



General Assembly

February Session, 2004

Raised Bill No. 60

LCO No. 538

00538 _____ PRI

Referred to Committee on Program Review and Investigations

Introduced by:
(PRI)

AN ACT CONCERNING MEDICAL MALPRACTICE.

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

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 Section 38a-32 of the general statutes is repealed and the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

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

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 Section 38a-33 of the general statutes is repealed and the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

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

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

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

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

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

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

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

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

75 (a) All proceedings, records, findings and deliberations of a hearing
76 panel shall be confidential and shall not be used in any other
77 proceedings, or otherwise publicized, except as provided in section
78 19a-17b and sections 38a-32 to 38a-36, inclusive, [nor] as amended by
79 this act, or disclosed by any party, witness, counsel, panel member or
80 other person, on penalty of being found in contempt of court.

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

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

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

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

103 Sec. 6. Section 52-190a of the general statutes, as amended by section
104 14 of public act 03-202, is repealed and the following is substituted in
105 lieu thereof (*Effective from passage and applicable to actions filed on or after*
106 *said date*):

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

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

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

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

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

165 (b) Upon the filing of any medical malpractice claim against an
166 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
167 383, the plaintiff shall mail a copy of the complaint to the Department
168 of Public Health.

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

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

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

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

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

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

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

228 (a) There shall be within the Department of Public Health a
229 Connecticut Medical Examining Board. Said board shall consist of
230 fifteen members appointed by the Governor, subject to the provisions
231 of section 4-9a, as amended, in the manner prescribed for department
232 heads in section 4-7, as follows: Five physicians practicing in the state;
233 one physician who shall be a full-time member of the faculty of The
234 University of Connecticut School of Medicine; one physician who shall
235 be a full-time chief of staff in a general-care hospital in the state; one
236 physician who shall be registered as a supervising physician for one or
237 more physician assistants; one physician who shall be a graduate of a
238 medical education program accredited by the American Osteopathic
239 Association; one physician assistant licensed pursuant to section
240 20-12b and practicing in this state; and five public members. No
241 professional member of said board shall be an elected or appointed
242 officer of a professional society or association relating to such

243 member's profession at the time of appointment to the board or have
244 been such an officer during the year immediately preceding
245 appointment or serve for more than two consecutive terms.
246 Professional members shall be practitioners in good professional
247 standing and residents of this state.

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

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

276 and appointments to fill a vacancy on the list shall possess the same
277 qualifications as those required of the member succeeded or replaced.
278 No person whose spouse, parent, brother, sister, child or spouse of a
279 child is a physician, as defined in section 20-13a, or a physician
280 assistant, as defined in section 20-12a, shall be appointed to the list as a
281 member of the public. Each person appointed to the list shall serve
282 without compensation at the pleasure of the commissioner.

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

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

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

302 (g) (1) Not later than December 31, 2004, the board, with the
303 assistance of the department, shall adopt regulations, in accordance
304 with chapter 54, to establish guidelines for use in the disciplinary
305 process. Such guidelines shall include, but need not be limited to: (A)
306 Identification of each type of violation; (B) a minimum and maximum
307 penalty for each type of violation; (C) additional optional conditions

308 that may be imposed by the board for each violation; (D) identification
309 of factors the board shall consider in determining if the maximum or
310 minimum penalty should apply; (E) conditions, such as mitigating
311 factors or other facts, that may be considered in allowing deviations
312 from the guidelines; and (F) a provision that when a deviation from
313 the guidelines occurs, the reason for the deviation shall be identified.

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

338 (3) The board shall refer all findings of no probable cause filed with
339 the board by the department pursuant to section 20-13e, as amended
340 by this act, to a medical hearing panel within sixty days of the receipt

341 of charges. This time period may be extended for good cause by the
342 board in a duly recorded vote. The panel shall review the petition and
343 the entire record of the investigation and may request the department
344 for more information or for a reconsideration of such finding. If the
345 panel takes no action within ninety days of the submission to the
346 board of such finding, the department's finding of no probable cause
347 shall be considered final.

348 (4) For purposes of this section, a medical hearing panel shall consist
349 of three members, at least one of whom shall be a member of the board
350 and one a member of the public. The public member may be a member
351 of either the board or of the list established pursuant to subsection (c)
352 of this section.

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

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

373 any member who resigns or otherwise fails to continue to serve on the
374 panel. Such replacement member shall review the record prior to the
375 next hearing.

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

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

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

398 Sec. 11. (NEW) (*Effective from passage*) (a) Each licensed hospital or
399 outpatient surgical facility shall establish protocols for screening
400 patients prior to any surgery. Such protocols shall require that: (1)
401 Prior to any surgery, members of the surgical team, including at least
402 one principal surgeon, but not exceeding five such members in total,
403 together (A) identify the patient and, where the patient is able to do so,
404 have the patient identify himself, and (B) identify the procedure to be

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

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

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

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

437 thereof, and prior to the rendering of a verdict by the jury or an award
438 by the court, the "offer of judgment" shall be considered rejected and
439 not subject to acceptance unless refiled. Any such "offer of judgment"
440 and any "acceptance of offer of judgment" shall be included by the
441 clerk in the record of the case.

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

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

470 (a) Each insurance company doing business in this state shall,
471 annually, on or before the first day of March, render to the Insurance
472 Commissioner a true record of the number, according to classification,
473 of cancellations of and refusals to renew professional liability
474 insurance policies for the year ending on the thirty-first day of
475 December next preceding.

476 (b) For purposes of sections 38a-393 to 38a-395, inclusive,
477 "professional liability insurance" means professional liability contracts
478 for: (1) Physicians and surgeons, (2) hospitals, (3) lawyers, (4) dentists,
479 (5) architects and engineers, (6) chiropractors, (7) licensed
480 natureopaths, (8) podiatrists, and (9) advanced practice registered
481 nurses and such other categories as the Insurance Commissioner, in
482 the commissioner's discretion, shall adopt by regulations in accordance
483 with chapter 54.

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

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

496 (a) (1) The department shall investigate each petition filed pursuant
497 to section 20-13d, in accordance with the provisions of subdivision (10)
498 of subsection (a) of section 19a-14, to determine if probable cause exists
499 to issue a statement of charges and to institute proceedings against the
500 physician under subsection (e) of this section. Such investigation shall
501 be concluded not later than eighteen months from the date the petition

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

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

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

529 (b) Each person holding a license to practice medicine, surgery,
530 podiatry, chiropractic or natureopathy shall, annually, during the
531 month of such person's birth, register with the Department of Public
532 Health, upon payment of the professional services fee for class I, as
533 defined in section 33-182l, on blanks to be furnished by the department

534 for such purpose, giving such person's name in full, such person's
535 residence and business address, the name of the insurance company
536 providing such person's professional liability insurance and the policy
537 number of such insurance, such person's area of specialization,
538 whether such person is actively involved in patient care, any
539 disciplinary action against such person, or malpractice payments made
540 on behalf of such person in any other state or jurisdiction, and such
541 other information as the department requests. The department may
542 compare information submitted pursuant to this subsection to
543 information contained in the National Practitioner Data Base.

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

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

557 Sec. 18. (NEW) (*Effective July 1, 2004*) The Connecticut Health and
558 Educational Facilities Authority shall establish a program, within
559 available appropriations, to finance low interest loans to hospitals to
560 install or upgrade electronic health record systems for the
561 establishment and maintenance of patient records and verification of
562 patient treatment. The program shall be known as the Connecticut
563 Electronic Health Records Program. Loans shall be made for the
564 purpose of establishing or upgrading electronic health record systems
565 for use by hospitals in order to promote patient safety and eliminate

566 errors.

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

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

587 (b) (1) Each filing as described in subsection (a) of this section for
588 workers' compensation or employers' liability insurance shall be on file
589 with the Insurance Commissioner for a waiting period of thirty days
590 before it becomes effective, which period may be extended by the
591 commissioner for an additional period not to exceed thirty days if the
592 commissioner gives written notice within such waiting period to the
593 insurer or rating organization which made the filing that the
594 commissioner needs such additional time for the consideration of such
595 filing. Upon written application by such insurer or rating organization,
596 the commissioner may authorize a filing which the commissioner has
597 reviewed to become effective before the expiration of the waiting

598 period or any extension thereof. A filing shall be deemed to meet the
599 requirements of sections 38a-663 to 38a-696, inclusive, unless
600 disapproved by the commissioner within the waiting period or any
601 extension thereof. If, within the waiting period or any extension
602 thereof, the commissioner finds that a filing does not meet the
603 requirements of said sections, the commissioner shall send to the
604 insurer or rating organization which made such filing written notice of
605 disapproval of such filing, specifying therein in what respects the
606 commissioner finds such filing fails to meet the requirements of said
607 sections and stating that such filing shall not become effective. Such
608 finding of the commissioner shall be subject to review as provided in
609 section 38a-19.

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

628 (c) The form of any insurance policy or contract the rates for which
629 are subject to the provisions of sections 38a-663 to 38a-696, inclusive,
630 other than fidelity, surety or guaranty bonds, and the form of any

631 endorsement modifying such insurance policy or contract, shall be
632 filed with the Insurance Commissioner prior to its issuance. The
633 commissioner shall adopt regulations, in accordance with the
634 provisions of chapter 54, establishing a procedure for review of such
635 policy or contract. If at any time the commissioner finds that any such
636 policy, contract or endorsement is not in accordance with such
637 provisions or any other provision of law, the commissioner shall issue
638 an order disapproving the issuance of such form and stating the
639 reasons for disapproval. The provisions of section 38a-19 shall apply to
640 any such order issued by the commissioner.

641 Sec. 20. (NEW) (*Effective October 1, 2004*) (a) On and after October 1,
642 2004, no captive insurer, as defined in section 38a-91 of the general
643 statutes, may insure a health care provider or entity in this state
644 against liability for medical malpractice unless the captive insurer has
645 obtained a certificate of authority from the Insurance Commissioner,
646 except that no certificate of authority shall be required for any captive
647 insurer that is duly licensed in this state to offer such insurance.

648 (b) Any captive insurer seeking to obtain a certificate of authority
649 shall make application to the commissioner, on such form as the
650 commissioner requires, setting forth the line or lines of business which
651 it is seeking authorization to write. The captive insurer shall file with
652 the commissioner a certified copy of its charter or articles of
653 association and evidence satisfactory to the commissioner that it has
654 complied with the laws of the jurisdiction under which it is organized,
655 a statement of its financial condition in such form as is required by the
656 commissioner, together with such evidence of its correctness as the
657 commissioner requires and evidence of good management in such
658 form as is required by the commissioner. The captive insurer shall
659 submit evidence of its ability to provide continuant and timely claims
660 settlement. If the information furnished is satisfactory to the
661 commissioner, and if all other requirements of law have been complied
662 with, the commissioner may issue to such insurer a certificate of
663 authority permitting it to do business in this state. Each such certificate

664 of authority shall expire on the first day of May succeeding the date of
665 its issuance, but may be renewed without any formalities except as
666 required by the commissioner. Failure of a captive insurer to exercise
667 its authority to write a particular line or lines of business in this state
668 for two consecutive calendar years may constitute sufficient cause for
669 revocation of the captive insurer's authority to write those lines of
670 business.

671 (c) The commissioner shall adopt regulations, in accordance with
672 chapter 54 of the general statutes, specifying the information and
673 evidence that a captive insurer seeking to obtain or renew a certificate
674 of authority shall submit and the requirements with which it shall
675 comply.

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

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

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

703 Sec. 21. Subsection (a) of section 38a-11 of the general statutes, as
704 amended by section 10 of public act 03-152 and section 9 of public act
705 03-169, is repealed and the following is substituted in lieu thereof
706 (*Effective October 1, 2004*):

707 (a) The commissioner shall demand and receive the following fees:
708 (1) For the annual fee for each license issued to a domestic insurance
709 company, one hundred dollars; (2) for receiving and filing annual
710 reports of domestic insurance companies, twenty-five dollars; (3) for
711 filing all documents prerequisite to the issuance of a license to an
712 insurance company, one hundred seventy-five dollars, except that the
713 fee for such filings by any health care center, as defined in section 38a-
714 175, shall be one thousand one hundred dollars; (4) for filing any
715 additional paper required by law, fifteen dollars; (5) for each certificate
716 of valuation, organization, reciprocity or compliance, twenty dollars;
717 (6) for each certified copy of a license to a company, twenty dollars; (7)
718 for each certified copy of a report or certificate of condition of a
719 company to be filed in any other state, twenty dollars; (8) for
720 amending a certificate of authority, one hundred dollars; (9) for each
721 license issued to a rating organization, one hundred dollars. In
722 addition, insurance companies shall pay any fees imposed under
723 section 12-211; (10) a filing fee of twenty-five dollars for each initial
724 application for a license made pursuant to section 38a-769; (11) with
725 respect to insurance agents' appointments: (A) A filing fee of twenty-
726 five dollars for each request for any agent appointment; (B) a fee of
727 forty dollars for each appointment issued to an agent of a domestic
728 insurance company or for each appointment continued; and (C) a fee

729 of twenty dollars for each appointment issued to an agent of any other
730 insurance company or for each appointment continued, except that no
731 fee shall be payable for an appointment issued to an agent of an
732 insurance company domiciled in a state or foreign country which does
733 not require any fee for an appointment issued to an agent of a
734 Connecticut insurance company; (12) with respect to insurance
735 producers: (A) An examination fee of seven dollars for each
736 examination taken, except when a testing service is used, the testing
737 service shall pay a fee of seven dollars to the commissioner for each
738 examination taken by an applicant; (B) a fee of forty dollars for each
739 license issued; and (C) a fee of forty dollars for each license renewed;
740 (13) with respect to public adjusters: (A) An examination fee of seven
741 dollars for each examination taken, except when a testing service is
742 used, the testing service shall pay a fee of seven dollars to the
743 commissioner for each examination taken by an applicant; and (B) a fee
744 of one hundred twenty-five dollars for each license issued or renewed;
745 (14) with respect to casualty adjusters: (A) An examination fee of ten
746 dollars for each examination taken, except when a testing service is
747 used, the testing service shall pay a fee of ten dollars to the
748 commissioner for each examination taken by an applicant; (B) a fee of
749 forty dollars for each license issued or renewed; and (C) the expense of
750 any examination administered outside the state shall be the
751 responsibility of the entity making the request and such entity shall
752 pay to the commissioner one hundred dollars for such examination
753 and the actual traveling expenses of the examination administrator to
754 administer such examination; (15) with respect to motor vehicle
755 physical damage appraisers: (A) An examination fee of forty dollars
756 for each examination taken, except when a testing service is used, the
757 testing service shall pay a fee of forty dollars to the commissioner for
758 each examination taken by an applicant; (B) a fee of forty dollars for
759 each license issued or renewed; and (C) the expense of any
760 examination administered outside the state shall be the responsibility
761 of the entity making the request and such entity shall pay to the
762 commissioner one hundred dollars for such examination and the

763 actual traveling expenses of the examination administrator to
764 administer such examination; (16) with respect to certified insurance
765 consultants: (A) An examination fee of thirteen dollars for each
766 examination taken, except when a testing service is used, the testing
767 service shall pay a fee of thirteen dollars to the commissioner for each
768 examination taken by an applicant; (B) a fee of two hundred dollars for
769 each license issued; and (C) a fee of one hundred twenty-five dollars
770 for each license renewed; (17) with respect to surplus lines brokers: (A)
771 An examination fee of ten dollars for each examination taken, except
772 when a testing service is used, the testing service shall pay a fee of ten
773 dollars to the commissioner for each examination taken by an
774 applicant; and (B) a fee of five hundred dollars for each license issued
775 or renewed; (18) with respect to fraternal agents, a fee of forty dollars
776 for each license issued or renewed; (19) a fee of thirteen dollars for
777 each license certificate requested, whether or not a license has been
778 issued; (20) with respect to domestic and foreign benefit societies shall
779 pay: (A) For service of process, twenty-five dollars for each person or
780 insurer to be served; (B) for filing a certified copy of its charter or
781 articles of association, five dollars; (C) for filing the annual report, ten
782 dollars; and (D) for filing any additional paper required by law, three
783 dollars; (21) with respect to foreign benefit societies: (A) For each
784 certificate of organization or compliance, four dollars; (B) for each
785 certified copy of permit, two dollars; and (C) for each copy of a report
786 or certificate of condition of a society to be filed in any other state, four
787 dollars; (22) with respect to reinsurance intermediaries: A fee of five
788 hundred dollars for each license issued or renewed; (23) with respect
789 to viatical settlement providers: (A) A filing fee of thirteen dollars for
790 each initial application for a license made pursuant to section 38a-465a;
791 and (B) a fee of twenty dollars for each license issued or renewed; (24)
792 with respect to viatical settlement brokers: (A) A filing fee of thirteen
793 dollars for each initial application for a license made pursuant to
794 section 38a-465a; and (B) a fee of twenty dollars for each license issued
795 or renewed; (25) with respect to viatical settlement investment agents:
796 (A) A filing fee of thirteen dollars for each initial application for a

797 license made pursuant to section 38a-465a; and (B) a fee of twenty
798 dollars for each license issued or renewed; (26) with respect to
799 preferred provider networks, a fee of two thousand five hundred
800 dollars for each license issued or renewed; (27) with respect to rental
801 companies, as defined in section 38a-799, a fee of forty dollars for each
802 permit issued or renewed; (28) with respect to a certificate of authority
803 for a captive insurer pursuant to section 21 of this act, a fee of one
804 hundred seventy-five dollars for each certificate issued or renewed;
805 and ~~[(28)]~~ (29) with respect to each duplicate license issued a fee of
806 twenty-five dollars for each license issued.

807 Sec. 22. (NEW) (*Effective from passage*) Any party to an action for
808 medical malpractice may file an application with the Superior Court
809 requesting that the case be designated as a complex litigation case and
810 be transferred by the Chief Court Administrator or any judge
811 designated by the Chief Court Administrator to the complex litigation
812 docket in a judicial district and court location determined by the Chief
813 Court Administrator or such designee.

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

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

825 (b) In any such contingency fee arrangement such fee shall be the
826 exclusive method for payment of the attorney by the claimant and
827 shall not exceed an amount equal to a percentage of the damages
828 awarded and received by the claimant or of the settlement amount

829 received by the claimant as follows: (1) Thirty-three and one-third per
830 cent of the first three hundred thousand dollars; (2) twenty-five per
831 cent of the next three hundred thousand dollars; (3) twenty per cent of
832 the next three hundred thousand dollars; (4) fifteen per cent of the next
833 three hundred thousand dollars; and (5) ten per cent of any amount
834 which exceeds one million two hundred thousand dollars.

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

854 [(c)] (d) For the purposes of this section, "damages awarded and
855 received" means in a civil action in which final judgment is entered,
856 that amount of the judgment or amended judgment entered by the
857 court that is received by the claimant after deduction for any
858 disbursements or costs incurred by the attorney in connection with the
859 prosecution or settlement of the civil action, other than ordinary office
860 overhead and expense, for which the claimant is liable, except that in a
861 civil action brought pursuant to section 38a-368 such amount shall be

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

876 Sec. 24. Section 38a-395 of the general statutes is repealed and the
877 following is substituted in lieu thereof (*Effective January 1, 2005*):

878 [The Insurance Commissioner may require all insurance companies
879 writing medical malpractice insurance in this state to submit, in such
880 manner and at such times as he specifies, such information as he
881 deems necessary to establish a data base on medical malpractice,
882 including information on all incidents of medical malpractice, all
883 settlements, all awards, other information relative to procedures and
884 specialties involved and any other information relating to risk
885 management.]

886 (a) As used in this section:

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

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

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

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

904 (c) The closed claim report shall include:

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

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

922 (3) Details about the claims process, including: (A) Whether a
923 lawsuit was filed, and if so, in which court; (B) the outcome of such

924 lawsuit; (C) the number of other defendants, if any; (D) the stage in the
925 process when the claim was closed; (E) the dates of the trial; (F) the
926 date of the judgment or settlement, if any; (G) whether an appeal was
927 filed, and if so, the date filed; (H) the resolution of the appeal and the
928 date such appeal was decided; (I) the date the claim was closed; (J) the
929 initial indemnity and expense reserve for the claim; and (K) the final
930 indemnity and expense reserve for the claim.

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

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

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

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

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

981 (e) The Insurance Commissioner shall provide the Commissioner of
982 Public Health with electronic access to all information received
983 pursuant to this section.

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>

Statement of Purpose:

To implement the recommendations of the Medical Malpractice Action Group.

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