



General Assembly

February Session, 2004

**Raised Bill No. 568**

LCO No. 2255

\*02255\_\_\_\_\_PRI\*

Referred to Committee on Program Review and Investigations

Introduced by:  
(PRI)

**AN ACT CONCERNING MEDICAL MALPRACTICE AND HEALTH CARE QUALITY.**

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

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 Section 38a-32 of the general statutes is repealed and the  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

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

15 Sec. 2. Section 38a-33 of the general statutes is repealed and the

16 following is substituted in lieu thereof (*Effective from passage*):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

269 (c) The Commissioner of Public Health shall establish a list of  
270 eighteen persons who may serve as members of medical hearing  
271 panels established pursuant to subsection (g) of this section. Persons  
272 appointed to the list shall serve as members of the medical hearing

273 panels and provide the same services as members of the Connecticut  
274 Medical Examining Board. Members from the list serving on such  
275 panels shall not be voting members of the Connecticut Medical  
276 Examining Board. The list shall consist of eighteen members appointed  
277 by the commissioner, eight of whom shall be physicians, as defined in  
278 section 20-13a, with at least one of such physicians being a graduate of  
279 a medical education program accredited by the American Osteopathic  
280 Association, one of whom shall be a physician assistant licensed  
281 pursuant to section 20-12b, and nine of whom shall be members of the  
282 public. No professional member of the list shall be an elected or  
283 appointed officer of a professional society or association relating to  
284 such member's profession at the time of appointment to the list or have  
285 been such an officer during the year immediately preceding such  
286 appointment to the list. A licensed professional appointed to the list  
287 shall be a practitioner in good professional standing and a resident of  
288 this state. All vacancies shall be filled by the commissioner. Successors  
289 and appointments to fill a vacancy on the list shall possess the same  
290 qualifications as those required of the member succeeded or replaced.  
291 No person whose spouse, parent, brother, sister, child or spouse of a  
292 child is a physician, as defined in section 20-13a, or a physician  
293 assistant, as defined in section 20-12a, shall be appointed to the list as a  
294 member of the public. Each person appointed to the list shall serve  
295 without compensation at the pleasure of the commissioner.

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

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

299 (f) The Governor shall appoint a chairperson from among the board  
300 members. Said board shall meet at least once during each calendar  
301 quarter and at such other times as the chairperson deems necessary.  
302 Special meetings shall be held on the request of a majority of the board  
303 after notice in accordance with the provisions of section 1-225. A  
304 majority of the members of the board shall constitute a quorum.

305 Members shall not be compensated for their services. Any member  
306 who fails to attend three consecutive meetings or who fails to attend  
307 fifty per cent of all meetings held during any calendar year shall be  
308 deemed to have resigned from office. Minutes of all meetings shall be  
309 recorded by the board. No member shall participate in the affairs of  
310 the board during the pendency of any disciplinary proceedings by the  
311 board against such member. Said board shall (1) hear and decide  
312 matters concerning suspension or revocation of licensure, (2)  
313 adjudicate complaints against practitioners, and (3) impose sanctions  
314 where appropriate. Said board shall inform the Chief State's Attorney  
315 if it appears that an individual currently or formerly under  
316 investigation violated any criminal statutes.

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

329 (2) The board shall refer all statements of charges filed with the  
330 board by the department pursuant to section 20-13e, as amended by  
331 this act, to a medical hearing panel within sixty days of the receipt of  
332 charges. This time period may be extended for good cause by the  
333 board in a duly recorded vote. [The panel shall consist of three  
334 members, at least one of whom shall be a member of the board and one  
335 a member of the public. The public member may be a member of either  
336 the board or of the list established pursuant to subsection (c) of this  
337 section.] The panel shall conduct a hearing, in accordance with the

338 provisions of chapter 54, and the regulations established by the  
339 Commissioner of Public Health concerning contested cases, except that  
340 the panel shall file a proposed final decision with the board within one  
341 hundred twenty days of the receipt of the issuance of the notice of  
342 hearing by the board. The time period for filing such proposed final  
343 decision with the board may be extended for good cause by the board  
344 in a duly recorded vote. If the panel has not conducted a hearing  
345 within sixty days of the date of referral of the statement of charges by  
346 the board, such hearing shall be conducted by the commissioner, in  
347 accordance with the provisions of chapter 54, and the regulations  
348 established by the commissioner concerning contested cases. The  
349 commissioner shall file a proposed final decision with the board not  
350 later than sixty days after such hearing. The time period for filing such  
351 proposed final decision with the board may be extended for good  
352 cause by the board in a duly recorded vote.

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

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

368 (h) The board shall review the panel's proposed final decision in  
369 accordance with the provisions of section 4-179, and adopt, modify or

370 remand said decision for further review or for the taking of additional  
371 evidence. The board shall act on the proposed final decision within  
372 ninety days of the filing of said decision by the panel. This time period  
373 may be extended by the board for good cause in a duly recorded vote.

374 (i) Except in a case in which a license has been summarily  
375 suspended, pursuant to subsection (c) of section 19a-17 or subsection  
376 (c) of section 4-182, all three panel members shall be present to hear  
377 any evidence and vote on a proposed final decision. The chairperson of  
378 the Medical Examining Board may exempt a member from a meeting  
379 of the panel if the chairperson finds that good cause exists for such an  
380 exemption. Such an exemption may be granted orally but shall be  
381 reduced to writing and included as part of the record of the panel  
382 within two business days of the granting of the exemption or the  
383 opening of the record and shall state the reason for the exemption.  
384 Such exemption shall be granted to a member no more than once  
385 during any contested case and shall not be granted for a meeting at  
386 which the panel is acting on a proposed final decision on a statement  
387 of charges. The board may appoint a member to the panel to replace  
388 any member who resigns or otherwise fails to continue to serve on the  
389 panel. Such replacement member shall review the record prior to the  
390 next hearing.

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

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

396 The department shall file with the Governor and the joint standing  
397 committee on public health of the General Assembly on or before  
398 January 1, 1986, and thereafter on or before January first of each  
399 succeeding year, a report of the activities of the department and the  
400 board conducted pursuant to sections 20-13d and 20-13e. Each such  
401 report shall include, but shall not be limited to, the following

402 information: The number of petitions received; the number of petitions  
403 not investigated, and the reasons why; the number of hearings held on  
404 such petitions; [and,] the outcome of such hearings; the timeliness of  
405 action taken on any petition considered to be a priority; without  
406 identifying the particular physician concerned, a brief description of  
407 the impairment alleged in each such petition and the actions taken  
408 with regard to each such petition by the department and the board; the  
409 number of notifications received pursuant to section 19a-17a, as  
410 amended by this act; the number of such notifications with no further  
411 action taken, and the reasons why; and the outcomes for notifications  
412 where further action is taken.

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

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

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

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

434 seeking the recovery of money damages, whether or not other relief is  
435 sought, the plaintiff may, not later than thirty days before trial, file  
436 with the clerk of the court a written "offer of judgment" signed by the  
437 plaintiff or the plaintiff's attorney, directed to the defendant or the  
438 defendant's attorney, offering to settle the claim underlying the action  
439 and to stipulate to a judgment for a sum certain. The plaintiff shall give  
440 notice of the offer of settlement to the defendant's attorney or, if the  
441 defendant is not represented by an attorney, to the defendant himself  
442 or herself. Within sixty days after being notified of the filing of the  
443 "offer of judgment" or within any extension or extensions thereof, not  
444 to exceed a total of one hundred twenty additional days, granted by  
445 the court for good cause shown, and prior to the rendering of a verdict  
446 by the jury or an award by the court, the defendant or the defendant's  
447 attorney may file with the clerk of the court a written "acceptance of  
448 offer of judgment" agreeing to a stipulation for judgment as contained  
449 in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter  
450 judgment immediately on the stipulation. If the "offer of judgment" is  
451 not accepted within [sixty days] the sixty-day period or any extension  
452 thereof, and prior to the rendering of a verdict by the jury or an award  
453 by the court, the "offer of judgment" shall be considered rejected and  
454 not subject to acceptance unless refiled. Any such "offer of judgment"  
455 and any "acceptance of offer of judgment" shall be included by the  
456 clerk in the record of the case.

457 (b) After trial the court shall examine the record to determine  
458 whether the plaintiff made an "offer of judgment" which the defendant  
459 failed to accept. If the court ascertains from the record that the plaintiff  
460 has recovered an amount equal to or greater than the sum certain  
461 stated in the plaintiff's "offer of judgment", the court shall add to the  
462 amount so recovered twelve per cent annual interest on said amount,  
463 [computed from the date such offer was filed in actions commenced  
464 before October 1, 1981. In those actions commenced on or after October  
465 1, 1981, the] with respect to an offer of judgment filed prior to the  
466 effective date of this section, and interest at an annual rate of four  
467 percentage points above the weekly average five-year constant

468 maturity yield of United States Treasury securities, as published by the  
469 Board of Governors of the Federal Reserve System, for the calendar  
470 week preceding the beginning of each year for which interest is owed,  
471 with respect to an offer of judgment filed on or after the effective date  
472 of this section. The interest shall be computed from the date the  
473 complaint in the civil action was filed with the court if the "offer of  
474 judgment" was filed not later than eighteen months from the filing of  
475 such complaint. If such offer was filed later than eighteen months from  
476 the date of filing of the complaint, the interest shall be computed from  
477 the date the "offer of judgment" was filed. The court may award  
478 reasonable attorney's fees in an amount not to exceed three hundred  
479 fifty dollars, and shall render judgment accordingly. This section shall  
480 not be interpreted to abrogate the contractual rights of any party  
481 concerning the recovery of attorney's fees in accordance with the  
482 provisions of any written contract between the parties to the action.

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

485 (a) Each insurance company doing business in this state shall,  
486 annually, on or before the first day of March, render to the Insurance  
487 Commissioner a true record of the number, according to classification,  
488 of cancellations of and refusals to renew professional liability  
489 insurance policies for the year ending on the thirty-first day of  
490 December next preceding.

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

499 (c) Each insurance company that issues a property and casualty

500 policy in this state and issues a medical malpractice policy in any state,  
501 district or territory of the United States shall offer for sale professional  
502 liability insurance policies for: (1) Physicians and surgeons, (2)  
503 hospitals, (3) dentists, (4) chiropractors, (5) licensed natureopaths, (6)  
504 podiatrists, (7) advanced practice registered nurses, and (8) such other  
505 categories as the Insurance Commissioner adopts pursuant to  
506 subsection (b) of this section related to medical professionals or  
507 entities.

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

511 (a) (1) The department shall investigate each petition filed pursuant  
512 to section 20-13d, in accordance with the provisions of subdivision (10)  
513 of subsection (a) of section 19a-14<sub>2</sub> to determine if probable cause exists  
514 to issue a statement of charges and to institute proceedings against the  
515 physician under subsection (e) of this section. Such investigation shall  
516 be concluded not later than eighteen months from the date the petition  
517 is filed with the department and, unless otherwise specified by this  
518 subsection, the record of such investigation shall be deemed a public  
519 record, in accordance with section 1-210, as amended, at the conclusion  
520 of such eighteen-month period. Any such investigation shall be  
521 confidential and no person shall disclose his knowledge of such  
522 investigation to a third party unless the physician requests that such  
523 investigation and disclosure be open. If the department determines  
524 that probable cause exists to issue a statement of charges, the entire  
525 record of such proceeding shall be public unless the department  
526 determines that the physician is an appropriate candidate for  
527 participation in a rehabilitation program in accordance with subsection  
528 (b) of this section and the physician agrees to participate in such  
529 program in accordance with terms agreed upon by the department and  
530 the physician. If at any time subsequent to the filing of a petition and  
531 during the eighteen-month period, the department makes a finding of  
532 no probable cause and the medical panel appointed pursuant to

533 subsection (g) of section 20-8a, as amended by this act, allows such  
534 finding to stand, the petition and the entire record of such  
535 investigation shall remain confidential unless the physician requests  
536 that such petition and record be open.

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

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

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

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

563 Sec. 17. (NEW) (*Effective July 1, 2004*) Each insurer that delivers,

564 issues for delivery or renews in this state a professional liability  
565 insurance policy for a medical professional or entity shall offer a  
566 premium discount on the policy to any insured who submits to the  
567 insurer proof that the insured will use an electronic health record  
568 system during the premium period to establish and maintain patient  
569 records and verify patient treatment. Such discount shall be not less  
570 than twenty per cent of the premium for a period of one year from the  
571 effective date of the policy or renewal.

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

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

584       (a) With respect to rates pertaining to commercial risk insurance,  
585 and subject to the provisions of subsection (b) of this section with  
586 respect to workers' compensation and employers' liability insurance  
587 and certain professional liability insurance, on or before the effective  
588 date [thereof, every] of such rates, each admitted insurer shall submit  
589 to the Insurance Commissioner for the commissioner's information,  
590 except as to inland marine risks which by general custom of the  
591 business are not written according to manual rates or rating plans,  
592 [every] each manual of classifications, rules and rates, and [every] each  
593 minimum, class rate, rating plan, rating schedule and rating system  
594 and any modification of the foregoing which it uses. Such submission  
595 by a licensed rating organization of which an insurer is a member or

596 subscriber shall be sufficient compliance with this section for any  
597 insurer maintaining membership or subscribership in such  
598 organization, to the extent that the insurer uses the manuals,  
599 minimums, class rates, rating plans, rating schedules, rating systems,  
600 policy or bond forms of such organization. The information shall be  
601 open to public inspection after its submission.

602 (b) (1) Each filing as described in subsection (a) of this section for  
603 workers' compensation or employers' liability insurance shall be on file  
604 with the Insurance Commissioner for a waiting period of thirty days  
605 before it becomes effective, which period may be extended by the  
606 commissioner for an additional period not to exceed thirty days if the  
607 commissioner gives written notice within such waiting period to the  
608 insurer or rating organization which made the filing that the  
609 commissioner needs such additional time for the consideration of such  
610 filing. Upon written application by such insurer or rating organization,  
611 the commissioner may authorize a filing which the commissioner has  
612 reviewed to become effective before the expiration of the waiting  
613 period or any extension thereof. A filing shall be deemed to meet the  
614 requirements of sections 38a-663 to 38a-696, inclusive, unless  
615 disapproved by the commissioner within the waiting period or any  
616 extension thereof. If, within the waiting period or any extension  
617 thereof, the commissioner finds that a filing does not meet the  
618 requirements of said sections, the commissioner shall send to the  
619 insurer or rating organization which made such filing written notice of  
620 disapproval of such filing, specifying therein in what respects the  
621 commissioner finds such filing fails to meet the requirements of said  
622 sections and stating that such filing shall not become effective. Such  
623 finding of the commissioner shall be subject to review as provided in  
624 section 38a-19.

625 (2) Each filing as described in subsection (a) of this section for  
626 professional liability insurance for physicians and surgeons, hospitals  
627 or advanced practice registered nurses shall be subject to prior rate  
628 approval in accordance with this section. On and after the effective

629 date of this section, each insurer or rating organization seeking to  
630 change its rates for such insurance shall (A) file a request for such  
631 change with the Insurance Department, and (B) provide written notice  
632 to its insureds with respect to any request for an increase in rates. Such  
633 request shall be filed and such notice, if applicable, shall be sent at  
634 least sixty days prior to the proposed effective date of the change. The  
635 notice to insureds of a request for an increase in rates shall indicate  
636 that a public hearing shall be held in accordance with this section. The  
637 Insurance Department shall review the request and, with respect to a  
638 request for an increase in rates, shall hold a public hearing on such  
639 increase prior to approving or denying the request. The Insurance  
640 Commissioner shall approve or deny the request within forty-five days  
641 of its receipt. Such finding of the commissioner shall be subject to  
642 review as provided in section 38a-19.

643 (c) The form of any insurance policy or contract the rates for which  
644 are subject to the provisions of sections 38a-663 to 38a-696, inclusive,  
645 other than fidelity, surety or guaranty bonds, and the form of any  
646 endorsement modifying such insurance policy or contract, shall be  
647 filed with the Insurance Commissioner prior to its issuance. The  
648 commissioner shall adopt regulations, in accordance with the  
649 provisions of chapter 54, establishing a procedure for review of such  
650 policy or contract. If at any time the commissioner finds that any such  
651 policy, contract or endorsement is not in accordance with such  
652 provisions or any other provision of law, the commissioner shall issue  
653 an order disapproving the issuance of such form and stating the  
654 reasons for disapproval. The provisions of section 38a-19 shall apply to  
655 any such order issued by the commissioner.

656 Sec. 20. (NEW) (*Effective October 1, 2004*) (a) On and after October 1,  
657 2004, no captive insurer, as defined in section 38a-91 of the general  
658 statutes, may insure a health care provider or entity in this state  
659 against liability for medical malpractice unless the captive insurer has  
660 obtained a certificate of authority from the Insurance Commissioner,  
661 except that no certificate of authority shall be required for any captive

662 insurer that is duly licensed in this state to offer such insurance.

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

686 (c) The commissioner shall adopt regulations, in accordance with  
687 chapter 54 of the general statutes, specifying the information and  
688 evidence that a captive insurer seeking to obtain or renew a certificate  
689 of authority shall submit and the requirements with which it shall  
690 comply.

691 (d) The commissioner may, at any time, for cause, suspend, revoke  
692 or reissue any such certificate of authority or in lieu of or in addition to  
693 suspension or revocation of such certificate of authority the

694 commissioner, after reasonable notice to and hearing of any holder of  
695 such certificate of authority, may impose a fine not to exceed ten  
696 thousand dollars. Such hearings may be held by the commissioner or  
697 any person designated by the commissioner. Whenever a person other  
698 than the commissioner acts as the hearing officer, the person shall  
699 submit to the commissioner a memorandum of findings and  
700 recommendations upon which the commissioner may base a decision.  
701 The commissioner may, if the commissioner deems it in the interest of  
702 the public, publish in one or more newspapers of the state a statement  
703 that, under the provisions of this section, the commissioner has  
704 suspended or revoked the certificate of authority of any captive insurer  
705 to do business in this state.

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

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

718 Sec. 21. Subsection (a) of section 38a-11 of the general statutes, as  
719 amended by section 10 of public act 03-152 and section 9 of public act  
720 03-169, is repealed and the following is substituted in lieu thereof  
721 (*Effective October 1, 2004*):

722 (a) The commissioner shall demand and receive the following fees:  
723 (1) For the annual fee for each license issued to a domestic insurance  
724 company, one hundred dollars; (2) for receiving and filing annual  
725 reports of domestic insurance companies, twenty-five dollars; (3) for

726 filing all documents prerequisite to the issuance of a license to an  
727 insurance company, one hundred seventy-five dollars, except that the  
728 fee for such filings by any health care center, as defined in section 38a-  
729 175, shall be one thousand one hundred dollars; (4) for filing any  
730 additional paper required by law, fifteen dollars; (5) for each certificate  
731 of valuation, organization, reciprocity or compliance, twenty dollars;  
732 (6) for each certified copy of a license to a company, twenty dollars; (7)  
733 for each certified copy of a report or certificate of condition of a  
734 company to be filed in any other state, twenty dollars; (8) for  
735 amending a certificate of authority, one hundred dollars; (9) for each  
736 license issued to a rating organization, one hundred dollars. In  
737 addition, insurance companies shall pay any fees imposed under  
738 section 12-211; (10) a filing fee of twenty-five dollars for each initial  
739 application for a license made pursuant to section 38a-769; (11) with  
740 respect to insurance agents' appointments: (A) A filing fee of twenty-  
741 five dollars for each request for any agent appointment; (B) a fee of  
742 forty dollars for each appointment issued to an agent of a domestic  
743 insurance company or for each appointment continued; and (C) a fee  
744 of twenty dollars for each appointment issued to an agent of any other  
745 insurance company or for each appointment continued, except that no  
746 fee shall be payable for an appointment issued to an agent of an  
747 insurance company domiciled in a state or foreign country which does  
748 not require any fee for an appointment issued to an agent of a  
749 Connecticut insurance company; (12) with respect to insurance  
750 producers: (A) An examination fee of seven dollars for each  
751 examination taken, except when a testing service is used, the testing  
752 service shall pay a fee of seven dollars to the commissioner for each  
753 examination taken by an applicant; (B) a fee of forty dollars for each  
754 license issued; and (C) a fee of forty dollars for each license renewed;  
755 (13) with respect to public adjusters: (A) An examination fee of seven  
756 dollars for each examination taken, except when a testing service is  
757 used, the testing service shall pay a fee of seven dollars to the  
758 commissioner for each examination taken by an applicant; and (B) a fee  
759 of one hundred twenty-five dollars for each license issued or renewed;

760 (14) with respect to casualty adjusters: (A) An examination fee of ten  
761 dollars for each examination taken, except when a testing service is  
762 used, the testing service shall pay a fee of ten dollars to the  
763 commissioner for each examination taken by an applicant; (B) a fee of  
764 forty dollars for each license issued or renewed; and (C) the expense of  
765 any examination administered outside the state shall be the  
766 responsibility of the entity making the request and such entity shall  
767 pay to the commissioner one hundred dollars for such examination  
768 and the actual traveling expenses of the examination administrator to  
769 administer such examination; (15) with respect to motor vehicle  
770 physical damage appraisers: (A) An examination fee of forty dollars  
771 for each examination taken, except when a testing service is used, the  
772 testing service shall pay a fee of forty dollars to the commissioner for  
773 each examination taken by an applicant; (B) a fee of forty dollars for  
774 each license issued or renewed; and (C) the expense of any  
775 examination administered outside the state shall be the responsibility  
776 of the entity making the request and such entity shall pay to the  
777 commissioner one hundred dollars for such examination and the  
778 actual traveling expenses of the examination administrator to  
779 administer such examination; (16) with respect to certified insurance  
780 consultants: (A) An examination fee of thirteen dollars for each  
781 examination taken, except when a testing service is used, the testing  
782 service shall pay a fee of thirteen dollars to the commissioner for each  
783 examination taken by an applicant; (B) a fee of two hundred dollars for  
784 each license issued; and (C) a fee of one hundred twenty-five dollars  
785 for each license renewed; (17) with respect to surplus lines brokers: (A)  
786 An examination fee of ten dollars for each examination taken, except  
787 when a testing service is used, the testing service shall pay a fee of ten  
788 dollars to the commissioner for each examination taken by an  
789 applicant; and (B) a fee of five hundred dollars for each license issued  
790 or renewed; (18) with respect to fraternal agents, a fee of forty dollars  
791 for each license issued or renewed; (19) a fee of thirteen dollars for  
792 each license certificate requested, whether or not a license has been  
793 issued; (20) with respect to domestic and foreign benefit societies shall

794 pay: (A) For service of process, twenty-five dollars for each person or  
 795 insurer to be served; (B) for filing a certified copy of its charter or  
 796 articles of association, five dollars; (C) for filing the annual report, ten  
 797 dollars; and (D) for filing any additional paper required by law, three  
 798 dollars; (21) with respect to foreign benefit societies: (A) For each  
 799 certificate of organization or compliance, four dollars; (B) for each  
 800 certified copy of permit, two dollars; and (C) for each copy of a report  
 801 or certificate of condition of a society to be filed in any other state, four  
 802 dollars; (22) with respect to reinsurance intermediaries: A fee of five  
 803 hundred dollars for each license issued or renewed; (23) with respect  
 804 to viatical settlement providers: (A) A filing fee of thirteen dollars for  
 805 each initial application for a license made pursuant to section 38a-465a;  
 806 and (B) a fee of twenty dollars for each license issued or renewed; (24)  
 807 with respect to viatical settlement brokers: (A) A filing fee of thirteen  
 808 dollars for each initial application for a license made pursuant to  
 809 section 38a-465a; and (B) a fee of twenty dollars for each license issued  
 810 or renewed; (25) with respect to viatical settlement investment agents:  
 811 (A) A filing fee of thirteen dollars for each initial application for a  
 812 license made pursuant to section 38a-465a; and (B) a fee of twenty  
 813 dollars for each license issued or renewed; (26) with respect to  
 814 preferred provider networks, a fee of two thousand five hundred  
 815 dollars for each license issued or renewed; (27) with respect to rental  
 816 companies, as defined in section 38a-799, a fee of forty dollars for each  
 817 permit issued or renewed; (28) with respect to a certificate of authority  
 818 for a captive insurer pursuant to section 21 of this act, a fee of one  
 819 hundred seventy-five dollars for each certificate issued or renewed;  
 820 and ~~[(28)]~~ (29) with respect to each duplicate license issued a fee of  
 821 twenty-five dollars for each license issued.

822       Sec. 22. (NEW) (*Effective from passage*) Any party to an action for  
 823 medical malpractice may file an application with the Superior Court  
 824 requesting that the case be designated as a complex litigation case and  
 825 be transferred by the Chief Court Administrator or any judge  
 826 designated by the Chief Court Administrator to the complex litigation  
 827 docket in a judicial district and court location determined by the Chief

828 Court Administrator or such designee.

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

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

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

850 (c) Whenever a claimant in a medical malpractice case enters into a  
851 contingency fee arrangement with an attorney which provides for a fee  
852 that would exceed the percentage limitations set forth in subsection (b)  
853 of this section, such arrangement shall not be valid unless the  
854 claimant's attorney files an application with the court for approval of  
855 such arrangement and the court, after a hearing, grants such  
856 application. The claimant's attorney shall attach to such application a  
857 copy of such fee arrangement and the proposed unsigned writ,  
858 summons and complaint in the case. The court shall grant such  
859 application if it finds that the case is sufficiently complex, unique or

860 different from other medical malpractice cases so as to warrant a  
861 deviation from such percentage limitations. At such hearing, the  
862 claimant's attorney shall have the burden of showing that such  
863 deviation is warranted. If the court does not grant such application, it  
864 shall advise the claimant of the claimant's right to seek representation  
865 by another attorney willing to abide by the percentage limitations set  
866 forth in subsection (b) of this section. The filing of such application  
867 shall toll the applicable statute of limitations for a period of ninety  
868 days.

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

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

893 [The Insurance Commissioner may require all insurance companies  
894 writing medical malpractice insurance in this state to submit, in such  
895 manner and at such times as he specifies, such information as he  
896 deems necessary to establish a data base on medical malpractice,  
897 including information on all incidents of medical malpractice, all  
898 settlements, all awards, other information relative to procedures and  
899 specialties involved and any other information relating to risk  
900 management.]

901 (a) As used in this section:

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

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

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

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

919 (c) The closed claim report shall include:

920 (1) Details about the insured and insurer, including: (A) The name  
921 of the insurer; (B) the professional liability insurance policy limits and  
922 whether the policy was an occurrence policy or was issued on a claims-

923 made basis; (C) the name, address, health care provider professional  
924 license number and specialty coverage of the insured; and (D) the  
925 insured's policy number and a unique claim number.

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

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

946 (4) Details about the amount paid on the claim, including: (A) The  
947 total amount of the initial judgment rendered by a jury or awarded by  
948 the court; (B) the total amount of the settlement if there was no  
949 judgment rendered or awarded; (C) the total amount of the settlement  
950 if the claim was settled after judgment was rendered or awarded; (D)  
951 the amount of economic damages, as defined in section 52-572h, or the  
952 insurer's estimate of the amount in the event of a settlement; (E) the  
953 amount of noneconomic damages, as defined in section 52-572h, or the  
954 insurer's estimate of the amount in the event of a settlement; (F) the

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

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

971 (2) The commissioner shall compile the data included in individual  
972 closed claim reports into an aggregated, summary format and shall  
973 prepare a written annual report of the summary data. The report shall  
974 provide an analysis of closed claim information including a minimum  
975 of five years of comparative data, when available, trends in frequency  
976 and severity of claims, itemization of damages, timeliness of the claims  
977 process, and any other descriptive or analytical information that would  
978 assist in interpreting the trends in closed claims.

979 (3) The annual report shall include a summary of rate filings for  
980 professional liability insurance for medical professionals and entities  
981 which have been approved by the department for the prior calendar  
982 year, including an analysis of the trend of direct losses, incurred losses,  
983 earned premiums and investment income as compared to prior years.  
984 The report shall include base premiums charged by medical  
985 malpractice insurers for each specialty and the number of providers  
986 insured by specialty for each insurer.

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

996       (e) The Insurance Commissioner shall provide the Commissioner of  
 997 Public Health with electronic access to all information received  
 998 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.]*