



General Assembly

February Session, 2004

Amendment

LCO No. 4041

HB0566904041HDO

Offered by:

REP. AMANN, 118th Dist.
REP. FRITZ, 90th Dist.
SEN. CRISCO, 17th Dist.
REP. WASSERMAN, 106th Dist.
REP. CHRIST, 11th Dist.
REP. STILLMAN, 38th Dist.
REP. FONTANA, 87th Dist.
REP. CANDELARIA, 95th Dist.
REP. DOYLE, 28th Dist.
REP. FARR, 19th Dist.
REP. MICHELE, 77th Dist.
REP. BEAMON, 72nd Dist.
REP. HYSLOP, 39th Dist.
REP. WALKER, 93rd Dist.
REP. NARDELLO, 89th Dist.
REP. BERGER, 73rd Dist.
REP. ABRAMS, 83rd Dist.
REP. COCCO, 127th Dist.
REP. MEGNA, 97th Dist.

REP. CARUSO, 126th Dist.
REP. CARTER, 7th Dist.
REP. GODFREY, 110th Dist.
REP. WALLACE, 109th Dist.
REP. DONOVAN, 84th Dist.
REP. TALLARITA, 58th Dist.
REP. FLEISCHMANN, 18th Dist.
REP. HAMM, 34th Dist.
REP. O'CONNOR, 35th Dist.
REP. OLSON, 46th Dist.
REP. STONE, 9th Dist.
REP. BARRY, 12th Dist.
REP. SHARKEY, 88th Dist.
REP. MCCLUSKEY, 20th Dist.
REP. OREFICE, 37th Dist.
REP. LAWLOR, 99th Dist.
SEN. MCDONALD, 27th Dist.
SEN. MURPHY, 16th Dist.

To: Subst. House Bill No. 5669

File No. 504

Cal. No. 355

"AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM."

1 Strike everything after the enacting clause and substitute the

2 following in lieu thereof:

3 "Section 1. (NEW) (*Effective from passage*) (a) All civil actions brought
4 to recover damages resulting from personal injury or wrongful death,
5 whether in tort or in contract, in which it is alleged that such injury or
6 death resulted from the negligence of a health care provider, as
7 defined in section 52-184b of the general statutes, shall be referred to
8 mandatory mediation pursuant to this section, unless the parties have
9 agreed to refer the civil action to an alternative dispute resolution
10 program.

11 (b) The purpose of such mandatory mediation shall be to (1) review
12 the certificate of good faith filed pursuant to section 52-190a of the
13 general statutes, as amended by this act, to determine whether there
14 are grounds for a good faith belief that the defendant has been
15 negligent in the care or treatment of the claimant, (2) attempt to
16 achieve a prompt settlement or resolution of the case, and (3) expedite
17 the litigation of the case.

18 (c) Upon the filing of the answer in such action by the defendant,
19 the clerk of the court for the judicial district in which the case is
20 pending shall refer the case to a judge of the superior court for
21 mediation. The mediation shall commence as soon as practicable, but
22 not later than thirty days after the filing of the answer. The mediation
23 shall not stay or delay the prosecution of the case, nor delay discovery
24 in or the trial of the case.

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

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

43 (f) All parties to the case, together with a representative of each
44 insurer that may be liable to pay all or part of any verdict or settlement
45 in the case, shall attend the mediation in person, unless attendance by
46 means of telephone is permitted upon written agreement of all parties
47 or written order of the court.

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

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

55 (a) No civil action or apportionment complaint shall be filed to
56 recover damages resulting from personal injury or wrongful death
57 occurring on or after October 1, 1987, whether in tort or in contract, in
58 which it is alleged that such injury or death resulted from the
59 negligence of a health care provider, unless the attorney or party filing
60 the action or apportionment complaint has made a reasonable inquiry
61 as permitted by the circumstances to determine that there are grounds
62 for a good faith belief that there has been negligence in the care or
63 treatment of the claimant. The complaint, [or] initial pleading or
64 apportionment complaint shall contain a certificate of the attorney or
65 party filing the action or apportionment complaint that such

66 reasonable inquiry gave rise to a good faith belief that grounds exist
67 for an action against each named defendant or for an apportionment
68 complaint against each named apportionment defendant. [For the
69 purposes of this section, such good faith may be shown to exist if the
70 claimant or his attorney has received a written opinion, which shall not
71 be subject to discovery by any party except for questioning the validity
72 of the certificate,] To show the existence of such good faith, the
73 claimant or such claimant's attorney, and any apportionment
74 complainant or such apportionment complainant's attorney, shall
75 obtain a written and signed opinion of a similar health care provider,
76 as defined in section 52-184c, which similar health care provider shall
77 be selected pursuant to the provisions of said section, that there
78 appears to be evidence of medical negligence and includes a detailed
79 basis for the formation of such opinion. Such written opinion shall not
80 be subject to discovery by any party except for questioning the validity
81 of the certificate. The claimant or such claimant's attorney, and any
82 apportionment complainant or such apportionment complainant's
83 attorney, shall retain the original written opinion and shall attach a
84 copy of such written opinion, with the name and signature of the
85 similar health care provider expunged, to such certificate. The similar
86 health care provider who provides such written opinion shall not,
87 without a showing of malice, be personally liable for any damages to
88 the defendant health care provider by reason of having provided such
89 written opinion. In addition to such written opinion, the court may
90 consider other factors with regard to the existence of good faith. If the
91 court determines, after the completion of discovery, that such
92 certificate was not made in good faith and that no justiciable issue was
93 presented against a health care provider that fully cooperated in
94 providing informal discovery, the court upon motion or upon its own
95 initiative shall impose upon the person who signed such certificate or a
96 represented party, or both, an appropriate sanction which may include
97 an order to pay to the other party or parties the amount of the
98 reasonable expenses incurred because of the filing of the pleading,
99 motion or other paper, including a reasonable attorney's fee. The court
100 may also submit the matter to the appropriate authority for

101 disciplinary review of the attorney if the claimant's attorney or
102 apportionment complainant's attorney submitted the certificate.

103 (b) If a claimant in a civil action asserts a claim against an
104 apportionment defendant pursuant to subsection (d) of section 52-
105 102b, the requirement under subsection (a) of this section that the
106 attorney or party filing the action make a reasonable inquiry and
107 submit a certificate of good faith shall be satisfied by the submission of
108 a certificate of good faith by the apportionment complainant pursuant
109 to subsection (a) of this section.

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

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

117 (a) Upon the filing of any civil action regarding a medical
118 malpractice claim against an individual licensed pursuant to chapter
119 370 to 373, inclusive, 375, 379, 380 or 383, the plaintiff or the plaintiff's
120 attorney shall mail a copy of the complaint to the Department of Public
121 Health and the Insurance Department. Receipt or review of a copy of a
122 complaint submitted pursuant to this subsection shall not be
123 considered an investigation of such individual licensee by the
124 Department of Public Health or any examining board.

125 (b) Upon entry of any medical malpractice award by a court or upon
126 the parties entering a settlement of a malpractice claim against an
127 individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379,
128 380 or 383, the entity making payment on behalf of a party or, if no
129 such entity exists, the party, shall [notify] provide to the Department of
130 Public Health and the Insurance Department notice of the terms of the
131 award or settlement and [shall provide to the department] a copy of
132 the award or settlement and the underlying complaint and answer, if

133 any. Such notice and copies provided to the Insurance Department
134 shall not identify the parties to the claim. The Department of Public
135 Health shall send the information received from such entity or party to
136 the state board of examiners having cognizance over any individual
137 licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383
138 who is a party to the claim. The [department] Department of Public
139 Health shall review all medical malpractice complaints, awards and
140 [all] settlements to determine whether further investigation or
141 disciplinary action against the providers involved is warranted. On
142 and after October 1, 2004, such review shall be conducted in
143 accordance with the guidelines adopted by the Department of Public
144 Health, in accordance with section 20-13b, as amended by this act, to
145 determine the basis for such further investigation or disciplinary
146 action. Any document received pursuant to this section shall not be
147 considered a petition and shall not be subject to [the provisions of]
148 disclosure under section 1-210, as amended, unless the [department]
149 Department of Public Health determines, following completion of its
150 review, that further investigation or disciplinary action is warranted.
151 As used in this subsection, "terms of the award or settlement" means
152 the rights and obligations of the parties to a medical malpractice claim,
153 as determined by a court or by agreement of the parties, and includes,
154 but is not limited to, (1) for any individual licensed pursuant to chapter
155 370 to 373, inclusive, 375, 379, 380 or 383 who is a party to the claim,
156 the type of healing art or other health care practice, and the specialty, if
157 any, in which such individual engages, (2) the amount of the award or
158 settlement, specifying the portion of the award or settlement
159 attributable to economic damages, the portion of the award or
160 settlement attributable, if determined by the parties, to noneconomic
161 damages, and, if an award was entered, the portion of the award, if
162 any, attributable to interest awarded pursuant to section 52-192a, as
163 amended by this act, and (3) if there are multiple defendants, the
164 allocation for payment of the award or settlement between or among
165 such defendants.

166 (c) No release of liability executed by a party to which payment is to

167 be made under a settlement of a malpractice claim against an
168 individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379,
169 380 or 383 shall be effective until the attorney for the entity making
170 payment on behalf of a party or, if no such entity exists, the attorney
171 for the party, files with the court an affidavit stating that such attorney
172 has provided the information required under subsection (b) of this
173 section to the Department of Public Health and the Insurance
174 Department.

175 (d) The Commissioner of Public Health and the Insurance
176 Commissioner shall each develop a system within the commissioner's
177 respective agency for collecting, storing, utilizing, interpreting,
178 reporting and providing public access to the information received
179 under subsections (a) and (b) of this section. Each commissioner shall
180 report the details of such system with respect to the commissioner's
181 agency to the joint standing committees of the General Assembly
182 having cognizance of matters relating to public health and insurance
183 on or before October 1, 2004, in accordance with section 11-4a.

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

186 The Commissioner of Public Health, with advice and assistance
187 from the board, may establish such regulations in accordance with
188 chapter 54 as may be necessary to carry out the provisions of sections
189 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1,
190 2004, such regulations shall include, but need not be limited to: (1)
191 Guidelines for screening complaints received to determine which
192 complaints will be investigated; (2) guidelines to provide a basis for
193 prioritizing the order in which complaints will be investigated; (3) a
194 system for conducting investigations to ensure prompt action when it
195 appears necessary; (4) guidelines to determine when an investigation
196 should be broadened beyond the initial complaint to include sampling
197 patient records to identify patterns of care, reviewing office practices
198 and procedures, reviewing performance and discharge data from
199 hospitals and managed care organizations and conducting additional

200 interviews of patients; and (5) guidelines to protect and ensure the
201 confidentiality of patient and provider identifiable information when
202 an investigation is broadened beyond the initial complaint.

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

205 (a) There shall be within the Department of Public Health a
206 Connecticut Medical Examining Board. Said board shall consist of
207 fifteen members appointed by the Governor, subject to the provisions
208 of section 4-9a, as amended, in the manner prescribed for department
209 heads in section 4-7, as follows: Five physicians practicing in the state;
210 one physician who shall be a full-time member of the faculty of The
211 University of Connecticut School of Medicine; one physician who shall
212 be a full-time chief of staff in a general-care hospital in the state; one
213 physician who shall be registered as a supervising physician for one or
214 more physician assistants; one physician who shall be a graduate of a
215 medical education program accredited by the American Osteopathic
216 Association; one physician assistant licensed pursuant to section
217 20-12b and practicing in this state; and five public members. No
218 professional member of said board shall be an elected or appointed
219 officer of a professional society or association relating to such
220 member's profession at the time of appointment to the board or have
221 been such an officer during the year immediately preceding
222 appointment or serve for more than two consecutive terms.
223 Professional members shall be practitioners in good professional
224 standing and residents of this state.

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

233 (c) The Commissioner of Public Health shall establish a list of
234 eighteen persons who may serve as members of medical hearing
235 panels established pursuant to [subsection (g) of] this section. Persons
236 appointed to the list shall serve as members of the medical hearing
237 panels and provide the same services as members of the Connecticut
238 Medical Examining Board. Members from the list serving on such
239 panels shall not be voting members of the Connecticut Medical
240 Examining Board. The list shall consist of eighteen members appointed
241 by the commissioner, eight of whom shall be physicians, as defined in
242 section 20-13a, with at least one of such physicians being a graduate of
243 a medical education program accredited by the American Osteopathic
244 Association, one of whom shall be a physician assistant licensed
245 pursuant to section 20-12b, and nine of whom shall be members of the
246 public. No professional member of the list shall be an elected or
247 appointed officer of a professional society or association relating to
248 such member's profession at the time of appointment to the list or have
249 been such an officer during the year immediately preceding such
250 appointment to the list. A licensed professional appointed to the list
251 shall be a practitioner in good professional standing and a resident of
252 this state. All vacancies shall be filled by the commissioner. Successors
253 and appointments to fill a vacancy on the list shall possess the same
254 qualifications as those required of the member succeeded or replaced.
255 No person whose spouse, parent, brother, sister, child or spouse of a
256 child is a physician, as defined in section 20-13a, or a physician
257 assistant, as defined in section 20-12a, shall be appointed to the list as a
258 member of the public. Each person appointed to the list shall serve
259 without compensation at the pleasure of the commissioner. Each
260 medical hearing panel shall consist of three members, one of whom
261 shall be a similar health care provider, as defined in section 52-184c, to
262 the person who is the subject of the complaint, and two of whom shall
263 be public members. At least one of the three members shall be a
264 member of the Connecticut Medical Examining Board. The public
265 members may be a member of the board or a member from the list
266 established pursuant to this subsection.

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

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

270 (f) The Governor shall appoint a chairperson from among the board
271 members. Said board shall meet at least once during each calendar
272 quarter and at such other times as the chairperson deems necessary.
273 Special meetings shall be held on the request of a majority of the board
274 after notice in accordance with the provisions of section 1-225. A
275 majority of the members of the board shall constitute a quorum.
276 Members shall not be compensated for their services. Any member
277 who fails to attend three consecutive meetings or who fails to attend
278 fifty per cent of all meetings held during any calendar year shall be
279 deemed to have resigned from office. Minutes of all meetings shall be
280 recorded by the board. No member shall participate in the affairs of
281 the board during the pendency of any disciplinary proceedings by the
282 board against such member. Said board shall (1) hear and decide
283 matters concerning suspension or revocation of licensure, (2)
284 adjudicate complaints against practitioners, and (3) impose sanctions
285 where appropriate.

286 (g) (1) Not later than July 1, 2004, the board, with the assistance of
287 the department, shall adopt regulations, in accordance with chapter 54,
288 to establish guidelines for use in the disciplinary process. Such
289 guidelines shall include, but need not be limited to: (A) Identification
290 of each type of violation; (B) a range of penalties for each type of
291 violation; (C) additional optional conditions that may be imposed by
292 the board for each violation; (D) identification of factors the board shall
293 consider in determining what penalty should apply; (E) conditions,
294 such as mitigating factors or other facts, that may be considered in
295 allowing deviations from the guidelines; and (F) a provision that when
296 a deviation from the guidelines occurs, the reason for the deviation
297 shall be identified.

298 (2) The board shall refer all statements of charges filed with the

299 board by the department pursuant to section 20-13e, as amended by
300 this act, to a medical hearing panel [within] not later than sixty days
301 [of] after the receipt of charges. [This] The time period may be
302 extended for good cause by the board in a duly recorded vote. [The
303 panel shall consist of three members, at least one of whom shall be a
304 member of the board and one a member of the public. The public
305 member may be a member of either the board or of the list established
306 pursuant to subsection (c) of this section.] The panel shall conduct a
307 hearing, in accordance with the provisions of chapter 54, and the
308 regulations [established] adopted by the Commissioner of Public
309 Health concerning contested cases, except that the panel shall file a
310 proposed final decision with the board [within] not later than one
311 hundred twenty days [of] after the receipt of the issuance of the notice
312 of hearing by the board. The time period for filing such proposed final
313 decision with the board may be extended for good cause by the board
314 in a duly recorded vote. If the panel does not conduct a hearing within
315 sixty days of the date of referral of the statement of charges by the
316 board, the commissioner shall conduct a hearing in accordance with
317 chapter 54 and the regulations adopted by the commissioner
318 concerning contested cases. The commissioner shall file a proposed
319 final decision with the board not later than sixty days after such
320 hearing, except that the time period for filing such proposed final
321 decision with the board may be extended for good cause by the board
322 in a duly recorded vote.

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

330 (i) Except in a case in which a license has been summarily
331 suspended, pursuant to subsection (c) of section 19a-17 or subsection
332 (c) of section 4-182, all three panel members shall be present to hear

333 any evidence and vote on a proposed final decision. The chairperson of
334 the Medical Examining Board may exempt a member from a meeting
335 of the panel if the chairperson finds that good cause exists for such an
336 exemption. Such an exemption may be granted orally but shall be
337 reduced to writing and included as part of the record of the panel
338 within two business days of the granting of the exemption or the
339 opening of the record and shall state the reason for the exemption.
340 Such exemption shall be granted to a member no more than once
341 during any contested case and shall not be granted for a meeting at
342 which the panel is acting on a proposed final decision on a statement
343 of charges. The board may appoint a member to the panel to replace
344 any member who resigns or otherwise fails to continue to serve on the
345 panel. Such replacement member shall review the record prior to the
346 next hearing.

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

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

352 The department shall file with the Governor and the joint standing
353 committee on public health of the General Assembly on or before
354 January 1, 1986, and thereafter on or before January first of each
355 succeeding year, a report of the activities of the department and the
356 board conducted pursuant to sections 20-13d and 20-13e, as amended
357 by this act. Each such report shall include, but shall not be limited to,
358 the following information: The number of petitions received; the
359 number of petitions not investigated, and the reasons why; the number
360 of hearings held on such petitions; [and,] the outcome of such
361 hearings; the timeliness of action taken on any petition considered to
362 be a priority; without identifying the particular physician concerned, a
363 brief description of the impairment alleged in each such petition and
364 the actions taken with regard to each such petition by the department
365 and the board; the number of notifications received pursuant to section

366 19a-17a, as amended by this act; the number of such notifications with
367 no further action taken, and the reasons why; and the outcomes for
368 notifications where further action is taken.

369 Sec. 7. (NEW) (*Effective from passage*) (a) The Department of Public
370 Health shall develop protocols for accurate identification procedures
371 that shall be used by hospitals and outpatient surgical facilities prior to
372 surgery. Such protocols shall include, but need not be limited to, (1)
373 procedures to be followed to identify the (A) patient, (B) surgical
374 procedure to be performed, and (C) body part on which the surgical
375 procedure is to be performed, and (2) alternative identification
376 procedures in urgent or emergency circumstances or where the patient
377 is nonspeaking, comatose or incompetent or is a child. After October
378 1, 2004, no hospital or outpatient surgical facility may anesthetize a
379 patient or perform surgery unless the protocols have been followed.

380 (b) Not later than October 1, 2004, the department shall report, in
381 accordance with section 11-4a of the general statutes, to the joint
382 standing committee of the General Assembly having cognizance of
383 matters relating to public health describing the protocols developed
384 pursuant to subsection (a) of this section.

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

387 (a) After commencement of any civil action based upon contract or
388 seeking the recovery of money damages, whether or not other relief is
389 sought, the plaintiff may, not later than thirty days before trial, file
390 with the clerk of the court a written "offer of judgment" signed by the
391 plaintiff or the plaintiff's attorney, directed to the defendant or the
392 defendant's attorney, offering to settle the claim underlying the action
393 and to stipulate to a judgment for a sum certain. The plaintiff shall give
394 notice of the offer of settlement to the defendant's attorney or, if the
395 defendant is not represented by an attorney, to the defendant himself
396 or herself. Within sixty days after being notified of the filing of the
397 "offer of judgment" or within any extension or extensions thereof, not

398 to exceed a total of one hundred twenty additional days, granted by
399 the court for good cause shown not later than the expiration of such
400 sixty-day period or any extension thereof, and prior to the rendering of
401 a verdict by the jury or an award by the court, the defendant or the
402 defendant's attorney may file with the clerk of the court a written
403 "acceptance of offer of judgment" agreeing to a stipulation for
404 judgment as contained in plaintiff's "offer of judgment". Upon such
405 filing, the clerk shall enter judgment immediately on the stipulation. If
406 the "offer of judgment" is not accepted within [sixty days] the sixty-day
407 period or any extension thereof, and prior to the rendering of a verdict
408 by the jury or an award by the court, the "offer of judgment" shall be
409 considered rejected and not subject to acceptance unless refiled. Any
410 such "offer of judgment" and any "acceptance of offer of judgment"
411 shall be included by the clerk in the record of the case.

412 (b) After trial the court shall examine the record to determine
413 whether the plaintiff made an "offer of judgment" which the defendant
414 failed to accept. [If] Except with respect to a civil action described in
415 subsection (c) of this section, if the court ascertains from the record that
416 the plaintiff has recovered an amount equal to or greater than the sum
417 certain stated in the plaintiff's "offer of judgment", the court shall add
418 to the amount so recovered twelve per cent annual interest on said
419 amount. [, computed from the date such offer was filed in actions
420 commenced before October 1, 1981. In those actions commenced on or
421 after October 1, 1981, the]

422 (c) With respect to any civil action brought to recover damages
423 resulting from personal injury or wrongful death, whether in tort or in
424 contract, in which it is alleged that such injury or death resulted from
425 the negligence of a health care provider, as defined in section 52-184b,
426 and where the cause of action accrued on or after the effective date of
427 this section, if the court ascertains from the record that the plaintiff has
428 recovered an amount equal to or greater than the sum certain stated in
429 the plaintiff's offer of judgment, the court shall add to the amount so
430 recovered eight per cent annual interest on said amount, except that if
431 the plaintiff has recovered an amount that is more than twice the sum

432 certain stated in the plaintiff's offer of judgment, the court shall add to
433 the amount so recovered (1) eight per cent annual interest on the
434 portion of the amount recovered that is equal to or less than twice the
435 sum certain stated in such offer of judgment, and (2) four per cent
436 annual interest on the portion of the amount recovered that is more
437 than twice the sum certain stated in such offer.

438 (d) The interest shall be computed from the date the complaint in
439 the civil action was filed with the court if the "offer of judgment" was
440 filed not later than eighteen months from the filing of such complaint.
441 If such offer was filed later than eighteen months from the date of
442 filing of the complaint, the interest shall be computed from the date the
443 "offer of judgment" was filed. The court may award reasonable
444 attorney's fees in an amount not to exceed three hundred fifty dollars,
445 and shall render judgment accordingly. This section shall not be
446 interpreted to abrogate the contractual rights of any party concerning
447 the recovery of attorney's fees in accordance with the provisions of any
448 written contract between the parties to the action.

449 Sec. 9. Section 52-194 of the general statutes is repealed and the
450 following is substituted in lieu thereof (*Effective from passage*):

451 In any action, the plaintiff may, within [ten] sixty days after being
452 notified by the defendant of the filing of an offer of judgment, or
453 within any extension or extensions thereof, not to exceed a total of one
454 hundred twenty additional days, granted by the court for good cause
455 shown not later than the expiration of such sixty-day period or any
456 extension thereof, file with the clerk of the court a written acceptance
457 of the offer signed by [himself or his] the plaintiff or the plaintiff's
458 attorney. Upon the filing of the written acceptance, the court shall
459 render judgment against the defendant as upon default for the sum so
460 named and for the costs accrued at the time of the defendant's giving
461 the plaintiff notice of the offer. No trial may be postponed because the
462 period within which the plaintiff may accept the offer has not expired,
463 except at the discretion of the court.

464 Sec. 10. Subsection (a) of section 20-13e of the general statutes is
465 repealed and the following is substituted in lieu thereof (*Effective from*
466 *passage*):

467 (a) (1) The department shall investigate each petition filed pursuant
468 to section 20-13d, in accordance with the provisions of subdivision (10)
469 of subsection (a) of section 19a-14₂ to determine if probable cause exists
470 to issue a statement of charges and to institute proceedings against the
471 physician under subsection (e) of this section. Such investigation shall
472 be concluded not later than eighteen months from the date the petition
473 is filed with the department and, unless otherwise specified by this
474 subsection, the record of such investigation shall be deemed a public
475 record, in accordance with section 1-210, as amended, at the conclusion
476 of such eighteen-month period. Any such investigation shall be
477 confidential and no person shall disclose his knowledge of such
478 investigation to a third party unless the physician requests that such
479 investigation and disclosure be open. If the department determines
480 that probable cause exists to issue a statement of charges, the entire
481 record of such proceeding shall be public unless the department
482 determines that the physician is an appropriate candidate for
483 participation in a rehabilitation program in accordance with subsection
484 (b) of this section and the physician agrees to participate in such
485 program in accordance with terms agreed upon by the department and
486 the physician. If at any time subsequent to the filing of a petition and
487 during the eighteen-month period, the department makes a finding of
488 no probable cause, the petition and the entire record of such
489 investigation shall remain confidential unless the physician requests
490 that such petition and record be open.

491 (2) If the department makes a finding of no probable cause, it shall
492 notify the person who filed the petition or such person's personal
493 representative and the physician of such finding and the reasons
494 therefor.

495 Sec. 11. Subsection (b) of section 19a-88 of the general statutes is
496 repealed and the following is substituted in lieu thereof (*Effective from*

497 *passage*):

498 (b) Each person holding a license to practice medicine, surgery,
499 podiatry, chiropractic or natureopathy shall, annually, during the
500 month of such person's birth, register with the Department of Public
501 Health, upon payment of the professional services fee for class I, as
502 defined in section 33-182l, on blanks to be furnished by the department
503 for such purpose, giving such person's name in full, such person's
504 residence and business address, the name of the insurance company
505 providing such person's professional liability insurance and the policy
506 number of such insurance, such person's area of specialization,
507 whether such person is actively involved in patient care, any
508 disciplinary action against such person, or malpractice payments made
509 on behalf of such person in any other state or jurisdiction, and such
510 other information as the department requests. The department may
511 compare information submitted pursuant to this subsection to
512 information contained in the National Practitioner Data Base. Persons
513 may fulfill their obligation to report the information required by this
514 subsection by submitting such information as part of their physician
515 profile, in accordance with section 20-13j. The department shall revise
516 any forms utilized pursuant to section 20-13j to incorporate any
517 additional information required pursuant to this subsection.

518 Sec. 12. (NEW) (*Effective from passage*) On or before January 1, 2005,
519 and annually thereafter, the Department of Public Health shall report,
520 in accordance with section 11-4a of the general statutes, the number of
521 physicians by specialty who are actively providing patient care.

522 Sec. 13. Section 38a-676 of the general statutes is repealed and the
523 following is substituted in lieu thereof (*Effective from passage*):

524 (a) With respect to rates pertaining to commercial risk insurance,
525 and subject to the provisions of subsection (b) of this section with
526 respect to professional liability insurance described in subsection (b) of
527 this section and workers' compensation and employers' liability
528 insurance, on or before the effective date [thereof, every] of such rates,

529 each admitted insurer shall submit to the Insurance Commissioner for
530 the commissioner's information, except as to inland marine risks which
531 by general custom of the business are not written according to manual
532 rates or rating plans, [every] each manual of classifications, rules and
533 rates, and [every] each minimum, class rate, rating plan, rating
534 schedule and rating system and any modification of the foregoing
535 which it uses. Such submission by a licensed rating organization of
536 which an insurer is a member or subscriber shall be sufficient
537 compliance with this section for any insurer maintaining membership
538 or subscribership in such organization, to the extent that the insurer
539 uses the manuals, minimums, class rates, rating plans, rating
540 schedules, rating systems, policy or bond forms of such organization.
541 The information shall be open to public inspection after its submission.

542 (b) (1) Each filing as described in subsection (a) of this section for
543 workers' compensation or employers' liability insurance shall be on file
544 with the Insurance Commissioner for a waiting period of thirty days
545 before it becomes effective, which period may be extended by the
546 commissioner for an additional period not to exceed thirty days if the
547 commissioner gives written notice within such waiting period to the
548 insurer or rating organization which made the filing that the
549 commissioner needs such additional time for the consideration of such
550 filing. Upon written application by such insurer or rating organization,
551 the commissioner may authorize a filing which the commissioner has
552 reviewed to become effective before the expiration of the waiting
553 period or any extension thereof. A filing shall be deemed to meet the
554 requirements of sections 38a-663 to 38a-696, inclusive, as amended by
555 this act, unless disapproved by the commissioner within the waiting
556 period or any extension thereof. If, within the waiting period or any
557 extension thereof, the commissioner finds that a filing does not meet
558 the requirements of said sections, the commissioner shall send to the
559 insurer or rating organization which made such filing written notice of
560 disapproval of such filing, specifying therein in what respects the
561 commissioner finds such filing fails to meet the requirements of said
562 sections and stating that such filing shall not become effective. Such

563 finding of the commissioner shall be subject to review as provided in
564 section 38a-19.

565 (2) (A) Each filing as described in subsection (a) of this section for
566 professional liability insurance for physicians and surgeons, hospitals
567 or advanced practice registered nurses shall be subject to prior rate
568 approval in accordance with this section. On and after the effective
569 date of this section, each insurer or rating organization seeking to
570 change its rates for such insurance shall (i) file a request for such
571 change with the Insurance Commissioner, and (ii) send written notice
572 of any request for an increase in rates to insureds who would be
573 subject to the increase. Such request shall be filed and such notice, if
574 applicable, shall be sent at least sixty days prior to the proposed
575 effective date of the change. The notice to insureds of a request for an
576 increase in rates shall indicate that the insured may request a public
577 hearing by submitting a written request to the Insurance
578 Commissioner not later than fifteen days after the date of the notice.
579 Any request for an increase in rates under this subdivision shall be
580 filed after notice is sent to insureds and shall indicate the date such
581 notice was sent.

582 (B) The insurer or rating organization shall demonstrate in the
583 filing, to the satisfaction of the commissioner, that (i) (I) the insurer or
584 rating organization offers a premium reduction or a separate reduced
585 rating classification for insureds who submit proof to the insurer that
586 the insured and its personnel will use an electronic health record
587 system during the premium period to establish and maintain patient
588 records and verify patient treatment, and (II) the premium or rate
589 reduction reflects the reduction in risk related to the use of such
590 system, or (ii) if the insurer or rating organization does not offer such
591 premium or rate reduction, that there is no measurable reduction in
592 risk related to the use of such system.

593 (C) The Insurance Commissioner shall review the filing and, with
594 respect to a request for an increase in rates, shall (i) not approve,
595 modify or deny the request until at least fifteen days after the date of

596 notice as indicated in the filing, and (ii) hold a public hearing, if
597 requested, on such increase prior to approving, modifying or denying
598 the request. The Insurance Commissioner shall approve, modify or
599 deny the filing not later than forty-five days after its receipt. Such
600 finding of the commissioner shall be subject to review as provided in
601 section 38a-19.

602 (c) The form of any insurance policy or contract the rates for which
603 are subject to the provisions of sections 38a-663 to 38a-696, inclusive, as
604 amended by this act, other than fidelity, surety or guaranty bonds, and
605 the form of any endorsement modifying such insurance policy or
606 contract, shall be filed with the Insurance Commissioner prior to its
607 issuance. The commissioner shall adopt regulations, in accordance
608 with the provisions of chapter 54, establishing a procedure for review
609 of such policy or contract. If at any time the commissioner finds that
610 any such policy, contract or endorsement is not in accordance with
611 such provisions or any other provision of law, the commissioner shall
612 issue an order disapproving the issuance of such form and stating the
613 reasons for disapproval. The provisions of section 38a-19 shall apply to
614 any such order issued by the commissioner.

615 Sec. 14. Section 38a-665 of the general statutes is repealed and the
616 following is substituted in lieu thereof (*Effective from passage*):

617 The following standards, methods and criteria shall apply to the
618 making and use of rates pertaining to commercial risk insurance:

619 (a) Rates shall not be excessive or inadequate, as [herein] defined in
620 this section, nor shall [they] rates be unfairly discriminatory. No rate
621 shall be held to be excessive unless (1) such rate is unreasonably high
622 for the insurance provided, or (2) a reasonable degree of competition
623 does not exist in the area with respect to the classification to which
624 such rate is applicable. No rate shall be held inadequate unless (A) it is
625 unreasonably low for the insurance provided, and (B) continued use
626 [of it] would endanger solvency of the insurer, or unless (C) such rate
627 is unreasonably low for the insurance provided and the use of such

628 rate by the insurer [using same has, or, if continued,] has, or if
629 continued will have, the effect of destroying competition or creating a
630 monopoly.

631 (b) (1) Consideration shall be given, to the extent possible, to past
632 and prospective loss experience within and outside this state, to
633 conflagration and catastrophe hazards, to a reasonable margin for
634 underwriting profit and contingencies, to past and prospective
635 expenses both country-wide and those specially applicable to this
636 state, to investment income earned or realized by insurers both from
637 their unearned premium and loss reserve funds, and to all other
638 factors, including judgment factors, deemed relevant within and
639 outside this state and in the case of fire insurance rates, consideration
640 may be given to the experience of the fire insurance business during
641 the most recent five-year period for which such experience is available.
642 Consideration may be given in the making and use of rates to
643 dividends, savings or unabsorbed premium deposits allowed or
644 returned by insurers to their policyholders, members or subscribers.

645 (2) With respect to rates for professional liability insurance for
646 physicians and surgeons, hospitals or advanced practice registered
647 nurses, consideration shall be given in the making and use of such
648 rates to relevant factors that may reduce such rates, including, but not
649 limited to: (A) Amendments to the offer of judgment provisions in
650 section 52-192a, as amended by this act, and section 52-194, as
651 amended by this act, (B) the other provisions of this act, and (C) any
652 reduction in risk from the use of electronic health record systems to
653 establish and maintain patient records and verify patient treatment.

654 (c) The systems of expense provisions included in the rates for use
655 by any insurer or group of insurers may differ from those of other
656 insurers or groups of insurers to reflect the operating methods of any
657 such insurer or group with respect to any kind of insurance, or with
658 respect to any subdivision or combination thereof.

659 (d) Risks may be grouped by classifications for the establishment of

660 rates and minimum premiums, provided no surcharge on any motor
661 vehicle liability or physical damage insurance premium may be
662 assigned for (1) any accident involving only property damage of one
663 thousand dollars or less, [or] (2) the first accident involving only
664 property damage of more than one thousand dollars which would
665 otherwise result in a surcharge to the policy of the insured, within the
666 experience period set forth in the insurer's safe driver classification
667 plan, [or] (3) any violation of section 14-219, unless such violation
668 results in the suspension or revocation of the operator's license under
669 section 14-111b, [or] (4) less than three violations of section 14-218a
670 within any one-year period, or (5) any accident caused by an operator
671 other than the named insured, a relative residing in the named
672 insured's household, or a person who customarily operates the insured
673 vehicle. Classification rates may be modified to produce rates for
674 individual risks in accordance with rating plans which provide for
675 recognition of variations in hazards or expense provisions or both.
676 Such rating plans may include application of the judgment of the
677 insurer and may measure any differences among risks that can be
678 demonstrated to have a probable effect upon losses or expenses.

679 (e) Each rating plan shall establish appropriate eligibility criteria for
680 determining significant risks which are to qualify under the plan,
681 provided all such plans shall include as an eligible significant risk the
682 state of Connecticut or its instrumentalities. Rating plans which
683 comply with the provisions of this subsection shall be deemed to
684 produce rates [which] that are not unfairly discriminatory.

685 (f) Notwithstanding the provisions of subsections (a) to (e),
686 inclusive, of this section, no rate shall include [any] an adjustment
687 designed to recover underwriting or operating losses incurred out-of-
688 state.

689 (g) The commissioner may adopt regulations, in accordance with
690 the provisions of chapter 54, concerning rating plans to [effectuate]
691 implement the provisions of this section.

692 Sec. 15. Section 52-251c of the general statutes is repealed and the
693 following is substituted in lieu thereof (*Effective from passage and*
694 *applicable to causes of action accruing on or after said date*):

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

704 (b) In any such contingency fee arrangement such fee shall be the
705 exclusive method for payment of the attorney by the claimant and
706 shall not exceed an amount equal to a percentage of the damages
707 awarded and received by the claimant or of the settlement amount
708 received by the claimant as follows: (1) Thirty-three and one-third per
709 cent of the first three hundred thousand dollars; (2) twenty-five per
710 cent of the next three hundred thousand dollars; (3) twenty per cent of
711 the next three hundred thousand dollars; (4) fifteen per cent of the next
712 three hundred thousand dollars; and (5) ten per cent of any amount
713 which exceeds one million two hundred thousand dollars.

714 (c) (1) Whenever a claimant in a medical malpractice case enters into
715 a contingency fee arrangement with an attorney which provides for a
716 fee that would exceed the percentage limitations set forth in subsection
717 (b) of this section, such arrangement shall not be valid unless the
718 claimant's attorney files an application with the court for approval of
719 such arrangement and the court, after a hearing, grants such
720 application. The claimant's attorney shall attach to such application a
721 copy of such fee arrangement and the proposed unsigned writ,
722 summons and complaint in the case. Such fee arrangement shall
723 provide that the attorney will advance all costs in connection with the
724 investigation and prosecution or settlement of the case and the

725 claimant will not be liable for the reimbursement of the attorney for
726 any such costs if there is no recovery.

727 (2) At the hearing the court shall address the claimant personally to
728 determine if the claimant understands his or her rights under
729 subsection (b) of this section and has knowingly and voluntarily
730 waived such rights. The court shall grant such application if it finds
731 that the claimant has knowingly and voluntarily waived such rights
732 and that the case is so substantially complex, unique or different from
733 other medical malpractice cases as to warrant a deviation from such
734 percentage limitations. The claimant's attorney shall have the burden
735 of showing at the hearing that such deviation is warranted. In no event
736 shall the court grant an application approving a fee arrangement that
737 provides for a fee that exceeds an amount equal to thirty-three and
738 one-third per cent of the damages awarded and received by the
739 claimant or of the settlement amount received by the claimant. If the
740 court denies the application, the court shall advise the claimant of the
741 claimant's right to seek representation by another attorney willing to
742 abide by the percentage limitations set forth in subsection (b) of this
743 section. Only one application may be filed under this subsection with
744 respect to the claimant and the claimant's case.

745 (3) The filing of such application shall toll the applicable statute of
746 limitations until ninety days after the court's decision to grant or deny
747 the application. The decision of the court to grant or deny the
748 application shall not be subject to appeal. The Chief Court
749 Administrator shall assign a judge or judges with experience in
750 personal injury cases to hear and determine applications filed under
751 this subsection. A transcript of the hearing shall be prepared, and such
752 transcript shall be sealed and available for the use of the court only.

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

758 [(c) For] (e) (1) Except as provided in subdivision (2) of this
759 subsection, for the purposes of this section, "damages awarded and
760 received" means in a civil action in which final judgment is entered,
761 that amount of the judgment or amended judgment entered by the
762 court that is received by the claimant; [, except that in a civil action
763 brought pursuant to section 38a-368 such amount shall be reduced by
764 any basic reparations benefits paid to the claimant pursuant to section
765 38a-365;] "settlement amount received" means in a claim or civil action
766 in which no final judgment is entered, the amount received by the
767 claimant pursuant to a settlement agreement; [, except that in a claim
768 or civil action brought pursuant to section 38a-368 such amount shall
769 be reduced by any basic reparations benefits paid to the claimant
770 pursuant to section 38a-365;] and "fee" shall not include disbursements
771 or costs incurred in connection with the prosecution or settlement of
772 the claim or civil action, other than ordinary office overhead and
773 expense.

774 (2) For the purposes of this section and with respect to a medical
775 malpractice case in which an application was granted by a court
776 pursuant to subsection (c) of this section, "damages awarded and
777 received" means in a medical malpractice civil action in which final
778 judgment is entered, that amount of the judgment or amended
779 judgment entered by the court that is received by the claimant after
780 deduction for any disbursements made or costs incurred by the
781 attorney in connection with the investigation and prosecution or
782 settlement of the civil action, other than ordinary office overhead and
783 expense, for which the claimant is liable; and "settlement amount
784 received" means in a medical malpractice claim or civil action in which
785 no final judgment is entered, the amount received by the claimant
786 pursuant to a settlement agreement after deduction for any
787 disbursements made or costs incurred by the attorney in connection
788 with the investigation and prosecution or settlement of the claim or
789 civil action, other than ordinary office overhead and expense, for
790 which the claimant is liable.

791 Sec. 16. Section 38a-395 of the general statutes is repealed and the

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

793 [The Insurance Commissioner may require all insurance companies
794 writing medical malpractice insurance in this state to submit, in such
795 manner and at such times as he specifies, such information as he
796 deems necessary to establish a data base on medical malpractice,
797 including information on all incidents of medical malpractice, all
798 settlements, all awards, other information relative to procedures and
799 specialties involved and any other information relating to risk
800 management.]

801 (a) As used in this section:

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

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

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

812 (b) On and after January 1, 2005, each insurer shall provide to the
813 Insurance Commissioner a closed claim report, on such form as the
814 commissioner prescribes, in accordance with this section. The insurer
815 shall submit the report not later than ten days after the last day of the
816 calendar quarter in which a claim is closed. The report shall only
817 include information about claims settled under the laws of this state.

818 (c) The closed claim report shall include:

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

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

825 (2) Details about the injury or loss, including: (A) The date of the
826 injury or loss that was the basis of the claim; (B) the date the injury or
827 loss was reported to the insurer; (C) the name of the institution or
828 location at which the injury or loss occurred; (D) the type of injury or
829 loss, including a severity of injury rating that corresponds with the
830 severity of injury scale that the Insurance Commissioner shall establish
831 based on the severity of injury scale developed by the National
832 Association of Insurance Commissioners; and (E) the name, age and
833 gender of any injured person covered by the claim. Any individually
834 identifiable health information, as defined in 45 CFR 160.103, as from
835 time to time amended, submitted pursuant to this subdivision shall be
836 confidential. The reporting of the information is required by law. If
837 necessary to comply with federal privacy laws, including the Health
838 Insurance Portability and Accountability Act of 1996, P.L. 104-191, as
839 from time to time amended, the insured shall arrange with the insurer
840 to release the required information.

841 (3) Details about the claims process, including: (A) Whether a
842 lawsuit was filed, and if so, in which court; (B) the outcome of such
843 lawsuit; (C) the number of other defendants, if any; (D) the stage in the
844 process when the claim was closed; (E) the dates of the trial; (F) the
845 date of the judgment or settlement, if any; (G) whether an appeal was
846 filed, and if so, the date filed; (H) the resolution of the appeal and the
847 date such appeal was decided; (I) the date the claim was closed; (J) the
848 initial indemnity and expense reserve for the claim; and (K) the final
849 indemnity and expense reserve for the claim.

850 (4) Details about the amount paid on the claim, including: (A) The
851 total amount of the initial judgment rendered by a jury or awarded by
852 the court; (B) the total amount of the settlement if there was no
853 judgment rendered or awarded; (C) the total amount of the settlement
854 if the claim was settled after judgment was rendered or awarded; (D)

855 the amount of economic damages, as defined in section 52-572h, or the
856 insurer's estimate of the amount in the event of a settlement; (E) the
857 amount of noneconomic damages, as defined in section 52-572h, or the
858 insurer's estimate of the amount in the event of a settlement; (F) the
859 amount of any interest awarded due to failure to accept an offer of
860 judgment; (G) the amount of any remittitur or additur; (H) the amount
861 of final judgment after remittitur or additur; (I) the amount paid by the
862 insurer; (J) the amount paid by the defendant due to a deductible or a
863 judgment or settlement in excess of policy limits; (K) the amount paid
864 by other insurers; (L) the amount paid by other defendants; (M)
865 whether a structured settlement was used; (N) the expense assigned to
866 and recorded with the claim, including, but not limited to, defense and
867 investigation costs, but not including the actual claim payment; and
868 (O) any other information the commissioner determines to be
869 necessary to regulate the professional liability insurance industry with
870 respect to medical professionals and entities, ensure the industry's
871 solvency and ensure that such liability insurance is available and
872 affordable.

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

875 (2) The commissioner shall compile the data included in individual
876 closed claim reports into an aggregated summary format and shall
877 prepare a written annual report of the summary data. The report shall
878 provide an analysis of closed claim information including a minimum
879 of five years of comparative data, when available, trends in frequency
880 and severity of claims, itemization of damages, timeliness of the claims
881 process, and any other descriptive or analytical information that would
882 assist in interpreting the trends in closed claims.

883 (3) The annual report shall include a summary of rate filings for
884 professional liability insurance for medical professionals and entities
885 which have been approved by the department for the prior calendar
886 year, including an analysis of the trend of direct losses, incurred losses,
887 earned premiums and investment income as compared to prior years.

888 The report shall include base premiums charged by medical
889 malpractice insurers for each specialty and the number of providers
890 insured by specialty for each insurer.

891 (4) Not later than March 15, 2006, and annually thereafter, the
892 commissioner shall submit the annual report to the joint standing
893 committee of the General Assembly having cognizance of matters
894 relating to insurance in accordance with section 11-4a. The
895 commissioner shall also (A) make the report available to the public, (B)
896 post the report on its Internet site, and (C) provide public access to the
897 contents of the electronic database after the commissioner establishes
898 that the names and other individually identifiable information about
899 the claimant and practitioner have been removed.

900 (e) The Insurance Commissioner shall provide the Commissioner of
901 Public Health with electronic access to all information received
902 pursuant to this section. The Commissioner of Public Health shall
903 maintain the confidentiality of such information in the same manner
904 and to the same extent as required for the Insurance Commissioner.

905 Sec. 17. (NEW) (*Effective from passage*) (a) The Commissioner of
906 Public Health shall develop and implement a process that will ensure a
907 continuing and coordinated focus on patient safety programs within
908 the Department of Public Health. Such process shall encompass
909 activities undertaken by the department to (1) coordinate state
910 initiatives on patient safety, (2) facilitate ongoing collaborations
911 between the public and private sectors, (3) promote patient safety
912 through education of health care providers and patients, (4) assure
913 coordination in collecting, analyzing and responding to adverse events
914 reports submitted to the department pursuant to section 19a-127n of
915 the general statutes, (5) coordinate state and federal patient safety
916 programs, (6) participate in the federal Patient Safety Improvement
917 Corps to identify the causes of medical errors, and (7) promote the
918 recommendations of the Quality of Care Advisory Committee.

919 (b) On or before January 1, 2005, and annually thereafter, the

920 Commissioner of Public Health shall submit a report, in accordance
921 with the provisions of section 11-4a of the general statutes, to the
922 Governor and the chairpersons of the joint standing committee of the
923 General Assembly having cognizance of matters relating to public
924 health, providing a description of the process developed pursuant to
925 subsection (a) of this section, an analysis of its operation and impact
926 with respect to the activities enumerated in subsection (a) of this
927 section, a description of the activities undertaken by the department's
928 patient safety programs, and recommendations for future action.

929 Sec. 18. (NEW) (*Effective from passage*) Whenever in a civil action to
930 recover damages resulting from personal injury or wrongful death,
931 whether in tort or in contract, in which it is alleged that such injury or
932 death resulted from the negligence of a health care provider, the jury
933 renders a verdict specifying noneconomic damages, as defined in
934 section 52-572h of the general statutes, in an amount exceeding one
935 million dollars, the court shall review the evidence presented to the
936 jury to determine if the amount of noneconomic damages specified in
937 the verdict is excessive as a matter of law in that it so shocks the sense
938 of justice as to compel the conclusion that the jury was influenced by
939 partiality, prejudice, mistake or corruption. If the court so concludes, it
940 shall order a remittitur and, upon failure of the party so ordered to
941 remit the amount ordered by the court, it shall set aside the verdict and
942 order a new trial.

943 Sec. 19. (NEW) (*Effective July 1, 2004, and applicable to taxable years*
944 *commencing on or after January 1, 2004*) (a) Any resident of this state, as
945 defined in subdivision (1) of subsection (a) of section 12-701 of the
946 general statutes, as amended, who is a physician and who is subject to
947 the tax imposed under chapter 229 of the general statutes for any
948 taxable year shall be entitled to a credit in determining the amount of
949 tax liability under said chapter, for a portion, as permitted by this
950 section, of the amount of medical malpractice insurance premiums first
951 becoming due and actually paid during such taxable year by such
952 person in accordance with this section.

953 (b) The credit allowed under this section shall be equal to one
954 hundred per cent of the amount by which the medical malpractice
955 insurance premiums first becoming due and actually paid during such
956 taxable year by such person exceed twenty-five per cent of the person's
957 Connecticut taxable income, provided such credit shall not exceed an
958 amount equal to fifteen per cent of such premiums.

959 (c) The credit may only be used to reduce such qualifying
960 taxpayer's tax liability for the year for which such credit is applicable
961 and shall not be used to reduce such tax liability to less than zero.

962 (d) The amount of tax due pursuant to sections 12-705 and 12-722 of
963 the general statutes shall be calculated without regard to this credit.

964 (e) Any physician who has had, at any time, a judgment entered
965 against him or her as a defendant in a civil action to recover damages
966 for personal injury or wrongful death resulting from the acts or
967 omissions of such physician in the medical diagnosis, care or treatment
968 of a person shall not be entitled to a credit under this section.

969 Sec. 20. Subsection (c) of section 46 of public act 03-1 of the June 30
970 special session is repealed and the following is substituted in lieu
971 thereof (*Effective from passage*):

972 (c) Notwithstanding any provision of the general statutes, for the
973 fiscal year ending June 30, 2004, and the fiscal year ending June 30,
974 2005, the sum of \$2,000,000 shall be transferred from the resources of
975 the Biomedical Research Trust Fund and credited to the resources of
976 the General Fund, except that for the fiscal year ending June 30, 2005,
977 any necessary portion of said sum shall be allocated to offset the
978 revenue loss resulting from the tax credit established in section 19 of
979 this act, as certified by the Commissioner of Revenue Services.

980 Sec. 21. Section 38a-25 of the general statutes is repealed and the
981 following is substituted in lieu thereof (*Effective from passage*):

982 (a) The Insurance Commissioner is the agent for receipt of service of

983 legal process on the following:

984 (1) Foreign and alien insurance companies authorized to do
985 business in this state in any proceeding arising from or related to any
986 transaction having a connection with this state.

987 (2) Fraternal benefit societies authorized to do business in this state.

988 (3) Insurance-support organizations as defined in section 38a-976,
989 transacting business outside this state which affects a resident of this
990 state.

991 (4) Risk retention groups, as defined in section 38a-250. [designating
992 the Insurance Commissioner as agent for receipt of service of process
993 pursuant to section 38a-252.]

994 (5) Purchasing groups designating the Insurance Commissioner as
995 agent for receipt of service of process pursuant to section 38a-261.

996 (6) Eligible surplus lines insurers authorized by the commissioner to
997 accept surplus lines insurance.

998 (7) Except as provided by section 38a-273, unauthorized insurers or
999 other persons assisting unauthorized insurers who directly or
1000 indirectly do any of the acts of insurance business as set forth in
1001 subsection (a) of section 38a-271.

1002 (8) The Connecticut Insurance Guaranty Association and the
1003 Connecticut Life and Health Insurance Guaranty Association.

1004 (9) Insurance companies designating the Insurance Commissioner
1005 as agent for receipt of service of process pursuant to subsection (g) of
1006 section 38a-85.

1007 (10) Nonresident insurance producers and nonresident surplus lines
1008 brokers licensed by the Insurance Commissioner.

1009 (11) Viatical settlement providers, viatical settlement brokers, and

1010 viatical settlement investment agents licensed by the commissioner.

1011 (12) Nonresident reinsurance intermediaries designating the
1012 commissioner as agent for receipt of service of process pursuant to
1013 section 38a-760b.

1014 (13) Workers' compensation self-insurance groups, as defined in
1015 section 38a-1001.

1016 (14) Persons alleged to have violated any provision of section 38a-
1017 130.

1018 (15) Captive insurers, as defined in section 38a-91.

1019 (b) Each foreign and alien insurer by applying for and receiving a
1020 license to do insurance business in this state, each fraternal benefit
1021 society by applying for and receiving a certificate to solicit members
1022 and do business, each surplus lines insurer declared to be an eligible
1023 surplus lines insurer by the commissioner, each insurance-support
1024 organization transacting business outside this state which affects a
1025 resident of this state, and each unauthorized insurer by doing an act of
1026 insurance business prohibited by section 38a-272, is considered to have
1027 irrevocably appointed the Insurance Commissioner as [his] agent for
1028 receipt of service of process in accordance with subsection (a) of this
1029 section. Such appointment shall continue in force so long as any
1030 certificate of membership, policy or liability remains outstanding in
1031 this state.

1032 (c) The commissioner is also agent for the executors, administrators
1033 or personal representatives, receivers, trustees or other successors in
1034 interest of the persons specified under subsection (a) of this section.

1035 (d) Any legal process that is served on the commissioner pursuant
1036 to this section shall be of the same legal force and validity as if served
1037 on the principal.

1038 (e) The right to effect service of process as provided under this
1039 section does not limit the right to serve legal process in any other

1040 manner provided by law.

1041 Sec. 22. (NEW) (*Effective July 1, 2004*) Each captive insurer, as
 1042 defined in section 38a-91 of the general statutes, that offers, renews or
 1043 continues insurance in this state shall provide the information
 1044 described in subsection (a) of section 38a-253 of the general statutes to
 1045 the Insurance Commissioner in the same manner required for risk
 1046 retention groups. If a captive insurer does not maintain information in
 1047 the form prescribed in section 38a-253 of the general statutes, the
 1048 captive insurer may submit the information to the Insurance
 1049 Commissioner on such form as the commissioner prescribes. The
 1050 provisions of this section shall not apply to a captive insurer that is
 1051 otherwise required by law to submit such information to the
 1052 commissioner.

1053 Sec. 23. (*Effective from passage*) Sections 38a-32 to 38a-36, inclusive, of
 1054 the general statutes are repealed."

This act shall take effect as follows:	
Section 1	<i>from passage</i>
Sec. 2	<i>from passage and applicable to actions filed on or after said date</i>
Sec. 3	<i>from passage</i>
Sec. 4	<i>from passage</i>
Sec. 5	<i>from passage</i>
Sec. 6	<i>from passage</i>
Sec. 7	<i>from passage</i>
Sec. 8	<i>from passage</i>
Sec. 9	<i>from passage</i>
Sec. 10	<i>from passage</i>
Sec. 11	<i>from passage</i>
Sec. 12	<i>from passage</i>
Sec. 13	<i>from passage</i>
Sec. 14	<i>from passage</i>
Sec. 15	<i>from passage and applicable to causes of action accruing on or after said date</i>
Sec. 16	<i>January 1, 2005</i>
Sec. 17	<i>from passage</i>

Sec. 18	<i>from passage</i>
Sec. 19	<i>July 1, 2004, and applicable to taxable years commencing on or after January 1, 2004</i>
Sec. 20	<i>from passage</i>
Sec. 21	<i>from passage</i>
Sec. 22	<i>July 1, 2004</i>
Sec. 23	<i>from passage</i>