



General Assembly

February Session, 2004

Raised Bill No. 394

LCO No. 1374

01374_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM.

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

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 Section 38a-32 of the general statutes is repealed and the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

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

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 Section 38a-33 of the general statutes is repealed and the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

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

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

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

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

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

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

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

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

78 (a) All proceedings, records, findings and deliberations of a hearing

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

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

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

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

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

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

110 *said date*):

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

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

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

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

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

169 (b) Upon the filing of any medical malpractice claim against an
170 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
171 383, the plaintiff shall mail a copy of the complaint to the Department
172 of Public Health and the Insurance Department.

173 (c) Upon entry of any medical malpractice award by a court or upon
174 the parties entering a settlement of a malpractice claim against an

175 individual licensed pursuant to chapter 370 to 373, inclusive, 379 or
176 383, the entity making payment on behalf of a party or, if no such
177 entity exists, the party, shall [notify] provide to the Department of
178 Public Health [of the terms of the award or settlement and shall
179 provide to the department] and the Insurance Department a copy of
180 the award or settlement and the underlying complaint and answer, if
181 any. Such copies provided to the Insurance Department shall not
182 identify the parties to the claim. The Department of Public Health shall
183 send the information received from such entity or party to the state
184 board of examiners having cognizance over any individual licensed
185 pursuant to chapter 370 to 373, inclusive, 379 or 383 who is a party to
186 the claim. The [department] Department of Public Health shall review
187 all medical malpractice claims and awards and all settlements to
188 determine whether further investigation or disciplinary action against
189 the providers involved is warranted. On and after July 1, 2004, such
190 review shall be conducted in accordance with guidelines adopted by
191 the Department of Public Health, in accordance with the provisions of
192 section 20-13b, as amended by this act, to determine the basis for such
193 further investigation or disciplinary action. Any document received
194 pursuant to this section shall not be considered a petition and shall not
195 be subject to the provisions of section 1-210, as amended, unless the
196 [department] Department of Public Health determines, following
197 completion of its review, that further investigation or disciplinary
198 action is warranted.

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

207 (e) The Commissioner of Public Health and the Insurance

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

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

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

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

234 (a) There shall be within the Department of Public Health a
235 Connecticut Medical Examining Board. Said board shall consist of
236 fifteen members appointed by the Governor, subject to the provisions
237 of section 4-9a, as amended, in the manner prescribed for department
238 heads in section 4-7, as follows: Five physicians practicing in the state;
239 one physician who shall be a full-time member of the faculty of The

240 University of Connecticut School of Medicine; one physician who shall
241 be a full-time chief of staff in a general-care hospital in the state; one
242 physician who shall be registered as a supervising physician for one or
243 more physician assistants; one physician who shall be a graduate of a
244 medical education program accredited by the American Osteopathic
245 Association; one physician assistant licensed pursuant to section
246 20-12b and practicing in this state; and five public members. No
247 professional member of said board shall be an elected or appointed
248 officer of a professional society or association relating to such
249 member's profession at the time of appointment to the board or have
250 been such an officer during the year immediately preceding
251 appointment or serve for more than two consecutive terms.
252 Professional members shall be practitioners in good professional
253 standing and residents of this state.

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

262 (c) The Commissioner of Public Health shall establish a list of
263 eighteen persons who may serve as members of medical hearing
264 panels established pursuant to subsection (g) of this section. Persons
265 appointed to the list shall serve as members of the medical hearing
266 panels and provide the same services as members of the Connecticut
267 Medical Examining Board. Members from the list serving on such
268 panels shall not be voting members of the Connecticut Medical
269 Examining Board. The list shall consist of eighteen members appointed
270 by the commissioner, eight of whom shall be physicians, as defined in
271 section 20-13a, with at least one of such physicians being a graduate of
272 a medical education program accredited by the American Osteopathic

273 Association, one of whom shall be a physician assistant licensed
274 pursuant to section 20-12b, and nine of whom shall be members of the
275 public. No professional member of the list shall be an elected or
276 appointed officer of a professional society or association relating to
277 such member's profession at the time of appointment to the list or have
278 been such an officer during the year immediately preceding such
279 appointment to the list. A licensed professional appointed to the list
280 shall be a practitioner in good professional standing and a resident of
281 this state. All vacancies shall be filled by the commissioner. Successors
282 and appointments to fill a vacancy on the list shall possess the same
283 qualifications as those required of the member succeeded or replaced.
284 No person whose spouse, parent, brother, sister, child or spouse of a
285 child is a physician, as defined in section 20-13a, or a physician
286 assistant, as defined in section 20-12a, shall be appointed to the list as a
287 member of the public. Each person appointed to the list shall serve
288 without compensation at the pleasure of the commissioner.

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

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

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

305 matters concerning suspension or revocation of licensure, (2)
306 adjudicate complaints against practitioners, and (3) impose sanctions
307 where appropriate.

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

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

338 chapter 54 and the regulations adopted by the commissioner
339 concerning contested cases. The commissioner shall file a proposed
340 final decision with the board not later than sixty days after such
341 hearing, except that the time period for filing such proposed final
342 decision with the board may be extended for good cause by the board
343 in a duly recorded vote.

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

354 (4) For purposes of this section, a medical hearing panel shall consist
355 of three members, at least one of whom shall be a member of the board
356 and one a member of the public. The public member may be a member
357 of either the board or of the list established pursuant to subsection (c)
358 of this section.

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

366 (i) Except in a case in which a license has been summarily
367 suspended, pursuant to subsection (c) of section 19a-17 or subsection
368 (c) of section 4-182, all three panel members shall be present to hear
369 any evidence and vote on a proposed final decision. The chairperson of

370 the Medical Examining Board may exempt a member from a meeting
371 of the panel if the chairperson finds that good cause exists for such an
372 exemption. Such an exemption may be granted orally but shall be
373 reduced to writing and included as part of the record of the panel
374 within two business days of the granting of the exemption or the
375 opening of the record and shall state the reason for the exemption.
376 Such exemption shall be granted to a member no more than once
377 during any contested case and shall not be granted for a meeting at
378 which the panel is acting on a proposed final decision on a statement
379 of charges. The board may appoint a member to the panel to replace
380 any member who resigns or otherwise fails to continue to serve on the
381 panel. Such replacement member shall review the record prior to the
382 next hearing.

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

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

388 The department shall file with the Governor and the joint standing
389 committee on public health of the General Assembly on or before
390 January 1, 1986, and thereafter on or before January first of each
391 succeeding year, a report of the activities of the department and the
392 board conducted pursuant to sections 20-13d and 20-13e, as amended
393 by this act. Each such report shall include, but shall not be limited to,
394 the following information: The number of petitions received; the
395 number of petitions not investigated, and the reasons why; the number
396 of hearings held on such petitions; [and,] the outcome of such
397 hearings; the timeliness of action taken on any petition considered to
398 be a priority; without identifying the particular physician concerned, a
399 brief description of the impairment alleged in each such petition and
400 the actions taken with regard to each such petition by the department
401 and the board; the number of notifications received pursuant to section

402 19a-17a, as amended by this act; the number of such notifications with
403 no further action taken, and the reasons why; and the outcomes for
404 notifications where further action is taken.

405 Sec. 11. (NEW) (*Effective from passage*) (a) Each licensed hospital or
406 outpatient surgical facility shall establish protocols for screening
407 patients prior to any surgery. Such protocols shall require that: (1)
408 Prior to any surgery the principal surgeon and four other persons
409 employed by or associated with the hospital or facility (A) identify the
410 patient and, if the patient is able to do so, have the patient identify
411 himself or herself, and (B) identify the procedure to be performed, and
412 (2) no patient may be anesthetized and no surgery may be performed
413 unless the identifications specified in subdivision (1) of this subsection
414 have been confirmed by all such members, except that such protocols
415 may provide for alternative identification procedures where the
416 patient is unconscious or under emergency circumstances. Each
417 licensed hospital or outpatient surgical facility shall annually submit to
418 the Department of Public Health a copy of such protocols and a report
419 on their implementation.

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

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

425 (a) After commencement of any civil action based upon contract or
426 seeking the recovery of money damages, whether or not other relief is
427 sought, the plaintiff may, not later than thirty days before trial, file
428 with the clerk of the court a written "offer of judgment" signed by the
429 plaintiff or the plaintiff's attorney, directed to the defendant or the
430 defendant's attorney, offering to settle the claim underlying the action
431 and to stipulate to a judgment for a sum certain. The plaintiff shall give
432 notice of the offer of settlement to the defendant's attorney or, if the
433 defendant is not represented by an attorney, to the defendant himself

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

449 (b) After trial the court shall examine the record to determine
450 whether the plaintiff made an "offer of judgment" which the defendant
451 failed to accept. If the court ascertains from the record that the plaintiff
452 has recovered an amount equal to or greater than the sum certain
453 stated in the plaintiff's "offer of judgment", the court shall add to the
454 amount so recovered twelve per cent annual interest on said amount,
455 [computed from the date such offer was filed in actions commenced
456 before October 1, 1981. In those actions commenced on or after October
457 1, 1981, the] with respect to an offer of judgment filed prior to the
458 effective date of this section, and interest at an annual rate of two
459 percentage points above the weekly average five-year constant
460 maturity yield of United States Treasury securities, as published by the
461 Board of Governors of the Federal Reserve System, for the calendar
462 week preceding the beginning of each year for which interest is owed,
463 with respect to an offer of judgment filed on or after the effective date
464 of this section. The interest shall be computed from the date the
465 complaint in the civil action was filed with the court if the "offer of
466 judgment" was filed not later than eighteen months from the filing of
467 such complaint. If such offer was filed later than eighteen months from

468 the date of filing of the complaint, the interest shall be computed from
469 the date the "offer of judgment" was filed. The court may award
470 reasonable attorney's fees in an amount not to exceed three hundred
471 fifty dollars, and shall render judgment accordingly. This section shall
472 not be interpreted to abrogate the contractual rights of any party
473 concerning the recovery of attorney's fees in accordance with the
474 provisions of any written contract between the parties to the action.

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

477 (a) Each insurance company doing business in this state shall,
478 annually, on or before the first day of March, render to the Insurance
479 Commissioner a true record of the number, according to classification,
480 of cancellations of and refusals to renew professional liability
481 insurance policies for the year ending on the thirty-first day of
482 December next preceding.

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

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

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

503 (a) (1) The department shall investigate each petition filed pursuant
504 to section 20-13d, in accordance with the provisions of subdivision (10)
505 of subsection (a) of section 19a-14₂ to determine if probable cause exists
506 to issue a statement of charges and to institute proceedings against the
507 physician under subsection (e) of this section. Such investigation shall
508 be concluded not later than eighteen months from the date the petition
509 is filed with the department and, unless otherwise specified by this
510 subsection, the record of such investigation shall be deemed a public
511 record, in accordance with section 1-210, as amended, at the conclusion
512 of such eighteen-month period. Any such investigation shall be
513 confidential and no person shall disclose his knowledge of such
514 investigation to a third party unless the physician requests that such
515 investigation and disclosure be open. If the department determines
516 that probable cause exists to issue a statement of charges, the entire
517 record of such proceeding shall be public unless the department
518 determines that the physician is an appropriate candidate for
519 participation in a rehabilitation program in accordance with subsection
520 (b) of this section and the physician agrees to participate in such
521 program in accordance with terms agreed upon by the department and
522 the physician. If at any time subsequent to the filing of a petition and
523 during the eighteen-month period, the department makes a finding of
524 no probable cause and the medical panel appointed pursuant to
525 subsection (g) of section 20-8a, as amended by this act, allows such
526 finding to stand, the petition and the entire record of such
527 investigation shall remain confidential unless the physician requests
528 that such petition and record be open.

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

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

536 (b) Each person holding a license to practice medicine, surgery,
537 podiatry, chiropractic or natureopathy shall, annually, during the
538 month of such person's birth, register with the Department of Public
539 Health, upon payment of the professional services fee for class I, as
540 defined in section 33-182l, on blanks to be furnished by the department
541 for such purpose, giving such person's name in full, such person's
542 residence and business address, the name of the insurance company
543 providing such person's professional liability insurance and the policy
544 number of such insurance, such person's area of specialization,
545 whether such person is actively involved in patient care, any
546 disciplinary action against such person, or malpractice payments made
547 on behalf of such person in any other state or jurisdiction, and such
548 other information as the department requests. The department may
549 compare information submitted pursuant to this subsection to
550 information contained in the National Practitioner Data Base.

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

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

564 Sec. 18. (NEW) (*Effective July 1, 2004*) The Connecticut Health and

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

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

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

594 (b) (1) Each filing as described in subsection (a) of this section for
595 workers' compensation or employers' liability insurance shall be on file
596 with the Insurance Commissioner for a waiting period of thirty days

597 before it becomes effective, which period may be extended by the
598 commissioner for an additional period not to exceed thirty days if the
599 commissioner gives written notice within such waiting period to the
600 insurer or rating organization which made the filing that the
601 commissioner needs such additional time for the consideration of such
602 filing. Upon written application by such insurer or rating organization,
603 the commissioner may authorize a filing which the commissioner has
604 reviewed to become effective before the expiration of the waiting
605 period or any extension thereof. A filing shall be deemed to meet the
606 requirements of sections 38a-663 to 38a-696, inclusive, unless
607 disapproved by the commissioner within the waiting period or any
608 extension thereof. If, within the waiting period or any extension
609 thereof, the commissioner finds that a filing does not meet the
610 requirements of said sections, the commissioner shall send to the
611 insurer or rating organization which made such filing written notice of
612 disapproval of such filing, specifying therein in what respects the
613 commissioner finds such filing fails to meet the requirements of said
614 sections and stating that such filing shall not become effective. Such
615 finding of the commissioner shall be subject to review as provided in
616 section 38a-19.

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

631 increase prior to approving or denying the request. The Insurance
632 Commissioner shall approve or deny the request within forty-five days
633 of its receipt. Such finding of the commissioner shall be subject to
634 review as provided in section 38a-19.

635 (c) The form of any insurance policy or contract the rates for which
636 are subject to the provisions of sections 38a-663 to 38a-696, inclusive,
637 other than fidelity, surety or guaranty bonds, and the form of any
638 endorsement modifying such insurance policy or contract, shall be
639 filed with the Insurance Commissioner prior to its issuance. The
640 commissioner shall adopt regulations₂ in accordance with the
641 provisions of chapter 54₂ establishing a procedure for review of such
642 policy or contract. If at any time the commissioner finds that any such
643 policy, contract or endorsement is not in accordance with such
644 provisions or any other provision of law, the commissioner shall issue
645 an order disapproving the issuance of such form and stating the
646 reasons for disapproval. The provisions of section 38a-19 shall apply to
647 any such order issued by the commissioner.

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

655 (b) Any captive insurer seeking to obtain a certificate of authority
656 shall make application to the commissioner, on such form as the
657 commissioner requires, setting forth the line or lines of business which
658 it is seeking authorization to write. The captive insurer shall file with
659 the commissioner a certified copy of its charter or articles of
660 association and evidence satisfactory to the commissioner that it has
661 complied with the laws of the jurisdiction under which it is organized,
662 a statement of its financial condition in such form as is required by the

663 commissioner, together with such evidence of its correctness as the
664 commissioner requires and evidence of good management in such
665 form as is required by the commissioner. The captive insurer shall
666 submit evidence of its ability to provide continuant and timely claims
667 settlement. If the information furnished is satisfactory to the
668 commissioner, and if all other requirements of law have been complied
669 with, the commissioner may issue to such insurer a certificate of
670 authority permitting it to do business in this state. Each such certificate
671 of authority shall expire on the first day of May succeeding the date of
672 its issuance, but may be renewed without any formalities except as
673 required by the commissioner. Failure of a captive insurer to exercise
674 its authority to write a particular line or lines of business in this state
675 for two consecutive calendar years may constitute sufficient cause for
676 revocation of the captive insurer's authority to write those lines of
677 business.

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

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

696 suspended or revoked the certificate of authority of any captive insurer
697 to do business in this state.

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

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

710 Sec. 21. Subsection (a) of section 38a-11 of the general statutes, as
711 amended by section 10 of public act 03-152 and section 9 of public act
712 03-169, is repealed and the following is substituted in lieu thereof
713 (*Effective October 1, 2004*):

714 (a) The commissioner shall demand and receive the following fees:
715 (1) For the annual fee for each license issued to a domestic insurance
716 company, one hundred dollars; (2) for receiving and filing annual
717 reports of domestic insurance companies, twenty-five dollars; (3) for
718 filing all documents prerequisite to the issuance of a license to an
719 insurance company, one hundred seventy-five dollars, except that the
720 fee for such filings by any health care center, as defined in section 38a-
721 175, shall be one thousand one hundred dollars; (4) for filing any
722 additional paper required by law, fifteen dollars; (5) for each certificate
723 of valuation, organization, reciprocity or compliance, twenty dollars;
724 (6) for each certified copy of a license to a company, twenty dollars; (7)
725 for each certified copy of a report or certificate of condition of a
726 company to be filed in any other state, twenty dollars; (8) for
727 amending a certificate of authority, one hundred dollars; (9) for each

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

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

796 to viatical settlement providers: (A) A filing fee of thirteen dollars for
797 each initial application for a license made pursuant to section 38a-465a,
798 as amended; and (B) a fee of twenty dollars for each license issued or
799 renewed; (24) with respect to viatical settlement brokers: (A) A filing
800 fee of thirteen dollars for each initial application for a license made
801 pursuant to section 38a-465a, as amended; and (B) a fee of twenty
802 dollars for each license issued or renewed; (25) with respect to viatical
803 settlement investment agents: (A) A filing fee of thirteen dollars for
804 each initial application for a license made pursuant to section 38a-465a,
805 as amended; and (B) a fee of twenty dollars for each license issued or
806 renewed; (26) with respect to preferred provider networks, a fee of two
807 thousand five hundred dollars for each license issued or renewed; (27)
808 with respect to rental companies, as defined in section 38a-799, a fee of
809 forty dollars for each permit issued or renewed; (28) with respect to a
810 certificate of authority for a captive insurer pursuant to section 20 of
811 this act, a fee of one hundred seventy-five dollars for each certificate
812 issued or renewed; and ~~[(28)]~~ (29) with respect to each duplicate
813 license issued a fee of twenty-five dollars for each license issued.

814 Sec. 22. (NEW) (*Effective from passage*) Any party to an action for
815 medical malpractice may file an application with the Superior Court
816 requesting that the case be designated as a complex litigation case and
817 be transferred by the Chief Court Administrator or any judge
818 designated by the Chief Court Administrator to the complex litigation
819 docket in a judicial district and court location determined by the Chief
820 Court Administrator or such designee.

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

823 (a) In any claim or civil action to recover damages resulting from
824 personal injury, wrongful death or damage to property occurring on or
825 after October 1, 1987, the attorney and the claimant may provide by
826 contract, which contract shall comply with all applicable provisions of
827 the rules of professional conduct governing attorneys adopted by the

828 judges of the Superior Court, that the fee for the attorney shall be paid
829 contingent upon, and as a percentage of: (1) Damages awarded and
830 received by the claimant; or (2) settlement amount pursuant to a
831 settlement agreement.

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

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

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

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

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

893 (a) As used in this section:

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

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

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

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

911 (c) The closed claim report shall include:

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

918 (2) Details about the injury or loss, including: (A) The date of the
919 injury or loss that was the basis of the claim; (B) the date the injury or
920 loss was reported to the insurer; (C) the name of the institution or
921 location at which the injury or loss occurred; (D) the type of injury or
922 loss, including a severity of injury rating that corresponds with the

923 severity of injury scale that the Insurance Commissioner shall establish
924 based on the severity of injury scale developed by the National
925 Association of Insurance Commissioners; and (E) the name, age and
926 gender of any injured person covered by the claim. Any individually
927 identifiable information submitted pursuant to this subdivision shall
928 be confidential.

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

938 (4) Details about the amount paid on the claim, including: (A) The
939 total amount of the initial judgment rendered by a jury or awarded by
940 the court; (B) the total amount of the settlement if there was no
941 judgment rendered or awarded; (C) the total amount of the settlement
942 if the claim was settled after judgment was rendered or awarded; (D)
943 the amount of economic damages, as defined in section 52-572h, or the
944 insurer's estimate of the amount in the event of a settlement; (E) the
945 amount of noneconomic damages, as defined in section 52-572h, or the
946 insurer's estimate of the amount in the event of a settlement; (F) the
947 amount of any interest awarded due to failure to accept an offer of
948 judgment; (G) the amount of any remittitur or additur; (H) the amount
949 of final judgment after remittitur or additur; (I) the amount paid by the
950 insurer; (J) the amount paid by the defendant due to a deductible or a
951 judgment or settlement in excess of policy limits; (K) the amount paid
952 by other insurers; (L) the amount paid by other defendants; (M)
953 whether a structured settlement was used; (N) the expense assigned to
954 and recorded with the claim, including, but not limited to, defense and
955 investigation costs, but not including the actual claim payment; and

956 (O) any other information the commissioner determines to be
957 necessary to regulate the professional liability insurance industry with
958 respect to medical professionals and entities, ensure the industry's
959 solvency and ensure that such liability insurance is available and
960 affordable.

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

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

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

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

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

991 Sec. 25. (NEW) (*Effective from passage*) (a) As used in this section and
992 section 26 of this act: (1) "Licensed health care provider" or "provider"
993 means a physician or surgeon; director, officer or trustee of a hospital
994 or nursing home; nurse; oral surgeon; dentist; pharmacist;
995 chiropractor; optometrist; podiatrist; hospital or nursing home; (2)
996 "fund" means the Healthy Connecticut Fund established in subsection
997 (b) of this section; and (3) "commissioner" means the Insurance
998 Commissioner.

999 (b) There is established a Healthy Connecticut Fund for the purpose
1000 of reimbursing any portion of a medical malpractice claim, settlement
1001 or judgment which represents the deductible applicable to a provider's
1002 coverage. The fund shall be liable only for (1) payment of such
1003 deductibles pursuant to claims, settlements or judgments against
1004 licensed health care providers who comply with the provisions of this
1005 section where the claim, settlement or judgment arises from an event
1006 that occurs on or after the effective date of the first plan of operation
1007 established pursuant to this section, and (2) reasonable and necessary
1008 expenses incurred in payment of such deductibles and the fund's
1009 administrative expenses. The fund may contain any moneys required
1010 by law to be deposited in the fund and shall be held by the State
1011 Treasurer separate and apart from all other moneys, funds and
1012 accounts. The interest derived from the investment of the fund shall be
1013 credited to the fund. Amounts in the fund may be expended only
1014 pursuant to the direction of the Insurance Commissioner in accordance
1015 with this section. Any balance remaining in the fund at the end of any
1016 fiscal year shall be carried forward in the fund for the fiscal year next
1017 succeeding.

1018 (c) Any Connecticut-licensed health care provider may participate
1019 in the fund.

1020 (d) Any deficit in the fund shall be paid by assessment pursuant to
1021 section 26 of this act. The state shall not be responsible for any costs,
1022 expenses, liabilities, judgments or other obligations of the fund.

1023 (e) All books, records and audits of the fund shall be public records,
1024 as defined in section 1-200 of the general statutes.

1025 (f) On or before December thirty-first of each year the Auditors of
1026 Public Accounts shall audit the records of the fund and shall furnish an
1027 audited financial report to the board, commissioner, State Treasurer
1028 and the General Assembly.

1029 (g) The Insurance Commissioner shall adopt regulations, in
1030 accordance with chapter 54 of the general statutes, to establish a plan
1031 of operation for the fund.

1032 Sec. 26. (NEW) (*Effective from passage*) (a) Not later than ____, and
1033 annually thereafter, the Insurance Commissioner shall determine the
1034 amount necessary to maintain solvency of the Healthy Connecticut
1035 Fund established in section 25 of this act.

1036 (b) Each medical malpractice insurer, health insurer, health care
1037 center, provider and attorney licensed in this state and each
1038 pharmaceutical company or manufacturer of medical equipment ____
1039 shall annually pay to the Insurance Commissioner, for deposit in the
1040 Healthy Connecticut Fund, an amount assessed by the commissioner
1041 pursuant to this section. ____ per cent of each medical malpractice
1042 award or settlement shall be paid into the fund. Not later than March
1043 1, 2005, the commissioner shall determine the assessment amount for
1044 the fiscal year ending June 30, 2005. Not later than April 1, 2005, and
1045 annually thereafter, the commissioner shall determine the assessment
1046 amount for the next fiscal year. Not later than May 1, 2005, and
1047 annually thereafter, the commissioner shall submit a statement to each
1048 person subject to assessment that includes the proposed assessment
1049 amount.

1050 (c) Any person aggrieved by an assessment levied under this section
 1051 may appeal therefrom in the same manner as provided for appeals
 1052 under section 38a-52 of the general statutes.

1053 Sec. 27. (NEW) (*Effective from passage*) The Insurance Commissioner
 1054 may approve professional liability insurance policies for providers
 1055 who participate in the Healthy Connecticut Fund established pursuant
 1056 to section 25 of this act that contain a deductible that does not exceed
 1057 (1) fifty thousand dollars with respect to a medical professional, and
 1058 (2) one hundred thousand dollars with respect to a medical entity,
 1059 including, but not limited to, a hospital. Such policies shall be subject
 1060 to title 38a of the general statutes.

This act shall take effect as follows:	
Section 1	<i>from passage</i>
Sec. 2	<i>from passage</i>
Sec. 3	<i>from passage</i>
Sec. 4	<i>from passage</i>
Sec. 5	<i>from passage</i>
Sec. 6	<i>from passage and applicable to actions filed on or after said date</i>
Sec. 7	<i>from passage</i>
Sec. 8	<i>from passage</i>
Sec. 9	<i>from passage</i>
Sec. 10	<i>from passage</i>
Sec. 11	<i>from passage</i>
Sec. 12	<i>from passage</i>
Sec. 13	<i>July 1, 2004</i>
Sec. 14	<i>from passage</i>
Sec. 15	<i>from passage</i>
Sec. 16	<i>from passage</i>
Sec. 17	<i>July 1, 2004</i>
Sec. 18	<i>July 1, 2004</i>
Sec. 19	<i>from passage</i>
Sec. 20	<i>October 1, 2004</i>
Sec. 21	<i>October 1, 2004</i>
Sec. 22	<i>from passage</i>

Sec. 23	<i>from passage</i>
Sec. 24	<i>January 1, 2005</i>
Sec. 25	<i>from passage</i>
Sec. 26	<i>from passage</i>
Sec. 27	<i>from passage</i>

Statement of Purpose:

To implement the recommendations of the Medical Malpractice Action Group and establish a Healthy Connecticut Fund.

[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.]