



Senate

General Assembly

File No. 186

February Session, 2004

Substitute Senate Bill No. 394

Senate, March 23, 2004

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

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM.

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 Section 38a-32 of the general statutes is repealed and the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] a
4 "Medical Malpractice Screening Panel" which shall consist of members
5 [whose names shall be supplied by the Connecticut State Medical
6 Society] recommended by professional societies or associations that
7 represent health care providers in this state and the Connecticut Bar
8 Association. [This] The membership of the panel may be added to
9 whenever the need arises by requesting further [names from either the
10 Connecticut State Medical Society or the Connecticut Bar Association]
11 recommendations from any such society or association. Members of
12 the panel shall serve without compensation. The Insurance
13 Commissioner may designate [a member of his] an employee of the

14 department to administer the operation of and maintain the records for
15 such screening panel.

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 Section 38a-33 of the general statutes is repealed and the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

18 (a) Unless all parties to a claim for medical malpractice agree to
19 resolve such claim by a civil action, no civil action shall be filed with
20 respect to such claim until the proposed complaint in such action is
21 filed with the Insurance Commissioner and a hearing panel selected
22 pursuant to subsection (c) of this section has made and recorded a
23 finding as to liability or dismissed the claim pursuant to sections 38a-
24 32 to 38a-36, inclusive, as amended by this act.

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

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

47 involved or the attorneys for the parties. [At least one of the
48 physicians] One health care provider member shall be from the same
49 profession or specialty as the [physician] health care provider against
50 whom such claim is filed and the other health care provider member
51 shall be from a hospital, outpatient surgical facility or outpatient clinic.
52 The attorney shall have experience in the trial of personal injury cases.
53 [The attorney so designated shall act as chairman.] Upon the filing of
54 such proposed complaint, the Insurance Commissioner shall notify the
55 Chief Court Administrator and the Chief Court Administrator shall,
56 not later than thirty days after such notice, select a judge trial referee to
57 be a member of the hearing panel and serve as chairperson of the
58 hearing panel. Whenever deemed necessary due to the nature of the
59 claim or the parties, the chairperson may select an additional member
60 or members for the hearing panel from the Medical Malpractice
61 Screening Panel established under section 38a-32, as amended by this
62 act.

63 (d) For the purposes of this section, "health care provider" means a
64 provider, as defined in section 38a-478, as amended, or an officer,
65 employee or other agent of the provider acting in the course and scope
66 of employment.

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

69 The hearing panel [so] selected pursuant to section 38a-33, as
70 amended by this act, shall decide when and at what place it will hold
71 its hearings. A transcript of the proceedings may be taken at the
72 discretion of either or both parties and the expense of the [same]
73 transcript shall be borne by the party ordering the [same] transcript or
74 desiring a copy [thereof] of the transcript. The original of [said] the
75 transcript and all pertinent records of [said] the panel shall be
76 maintained by the Insurance Commissioner.

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

79 (a) All proceedings, records, findings and deliberations of a hearing
80 panel shall be confidential and shall not be used in any other
81 proceedings, or otherwise publicized, except as provided in section
82 19a-17b and sections 38a-32 to 38a-36, inclusive, as amended by this
83 act, [nor] or disclosed by any party, witness, counsel, panel member or
84 other person, on penalty of being found in contempt of court.

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

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

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

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

108 Sec. 6. Section 52-190a of the general statutes, as amended by section
109 14 of public act 03-202, is repealed and the following is substituted in
110 lieu thereof (*Effective from passage and applicable to actions filed on or after*

111 *said date*):

112 (a) No civil action shall be filed to recover damages resulting from
113 personal injury or wrongful death occurring on or after October 1,
114 1987, whether in tort or in contract, in which it is alleged that such
115 injury or death resulted from the negligence of a health care provider,
116 unless the attorney or party filing the action has made a reasonable
117 inquiry as permitted by the circumstances to determine that there are
118 grounds for a good faith belief that there has been negligence in the
119 care or treatment of the claimant. The complaint or initial pleading
120 shall contain a certificate of the attorney or party filing the action that
121 such reasonable inquiry gave rise to a good faith belief that grounds
122 exist for an action against each named defendant. [For the purposes of
123 this section, such good faith may be shown to exist if the claimant or
124 his attorney has received a written opinion, which shall not be subject
125 to discovery by any party except for questioning the validity of the
126 certificate,] To show the existence of such good faith, the claimant or
127 the claimant's attorney shall obtain a written and signed opinion of a
128 similar health care provider, as defined in section 52-184c, which
129 similar health care provider shall be selected pursuant to the
130 provisions of said section, that there appears to be evidence of medical
131 negligence and includes a detailed basis for the formation of such
132 opinion. Such written opinion shall not be subject to discovery by any
133 party except for questioning the validity of the certificate. The claimant
134 or the claimant's attorney shall retain the original written opinion and
135 shall attach a copy of such written opinion, with the name and
136 signature of the similar health care provider expunged, to such
137 certificate. In addition to such written opinion, the court may consider
138 other factors with regard to the existence of good faith. If the court
139 determines, after the completion of discovery, that such certificate was
140 not made in good faith and that no justiciable issue was presented
141 against a health care provider that fully cooperated in providing
142 informal discovery, the court upon motion or upon its own initiative
143 shall impose upon the person who signed such certificate or a
144 represented party, or both, an appropriate sanction which may include
145 an order to pay to the other party or parties the amount of the

146 reasonable expenses incurred because of the filing of the pleading,
147 motion or other paper, including a reasonable attorney's fee. The court
148 may also submit the matter to the appropriate authority for
149 disciplinary review of the attorney if the claimant's attorney submitted
150 the certificate.

151 (b) Upon petition to the clerk of the court where the action will be
152 filed, an automatic ninety-day extension of the statute of limitations
153 shall be granted to allow the reasonable inquiry required by subsection
154 (a) of this section. This period shall be in addition to other tolling
155 periods.

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

158 (a) Upon the filing of any medical malpractice claim against an
159 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
160 383, the plaintiff shall mail a copy of the complaint to the Department
161 of Public Health and the Insurance Department.

162 (b) Upon entry of any medical malpractice award by a court or upon
163 the parties entering a settlement of a malpractice claim against an
164 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
165 383, the entity making payment on behalf of a party or, if no such
166 entity exists, the party, shall [notify] provide to the Department of
167 Public Health and the Insurance Department notice of the terms of the
168 award or settlement and [shall provide to the department] a copy of
169 the award or settlement and the underlying complaint and answer, if
170 any. Such notice and copies provided to the Insurance Department
171 shall not identify the parties to the claim. The Department of Public
172 Health shall send the information received from such entity or party to
173 the state board of examiners having cognizance over any individual
174 licensed pursuant to chapter 370 to 373, inclusive, 379 or 383 who is a
175 party to the claim. The [department] Department of Public Health shall
176 review all medical malpractice claims, awards and [all] settlements to
177 determine whether further investigation or disciplinary action against
178 the providers involved is warranted. On and after July 1, 2004, such

179 review shall be conducted in accordance with the guidelines adopted
180 by the Department of Public Health, in accordance with section 20-13b,
181 as amended by this act, to determine the basis for such further
182 investigation or disciplinary action. Any document received pursuant
183 to this section shall not be considered a petition and shall not be
184 subject to [the provisions of] disclosure under section 1-210, as
185 amended, unless the [department] Department of Public Health
186 determines, following completion of its review, that further
187 investigation or disciplinary action is warranted. As used in this
188 section, "terms of the award or settlement" means the rights and
189 obligations of the parties to a medical malpractice claim, as determined
190 by a court or by agreement of the parties, and shall include, but not be
191 limited to, (1) for any individual licensed pursuant to chapter 370 to
192 373, inclusive, 379 or 383 who is a party to the claim, the type of
193 healing art or other health care practice, and the specialty, if any, in
194 which such individual engages, (2) the amount of the award or
195 settlement, specifying the portion of the award or settlement
196 attributable to economic damages and the portion of the award or
197 settlement attributable to noneconomic damages, and (3) if there are
198 multiple defendants, the allocation for payment of the award between
199 or among such defendants.

200 (c) No release of liability executed by a party to which payment is to
201 be made under a settlement of a malpractice claim against an
202 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
203 383 shall be effective until the attorney for the entity making payment
204 on behalf of a party or, if no such entity exists, the attorney for the
205 party, files with the court an affidavit stating that such attorney has
206 provided the information required under subsection (b) of this section
207 to the Department of Public Health and the Insurance Department.

208 (d) The Commissioner of Public Health and the Insurance
209 Commissioner shall each develop a system within the commissioner's
210 respective agency for collecting, storing, utilizing, interpreting,
211 reporting and providing public access to the information received
212 under subsections (a) and (b) of this section. Each commissioner shall

213 report the details of such system with respect to the commissioner's
214 agency to the joint standing committees of the General Assembly
215 having cognizance of matters relating to public health and insurance
216 on or before July 1, 2004, in accordance with section 11-4a.

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

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

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

235 (a) There shall be within the Department of Public Health a
236 Connecticut Medical Examining Board. Said board shall consist of
237 fifteen members appointed by the Governor, subject to the provisions
238 of section 4-9a, as amended, in the manner prescribed for department
239 heads in section 4-7, as follows: Five physicians practicing in the state;
240 one physician who shall be a full-time member of the faculty of The
241 University of Connecticut School of Medicine; one physician who shall
242 be a full-time chief of staff in a general-care hospital in the state; one
243 physician who shall be registered as a supervising physician for one or
244 more physician assistants; one physician who shall be a graduate of a
245 medical education program accredited by the American Osteopathic

246 Association; one physician assistant licensed pursuant to section
247 20-12b and practicing in this state; and five public members. No
248 professional member of said board shall be an elected or appointed
249 officer of a professional society or association relating to such
250 member's profession at the time of appointment to the board or have
251 been such an officer during the year immediately preceding
252 appointment or serve for more than two consecutive terms.
253 Professional members shall be practitioners in good professional
254 standing and residents of this state.

255 (b) All vacancies shall be filled by the Governor in the manner
256 prescribed for department heads in section 4-7. Successors and
257 appointments to fill a vacancy shall fulfill the same qualifications as
258 the member succeeded or replaced. In addition to the requirements in
259 sections 4-9a, as amended, and 19a-8, no person whose spouse, parent,
260 brother, sister, child or spouse of a child is a physician, as defined in
261 section 20-13a, or a physician assistant, as defined in section 20-12a,
262 shall be appointed as a public member.

263 (c) The Commissioner of Public Health shall establish a list of
264 eighteen persons who may serve as members of medical hearing
265 panels established pursuant to [subsection (g) of] this section. Persons
266 appointed to the list shall serve as members of the medical hearing
267 panels and provide the same services as members of the Connecticut
268 Medical Examining Board. Members from the list serving on such
269 panels shall not be voting members of the Connecticut Medical
270 Examining Board. The list shall consist of eighteen members appointed
271 by the commissioner, eight of whom shall be physicians, as defined in
272 section 20-13a, with at least one of such physicians being a graduate of
273 a medical education program accredited by the American Osteopathic
274 Association, one of whom shall be a physician assistant licensed
275 pursuant to section 20-12b, and nine of whom shall be members of the
276 public. No professional member of the list shall be an elected or
277 appointed officer of a professional society or association relating to
278 such member's profession at the time of appointment to the list or have
279 been such an officer during the year immediately preceding such

280 appointment to the list. A licensed professional appointed to the list
281 shall be a practitioner in good professional standing and a resident of
282 this state. All vacancies shall be filled by the commissioner. Successors
283 and appointments to fill a vacancy on the list shall possess the same
284 qualifications as those required of the member succeeded or replaced.
285 No person whose spouse, parent, brother, sister, child or spouse of a
286 child is a physician, as defined in section 20-13a, or a physician
287 assistant, as defined in section 20-12a, shall be appointed to the list as a
288 member of the public. Each person appointed to the list shall serve
289 without compensation at the pleasure of the commissioner. Each
290 medical hearing panel shall consist of three members, at least one of
291 whom shall be a member of the Connecticut Medical Examining Board
292 and one of whom shall be a member of the public. The public member
293 may be a member of the board or a member from the list established
294 pursuant to this subsection.

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

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

298 (f) The Governor shall appoint a chairperson from among the board
299 members. Said board shall meet at least once during each calendar
300 quarter and at such other times as the chairperson deems necessary.
301 Special meetings shall be held on the request of a majority of the board
302 after notice in accordance with the provisions of section 1-225. A
303 majority of the members of the board shall constitute a quorum.
304 Members shall not be compensated for their services. Any member
305 who fails to attend three consecutive meetings or who fails to attend
306 fifty per cent of all meetings held during any calendar year shall be
307 deemed to have resigned from office. Minutes of all meetings shall be
308 recorded by the board. No member shall participate in the affairs of
309 the board during the pendency of any disciplinary proceedings by the
310 board against such member. Said board shall (1) hear and decide
311 matters concerning suspension or revocation of licensure, (2)
312 adjudicate complaints against practitioners, and (3) impose sanctions

313 where appropriate.

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

326 (2) The board shall refer all statements of charges filed with the
327 board by the department pursuant to section 20-13e, as amended by
328 this act, to a medical hearing panel within sixty days of the receipt of
329 charges. [This] The time period may be extended for good cause by the
330 board in a duly recorded vote. [The panel shall consist of three
331 members, at least one of whom shall be a member of the board and one
332 a member of the public. The public member may be a member of either
333 the board or of the list established pursuant to subsection (c) of this
334 section.] The panel shall conduct a hearing, in accordance with the
335 provisions of chapter 54, and the regulations [established] adopted by
336 the Commissioner of Public Health concerning contested cases, except
337 that the panel shall file a proposed final decision with the board within
338 one hundred twenty days of the receipt of the issuance of the notice of
339 hearing by the board. The time period for filing such proposed final
340 decision with the board may be extended for good cause by the board
341 in a duly recorded vote. If the panel does not conduct a hearing within
342 sixty days of the date of referral of the statement of charges by the
343 board, the commissioner shall conduct a hearing in accordance with
344 chapter 54 and the regulations adopted by the commissioner
345 concerning contested cases. The commissioner shall file a proposed
346 final decision with the board not later than sixty days after such

347 hearing, except that the time period for filing such proposed final
348 decision with the board may be extended for good cause by the board
349 in a duly recorded vote.

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

360 (h) The board shall review the panel's proposed final decision in
361 accordance with the provisions of section 4-179, and adopt, modify or
362 remand said decision for further review or for the taking of additional
363 evidence. The board shall act on the proposed final decision within
364 ninety days of the filing of said decision by the panel. [This] The time
365 period may be extended by the board for good cause in a duly
366 recorded vote.

367 (i) Except in a case in which a license has been summarily
368 suspended, pursuant to subsection (c) of section 19a-17 or subsection
369 (c) of section 4-182, all three panel members shall be present to hear
370 any evidence and vote on a proposed final decision. The chairperson of
371 the Medical Examining Board may exempt a member from a meeting
372 of the panel if the chairperson finds that good cause exists for such an
373 exemption. Such an exemption may be granted orally but shall be
374 reduced to writing and included as part of the record of the panel
375 within two business days of the granting of the exemption or the
376 opening of the record and shall state the reason for the exemption.
377 Such exemption shall be granted to a member no more than once
378 during any contested case and shall not be granted for a meeting at
379 which the panel is acting on a proposed final decision on a statement

380 of charges. The board may appoint a member to the panel to replace
381 any member who resigns or otherwise fails to continue to serve on the
382 panel. Such replacement member shall review the record prior to the
383 next hearing.

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

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

389 The department shall file with the Governor and the joint standing
390 committee on public health of the General Assembly on or before
391 January 1, 1986, and thereafter on or before January first of each
392 succeeding year, a report of the activities of the department and the
393 board conducted pursuant to sections 20-13d and 20-13e, as amended
394 by this act. Each such report shall include, but shall not be limited to,
395 the following information: The number of petitions received; the
396 number of petitions not investigated, and the reasons why; the number
397 of hearings held on such petitions; [and,] the outcome of such
398 hearings; the timeliness of action taken on any petition considered to
399 be a priority; without identifying the particular physician concerned, a
400 brief description of the impairment alleged in each such petition and
401 the actions taken with regard to each such petition by the department
402 and the board; the number of notifications received pursuant to section
403 19a-17a, as amended by this act; the number of such notifications with
404 no further action taken, and the reasons why; and the outcomes for
405 notifications where further action is taken.

406 Sec. 11. (NEW) (*Effective from passage*) (a) Each licensed hospital or
407 outpatient surgical facility shall establish protocols for screening
408 patients prior to any surgery. Such protocols shall require that: (1)
409 Prior to any surgery the principal surgeon and four other persons
410 employed by or associated with the hospital or facility (A) identify the
411 patient and, if the patient is able to do so, have the patient identify
412 himself or herself, and (B) identify the procedure to be performed, and

413 (2) no patient may be anesthetized and no surgery may be performed
414 unless the identifications specified in subdivision (1) of this subsection
415 have been confirmed by all such members, except that such protocols
416 may provide for alternative identification procedures where the
417 patient is unconscious or under emergency circumstances. Each
418 licensed hospital or outpatient surgical facility shall annually submit to
419 the Department of Public Health a copy of such protocols and a report
420 on their implementation.

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

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

426 (a) After commencement of any civil action based upon contract or
427 seeking the recovery of money damages, whether or not other relief is
428 sought, the plaintiff may, not later than thirty days before trial, file
429 with the clerk of the court a written "offer of judgment" signed by the
430 plaintiff or the plaintiff's attorney, directed to the defendant or the
431 defendant's attorney, offering to settle the claim underlying the action
432 and to stipulate to a judgment for a sum certain. The plaintiff shall give
433 notice of the offer of settlement to the defendant's attorney or, if the
434 defendant is not represented by an attorney, to the defendant himself
435 or herself. Within sixty days after being notified of the filing of the
436 "offer of judgment" or within any extension or extensions thereof, not
437 to exceed a total of one hundred twenty additional days, granted by
438 the court for good cause shown, and prior to the rendering of a verdict
439 by the jury or an award by the court, the defendant or the defendant's
440 attorney may file with the clerk of the court a written "acceptance of
441 offer of judgment" agreeing to a stipulation for judgment as contained
442 in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter
443 judgment immediately on the stipulation. If the "offer of judgment" is
444 not accepted within [sixty days] the sixty-day period or any extension
445 thereof, and prior to the rendering of a verdict by the jury or an award

446 by the court, the "offer of judgment" shall be considered rejected and
447 not subject to acceptance unless refiled. Any such "offer of judgment"
448 and any "acceptance of offer of judgment" shall be included by the
449 clerk in the record of the case.

450 (b) After trial the court shall examine the record to determine
451 whether the plaintiff made an "offer of judgment" which the defendant
452 failed to accept. If the court ascertains from the record that the plaintiff
453 has recovered an amount equal to or greater than the sum certain
454 stated in the plaintiff's "offer of judgment", the court shall add to the
455 amount so recovered twelve per cent annual interest on said amount,
456 [computed from the date such offer was filed in actions commenced
457 before October 1, 1981. In those actions commenced on or after October
458 1, 1981, the] with respect to an offer of judgment filed prior to the
459 effective date of this section, and interest at an annual rate of two
460 percentage points above the weekly average five-year constant
461 maturity yield of United States Treasury securities, as published by the
462 Board of Governors of the Federal Reserve System, for the calendar
463 week preceding the beginning of each year for which interest is owed,
464 with respect to an offer of judgment filed on or after the effective date
465 of this section. The interest shall be computed from the date the
466 complaint in the civil action was filed with the court if the "offer of
467 judgment" was filed not later than eighteen months from the filing of
468 such complaint. If such offer was filed later than eighteen months from
469 the date of filing of the complaint, the interest shall be computed from
470 the date the "offer of judgment" was filed. The court may award
471 reasonable attorney's fees in an amount not to exceed three hundred
472 fifty dollars, and shall render judgment accordingly. This section shall
473 not be interpreted to abrogate the contractual rights of any party
474 concerning the recovery of attorney's fees in accordance with the
475 provisions of any written contract between the parties to the action.

476 Sec. 13. Section 38a-393 of the general statutes is repealed and the
477 following is substituted in lieu thereof (*Effective July 1, 2004*):

478 (a) Each insurance company doing business in this state shall,

479 annually, on or before the first day of March, render to the Insurance
480 Commissioner a true record of the number, according to classification,
481 of cancellations of and refusals to renew professional liability
482 insurance policies for the year ending on the thirty-first day of
483 December next preceding.

484 (b) For purposes of sections 38a-393 to 38a-395, inclusive, as
485 amended by this act, "professional liability insurance" means
486 professional liability contracts for: (1) Physicians and surgeons, (2)
487 hospitals, (3) lawyers, (4) dentists, (5) architects and engineers, (6)
488 chiropractors, (7) licensed natureopaths, (8) podiatrists, and (9)
489 advanced practice registered nurses and such other categories as the
490 Insurance Commissioner, in the commissioner's discretion, shall adopt
491 by regulations in accordance with chapter 54.

492 (c) Each insurance company that issues a property and casualty
493 policy in this state and issues a medical malpractice policy in any state,
494 district or territory of the United States shall offer for sale professional
495 liability insurance policies for: (1) Physicians and surgeons, (2)
496 hospitals, (3) dentists, (4) chiropractors, (5) licensed natureopaths, (6)
497 podiatrists, (7) advanced practice registered nurses, and (8) such other
498 categories as the Insurance Commissioner adopts pursuant to
499 subsection (b) of this section related to medical professionals or
500 entities.

501 Sec. 14. Subsection (a) of section 20-13e of the general statutes is
502 repealed and the following is substituted in lieu thereof (*Effective from*
503 *passage*):

504 (a) (1) The department shall investigate each petition filed pursuant
505 to section 20-13d, in accordance with the provisions of subdivision (10)
506 of subsection (a) of section 19a-14, to determine if probable cause exists
507 to issue a statement of charges and to institute proceedings against the
508 physician under subsection (e) of this section. Such investigation shall
509 be concluded not later than eighteen months from the date the petition
510 is filed with the department and, unless otherwise specified by this
511 subsection, the record of such investigation shall be deemed a public

512 record, in accordance with section 1-210, as amended, at the conclusion
513 of such eighteen-month period. Any such investigation shall be
514 confidential and no person shall disclose his knowledge of such
515 investigation to a third party unless the physician requests that such
516 investigation and disclosure be open. If the department determines
517 that probable cause exists to issue a statement of charges, the entire
518 record of such proceeding shall be public unless the department
519 determines that the physician is an appropriate candidate for
520 participation in a rehabilitation program in accordance with subsection
521 (b) of this section and the physician agrees to participate in such
522 program in accordance with terms agreed upon by the department and
523 the physician. If at any time subsequent to the filing of a petition and
524 during the eighteen-month period, the department makes a finding of
525 no probable cause and the medical panel appointed pursuant to
526 section 20-8a, as amended by this act, allows such finding to stand, the
527 petition and the entire record of such investigation shall remain
528 confidential unless the physician requests that such petition and record
529 be open.

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

534 Sec. 15. Subsection (b) of section 19a-88 of the general statutes is
535 repealed and the following is substituted in lieu thereof (*Effective from*
536 *passage*):

537 (b) Each person holding a license to practice medicine, surgery,
538 podiatry, chiropractic or natureopathy shall, annually, during the
539 month of such person's birth, register with the Department of Public
540 Health, upon payment of the professional services fee for class I, as
541 defined in section 33-182l, on blanks to be furnished by the department
542 for such purpose, giving such person's name in full, such person's
543 residence and business address, the name of the insurance company
544 providing such person's professional liability insurance and the policy

545 number of such insurance, such person's area of specialization,
546 whether such person is actively involved in patient care, any
547 disciplinary action against such person, or malpractice payments made
548 on behalf of such person in any other state or jurisdiction, and such
549 other information as the department requests. The department may
550 compare information submitted pursuant to this subsection to
551 information contained in the National Practitioner Data Base.

552 Sec. 16. (NEW) (*Effective from passage*) On or before January 1, 2005,
553 and annually thereafter, the Department of Public Health shall report,
554 in accordance with section 11-4a of the general statutes, the number of
555 physicians by specialty who are actively providing patient care.

556 Sec. 17. (NEW) (*Effective July 1, 2004*) Each insurer that delivers,
557 issues for delivery or renews in this state a professional liability
558 insurance policy for a medical professional or entity shall offer a
559 premium discount on the policy to any insured who submits to the
560 insurer proof that the insured will use an electronic health record
561 system during the premium period to establish and maintain patient
562 records and verify patient treatment. Such discount shall be not less
563 than twenty per cent of the premium for a period of one year from the
564 effective date of the policy or renewal.

565 Sec. 18. (NEW) (*Effective July 1, 2004*) The Connecticut Health and
566 Educational Facilities Authority shall establish a program, within
567 available appropriations, to finance low interest loans to hospitals to
568 install or upgrade electronic health record systems for the
569 establishment and maintenance of patient records and verification of
570 patient treatment. The program shall be known as the Connecticut
571 Electronic Health Records Program. Loans shall be made for the
572 purpose of establishing or upgrading electronic health record systems
573 for use by hospitals in order to promote patient safety and eliminate
574 errors.

575 Sec. 19. Section 38a-676 of the general statutes is repealed and the
576 following is substituted in lieu thereof (*Effective from passage*):

577 (a) With respect to rates pertaining to commercial risk insurance,
578 and subject to the provisions of subsection (b) of this section with
579 respect to workers' compensation and employers' liability insurance
580 and certain professional liability insurance, on or before the effective
581 date [thereof, every] of such rates, each admitted insurer shall submit
582 to the Insurance Commissioner for the commissioner's information,
583 except as to inland marine risks which by general custom of the
584 business are not written according to manual rates or rating plans,
585 [every] each manual of classifications, rules and rates, and [every] each
586 minimum, class rate, rating plan, rating schedule and rating system
587 and any modification of the foregoing which it uses. Such submission
588 by a licensed rating organization of which an insurer is a member or
589 subscriber shall be sufficient compliance with this section for any
590 insurer maintaining membership or subscribership in such
591 organization, to the extent that the insurer uses the manuals,
592 minimums, class rates, rating plans, rating schedules, rating systems,
593 policy or bond forms of such organization. The information shall be
594 open to public inspection after its submission.

595 (b) (1) Each filing as described in subsection (a) of this section for
596 workers' compensation or employers' liability insurance shall be on file
597 with the Insurance Commissioner for a waiting period of thirty days
598 before it becomes effective, which period may be extended by the
599 commissioner for an additional period not to exceed thirty days if the
600 commissioner gives written notice within such waiting period to the
601 insurer or rating organization which made the filing that the
602 commissioner needs such additional time for the consideration of such
603 filing. Upon written application by such insurer or rating organization,
604 the commissioner may authorize a filing which the commissioner has
605 reviewed to become effective before the expiration of the waiting
606 period or any extension thereof. A filing shall be deemed to meet the
607 requirements of sections 38a-663 to 38a-696, inclusive, unless
608 disapproved by the commissioner within the waiting period or any
609 extension thereof. If, within the waiting period or any extension
610 thereof, the commissioner finds that a filing does not meet the

611 requirements of said sections, the commissioner shall send to the
612 insurer or rating organization which made such filing written notice of
613 disapproval of such filing, specifying therein in what respects the
614 commissioner finds such filing fails to meet the requirements of said
615 sections and stating that such filing shall not become effective. Such
616 finding of the commissioner shall be subject to review as provided in
617 section 38a-19.

618 (2) Each filing as described in subsection (a) of this section for
619 professional liability insurance for physicians and surgeons, hospitals
620 or advanced practice registered nurses shall be subject to prior rate
621 approval in accordance with this section. On and after the effective
622 date of this section, each insurer or rating organization seeking to
623 change its rates for such insurance shall (A) file a request for such
624 change with the Insurance Department, and (B) provide written notice
625 to its insureds with respect to any request for an increase in rates. Such
626 request shall be filed and such notice, if applicable, shall be sent at
627 least sixty days prior to the proposed effective date of the change. The
628 notice to insureds of a request for an increase in rates shall indicate
629 that a public hearing shall be held in accordance with this section. The
630 Insurance Department shall review the request and, with respect to a
631 request for an increase in rates, shall hold a public hearing on such
632 increase prior to approving or denying the request. The Insurance
633 Commissioner shall approve or deny the request within forty-five days
634 of its receipt. Such finding of the commissioner shall be subject to
635 review as provided in section 38a-19.

636 (c) The form of any insurance policy or contract the rates for which
637 are subject to the provisions of sections 38a-663 to 38a-696, inclusive,
638 other than fidelity, surety or guaranty bonds, and the form of any
639 endorsement modifying such insurance policy or contract, shall be
640 filed with the Insurance Commissioner prior to its issuance. The
641 commissioner shall adopt regulations₂ in accordance with the
642 provisions of chapter 54₂ establishing a procedure for review of such
643 policy or contract. If at any time the commissioner finds that any such
644 policy, contract or endorsement is not in accordance with such

645 provisions or any other provision of law, the commissioner shall issue
646 an order disapproving the issuance of such form and stating the
647 reasons for disapproval. The provisions of section 38a-19 shall apply to
648 any such order issued by the commissioner.

649 Sec. 20. (NEW) (*Effective October 1, 2004*) (a) On and after October 1,
650 2004, no captive insurer, as defined in section 38a-91 of the general
651 statutes, may insure a health care provider or entity in this state
652 against liability for medical malpractice unless the captive insurer has
653 obtained a certificate of authority from the Insurance Commissioner,
654 except that no certificate of authority shall be required for any captive
655 insurer that is duly licensed in this state to offer such insurance.

656 (b) Any captive insurer seeking to obtain a certificate of authority
657 shall make application to the commissioner, on such form as the
658 commissioner requires, setting forth the line or lines of business which
659 it is seeking authorization to write. The captive insurer shall file with
660 the commissioner a certified copy of its charter or articles of
661 association and evidence satisfactory to the commissioner that it has
662 complied with the laws of the jurisdiction under which it is organized,
663 a statement of its financial condition in such form as is required by the
664 commissioner, together with such evidence of its correctness as the
665 commissioner requires and evidence of good management in such
666 form as is required by the commissioner. The captive insurer shall
667 submit evidence of its ability to provide continuous and timely claims
668 settlement. If the information furnished is satisfactory to the
669 commissioner, and if all other requirements of law have been complied
670 with, the commissioner may issue to such insurer a certificate of
671 authority permitting it to do business in this state. Each such certificate
672 of authority shall expire on the first day of May succeeding the date of
673 its issuance, but may be renewed without any formalities except as
674 required by the commissioner. Failure of a captive insurer to exercise
675 its authority to write a particular line or lines of business in this state
676 for two consecutive calendar years may constitute sufficient cause for
677 revocation of the captive insurer's authority to write those lines of
678 business.

679 (c) The commissioner shall adopt regulations, in accordance with
680 chapter 54 of the general statutes, specifying the information and
681 evidence that a captive insurer seeking to obtain or renew a certificate
682 of authority shall submit and the requirements with which it shall
683 comply.

684 (d) The commissioner may, at any time, for cause, suspend, revoke
685 or refuse to renew any such certificate of authority or in lieu of or in
686 addition to suspension or revocation of such certificate of authority the
687 commissioner, after reasonable notice to and hearing of any holder of
688 such certificate of authority, may impose a fine not to exceed ten
689 thousand dollars. Such hearings may be held by the commissioner or
690 any person designated by the commissioner. Whenever a person other
691 than the commissioner acts as the hearing officer, the person shall
692 submit to the commissioner a memorandum of findings and
693 recommendations upon which the commissioner may base a decision.
694 The commissioner may, if the commissioner deems it in the interest of
695 the public, publish in one or more newspapers of the state a statement
696 that, under the provisions of this section, the commissioner has
697 suspended or revoked the certificate of authority of any captive insurer
698 to do business in this state.

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

704 (f) Any captive insurer aggrieved by the action of the commissioner
705 in revoking, suspending or refusing to renew a certificate of authority
706 or in imposing a fine may appeal therefrom, in accordance with the
707 provisions of section 4-183 of the general statutes, except venue for
708 such appeal shall be in the judicial district of New Britain. Appeals
709 under this section shall be privileged in respect to the order of trial
710 assignment.

711 Sec. 21. Subsection (a) of section 38a-11 of the general statutes, as

712 amended by section 10 of public act 03-152 and section 9 of public act
713 03-169, is repealed and the following is substituted in lieu thereof
714 (*Effective October 1, 2004*):

715 (a) The commissioner shall demand and receive the following fees:
716 (1) For the annual fee for each license issued to a domestic insurance
717 company, one hundred dollars; (2) for receiving and filing annual
718 reports of domestic insurance companies, twenty-five dollars; (3) for
719 filing all documents prerequisite to the issuance of a license to an
720 insurance company, one hundred seventy-five dollars, except that the
721 fee for such filings by any health care center, as defined in section 38a-
722 175, shall be one thousand one hundred dollars; (4) for filing any
723 additional paper required by law, fifteen dollars; (5) for each certificate
724 of valuation, organization, reciprocity or compliance, twenty dollars;
725 (6) for each certified copy of a license to a company, twenty dollars; (7)
726 for each certified copy of a report or certificate of condition of a
727 company to be filed in any other state, twenty dollars; (8) for
728 amending a certificate of authority, one hundred dollars; (9) for each
729 license issued to a rating organization, one hundred dollars. In
730 addition, insurance companies shall pay any fees imposed under
731 section 12-211; (10) a filing fee of twenty-five dollars for each initial
732 application for a license made pursuant to section 38a-769; (11) with
733 respect to insurance agents' appointments: (A) A filing fee of twenty-
734 five dollars for each request for any agent appointment; (B) a fee of
735 forty dollars for each appointment issued to an agent of a domestic
736 insurance company or for each appointment continued; and (C) a fee
737 of twenty dollars for each appointment issued to an agent of any other
738 insurance company or for each appointment continued, except that no
739 fee shall be payable for an appointment issued to an agent of an
740 insurance company domiciled in a state or foreign country which does
741 not require any fee for an appointment issued to an agent of a
742 Connecticut insurance company; (12) with respect to insurance
743 producers: (A) An examination fee of seven dollars for each
744 examination taken, except when a testing service is used, the testing
745 service shall pay a fee of seven dollars to the commissioner for each
746 examination taken by an applicant;

747 license issued; and (C) a fee of forty dollars for each license renewed;
748 (13) with respect to public adjusters: (A) An examination fee of seven
749 dollars for each examination taken, except when a testing service is
750 used, the testing service shall pay a fee of seven dollars to the
751 commissioner for each examination taken by an applicant; and (B) a fee
752 of one hundred twenty-five dollars for each license issued or renewed;
753 (14) with respect to casualty adjusters: (A) An examination fee of ten
754 dollars for each examination taken, except when a testing service is
755 used, the testing service shall pay a fee of ten dollars to the
756 commissioner for each examination taken by an applicant; (B) a fee of
757 forty dollars for each license issued or renewed; and (C) the expense of
758 any examination administered outside the state shall be the
759 responsibility of the entity making the request and such entity shall
760 pay to the commissioner one hundred dollars for such examination
761 and the actual traveling expenses of the examination administrator to
762 administer such examination; (15) with respect to motor vehicle
763 physical damage appraisers: (A) An examination fee of forty dollars
764 for each examination taken, except when a testing service is used, the
765 testing service shall pay a fee of forty dollars to the commissioner for
766 each examination taken by an applicant; (B) a fee of forty dollars for
767 each license issued or renewed; and (C) the expense of any
768 examination administered outside the state shall be the responsibility
769 of the entity making the request and such entity shall pay to the
770 commissioner one hundred dollars for such examination and the
771 actual traveling expenses of the examination administrator to
772 administer such examination; (16) with respect to certified insurance
773 consultants: (A) An examination fee of thirteen dollars for each
774 examination taken, except when a testing service is used, the testing
775 service shall pay a fee of thirteen dollars to the commissioner for each
776 examination taken by an applicant; (B) a fee of two hundred dollars for
777 each license issued; and (C) a fee of one hundred twenty-five dollars
778 for each license renewed; (17) with respect to surplus lines brokers: (A)
779 An examination fee of ten dollars for each examination taken, except
780 when a testing service is used, the testing service shall pay a fee of ten
781 dollars to the commissioner for each examination taken by an

782 applicant; and (B) a fee of five hundred dollars for each license issued
783 or renewed; (18) with respect to fraternal agents, a fee of forty dollars
784 for each license issued or renewed; (19) a fee of thirteen dollars for
785 each license certificate requested, whether or not a license has been
786 issued; (20) with respect to domestic and foreign benefit societies shall
787 pay: (A) For service of process, twenty-five dollars for each person or
788 insurer to be served; (B) for filing a certified copy of its charter or
789 articles of association, five dollars; (C) for filing the annual report, ten
790 dollars; and (D) for filing any additional paper required by law, three
791 dollars; (21) with respect to foreign benefit societies: (A) For each
792 certificate of organization or compliance, four dollars; (B) for each
793 certified copy of permit, two dollars; and (C) for each copy of a report
794 or certificate of condition of a society to be filed in any other state, four
795 dollars; (22) with respect to reinsurance intermediaries: A fee of five
796 hundred dollars for each license issued or renewed; (23) with respect
797 to viatical settlement providers: (A) A filing fee of thirteen dollars for
798 each initial application for a license made pursuant to section 38a-465a,
799 as amended; and (B) a fee of twenty dollars for each license issued or
800 renewed; (24) with respect to viatical settlement brokers: (A) A filing
801 fee of thirteen dollars for each initial application for a license made
802 pursuant to section 38a-465a, as amended; and (B) a fee of twenty
803 dollars for each license issued or renewed; (25) with respect to viatical
804 settlement investment agents: (A) A filing fee of thirteen dollars for
805 each initial application for a license made pursuant to section 38a-465a,
806 as amended; and (B) a fee of twenty dollars for each license issued or
807 renewed; (26) with respect to preferred provider networks, a fee of two
808 thousand five hundred dollars for each license issued or renewed; (27)
809 with respect to rental companies, as defined in section 38a-799, a fee of
810 forty dollars for each permit issued or renewed; (28) with respect to a
811 certificate of authority for a captive insurer pursuant to section 20 of
812 this act, a fee of one hundred seventy-five dollars for each certificate
813 issued or renewed; and ~~[(28)]~~ (29) with respect to each duplicate
814 license issued a fee of twenty-five dollars for each license issued.

815 Sec. 22. (NEW) (*Effective from passage*) Any party to an action for
816 medical malpractice may file an application with the Superior Court

817 requesting that the case be designated as a complex litigation case and
818 be transferred by the Chief Court Administrator or any judge
819 designated by the Chief Court Administrator to the complex litigation
820 docket in a judicial district and court location determined by the Chief
821 Court Administrator or such designee.

822 Sec. 23. Section 52-251c of the general statutes is repealed and the
823 following is substituted in lieu thereof (*Effective from passage*):

824 (a) In any claim or civil action to recover damages resulting from
825 personal injury, wrongful death or damage to property occurring on or
826 after October 1, 1987, the attorney and the claimant may provide by
827 contract, which contract shall comply with all applicable provisions of
828 the rules of professional conduct governing attorneys adopted by the
829 judges of the Superior Court, that the fee for the attorney shall be paid
830 contingent upon, and as a percentage of: (1) Damages awarded and
831 received by the claimant; or (2) settlement amount pursuant to a
832 settlement agreement.

833 (b) In any such contingency fee arrangement such fee shall be the
834 exclusive method for payment of the attorney by the claimant and
835 shall not exceed an amount equal to a percentage of the damages
836 awarded and received by the claimant or of the settlement amount
837 received by the claimant as follows: (1) Thirty-three and one-third per
838 cent of the first three hundred thousand dollars; (2) twenty-five per
839 cent of the next three hundred thousand dollars; (3) twenty per cent of
840 the next three hundred thousand dollars; (4) fifteen per cent of the next
841 three hundred thousand dollars; and (5) ten per cent of any amount
842 which exceeds one million two hundred thousand dollars.

843 (c) Whenever a claimant in a medical malpractice case enters into a
844 contingency fee arrangement with an attorney which provides for a fee
845 that would exceed the percentage limitations set forth in subsection (b)
846 of this section, such arrangement shall not be valid unless the
847 claimant's attorney files an application with the court for approval of
848 such arrangement and the court, after a hearing, grants such
849 application. The claimant's attorney shall attach to such application a

850 copy of such fee arrangement and the proposed unsigned writ,
851 summons and complaint in the case. The court shall grant such
852 application if it finds that the case is sufficiently complex, unique or
853 different from other medical malpractice cases so as to warrant a
854 deviation from such percentage limitations. At the hearing, the
855 claimant's attorney shall have the burden of showing that such
856 deviation is warranted. If the court does not grant the application, the
857 court shall advise the claimant of the claimant's right to seek
858 representation by another attorney willing to abide by the percentage
859 limitations set forth in subsection (b) of this section. The filing of such
860 application shall toll the applicable statute of limitations for a period of
861 ninety days.

862 [(c)] (d) For the purposes of this section, "damages awarded and
863 received" means in a civil action in which final judgment is entered,
864 that amount of the judgment or amended judgment entered by the
865 court that is received by the claimant [, except that in a civil action
866 brought pursuant to section 38a-368 such amount shall be reduced by
867 any basic reparations benefits paid to the claimant pursuant to section
868 38a-365;] after deduction for any disbursements or costs incurred by
869 the attorney in connection with the prosecution or settlement of the
870 civil action, other than ordinary office overhead and expense, for
871 which the claimant is liable; and "settlement amount received" means
872 in a claim or civil action in which no final judgment is entered, the
873 amount received by the claimant pursuant to a settlement agreement [,
874 except that in a claim or civil action brought pursuant to section 38a-
875 368 such amount shall be reduced by any basic reparations benefits
876 paid to the claimant pursuant to section 38a-365; and "fee" shall not
877 include disbursements or costs incurred in connection with the
878 prosecution or settlement of the claim or civil action, other than
879 ordinary office overhead and expense] after deduction for any
880 disbursements or costs incurred by the attorney in connection with the
881 prosecution or settlement of the claim or civil action, other than
882 ordinary office overhead and expense, for which the claimant is liable.

883 Sec. 24. Section 38a-395 of the general statutes is repealed and the

884 following is substituted in lieu thereof (*Effective January 1, 2005*):

885 [The Insurance Commissioner may require all insurance companies
886 writing medical malpractice insurance in this state to submit, in such
887 manner and at such times as he specifies, such information as he
888 deems necessary to establish a data base on medical malpractice,
889 including information on all incidents of medical malpractice, all
890 settlements, all awards, other information relative to procedures and
891 specialties involved and any other information relating to risk
892 management.]

893 (a) As used in this section:

894 (1) "Claim" means a request for indemnification filed by a medical
895 professional or entity pursuant to a professional liability policy for a
896 loss for which a reserve amount has been established by an insurer;

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

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

904 (b) On and after January 1, 2005, each insurer shall provide to the
905 Insurance Commissioner a closed claim report, on such form as the
906 commissioner prescribes, in accordance with this section. The insurer
907 shall submit the report not later than ten days after the last day of the
908 calendar quarter in which a claim for recovery under a medical
909 liability policy is closed. The report shall only include information
910 about claims settled under the laws of this state.

911 (c) The closed claim report shall include:

912 (1) Details about the insured and insurer, including: (A) The name
913 of the insurer; (B) the professional liability insurance policy limits and

914 whether the policy was an occurrence policy or was issued on a claims-
915 made basis; (C) the name, address, health care provider professional
916 license number and specialty coverage of the insured; and (D) the
917 insured's policy number and a unique claim number.

918 (2) Details about the injury or loss, including: (A) The date of the
919 injury or loss that was the basis of the claim; (B) the date the injury or
920 loss was reported to the insurer; (C) the name of the institution or
921 location at which the injury or loss occurred; (D) the type of injury or
922 loss, including a severity of injury rating that corresponds with the
923 severity of injury scale that the Insurance Commissioner shall establish
924 based on the severity of injury scale developed by the National
925 Association of Insurance Commissioners; and (E) the name, age and
926 gender of any injured person covered by the claim. Any individually
927 identifiable information submitted pursuant to this subdivision shall
928 be confidential.

929 (3) Details about the claims process, including: (A) Whether a
930 lawsuit was filed, and if so, in which court; (B) the outcome of such
931 lawsuit; (C) the number of other defendants, if any; (D) the stage in the
932 process when the claim was closed; (E) the dates of the trial; (F) the
933 date of the judgment or settlement, if any; (G) whether an appeal was
934 filed, and if so, the date filed; (H) the resolution of the appeal and the
935 date such appeal was decided; (I) the date the claim was closed; (J) the
936 initial indemnity and expense reserve for the claim; and (K) the final
937 indemnity and expense reserve for the claim.

938 (4) Details about the amount paid on the claim, including: (A) The
939 total amount of the initial judgment rendered by a jury or awarded by
940 the court; (B) the total amount of the settlement if there was no
941 judgment rendered or awarded; (C) the total amount of the settlement
942 if the claim was settled after judgment was rendered or awarded; (D)
943 the amount of economic damages, as defined in section 52-572h, or the
944 insurer's estimate of the amount in the event of a settlement; (E) the
945 amount of noneconomic damages, as defined in section 52-572h, or the
946 insurer's estimate of the amount in the event of a settlement; (F) the

947 amount of any interest awarded due to failure to accept an offer of
948 judgment; (G) the amount of any remittitur or additur; (H) the amount
949 of final judgment after remittitur or additur; (I) the amount paid by the
950 insurer; (J) the amount paid by the defendant due to a deductible or a
951 judgment or settlement in excess of policy limits; (K) the amount paid
952 by other insurers; (L) the amount paid by other defendants; (M)
953 whether a structured settlement was used; (N) the expense assigned to
954 and recorded with the claim, including, but not limited to, defense and
955 investigation costs, but not including the actual claim payment; and
956 (O) any other information the commissioner determines to be
957 necessary to regulate the professional liability insurance industry with
958 respect to medical professionals and entities, ensure the industry's
959 solvency and ensure that such liability insurance is available and
960 affordable.

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

963 (2) The commissioner shall compile the data included in individual
964 closed claim reports into an aggregated summary format and shall
965 prepare a written annual report of the summary data. The report shall
966 provide an analysis of closed claim information including a minimum
967 of five years of comparative data, when available, trends in frequency
968 and severity of claims, itemization of damages, timeliness of the claims
969 process, and any other descriptive or analytical information that would
970 assist in interpreting the trends in closed claims.

971 (3) The annual report shall include a summary of rate filings for
972 professional liability insurance for medical professionals and entities
973 which have been approved by the department for the prior calendar
974 year, including an analysis of the trend of direct losses, incurred losses,
975 earned premiums and investment income as compared to prior years.
976 The report shall include base premiums charged by medical
977 malpractice insurers for each specialty and the number of providers
978 insured by specialty for each insurer.

979 (4) Not later than March 15, 2006, and annually thereafter, the

980 commissioner shall submit the annual report to the joint standing
981 committee of the General Assembly having cognizance of matters
982 relating to insurance in accordance with section 11-4a. The
983 commissioner shall also (A) make the report available to the public, (B)
984 post the report on its Internet site, and (C) provide public access to the
985 contents of the electronic database after the commissioner establishes
986 that the names and other individually identifiable information about
987 the claimant and practitioner have been removed.

988 (e) The Insurance Commissioner shall provide the Commissioner of
989 Public Health with electronic access to all information received
990 pursuant to this section.

991 Sec. 25. (NEW) (*Effective July 1, 2004*) (a) As used in this section: (1)
992 "Licensed health care provider" or "provider" means a physician or
993 surgeon; director, officer or trustee of a hospital or nursing home;
994 nurse; oral surgeon; dentist; pharmacist; chiropractor; optometrist;
995 podiatrist; hospital or nursing home; (2) "fund" means the Healthy
996 Connecticut Fund established in subsection (b) of this section; and (3)
997 "commissioner" means the Insurance Commissioner.

998 (b) There is established a Healthy Connecticut Fund for the purpose
999 of reimbursing any portion of a medical malpractice claim, settlement
1000 or judgment which represents the deductible applicable to a provider's
1001 coverage. The fund shall be liable only for (1) payment of such
1002 deductibles pursuant to claims, settlements or judgments against
1003 licensed health care providers who comply with the provisions of this
1004 section where the claim, settlement or judgment arises from an event
1005 that occurs on or after the effective date of the first plan of operation
1006 established pursuant to subsection (g) of this section, and (2)
1007 reasonable and necessary expenses incurred in payment of such
1008 deductibles and the fund's administrative expenses. The fund may
1009 contain any moneys required by law to be deposited in the fund and
1010 shall be held by the State Treasurer separate and apart from all other
1011 moneys, funds and accounts. The interest derived from the investment
1012 of the fund shall be credited to the fund. Amounts in the fund may be

1013 expended only at the direction of the Insurance Commissioner in
1014 accordance with this section. Any balance remaining in the fund at the
1015 end of any fiscal year shall be carried forward in the fund to the next
1016 fiscal year.

1017 (c) Any provider licensed in this state may participate in the fund if
1018 (1) the provider's primary place of practice is in this state, and (2) the
1019 provider meets the standards set forth in the plan of operation adopted
1020 pursuant to subsection (g) of this section.

1021 (d) (1) Any deficit in the fund shall be paid by the Tobacco
1022 Settlement Fund in accordance with section 4-28e of the general
1023 statutes, as amended by this act.

1024 (2) Except as provided in subdivision (1) of this subsection, the state
1025 shall not be responsible for any costs, expenses, liabilities, judgments
1026 or other obligations of the fund.

1027 (e) All books, records and audits of the fund shall be public records,
1028 as defined in section 1-200 of the general statutes.

1029 (f) On or before December thirty-first of each year the Auditors of
1030 Public Accounts shall audit the records of the fund and shall furnish an
1031 audited financial report to the commissioner, State Treasurer and the
1032 General Assembly. The report to the General Assembly shall be
1033 submitted in accordance with section 11-4a of the general statutes.

1034 (g) The Insurance Commissioner shall adopt regulations, in
1035 accordance with chapter 54 of the general statutes, to establish a plan
1036 of operation for the fund.

1037 Sec. 26. (NEW) (*Effective July 1, 2004*) The Insurance Commissioner
1038 may approve professional liability insurance policies for providers
1039 who participate in the Healthy Connecticut Fund established pursuant
1040 to section 25 of this act that contain a deductible that does not exceed
1041 (1) fifty thousand dollars with respect to a medical professional, and
1042 (2) one hundred thousand dollars with respect to a medical entity,
1043 including, but not limited to, a hospital. Such policies shall be subject

1044 to title 38a of the general statutes.

1045 Sec. 27. Section 4-28e of the general statutes is repealed and the
1046 following is substituted in lieu thereof (*Effective July 1, 2004*):

1047 (a) There is created a Tobacco Settlement Fund which shall be a
1048 separate nonlapsing fund. Any funds received by the state from the
1049 Master Settlement Agreement executed November 23, 1998, shall be
1050 deposited into the fund.

1051 (b) (1) The Treasurer is authorized to invest all or any part of the
1052 Tobacco Settlement Fund, all or any part of the Tobacco and Health
1053 Trust Fund created in section 4-28f, as amended, and all or any part of
1054 the Biomedical Research Trust Fund created in section 19a-32c. The
1055 interest derived from any such investment shall be credited to the
1056 resources of the fund from which the investment was made.

1057 (2) Notwithstanding sections 3-13 to 3-13h, inclusive, the Treasurer
1058 shall invest the amounts on deposit in the Tobacco Settlement Fund,
1059 the Tobacco and Health Trust Fund and the Biomedical Research Trust
1060 Fund in a manner reasonable and appropriate to achieve the objectives
1061 of such funds, exercising the discretion and care of a prudent person in
1062 similar circumstances with similar objectives. The Treasurer shall give
1063 due consideration to rate of return, risk, term or maturity,
1064 diversification of the total portfolio within such funds, liquidity, the
1065 projected disbursements and expenditures, and the expected
1066 payments, deposits, contributions and gifts to be received. The
1067 Treasurer shall not be required to invest such funds directly in
1068 obligations of the state or any political subdivision of the state or in
1069 any investment or other fund administered by the Treasurer. The
1070 assets of such funds shall be continuously invested and reinvested in a
1071 manner consistent with the objectives of such funds until disbursed in
1072 accordance with this section, section 4-28f, as amended, or section 19a-
1073 32c.

1074 (c) (1) For the fiscal year ending June 30, 2001, disbursements from
1075 the Tobacco Settlement Fund shall be made as follows: (A) To the

1076 General Fund in the amount identified as "Transfer from Tobacco
1077 Settlement Fund" in the General Fund revenue schedule adopted by
1078 the General Assembly; (B) to the Department of Mental Health and
1079 Addiction Services for a grant to the regional action councils in the
1080 amount of five hundred thousand dollars; and (C) to the Tobacco and
1081 Health Trust Fund in an amount equal to nineteen million five
1082 hundred thousand dollars.

1083 (2) For the fiscal [year] years ending June 30, 2002, [and each fiscal
1084 year thereafter] June 30, 2003, and June 30, 2004, disbursements from
1085 the Tobacco Settlement Fund shall be made as follows: (A) To the
1086 Tobacco and Health Trust Fund in an amount equal to twelve million
1087 dollars; (B) to the Biomedical Research Trust Fund in an amount equal
1088 to four million dollars; (C) to the General Fund in the amount
1089 identified as "Transfer from Tobacco Settlement Fund" in the General
1090 Fund revenue schedule adopted by the General Assembly; and (D) any
1091 remainder to the Tobacco and Health Trust Fund.

1092 (3) For the fiscal year ending June 30, 2005, and each fiscal year
1093 thereafter, disbursements from the Tobacco Settlement Fund shall be
1094 made as follows: (A) To the Tobacco and Health Trust Fund in an
1095 amount equal to twelve million dollars; (B) to the Biomedical Research
1096 Trust Fund in an amount equal to four million dollars; (C) to the
1097 General Fund in the amount identified as "Transfer from Tobacco
1098 Settlement Fund" in the General Fund revenue schedule adopted by
1099 the General Assembly; (D) to the Healthy Connecticut Fund in an
1100 amount identified as "Transfer from Tobacco Settlement Fund to
1101 Healthy Connecticut Fund" in the revenue schedule adopted by the
1102 General Assembly; and (E) any remainder to the Tobacco and Health
1103 Trust Fund.

1104 (d) For the fiscal year ending June 30, 2000, five million dollars shall
1105 be disbursed from the Tobacco Settlement Fund to a tobacco grant
1106 account to be established in the Office of Policy and Management.
1107 Such funds shall not lapse on June 30, 2000, and shall continue to be
1108 available for expenditure during the fiscal year ending June 30, 2001.

1109 (e) Tobacco grants shall be made from the account established
1110 pursuant to subsection (d) of this section by the Secretary of the Office
1111 of Policy and Management in consultation with the speaker of the
1112 House of Representatives, the president pro tempore of the Senate, the
1113 majority leader of the House of Representatives, the majority leader of
1114 the Senate, the minority leader of the House of Representatives, the
1115 minority leader of the Senate, and the cochairpersons and ranking
1116 members of the joint standing committees of the General Assembly
1117 having cognizance of matters relating to public health and
1118 appropriations and the budgets of state agencies, or their designees.
1119 Such grants shall be used to reduce tobacco abuse through prevention,
1120 education, cessation, treatment, enforcement and health needs
1121 programs.

1122 Sec. 28. Section 19a-20 of the general statutes is repealed and the
1123 following is substituted in lieu thereof (*Effective from passage*):

1124 No member of any board or commission subject to the provisions of
1125 chapter 368v, chapters 369 to 375, inclusive, 378 to 381, inclusive, 383 to
1126 388, inclusive, 398 and 399, including a member of a medical hearing
1127 panel established pursuant to [subsection (g) of] section 20-8a, as
1128 amended by this act, and no person making a complaint or providing
1129 information to any of such boards or commissions or the Department
1130 of Public Health as part of an investigation pursuant to section 19a-14,
1131 or a disciplinary action pursuant to section 19a-17, shall, without a
1132 showing of malice, be personally liable for damage or injury to a
1133 practitioner arising out of any proceeding of such boards and
1134 commissions or department. A person making a complaint or
1135 providing information to any of such boards or commissions or to the
1136 Department of Public Health as part of an investigation pursuant to
1137 section 19a-14 or a disciplinary action pursuant to section 19a-17 shall
1138 be entitled to indemnification and defense in the manner set forth in
1139 section 5-141d with respect to a state officer or employee.

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>July 1, 2004</i>
Sec. 14	<i>from passage</i>
Sec. 15	<i>from passage</i>
Sec. 16	<i>from passage</i>
Sec. 17	<i>July 1, 2004</i>
Sec. 18	<i>July 1, 2004</i>
Sec. 19	<i>from passage</i>
Sec. 20	<i>October 1, 2004</i>
Sec. 21	<i>October 1, 2004</i>
Sec. 22	<i>from passage</i>
Sec. 23	<i>from passage</i>
Sec. 24	<i>January 1, 2005</i>
Sec. 25	<i>July 1, 2004</i>
Sec. 26	<i>July 1, 2004</i>
Sec. 27	<i>July 1, 2004</i>
Sec. 28	<i>from passage</i>

INS *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\$
Judicial Dept.	GF - Cost	Less than 50,000	Less than 50,000	Less than 300,000
Judicial Dept.	GF - Potential Savings	0	175,000	175,000
Public Health, Dept.	GF - Cost	50,500	776,880	687,880
UConn Health Ctr.	Various - Savings	Potential	Potential	Potential
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	10,100	131,000	296,920
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
Public Health, Dept.; Insurance Dept.	Various - Revenue Gain	Potential Minimal	Potential Minimal	Potential Minimal
Auditors	GF - None	None	None	None

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 (assuming 100 pp.) 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.

Section 7 Section 7: Under the bill, the person who pays the damages must notify the Department of Insurance. This has no fiscal impact on

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

the Department of Insurance.

Implementation of **Sections 7-9 and 14** will result in a significant cost to the Department of Public Health (DPH). The predominant reason for these costs 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 CMEB has accepted a recommendation of 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 14**. This reflects the full-year salaries of: one Physician (at

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

\$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.

Section 9 requires the Connecticut Medical Examining Board (CMEB) to adopt regulations by December 31, 2004, to establish guidelines for use in its disciplinary process. It also establishes a requirement that the CMEB refer all findings of no probable cause to a medical hearing panel within 60 days of receipt from the DPH. The CMEB and medical hearing panels are comprised of volunteers who are not compensated for their time. Therefore, no direct state cost will result from an increased workload of their members.

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

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.

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 and outpatient surgical facility to establish protocols for screening patients prior to any surgery. 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 at the University of Connecticut Health Center 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 13 requires insurance companies that offer property and casualty insurance in Connecticut and medical malpractice insurance in any state to offer medical malpractice insurance in Connecticut for specific health care providers and entities, as regulated by the Insurance Commissioner. This has no fiscal impact on the Department

of Insurance.

Section 15 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 16** 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.

Section 17 requires medical malpractice insurance companies to offer a discount to any insured that will use an electronic health record system to maintain patient records and verify patient treatment. This has no fiscal impact on the Department of Insurance.

Section 18 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 19 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.

Section 20 & 21 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 22 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 23 requires the court to grant any waiver of attorneys' contingency fees in medical malpractice cases. There is no related fiscal impact.

Section 24 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 25- 27 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. Any provider licensed in the state may participate in the fund only if their primary practice is in the state and the provider meets conditions established by the commissioner. The bill sets the

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.

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.

The bill requires that these reimbursements be funded by assessments on various medical providers and other entities. A summary listing of the parties subject to assessment including the estimated number of each appears below.

Medical Malpractice Insurers	60
Health Insurers/Health Care Centers (HMOs)	466
Physicians/Surgeons (including oral surgeons)	13,424
Directors/Officers/Trustees of Hospital	820
Directors/Officers/Trustees of Nursing Home	2,100
Nurses	63,298
Dentists	2,967
Pharmacists	8,613
Chiropractors	932
Optometrists	627
Podiatrists	300
Hospitals	41
Nursing Homes	250
Attorneys	32,106
Pharmaceutical Companies	18
Medical Equipment Manufacturers	30
Total	126,052

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.

The bill also requires a percentage of medical malpractice settlements and awards to be deposited in the Healthy Connecticut Fund (but does not specify the amount).

Known medical malpractice settlements and awards (including projected future settlements/awards associated with pending cases) totaled \$209.3 million in 2002. Since the bill requires a percentage of actual settlements and awards to be deposited in the Healthy CT Fund, pending projected losses must be deducted. In 2002, projected losses made up 37% of total losses. Therefore, the amount that would have been subject to assessment in 2002 would have been \$132.4 million.

	2001 \$	2002 \$
Total Losses (Actual+Pending)	185,515,677	209,347,908
Less Pending Projected Losses	(46,716,164)	(76,914,964)
Actual Losses (Settlements, Awards)	138,799,513	132,432,944
Plus Defense/Legal Costs	25,818,278	24,818,968
Actual Losses Including Legal Costs	164,617,791	157,251,912

(NAIC Figures)

It is anticipated that the Auditors of Public Accounts will be able to complete an annual audit (by December 31st) of the above fund and submit an audited financial report to the Department of Insurance (DOI), the State Treasurer and the General Assembly within its anticipated budgetary resources.

OLR Bill Analysis

sSB 394

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM**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.

Civil Litigation Reform (§§ 1-6, 12, 22 and 23)

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, unless all parties agree to go directly to court and increases its membership of the hearing panel in malpractice cases from three to four by adding a judge trial referee to serve as chairperson;
3. gives immunity to anyone who provides testimony or information to a hearing panel, unless he acted with malice;
4. requires, as a condition of filing a medical malpractice lawsuit, that a signed opinion of a similar health care practitioner (a) be prepared to show the existence of a good faith belief that there has been negligence and (b) a copy be attached to the lawsuit complaint;
5. 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;
6. allows attorneys for plaintiffs or defendants to ask that their case be put on the complex litigation docket; and
7. 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 (§§ 13,17, 19, 20, 21, 24)

The bill:

1. requires insurance companies that offer property and casualty policies in Connecticut and medical malpractice policies in other states to offer medical malpractice insurance in Connecticut;
2. requires insurance companies to offer discounts to health care providers with electronic health records;
3. requires prior rate approval by the Insurance Department for all medical malpractice insurance rates;
4. 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
5. 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, 14, 15, 16, 18)

The bill:

1. requires anyone who pays a medical malpractice award or settlement to provide copies of the award to settlement and complaint and answer, if any, to the Insurance Department instead of just the Department of Public Health (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 such 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. requires the Medical Malpractice Examining Board, with DPH's assistance, to adopt guidelines for its disciplinary process and requires DPH's 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;
 7. requires that any finding of no probable cause by DPH after 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;
 8. 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;
 9. requires hospitals and outpatients surgical facilities to establish certain presurgery protocols;
 10. 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;
 11. requires doctors to annually provide certain information to DPH, including their malpractice insurer, policy number, area of specialization, and disciplinary actions and malpractice payments made in other jurisdictions;
 12. requires DPH to report annually the number of doctors, by specialty, who are actively providing patient care; and
 13. requires CHEFA to establish a loan program for hospitals to upgrade their health record system.

Healthy Connecticut Fund (§ 25)

The bill establishes a Healthy Connecticut Fund to reimburse any portion of a medical malpractice claim, settlement, or judgment, which represents the deductible applicable to a provider's coverage. The fund is liable only for payment of such deductibles pursuant to claims, settlements, or judgments against licensed health care providers who comply with the bill's requirements where the claim, settlement, 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 payment of such deductibles and the fund's administrative expenses.

The bill authorizes the Insurance Commissioner to approve professional liability insurance policies for providers who participate in the Healthy Connecticut Fund that contain a deductible that does not exceed (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 bill requires that the Tobacco Settlement Fund pay any deficit in the fund. The bill specifies that state is not responsible for any costs, expenses, liabilities, judgments, or other obligations of the fund, and that all books, records, and audits of the fund are public records.

EFFECTIVE DATE: The bill takes effect upon passage except the provisions requiring insurance companies to offer medical malpractice insurance, and discounts to providers with electronic health records, requiring CHEFA to establish a loan program for hospitals to upgrade their health record system and establishing the Healthy Connecticut Fund take 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 regarding 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 (CBA). 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 PANEL MAKE-UP (§ 2)

Under current law, the use of the malpractice screening panel is voluntary. Instead, the bill requires that, unless all parties agree to go directly to court, 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 as to 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 and the other be from a hospital, outpatient, surgical facility, or outpatient clinic.

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.

§ 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 may, without a showing of malice, from damages resulting from such testimony or information.

§ 5

This section makes technical changes.

GOOD FAITH CERTIFICATE (§ 6)

Current law prohibits filing malpractice lawsuits unless the attorney or claimant made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the claimant's care or treatment. The complaint or initial pleading must contain a certificate of 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 (SECTION 7)

The bill requires anyone filing a medical malpractice case against certain health care providers to mail a copy of the complaint to the Department of Public Health (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. The bill requires that the person provide a copy of the award or settlement instead of notifying DPH of their terms.

It also requires that it specify the portion of the award or settlement attributable to economic damages and the portion of the award or settlement attributable to noneconomic damages. It also requires that if there are multiple defendants, it 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 also 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 (§ 9)

The 15-member Connecticut Medical Examining Board (the board) is empowered to restrict, suspend, or revoke the license of a physician or limit his right to practice for certain misconduct.

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 concerning 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 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 not investigated and the reasons why, the outcome of the hearings held on such petitions, and the timeliness of action taken on petitions

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 no patient may be anesthetized and no surgery may be performed unless this identification process has been confirmed by all team members. But, the bill allows the protocols to provide for alternative identification procedures where the patient is unconscious or under emergency circumstances. The bill 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 certain 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 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 United States 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, with respect to an offer of judgment filed on or after the effective date of this section.

REQUIRING COMPANIES TO OFFER MALPRACTICE INSURANCE (§ 13)

The bill requires insurance companies that issue property and casualty policies in Connecticut and issue medical malpractice policies in any state, district, or territory of the United States to offer medical malpractice insurance in Connecticut for (1) physicians and surgeons, (2) hospitals, (3) dentists, (4) chiropractors, (5) licensed naturopaths, (6) podiatrists, (7) advanced practice registered nurses, and (8) other categories as the insurance commissioner adopts by regulation.

DPH INVESTIGATION OF PETITIONS (§ 14)

The law requires DPH to investigate each petition filed with it to determine if probable cause exists to issue a statement of charges and to 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 (§ 15)

By law, each person holding a license to practice medicine, surgery, podiatry, chiropractic or naturopathy must annually register with DPH and provide his name, residence, and business address, and other information DPH requests. The bill also requires him 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 (§ 16)

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 (§ 17)

The bill requires medical malpractice insurance companies to offer a premium discount on the 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 (§ 18)

The bill requires the Connecticut Health and Educational Facilities Authority to establish a 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 of patient treatment. The program will be known as the Connecticut Electronic Health Records Program. The bill authorizes loans to establish and upgrade electronic health record systems for use by hospitals in order to promote patient safety and eliminate errors.

PRIOR RATE APPROVAL (§ 19)

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 with respect to any 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 (§§ 20 AND 21)

Beginning October 1, 2004, the bill prohibits captive insurers from insuring a health care provider or entity in this state 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, which 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 the commissioner or her designee to hold the hearings. The bill mandates that whenever any one other than the commissioner acts as the hearing officer, he must submit to the commissioner a memorandum of findings and recommendations upon which she may base a decision. The commissioner may, if the commissioner 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 (§ 22)

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 (§ 23)

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 33 1/3% of the first \$ 300,000, 25% of the next \$300,000, 20% of the next \$ 300,000, 15% of the next \$300,000 and 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 so as 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 percentage limitations set forth in law. 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 (§ 24)

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 to the commissioner a closed claim report, on whatever form the commissioner 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 the laws of this state. 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 Summary of Data

The bill requires the 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. The commissioner must also (1) make the report available to the public, (2) post the report on its 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 (§§ 25 AND 26)

The bill allows the fund to contain any money required by law to be deposited in them. The fund must be held by the State Treasurer separate and apart from all other moneys, funds, and accounts. The interest derived from the investment of the fund must be credited to it. Amounts in the fund may be expended only at the Insurance Commissioner's direction. Any balance remaining in the fund at the end of any fiscal year must be carried forward in them to the next fiscal year.

The bill allows any licensed provider to participate in the fund if (1) the provider's primary place of practice is in this state, and (2) the provider meets the standards set forth in the plan of operation adopted by the Insurance Commissioner in regulation.

The bill requires that the Tobacco Settlement Fund pay any deficit in the fund. The bill specifies that state is not responsible for any costs, expenses, liabilities, judgments, or other obligations of the fund, and that all books, records, and audits of the funds are public records.

The bill requires that by December 31 of each year the Auditors of Public Accounts must audit the records of the fund and furnish an audited financial report to the commissioner, State Treasurer, and the General Assembly.

TOBACCO SETTLEMENT FUND DISBURSEMENTS (SECTION 27)

By law, disbursements from the Tobacco Settlement Fund must ordinarily be made: (1) \$12 million to the Tobacco and Health Trust

Fund, (2) \$4 million to the Biomedical Research Trust Fund, (3) an amount to the General Fund set in the General Fund revenue schedule adopted by the General Assembly; and (4) any remainder to the Tobacco and Health Trust Fund.

But for FY 2003-04 and FY 2004-05, the state budget act overrides the statutory distribution to transfer from the Tobacco Settlement Fund to the General Fund (1) \$12 million per year that otherwise would go to the Tobacco and Health Trust Fund and (2) \$2 of the \$4 million per year that would otherwise go to the Biomedical Research Trust Fund (PA 03-1, June 30 Special Session). For FY 2004-05, the bill appears to eliminate these transfers, and adds, for FY 2004-05 and all subsequent fiscal years, a requirement that there also be a transfer of an unspecified amount to the Healthy Connecticut Fund. (Because the budget act has a notwithstanding clause, it is not clear whether the bill actually eliminates the transfers the budget act makes.)

BACKGROUND

Attorney Fees

Table 1 shows how the statutory formula under current law works for each of four hypothetical awards. In addition to showing the actual amount of fees the statute allows the attorney to collect, the table also shows 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%	\$8,884,000	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 case addressed this issue. Judge Vertefeuille held that tort victims could waive their right to the protections afforded by the contingency fee law. She 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)).

Judge Vertefeuille resolved the case on nonconstitutional grounds. She first noted 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. She 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).

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

Related Bills

sSB 60, reported favorably by the Program Review and Investigations Committee on March 9. The bill is essentially same as sSB 394 except it does not have the Healthy Connecticut Fund provisions.

sSB 61, reported favorably by the Program Review and Investigations Committee on March 3, 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, reported favorably by the Program Review and Investigations Committee on March 3, 2004, 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.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 17 Nay 1