



General Assembly

January Session, 2005

Amendment

LCO No. 7695

SB0105207695SD0

Offered by:

SEN. WILLIAMS, 29th Dist.
SEN. LOONEY, 11th Dist.
SEN. MCDONALD, 27th Dist.
SEN. MURPHY, 16th Dist.
SEN. CRISCO, 17th Dist.
SEN. FINCH, 22nd Dist.
SEN. KISSEL, 7th Dist.
SEN. DUFF, 25th Dist.
SEN. HARP, 10th Dist.
SEN. STILLMAN, 20th Dist.
SEN. LEBEAU, 3rd Dist.
SEN. HARRIS, 5th Dist.
SEN. CIOTTO, 9th Dist.
SEN. COLEMAN, 2nd Dist.
SEN. HANDLEY, 4th Dist.
SEN. SLOSSBERG, 14th Dist.
SEN. PRAGUE, 19th Dist.
SEN. FONFARA, 1st Dist.
SEN. MEYER, 12th Dist.
SEN. RORABACK, 30th Dist.
SEN. NEWTON, 23rd Dist.
SEN. COLAPIETRO, 31st Dist.
SEN. FASANO, 34th Dist.
REP. AMANN, 118th Dist.
REP. DONOVAN, 84th Dist.
REP. LAWLOR, 99th Dist.

REP. SAYERS, 60th Dist.
REP. FRITZ, 90th Dist.
REP. GODFREY, 110th Dist.
REP. KIRKLEY-BEY, 5th Dist.
REP. SPALLONE, 36th Dist.
REP. BARRY, 12th Dist.
REP. DOYLE, 28th Dist.
REP. WASSERMAN, 106th Dist.
REP. NARDELLO, 89th Dist.
REP. SERRA, 33rd Dist.
REP. JANOWSKI, 56th Dist.
REP. SHARKEY, 88th Dist.
REP. LEONE, 148th Dist.
REP. FOX, 146th Dist.
REP. BEAMON, 72nd Dist.
REP. MCCLUSKEY, 20th Dist.
REP. HAMM, 34th Dist.
REP. GERAGOSIAN, 25th Dist.
REP. CHRIST, 11th Dist.
REP. DARGAN, 115th Dist.
REP. TALLARITA, 58th Dist.
REP. MANTILLA, 4th Dist.
REP. DIAMANTIS, 79th Dist.
REP. KEELEY, 129th Dist.
REP. CARDIN, 53rd Dist.

To: Subst. Senate Bill No. 1052

File No. 554

Cal. No. 412

"AN ACT CONCERNING MEDICAL MALPRACTICE."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

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 Section 52-251c of the general statutes is repealed and the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

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

15 (b) In any such contingency fee [arrangement] agreement such fee
16 shall be the exclusive method for payment of the attorney by the
17 claimant and shall not exceed an amount equal to a percentage of the
18 damages awarded and received by the claimant or of the settlement
19 amount received by the claimant as follows: (1) Thirty-three and one-
20 third per cent of the first three hundred thousand dollars; (2) twenty-
21 five per cent of the next three hundred thousand dollars; (3) twenty per
22 cent of the next three hundred thousand dollars; (4) fifteen per cent of
23 the next three hundred thousand dollars; and (5) ten per cent of any
24 amount which exceeds one million two hundred thousand dollars.

25 (c) Notwithstanding the provisions of subsection (b) of this section,
26 a claimant may waive the percentage limitations of said subsection if
27 the claim or civil action is so substantially complex, unique or different

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

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

53 (e) No waiver of the percentage limitations of subsection (b) of this
54 section shall be valid unless the contingency fee agreement (1) is in
55 writing, (2) sets forth in full the fee schedule of subsection (b) of this
56 section, (3) contains a conspicuous statement, printed in boldface type
57 at least twelve points in size, in substantially the following form: "I
58 UNDERSTAND THAT THE FEE SCHEDULE SET FORTH IN
59 SECTION 52-251c OF THE CONNECTICUT GENERAL STATUTES
60 LIMITS THE AMOUNT OF ATTORNEY'S FEES PAYABLE BY A
61 CLAIMANT AND THAT THE STATUTE WAS INTENDED TO

62 INCREASE THE PORTION OF THE JUDGMENT OR SETTLEMENT
63 THAT WAS ACTUALLY RECEIVED BY A CLAIMANT.
64 NOTWITHSTANDING THAT THE LEGISLATIVE INTENT IN
65 ENACTING THAT FEE SCHEDULE WAS TO CONFER A BENEFIT
66 ON A CLAIMANT LIKE MYSELF, I KNOWINGLY AND
67 VOLUNTARILY WAIVE THAT FEE SCHEDULE IN THIS CLAIM OR
68 CIVIL ACTION.", and (4) is signed and acknowledged by the claimant
69 before a notary public or other person authorized to take
70 acknowledgments.

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

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

84 [(c)] (h) For the purposes of this section, "damages awarded and
85 received" means in a civil action in which final judgment is entered,
86 that amount of the judgment or amended judgment entered by the
87 court that is received by the claimant; [, except that in a civil action
88 brought pursuant to section 38a-368 such amount shall be reduced by
89 any basic reparations benefits paid to the claimant pursuant to section
90 38a-365;] "settlement amount received" means in a claim or civil action
91 in which no final judgment is entered, the amount received by the
92 claimant pursuant to a settlement agreement; [, except that in a claim
93 or civil action brought pursuant to section 38a-368 such amount shall
94 be reduced by any basic reparations benefits paid to the claimant

95 pursuant to section 38a-365;] and "fee" shall not include disbursements
96 or costs incurred in connection with the prosecution or settlement of
97 the claim or civil action, other than ordinary office overhead and
98 expense.

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

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

109 (a) No civil action or apportionment complaint shall be filed to
110 recover damages resulting from personal injury or wrongful death
111 occurring on or after October 1, 1987, whether in tort or in contract, in
112 which it is alleged that such injury or death resulted from the
113 negligence of a health care provider, unless the attorney or party filing
114 the action or apportionment complaint has made a reasonable inquiry
115 as permitted by the circumstances to determine that there are grounds
116 for a good faith belief that there has been negligence in the care or
117 treatment of the claimant. The complaint, [or] initial pleading or
118 apportionment complaint shall contain a certificate of the attorney or
119 party filing the action or apportionment complaint that such
120 reasonable inquiry gave rise to a good faith belief that grounds exist
121 for an action against each named defendant or for an apportionment
122 complaint against each named apportionment defendant. [For the
123 purposes of this section, such good faith may be shown to exist if the
124 claimant or his attorney has received a written opinion, which shall not
125 be subject to discovery by any party except for questioning the validity
126 of the certificate,] To show the existence of such good faith, the
127 claimant or the claimant's attorney, and any apportionment

128 complainant or the apportionment complainant's attorney, shall obtain
129 a written and signed opinion of a similar health care provider, as
130 defined in section 52-184c, which similar health care provider shall be
131 selected pursuant to the provisions of said section, that there appears
132 to be evidence of medical negligence and includes a detailed basis for
133 the formation of such opinion. Such written opinion shall not be
134 subject to discovery by any party except for questioning the validity of
135 the certificate. The claimant or the claimant's attorney, and any
136 apportionment complainant or apportionment complainant's attorney,
137 shall retain the original written opinion and shall attach a copy of such
138 written opinion, with the name and signature of the similar health care
139 provider expunged, to such certificate. The similar health care
140 provider who provides such written opinion shall not, without a
141 showing of malice, be personally liable for any damages to the
142 defendant health care provider by reason of having provided such
143 written opinion. In addition to such written opinion, the court may
144 consider other factors with regard to the existence of good faith. If the
145 court determines, after the completion of discovery, that such
146 certificate was not made in good faith and that no justiciable issue was
147 presented against a health care provider that fully cooperated in
148 providing informal discovery, the court upon motion or upon its own
149 initiative shall impose upon the person who signed such certificate or a
150 represented party, or both, an appropriate sanction which may include
151 an order to pay to the other party or parties the amount of the
152 reasonable expenses incurred because of the filing of the pleading,
153 motion or other paper, including a reasonable attorney's fee. The court
154 may also submit the matter to the appropriate authority for
155 disciplinary review of the attorney if the claimant's attorney or the
156 apportionment complainant's attorney submitted the certificate.

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

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

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

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

181 (a) After commencement of any civil action based upon contract or
182 seeking the recovery of money damages, whether or not other relief is
183 sought, the plaintiff may, not earlier than one hundred eighty days
184 after service of process is made upon the defendant in such action but
185 not later than thirty days before trial, file with the clerk of the court a
186 written ["offer of judgment"] offer of compromise signed by the
187 plaintiff or the plaintiff's attorney, directed to the defendant or the
188 defendant's attorney, offering to settle the claim underlying the action
189 [and to stipulate to a judgment] for a sum certain. The plaintiff shall
190 give notice of the offer of [settlement] compromise to the defendant's
191 attorney or, if the defendant is not represented by an attorney, to the
192 defendant himself or herself. Within [sixty] thirty days after being
193 notified of the filing of the ["offer of judgment"] offer of compromise
194 and prior to the rendering of a verdict by the jury or an award by the

195 court, the defendant or the defendant's attorney may file with the clerk
196 of the court a written ["acceptance of offer of judgment"] acceptance of
197 the offer of compromise agreeing to [a stipulation for judgment as
198 contained] settle the claim underlying the action for the sum certain
199 specified in the plaintiff's ["offer of judgment"] offer of compromise.
200 Upon such filing [,] and the receipt by the plaintiff of such sum certain,
201 the plaintiff shall file a withdrawal of the action with the clerk and the
202 clerk shall [enter judgment immediately on the stipulation] record the
203 withdrawal of the action against the defendant accordingly. If the
204 ["offer of judgment"] offer of compromise is not accepted within [sixty]
205 thirty days and prior to the rendering of a verdict by the jury or an
206 award by the court, the ["offer of judgment"] offer of compromise shall
207 be considered rejected and not subject to acceptance unless refiled.
208 Any such ["offer of judgment"] offer of compromise and any
209 ["acceptance of offer of judgment"] acceptance of the offer of
210 compromise shall be included by the clerk in the record of the case.

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

228 [(b)] (c) After trial the court shall examine the record to determine

229 whether the plaintiff made an ["offer of judgment"] offer of
230 compromise which the defendant failed to accept. If the court
231 ascertains from the record that the plaintiff has recovered an amount
232 equal to or greater than the sum certain [stated] specified in the
233 plaintiff's ["offer of judgment"] offer of compromise, the court shall
234 add to the amount so recovered [twelve] eight per cent annual interest
235 on said amount. [, computed from the date such offer was filed in
236 actions commenced before October 1, 1981. In those actions
237 commenced on or after October 1, 1981, the] The interest shall be
238 computed from the date the complaint in the civil action was filed with
239 the court if the ["offer of judgment"] offer of compromise was filed not
240 later than eighteen months from the filing of such complaint. If such
241 offer was filed later than eighteen months from the date of filing of the
242 complaint, the interest shall be computed from the date the ["offer of
243 judgment"] offer of compromise was filed. The court may award
244 reasonable attorney's fees in an amount not to exceed three hundred
245 fifty dollars, and shall render judgment accordingly. This section shall
246 not be interpreted to abrogate the contractual rights of any party
247 concerning the recovery of attorney's fees in accordance with the
248 provisions of any written contract between the parties to the action.

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

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

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

262 In any action, the plaintiff may, within [ten] sixty days after being
263 notified by the defendant of the filing of an offer of [judgment]
264 compromise, file with the clerk of the court a written acceptance of the
265 offer signed by [himself or his] the plaintiff or the plaintiff's attorney
266 agreeing to settle the underlying action for the sum certain specified in
267 the defendant's offer of compromise. Upon the filing of the written
268 acceptance [, the court shall render judgment against the defendant as
269 upon default for the sum so named and for the costs accrued at the
270 time of the defendant's giving the plaintiff notice of the offer] and
271 receipt by the plaintiff of such sum certain, the plaintiff shall file a
272 withdrawal of the action with the clerk of the court and the clerk shall
273 record the withdrawal of the action against the defendant accordingly.
274 No trial may be postponed because the period within which the
275 plaintiff may accept the offer has not expired, except at the discretion
276 of the court.

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

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

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

291 (c) This section shall not be interpreted to abrogate the contractual
292 rights of any party concerning the recovery of attorney's fees in
293 accordance with the provisions of any written contract between the

294 parties to the action. The provisions of this section shall not apply to
295 cases in which nominal damages have been assessed upon a hearing
296 after a default or after a demurrer has been overruled.

297 Sec. 8. (NEW) (*Effective October 1, 2005, and applicable to actions*
298 *accruing on or after said date*) (a) For the purposes of this section:

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

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

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

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

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

321 (2) "Relative" means a victim's spouse, parent, grandparent,
322 stepfather, stepmother, child, grandchild, brother, sister, half brother,
323 half sister or spouse's parents, and includes such relationships that are

324 created as a result of adoption and any person who has a family-type
325 relationship with a victim;

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

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

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

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

356 order a new trial. For the purposes of this section, "health care
357 provider" means a provider, as defined in subsection (b) of section 20-
358 7b of the general statutes, or an institution, as defined in section 19a-
359 490 of the general statutes.

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

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

381 (b) (1) Each filing [as] described in subsection (a) of this section for
382 workers' compensation or employers' liability insurance shall be on file
383 with the Insurance Commissioner for a waiting period of thirty days
384 before it becomes effective, which period may be extended by the
385 commissioner for an additional period not to exceed thirty days if the
386 commissioner gives written notice within such waiting period to the
387 insurer or rating organization which made the filing that the
388 commissioner needs such additional time for the consideration of such

389 filing. Upon written application by such insurer or rating organization,
390 the commissioner may authorize a filing which the commissioner has
391 reviewed to become effective before the expiration of the waiting
392 period or any extension thereof. A filing shall be deemed to meet the
393 requirements of sections 38a-663 to 38a-696, inclusive, unless
394 disapproved by the commissioner within the waiting period or any
395 extension thereof. If, within the waiting period or any extension
396 thereof, the commissioner finds that a filing does not meet the
397 requirements of said sections, the commissioner shall send to the
398 insurer or rating organization which made such filing written notice of
399 disapproval of such filing, specifying therein in what respects the
400 commissioner finds such filing fails to meet the requirements of said
401 sections and stating that such filing shall not become effective. Such
402 finding of the commissioner shall be subject to review as provided in
403 section 38a-19.

404 (2) (A) Each filing described in subsection (a) of this section for
405 professional liability insurance for physicians and surgeons, hospitals,
406 advanced practice registered nurses or physician assistants shall be
407 subject to prior rate approval in accordance with this section. On and
408 after the effective date of this section, each insurer or rating
409 organization seeking to increase its rates over the rates in the insurer's
410 previous filing for such insurance by seven and one-half per cent or
411 more shall (i) file a request for such change with the Insurance
412 Commissioner, and (ii) send written notice of any request for an
413 increase in rates to insureds who would be subject to the increase on
414 such form as the commissioner prescribes by certified mail, return
415 receipt requested. Such request shall be filed and such notice shall be
416 sent at least sixty days prior to the proposed effective date of the
417 increase. The notice to insureds of a request for an increase in rates
418 shall indicate that the insured may request a public hearing by
419 submitting a written request to the Insurance Commissioner not later
420 than fifteen days after the date notice was sent. Any request for an
421 increase in rates under this subdivision shall be filed after notice is sent
422 to insureds and shall indicate the date such notice was sent. Not later

423 than fifteen days after such notice is sent, the insurer shall submit a list
424 to the commissioner indicating the name of each insured to whom
425 notice was sent and whether a return receipt was received for the
426 notice sent to the insured.

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

436 (c) The form of any insurance policy or contract the rates for which
437 are subject to the provisions of sections 38a-663 to 38a-696, inclusive,
438 other than fidelity, surety or guaranty bonds, and the form of any
439 endorsement modifying such insurance policy or contract, shall be
440 filed with the Insurance Commissioner prior to its issuance. The
441 commissioner shall adopt regulations₂ in accordance with the
442 provisions of chapter 54₂ establishing a procedure for review of such
443 policy or contract. If at any time the commissioner finds that any such
444 policy, contract or endorsement is not in accordance with such
445 provisions or any other provision of law, the commissioner shall issue
446 an order disapproving the issuance of such form and stating the
447 reasons for disapproval. The provisions of section 38a-19 shall apply to
448 any such order issued by the commissioner.

449 Sec. 12. (NEW) (*Effective October 1, 2005*) (a) Not earlier than October
450 1, 2008, the Insurance Commissioner shall review professional liability
451 insurance rates in this state for physicians and surgeons, hospitals,
452 advanced practice registered nurses and physicians assistants to
453 determine whether (1) the amount or frequency of insured awards
454 and settlements against physicians and surgeons, hospitals, advanced
455 practice registered nurses and physicians assistance have decreased

456 since October 1, 2005, (2) such rates reflect any such decrease, and (3)
457 such rates bear a reasonable relationship to the costs of writing such
458 insurance in this state. In conducting the review, the commissioner
459 shall examine the rates for such insurance under policies issued by (A)
460 captive insurers and risk retention groups, to the extent such
461 information is available to the commissioner, and (B) insurers licensed
462 in this state.

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

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

480 (1) The chairpersons and ranking members, or their designees, of
481 (A) the joint standing committees of the General Assembly having
482 cognizance of matters relating to the judiciary, public health and
483 insurance, and (B) the Legislative Program Review and Investigations
484 Committee;

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

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

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

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

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

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

496 (8) The Insurance Commissioner.

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

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

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

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

515 (a) As used in this section:

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

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

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

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

533 (c) The closed claim report shall include:

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

540 (2) Details about the injury or loss, including: (A) The date of the
541 injury or loss that was the basis of the claim; (B) the date the injury or
542 loss was reported to the insurer; (C) the name of the institution or
543 location at which the injury or loss occurred; (D) the type of injury or
544 loss, including a severity of injury rating that corresponds with the
545 severity of injury scale that the Insurance Commissioner shall establish
546 based on the severity of injury scale developed by the National

547 Association of Insurance Commissioners; and (E) the name, age and
548 gender of any injured person covered by the claim. Any individually
549 identifiable health information, as defined in 45 CFR 160.103, as from
550 time to time amended, submitted pursuant to this subdivision shall be
551 confidential. The reporting of the information is required by law. If
552 necessary to comply with federal privacy laws, including the Health
553 Insurance Portability and Accountability Act of 1996, (P.L. 104-191)
554 (HIPAA), as from time to time amended, the insured shall arrange
555 with the insurer to release the required information.

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

565 (4) Details about the amount paid on the claim, including: (A) The
566 total amount of the initial judgment rendered by a jury or awarded by
567 the court; (B) the total amount of the settlement if there was no
568 judgment rendered or awarded; (C) the total amount of the settlement
569 if the claim was settled after judgment was rendered or awarded; (D)
570 the amount of economic damages, as defined in section 52-572h, or the
571 insurer's estimate of the amount in the event of a settlement; (E) the
572 amount of noneconomic damages, as defined in section 52-572h, or the
573 insurer's estimate of the amount in the event of a settlement; (F) the
574 amount of any interest awarded due to the failure to accept an offer of
575 judgment or compromise; (G) the amount of any remittitur or additur;
576 (H) the amount of final judgment after remittitur or additur; (I) the
577 amount paid by the insurer; (J) the amount paid by the defendant due
578 to a deductible or a judgment or settlement in excess of policy limits;
579 (K) the amount paid by other insurers; (L) the amount paid by other
580 defendants; (M) whether a structured settlement was used; (N) the

581 expense assigned to and recorded with the claim, including, but not
582 limited to, defense and investigation costs, but not including the actual
583 claim payment; and (O) any other information the commissioner
584 determines to be necessary to regulate the professional liability
585 insurance industry with respect to physicians, surgeons, hospitals,
586 advanced practice registered nurses or physician assistants, ensure the
587 industry's solvency and ensure that such liability insurance is available
588 and affordable.

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

591 (2) The commissioner shall compile the data included in individual
592 closed claim reports into an aggregated summary format and shall
593 prepare a written annual report of the summary data. The report shall
594 provide an analysis of closed claim information including a minimum
595 of five years of comparative data, when available, trends in frequency
596 and severity of claims, itemization of damages, timeliness of the claims
597 process, and any other descriptive or analytical information that would
598 assist in interpreting the trends in closed claims.

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

608 (4) Not later than March 15, 2007, and annually thereafter, the
609 commissioner shall submit the annual report to the joint standing
610 committee of the General Assembly having cognizance of matters
611 relating to insurance in accordance with section 11-4a. The
612 commissioner shall also (A) make the report available to the public, (B)

613 post the report on its Internet site, and (C) provide public access to the
614 contents of the electronic database after the commissioner establishes
615 that the names and other individually identifiable information about
616 the claimant and practitioner have been removed.

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

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

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

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

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

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

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

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

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

640 (7) Except as provided by section 38a-273, unauthorized insurers or

641 other persons assisting unauthorized insurers who directly or
642 indirectly do any of the acts of insurance business as set forth in
643 subsection (a) of section 38a-271.

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

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

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

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

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

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

658 (14) Persons alleged to have violated any provision of section 38a-
659 130.

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

661 (b) Each foreign and alien insurer by applying for and receiving a
662 license to do insurance business in this state, each fraternal benefit
663 society by applying for and receiving a certificate to solicit members
664 and do business, each surplus lines insurer declared to be an eligible
665 surplus lines insurer by the commissioner, each insurance-support
666 organization transacting business outside this state which affects a
667 resident of this state, and each unauthorized insurer by doing an act of
668 insurance business prohibited by section 38a-272, is considered to have
669 irrevocably appointed the Insurance Commissioner as [his] agent for

670 receipt of service of process in accordance with subsection (a) of this
671 section. Such appointment shall continue in force so long as any
672 certificate of membership, policy or liability remains outstanding in
673 this state.

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

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

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

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

699 Sec. 17. (NEW) (*Effective October 1, 2005*) Not later than January 1,
700 2006, the Department of Public Health, with the advice and assistance
701 of the Connecticut Medical Examining Board, shall establish guidelines

702 for use in the disciplinary process. Such guidelines shall include, but
703 need not be limited to: (1) Identification of each type of violation; (2) a
704 range of penalties for each type of violation; (3) additional optional
705 conditions that may be imposed by the board for each violation; (4)
706 identification of factors the board shall consider in determining what
707 penalty should apply; (5) conditions, such as mitigating factors or
708 other facts, that may be considered in allowing deviations from the
709 guidelines; and (6) a provision that when a deviation from the
710 guidelines occurs, the reason for the deviation shall be identified. Such
711 guidelines shall not be considered regulations, as defined in section 4-
712 166 of the general statutes.

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

716 (c) The Commissioner of Public Health shall establish a list of
717 [eighteen] twenty-four persons who may serve as members of medical
718 hearing panels established pursuant to subsection (g) of this section.
719 Persons appointed to the list shall serve as members of the medical
720 hearing panels and provide the same services as members of the
721 Connecticut Medical Examining Board. Members from the list serving
722 on such panels shall not be voting members of the Connecticut
723 Medical Examining Board. The list shall consist of [eighteen] twenty-
724 four members appointed by the commissioner, at least eight of whom
725 shall be physicians, as defined in section 20-13a, with at least one of
726 such physicians being a graduate of a medical education program
727 accredited by the American Osteopathic Association, at least one of
728 whom shall be a physician assistant licensed pursuant to section 20-
729 12b, and nine of whom shall be members of the public. No professional
730 member of the list shall be an elected or appointed officer of a
731 professional society or association relating to such member's
732 profession at the time of appointment to the list or have been such an
733 officer during the year immediately preceding such appointment to the
734 list. A licensed professional appointed to the list shall be a practitioner
735 in good professional standing and a resident of this state. All vacancies

736 shall be filled by the commissioner. Successors and appointments to fill
737 a vacancy on the list shall possess the same qualifications as those
738 required of the member succeeded or replaced. No person whose
739 spouse, parent, brother, sister, child or spouse of a child is a physician,
740 as defined in section 20-13a, or a physician assistant, as defined in
741 section 20-12a, shall be appointed to the list as a member of the public.
742 Each person appointed to the list shall serve without compensation at
743 the pleasure of the commissioner. Each medical hearing panel shall
744 consist of three members, one of whom shall be a physician or
745 physician assistant, as appropriate, from the list established pursuant
746 to this subsection. At least one of the three members shall be a
747 member of the Connecticut Medical Examining Board. The public
748 member may be a member of the board or a member from the list
749 established pursuant to this subsection.

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

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

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

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

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

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

802 or concealment of a material fact in the obtaining or reinstatement of a
803 license to practice medicine; (7) failure to adequately supervise a
804 physician assistant; (8) failure to fulfill any obligation resulting from
805 participation in the National Health Service Corps; (9) failure to
806 maintain professional liability insurance or other indemnity against
807 liability for professional malpractice as provided in subsection (a) of
808 section 20-11b; (10) failure to provide information requested by the
809 department for purposes of completing a health care provider profile,
810 as required by section 20-13j, as amended by this act; (11) engaging in
811 any activity for which accreditation is required under section 19a-690
812 or 19a-691 without the appropriate accreditation required by section
813 19a-690 or 19a-691; (12) failure to provide evidence of accreditation
814 required under section 19a-690 or 19a-691 as requested by the
815 department pursuant to section 19a-690 or 19a-691; (13) failure to
816 comply with the continuing medical education requirements set forth
817 in section 25 of this act; or [(13)] (14) violation of any provision of this
818 chapter or any regulation established hereunder. In each case, the
819 board shall consider whether the physician poses a threat, in the
820 practice of medicine, to the health and safety of any person. If the
821 board finds that the physician poses such a threat, the board shall
822 include such finding in its final decision and act to suspend or revoke
823 the license of said physician.

824 Sec. 22. Section 20-13i of the general statutes is repealed and the
825 following is substituted in lieu thereof (*Effective from passage*):

826 The department shall file with the Governor and the joint standing
827 committee [on public health] of the General Assembly having
828 cognizance of matters relating to public health on or before January 1,
829 1986, and thereafter on or before January first of each succeeding year,
830 a report of the activities of the department and the board conducted
831 pursuant to sections 20-13d and 20-13e. Each such report shall include,
832 but shall not be limited to, the following information: The number of
833 petitions received; the number of petitions not investigated and the
834 reasons why; the number of hearings held on such petitions; [and,] the
835 outcome of such hearings; the timeliness of action taken on any

836 petition considered to be a priority; without identifying the particular
837 physician concerned, a brief description of the impairment alleged in
838 each such petition and the actions taken with regard to each such
839 petition by the department and the board; the number of notifications
840 received pursuant to section 19a-17a; the number of such notifications
841 with no further action taken, and the reasons why; and the outcomes
842 for notifications where further action is taken.

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

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

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

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

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

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

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

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

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

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

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

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

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

874 (12) Any hospital disciplinary actions against the physician that
875 resulted, within the past ten years, in the termination or revocation of
876 the physician's hospital privileges for a medical disciplinary cause or
877 reason, or the resignation from, or nonrenewal of, medical staff
878 membership or the restriction of privileges at a hospital taken in lieu of
879 or in settlement of a pending disciplinary case related to medical
880 competence in such hospital;

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

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

894 (15) An indication as to whether the physician is actively involved

895 in patient care; and

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

898 Sec. 24. Subsection (k) of section 20-13j of the general statutes is
899 repealed and the following is substituted in lieu thereof (*Effective*
900 *October 1, 2005*):

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

907 Sec. 25. (NEW) (*Effective October 1, 2005*) (a) As used in this section:

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

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

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

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

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

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

920 (b) Except as otherwise provided in subsections (d), (e) and (f) of
921 this section, for registration periods beginning on and after October 1,
922 2007, a licensee applying for license renewal shall earn a minimum of

923 fifty contact hours of continuing medical education within the
924 preceding twenty-four-month period. Such continuing medical
925 education shall (1) be in an area of the physician's practice; (2) reflect
926 the professional needs of the licensee in order to meet the health care
927 needs of the public; and (3) include at least one contact hour of training
928 or education in infectious diseases, including, but not limited to,
929 acquired immune deficiency syndrome and human immunodeficiency
930 virus, risk management, sexual assault and domestic violence. For
931 purposes of this section, qualifying continuing medical education
932 activities include, but are not limited to, courses offered or approved
933 by the American Medical Association, American Osteopathic Medical
934 Association, Connecticut Hospital Association, Connecticut State
935 Medical Society, county medical societies or equivalent organizations
936 in another jurisdiction, educational offerings sponsored by a hospital
937 or other health care institution or courses offered by a regionally
938 accredited academic institution or a state or local health department.

939 (c) Each licensee applying for license renewal pursuant to section
940 19a-88 of the general statutes shall sign a statement attesting that the
941 licensee has satisfied the continuing education requirements of
942 subsection (b) of this section on a form prescribed by the department.
943 Each licensee shall retain records of attendance or certificates of
944 completion that demonstrate compliance with the continuing
945 education requirements of subsection (b) of this section for a minimum
946 of three years following the year in which the continuing education
947 activities were completed and shall submit such records or certificates
948 to the department for inspection not later than forty-five days after a
949 request by the department for such records or certificates.

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

953 (e) (1) A licensee who is not engaged in active professional practice
954 in any form during a registration period shall be exempt from the
955 continuing medical education requirements of this section, provided

956 the licensee submits to the department, prior to the expiration of the
957 registration period, a notarized application for exemption on a form
958 prescribed by the department and such other documentation as may
959 be required by the department. The application for exemption
960 pursuant to this subdivision shall contain a statement that the licensee
961 may not engage in professional practice until the licensee has met the
962 requirements set forth in subdivision (2) or (3) of this subsection, as
963 appropriate.

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

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

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

989 (g) Any licensee whose license has become void pursuant to section
990 19a-88 of the general statutes and who applies to the department for
991 reinstatement of such license pursuant to section 19a-14 of the general
992 statutes shall submit evidence documenting successful completion of
993 twenty-five contact hours of continuing education within the one-year
994 period immediately preceding application for reinstatement.

995 Sec. 26. Section 19a-88b of the general statutes is repealed and the
996 following is substituted in lieu thereof (*Effective October 1, 2005*):

997 (a) (1) Notwithstanding section 19a-14 or any other provisions of the
998 general statutes relating to continuing education or refresher training,
999 the Department of Public Health shall renew a license, certificate,
1000 permit or registration issued to an individual pursuant to chapters
1001 368d, 368v, [370] 371 to 388, inclusive, 393a, 395, 398, 399, 400a and
1002 400c [which] that becomes void pursuant to section 19a-88 or 19a-195b
1003 while the holder [thereof] of the license, certificate, permit or
1004 registration is on active duty in the armed forces of the United States,
1005 [within] not later than six months from the date of discharge from
1006 active duty, upon completion of any continuing education or refresher
1007 training required to renew a license, certificate, registration or permit
1008 [which] that has not become void pursuant to section 19a-88 or 19a-
1009 195b. A licensee applying for license renewal pursuant to this section
1010 shall submit an application on a form prescribed by the department
1011 and other such documentation as may be required by the department.

1012 (2) Notwithstanding section 19a-14 or any other provisions of the
1013 general statutes relating to continuing education, the Department of
1014 Public Health shall renew a license issued to an individual pursuant to
1015 chapter 370 that becomes void pursuant to section 19a-88 while the
1016 holder of the license is on active duty in the armed forces of the United
1017 States, not later than one year from the date of discharge from active
1018 duty, upon completion of twenty-five contact hours of continuing
1019 education that meet the criteria set forth in subsection (b) of section 25
1020 of this act. A licensee applying for license renewal pursuant to this
1021 subdivision shall submit an application on a form prescribed by the

1022 department and other such documentation as may be required by the
1023 department.

1024 (b) The provisions of this section [shall] do not apply to reservists or
1025 National Guard members on active duty for annual training that is a
1026 regularly scheduled obligation for reservists or members of the
1027 National Guard for training [which] that is not a part of mobilization.

1028 (c) No license shall be issued under this section to any applicant
1029 against whom professional disciplinary action is pending or who is the
1030 subject of an unresolved complaint.

1031 Sec. 27. (NEW) (*Effective from passage*) (a) Each hospital and
1032 outpatient surgical facility shall develop protocols for accurate
1033 identification procedures that shall be used by such hospital or
1034 outpatient surgical facility prior to surgery. Such protocols shall
1035 include, but need not be limited to, (1) procedures to be followed to
1036 identify the (A) patient, (B) surgical procedure to be performed, and
1037 (C) body part on which the surgical procedure is to be performed, and
1038 (2) alternative identification procedures in urgent or emergency
1039 circumstances or where the patient is nonspeaking, comatose or
1040 incompetent or is a child. After January 1, 2006, no hospital or
1041 outpatient surgical facility may anesthetize a patient or perform
1042 surgery unless the protocols have been followed. Each hospital and
1043 outpatient surgical facility shall make a copy of the protocols available
1044 to the Commissioner of Public Health upon request.

1045 (b) Not later than October 1, 2006, the Department of Public Health
1046 shall report, in accordance with section 11-4a of the general statutes, to
1047 the joint standing committee of the General Assembly having
1048 cognizance of matters relating to public health describing the protocols
1049 developed pursuant to subsection (a) of this section.

1050 Sec. 28. (NEW) (*Effective from passage*) On or before January 1, 2006,
1051 each hospital licensed under chapter 368v of the general statutes shall
1052 (1) contract with a patient safety organization, as defined in section
1053 19a-127o of the general statutes, to gather medical or health care

1054 related data from the hospital and make recommendations to the
 1055 hospital on ways to improve patient care and safety, and (2) provide
 1056 documentation to the Department of Public Health, in such form and
 1057 manner as the department prescribes, that the hospital has complied
 1058 with the provisions of subdivision (1) of this section.

1059 Sec. 29. Sections 38a-32 to 38a-36, inclusive, of the general statutes
 1060 are repealed. (*Effective from passage*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage and applicable to causes of action accruing on or after said date</i>	52-251c
Sec. 2	<i>October 1, 2005, and applicable to actions filed on or after said date</i>	52-190a
Sec. 3	<i>from passage</i>	New section
Sec. 4	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	52-192a
Sec. 5	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	52-193
Sec. 6	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	52-194
Sec. 7	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	52-195
Sec. 8	<i>October 1, 2005, and applicable to actions accruing on or after said date</i>	New section
Sec. 9	<i>from passage</i>	New section

Sec. 10	<i>from passage</i>	New section
Sec. 11	<i>from passage</i>	38a-676
Sec. 12	<i>October 1, 2005</i>	New section
Sec. 13	<i>from passage</i>	38a-8
Sec. 14	<i>January 1, 2006</i>	38a-395
Sec. 15	<i>from passage</i>	38a-25
Sec. 16	<i>July 1, 2005</i>	New section
Sec. 17	<i>October 1, 2005</i>	New section
Sec. 18	<i>from passage</i>	20-8a(c)
Sec. 19	<i>from passage</i>	20-8a(g)
Sec. 20	<i>from passage</i>	20-13b
Sec. 21	<i>October 1, 2005</i>	20-13c
Sec. 22	<i>from passage</i>	20-13i
Sec. 23	<i>October 1, 2005</i>	20-13j(b)
Sec. 24	<i>October 1, 2005</i>	20-13j(k)
Sec. 25	<i>October 1, 2005</i>	New section
Sec. 26	<i>October 1, 2005</i>	19a-88b
Sec. 27	<i>from passage</i>	New section
Sec. 28	<i>from passage</i>	New section
Sec. 29	<i>from passage</i>	Repealer section