



# Senate

General Assembly

**File No. 554**

January Session, 2005

Substitute Senate Bill No. 1052

*Senate, April 28, 2005*

The Committee on Judiciary reported through SEN. MCDONALD of the 27th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

## ***AN ACT CONCERNING MEDICAL MALPRACTICE.***

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

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 Section 52-190a of the general statutes is repealed and the  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

4 (a) No civil action or apportionment complaint shall be filed to  
5 recover damages resulting from personal injury or wrongful death  
6 occurring on or after October 1, 1987, whether in tort or in contract, in  
7 which it is alleged that such injury or death resulted from the  
8 negligence of a health care provider, unless the attorney or party filing  
9 the action or apportionment complaint has made a reasonable inquiry  
10 as permitted by the circumstances to determine that there are grounds  
11 for a good faith belief that there has been negligence in the care or  
12 treatment of the claimant. The complaint, [or] initial pleading or  
13 apportionment complaint shall contain a certificate of the attorney or  
14 party filing the action or apportionment complaint that such

15 reasonable inquiry gave rise to a good faith belief that grounds exist  
16 for an action against each named defendant or for an apportionment  
17 complaint against each named apportionment defendant. [For the  
18 purposes of this section, such good faith may be shown to exist if the  
19 claimant or his attorney has received a written opinion, which shall not  
20 be subject to discovery by any party except for questioning the validity  
21 of the certificate,] To show the existence of such good faith, the  
22 claimant or the claimant's attorney, and any apportionment  
23 complainant or the apportionment complainant's attorney, shall obtain  
24 a written and signed opinion of a similar health care provider, as  
25 defined in section 52-184c, which similar health care provider shall be  
26 selected pursuant to the provisions of said section, that there appears  
27 to be evidence of medical negligence and includes a detailed basis for  
28 the formation of such opinion. Such written opinion shall not be  
29 subject to discovery by any party except for questioning the validity of  
30 the certificate. The claimant or the claimant's attorney, and any  
31 apportionment complainant or apportionment complainant's attorney,  
32 shall retain the original written opinion and shall attach a copy of such  
33 written opinion, with the name and signature of the similar health care  
34 provider expunged, to such certificate. The similar health care  
35 provider who provides such written opinion shall not, without a  
36 showing of malice, be personally liable for any damages to the  
37 defendant health care provider by reason of having provided such  
38 written opinion. In addition to such written opinion, the court may  
39 consider other factors with regard to the existence of good faith. If the  
40 court determines, after the completion of discovery, that such  
41 certificate was not made in good faith and that no justiciable issue was  
42 presented against a health care provider that fully cooperated in  
43 providing informal discovery, the court upon motion or upon its own  
44 initiative shall impose upon the person who signed such certificate or a  
45 represented party, or both, an appropriate sanction which may include  
46 an order to pay to the other party or parties the amount of the  
47 reasonable expenses incurred because of the filing of the pleading,  
48 motion or other paper, including a reasonable attorney's fee. The court  
49 may also submit the matter to the appropriate authority for

50 disciplinary review of the attorney if the claimant's attorney or the  
51 apportionment complainant's attorney submitted the certificate.

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

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

60 Sec. 2. (NEW) (*Effective October 1, 2005, and applicable to actions*  
61 *accruing on or after said date*) (a) For the purposes of this section:

62 (1) "Licensed health care provider" means any health care institution  
63 licensed pursuant to the provisions of chapter 368v of the general  
64 statutes or any individual provider of health care licensed pursuant to  
65 the provisions of chapters 370 to 373, inclusive, 375 to 383c, inclusive,  
66 or chapter 400j of the general statutes;

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

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

78 Sec. 3. Section 52-192a of the general statutes is repealed and the  
79 following is substituted in lieu thereof (*Effective October 1, 2005, and*  
80 *applicable to actions accruing on or after said date*):

81 (a) After commencement of any civil action based upon contract or  
82 seeking the recovery of money damages, whether or not other relief is  
83 sought, the plaintiff may, not earlier than one hundred eighty days  
84 after service of process is made upon the defendant in such action but  
85 not later than thirty days before trial, file with the clerk of the court a  
86 written ["offer of judgment"] offer of compromise signed by the  
87 plaintiff or the plaintiff's attorney, directed to the defendant or the  
88 defendant's attorney, offering to settle the claim underlying the action  
89 [and to stipulate to a judgment] for a sum certain. The plaintiff shall  
90 give notice of the offer of [settlement] compromise to the defendant's  
91 attorney or, if the defendant is not represented by an attorney, to the  
92 defendant himself or herself. Within [sixty] thirty days after being  
93 notified of the filing of the ["offer of judgment"] offer of compromise  
94 and prior to the rendering of a verdict by the jury or an award by the  
95 court, the defendant or the defendant's attorney may file with the clerk  
96 of the court a written ["acceptance of offer of judgment"] acceptance of  
97 the offer of compromise agreeing to [a stipulation for judgment] settle  
98 the underlying action for the sum certain as contained in the plaintiff's  
99 ["offer of judgment"] offer of compromise. Upon such filing [,] and the  
100 receipt by the plaintiff of such sum certain, the plaintiff shall file a  
101 withdrawal of the action with the clerk and the clerk shall [enter  
102 judgment immediately on the stipulation] record the withdrawal of the  
103 action against the defendant accordingly. If the ["offer of judgment"]  
104 offer of compromise is not accepted within [sixty] thirty days and prior  
105 to the rendering of a verdict by the jury or an award by the court, the  
106 ["offer of judgment"] offer of compromise shall be considered rejected  
107 and not subject to acceptance unless refiled. Any such ["offer of  
108 judgment"] offer of compromise and any ["acceptance of offer of  
109 judgment"] acceptance of the offer of compromise shall be included by  
110 the clerk in the record of the case.

111 (b) In the case of any action to recover damages resulting from  
112 personal injury or wrongful death, whether in tort or in contract, in  
113 which it is alleged that such injury or death resulted from the  
114 negligence of a health care provider, an offer of compromise pursuant  
115 to subsection (a) of this section shall state with specificity all damages

116 then known to the plaintiff or the plaintiff's attorney upon which the  
117 action is based. Sixty days prior to filing such an offer, the plaintiff or  
118 the plaintiff's attorney shall provide the defendant or the defendant's  
119 attorney with an authorization to disclose medical records that meets  
120 the privacy provisions of the Health Insurance Portability and  
121 Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from  
122 time to time, or regulations adopted thereunder, and disclose any and  
123 all expert witnesses who will testify as to the prevailing professional  
124 standard of care. The plaintiff shall file with the court a certification  
125 that the plaintiff has provided each defendant or such defendant's  
126 attorney with all documentation supporting such damages.

127 [(b)] (c) After trial the court shall examine the record to determine  
128 whether the plaintiff made an ["offer of judgment"] offer of  
129 compromise which the defendant failed to accept. If the court  
130 ascertains from the record that the plaintiff has recovered an amount  
131 equal to or greater than the sum certain stated in the plaintiff's ["offer  
132 of judgment"] offer of compromise, the court shall add to the amount  
133 so recovered [twelve] eight per cent annual interest on said amount. [,  
134 computed from the date such offer was filed in actions commenced  
135 before October 1, 1981. In those actions commenced on or after October  
136 1, 1981, the] The interest shall be computed from the date the  
137 complaint in the civil action was filed with the court if the ["offer of  
138 judgment"] offer of compromise was filed not later than eighteen  
139 months from the filing of such complaint. If such offer was filed later  
140 than eighteen months from the date of filing of the complaint, the  
141 interest shall be computed from the date the ["offer of judgment"] offer  
142 of compromise was filed. The court may award reasonable attorney's  
143 fees in an amount not to exceed three hundred fifty dollars, and shall  
144 render judgment accordingly. This section shall not be interpreted to  
145 abrogate the contractual rights of any party concerning the recovery of  
146 attorney's fees in accordance with the provisions of any written  
147 contract between the parties to the action.

148 Sec. 4. Section 52-193 of the general statutes is repealed and the  
149 following is substituted in lieu thereof (*Effective October 1, 2005, and*

150 *applicable to actions accruing on or after said date):*

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

158 Sec. 5. Section 52-194 of the general statutes is repealed and the  
159 following is substituted in lieu thereof (*Effective October 1, 2005, and*  
160 *applicable to actions accruing on or after said date):*

161 In any action, the plaintiff may, within ten days after being notified  
162 by the defendant of the filing of an offer of [judgment] compromise,  
163 file with the clerk of the court a written acceptance of the offer signed  
164 by [himself or his] the plaintiff or the plaintiff's attorney agreeing to  
165 settle the underlying action for the sum certain as contained in the  
166 defendant's offer of compromise. Upon the filing of the written  
167 acceptance [, the court shall render judgment against the defendant as  
168 upon default for the sum so named and for the costs accrued at the  
169 time of the defendant's giving the plaintiff notice of the offer] and  
170 receipt by the plaintiff of such sum certain, the plaintiff shall file a  
171 withdrawal of the action with the clerk of the court and the clerk shall  
172 record the withdrawal of the action against the defendant accordingly.  
173 No trial may be postponed because the period within which the  
174 plaintiff may accept the offer has not expired, except at the discretion  
175 of the court.

176 Sec. 6. Section 52-195 of the general statutes is repealed and the  
177 following is substituted in lieu thereof (*Effective October 1, 2005, and*  
178 *applicable to actions accruing on or after said date):*

179 (a) If the plaintiff does not, within the time allowed for acceptance  
180 of the offer of [judgment] compromise and before the commencement  
181 of the trial, file [his] the plaintiff's notice of acceptance, the offer shall

182 be deemed to be withdrawn and shall not be given in evidence.

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

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

196 Sec. 7. Section 38a-676 of the general statutes is repealed and the  
197 following is substituted in lieu thereof (*Effective from passage*):

198 (a) With respect to rates pertaining to commercial risk insurance,  
199 and subject to the provisions of subsection (b) of this section with  
200 respect to workers' compensation and employers' liability insurance  
201 and professional liability insurance for physicians and surgeons,  
202 hospitals, advance practice registered nurses and physician assistants,  
203 on or before the effective date [thereof, every] of such rates, each  
204 admitted insurer shall submit to the Insurance Commissioner for the  
205 commissioner's information, except as to inland marine risks which by  
206 general custom of the business are not written according to manual  
207 rates or rating plans, [every] each manual of classifications, rules and  
208 rates, and [every] each minimum, class rate, rating plan, rating  
209 schedule and rating system and any modification of the foregoing  
210 which it uses. Such submission by a licensed rating organization of  
211 which an insurer is a member or subscriber shall be sufficient  
212 compliance with this section for any insurer maintaining membership  
213 or subscribership in such organization, to the extent that the insurer

214 uses the manuals, minimums, class rates, rating plans, rating  
215 schedules, rating systems, policy or bond forms of such organization.  
216 The information shall be open to public inspection after its submission.

217 (b) (1) Each filing [as] described in subsection (a) of this section for  
218 workers' compensation or employers' liability insurance shall be on file  
219 with the Insurance Commissioner for a waiting period of thirty days  
220 before it becomes effective, which period may be extended by the  
221 commissioner for an additional period not to exceed thirty days if the  
222 commissioner gives written notice within such waiting period to the  
223 insurer or rating organization which made the filing that the  
224 commissioner needs such additional time for the consideration of such  
225 filing. Upon written application by such insurer or rating organization,  
226 the commissioner may authorize a filing which the commissioner has  
227 reviewed to become effective before the expiration of the waiting  
228 period or any extension thereof. A filing shall be deemed to meet the  
229 requirements of sections 38a-663 to 38a-696, inclusive, unless  
230 disapproved by the commissioner within the waiting period or any  
231 extension thereof. If, within the waiting period or any extension  
232 thereof, the commissioner finds that a filing does not meet the  
233 requirements of said sections, the commissioner shall send to the  
234 insurer or rating organization which made such filing written notice of  
235 disapproval of such filing, specifying therein in what respects the  
236 commissioner finds such filing fails to meet the requirements of said  
237 sections and stating that such filing shall not become effective. Such  
238 finding of the commissioner shall be subject to review as provided in  
239 section 38a-19.

240 (2) (A) Each filing described in subsection (a) of this section for  
241 professional liability insurance for physicians and surgeons, hospitals,  
242 advanced practice registered nurses or physician assistants shall be  
243 subject to prior rate approval in accordance with this section. On and  
244 after the effective date of this section, each insurer or rating  
245 organization seeking to increase its rates over the rates in the insurer's  
246 previous filing for such insurance by five per cent shall (i) file a request  
247 for such change with the Insurance Commissioner, and (ii) send

248 written notice of any request for an increase in rates to insureds who  
249 would be subject to the increase. Such request shall be filed and such  
250 notice, if applicable, shall be sent at least sixty days prior to the  
251 proposed effective date of the increase. The notice to insureds of a  
252 request for an increase in rates shall indicate that the insured may  
253 request a public hearing by submitting a written request to the  
254 Insurance Commissioner not later than fifteen days after the date of the  
255 notice. Any request for an increase in rates under this subdivision shall  
256 be filed after notice is sent to insureds and shall indicate the date such  
257 notice was sent.

258 (B) The Insurance Commissioner shall review the filing and, with  
259 respect to a request for an increase in rates, shall (i) not approve,  
260 modify or deny the request until at least fifteen days after the date of  
261 notice as indicated in the filing, and (ii) hold a public hearing, if  
262 requested by insureds, on such increase prior to approving, modifying  
263 or denying the request. The Insurance Commissioner shall approve,  
264 modify or deny the filing not later than forty-five days after its receipt.  
265 Such finding of the commissioner shall be subject to review as  
266 provided in section 38a-19.

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

280 Sec. 8. Section 20-13b of the general statutes is repealed and the

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

282 The Commissioner of Public Health, with advice and assistance  
283 from the board, [may establish such regulations in accordance with  
284 chapter 54] shall establish guidelines as may be necessary to carry out  
285 the provisions of sections 20-13a to 20-13i, inclusive, as amended by  
286 this act. Not later than October 1, 2005, such guidelines shall include,  
287 but need not be limited to: (1) Guidelines for screening complaints  
288 received to determine which complaints will be investigated; (2)  
289 guidelines to provide a basis for prioritizing the order in which  
290 complaints will be investigated; (3) a system for conducting  
291 investigations to ensure prompt action when it appears necessary; (4)  
292 guidelines to determine when an investigation should be broadened  
293 beyond the scope of the initial complaint to include sampling patient  
294 records to identify patterns of care, reviewing office practices and  
295 procedures, reviewing performance and discharge data from hospitals  
296 and managed care organizations and conducting additional interviews  
297 of patients; and (5) guidelines to protect and ensure the confidentiality  
298 of patient and provider identifiable information when an investigation  
299 is broadened beyond the scope of the initial complaint.

300 Sec. 9. (NEW) (*Effective from passage*) Not later than October 1, 2005,  
301 the Connecticut Medical Examining Board, with the assistance of the  
302 Department of Public Health, shall adopt guidelines for use in the  
303 disciplinary process. Such guidelines shall include, but need not be  
304 limited to: (1) Identification of each type of violation; (2) a range of  
305 penalties for each type of violation; (3) additional optional conditions  
306 that may be imposed by the board for each violation; (4) identification  
307 of factors the board shall consider in determining what penalty should  
308 apply; (5) conditions, such as mitigating factors or other facts, that may  
309 be considered in allowing deviations from the guidelines; and (6) a  
310 provision that when a deviation from the guidelines occurs, the reason  
311 for the deviation shall be identified.

312 Sec. 10. (NEW) (*Effective from passage*) (a) Each health care facility  
313 shall develop protocols for accurate identification procedures that shall

314 be used by hospitals and outpatient surgical facilities prior to surgery.  
315 Such protocols shall include, but need not be limited to, (1) procedures  
316 to be followed to identify the (A) patient, (B) surgical procedure to be  
317 performed, and (C) body part on which the surgical procedure is to be  
318 performed, and (2) alternative identification procedures in urgent or  
319 emergency circumstances or where the patient is nonspeaking,  
320 comatose or incompetent or is a child. After October 1, 2005, no  
321 hospital or outpatient surgical facility may anesthetize a patient or  
322 perform surgery unless the protocols have been followed. Each health  
323 care facility shall make a copy of the protocols available to the  
324 Commissioner of Public Health upon request.

325 (b) Not later than October 1, 2005, the Department of Public Health  
326 shall report, in accordance with section 11-4a of the general statutes, to  
327 the joint standing committee of the General Assembly having  
328 cognizance of matters relating to public health describing the protocols  
329 developed pursuant to subsection (a) of this section.

330 Sec. 11. (NEW) (*Effective October 1, 2005*) (a) Not earlier than October  
331 1, 2008, the Insurance Commissioner shall review professional liability  
332 insurance rates in this state for physicians and surgeons, hospitals,  
333 advanced practice registered nurses and physicians assistants to  
334 determine if such rates have decreased and whether such rates bear a  
335 reasonable relationship to the costs of writing such insurance in this  
336 state. In conducting the review, the commissioner shall examine the  
337 rates for such insurance under policies issued by (1) captive insurers  
338 and risk retention groups, to the extent such information is available to  
339 the commissioner, and (2) insurers licensed in this state.

340 (b) If after such review the commissioner determines that such  
341 insurance rates have not decreased and are not reasonably related to  
342 the costs of writing such insurance, the commissioner shall convene a  
343 working group, in accordance with subsection (c) of this section, to  
344 recommend appropriate revisions, if any, to the general statutes in  
345 order to decrease rates or establish reasonable rates. Such revisions  
346 may include, but need not be limited to, reasonable limitations on

347 noneconomic damages awards, revisions to procedures used by  
348 insurers to establish rates, and regulation of reimbursement rates paid  
349 by health insurers and health care centers to health care providers in  
350 this state.

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

353 (1) The chairpersons and ranking members of (A) the joint standing  
354 committees of the General Assembly having cognizance of matters  
355 relating to the judiciary, public health and insurance, and (B) the  
356 Legislative Program Review and Investigations Committee;

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

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

359 (4) One member appointed by the Connecticut Bar Association;

360 (5) One member appointed by the Connecticut Trial Lawyers  
361 Association;

362 (6) One representative of a patient advocacy group appointed by the  
363 Insurance Commissioner;

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

366 (8) The Insurance Commissioner.

367 Sec. 12. Section 38a-8 of the general statutes is amended by adding  
368 subsection (g) as follows (*Effective from passage*):

369 (NEW) (g) Not later than October 1, 2005, the Insurance  
370 Commissioner shall develop a plan to maintain a viable medical  
371 malpractice insurance industry in this state for physicians and  
372 surgeons, hospitals, advanced practice registered nurses and physician  
373 assistants. Such plan shall be submitted to the Governor upon its  
374 completion.

375 Sec. 13. Section 19a-88b of the general statutes is repealed and the  
376 following is substituted in lieu thereof (*Effective October 1, 2005*):

377 (a) (1) Notwithstanding section 19a-14 or any other provisions of the  
378 general statutes relating to continuing education or refresher training,  
379 the Department of Public Health shall renew a license, certificate,  
380 permit or registration issued to an individual pursuant to chapters  
381 368d, 368v, [370] 371 to 388, inclusive, 393a, 395, 398, 399, 400a and  
382 400c [which] that becomes void pursuant to section 19a-88 or 19a-195b  
383 while the holder [thereof] of the license, certificate, permit or  
384 registration is on active duty in the armed forces of the United States,  
385 [within] not later than six months from the date of discharge from  
386 active duty, upon completion of any continuing education or refresher  
387 training required to renew a license, certificate, registration or permit  
388 [which] that has not become void pursuant to section 19a-88 or 19a-  
389 195b. A licensee applying for license renewal pursuant to this section  
390 shall submit an application on a form prescribed by the department  
391 and other such documentation as may be required by the department.

392 (2) Notwithstanding section 19a-14 or any other provisions of the  
393 general statutes relating to continuing education, the Department of  
394 Public Health shall renew a license issued to an individual pursuant to  
395 chapter 370 that becomes void pursuant to section 19a-88 while the  
396 holder of the license is on active duty in the armed forces of the United  
397 States, not later than one year from the date of discharge from active  
398 duty, upon completion of twenty-five contact hours of continuing  
399 education that meet the criteria set forth in subsection (b) of section 17  
400 of this act. A licensee applying for license renewal pursuant to this  
401 subdivision shall submit an application on a form prescribed by the  
402 department and other such documentation as may be required by the  
403 department.

404 (b) The provisions of this section [shall] do not apply to reservists or  
405 National Guard members on active duty for annual training that is a  
406 regularly scheduled obligation for reservists or members of the  
407 National Guard for training [which] that is not a part of mobilization.

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

411 Sec. 14. Section 20-13c of the general statutes is repealed and the  
412 following is substituted in lieu thereof (*Effective October 1, 2005*):

413 The board is authorized to restrict, suspend or revoke the license or  
414 limit the right to practice of a physician or take any other action in  
415 accordance with section 19a-17, for any of the following reasons: (1)  
416 Physical illness or loss of motor skill, including, but not limited to,  
417 deterioration through the aging process; (2) emotional disorder or  
418 mental illness; (3) abuse or excessive use of drugs, including alcohol,  
419 narcotics or chemicals; (4) illegal, incompetent or negligent conduct in  
420 the practice of medicine; (5) possession, use, prescription for use, or  
421 distribution of controlled substances or legend drugs, except for  
422 therapeutic or other medically proper purposes; (6) misrepresentation  
423 or concealment of a material fact in the obtaining or reinstatement of a  
424 license to practice medicine; (7) failure to adequately supervise a  
425 physician assistant; (8) failure to fulfill any obligation resulting from  
426 participation in the National Health Service Corps; (9) failure to  
427 maintain professional liability insurance or other indemnity against  
428 liability for professional malpractice as provided in subsection (a) of  
429 section 20-11b; (10) failure to provide information requested by the  
430 department for purposes of completing a health care provider profile,  
431 as required by section 20-13j, as amended by this act; (11) engaging in  
432 any activity for which accreditation is required under section 19a-690  
433 or 19a-691 without the appropriate accreditation required by section  
434 19a-690 or 19a-691; (12) failure to provide evidence of accreditation  
435 required under section 19a-690 or 19a-691 as requested by the  
436 department pursuant to section 19a-690 or 19a-691; (13) failure to  
437 comply with the continuing medical education requirements set forth  
438 in section 17 of this act; or [(13)] (14) violation of any provision of this  
439 chapter or any regulation established hereunder. In each case, the  
440 board shall consider whether the physician poses a threat, in the  
441 practice of medicine, to the health and safety of any person. If the

442 board finds that the physician poses such a threat, the board shall  
443 include such finding in its final decision and act to suspend or revoke  
444 the license of said physician.

445 Sec. 15. Subsection (b) of section 20-13j of the general statutes is  
446 repealed and the following is substituted in lieu thereof (*Effective*  
447 *October 1, 2005*):

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

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

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

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

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

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

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

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

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

469 (9) Any appointments of the physician to Connecticut medical

470 school faculties and an indication as to whether the physician has  
471 current responsibility for graduate medical education;

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

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

476 (12) Any hospital disciplinary actions against the physician that  
477 resulted, within the past ten years, in the termination or revocation of  
478 the physician's hospital privileges for a medical disciplinary cause or  
479 reason, or the resignation from, or nonrenewal of, medical staff  
480 membership or the restriction of privileges at a hospital taken in lieu of  
481 or in settlement of a pending disciplinary case related to medical  
482 competence in such hospital;

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

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

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

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

500 Sec. 16. Subsection (k) of section 20-13j of the general statutes is  
501 repealed and the following is substituted in lieu thereof (*Effective*  
502 *October 1, 2005*):

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

507 Sec. 17. (NEW) (*Effective October 1, 2005*) (a) As used in this section:

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

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

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

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

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

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

520 (b) Except as otherwise provided in subsections (d), (e) and (f) of  
521 this section, for registration periods beginning on and after October 1,  
522 2007, the department shall not renew a license for any licensee  
523 applying for license renewal pursuant to section 19a-88 of the general  
524 statutes unless the licensee has earned a minimum of fifty contact  
525 hours of continuing medical education within the preceding twenty-  
526 four-month period. Such continuing medical education shall (1) be in  
527 an area of the physician's practice specialty; (2) reflect the professional  
528 needs of the licensee in order to meet the health care needs of the

529 public; and (3) include at least one contact hour of training or  
530 education in infectious diseases, including, but not limited to, acquired  
531 immune deficiency syndrome and human immunodeficiency virus,  
532 and risk management, sexual assault and domestic violence. For  
533 purposes of this section, qualifying continuing medical education  
534 activities include, but are not limited to, courses offered or approved  
535 by the American Medical Association, American Osteopathic Medical  
536 Association, Connecticut Hospital Association or the Connecticut State  
537 Medical Society, county medical societies or equivalent organizations  
538 in another jurisdiction, educational offerings sponsored by a hospital  
539 or other health care institution or courses offered by a regionally  
540 accredited academic institution.

541 (c) Each licensee applying for license renewal pursuant to section  
542 19a-88 of the general statutes shall sign a statement attesting that the  
543 licensee has satisfied the continuing education requirements of  
544 subsection (a) of this section on a form prescribed by the department.  
545 Each licensee shall retain records of attendance or certificates of  
546 completion that demonstrate compliance with the continuing  
547 education requirements of subsection (a) of this section for a minimum  
548 of three years following the year in which the continuing education  
549 activities were completed and shall submit such records to the  
550 department for inspection not later than forty-five days after a request  
551 by the department for such records.

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

555 (e) (1) A licensee who is not engaged in active professional practice  
556 in any form during a registration period shall be exempt from the  
557 continuing medical education requirements of this section, provided  
558 the licensee submits to the department, prior to the expiration of the  
559 registration period, a notarized application for exemption on a form  
560 prescribed by the department and such other documentation as may  
561 be required by the department. The application for exemption

562 pursuant to this subdivision shall contain a statement that the licensee  
563 may not engage in professional practice until the licensee has met the  
564 requirements set forth in subdivision (2) or (3) of this subsection, as  
565 appropriate.

566 (2) Any licensee who is exempt from the provisions of subsection (b)  
567 of this section for less than two years shall be required to complete  
568 twenty-five contact hours of continuing medical education that meets  
569 the criteria set forth in subsection (b) of this section within the twelve-  
570 month period immediately preceding the licensee's return to active  
571 professional practice.

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

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

591 (g) The department shall renew a license issued to any licensee that  
592 becomes void pursuant to section 19a-88 of the general statutes,  
593 provided the licensee (1) applies to the commissioner for  
594 reinstatement, and (2) submits evidence documenting successful

595 completion of twenty-five contact hours of continuing education  
596 within the one-year period immediately preceding application for  
597 reinstatement.

598 Sec. 18. Section 38a-395 of the general statutes is repealed and the  
599 following is substituted in lieu thereof (*Effective January 1, 2006*):

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

608 (a) As used in this section:

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

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

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

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

626 (c) The closed claim report shall include:

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

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

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

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

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

681 (d) (1) The commissioner shall, within available appropriations,  
682 establish an electronic database composed of closed claim reports filed  
683 pursuant to this section.

684 (2) The commissioner shall, within available appropriations,  
685 compile the data included in individual closed claim reports into an  
686 aggregated summary format and shall prepare a written annual report  
687 of the summary data. The report shall provide an analysis of closed  
688 claim information including a minimum of five years of comparative  
689 data, when available, trends in frequency and severity of claims,  
690 itemization of damages, timeliness of the claims process, and any other  
691 descriptive or analytical information that would assist in interpreting  
692 the trends in closed claims.

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

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

711       (e) The Insurance Commissioner shall, within available  
712 appropriations, provide the Commissioner of Public Health with  
713 electronic access to all information received pursuant to this section.  
714 The Commissioner of Public Health shall maintain the confidentiality  
715 of such information in the same manner and to the same extent as  
716 required for the Insurance Commissioner.

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

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

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

- 724 (2) Fraternal benefit societies authorized to do business in this state.
- 725 (3) Insurance-support organizations as defined in section 38a-976,  
726 transacting business outside this state which affects a resident of this  
727 state.
- 728 (4) Risk retention groups, [designating the Insurance Commissioner  
729 as agent for receipt of service of process pursuant to section 38a-252] as  
730 defined in section 38a-250.
- 731 (5) Purchasing groups designating the Insurance Commissioner as  
732 agent for receipt of service of process pursuant to section 38a-261.
- 733 (6) Eligible surplus lines insurers authorized by the commissioner to  
734 accept surplus lines insurance.
- 735 (7) Except as provided by section 38a-273, unauthorized insurers or  
736 other persons assisting unauthorized insurers who directly or  
737 indirectly do any of the acts of insurance business as set forth in  
738 subsection (a) of section 38a-271.
- 739 (8) The Connecticut Insurance Guaranty Association and the  
740 Connecticut Life and Health Insurance Guaranty Association.
- 741 (9) Insurance companies designating the Insurance Commissioner  
742 as agent for receipt of service of process pursuant to subsection (g) of  
743 section 38a-85.
- 744 (10) Nonresident insurance producers and nonresident surplus lines  
745 brokers licensed by the Insurance Commissioner.
- 746 (11) Viatical settlement providers, viatical settlement brokers, and  
747 viatical settlement investment agents licensed by the commissioner.
- 748 (12) Nonresident reinsurance intermediaries designating the  
749 commissioner as agent for receipt of service of process pursuant to  
750 section 38a-760b.
- 751 (13) Workers' compensation self-insurance groups, as defined in

752 section 38a-1001.

753 (14) Persons alleged to have violated any provision of section 38a-  
754 130.

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

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

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

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

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

778 Sec. 20. (NEW) (*Effective July 1, 2005*) Each captive insurer that  
779 offers, renews or continues insurance in this state shall provide the  
780 information described in subdivisions (1) to (3), inclusive, of  
781 subsection (a) of section 38a-253 of the general statutes to the Insurance  
782 Commissioner in the same manner required for risk retention groups.

783 If a captive insurer does not maintain information in the form  
784 prescribed in section 38a-253 of the general statutes, the captive insurer  
785 may submit the information to the Insurance Commissioner on such  
786 form as the commissioner prescribes. As used in this section and  
787 section 38a-25 of the general statutes, as amended by this act, "captive  
788 insurer" means an insurance company owned by another organization  
789 whose primary purpose is to insure risks of a parent organization or  
790 affiliated persons, as defined in section 38a-1 of the general statutes, or  
791 in the case of groups and associations, an insurance organization  
792 owned by the insureds whose primary purpose is to insure risks of  
793 member organizations and group members and their affiliates.

794 Sec. 21. (NEW) (*Effective from passage*) Not later than six months after  
795 the filing of an action to recover damages resulting from personal  
796 injury or wrongful death, whether in tort or in contract, in which it is  
797 alleged that such injury or death resulted from the negligence of a  
798 health care provider, the court shall schedule a conference of the  
799 parties at which the court shall determine whether to recommend to  
800 the Chief Court Administrator, or the Chief Court Administrator's  
801 designee, that the action be designated as a complex litigation case and  
802 be transferred to the complex litigation docket. Nothing in this section  
803 shall be construed to preclude any party or a judge from, at any time,  
804 requesting the Chief Court Administrator, or the Chief Court  
805 Administrator's designee, to designate such action as a complex  
806 litigation case and transfer such action to the complex litigation docket.

807 Sec. 22. (NEW) (*Effective from passage*) (a) For the purposes of this  
808 section:

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

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

816 relationship with a victim;

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

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

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

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2005, and applicable to actions filed on or after said date</i>	52-190a
Sec. 2	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	New section
Sec. 3	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	52-192a
Sec. 4	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	52-193

Sec. 5	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	52-194
Sec. 6	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	52-195
Sec. 7	<i>from passage</i>	38a-676
Sec. 8	<i>from passage</i>	20-13b
Sec. 9	<i>from passage</i>	New section
Sec. 10	<i>from passage</i>	New section
Sec. 11	<i>October 1, 2005</i>	New section
Sec. 12	<i>from passage</i>	38a-8
Sec. 13	<i>October 1, 2005</i>	19a-88b
Sec. 14	<i>October 1, 2005</i>	20-13c
Sec. 15	<i>October 1, 2005</i>	20-13j(b)
Sec. 16	<i>October 1, 2005</i>	20-13j(k)
Sec. 17	<i>October 1, 2005</i>	New section
Sec. 18	<i>January 1, 2006</i>	38a-395
Sec. 19	<i>from passage</i>	38a-25
Sec. 20	<i>July 1, 2005</i>	New section
Sec. 21	<i>from passage</i>	New section
Sec. 22	<i>from passage</i>	New section

**JUD**      *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

## OFA Fiscal Note

### State Impact:

Agency Affected	Fund-Effect	FY 06 \$	FY 07 \$
Judicial Dept.	GF - Savings; Revenue	Minimal	Minimal
Public Health, Dept.	GF - None	None	None
UConn Health Ctr.	Various - Savings	Potential	Potential
Insurance Dept.	GF - Cost	174,000	174,000

Note: GF=General Fund

**Municipal Impact:** None

### Explanation

**Sections 1 through 6, 21 and 22** make various tort reforms in order to reduce the number of claims filed initially, promote settlements, and expedite the processing of cases. These changes would reduce the workload of the Judicial Department and allow for cases to be disposed of more quickly. Any fiscal impact resulting from these changes (related to court fees and potential cost savings) is expected to be minimal.

**Section 7** requires medical malpractice insurance companies to file a request for rate approval with the Insurance Commissioner 60 days prior to the effective date. This has no fiscal impact on the Department of Insurance.

**Section 8** requires the Department of Public Health (DPH) to adopt guidelines, by October 1, 2005, concerning the screening of complaints against physicians and the conduct of subsequent investigations. It is anticipated that the agency can do so without requiring additional resources.

**Section 9** requires the Connecticut Medical Examining Board (CMEB), with the assistance of the DPH, to adopt regulations by

October 1, 2005, to establish guidelines for use in its disciplinary process. The CMEB is comprised of volunteers who are not compensated for their time. Therefore, no direct state cost will result from an increased workload of their members. The department can assist in this effort within its anticipated budgetary resources.

**Section 10** requires each hospital or outpatient surgical facility to establish protocols for screening patients prior to any surgery. The development and implementation of these protocols will lead to additional costs for the John Dempsey Hospital at the University of Connecticut Health Center (UCHC). However, as it is expected that UCHC will coordinate with other hospitals in the state, these additional costs are expected to be minimal. To the extent that the measures in this bill lower medical malpractice and malpractice insurance costs, the John Dempsey Hospital may realize future savings. The extent of these savings cannot be determined at this time. It is anticipated that the DPH can submit the required report by October 1, 2005, within its anticipated budgetary resources.

**Section 11** requires the Insurance Commissioner, by October 1, 2008 to review professional liability insurance rates and to convene a working group to recommend appropriate changes to the law regarding rates. This has no fiscal impact.

**Section 12** requires the Insurance Commissioner to develop a plan to maintain a viable medical malpractice insurance industry. It is anticipated that the Department of Insurance will be able to implement this section of the bill within available resources.

**Sections 13 - 14, and 17** make failure to comply with continuing education requirements a cause for disciplinary action by the Connecticut Medical Examining Board. Per Section 19a-17 CGS, disciplinary action may include assessment of a civil penalty of up to \$10,000. The DPH would also be required to provide forms for use by physicians when attesting to their satisfactory completion of continuing education requirements, or when applying for an exemption, waiver or extension of time. It is anticipated that the

agency can do so without requiring additional resources.

**Sections 15 - 16** makes changes to the information that must be reported by physicians within their physician profiles. It is anticipated that the DPH can accommodate these changes without requiring additional resources.

**Sections 18 - 20** require the Insurance Commissioner to establish an electronic database composed of closed claim reports. It also requires the commissioner to provide an annual report consisting of trend analysis of closed claim information. Due to the need to collect, input, and process additional information the department would incur costs of \$173,929 in FY 06 and FY 07. These costs would consist of \$51,200 in other expenses and equipment, \$89,920 in salary and fringe benefits for an examiner (annual salary \$61,665), and \$32,810 in salary and fringe benefits for one-quarter of an actuary.

**OLR Bill Analysis**

sSB 1052

**AN ACT CONCERNING MEDICAL MALPRACTICE.****SUMMARY:**

This bill makes numerous changes in the laws dealing with civil litigation, primarily relating to medical malpractice; medical malpractice insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors.

Regarding litigation reform, the bill:

1. requires, as a condition of filing a medical malpractice lawsuit, a signed opinion from a similar health care provider indicating that malpractice has occurred (§ 1);
2. allows defendants in medical malpractice cases that accrue after September 30, 2005, to introduce evidence of the amount of damages awarded to the plaintiff for the same injury or death by a court or jury in a separate lawsuit by the plaintiff against a different health care provider (In general, a cause of action accrues when the right to bring suit on a claim is complete.) (§2);
3. changes the “offer of judgment” law in several ways including changing the terminology to “offer of compromise” and having the process end in a withdrawal of the lawsuit after payment instead of a judgment against the defendant (§ 3-7);
4. reduces the interest rate the court may award with respect to an offer of compromise for medical malpractice cases that accrue after September 30, 2005 from 12% to 8%, and establishes some additional requirements for such cases (§3) ;
5. requires the court, within six months after a medical malpractice case is filed, to schedule a conference to determine whether to recommend it be designated as a complex litigation case and transferred to the complex litigation docket (§ 21) ; and

6. makes expressions of sympathy by health care providers inadmissible in lawsuits by victims of unanticipated outcomes of medical care (§ 22).

Regarding insurance regulation and oversight, the bill

1. requires prior rate approval when an insurer wants to increase medical malpractice insurance rates by 5% for physicians, hospitals, and certain other health care providers, and requires an insurer to notify insureds of (a) the proposed rate increase and (b) their right to request a hearing on the matter before the insurance commissioner (§ 7);
2. requires the insurance commissioner, by October 1, 2008, to review professional liability insurance rates to determine if they have decreased and whether they bear a reasonable relationship to the costs of writing such insurance in this state, and requires her to convene a working group to recommend appropriate changes to the law in decrease rates or establish reasonable rates if after review she determines that rates have not decreased and are not reasonably related to the costs of writing such insurance (§11);
3. requires the commissioner to develop a plan to maintain a viable medical malpractice insurance industry in Connecticut and submit it to the governor (§ 12);
4. requires insurers to report to the insurance commissioner on each malpractice claim that they close and requires her to compile and analyze the reported data, and report on it to the Insurance and Real Estate Committee and the public (§ 18); and
5. requires captive insurers to provide certain information to the insurance commissioner (§§ 19 and 20).

Regarding medical provider regulation and oversight, the bill:

1. requires the Department of Public Health (DPH) and the Medical Examining Board to adopt guidelines for investigating complaints against, and disciplining, physicians (§§ 8 & 9);

2. requires each health care facility to develop surgery protocols by October 1, 2005 and the DPH commissioner to report on them to the Public Health Committee by that date (§ 10);
3. amends the physician profile law to require more information about adverse licensure actions in other states, professional liability insurance, and active involvement in patient care, and requires physicians to report any changes or updates in mandatory reporting information (§ 15);
4. establishes continuing education requirements for physicians as a condition of license renewal, along with exemptions from the requirements under certain conditions (§§ 13 & 17); and
5. requires a physician whose license becomes void for failure to renew while on active duty in the armed forces to complete continuing education requirements in order to have his license renewed (§13).

EFFECTIVE DATE: Upon passage, except for the provision requiring captive insurers to provide information, which takes effect July 1, 2005, the provisions dealing with good faith certificates, evidence of awards, offer of compromise, review of malpractice insurance rates, continuing education, and the physician profile, which take effect October 1, 2005, and the provision dealing with closed claims reports, which takes effect January 1, 2006.

### **GOOD FAITH CERTIFICATE (§ 1)**

The law prohibits filing malpractice lawsuits unless the attorney or claimant has made as reasonable an inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that the claimant received negligent care or treatment. The complaint or initial pleading must contain a certificate of the attorney or claimant that his inquiry resulted in a good faith belief that grounds exist for a lawsuit against each named defendant.

Under current law, a good faith belief can be shown if the claimant or his attorney receives a written opinion from a similar health care provider that there appears to be evidence of medical negligence. But it can also be shown in some other way. The bill instead requires a written signed opinion from a similar health care provider in order to

show good faith. The opinion must include the reasons for concluding that medical negligence occurred. It is not subject to discovery by the defendants except for questioning the certificate's validity.

The bill makes the failure to obtain and file the written opinion grounds for the dismissing the case.

The bill requires the claimant or his attorney to retain the original written opinion and attach a copy of it to the complaint, with the health care provider's name and signature removed.

The bill imposes the same good faith certificate requirement on defendants who file an apportionment complaint against another health care provider. An apportionment complaint is a defendant's claim in a medical malpractice lawsuit that another health care provider who the plaintiff did not make a defendant committed malpractice and partially or totally caused the plaintiff's damages. By filing the apportionment complaint, the defendant in essence makes the other health care provider a party to the plaintiff's lawsuit.

The bill makes the health care provider who provides the opinion immune from liability unless it is shown he acted with malice.

By law, the court may impose sanctions if a certificate is not made in good faith.

## **EVIDENCE OF DAMAGES AWARDED (§ 2)**

The bill allows defendants in medical malpractice cases that accrue after September 30, 2005, to introduce evidence of the amount of damages awarded to the plaintiff for the same injury or death in a separate lawsuit the plaintiff filed against a different health care provider.

## **OFFER OF COMPROMISE BY PLAINTIFFS AND DEFENDANTS (§§ 3, 4, 5, & 6)**

### ***Contract Cases or Cases Seeking Money Judgments***

By law, in any contract case or a case seeking money damages, plaintiffs and defendants can use a statutory procedure to offer to settle the case for a specified amount. This is called an "offer of judgment."

Plaintiffs can file an offer of judgment with the court clerk up to 30 days before trial. After trial, the court must examine the record to determine whether the plaintiff made an offer of judgment that the defendant failed to accept. Under current law, if it determines that the plaintiff recovered an amount equal to or greater than the sum stated in his offer of judgment, the court must add 12% annual interest.

By law, a defendant has 60 days to file an acceptance of the offer with the court clerk. If the defendant notifies the clerk that he accepts the offer, the clerk must enter judgment.

Regarding lawsuits that accrue after September 30, 2005, the bill makes several changes in this process. It reduces the interest the court must add from 12% to 8%. It prohibits the plaintiff from making the offer for at least 180 days after service of process on the defendant. It changes the terminology from “offer of judgment” to “offer of compromise,” and gives the defendant 30 instead of 60 days to accept.

If the defendant accepts the offer, he must file his acceptance with the court clerk. After the plaintiff receives the amount specified in the offer from the defendant, he must file a withdrawal of the lawsuit with the clerk, which the clerk must record. Thus, no judgment is entered against the defendant.

By law, defendants may also file an offer with the court clerk up to 30 days before trial. The plaintiff has 10 days after being notified of the defendant’s offer to accept it. If the plaintiff recovers less than the offer of judgment, he must pay the defendant’s costs accruing after he received his offer, including reasonable attorney’s fees up to \$300.

The bill changes the term “offer of judgment” to “offer of compromise” for this law also, and after the plaintiff files an acceptance with the clerk and receives the amount specified in the offer, the plaintiff must file a withdrawal of the lawsuit with the clerk, who must record its withdrawal.

### ***Medical Malpractice Cases***

The bill requires that, in medical malpractice cases, an offer of compromise must specify all damages then known to the plaintiff or his attorney when the offer is made. Sixty days before filing the offer,

the plaintiff or his attorney must provide the defendant or his attorney with an authorization to disclose medical records that meets federal health care privacy provisions under the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA), and disclose all expert witnesses who will testify as to the prevailing professional standard of care. The plaintiff must file with the court a certification that the plaintiff has provided each defendant or his attorney with all documentation supporting the damages.

### **PRIOR MALPRACTICE INSURANCE RATE APPROVAL (§ 7)**

The bill subjects malpractice insurance rates for physicians, hospitals, advanced practice registered nurses, and physician assistants to prior rate approval by the insurance commissioner. On and after the bill's effective date, each insurer or rating organization seeking to increase its rates by 5% (but not more) must file a request with the Insurance Department and send written notice to all affected insureds at least 60 days before the change's effective date.

The request for a rate increase must be filed after this notice is sent and must indicate the date the notice was sent. The notice must indicate that the insured can request a public hearing by submitting a written request to the insurance commissioner within 15 days after the notice date. (Apparently the notice date is the date the insurers sent the notice.)

The bill prohibits the insurance commissioner from approving, modifying, or denying a requested rate increase until at least 15 days after the notice date as indicated in the filing. It requires the commissioner to hold a public hearing, if requested, before taking action.

The commissioner must approve, modify, or deny the filing within 45 days after receipt. If a hearing was not previously held, a person or insurer aggrieved by her decision may submit a written request for a hearing to the insurance commissioner within 30 days of the decision. The commissioner must hold a hearing within 20 days of receiving the request and give at least 10 days notice of the time and place for it. The commissioner must affirm, reverse, or modify her previous decision within 15 days of the hearing, specifying the reasons for her action. While the hearing and outcome is pending, the commissioner can suspend or postpone the effective date of her previous decision. Her

final decision may be appealed to Superior Court.

### **DPH INVESTIGATION GUIDELINES CONCERNING COMPLAINTS AGAINST PHYSICIANS (§ 8)**

Under current law, the DPH commissioner, with the Connecticut Medical Examining Board's advice and assistance, may establish regulations to carry out his physician licensing duties. The bill instead requires the commissioner to establish guidelines to carry out these duties, and requires that, by October 1, 2005, they include guidelines:

1. for screening complaints about physicians' competence to determine which complaints DPH will investigate and in what order;
2. for setting priorities and conducting investigations to ensure prompt action when it appears necessary;
3. to determine when an investigation should be broadened to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations, and additional interviews of patients; and
4. to protect and ensure the confidentiality of patient and provider identities when an investigation is broadened.

### **DPH DISCIPLINARY GUIDELINES AGAINST DOCTORS (§ 9)**

The 15-member Connecticut Medical Examining Board may restrict, suspend, or revoke a physician's license or limit his right to practice for certain misconduct. The bill requires that, by October 1, 2005, the board, with DPH's assistance, adopt guidelines for use in the disciplinary process. The guidelines must include, at a minimum:

1. identification of each type of violation;
2. a range of penalties for each type of violation;
3. additional conditions that the board may impose;
4. identification of factors the board must consider to determine if the maximum or minimum penalty should apply;

5. conditions, such as mitigating factors or other facts, that the board may consider in deviating from the guidelines; and
6. a requirement for specifying the reason for any deviation from the guidelines.

### **PRE-SURGICAL PROTOCOLS (§ 10)**

The bill requires each health care facility to develop protocols for accurate identification procedures that hospitals and outpatient surgical facilities must use before surgery. The protocols must include (1) procedures to identify the patient, the surgical procedure to be performed, and the body part on which it is to be performed and (2) alternative identification procedures in urgent or emergency circumstances or where the patient cannot speak or is comatose, incompetent, or a child. After October 1, 2005, no hospital or outpatient surgical facility may anesthetize a patient or perform surgery unless the protocols have been followed. Each health care facility must make a copy of its protocols available to the commissioner upon request. DPH must report to the Public Health Committee by October 1, 2005 and describe the protocols developed.

### **INSURANCE COMMISSIONER REVIEW OF MALPRACTICE INSURANCE RATES (§11)**

By October 1, 2008, the bill requires the insurance commissioner to review medical malpractice insurance rates in Connecticut for physicians, hospitals, advanced practice registered nurses, and physicians' assistants to determine if they have decreased, and whether they bear a reasonable relationship to the costs of writing such insurance in this state. She must examine the rates for policies issued by (1) captive insurers and risk retention groups, to the extent this information is available, and (2) insurers licensed in Connecticut.

If the commissioner determines that rates have not decreased and are not reasonably related to the costs of writing such insurance, she must convene a working group to recommend appropriate changes in the law to decrease rates or establish reasonable ones. These changes may include reasonable limits on noneconomic damages awards, revisions to procedures insurers use to establish rates, and regulation of reimbursement rates health insurers and health care centers pay to health care providers.

The working group must consist of:

1. the chairmen and ranking members of the Judiciary, Public Health, Insurance and Real Estate, and the Legislative Program Review and Investigations committees;
2. one member each appointed by the Connecticut Medical Society, the Connecticut Hospital Association, the Connecticut Bar Association, the Connecticut Trial Lawyers Association;
3. one representative of a patient advocacy group appointed by the insurance commissioner;
4. the commissioner of the Office of Health Care Access, or a designee; and
5. the insurance commissioner.

**PLAN TO MAINTAIN A VIABLE MEDICAL MALPRACTICE INSURANCE INDUSTRY (§ 12)**

By October 1, 2005, the insurance commissioner must develop and submit to the governor a plan to maintain a viable medical malpractice insurance industry in Connecticut for physicians, hospitals, advanced practice registered nurses, and physician assistants.

**PHYSICIAN PROFILES (§15 & 16)**

The bill amends DPH's physician profile program to require physicians to report adverse licensure actions taken in other states. Current law only requires them to report only disciplinary action taken by DPH or the State Medical Examining Board. The bill also requires the physician to report, for the first time, (1) whether he is actively involved in patient care and (2) the name of his professional liability insurance carrier.

Current law requires the physician periodically to update certain information in his profile about practice specialty, board certifications, practice location, languages spoken, hospital and nursing home privileges, and any felony convictions. The bill requires periodic updating of all physician profile elements, including hospital

disciplinary actions, medical malpractice judgments, arbitration awards, and settlements.

## **CONTINUING EDUCATION (§§13 & 17)**

### ***Requirements and Acceptable Education and Activities***

Beginning October 1, 2007, the bill requires a physician applying for license renewal to have completed at least 50 contact hours of continuing education during the previous 24 months. A “contact hour” means a minimum of 50 minutes of continuing education activity. It must (1) be in the physician’s practice area; (2) reflect the physician’s professional needs in order to meet the public’s health care needs; and (3) include at least one contact hour of training or education in infectious diseases (e.g. AIDS, HIV), risk management, sexual assault, and domestic violence.

Acceptable continuing medical education includes 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 bodies in other jurisdictions; education sponsored by hospitals and other health institutions; and courses offered by regionally accredited academic institutions.

### ***Attesting to Continuing Education When Renewing a License***

A physician applying for license renewal must sign a statement that he satisfied the continuing education requirements. The physician must keep attendance records or certificates of completion showing compliance with the continuing education requirements for at least three years following the year in which they were completed. He must provide the records to DPH for inspection within 45 days after a request is made.

### ***Exemptions***

A first-time applicant for license renewal is exempt from the continuing education requirements. Also exempt is a physician not actively practicing during a one-year registration (license renewal) if he provides DPH, before the registration period ends, a notarized application for exemption on a DPH form. DPH may require other documentation. The exemption application must include a statement

that the physician cannot practice until he meets the continuing education requirements. The bill specifies that “active professional practice” includes the activities of a licensed physician who functions as the medical director of a managed care or other organization.

A physician exempt from the continuing education requirements for less than two years must complete 25 contact hours of continuing education within the 12 months immediately preceding his return to active practice. A physician exempt for two or more years must complete the Special Purpose Examination of the Federation of State Medical Boards before returning to active practice.

### ***Medical Disability or Illness Waiver***

The bill allows the DPH commissioner to waive the continuing education requirements or grant an extension to a physician in the case of medical disability or illness. The physician must apply to DPH for a waiver or extension on a DPH form and provide a licensed physician’s certification of the disability or illness, as well as other documentation the commissioner may require. DPH can grant a waiver or extension for up to one registration period. It can grant additional waivers or extensions if the disability or illness continues beyond that period and the physician applies for the additional waiver or extension.

### ***Failure to Renew License***

A physician whose license lapses and who applies for reinstatement must document to DPH successful completion of the 25-hour continuing education requirement within the one-year preceding the application.

### **PHYSICIANS IN THE ARMED FORCES (§ 13)**

Under the bill, DPH must renew the license of a physician that becomes void for nonrenewal because he is on active duty in the armed forces within one year from the discharge date upon completion of the 25 contact hours of continuing education. The physician must apply to DPH and provide any documentation required. Under current law, DPH must renew a license in such a situation within six months from the discharge date.

### **MEDICAL MALPRACTICE DATA BASE-CLOSED CLAIM REPORTS (§ 18)**

***Closed Claim Reports***

Current law authorizes the insurance commissioner to require all medical malpractice insurers in Connecticut to submit whatever information she deems necessary to establish a medical malpractice database. The database can include 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.

The bill instead requires, beginning January 1, 2006, each insurer (including captive insurers and self-insured entities) provide to the commissioner a closed claim report, on whatever form she requires. A "closed claim" is one that has been settled or otherwise disposed of, where the insurer has paid all claims regarding physicians, hospitals, advanced practice registered nurses, and physician assistants.

The bill requires the insurer to report within 10 days after the end of the calendar quarter in which a claim is closed. The report must include information only about claims settled under Connecticut's laws. It must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid on the claim.

***Details About the Insured and Insurer***

The report must include the (1) insurer's name; (2) policy limits and whether it was an occurrence policy or was issued on a claims-made basis; (3) insured's name, address, license number, and specialty coverage; and (4) insured's policy number and unique claim number. An "occurrence policy" provides protection for malpractice that occurred during the time the policy was in effect. A "claims-made" policy provides protection for claims made during the period the policy is in effect.

***Details About the Injury or Loss***

The report must specify the

1. date of the injury or loss that was the basis of the claim;
2. date the injury or loss was reported to the insurer;

3. name of the institution or location where the injury or loss occurred;
4. type of injury or loss, including a severity of injury rating that corresponds with the injury scale that the commissioner must establish based on the severity scale developed by the National Association of Insurance Commissioners; and
5. name, age, and gender of any injured person covered by the claim.

Any individually identifiable information (as defined by federal regulation) is confidential. The bill specifies that reporting this information is required by law. It requires that if necessary to comply with federal privacy laws, the insured must arrange with the insurer to release the required information.

### ***Details About the Claims Process***

The bill specifies that details about the claims process include

1. whether a lawsuit was filed, and if so, in which court;
2. its outcome;
3. the number of other defendants, if any;
4. the stage in the process when the claim was closed;
5. the trial dates;
6. the date of any judgment or settlement;
7. whether an appeal was filed, and if so, the date filed;
8. the resolution of the appeal and the date it was decided;
9. the date the claim was closed; and
10. the initial and final initial indemnity and expense reserve for the claim.

### ***Details About the Amount Paid on the Claim***

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The report must include:

1. the total amount of the initial judgment rendered by a jury or awarded by the court;
2. the total amount of the settlement if no judgment was rendered or awarded or the claim was settled after judgment was rendered or awarded;
3. the amount of economic and noneconomic damages, or the insurer's estimate of these amounts in a settlement;
4. the amount of any interest awarded due to failure to accept an offer of judgment;
5. the amount of any remittitur (reduction) or additur (addition) and the amount of final judgment after such reductions or additions;
6. the amount the insurer paid;
7. the amount the defendant paid due to a deductible or a judgment or settlement in excess of policy limits;
8. the amount other insurers or other defendants paid;
9. whether a structured settlement was used;
10. the expense assigned to and recorded with the claim, including defense and investigation costs but not including the actual claim payment; and
11. any other information the commissioner determines necessary to regulate the medical malpractice insurance industry, ensure its solvency, and ensure that such liability insurance is available and affordable.

The bill requires the commissioner to establish, within available appropriations, a closed claim reports electronic database.

### ***Annual Data Summary***

The bill requires the insurance commissioner, within available appropriations, to aggregate the data in individual closed claim reports into a summary and annually report the summary data. The report must analyze the closed claim information, including

1. a minimum of five years of comparative data, when available;
2. trends in frequency and severity of claims;
3. itemization of damages;
4. timeliness of the claims process; and
5. any other descriptive or analytical information that would help interpret the trends in closed claims.

The annual report must include a summary of rate filings for medical malpractice insurance for medical professionals and entities that the department approved for the prior calendar year. The summary must include an analysis of the trend of direct losses, incurred losses, earned premiums, and investment income as compared to prior years. The report must also include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

Beginning March 15, 2007, the commissioner must annually submit the report to the Insurance and Real Estate Committee. She must also (1) make the report available to the public, (2) post it on the department's Internet site, and (3) provide public access to the contents of the electronic database after establishing that the names and other individually identifiable information about claimants and practitioners have been removed.

The bill requires the commissioner to provide the DPH commissioner with electronic access to all the closed case information she receives. It also requires the DPH commissioner to keep such information as confidential as the law requires the insurance commissioner to do.

### **CAPTIVE INSURERS (§§ 19 AND 20)**

A "captive insurer" is an insurance company owned by another

organization and whose primary purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, it is an insurance organization owned by the insureds whose primary purpose is to insure risks of member organizations, group members, and their affiliates.

The bill requires each captive insurer that offers, renews, or continues insurance in Connecticut to provide the following information to the insurance commissioner in the same manner required for risk retention groups:

1. a copy of the group's financial statement submitted to its state of domicile, which must be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist;
2. a copy of each examination of the captive as certified by the commissioner or public official conducting the examination; and
3. at the commissioner's request, a copy of any audit performed with respect to the captive.

If a captive insurer does not maintain this information in this form, the bill permits it to submit the information to the commissioner on whatever form she prescribes.

The bill requires the commissioner to act as agent for service of process for risk retention groups domiciled outside the United States and for captive insurers. By law, the commissioner acts as agent for risk retention groups domiciled in another state that offer insurance in Connecticut.

### **COMPLEX LITIGATION CASE (§ 21)**

The bill requires the court, within six months after a medical malpractice case is filed, to schedule a conference to determine whether to recommend to the chief court administrator, or his designee, that it be designated as a complex litigation case and transferred to the complex litigation docket. The bill specifies that it

does not prevent any party or a judge from, at any time, asking the chief court administrator to designate it as a complex litigation case.

## **EXPRESSIONS OF SYMPATHY (§ 22)**

The bill makes certain statements or other conduct inadmissible evidence as an admission of liability or an admission against interest in any lawsuit, or in any arbitration proceeding related to it. This rule applies to statements, affirmations, gestures, or conduct expressing apology, fault, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that a health care provider or his employee makes to the alleged victim, his relative, or representative regarding the victim's discomfort, pain, suffering, injury, or death as a result of the outcome of a medical treatment or procedure that differs from an expected result.

The victim's relatives include his spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half-sibling, or his spouse's parents; relationships that are created by adoption; and any person who has a family-type relationship with a victim. A victim's representative is his legal guardian, attorney, health care agent, or any one else recognized in law or custom as a his agent.

## **BACKGROUND**

### ***"Similar Health Care Provider"***

By law, if the defendant health care provider is not certified by the appropriate American board as a specialist, is not trained and experienced in a medical specialty, or does not hold himself out as a specialist, a "similar health care provider" is one who is (1) licensed by the appropriate regulatory agency of this state or another state requiring the same or greater qualifications and (2) trained and experienced in the same discipline or school of practice. Such training and experience must be a result of active involvement in the practice or teaching of medicine within the five-year period before the incident giving rise to the claim.

If the defendant health care provider is certified by the appropriate American board as a specialist, is trained and experienced in a medical specialty, or holds himself out as a specialist, a "similar health care provider" is one who is (1) trained and experienced in the same specialty and (2) certified by the appropriate American board in the

same specialty. But, if the defendant health care provider is providing treatment or diagnosis for a condition that is not within his specialty, a similar health care provider is a specialist trained in the treatment or diagnosis of that condition.

### ***Sanctions if Certificate Not Filed in Good Faith***

By law, the court must impose an appropriate sanction on the person who signed the certificate if it determines, after discovery is completed, that the certificate was not made in good faith and that no valid issue was presented against a health care provider who fully cooperated in providing informal discovery. It may also sanction the claimant. The sanction may include an order to pay to the other party or parties the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee. The court also may submit the matter to the appropriate authority for disciplinary review of a claimant's attorney who submitted the certificate.

### ***Licensed Health Care Providers and Institutions***

The provisions of the bill relating to expressions of sympathy, apply to medical malpractice lawsuits filed against the following licensed health care providers:

1. doctors and surgeons,
2. chiropractors,
3. natureopaths,
4. podiatrists,
5. athletic trainers,
6. physical and occupational therapists,
7. substance abuse counselors,
8. radiographers and radiologic technologists,
9. midwives,

10. nurses and nurses aides,
11. dentists and dental hygienists,
12. optometrists and opticians,
13. respiratory care practitioners,
14. pharmacists,
15. psychologists,
16. marital therapists and professional counselors,
17. clinical social workers,
18. veterinarians,
19. massage therapists,
20. electrologists,
21. hearing instrument specialists and audiologists,
22. ambulance drivers, and
23. emergency medical technicians and communications personnel.

The provisions also apply to the following health care institutions: hospitals; outpatient surgical facilities; residential care homes; health care facilities for the handicapped; nursing homes; rest homes; home health and homemaker-home health aide agencies; mental health and substance abuse treatment facilities; college infirmaries; diagnostic and treatment facilities, including those operated and maintained by a state agency, except facilities for the care or treatment of mentally ill or substance abusing people; and intermediate care facilities for the mentally retarded.

***Related Bill***

sHB 6714, File 466 contains almost identical requirements concerning physician profiles, continuing education, and physicians in the armed

forces.

**COMMITTEE ACTION**

Judiciary Committee

Joint Favorable Substitute

Yea 39    Nay 1