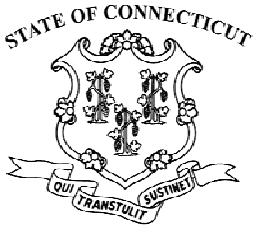

Substitute Senate Bill No. 1052

Public Act No. 05-275

AN ACT CONCERNING MEDICAL MALPRACTICE.

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

Section 1. Section 52-251c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to causes of action accruing on or after said date*):

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

(b) In any such contingency fee **[**arrangement**]** agreement such fee shall be the exclusive method for payment of the attorney by the claimant and shall not exceed an amount equal to a percentage of the damages awarded and received by the claimant or of the settlement amount received by the claimant as follows: (1) Thirty-three and one-third per cent of the first three hundred thousand dollars; (2) twenty-

five per cent of the next three hundred thousand dollars; (3) twenty per cent of the next three hundred thousand dollars; (4) fifteen per cent of the next three hundred thousand dollars; and (5) ten per cent of any amount which exceeds one million two hundred thousand dollars.

(c) Notwithstanding the provisions of subsection (b) of this section, a claimant may waive the percentage limitations of said subsection if the claim or civil action is so substantially complex, unique or different from other wrongful death, personal injury or property damage claims or civil actions as to warrant a deviation from such percentage limitations. Factors that may indicate that a claim or civil action is substantially complex, unique or different from other wrongful death, personal injury or property damage claims or civil actions include, but are not limited to, if the claim or civil action (1) involves complex factual medical or legal issues, (2) involves serious permanent personal injury or death, (3) is likely to require extensive investigation and discovery proceedings, including multiple depositions, or (4) requires independent expert witness testimony. For the purposes of this subsection, "independent expert witness testimony" means testimony, whether at trial or in a deposition, from an expert who has not participated in the care of the claimant and has not participated in any official investigation of the incident involved.

(d) Prior to a claimant entering into a contingency fee agreement that provides for a fee that exceeds the percentage limitations of subsection (b) of this section, the attorney shall (1) explain the percentage limitations of subsection (b) of this section to the claimant and the reasons the attorney is unable to abide by those limitations; (2) advise the claimant of the claimant's right to seek representation by another attorney willing to abide by the percentage limitations of subsection (b) of this section; and (3) allow the claimant a sufficient period of time to review the proposed contingency fee agreement and, if the claimant wishes, seek representation by another attorney prior to

entering into such agreement.

(e) No waiver of the percentage limitations of subsection (b) of this section shall be valid unless the contingency fee agreement (1) is in writing, (2) sets forth in full the fee schedule of subsection (b) of this section, (3) contains a conspicuous statement, printed in boldface type at least twelve points in size, in substantially the following form: "I UNDERSTAND THAT THE FEE SCHEDULE SET FORTH IN SECTION 52-251c OF THE CONNECTICUT GENERAL STATUTES LIMITS THE AMOUNT OF ATTORNEY'S FEES PAYABLE BY A CLAIMANT AND THAT THE STATUTE WAS INTENDED TO INCREASE THE PORTION OF THE JUDGMENT OR SETTLEMENT THAT WAS ACTUALLY RECEIVED BY A CLAIMANT. NOTWITHSTANDING THAT THE LEGISLATIVE INTENT IN ENACTING THAT FEE SCHEDULE WAS TO CONFER A BENEFIT ON A CLAIMANT LIKE MYSELF, I KNOWINGLY AND VOLUNTARILY WAIVE THAT FEE SCHEDULE IN THIS CLAIM OR CIVIL ACTION.", and (4) is signed and acknowledged by the claimant before a notary public or other person authorized to take acknowledgments.

(f) If a claimant waives the percentage limitations of subsection (b) of this section pursuant to this section, in no event shall (1) the total fee under the contingency fee agreement exceed thirty-three and one-third per cent of the damages awarded and received by the claimant or of the settlement amount received by the claimant, and (2) the claimant be required to repay any costs that the attorney incurred in investigating and prosecuting the claim or civil action if there is no recovery.

(g) No fee shall be payable to any attorney who seeks a fee that exceeds the percentage limitations of subsection (b) of this section unless the claimant has waived such limitations pursuant to this section and the contingency fee agreement complies with the

requirements of subsection (e) of this section.

[(c)**]** (h) For the purposes of this section, "damages awarded and received" means in a civil action in which final judgment is entered, that amount of the judgment or amended judgment entered by the court that is received by the claimant; **[**, except that in a civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365;**]** "settlement amount received" means in a claim or civil action in which no final judgment is entered, the amount received by the claimant pursuant to a settlement agreement; **[**, except that in a claim or civil action brought pursuant to section 38a-368 such amount shall be reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365;**]** and "fee" shall not include disbursements or costs incurred in connection with the prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense.

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

Sec. 2. Section 52-190a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005, and applicable to actions filed on or after said date*):

(a) No civil action or apportionment complaint shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after October 1, 1987, whether in tort or in contract, in which it is alleged that such injury or death resulted from the

negligence of a health care provider, unless the attorney or party filing the action or apportionment complaint has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint, **[**or**]** initial pleading or apportionment complaint shall contain a certificate of the attorney or party filing the action or apportionment complaint that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant or for an apportionment complaint against each named apportionment defendant. **[**For the purposes of this section, such good faith may be shown to exist if the claimant or his attorney has received a written opinion, which shall not be subject to discovery by any party except for questioning the validity of the certificate,**]** To show the existence of such good faith, the claimant or the claimant's attorney, and any apportionment complainant or the apportionment complainant's attorney, shall obtain a written and signed opinion of a similar health care provider, as defined in section 52-184c, which similar health care provider shall be selected pursuant to the provisions of said section, that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion. Such written opinion shall not be subject to discovery by any party except for questioning the validity of the certificate. The claimant or the claimant's attorney, and any apportionment complainant or apportionment complainant's attorney, shall retain the original written opinion and shall attach a copy of such written opinion, with the name and signature of the similar health care provider expunged, to such certificate. The similar health care provider who provides such written opinion shall not, without a showing of malice, be personally liable for any damages to the defendant health care provider by reason of having provided such written opinion. In addition to such written opinion, the court may consider other factors with regard to the existence of good faith. If the court determines, after the completion of discovery, that such

certificate was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court upon motion or upon its own initiative shall impose upon the person who signed such certificate or a represented party, or both, an appropriate sanction which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney or the apportionment complainant's attorney submitted the certificate.

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

(c) The failure to obtain and file the written opinion required by subsection (a) of this section shall be grounds for the dismissal of the action.

Sec. 3. (NEW) (*Effective from passage*) Not later than six months after the filing of an action to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, the court shall schedule a conference of the parties at which the court shall determine whether to recommend to the Chief Court Administrator, or the Chief Court Administrator's designee, that the action be designated as a complex litigation case and be transferred to the complex litigation docket. Nothing in this section shall be construed to preclude any party or a judge from, at any time, requesting the Chief Court Administrator, or the Chief Court Administrator's designee, to designate such action as a complex

litigation case and transfer such action to the complex litigation docket.

Sec. 4. Section 52-192a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005, and applicable to actions accruing on or after said date*):

(a) After commencement of any civil action based upon contract or seeking the recovery of money damages, whether or not other relief is sought, the plaintiff may, not earlier than one hundred eighty days after service of process is made upon the defendant in such action but not later than thirty days before trial, file with the clerk of the court a written **[**"offer of judgment"**]** offer of compromise signed by the plaintiff or the plaintiff's attorney, directed to the defendant or the defendant's attorney, offering to settle the claim underlying the action **[**and to stipulate to a judgment**]** for a sum certain. The plaintiff shall give notice of the offer of **[**settlement**]** compromise to the defendant's attorney or, if the defendant is not represented by an attorney, to the defendant himself or herself. Within **[**sixty**]** thirty days after being notified of the filing of the **[**"offer of judgment"**]** offer of compromise and prior to the rendering of a verdict by the jury or an award by the court, the defendant or the defendant's attorney may file with the clerk of the court a written **[**"acceptance of offer of judgment"**]** acceptance of the offer of compromise agreeing to **[**a stipulation for judgment as contained**]** settle the claim underlying the action for the sum certain specified in the plaintiff's **[**"offer of judgment"**]** offer of compromise. Upon such filing **[**,**]** and the receipt by the plaintiff of such sum certain, the plaintiff shall file a withdrawal of the action with the clerk and the clerk shall **[**enter judgment immediately on the stipulation**]** record the withdrawal of the action against the defendant accordingly. If the **[**"offer of judgment"**]** offer of compromise is not accepted within **[**sixty**]** thirty days and prior to the rendering of a verdict by the jury or an award by the court, the **[**"offer of judgment"**]** offer of compromise shall be considered rejected and not subject to acceptance unless refiled.

Any such **[**"offer of judgment"**]** offer of compromise and any **[**"acceptance of offer of judgment"**]** acceptance of the offer of compromise shall be included by the clerk in the record of the case.

(b) In the case of any action to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, an offer of compromise pursuant to subsection (a) of this section shall state with specificity all damages then known to the plaintiff or the plaintiff's attorney upon which the action is based. At least sixty days prior to filing such an offer, the plaintiff or the plaintiff's attorney shall provide the defendant or the defendant's attorney with an authorization to disclose medical records that meets the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, or regulations adopted thereunder, and disclose any and all expert witnesses who will testify as to the prevailing professional standard of care. The plaintiff shall file with the court a certification that the plaintiff has provided each defendant or such defendant's attorney with all documentation supporting such damages.

[(b)**]** (c) After trial the court shall examine the record to determine whether the plaintiff made an **[**"offer of judgment"**]** offer of compromise which the defendant failed to accept. If the court ascertains from the record that the plaintiff has recovered an amount equal to or greater than the sum certain **[**stated**]** specified in the plaintiff's **[**"offer of judgment"**]** offer of compromise, the court shall add to the amount so recovered **[**twelve**]** eight per cent annual interest on said amount. **[**, computed from the date such offer was filed in actions commenced before October 1, 1981. In those actions commenced on or after October 1, 1981, the**]** The interest shall be computed from the date the complaint in the civil action was filed with

the court if the **[**"offer of judgment"**]** offer of compromise was filed not later than eighteen months from the filing of such complaint. If such offer was filed later than eighteen months from the date of filing of the complaint, the interest shall be computed from the date the **[**"offer of judgment"**]** offer of compromise was filed. The court may award reasonable attorney's fees in an amount not to exceed three hundred fifty dollars, and shall render judgment accordingly. This section shall not be interpreted to abrogate the contractual rights of any party concerning the recovery of attorney's fees in accordance with the provisions of any written contract between the parties to the action.

Sec. 5. Section 52-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005, and applicable to actions accruing on or after said date*):

In any action on contract, or seeking the recovery of money damages, whether or not other relief is sought, the defendant may, not later than thirty days before trial, file with the clerk of the court a written **[**notice**]** offer of compromise signed by the defendant or the defendant's attorney, directed to the plaintiff or the plaintiff's attorney, offering to **[**allow the plaintiff to take judgment for the sum named in such notice**]** settle the claim underlying the action for a sum certain.

Sec. 6. Section 52-194 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005, and applicable to actions accruing on or after said date*):

In any action, the plaintiff may, within **[**ten**]** sixty days after being notified by the defendant of the filing of an offer of **[**judgment**]** compromise, file with the clerk of the court a written acceptance of the offer signed by **[**himself or his**]** the plaintiff or the plaintiff's attorney agreeing to settle the underlying action for the sum certain specified in the defendant's offer of compromise. Upon the filing of the written acceptance **[**, the court shall render judgment against the defendant as

upon default for the sum so named and for the costs accrued at the time of the defendant's giving the plaintiff notice of the offer**]** and receipt by the plaintiff of such sum certain, the plaintiff shall file a withdrawal of the action with the clerk of the court and the clerk shall record the withdrawal of the action against the defendant accordingly. No trial may be postponed because the period within which the plaintiff may accept the offer has not expired, except at the discretion of the court.

Sec. 7. Section 52-195 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005, and applicable to actions accruing on or after said date*):

(a) If the plaintiff does not, within the time allowed for acceptance of the offer of **[**judgment**]** compromise and before the commencement of the trial, file **[**his**]** the plaintiff's notice of acceptance, the offer shall be deemed to be withdrawn and shall not be given in evidence.

(b) Unless the plaintiff recovers more than the sum **[**named**]** specified in the offer of **[**judgment**]** compromise, with interest from its date, **[**he**]** the plaintiff shall recover no costs accruing after **[**he**]** the plaintiff received notice of the filing of such offer, but shall pay the defendant's costs accruing after **[**he**]** the plaintiff received notice. Such costs may include reasonable attorney's fees in an amount not to exceed three hundred fifty dollars.

(c) This section shall not be interpreted to abrogate the contractual rights of any party concerning the recovery of attorney's fees in accordance with the provisions of any written contract between the parties to the action. The provisions of this section shall not apply to cases in which nominal damages have been assessed upon a hearing after a default or after a demurrer has been overruled.

Sec. 8. (NEW) (*Effective October 1, 2005, and applicable to actions*

accruing on or after said date) (a) For the purposes of this section:

(1) "Licensed health care provider" means any health care institution licensed pursuant to the provisions of chapter 368v of the general statutes or any individual provider of health care licensed pursuant to the provisions of chapters 370 to 373, inclusive, or 375 to 383c, inclusive, of the general statutes or a pharmacist or other person licensed pursuant to chapter 400j of the general statutes;

(2) "Health care services" means acts of diagnosis, treatment, medical evaluation or advice or such other acts as may be permissible under the health care licensing statutes of this state.

(b) In any action to recover damages resulting from personal injury or wrongful death, whether in tort or contract, in which it is alleged that such injury or death resulted from the professional negligence of a licensed health care provider in the provision of health care services, such provider may introduce evidence of the amount of damages awarded to the plaintiff for such injury or death by the trier of fact in a separate action by such plaintiff against a different health care provider.

Sec. 9. (NEW) (*Effective from passage*) (a) For the purposes of this section:

(1) "Health care provider" means a provider, as defined in subsection (b) of section 20-7b of the general statutes, or an institution, as defined in section 19a-490 of the general statutes;

(2) "Relative" means a victim's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half brother, half sister or spouse's parents, and includes such relationships that are created as a result of adoption and any person who has a family-type relationship with a victim;

(3) "Representative" means a legal guardian, attorney, health care agent or any person recognized in law or custom as a patient's agent; and

(4) "Unanticipated outcome" means the outcome of a medical treatment or procedure that differs from an expected result.

(b) In any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to such civil action, any and all statements, affirmations, gestures or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion or a general sense of benevolence that are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim or a representative of the alleged victim and that relate to the discomfort, pain, suffering, injury or death of the alleged victim as a result of the unanticipated outcome of medical care shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

Sec. 10. (NEW) (*Effective from passage*) Whenever in a civil action to recover damages resulting from personal injury or wrongful death, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, the jury renders a verdict specifying noneconomic damages, as defined in section 52-572h of the general statutes, in an amount exceeding one million dollars, the court shall review the evidence presented to the jury to determine if the amount of noneconomic damages specified in the verdict is excessive as a matter of law in that it so shocks the sense of justice as to compel the conclusion that the jury was influenced by partiality, prejudice, mistake or corruption. If the court so concludes, it shall order a remittitur and, upon failure of the party so ordered to remit the amount ordered by the court, it shall set aside the verdict and order a new trial. For the purposes of this section, "health care

provider" means a provider, as defined in subsection (b) of section 20-7b of the general statutes, or an institution, as defined in section 19a-490 of the general statutes.

Sec. 11. Section 38a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) With respect to rates pertaining to commercial risk insurance, and subject to the provisions of subsection (b) of this section with respect to workers' compensation and employers' liability insurance and professional liability insurance for physicians and surgeons, hospitals, advance practice registered nurses and physician assistants, on or before the effective date **[**thereof, every**]** of such rates, each admitted insurer shall submit to the Insurance Commissioner for the commissioner's information, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, **[**every**]** each manual of classifications, rules and rates, and **[**every**]** each minimum, class rate, rating plan, rating schedule and rating system and any modification of the foregoing which it uses. Such submission by a licensed rating organization of which an insurer is a member or subscriber shall be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the manuals, minimums, class rates, rating plans, rating schedules, rating systems, policy or bond forms of such organization. The information shall be open to public inspection after its submission.

(b) (1) Each filing **[**as**]** described in subsection (a) of this section for workers' compensation or employers' liability insurance shall be on file with the Insurance Commissioner for a waiting period of thirty days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty days if the commissioner gives written notice within such waiting period to the

insurer or rating organization which made the filing that the commissioner needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, unless disapproved by the commissioner within the waiting period or any extension thereof. If, within the waiting period or any extension thereof, the commissioner finds that a filing does not meet the requirements of said sections, the commissioner shall send to the insurer or rating organization which made such filing written notice of disapproval of such filing, specifying therein in what respects the commissioner finds such filing fails to meet the requirements of said sections and stating that such filing shall not become effective. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(2) (A) Each filing described in subsection (a) of this section for professional liability insurance for physicians and surgeons, hospitals, advanced practice registered nurses or physician assistants shall be subject to prior rate approval in accordance with this section. On and after the effective date of this section, each insurer or rating organization seeking to increase its rates over the rates in the insurer's previous filing for such insurance by seven and one-half per cent or more shall (i) file a request for such change with the Insurance Commissioner, and (ii) send written notice of any request for an increase in rates to insureds who would be subject to the increase on such form as the commissioner prescribes by certified mail, return receipt requested. Such request shall be filed and such notice shall be sent at least sixty days prior to the proposed effective date of the increase. The notice to insureds of a request for an increase in rates shall indicate that the insured may request a public hearing by

submitting a written request to the Insurance Commissioner not later than fifteen days after the date notice was sent. Any request for an increase in rates under this subdivision shall be filed after notice is sent to insureds and shall indicate the date such notice was sent. Not later than fifteen days after such notice is sent, the insurer shall submit a list to the commissioner indicating the name of each insured to whom notice was sent and whether a return receipt was received for the notice sent to the insured.

(B) The Insurance Commissioner shall review each filing under subparagraph (A) of this subdivision and shall (i) not approve, modify or deny the request until the expiration of the period for insureds to request a hearing pursuant to subparagraph (A) of this subdivision, and (ii) hold a public hearing, if requested by insureds, on such increase prior to approving, modifying or denying the request. The Insurance Commissioner shall approve, modify or deny the filing not later than forty-five days after its receipt. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

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

Sec. 12. (NEW) (*Effective October 1, 2005*) (a) Not earlier than October

1, 2008, the Insurance Commissioner shall review professional liability insurance rates in this state for physicians and surgeons, hospitals, advanced practice registered nurses and physicians assistants to determine whether (1) the amount or frequency of insured awards and settlements against physicians and surgeons, hospitals, advanced practice registered nurses and physicians assistance have decreased since October 1, 2005, (2) such rates reflect any such decrease, and (3) such rates bear a reasonable relationship to the costs of writing such insurance in this state. In conducting the review, the commissioner shall examine the rates for such insurance under policies issued by (A) captive insurers and risk retention groups, to the extent such information is available to the commissioner, and (B) insurers licensed in this state.

(b) If after such review the commissioner determines that such insurance rates have not decreased, and such insurance rates are not reasonably related to the costs of writing such insurance in this state, the commissioner shall convene a working group in accordance with subsection (c) of this section. The working group shall consider, among other things, the amounts of awards and settlements during the prior ten years and shall recommend appropriate revisions, if any, to the general statutes in order to decrease rates or establish reasonable rates. Such revisions may include, but need not be limited to, reasonable limitations on noneconomic damages awards, revisions to procedures used by insurers to establish rates, and regulation of reimbursement rates paid by health insurers and health care centers to health care providers in this state. The working group shall submit its recommendations to the General Assembly and the Governor in accordance with section 11-4a of the general statutes.

(c) Any working group convened pursuant to subsection (b) of this section shall consist of:

(1) The chairpersons and ranking members, or their designees, of

(A) the joint standing committees of the General Assembly having cognizance of matters relating to the judiciary, public health and insurance, and (B) the Legislative Program Review and Investigations Committee;

(2) One member appointed by the Connecticut Medical Society;

(3) One member appointed by the Connecticut Hospital Association;

(4) One member appointed by the Connecticut Trial Lawyers Association;

(5) One representative of a patient advocacy group appointed by the speaker of the House of Representatives;

(6) One representative of a medical malpractice insurer licensed and actively doing business in this state appointed by the president pro tempore of the Senate;

(7) The Commissioner of the Office of Health Care Access, or a designee; and

(8) The Insurance Commissioner.

Sec. 13. Section 38a-8 of the general statutes is amended by adding subsection (g) as follows (*Effective from passage*):

(NEW) (g) Not later than January 1, 2006, the Insurance Commissioner shall develop a plan to maintain a viable medical malpractice insurance industry in this state for physicians and surgeons, hospitals, advanced practice registered nurses and physician assistants. Such plan shall be submitted to the Governor upon its completion.

Sec. 14. Section 38a-395 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2006*):

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

(a) As used in this section:

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

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

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

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

(c) The closed claim report shall include:

(1) Details about the insured and insurer, including: (A) The name

of the insurer; (B) the professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the insured's policy number and a unique claim number.

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

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

(4) Details about the amount paid on the claim, including: (A) The

total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (E) the amount of noneconomic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (F) the amount of any interest awarded due to the failure to accept an offer of judgment or compromise; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount paid by the insurer; (J) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; (K) the amount paid by other insurers; (L) the amount paid by other defendants; (M) whether a structured settlement was used; (N) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and (O) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to physicians, surgeons, hospitals, advanced practice registered nurses or physician assistants, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

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

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims

process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

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

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

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

Sec. 15. Section 38a-25 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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

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

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

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

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

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

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

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

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

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

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

viatical settlement investment agents licensed by the commissioner.

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

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

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

(15) Captive insurers, as defined in section 16 of this act.

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

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

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

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

Sec. 16. (NEW) (*Effective July 1, 2005*) Each captive insurer that offers, renews or continues insurance in this state shall provide the information described in subdivisions (1) to (3), inclusive, of subsection (a) of section 38a-253 of the general statutes to the Insurance Commissioner in the same manner required for risk retention groups. If a captive insurer does not maintain information in the form prescribed in section 38a-253 of the general statutes, the captive insurer may submit the information to the Insurance Commissioner on such form as the commissioner prescribes. As used in this section and section 38a-25 of the general statutes, as amended by this act, "captive insurer" means an insurance company owned by another organization whose primary purpose is to insure risks of a parent organization or affiliated persons, as defined in section 38a-1 of the general statutes, or in the case of groups and associations, an insurance organization owned by the insureds whose primary purpose is to insure risks of member organizations and group members and their affiliates.

Sec. 17. (NEW) *(Effective October 1, 2005*) Not later than January 1, 2006, the Department of Public Health, with the advice and assistance of the Connecticut Medical Examining Board and relevant medical professional associations, shall establish guidelines for use in the disciplinary process. Such guidelines shall include, but need not be limited to: (1) Identification of each type of violation; (2) a range of penalties for each type of violation; (3) additional optional conditions that may be imposed by the board for each violation; (4) identification of factors the board shall consider in determining what penalty should apply; (5) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (6) a provision that when a deviation from the guidelines occurs, the reason

for the deviation shall be identified. Such guidelines shall not be considered regulations, as defined in section 4-166 of the general statutes.

Sec. 18. Subsection (c) of section 20-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The Commissioner of Public Health shall establish a list of **[**eighteen**]** twenty-four persons who may serve as members of medical hearing panels established pursuant to subsection (g) of this section. Persons appointed to the list shall serve as members of the medical hearing panels and provide the same services as members of the Connecticut Medical Examining Board. Members from the list serving on such panels shall not be voting members of the Connecticut Medical Examining Board. The list shall consist of **[**eighteen**]** twenty-four members appointed by the commissioner, at least eight of whom shall be physicians, as defined in section 20-13a, with at least one of such physicians being a graduate of a medical education program accredited by the American Osteopathic Association, at least one of whom shall be a physician assistant licensed pursuant to section 20-12b, and nine of whom shall be members of the public. No professional member of the list shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the list or have been such an officer during the year immediately preceding such appointment to the list. A licensed professional appointed to the list shall be a practitioner in good professional standing and a resident of this state. All vacancies shall be filled by the commissioner. Successors and appointments to fill a vacancy on the list shall possess the same qualifications as those required of the member succeeded or replaced. No person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in

section 20-12a, shall be appointed to the list as a member of the public. Each person appointed to the list shall serve without compensation at the pleasure of the commissioner. Each medical hearing panel shall consist of three members, one of whom shall be a physician or physician assistant, as appropriate, from the list established pursuant to this subsection. At least one of the three members shall be a member of the Connecticut Medical Examining Board. The public member may be a member of the board or a member from the list established pursuant to this subsection.

Sec. 19. Subsection (g) of section 20-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(g) The board shall refer all statements of charges filed with the board by the department pursuant to section 20-13e to a medical hearing panel within sixty days of the receipt of charges. **[**This**]** The time period may be extended for good cause by the board in a duly recorded vote. **[**The panel shall consist of three members, at least one of whom shall be a member of the board and one a member of the public. The public member may be a member of either the board or of the list established pursuant to subsection (c) of this section.**]** The panel shall conduct a hearing in accordance with the provisions of chapter 54 and the regulations **[**established**]** adopted by the Commissioner of Public Health concerning contested cases, except that the panel shall file a proposed final decision with the board **[**within**]** not later than one hundred twenty days **[**of**]** after the receipt of the issuance of the notice of hearing by the board. The time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote.

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

The Commissioner of Public Health, with advice and assistance from the board, **[**may establish such regulations in accordance with chapter 54**]** shall establish guidelines as may be necessary to carry out the provisions of sections 20-13a to 20-13i, inclusive, as amended by this act. Not later than January 1, 2006, such guidelines shall include, but need not be limited to: (1) Guidelines for screening complaints received to determine which complaints will be investigated; (2) guidelines to provide a basis for prioritizing the order in which complaints will be investigated; (3) a system for conducting investigations to ensure prompt action when it appears necessary; (4) guidelines to determine when an investigation should be broadened beyond the scope of the initial complaint to include, but not be limited to, sampling patient records to identify patterns of care, reviewing office practices and procedures, and reviewing performance and discharge data from hospitals; and (5) guidelines to protect and ensure the confidentiality of patient and provider identifiable information when an investigation is broadened beyond the scope of the initial complaint. Such guidelines shall not be considered regulations, as defined in section 4-166.

Sec. 21. Section 20-13c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

The board is authorized to restrict, suspend or revoke the license or limit the right to practice of a physician or take any other action in accordance with section 19a-17, for any of the following reasons: (1) Physical illness or loss of motor skill, including, but not limited to, deterioration through the aging process; (2) emotional disorder or mental illness; (3) abuse or excessive use of drugs, including alcohol, narcotics or chemicals; (4) illegal, incompetent or negligent conduct in the practice of medicine; (5) possession, use, prescription for use, or distribution of controlled substances or legend drugs, except for therapeutic or other medically proper purposes; (6) misrepresentation

or concealment of a material fact in the obtaining or reinstatement of a license to practice medicine; (7) failure to adequately supervise a physician assistant; (8) failure to fulfill any obligation resulting from participation in the National Health Service Corps; (9) failure to maintain professional liability insurance or other indemnity against liability for professional malpractice as provided in subsection (a) of section 20-11b; (10) failure to provide information requested by the department for purposes of completing a health care provider profile, as required by section 20-13j, as amended by this act; (11) engaging in any activity for which accreditation is required under section 19a-690 or 19a-691 without the appropriate accreditation required by section 19a-690 or 19a-691; (12) failure to provide evidence of accreditation required under section 19a-690 or 19a-691 as requested by the department pursuant to section 19a-690 or 19a-691; (13) failure to comply with the continuing medical education requirements set forth in section 24 of this act; or **[**(13)**]** (14) violation of any provision of this chapter or any regulation established hereunder. In each case, the board shall consider whether the physician poses a threat, in the practice of medicine, to the health and safety of any person. If the board finds that the physician poses such a threat, the board shall include such finding in its final decision and act to suspend or revoke the license of said physician.

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) Any hospital disciplinary actions against the physician that resulted, within the past ten years, in the termination or revocation of the physician's hospital privileges for a medical disciplinary cause or reason, or the resignation from, or nonrenewal of, medical staff

membership or the restriction of privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to medical competence in such hospital;

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

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

(15) An indication as to whether the physician is actively involved in patient care; and

(16) The name of the physician's professional liability insurance carrier.

Sec. 23. Subsection (k) of section 20-13j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(k) **[**A**]** Except for the information in subdivisions (1), (2), (10) and (11) of subsection (b) of this section, as amended by this act, a physician shall notify the department of any changes to the information required in **[**subdivisions (3), (4), (5), (7), (8) and (13) of**]** said subsection (b) **[**of this section**]** not later than sixty days after such change.

Sec. 24. (NEW) (*Effective October 1, 2005*) (a) As used in this section:

(1) "Active professional practice" includes, but is not limited to, activities of a currently licensed physician who functions as the medical director of a managed care organization or other organization;

(2) "Commissioner" means the Commissioner of Public Health;

(3) "Contact hour" means a minimum of fifty minutes of continuing education activity;

(4) "Department" means the Department of Public Health;

(5) "Licensee" means any person who receives a license from the department pursuant to section 20-13 of the general statutes; and

(6) "Registration period" means the one-year period for which a license has been renewed in accordance with section 19a-88 of the general statutes and is current and valid.

(b) Except as otherwise provided in subsections (d), (e) and (f) of this section, for registration periods beginning on and after October 1, 2007, a licensee applying for license renewal shall earn a minimum of fifty contact hours of continuing medical education within the preceding twenty-four-month period. Such continuing medical education shall (1) be in an area of the physician's practice; (2) reflect the professional needs of the licensee in order to meet the health care needs of the public; and (3) include at least one contact hour of training or education in infectious diseases, including, but not limited to, acquired immune deficiency syndrome and human immunodeficiency virus, risk management, sexual assault and domestic violence. For purposes of this section, qualifying continuing medical education activities include, but are not limited to, courses offered or approved by the American Medical Association, American Osteopathic Medical Association, Connecticut Hospital Association, Connecticut State

Medical Society, county medical societies or equivalent organizations in another jurisdiction, educational offerings sponsored by a hospital or other health care institution or courses offered by a regionally accredited academic institution or a state or local health department.

(c) Each licensee applying for license renewal pursuant to section 19a-88 of the general statutes shall sign a statement attesting that the licensee has satisfied the continuing education requirements of subsection (b) of this section on a form prescribed by the department. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements of subsection (b) of this section for a minimum of three years following the year in which the continuing education activities were completed and shall submit such records or certificates to the department for inspection not later than forty-five days after a request by the department for such records or certificates.

(d) A licensee applying for the first time for license renewal pursuant to section 19a-88 of the general statutes is exempt from the continuing medical education requirements of this section.

(e) (1) A licensee who is not engaged in active professional practice in any form during a registration period shall be exempt from the continuing medical education requirements of this section, provided the licensee submits to the department, prior to the expiration of the registration period, a notarized application for exemption on a form prescribed by the department and such other documentation as may be required by the department. The application for exemption pursuant to this subdivision shall contain a statement that the licensee may not engage in professional practice until the licensee has met the requirements set forth in subdivision (2) or (3) of this subsection, as appropriate.

(2) Any licensee who is exempt from the provisions of subsection (b)

of this section for less than two years shall be required to complete twenty-five contact hours of continuing medical education that meets the criteria set forth in said subsection (b) within the twelve-month period immediately preceding the licensee's return to active professional practice.

(3) Any licensee who is exempt from the requirements of subsection (b) of this section for two or more years shall be required to successfully complete the Special Purpose Examination of the Federation of State Medical Boards prior to returning to active professional practice.

(f) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

(g) Any licensee whose license has become void pursuant to section 19a-88 of the general statutes and who applies to the department for reinstatement of such license pursuant to section 19a-14 of the general statutes shall submit evidence documenting successful completion of twenty-five contact hours of continuing education within the one-year period immediately preceding application for reinstatement.

Sec. 25. Section 19a-88b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) (1) Notwithstanding section 19a-14 or any other provisions of the general statutes relating to continuing education or refresher training, the Department of Public Health shall renew a license, certificate, permit or registration issued to an individual pursuant to chapters 368d, 368v, **[**370**]** 371 to 388, inclusive, 393a, 395, 398, 399, 400a and 400c **[**which**]** that becomes void pursuant to section 19a-88 or 19a-195b while the holder **[**thereof**]** of the license, certificate, permit or registration is on active duty in the armed forces of the United States, **[**within**]** not later than six months from the date of discharge from active duty, upon completion of any continuing education or refresher training required to renew a license, certificate, registration or permit **[**which**]** that has not become void pursuant to section 19a-88 or 19a-195b. A licensee applying for license renewal pursuant to this section shall submit an application on a form prescribed by the department and other such documentation as may be required by the department.

(2) Notwithstanding section 19a-14 or any other provisions of the general statutes relating to continuing education, the Department of Public Health shall renew a license issued to an individual pursuant to chapter 370 that becomes void pursuant to section 19a-88 while the holder of the license is on active duty in the armed forces of the United States, not later than one year from the date of discharge from active duty, upon completion of twenty-five contact hours of continuing education that meet the criteria set forth in subsection (b) of section 24 of this act. A licensee applying for license renewal pursuant to this subdivision shall submit an application on a form prescribed by the department and other such documentation as may be required by the department.

(b) The provisions of this section **[**shall**]** do not apply to reservists or National Guard members on active duty for annual training that is a

regularly scheduled obligation for reservists or members of the National Guard for training **[**which**]** that is not a part of mobilization.

(c) No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

Sec. 26. (NEW) (*Effective from passage*) (a) Each hospital and outpatient surgical facility shall develop protocols for accurate identification procedures that shall be used by such hospital or outpatient surgical facility prior to surgery. Such protocols shall include, but need not be limited to, (1) procedures to be followed to identify the (A) patient, (B) surgical procedure to be performed, and (C) body part on which the surgical procedure is to be performed, and (2) alternative identification procedures in urgent or emergency circumstances or where the patient is nonspeaking, comatose or incompetent or is a child. After January 1, 2006, no hospital or outpatient surgical facility may anesthetize a patient or perform surgery unless the protocols have been followed. Each hospital and outpatient surgical facility shall make a copy of the protocols available to the Commissioner of Public Health upon request.

(b) Not later than October 1, 2006, the Department of Public Health shall report, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health describing the protocols developed pursuant to subsection (a) of this section.

Sec. 27. (NEW) (*Effective from passage*) On or before January 1, 2006, each hospital licensed under chapter 368v of the general statutes shall (1) contract with a patient safety organization, as defined in section 19a-127o of the general statutes, to gather medical or health care related data from the hospital and make recommendations to the hospital on ways to improve patient care and safety, and (2) provide

documentation to the Department of Public Health, in such form and manner as the department prescribes, that the hospital has complied with the provisions of subdivision (1) of this section.

Sec. 28. Sections 38a-32 to 38a-36, inclusive, of the general statutes are repealed. (*Effective from passage*)

Approved July 13, 2005