



General Assembly

Substitute Bill No. 5669

February Session, 2004

* HB05669JUD 032204 *

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM.

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

1 Section 1. (NEW) (*Effective from passage*) (a) In all civil actions
2 brought to recover damages resulting from personal injury or
3 wrongful death, whether in tort or in contract, in which it is alleged
4 that such injury or death resulted from the negligence of a health care
5 provider, there shall be a program of mandatory mediation. The
6 purpose of such mandatory mediation shall be to (1) review the
7 certificate of good faith filed pursuant to section 52-190a of the general
8 statutes, as amended by this act, to determine whether there are
9 grounds for a good faith belief that the defendant has been negligent in
10 the care or treatment of the claimant, (2) attempt to achieve a prompt
11 settlement or resolution of the case, and (3) expedite the litigation of
12 the case.

13 (b) Upon the filing of the answer in such action by the defendant,
14 the clerk of the court for the judicial district in which the case is
15 pending shall refer the case to a judge of the superior court for
16 mediation. The mediation shall take place not later than the filing of
17 the answer or as thereafter continued by the court. The mediation shall
18 not stay or delay the prosecution of the case, nor delay discovery in or
19 the trial of the case.

20 (c) At the mediation, the court shall review the certificate of good
21 faith filed pursuant to section 52-190a of the general statutes, as
22 amended by this act, to determine whether there are grounds for a
23 good faith belief that the defendant has been negligent in the care or
24 treatment of the claimant. If the court determines that the certificate of
25 good faith is inadequate to permit such a determination, it may order
26 the party submitting the certificate to file, within thirty days, a
27 supplemental certificate setting forth the grounds for the opinion that
28 there has been negligence in the care or treatment of the claimant.

29 (d) If the court determines that the certificate of good faith or any
30 supplemental certificate is inadequate to support a determination that
31 there are grounds for a good faith belief that there has been negligence
32 in the care or treatment of the claimant, it shall order the party
33 asserting such a claim to post a cash or surety bond in the amount of
34 five thousand dollars as a condition of continuing the prosecution of
35 the case, which bond shall be used to pay the taxable costs of the other
36 party, as permitted by the general statutes, in the event of the
37 unsuccessful prosecution of the case.

38 (e) All parties to the case, together with a representative of each
39 insurer that may be liable to pay all or part of any verdict or settlement
40 in the case, shall attend the mediation in person, unless attendance by
41 means of telephone is permitted upon written agreement of all parties
42 or written order of the court.

43 (f) If the mediation does not settle or conclude the case, the court
44 shall enter such orders as are necessary to narrow the issues, expedite
45 discovery and assist the parties in preparing the case for trial.

46 Sec. 2. Section 52-190a of the general statutes, as amended by section
47 14 of public act 03-202, is repealed and the following is substituted in
48 lieu thereof (*Effective from passage and applicable to actions filed on or after*
49 *said date*):

50 (a) No civil action or apportionment complaint shall be filed to
51 recover damages resulting from personal injury or wrongful death

52 occurring on or after October 1, 1987, whether in tort or in contract, in
53 which it is alleged that such injury or death resulted from the
54 negligence of a health care provider, unless the attorney or party filing
55 the action or apportionment complaint has made a reasonable inquiry
56 as permitted by the circumstances to determine that there are grounds
57 for a good faith belief that there has been negligence in the care or
58 treatment of the claimant. The complaint, [or] initial pleading or
59 apportionment complaint shall contain a certificate of the attorney or
60 party filing the action or apportionment complaint that such
61 reasonable inquiry gave rise to a good faith belief that grounds exist
62 for an action against each named defendant or for an apportionment
63 complaint against each named apportionment defendant. [For the
64 purposes of this section, such good faith may be shown to exist if the
65 claimant or his attorney has received a written opinion, which shall not
66 be subject to discovery by any party except for questioning the validity
67 of the certificate,] To show the existence of such good faith, the
68 claimant or such claimant's attorney, and any apportionment
69 complainant or such apportionment complainant's attorney, shall
70 obtain a written and signed opinion of a similar health care provider,
71 as defined in section 52-184c, which similar health care provider shall
72 be selected pursuant to the provisions of said section, that there
73 appears to be evidence of medical negligence and includes a detailed
74 basis for the formation of such opinion. Such written opinion shall not
75 be subject to discovery by any party except for questioning the validity
76 of the certificate. The claimant or such claimant's attorney, and any
77 apportionment complainant or such apportionment complainant's
78 attorney, shall retain the original written opinion and shall attach a
79 copy of such written opinion, with the name and signature of the
80 similar health care provider expunged, to such certificate. The similar
81 health care provider who provides such written opinion shall not,
82 without a showing of malice, be personally liable for any damages to
83 the defendant health care provider by reason of having provided such
84 written opinion. In addition to such written opinion, the court may
85 consider other factors with regard to the existence of good faith. If the
86 court determines, after the completion of discovery, that such

87 certificate was not made in good faith and that no justiciable issue was
88 presented against a health care provider that fully cooperated in
89 providing informal discovery, the court upon motion or upon its own
90 initiative shall impose upon the person who signed such certificate or a
91 represented party, or both, an appropriate sanction which may include
92 an order to pay to the other party or parties the amount of the
93 reasonable expenses incurred because of the filing of the pleading,
94 motion or other paper, including a reasonable attorney's fee. The court
95 may also submit the matter to the appropriate authority for
96 disciplinary review of the attorney if the claimant's attorney or
97 apportionment complainant's attorney submitted the certificate.

98 (b) If a claimant in a civil action asserts a claim against an
99 apportionment defendant pursuant to subsection (d) of section 52-
100 102b, the requirement under subsection (a) of this section that the
101 attorney or party filing the action make a reasonable inquiry and
102 submit a certificate of good faith shall be satisfied by the submission of
103 a certificate of good faith by the apportionment complainant pursuant
104 to subsection (a) of this section.

105 [(b)] (c) Upon petition to the clerk of the court where the action will
106 be filed, an automatic ninety-day extension of the statute of limitations
107 shall be granted to allow the reasonable inquiry required by subsection
108 (a) of this section. This period shall be in addition to other tolling
109 periods.

110 Sec. 3. Section 19a-17a of the general statutes is repealed and the
111 following is substituted in lieu thereof (*Effective from passage*):

112 (a) Upon the filing of any medical malpractice claim against an
113 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
114 383, the plaintiff or the plaintiff's attorney shall mail a copy of the
115 complaint to the Department of Public Health and the Insurance
116 Department.

117 (b) Upon entry of any medical malpractice award by a court or upon
118 the parties entering a settlement of a malpractice claim against an

119 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
120 383, the entity making payment on behalf of a party or, if no such
121 entity exists, the party, shall [notify] provide to the Department of
122 Public Health and the Insurance Department notice of the terms of the
123 award or settlement and [shall provide to the department] a copy of
124 the award or settlement and the underlying complaint and answer, if
125 any. Such notice and copies provided to the Insurance Department
126 shall not identify the parties to the claim. The Department of Public
127 Health shall send the information received from such entity or party to
128 the state board of examiners having cognizance over any individual
129 licensed pursuant to chapter 370 to 373, inclusive, 379 or 383 who is a
130 party to the claim. The [department] Department of Public Health shall
131 review all medical malpractice claims, awards and [all] settlements to
132 determine whether further investigation or disciplinary action against
133 the providers involved is warranted. On and after October 1, 2004,
134 such review shall be conducted in accordance with the guidelines
135 adopted by the Department of Public Health, in accordance with
136 section 20-13b, as amended by this act, to determine the basis for such
137 further investigation or disciplinary action. Any document received
138 pursuant to this section shall not be considered a petition and shall not
139 be subject to [the provisions of] disclosure under section 1-210, as
140 amended, unless the [department] Department of Public Health
141 determines, following completion of its review, that further
142 investigation or disciplinary action is warranted. As used in this
143 subsection, "terms of the award or settlement" means the rights and
144 obligations of the parties to a medical malpractice claim, as determined
145 by a court or by agreement of the parties, and includes, but is not
146 limited to, (1) for any individual licensed pursuant to chapter 370 to
147 373, inclusive, 379 or 383 who is a party to the claim, the type of
148 healing art or other health care practice, and the specialty, if any, in
149 which such individual engages, (2) the amount of the award or
150 settlement, specifying the portion of the award or settlement
151 attributable to economic damages and the portion of the award or
152 settlement attributable to noneconomic damages, and (3) if there are
153 multiple defendants, the allocation for payment of the award or

154 settlement between or among such defendants.

155 (c) No release of liability executed by a party to which payment is to
156 be made under a settlement of a malpractice claim against an
157 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
158 383 shall be effective until the attorney for the entity making payment
159 on behalf of a party or, if no such entity exists, the attorney for the
160 party, files with the court an affidavit stating that such attorney has
161 provided the information required under subsection (b) of this section
162 to the Department of Public Health and the Insurance Department.

163 (d) The Commissioner of Public Health and the Insurance
164 Commissioner shall each develop a system within the commissioner's
165 respective agency for collecting, storing, utilizing, interpreting,
166 reporting and providing public access to the information received
167 under subsections (a) and (b) of this section. Each commissioner shall
168 report the details of such system with respect to the commissioner's
169 agency to the joint standing committees of the General Assembly
170 having cognizance of matters relating to public health and insurance
171 on or before October 1, 2004, in accordance with section 11-4a.

172 Sec. 4. Section 20-13b of the general statutes is repealed and the
173 following is substituted in lieu thereof (*Effective from passage*):

174 The Commissioner of Public Health, with advice and assistance
175 from the board, may establish such regulations in accordance with
176 chapter 54 as may be necessary to carry out the provisions of sections
177 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1,
178 2004, such regulations shall include, but need not be limited to: (1)
179 Guidelines for screening complaints received to determine which
180 complaints will be investigated; (2) a prioritization system for
181 conducting investigations to ensure prompt action when it appears
182 necessary; and (3) guidelines to determine when an investigation
183 should be broadened beyond the initial complaint to include sampling
184 patient records to identify patterns of care, reviewing office practices
185 and procedures, reviewing performance and discharge data from

186 hospitals and managed care organizations and conducting additional
187 interviews of patients and peers.

188 Sec. 5. Section 20-8a of the general statutes is repealed and the
189 following is substituted in lieu thereof (*Effective from passage*):

190 (a) There shall be within the Department of Public Health a
191 Connecticut Medical Examining Board. Said board shall consist of
192 fifteen members appointed by the Governor, subject to the provisions
193 of section 4-9a, as amended, in the manner prescribed for department
194 heads in section 4-7, as follows: Five physicians practicing in the state;
195 one physician who shall be a full-time member of the faculty of The
196 University of Connecticut School of Medicine; one physician who shall
197 be a full-time chief of staff in a general-care hospital in the state; one
198 physician who shall be registered as a supervising physician for one or
199 more physician assistants; one physician who shall be a graduate of a
200 medical education program accredited by the American Osteopathic
201 Association; one physician assistant licensed pursuant to section
202 20-12b and practicing in this state; and five public members. No
203 professional member of said board shall be an elected or appointed
204 officer of a professional society or association relating to such
205 member's profession at the time of appointment to the board or have
206 been such an officer during the year immediately preceding
207 appointment or serve for more than two consecutive terms.
208 Professional members shall be practitioners in good professional
209 standing and residents of this state.

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

218 (c) The Commissioner of Public Health shall establish a list of
219 eighteen persons who may serve as members of medical hearing
220 panels established pursuant to [subsection (g) of] this section. Persons
221 appointed to the list shall serve as members of the medical hearing
222 panels and provide the same services as members of the Connecticut
223 Medical Examining Board. Members from the list serving on such
224 panels shall not be voting members of the Connecticut Medical
225 Examining Board. The list shall consist of eighteen members appointed
226 by the commissioner, eight of whom shall be physicians, as defined in
227 section 20-13a, with at least one of such physicians being a graduate of
228 a medical education program accredited by the American Osteopathic
229 Association, one of whom shall be a physician assistant licensed
230 pursuant to section 20-12b, and nine of whom shall be members of the
231 public. No professional member of the list shall be an elected or
232 appointed officer of a professional society or association relating to
233 such member's profession at the time of appointment to the list or have
234 been such an officer during the year immediately preceding such
235 appointment to the list. A licensed professional appointed to the list
236 shall be a practitioner in good professional standing and a resident of
237 this state. All vacancies shall be filled by the commissioner. Successors
238 and appointments to fill a vacancy on the list shall possess the same
239 qualifications as those required of the member succeeded or replaced.
240 No person whose spouse, parent, brother, sister, child or spouse of a
241 child is a physician, as defined in section 20-13a, or a physician
242 assistant, as defined in section 20-12a, shall be appointed to the list as a
243 member of the public. Each person appointed to the list shall serve
244 without compensation at the pleasure of the commissioner. Each
245 medical hearing panel shall consist of three members, at least one of
246 whom shall be a member of the Connecticut Medical Examining Board
247 and one of whom shall be a member of the public. The public member
248 may be a member of the board or a member from the list established
249 pursuant to this subsection.

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

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

253 (f) The Governor shall appoint a chairperson from among the board
254 members. Said board shall meet at least once during each calendar
255 quarter and at such other times as the chairperson deems necessary.
256 Special meetings shall be held on the request of a majority of the board
257 after notice in accordance with the provisions of section 1-225. A
258 majority of the members of the board shall constitute a quorum.
259 Members shall not be compensated for their services. Any member
260 who fails to attend three consecutive meetings or who fails to attend
261 fifty per cent of all meetings held during any calendar year shall be
262 deemed to have resigned from office. Minutes of all meetings shall be
263 recorded by the board. No member shall participate in the affairs of
264 the board during the pendency of any disciplinary proceedings by the
265 board against such member. Said board shall (1) hear and decide
266 matters concerning suspension or revocation of licensure, (2)
267 adjudicate complaints against practitioners, and (3) impose sanctions
268 where appropriate.

269 (g) (1) Not later than December 31, 2004, the board, with the
270 assistance of the department, shall adopt regulations, in accordance
271 with chapter 54, to establish guidelines for use in the disciplinary
272 process. Such guidelines shall include, but need not be limited to: (A)
273 Identification of each type of violation; (B) a minimum and maximum
274 penalty for each type of violation; (C) additional optional conditions
275 that may be imposed by the board for each violation; (D) identification
276 of factors the board shall consider in determining if the maximum or
277 minimum penalty should apply; (E) conditions, such as mitigating
278 factors or other facts, that may be considered in allowing deviations
279 from the guidelines; and (F) a provision that when a deviation from
280 the guidelines occurs, the reason for the deviation shall be identified.

281 (2) The board shall refer all statements of charges filed with the
282 board by the department pursuant to section 20-13e, as amended by
283 this act, to a medical hearing panel [within] not later than sixty days
284 [of] after the receipt of charges. [This] The time period may be

285 extended for good cause by the board in a duly recorded vote. [The
286 panel shall consist of three members, at least one of whom shall be a
287 member of the board and one a member of the public. The public
288 member may be a member of either the board or of the list established
289 pursuant to subsection (c) of this section.] The panel shall conduct a
290 hearing, in accordance with the provisions of chapter 54, and the
291 regulations [established] adopted by the Commissioner of Public
292 Health concerning contested cases, except that the panel shall file a
293 proposed final decision with the board [within] not later than one
294 hundred twenty days [of] after the receipt of the issuance of the notice
295 of hearing by the board. The time period for filing such proposed final
296 decision with the board may be extended for good cause by the board
297 in a duly recorded vote. If the panel does not conduct a hearing within
298 sixty days of the date of referral of the statement of charges by the
299 board, the commissioner shall conduct a hearing in accordance with
300 chapter 54 and the regulations adopted by the commissioner
301 concerning contested cases. The commissioner shall file a proposed
302 final decision with the board not later than sixty days after such
303 hearing, except that the time period for filing such proposed final
304 decision with the board may be extended for good cause by the board
305 in a duly recorded vote.

306 (3) The board shall refer all findings of no probable cause filed with
307 the board by the department pursuant to section 20-13e, as amended
308 by this act, to a medical hearing panel not later than sixty days after
309 the receipt of charges. The time period may be extended for good
310 cause by the board in a duly recorded vote. The panel shall review the
311 petition and the entire record of the investigation and may ask the
312 department for more information or for a reconsideration of such
313 finding. If the panel takes no action within ninety days of the
314 submission to the board of such finding, the department's finding of
315 no probable cause shall be considered final.

316 (h) The board shall review the panel's proposed final decision in
317 accordance with the provisions of section 4-179, and adopt, modify or
318 remand said decision for further review or for the taking of additional

319 evidence. The board shall act on the proposed final decision within
320 ninety days of the filing of said decision by the panel. [This] The time
321 period may be extended by the board for good cause in a duly
322 recorded vote.

323 (i) Except in a case in which a license has been summarily
324 suspended, pursuant to subsection (c) of section 19a-17 or subsection
325 (c) of section 4-182, all three panel members shall be present to hear
326 any evidence and vote on a proposed final decision. The chairperson of
327 the Medical Examining Board may exempt a member from a meeting
328 of the panel if the chairperson finds that good cause exists for such an
329 exemption. Such an exemption may be granted orally but shall be
330 reduced to writing and included as part of the record of the panel
331 within two business days of the granting of the exemption or the
332 opening of the record and shall state the reason for the exemption.
333 Such exemption shall be granted to a member no more than once
334 during any contested case and shall not be granted for a meeting at
335 which the panel is acting on a proposed final decision on a statement
336 of charges. The board may appoint a member to the panel to replace
337 any member who resigns or otherwise fails to continue to serve on the
338 panel. Such replacement member shall review the record prior to the
339 next hearing.

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

343 Sec. 6. Section 20-13i of the general statutes is repealed and the
344 following is substituted in lieu thereof (*Effective from passage*):

345 The department shall file with the Governor and the joint standing
346 committee on public health of the General Assembly on or before
347 January 1, 1986, and thereafter on or before January first of each
348 succeeding year, a report of the activities of the department and the
349 board conducted pursuant to sections 20-13d and 20-13e, as amended
350 by this act. Each such report shall include, but shall not be limited to,

351 the following information: The number of petitions received; the
352 number of petitions not investigated, and the reasons why; the number
353 of hearings held on such petitions; [and,] the outcome of such
354 hearings; the timeliness of action taken on any petition considered to
355 be a priority; without identifying the particular physician concerned, a
356 brief description of the impairment alleged in each such petition and
357 the actions taken with regard to each such petition by the department
358 and the board; the number of notifications received pursuant to section
359 19a-17a, as amended by this act; the number of such notifications with
360 no further action taken, and the reasons why; and the outcomes for
361 notifications where further action is taken.

362 Sec. 7. (NEW) (*Effective from passage*) (a) Each licensed hospital or
363 outpatient surgical facility shall establish protocols for screening
364 patients prior to any surgery. Such protocols shall require that: (1)
365 Prior to any surgery the principal surgeon and four other persons
366 employed by or associated with the hospital or facility (A) identify the
367 patient and, if the patient is able to do so, have the patient identify
368 himself or herself, and (B) identify the procedure to be performed, and
369 (2) no patient may be anesthetized and no surgery may be performed
370 unless the identifications specified in subdivision (1) of this subsection
371 have been confirmed by all such persons, except that such protocols
372 may provide for alternative identification procedures where the
373 patient is unconscious or under emergency circumstances. Each
374 licensed hospital or outpatient surgical facility shall annually submit to
375 the Department of Public Health a copy of such protocols and a report
376 on their implementation.

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

380 Sec. 8. Section 52-192a of the general statutes is repealed and the
381 following is substituted in lieu thereof (*Effective from passage*):

382 (a) After commencement of any civil action based upon contract or

383 seeking the recovery of money damages, whether or not other relief is
384 sought, the plaintiff may, not later than thirty days before trial, file
385 with the clerk of the court a written "offer of judgment" signed by the
386 plaintiff or the plaintiff's attorney, directed to the defendant or the
387 defendant's attorney, offering to settle the claim underlying the action
388 and to stipulate to a judgment for a sum certain. The plaintiff shall give
389 notice of the offer of settlement to the defendant's attorney or, if the
390 defendant is not represented by an attorney, to the defendant himself
391 or herself. Within sixty days after being notified of the filing of the
392 "offer of judgment" or within any extension or extensions thereof, not
393 to exceed a total of one hundred twenty additional days, granted by
394 the court for good cause shown, and prior to the rendering of a verdict
395 by the jury or an award by the court, the defendant or the defendant's
396 attorney may file with the clerk of the court a written "acceptance of
397 offer of judgment" agreeing to a stipulation for judgment as contained
398 in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter
399 judgment immediately on the stipulation. If the "offer of judgment" is
400 not accepted within [sixty days] the sixty-day period or any extension
401 thereof, and prior to the rendering of a verdict by the jury or an award
402 by the court, the "offer of judgment" shall be considered rejected and
403 not subject to acceptance unless refiled. Any such "offer of judgment"
404 and any "acceptance of offer of judgment" shall be included by the
405 clerk in the record of the case.

406 (b) After trial the court shall examine the record to determine
407 whether the plaintiff made an "offer of judgment" which the defendant
408 failed to accept. If the cause of action accrued prior to the effective date
409 of this section and the court ascertains from the record that the plaintiff
410 has recovered an amount equal to or greater than the sum certain
411 stated in the plaintiff's "offer of judgment", the court shall add to the
412 amount so recovered twelve per cent annual interest on said amount. [,
413 computed from the date such offer was filed in actions commenced
414 before October 1, 1981. In those actions commenced on or after October
415 1, 1981, the] If the cause of action accrued on or after the effective date
416 of this section and the court ascertains from the record that the plaintiff

417 has recovered an amount equal to or greater than the sum certain
418 stated in the plaintiff's offer of judgment, the court shall add to the
419 amount so recovered twelve per cent annual interest on said amount,
420 except that if the plaintiff has recovered an amount that is more than
421 twice the sum certain stated in the plaintiff's offer of judgment, the
422 court shall add to the amount so recovered (1) twelve per cent annual
423 interest on the portion of the amount recovered that is equal to or less
424 than twice the sum certain stated in such offer of judgment, and (2) six
425 per cent annual interest on the portion of the amount recovered that is
426 more than twice the sum certain stated in such offer. The interest shall
427 be computed from the date the complaint in the civil action was filed
428 with the court if the "offer of judgment" was filed not later than
429 eighteen months from the filing of such complaint. If such offer was
430 filed later than eighteen months from the date of filing of the
431 complaint, the interest shall be computed from the date the "offer of
432 judgment" was filed. The court may award reasonable attorney's fees
433 in an amount not to exceed three hundred fifty dollars, and shall
434 render judgment accordingly. This section shall not be interpreted to
435 abrogate the contractual rights of any party concerning the recovery of
436 attorney's fees in accordance with the provisions of any written
437 contract between the parties to the action.

438 Sec. 9. Subsection (a) of section 20-13e of the general statutes is
439 repealed and the following is substituted in lieu thereof (*Effective from*
440 *passage*):

441 (a) (1) The department shall investigate each petition filed pursuant
442 to section 20-13d, in accordance with the provisions of subdivision (10)
443 of subsection (a) of section 19a-14₂ to determine if probable cause exists
444 to issue a statement of charges and to institute proceedings against the
445 physician under subsection (e) of this section. Such investigation shall
446 be concluded not later than eighteen months from the date the petition
447 is filed with the department and, unless otherwise specified by this
448 subsection, the record of such investigation shall be deemed a public
449 record, in accordance with section 1-210, as amended, at the conclusion
450 of such eighteen-month period. Any such investigation shall be

451 confidential and no person shall disclose his knowledge of such
452 investigation to a third party unless the physician requests that such
453 investigation and disclosure be open. If the department determines
454 that probable cause exists to issue a statement of charges, the entire
455 record of such proceeding shall be public unless the department
456 determines that the physician is an appropriate candidate for
457 participation in a rehabilitation program in accordance with subsection
458 (b) of this section and the physician agrees to participate in such
459 program in accordance with terms agreed upon by the department and
460 the physician. If at any time subsequent to the filing of a petition and
461 during the eighteen-month period, the department makes a finding of
462 no probable cause and the medical panel appointed pursuant to
463 section 20-8a, as amended by this act, allows such finding to stand, the
464 petition and the entire record of such investigation shall remain
465 confidential unless the physician requests that such petition and record
466 be open.

467 (2) If the department makes a finding of no probable cause, it shall
468 notify the person who filed the petition or such person's legal
469 representative of such finding and the reasons therefor.

470 Sec. 10. Subsection (b) of section 19a-88 of the general statutes is
471 repealed and the following is substituted in lieu thereof (*Effective from*
472 *passage*):

473 (b) Each person holding a license to practice medicine, surgery,
474 podiatry, chiropractic or natureopathy shall, annually, during the
475 month of such person's birth, register with the Department of Public
476 Health, upon payment of the professional services fee for class I, as
477 defined in section 33-182l, on blanks to be furnished by the department
478 for such purpose, giving such person's name in full, such person's
479 residence and business address, the name of the insurance company
480 providing such person's professional liability insurance and the policy
481 number of such insurance, such person's area of specialization,
482 whether such person is actively involved in patient care, any
483 disciplinary action against such person, or malpractice payments made

484 on behalf of such person in any other state or jurisdiction, and such
485 other information as the department requests. The department may
486 compare information submitted pursuant to this subsection to
487 information contained in the National Practitioner Data Base.

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

492 Sec. 12. (NEW) (*Effective July 1, 2004*) Each insurer that delivers,
493 issues for delivery or renews in this state a professional liability
494 insurance policy for a medical professional or entity shall offer a
495 premium discount on the policy to any insured who submits to the
496 insurer proof that the insured will use an electronic health record
497 system during the premium period to establish and maintain patient
498 records and verify patient treatment. Such discount shall be not less
499 than ten per cent of the premium for a period of one year from the
500 effective date of the policy or renewal.

501 Sec. 13. (NEW) (*Effective July 1, 2004*) The Connecticut Health and
502 Educational Facilities Authority shall establish a program, within
503 available appropriations, to finance grants to hospitals to install or
504 upgrade electronic health record systems for the establishment and
505 maintenance of patient records and verification of patient treatment.
506 The program shall be known as the Connecticut Electronic Health
507 Records Program. Grants shall be made for the purpose of establishing
508 or upgrading electronic health record systems for use by hospitals in
509 order to promote patient safety and eliminate errors.

510 Sec. 14. Section 38a-676 of the general statutes is repealed and the
511 following is substituted in lieu thereof (*Effective from passage*):

512 (a) With respect to rates pertaining to commercial risk insurance,
513 and subject to the provisions of subsection (b) of this section with
514 respect to workers' compensation and employers' liability insurance
515 and certain professional liability insurance, on or before the effective

516 date [thereof, every] of such rates, each admitted insurer shall submit
517 to the Insurance Commissioner for the commissioner's information,
518 except as to inland marine risks which by general custom of the
519 business are not written according to manual rates or rating plans,
520 [every] each manual of classifications, rules and rates, and [every] each
521 minimum, class rate, rating plan, rating schedule and rating system
522 and any modification of the foregoing which it uses. Such submission
523 by a licensed rating organization of which an insurer is a member or
524 subscriber shall be sufficient compliance with this section for any
525 insurer maintaining membership or subscribership in such
526 organization, to the extent that the insurer uses the manuals,
527 minimums, class rates, rating plans, rating schedules, rating systems,
528 policy or bond forms of such organization. The information shall be
529 open to public inspection after its submission.

530 (b) (1) Each filing as described in subsection (a) of this section for
531 workers' compensation or employers' liability insurance shall be on file
532 with the Insurance Commissioner for a waiting period of thirty days
533 before it becomes effective, which period may be extended by the
534 commissioner for an additional period not to exceed thirty days if the
535 commissioner gives written notice within such waiting period to the
536 insurer or rating organization which made the filing that the
537 commissioner needs such additional time for the consideration of such
538 filing. Upon written application by such insurer or rating organization,
539 the commissioner may authorize a filing which the commissioner has
540 reviewed to become effective before the expiration of the waiting
541 period or any extension thereof. A filing shall be deemed to meet the
542 requirements of sections 38a-663 to 38a-696, inclusive, unless
543 disapproved by the commissioner within the waiting period or any
544 extension thereof. If, within the waiting period or any extension
545 thereof, the commissioner finds that a filing does not meet the
546 requirements of said sections, the commissioner shall send to the
547 insurer or rating organization which made such filing written notice of
548 disapproval of such filing, specifying therein in what respects the
549 commissioner finds such filing fails to meet the requirements of said

550 sections and stating that such filing shall not become effective. Such
551 finding of the commissioner shall be subject to review as provided in
552 section 38a-19.

553 (2) Each filing as described in subsection (a) of this section for
554 professional liability insurance for physicians and surgeons, hospitals
555 or advanced practice registered nurses shall be subject to prior rate
556 approval in accordance with this section. On and after the effective
557 date of this section, each insurer or rating organization seeking to
558 change its rates for such insurance shall (A) file a request for such
559 change with the Insurance Department, and (B) provide written notice
560 to its insureds with respect to any request for an increase in rates. Such
561 request shall be filed and such notice, if applicable, shall be sent at
562 least sixty days prior to the proposed effective date of the change. The
563 notice to insureds of a request for an increase in rates shall indicate
564 that a public hearing shall be held in accordance with this section. The
565 Insurance Department shall review the request and, with respect to a
566 request for an increase in rates, shall hold a public hearing on such
567 increase prior to approving or denying the request. The Insurance
568 Commissioner shall approve or deny the request not later than forty-
569 five days after its receipt. Such finding of the commissioner shall be
570 subject to review as provided in section 38a-19.

571 (c) The form of any insurance policy or contract the rates for which
572 are subject to the provisions of sections 38a-663 to 38a-696, inclusive,
573 other than fidelity, surety or guaranty bonds, and the form of any
574 endorsement modifying such insurance policy or contract, shall be
575 filed with the Insurance Commissioner prior to its issuance. The
576 commissioner shall adopt regulations₂ in accordance with the
577 provisions of chapter 54₂ establishing a procedure for review of such
578 policy or contract. If at any time the commissioner finds that any such
579 policy, contract or endorsement is not in accordance with such
580 provisions or any other provision of law, the commissioner shall issue
581 an order disapproving the issuance of such form and stating the
582 reasons for disapproval. The provisions of section 38a-19 shall apply to
583 any such order issued by the commissioner.

584 Sec. 15. (NEW) (*Effective October 1, 2004*) (a) On and after October 1,
585 2004, no captive insurer, as defined in section 38a-91 of the general
586 statutes, may insure a health care provider or entity in this state
587 against liability for medical malpractice unless the captive insurer has
588 obtained a certificate of authority from the Insurance Commissioner,
589 except that no certificate of authority shall be required for any captive
590 insurer that is duly licensed in this state to offer such insurance.

591 (b) Any captive insurer seeking to obtain a certificate of authority
592 shall make application to the commissioner, on such form as the
593 commissioner requires, setting forth the line or lines of business which
594 it is seeking authorization to write. The captive insurer shall file with
595 the commissioner a certified copy of its charter or articles of
596 association and evidence satisfactory to the commissioner that it has
597 complied with the laws of the jurisdiction under which it is organized,
598 a statement of its financial condition in such form as is required by the
599 commissioner, together with such evidence of its correctness as the
600 commissioner requires and evidence of good management in such
601 form as is required by the commissioner. The captive insurer shall
602 submit evidence of its ability to provide continuous and timely claims
603 settlement. If the information furnished is satisfactory to the
604 commissioner, and if all other requirements of law have been complied
605 with, the commissioner may issue to such insurer a certificate of
606 authority permitting it to do business in this state. Each such certificate
607 of authority shall expire on the first day of May succeeding the date of
608 its issuance, but may be renewed without any formalities except as
609 required by the commissioner. Failure of a captive insurer to exercise
610 its authority to write a particular line or lines of business in this state
611 for two consecutive calendar years may constitute sufficient cause for
612 revocation of the captive insurer's authority to write those lines of
613 business.

614 (c) The commissioner shall adopt regulations, in accordance with
615 chapter 54 of the general statutes, specifying the information and
616 evidence that a captive insurer seeking to obtain or renew a certificate
617 of authority shall submit and the requirements with which it shall

618 comply.

619 (d) The commissioner may, at any time, for cause, suspend, revoke
620 or refuse to renew any such certificate of authority or in lieu of or in
621 addition to suspension or revocation of such certificate of authority the
622 commissioner, after reasonable notice to and hearing of any holder of
623 such certificate of authority, may impose a fine not to exceed ten
624 thousand dollars. Such hearings may be held by the commissioner or
625 any person designated by the commissioner. Whenever a person other
626 than the commissioner acts as the hearing officer, the person shall
627 submit to the commissioner a memorandum of findings and
628 recommendations upon which the commissioner may base a decision.
629 The commissioner may, if the commissioner deems it in the interest of
630 the public, publish in one or more newspapers of the state a statement
631 that, under the provisions of this section, the commissioner has
632 suspended or revoked the certificate of authority of any captive insurer
633 to do business in this state.

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

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

646 Sec. 16. Subsection (a) of section 38a-11 of the general statutes, as
647 amended by section 10 of public act 03-152 and section 9 of public act
648 03-169, is repealed and the following is substituted in lieu thereof
649 (*Effective October 1, 2004*):

650 (a) The commissioner shall demand and receive the following fees:
651 (1) For the annual fee for each license issued to a domestic insurance
652 company, one hundred dollars; (2) for receiving and filing annual
653 reports of domestic insurance companies, twenty-five dollars; (3) for
654 filing all documents prerequisite to the issuance of a license to an
655 insurance company, one hundred seventy-five dollars, except that the
656 fee for such filings by any health care center, as defined in section 38a-
657 175, shall be one thousand one hundred dollars; (4) for filing any
658 additional paper required by law, fifteen dollars; (5) for each certificate
659 of valuation, organization, reciprocity or compliance, twenty dollars;
660 (6) for each certified copy of a license to a company, twenty dollars; (7)
661 for each certified copy of a report or certificate of condition of a
662 company to be filed in any other state, twenty dollars; (8) for
663 amending a certificate of authority, one hundred dollars; (9) for each
664 license issued to a rating organization, one hundred dollars. In
665 addition, insurance companies shall pay any fees imposed under
666 section 12-211; (10) a filing fee of twenty-five dollars for each initial
667 application for a license made pursuant to section 38a-769; (11) with
668 respect to insurance agents' appointments: (A) A filing fee of twenty-
669 five dollars for each request for any agent appointment; (B) a fee of
670 forty dollars for each appointment issued to an agent of a domestic
671 insurance company or for each appointment continued; and (C) a fee
672 of twenty dollars for each appointment issued to an agent of any other
673 insurance company or for each appointment continued, except that no
674 fee shall be payable for an appointment issued to an agent of an
675 insurance company domiciled in a state or foreign country which does
676 not require any fee for an appointment issued to an agent of a
677 Connecticut insurance company; (12) with respect to insurance
678 producers: (A) An examination fee of seven dollars for each
679 examination taken, except when a testing service is used, the testing
680 service shall pay a fee of seven dollars to the commissioner for each
681 examination taken by an applicant; (B) a fee of forty dollars for each
682 license issued; and (C) a fee of forty dollars for each license renewed;
683 (13) with respect to public adjusters: (A) An examination fee of seven
684 dollars for each examination taken, except when a testing service is

685 used, the testing service shall pay a fee of seven dollars to the
686 commissioner for each examination taken by an applicant; and (B) a fee
687 of one hundred twenty-five dollars for each license issued or renewed;
688 (14) with respect to casualty adjusters: (A) An examination fee of ten
689 dollars for each examination taken, except when a testing service is
690 used, the testing service shall pay a fee of ten dollars to the
691 commissioner for each examination taken by an applicant; (B) a fee of
692 forty dollars for each license issued or renewed; and (C) the expense of
693 any examination administered outside the state shall be the
694 responsibility of the entity making the request and such entity shall
695 pay to the commissioner one hundred dollars for such examination
696 and the actual traveling expenses of the examination administrator to
697 administer such examination; (15) with respect to motor vehicle
698 physical damage appraisers: (A) An examination fee of forty dollars
699 for each examination taken, except when a testing service is used, the
700 testing service shall pay a fee of forty dollars to the commissioner for
701 each examination taken by an applicant; (B) a fee of forty dollars for
702 each license issued or renewed; and (C) the expense of any
703 examination administered outside the state shall be the responsibility
704 of the entity making the request and such entity shall pay to the
705 commissioner one hundred dollars for such examination and the
706 actual traveling expenses of the examination administrator to
707 administer such examination; (16) with respect to certified insurance
708 consultants: (A) An examination fee of thirteen dollars for each
709 examination taken, except when a testing service is used, the testing
710 service shall pay a fee of thirteen dollars to the commissioner for each
711 examination taken by an applicant; (B) a fee of two hundred dollars for
712 each license issued; and (C) a fee of one hundred twenty-five dollars
713 for each license renewed; (17) with respect to surplus lines brokers: (A)
714 An examination fee of ten dollars for each examination taken, except
715 when a testing service is used, the testing service shall pay a fee of ten
716 dollars to the commissioner for each examination taken by an
717 applicant; and (B) a fee of five hundred dollars for each license issued
718 or renewed; (18) with respect to fraternal agents, a fee of forty dollars
719 for each license issued or renewed; (19) a fee of thirteen dollars for

720 each license certificate requested, whether or not a license has been
721 issued; (20) with respect to domestic and foreign benefit societies shall
722 pay: (A) For service of process, twenty-five dollars for each person or
723 insurer to be served; (B) for filing a certified copy of its charter or
724 articles of association, five dollars; (C) for filing the annual report, ten
725 dollars; and (D) for filing any additional paper required by law, three
726 dollars; (21) with respect to foreign benefit societies: (A) For each
727 certificate of organization or compliance, four dollars; (B) for each
728 certified copy of permit, two dollars; and (C) for each copy of a report
729 or certificate of condition of a society to be filed in any other state, four
730 dollars; (22) with respect to reinsurance intermediaries: A fee of five
731 hundred dollars for each license issued or renewed; (23) with respect
732 to viatical settlement providers: (A) A filing fee of thirteen dollars for
733 each initial application for a license made pursuant to section 38a-465a,
734 as amended; and (B) a fee of twenty dollars for each license issued or
735 renewed; (24) with respect to viatical settlement brokers: (A) A filing
736 fee of thirteen dollars for each initial application for a license made
737 pursuant to section 38a-465a, as amended; and (B) a fee of twenty
738 dollars for each license issued or renewed; (25) with respect to viatical
739 settlement investment agents: (A) A filing fee of thirteen dollars for
740 each initial application for a license made pursuant to section 38a-465a,
741 as amended; and (B) a fee of twenty dollars for each license issued or
742 renewed; (26) with respect to preferred provider networks, a fee of two
743 thousand five hundred dollars for each license issued or renewed; (27)
744 with respect to rental companies, as defined in section 38a-799, a fee of
745 forty dollars for each permit issued or renewed; (28) with respect to a
746 certificate of authority for a captive insurer pursuant to section 15 of
747 this act, a fee of one hundred seventy-five dollars for each certificate
748 issued or renewed; and ~~[(28)]~~ (29) with respect to each duplicate
749 license issued a fee of twenty-five dollars for each license issued.

750 Sec. 17. Section 52-251c of the general statutes is repealed and the
751 following is substituted in lieu thereof (*Effective from passage and*
752 *applicable to causes of action accruing on or after said date*):

753 (a) In any claim or civil action to recover damages resulting from

754 personal injury, wrongful death or damage to property occurring on or
755 after October 1, 1987, the attorney and the claimant may provide by
756 contract, which contract shall comply with all applicable provisions of
757 the rules of professional conduct governing attorneys adopted by the
758 judges of the Superior Court, that the fee for the attorney shall be paid
759 contingent upon, and as a percentage of: (1) Damages awarded and
760 received by the claimant; or (2) settlement amount pursuant to a
761 settlement agreement.

762 (b) In any such contingency fee arrangement such fee shall be the
763 exclusive method for payment of the attorney by the claimant and
764 shall not exceed an amount equal to a percentage of the damages
765 awarded and received by the claimant or of the settlement amount
766 received by the claimant as follows: (1) Thirty-three and one-third per
767 cent of the first three hundred thousand dollars; (2) twenty-five per
768 cent of the next three hundred thousand dollars; (3) twenty per cent of
769 the next three hundred thousand dollars; (4) fifteen per cent of the next
770 three hundred thousand dollars; and (5) ten per cent of any amount
771 which exceeds one million two hundred thousand dollars.

772 (c) Whenever a claimant in a medical malpractice case enters into a
773 contingency fee arrangement with an attorney which provides for a fee
774 that would exceed the percentage limitations set forth in subsection (b)
775 of this section, such arrangement shall not be valid unless the
776 claimant's attorney files an application with the court for approval of
777 such arrangement and the court, after a hearing, grants such
778 application. The claimant's attorney shall attach to such application a
779 copy of such fee arrangement and the proposed unsigned writ,
780 summons and complaint in the case. Such fee arrangement shall
781 provide that the attorney will advance all costs in connection with the
782 investigation and prosecution or settlement of the case and the
783 claimant will not be liable for the reimbursement of the attorney for
784 any such costs if there is no recovery. The court shall grant such
785 application if it finds that the case is sufficiently complex, unique or
786 different from other medical malpractice cases so as to warrant a
787 deviation from such percentage limitations. At the hearing, the

788 claimant's attorney shall have the burden of showing that such
789 deviation is warranted. In no event shall the court grant an application
790 approving a fee arrangement that provides for a fee that exceeds an
791 amount equal to thirty-three and one-third per cent of the damages
792 awarded and received by the claimant or of the settlement amount
793 received by the claimant. If the court denies the application, the court
794 shall advise the claimant of the claimant's right to seek representation
795 by another attorney willing to abide by the percentage limitations set
796 forth in subsection (b) of this section. The decision of the court to grant
797 or deny the application shall not be subject to appeal. The filing of such
798 application shall toll the applicable statute of limitations until ninety
799 days after the court's decision to grant or deny the application. The
800 Chief Court Administrator shall assign a judge or judges with
801 experience in personal injury cases to hear and determine applications
802 filed under this subsection.

803 (d) If the attorney makes disbursements or incurs costs in
804 connection with the investigation and prosecution or settlement of the
805 claim or civil action for which the claimant is liable, in no event shall
806 the claimant be required to pay interest on the amount of such
807 disbursements and costs.

808 [(c)] (e) For the purposes of this section, "damages awarded and
809 received" means in a civil action in which final judgment is entered,
810 that amount of the judgment or amended judgment entered by the
811 court that is received by the claimant [, except that in a civil action
812 brought pursuant to section 38a-368 such amount shall be reduced by
813 any basic reparations benefits paid to the claimant pursuant to section
814 38a-365;] after deduction for any disbursements made or costs incurred
815 by the attorney in connection with the investigation and prosecution or
816 settlement of the civil action, other than ordinary office overhead and
817 expense, for which the claimant is liable; and "settlement amount
818 received" means in a claim or civil action in which no final judgment is
819 entered, the amount received by the claimant pursuant to a settlement
820 agreement [, except that in a claim or civil action brought pursuant to
821 section 38a-368 such amount shall be reduced by any basic reparations

822 benefits paid to the claimant pursuant to section 38a-365; and "fee"
823 shall not include disbursements or costs incurred in connection with
824 the prosecution or settlement of the claim or civil action, other than
825 ordinary office overhead and expense] after deduction for any
826 disbursements made or costs incurred by the attorney in connection
827 with the investigation and prosecution or settlement of the claim or
828 civil action, other than ordinary office overhead and expense, for
829 which the claimant is liable.

830 Sec. 18. Section 38a-395 of the general statutes is repealed and the
831 following is substituted in lieu thereof (*Effective January 1, 2005*):

832 [The Insurance Commissioner may require all insurance companies
833 writing medical malpractice insurance in this state to submit, in such
834 manner and at such times as he specifies, such information as he
835 deems necessary to establish a data base on medical malpractice,
836 including information on all incidents of medical malpractice, all
837 settlements, all awards, other information relative to procedures and
838 specialties involved and any other information relating to risk
839 management.]

840 (a) As used in this section:

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

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

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

851 (b) On and after January 1, 2005, each insurer shall provide to the

852 Insurance Commissioner a closed claim report, on such form as the
853 commissioner prescribes, in accordance with this section. The insurer
854 shall submit the report not later than ten days after the last day of the
855 calendar quarter in which a claim is closed. The report shall only
856 include information about claims settled under the laws of this state.

857 (c) The closed claim report shall include:

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

864 (2) Details about the injury or loss, including: (A) The date of the
865 injury or loss that was the basis of the claim; (B) the date the injury or
866 loss was reported to the insurer; (C) the name of the institution or
867 location at which the injury or loss occurred; (D) the type of injury or
868 loss, including a severity of injury rating that corresponds with the
869 severity of injury scale that the Insurance Commissioner shall establish
870 based on the severity of injury scale developed by the National
871 Association of Insurance Commissioners; and (E) the name, age and
872 gender of any injured person covered by the claim. Any individually
873 identifiable information submitted pursuant to this subdivision shall
874 be confidential.

875 (3) Details about the claims process, including: (A) Whether a
876 lawsuit was filed, and if so, in which court; (B) the outcome of such
877 lawsuit; (C) the number of other defendants, if any; (D) the stage in the
878 process when the claim was closed; (E) the dates of the trial; (F) the
879 date of the judgment or settlement, if any; (G) whether an appeal was
880 filed, and if so, the date filed; (H) the resolution of the appeal and the
881 date such appeal was decided; (I) the date the claim was closed; (J) the
882 initial indemnity and expense reserve for the claim; and (K) the final
883 indemnity and expense reserve for the claim.

884 (4) Details about the amount paid on the claim, including: (A) The
885 total amount of the initial judgment rendered by a jury or awarded by
886 the court; (B) the total amount of the settlement if there was no
887 judgment rendered or awarded; (C) the total amount of the settlement
888 if the claim was settled after judgment was rendered or awarded; (D)
889 the amount of economic damages, as defined in section 52-572h, or the
890 insurer's estimate of the amount in the event of a settlement; (E) the
891 amount of noneconomic damages, as defined in section 52-572h, or the
892 insurer's estimate of the amount in the event of a settlement; (F) the
893 amount of any interest awarded due to failure to accept an offer of
894 judgment; (G) the amount of any remittitur or additur; (H) the amount
895 of final judgment after remittitur or additur; (I) the amount paid by the
896 insurer; (J) the amount paid by the defendant due to a deductible or a
897 judgment or settlement in excess of policy limits; (K) the amount paid
898 by other insurers; (L) the amount paid by other defendants; (M)
899 whether a structured settlement was used; (N) the expense assigned to
900 and recorded with the claim, including, but not limited to, defense and
901 investigation costs, but not including the actual claim payment; and
902 (O) any other information the commissioner determines to be
903 necessary to regulate the professional liability insurance industry with
904 respect to medical professionals and entities, ensure the industry's
905 solvency and ensure that such liability insurance is available and
906 affordable.

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

909 (2) The commissioner shall compile the data included in individual
910 closed claim reports into an aggregated summary format and shall
911 prepare a written annual report of the summary data. The report shall
912 provide an analysis of closed claim information including a minimum
913 of five years of comparative data, when available, trends in frequency
914 and severity of claims, itemization of damages, timeliness of the claims
915 process, and any other descriptive or analytical information that would
916 assist in interpreting the trends in closed claims.

917 (3) The annual report shall include a summary of rate filings for
918 professional liability insurance for medical professionals and entities
919 which have been approved by the department for the prior calendar
920 year, including an analysis of the trend of direct losses, incurred losses,
921 earned premiums and investment income as compared to prior years.
922 The report shall include base premiums charged by medical
923 malpractice insurers for each specialty and the number of providers
924 insured by specialty for each insurer.

925 (4) Not later than March 15, 2006, and annually thereafter, the
926 commissioner shall submit the annual report to the joint standing
927 committee of the General Assembly having cognizance of matters
928 relating to insurance in accordance with section 11-4a. The
929 commissioner shall also (A) make the report available to the public, (B)
930 post the report on its Internet site, and (C) provide public access to the
931 contents of the electronic database after the commissioner establishes
932 that the names and other individually identifiable information about
933 the claimant and practitioner have been removed.

934 (e) The Insurance Commissioner shall provide the Commissioner of
935 Public Health with electronic access to all information received
936 pursuant to this section.

937 Sec. 19. (NEW) (*Effective from passage*) (a) The Commissioner of
938 Public Health shall designate a patient safety ombudsman within the
939 Department of Public Health to improve patient safety and reduce
940 medical errors by coordinating state initiatives on patient safety,
941 facilitating ongoing collaborations between the public and private
942 sectors, and promoting patient safety through education of health care
943 providers and patients.

944 (b) The duties of the patient safety ombudsman shall be to: (1)
945 Establish a Patient Safety and Medical Errors Program; (2) create an
946 education and research program for the health care industry and the
947 public on issues relating to the causes and consequences of medical
948 errors; (3) establish a clearinghouse for reporting on best practices that

949 improve patient safety; (4) coordinate data collection and analysis, in
950 conjunction with other offices in the Department of Public Health, to
951 develop programs that promote patient safety; (5) coordinate state and
952 federal patient safety programs; and (6) participate in the federal
953 Patient Safety Improvement Corps to identify the causes of medical
954 errors.

955 (c) On or before January 1, 2005, and annually thereafter, the patient
956 safety ombudsman shall submit a report, in accordance with the
957 provisions of section 11-4a of the general statutes, to the Governor and
958 the chairpersons of the joint standing committee of the General
959 Assembly having cognizance of matters relating to public health,
960 describing the progress in completing his or her duties, a description
961 of activities undertaken, the groups and number of persons served and
962 recommendations for future action.

963 Sec. 20. (NEW) (*Effective from passage*) Whenever in a civil action to
964 recover damages resulting from personal injury or wrongful death,
965 whether in tort or in contract, in which it is alleged that such injury or
966 death resulted from the negligence of a health care provider, the jury
967 renders a verdict specifying noneconomic damages, as defined in
968 section 52-572h of the general statutes, in an amount exceeding one
969 million dollars, the court shall review the evidence presented to the
970 jury to determine if the amount of noneconomic damages specified in
971 the verdict is excessive as a matter of law in that it so shocks the sense
972 of justice as to compel the conclusion that the jury was influenced by
973 partiality, prejudice, mistake or corruption. If the court so concludes, it
974 shall order a remittitur and, upon failure of the party so ordered to
975 remit the amount ordered by the court, it shall set aside the verdict
976 and order a new trial.

977 Sec. 21. Subdivision (20) of subsection (a) of section 12-701 of the
978 general statutes, as amended by section 13 of public act 03-225, is
979 repealed and the following is substituted in lieu thereof (*Effective from*
980 *passage and applicable to taxable years commencing on or after January 1,*
981 *2004*):

982 (20) "Connecticut adjusted gross income" means adjusted gross
983 income, with the following modifications:

984 (A) There shall be added thereto (i) to the extent not properly
985 includable in gross income for federal income tax purposes, any
986 interest income from obligations issued by or on behalf of any state,
987 political subdivision thereof, or public instrumentality, state or local
988 authority, district or similar public entity, exclusive of such income
989 from obligations issued by or on behalf of the state of Connecticut, any
990 political subdivision thereof, or public instrumentality, state or local
991 authority, district or similar public entity created under the laws of the
992 state of Connecticut and exclusive of any such income with respect to
993 which taxation by any state is prohibited by federal law, (ii) any
994 exempt-interest dividends, as defined in Section 852(b)(5) of the
995 Internal Revenue Code, exclusive of such exempt-interest dividends
996 derived from obligations issued by or on behalf of the state of
997 Connecticut, any political subdivision thereof, or public
998 instrumentality, state or local authority, district or similar public entity
999 created under the laws of the state of Connecticut and exclusive of
1000 such exempt-interest dividends derived from obligations, the income
1001 with respect to which taxation by any state is prohibited by federal
1002 law, (iii) any interest or dividend income on obligations or securities of
1003 any authority, commission or instrumentality of the United States
1004 which federal law exempts from federal income tax but does not
1005 exempt from state income taxes, (iv) to the extent included in gross
1006 income for federal income tax purposes for the taxable year, the total
1007 taxable amount of a lump sum distribution for the taxable year
1008 deductible from such gross income in calculating federal adjusted
1009 gross income, (v) to the extent properly includable in determining the
1010 net gain or loss from the sale or other disposition of capital assets for
1011 federal income tax purposes, any loss from the sale or exchange of
1012 obligations issued by or on behalf of the state of Connecticut, any
1013 political subdivision thereof, or public instrumentality, state or local
1014 authority, district or similar public entity created under the laws of the
1015 state of Connecticut, in the income year such loss was recognized, (vi)

1016 to the extent deductible in determining federal adjusted gross income,
1017 any income taxes imposed by this state, (vii) to the extent deductible in
1018 determining federal adjusted gross income, any interest on
1019 indebtedness incurred or continued to purchase or carry obligations or
1020 securities the interest on which is exempt from tax under this chapter,
1021 (viii) expenses paid or incurred during the taxable year for the
1022 production or collection of income which is exempt from taxation
1023 under this chapter or the management, conservation or maintenance of
1024 property held for the production of such income, and the amortizable
1025 bond premium for the taxable year on any bond the interest on which
1026 is exempt from tax under this chapter to the extent that such expenses
1027 and premiums are deductible in determining federal adjusted gross
1028 income, and (ix) for property placed in service after September 10,
1029 2001, but prior to September 11, 2004, in taxable years ending after
1030 September 10, 2001, any additional allowance for depreciation under
1031 subsection (k) of Section 168 of the Internal Revenue Code, as provided
1032 by Section 101 of the Job Creation and Worker Assistance Act of 2002,
1033 to the extent deductible in determining federal adjusted gross income.

1034 (B) There shall be subtracted therefrom (i) to the extent properly
1035 includable in gross income for federal income tax purposes, any
1036 income with respect to which taxation by any state is prohibited by
1037 federal law, (ii) to the extent allowable under section 12-718, exempt
1038 dividends paid by a regulated investment company, (iii) the amount of
1039 any refund or credit for overpayment of income taxes imposed by this
1040 state, or any other state of the United States or a political subdivision
1041 thereof, or the District of Columbia, to the extent properly includable
1042 in gross income for federal income tax purposes, (iv) to the extent
1043 properly includable in gross income for federal income tax purposes
1044 and not otherwise subtracted from federal adjusted gross income
1045 pursuant to clause (x) of this subparagraph in computing Connecticut
1046 adjusted gross income, any tier 1 railroad retirement benefits, (v) to the
1047 extent any additional allowance for depreciation under Section 168(k)
1048 of the Internal Revenue Code, as provided by Section 101 of the Job
1049 Creation and Worker Assistance Act of 2002, for property placed in

1050 service after December 31, 2001, but prior to September 10, 2004, was
1051 added to federal adjusted gross income pursuant to subparagraph (A)
1052 (ix) of this subdivision in computing Connecticut adjusted gross
1053 income for a taxable year ending after December 31, 2001, twenty-five
1054 per cent of such additional allowance for depreciation in each of the
1055 four succeeding taxable years, (vi) to the extent properly includable in
1056 gross income for federal income tax purposes, any interest income
1057 from obligations issued by or on behalf of the state of Connecticut, any
1058 political subdivision thereof, or public instrumentality, state or local
1059 authority, district or similar public entity created under the laws of the
1060 state of Connecticut, (vii) to the extent properly includable in
1061 determining the net gain or loss from the sale or other disposition of
1062 capital assets for federal income tax purposes, any gain from the sale
1063 or exchange of obligations issued by or on behalf of the state of
1064 Connecticut, any political subdivision thereof, or public
1065 instrumentality, state or local authority, district or similar public entity
1066 created under the laws of the state of Connecticut, in the income year
1067 such gain was recognized, (viii) any interest on indebtedness incurred
1068 or continued to purchase or carry obligations or securities the interest
1069 on which is subject to tax under this chapter but exempt from federal
1070 income tax, to the extent that such interest on indebtedness is not
1071 deductible in determining federal adjusted gross income and is
1072 attributable to a trade or business carried on by such individual, (ix)
1073 ordinary and necessary expenses paid or incurred during the taxable
1074 year for the production or collection of income which is subject to
1075 taxation under this chapter but exempt from federal income tax, or the
1076 management, conservation or maintenance of property held for the
1077 production of such income, and the amortizable bond premium for the
1078 taxable year on any bond the interest on which is subject to tax under
1079 this chapter but exempt from federal income tax, to the extent that
1080 such expenses and premiums are not deductible in determining federal
1081 adjusted gross income and are attributable to a trade or business
1082 carried on by such individual, (x) (I) for a person who files a return
1083 under the federal income tax as an unmarried individual whose
1084 federal adjusted gross income for such taxable year is less than fifty

1085 thousand dollars, or as a married individual filing separately whose
1086 federal adjusted gross income for such taxable year is less than fifty
1087 thousand dollars, or for a husband and wife who file a return under
1088 the federal income tax as married individuals filing jointly whose
1089 federal adjusted gross income for such taxable year is less than sixty
1090 thousand dollars or a person who files a return under the federal
1091 income tax as a head of household whose federal adjusted gross
1092 income for such taxable year is less than sixty thousand dollars, an
1093 amount equal to the Social Security benefits includable for federal
1094 income tax purposes; and (II) for a person who files a return under the
1095 federal income tax as an unmarried individual whose federal adjusted
1096 gross income for such taxable year is fifty thousand dollars or more, or
1097 as a married individual filing separately whose federal adjusted gross
1098 income for such taxable year is fifty thousand dollars or more, or for a
1099 husband and wife who file a return under the federal income tax as
1100 married individuals filing jointly whose federal adjusted gross income
1101 from such taxable year is sixty thousand dollars or more or for a
1102 person who files a return under the federal income tax as a head of
1103 household whose federal adjusted gross income for such taxable year
1104 is sixty thousand dollars or more, an amount equal to the difference
1105 between the amount of Social Security benefits includable for federal
1106 income tax purposes and the lesser of twenty-five per cent of the Social
1107 Security benefits received during the taxable year, or twenty-five per
1108 cent of the excess described in Section 86(b)(1) of the Internal Revenue
1109 Code, (xi) to the extent properly includable in gross income for federal
1110 income tax purposes, any amount rebated to a taxpayer pursuant to
1111 section 12-746, (xii) to the extent properly includable in the gross
1112 income for federal income tax purposes of a designated beneficiary,
1113 any distribution to such beneficiary from any qualified state tuition
1114 program, as defined in Section 529(b) of the Internal Revenue Code,
1115 established and maintained by this state or any official, agency or
1116 instrumentality of the state, (xiii) to the extent properly includable in
1117 gross income for federal income tax purposes, the amount of any
1118 Holocaust victims' settlement payment received in the taxable year by
1119 a Holocaust victim, [and] (xiv) to the extent properly includable in

1120 gross income for federal income tax purposes of an account holder, as
1121 defined in section 31-51ww, interest earned on funds deposited in the
1122 individual development account, as defined in section 31-51ww, of
1123 such account holder, and (xv) for the taxable years commencing
1124 January 1, 2004, January 1, 2005, and January 1, 2006, any amount paid
1125 by a physician licensed in this state for premiums on a professional
1126 liability insurance policy for risks related to the provision of health
1127 care.

1128 (C) With respect to a person who is the beneficiary of a trust or
1129 estate, there shall be added or subtracted, as the case may be, from
1130 adjusted gross income such person's share, as determined under
1131 section 12-714, in the Connecticut fiduciary adjustment.

1132 Sec. 22. Section 4-28e of the general statutes is repealed and the
1133 following is substituted in lieu thereof (*Effective July 1, 2004*):

1134 (a) There is created a Tobacco Settlement Fund which shall be a
1135 separate nonlapsing fund. Any funds received by the state from the
1136 Master Settlement Agreement executed November 23, 1998, shall be
1137 deposited into the fund.

1138 (b) (1) The Treasurer is authorized to invest all or any part of the
1139 Tobacco Settlement Fund, all or any part of the Tobacco and Health
1140 Trust Fund created in section 4-28f, as amended, and all or any part of
1141 the Biomedical Research Trust Fund created in section 19a-32c. The
1142 interest derived from any such investment shall be credited to the
1143 resources of the fund from which the investment was made.

1144 (2) Notwithstanding sections 3-13 to 3-13h, inclusive, the Treasurer
1145 shall invest the amounts on deposit in the Tobacco Settlement Fund,
1146 the Tobacco and Health Trust Fund and the Biomedical Research Trust
1147 Fund in a manner reasonable and appropriate to achieve the objectives
1148 of such funds, exercising the discretion and care of a prudent person in
1149 similar circumstances with similar objectives. The Treasurer shall give
1150 due consideration to rate of return, risk, term or maturity,
1151 diversification of the total portfolio within such funds, liquidity, the

1152 projected disbursements and expenditures, and the expected
1153 payments, deposits, contributions and gifts to be received. The
1154 Treasurer shall not be required to invest such funds directly in
1155 obligations of the state or any political subdivision of the state or in
1156 any investment or other fund administered by the Treasurer. The
1157 assets of such funds shall be continuously invested and reinvested in a
1158 manner consistent with the objectives of such funds until disbursed in
1159 accordance with this section, section 4-28f, as amended, or section 19a-
1160 32c.

1161 (c) (1) For the fiscal year ending June 30, 2001, disbursements from
1162 the Tobacco Settlement Fund shall be made as follows: (A) To the
1163 General Fund in the amount identified as "Transfer from Tobacco
1164 Settlement Fund" in the General Fund revenue schedule adopted by
1165 the General Assembly; (B) to the Department of Mental Health and
1166 Addiction Services for a grant to the regional action councils in the
1167 amount of five hundred thousand dollars; and (C) to the Tobacco and
1168 Health Trust Fund in an amount equal to nineteen million five
1169 hundred thousand dollars.

1170 (2) For the fiscal year ending June 30, 2002, and each fiscal year
1171 thereafter disbursements from the Tobacco Settlement Fund shall be
1172 made as follows: (A) To the Tobacco and Health Trust Fund in an
1173 amount equal to twelve million dollars; (B) to the Biomedical Research
1174 Trust Fund in an amount equal to four million dollars; (C) to the
1175 General Fund in the amount identified as "Transfer from Tobacco
1176 Settlement Fund" in the General Fund revenue schedule adopted by
1177 the General Assembly, which amount shall include, but not be limited
1178 to, an amount equal to (i) the total exemptions claimed by physicians
1179 for premiums on professional liability insurance policies pursuant to
1180 subdivision (20) of subsection (a) of section 12-701, as amended by this
1181 act, and (ii) the amount identified in the General Fund revenue
1182 schedule as necessary to fund the program for the forgiveness of loans
1183 established in section 23 of this act; and (D) any remainder to the
1184 Tobacco and Health Trust Fund.

1185 (d) For the fiscal year ending June 30, 2000, five million dollars shall
1186 be disbursed from the Tobacco Settlement Fund to a tobacco grant
1187 account to be established in the Office of Policy and Management.
1188 Such funds shall not lapse on June 30, 2000, and shall continue to be
1189 available for expenditure during the fiscal year ending June 30, 2001.

1190 (e) Tobacco grants shall be made from the account established
1191 pursuant to subsection (d) of this section by the Secretary of the Office
1192 of Policy and Management in consultation with the speaker of the
1193 House of Representatives, the president pro tempore of the Senate, the
1194 majority leader of the House of Representatives, the majority leader of
1195 the Senate, the minority leader of the House of Representatives, the
1196 minority leader of the Senate, and the cochairpersons and ranking
1197 members of the joint standing committees of the General Assembly
1198 having cognizance of matters relating to public health and
1199 appropriations and the budgets of state agencies, or their designees.
1200 Such grants shall be used to reduce tobacco abuse through prevention,
1201 education, cessation, treatment, enforcement and health needs
1202 programs.

1203 Sec. 23. (NEW) (*Effective July 1, 2004*) The Board of Governors of
1204 Higher Education, in consultation with the Connecticut Medical
1205 Examining Board and the Commissioner of Public Health, shall
1206 establish a program for the forgiveness of loans provided by the state
1207 to individuals for the purpose of completing medical training in
1208 obstetrics or neurosurgery at a medical school in this state accredited
1209 by the Liaison Committee on Medical Education or the American
1210 Osteopathic Association. An individual shall be eligible for such loan
1211 forgiveness if the individual obtains a license as a physician pursuant
1212 to chapter 370 of the general statutes and practices in this state as a
1213 physician or surgeon in the field of obstetrics or neurosurgery for at
1214 least five years. The board of governors, in consultation with the
1215 Connecticut Medical Examining Board and the Commissioner of
1216 Public Health, shall adopt regulations in accordance with chapter 54 of
1217 the general statutes, to establish procedures to administer the program
1218 for the forgiveness of loans.

1219 Sec. 24. (NEW) (*Effective July 1, 2004*) The Connecticut Health and
 1220 Educational Facilities Authority shall establish a pilot program, within
 1221 available appropriations, to finance and provide grants to nonprofit
 1222 hospitals in accordance with this section. The grants shall be used by
 1223 such hospital to provide medical malpractice indemnity or insurance
 1224 to physicians and surgeons who enjoy privileges at the hospital. Such
 1225 indemnity or insurance shall be provided through any risk
 1226 management program or insurance maintained by the hospital. The
 1227 pilot program shall be known as the Connecticut Physician Insurance
 1228 Program. A hospital may apply for a grant on such form as the
 1229 authority prescribes. Grants provided under the pilot program shall
 1230 not exceed seven hundred fifty thousand dollars in the aggregate.

1231 Sec. 25. (*Effective from passage*) Sections 38a-32 to 38a-36, inclusive, of
 1232 the general statutes are repealed.

This act shall take effect as follows:	
Section 1	<i>from passage</i>
Sec. 2	<i>from passage and applicable to actions filed on or after said date</i>
Sec. 3	<i>from passage</i>
Sec. 4	<i>from passage</i>
Sec. 5	<i>from passage</i>
Sec. 6	<i>from passage</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>July 1, 2004</i>
Sec. 13	<i>July 1, 2004</i>
Sec. 14	<i>from passage</i>
Sec. 15	<i>October 1, 2004</i>
Sec. 16	<i>October 1, 2004</i>
Sec. 17	<i>from passage and applicable to causes of action accruing on or after said date</i>
Sec. 18	<i>January 1, 2005</i>
Sec. 19	<i>from passage</i>

Sec. 20	<i>from passage</i>
Sec. 21	<i>from passage and applicable to taxable years commencing on or after January 1, 2004</i>
Sec. 22	<i>July 1, 2004</i>
Sec. 23	<i>July 1, 2004</i>
Sec. 24	<i>July 1, 2004</i>
Sec. 25	<i>from passage</i>

Statement of Legislative Commissioners:

In section 3(b)(3), "award" was changed to "award or settlement" for accuracy, in sections 1(b), 5(g) and 14(b)(2), "within" was changed to "not later than" for statutory consistency, in section 4(3), "conducting" was added for purposes of grammar, in section 7(a), "members" was changed to "persons" for accuracy, in section 9(a)(2), the language was rephrased for clarity, and in section 18(b), "claim for recovery under a medical liability policy" was replaced by the defined term "claim" for conciseness.

JUD *Joint Favorable Subst.*