership on the panel, from three to four, by adding a judge trial referee to serve as chairperson and requires a majority, instead of a unanimous, vote of the panel as to liability for the finding to be admissible into evidence at any subsequent trial;
4. gives immunity to anyone who provides testimony or information to a hearing panel, unless he acted with malice;
5. requires, as a condition of filing a medical malpractice lawsuit, that a signed opinion of a similar health care practitioner be prepared to show the existence of a good faith belief that there has been negligence and a copy be attached to the lawsuit complaint;
6. reduces the amount of interest that a defendant must pay under the

offer of judgment law from a flat rate of 12% to 4% above the interest rate on a two-year Treasury bill and authorizes the defendants to get an extension of up to 120 days to respond to the offer;

7. allows attorneys for plaintiffs or defendants to ask that their case be put on the complex litigation docket; and
8. allows the attorney fee schedule for contingency fees to be waived only upon an application to and approval by a judge. The burden is on the claimant's attorney to show that deviation from the schedule is warranted due to the nature of the case.

Insurance Regulation and Oversight (§§ 16,18, 19, 20, 23)

The bill:

1. requires insurance companies to offer discounts to health care providers with electronic health records;
2. requires prior rate approval by the Insurance Department for all medical malpractice insurance rates;
3. requires captive insurers to get a certificate of authority from the Insurance Department and provide it with certain financial information and establishes a \$175 fee for the issuance or renewal of a certificate of authority; and
4. beginning June 1, 2005, requires entities that insure people or entities against medical malpractice lawsuits to provide the insurance commissioner with a closed claim report on each malpractice claim that the insurer closes. The report must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid. The bill requires the commissioner to compile and analyze the data and annually submit a report on this to the Insurance and Real Estate Committee and the public.

Regulation, Oversight, and Discipline of Medical Providers (§§ 7, 8, 9, 10, 11, 13, 14, 15, 17)

The bill:

1. requires anyone who pays a medical malpractice award or settlement to provide copies of the award or settlement and complaint and answer, if any, to the Insurance Department instead of just the Department of Public Health (DPH) and also requires anyone who files a malpractice complaint against a provider to mail a copy of it to DPH;
2. requires DPH to adopt guidelines to determine the basis for further investigation or disciplinary action;
3. requires DPH and the insurance commissioner to develop systems to collect, store, use, interpret, report, and provide public access to malpractice lawsuit related information;
4. makes release of liability invalid until the attorney representing the paying party files an affidavit with the court that he has provided DPH and the insurance commissioner with the required information;
5. requires DPH to adopt regulations establishing guidelines for screening complaints, prohibiting investigation, and determining when an investigation should be broadened;
6. changes appointments to, and the appointing authority of members of, the Connecticut Medical Examining Board;
7. requires the Medical Malpractice Examining Board, with DPH's assistance, to adopt guidelines for its disciplinary process and requires the DPH commissioner to conduct a hearing on charges against a doctor if a hearing panel the board appoints has not done so within 60 days after the board reports charges to it;
8. requires that any DPH finding of no probable cause after an investigation be reviewed by a hearing panel the board appoints and authorizes the panel to ask DPH to provide more information or reconsider its findings;
9. requires that DPH's annual report to the governor and Public Health Committee include additional information, such as the number of complaints filed against doctors, and the number of notices of malpractice lawsuits filed that were not investigated and the reasons why;

10. requires hospitals and outpatient surgical facilities to establish certain presurgery protocols;
11. requires DPH to notify those who file petitions with it against doctors when it makes a finding of no probable cause and indicate the reason for its finding;
12. requires doctors annually to provide certain information to DPH, including their malpractice insurer, policy number, area of specialization, and disciplinary actions and malpractice payments made in other jurisdictions;
13. requires DPH to report annually the number of doctors, by specialty, actively providing patient care; and
14. requires the Connecticut Health and Education Facilities Authority (CHEFA) to establish a loan program for hospitals to upgrade their health record system.

Healthy Connecticut Fund (§§ 24, 25, 26, 27)

The bill establishes a Healthy Connecticut Fund to reimburse any portion of a medical malpractice claim, settlement, or judgment that represents the deductible applicable to a provider's coverage. The fund is liable for paying such deductibles pursuant to claims, settlements, or judgments against licensed health care providers who comply with the bill only when they arise from an event that occurs on or after the effective date of the first plan or operation established by the bill. The fund is also liable for reasonable and necessary expenses incurred in payment of such deductibles and the fund's administrative expenses. The insurance commissioner must adopt regulations establishing a plan of operation for the fund.

The bill authorizes the insurance commissioner to approve, for providers who participate in the fund, professional liability insurance policies that contain a deductible of up to (1) \$50,000 for a medical professional and (2) \$100,000 for a medical entity, including, but not limited to, a hospital. These policies are subject to laws governing insurance policies issued in Connecticut.

The fund is supported by assessments on malpractice awards or

settlements in the state and on health care providers under certain conditions. The bill also authorizes the State Bond Commission to issue bonds, with proceeds from the sale used for purposes of the fund.

EFFECTIVE DATE: The bill takes effect upon passage, except the provisions on discounts to providers with electronic health records, and requiring CHEFA to establish a loan program for hospitals to upgrade their health record system take effect July 1, 2004; the bond authorization provision takes effect July 1, 2004; the provisions requiring captive insurers to receive a certificate of authority and provide certain information to the commissioner take effect October 1, 2004; and the provision on closed claims reporting takes effect January 1, 2005.

MEDICAL MALPRACTICE SCREENING PANEL—SELECTION OF MEMBERS (§ 1)

Under current law, members of the Medical Malpractice Screening Panel, which is within the Insurance Department, are selected from names supplied by the Connecticut State Medical Society (CSMS) and the Connecticut Bar Association. The bill requires that the professional societies or associations that represent health care providers in Connecticut also provide names for the panel.

It also makes technical and conforming changes.

MANDATORY PANEL SERVICE AND COMPOSITION (§ 2)

Under current law, the use of the malpractice screening panel is voluntary. Instead, the bill specifies that, no lawsuit may be filed until the proposed complaint is filed with the insurance commissioner and a hearing panel has made and recorded a finding of liability or dismissed the claim.

The bill requires the claimant to personally deliver or have delivered, or send, by registered or certified mail, return receipt requested, the proposed complaint to the commissioner. Within 10 days after receiving the complaint, she must send a copy of it by registered or certified mail, return receipt requested, to each health care provider named as a defendant at his last known place of residence or business. The filing of a complaint with the commissioner tolls the statute of limitations until 60 days after the date the claimant receives a copy of

the hearing panel's finding or decision dismissing the claim.

The bill requires the commissioner to select a panel within 30 days after the complaint is filed. Under current law, the panel consists of two physicians and one attorney. Under the bill, the panel consists of two health care providers, one attorney, and a judge trial referee. The bill defines a "health care provider" as (1) a person licensed by Connecticut to provide health care or professional services or (2) an officer, employee, or agent of a corporation, facility, or institution licensed by this state to do so, acting in the course and scope of his employment.

Current law requires that at least one physician be of the same specialty as the physician accused of malpractice. The bill instead requires that one health care provider be from the same profession or specialty as the health care provider against whom the claim is filed. It specifies that the attorney member, in addition to having experience in trying personal injury cases, must have experience representing both plaintiffs and defendants.

Under current law, the attorney acts as chairperson of the panel. Instead, the bill requires the insurance commissioner to notify the chief court administrator who must, within 30 days, select a judge trial referee to be a member and chairperson of the panel.

The bill authorizes the chairperson, whenever he deems it necessary due to the nature of the claim or the parties, to select additional hearing panel members from the Medical Malpractice Screening Panel.

SECTION 3

This section makes technical changes.

IMMUNITY FOR WITNESSES (§ 4)

The bill immunizes anyone who provides testimony or information to a hearing panel on any matter submitted to it, without a showing of malice, from damages resulting from such testimony or information.

HEARING PANEL FINDING-ADMISSIBILITY (§ 5)

Under current law, the hearing panel's findings as to liability must be unanimous for them to be admissible in evidence at any subsequent trial of the issue. The bill instead requires a majority vote for

admissibility.

GOOD FAITH CERTIFICATE (§ 6)

Current law prohibits filing malpractice lawsuits unless the attorney or claimant made a reasonable inquiry as the circumstances permit to determine that there are grounds for a good faith belief that there has been negligence in the claimant's care from treatment. The complaint or initial pleading must contain a certificate from the attorney or claimant that such reasonable inquiry resulted in a good faith belief that grounds exist for a lawsuit against each named defendant.

Under current law, a good faith belief may be shown if the claimant or his attorney receives written opinion from a similar health care provider that there appears to be evidence of medical negligence. The bill instead requires that there be a written opinion to show the existence of good faith. It requires that the opinion include a detailed basis for the formation of such opinion.

The bill requires the claimant or his attorney to retain the original written opinion and attach a copy of it to the complaint, with the similar health care provider's name and signature removed. Under existing law, unchanged by the bill, in addition to the written opinion, the court may consider other factors with regard to the existence of good faith.

Under existing law, unchanged by the bill, the court must impose upon the person who signed the certificate an appropriate sanction if it determines, after the completion of discovery, that the certificate was not made in good faith and that no valid issue was presented against a health care provider that fully cooperated in providing informal discovery. It may also impose the sanction on the claimant. The sanction may include an order to pay to the other party or parties the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney submitted the certificate.

NOTICE OF LAWSUITS TO DPH (§ 7)

The bill requires anyone filing a medical malpractice case against certain health care providers to mail a copy of the complaint to the DPH. The requirement applies to lawsuits filed against licensed

physicians, chiropractors, naturopaths, dentists, and psychologists.

Existing law requires that anyone who pays damages in any medical malpractice case notify DPH of the terms of the award or settlement and provide a copy of the award or settlement and the underlying complaint and answer, if any. It requires that the information specify the portion of the award or settlement attributable to economic damages and the portion attributable to noneconomic damages. It also requires that if there are multiple defendants, the information include the allocation for payment of the award between or among such defendants.

The bill (1) requires that the person who pays damages also provide this information to the Insurance Department, (2) specifies that the copies provided to the department may not identify the parties to the claim, and (3) requires that DPH send this information to the state board of examiners that oversees the health care provider who was a defendant in the lawsuit.

Under current law, DPH must review all medical malpractice awards and all settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. The bill requires that DPH review all malpractice claims as well. It requires that, beginning July 1, 2004, DPH conduct its reviews in accordance with guidelines DPH adopts to determine the basis for such further investigation or disciplinary action.

The bill requires the DPH and insurance commissioners to develop systems within their respective agencies for collecting, storing, using, interpreting, reporting, and providing public access to the information they receive. It requires each commissioner to report the details of such systems within its agency to the Public Health and Insurance and Real Estate committees by July 1, 2004.

Release of Liability

Under current law and practice, people receiving a settlement in a malpractice claim sign a liability release to the person or entity paying the settlement. The bill makes such releases invalid until the attorney for the entity making payment on behalf of a party or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that he has provided the information the bill and law require to DPH

and the Insurance Department.

DPH INVESTIGATION OF COMPLAINTS AGAINST PHYSICIANS (§ 8)

By law, the DPH commissioner, with the Connecticut Medical Examining Board's advice and assistance, may establish regulations to carry out its oversight and regulatory duties. The bill requires the commissioner, by July 1, 2004, to adopt regulations that establish (1) guidelines for screening complaints that physicians may be unable to practice medicine with reasonable skill and safety to determine which complaints will be investigated; (2) a prioritization system for conducting investigations to ensure prompt action when it appears necessary; and (3) guidelines to determine when an investigation should be broadened beyond the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations, and additional interviews of patients and peers.

DISCIPLINARY PROCEEDINGS AGAINST DOCTORS; CONNECTICUT MEDICAL EXAMINING BOARD (§ 9)

The 15-member Connecticut Medical Examining Board has nine physician members all appointed by the governor. The board is empowered to restrict, suspend, or revoke the license of a physician or limit his right to practice for certain misconduct.

State law requires that the nine physicians be as follows: (1) five practicing in the state, (2) one a full-time faculty member of UConn Medical School, (3) one a full-time chief of staff of a state general care hospital, (4) one who supervises physician assistants, and (5) one osteopathic physician. The other board members are a physician assistant and five public members. Professional members of the board must be practitioners in good professional standing and state residents.

The bill changes the membership and method of appointment of board members. Under the bill, the governor appoints three physicians practicing in the state and three public members. Other members and appointing authorities are as follows:

1. a UConn faculty member physician, appointed by the House

Speaker;

2. a full-time hospital chief of staff, appointed by the Senate president;
3. a physician who supervises physician assistants, appointed by the House majority leader;
4. an osteopathic physician, appointed by the Senate majority leader;
5. a physician assistant, appointed by the House minority leader;
6. a practicing state physician, appointed by the Senate minority leader;
7. a practicing state physician, appointed by a patient advocacy group selected by the Public Health Committee chairpersons; and
8. two public members, one an attorney with criminal law expertise, appointed by the approved patient advocacy group.

The governor currently fills any vacancies. Under the bill, the vacancies are filled by the appointing authority. It allows the Public Health Committee chairpersons to designate different patient advocacy groups for subsequent appointments.

The bill requires the medical examining board to inform the chief state's attorney if it appears that a person currently or previously under investigation violated any criminal laws.

The bill requires that by December 31, 2004, the board, with DPH's assistance, adopt regulations that establish guidelines for use in the disciplinary process. The guidelines must include, but need not be limited to (1) identification of each type of violation; (2) minimum and maximum penalties for each type of violation; (3) additional optional conditions that the board may impose for each violation; (4) identification of factors the board must consider in determining if the maximum or minimum penalty should apply; (5) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (6) a provision that when a deviation from the guidelines occurs, the reason for the deviation must be identified.

By law, the board must refer all statements of charges DPH files with it to a medical hearing panel within 60 days of receiving them. Also by law, the panel must conduct a hearing on contested cases. The panel must file a proposed final decision with the board within 120 days of the receipt of the issuance of the notice of hearing by the board. The board may, for good cause, vote to extend both of these deadlines.

The bill requires that the panel consist of three members, at least one who is a board member and one a member of the public. The public member can be either a member of the board or selected from a list of individuals DPH must keep under current law who can serve on medical hearing panels.

The bill requires the DPH commissioner to conduct the hearing if the panel has not done so within 60 days of the date of referral of the statement of charges by the board. The hearing must be conducted in accordance with the regulations the commissioner adopts concerning contested cases. The bill requires the commissioner to file a proposed final decision with the board within 60 days after the hearing. The board may extend the filing deadlines in a recorded vote.

The bill requires the board to refer all findings of no probable cause that DPH files with it to a medical hearing panel within 60 days of receiving the charges. The board may extend this deadline for good cause by a duly recorded vote. The panel must review the petition and the entire record of the investigation and may ask DPH to provide more information or reconsider its finding. If the panel takes no action within 90 days after DPH submits the finding to the board it is considered final.

DPH GUIDELINES FOR REVIEW OF MALPRACTICE AWARDS AND SETTLEMENTS (§ 10)

By law, DPH must review all medical malpractice awards and settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. It must also file with the governor and the Public Health Committee an annual report of its disciplinary activities, which must include certain information. The bill requires that the report specify the number of petitions and notification of lawsuits not investigated and the reasons why, the outcome of the hearings held on such petitions and notifications, and the timeliness of action taken on petitions and notifications considered

to be a priority.

PRE-SURGICAL PROTOCOLS (§ 11)

The bill requires each licensed hospital or outpatient surgical facility to establish protocols for screening patients before surgery. These protocols must require that before surgery, members of the surgical team, including at least one principal surgeon, but not exceeding five such members in total, together (1) identify the patient and, where the patient is able to do so, have the patient identify himself and (2) identify the procedure to be performed. They must also require that all team members confirm the identification process before any patient is anesthetized or any surgery is performed. But, the bill allows the protocols to provide for alternative identification procedures where the patient is unconscious or under emergency circumstances. It requires each licensed hospital or outpatient surgical facility annually to submit to DPH a copy of the protocols and a report on their implementation.

The bill directs DPH to assist each hospital or outpatient surgical facility to develop and implement these screening protocols.

OFFER OF JUDGMENT (§ 12)

Under current law, the plaintiff in a contract case or a case seeking money damages, may up to 30 days before trial, file with the court clerk a written “offer of judgment” offering to settle the claim for a specific amount. After trial, the court must examine the record to determine whether the plaintiff made an offer of judgment, which the defendant failed to accept. If it determines that the plaintiff recovered an amount equal to or greater than the sum stated in the plaintiff’s offer of judgment, the court must add 12% annual interest.

By law, a defendant has 60 days to file with the clerk an acceptance of the offer. The bill allows the court to grant the defendant one or more extensions of up to 120 additional days to file an acceptance.

The bill changes the interest rate the court may award with respect to an offer of judgment filed on or after the bill’s effective date. Specifically, it authorizes the court to add interest at an annual rate of 4% above the weekly average five-year constant maturity yield of U. S. Treasury securities, as published by the Board of Governors of the

Federal Reserve System, for the calendar week preceding the beginning of each year for which interest is owed, for an offer of judgment filed on or after the effective date of this section.

DPH INVESTIGATION OF PETITIONS (§ 13)

The law requires DPH to investigate each petition filed with it to determine if probable cause exists to issue a statement of charges and institute proceedings against the physician.

Under current law, the investigation must be concluded within 18 months from the date the petition was filed. The investigation is confidential and no one may disclose his knowledge of it to a third party unless the physician asks that the investigation be opened. If DPH determines that probable cause exists to issue a statement of charges, the entire record is public unless it determines the physician is an appropriate candidate for participation in a rehabilitation program and the physician agrees to participate in accordance with terms agreed upon by DPH and the physician. If after the filing of a petition and during the 18-month period, DPH makes a finding of no probable cause, the petition and the entire record of the investigation must remain confidential unless the physician asks that such petition and record be open. The bill specifies that the investigation remain confidential only if the medical panel the board appointed allows the finding of no probable cause to stand.

The bill requires DPH to notify the person who filed a petition or his legal representative when it makes a finding of no probable cause. It must include the reason for such finding.

DPH DATA REGARDING PRACTITIONERS (§ 14)

By law, each person holding a license to practice medicine, surgery, podiatry, chiropractic or naturopathy must register annually with DPH and provide his name, residence, and business address, and other information DPH requests. The bill also requires the licensee to provide the name of the insurance company providing his malpractice insurance and the policy number, his area of specialization, whether he is actively involved in patient care, and any disciplinary action against him or malpractice payments made on his behalf in any other state or jurisdiction. The bill authorizes DPH to compare the information submitted to information contained in the National Practitioner Data

Base.

NUMBER OF PHYSICIANS (§ 15)

The bill requires DPH by January 1, 2005, and annually thereafter, to report to the Senate and House clerks, the state librarian, and the Office of Legislative Research the number of physicians, by specialty, who are actively providing patient care in Connecticut.

REQUIRED DISCOUNTS—ELECTRONIC HEALTH RECORDS (§ 16)

The bill requires medical malpractice insurance companies to offer a premium discount on a policy to any insured that submits to the insurer proof that it will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment. The discount must be at least 20% of the premium for a period of one year from the effective date of the policy or renewal.

LOANS FOR ELECTRONIC HEALTH RECORD SYSTEMS (§ 17)

The bill requires the Connecticut Health and Educational Facilities Authority to establish the Connecticut Electronic Health Records Program, within available appropriations, to finance low interest loans to hospitals to install or upgrade electronic health record systems for establishing and maintaining patient records and verifying patient treatment in order to promote patient safety and eliminate errors.

PRIOR RATE APPROVAL (§ 18)

The bill subjects malpractice insurance rates for physicians and surgeons, hospitals, or advanced practice registered nurses to prior rate approval by the insurance commissioner. On and after the bill's effective date, each insurer or rating organization seeking to change its rates for such insurance must (1) file a request for such change with the Insurance Department and (2) provide written notice to its insureds of request for a rate increase.

They must file the request and send the notice at least 60 days before the change's effective date. The notice must indicate that a public hearing will be held. The Insurance Department must review the request and, hold a public hearing on the rate increase before approving or denying it. The bill gives the commissioner 45 days to

approve or deny the request. Her findings may be appealed to Superior Court.

CAPTIVE INSURERS (§§ 19 AND 20)

Beginning October 1, 2004, the bill prohibits captive insurers from insuring a health care provider or entity in Connecticut against liability for medical malpractice unless it has obtained a certificate of authority from the insurance commissioner. It does not require a certificate of authority for captive insurers duly licensed in Connecticut to offer such insurance. The bill establishes a \$175 fee for each certificate issued.

A “captive insurer” is an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, it is an insurance organization owned by the insureds whose exclusive purpose is to insure risks of member organizations and group members and their affiliates.

Application to Insurance Commissioner

The bill requires any captive insurer seeking to obtain a certificate of authority to apply to the commissioner, on such form as she requires, specifying the line or lines of business that it is seeking authorization to write. The captive insurer must file with the commissioner (1) a certified copy of its charter or articles of association, (2) evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, (3) a statement of its financial condition together with whatever evidence of its correctness the commissioner requires, and (4) evidence of good management in such form as the commissioner requires.

The bill requires the captive insurer to submit evidence of its ability to provide continuous and timely claims settlement. It authorizes the commissioner to issue to such insurer a certificate of authority permitting it to do business in Connecticut if she finds that information furnished is satisfactory and the insurer complied with all other requirements of law. The certificate expires on the first day of May succeeding the date of its issuance, but may be renewed without any formalities except as the commissioner requires.

The bill requires the commissioner to adopt regulations specifying the information and evidence that a captive insurer seeking to obtain or renew a certificate of authority must submit and the requirements with which it must comply.

Cause for Revocation

Under the bill, the failure of a captive insurer to exercise its authority to write a particular line or lines of business in Connecticut for two consecutive calendar years may constitute sufficient cause for revoking its authority to write those lines of business.

The bill authorizes the commissioner, for cause, after notice and a hearing, to suspend, revoke, or reissue a certificate of authority. She may also impose a fine of up to \$10,000. The bill authorizes her or her designee to hold the hearings. It mandates that whenever any one other than the commissioner acts as the hearing officer, the person must submit to the commissioner a memorandum of findings and recommendations upon which she may base a decision. The commissioner may, if she deems it in the public interest, publish in one or more state newspapers a statement that she has suspended or revoked the certificate of authority of any captive insurer to do business in Connecticut.

The bill requires the applicant to pay all expenses the commissioner incurs in connection with a captive insurer.

Any captive insurer aggrieved by the commissioner's action in revoking, suspending, or refusing to reissue a certificate of authority, or in imposing a fine may appeal to Superior Court. The appeal must be filed in the New Britain Judicial District.

COMPLEX LITIGATION DOCKET (§ 21)

The bill authorizes any party to a medical malpractice lawsuit to file an application with the Superior Court asking that the case be designated as a complex litigation case and that the chief court administrator or any judge he designates transfer it to the complex litigation docket in a judicial district and court location determined by the chief court administrator or such designee.

CONTINGENCY FEE (§ 22)

Current law establishes a sliding scale on contingency fees attorneys may charge clients. It establishes an upper limit on contingency fees attorneys may collect from their clients based on the amount of the settlement or judgment. It allows (1) 33 1/3% of the first \$300,000, (2) 25% of the next \$300,000, (3) 20% of the next \$300,000, (4) 15% of the next \$300,000 and (5) 10% of amounts exceeding \$1,250,000. This sliding scale applies to any lawsuit to recover damages resulting from personal injury, wrongful death, or property damage involving contingency fees, not just to medical malpractice cases. A Superior Court judge interpreted this law to allow clients to waive its protections and agree to pay a higher contingency fee (see BACKGROUND).

The bill makes fee waivers invalid in a medical malpractice case, unless the claimant's attorney files an application with the court for approval of such arrangement and the court, after a hearing, grants such application. The bill requires the claimant's attorney to attach to the application a copy of the fee arrangement and the proposed unsigned writ, summons, and complaint in the case. The court must grant the application if it finds that the case is sufficiently complex, unique, or different from other medical malpractice cases to warrant a deviation from the percentage limitations. At the hearing, the claimant's attorney has the burden of showing that the deviation is warranted.

If the court does not grant the application, it must advise the claimant of his right to seek representation by another attorney willing to abide by the law's percentage limitations. The filing of such application tolls the applicable statute of limitations for a period of 90 days.

Method by Which Fee is Calculated

For all contingency fee arrangements, not just those involving medical malpractice cases, the bill requires that the percentages that go to the client and to the attorney be calculated after deductions for any disbursements or costs the attorney incurred other than ordinary office overhead and expenses.

MEDICAL MALPRACTICE DATA BASE (§ 23)

Current law authorizes the insurance commissioner to require all insurance companies writing medical malpractice insurance in

Connecticut to submit, in such manner and at such times as she specifies, whatever information she deems necessary to establish a database on medical malpractice. The database may include information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved, and any other information relating to risk management.

The bill eliminates this authority and instead, beginning January 1, 2005, requires each insurer to provide the commissioner with a closed claim report, on whatever form she requires. A "closed claim" is a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim. The duty to report applies to a captive insurer or a self-insured person.

The bill requires the insurer to submit the report within 10 days after the last day of the calendar quarter in which a claim for recovery under a medical liability policy is closed. The report must include information only about claims settled under Connecticut's laws. It must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid on the claim.

Details About the Insured and Insurer

The bill requires details about the insured and insurer to include the (1) insurer's name, (2) professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (3) name, address, health care provider professional license number and specialty coverage of the insured; and (4) insured's policy number and a unique claim number.

Details About the Injury or Loss

The bill specifies that details about the injury or loss include the (1) date of the injury or loss that was the basis of the claim; (2) date the injury or loss was reported to the insurer; (3) name of the institution or location at which the injury or loss occurred; (4) type of injury or loss, including a severity of injury rating that corresponds with the injury scale that the commissioner must establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (5) name, age, and gender of any injured person covered by the claim. Any individually identifiable information must be confidential.

Details About the Claims Process

The bill specifies that details about the claims process include (1) whether a lawsuit was filed, and if so, in which court; (2) the outcome of such lawsuit; (3) the number of other defendants, if any; (4) the stage in the process when the claim was closed; (5) the trial dates; (6) the date of the judgment or settlement, if any; (7) whether an appeal was filed, and if so, the date filed; (8) the resolution of the appeal and the date such appeal was decided; (9) the date the claim was closed; (10) the initial indemnity and expense reserve for the claim; and (11) the final indemnity and expense reserve for the claim.

Details About the Amount Paid on the Claim

The bill specifies that details about the amount paid on the claim include:

1. the total amount of the initial judgment rendered by a jury or awarded by the court;
2. the total amount of the settlement if there was no judgment rendered or awarded;
3. the total amount of the settlement if the claim was settled after judgment was rendered or awarded;
4. the amount of economic damages, or the insurer's estimate of the amount in the event of a settlement;
5. the amount of noneconomic damages, or the insurer's estimate of the amount in the event of a settlement;
6. the amount of any interest awarded due to failure to accept an offer of judgment;
7. the amount of any remittitur or additur;
8. the amount of final judgment after remittitur or additur;
9. the amount paid by the insurer;

10. the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits;
11. the amount paid by other insurers;
12. the amount paid by other defendants;
13. whether a structured settlement was used;
14. the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and
15. any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to medical professionals and entities, ensure the industry's solvency, and ensure that such liability insurance is available and affordable.

The bill requires the commissioner to establish an electronic database composed of closed claim reports.

Annual Data Summary

The bill requires the insurance commissioner to compile the data included in individual closed claim reports into an aggregated, summary format and prepare a written annual report of the summary data. The report must provide an analysis of closed claim information, including a minimum of five years of comparative data, when available; trends in frequency and severity of claims; itemization of damages; timeliness of the claims process; and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

The bill requires the annual report to include a summary of rate filings for professional liability insurance for medical professionals and entities that the department approved for the prior calendar year. The summary must include an analysis of the trend of direct losses, incurred losses, earned premiums, and investment income as compared to prior years. The report must also include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

The bill requires that by March 15, 2006, and annually thereafter, the commissioner must submit the annual report to the Insurance and Real Estate Committee. 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 have been removed.

The bill requires the insurance commissioner provide the DPH commissioner with electronic access to all the closed case information she receives.

HEALTHY CONNECTICUT FUND (§§ 24,25,26,27)

Fund Purposes and Operation

This bill establishes a Healthy Connecticut Fund to reimburse any portion of a medical malpractice claim, settlement, or judgment that represents the deductible applicable to a provider's coverage. The fund is liable for paying such deductibles pursuant to claims, settlements, or judgments against licensed health care providers who comply with the bill only where the settlement, claim, or judgment arises from an event that occurs on or after the effective date of the first plan of operation established by the bill. It is also liable for reasonable and necessary expenses incurred in paying such deductibles and the fund's administrative expenses.

The bill defines "health care provider" as a physician or surgeon; director, officer, or trustee of a hospital or nursing home; nurse; oral surgeon; dentist; pharmacist; chiropractor; optometrist; podiatrist; or hospital or nursing home. The bill specifies that any Connecticut-licensed health care provider may participate in the fund (presumably this means any provider that meets the definition above).

The fund includes any money required by law to be deposited in it. It must be held by the state treasurer separate from all other funds and accounts. Interest derived from fund investment must be credited to it. Money in the fund can be spent only as directed by the insurance commissioner as described below. Any balance left at the end of a fiscal year must be carried forward in the fund for the next fiscal year. All books, records, and audits of the fund are public records. The bill

requires an annual audit of the fund, by December 31, by the auditors of public accounts, which must give an audited financial report to the commissioner, state treasurer and the general assembly.

The insurance commissioner must adopt regulations to establish a fund plan of operation.

The state is not responsible for any costs, expenses, liabilities, judgments, or other fund obligations.

Sources of Funding

The bill requires the insurance commissioner to determine annually, beginning January 1, 2005, the amount necessary to maintain the fund's solvency. Under the bill, the following percentages of each medical malpractice award or settlement must be paid into the fund: (1) 4% of amounts under \$500,000, (2) 6% of amounts from \$500,000 to \$1 million, and (3) 10% of amounts over \$1 million. By January 1, 2005, the bill requires the commissioner to establish procedures for collecting these amounts from medical malpractice insurers.

The bill specifies that if these assessments are not enough to meet the fund's solvency requirements, the commissioner can assess each licensed health care provider an annual amount she determines. The bill allows her to exempt certain specialty groups with high malpractice premiums from the assessment. By January 1, 2005, and annually afterwards, she must (1) determine the assessment amount for the next fiscal year and determine which specialty groups will be exempt and (2) submit a statement to each provider subject to the assessment that includes the proposed amount. A person aggrieved by the assessment can appeal to the New Britain Superior Court district.

Professional Liability Insurance Policies for Fund Participants

The bill authorizes the insurance commissioner to approve, for providers who participate in the Healthy Connecticut Fund, professional liability insurance policies that have a deductible of up to (1) \$50,000 for a medical professional and (2) \$100,000 for a medical entity, including a hospital.

The bill authorizes any professional liability insurer to apply to the insurance commissioner for a disbursement from the fund in an

amount equal to the deductible described above in connection with any claim for award or settlement against a professional liability policy approved by the commissioner as described above. The commissioner must prepare an application for use. She must promptly make a disbursement to the applying professional liability insurer if she finds the application complete and sufficient funds are available. She cannot disburse more than \$50,000 to a medical professional or more than \$100,000 to a medical entity, and the disbursement cannot exceed the total amount of the award or settlement.

Bond Authorization

The bill authorizes the State Bond Commission to authorize the issuance of general obligation bonds in principal amounts up to \$10 million in the aggregate. The Insurance Department may use proceeds of the sale of such bonds for the Healthy Connecticut Fund purposes.

BACKGROUND

Attorney's Fees

Table 1 shows how the statutory formula under current law works for each of four hypothetical awards. It shows the actual amount of fees the statute allows the attorney to collect and the resulting percentage of the total award the attorney's fees constitute, the amount the client would receive, and the resulting percentage the client receives.

Table 1: Attorney's Fees for Various Damage Awards

| <i>Damage Award or Settlement</i> | <i>Contingency Fee the Law Allows</i> | <i>Percentage of Total Award to Attorney</i> | <i>Amount Client Receives</i> | <i>Percentage of Total Award to Client</i> |
|-----------------------------------|---------------------------------------|--|-------------------------------|--|
| \$100,000 | \$33,333 | 33.33% | \$66,667 | 66.67% |
| \$500,000 | \$150,000 | 30% | \$350,000 | 70% |
| \$1,000,000 | \$250,000 | 25% | \$750,000 | 75% |
| \$5,000,000 | \$660,000 | 13.2% | \$4,540,000 | 86.8% |
| \$10,000,000 | \$1,160,000 | 11.6% | \$8,840,000 | 88.4% |

Waiver of Fee Schedule

Current law does not explicitly indicate whether a client can waive the

contingency fee limits that the statute imposes. One Superior Court held that tort victims could waive their right to the protections afforded by the contingency fee law. The court also decided the plaintiff's waiver was valid, and the fee arrangement the plaintiff entered into with her attorney was reasonable (*In re Estate of Salerno*, 42 Conn. Supp. 526 (1993)).

The court resolved the case on nonconstitutional grounds noting that rights granted by statute could be waived unless the statute is meant to protect the general rights of the public rather than private rights. It cited instances where statutes relating to litigation have been construed as conferring a private right that can be waived (e.g., statute of limitations for tort actions, right to trial by jury, defense of statute of fraud).

It concluded that the fee cap statute clearly confers a private right and does not protect the general rights of the public. It also cited the legislative history where proponents of the law indicated that the fee limits could be waived.

Related Bills

sSB 60 (File 165) is very similar to this bill (sSB 356). sSB 60 does not have the changes to the Medical Examining Board membership or the Healthy Connecticut Fund provisions.

sSB 61 (File 166), establishes a fund to reimburse a portion of a malpractice claim, settlement, or judgment, which represents the deductible portion applicable to a provider's coverage. It authorizes the insurance commissioner to approve policies that contain deductibles up to \$50,000 for an individual and \$100,000 for a hospital.

The bill establishes another fund that pays a portion of a malpractice award or settlement that exceeds certain amounts. The maximum amount the fund may pay per claim is \$500,000.

SB 141 (File 132), makes numerous changes to tort law, insurance regulation, and disciplining of health care providers. Tort reform provisions deal with such areas as offer of judgments, mediation, attorney's fees, elimination of the screening panel, and establishing a task force to study alternatives to a tort system. Insurance provisions

include prior rate approval, data gathering, and captive insurers.

Other provisions deal with investigatory complaints against doctors, the complaint investigation process and standards, data gathering, mandatory continuing education for doctors, and a task force to examine the feasibility of developing a doctor relicensing exam.

sSB 394 (File 186), makes numerous changes to tort law; insurance regulation; and the oversight, regulation, and discipline of doctors. It is very similar to this bill except it contains a provision for a fund. The insurance provisions relate to prior rate approval, captive insurers, data collection, and the requirement of certain companies to offer malpractice insurance. It establishes surgery protocols, electronic medical records, and investigation of doctors.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute

Yea 22 Nay 0