2A:53A-30

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2001 **CHAPTER:** 187

NJSA: 2A:53A-30 ("Health Care Accountability Act")

BILL NO: S1333/722 (SCS) (Substituted for A3136/2055 (ACS))

SPONSOR(S): Connors and Singer

DATE INTRODUCED: May 22, 2000

COMMITTEE: **ASSEMBLY:** Health

SENATE: Health

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** June 28, 200l

SENATE: June 28, 2001

DATE OF APPROVAL: July 30, 2001

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL: (Senate Committee Substitute (1st reprint) enacted)

(Amendments during passage denoted by superscript numbers)

SCS for S1333/722

SPONSORS STATEMENT (S1333): (Begins on page 7 of original bill) Yes

SPONSORS STATEMENT (S722): (Begins on page 5 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: Yes

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

ACS for A3136/2055

SPONSORS STATEMENT (A3136): (Begins on page 7 of original bill) Yes

SPONSORS STATEMENT (A2055): (Begins on page 5 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

Identical to Assembly Committee Statement for S1333/722

SENATE: No

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

A724

SPONSORS STATEMENT: (Begins on page 7 of original bill) Yes

Bill and sponsor's statement identical to S1333

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: No

FLOOR AMENDMENT STATEMENTS: No

LEGISLATIVE FISCAL ESTIMATE: No

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER CLIPPINGS: Yes

"Patients get right to sue if HMO delays or denies care", The Record, 7-31-2001, p.3

"Suing HMOs gets OK", The Times, 7-31-2001, p.1

"N.J. enacts patients' rights law", Philadelphia Inquirer, 7-31-2001

SENATE, No. 722

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED JANUARY 24, 2000

Sponsored by:
Senator C. LOUIS BASSANO
District 21 (Essex and Union)
Senator SHIRLEY K. TURNER
District 15 (Mercer)

SYNOPSIS

Makes health insurance carriers liable for medical malpractice.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 9/15/2000)

AN ACT concerning liability for certain health care treatment decisions and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with the prevailing practices and standards of the medical profession and the community.

"Carrier" means an insurance company, health, hospital or medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan. Health care provider includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care treatment decision" means a determination made at the time health care services are provided by a health benefits plan, which determination affects the quality of the diagnosis, care or treatment provided to a covered person.

"Independent utilization review organization" means an independent entity comprised of physicians and other health care professionals who are representative of the active practitioners in the area in which the

organization will operate and which is under contract with the Department of Health and Senior Services to provide medical necessity or appropriateness of services appeal reviews pursuant to statute or by regulation of the Commissioner of Health and Senior Services.

"Ordinary care" means, in the case of a carrier, that degree of care which a carrier of ordinary prudence would use under the same or similar circumstances, and, in the case of an employee, agent or other representative of the carrier, that degree of care which a person of ordinary prudence in the same profession, specialty or area of practice would use under the same or similar circumstances.

2. a. A carrier has the duty to exercise ordinary care when making health care treatment decisions and shall be liable for damages for harm to a covered person proximately caused by its failure to exercise ordinary care.

b. A carrier shall also be liable for damages for harm to a covered person proximately caused by health care treatment decisions made by an employee, agent or other representative thereof who is acting on the carrier's behalf and over whom the carrier has the right to exercise influence or control, or has actually exercised influence or control, which result in the failure to exercise ordinary care.

c. It shall be a defense to any action asserted against a carrier that:

(1) neither the carrier nor any employee, agent or other representative thereof for whose conduct the carrier is liable pursuant to subsection b. of this section controlled, influenced or participated in the health care treatment decision; and

(2) the carrier did not deny or delay payment for any treatment prescribed or recommended by a health care provider to the covered person.

d. The provisions of subsection a. and b. of this section shall not be construed to:

(1) require a carrier to pay benefits or provide services for a health care service which is not a covered service; or

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees.

e. A carrier may not include a provision in a contract with a health care provider that exempts the carrier from liability for the acts or conduct of the carrier, and any such provision in an existing contract shall be void.

f. The provisions of any State law which prohibit a carrier from practicing, or being licensed to practice, medicine may not be asserted as a defense by a carrier in an action brought against it pursuant to this or any other act.

g. In an action brought against a carrier, a finding that a health care

provider is an employee, agent or other representative of the carrier shall not be based solely on proof that the provider' s name appears on a list of approved health care providers made available to covered persons under a health benefits plan.

h. A covered person who brings an action against a carrier pursuant to this act shall comply with any requirements as provided by law or court rule for a plaintiff in a medical malpractice case.

3. a. Except as otherwise provided in this section, a covered person may not bring an action against a carrier pursuant to the provisions of subsections a. and b. of section 2 of this act unless the covered person has:

(1) first exhausted an appeal to an independent utilization review organization in accordance with the appeal process set forth at N.J.A.C.8:38-8.7, in the case of a health maintenance organization enrollee, or a comparable appeal process as may be established by statute or by regulation of the Commissioner of Health and Senior Services, in the case of a person covered by another health benefits plan; or

(2) provided written notice by personal delivery or mail of the intended action to the carrier against whom the action is to be brought no later than the 30th day prior to instituting the action, and agreed to submit to an appeal process as provided in paragraph (1) of this subsection.

b. The covered person who has provided written notice to the carrier pursuant to paragraph (2) of subsection a. of this section shall be required to file an appeal as provided in paragraph (1) of that subsection before bringing an action against the carrier, if the carrier requests a review by an independent utilization review organization no later than the 14th day after receipt by the carrier of the written notice from the covered person. If the carrier fails to request the review within that time period, the covered person may bring an action against the carrier without first filing an appeal.

c. Except as otherwise provided in this section, if a covered person has not complied with the provisions of subsection a. of this section prior to bringing an action against a carrier, the court shall not dismiss the action but shall order the parties to the action to submit to the appeal process required pursuant to subsection a. of this section or, at the discretion of the court, an alternative nonbinding dispute resolution process, and shall abate the action for such period as the court determines necessary for that purpose. This order of the court shall be the sole remedy available to a party complaining of a covered person's failure to comply with the provisions of subsection a. of this section.

d. A covered person shall be exempted from the provisions of subsection a. of this section if that person has filed a pleading alleging

in substance that:

(1) harm to the covered person has already occurred because of the conduct of the carrier or because of the act or omission of an employee, agent or other representative thereof for whose conduct the carrier is liable pursuant to subsection b. of section 2 of this act; and

(2) the appeal required pursuant to subsection a. of this section would not be beneficial to the covered person, unless the court, upon the motion of the defendant carrier, finds after a hearing that the pleading filed by the covered person was not made in good faith, in which case the court shall enter an order pursuant to subsection c. of this section.

e. If a covered person seeks to exhaust an appeal as required pursuant to subsection a. of this section before the statute of limitations applicable to a claim against a carrier has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date that the covered person exhausted the appeal; or

(2) the 40th day after the date that the covered person provided written notice to the carrier pursuant to paragraph (2) of subsection a. of this section.

f. The provisions of subsection a. of this section shall not be construed to prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment or relief available under law, if the requirement of exhausting an appeal pursuant to that subsection would place the covered person's health in serious jeopardy.

4. This act shall take effect on the 90th day after enactment.

STATEMENT

This bill would allow consumers to sue their health insurance carrier for medical malpractice.

The bill is premised on a recognition that insurance companies and, in particular, health maintenance organizations and other managed care entities, have increasingly interposed themselves in medical decisions in recent years in an effort to reduce or at least slow the rate of increase in their health care costs, by refusing to pay for treatments that physicians recommend for their patients, delaying such care or requiring physicians to try less expensive and less effective treatments first. This bill would enable a consumer to file a malpractice claim and collect an award against a health insurance carrier if the consumer can show that his or her illness or condition was made worse by the carrier's decision to deny, delay or reduce treatments for that person. The bill would subject health insurers to the same potential threat of

lawsuits for failure to deliver appropriate health care as health care providers now confront, as an additional means of ensuring that consumers receive quality health care services.

SENATE, No. 1333

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED MAY 22, 2000

Sponsored by:
Senator LEONARD T. CONNORS, JR.
District 9 (Atlantic, Burlington and Ocean)
Senator ROBERT W. SINGER
District 30 (Burlington, Monmouth and Ocean)

Co-Sponsored by:
Senators Bassano, Allen, Bennett and Adler

SYNOPSIS

The "Health Care Insurer Accountability Act of 2000."

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 6/27/2000)

AN ACT concerning liability for certain health care treatment decisions, amending P.L.1995, c.139 and P.L.1973, c.337 and supplementing Title 2A of the New Jersey Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) This act shall be known and may be cited as the "Health Care Insurer Accountability Act of 1998."

2. (New section) The Legislature hereby finds and declares that:

a. Health insurance companies, in particular health maintenance organizations and other managed care entities, have become increasingly involved in health care treatment decisions in an effort to reduce health care costs;

b. Many carriers have been reducing or denying health care treatments for their insured patients as part of these cost containment efforts;

c. Since the carriers are in many instances making medical decisions when they deny, delay, or diminish health care treatments, they should be held to the same level of legal responsibility as physicians and other health care providers who make decisions regarding the necessity and appropriateness of medical care;

d. It is fair and appropriate that insured patients have the opportunity to dispute carrier decisions in court, as well as in informal appeals procedures, so that these disputes may be quickly and efficiently resolved in ways that best accommodate the needs of the insured patient.

3. (New section) As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with the prevailing practices and standards of the medical profession and the community.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Covered person" means a person on whose behalf a carrier offering a health benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

obligated to pay benefits or provide services.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, "health benefits plan" shall not include coverage arising out of a workers' compensation or similar law.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan. Health care provider includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care service" means a service or product provided by a health care provider to a covered person pursuant to a health benefits plan.

"Health care treatment decision" means a determination made at the time health care services are provided by a health benefits plan, which determination affects the quality of the diagnosis, care or treatment provided to a covered person.

"Independent utilization review organization" means an independent entity comprised of physicians and other health care professionals who are representative of the active practitioners in the area in which the organization will operate and which is under contract with the Department of Health and Senior Services to provide medical necessity or appropriateness of services appeal reviews pursuant to section 12 of the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-12).

"Ordinary care" means, in the case of a carrier, the degree of care that a carrier of ordinary prudence would use under the same or similar circumstances, and, in the case of an employee, agent or other representative of the carrier, the degree of care that a person of ordinary prudence in the same profession, specialty or area of practice would use under the same or similar circumstances.

4. (New section) a. A carrier has the duty to exercise ordinary care when making health care treatment decisions and shall be liable for damages for harm to a covered person proximately caused by its failure to exercise ordinary care in making health care treatment decisions.

b. Notwithstanding the provisions of section 13 of the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-13) or any other law, a carrier shall be liable for damages for harm to a covered person

proximately caused by the health care treatment decisions of employees, agents or other representatives of the carrier who act on the carrier's behalf and over whom the carrier has the right to exercise influence or control, or has actually exercised influence or control, and who fail to exercise ordinary care in making health care treatment decisions.

c. It shall be a defense to any action brought against a carrier that:

(1) neither the carrier nor any employee, agent or other representative of the carrier, for whose conduct the carrier is liable pursuant to subsection b. of this section, controlled, influenced or participated in the health care treatment decision; and

(2) the carrier did not deny or delay payment for any treatment prescribed or recommended to the covered person by a health care provider.

d. The provisions of subsection a. and b. of this section shall not be construed to:

(1) require a carrier to pay benefits or provide a health care service that is not a covered service; or

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees.

e. A carrier may not include a provision in a contract with a health care provider that exempts the carrier from liability for the acts or conduct of the carrier, and any such provision in an existing contract shall be void as contrary to the public policy of this State.

f. The provisions of any State law that prohibit a carrier from practicing medicine, or being licensed to practice medicine, may not be asserted as a defense by a carrier in an action brought against it pursuant to this act.

g. In an action brought against a carrier pursuant to this act, a finding that a health care provider is an employee, agent or other representative of the carrier shall not be based solely on proof that the provider's name appears on a list of approved health care providers made available to covered persons under a health benefits plan.

h. A covered person who brings an action against a carrier pursuant to this act shall comply with the provisions of section 2 of P.L.1995, c.139 (C.2A:53A-27) and any other law or court rule applicable to a plaintiff in a medical malpractice action.

5. (New section) A covered person shall file an appeal of a carrier's health care treatment decision under the carrier's internal patient appeals process, if any, or with the Independent Health Care Appeals Program created pursuant to section 11 of the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-11), as appropriate, at the same time that the covered person institutes an action against a carrier pursuant to this act.

6. (New section) a. The court hearing the action authorized by this act may take judicial notice of the recommendation of the independent utilization review organization reviewing the internal patient appeal and other records of the Department of Health and Senior Services and the parties to the appeal. The court shall employ alternative dispute resolution methods, including, but not limited to mediation and binding arbitration, in order to expedite the action, accommodate the needs of the covered person, and achieve a solution that is fair and equitable to all the parties.

b. Nothing in this act shall prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment or any other relief available under applicable law.

7. Section 1 of P.L.1995, c.139 (C.2A:53A-26) is amended as follows:

1. As used in this act, "licensed person" means any person who is licensed as:

a. an accountant pursuant to P.L.1977, c.144 (C.45:2B-1 et seq.);

b. an architect pursuant to R.S.45:3-1 et seq.;

c. an attorney admitted to practice law in New Jersey;

d. a dentist pursuant to R.S.45:6-1 et seq.;

e. an engineer pursuant to P.L.1938, c.342 (C.45:8-27 et seq.);

f. a physician in the practice of medicine or surgery pursuant to R.S.45:9-1 et seq;

g. a podiatrist pursuant to R.S.45:5-1 et seq.;

h. a chiropractor pursuant to P.L.1989, c.153 (C.45:9-41.17 et seq.);

i. a registered professional nurse pursuant to P.L.1947, c.262 (C.45:11-23 et seq.); **[**and**]**

j. a health care facility as defined in section 2 of P.L.1971, c.136 (C.26:2H-2)<u>; and</u>

<u>k. a carrier as defined in section 3 of P.L. , c. (C.)(pending before the Legislature as this bill)</u>.

(cf: P.L.1995, c.139, s.1.)

8. Section 2 of P.L.1995, c.139 (C.2A:53A-27) is amended as follows:

2. In any action for damages for personal injuries, wrongful death or property damage resulting from an alleged act of malpractice or negligence by a licensed person in his profession or occupation, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational

standards or treatment practices; except that if the defendant is a carrier, the affidavit shall be provided by a physician or other appropriate licensed natural person. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state; have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

(cf: P.L.1995, c.139, s.2.)

9. Section 25 of P.L.1973, c.337 (C.26:2J-25) is amended to read as follows:

25. Statutory construction and relationship to other laws.

a. Except as otherwise provided in this act, provisions of the insurance law and provisions of hospital **[**or**]**, medical or health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital **[**or**]**, medical or health service corporation licensed and regulated pursuant to the insurance laws or the hospital **[**or**]**, medical or health service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act. Charges paid by or on behalf of enrollees of a health maintenance organization with respect to health care services shall not be subject to taxation by the State or any of its political subdivisions.

b. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine.

d. No person participating in the arrangements of a health maintenance organization other than the officers and employees of a health maintenance organization and the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies.

(cf: P.L.1973, c.337, s.25)

10. This act shall take effect on the 90th day after enactment.

STATEMENT

This bill allows covered persons to sue their health insurance carrier for medical malpractice arising from health care treatment decisions made by the carrier. Currently, health insurance carriers, especially health maintenance organizations and other managed care entities, take advantage of defenses that make it difficult, if not impossible, to hold them accountable for treatment decisions that amount to malpractice. In their contracts with participating providers, carriers often require providers to assume all legal and financial responsibility for health care treatment decisions.

This bill provides that at the same time a covered person institutes a malpractice action against a carrier, they must file an appeal under the carrier's internal grievance procedure, if any, or with the Independent Health Care Appeals Program, created pursuant to the "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.), as appropriate. Information generated in the appeal process will augment the lawsuit in ways that will encourage the quick and efficient resolution of disputes. The bill requires covered persons and carriers to make full use of alternative dispute resolution techniques to expedite the case in order to accommodate the needs of the covered person and the often time-sensitive nature of these disputes, and to achieve a solution that is fair and equitable to the parties. Litigants will still have the ability to apply for appropriate remedies from the court, including injunctive relief. The bill also requires that covered persons who institute a lawsuit against a carrier for medical malpractice comply with the affidavit of merit requirement of section 2 of P.L.1995, c.139 (C.2A:53A-27).

Under the bill, the health insurance carrier, its employees, agents, or representatives over whom the carrier has the right to exercise influence or control, would be held to a standard of ordinary care in making health care treatment decisions. "Ordinary care" is defined in the bill as the degree of care that a carrier of ordinary prudence would use under the same or similar circumstances, and, in the case of an employee, agent or other representative of the carrier, the degree of care that a person of ordinary prudence in the same profession, specialty or area of practice would use under the same or similar circumstances.

The bill bars carriers from including in their provider contracts provisions that exempt the carrier from liability for the acts or conduct of the carrier. Any such provision shall be void as contrary to the public policy of this State. Additionally, carriers may not argue in court that they cannot be sued for malpractice since they are not

licensed to practice medicine.

Finally, the bill does not require carriers to pay benefits or provide services that are not covered, and also provides certain defenses for carriers.

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, Nos. 1333 and 722

STATE OF NEW JERSEY

209th LEGISLATURE

ADOPTED SEPTEMBER 25, 2000

Sponsored by:
Senator LEONARD T. CONNORS, JR.
District 9 (Atlantic, Burlington and Ocean)
Senator ROBERT W. SINGER
District 30 (Burlington, Monmouth and Ocean)
Senator C. LOUIS BASSANO
District 21 (Essex and Union)
Senator SHIRLEY K. TURNER
District 15 (Mercer)

Co-Sponsored by:
Senators Allen, Bennett, Adler, Robertson, Baer, McNamara, Gormley, Vitale, Kosco, Sinagra and Zane

SYNOPSIS

"Health Care Carrier Accountability Act."

CURRENT VERSION OF TEXT

Substitute as adopted by the Senate Health Committee.

(Sponsorship Updated As Of: 5/4/2001)

AN ACT concerning liability for certain health care treatment decisions, supplementing Title 2A of the New Jersey Statutes and amending P.L.1973, c.337.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) This act shall be known and may be cited as the "Health Care Carrier Accountability Act."

2. (New section) The Legislature hereby finds and declares that:

a. Health and dental carriers, in particular health maintenance organizations and other managed care entities, have become increasingly involved in health care treatment decisions, including, but not limited to, the use of financial incentives to providers and practice guidelines, in an effort to reduce health care costs;

b. As a result, many carriers have been reducing or denying medically necessary health care treatments for their insured patients;

c. Since the carriers are in many instances making medical decisions when they deny, delay, or diminish health care treatments, they should be held to the same level of legal responsibility as physicians and other health care providers who make decisions regarding the necessity and appropriateness of medical care; and

d. It is fair and appropriate that insured patients have the opportunity to dispute carrier or organized delivery system decisions in court, as well as in internal and external appeals procedures, so that these disputes may be quickly and efficiently resolved in ways that best accommodate the needs of the insured patient.

3. (New section) As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with generally accepted standards of health care practice.

"Carrier" means an insurance company, health, hospital or medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State or a dental service corporation or dental plan organization authorized to issue dental benefits plans in this State.

"Covered person" means a person on whose behalf a carrier or organized delivery system offering a health or dental benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a covered person under a health or dental benefits plan for which the

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

carrier or organized delivery system is obligated to pay benefits or provide services.

"Dental benefits plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health or dental benefits plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care service" means a service or product provided by a health care provider to a covered person pursuant to a health or dental benefits plan.

"Health care treatment decision" means a decision made by a health or dental benefits plan at the time health care services are provided or to be provided, which decision affects the diagnosis, care or treatment provided to a covered person.

"Organized delivery system" means an organized delivery system certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

4. (New section) a. Notwithstanding the provisions of any other law to the contrary, a carrier or organized delivery system shall be liable to a covered person for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of the covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition

resulting in chronic and significant pain; or (7) any physical or mental harm which resulted in further medically necessary medical treatment made necessary by the denial or delay of care.

Under the provisions of this section, a carrier or organized delivery system shall be liable for the health care treatment decisions of its employees, agents or other representatives over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control.

b. It shall be a defense to any action brought against a carrier or organized delivery system that:

(1) neither the carrier or organized delivery system nor any employee, agent or other representative of the carrier or organized delivery system, for whose conduct the carrier or organized delivery system is liable pursuant to subsection a. of this section, controlled, influenced or participated in the health care treatment decision; and

(2) the carrier or organized delivery system did not deny or delay authorization for any treatment prescribed or recommended to the covered person by a health care provider.

c. The provisions of subsection a. of this section shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits for or provide a health care service that is not a covered service; or

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees.

d. (1) A carrier or organized delivery system shall not include a provision in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system. Any such provision in a contract executed or renewed after the date of enactment of this act shall be void as contrary to the public policy of this State.

(2) The provisions of this subsection shall not be waived, shifted or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate or shift liability for a breach of the indemnification or otherwise, that is executed or renewed after the date of enactment of this act shall be void as contrary to the public policy of this State.

e. The provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it pursuant to subsection a. of this section.

f. In an action brought against a carrier or organized delivery system pursuant to subsection a. of this section, a finding that a health

care provider is an employee, agent or other representative of the carrier or organized delivery system shall not be based solely on proof that the provider's name appears on a list of approved health care providers made available to covered persons under a health or dental benefits plan.

5. (New section) An individual who brings an action against a carrier or organized delivery system pursuant to paragraphs (1) through (5), inclusive, of subsection a. of section 4 of this act shall not be required to file an appeal through the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action.

6. (New section) a. The court hearing the action authorized by paragraphs (1) through (5), inclusive, of subsection a. of section 4 of this act shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

b. The court hearing the action authorized by paragraphs (6) and (7) of subsection a. of section 4 of this act may employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

c. If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan.

d. Nothing in this act shall prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, an appeal to the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) or any other relief available under applicable law.

7. (New section) a. In any action for economic or non-economic loss to a covered person pursuant to subsection a. of section 4 this act, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services.

b. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause. The person executing the affidavit shall be

licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

c. An affidavit shall not be required pursuant to subsection a. of this section if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request.

d. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, pursuant to this section, it shall be deemed a failure to state a cause of action.

8. Section 25 of P.L.1973, c.337 (C.26:2J-25) is amended to read as follows:

25. Statutory construction and relationship to other laws.

a. Except as otherwise provided in this act, provisions of the insurance law and provisions of hospital **[**or**]**, medical or health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital **[**or**]**, medical or health service corporation licensed and regulated pursuant to the insurance laws or the hospital **[**or**]**, medical or health service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act. Charges paid by or on behalf of enrollees of a health maintenance organization with respect to health care services shall not be subject to taxation by the State or any of its political subdivisions.

b. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the **[**provision**]** provisions of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine.

d. **[**No**]** Except as provided in P.L. , c. (C.)(pending before the Legislature as this bill), no person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies. The provisions of this subsection shall not be construed to eliminate any cause of action against a health maintenance organization otherwise provided by law.

(cf: P.L.1973, c.337, s.25)

9. This act shall take effect on the 90th day after enactment.

SENATE HEALTH COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, Nos. 1333 and 722

STATE OF NEW JERSEY

DATED: SEPTEMBER 25, 2000

The Senate Health Committee reports favorably a Senate Committee Substitute for Senate Bill Nos. 1333 and 722.

This substitute, the "Health Care Carrier Accountability Act," allows persons covered under a health or dental benefits plan issued by a carrier (an insurance company, health, hospital or medical service corporation, health maintenance organization, dental plan organization or dental service corporation) to sue their carrier or an organized delivery system (which contracts with the carrier) for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services. The carrier or organized delivery system is liable when the denial or delay is the proximate cause of: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition; (6) a physical condition resulting in chronic and significant pain; or (7) any physical or mental harm which resulted in further medically necessary medical treatment made necessary by the denial or delay of care.

Under the substitute, a carrier or organized delivery system shall be liable for the health care treatment decisions of employees, agents or other representatives of the carrier or organized delivery system over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control. Also, the provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it under this substitute.

The substitute provides that its provisions shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits or provide a health care service that is not a covered service; or

(2) create any liability on the part of an employer or other entity

that purchases a contract for health care services or assumes risk on behalf of its employees.

Further, the substitute prohibits a carrier or organized delivery system from including a provision in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system. Any such provision in a contract executed or renewed after the date of enactment of the substitute shall be void as contrary to the public policy of this State.

The substitute provides that when the covered person's cause of action is: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; or (5) exacerbation of a serious or life-threatening disease or condition, the court hearing the action shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute. Under the substitute, the covered person is not required to file an appeal through the Independent Health Care Appeals Program established in N.J.S.A.26:2S-11 before proceeding with an action against the carrier or organized delivery system that is listed in this paragraph.

When the covered person's cause of action is : a physical condition resulting in chronic and significant pain; or any physical or mental harm which resulted in further medically necessary medical treatment made necessary by the denial or delay of care, the court hearing the action may employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan. Also, the substitute provides that its provisions do not preclude a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, an appeal through the Independent Health Care Appeals Program or any other relief available under applicable law.

The substitute also contains requirements for an affidavit of merit in any action for economic or non-economic loss to a covered person, that are similar to those provided in N.J.S.A.2A:53A-26 et seq. A plaintiff is required, within 60 days following the date of filing of the answer to the complaint by the defendant, to provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or

providing medically necessary covered services.

The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. An affidavit shall not be required if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, it shall be deemed a failure to state a cause of action.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, Nos. 1333 and 722

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 17, 2001

The Assembly Health Committee reports favorably and with committee amendments the Senate Committee Substitute for Senate Bill Nos. 1333 and 722.

As amended by the committee, this committee substitute, which is designated as the "Health Care Carrier Accountability Act," allows persons covered under a health or dental benefits plan issued by a carrier (an insurance company, health, hospital or medical service corporation, health maintenance organization, dental plan organization or dental service corporation) to sue their carrier or an organized delivery system (which contracts with the carrier) for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services. The carrier or organized delivery system is liable when the denial or delay is the proximate cause of: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.

Under the substitute, a carrier or organized delivery system shall be liable for the health care treatment decisions of employees, agents or other representatives of the carrier or organized delivery system over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control. Also, the provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it under this substitute.

The substitute provides that its provisions shall not be construed

to:

(1) require a carrier or organized delivery system to pay benefits or provide a health care service that is not a covered service;

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees; or

(3) create any liability on the part of a labor/management Taft-Hartley welfare trust fund established pursuant to 29 U.S.C. s.186.

Further, the substitute prohibits a carrier or organized delivery system from including a provision:

-- in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system; or

-- in a contract or agreement that waives, modifies, delegates or shifts the liability established by this substitute.

Any such provisions in a contract or agreement executed or renewed after the date of enactment of the substitute shall be void as contrary to the public policy of this State.

The substitute provides that the court hearing an action pursuant to this substitute shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

Under the substitute, the covered person is required to exhaust an appeal through the Independent Health Care Appeals Program established in N.J.S.A.26:2S-11 before proceeding with an action against a carrier or organized delivery system, unless serious or significant harm to the covered person has occurred or will imminently occur. The substitute defines "serious or significant harm" to mean: death, serious and protracted or permanent impairment of a bodily function or system, loss of a body organ necessary for normal bodily function, loss of a body member, or exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment.

When the covered person's cause of action is : a physical condition resulting in chronic and significant pain; or substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care, the court hearing the action may employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan.

The substitute provides that its provisions do not preclude a covered person from pursuing other appropriate remedies, including

injunctive relief, a declaratory judgment, or any other relief available under applicable law, if serious or significant harm to the covered person (as defined above) has occurred or will imminently occur.

The substitute also contains requirements for an affidavit of merit in any action for economic or non-economic loss to a covered person, which are similar to those provided in N.J.S.A.2A:53A-26 et seq. A plaintiff is required, within 60 days following the date of filing of the answer to the complaint by the defendant, to provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services.

The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. An affidavit shall not be required if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, it shall be deemed a failure to state a cause of action.

The committee amendments:

- revise a covered person's cause of action under paragraph (7) of subsection a. of section 4 from: "any physical or mental harm which resulted in further medically necessary medical treatment made necessary by the denial or delay of care" to "substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care";
- provide that the provisions of this substitute shall not be construed to create any liability on the part of a labor/management Taft-Hartley welfare trust fund established pursuant to 29 U.S.C. s.186;
- clarify the language in paragraph (2) of subsection d. of section 4 to reflect the intent of its provisions to preclude a carrier or organized delivery system from including a provision in any contract or agreement that waives, modifies, delegates or shifts the liability established by this substitute;

- require that a covered person exhaust an appeal through the Independent Health Care Appeals Program established in N.J.S.A.26:2S-11 before proceeding with an action against a carrier or organized delivery system pursuant to this substitute, unless serious or significant harm to the covered person has occurred or will imminently occur;
- provide that nothing in this substitute shall prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or any other relief available under applicable law, if serious or significant harm to the covered person has occurred or will imminently occur;
- define "serious or significant harm" to mean: death, serious and protracted or permanent impairment of a bodily function or system, loss of a body organ necessary for normal bodily function, loss of a body member, or exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment;
- require that the court hearing an action pursuant to this substitute, with the plaintiff's consent, employ alternative dispute resolution methods for all the possible causes of action provided for under the substitute (i.e., for paragraphs (1) through (7) of subsection a. of section 4), including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute; and
- make a technical change to section 8 of the substitute, which amends N.J.S.A.26:2J-25, to reflect the provisions of section 1 of P.L.2001, c.2, by incorporating in that section the new subsection e. that was added by the latter statute .

As reported by the committee, this substitute is identical to the Assembly Committee Substitute for Assembly Bill Nos. 3136 and 2055 (Corodemus/Talarico/Kelly/Gusciora), which the committee also reported on this date.

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, Nos. 1333 and 722

STATE OF NEW JERSEY

209th LEGISLATURE

ADOPTED SEPTEMBER 25, 2000

Sponsored by:
Senator LEONARD T. CONNORS, JR.
District 9 (Atlantic, Burlington and Ocean)
Senator ROBERT W. SINGER
District 30 (Burlington, Monmouth and Ocean)
Senator C. LOUIS BASSANO
District 21 (Essex and Union)
Senator SHIRLEY K. TURNER
District 15 (Mercer)

Co-Sponsored by:
Senators Allen, Bennett, Adler, Robertson, Baer, McNamara, Gormley, Vitale, Kosco, Sinagra, Zane, Assemblymen Corodemus, Talarico, Kelly, Gusciora, Asselta, Connors, DiGaetano, Assemblywoman Friscia, Assemblymen Gibson, Holzapfel, Lance, Moran, B.Smith, Zecker, Charles, Conaway, Cottrell, Assemblywoman Crecco, Assemblyman Doria, Assemblywoman Greenstein, Assemblymen Impreveduto, Jones, LeFevre, Wisniewski, Wolfe, Biondi, Arnone, Bagger, Blee, Cohen, Felice, Garcia, Payne, Assemblywoman Quigley, Assemblymen Roberts, Sires, Suliga, Assemblywoman Weinberg, Assemblymen Geist, Zisa, Azzolina, Barnes, T.Smith, DeCroce, Assemblywoman Gill, Assemblyman Thompson and Assemblywoman Watson Coleman

SYNOPSIS

"Health Care Carrier Accountability Act."

CURRENT VERSION OF TEXT

As reported by the Assembly Health Committee on May 17, 2001, with amendments.

(Sponsorship Updated As Of: 6/29/2001)

AN ACT concerning liability for certain health care treatment decisions, supplementing Title 2A of the New Jersey Statutes and amending P.L.1973, c.337.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) This act shall be known and may be cited as the "Health Care Carrier Accountability Act."

2. (New section) The Legislature hereby finds and declares that:

a. Health and dental carriers, in particular health maintenance organizations and other managed care entities, have become increasingly involved in health care treatment decisions, including, but not limited to, the use of financial incentives to providers and practice guidelines, in an effort to reduce health care costs;

b. As a result, many carriers have been reducing or denying medically necessary health care treatments for their insured patients;

c. Since the carriers are in many instances making medical decisions when they deny, delay, or diminish health care treatments, they should be held to the same level of legal responsibility as physicians and other health care providers who make decisions regarding the necessity and appropriateness of medical care; and

d. It is fair and appropriate that insured patients have the opportunity to dispute carrier or organized delivery system decisions in court, as well as in internal and external appeals procedures, so that these disputes may be quickly and efficiently resolved in ways that best accommodate the needs of the insured patient.

3. (New section) As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with generally accepted standards of health care practice.

"Carrier" means an insurance company, health, hospital or medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State or a dental service corporation or dental plan organization authorized to issue dental benefits plans in this State.

"Covered person" means a person on whose behalf a carrier or organized delivery system offering a health or dental benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted May 17, 2001.

covered person under a health or dental benefits plan for which the carrier or organized delivery system is obligated to pay benefits or provide services.

"Dental benefits plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health or dental benefits plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care service" means a service or product provided by a health care provider to a covered person pursuant to a health or dental benefits plan.

"Health care treatment decision" means a decision made by a health or dental benefits plan at the time health care services are provided or to be provided, which decision affects the diagnosis, care or treatment provided to a covered person.

"Organized delivery system" means an organized delivery system certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

[1]<u>"Serious or significant harm" means death, serious and protracted or permanent impairment of a bodily function or system, loss of a body organ necessary for normal bodily function, loss of a body member, or exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment.</u>[1]

4. (New section) a. Notwithstanding the provisions of any other law to the contrary, a carrier or organized delivery system shall be liable to a covered person for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or

providing medically necessary covered services, which denial or delay is the proximate cause of the covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) [1]**[**any**]** substantial[1] physical or mental harm which resulted in further [1]**[**medically necessary**]** substantial[1] medical treatment made [1]medically[1] necessary by the denial or delay of care.

Under the provisions of this section, a carrier or organized delivery system shall be liable for the health care treatment decisions of its employees, agents or other representatives over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control.

b. It shall be a defense to any action brought against a carrier or organized delivery system that:

(1) neither the carrier or organized delivery system nor any employee, agent or other representative of the carrier or organized delivery system, for whose conduct the carrier or organized delivery system is liable pursuant to subsection a. of this section, controlled, influenced or participated in the health care treatment decision; and

(2) the carrier or organized delivery system did not deny or delay authorization for any treatment prescribed or recommended to the covered person by a health care provider.

c. The provisions of subsection a. of this section shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits for or provide a health care service that is not a covered service; [1]**[**or**]**[1]

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees[1]; or

(3) create any liability on the part of a labor/management Taft-Hartley welfare trust fund established pursuant to 29 U.S.C. s.186[1].

d. (1) A carrier or organized delivery system shall not include a provision in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system. Any such provision in a contract executed or renewed after the date of enactment of this act shall be void as contrary to the public policy of this State.

(2) The provisions of [1]subsection a. of[1] this [1]**[**subsection**]**section[1] shall not be waived, shifted or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be

delegated. Any effort to waive, modify, delegate or shift [1]the[1] liability [1]established by subsection a. of this section through a contract[1] for [1][a breach of the][1] indemnification or otherwise, that is executed or renewed after the date of enactment of this act[1],[1] shall be void as contrary to the public policy of this State.

e. The provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it pursuant to subsection a. of this section.

f. In an action brought against a carrier or organized delivery system pursuant to subsection a. of this section, a finding that a health care provider is an employee, agent or other representative of the carrier or organized delivery system shall not be based solely on proof that the provider's name appears on a list of approved health care providers made available to covered persons under a health or dental benefits plan.

5. (New section) An individual who brings an action against a carrier or organized delivery system pursuant to [1][paragraphs (1) through (5), inclusive, of][1] subsection a. of section 4 of this act shall [1][not][1] be required to [1][file] exhaust[1] an appeal through the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action[1], unless serious or significant harm to the covered person has occurred or will imminently occur[1].

6. (New section) a. The court hearing the action authorized by [1][paragraphs (1) through (5), inclusive, of][1] subsection a. of section 4 of this act shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

b. [1][The court hearing the action authorized by paragraphs (6) and (7) of subsection a. of section 4 of this act may employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

c.][1] If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan.

[1][d.] c.[1] Nothing in this act shall prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, [1][an appeal to the Independent Health Care

Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)**]**[1] or any other relief available under applicable law[1], if serious or significant harm to the covered person has occurred or will imminently occur[1].

7. (New section) a. In any action for economic or non-economic loss to a covered person pursuant to subsection a. of section 4 [1]of[1] this act, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services.

b. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

c. An affidavit shall not be required pursuant to subsection a. of this section if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request.

d. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, pursuant to this section, it shall be deemed a failure to state a cause of action.

8. Section 25 of P.L.1973, c.337 (C.26:2J-25) is amended to read as follows:

25. Statutory construction and relationship to other laws.

a. Except as otherwise provided in this act, provisions of the insurance law and provisions of hospital **[**or**]**, medical or health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this

act. This provision shall not apply to an insurer or hospital [or], medical or health service corporation licensed and regulated pursuant to the insurance laws or the hospital [or], medical or health service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act. Charges paid by or on behalf of enrollees of a health maintenance organization with respect to health care services shall not be subject to taxation by the State or any of its political subdivisions.

b. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the [provision] provisions of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine.

d. [No] Except as provided in P.L. , c. (C.)(pending before the Legislature as this bill), no person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies. The provisions of this subsection shall not be construed to eliminate any cause of action against a health maintenance organization otherwise provided by law.

[1]e. A health maintenance organization shall be subject to the provisions of P.L.1970, c.22 (C.17:27A-1 et seq.), including those relating to merger or acquisition of control.[1]

(cf: P.L.1973, c.337, s.25)

9. This act shall take effect on the 90th day after enactment.

ASSEMBLY, No. 3136

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED JANUARY 18, 2001

Sponsored by:
Assemblyman STEVE CORODEMUS
District 11 (Monmouth)
Assemblyman GUY F. TALARICO
District 38 (Bergen)

Co-Sponsored by:
Assemblymen Asselta, Connors, DiGaetano, Assemblywoman Friscia, Assemblymen Gibson, Holzapfel, Kelly, Lance, Moran, B.Smith, Zecker, Charles, Conaway, Cottrell, Assemblywoman Crecco, Assemblyman Doria, Assemblywoman Greenstein, Assemblymen Impreveduto, Jones, LeFevre, Wisniewski, Wolfe, Biondi, Arnone, Bagger, Blee, Cohen, Felice, Garcia, Payne, Assemblywoman Quigley, Assemblymen Roberts, Sires, Suliga, Assemblywoman Weinberg, Assemblymen Geist, Zisa, Azzolina, Barnes, T.Smith and DeCroce

SYNOPSIS

"Health Care Carrier Accountability Act."

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 4/20/2001)

AN ACT concerning liability for certain health care treatment decisions, supplementing Title 2A of the New Jersey Statutes and amending P.L.1973, c.337.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) This act shall be known and may be cited as the "Health Care Carrier Accountability Act."

2. (New section) The Legislature hereby finds and declares that:

a. Health and dental carriers, in particular health maintenance organizations and other managed care entities, have become increasingly involved in health care treatment decisions, including, but not limited to, the use of financial incentives to providers and practice guidelines, in an effort to reduce health care costs;

b. As a result, many carriers have been reducing or denying medically necessary health care treatments for their insured patients;

c. Since the carriers are in many instances making medical decisions when they deny, delay, or diminish health care treatments, they should be held to the same level of legal responsibility as physicians and other health care providers who make decisions regarding the necessity and appropriateness of medical care; and

d. It is fair and appropriate that insured patients have the opportunity to dispute carrier or organized delivery system decisions in court, as well as in internal and external appeals procedures, so that these disputes may be quickly and efficiently resolved in ways that best accommodate the needs of the insured patient.

3. (New section) As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with generally accepted standards of health care practice.

"Carrier" means an insurance company, health, hospital or medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State or a dental service corporation or dental plan organization authorized to issue dental benefits plans in this State.

"Covered person" means a person on whose behalf a carrier or organized delivery system offering a health or dental benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a covered person under a health or dental benefits plan for which the

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

carrier or organized delivery system is obligated to pay benefits or provide services.

"Dental benefits plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health or dental benefits plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care service" means a service or product provided by a health care provider to a covered person pursuant to a health or dental benefits plan.

"Health care treatment decision" means a decision made by a health or dental benefits plan at the time health care services are provided or to be provided, which decision affects the diagnosis, care or treatment provided to a covered person.

"Organized delivery system" means an organized delivery system certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

4. (New section) a. Notwithstanding the provisions of any other law to the contrary, a carrier or organized delivery system shall be liable to a covered person for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of the covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition

resulting in chronic and significant pain; or (7) any physical or mental harm which resulted in further medically necessary medical treatment made necessary by the denial or delay of care.

Under the provisions of this section, a carrier or organized delivery system shall be liable for the health care treatment decisions of its employees, agents or other representatives over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control.

b. It shall be a defense to any action brought against a carrier or organized delivery system that:

(1) neither the carrier or organized delivery system nor any employee, agent or other representative of the carrier or organized delivery system, for whose conduct the carrier or organized delivery system is liable pursuant to subsection a. of this section, controlled, influenced or participated in the health care treatment decision; and

(2) the carrier or organized delivery system did not deny or delay authorization for any treatment prescribed or recommended to the covered person by a health care provider.

c. The provisions of subsection a. of this section shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits for or provide a health care service that is not a covered service; or

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees.

d. (1) A carrier or organized delivery system shall not include a provision in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system. Any such provision in a contract executed or renewed after the date of enactment of this act shall be void as contrary to the public policy of this State.

(2) The provisions of this subsection shall not be waived, shifted or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate or shift liability for a breach of the indemnification or otherwise, that is executed or renewed after the date of enactment of this act shall be void as contrary to the public policy of this State.

e. The provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it pursuant to subsection a. of this section.

f. In an action brought against a carrier or organized delivery system pursuant to subsection a. of this section, a finding that a health care provider is an employee, agent or other representative of the

carrier or organized delivery system shall not be based solely on proof that the provider's name appears on a list of approved health care providers made available to covered persons under a health or dental benefits plan.

5. (New section) An individual who brings an action against a carrier or organized delivery system pursuant to paragraphs (1) through (5), inclusive, of subsection a. of section 4 of this act shall not be required to file an appeal through the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action.

6. (New section) a. The court hearing the action authorized by paragraphs (1) through (5), inclusive, of subsection a. of section 4 of this act shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

b. The court hearing the action authorized by paragraphs (6) and (7) of subsection a. of section 4 of this act may employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

c. If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan.

d. Nothing in this act shall prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, an appeal to the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) or any other relief available under applicable law.

7. (New section) a. In any action for economic or non-economic loss to a covered person pursuant to subsection a. of section 4 this act, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services.

b. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the

general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

c. An affidavit shall not be required pursuant to subsection a. of this section if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request.

d. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, pursuant to this section, it shall be deemed a failure to state a cause of action.

8. Section 25 of P.L.1973, c.337 (C.26:2J-25) is amended to read as follows:

25. Statutory construction and relationship to other laws.

a. Except as otherwise provided in this act, provisions of the insurance law and provisions of hospital **[**or**]**, medical or health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital **[**or**]**, medical or health service corporation licensed and regulated pursuant to the insurance laws or the hospital **[**or**]**, medical or health service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act. Charges paid by or on behalf of enrollees of a health maintenance organization with respect to health care services shall not be subject to taxation by the State or any of its political subdivisions.

b. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the **[**provision**]** provisions of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine.

d. **[**No**]** Except as provided in P.L. , c. (C.)(pending before

the Legislature as this bill), no person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies. The provisions of this subsection shall not be construed to eliminate any cause of action against a health maintenance organization otherwise provided by law.
(cf: P.L.1973, c.337, s.25)

9. This act shall take effect on the 90th day after enactment.

STATEMENT

This bill, the "Health Care Carrier Accountability Act," allows persons covered under a health or dental benefits plan issued by a carrier (an insurance company, health, hospital or medical service corporation, health maintenance organization, dental plan organization or dental service corporation) to sue their carrier or an organized delivery system (which contracts with the carrier) for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services. The carrier or organized delivery system is liable when the denial or delay is the proximate cause of: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition; (6) a physical condition resulting in chronic and significant pain; or (7) any physical or mental harm which resulted in further medically necessary medical treatment made necessary by the denial or delay of care.

Under the bill, a carrier or organized delivery system shall be liable for the health care treatment decisions of employees, agents or other representatives of the carrier or organized delivery system over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control. Also, the provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it under this substitute.

The bill provides that its provisions shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits or provide a health care service that is not a covered service; or

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees.

Further, the bill prohibits a carrier or organized delivery system from including a provision in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system. Any such provision in a contract executed or renewed after the date of enactment of the bill shall be void as contrary to the public policy of this State.

The bill provides that when the covered person's cause of action is: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; or (5) exacerbation of a serious or life-threatening disease or condition, the court hearing the action shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute. Under the bill, the covered person is not required to file an appeal through the Independent Health Care Appeals Program established in N.J.S.A.26:2S-11 before proceeding with an action against the carrier or organized delivery system that is listed in this paragraph.

When the covered person's cause of action is : a physical condition resulting in chronic and significant pain; or any physical or mental harm which resulted in further medically necessary medical treatment made necessary by the denial or delay of care, the court hearing the action may employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan. Also, the bill provides that its provisions do not preclude a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, an appeal through the Independent Health Care Appeals Program or any other relief available under applicable law.

The bill also contains requirements for an affidavit of merit in any action for economic or non-economic loss to a covered person, that are similar to those provided in N.J.S.A.2A:53A-26 et seq. A plaintiff is required, within 60 days following the date of filing of the answer to the complaint by the defendant, to provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred

was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services.

The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. An affidavit shall not be required if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, it shall be deemed a failure to state a cause of action.

ASSEMBLY, No. 2055

STATE OF NEW JERSEY

209th LEGISLATURE

INTRODUCED FEBRUARY 10, 2000

Sponsored by:
Assemblyman JOHN V. KELLY
District 36 (Bergen, Essex and Passaic)
Assemblyman REED GUSCIORA
District 15 (Mercer)

Co-Sponsored by:
Assemblyman Zecker and Assemblywoman Friscia

SYNOPSIS
Makes health insurance carriers liable for medical malpractice.

CURRENT VERSION OF TEXT
As introduced.

(Sponsorship Updated As Of: 10/31/2000)

AN ACT concerning liability for certain health care treatment decisions and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with the prevailing practices and standards of the medical profession and the community.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Covered person" means a person on whose behalf a carrier offering a health benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a covered person under a health benefits plan for which the carrier is obligated to pay benefits or provide services.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include coverage arising out of a workers' compensation or similar law.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health benefits plan. Health care provider includes, but is not limited to, a physician and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care treatment decision" means a determination made at the time health care services are provided by a health benefits plan, which determination affects the quality of the diagnosis, care or treatment provided to a covered person.

"Independent utilization review organization" means an independent entity comprised of physicians and other health care professionals who are representative of the active practitioners in the area in which the organization will operate and which is under contract with the Department of Health and Senior Services to provide medical necessity or appropriateness of services appeal reviews pursuant to

statute or by regulation of the Commissioner of Health and Senior Services.

"Ordinary care" means, in the case of a carrier, that degree of care which a carrier of ordinary prudence would use under the same or similar circumstances, and, in the case of an employee, agent or other representative of the carrier, that degree of care which a person of ordinary prudence in the same profession, specialty or area of practice would use under the same or similar circumstances.

2. a. A carrier has the duty to exercise ordinary care when making health care treatment decisions and shall be liable for damages for harm to a covered person proximately caused by its failure to exercise ordinary care.

b. A carrier shall also be liable for damages for harm to a covered person proximately caused by health care treatment decisions made by an employee, agent or other representative thereof who is acting on the carrier's behalf and over whom the carrier has the right to exercise influence or control, or has actually exercised influence or control, which result in the failure to exercise ordinary care.

c. It shall be a defense to any action asserted against a carrier that:

(1) neither the carrier nor any employee, agent or other representative thereof for whose conduct the carrier is liable pursuant to subsection b. of this section controlled, influenced or participated in the health care treatment decision; and

(2) the carrier did not deny or delay payment for any treatment prescribed or recommended by a health care provider to the covered person.

d. The provisions of subsection a. and b. of this section shall not be construed to:

(1) require a carrier to pay benefits or provide services for a health care service which is not a covered service; or

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees.

e. A carrier may not include a provision in a contract with a health care provider that exempts the carrier from liability for the acts or conduct of the carrier, and any such provision in an existing contract shall be void.

f. The provisions of any State law which prohibit a carrier from practicing, or being licensed to practice, medicine may not be asserted as a defense by a carrier in an action brought against it pursuant to this or any other act.

g. In an action brought against a carrier, a finding that a health care provider is an employee, agent or other representative of the carrier shall not be based solely on proof that the provider' s name appears on a list of approved health care providers made available to covered

persons under a health benefits plan.

h. A covered person who brings an action against a carrier pursuant to this act shall comply with any requirements as provided by law or court rule for a plaintiff in a medical malpractice case.

3. a. Except as otherwise provided in this section, a covered person may not bring an action against a carrier pursuant to the provisions of subsections a. and b. of section 2 of this act unless the covered person has:

(1) first exhausted an appeal to an independent utilization review organization in accordance with the appeal process set forth at N.J.A.C.8:38-8.7, in the case of a health maintenance organization enrollee, or a comparable appeal process as may be established by statute or by regulation of the Commissioner of Health and Senior Services, in the case of a person covered by another health benefits plan; or

(2) provided written notice by personal delivery or mail of the intended action to the carrier against whom the action is to be brought no later than the 30th day prior to instituting the action, and agreed to submit to an appeal process as provided in paragraph (1) of this subsection.

b. The covered person who has provided written notice to the carrier pursuant to paragraph (2) of subsection a. of this section shall be required to file an appeal as provided in paragraph (1) of that subsection before bringing an action against the carrier, if the carrier requests a review by an independent utilization review organization no later than the 14th day after receipt by the carrier of the written notice from the covered person. If the carrier fails to request the review within that time period, the covered person may bring an action against the carrier without first filing an appeal.

c. Except as otherwise provided in this section, if a covered person has not complied with the provisions of subsection a. of this section prior to bringing an action against a carrier, the court shall not dismiss the action but shall order the parties to the action to submit to the appeal process required pursuant to subsection a. of this section or, at the discretion of the court, an alternative nonbinding dispute resolution process, and shall abate the action for such period as the court determines necessary for that purpose. This order of the court shall be the sole remedy available to a party complaining of a covered person's failure to comply with the provisions of subsection a. of this section.

d. A covered person shall be exempted from the provisions of subsection a. of this section if that person has filed a pleading alleging in substance that:

(1) harm to the covered person has already occurred because of the conduct of the carrier or because of the act or omission of an

employee, agent or other representative thereof for whose conduct the carrier is liable pursuant to subsection b. of section 2 of this act; and

(2) the appeal required pursuant to subsection a. of this section would not be beneficial to the covered person, unless the court, upon the motion of the defendant carrier, finds after a hearing that the pleading filed by the covered person was not made in good faith, in which case the court shall enter an order pursuant to subsection c. of this section.

e. If a covered person seeks to exhaust an appeal as required pursuant to subsection a. of this section before the statute of limitations applicable to a claim against a carrier has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date that the covered person exhausted the appeal; or

(2) the 40th day after the date that the covered person provided written notice to the carrier pursuant to paragraph (2) of subsection a. of this section.

f. The provisions of subsection a. of this section shall not be construed to prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment or relief available under law, if the requirement of exhausting an appeal pursuant to that subsection would place the covered person's health in serious jeopardy.

4. This act shall take effect on the 90th day after enactment.

STATEMENT

This bill would allow consumers to sue their health insurance carrier for medical malpractice.

The bill is premised on a recognition that insurance companies, and in particular health maintenance organizations and other managed care entities, have increasingly interposed themselves in medical decisions in recent years in an effort to reduce or at least slow the rate of increase in their health care costs, by refusing to pay for treatments that physicians recommend for their patients, delaying such care or requiring physicians to try less expensive and less effective treatments first. This bill would enable a consumer to file a malpractice claim and collect an award against a health insurance carrier if the consumer can show that his or her illness or condition was made worse by the carrier's decision to deny, delay or reduce treatments for that person. The bill would subject health insurers to the same potential threat of lawsuits for failure to deliver appropriate health care as health care providers now confront, as an additional means of ensuring that consumers receive quality health care services.

ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, Nos. 3136 and 2055

STATE OF NEW JERSEY

209th LEGISLATURE

ADOPTED MAY 17, 2001

Sponsored by:
Assemblyman STEVE CORODEMUS
District 11 (Monmouth)
Assemblyman GUY F. TALARICO
District 38 (Bergen)
Assemblyman JOHN V. KELLY
District 36 (Bergen, Essex and Passaic)
Assemblyman REED GUSCIORA
District 15 (Mercer)

Co-Sponsored by:
Assemblymen Asselta, Connors, DiGaetano, Assemblywoman Friscia, Assemblymen Gibson, Holzapfel, Lance, Moran, B.Smith, Zecker, Charles, Conaway, Cottrell, Assemblywoman Crecco, Assemblyman Doria, Assemblywoman Greenstein, Assemblymen Impreveduto, Jones, LeFevre, Wisniewski, Wolfe, Biondi, Arnone, Bagger, Blee, Cohen, Felice, Garcia, Payne, Assemblywoman Quigley, Assemblymen Roberts, Sires, Suliga, Assemblywoman Weinberg, Assemblymen Geist, Zisa, Azzolina, Barnes, T.Smith, DeCroce, Assemblywoman Gill, Assemblyman Thompson, Assemblywomen Heck and Watson Coleman

SYNOPSIS

"Health Care Carrier Accountability Act."

CURRENT VERSION OF TEXT

Substitute as adopted by the Assembly Health Committee.

(Sponsorship Updated As Of: 6/29/2001)

AN ACT concerning liability for certain health care treatment decisions, supplementing Title 2A of the New Jersey Statutes and amending P.L.1973, c.337.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) This act shall be known and may be cited as the "Health Care Carrier Accountability Act."

2. (New section) The Legislature hereby finds and declares that:

a. Health and dental carriers, in particular health maintenance organizations and other managed care entities, have become increasingly involved in health care treatment decisions, including, but not limited to, the use of financial incentives to providers and practice guidelines, in an effort to reduce health care costs;

b. As a result, many carriers have been reducing or denying medically necessary health care treatments for their insured patients;

c. Since the carriers are in many instances making medical decisions when they deny, delay, or diminish health care treatments, they should be held to the same level of legal responsibility as physicians and other health care providers who make decisions regarding the necessity and appropriateness of medical care; and

d. It is fair and appropriate that insured patients have the opportunity to dispute carrier or organized delivery system decisions in court, as well as in internal and external appeals procedures, so that these disputes may be quickly and efficiently resolved in ways that best accommodate the needs of the insured patient.

3. (New section) As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with generally accepted standards of health care practice.

"Carrier" means an insurance company, health, hospital or medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State or a dental service corporation or dental plan organization authorized to issue dental benefits plans in this State.

"Covered person" means a person on whose behalf a carrier or organized delivery system offering a health or dental benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a covered person under a health or dental benefits plan for which the

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

carrier or organized delivery system is obligated to pay benefits or provide services.

"Dental benefits plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health or dental benefits plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care service" means a service or product provided by a health care provider to a covered person pursuant to a health or dental benefits plan.

"Health care treatment decision" means a decision made by a health or dental benefits plan at the time health care services are provided or to be provided, which decision affects the diagnosis, care or treatment provided to a covered person.

"Organized delivery system" means an organized delivery system certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Serious or significant harm" means death, serious and protracted or permanent impairment of a bodily function or system, loss of a body organ necessary for normal bodily function, loss of a body member, or exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment.

4. (New section) a. Notwithstanding the provisions of any other law to the contrary, a carrier or organized delivery system shall be liable to a covered person for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay

is the proximate cause of the covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.

Under the provisions of this section, a carrier or organized delivery system shall be liable for the health care treatment decisions of its employees, agents or other representatives over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control.

b. It shall be a defense to any action brought against a carrier or organized delivery system that:

(1) neither the carrier or organized delivery system nor any employee, agent or other representative of the carrier or organized delivery system, for whose conduct the carrier or organized delivery system is liable pursuant to subsection a. of this section, controlled, influenced or participated in the health care treatment decision; and

(2) the carrier or organized delivery system did not deny or delay authorization for any treatment prescribed or recommended to the covered person by a health care provider.

c. The provisions of subsection a. of this section shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits for or provide a health care service that is not a covered service;

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees; or

(3) create any liability on the part of a labor/management Taft-Hartley welfare trust fund established pursuant to 29 U.S.C. s.186.

d. (1) A carrier or organized delivery system shall not include a provision in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system. Any such provision in a contract executed or renewed after the date of enactment of this act shall be void as contrary to the public policy of this State.

(2) The provisions of subsection a. of this section shall not be waived, shifted or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate or shift the liability established by subsection a. of this section through a contract for indemnification or otherwise, that is executed or renewed after the

date of enactment of this act, shall be void as contrary to the public policy of this State.

e. The provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it pursuant to subsection a. of this section.

f. In an action brought against a carrier or organized delivery system pursuant to subsection a. of this section, a finding that a health care provider is an employee, agent or other representative of the carrier or organized delivery system shall not be based solely on proof that the provider's name appears on a list of approved health care providers made available to covered persons under a health or dental benefits plan.

5. (New section) An individual who brings an action against a carrier or organized delivery system pursuant to subsection a. of section 4 of this act shall be required to exhaust an appeal through the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action, unless serious or significant harm to the covered person has occurred or will imminently occur.

6. (New section) a. The court hearing the action authorized by subsection a. of section 4 of this act shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

b. If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan.

c. Nothing in this act shall prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or any other relief available under applicable law, if serious or significant harm to the covered person has occurred or will imminently occur.

7. (New section) a. In any action for economic or non-economic loss to a covered person pursuant to subsection a. of section 4 of this act, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence

with respect to the denial of or delay in approving or providing medically necessary covered services.

b. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

c. An affidavit shall not be required pursuant to subsection a. of this section if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request.

d. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, pursuant to this section, it shall be deemed a failure to state a cause of action.

8. Section 25 of P.L.1973, c.337 (C.26:2J-25) is amended to read as follows:

25. Statutory construction and relationship to other laws.

a. Except as otherwise provided in this act, provisions of the insurance law and provisions of hospital **[**or**]**, medical or health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital **[**or**]**, medical or health service corporation licensed and regulated pursuant to the insurance laws or the hospital **[**or**]**, medical or health service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act. Charges paid by or on behalf of enrollees of a health maintenance organization with respect to health care services shall not be subject to taxation by the State or any of its political subdivisions.

b. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the **[**provision**]** provisions of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine.

d. **[**No**]** Except as provided in P.L. , c. (C.)(pending before the Legislature as this bill), no person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies. The provisions of this subsection shall not be construed to eliminate any cause of action against a health maintenance organization otherwise provided by law.

e. A health maintenance organization shall be subject to the provisions of P.L.1970, c.22 (C.17:27A-1 et seq.), including those relating to merger or acquisition of control.

(cf: P.L.2001, c.2, s.1)

9. This act shall take effect on the 90th day after enactment.

ASSEMBLY HEALTH COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, Nos. 3136 and 2055

STATE OF NEW JERSEY

DATED: MAY 17, 2001

The Assembly Health Committee reports favorably an Assembly Committee Substitute for Assembly Bill Nos. 3136 and 2055.

This committee substitute, which is designated as the "Health Care Carrier Accountability Act," allows persons covered under a health or dental benefits plan issued by a carrier (an insurance company, health, hospital or medical service corporation, health maintenance organization, dental plan organization or dental service corporation) to sue their carrier or an organized delivery system (which contracts with the carrier) for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services. The carrier or organized delivery system is liable when the denial or delay is the proximate cause of: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.

Under the substitute, a carrier or organized delivery system shall be liable for the health care treatment decisions of employees, agents or other representatives of the carrier or organized delivery system over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control. Also, the provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it under this substitute.

The substitute provides that its provisions shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits or provide a health care service that is not a covered service;

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees; or

(3) create any liability on the part of a labor/management Taft-Hartley welfare trust fund established pursuant to 29 U.S.C. s.186.

Further, the substitute prohibits a carrier or organized delivery system from including a provision:

-- in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system; or

-- in a contract or agreement that waives, modifies, delegates or shifts the liability established by this substitute.

Any such provisions in a contract or agreement executed or renewed after the date of enactment of the substitute shall be void as contrary to the public policy of this State.

The substitute provides that the court hearing an action pursuant to this substitute shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

Under the substitute, the covered person is required to exhaust an appeal through the Independent Health Care Appeals Program established in N.J.S.A.26:2S-11 before proceeding with an action against a carrier or organized delivery system, unless serious or significant harm to the covered person has occurred or will imminently occur. The substitute defines "serious or significant harm" to mean: death, serious and protracted or permanent impairment of a bodily function or system, loss of a body organ necessary for normal bodily function, loss of a body member, or exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment.

When the covered person's cause of action is: a physical condition resulting in chronic and significant pain; or substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care, the court hearing the action may employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan.

The substitute provides that its provisions do not preclude a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or any other relief available under applicable law, if serious or significant harm to the covered

person (as defined above) has occurred or will imminently occur.

The substitute also contains requirements for an affidavit of merit in any action for economic or non-economic loss to a covered person, which are similar to those provided in N.J.S.A.2A:53A-26 et seq. A plaintiff is required, within 60 days following the date of filing of the answer to the complaint by the defendant, to provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services.

The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. An affidavit shall not be required if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, it shall be deemed a failure to state a cause of action.

This substitute is identical to the Senate Committee Substitute for Senate Bill Nos. 1333 and 722 Aca (Connors/Singer/Bassano/Turner), which the committee also reported on this date.

§§1-7 -
C.2A:53A-30
to 2A:53A-36
§9 - Note to
§§1-8

P.L. 2001, CHAPTER 187, ***approved July 30, 2001***
Senate Committee Substitute ***(First Reprint)*** for
Senate, Nos. 1333 and 722

AN ACT concerning liability for certain health care treatment decisions, supplementing Title 2A of the New Jersey Statutes and amending P.L.1973, c.337.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. (New section) This act shall be known and may be cited as the "Health Care Carrier Accountability Act."

2. (New section) The Legislature hereby finds and declares that:

a. Health and dental carriers, in particular health maintenance organizations and other managed care entities, have become increasingly involved in health care treatment decisions, including, but not limited to, the use of financial incentives to providers and practice guidelines, in an effort to reduce health care costs;

b. As a result, many carriers have been reducing or denying medically necessary health care treatments for their insured patients;

c. Since the carriers are in many instances making medical decisions when they deny, delay, or diminish health care treatments, they should be held to the same level of legal responsibility as physicians and other health care providers who make decisions regarding the necessity and appropriateness of medical care; and

d. It is fair and appropriate that insured patients have the opportunity to dispute carrier or organized delivery system decisions in court, as well as in internal and external appeals procedures, so that these disputes may be quickly and efficiently resolved in ways that best accommodate the needs of the insured patient.

3. (New section) As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with generally accepted standards of health care practice.

"Carrier" means an insurance company, health, hospital or medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State or a dental service corporation

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted May 17, 2001.

or dental plan organization authorized to issue dental benefits plans in this State.

"Covered person" means a person on whose behalf a carrier or organized delivery system offering a health or dental benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a covered person under a health or dental benefits plan for which the carrier or organized delivery system is obligated to pay benefits or provide services.

"Dental benefits plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health or dental benefits plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care service" means a service or product provided by a health care provider to a covered person pursuant to a health or dental benefits plan.

"Health care treatment decision" means a decision made by a health or dental benefits plan at the time health care services are provided or to be provided, which decision affects the diagnosis, care or treatment provided to a covered person.

"Organized delivery system" means an organized delivery system certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

[1]"Serious or significant harm" means death, serious and protracted or permanent impairment of a bodily function or system, loss of a body organ necessary for normal bodily function, loss of a body member, or exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment.[1]

4. (New section) a. Notwithstanding the provisions of any other law to the contrary, a carrier or organized delivery system shall be liable to a covered person for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of the covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) [1]**[**any**]** substantial[1] physical or mental harm which resulted in further [1]**[**medically necessary**]** substantial[1] medical treatment made [1]medically[1] necessary by the denial or delay of care.

Under the provisions of this section, a carrier or organized delivery system shall be liable for the health care treatment decisions of its employees, agents or other representatives over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control.

b. It shall be a defense to any action brought against a carrier or organized delivery system that:

(1) neither the carrier or organized delivery system nor any employee, agent or other representative of the carrier or organized delivery system, for whose conduct the carrier or organized delivery system is liable pursuant to subsection a. of this section, controlled, influenced or participated in the health care treatment decision; and

(2) the carrier or organized delivery system did not deny or delay authorization for any treatment prescribed or recommended to the covered person by a health care provider.

c. The provisions of subsection a. of this section shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits for or provide a health care service that is not a covered service; [1]**[**or**]**[1]

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees[1]; or

(3) create any liability on the part of a labor/management Taft-Hartley welfare trust fund established pursuant to 29 U.S.C. s.186[1].

d. (1) A carrier or organized delivery system shall not include a provision in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system. Any such provision in a contract executed or renewed after the date of

enactment of this act shall be void as contrary to the public policy of this State.

(2) The provisions of [1]subsection a. of[1] this [1][subsection]section[1] shall not be waived, shifted or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate or shift [1]the[1] liability [1]established by subsection a. of this section through a contract[1] for [1][a breach of the][1] indemnification or otherwise, that is executed or renewed after the date of enactment of this act[1],[1] shall be void as contrary to the public policy of this State.

e. The provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it pursuant to subsection a. of this section.

f. In an action brought against a carrier or organized delivery system pursuant to subsection a. of this section, a finding that a health care provider is an employee, agent or other representative of the carrier or organized delivery system shall not be based solely on proof that the provider's name appears on a list of approved health care providers made available to covered persons under a health or dental benefits plan.

5. (New section) An individual who brings an action against a carrier or organized delivery system pursuant to [1][paragraphs (1) through (5), inclusive, of][1] subsection a. of section 4 of this act shall [1][not][1] be required to [1][file] exhaust[1] an appeal through the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action[1], unless serious or significant harm to the covered person has occurred or will imminently occur[1].

6. (New section) a. The court hearing the action authorized by [1][paragraphs (1) through (5), inclusive, of][1] subsection a. of section 4 of this act shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

b. [1][The court hearing the action authorized by paragraphs (6) and (7) of subsection a. of section 4 of this act may employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

c.][1] If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or

dental benefits plan.

[1][d.] c.[1] Nothing in this act shall prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, [1][an appeal to the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11)][1] or any other relief available under applicable law[1], if serious or significant harm to the covered person has occurred or will imminently occur[1].

7. (New section) a. In any action for economic or non-economic loss to a covered person pursuant to subsection a. of section 4 [1]of[1] this act, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services.

b. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

c. An affidavit shall not be required pursuant to subsection a. of this section if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request.

d. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, pursuant to this section, it shall be deemed a failure to state a cause of action.

8. Section 25 of P.L.1973, c.337 (C.26:2J-25) is amended to read as follows:

25. Statutory construction and relationship to other laws.

a. Except as otherwise provided in this act, provisions of the insurance law and provisions of hospital [or], medical or health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital [or], medical or health service corporation licensed and regulated pursuant to the insurance laws or the hospital [or], medical or health service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act. Charges paid by or on behalf of enrollees of a health maintenance organization with respect to health care services shall not be subject to taxation by the State or any of its political subdivisions.

b. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the [provision] provisions of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine.

d. [No] Except as provided in P.L. , c. (C.)(pending before the Legislature as this bill), no person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies. The provisions of this subsection shall not be construed to eliminate any cause of action against a health maintenance organization otherwise provided by law.

[1]e. A health maintenance organization shall be subject to the provisions of P.L.1970, c.22 (C.17:27A-1 et seq.), including those relating to merger or acquisition of control.[1]

(cf: P.L.1973, c.337, s.25)

9. This act shall take effect on the 90th day after enactment.

"Health Care Carrier Accountability Act."

CHAPTER 187

AN ACT concerning liability for certain health care treatment decisions, supplementing Title 2A of the New Jersey Statutes and amending P.L.1973, c.337.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.2A:53A-30 Short title.

1. This act shall be known and may be cited as the "Health Care Carrier Accountability Act."

C.2A:53A-31 Findings, declarations relative to liability for certain health care treatment decisions.

2. The Legislature hereby finds and declares that:

a. Health and dental carriers, in particular health maintenance organizations and other managed care entities, have become increasingly involved in health care treatment decisions, including, but not limited to, the use of financial incentives to providers and practice guidelines, in an effort to reduce health care costs;

b. As a result, many carriers have been reducing or denying medically necessary health care treatments for their insured patients;

c. Since the carriers are in many instances making medical decisions when they deny, delay, or diminish health care treatments, they should be held to the same level of legal responsibility as physicians and other health care providers who make decisions regarding the necessity and appropriateness of medical care; and

d. It is fair and appropriate that insured patients have the opportunity to dispute carrier or organized delivery system decisions in court, as well as in internal and external appeals procedures, so that these disputes may be quickly and efficiently resolved in ways that best accommodate the needs of the insured patient.

C.2A:53A-32 Definitions relative to liability for certain health care treatment decisions.

3. As used in this act:

"Appropriate and medically necessary" means the standard for health care services as determined by health care providers in accordance with generally accepted standards of health care practice.

"Carrier" means an insurance company, health, hospital or medical service corporation, or health maintenance organization authorized to issue health benefits plans in this State or a dental service corporation or dental plan organization authorized to issue dental benefits plans in this State.

"Covered person" means a person on whose behalf a carrier or organized delivery system offering a health or dental benefits plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a health care service provided to a covered person under a health or dental benefits plan for which the carrier or organized delivery system is obligated to pay benefits or provide services.

"Dental benefits plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

"Health benefits plan" means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by federal law. For the purposes of this act, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service defined by the health or dental benefits plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professionals licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other

health care facilities licensed pursuant to Title 26 of the Revised Statutes.

"Health care service" means a service or product provided by a health care provider to a covered person pursuant to a health or dental benefits plan.

"Health care treatment decision" means a decision made by a health or dental benefits plan at the time health care services are provided or to be provided, which decision affects the diagnosis, care or treatment provided to a covered person.

"Organized delivery system" means an organized delivery system certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Serious or significant harm" means death, serious and protracted or permanent impairment of a bodily function or system, loss of a body organ necessary for normal bodily function, loss of a body member, or exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment.

C.2A:53A-33 Liability of carrier, organized delivery system to covered person.

4. a. Notwithstanding the provisions of any other law to the contrary, a carrier or organized delivery system shall be liable to a covered person for economic and non-economic loss that occurs as a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of the covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay of care.

Under the provisions of this section, a carrier or organized delivery system shall be liable for the health care treatment decisions of its employees, agents or other representatives over whom the carrier or organized delivery system has the right to exercise influence or control, or has actually exercised influence or control.

b. It shall be a defense to any action brought against a carrier or organized delivery system that:

(1) neither the carrier or organized delivery system nor any employee, agent or other representative of the carrier or organized delivery system, for whose conduct the carrier or organized delivery system is liable pursuant to subsection a. of this section, controlled, influenced or participated in the health care treatment decision; and

(2) the carrier or organized delivery system did not deny or delay authorization for any treatment prescribed or recommended to the covered person by a health care provider.

c. The provisions of subsection a. of this section shall not be construed to:

(1) require a carrier or organized delivery system to pay benefits for or provide a health care service that is not a covered service;

(2) create any liability on the part of an employer or other entity that purchases a contract for health care services or assumes risk on behalf of its employees; or

(3) create any liability on the part of a labor/management Taft-Hartley welfare trust fund established pursuant to 29 U.S.C. s.186.

d. (1) A carrier or organized delivery system shall not include a provision in a contract with a health care provider that exempts the carrier or organized delivery system from liability for the acts or conduct of the carrier or organized delivery system. Any such provision in a contract executed or renewed after the date of enactment of this act shall be void as contrary to the public policy of this State.

(2) The provisions of subsection a. of this section shall not be waived, shifted or modified by contract or agreement and responsibility for the provisions shall be a duty that cannot be delegated. Any effort to waive, modify, delegate or shift the liability established by subsection a. of this section through a contract for indemnification or otherwise, that is executed or renewed after the date of enactment of this act,shall be void as contrary to the public policy of this State.

e. The provisions of any State law that prohibit a carrier or organized delivery system from practicing medicine or dentistry, or being licensed to practice medicine or dentistry, may not be asserted as a defense by a carrier or organized delivery system in an action brought against it pursuant to subsection a. of this section.

f. In an action brought against a carrier or organized delivery system pursuant to subsection a. of this section, a finding that a health care provider is an employee, agent or other representative of the carrier or organized delivery system shall not be based solely on proof that the provider's name appears on a list of approved health care providers made available to covered persons under a health or dental benefits plan.

C.2A:53A-34 Exhausting appeal before filing action; exception.

5. An individual who brings an action against a carrier or organized delivery system pursuant to subsection a. of section 4 of this act shall be required to exhaust an appeal through the Independent Health Care Appeals Program created pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action, unless serious or significant harm to the covered person has occurred or will imminently occur.

C.2A:53A-35 Use of alternative dispute resolution methods.

6. a. The court hearing the action authorized by subsection a. of section 4 of this act shall, with the plaintiff's consent, employ alternative dispute resolution methods, including, but not limited to, mediation, binding arbitration and non-binding arbitration, in order to expedite the action and accommodate the needs of the parties to the dispute.

b. If alternative dispute resolution methods are employed, the mediator or arbitrator, as the case may be, may consider whether services denied or delayed are covered services under the health or dental benefits plan.

c. Nothing in this act shall prohibit a covered person from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or any other relief available under applicable law, if serious or significant harm to the covered person has occurred or will imminently occur.

C.2A:53A-36 Affidavit of loss as a result of denial or delay; requirements.

7. a. In any action for economic or non-economic loss to a covered person pursuant to subsection a. of section 4 of this act, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of a physician or other appropriate licensed natural person that there exists a reasonable probability that the loss that occurred was a result of the carrier's or organized delivery system's negligence with respect to the denial of or delay in approving or providing medically necessary covered services.

b. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause. The person executing the affidavit shall be licensed in this or any other state and have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

c. An affidavit shall not be required pursuant to subsection a. of this section if the plaintiff provides a sworn statement in lieu of the affidavit setting forth that: the defendant or other appropriate party involved in the treatment of the covered person has failed to provide the plaintiff with medical records or other records or information having a substantial bearing on preparation of the affidavit; a written request therefor along with, if necessary, a signed authorization by the plaintiff for release of the medical records or other records or information requested, has been made by certified mail or personal service; and at least 45 days have elapsed since the defendant received the request.

d. If the plaintiff fails to provide an affidavit or a statement in lieu thereof, pursuant to this

section, it shall be deemed a failure to state a cause of action.

8. Section 25 of P.L.1973, c.337 (C.26:2J-25) is amended to read as follows:

C.26:2J-25 Statutory construction and relationship to other laws.

25. Statutory construction and relationship to other laws.

a. Except as otherwise provided in this act, provisions of the insurance law and provisions of hospital, medical or health service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital, medical or health service corporation licensed and regulated pursuant to the insurance laws or the hospital, medical or health service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act. Charges paid by or on behalf of enrollees of a health maintenance organization with respect to health care services shall not be subject to taxation by the State or any of its political subdivisions.

b. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

c. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provisions of chapter 9 of Title 45, Medicine and Surgery, of the Revised Statutes relating to the practice of medicine.

d. Except as provided in P.L.2001, c.187 (C.2A:53A-30 et al.), no person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence, misfeasance, nonfeasance or malpractice in connection with the furnishings of such services and supplies. The provisions of this subsection shall not be construed to eliminate any cause of action against a health maintenance organization otherwise provided by law.

e. A health maintenance organization shall be subject to the provisions of P.L.1970, c.22 (C.17:27A-1 et seq.), including those relating to merger or acquisition of control.

9. This act shall take effect on the 90th day after enactment.

Approved July 30, 2001.

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NEWS RELEASE

RELEASE: July 30 , 2001

DiFRANCESCO SIGNS LANDMARK HMO RIGHT TO SUE LEGISTLATION

Acting Governor Donald T. DiFrancesco today signed legislation giving patients the right to sue their health maintenance organizations (HMOs) for delay or denial of care resulting in serious harm.

"While Congress has once again delayed considered of managed care reform in Washington, here in New Jersey we are enacting bipartisan solutions right now. From being one of the first states to enact a patient's bill of rights to the recently enacted Senior Gold discount prescription drug programs for seniors and the disabled, New Jersey has long been a national leader in health care policy. And with today's signing of legislation giving patients the right to sue their health insurance companies New Jersey is again at the forefront of health care policy," stated DiFrancesco.

The new law provides consumers with the right to sue their HMO if the insurer's decision to deny or delay care results in serious harm. In those cases where the serious harm threshold has not been met, patients will first appeal the HMO's care decision through the Independent Health Care Appeals Program and, if no resolution is met, will be able to file suit.

"By utilizing an independent review process, we will safeguard against frivolous lawsuits that could result in increased health care costs, while serving the clear purpose of protecting patients and their families. The legislation is aimed at increasing quality health practices - not lawsuits.

"This new protection is good for patients and preserves the doctor-patient relationship. It also makes out patient's bill of rights one of the strongest in the nation," remarked the acting Governor.

Right to sue legislation is the latest addition to the many programs New Jersey has instituted in recent years to improve the state's health care system. In addition to the patients' bill of rights, KidCare and FamilyCare, the recently enacted Senior Gold program is providing discount prescription drugs to middle-income seniors and the disabled. Taken as a whole, these bills will truly empower New Jersey's patients by providing greater accountability within the health care system, as well as improving access and affordability of services.

The Health Care Carrier Accountability Act was sponsored by Senators Len Connors (R-Atlantic/Burlington/Ocean), Bob Singer (R-Burlington/ Monmouth/Ocean), Lou Bassano (R-Essex/Union) and Shirley Turner (D-Mercer) and by Assemblymembers Steve Corodemus (R-Monmouth), Guy Talarico (R-Bergen), John Kelly (R-Bergen/Essex/Passaic) and Reed Guscoria (D-Mercer).

"I've said it before - health care decisions should be made in a doctor's office, not in an insurance company boardroom. The best possible care should be foremost in any decision made for patients. And we here in New Jersey want it to make sure it stays that way," DiFrancesco concluded.