



General Assembly

**Substitute Bill No. 131**

January Session, 2005

\* SB00131PH 042605 \*

**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, as amended by this act. The  
519 department shall revise any forms utilized pursuant to section 20-13j,  
520 as amended by this act, to incorporate any additional information  
521 required pursuant to this subsection.

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

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 Section 38a-676 of the general statutes is repealed and the  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

528 (a) With respect to rates pertaining to commercial risk insurance,  
529 and subject to the provisions of subsection (b) of this section with  
530 respect to professional liability insurance described in subsection (b) of  
531 this section and workers' compensation and employers' liability  
532 insurance, on or before the effective date [thereof, every] of such rates,  
533 each admitted insurer shall submit to the Insurance Commissioner for  
534 the commissioner's information, except as to inland marine risks which  
535 by general custom of the business are not written according to manual  
536 rates or rating plans, [every] each manual of classifications, rules and  
537 rates, and [every] each minimum, class rate, rating plan, rating  
538 schedule and rating system and any modification of the foregoing  
539 which it uses. Such submission by a licensed rating organization of  
540 which an insurer is a member or subscriber shall be sufficient  
541 compliance with this section for any insurer maintaining membership  
542 or subscribership in such organization, to the extent that the insurer  
543 uses the manuals, minimums, class rates, rating plans, rating  
544 schedules, rating systems, policy or bond forms of such organization.  
545 The information shall be open to public inspection after its submission.

546 (b) (1) Each filing as described in subsection (a) of this section for  
547 workers' compensation or employers' liability insurance shall be on file  
548 with the Insurance Commissioner for a waiting period of thirty days  
549 before it becomes effective, which period may be extended by the

550 commissioner for an additional period not to exceed thirty days if the  
551 commissioner gives written notice within such waiting period to the  
552 insurer or rating organization which made the filing that the  
553 commissioner needs such additional time for the consideration of such  
554 filing. Upon written application by such insurer or rating organization,  
555 the commissioner may authorize a filing which the commissioner has  
556 reviewed to become effective before the expiration of the waiting  
557 period or any extension thereof. A filing shall be deemed to meet the  
558 requirements of sections 38a-663 to 38a-696, inclusive, as amended by  
559 this act, unless disapproved by the commissioner within the waiting  
560 period or any extension thereof. If, within the waiting period or any  
561 extension thereof, the commissioner finds that a filing does not meet  
562 the requirements of said sections, the commissioner shall send to the  
563 insurer or rating organization which made such filing written notice of  
564 disapproval of such filing, specifying therein in what respects the  
565 commissioner finds such filing fails to meet the requirements of said  
566 sections and stating that such filing shall not become effective. Such  
567 finding of the commissioner shall be subject to review as provided in  
568 section 38a-19.

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

584 be filed after notice is sent to insureds and shall indicate the date such  
585 notice was sent.

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

597 (C) The Insurance Commissioner shall review the filing and, with  
598 respect to a request for an increase in rates, shall (i) not approve,  
599 modify or deny the request until at least fifteen days after the date of  
600 notice as indicated in the filing, and (ii) hold a public hearing, if  
601 requested, on such increase prior to approving, modifying or denying  
602 the request. The Insurance Commissioner shall approve, modify or  
603 deny the filing not later than forty-five days after its receipt. Such  
604 finding of the commissioner shall be subject to review as provided in  
605 section 38a-19.

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

617 reasons for disapproval. The provisions of section 38a-19 shall apply to  
618 any such order issued by the commissioner.

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

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

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

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

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

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

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

682 insurer and may measure any differences among risks that can be  
683 demonstrated to have a probable effect upon losses or expenses.

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

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

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

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

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

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

713 received by the claimant as follows: (1) Thirty-three and one-third per  
714 cent of the first three hundred thousand dollars; (2) twenty-five per  
715 cent of the next three hundred thousand dollars; (3) twenty per cent of  
716 the next three hundred thousand dollars; (4) fifteen per cent of the next  
717 three hundred thousand dollars; and (5) ten per cent of any amount  
718 which exceeds one million two hundred thousand dollars.

719 (c) (1) Whenever a claimant in a medical malpractice claim or civil  
720 action enters into a contingency fee arrangement with an attorney  
721 which provides for a fee that would exceed the percentage limitations  
722 set forth in subsection (b) of this section, such fee arrangement shall  
723 not be valid unless the claimant's attorney files an application with the  
724 court for approval of such fee arrangement and the court, after a  
725 hearing, grants such application. The claimant's attorney shall attach to  
726 such application a copy of such fee arrangement and the proposed  
727 unsigned writ, summons and complaint. Such fee arrangement shall  
728 provide that the attorney will advance all costs in connection with the  
729 investigation and prosecution or settlement of the medical malpractice  
730 claim or civil action and the claimant will not be liable for the  
731 reimbursement of the attorney for any such costs if there is no  
732 recovery.

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

747 received by the claimant. If the court denies the application, the court  
748 shall advise the claimant of the claimant's right to seek representation  
749 by another attorney willing to abide by the percentage limitations set  
750 forth in subsection (b) of this section. Only one application may be  
751 filed under this subsection with respect to the claimant and the  
752 claimant's medical malpractice claim or civil action.

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

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

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

780 or costs incurred in connection with the prosecution or settlement of  
781 the claim or civil action, other than ordinary office overhead and  
782 expense.

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

799 [(d)] (f) For the purposes of this section, "medical malpractice claim  
800 or civil action" means a claim or civil action brought to recover  
801 damages resulting from personal injury or wrongful death, whether in  
802 tort or in contract, in which it is alleged that such injury or death  
803 resulted from the negligence of a health care provider, and "health care  
804 provider" means a provider, as defined in subsection (b) of section 20-  
805 7b, or an institution, as defined in section 19a-490.

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

808 [The Insurance Commissioner may require all insurance companies  
809 writing medical malpractice insurance in this state to submit, in such  
810 manner and at such times as he specifies, such information as he  
811 deems necessary to establish a data base on medical malpractice,

812 including information on all incidents of medical malpractice, all  
813 settlements, all awards, other information relative to procedures and  
814 specialties involved and any other information relating to risk  
815 management.]

816 (a) As used in this section:

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

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

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

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

834 (c) The closed claim report shall include:

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

841 (2) Details about the injury or loss, including: (A) The date of the

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

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

866 (4) Details about the amount paid on the claim, including: (A) The  
867 total amount of the initial judgment rendered by a jury or awarded by  
868 the court; (B) the total amount of the settlement if there was no  
869 judgment rendered or awarded; (C) the total amount of the settlement  
870 if the claim was settled after judgment was rendered or awarded; (D)  
871 the amount of economic damages, as defined in section 52-572h, or the  
872 insurer's estimate of the amount in the event of a settlement; (E) the  
873 amount of noneconomic damages, as defined in section 52-572h, or the  
874 insurer's estimate of the amount in the event of a settlement; (F) the  
875 amount of any interest awarded due to failure to accept an offer of

876 judgment; (G) the amount of any remittitur or additur; (H) the amount  
877 of final judgment after remittitur or additur; (I) the amount paid by the  
878 insurer; (J) the amount paid by the defendant due to a deductible or a  
879 judgment or settlement in excess of policy limits; (K) the amount paid  
880 by other insurers; (L) the amount paid by other defendants; (M)  
881 whether a structured settlement was used; (N) the expense assigned to  
882 and recorded with the claim, including, but not limited to, defense and  
883 investigation costs, but not including the actual claim payment; and  
884 (O) any other information the commissioner determines to be  
885 necessary to regulate the professional liability insurance industry with  
886 respect to physicians, surgeons, hospitals, advanced practice registered  
887 nurses or physician assistants, ensure the industry's solvency and  
888 ensure that such liability insurance is available and affordable.

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

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

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

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

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

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

937 (b) On or before January 1, 2006, and annually thereafter, the  
938 Commissioner of Public Health shall submit a report, in accordance  
939 with the provisions of section 11-4a of the general statutes, to the  
940 Governor and the chairpersons of the joint standing committee of the

941 General Assembly having cognizance of matters relating to public  
942 health, providing a description of the process developed pursuant to  
943 subsection (a) of this section, an analysis of its operation and impact  
944 with respect to the activities enumerated in subsection (a) of this  
945 section, a description of the activities undertaken by the department's  
946 patient safety programs, and recommendations for future action.

947 Sec. 18. (NEW) (*Effective from passage*) Whenever in a civil action to  
948 recover damages resulting from personal injury or wrongful death,  
949 whether in tort or in contract, in which it is alleged that such injury or  
950 death resulted from the negligence of a health care provider, the jury  
951 renders a verdict specifying noneconomic damages, as defined in  
952 section 52-572h of the general statutes, in an amount exceeding one  
953 million dollars, the court shall review the evidence presented to the  
954 jury to determine if the amount of noneconomic damages specified in  
955 the verdict is excessive as a matter of law in that it so shocks the sense  
956 of justice as to compel the conclusion that the jury was influenced by  
957 partiality, prejudice, mistake or corruption. If the court so concludes, it  
958 shall order a remittitur and, upon failure of the party so ordered to  
959 remit the amount ordered by the court, it shall set aside the verdict and  
960 order a new trial. For the purposes of this section, "health care  
961 provider" means a provider, as defined in subsection (b) of section 20-  
962 7b of the general statutes, or an institution, as defined in section 19a-  
963 490 of the general statutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1000 (14) Persons alleged to have violated any provision of section 38a-  
1001 130.

1002 (15) Captive insurers, as defined in section 20 of this act.

1003 (b) Each foreign and alien insurer by applying for and receiving a  
1004 license to do insurance business in this state, each fraternal benefit  
1005 society by applying for and receiving a certificate to solicit members  
1006 and do business, each surplus lines insurer declared to be an eligible  
1007 surplus lines insurer by the commissioner, each insurance-support  
1008 organization transacting business outside this state which affects a  
1009 resident of this state, and each unauthorized insurer by doing an act of  
1010 insurance business prohibited by section 38a-272, is considered to have  
1011 irrevocably appointed the Insurance Commissioner as [his] agent for  
1012 receipt of service of process in accordance with subsection (a) of this  
1013 section. Such appointment shall continue in force so long as any  
1014 certificate of membership, policy or liability remains outstanding in  
1015 this state.

1016 (c) The commissioner is also agent for the executors, administrators  
1017 or personal representatives, receivers, trustees or other successors in  
1018 interest of the persons specified under subsection (a) of this section.

1019 (d) Any legal process that is served on the commissioner pursuant  
1020 to this section shall be of the same legal force and validity as if served  
1021 on the principal.

1022 (e) The right to effect service of process as provided under this  
1023 section does not limit the right to serve legal process in any other  
1024 manner provided by law.

1025 Sec. 20. (NEW) (*Effective July 1, 2005*) Each captive insurer that  
1026 offers, renews or continues insurance in this state shall provide the  
1027 information described in subdivisions (1) to (3), inclusive, of  
1028 subsection (a) of section 38a-253 of the general statutes to the Insurance  
1029 Commissioner in the same manner required for risk retention groups.  
1030 If a captive insurer does not maintain information in the form

1031 prescribed in section 38a-253 of the general statutes, the captive insurer  
1032 may submit the information to the Insurance Commissioner on such  
1033 form as the commissioner prescribes. As used in this section and  
1034 section 38a-25 of the general statutes, as amended by this act, "captive  
1035 insurer" means an insurance company owned by another organization  
1036 whose primary purpose is to insure risks of a parent organization or  
1037 affiliated persons, as defined in section 38a-1 of the general statutes, or  
1038 in the case of groups and associations, an insurance organization  
1039 owned by the insureds whose primary purpose is to insure risks of  
1040 member organizations and group members and their affiliates.

1041 Sec. 21. Subsection (b) of section 20-13j of the general statutes is  
1042 repealed and the following is substituted in lieu thereof (*Effective*  
1043 *October 1, 2005*):

1044 (b) The department, after consultation with the Connecticut Medical  
1045 Examining Board and the Connecticut State Medical Society shall  
1046 collect the following information to create an individual profile on  
1047 each physician for dissemination to the public:

1048 (1) The name of the medical school attended by the physician and  
1049 the date of graduation;

1050 (2) The site, training, discipline and inclusive dates of the  
1051 physician's postgraduate medical education required pursuant to the  
1052 applicable licensure section of the general statutes;

1053 (3) The area of the physician's practice specialty;

1054 (4) The address of the physician's primary practice location or  
1055 primary practice locations, if more than one;

1056 (5) A list of languages, other than English, spoken at the physician's  
1057 primary practice locations;

1058 (6) An indication of any disciplinary action taken against the  
1059 physician by the department, [or by] the state board or any  
1060 professional licensing or disciplinary body in another jurisdiction;

1061 (7) Any current certifications issued to the physician by a specialty  
1062 board of the American Board of Medical Specialties;

1063 (8) The hospitals and nursing homes at which the physician has  
1064 admitting privileges;

1065 (9) Any appointments of the physician to Connecticut medical  
1066 school faculties and an indication as to whether the physician has  
1067 current responsibility for graduate medical education;

1068 (10) A listing of the physician's publications in peer reviewed  
1069 literature;

1070 (11) A listing of the physician's professional services, activities and  
1071 awards;

1072 (12) Any hospital disciplinary actions against the physician that  
1073 resulted, within the past ten years, in the termination or revocation of  
1074 the physician's hospital privileges for a medical disciplinary cause or  
1075 reason, or the resignation from, or nonrenewal of, medical staff  
1076 membership or the restriction of privileges at a hospital taken in lieu of  
1077 or in settlement of a pending disciplinary case related to medical  
1078 competence in such hospital;

1079 (13) A description of any criminal conviction of the physician for a  
1080 felony within the last ten years. For the purposes of this subdivision, a  
1081 physician shall be deemed to be convicted of a felony if the physician  
1082 pleaded guilty or was found or adjudged guilty by a court of  
1083 competent jurisdiction or has been convicted of a felony by the entry of  
1084 a plea of nolo contendere; [and]

1085 (14) To the extent available, and consistent with the provisions of  
1086 subsection (c) of this section, all medical malpractice court judgments  
1087 and all medical malpractice arbitration awards against the physician in  
1088 which a payment was awarded to a complaining party during the last  
1089 ten years, and all settlements of medical malpractice claims against the  
1090 physician in which a payment was made to a complaining party

1091 within the last ten years;

1092 (15) An indication as to whether the physician has current  
 1093 responsibility for providing direct patient care services; and

1094 (16) The name of the physician's professional liability insurance  
 1095 carrier and the policy number.

1096 Sec. 22. Subsection (k) of section 20-13j of the general statutes is  
 1097 repealed and the following is substituted in lieu thereof (*Effective*  
 1098 *October 1, 2005*):

1099 (k) A physician shall notify the department of any changes to the  
 1100 information required in [subdivisions (3), (4), (5), (7), (8) and (13) of]  
 1101 subsection (b) of this section, as amended by this act, not later than  
 1102 sixty days after such change.

1103 Sec. 23. Sections 38a-32 to 38a-36, inclusive, of the general statutes  
 1104 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>October 1, 2005</i>	20-13j(b)
Sec. 22	<i>October 1, 2005</i>	20-13j(k)
Sec. 23	<i>from passage</i>	38a-32 to 38a-36 repealed

**INS**      *Joint Favorable Subst.*

**PH**        *Joint Favorable*