

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

S1333/722

Identical to Assembly Committee Statement for

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

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"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)

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

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. As used in this act:

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

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

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

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

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

33 "Health care provider" means an individual or entity which, acting
34 within the scope of its licensure or certification, provides a covered
35 service defined by the health benefits plan. Health care provider
36 includes, but is not limited to, a physician and other health care
37 professionals licensed pursuant to Title 45 of the Revised Statutes,
38 and a hospital and other health care facilities licensed pursuant to Title
39 26 of the Revised Statutes.

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

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

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

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

12

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

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

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

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

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

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

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

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

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

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

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

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

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

8

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

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

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

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

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

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

1 in substance that:

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

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

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

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

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

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

27

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

29

30

31

STATEMENT

32

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

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

- 1 lawsuits for failure to deliver appropriate health care as health care
- 2 providers now confront, as an additional means of ensuring that
- 3 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)

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

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. (New section) This act shall be known and may be cited as the
9 "Health Care Insurer Accountability Act of 1998."

10
11 2. (New section) The Legislature hereby finds and declares that:

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

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

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

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

29
30 3. (New section) As used in this act:

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

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

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

42 "Covered service" means a health care service provided to a
43 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 thus is new matter.

1 obligated to pay benefits or provide services.

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

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

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

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

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

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

38

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

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

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

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

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

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

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

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

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

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

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

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

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

39
40 5. (New section) A covered person shall file an appeal of a
41 carrier's health care treatment decision under the carrier's internal
42 patient appeals process, if any, or with the Independent Health Care
43 Appeals Program created pursuant to section 11 of the "Health Care
44 Quality Act," P.L.1997, c.192 (C.26:2S-11), as appropriate, at the
45 same time that the covered person institutes an action against a carrier
46 pursuant to this act.

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

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

13
14 7. Section 1 of P.L.1995, c.139 (C.2A:53A-26) is amended as
15 follows:

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

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

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

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

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

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

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

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

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

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

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

32 k. a carrier as defined in section 3 of P.L. , c. (C.)(pending
33 before the Legislature as this bill).

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

35
36 8. Section 2 of P.L.1995, c.139 (C.2A:53A-27) is amended as
37 follows:

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

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

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

15

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

18 25. Statutory construction and relationship to other laws.

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

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

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

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

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

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

2

3

4

STATEMENT

5

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

15 This bill provides that at the same time a covered person institutes
16 a malpractice action against a carrier, they must file an appeal under
17 the carrier's internal grievance procedure, if any, or with the
18 Independent Health Care Appeals Program, created pursuant to the
19 "Health Care Quality Act," P.L.1997, c.192 (C.26:2S-1 et seq.), as
20 appropriate. Information generated in the appeal process will augment
21 the lawsuit in ways that will encourage the quick and efficient
22 resolution of disputes. The bill requires covered persons and carriers
23 to make full use of alternative dispute resolution techniques to
24 expedite the case in order to accommodate the needs of the covered
25 person and the often time-sensitive nature of these disputes, and to
26 achieve a solution that is fair and equitable to the parties. Litigants
27 will still have the ability to apply for appropriate remedies from the
28 court, including injunctive relief. The bill also requires that covered
29 persons who institute a lawsuit against a carrier for medical
30 malpractice comply with the affidavit of merit requirement of section
31 2 of P.L.1995, c.139 (C.2A:53A-27).

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

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

1 licensed to practice medicine.

2 Finally, the bill does not require carriers to pay benefits or provide
3 services that are not covered, and also provides certain defenses for
4 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:

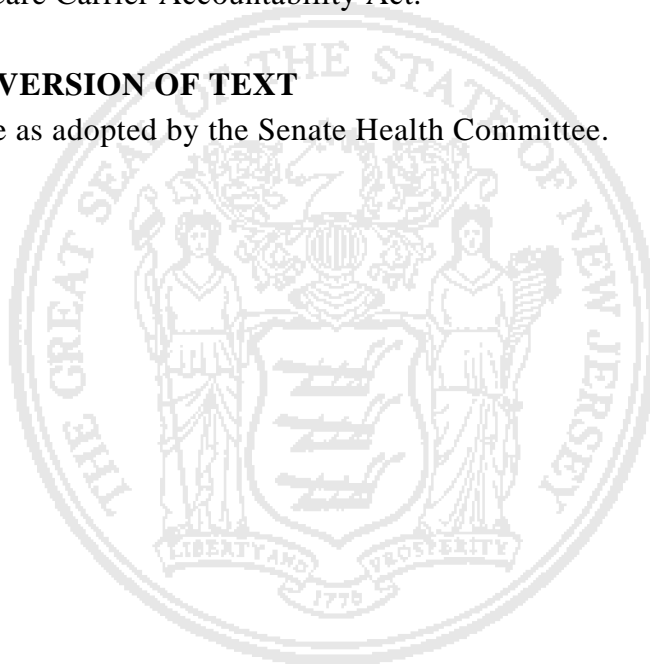
**Senators Allen, Bennett, Adler, Robertson, Baer, McNamara, Gormley,
Vitale, Kosco, Sinagra and Zane**

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)

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

4

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

7

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

10

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

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

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

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

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

29

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

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

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

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

42 "Covered service" means a health care service provided to a
43 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 thus is new matter.

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

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

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

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

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

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

32 "Organized delivery system" means an organized delivery system
33 certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).
34

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6
7 5. (New section) An individual who brings an action against a
8 carrier or organized delivery system pursuant to paragraphs (1)
9 through (5), inclusive, of subsection a. of section 4 of this act shall not
10 be required to file an appeal through the Independent Health Care
11 Appeals Program created pursuant to section 11 of P.L.1997, c.192
12 (C.26:2S-11) before filing an action.

13
14 6. (New section) a. The court hearing the action authorized by
15 paragraphs (1) through (5), inclusive, of subsection a. of section 4 of
16 this act shall, with the plaintiff's consent, employ alternative dispute
17 resolution methods, including, but not limited to, mediation, binding
18 arbitration and non-binding arbitration, in order to expedite the action
19 and accommodate the needs of the parties to the dispute.

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

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

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

34
35 7. (New section) a. In any action for economic or non-economic
36 loss to a covered person pursuant to subsection a. of section 4 this act,
37 the plaintiff shall, within 60 days following the date of filing of the
38 answer to the complaint by the defendant, provide each defendant with
39 an affidavit of a physician or other appropriate licensed natural person
40 that there exists a reasonable probability that the loss that occurred
41 was a result of the carrier's or organized delivery system's negligence
42 with respect to the denial of or delay in approving or providing
43 medically necessary covered services.

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

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

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

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

22

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

25 25. Statutory construction and relationship to other laws.

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

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

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

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

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

11

12 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:

- C 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";
- C 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;
- C 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;

- C 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;
- C 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;
- C 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;
- C 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
- C 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)

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

4

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

7

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

10

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

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

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

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

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

29

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

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

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

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

42 "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 thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹ Assembly AHL committee amendments adopted May 17, 2001.

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

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

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

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

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

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

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

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

41

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

1 providing medically necessary covered services, which denial or delay
2 is the proximate cause of the covered person's: (1) death; (2) serious
3 and protracted or permanent impairment of a bodily function or
4 system; (3) loss of a body organ necessary for normal bodily function;
5 (4) loss of a body member; (5) exacerbation of a serious or life-
6 threatening disease or condition that results in serious or significant
7 harm or requires substantial medical treatment; (6) a physical condition
8 resulting in chronic and significant pain; or (7) ¹[any] substantial¹
9 physical or mental harm which resulted in further ¹[medically
10 necessary] substantial¹ medical treatment made ¹medically¹ necessary
11 by the denial or delay of care.

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

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

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

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

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

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

32 (2) create any liability on the part of an employer or other entity
33 that purchases a contract for health care services or assumes risk on
34 behalf of its employees¹; or

35 (3) create any liability on the part of a labor/management Taft-
36 Hartley welfare trust fund established pursuant to 29 U.S.C. s.186¹.

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

44 (2) The provisions of ¹subsection a. of¹ this ¹[subsection]section¹
45 shall not be waived, shifted or modified by contract or agreement and
46 responsibility for the provisions shall be a duty that cannot be

1 delegated. Any effort to waive, modify, delegate or shift ¹the¹ liability
2 ¹established by subsection a. of this section through a contract¹ for
3 ¹[a breach of the]¹ indemnification or otherwise, that is executed or
4 renewed after the date of enactment of this act^{1,1} shall be void as
5 contrary to the public policy of this State.

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

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

18
19 5. (New section) An individual who brings an action against a
20 carrier or organized delivery system pursuant to ¹[paragraphs (1)
21 through (5), inclusive, of]¹ subsection a. of section 4 of this act shall
22 ¹[not]¹ be required to ¹[file] exhaust¹ an appeal through the
23 Independent Health Care Appeals Program created pursuant to section
24 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action¹, unless
25 serious or significant harm to the covered person has occurred or will
26 imminently occur¹.

27
28 6. (New section) a. The court hearing the action authorized by
29 ¹[paragraphs (1) through (5), inclusive, of]¹ subsection a. of section
30 4 of this act shall, with the plaintiff's consent, employ alternative
31 dispute resolution methods, including, but not limited to, mediation,
32 binding arbitration and non-binding arbitration, in order to expedite
33 the action and accommodate the needs of the parties to the dispute.

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

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

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

1 Appeals Program created pursuant to section 11 of P.L.1997, c.192
2 (C.26:2S-11)]¹ or any other relief available under applicable law¹, if
3 serious or significant harm to the covered person has occurred or will
4 imminently occur¹.

5
6 7. (New section) a. In any action for economic or non-economic
7 loss to a covered person pursuant to subsection a. of section 4 ¹of¹
8 this act, the plaintiff shall, within 60 days following the date of filing
9 of the answer to the complaint by the defendant, provide each
10 defendant with an affidavit of a physician or other appropriate licensed
11 natural person that there exists a reasonable probability that the loss
12 that occurred was a result of the carrier's or organized delivery
13 system's negligence with respect to the denial of or delay in approving
14 or providing medically necessary covered services.

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

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

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

39
40 8. Section 25 of P.L.1973, c.337 (C.26:2J-25) is amended to read
41 as follows:

42 25. Statutory construction and relationship to other laws.

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

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

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

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

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

26 ¹e. A health maintenance organization shall be subject to the
27 provisions of P.L.1970, c.22 (C.17:27A-1 et seq.), including those
28 relating to merger or acquisition of control.¹
29 (cf: P.L.1973, c.337, s.25)

30

31 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:

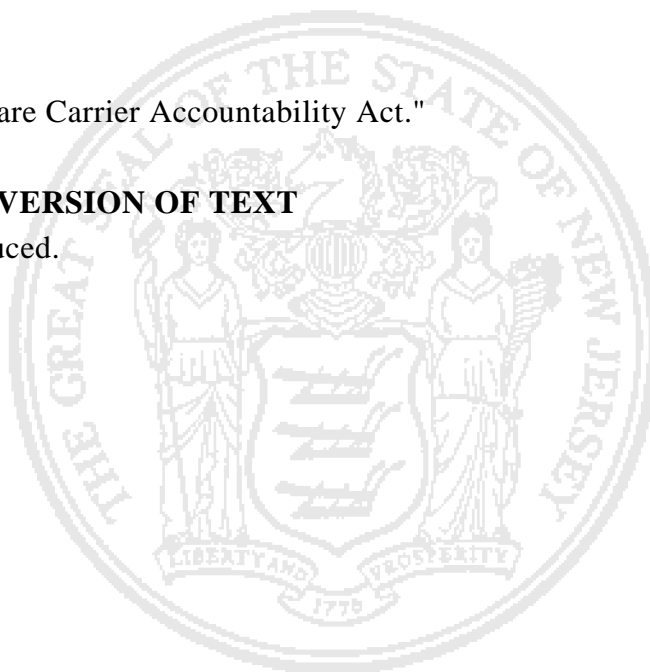
Assemblymen Asselta, Connors, DiGaetano, Assemblywoman Friscia, Assemblymen Gibson, Holzapfel, Kelly, Lance, Moran, B.Smith, Zecker, Charles, Conaway, Cottrell, Assemblywoman Crecco, Assemblyman Doria, Assemblywoman Greenstein, Assemblymen Impreveduto, Jones, LeFevre, Wisniewski, Wolfe, Biondi, Arnone, 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)

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

4

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

7

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

10

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

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

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

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

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

29

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

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

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

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

42 "Covered service" means a health care service provided to a
43 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 thus is new matter.

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

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

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

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

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

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

32 "Organized delivery system" means an organized delivery system
33 certified or licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).
34

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12
13 6. (New section) a. The court hearing the action authorized by
14 paragraphs (1) through (5), inclusive, of subsection a. of section 4 of
15 this act shall, with the plaintiff's consent, employ alternative dispute
16 resolution methods, including, but not limited to, mediation, binding
17 arbitration and non-binding arbitration, in order to expedite the action
18 and accommodate the needs of the parties to the dispute.

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

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

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

33
34 7. (New section) a. In any action for economic or non-economic
35 loss to a covered person pursuant to subsection a. of section 4 this act,
36 the plaintiff shall, within 60 days following the date of filing of the
37 answer to the complaint by the defendant, provide each defendant with
38 an affidavit of a physician or other appropriate licensed natural person
39 that there exists a reasonable probability that the loss that occurred
40 was a result of the carrier's or organized delivery system's negligence
41 with respect to the denial of or delay in approving or providing
42 medically necessary covered services.

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

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

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

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

21

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

24 25. Statutory construction and relationship to other laws.

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

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

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

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

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

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

12
13
14 STATEMENT

15
16 This bill, the "Health Care Carrier Accountability Act," allows
17 persons covered under a health or dental benefits plan issued by a
18 carrier (an insurance company, health, hospital or medical service
19 corporation, health maintenance organization, dental plan organization
20 or dental service corporation) to sue their carrier or an organized
21 delivery system (which contracts with the carrier) for economic and
22 non-economic loss that occurs as a result of the carrier's or organized
23 delivery system's negligence with respect to the denial of or delay in
24 approving or providing medically necessary covered services. The
25 carrier or organized delivery system is liable when the denial or delay
26 is the proximate cause of: (1) death; (2) serious and protracted or
27 permanent impairment of a bodily function or system; (3) loss of a
28 body organ necessary for normal bodily function; (4) loss of a body
29 member; (5) exacerbation of a serious or life-threatening disease or
30 condition; (6) a physical condition resulting in chronic and significant
31 pain; or (7) any physical or mental harm which resulted in further
32 medically necessary medical treatment made necessary by the denial or
33 delay of care.

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

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

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

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

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

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

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

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

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

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

4 The court may grant no more than one additional period, not to
5 exceed 60 days, to file the affidavit, upon a finding of good cause.
6 The person executing the affidavit shall be licensed in this or any other
7 state and have particular expertise in the general area or specialty
8 involved in the action, as evidenced by board certification or by
9 devotion of the person's practice substantially to the general area or
10 specialty involved in the action for a period of at least five years. An
11 affidavit shall not be required if the plaintiff provides a sworn
12 statement in lieu of the affidavit setting forth that: the defendant or
13 other appropriate party involved in the treatment of the covered
14 person has failed to provide the plaintiff with medical records or other
15 records or information having a substantial bearing on preparation of
16 the affidavit; a written request therefor along with, if necessary, a
17 signed authorization by the plaintiff for release of the medical records
18 or other records or information requested, has been made by certified
19 mail or personal service; and at least 45 days have elapsed since the
20 defendant received the request. If the plaintiff fails to provide an
21 affidavit or a statement in lieu thereof, it shall be deemed a failure to
22 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)

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

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. As used in this act:

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

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

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

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

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

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

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

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

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

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

9

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

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

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

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

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

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

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

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

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

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

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

1 persons under a health benefits plan.

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

5

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

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

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

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

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

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

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

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

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

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

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

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

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

24

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

26

27

28

STATEMENT

29

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

32 The bill is premised on a recognition that insurance companies, and
33 in particular health maintenance organizations and other managed care
34 entities, have increasingly interposed themselves in medical decisions
35 in recent years in an effort to reduce or at least slow the rate of
36 increase in their health care costs, by refusing to pay for treatments
37 that physicians recommend for their patients, delaying such care or
38 requiring physicians to try less expensive and less effective treatments
39 first. This bill would enable a consumer to file a malpractice claim and
40 collect an award against a health insurance carrier if the consumer can
41 show that his or her illness or condition was made worse by the
42 carrier's decision to deny, delay or reduce treatments for that person.
43 The bill would subject health insurers to the same potential threat of
44 lawsuits for failure to deliver appropriate health care as health care
45 providers now confront, as an additional means of ensuring that
46 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)

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

4

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

7

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

10

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

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

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

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

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

29

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

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

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

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

42 "Covered service" means a health care service provided to a
43 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 thus is new matter.

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

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

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

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

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

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

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

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

40

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15

16 5. (New section) An individual who brings an action against a
17 carrier or organized delivery system pursuant to subsection a. of
18 section 4 of this act shall be required to exhaust an appeal through the
19 Independent Health Care Appeals Program created pursuant to section
20 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action, unless
21 serious or significant harm to the covered person has occurred or will
22 imminently occur.

23

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

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

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

39

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

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

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

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

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

27

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

30 25. Statutory construction and relationship to other laws.

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

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

- 1 c. Any health maintenance organization authorized under this act
2 shall not be deemed to be practicing medicine and shall be exempt
3 from the ~~[provision]~~ provisions of chapter 9 of Title 45, Medicine and
4 Surgery, of the Revised Statutes relating to the practice of medicine.
- 5 d. ~~[No]~~ Except as provided in P.L. , c. (C.)(pending before
6 the Legislature as this bill), no person participating in the
7 arrangements of a health maintenance organization other than the
8 actual provider of health care services or supplies directly to enrollees
9 and their families shall be liable for negligence, misfeasance,
10 nonfeasance or malpractice in connection with the furnishings of such
11 services and supplies. The provisions of this subsection shall not be
12 construed to eliminate any cause of action against a health
13 maintenance organization otherwise provided by law.
- 14 e. A health maintenance organization shall be subject to the
15 provisions of P.L.1970, c.22 (C.17:27A-1 et seq.), including those
16 relating to merger or acquisition of control.
17 (cf: P.L.2001, c.2, s.1)
18
- 19 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.

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

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

4

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

7

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

10

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

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

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

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

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

29

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

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

34 "Carrier" means an insurance company, health, hospital or medical
35 service corporation, or health maintenance organization authorized to
36 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.

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

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

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

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

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

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

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

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

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

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

1 4. (New section) a. Notwithstanding the provisions of any other
2 law to the contrary, a carrier or organized delivery system shall be
3 liable to a covered person for economic and non-economic loss that
4 occurs as a result of the carrier's or organized delivery system's
5 negligence with respect to the denial of or delay in approving or
6 providing medically necessary covered services, which denial or delay
7 is the proximate cause of the covered person's: (1) death; (2) serious
8 and protracted or permanent impairment of a bodily function or
9 system; (3) loss of a body organ necessary for normal bodily function;
10 (4) loss of a body member; (5) exacerbation of a serious or life-
11 threatening disease or condition that results in serious or significant
12 harm or requires substantial medical treatment; (6) a physical condition
13 resulting in chronic and significant pain; or (7) ¹[any] substantial¹
14 physical or mental harm which resulted in further ¹[medically
15 necessary] substantial¹ medical treatment made ¹medically¹ necessary
16 by the denial or delay of care.

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

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

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

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

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

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

37 (2) create any liability on the part of an employer or other entity
38 that purchases a contract for health care services or assumes risk on
39 behalf of its employees¹; or

40 (3) create any liability on the part of a labor/management Taft-
41 Hartley welfare trust fund established pursuant to 29 U.S.C. s.186¹.

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

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

3 (2) The provisions of ¹subsection a. of¹ this ¹~~subsection~~¹section¹
4 shall not be waived, shifted or modified by contract or agreement and
5 responsibility for the provisions shall be a duty that cannot be
6 delegated. Any effort to waive, modify, delegate or shift ¹~~the~~¹ liability
7 ¹established by subsection a. of this section through a contract¹ for
8 ¹~~a breach of the~~¹ indemnification or otherwise, that is executed or
9 renewed after the date of enactment of this act^{1,1} shall be void as
10 contrary to the public policy of this State.

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

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

23

24 5. (New section) An individual who brings an action against a
25 carrier or organized delivery system pursuant to ¹~~paragraphs (1)~~¹
26 ~~through (5), inclusive, of]~~¹ subsection a. of section 4 of this act shall
27 ¹~~not~~¹ be required to ¹~~file]~~ exhaust¹ an appeal through the
28 Independent Health Care Appeals Program created pursuant to section
29 11 of P.L.1997, c.192 (C.26:2S-11) before filing an action¹, unless
30 serious or significant harm to the covered person has occurred or will
31 imminently occur¹.

32

33 6. (New section) a. The court hearing the action authorized by
34 ¹~~paragraphs (1) through (5), inclusive, of]~~¹ subsection a. of section
35 4 of this act shall, with the plaintiff's consent, employ alternative
36 dispute resolution methods, including, but not limited to, mediation,
37 binding arbitration and non-binding arbitration, in order to expedite
38 the action and accommodate the needs of the parties to the dispute.

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

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

1 dental benefits plan.

2 ¹[d.] c.¹ Nothing in this act shall prohibit a covered person from
3 pursuing other appropriate remedies, including injunctive relief, a
4 declaratory judgment, ¹[an appeal to the Independent Health Care
5 Appeals Program created pursuant to section 11 of P.L.1997, c.192
6 (C.26:2S-11)]¹ or any other relief available under applicable law¹ if
7 serious or significant harm to the covered person has occurred or will
8 imminently occur¹.

9

10 7. (New section) a. In any action for economic or non-economic
11 loss to a covered person pursuant to subsection a. of section 4 ¹of¹
12 this act, the plaintiff shall, within 60 days following the date of filing
13 of the answer to the complaint by the defendant, provide each
14 defendant with an affidavit of a physician or other appropriate licensed
15 natural person that there exists a reasonable probability that the loss
16 that occurred was a result of the carrier's or organized delivery
17 system's negligence with respect to the denial of or delay in approving
18 or providing medically necessary covered services.

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

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

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

43

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

46 25. Statutory construction and relationship to other laws.

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

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

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

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

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

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

34

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

36

37

38

39

40 "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.

Office of the Governor

PO BOX 004
TRENTON, NJ 08625

NEWS RELEASE

CONTACT: Rae Hutton
609-777-2600

RELEASE: July 30 , 2001

DiFRANCESCO SIGNS LANDMARK HMO RIGHT TO SUE LEGISLATION

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.