



General Assembly

January Session, 2005

Committee Bill No. 131

LCO No. 3193

03193SB00131INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING MEDICAL MALPRACTICE INSURANCE REFORM.

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

1 Section 1. (NEW) (*Effective from passage*) (a) All civil actions brought
2 to recover damages resulting from personal injury or wrongful death,
3 whether in tort or in contract, in which it is alleged that such injury or
4 death resulted from the negligence of a health care provider, shall be
5 referred to mandatory mediation pursuant to this section, unless the
6 parties have agreed to refer the civil action to an alternative dispute
7 resolution program. For the purposes of this section, "health care
8 provider" means a provider, as defined in subsection (b) of section 20-
9 7b of the general statutes, or an institution, as defined in section 19a-
10 490 of the general statutes.

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 is repealed and the
52 following is substituted in lieu thereof (*Effective from passage and*
53 *applicable to actions filed on or after said date*):

54 (a) No civil action or apportionment complaint shall be filed to
55 recover damages resulting from personal injury or wrongful death
56 occurring on or after October 1, 1987, whether in tort or in contract, in
57 which it is alleged that such injury or death resulted from the
58 negligence of a health care provider, unless the attorney or party filing
59 the action or apportionment complaint has made a reasonable inquiry
60 as permitted by the circumstances to determine that there are grounds
61 for a good faith belief that there has been negligence in the care or
62 treatment of the claimant. The complaint, [or] initial pleading or
63 apportionment complaint shall contain a certificate of the attorney or
64 party filing the action or apportionment complaint that such
65 reasonable inquiry gave rise to a good faith belief that grounds exist
66 for an action against each named defendant or for an apportionment
67 complaint against each named apportionment defendant. [For the
68 purposes of this section, such good faith may be shown to exist if the
69 claimant or his attorney has received a written opinion, which shall not
70 be subject to discovery by any party except for questioning the validity
71 of the certificate,] To show the existence of such good faith, the
72 claimant or such claimant's attorney, and any apportionment
73 complainant or such apportionment complainant's attorney, shall
74 obtain a written and signed opinion of a similar health care provider,
75 as defined in section 52-184c, which similar health care provider shall
76 be selected pursuant to the provisions of said section, that there
77 appears to be evidence of medical negligence and includes a detailed
78 basis for the formation of such opinion. Such written opinion shall not
79 be subject to discovery by any party except for questioning the validity
80 of the certificate. The claimant or such claimant's attorney, and any

81 apportionment complainant or such apportionment complainant's
82 attorney, shall retain the original written opinion and shall attach a
83 copy of such written opinion, with the name and signature of the
84 similar health care provider expunged, to such certificate. The similar
85 health care provider who provides such written opinion shall not,
86 without a showing of malice, be personally liable for any damages to
87 the defendant health care provider by reason of having provided such
88 written opinion. In addition to such written opinion, the court may
89 consider other factors with regard to the existence of good faith. If the
90 court determines, after the completion of discovery, that such
91 certificate was not made in good faith and that no justiciable issue was
92 presented against a health care provider that fully cooperated in
93 providing informal discovery, the court upon motion or upon its own
94 initiative shall impose upon the person who signed such certificate or a
95 represented party, or both, an appropriate sanction which may include
96 an order to pay to the other party or parties the amount of the
97 reasonable expenses incurred because of the filing of the pleading,
98 motion or other paper, including a reasonable attorney's fee. The court
99 may also submit the matter to the appropriate authority for
100 disciplinary review of the attorney if the claimant's attorney or
101 apportionment complainant's attorney submitted the certificate.

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

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

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

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

124 (b) Upon entry of any medical malpractice award by a court or upon
125 the parties entering a settlement of a malpractice claim against an
126 individual licensed pursuant to chapter 370 to 373, inclusive, 375, 379,
127 380 or 383, the entity making payment on behalf of a party or, if no
128 such entity exists, the party, shall [notify] provide to the Department of
129 Public Health and the Insurance Department notice of the terms of the
130 award or settlement and [shall provide to the department] a copy of
131 the award or settlement and the underlying complaint and answer, if
132 any. Such notice and copies provided to the Insurance Department
133 shall not identify the parties to the claim. The Department of Public
134 Health shall send the information received from such entity or party to
135 the state board of examiners having cognizance over any individual
136 licensed pursuant to chapter 370 to 373, inclusive, 375, 379, 380 or 383
137 who is a party to the claim. The [department] Department of Public
138 Health shall review all medical malpractice complaints, awards and
139 [all] settlements to determine whether further investigation or
140 disciplinary action against the providers involved is warranted. On
141 and after October 1, 2005, such review shall be conducted in
142 accordance with the guidelines adopted by the Department of Public
143 Health, in accordance with section 20-13b, as amended by this act, to
144 determine the basis for such further investigation or disciplinary
145 action. Any document received pursuant to this section shall not be
146 considered a petition and shall not be subject to [the provisions of]

147 disclosure under section 1-210 unless the [department] Department of
148 Public Health determines, following completion of its review, that
149 further investigation or disciplinary action is warranted. As used in
150 this subsection, "terms of the award or settlement" means the rights
151 and obligations of the parties to a medical malpractice claim, as
152 determined by a court or by agreement of the parties, and includes, but
153 is not limited to, (1) for any individual licensed pursuant to chapter
154 370 to 373, inclusive, 375, 379, 380 or 383 who is a party to the claim,
155 the type of healing art or other health care practice, and the specialty, if
156 any, in which such individual engages, (2) the amount of the award or
157 settlement, specifying the portion of the award or settlement
158 attributable to economic damages, the portion of the award or
159 settlement attributable, if determined by the parties, to noneconomic
160 damages, and, if an award was entered, the portion of the award, if
161 any, attributable to interest awarded pursuant to section 52-192a, as
162 amended by this act, and (3) if there are multiple defendants, the
163 allocation for payment of the award or settlement between or among
164 such defendants.

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

174 (d) The Commissioner of Public Health and the Insurance
175 Commissioner shall each develop a system within the commissioner's
176 respective agency for collecting, storing, utilizing, interpreting,
177 reporting and providing public access to the information received
178 under subsections (a) and (b) of this section. Each commissioner shall
179 report the details of such system with respect to the commissioner's

180 agency to the joint standing committees of the General Assembly
181 having cognizance of matters relating to public health and insurance
182 on or before October 1, 2005, in accordance with section 11-4a.

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

185 The Commissioner of Public Health, with advice and assistance
186 from the board, may establish such regulations in accordance with
187 chapter 54 as may be necessary to carry out the provisions of sections
188 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1,
189 2005, such regulations shall include, but need not be limited to: (1)
190 Guidelines for screening complaints received to determine which
191 complaints will be investigated; (2) guidelines to provide a basis for
192 prioritizing the order in which complaints will be investigated; (3) a
193 system for conducting investigations to ensure prompt action when it
194 appears necessary; (4) guidelines to determine when an investigation
195 should be broadened beyond the scope of the initial complaint to
196 include sampling patient records to identify patterns of care, reviewing
197 office practices and procedures, reviewing performance and discharge
198 data from hospitals and managed care organizations and conducting
199 additional interviews of patients; and (5) guidelines to protect and
200 ensure the confidentiality of patient and provider identifiable
201 information when an investigation is broadened beyond the scope of
202 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, in the manner prescribed for department heads in
209 section 4-7, as follows: Five physicians practicing in the state; one
210 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 and 19a-8, no person whose spouse, parent, brother,
230 sister, child or spouse of a child is a physician, as defined in section
231 20-13a, or a physician assistant, as defined in section 20-12a, shall be
232 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, 2005, 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 and included as part of the record.

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 not later than ninety days [of] after the filing of said decision by the
328 panel. [This] The time period may be extended by the board for good
329 cause in a duly 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 having
354 cognizance of matters relating to public health on or before January 1,
355 1986, and thereafter on or before January first of each succeeding year,
356 a report of the activities of the department and the board conducted
357 pursuant to sections 20-13d and 20-13e, as amended by this act. Each
358 such report shall include, but shall not be limited to, the following
359 information: The number of petitions received; the number of petitions
360 not investigated, and the reasons why; the number of hearings held on
361 such petitions; [and,] the outcome of such hearings; the timeliness of
362 action taken on any petition considered to be a priority; without
363 identifying the particular physician concerned, a brief description of
364 the impairment alleged in each such petition and the actions taken
365 with regard to each such petition by the department and the board; the
366 number of notifications received pursuant to section 19a-17a, as
367 amended by this act; the number of such notifications with no further
368 action taken, and the reasons why; and the outcomes for notifications
369 where further action is taken.

370 Sec. 7. (NEW) (*Effective from passage*) (a) The Department of Public
371 Health shall develop protocols for accurate identification procedures
372 that shall be used by hospitals and outpatient surgical facilities prior to
373 surgery. Such protocols shall include, but need not be limited to, (1)
374 procedures to be followed to identify the (A) patient, (B) surgical

375 procedure to be performed, and (C) body part on which the surgical
376 procedure is to be performed, and (2) alternative identification
377 procedures in urgent or emergency circumstances or where the patient
378 is nonspeaking, comatose or incompetent or is a child. After October 1,
379 2005, no hospital or outpatient surgical facility may anesthetize a
380 patient or perform surgery unless the protocols have been followed.

381 (b) Not later than October 1, 2005, the department shall report, in
382 accordance with section 11-4a of the general statutes, to the joint
383 standing committee of the General Assembly having cognizance of
384 matters relating to public health describing the protocols developed
385 pursuant to subsection (a) of this section.

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

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

407 the "offer of judgment" is not accepted within [sixty days] the sixty-day
408 period or any extension thereof, and prior to the rendering of a verdict
409 by the jury or an award by the court, the "offer of judgment" shall be
410 considered rejected and not subject to acceptance unless refiled. Any
411 such "offer of judgment" and any "acceptance of offer of judgment"
412 shall be included by the clerk in the record of the case.

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

423 (c) With respect to any civil action brought to recover damages
424 resulting from personal injury or wrongful death, whether in tort or in
425 contract, in which it is alleged that such injury or death resulted from
426 the negligence of a health care provider, and where the cause of action
427 accrued on or after the effective date of this section, if the court
428 ascertains from the record that the plaintiff has recovered an amount
429 equal to or greater than the sum certain stated in the plaintiff's offer of
430 judgment, the court shall add to the amount so recovered eight per
431 cent annual interest on said amount, except that if the plaintiff has
432 recovered an amount that is more than twice the sum certain stated in
433 the plaintiff's offer of judgment, the court shall add to the amount so
434 recovered (1) eight per cent annual interest on the portion of the
435 amount recovered that is equal to or less than twice the sum certain
436 stated in such offer of judgment, and (2) four per cent annual interest
437 on the portion of the amount recovered that is more than twice the
438 sum certain stated in such offer. For the purposes of this subsection,
439 "health care provider" means a provider, as defined in subsection (b) of

440 section 20-7b, or an institution, as defined in section 19a-490.

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

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

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

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

470 (a) (1) The department shall investigate each petition filed pursuant

471 to section 20-13d, in accordance with the provisions of subdivision (10)
472 of subsection (a) of section 19a-14 to determine if probable cause exists
473 to issue a statement of charges and to institute proceedings against the
474 physician under subsection (e) of this section. Such investigation shall
475 be concluded not later than eighteen months from the date the petition
476 is filed with the department and, unless otherwise specified by this
477 subsection, the record of such investigation shall be deemed a public
478 record, in accordance with section 1-210, at the conclusion of such
479 eighteen-month period. Any such investigation shall be confidential
480 and no person shall disclose his knowledge of such investigation to a
481 third party unless the physician requests that such investigation and
482 disclosure be open. If the department determines that probable cause
483 exists to issue a statement of charges, the entire record of such
484 proceeding shall be public unless the department determines that the
485 physician is an appropriate candidate for participation in a
486 rehabilitation program in accordance with subsection (b) of this section
487 and the physician agrees to participate in such program in accordance
488 with terms agreed upon by the department and the physician. If at any
489 time subsequent to the filing of a petition and during the eighteen-
490 month period, the department makes a finding of no probable cause,
491 the petition and the entire record of such investigation shall remain
492 confidential unless the physician requests that such petition and record
493 be open.

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

498 Sec. 11. Subsection (b) of section 19a-88 of the general statutes is
499 repealed and the following is substituted in lieu thereof (*Effective from*
500 *passage*):

501 (b) Each person holding a license to practice medicine, surgery,
502 podiatry, chiropractic or natureopathy shall, annually, during the

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

521 Sec. 12. (NEW) (*Effective from passage*) On or before January 1, 2006,
522 and annually thereafter, the Department of Public Health shall report,
523 in accordance with section 11-4a of the general statutes, the number of
524 physicians by specialty who are actively providing patient care.

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

527 (a) With respect to rates pertaining to commercial risk insurance,
528 and subject to the provisions of subsection (b) of this section with
529 respect to professional liability insurance described in subsection (b) of
530 this section and workers' compensation and employers' liability
531 insurance, on or before the effective date [thereof, every] of such rates,
532 each admitted insurer shall submit to the Insurance Commissioner for
533 the commissioner's information, except as to inland marine risks which
534 by general custom of the business are not written according to manual

535 rates or rating plans, [every] each manual of classifications, rules and
536 rates, and [every] each minimum, class rate, rating plan, rating
537 schedule and rating system and any modification of the foregoing
538 which it uses. Such submission by a licensed rating organization of
539 which an insurer is a member or subscriber shall be sufficient
540 compliance with this section for any insurer maintaining membership
541 or subscribership in such organization, to the extent that the insurer
542 uses the manuals, minimums, class rates, rating plans, rating
543 schedules, rating systems, policy or bond forms of such organization.
544 The information shall be open to public inspection after its submission.

545 (b) (1) Each filing as described in subsection (a) of this section for
546 workers' compensation or employers' liability insurance shall be on file
547 with the Insurance Commissioner for a waiting period of thirty days
548 before it becomes effective, which period may be extended by the
549 commissioner for an additional period not to exceed thirty days if the
550 commissioner gives written notice within such waiting period to the
551 insurer or rating organization which made the filing that the
552 commissioner needs such additional time for the consideration of such
553 filing. Upon written application by such insurer or rating organization,
554 the commissioner may authorize a filing which the commissioner has
555 reviewed to become effective before the expiration of the waiting
556 period or any extension thereof. A filing shall be deemed to meet the
557 requirements of sections 38a-663 to 38a-696, inclusive, as amended by
558 this act, unless disapproved by the commissioner within the waiting
559 period or any extension thereof. If, within the waiting period or any
560 extension thereof, the commissioner finds that a filing does not meet
561 the requirements of said sections, the commissioner shall send to the
562 insurer or rating organization which made such filing written notice of
563 disapproval of such filing, specifying therein in what respects the
564 commissioner finds such filing fails to meet the requirements of said
565 sections and stating that such filing shall not become effective. Such
566 finding of the commissioner shall be subject to review as provided in
567 section 38a-19.

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

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

596 (C) The Insurance Commissioner shall review the filing and, with
597 respect to a request for an increase in rates, shall (i) not approve,
598 modify or deny the request until at least fifteen days after the date of
599 notice as indicated in the filing, and (ii) hold a public hearing, if
600 requested, on such increase prior to approving, modifying or denying

601 the request. The Insurance Commissioner shall approve, modify or
602 deny the filing not later than forty-five days after its receipt. Such
603 finding of the commissioner shall be subject to review as provided in
604 section 38a-19.

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

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

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

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

632 continued will have, the effect of destroying competition or creating a
633 monopoly.

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

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

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

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

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

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

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

693 (g) The commissioner may adopt regulations in accordance with the
694 provisions of chapter 54 concerning rating plans to [effectuate]
695 implement the provisions of this section.

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

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

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

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

728 investigation and prosecution or settlement of the medical malpractice
729 claim or civil action and the claimant will not be liable for the
730 reimbursement of the attorney for any such costs if there is no
731 recovery.

732 (2) At the hearing required under subdivision (1) of this subsection,
733 the court shall address the claimant personally to determine if the
734 claimant understands his or her rights under subsection (b) of this
735 section and has knowingly and voluntarily waived such rights. The
736 court shall grant such application if it finds that the claimant has
737 knowingly and voluntarily waived such rights and that the medical
738 malpractice claim or civil action is so substantially complex, unique or
739 different from other medical malpractice claims or civil actions as to
740 warrant a deviation from such percentage limitations. The claimant's
741 attorney shall have the burden of showing at the hearing that such
742 deviation is warranted. In no event shall the court grant an application
743 approving a fee arrangement that provides for a fee that exceeds an
744 amount equal to thirty-three and one-third per cent of the damages
745 awarded and received by the claimant or of the settlement amount
746 received by the claimant. If the court denies the application, the court
747 shall advise the claimant of the claimant's right to seek representation
748 by another attorney willing to abide by the percentage limitations set
749 forth in subsection (b) of this section. Only one application may be
750 filed under this subsection with respect to the claimant and the
751 claimant's medical malpractice claim or civil action.

752 (3) The filing of such application shall toll the applicable statute of
753 limitations until ninety days after the court's decision to grant or deny
754 the application. The decision of the court to grant or deny the
755 application shall not be subject to appeal. The Chief Court
756 Administrator shall assign a judge or judges with experience in
757 personal injury claims or civil actions to hear and determine
758 applications filed under this subsection. A transcript of the hearing
759 shall be prepared, and such transcript shall be sealed and available for
760 the use of the court only.

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

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

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

794 deduction for any disbursements made or costs incurred by the
795 attorney in connection with the investigation and prosecution or
796 settlement of the claim or civil action, other than ordinary office
797 overhead and expense, for which the claimant is liable.

798 [(d)] (f) For the purposes of this section, "medical malpractice claim
799 or civil action" means a claim or civil action brought to recover
800 damages resulting from personal injury or wrongful death, whether in
801 tort or in contract, in which it is alleged that such injury or death
802 resulted from the negligence of a health care provider, and "health care
803 provider" means a provider, as defined in subsection (b) of section 20-
804 7b, or an institution, as defined in section 19a-490.

805 Sec. 16. Section 38a-395 of the general statutes is repealed and the
806 following is substituted in lieu thereof (*Effective January 1, 2006*):

807 [The Insurance Commissioner may require all insurance companies
808 writing medical malpractice insurance in this state to submit, in such
809 manner and at such times as he specifies, such information as he
810 deems necessary to establish a data base on medical malpractice,
811 including information on all incidents of medical malpractice, all
812 settlements, all awards, other information relative to procedures and
813 specialties involved and any other information relating to risk
814 management.]

815 (a) As used in this section:

816 (1) "Claim" means a request for indemnification filed by a physician,
817 surgeon, hospital, advanced practice registered nurse or physician
818 assistant pursuant to a professional liability policy for a loss for which
819 a reserve amount has been established by an insurer;

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

823 (3) "Insurer" means an insurer that insures a physician, surgeon,
824 hospital, advanced practice registered nurse or physician assistant
825 against professional liability. "Insurer" includes, but is not limited to, a
826 captive insurer or a self-insured person.

827 (b) On and after January 1, 2006, each insurer shall provide to the
828 Insurance Commissioner a closed claim report, on such form as the
829 commissioner prescribes, in accordance with this section. The insurer
830 shall submit the report not later than ten days after the last day of the
831 calendar quarter in which a claim is closed. The report shall only
832 include information about claims settled under the laws of this state.

833 (c) The closed claim report shall include:

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

840 (2) Details about the injury or loss, including: (A) The date of the
841 injury or loss that was the basis of the claim; (B) the date the injury or
842 loss was reported to the insurer; (C) the name of the institution or
843 location at which the injury or loss occurred; (D) the type of injury or
844 loss, including a severity of injury rating that corresponds with the
845 severity of injury scale that the Insurance Commissioner shall establish
846 based on the severity of injury scale developed by the National
847 Association of Insurance Commissioners; and (E) the name, age and
848 gender of any injured person covered by the claim. Any individually
849 identifiable health information, as defined in 45 CFR 160.103, as from
850 time to time amended, submitted pursuant to this subdivision shall be
851 confidential. The reporting of the information is required by law. If
852 necessary to comply with federal privacy laws, including the Health
853 Insurance Portability and Accountability Act of 1996, (P.L. 104-191)
854 (HIPAA), as from time to time amended, the insured shall arrange

855 with the insurer to release the required information.

856 (3) Details about the claims process, including: (A) Whether a
857 lawsuit was filed, and if so, in which court; (B) the outcome of such
858 lawsuit; (C) the number of other defendants, if any; (D) the stage in the
859 process when the claim was closed; (E) the dates of the trial, if any; (F)
860 the date of the judgment or settlement, if any; (G) whether an appeal
861 was filed, and if so, the date filed; (H) the resolution of any appeal and
862 the date such appeal was decided; (I) the date the claim was closed; (J)
863 the initial indemnity and expense reserve for the claim; and (K) the
864 final indemnity and expense reserve for the claim.

865 (4) Details about the amount paid on the claim, including: (A) The
866 total amount of the initial judgment rendered by a jury or awarded by
867 the court; (B) the total amount of the settlement if there was no
868 judgment rendered or awarded; (C) the total amount of the settlement
869 if the claim was settled after judgment was rendered or awarded; (D)
870 the amount of economic damages, as defined in section 52-572h, or the
871 insurer's estimate of the amount in the event of a settlement; (E) the
872 amount of noneconomic damages, as defined in section 52-572h, or the
873 insurer's estimate of the amount in the event of a settlement; (F) the
874 amount of any interest awarded due to failure to accept an offer of
875 judgment; (G) the amount of any remittitur or additur; (H) the amount
876 of final judgment after remittitur or additur; (I) the amount paid by the
877 insurer; (J) the amount paid by the defendant due to a deductible or a
878 judgment or settlement in excess of policy limits; (K) the amount paid
879 by other insurers; (L) the amount paid by other defendants; (M)
880 whether a structured settlement was used; (N) the expense assigned to
881 and recorded with the claim, including, but not limited to, defense and
882 investigation costs, but not including the actual claim payment; and
883 (O) any other information the commissioner determines to be
884 necessary to regulate the professional liability insurance industry with
885 respect to physicians, surgeons, hospitals, advanced practice registered
886 nurses or physician assistants, ensure the industry's solvency and
887 ensure that such liability insurance is available and affordable.

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

890 (2) The commissioner shall compile the data included in individual
891 closed claim reports into an aggregated summary format and shall
892 prepare a written annual report of the summary data. The report shall
893 provide an analysis of closed claim information including a minimum
894 of five years of comparative data, when available, trends in frequency
895 and severity of claims, itemization of damages, timeliness of the claims
896 process, and any other descriptive or analytical information that would
897 assist in interpreting the trends in closed claims.

898 (3) The annual report shall include a summary of rate filings for
899 professional liability insurance for physicians, surgeons, hospitals,
900 advanced practice registered nurses and physician assistants, which
901 have been approved by the department for the prior calendar year,
902 including an analysis of the trend of direct losses, incurred losses,
903 earned premiums and investment income as compared to prior years.
904 The report shall include base premiums charged by insurers for each
905 specialty and the number of providers insured by specialty for each
906 insurer.

907 (4) Not later than March 15, 2007, and annually thereafter, the
908 commissioner shall submit the annual report to the joint standing
909 committee of the General Assembly having cognizance of matters
910 relating to insurance in accordance with section 11-4a. The
911 commissioner shall also (A) make the report available to the public, (B)
912 post the report on its Internet site, and (C) provide public access to the
913 contents of the electronic database after the commissioner establishes
914 that the names and other individually identifiable information about
915 the claimant and practitioner have been removed.

916 (e) The Insurance Commissioner shall provide the Commissioner of
917 Public Health with electronic access to all information received
918 pursuant to this section. The Commissioner of Public Health shall
919 maintain the confidentiality of such information in the same manner

920 and to the same extent as required for the Insurance Commissioner.

921 Sec. 17. (NEW) (*Effective from passage*) (a) The Commissioner of
922 Public Health shall develop and implement a process to ensure a
923 continuing and coordinated focus on patient safety programs within
924 the Department of Public Health. Such process shall encompass
925 activities undertaken by the department to (1) coordinate state
926 initiatives on patient safety, (2) facilitate ongoing collaborations
927 between the public and private sectors, (3) promote patient safety
928 through education of health care providers and patients, (4) assure
929 coordination in collecting, analyzing and responding to adverse events
930 reports submitted to the department pursuant to section 19a-127n of
931 the general statutes, (5) coordinate state and federal patient safety
932 programs, (6) participate in the federal Patient Safety Improvement
933 Corps to identify the causes of medical errors, and (7) promote the
934 recommendations of the Quality of Care Advisory Committee
935 established in section 19a-127l of the general statutes.

936 (b) On or before January 1, 2006, and annually thereafter, the
937 Commissioner of Public Health shall submit a report, in accordance
938 with the provisions of section 11-4a of the general statutes, to the
939 Governor and the chairpersons of the joint standing committee of the
940 General Assembly having cognizance of matters relating to public
941 health, providing a description of the process developed pursuant to
942 subsection (a) of this section, an analysis of its operation and impact
943 with respect to the activities enumerated in subsection (a) of this
944 section, a description of the activities undertaken by the department's
945 patient safety programs, and recommendations for future action.

946 Sec. 18. (NEW) (*Effective from passage*) Whenever in a civil action to
947 recover damages resulting from personal injury or wrongful death,
948 whether in tort or in contract, in which it is alleged that such injury or
949 death resulted from the negligence of a health care provider, the jury
950 renders a verdict specifying noneconomic damages, as defined in
951 section 52-572h of the general statutes, in an amount exceeding one

952 million dollars, the court shall review the evidence presented to the
953 jury to determine if the amount of noneconomic damages specified in
954 the verdict is excessive as a matter of law in that it so shocks the sense
955 of justice as to compel the conclusion that the jury was influenced by
956 partiality, prejudice, mistake or corruption. If the court so concludes, it
957 shall order a remittitur and, upon failure of the party so ordered to
958 remit the amount ordered by the court, it shall set aside the verdict and
959 order a new trial. For the purposes of this section, "health care
960 provider" means a provider, as defined in subsection (b) of section 20-
961 7b of the general statutes, or an institution, as defined in section 19a-
962 490 of the general statutes.

963 Sec. 19. Section 38a-25 of the general statutes is repealed and the
964 following is substituted in lieu thereof (*Effective from passage*):

965 (a) The Insurance Commissioner is the agent for receipt of service of
966 legal process on the following:

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

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

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

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

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

979 (6) Eligible surplus lines insurers authorized by the commissioner to
980 accept surplus lines insurance.

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

985 (8) The Connecticut Insurance Guaranty Association and the
986 Connecticut Life and Health Insurance Guaranty Association.

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

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

992 (11) Viatical settlement providers, viatical settlement brokers, and
993 viatical settlement investment agents licensed by the commissioner.

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

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

999 (14) Persons alleged to have violated any provision of section 38a-
1000 130.

1001 (15) Captive insurers, as defined in section 20 of this act.

1002 (b) Each foreign and alien insurer by applying for and receiving a
1003 license to do insurance business in this state, each fraternal benefit
1004 society by applying for and receiving a certificate to solicit members
1005 and do business, each surplus lines insurer declared to be an eligible
1006 surplus lines insurer by the commissioner, each insurance-support
1007 organization transacting business outside this state which affects a
1008 resident of this state, and each unauthorized insurer by doing an act of

1009 insurance business prohibited by section 38a-272, is considered to have
1010 irrevocably appointed the Insurance Commissioner as [his] agent for
1011 receipt of service of process in accordance with subsection (a) of this
1012 section. Such appointment shall continue in force so long as any
1013 certificate of membership, policy or liability remains outstanding in
1014 this state.

1015 (c) The commissioner is also agent for the executors, administrators
1016 or personal representatives, receivers, trustees or other successors in
1017 interest of the persons specified under subsection (a) of this section.

1018 (d) Any legal process that is served on the commissioner pursuant
1019 to this section shall be of the same legal force and validity as if served
1020 on the principal.

1021 (e) The right to effect service of process as provided under this
1022 section does not limit the right to serve legal process in any other
1023 manner provided by law.

1024 Sec. 20. (NEW) (*Effective July 1, 2005*) Each captive insurer that
1025 offers, renews or continues insurance in this state shall provide the
1026 information described in subdivisions (1) to (3), inclusive, of
1027 subsection (a) of section 38a-253 of the general statutes to the Insurance
1028 Commissioner in the same manner required for risk retention groups.
1029 If a captive insurer does not maintain information in the form
1030 prescribed in section 38a-253 of the general statutes, the captive insurer
1031 may submit the information to the Insurance Commissioner on such
1032 form as the commissioner prescribes. As used in this section and
1033 section 38a-25 of the general statutes, as amended by this act, "captive
1034 insurer" means an insurance company owned by another organization
1035 whose primary purpose is to insure risks of a parent organization or
1036 affiliated persons, as defined in section 38a-1 of the general statutes, or
1037 in the case of groups and associations, an insurance organization
1038 owned by the insureds whose primary purpose is to insure risks of
1039 member organizations and group members and their affiliates.

1040 Sec. 21. Sections 38a-32 to 38a-36, inclusive, of the general statutes
1041 are repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section
Sec. 2	<i>from passage and applicable to actions filed on or after said date</i>	52-190a
Sec. 3	<i>from passage</i>	19a-17a
Sec. 4	<i>from passage</i>	20-13b
Sec. 5	<i>from passage</i>	20-8a
Sec. 6	<i>from passage</i>	20-13i
Sec. 7	<i>from passage</i>	New section
Sec. 8	<i>from passage</i>	52-192a
Sec. 9	<i>from passage</i>	52-194
Sec. 10	<i>from passage</i>	20-13e(a)
Sec. 11	<i>from passage</i>	19a-88(b)
Sec. 12	<i>from passage</i>	New section
Sec. 13	<i>from passage</i>	38a-676
Sec. 14	<i>from passage</i>	38a-665
Sec. 15	<i>from passage and applicable to causes of action accruing on or after said date</i>	52-251c
Sec. 16	<i>January 1, 2006</i>	38a-395
Sec. 17	<i>from passage</i>	New section
Sec. 18	<i>from passage</i>	New section
Sec. 19	<i>from passage</i>	38a-25
Sec. 20	<i>July 1, 2005</i>	New section
Sec. 21	<i>from passage</i>	38a-32 to 38a-36 repealed

Statement of Purpose:

To revise provisions concerning medical malpractice claims and insurance rates by: (1) Establishing mandatory mediation for medical malpractice claims; (2) revising requirements for good faith certificates and requiring such certificates for apportionment complaints; (3) reducing the interest rate that the court may award with respect to

offers of judgment; (4) regulating deviations from the statutory attorney fee schedule; (5) requiring court review of evidence in certain cases when noneconomic damages awarded exceed one million dollars; (6) requiring prior rate approval for medical malpractice insurance rates; (7) revising provisions concerning health care provider oversight; (8) requiring provider-related reporting; and (9) requiring reports from captive insurers.

[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.]

Co-Sponsors: SEN. CRISCO, 17th Dist.