# 2A:53A-37

**LEGISLATIVE HISTORY CHECKLIST**

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**LAWS OF**: 2004 **CHAPTER:** 17

**NJSA:** 2A:53A-37 ("New Jersey Medical Care Access…Act")

**BILL NO**: A50 (Substituted for S50/551)

**SPONSOR(S):** Roberts and others

**DATE INTRODUCED:** March 4, 2004

**COMMITTEE:** **ASSEMBLY:** Appropriations; Health and Human Services; Financial Institutions

**SENATE:** Health, Human Services and Senior Citizens

**AMENDED DURING PASSAGE**: Yes

**DATE OF PASSAGE:** **ASSEMBLY:** May 24, 2004

**SENATE:** March 29, 2004

**DATE OF APPROVAL:** June 7, 2004

**FOLLOWING ARE ATTACHED IF AVAILABLE:**

**FINAL TEXT OF BILL** (Assembly Committee Substitute (2R) enacted)

(Amendments during passage denoted by asterisks)

**A50**

**SPONSOR'S STATEMENT**: (Begins on page 19 of original bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY**: Yes 3-4-2004 (Approp.)
3-4-2004 (Health)
3-4-2004 (Finan. Inst.)

**SENATE**: Yes

**FLOOR AMENDMENT STATEMENT**: Yes

**LEGISLATIVE FISCAL ESTIMATE**: Yes

**S50/551**

**SPONSOR'S STATEMENT (S50)**: (Begins on page 25 of original bill) Yes

**SPONSOR'S STATEMENT (S551)**: (Begins on page 23 of original bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY**: No

**SENATE**: Yes

**FLOOR AMENDMENT STATEMENT:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

**VETO MESSAGE:** No

**GOVERNOR'S PRESS RELEASE ON SIGNING:** Yes

**FOLLOWING WERE PRINTED:**

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext. 103 or mailto:refdesk@njstatelib.org.

**REPORTS:** No

**HEARINGS:**

974.90 New Jersey. Legislature. Assembly. Health and Human Services and Banking and Insurance
H434 "Testimony concerning issues…enhancement of patient safety", held August 1, 2002.
2002b Trenton, 2002

974.90 New Jersey.Legislature. Assembly. Health and Human Services and Banking and Insurance Committee
I59 Public hearing on "testimony to provide medical malpractice insurance….held May 1, 2003
2003 Trenton, 2003.

974.90 New Jersey. Legislature. Special Committee to Investigate Medical Malpractice Insurer Business
I59 Practices
2003a Testimony on information related to the business practices of medical malpractice insurance Companies, held 10-2-2003. Trenton, 2003

**NEWSPAPER ARTICLES:** Yes

"Medical malpractice law is enacted," 1-8-2004 Philadelphia Inquirer, p.B1
"New Jersey starts fund for malpractice costs," 6-8-2004 New York Times p.B5
"McGreevey approves bill on medical-malpractice aid," 6-8-2004 Home News Tribune pA4
"Governor signs medical malpractice law," 6-8-2004 The Record, pA3
"Malpractice bill is signed into law," 6-8-2004 Star Ledger, p20
"Long ordeal ends; malpractice reform adopted," 1-8-2004 Asbury Park Press, pA1

§§1,2, 5-7, 9
C.2A:53A-37
to
2A:53A-42
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C.2A:62A-1.3
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Chapter 71a
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OB/GYN STUDENT
LOAN PROGRAM
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P.L. 2004, CHAPTER 17, ***approved June 7, 2004***
Assembly Committee Substitute ***(Second Reprint)*** for
Assembly, No. 50

**AN ACT** concerning medical professional liability, insurance reform and patient protection and revising parts of the statutory law.

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

1. (New section) This act shall be known and may be cited as the "New Jersey Medical Care Access and Responsibility and Patients First Act."

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

a. One of the most vital interests of the State is to ensure that high-quality health care continues to be available in this State and that the residents of this State continue to have access to a full spectrum of health care providers, including highly trained physicians in all specialties;

b. The State's health care system and its residents' access to health care providers are threatened by a dramatic escalation in medical

**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 floor amendments adopted March 11, 2004.**
**[2] Senate SHH committee amendments adopted March 22, 2004.**

malpractice liability insurance premiums, which is creating a crisis of affordability in the purchase of necessary liability coverage for our health care providers;

c. One particularly alarming result of rising premiums is that there are increasing reports of doctors retiring or moving to other states where insurance premiums are lower, dropping high-risk patients and procedures, and practicing defensive medicine in a manner that may significantly increase the cost of health care for all our citizens;

d. The reasons for the steep increases in the cost of medical malpractice liability insurance are complex and involve issues related to: the State's tort liability system; the State's health care system, which includes issues related to patient safety and medical error reporting; and the State's regulation and requirements concerning medical malpractice liability insurers;

e. It is necessary and appropriate for the State to take meaningful and prompt action to address the various interrelated aspects of these issues that are impacted by, or impact on, the State's health care system; and

f. To that end, this act provides for a comprehensive set of reforms affecting the State's tort liability system, health care system and medical malpractice liability insurance carriers to ensure that health care services continue to be available and accessible to residents of the State and to enhance patient safety at health care facilities.

3. N.J.S.2A:14-2 is amended to read as follows:

2A:14-2. [1] a.[1] Every action at law for an injury to the person caused by the wrongful act, neglect or default of any person within this [state] State shall be commenced within 2 years next after the cause of any such action shall have accrued; except that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 13th birthday.

[1]b. In the event that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth is not commenced by the minor's parent or guardian prior to the minor's 12th birthday, the minor or a person 18 years of age or older designated by the minor to act on the minor's behalf may commence such an action. For this purpose, the minor or designated person may petition the court for the appointment of a guardian ad litem to act on the minor's behalf.[1]

(cf: N.J.S.2A:14-2)

4. N.J.S.2A:14-21 is amended to read as follows:

2A:14-21. If any person entitled to any of the actions or proceedings specified in [sections] N.J.S.2A:14-1 to 2A:14-8 or [sections] N.J.S.2A:14-16 to 2A:14-20 [of this title] or to a right or

title of entry under [section] N.J.S.2A:14-6 [of this title] is or shall be, at the time of any such cause of action or right or title accruing, under the age of 21 years, or insane, such person may commence such action or make such entry, within such time as limited by [said sections] those statutes, after his coming to or being of full age or of sane mind. Notwithstanding the provisions of this section to the contrary, an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 13th birthday, as provided in N.J.S.2A:14-2.
(cf: N.J.S.2A:14-21)

5. (New section) The judge presiding over a medical malpractice action, or the judge's designee, shall, within 30 days after the discovery end date, determine whether referral to a complementary dispute resolution mechanism may encourage early disposition or settlement of the action. If the judge makes such a determination, the matter shall be referred to complementary dispute resolution pursuant to Rule 1:40 of the Rules Governing the Courts of the State of New Jersey.

Nothing in this section shall be construed to limit the authority of the judge to refer an action to complementary dispute resolution prior to the discovery end date.

6. (New section) a. A health care provider named as a defendant in a medical malpractice action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant, and could not have caused the alleged malpractice, either individually or through its servants or employees, in any way.

b. A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting an affidavit that contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

c. If the court determines that a health care provider named as a defendant falsely files or makes false or inaccurate statements in an affidavit of noninvolvement, the court, upon motion or upon its own initiative, shall immediately reinstate the claim against that provider. Reinstatement of a party pursuant to this subsection shall not be barred by any statute of limitations defense that was not valid at the time the original action was filed.

In any action in which the health care provider is found by the

court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the party, or both, an appropriate sanction, including, but not limited to, [2][a civil penalty not to exceed $10,000 and]2 an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the filing of the false or inaccurate affidavit, including a reasonable attorney fee. The court shall also refer the matter to the Attorney General and the appropriate professional licensing board for further review.

d. If the court determines that a plaintiff falsely objected to a health care provider's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a health care provider's affidavit, the court shall impose upon the plaintiff or the plaintiff's counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the [2]submission of the[2] false objection or inaccurate statement, including a reasonable attorney fee. [2]The court shall also refer the matter to the Attorney General and the appropriate professional licensing board for further review.[2]

e. As used in this section, "health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to: a physician, dentist, nurse, pharmacist or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes; and a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.)

7. (New section) In an action alleging medical malpractice, a person shall not give expert testimony or execute an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.) on the appropriate standard of practice or care unless the person is licensed as a physician or other health care professional in the United States and meets the following criteria:

a. If the party against whom or on whose behalf the testimony is offered is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association and the care or treatment at issue involves that specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, the person providing the testimony shall have specialized at the time of the occurrence that is the basis for the action in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American Osteopathic Association, as the party against whom or on whose behalf the testimony is offered, and if the person against whom or on whose behalf the testimony is being offered is board certified and the care or treatment at issue involves that board specialty or

subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, the expert witness shall be:

(1) a physician credentialed by a hospital to treat patients for the medical condition, or to perform the procedure, that is the basis for the claim or action; or

(2) a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association who is board certified in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American Osteopathic Association, and during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to either:

(a) the active clinical practice of the same health care profession in which the defendant is licensed, and, if the defendant is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, the active clinical practice of that specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(b) the instruction of students in an accredited medical school, other accredited health professional school or accredited residency or clinical research program in the same health care profession in which the defendant is licensed, and, if that party is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, an accredited medical school, health professional school or accredited residency or clinical research program in the same specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(c) both.

b. If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to:

(1) active clinical practice as a general practitioner; or active clinical practice that encompasses the medical condition, or that includes performance of the procedure, that is the basis of the claim or action; or

(2) the instruction of students in an accredited medical school, health professional school, or accredited residency or clinical research program in the same health care profession in which the party against whom or on whose behalf the testimony is licensed; or

(3) both.

c. A court may waive the same specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association and board certification

requirements of this section, upon motion by the party seeking a waiver, if, after the moving party has demonstrated to the satisfaction of the court that a good faith effort has been made to identify an expert in the same specialty or subspecialty, the court determines that the expert possesses sufficient training, experience and knowledge to provide the testimony as a result of active involvement in, or full-time teaching of, medicine in the applicable area of practice or a related field of medicine.

d. Nothing in this section shall limit the power of the trial court to disqualify an expert witness on grounds other than the qualifications set forth in this section.

e. In an action alleging medical malpractice, an expert witness shall not testify on a contingency fee basis.

f. An individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.), which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure, shall be liable to a civil penalty not to exceed $10,000 and other damages incurred by the person and the party for whom the person was testifying as an expert.

**[1]**8. Section 2 of P.L.1995, c.139 (C.2A:53A-27) is amended to read as follows:

2. In any action for damages for personal injuries, wrongful death or property damage resulting from an alleged act of malpractice or negligence by a licensed person in his profession or occupation, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational standards or treatment practices. 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**]** <u>In the case of an action for medical malpractice, the person executing the affidavit shall meet the requirements of a person who provides expert testimony or executes an affidavit as set forth in section 7 of P.L. , c. (C. )(pending before the Legislature as this bill). In all other cases, the</u> person executing the affidavit shall be licensed in this or any other state; have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome

of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.[1]

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

[1][8.] 9.[1] (New section) [2][a.][2] A judge presiding over an action alleging medical malpractice, in which the jury has rendered a verdict in favor of the complaining party, shall, upon a motion by any party for additur or remittitur on the issue of the quantum of damages, consider the evidence in the light most favorable to the non-moving party and determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

[2][b. The provisions of subsection a. of this section shall apply to claims filed on or after the effective date of this act.][2]

[1][9.] 10.[1] (New section) a. If an individual's actual health care facility duty, including on-call duty, does not require a response to a patient emergency situation, a health care professional who, in good faith, responds to a life-threatening emergency or responds to a request for emergency assistance in a life-threatening emergency within a hospital or other health care facility, is not liable for civil damages as a result of an act or omission in the rendering of emergency care. The immunity granted pursuant to this section shall not apply to acts or omissions constituting gross negligence, recklessness or willful misconduct.

b. The provisions of subsection a. of this section shall not apply to a health care professional if a provider-patient relationship existed before the emergency, or if consideration in any form is provided to the health care professional for the service rendered.

c. The provisions of subsection a. of this section [2][shall not apply if a general hospital has not reasonably and adequately staffed its emergency department] do not diminish a general hospital's responsibility to comply with all Department of Health and Senior Services licensure requirements concerning medical staff availability at the hospital[2].

d. A health care professional shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

(1) the patient was unconscious;

(2) the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

(3) the medical procedure was performed on a person legally

incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The provisions of this subsection shall apply only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

e. As used in this section:

(1) "Health care professional" means a physician, dentist, nurse or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes and an emergency medical technician or mobile intensive care paramedic certified by the Commissioner of Health and Senior Services pursuant to Title 26 of the Revised Statutes; and

(2) "Health care facility" means a health care facility licensed by the Department of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

**[1]** **[**10.**]** 11. **[1]** Section 1 of P.L.1995, c.69 (C.45:9-19.16) is amended to read as follows:

1. a. A physician licensed by the State Board of Medical Examiners, or a physician who is an applicant for a license from the State Board of Medical Examiners, shall notify the board within 10 days of :

(1) any action taken against the physician's medical license by any other state licensing board or any action affecting the physician's privileges to practice medicine by any out-of-State hospital, health care facility, health maintenance organization or other employer;

(2) any pending or final action by any criminal authority for violations of law or regulation, or any arrest or conviction for any criminal or quasi-criminal offense pursuant to the laws of the United States, this State or another state, including, but not limited to:

(a) criminal homicide pursuant to N.J.S.2C:11-2;

(b) aggravated assault pursuant to N.J.S.2C:12-1;

(c) sexual assault, criminal sexual contact or lewdness pursuant to N.J.S.2C:14-2 through 2C:14-4; or

(d) an offense involving any controlled dangerous substance or controlled substance analog as set forth in chapter 35 of Title 2C of the New Jersey Statutes.

b. A physician who is in violation of this section is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).

c. The State Board of Medical Examiners shall notify all physicians licensed by the board of the requirements of this section

within 30 days of the date of enactment of this act.
(cf: P.L.1995, c.69, s.1)

[1][11.] 12.[1] Section 13 of P.L.1989, c.300 (C.45:9-19.13) is amended to read as follows:

13. a. In any case in which the State Board of Medical Examiners refuses to issue, suspends, revokes or otherwise conditions the license, registration, or permit of a physician, podiatrist or medical resident or intern, the board shall, within 30 days of its action, notify each licensed health care facility, psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7, and health maintenance organization with which the person is affiliated and every board licensee in the State with which the person is directly associated in his private medical practice.

b. If, during the course of an investigation of a physician, the board requests information from a health care facility, psychiatric hospital operated by the Department of Human Services or health maintenance organization regarding that physician, and the board subsequently makes a finding of no basis for disciplinary action, the board shall, within 30 days of making that finding, notify the health care facility, State psychiatric hospital or health maintenance organization of its determination.
(cf: P.L.1989, c.300, s.13)

[1][12.] 13.[1] (New section) a. On or after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill) and except as provided in subsection d. of this section, no person who is an officer, director or board member of a professional association for health care providers shall serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that is licensed in the State and offering medical malpractice liability insurance policies on that effective date.

b. As used in this section, "health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes, and a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

c. A person or professional association who violates the provisions of this section shall be liable for a civil penalty of $10,000 for each violation. The penalty shall be sued for and collected by the Commissioner of Banking and Insurance in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

d. In the case of an officer, director or board member of a medical malpractice liability insurer who is an officer, director or board

member of a professional association for health care providers on the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), the officer, director or board member shall have 180 days to comply with the requirements of this section.

[1][13.] 14.[1] (New section) Physicians may join together, by means of a joint contract under the procedures established by this section, to form a "Medical Malpractice Liability Insurance Purchasing Alliance" for the purpose of negotiating a reduced premium for its members in the purchase of medical malpractice liability insurance. The joint contract shall be executed by all members of the purchasing alliance.

a. As used in this section:

"Board" means a medical malpractice liability insurance purchasing alliance board of directors provided for in this section.

"Commissioner" means the Commissioner of Banking and Insurance.

"Medical Malpractice Liability Insurance Purchasing Alliance," "purchasing alliance" or "alliance" means a purchasing alliance established pursuant to this section.

"Member" means a physician who is a member of a medical malpractice liability insurance purchasing alliance as provided for in this section.

b. The purchasing alliance, which may be a corporation, shall be governed by a board of directors, elected by the members of the purchasing alliance. No person may serve as an officer or director of an alliance who has a prior record of administrative, civil or criminal violations within the financial services industry. The directors shall serve for terms of three years, and shall serve until their successors are elected and qualified. Each director shall serve without compensation, except for reimbursement for actual expenses incurred by that director.

c. The board shall adopt by-laws for the operation of the purchasing alliance, which shall be effective upon ratification by a two-thirds majority of the members. The by-laws shall include, but not be limited to:

(1) the establishment of procedures for the organization and administration of the alliance; and

(2) procedures for the qualifications and admission of the members of the alliance.

The bases for denial of membership shall include, but not be limited to:

(a) performance of an act or practice that constitutes fraud or intentional misrepresentation of material fact;

(b) previous denial of membership in the alliance; or

(c) previous expulsion from the alliance;

(3) procedures for the withdrawal of members from the alliance;

(4) procedures for the expulsion of members from the alliance.

The bases for expulsion shall include, but not be limited to:

(a) failure to pay membership or other fees required by the purchasing alliance;

(b) failure to pay premiums in accordance with the terms of the medical malpractice liability insurance policy or the terms of the joint contract; or

(c) performance of an act or practice that constitutes fraud or intentional misrepresentation of material fact; and

(5) procedures for the termination of the alliance.

d. In addition to the other powers authorized under this section, a purchasing alliance shall have the authority to:

(1) set reasonable fees for membership in the alliance that will finance reasonable and necessary costs incurred in administering the purchasing alliance;

(2) negotiate premium rates for medical malpractice liability insurance with insurers on behalf of the members of the alliance, provided that negotiations are conducted by a person other than a member of the alliance or an employee of a member of the alliance;

(3) provide premium collection services for insurance purchased through the alliance for members;

(4) contract with third parties for any services necessary to carry out the powers and duties authorized or required pursuant to this section; and

(5) establish procedures for keeping confidential all communications between the members of the purchasing alliance and for prohibiting the dissemination and discussion of pricing information and other business-related information between and among members of the alliance.

e. A purchasing alliance established pursuant to the provisions of this section shall not:

(1) assume risk for the cost or provision of medical malpractice liability insurance;

(2) exclude a member who agrees to pay fees for membership and the premium for medical malpractice liability insurance coverage and who abides by the by-laws of the alliance;

(3) engage in any trade practice or activity prohibited pursuant to P.L.1947, c.379 (C.17:29B-1 et seq.);

(4) represent more than 35% of the physicians in a county or other relevant geographic service area; or

(5) require a member to purchase medical malpractice liability insurance only through the alliance.

f. Within 30 days after its organization, the purchasing alliance board shall file with the commissioner a certificate that shall list: the members of the alliance; the names of the directors, chairman, treasurer and secretary of the alliance; the address at which communications for the alliance are to be received; a copy of the certificate of incorporation of the alliance, if any; and a copy of the joint contract executed by all of the members. Any change in the

information required by the provisions of this section shall be filed with the commissioner within 30 days of the change.

g. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the provisions of this section.

[1][14.] 15.[1] (New section) a. A medical malpractice liability insurance policy, which is made, issued or delivered pursuant to Subtitle 3 of Title 17 of the Revised Statutes in this State on or after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; except that, if the policy contains that provision, the insurer shall offer an endorsement, to be included in the policy at the option of the insured, providing the insurer with the right to settle a claim filed under the policy without first having obtained the insured's consent. The insurer shall establish a premium for the endorsement, which premium shall reflect any savings or reduced costs attributable to the endorsement.

b. The Commissioner of Banking and Insurance, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the provisions of this section.

[1][15.] 16.[1] (New section) a. Every insurer authorized to transact medical malpractice liability insurance in this State shall offer medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1,000,000 per claim, and may require the insured to provide collateral for the deductible amount to the insurer.

b. Every insurer authorized to transact medical malpractice liability insurance in this State shall provide an appropriate premium reduction for any deductible chosen pursuant to subsection a. of this section.

c. In the case of a policy with any deductible, the insurer shall be responsible for payment of the deductible and shall be reimbursed for that amount by the insured.

[1][16.] 17.[1] (New section) Notwithstanding any other law or regulation to the contrary, an insurer authorized to transact medical malpractice liability insurance in this State shall not increase the premium of any medical malpractice liability insurance policy based on a claim of medical negligence or malpractice against the insured if the insured is dismissed from an action alleging medical malpractice [1][within 180 days of the filing of the last responsive pleading] [2][prior to the close of discovery[1]] within 180 days of the filing of the last

responsive pleading[2].

[1][17.] 18.[1] (New section) Each annual statement made after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), pursuant to the provisions of section 16 of P.L.1982, c.114 (C.17:29AA-16), by an insurer writing medical malpractice in this State, shall include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory, or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

[1][18.] 19.[1] (New section) Notwithstanding the provisions of section 1 of P.L.1968, c.131 (C.17:29C-1) to the contrary, each notice of renewal or nonrenewal by an insurer authorized to transact medical malpractice liability insurance in this State shall be mailed or delivered by the insurer to the insured not less than 60 days prior to the expiration of the policy and, in the case of a nonrenewal, shall contain the reason for the nonrenewal.

[1][19. Section 3 of P.L.1982, c.114 (C.17:29AA-3) is amended to read as follows:

3. As used in this act:

a. "Commercial lines insurance" includes all insurance policies issued by a licensed insurer pursuant to Title 17 of the Revised Statutes, except:

(1) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine insurance policies;

(2) Title insurance;

(3) Mortgage guaranty insurance;

(4) Workers' compensation and employers' liability insurance;

(5) Any policy or contract of reinsurance, other than joint reinsurance to the extent provided for under section 22 of this act;

(6) Insurance written through the New Jersey Medical Malpractice Reinsurance Association established pursuant to P.L.1975, c. 301 (C. 17:30D-1 et seq.);

(7) Insurance written through the New Jersey Insurance Underwriting Association established pursuant to P.L.1968, c. 129 (C. 17:37A-1 et seq.);

(8) Insurance issued by hospital service corporations and medical service corporations; [and]

(9) Insurance issued for personal, family or household purposes, as determined by the commissioner; and

(10) Medical malpractice liability insurance.

b. "Commissioner" means Commissioner of Banking and

Insurance.

c. "Department" means the Department of Banking and Insurance.

d. "Insurer" means any person, corporation, association, joint underwriting association subject to section 22 of this act, partnership or company licensed under the laws of this State to transact the business of insurance in this State.

e. "Premium" means the consideration paid or to be paid to an insurer for the issuance and delivery of any binder or policy of insurance.

f. "Rate" means the unit charge by which the measure of exposure or the amount of insurance specified in a policy of insurance or covered thereunder is multiplied to determine the premium.

g. "Rate-making" means the examination and analysis of every factor and influence related to and bearing upon the hazard and risk made the subject of insurance; the collection and collation of such factors and influences into rating systems; and the application of such rating systems to individual risks.

h. "Rating system" means every schedule, class, classification, rule, guide, standard, manual, table, rating plan, or compilation by whatever name described, containing the rates used by any rating organization or by any insurer, or used by any insurer or by any rating organization in determining or ascertaining a rate.

i. "Reasonable degree of competition" means that degree of competition which would tend to produce rates that are not excessive, inadequate, or unfairly discriminatory, or forms that are not unfair, inequitable, misleading or contrary to law, as determined by the commissioner.

j. "Risk," as the context may require, means (1) as to fire insurance or any other kind of insurance which, by law, may be embraced in a policy of fire insurance as part thereof or as supplemental thereto, any property, real or personal, described in a policy, exposed to any hazard or peril named in such policy; and (2) as to all other kinds of insurance not specifically included in clause (1) of this subsection, the hazard or peril named in a policy of insurance.

k. "Special risks" mean (1) those commercial lines insurance risks as specified on a list promulgated by the commissioner, which are of an unusual nature or high loss hazard or are difficult to place or rate or which are excess or umbrella or which are eligible for export; (2) commercial lines insurance risks which produce minimum annual premiums in excess of $10,000.00; (3) inland marine insurance; or (4) fidelity, surety or forgery bonds. Additions or deletions to the list promulgated may be made by the commissioner without a hearing upon notice to all licensed insurers.

l. "Supplementary rate information" includes any manual or plan of rates, statistical plan, classification, rating schedule, rating rule and any other rule used by an insurer in making rates.

(cf: P.L.1982, c.114, s.3)**]**[1]

[1]**[**20. Section 10 of P.L.1982, c.114 (C.17:29AA-10) is amended to read as follows:

10. a. Rates shall not be excessive, inadequate or unfairly discriminatory.

b. (1) Notwithstanding the provisions of P.L.1982, c.114 (C.17:29AA-1 et seq.) to the contrary, no insurer writing medical malpractice liability insurance in this State shall implement an alteration, supplement or amendment to its rates or rating systems, or any part thereof, which would result in a rate increase of 15% or more on an annual basis for any medical specialty without complying with the provisions of this subsection.

(2) Any alteration, supplement or amendment by a medical malpractice liability insurer to its rates or rating systems, or any part thereof, as described in paragraph (1) of this subsection shall be filed for "file and use" with the commissioner at least 45 days prior to becoming effective. The filing shall include a statement that explains the reason for the proposed change and such information as the commissioner may prescribe. Unless disapproved by the commissioner prior to its effective date, the rate filing shall be deemed effective.

(3) If the commissioner finds that the rates as altered are excessive, inadequate or unfairly discriminatory, the commissioner shall issue an order disapproving of the alteration, supplement or amendment.

(4) Upon satisfying the submission requirements of a rate filing pursuant to this subsection or upon its disapproval by the commissioner, the insurer may request that the filing be transmitted to the Office of Administrative Law for a hearing, and may elect to implement the proposed rates pending the outcome of that hearing; except, however, that the final order issued on the filing may provide for retroactive adjustment of the implemented rates.

(5) A rate filing that would result in a rate increase of less than 15% on an annual basis for any medical specialty is subject to the provisions of P.L.1982, c.114 (C.17:29AA-1 et seq.).

(cf: P.L.1982, c.114, s.10)**]**[1]

[1]20. Section 13 of P.L.1982, c.114 (C.17:29AA-13) is amended to read as follows:

13. a. If the commissioner finds, after a hearing, that a rate or policy form in effect for any rating organization or insurer, whether or not a member or subscriber of a rating organization is not in compliance with the standards of this act, he shall issue an order specifying in what respects it so fails, and stating when, within a reasonable period thereafter, such rate or form shall be deemed no longer effective. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

b. If the commissioner finds, after a hearing, that a rate in effect for any insurer writing medical malpractice liability insurance is not in

compliance with the provisions of P.L.1982, c.114 (C.17:29AA-1 et seq.), the commissioner shall issue an order specifying in what respects it so fails, and stating when such rate shall no longer be deemed effective. The order may provide for the retroactive adjustment of rates and require the payment or credit of interest to insureds covered during the adjusted rate period. Interest shall be calculated at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.[1]

(cf: P.L.1982, c.114, s.13)

21. (New section) Subject to standards adopted by the National Association of Insurance Commissioners, the Commissioner of Banking and Insurance shall, within 180 days after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill) and annually thereafter, review the current capitalization and reserve requirements applicable to insurers authorized or admitted to transact medical malpractice liability insurance in this State, as those requirements are established by statute or regulation, or both.

Based upon the findings of that review, the commissioner shall adopt regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to modify those requirements, as the commissioner determines necessary in order to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in this State. If the commissioner determines that legislation is necessary to effect any such modification, the commissioner shall notify the Governor and the Legislature within the 180-day period provided in this section.

22. (New section) Every insurer authorized to transact medical malpractice liability insurance in this State shall offer its insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance by regulation.

23. Section 2 of P.L.1983, c.247 (C.17:30D-17) is amended to read as follows:

2. a. Any insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the Medical Practitioner Review Panel established pursuant to section 8 of P.L.1989, c.300 (C.45:9-19.8) in writing of any medical malpractice claim settlement, judgment or arbitration award involving any practitioner licensed by the State Board of Medical Examiners and insured by the insurer or insurance association. Any practitioner licensed by the board who is not covered by medical malpractice liability insurance issued in this State, who has coverage through a self-insured health care facility or health maintenance organization, or has medical malpractice liability insurance which has been issued by an insurer or insurance association from outside the State, shall notify the

review panel in writing of any medical malpractice claim settlement, judgment or arbitration award to which the practitioner is a party. The review panel or board, as the case may be, shall not presume that the judgment or award is conclusive evidence in any disciplinary proceeding and the fact of a settlement is not admissible in any disciplinary proceeding.

In any malpractice action against a practitioner, a settlement prohibiting a complaint against the practitioner or the providing of information to the review panel or board concerning the underlying facts or circumstances of the action is void and unenforceable.

b. An insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the review panel in writing of any termination or denial of coverage to a practitioner or surcharge assessed on account of the practitioner's practice method or medical malpractice claims history.

c. The form of notification shall be prescribed by the Commissioner of Banking and Insurance, shall contain such information as may be required by the board and the review panel, and shall be made within seven days of the settlement, judgment or award or the final action for a termination or denial of, or surcharge on, the medical malpractice liability insurance. Upon request of the board, the review panel or the commissioner, an insurer or insurance association shall provide all records regarding the defense of a malpractice claim, the processing of the claim and the legal proceeding; except that nothing in this subsection shall be construed to authorize disclosure of any confidential communication which is otherwise protected by statute, court rule or common law.

An insurer or insurance association, or any employee thereof, shall be immune from liability for furnishing information to the review panel and the board in fulfillment of the requirements of this section unless the insurer or insurance association, or any employee thereof, knowingly provided false information.

d. An insurer, insurance association or practitioner who fails to notify the review panel as required pursuant to this section shall be subject to such penalties as the Commissioner of Banking and Insurance may determine pursuant to section 12 of P.L.1975, c.301 (C.17:30D-12). In addition to, or in lieu of suspension or revocation, the commissioner may assess a fine which shall not exceed $1,000 for the first offense and $2,000 for the second and each subsequent offense, which may be recovered in a summary proceeding, brought in the name of the State in a court of competent jurisdiction pursuant to **[**"the penalty enforcement law," N.J.S.2A:58-1 et seq.**]** the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

e. A practitioner who fails to notify the review panel as required pursuant to this section shall be subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 45:1-22 and 45:1-25).

f. An insurer or insurance association shall make available to the

review panel or the board, upon request, any records of termination or denial of coverage to a practitioner or surcharge assessed on account of the practitioner's practice method or medical malpractice claims history, which occurred up to five years prior to the effective date of P.L.1989, c.300 (C.45:9-19.4 et al.).

g. For the purposes of this section, "practitioner" means a person licensed to practice: medicine and surgery under chapter 9 of Title 45 of the Revised Statutes or a medical resident or intern; or podiatry under chapter 5 of Title 45 of the Revised Statutes.

h. Any insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the Commissioner of Banking and Insurance, in a form and manner specified by the commissioner, of any medical malpractice claim settlement, judgment or arbitration award involving any practitioner licensed by the State Board of Medical Examiners and insured by the insurer or insurance association. The notification shall include the specialty or area of professional practice of the practitioner and the amount of the settlement, judgment or arbitration award, but shall not include the name or other identifying information of the practitioner.

(cf: P.L.1989, c.300, s.4)

24. (New section) a. As used in this section:

"Annuity" means an annuity issued by an insurer licensed or authorized to do business in this State which is a qualified assignment under section 130 of the federal Internal Revenue Code of 1986, 26 U.S.C. s.130.

"Judgment creditor" means a claimant who is the recipient of an award for economic or noneconomic damages, or both, that is the result of an action filed against a health care provider for medical malpractice, which award is subject to the provisions of subsection b. of this section.

"Judgment debtor" means a health care provider who, as a defendant in an action brought for medical malpractice, is required to pay the claimant an award that is subject to the provisions of this section.

"Noneconomic damages" means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

"Structured payment agreement" means an agreement made to settle a claim or lawsuit or respond to a judgment in an action brought for medical malpractice by an injured person whereby a series of periodic payments, rather than a lump sum payment, is made over time to a claimant, in accordance with the needs of the claimant or the claimant's family, either through the purchase of an annuity or the establishment of a trust fund, or by another means approved by the court.

b. (1) Unless otherwise agreed to by the parties, in any judgment resulting from a medical malpractice action brought by a claimant for medical malpractice in which the noneconomic damages are less than or equal to $1,000,000, the court shall enter a judgment ordering that all of the money damages, both economic and noneconomic, be paid immediately.

(2) Unless otherwise agreed to by the parties, in any judgment resulting from a medical malpractice action brought by a claimant for medical malpractice in which the noneconomic damages exceed $1,000,000, the court shall enter a judgment ordering that 50% of the noneconomic damages be paid immediately, with the costs and attorney's fees to be paid from that amount. The remaining 50% of the judgment shall be paid over 60 months in the form of a structured payment agreement by any person, organization, group, or insurer that is contractually liable to pay the judgment.

c. The structured payment agreement shall specify: the recipient of the payments; the dollar amount of the payments; the interval between payments; the number of payments or the period of time over which payments are to be made; and the persons to whom money damages are owed, if any, in the event of the judgment creditor's death.

d. In the event of the judgment creditor's death, any amounts due and owing pursuant to subsection b. of this section shall be paid to the judgment creditor's estate.

e. The judgment debtor or the judgment debtor's insurer shall be required to: post a bond or security; or, as otherwise provided by regulation of the Department of Banking and Insurance, assure full payment of the noneconomic damages awarded. A bond shall not be deemed adequate unless it is written by a company authorized to do business in this State and is rated [1][A+] A-, or better,[1] by A.M. Best Company [1]or such other company as is approved by the Department of Banking and Insurance[1]. If the judgment debtor is unable to adequately assure full payment of the judgment, the judgment, reduced to present value, shall be paid to the claimant in a lump sum. No bond may be canceled or be subject to cancellation unless at least 60 days' advance written notice is filed with the court and the claimant. Upon termination of periodic payments, the security, or so much as remains, shall be returned to the judgment debtor.

f. Upon the purchase of an annuity, establishment of a trust, or approval of another arrangement for periodic payments by a court, any obligation of the judgment debtor with respect to the judgment shall cease.

25. Section 1 of P.L.1997, c.365 (C.45:9-19.17) is amended to read as follows:

1. a. A physician who maintains a professional medical practice in this State and has responsibility for patient care is required to be covered by medical malpractice liability insurance [2]issued by a carrier

authorized to write medical malpractice liability insurance policies in this State,[2] in the sum of $1,000,000 per occurrence and $3,000,000 per policy year [2][, with] and unless renewal coverage includes the premium retroactive date, the policy shall provide for[2] extended reporting endorsement coverage for claims made policies, also known as "tail coverage," [2][issued by a carrier authorized to write medical malpractice liability insurance policies in this State,][2] or, if such liability coverage is not available, by a letter of credit for at least [the minimum amount required by the State Board of Medical Examiners] $500,000.

The physician shall notify the State Board of Medical Examiners of the name and address of the insurance carrier or the institution issuing the letter of credit, pursuant to section 7 of P.L.1989, c.300 (C.45:9-19.7).

b. A physician who is in violation of this section is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).

c. The State Board of Medical Examiners [shall] may, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), [adopt regulations which] establish [the] by regulation, minimum [amount of a line] amounts for medical malpractice liability insurance coverage and lines of credit [that is] in excess of those amounts required pursuant to subsection a. of this section.

d. The State Board of Medical Examiners shall notify all physicians licensed by the board of the requirements of this section within 30 days of the date of enactment of [this act] P.L. , c. (now before the Legislature as this bill).

(cf: P.L.1997, c.365, s.1)

26. (New section) For the purposes of sections 27 and 28 of P.L. , c. (C. )(pending before the Legislature as this bill):

"Commissioner" means the Commissioner of Banking and Insurance.

"Fund" means the Medical Malpractice Liability Insurance Premium Assistance Fund established pursuant to section 27 of P.L. , c. (C. )(pending before the Legislature as this bill).

"Health care provider" means a physician, podiatrist, dentist and chiropractor licensed pursuant to the provisions of Title 45 of the Revised Statutes, a nurse licensed pursuant to the provisions of Title 45 of the Revised Statutes who is employed by a licensed hospital, long-term care facility or assisted living facility in this State and any person who purchases professional liability insurance on behalf of or for a [1][health care provider] practitioner[1], including professional liability insurance protection which is provided for hospital employed physicians through hospital funding supplemented by purchased commercial insurance coverage.

[1]"Practitioner" means a physician, podiatrist, dentist and

chiropractor and a nurse employed by a licensed hospital, long-term care facility or assisted living facility in this State.[1]

27. (New section) a. There is established a Medical Malpractice Liability Insurance Premium Assistance Fund within the Department of the Treasury as a nonlapsing, revolving fund.

b. The fund shall be comprised of the following revenue:

(1) an annual surcharge of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law," R.S.43:21-1 et seq., collected by the comptroller for the New Jersey Unemployment Compensation Fund and paid over to the State Treasurer for deposit in the fund annually, as provided by the commissioner, which surcharge may, at the option of the employer, be treated as a payroll deduction to each covered employee;

(2) an annual charge of [2]**[**$50**]** $75[2] to be imposed by the State Board of Medical Examiners on every physician and podiatrist licensed by the board pursuant to the provisions of R.S.45:9-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund;

(3) an annual charge of [2]**[**$50**]** $75[2] to be imposed by the State Board of Chiropractic Examiners on every chiropractor licensed by the board pursuant to the provisions of P.L.1989, c.153 (C.45:9-41.17 et seq.), collected by the board and remitted to the State Treasurer for deposit into the fund;

(4) an annual charge of [2]**[**$50**]** $75[2] to be imposed by the New Jersey State Board of Dentistry on every dentist licensed pursuant to the provisions of R.S. 45:6-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund;

(5) an annual charge of [2]**[**$50**]** $75[2] to be imposed by the New Jersey State Board of Optometrists on every optometrist licensed by the board pursuant to the provisions of R.S.45:12-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund; and

(6) an annual fee of [2]**[**$50**]** $75[2] to be assessed by the State Treasurer and payable by each person licensed to practice law in this State, for deposit into the fund.

The provisions of paragraphs (2) through (5) of this subsection shall not apply to physicians, podiatrists, chiropractors, dentists or optometrists who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; or have not practiced their profession for at least one year.

The provisions of paragraph (6) of this subsection shall not apply to attorneys who: are constitutionally or statutorily barred from the

practice of law; can show that they do not maintain a bona fide office for the practice of law in this State; are completely retired from the practice of law; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment; or have not practiced law for at least one year.

c. The State Treasurer shall deposit all moneys collected by him pursuant to this section into the fund. Monies credited to the fund may be invested in the same manner as assets of the General Fund and any investment earnings on the fund shall accrue to the fund and shall be available subject to the same terms and conditions as other monies in the fund.

d. The fund shall be administered by the Department of Banking and Insurance in accordance with the provisions of [1][this act] P.L. , c. (C. )(pending before the Legislature as this bill)[1].

e. The monies in the fund are specifically dedicated and shall be utilized exclusively for the following purposes:

(1) [2][$20] $17[2] million shall be allocated [1]annually[1] for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established pursuant to section 28 of P.L. , c. (C. )(pending before the Legislature as this bill);

(2) [2][$8] $6.9[2] million shall be allocated [1]annually[1] to the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58) for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.);

(3) [1][$2] $1[1] million shall be allocated[1]annually[1] for a student loan expense reimbursement program for [1][health care providers who are members of specialties and subspecialties who qualify for relief under subsection b. of section 28 of P.L. , c. (C. )(pending before the Legislature as this bill)] obstetrician/gynecologists[1], to be established pursuant to section 29 of P.L. , c. (C. )(pending before the Legislature as this bill); and

(4) [1][the balance of any unexpended monies in the fund] [2][$1] $1.2[2] million[1] shall be allocated [1]annually[1] to the Division of Medical Assistance and Health Services in the Department of Human Services for the [1][provision of other health care services as determined by the Commissioner of Human Services] purposes provided in section 30 of P.L. , c. (C. )(pending before the Legislature as this bill)[1].

f. The fund [2]and the annual surcharge, charges and fee provided for in subsection b. of this section[2] shall expire three years after the

effective date of P.L. , c. (C. )(pending before the Legislature as this bill).

[2]g. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to carry out the purposes of sections 26 through 29 of P.L. , c. (C. )(pending before the Legislature as this bill); except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of sections 26 through 29 of P.L. , c. (pending before the Legislature as this bill), which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.[2]

28. (New section) a. In order to carry out the purposes of section 27 of P.L. , c. (C. )(pending before the Legislature as this bill), the commissioner shall, at a minimum:

(1) establish a program to provide medical malpractice liability insurance premium subsidies to health care providers from monies that are contained in the fund;

(2) establish a methodology and procedures for determining eligibility for, and providing subsidies from, the fund;

(3) maintain confidential records on each health care provider who receives assistance from the fund;

(4) take all necessary action to recover the cost of the subsidy provided to a health care provider that the commissioner determines to have been incorrectly provided; and

(5) provide for subsidies to all [1]**[**health care providers**]** practitioners[1] who are members of specialties and subspecialties who qualify for relief under subsection b. of this section, including those whose professional liability insurance protection is provided by hospital funding supplemented by purchased commercial insurance coverage.

b. The commissioner shall certify classes of [1]**[**health care providers**]** practitioners[1] by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount per year as determined by the commissioner by regulation. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of [1]**[**health care providers**]** practitioners[1], as applicable, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

(1) In order to be eligible for a subsidy from the fund, a [1]**[**health

care provider] practitioner[1] shall have received a medical malpractice liability insurance premium increase in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in calendar year 2005; or

(2) In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding supplemented with purchased commercial insurance coverage, in order to be eligible for a subsidy from the fund, that provider shall have increased its total professional liability funding obligation in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that provider in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that provider in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that provider in calendar year 2005.

(3) The amount of the subsidy shall be an amount, as determined by the commissioner by regulation, of the increase from the preceding year's premium or self-insured professional liability funding obligation; except that no health care provider shall receive a subsidy in any year that is greater than an amount as determined by the commissioner by regulation.

c. A [1][health care provider] practitioner[1] who has been subject to a disciplinary action or civil penalty by the practitioner's respective licensing board pursuant to sections 8, 9 or 12 of P.L.1978, c.73 (C.45:1-21, 22 or 25), when that action or penalty relates to the [1][provider's] practitioner's[1] provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

d. (1) A [1][health care provider] practitioner [1] who receives a subsidy from the fund shall be required to practice in that [1][provider's] practitioner's[1] specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy.

(2) A [1][health care provider] practitioner[1] who fails to comply with the provisions of paragraph (1) of this subsection shall be required to repay to the commissioner the amount of the subsidy, in whole or in part as determined by the commissioner.

e. The commissioner may waive the criteria for eligibility for a subsidy established pursuant to this section, if the commissioner determines that access to care for a particular specialty is threatened because of an inability of a sufficient number of practitioners in that specialty or subspecialty to practice in a geographic area of the State.

f. The State Board of Medical Examiners, the State Board of Chiropractic Examiners, the New Jersey State Board of Dentistry and the New Jersey Board of Nursing shall each provide to the commissioner, on a quarterly basis, the names of the practitioners who have been subject to a disciplinary action or civil penalty by the practitioner's respective licensing board.

[2]g. For the purposes of section 29 of P.L. , c. (C. )(pending before the Legislature as this bill), the commissioner, in consultation with the State Board of Medical Examiners, shall provide to the Higher Education Student Assistance Authority the names of obstetrician/gynecologists licensed by the board who may qualify for the student loan reimbursement program established pursuant to P.L. , c. (pending before the Legislature as this bill). A physician who has been subject to a disciplinary action or civil penalty by the board, as provided in subsection c. of this section, shall not be eligible for the program.[2]

29. (New section) a. There is established a student loan expense reimbursement program within the Higher Education Student Assistance Authority for [1][health care providerswho are members of specialties and subspecialties who qualify for relief under subsection b. of section 28 of P.L. , c. (C. )(pending before the Legislature as this bill)] obstetrician/gynecologists who agree to practice in State designated underserved areas as established pursuant to section 1 of P.L.1999, c.46 (C.18A:71C-35)[1]. [2]Any loans provided through the NJCLASS Loan Program pursuant to P.L.1999, c.46 (C.18A:71C-21 et seq.) or a student loan program of the federal government shall be eligible for reimbursement under this program.[2]

The authority shall implement the program in consultation with the Commissioners of Banking and Insurance and Health and Senior Services [2]and the State Board of Medical Examiners[2].

b. (1) [1][A health care provider] An obstetrician/gynecologist[1] who receives a payment under the student loan expense reimbursement program shall be required to practice [1][in that provider's specialty or subspecialty] as an obstetrician/gynecologist in an underserved area[1] in this State for a period of at least four years after receipt of the payment.

(2) [1][A health care provider] An obstetrician/gynecologist[1] who fails to comply with the provisions of paragraph (1) of this subsection shall be required to repay to the Higher Education Student Assistance Authority the amount of the payment, in whole or in part as determined by the authority.

c. The authority shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of [2][subsection a. of][2] this section, including, but not limited to: eligibility for the program, procedures for application, selection of participants, establishment and

nullification of contracts established with participants under the program, [2]and[2] reports to the program by participants[2][, and recruitment of participants]2].

[1]30. (New section) Within the limits of funds appropriated pursuant to section 27 of P.L. , c. (C. )(pending before the Legislature as this bill) and such other funds as may be available for this purpose, the FamilyCare Health Coverage Program established pursuant to P.L.2000, c.71 (C.30:4J-1 et seq.) shall enroll into the program women whose eligibility under the Medicaid New Jersey Care pregnant women program or the "New Jersey Standardized Parent Service Package," Demonstration Population 3, Medicaid expansion for uninsured pregnant woman, has expired and whose family income does not exceed 100% of the federal poverty level.

The Commissioner of Human Services shall establish a presumptive eligibility process to provide for an efficient transition into the FamilyCare Health Coverage Program from the Medicaid program pursuant to this section.[1]

[1][30.] 31.[1] There is established the "Medical Care Availability Task Force."

a. The task force shall consist of 17 members as follows:

(1) the Commissioners of Banking and Insurance, Health and Senior Services, and Human Services, and the Director of the Administrative Office of the Courts, or their designees, who shall serve ex officio; and

(2) 13 public members, who shall include: one person appointed upon the recommendation of an organization that represents physicians; one person appointed upon the recommendation of an organization that represents osteopathic physicians and surgeons; one person appointed upon the recommendation of an organization that represents dentists; one person appointed upon the recommendation of an organization that represents hospitals; one person appointed upon the recommendation of an organization that represents teaching hospitals; one person appointed upon the recommendation of an organization that represents trial lawyers; one person appointed upon the recommendation of an organization that represents attorneys; one person appointed upon the recommendation of an organization that represents medical malpractice insurers; one person appointed upon the recommendation of an organization that represents managed care carriers; and four persons who represent the interests of health care consumers.

Of the 13 public members, five shall be appointed by the Governor, with the advice and consent of the Senate; four shall be appointed by the President of the Senate; and four shall be appointed by the Speaker of the General Assembly. The Governor, the President of the Senate, and the Speaker of the General Assembly shall consult with each other on the appointment of the public members.

b. Vacancies in the membership of the task force shall be filled in the same manner provided for the original appointments. The public members of the task force shall serve without compensation but may be reimbursed for traveling and other miscellaneous expenses necessary to perform their duties, within the limits of funds made available to the task force for its purposes.

c. (1) The task force shall organize as soon as practicable, but no later than the 30th day after the appointment of its members, and shall select a chairperson and vice-chairperson from among the members. The chairperson shall appoint a secretary who need not be a member of the task force.

(2) The task force may meet at the call of the chairperson and hold hearings at the times and in the places it may deem appropriate and necessary to fulfill its charge. The task force shall be entitled to call to its assistance, and avail itself of the services of, the employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for its purposes.

(3) The Department of Banking and Insurance shall provide staff services to the task force.

d. The purpose of the task force shall be to study the following issues:

(1) the advantages and disadvantages of establishing limitations on noneconomic damages for medical malpractice judgments and on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

(2) the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

(3) the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

(4) the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits; [1]and[1]

(5) the advantages and disadvantages of establishing a pre-suit procedure [1][; and

(6) the necessity for, and advantages and disadvantages of, reactivating the Medical Malpractice Reinsurance Association established pursuant to P.L.1975, c.301 (C.17:30D-1 et seq.)][1].

e. The task force shall present a report of its findings and recommendations to the Governor and the Legislature no later than 24 months after the date of its initial meeting, and shall be authorized to periodically issue a summary of its deliberations prior to the presentation of its report.

[2]32. The Commissioner of Banking and Insurance shall adopt rules

and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to carry out the purposes of sections 13, 16 through 19, 21, 22 and 24 of this act.[2]

[1][31.][2][32.[1]] 33.[2] This act shall take effect on the 30th day after enactment and shall apply to causes of action for medical malpractice that accrue on or after that effective date; except that [2]section 9 shall take effect upon action by the court,[2] sections [1][13 through 15] 14 through 16[1] and section 22 shall take effect on the 180th day after the date of enactment, sections [1][16 and 18] 17 and 19[1] shall take effect on the 90th day after the date of enactment, and the amendatory provisions of sections 3 and 4 shall apply to injuries sustained at birth on or after the effective date of this act. Section 29 shall expire three years after the effective date.

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"New Jersey Medical Care Access and Responsibility and Patients First Act."

# ASSEMBLY, No. 50

# STATE OF NEW JERSEY

## 211th LEGISLATURE

INTRODUCED MARCH 4, 2004

**Sponsored by:**
**Assemblyman JOSEPH J. ROBERTS, JR.**
**District 5 (Camden and Gloucester)**
**Assemblyman NEIL M. COHEN**
**District 20 (Union)**
**Assemblywoman LORETTA WEINBERG**
**District 37 (Bergen)**
**Assemblyman JOHN F. MCKEON**
**District 27 (Essex)**

**SYNOPSIS**

"New Jersey Medical Care Access and Responsibility and Patients First Act."

**CURRENT VERSION OF TEXT**

As introduced.

**AN ACT** concerning medical professional liability, insurance reform and patient protection and revising parts of the statutory law.

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

1. (New section) This act shall be known and may be cited as the "New Jersey Medical Care Access and Responsibility and Patients First Act."

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

a. One of the most vital interests of the State is to ensure that high-quality health care continues to be available in this State and that the residents of this State continue to have access to a full spectrum of health care providers, including highly trained physicians in all specialties;

b. The State's health care system and its residents' access to health care providers are threatened by a dramatic escalation in medical malpractice liability insurance premiums, which is creating a crisis of affordability in the purchase of necessary liability coverage for our health care providers;

c. One particularly alarming result of rising premiums is that there are increasing reports of doctors retiring or moving to other states where insurance premiums are lower, dropping high-risk patients and procedures, and practicing defensive medicine in a manner that may significantly increase the cost of health care for all our citizens;

d. The reasons for the steep increases in the cost of medical malpractice liability insurance are complex and involve issues related to: the State's tort liability system; the State's health care system, which includes issues related to patient safety and medical error reporting; and the State's regulation and requirements concerning medical malpractice liability insurers;

e. It is necessary and appropriate for the State to take meaningful and prompt action to address the various interrelated aspects of these issues that are impacted by, or impact on, the State's health care system; and

f. To that end, this act provides for a comprehensive set of reforms affecting the State's tort liability system, health care system and medical malpractice liability insurance carriers to ensure that health care services continue to be available and accessible to residents of the State and to enhance patient safety at health care facilities.

3. N.J.S.2A:14-2 is amended to read as follows:

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

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

2A:14-2. Every action at law for an injury to the person caused by the wrongful act, neglect or default of any person within this [state] State shall be commenced within 2 years next after the cause of any such action shall have accrued; except that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 11th birthday.
(cf: N.J.S.2A:14-2)

4. N.J.S.2A:14-21 is amended to read as follows:

2A:14-21. If any person entitled to any of the actions or proceedings specified in [sections] N.J.S.2A:14-1 to 2A:14-8 or [sections] N.J.S.2A:14-16 to 2A:14-20 [of this title] or to a right or title of entry under [section] N.J.S.2A:14-6 [of this title] is or shall be, at the time of any such cause of action or right or title accruing, under the age of 21 years, or insane, such person may commence such action or make such entry, within such time as limited by [said sections] those statutes, after his coming to or being of full age or of sane mind. Notwithstanding the provisions of this section to the contrary, an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 11th birthday, as provided in N.J.S.2A:14-2.
(cf: N.J.S.2A:14-21)

5. (New section) The judge presiding over a medical malpractice action, or the judge's designee, shall, within 30 days after the discovery end date, determine whether referral to a complementary dispute resolution mechanism may encourage early disposition or settlement of the action. If the judge makes such a determination, the matter shall be referred to complementary dispute resolution pursuant to Rule 1:40 of the Rules Governing the Courts of the State of New Jersey.

Nothing in this section shall be construed to limit the authority of the judge to refer an action to complementary dispute resolution prior to the discovery end date.

6. (New section) a. A health care provider named as a defendant in a medical malpractice action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant, and could not have caused the alleged malpractice, either individually or through its servants or employees, in any way.

b. A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting an affidavit that contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

c. If the court determines that a health care provider named as a defendant falsely files or makes false or inaccurate statements in an affidavit of noninvolvement, the court, upon motion or upon its own initiative, shall immediately reinstate the claim against that provider. Reinstatement of a party pursuant to this subsection shall not be barred by any statute of limitations defense that was not valid at the time the original action was filed.

In any action in which the health care provider is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the party, or both, an appropriate sanction, including, but not limited to, a civil penalty not to exceed $10,000 and an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the filing of the false or inaccurate affidavit, including a reasonable attorney fee. The court shall also refer the matter to the Attorney General and the appropriate professional licensing board for further review.

d. If the court determines that a plaintiff falsely objected to a health care provider's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a health care provider's affidavit, the court shall impose upon the plaintiff or the plaintiff's counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the false objection or inaccurate statement, including a reasonable attorney fee.

e. As used in this section, "health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to: a physician, dentist, nurse, pharmacist or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes; and a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

7. (New section) In an action alleging medical malpractice, a person shall not give expert testimony or execute an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.) on the appropriate standard of practice or care unless the person is licensed as a physician or other health care professional in the United States and meets the following criteria:

a. If the party against whom or on whose behalf the testimony is offered is a specialist or subspecialist recognized by the American Board of Medical Specialties and the care or treatment at issue

involves that specialty or subspecialty recognized by the American Board of Specialties, the person providing the testimony shall have specialized at the time of the occurrence that is the basis for the action in the same specialty or subspecialty, recognized by the American Board of Medical Specialties, as the party against whom or on whose behalf the testimony is offered, and if the person against whom or on whose behalf the testimony is being offered is board certified and the care or treatment at issue involves that board specialty or subspecialty recognized by the American Board of Medical Specialties, the expert witness shall be a specialist or subspecialist recognized by the American Board of Medical Specialties who is board certified in the same specialty or subspecialty, recognized by the American Board of Medical Specialties, and during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to either:

(1) the active clinical practice of the same health care profession in which the defendant is licensed, and, if the defendant is a specialist or subspecialist recognized by the American Board of Medical Specialties, the active clinical practice of that specialty or subspecialty recognized by the American Board of Medical Specialties; or

(2) the instruction of students in an accredited medical school, other accredited health professional school or accredited residency or clinical research program in the same health care profession in which the defendant is licensed, and, if that party is a specialist or subspecialist recognized by the American Board of Medical Specialties, an accredited medical school, health professional school or accredited residency or clinical research program in the same specialty or subspecialty recognized by the American Board of Medical Specialties; or

(3) both.

b. If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to:

(1) active clinical practice as a general practitioner; or

(2) the instruction of students in an accredited medical school, health professional school, or accredited residency or clinical research program in the same health care profession in which the party against whom or on whose behalf the testimony is licensed; or

(3) both.

c. A court may waive the same specialty or subspecialty recognized by the American Board of Medical Specialties and board certification requirements of this section if the court determines that the expert possesses sufficient training, experience and knowledge to provide the testimony as a result of active involvement in, or full-time teaching of,

medicine in the applicable area of practice or a related field of medicine.

d. Nothing in this section shall limit the power of the trial court to disqualify an expert witness on grounds other than the qualifications set forth in this section.

e. In an action alleging medical malpractice, an expert witness shall not testify on a contingency fee basis.

f. A person who provides expert testimony or executes an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.) pursuant to this section, who deliberately misrepresents the applicable appropriate standard of practice or care, shall be liable to a civil penalty not to exceed $10,000 and other expenses incurred as a result of the testimony provided or affidavit that was executed.

g. An individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.), which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure, shall be liable to a civil penalty not to exceed $10,000 and other damages incurred by the person and the party for whom the person was testifying as an expert.

8. (New section) A judge presiding over an action alleging medical malpractice, in which the jury has rendered a verdict in favor of the complaining party, shall, upon a motion by any party for additur or remittitur on the issue of the quantum of damages, consider the evidence in the light most favorable to the non-moving party and determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

9. (New section) a. If an individual's actual health care facility duty, including on-call duty, does not require a response to a patient emergency situation, a health care professional who, in good faith, responds to a life-threatening emergency or responds to a request for emergency assistance in a life-threatening emergency within a hospital or other health care facility, is not liable for civil damages as a result of an act or omission in the rendering of emergency care. The immunity granted pursuant to this section shall not apply to acts or omissions constituting gross negligence, recklessness or willful misconduct.

b. The provisions of subsection a. of this section shall not apply to a health care professional if a provider-patient relationship existed before the emergency, or if consideration in any form is provided to the health care professional for the service rendered.

c. The provisions of subsection a. of this section shall not apply if a general hospital has not reasonably and adequately staffed its emergency department.

d. A health care professional shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

(1) the patient was unconscious;

(2) the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

(3) the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The provisions of this subsection shall apply only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

e. As used in this section:

(1) "Health care professional" means a physician, dentist, nurse or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes and an emergency medical technician or mobile intensive care paramedic certified by the Commissioner of Health and Senior Services pursuant to Title 26 of the Revised Statutes; and

(2) "Health care facility" means a health care facility licensed by the Department of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

10. Section 1 of P.L.1995, c.69 (C.45:9-19.16) is amended to read as follows:

1. a. A physician licensed by the State Board of Medical Examiners, or a physician who is an applicant for a license from the State Board of Medical Examiners**,** shall notify the board within 10 days of **:**

(1) any action taken against the physician's medical license by any other state licensing board or any action affecting the physician's privileges to practice medicine by any out-of-State hospital, health care facility, health maintenance organization or other employer**;**

(2) any pending or final action by any criminal authority for violations of law or regulation, or any arrest or conviction for any criminal or quasi-criminal offense pursuant to the laws of the United States, this State or another state, including, but not limited to:

(a) criminal homicide pursuant to N.J.S.2C:11-2;

(b) aggravated assault pursuant to N.J.S.2C:12-1;

(c) sexual assault, criminal sexual contact or lewdness pursuant to N.J.S.2C:14-2 through 2C:14-4; or

(d) an offense involving any controlled dangerous substance or controlled substance analog as set forth in chapter 35 of Title 2C of the New Jersey Statutes.

b. A physician who is in violation of this section is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).

c. The State Board of Medical Examiners shall notify all physicians licensed by the board of the requirements of this section within 30 days of the date of enactment of this act.

(cf: P.L.1995, c.69, s.1)

11. Section 13 of P.L.1989, c.300 (C.45:9-19.13) is amended to read as follows:

13. a. In any case in which the State Board of Medical Examiners refuses to issue, suspends, revokes or otherwise conditions the license, registration, or permit of a physician, podiatrist or medical resident or intern, the board shall, within 30 days of its action, notify each licensed health care facility, psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7, and health maintenance organization with which the person is affiliated and every board licensee in the State with which the person is directly associated in his private medical practice.

b. If, during the course of an investigation of a physician, the board requests information from a health care facility, psychiatric hospital operated by the Department of Human Services or health maintenance organization regarding that physician, and the board subsequently makes a finding of no basis for disciplinary action, the board shall, within 30 days of making that finding, notify the health care facility, State psychiatric hospital or health maintenance organization of its determination.

(cf: P.L.1989, c.300, s.13)

12. (New section) a. On or after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill) and except as provided in subsection e. of this section, no person who is an officer, director or board member of a professional association for health care providers shall serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that

is licensed in the State and offering medical malpractice liability insurance policies on that effective date.

b. On or after the effective date of P.L. , c. (C. )(pending before the Legislature as this bill) and except as provided in subsection e. of this section, no more than one person who has been an officer, director or board member of a professional association for health care providers shall serve as an officer, director or board member of a State-domiciled medical malpractice liability insurer that is licensed in the State and offering medical malpractice liability insurance policies on that effective date.

c. As used in this section, "health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes, and a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

d. A person or professional association who violates the provisions of this section shall be liable for a civil penalty of $10,000 for each violation. The penalty shall be sued for and collected by the Commissioner of Banking and Insurance in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

e. In the case of an officer, director or board member of a medical malpractice liability insurer who is an officer, director or board member of a professional association for health care providers on the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), the officer, director or board member shall have 180 days to comply with the requirements of this section.

13. (New section) Physicians may join together, by means of a joint contract under the procedures established by this section, to form a "Medical Malpractice Liability Insurance Purchasing Alliance" for the purpose of negotiating a reduced premium for its members in the purchase of medical malpractice liability insurance. The joint contract shall be executed by all members of the purchasing alliance.

a. As used in this section:

"Board" means a medical malpractice liability insurance purchasing alliance board of directors provided for in this section.

"Commissioner" means the Commissioner of Banking and Insurance.

"Medical Malpractice Liability Insurance Purchasing Alliance," "purchasing alliance" or "alliance" means a purchasing alliance established pursuant to this section.

"Member" means a physician who is a member of a medical malpractice liability insurance purchasing alliance as provided for in this section.

b. The purchasing alliance, which may be a corporation, shall be governed by a board of directors, elected by the members of the purchasing alliance. No person may serve as an officer or director of an alliance who has a prior record of administrative, civil or criminal violations within the financial services industry. The directors shall serve for terms of three years, and shall serve until their successors are elected and qualified. Each director shall serve without compensation, except for reimbursement for actual expenses incurred by that director.

c. The board shall adopt by-laws for the operation of the purchasing alliance, which shall be effective upon ratification by a two-thirds majority of the members. The by-laws shall include, but not be limited to:

(1) the establishment of procedures for the organization and administration of the alliance; and

(2) procedures for the qualifications and admission of the members of the alliance.

The bases for denial of membership shall include, but not be limited to:

(a) performance of an act or practice that constitutes fraud or intentional misrepresentation of material fact;

(b) previous denial of membership in the alliance; or

(c) previous expulsion from the alliance;

(3) procedures for the withdrawal of members from the alliance;

(4) procedures for the expulsion of members from the alliance.

The bases for expulsion shall include, but not be limited to:

(a) failure to pay membership or other fees required by the purchasing alliance;

(b) failure to pay premiums in accordance with the terms of the medical malpractice liability insurance policy or the terms of the joint contract; or

(c) performance of an act or practice that constitutes fraud or intentional misrepresentation of material fact; and

(5) procedures for the termination of the alliance.

d. In addition to the other powers authorized under this section, a purchasing alliance shall have the authority to:

(1) set reasonable fees for membership in the alliance that will finance reasonable and necessary costs incurred in administering the purchasing alliance;

(2) negotiate premium rates for medical malpractice liability insurance with insurers on behalf of the members of the alliance, provided that negotiations are conducted by a person other than a member of the alliance or an employee of a member of the alliance;

(3) provide premium collection services for insurance purchased through the alliance for members;

(4) contract with third parties for any services necessary to carry out the powers and duties authorized or required pursuant to this section; and

(5) establish procedures for keeping confidential all communications between the members of the purchasing alliance and for prohibiting the dissemination and discussion of pricing information and other business-related information between and among members of the alliance.

e. A purchasing alliance established pursuant to the provisions of this section shall not:

(1) assume risk for the cost or provision of medical malpractice liability insurance;

(2) exclude a member who agrees to pay fees for membership and the premium for medical malpractice liability insurance coverage and who abides by the by-laws of the alliance;

(3) engage in any trade practice or activity prohibited pursuant to P.L.1947, c.379 (C.17:29B-1 et seq.);

(4) represent more than 35% of the physicians in a county or other relevant geographic service area; or

(5) require a member to purchase medical malpractice liability insurance only through the alliance.

f. Within 30 days after its organization, the purchasing alliance board shall file with the commissioner a certificate that shall list: the members of the alliance; the names of the directors, chairman, treasurer and secretary of the alliance; the address at which communications for the alliance are to be received; a copy of the certificate of incorporation of the alliance, if any; and a copy of the joint contract executed by all of the members. Any change in the information required by the provisions of this section shall be filed with the commissioner within 30 days of the change.

g. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the provisions of this section.

14. (New section) a. A medical malpractice liability insurance policy, which is made, issued or delivered pursuant to Subtitle 3 of Title 17 of the Revised Statutes in this State on or after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; except that, if the policy contains that provision, the insurer shall offer an endorsement, to be included in the policy at the option of the insured, providing the insurer with the right to settle a claim filed under the policy without first having obtained the insured's consent. The insurer shall establish a premium for the endorsement, which premium shall reflect any savings or reduced costs attributable to the endorsement.

b. The Commissioner of Banking and Insurance, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the provisions of this section.

15. (New section) a. Every insurer authorized to transact medical malpractice liability insurance in this State shall offer medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1,000,000 per claim, and may require the insured to provide collateral for the deductible amount to the insurer.

b. Every insurer authorized to transact medical malpractice liability insurance in this State shall provide an appropriate premium reduction for any deductible chosen pursuant to subsection a. of this section.

c. In the case of a policy with any deductible, the insurer shall be responsible for payment of the deductible and shall be reimbursed for that amount by the insured.

16. (New section) Notwithstanding any other law or regulation to the contrary, an insurer authorized to transact medical malpractice liability insurance in this State shall not increase the premium of any medical malpractice liability insurance policy based on a claim of medical negligence or malpractice against the insured if the insured is dismissed from an action alleging medical malpractice within 300 days of the filing of that action.

17. (New section) Each annual statement made after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), pursuant to the provisions of section 16 of P.L.1982, c.114 (C.17:29AA-16), by an insurer writing medical malpractice in this State, shall include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory, or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

18. (New section) Notwithstanding the provisions of section 1 of P.L.1968, c.131 (C.17:29C-1) to the contrary, each notice of renewal or nonrenewal by an insurer authorized to transact medical malpractice liability insurance in this State shall be mailed or delivered by the insurer to the insured not less than 60 days prior to the expiration of the policy and, in the case of a nonrenewal, shall contain the reason for the nonrenewal.

19. Section 10 of P.L.1982, c.114 (C.17:29AA-10) is amended to read as follows:

10. a. Rates shall not be excessive, inadequate or unfairly discriminatory.

b. In the case of rates for medical malpractice liability insurance, if the commissioner finds, after a hearing, that a rate in effect for any insurer is not in compliance with the standards of P.L.1982, c.114 (C.17:29AA-1 et seq.), and has increased in excess of 25% of the rate previously in effect, the commissioner shall issue an order specifying in what respects the rate so fails and directing that the rate change is no longer in effect, and shall order the insurer to refund with interest any premiums collected pursuant to the non-compliant rate.

c. Pursuant to procedures and standards adopted by the commissioner, insureds may petition the commissioner to investigate and, if appropriate, to conduct a hearing into whether medical malpractice liability insurance rates fail to comply with the standards of P.L.1982, c.114 (C.17:29AA-1 et seq.).

(cf: P.L.1982, c.114, s.10)

20. (New section) Subject to standards adopted by the National Association of Insurance Commissioners, the Commissioner of Banking and Insurance shall, within 180 days after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), review the current capitalization and reserve requirements applicable to insurers authorized or admitted to transact medical malpractice liability insurance in this State, as those requirements are established by statute or regulation, or both.

Based upon the findings of that review, the commissioner shall adopt regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to modify those requirements, as the commissioner determines necessary in order to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in this State. If the commissioner determines that legislation is necessary to effect any such modification, the commissioner shall notify the Governor and the Legislature within the 180-day period provided in this section.

21. (New section) The provisions of P.L.1970, c.22 (C.17:27A-1 et seq.), regulating insurance company holding systems, shall apply to attorneys in fact and other persons engaged in reciprocal exchange or interinsurance contracts for the provision of medical malpractice insurance pursuant to Subtitle 3 of Title 17 of the Revised Statutes.

22. (New section) Every insurer authorized to transact medical malpractice liability insurance in this State shall offer its insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance by regulation.

23. Section 2 of P.L.1983, c.247 (C.17:30D-17) is amended to read as follows:

2. a. Any insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the Medical Practitioner Review Panel established pursuant to section 8 of P.L.1989, c.300 (C.45:9-19.8) in writing of any medical malpractice claim settlement, judgment or arbitration award involving any practitioner licensed by the State Board of Medical Examiners and insured by the insurer or insurance association. Any practitioner licensed by the board who is not covered by medical malpractice liability insurance issued in this State, who has coverage through a self-insured health care facility or health maintenance organization, or has medical malpractice liability insurance which has been issued by an insurer or insurance association from outside the State, shall notify the review panel in writing of any medical malpractice claim settlement, judgment or arbitration award to which the practitioner is a party. The review panel or board, as the case may be, shall not presume that the judgment or award is conclusive evidence in any disciplinary proceeding and the fact of a settlement is not admissible in any disciplinary proceeding.

In any malpractice action against a practitioner, a settlement prohibiting a complaint against the practitioner or the providing of information to the review panel or board concerning the underlying facts or circumstances of the action is void and unenforceable.

b. An insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the review panel in writing of any termination or denial of coverage to a practitioner or surcharge assessed on account of the practitioner's practice method or medical malpractice claims history.

c. The form of notification shall be prescribed by the Commissioner of Banking and Insurance, shall contain such information as may be required by the board and the review panel, and shall be made within seven days of the settlement, judgment or award or the final action for a termination or denial of, or surcharge on, the medical malpractice liability insurance. Upon request of the board, the review panel or the commissioner, an insurer or insurance association shall provide all records regarding the defense of a malpractice claim, the processing of the claim and the legal proceeding; except that nothing in this subsection shall be construed to authorize disclosure of any confidential communication which is otherwise protected by statute, court rule or common law.

An insurer or insurance association, or any employee thereof, shall be immune from liability for furnishing information to the review panel and the board in fulfillment of the requirements of this section unless the insurer or insurance association, or any employee thereof, knowingly provided false information.

d. An insurer, insurance association or practitioner who fails to notify the review panel as required pursuant to this section shall be subject to such penalties as the Commissioner of Banking and Insurance may determine pursuant to section 12 of P.L.1975, c.301 (C.17:30D-12). In addition to, or in lieu of suspension or revocation, the commissioner may assess a fine which shall not exceed $1,000 for the first offense and $2,000 for the second and each subsequent offense, which may be recovered in a summary proceeding, brought in the name of the State in a court of competent jurisdiction pursuant to **[**"the penalty enforcement law," N.J.S.2A:58-1 et seq.**]** the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A: 58-10 et seq.).

e. A practitioner who fails to notify the review panel as required pursuant to this section shall be subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 45:1-22 and 45:1-25).

f. An insurer or insurance association shall make available to the review panel or the board, upon request, any records of termination or denial of coverage to a practitioner or surcharge assessed on account of the practitioner's practice method or medical malpractice claims history, which occurred up to five years prior to the effective date of P.L.1989, c.300 (C.45:9-19.4 et al.).

g. For the purposes of this section, "practitioner" means a person licensed to practice: medicine and surgery under chapter 9 of Title 45 of the Revised Statutes or a medical resident or intern; or podiatry under chapter 5 of Title 45 of the Revised Statutes.

h. Any insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the Commissioner of Banking and Insurance, in a form and manner specified by the commissioner, of any medical malpractice claim settlement, judgment or arbitration award involving any practitioner licensed by the State Board of Medical Examiners and insured by the insurer or insurance association. The notification shall include the specialty or area of professional practice of the practitioner and the amount of the settlement, judgment or arbitration award, but shall not include the name or other identifying information of the practitioner.

(cf: P.L.1989, c.300, s.4)

24. (New section) a. Notwithstanding any provision of law to the contrary, every insurer authorized to transact medical malpractice liability insurance in this State shall, during the period ending on the 91st day after the effective date of this act, permit a health care professional, who has a policy issued by that insurer that is in effect on the effective date of this act, to:

(1) request that the premium for that policy be recalculated to reflect any cost-saving provisions of this act; and

(2) cancel the policy with a return of the amount of the gross unearned premium to be returned on a pro rata basis.

b. The provisions of subsection a. of this section shall not be construed to permit an insurer to increase a premium on a policy, which is in effect on the effective date of this act, during the term of that policy.

25. (New section) a. As used in this section:

"Annuity" means an annuity issued by an insurer licensed or authorized to do business in this State which is a qualified assignment under section 130 of the federal Internal Revenue Code of 1986, 26 U.S.C. s.130.

"Judgment creditor" means a claimant who is the recipient of an award for economic or noneconomic damages, or both, that is the result of an action filed against a health care provider for medical malpractice, which award is subject to the provisions of subsection b. of this section.

"Judgment debtor" means a health care provider who, as a defendant in an action brought for medical malpractice, is required to pay the claimant an award that is subject to the provisions of this section.

"Noneconomic damages" means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

"Structured payment agreement" means an agreement made to settle a claim or lawsuit or respond to a judgment in an action brought for medical malpractice by an injured person whereby a series of periodic payments, rather than a lump sum payment, is made over time to a claimant, in accordance with the needs of the claimant or the claimant's family, either through the purchase of an annuity or the establishment of a trust fund, or by another means approved by the court.

b. (1) Unless otherwise agreed to by the parties, in any judgment resulting from a medical malpractice action brought by a claimant for medical malpractice in which the noneconomic damages are less than or equal to $1,000,000, the court shall enter a judgment ordering that all of the money damages, both economic and noneconomic, be paid immediately.

(2) Unless otherwise agreed to by the parties, in any judgment resulting from a medical malpractice action brought by a claimant for medical malpractice in which the noneconomic damages exceed $1,000,000, the court shall enter a judgment ordering that 50% of the noneconomic damages be paid immediately, with the costs and

attorney's fees to be paid from that amount. The remaining 50% of the judgment shall be paid over 60 months in the form of a structured payment agreement by any person, organization, group, or insurer that is contractually liable to pay the judgment.

c. The structured payment agreement shall specify: the recipient of the payments; the dollar amount of the payments; the interval between payments; the number of payments or the period of time over which payments are to be made; and the persons to whom money damages are owed, if any, in the event of the judgment creditor's death.

d. In the event of the judgment creditor's death, any amounts due and owing pursuant to subsection b. of this section shall be paid to the judgment creditor's estate.

e. The judgment debtor or the judgment debtor's insurer shall be required to: post a bond or security; or, as otherwise provided by regulation of the Department of Banking and Insurance, assure full payment of the noneconomic damages awarded. A bond shall not be deemed adequate unless it is written by a company authorized to do business in this State and is rated A+ by A.M. Best Company. If the judgment debtor is unable to adequately assure full payment of the judgment, the judgment, reduced to present value, shall be paid to the claimant in a lump sum. No bond may be canceled or be subject to cancellation unless at least 60 days' advance written notice is filed with the court and the claimant. Upon termination of periodic payments, the security, or so much as remains, shall be returned to the judgment debtor.

f. Upon the purchase of an annuity, establishment of a trust, or approval of another arrangement for periodic payments by a court, any obligation of the judgment debtor with respect to the judgment shall cease.

26. There is established the "Medical Care Availability Task Force."

a. The task force shall consist of 33 members as follows:

(1) the Commissioners of Banking and Insurance, Health and Senior Services, and Human Services, and the Director of the Administrative Office of the Courts, or their designees, who shall serve ex officio;

(2) two members of the Senate to be appointed by the President of the Senate, no more than one of whom shall be of the same political party, and two members of the General Assembly to be appointed by the Speaker of the General Assembly, no more than one of whom shall be of the same political party; and

(3) 25 public members, each of whom shall be selected by the governing body of an organization to represent that organization. The

following organizations shall each be represented by one public member: New Jersey Association of Health Plans; AAHP-HIAA; Physicians and Patients for Quality Care; Princeton Insurance Company; Medical Society of New Jersey; New Jersey Association of Osteopathic Physicians and Surgeons; New Jersey Section, American College of Obstetrics and Gynecology; American College of Emergency Physicians-New Jersey Chapter; New Jersey Neurosurgical Society; New Jersey Academy of Family Physicians; New Jersey State Nurses Association; New Jersey Hospital Association; New Jersey Council of Teaching Hospitals; Health Care Association of New Jersey; Association of Trial Attorneys-New Jersey; New Jersey State Bar Association; Garden State Bar Association; Hispanic Bar Association of New Jersey; Trial Attorneys of New Jersey; Consumers for Civil Justice; New Jersey Citizen Action; AARP; New Jersey Public Interest Research Group (PIRG); Legal Services of New Jersey; and Health Professionals and Allied Employees (HPAE) union.

b. Vacancies in the membership of the task force shall be filled in the same manner provided for the original appointments. The public members of the task force shall serve without compensation but may be reimbursed for traveling and other miscellaneous expenses necessary to perform their duties, within the limits of funds made available to the task force for its purposes.

c. (1) The task force shall organize as soon as practicable, but no later than the 30th day after the appointment of its members, and shall select a chairperson and vice-chairperson from among the members. The chairperson shall appoint a secretary who need not be a member of the task force.

(2) The task force may meet at the call of the chairperson and hold hearings at the times and in the places it may deem appropriate and necessary to fulfill its charge. The task force shall be entitled to call to its assistance, and avail itself of the services of, the employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for its purposes.

(3) The Department of Banking and Insurance shall provide staff services to the task force.

d. The purpose of the task force shall be to study the following issues:

(1) the advantages and disadvantages of establishing limitations on noneconomic damages for medical malpractice judgments and on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

(2) the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

(3) the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

(4) the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits; and

(5) the necessity for, and advantages and disadvantages of, reactivating the Medical Malpractice Reinsurance Association established pursuant to P.L.1975, c.301 (C.17:30D-1 et seq.).

e. The task force shall present a report of its findings and recommendations to the Governor and the Legislature no later than 12 months after the date of its initial meeting.

27. This act shall take effect on the 30th day after enactment and shall apply to causes of action for medical malpractice that accrue on or after that effective date; except that, sections 13 and 14 shall take effect on the 180th day after the date of enactment and section 18 shall take effect on the 90th day after the date of enactment, and the amendatory provisions of sections 3 and 4 shall apply to injuries sustained at birth on or after the effective date of this act.

STATEMENT

This bill, which is designated the "New Jersey Medical Care Access and Responsibility and Patients First Act," is designed to implement a number of tort liability, health care system and medical malpractice liability reforms.

Specifically, the bill provides for the following:

**Tort Liability Reforms:**

The bill amends N.J.S.2A:14-2 and N.J.S.2A:14-21 to provide that actions by or on behalf of a minor that have accrued for medical malpractice for injuries sustained at birth must be commenced prior to the minor's 11th birthday, and do not affect the discovery doctrine in any way.

The bill provides for court referral of a medical malpractice action to a complementary dispute resolution mechanism if the judge presiding over the action determines, within 30 days after the discovery end date, that the referral may encourage early disposition or settlement of the action. If the judge makes that determination, the matter is to be referred to complementary dispute resolution pursuant to Rule 1:40 of the New Jersey Court Rules.

The bill also provides that a health care provider named as a defendant in a medical malpractice action may file an affidavit of noninvolvement with the court. The affidavit of noninvolvement is to

set forth the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant. The bill also provides penalties for false statements made in the affidavit or in challenging the affidavit.

The bill establishes qualifications for expert witnesses in medical malpractice actions and for the purpose of executing an affidavit of merit, and provides that an expert must have the same type of practice and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court. The bill prohibits expert witnesses from testifying on a contingency fee basis and provides for penalties for expert witnesses who intentionally misrepresent the applicable standard of practice or care. The bill also provides for penalties for an individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit of merit, which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure.

With respect to the payment of medical malpractice judgments, the bill provides that in any medical malpractice judgment in which the noneconomic damages (those for pain and suffering) are $1 million or less, unless otherwise agreed to by the parties, the court is to enter a judgment ordering that money damages be paid immediately. In any judgment in which the noneconomic damages exceed $1 million, unless otherwise agreed to by the parties, 50% of the money damages are to be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50% of the judgment is to be paid over 60 months in the form of a structured payment agreement.

Further, in order to provide the court with discretion to modify jury awards, the bill modifies the standard of review to be used by the court in reviewing the amount of a jury award to require the court to consider the evidence in the light most favorable to the non-moving party and to allow the court to determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

**Health Care System Reforms:**

The bill expands the State's "Good Samaritan" law to provide immunity from civil damages to licensed health care professionals, emergency medical technicians and mobile intensive care paramedics whose duty does not require a response to a patient emergency situation, who, in good faith, respond to a life-threatening emergency or respond to a request for emergency assistance in a life-threatening

emergency within a hospital or other licensed health care facility or a State psychiatric hospital operated by the Department of Human Services. The immunity shall not apply: to acts or omissions constituting gross negligence, recklessness or willful misconduct; if a provider-patient relationship existed before the emergency; if consideration in any form is provided to the health care professional for the service rendered; or if a general hospital has not reasonably and adequately staffed its emergency department.

Further, the bill provides that a health care professional is not liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility or State psychiatric hospital on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

- the patient was unconscious;

- the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

- a medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The immunity provided is applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

The bill strengthens reporting requirements by physicians to the State Board of Medical Examiners (BME) to ensure that the BME is promptly informed of any pending or final action by any criminal authority in this State or any other state or federal jurisdiction or any arrest or conviction for a criminal or quasi-criminal act, by requiring that a physician report, within 10 days, the action or his arrest or conviction, for crimes that include, but are not limited to, criminal homicide, aggravated assault, sexual assault, criminal sexual contact or lewdness, or an offense involving any controlled dangerous substance or controlled substance analog.

The bill also ensures that health care facilities, State psychiatric hospitals and other physicians affiliated with a physician who has been disciplined by the BME, are notified of its action, within 30 days of the action. Similarly, the bill ensures that a health care facility, State psychiatric hospital or health maintenance organization is promptly notified by the BME if, during the course of an investigation of a physician, it requests information from that facility or health

maintenance organization regarding that physician, and subsequently determines that no disciplinary action is warranted.

**Medical Malpractice Liability Insurance Reforms:**

To avoid the appearance of any conflicts of interest, the bill prohibits any person who is an officer, director or board member of a professional association for health care providers to serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that is issuing policies in the State. The bill also provides that no more than one person who has been an officer, director or board member of a professional association for health care providers is to serve as an officer, director or board member of a State-domiciled medical malpractice liability insurer that is issuing policies in the State.

For the purpose of negotiating a reduced medical malpractice liability insurance premium, the bill would permit physicians to join together, by means of a joint contract, to form a "Medical Malpractice Liability Insurance Purchasing Alliance."

The bill provides that a medical malpractice liability insurance policy may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; but, if the policy contains that provision, the insurer would be required to offer an endorsement to the policy that permits the insurer to settle a claim filed under the policy without first having obtained the insured's consent. The insurer would be required to establish a premium for the endorsement which reflects any savings or reduced costs attributable to the endorsement, and the insured would have the option of accepting or refusing the endorsement.

Another provision to provide premium relief to health care providers is the requirement that every medical malpractice liability insurer offer individual or group medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1 million per claim, with the insurer being permitted to require the insured to provide collateral for the deductible amount to the insurer. The deductibles offered by an insurer are subject to the approval of the Commissioner of Banking and Insurance. For policies with any deductible, the insurer would be responsible for payment of the deductible and would be reimbursed for that amount by the insured.

To provide increased oversight of medical malpractice insurers, the bill requires that every annual statement filed by a medical malpractice insurer in this State with the Department of Banking and Insurance include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory or risk classification are adequate to cover expected losses and expenses of

the insurer and to ensure the safety and soundness of the insurer.

The bill requires insurers authorized to transact medical malpractice liability insurance in this State to provide at least 60 days' notice to the insured for policy renewals and nonrenewals. Also, in the case of a nonrenewal, the insurer must provide the reason for the nonrenewal.

The bill provides for oversight by the Commissioner of Banking and Insurance with respect to certain rates in effect for any category or subcategory of insureds, of any medical malpractice liability insurer, that increase in excess of 25%, and provides that the insured may petition the commissioner to investigate and, if appropriate, to conduct a hearing into whether the rates fail to comply with the standards of N.J.S.A.17:29AA-1 et seq. The bill also directs the commissioner, subject to standards adopted by the National Association of Insurance Commissioners, to review the current capitalization and reserve requirements applicable to medical malpractice insurers, and to modify those requirements, as necessary, to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in the State.

The bill provides that the insurance holding company systems act, N.J.S.A.17:27A-1 et seq., applies to reciprocal exchanges, to ensure that the provisions of that law are applicable to any future conversion by a reciprocal medical malpractice liability insurer to a stock company.

Also, the bill requires medical malpractice liability insurers to offer their insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance, by regulation.

In addition, N.J.S.A.17:30D-17, which requires all medical malpractice insurers to notify the BME of every medical malpractice judgment, settlement and award involving a physician or podiatrist licensed in this State, is amended to also require notification to the Commissioner of Banking and Insurance of these payments. The notification to the commissioner is to enable the commissioner to compile statistical data about medical malpractice payouts, and would not include the name of or other identifying information about the practitioner.

The bill permits health care professionals, under terms and conditions established by the Commissioner of Banking and Insurance, to request their medical malpractice insurer to recalculate their premium to reflect any cost saving provisions of the bill, and to cancel their policy without penalty in the event the professional is able to obtain less expensive coverage from another insurer.

Finally, the bill establishes a 33-member "Medical Care Availability Task Force" to study the following issues:

-- the advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and on

extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

-- the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

-- the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

-- the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits; and

-- the necessity for, and advantages and disadvantages of, reactivating the Medical Malpractice Reinsurance Association established pursuant to N.J.S.A.17:30D-1 et seq.

The task force may also study the causes, and any related issues, relative to the affordability of medical malpractice liability insurance.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
**ASSEMBLY, No. 50**

# STATE OF NEW JERSEY

DATED: MARCH 4, 2004

The Assembly Appropriations Committee reports favorably Assembly Bill No. 50 (ACS).

Assembly Bill No. 50 (ACS) which is designated the "New Jersey Medical Care Access and Responsibility and Patients First Act," is designed to implement a number of reforms relating to tort liability as it concerns medical malpractice, as well as health care system and medical malpractice liability insurance reforms.

Specifically, the bill provides for the following:

**Tort Liability Reforms:**

The bill amends N.J.S.2A:14-2 and N.J.S.2A:14-21 to provide that actions by or on behalf of a minor that have accrued for medical malpractice for injuries sustained at birth must be commenced prior to the minor's 13th birthday. These statutory changes would not affect the discovery doctrine in any way.

The bill provides for court referral of a medical malpractice action to a complementary dispute resolution mechanism if the judge presiding over the action determines, within 30 days after the discovery end date, that the referral may encourage early disposition or settlement of the action. If the judge makes that determination, the matter is to be referred to complementary dispute resolution pursuant to Rule 1:40 of the New Jersey Rules of Court.

The bill also provides that a health care provider named as a defendant in a medical malpractice action may file an affidavit of noninvolvement with the court. The affidavit of noninvolvement is to set forth the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant. The bill also provides penalties for false statements made in the affidavit or in challenging the affidavit.

The bill establishes qualifications for expert witnesses in medical malpractice actions and for the purpose of executing an affidavit of merit, and provides that an expert must have the same type of practice

and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court. The bill prohibits expert witnesses from testifying on a contingency fee basis and provides for penalties for expert witnesses who intentionally misrepresent the applicable standard of practice or care. The bill also provides for penalties for an individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit of merit, which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure.

With respect to the payment of medical malpractice judgments, the bill provides that in any medical malpractice judgment in which the noneconomic damages (those for pain and suffering) are $1 million or less, unless otherwise agreed to by the parties, the court is to enter a judgment ordering that money damages be paid immediately. In any judgment in which the noneconomic damages exceed $1 million, unless otherwise agreed to by the parties, 50% of the money damages are to be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50% of the judgment is to be paid over 60 months in the form of a structured payment agreement.

Further, in order to provide the court with discretion to modify jury awards, the bill modifies the standard of review to be used by the court in reviewing the amount of a jury award to require the court to consider the evidence in the light most favorable to the non-moving party and to allow the court to determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

**Health Care System Reforms:**

The bill expands the State's "Good Samaritan" law to provide immunity from civil damages to licensed health care professionals, emergency medical technicians and mobile intensive care paramedics whose duty does not require a response to a patient emergency situation, who, in good faith, respond to a life-threatening emergency or respond to a request for emergency assistance in a life-threatening emergency within a hospital or other licensed health care facility or a State psychiatric hospital operated by the Department of Human Services. The immunity shall not apply: to acts or omissions constituting gross negligence, recklessness or willful misconduct; if a provider-patient relationship existed before the emergency; if consideration in any form is provided to the health care professional for the service rendered; or if a general hospital has not reasonably and adequately staffed its emergency department.

Further, the bill provides that a health care professional is not liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility or State psychiatric hospital on account of a failure

to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

- the patient was unconscious;

- the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

- the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The immunity provided is applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

The bill strengthens reporting requirements by physicians to the State Board of Medical Examiners (BME) to ensure that the BME is promptly informed of any pending or final action by any criminal authority in this State or any other state or federal jurisdiction or any arrest or conviction for a criminal or quasi-criminal act, by requiring that a physician report, within 10 days, the action or his arrest or conviction, for crimes that include, but are not limited to, criminal homicide, aggravated assault, sexual assault, criminal sexual contact or lewdness, or an offense involving any controlled dangerous substance or controlled substance analog.

The bill also ensures that health care facilities, State psychiatric hospitals and other physicians affiliated with a physician who has been disciplined by the BME, are notified of its action, within 30 days of the action. Similarly, the bill ensures that a health care facility, State psychiatric hospital or health maintenance organization is promptly notified by the BME if, during the course of an investigation of a physician, it requests information from that facility or health maintenance organization regarding that physician, and subsequently determines that no disciplinary action is warranted.

**Medical Malpractice Liability Insurance Reforms:**

To avoid the appearance of any conflicts of interest, the bill prohibits any person who is an officer, director or board member of a professional association for health care providers to serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that is issuing policies in the State.

For the purpose of negotiating a reduced medical malpractice liability insurance premium, the bill would permit physicians to join together, by means of a joint contract, to form a "Medical Malpractice Liability Insurance Purchasing Alliance."

The bill provides that a medical malpractice liability insurance

policy may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; but, if the policy contains that provision, the insurer would be required to offer an endorsement to the policy that permits the insurer to settle a claim filed under the policy without first having obtained the insured's consent. The insurer would be required to establish a premium for the endorsement which reflects any savings or reduced costs attributable to the endorsement, and the insured would have the option of accepting or refusing the endorsement.

Another provision to provide premium relief to health care providers is the requirement that every medical malpractice liability insurer offer individual or group medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1 million per claim, with the insurer being permitted to require the insured to provide collateral for the deductible amount to the insurer. The deductibles offered by an insurer are subject to the approval of the Commissioner of Banking and Insurance. For policies with any deductible, the insurer would be responsible for payment of the deductible and would be reimbursed for that amount by the insured.

To provide increased oversight of medical malpractice insurers, the bill requires that every annual statement filed by a medical malpractice insurer in this State with the Department of Banking and Insurance include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

The bill requires insurers authorized to transact medical malpractice liability insurance in this State to provide at least 60 days' notice to the insured for policy renewals and nonrenewals. Also, in the case of a nonrenewal, the insurer must provide the reason for the nonrenewal.

The bill provides for implementation by the Commissioner of Banking and Insurance of a "file and use" system with respect to any proposed rate increase by a medical malpractice liability insurer of 15% or more on an annual basis for any medical specialty. Any such increase must be filed with the commissioner at least 45 days prior to becoming effective and include the reason for the proposed change. Unless disapproved by the commissioner prior to its effective date, the rate filing is to be deemed effective; however, the commissioner must disapprove the increase if the commissioner finds that the increased rates are excessive, inadequate or unfairly discriminatory. A rate filing that would result in a rate increase of less than 15% on an annual basis for any medical specialty would be subject to the provisions of N.J.S.A.17:29AA-1 et seq.

The bill also directs the commissioner, subject to standards adopted by the National Association of Insurance Commissioners, to

review the current capitalization and reserve requirements applicable to medical malpractice insurers, and to modify those requirements, as necessary, to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in the State.

Also, the bill requires medical malpractice liability insurers to offer their insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance, by regulation.

In addition, N.J.S.A.17:30D-17, which requires all medical malpractice insurers to notify the BME of every medical malpractice judgment, settlement and award involving a physician or podiatrist licensed in this State, is amended to also require notification to the Commissioner of Banking and Insurance of these payments. The notification to the commissioner is to enable the commissioner to compile statistical data about medical malpractice payouts, and would not include the name of or other identifying information about the practitioner.

The bill removes from the BME the authority and discretion to set the minimum amounts of medical malpractice liability insurance that a physician who maintains a professional medical practice in this State and has responsibility for patient care is required to carry, and instead establishes those minimum amounts by statute. The bill sets the limits at those currently in effect by virtue of regulations promulgated by the BME, that is: medical malpractice liability insurance in the sum of $1 million per occurrence and $3 million per policy year, with extended reporting endorsement coverage for claims made, also known as "tail coverage;" or, if liability coverage is not available, by a letter of credit for at least $500,000. The BME may, however, increase these minimum amounts by regulation.

The bill establishes the Medical Malpractice Liability Insurance Premium Assistance Fund in the Department of the Treasury to provide relief towards the payment of medical malpractice liability insurance premiums to certain health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the Commissioner of Banking and Insurance by regulation. The fund will be administered by the Department of Banking and Insurance, and will expire three years after the effective date of the bill.

The bill provides that the Commissioner of Banking and Insurance will certify classes of health care providers (practitioners), by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount determined by the commissioner, or in the case of health care practitioners whose professional liability insurance protection is provided through self-insured hospital funding supplemented with purchased commercial insurance, the total professional liability funding obligation has increased in excess of an amount determined by the commissioner. In certifying classes eligible

for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

In order to be eligible for a subsidy from the fund, a practitioner must have received a medical malpractice liability insurance premium increase in an amount determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in 2005. The amount of the subsidy will be determined by the commissioner by regulation.

In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding supplemented with purchased commercial insurance coverage, that provider must have increased its total professional liability funding obligation in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that practitioner in calendar year 2005.

The Medical Malpractice Liability Insurance Premium Assistance Fund is to be comprised of the following revenue:

-- an annual surcharge of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law";

-- an annual charge of $50 imposed on each licensed physician, podiatrist, chiropractor, dentist and optometrist by the appropriate professional licensing board; and

-- an annual fee of $50 imposed on each licensed attorney by the State Treasurer.

The above charges and fees will not apply to physicians, podiatrists, chiropractors, dentists, optometrists or attorneys who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; have not practiced their profession for at least one year; or, in the case of attorneys, are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment.

The bill also specifies that a practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's licensing

board, when that action or penalty relates to the practitioner's provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

The bill requires that a health care provider who receives a subsidy from the fund practice in that provider's specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy; and a provider who fails to comply with this requirement must repay the Commissioner of Banking and Insurance the amount of the subsidy, in whole or in part as determined by the commissioner.

The monies in the Medical Malpractice Liability Insurance Premium Assistance Fund are specifically dedicated and to be utilized exclusively for the following purposes:

-- $20 million is to be allocated for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established under the bill;

-- $8 million is to be allocated to the Health Care Subsidy Fund established pursuant to N.J.S.A.26:2H-18.58 for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to N.J.S.A.26:2H-18.51 et al.;

-- $2 million is to be allocated for a student loan expense reimbursement program for health care providers who are members of specialties and subspecialties who qualify for relief from the fund (as described below); and

-- the balance of any unexpended monies in the fund is to be allocated to the Division of Medical Assistance and Health Services in the Department of Human Services for the provision of other health care services as determined by the Commissioner of Human Services.

The bill establishes a three-year student loan expense reimbursement program within the Higher Education Student Assistance Authority for health care providers who are members of specialties and subspecialties who qualify for relief from the Fund. A provider who receives a payment under the program is required to practice in that provider's specialty or subspecialty in this State for a period of at least four years after receipt of the payment; and a provider who fails to comply with this requirement must repay the authority the amount of the payment, in whole or in part as determined by the authority. The authority is to implement the program in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, and to adopt rules and regulations, pursuant to the "Administrative Procedure Act," to effectuate the purposes of this new program, including, but not limited to: eligibility for the program, procedures for application, selection of participants, establishment and nullification of contracts established with participants under the program, reports to the program by participants,

and recruitment of participants.

Finally, the bill establishes a 17-member "Medical Care Availability Task Force" to study the following issues:

-- the advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

-- the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

-- the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

-- the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits;

-- the advantages and disadvantages of establishing a pre-suit procedure; and

-- the necessity for, and advantages and disadvantages of, reactivating the Medical Malpractice Reinsurance Association established pursuant to N.J.S.A.17:30D-1 et seq.

FISCAL IMPACT:

The balance of the Medical Malpractice Liability Insurance Premium Assistance Fund is to be the comprised of the following revenue:

an annual surcharge of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law";

an annual charge of $50 imposed on each licensed physician, podiatrist, chiropractor, dentist and optometrist by the appropriate professional licensing board; and

an annual fee of $50 imposed on each licensed attorney by the State Treasurer.

The monies in the Medical Malpractice Liability Insurance Premium Assistance Fund are specifically dedicated and to be utilized exclusively for the following purposes:

$20 million is to be allocated for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established under the bill;

$8 million is to be allocated to the Health Care Subsidy Fund established pursuant to N.J.S.A.26:2H-18.58 for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to N.J.S.A.26:2H-18.51 et al.;

$2 million is to be allocated for a student loan expense reimbursement program for health care providers who are members of specialties and subspecialties who qualify for relief from the fund (as described below); and

the balance of any unexpended monies in the fund is to be allocated to the Division of Medical Assistance and Health Services in the Department of Human Services for the provision of other health care services as determined by the Commissioner of Human Services.

No other information has been made available to the Office of Legislative Services concerning the fiscal implications of the bill.

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
**ASSEMBLY, No. 50**

# STATE OF NEW JERSEY

DATED: MARCH 4, 2004

The Assembly Health and Human Services Committee reports favorably an Assembly Committee Substitute for Assembly Bill No. 50.

This committee substitute, which is designated the "New Jersey Medical Care Access and Responsibility and Patients First Act," is designed to implement a number of reforms relating to tort liability as it concerns medical malpractice, as well as health care system and medical malpractice liability insurance reforms.

Specifically, the substitute provides for the following:

**Tort Liability Reforms:**

The substitute amends N.J.S.2A:14-2 and N.J.S.2A:14-21 to provide that actions by or on behalf of a minor that have accrued for medical malpractice for injuries sustained at birth must be commenced prior to the minor's 13th birthday. These statutory changes would not affect the discovery doctrine in any way.

The substitute provides for court referral of a medical malpractice action to a complementary dispute resolution mechanism if the judge presiding over the action determines, within 30 days after the discovery end date, that the referral may encourage early disposition or settlement of the action. If the judge makes that determination, the matter is to be referred to complementary dispute resolution pursuant to Rule 1:40 of the New Jersey Rules of Court.

The substitute also provides that a health care provider named as a defendant in a medical malpractice action may file an affidavit of noninvolvement with the court. The affidavit of noninvolvement is to set forth the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant. The substitute also provides penalties for false statements made in the affidavit or in challenging the affidavit.

The substitute establishes qualifications for expert witnesses in medical malpractice actions and for the purpose of executing an

affidavit of merit, and provides that an expert must have the same type of practice and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court. The substitute prohibits expert witnesses from testifying on a contingency fee basis. The substitute also provides for penalties for an individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit of merit, which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure.

With respect to the payment of medical malpractice judgments, the substitute provides that in any medical malpractice judgment in which the noneconomic damages (those for pain and suffering) are $1 million or less, unless otherwise agreed to by the parties, the court is to enter a judgment ordering that money damages be paid immediately. In any judgment in which the noneconomic damages exceed $1 million, unless otherwise agreed to by the parties, 50% of the money damages are to be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50% of the judgment is to be paid over 60 months in the form of a structured payment agreement.

Further, in order to provide the court with discretion to modify jury awards, the substitute modifies the standard of review to be used by the court in reviewing the amount of a jury award to require the court to consider the evidence in the light most favorable to the non-moving party and to allow the court to determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

**Health Care System Reforms:**

The substitute expands the State's "Good Samaritan" law to provide immunity from civil damages to licensed health care professionals, emergency medical technicians and mobile intensive care paramedics whose duty does not require a response to a patient emergency situation, who, in good faith, respond to a life-threatening emergency or respond to a request for emergency assistance in a life-threatening emergency within a hospital or other licensed health care facility or a State psychiatric hospital operated by the Department of Human Services. The immunity shall not apply: to acts or omissions constituting gross negligence, recklessness or willful misconduct; if a provider-patient relationship existed before the emergency; if consideration in any form is provided to the health care professional for the service rendered; or if a general hospital has not reasonably and adequately staffed its emergency department.

Further, the substitute provides that a health care professional is not liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility or State psychiatric hospital on account of a

failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

- the patient was unconscious;

- the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

- the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The immunity provided is applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

The substitute strengthens reporting requirements by physicians to the State Board of Medical Examiners (BME) to ensure that the BME is promptly informed of any pending or final action by any criminal authority in this State or any other state or federal jurisdiction or any arrest or conviction for a criminal or quasi-criminal act, by requiring that a physician report, within 10 days, the action or his arrest or conviction, for crimes that include, but are not limited to, criminal homicide, aggravated assault, sexual assault, criminal sexual contact or lewdness, or an offense involving any controlled dangerous substance or controlled substance analog.

The substitute also ensures that health care facilities, State psychiatric hospitals and other physicians affiliated with a physician who has been disciplined by the BME, are notified of its action, within 30 days of the action. Similarly, the substitute ensures that a health care facility, State psychiatric hospital or health maintenance organization is promptly notified by the BME if, during the course of an investigation of a physician, it requests information from that facility or health maintenance organization regarding that physician, and subsequently determines that no disciplinary action is warranted.

**Medical Malpractice Liability Insurance Reforms:**

To avoid the appearance of any conflicts of interest, the substitute prohibits any person who is an officer, director or board member of a professional association for health care providers to serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that issues policies in the State.

For the purpose of negotiating a reduced medical malpractice liability insurance premium, the substitute would permit physicians to join together, by means of a joint contract, to form a "Medical Malpractice Liability Insurance Purchasing Alliance."

The substitute provides that a medical malpractice liability

insurance policy may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; but, if the policy contains that provision, the insurer would be required to offer an endorsement to the policy that permits the insurer to settle a claim filed under the policy without first having obtained the insured's consent. The insurer would be required to establish a premium for the endorsement which reflects any savings or reduced costs attributable to the endorsement, and the insured would have the option of accepting or refusing the endorsement.

Another provision to provide premium relief to health care providers is the requirement that every medical malpractice liability insurer offer individual or group medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1 million per claim, with the insurer being permitted to require the insured to provide collateral for the deductible amount to the insurer. The deductibles offered by an insurer are subject to the approval of the Commissioner of Banking and Insurance. For policies with any deductible, the insurer would be responsible for payment of the deductible and would be reimbursed for that amount by the insured.

To provide increased oversight of medical malpractice insurers, the substitute requires that every annual statement filed by a medical malpractice insurer in this State with the Department of Banking and Insurance include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

The substitute requires insurers authorized to transact medical malpractice liability insurance in this State to provide at least 60 days' notice to the insured for policy renewals and nonrenewals. Also, in the case of a nonrenewal, the insurer must provide the reason for the nonrenewal.

The substitute provides for implementation by the Commissioner of Banking and Insurance of a "file and use" system with respect to any proposed rate increase by a medical malpractice liability insurer of 15% or more on an annual basis for any medical specialty. Any such increase must be filed with the commissioner at least 45 days prior to becoming effective and include the reason for the proposed change. Unless disapproved by the commissioner prior to its effective date, the rate filing is to be deemed effective; however, the commissioner must disapprove the increase if the commissioner finds that the increased rates are excessive, inadequate or unfairly discriminatory. A rate filing that would result in a rate increase of less than 15% on an annual basis for any medical specialty would be subject to the provisions of N.J.S.A.17:29AA-1 et seq.

The substitute also directs the commissioner, subject to standards adopted by the National Association of Insurance Commissioners, to

review the current capitalization and reserve requirements applicable to medical malpractice insurers, and to modify those requirements, as necessary, to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in the State.

Also, the substitute requires medical malpractice liability insurers to offer their insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance, by regulation.

In addition, N.J.S.A.17:30D-17, which requires all medical malpractice insurers to notify the BME of every medical malpractice judgment, settlement and award involving a physician or podiatrist licensed in this State, is amended to also require notification to the Commissioner of Banking and Insurance of these payments. The notification to the commissioner is to enable the commissioner to compile statistical data about medical malpractice payouts, and would not include the name of or other identifying information about the practitioner.

The substitute removes from the BME the authority and discretion to set the minimum amounts of medical malpractice liability insurance that a physician who maintains a professional medical practice in this State and has responsibility for patient care is required to carry, and instead establishes those minimum amounts by statute. The substitute sets the limits at those currently in effect by virtue of regulations promulgated by the BME, that is: medical malpractice liability insurance in the sum of $1 million per occurrence and $3 million per policy year, with extended reporting endorsement coverage for claims made, also known as "tail coverage;" or, if liability coverage is not available, by a letter of credit for at least $500,000. The BME may, however, increase these minimum amounts by regulation.

The substitute establishes the Medical Malpractice Liability Insurance Premium Assistance Fund in the Department of the Treasury to provide relief towards the payment of medical malpractice liability insurance premiums to certain health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the Commissioner of Banking and Insurance by regulation. The fund will be administered by the Department of Banking and Insurance, and will expire three years after the effective date of the substitute.

The substitute provides that the Commissioner of Banking and Insurance will certify classes of health care providers (practitioners), by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount determined by the commissioner, or in the case of health care practitioners whose professional liability insurance protection is provided through self-insured hospital funding supplemented with purchased commercial insurance, the total professional liability funding obligation has increased in excess of an amount determined by the commissioner. In certifying classes eligible

for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

In order to be eligible for a subsidy from the fund, a practitioner must have received a medical malpractice liability insurance premium increase in an amount determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in 2005. The amount of the subsidy will be determined by the commissioner by regulation.

In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding supplemented with purchased commercial insurance coverage, that provider must have increased its total professional liability funding obligation in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that practitioner in calendar year 2005.

The Medical Malpractice Liability Insurance Premium Assistance Fund is to be comprised of the following revenue:

-- an annual surcharge of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law";

-- an annual charge of $50 imposed on each licensed physician, podiatrist, chiropractor, dentist and optometrist by the appropriate professional licensing board; and

-- an annual fee of $50 imposed on each licensed attorney by the State Treasurer.

The above charges and fees will not apply to physicians, podiatrists, chiropractors, dentists, optometrists or attorneys who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; have not practiced their profession for at least one year; or, in the case of attorneys, are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment.

The substitute also specifies that a practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's

licensing board, when that action or penalty relates to the practitioner's provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

The substitute requires that a health care provider who receives a subsidy from the fund practice in that provider's specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy; and a provider who fails to comply with this requirement must repay the Commissioner of Banking and Insurance the amount of the subsidy, in whole or in part as determined by the commissioner.

The monies in the Medical Malpractice Liability Insurance Premium Assistance Fund are specifically dedicated and to be utilized exclusively for the following purposes:

-- $20 million is to be allocated for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established under the substitute;

-- $8 million is to be allocated to the Health Care Subsidy Fund established pursuant to N.J.S.A.26:2H-18.58 for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to N.J.S.A.26:2H-18.51 et al.;

-- $2 million is to be allocated for a student loan expense reimbursement program for health care providers who are members of specialties and subspecialties who qualify for relief from the fund (as described below); and

-- the balance of any unexpended monies in the fund is to be allocated to the Division of Medical Assistance and Health Services in the Department of Human Services for the provision of other health care services as determined by the Commissioner of Human Services.

The substitute establishes a three-year student loan expense reimbursement program within the Higher Education Student Assistance Authority for health care providers who are members of specialties and subspecialties who qualify for relief from the Medical Malpractice Liability Insurance Premium Assistance Fund. A provider who receives a payment under the program is required to practice in that provider's specialty or subspecialty in this State for a period of at least four years after receipt of the payment; and a provider who fails to comply with this requirement must repay the authority the amount of the payment, in whole or in part as determined by the authority. The authority is to implement the program in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, and to adopt rules and regulations, pursuant to the "Administrative Procedure Act," to effectuate the purposes of this new program, including, but not limited to: eligibility for the program, procedures for application, selection of participants, establishment and

nullification of contracts established with participants under the program, reports to the program by participants, and recruitment of participants.

Finally, the substitute establishes a 17-member "Medical Care Availability Task Force" to study the following issues:

-- the advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

-- the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

-- the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

-- the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits;

-- the advantages and disadvantages of establishing a pre-suit procedure; and

-- the necessity for, and advantages and disadvantages of, reactivating the Medical Malpractice Reinsurance Association established pursuant to N.J.S.A.17:30D-1 et seq.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
**ASSEMBLY, No. 50**

# STATE OF NEW JERSEY

DATED: MARCH 4, 2004

The Assembly Financial Institutions and Insurance Committee reports favorably the Assembly Committee Substitute for Assembly Bill No. 50.

This committee substitute, which is designated the "New Jersey Medical Care Access and Responsibility and Patients First Act," is designed to implement a number of reforms relating to tort liability as it concerns medical malpractice, as well as health care system and medical malpractice liability insurance reforms.

Specifically, the substitute provides for the following:

**Tort Liability Reforms:**

The substitute amends N.J.S.2A:14-2 and N.J.S.2A:14-21 to provide that actions by or on behalf of a minor that have accrued for medical malpractice for injuries sustained at birth must be commenced prior to the minor's 13th birthday, and do not affect the discovery doctrine in any way.

The substitute provides for court referral of a medical malpractice action to a complementary dispute resolution mechanism if the judge presiding over the action determines, within 30 days after the discovery end date, that the referral may encourage early disposition or settlement of the action. If the judge makes that determination, the matter is to be referred to complementary dispute resolution pursuant to Rule 1:40 of the New Jersey Court Rules.

The substitute also provides that a health care provider named as a defendant in a medical malpractice action may file an affidavit of noninvolvement with the court. The affidavit of noninvolvement is to set forth the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant. The substitute also provides penalties for false statements made in the affidavit or in challenging the affidavit.

The substitute establishes qualifications for expert witnesses in medical malpractice actions and for the purpose of executing an affidavit of merit, and provides that an expert must have the same type of practice and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court. The substitute prohibits expert witnesses from testifying on a contingency fee basis and provides for penalties for expert witnesses who intentionally misrepresent the applicable standard of practice or care. The substitute also provides for penalties for an individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit of merit, which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure.

With respect to the payment of medical malpractice judgments, the substitute provides that in any medical malpractice judgment in which the noneconomic damages (those for pain and suffering) are $1 million or less, unless otherwise agreed to by the parties, the court is to enter a judgment ordering that money damages be paid immediately. In any judgment in which the noneconomic damages exceed $1 million, unless otherwise agreed to by the parties, 50% of the money damages are to be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50% of the judgment is to be paid over 60 months in the form of a structured payment agreement.

Further, in order to provide the court with discretion to modify jury awards, the substitute modifies the standard of review to be used by the court in reviewing the amount of a jury award to require the court to consider the evidence in the light most favorable to the non-moving party and to allow the court to determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

**Health Care System Reforms:**

The substitute expands the State's "Good Samaritan" law to provide immunity from civil damages to licensed health care professionals, emergency medical technicians and mobile intensive care paramedics whose duty does not require a response to a patient emergency situation, who, in good faith, respond to a life-threatening emergency or respond to a request for emergency assistance in a life-threatening emergency within a hospital or other licensed health care facility or a State psychiatric hospital operated by the Department of Human Services. The immunity shall not apply: to acts or omissions constituting gross negligence, recklessness or willful misconduct; if a provider-patient relationship existed before the emergency; if consideration in any form is provided to the health care professional for the service rendered; or if a general hospital has not reasonably and adequately staffed its emergency department.

Further, the substitute provides that a health care professional is not liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility or State psychiatric hospital on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

-the patient was unconscious;

-the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

-the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The immunity provided is applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

The substitute strengthens reporting requirements by physicians to the State Board of Medical Examiners (BME) to ensure that the BME is promptly informed of any pending or final action by any criminal authority in this State or any other state or federal jurisdiction or any arrest or conviction for a criminal or quasi-criminal act, by requiring that a physician report, within 10 days, the action or his arrest or conviction, for crimes that include, but are not limited to, criminal homicide, aggravated assault, sexual assault, criminal sexual contact or lewdness, or an offense involving any controlled dangerous substance or controlled substance analog.

The substitute also ensures that health care facilities, State psychiatric hospitals and other physicians affiliated with a physician who has been disciplined by the BME, are notified of its action, within 30 days of the action. Similarly, the substitute ensures that a health care facility, State psychiatric hospital or health maintenance organization is promptly notified by the BME if, during the course of an investigation of a physician, it requests information from that facility or health maintenance organization regarding that physician, and subsequently determines that no disciplinary action is warranted.

**Medical Malpractice Liability Insurance Reforms:**

To avoid the appearance of any conflicts of interest, the substitute prohibits any person who is an officer, director or board member of a professional association for health care providers to serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that is issuing policies in the State.

For the purpose of negotiating a reduced medical malpractice

liability insurance premium, the substitute would permit physicians to join together, by means of a joint contract, to form a "Medical Malpractice Liability Insurance Purchasing Alliance."

The substitute provides that a medical malpractice liability insurance policy may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; but, if the policy contains that provision, the insurer would be required to offer an endorsement to the policy that permits the insurer to settle a claim filed under the policy without first having obtained the insured's consent. The insurer would be required to establish a premium for the endorsement which reflects any savings or reduced costs attributable to the endorsement, and the insured would have the option of accepting or refusing the endorsement.

Another provision to provide premium relief to health care providers is the requirement that every medical malpractice liability insurer offer individual or group medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1 million per claim, with the insurer being permitted to require the insured to provide collateral for the deductible amount to the insurer. The deductibles offered by an insurer are subject to the approval of the Commissioner of Banking and Insurance. For policies with any deductible, the insurer would be responsible for payment of the deductible and would be reimbursed for that amount by the insured.

To provide increased oversight of medical malpractice insurers, the substitute requires that every annual statement filed by a medical malpractice insurer in this State with the Department of Banking and Insurance include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

The substitute requires insurers authorized to transact medical malpractice liability insurance in this State to provide at least 60 days' notice to the insured for policy renewals and nonrenewals. Also, in the case of a nonrenewal, the insurer must provide the reason for the nonrenewal.

The substitute provides for implementation by the Commissioner of Banking and Insurance of a "file and use" system with respect to any proposed rate increase by a medical malpractice liability insurer of 15% or more on an annual basis for any medical specialty. Any such increase must be filed with the commissioner at least 45 days prior to becoming effective and include the reason for the proposed change. Unless disapproved by the commissioner prior to its effective date, the rate filing is to be deemed effective; however, the commissioner must disapprove the increase if the commissioner finds that the increased rates are excessive, inadequate or unfairly discriminatory. A rate filing that would result in a rate increase of less than 15% on an annual basis

for any medical specialty would be subject to the provisions of N.J.S.A.17:29AA-1 et seq.

The substitute also directs the commissioner, subject to standards adopted by the National Association of Insurance Commissioners, to review the current capitalization and reserve requirements applicable to medical malpractice insurers, and to modify those requirements, as necessary, to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in the State.

Also, the substitute requires medical malpractice liability insurers to offer their insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance, by regulation.

In addition, N.J.S.A.17:30D-17, which requires all medical malpractice insurers to notify the BME of every medical malpractice judgment, settlement and award involving a physician or podiatrist licensed in this State, is amended to also require notification to the Commissioner of Banking and Insurance of these payments. The notification to the commissioner is to enable the commissioner to compile statistical data about medical malpractice payouts, and would not include the name of or other identifying information about the practitioner.

The substitute removes from the BME the authority and discretion to set the minimum amounts of medical malpractice liability insurance that a physician who maintains a professional medical practice in this State and has responsibility for patient care is required to carry, and instead establishes those minimum amounts by statute. The substitute sets the limits at those currently in effect by virtue of regulations promulgated by the BME, that is: medical malpractice liability insurance in the sum of $1 million per occurrence and $3 million per policy year, with extended reporting endorsement coverage for claims made, also known as "tail coverage;" or, if liability coverage is not available, by a letter of credit for at least $500,000. The BME may, however, increase these minimum amounts by regulation.

The substitute establishes the Medical Malpractice Liability Insurance Premium Assistance Fund in the Department of the Treasury to provide relief towards the payment of medical malpractice liability insurance premiums to certain health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the Commissioner of Banking and Insurance by regulation. The fund will be administered by the Department of Banking and Insurance, and will expire three years after the effective date of the substitute.

The substitute provides that the Commissioner of Banking and Insurance will certify classes of health care providers (practitioners), by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount determined by the commissioner, or in the case of health care providers whose professional liability

insurance protection is provided through self-insured hospital funding supplemented with purchased commercial insurance, the total professional liability funding obligation has increased in excess of an amount determined by the commissioner. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

In order to be eligible for a subsidy from the fund, a practitioner must have received a medical malpractice liability insurance premium increase in an amount determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in 2005. The amount of the subsidy will be determined by the commissioner by regulation.

In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding supplemented with purchased commercial insurance coverage, that provider must have increased its total professional liability funding obligation in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that practitioner in calendar year 2005.

The Medical Malpractice Liability Insurance Premium Assistance Fund is to be comprised of the following revenue:

--an annual surcharge of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law";

--an annual charge of $50 imposed on each licensed physician, podiatrist, chiropractor, dentist and optometrist by the appropriate professional licensing board; and

--an annual fee of $50 imposed on each licensed attorney by the State Treasurer.

The above revenue-raising provisions will not apply to physicians, podiatrists, chiropractors, dentists, optometrists or attorneys who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; have not practiced their profession for at least one year; or, in the case of attorneys, are ineligible to practice law because they

have not made their New Jersey Lawyers' Fund for Client Protection payment.

The substitute also specifies that a practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's licensing board, when that action or penalty relates to the provider's provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

The substitute requires that a health care provider who receives a subsidy from the fund practice in that provider's specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy. A health care provider who fails to comply with this requirement must repay the Commissioner of Banking and Insurance the amount of the subsidy, in whole or in part as determined by the commissioner.

The monies in the Medical Malpractice Liability Insurance Premium Assistance Fund are specifically dedicated and to be utilized exclusively for the following purposes:

--$20 million is to be allocated for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established under the substitute;

--$8 million is to be allocated to the Health Care Subsidy Fund established pursuant to N.J.S.A.26:2H-18.58 for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to N.J.S.A.26:2H-18.51 et al.;

--$2 million is to be allocated for a student loan expense reimbursement program for health care providers who are members of specialties and subspecialties who qualify for relief from the fund (as described below); and

--the balance of any unexpended monies in the fund is to be allocated to the Division of Medical Assistance and Health Services in the Department of Human Services for the provision of other health care services as determined by the Commissioner of Human Services.

The substitute establishes a three-year student loan expense reimbursement program within the Higher Education Student Assistance Authority for health care providers who are members of specialties and subspecialties who qualify for relief from the Fund. The authority is to implement the program in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, and to adopt rules and regulations, pursuant to the "Administrative Procedure Act," to effectuate the purposes of this new program, including, but not limited to: eligibility for the program, procedures for application, selection of participants, establishment and nullification of contracts established with participants under the program, reports to the program by participants, and recruitment of

participants.

Finally, the substitute establishes a 17-member "Medical Care Availability Task Force" to study the following issues:

--the advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

--the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

--the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

--the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits;

--the advantages and disadvantages of establishing a pre-suit procedure; and

--the necessity for, and advantages and disadvantages of, reactivating the Medical Malpractice Reinsurance Association established pursuant to N.J.S.A.17:30D-1 et seq.

The task force may also study the causes, and any related issues, relative to the affordability of medical malpractice liability insurance.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

[First Reprint]
ASSEMBLY COMMITTEE SUBSTITUTE FOR
**ASSEMBLY, No. 50**

with committee amendments

# STATE OF NEW JERSEY

DATED: MARCH 22, 2004

The Senate Health, Human Services and Senior Citizens Committee reports favorably with committee amendments Assembly Bill No. 50 (ACS/1R).

As amended by committee, this substitute, which is designated the "New Jersey Medical Care Access and Responsibility and Patients First Act," is designed to implement a number of reforms relating to tort liability as it concerns medical malpractice, as well as health care system and medical malpractice liability insurance reforms.

Specifically, the substitute provides for the following:

**Tort Liability Reforms:**

The substitute amends N.J.S.2A:14-2 and N.J.S.2A:14-21 to provide that actions by or on behalf of a minor that have accrued for medical malpractice for injuries sustained at birth must be commenced prior to the minor's 13th birthday. These statutory changes would not affect the discovery doctrine in any way. The substitute also provides that in the event that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth is not commenced by the minor's parent or guardian prior to the minor's 12th birthday, the minor or a person 18 years of age or older designated by the minor to act on the minor's behalf would be permitted to commence such an action.

The substitute provides for court referral of a medical malpractice action to a complementary dispute resolution mechanism if the judge presiding over the action determines, within 30 days after the discovery end date, that the referral may encourage early disposition or settlement of the action. If the judge makes that determination, the matter is to be referred to complementary dispute resolution pursuant to Rule 1:40 of the New Jersey Rules of Court.

The substitute also provides that a health care provider named as

a defendant in a medical malpractice action may file an affidavit of noninvolvement with the court. The affidavit of noninvolvement is to set forth the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant. The substitute also provides penalties for false statements made in the affidavit or in challenging the affidavit.

The substitute establishes qualifications for expert witnesses in medical malpractice actions and for the purpose of executing an affidavit of merit, and provides that an expert must have the same type of practice and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court. The substitute prohibits expert witnesses from testifying on a contingency fee basis. The substitute also provides for penalties for an individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit of merit, which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure.

With respect to the payment of medical malpractice judgments, the substitute provides that in any medical malpractice judgment in which the noneconomic damages (those for pain and suffering) are $1 million or less, unless otherwise agreed to by the parties, the court is to enter a judgment ordering that money damages be paid immediately. In any judgment in which the noneconomic damages exceed $1 million, unless otherwise agreed to by the parties, 50% of the money damages are to be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50% of the judgment is to be paid over 60 months in the form of a structured payment agreement.

Further, in order to provide the court with discretion to modify jury awards, the substitute modifies the standard of review to be used by the court in reviewing the amount of a jury award to require the court to consider the evidence in the light most favorable to the non-moving party and to allow the court to determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury. This provision shall take effect upon action by the court.

**Health Care System Reforms:**

The substitute expands the State's "Good Samaritan" law to provide immunity from civil damages to licensed health care professionals, emergency medical technicians and mobile intensive care paramedics whose duty does not require a response to a patient emergency situation, who, in good faith, respond to a life-threatening emergency or respond to a request for emergency assistance in a life-

threatening emergency within a hospital or other licensed health care facility or a State psychiatric hospital operated by the Department of Human Services. The immunity shall not apply: to acts or omissions constituting gross negligence, recklessness or willful misconduct; if a provider-patient relationship existed before the emergency; or if consideration in any form is provided to the health care professional for the service rendered. The immunity does not diminish a general hospital's responsibility to comply with all Department of Health and Senior Services licensure requirements concerning medical staff availability at the hospital.

Further, the substitute provides that a health care professional is not liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility or State psychiatric hospital on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

- the patient was unconscious;

- the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

- the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The immunity provided is applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

The substitute strengthens reporting requirements by physicians to the State Board of Medical Examiners (BME) to ensure that the BME is promptly informed of any pending or final action by any criminal authority in this State or any other state or federal jurisdiction or any arrest or conviction for a criminal or quasi-criminal act, by requiring that a physician report, within 10 days, the action or his arrest or conviction, for crimes that include, but are not limited to, criminal homicide, aggravated assault, sexual assault, criminal sexual contact or lewdness, or an offense involving any controlled dangerous substance or controlled substance analog.

The substitute also ensures that health care facilities, State psychiatric hospitals and other physicians affiliated with a physician who has been disciplined by the BME, are notified of its action, within 30 days of the action. Similarly, the substitute ensures that a health care facility, State psychiatric hospital or health maintenance organization is promptly notified by the BME if, during the course of an investigation of a physician, it requests information from that

facility or health maintenance organization regarding that physician, and subsequently determines that no disciplinary action is warranted.

**Medical Malpractice Liability Insurance Reforms:**

To avoid the appearance of any conflicts of interest, the substitute prohibits any person who is an officer, director or board member of a professional association for health care providers to serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that issues policies in the State.

For the purpose of negotiating a reduced medical malpractice liability insurance premium, the substitute would permit physicians to join together, by means of a joint contract, to form a "Medical Malpractice Liability Insurance Purchasing Alliance."

The substitute provides that a medical malpractice liability insurance policy may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; but, if the policy contains that provision, the insurer would be required to offer an endorsement to the policy that permits the insurer to settle a claim filed under the policy without first having obtained the insured's consent. The insurer would be required to establish a premium for the endorsement which reflects any savings or reduced costs attributable to the endorsement, and the insured would have the option of accepting or refusing the endorsement.

Another provision to provide premium relief to health care providers is the requirement that every medical malpractice liability insurer offer individual or group medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1 million per claim, with the insurer being permitted to require the insured to provide collateral for the deductible amount to the insurer. The deductibles offered by an insurer are subject to the approval of the Commissioner of Banking and Insurance. For policies with any deductible, the insurer would be responsible for payment of the deductible and would be reimbursed for that amount by the insured.

The substitute prohibits a medical malpractice insurer from increasing the premium of a policy based on a claim of medical negligence or malpractice against the insured if the insured is dismissed from an action alleging medical malpractice within 180 days of the filing of the last responsive pleading.

To provide increased oversight of medical malpractice insurers, the substitute requires that every annual statement filed by a medical malpractice insurer in this State with the Department of Banking and Insurance include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

The substitute requires insurers authorized to transact medical

malpractice liability insurance in this State to provide at least 60 days' notice to the insured for policy renewals and nonrenewals. Also, in the case of a nonrenewal, the insurer must provide the reason for the nonrenewal.

The substitute provides that if the Commissioner of Banking and Insurance finds, after a hearing, that a rate in effect for any medical malpractice insurer is not in compliance with the provisions of N.J.S.A.17:29AA-1 et seq., the commissioner is to issue an order specifying in what respects it so fails, and stating when the rate will no longer be deemed effective. The order may provide for the retroactive adjustment of rates and require the payment or credit of interest to insureds covered during the adjusted rate period. Interest is to be calculated at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.

The substitute also directs the commissioner, subject to standards adopted by the National Association of Insurance Commissioners, to review the current capitalization and reserve requirements applicable to medical malpractice insurers, and to modify those requirements, as necessary, to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in the State.

Also, the substitute requires medical malpractice liability insurers to offer their insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance, by regulation.

In addition, N.J.S.A.17:30D-17, which requires all medical malpractice insurers to notify the BME of every medical malpractice judgment, settlement and award involving a physician or podiatrist licensed in this State, is amended to also require notification to the Commissioner of Banking and Insurance of these payments. The notification to the commissioner is to enable the commissioner to compile statistical data about medical malpractice payouts, and would not include the name of or other identifying information about the practitioner.

The substitute removes from the BME the authority and discretion to set the minimum amounts of medical malpractice liability insurance that a physician who maintains a professional medical practice in this State and has responsibility for patient care is required to carry, and instead establishes those minimum amounts by statute. The substitute sets the limits at those currently in effect by virtue of regulations promulgated by the BME, that is: medical malpractice liability insurance in the sum of $1 million per occurrence and $3 million per policy year, with extended reporting endorsement coverage for claims made, also known as "tail coverage," (unless renewal coverage includes the premium retroactive date); or, if liability coverage is not available, by a letter of credit for at least $500,000. The BME may, however, increase these minimum amounts by regulation.

The substitute establishes the Medical Malpractice Liability

Insurance Premium Assistance Fund in the Department of the Treasury to provide relief towards the payment of medical malpractice liability insurance premiums to certain health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the Commissioner of Banking and Insurance by regulation. The fund will be administered by the Department of Banking and Insurance, and will expire three years after the effective date of the substitute.

The substitute provides that the Commissioner of Banking and Insurance will certify classes of health care practitioners, by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount determined by the commissioner, or in the case of health care practitioners whose professional liability insurance protection is provided through self-insured hospital funding supplemented with purchased commercial insurance, the total professional liability funding obligation has increased in excess of an amount determined by the commissioner. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

In order to be eligible for a subsidy from the fund, a practitioner must have received a medical malpractice liability insurance premium increase in an amount determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in 2005. The amount of the subsidy will be determined by the commissioner by regulation.

In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding supplemented with purchased commercial insurance coverage, that provider must have increased its total professional liability funding obligation in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that practitioner in calendar year 2005.

The Medical Malpractice Liability Insurance Premium Assistance Fund is to be comprised of the following revenue:

-- an annual surcharge (for three years) of $3 per employee for all employers who are subject to the New Jersey "unemployment

compensation law";

-- an annual charge (for three years) of $75 imposed on each licensed physician, podiatrist, chiropractor, dentist and optometrist by the appropriate professional licensing board; and

-- an annual fee (for three years) of $75 imposed on each licensed attorney by the State Treasurer.

The above charges and fees will not apply to physicians, podiatrists, chiropractors, dentists, optometrists or attorneys who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; have not practiced their profession for at least one year; or, in the case of attorneys, are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment.

The substitute also specifies that a practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's licensing board, when that action or penalty relates to the practitioner's provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

The substitute requires that a health care practitioner who receives a subsidy from the fund practice in that practitioner's specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy; and a practitioner who fails to comply with this requirement must repay the Commissioner of Banking and Insurance the amount of the subsidy, in whole or in part as determined by the commissioner.

The monies in the Medical Malpractice Liability Insurance Premium Assistance Fund are specifically dedicated and to be utilized exclusively for the following purposes:

-- $17 million is to be allocated annually for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established under the substitute;

-- $6.9 million is to be allocated annually to the Health Care Subsidy Fund established pursuant to N.J.S.A.26:2H-18.58 for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to N.J.S.A.26:2H-18.51 et al.;

-- $1.0 million is to be allocated annually for a student loan expense reimbursement program for obstetrician/gynecologists (as described below); and

-- $ 1.2 million is to be allocated annually to the Division of Medical Assistance and Health Services in the Department of Human

Services to expand the NJ FamilyCare program (as described below).

The substitute establishes a three-year student loan expense reimbursement program within the Higher Education Student Assistance Authority for obstetrician/gynecologists who agree to practice in State designated underserved areas as established pursuant to N.J.S.A.18A:71C-35. An obstetrician/gynecologist who receives a payment under the program is required to practice as an obstetrician/gynecologist in an underserved area in this State for a period of at least four years after receipt of the payment; and an obstetrician/gynecologist who fails to comply with this requirement must repay the authority the amount of the payment, in whole or in part as determined by the authority. The authority is to implement the program in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and the State Board of Medical Examiners, and to adopt rules and regulations, pursuant to the "Administrative Procedure Act," to effectuate the purposes of this new program, including, but not limited to: eligibility for the program, procedures for application, selection of participants, establishment and nullification of contracts established with participants under the program, and reports to the program by participants.

The substitute provides that, within the limits of funds appropriated pursuant to the substitute and such other funds as may be available for this purpose, NJ FamilyCare is to enroll into the program women whose eligibility under the Medicaid New Jersey Care pregnant women program or the "New Jersey Standardized Parent Service Package," Demonstration Population 3, Medicaid expansion for uninsured pregnant woman, has expired and whose family income does not exceed 100% of the federal poverty level. The Commissioner of Human Services is to establish a presumptive eligibility process to provide for an efficient transition into NJ FamilyCare from the Medicaid program pursuant to this provision.

Finally, the substitute establishes a 17-member "Medical Care Availability Task Force" to study the following issues:

-- the advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

-- the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

-- the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

-- the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits; and

-- the advantages and disadvantages of establishing a pre-suit procedure.

COMMITTEE AMENDMENTS:

The committee amended the substitute to:

- provide that the penalties for filing a false or inaccurate affidavit of noninvolvement (section 6) shall be the same as for falsely objecting to a health care provider's affidavit of noninvolvement, that is, an appropriate sanction, including, but not limited to, an order to pay to the other party the amount of the reasonable expenses incurred as a result of the false filing or objection, including a reasonable attorney fee, and referral of the matter by the court to the Attorney General and the appropriate professional licensing board for further review;

- provide that the additur/remittitur provisions (section 9) shall take effect upon action by the court, rather than specify that the provisions would apply to claims filed after the effective date of the substitute, as the substitute originally provided;

- provide that the "Good Samaritan" immunity (section 10) does not diminish a general hospital's responsibility to comply with all Department of Health and Senior Services licensure requirements concerning medical staff availability at the hospital, and delete language providing that the immunity shall not apply if a hospital has not reasonably and adequately staffed its emergency room;

- restore the original language of the substitute regarding the prohibition on premium increases based on a claim of medical negligence or malpractice (section 17), to provide that the prohibition applies if the insured is dismissed from the action within 180 days of the filing of the last responsive pleading;

- clarify the requirements for medical malpractice liability insurance coverage for physicians (section 25) to provide that tail coverage would be required unless renewal coverage includes the premium retroactive date;

- revise the amounts of the allocations for the Medical Malpractice Liability Insurance Premium Assistance Fund (section 27) to: $17 million for health care providers, $6.9 million for hospitals, $1.2 million for the NJ FamilyCare expansion, and $1.0 million for the student loan reimbursement program;

- provide the Commissioner of Banking and Insurance with emergency rulemaking authority for the fund (section 27);

- increase the annual health care professional charges and attorney fee from $50 to $75, and clarify that the $3 employee surcharge, $75 health care professional charges and $75 attorney fee expire after three years (section 27);

- clarify that the Commissioner of Banking and Insurance, in consultation with the Board of Medical Examiners, shall provide the names of obstetrician/gynecologists who qualify for the student loan reimbursement, provided in the substitute, to the Higher Education Student Assistance Authority (section 28); and

- clarify that loans provided through NJCLASS and the federal government are eligible for reimbursement under the student loan expense reimbursement program created in the substitute (section 29).

This committee substitute is identical to the Senate Committee Substitute for S-50/551 (Vitale/Lesniak), which the committee also reported favorably on this date.

# STATEMENT TO

# ASSEMBLY COMMITTEE SUBSTITUTE FOR
# **ASSEMBLY, No. 50**

with Assembly Floor Amendments
(Proposed By Assemblymen ROBERTS, COHEN, Assemblywoman WEINBERG and Assemblyman MCKEON)

ADOPTED: MARCH 11, 2004

These amendments:

1) Amend N.J.S.A.2A:14-2 concerning the statute of limitations to provide that in the event that a medical malpractice action by or on behalf of a minor for injuries sustained at birth is not commenced by the minor's parent or guardian prior to the minor's 12th birthday, the minor or a person 18 years of age or older designated by the minor to act on the minor's behalf may commence such an action. For this purpose, the minor or designated person may petition the court for the appointment of a guardian ad litem to act on the minor's behalf.

2) Amend N.J.S.A.2A:53A-27 concerning the affidavit of merit to clarify that the person executing the affidavit shall meet the requirements set forth in section 7 of the committee substitute concerning expert witnesses.

3) Provide that a medical malpractice insurer shall not increase the premium of any medical malpractice liability insurance policy based on a claim of medical negligence or malpractice against the insured if the insured is dismissed from an action alleging medical malpractice prior to the close of discovery, rather than within 180 days of the filing of the last responsive pleading, as the substitute originally provided.

4) Omit the amendments in the substitute to N.J.S.A.17:29AA-1 et seq. concerning "file and use" for medical malpractice insurers, and provide instead that if the Commissioner of Banking and Insurance finds, after a hearing, that a medical malpractice insurer's rate is not in compliance with the provisions of NJSA17:29AA-1 et seq., the commissioner shall issue an order specifying in what respects it so fails, and stating when such rate shall no longer be deemed effective. The order may provide for the retroactive adjustment of rates and require the payment or credit of interest to insureds covered during the adjusted rate period.

5) Provide that bonds required for structured payment agreements (section 24 of the substitute) shall be written by a company that is rated A- or better by A.M. Best Co., or such other company as is approved by the Department of Banking and Insurance. The substitute originally provided that the company be rated as A+.

6) Clarify, in sections 26 through 28 of the substitute, the use of the terms "health care provider" and "practitioner."

7) Provide that $1 million annually from the Medical Malpractice Liability Insurance Premium Assistance Fund, rather than $2 million, will be allocated to the student loan expense reimbursement program, and provide that the program will be limited to obstetrician/gynecologists who agree to practice in medically underserved areas of the State for at least four years.

8) Provide that $1 million annually from the fund will be allocated to the NJ FamilyCare program to enroll new mothers with income up to 100% of the federal poverty level whose postpartum eligibility for Medicaid (provided under federal waivers) has expired.

9) Clarify that the allocations from the fund (specified in the substitute) are annual allocations.

10) Delete the reactivation of the Medical Malpractice Reinsurance Association as one of the issues that the Medical Care Availability Task Force shall study, since the association was recently reactivated by the Department of Banking and Insurance.

# LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR

# ASSEMBLY, No. 50

# STATE OF NEW JERSEY

# 211th LEGISLATURE

DATED: MAY 14, 2004

## SUMMARY

**Synopsis:** "New Jersey Medical Care Access and Responsibility and Patients First Act."

**Type of Impact:** Revenue generated for the proposed Medical Malpractice Liability Insurance Premium Assistance Fund (MMLIPA) and expenditures from MMLIPA.

**Agencies Affected:** Department of Banking and Insurance; Department of Human Services; Department of Health and Senior Services; and Department of Treasury.

**Office of Legislative Services Estimate**

| Fiscal Impact | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| **MMLIPA Fund Revenue** | $26.1 million | $26.1 million | $26.1 million |
| **MMLIPA Fund Expenditures** | $26.1 million | $26.1 million | $26.1 million |

* The MMLIPA fund is comprised of revenue from $3 annual surcharges paid on or by employees of employers who are subject to the "unemployment compensation law" and $75 annual surcharges paid on the professional licenses of physicians, podiatrists, dentists, chiropractors and attorneys, unless exempted under the substitute.
* This estimate is based on the fact that the Catastrophic Illness in Children Relief Fund (P.L.1984, c.370), receives $6.0 million annually from a $1 surcharge per employee for all employers who are subject to the "unemployment compensation law." It is therefore estimated that the $3 surcharge as proposed in the substitute will generate $18 million in annual revenue for the MMLIPA fund. In addition, approximately 108,000 licensees will likely be subject to the proposed $75 surcharge, resulting in $8.1 million in MMLIPA fund revenue.
* An estimated $26.1 million in annual revenue will be collected for the Medical Malpractice Liability Insurance Premium Assistance Fund (MMLIPA). The fund will stay active for a

three-year period.

* Under the substitute as amended, the MMLIPA fund annually allocates the following amounts: $17 million for the purpose of providing premium relief to eligible health care providers who have experienced or are experiencing a premium increase in an amount as established by the Commissioner of Banking and Insurance by regulation; $6.9 million for the Health Care Subsidy Fund; $1 million for a student loan expense reimbursement program for obstetrician/gynecologists who agree to practice in medically underserved areas of the State for a minimum of four years; and $1.2 million for the NJ FamilyCare program to enroll new mothers with income up to 100 percent of the federal poverty level whose postpartum eligibility for Medicaid has expired.

## BILL DESCRIPTION

Assembly Committee Substitute for Assembly Bill No. 50 (2R) of 2004, among other things, establishes the Medical Malpractice Liability Insurance Premium Assistance Fund (MMLIPA), the purpose of which is to provide medical malpractice liability insurance premium relief to certain health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the Commissioner of Banking and Insurance by regulation. The fund will be administered by the Department of Banking and Insurance, and will expire three years after the effective date of the substitute.

The substitute provides that the Commissioner of Banking and Insurance will certify classes of health care practitioners, by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount determined by the commissioner, or in the case of health care providers whose professional liability insurance protection is provided through self-insured hospital funding supplemented with purchased commercial insurance, the total professional liability funding obligation has increased in excess of an amount determined by the commissioner. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

## FISCAL ANALYSIS

### *EXECUTIVE BRANCH*

None received.

### *OFFICE OF LEGISLATIVE SERVICES*

Among its provisions, this substitute establishes the Medical Malpractice Liability Insurance Premium Assistance (MMLIPA) fund, in the Department of Treasury. The purpose of the fund is to provide premium relief, in an amount as established by the Commissioner of Banking and Insurance by regulation, to eligible health care providers who have experienced or are experiencing a premium increase. The fund is comprised of revenue from $3 annual surcharges paid on or by employees of employers who are subject to the "unemployment compensation law"

and $75 annual surcharges paid on the professional licenses of physicians, podiatrists, dentists, chiropractors, optometrists and attorneys, unless exempted under the substitute. Based on the number of licensed professionals who are subject to charges and the number of employees who fall under the "unemployment compensation law," approximately $26.1 million in revenue will be collected by the MMLIPA fund annually. This estimate is calculated as follows: 1) the Catastrophic Illness in Children Relief Fund (P.L.1984, c.370), receives $6.0 million in revenue annually from a $1 surcharge per employee for all employers who are subject to the "unemployment compensation law." Based on this data, the $3 surcharge as proposed in the substitute will generate $18 million in annual revenue for the MMLIPA fund; and 2) approximately 108,000 licensees will likely be subject to the proposed $75 surcharge, resulting in $8.1 million in MMLIPA fund revenue.

Under the substitute as amended, the MMLIPA fund annually allocates the following amounts: $17 million for the purpose of providing premium relief to eligible health care providers who have experienced or are experiencing a premium increase in an amount as established by the Commissioner of Banking and Insurance by regulation; $6.9 million for the Health Care Subsidy Fund: $1 million for a student loan expense reimbursement program for obstetrician/gynecologists who agree to practice in medically underserved areas of the State for a minimum of four years; and $1.2 million for the NJ FamilyCare program to enroll new mothers with income up to 100 percent of the federal poverty level whose postpartum eligibility for Medicaid has expired.

| | |
|---|---|
| Section: | *Commerce, Labor and Industry* |
| Analyst: | *Sonya S. Hough*<br>*Associate Fiscal Analyst* |
| Approved: | *David J. Rosen*<br>*Legislative Budget and Finance Officer* |

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67.

# SENATE, No. 50

# STATE OF NEW JERSEY

## 211th LEGISLATURE

INTRODUCED MARCH 22, 2004

**Sponsored by:**
**Senator JOSEPH F. VITALE**
**District 19 (Middlesex)**
**Senator RAYMOND J. LESNIAK**
**District 20 (Union)**

**Co-Sponsored by:**
**Senator Madden**

**SYNOPSIS**

"New Jersey Medical Care Access and Responsibility and Patients First Act."

**CURRENT VERSION OF TEXT**

As introduced.

**AN ACT** concerning medical professional liability, insurance reform and patient protection and revising parts of the statutory law.

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

1. (New section) This act shall be known and may be cited as the "New Jersey Medical Care Access and Responsibility and Patients First Act."

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

a. One of the most vital interests of the State is to ensure that high-quality health care continues to be available in this State and that the residents of this State continue to have access to a full spectrum of health care providers, including highly trained physicians in all specialties;

b. The State's health care system and its residents' access to health care providers are threatened by a dramatic escalation in medical malpractice liability insurance premiums, which is creating a crisis of affordability in the purchase of necessary liability coverage for our health care providers;

c. One particularly alarming result of rising premiums is that there are increasing reports of doctors retiring or moving to other states where insurance premiums are lower, dropping high-risk patients and procedures, and practicing defensive medicine in a manner that may significantly increase the cost of health care for all our citizens;

d. The reasons for the steep increases in the cost of medical malpractice liability insurance are complex and involve issues related to: the State's tort liability system; the State's health care system, which includes issues related to patient safety and medical error reporting; and the State's regulation and requirements concerning medical malpractice liability insurers;

e. It is necessary and appropriate for the State to take meaningful and prompt action to address the various interrelated aspects of these issues that are impacted by, or impact on, the State's health care system; and

f. To that end, this act provides for a comprehensive set of reforms affecting the State's tort liability system, health care system and medical malpractice liability insurance carriers to ensure that health care services continue to be available and accessible to residents of the State and to enhance patient safety at health care facilities.

3. N.J.S.2A:14-2 is amended to read as follows:

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

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

2A:14-2. a. Every action at law for an injury to the person caused by the wrongful act, neglect or default of any person within this **[**state**]** State shall be commenced within 2 years next after the cause of any such action shall have accrued; except that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 13th birthday.

b. In the event that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth is not commenced by the minor's parent or guardian prior to the minor's 12th birthday, the minor or a person 18 years of age or older designated by the minor to act on the minor's behalf may commence such an action. For this purpose, the minor or designated person may petition the court for the appointment of a guardian ad litem to act on the minor's behalf.

(cf: N.J.S.2A:14-2)

4. N.J.S.2A:14-21 is amended to read as follows:

2A:14-21. If any person entitled to any of the actions or proceedings specified in **[**sections**]** N.J.S.2A:14-1 to 2A:14-8 or **[**sections**]** N.J.S.2A:14-16 to 2A:14-20 **[**of this title**]** or to a right or title of entry under **[**section**]** N.J.S.2A:14-6 **[**of this title**]** is or shall be, at the time of any such cause of action or right or title accruing, under the age of 21 years, or insane, such person may commence such action or make such entry, within such time as limited by **[**said sections**]** those statutes, after his coming to or being of full age or of sane mind. Notwithstanding the provisions of this section to the contrary, an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 13th birthday, as provided in N.J.S.2A:14-2.

(cf: N.J.S.2A:14-21)

5. (New section) The judge presiding over a medical malpractice action, or the judge's designee, shall, within 30 days after the discovery end date, determine whether referral to a complementary dispute resolution mechanism may encourage early disposition or settlement of the action. If the judge makes such a determination, the matter shall be referred to complementary dispute resolution pursuant to Rule 1:40 of the Rules Governing the Courts of the State of New Jersey.

Nothing in this section shall be construed to limit the authority of the judge to refer an action to complementary dispute resolution prior to the discovery end date.

6. (New section) a. A health care provider named as a defendant in a medical malpractice action may cause the action against that

provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant, and could not have caused the alleged malpractice, either individually or through its servants or employees, in any way.

b. A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting an affidavit that contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

c. If the court determines that a health care provider named as a defendant falsely files or makes false or inaccurate statements in an affidavit of noninvolvement, the court, upon motion or upon its own initiative, shall immediately reinstate the claim against that provider. Reinstatement of a party pursuant to this subsection shall not be barred by any statute of limitations defense that was not valid at the time the original action was filed.

In any action in which the health care provider is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the party, or both, an appropriate sanction, including, but not limited to, a civil penalty not to exceed $10,000 and an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the filing of the false or inaccurate affidavit, including a reasonable attorney fee. The court shall also refer the matter to the Attorney General and the appropriate professional licensing board for further review.

d. If the court determines that a plaintiff falsely objected to a health care provider's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a health care provider's affidavit, the court shall impose upon the plaintiff or the plaintiff's counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the false objection or inaccurate statement, including a reasonable attorney fee.

e. As used in this section, "health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to: a physician, dentist, nurse, pharmacist or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes; and a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.)

7. (New section) In an action alleging medical malpractice, a person shall not give expert testimony or execute an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.) on the appropriate standard of practice or care unless the person is licensed as a physician or other health care professional in the United States and meets the following criteria:

a. If the party against whom or on whose behalf the testimony is offered is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association and the care or treatment at issue involves that specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, the person providing the testimony shall have specialized at the time of the occurrence that is the basis for the action in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American Osteopathic Association, as the party against whom or on whose behalf the testimony is offered, and if the person against whom or on whose behalf the testimony is being offered is board certified and the care or treatment at issue involves that board specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association, the expert witness shall be:

(1) a physician credentialed by a hospital to treat patients for the medical condition, or to perform the procedure, that is the basis for the claim or action; or

(2) a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association who is board certified in the same specialty or subspecialty, recognized by the American Board of Medical Specialties or the American Osteopathic Association, and during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to either:

(a) the active clinical practice of the same health care profession in which the defendant is licensed, and, if the defendant is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, the active clinical practice of that specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(b) the instruction of students in an accredited medical school, other accredited health professional school or accredited residency or clinical research program in the same health care profession in which the defendant is licensed, and, if that party is a specialist or subspecialist recognized by the American Board of Medical Specialties or the American Osteopathic Association, an accredited medical school, health professional school or accredited residency or clinical research program in the same specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association; or

(c) both.

b. If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to:

(1) active clinical practice as a general practitioner; or active clinical practice that encompasses the medical condition, or that includes performance of the procedure, that is the basis of the claim or action; or

(2) the instruction of students in an accredited medical school, health professional school, or accredited residency or clinical research program in the same health care profession in which the party against whom or on whose behalf the testimony is licensed; or

(3) both.

c. A court may waive the same specialty or subspecialty recognized by the American Board of Medical Specialties or the American Osteopathic Association and board certification requirements of this section, upon motion by the party seeking a waiver, if, after the moving party has demonstrated to the satisfaction of the court that a good faith effort has been made to identify an expert in the same specialty or subspecialty, the court determines that the expert possesses sufficient training, experience and knowledge to provide the testimony as a result of active involvement in, or full-time teaching of, medicine in the applicable area of practice or a related field of medicine.

d. Nothing in this section shall limit the power of the trial court to disqualify an expert witness on grounds other than the qualifications set forth in this section.

e. In an action alleging medical malpractice, an expert witness shall not testify on a contingency fee basis.

f. An individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.), which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure, shall be liable to a civil penalty not to exceed $10,000 and other damages incurred by the person and the party for whom the person was testifying as an expert.

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

2. In any action for damages for personal injuries, wrongful death or property damage resulting from an alleged act of malpractice or negligence by a licensed person in his profession or occupation, the plaintiff shall, within 60 days following the date of filing of the answer

to the complaint by the defendant, provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational standards or treatment practices. 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**]** In the case of an action for medical malpractice, the person executing the affidavit shall meet the requirements of a person who provides expert testimony or executes an affidavit as set forth in section 7 of P.L. , c. (C. )(pending before the Legislature as this bill). In all other cases, the person executing the affidavit shall be licensed in this or any other state; have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

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

9. (New section) a. A judge presiding over an action alleging medical malpractice, in which the jury has rendered a verdict in favor of the complaining party, shall, upon a motion by any party for additur or remittitur on the issue of the quantum of damages, consider the evidence in the light most favorable to the non-moving party and determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

b. The provisions of subsection a. of this section shall apply to claims filed on or after the effective date of this act.

10. (New section) a. If an individual's actual health care facility duty, including on-call duty, does not require a response to a patient emergency situation, a health care professional who, in good faith, responds to a life-threatening emergency or responds to a request for emergency assistance in a life-threatening emergency within a hospital or other health care facility, is not liable for civil damages as a result of an act or omission in the rendering of emergency care. The immunity granted pursuant to this section shall not apply to acts or omissions constituting gross negligence, recklessness or willful misconduct.

b. The provisions of subsection a. of this section shall not apply to a health care professional if a provider-patient relationship existed before the emergency, or if consideration in any form is provided to the health care professional for the service rendered.

c. The provisions of subsection a. of this section shall not apply if a general hospital has not reasonably and adequately staffed its emergency department.

d. A health care professional shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

(1) the patient was unconscious;

(2) the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

(3) the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The provisions of this subsection shall apply only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

e. As used in this section:

(1) "Health care professional" means a physician, dentist, nurse or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes and an emergency medical technician or mobile intensive care paramedic certified by the Commissioner of Health and Senior Services pursuant to Title 26 of the Revised Statutes; and

(2) "Health care facility" means a health care facility licensed by the Department of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

11. Section 1 of P.L.1995, c.69 (C.45:9-19.16) is amended to read as follows:

1. a. A physician licensed by the State Board of Medical Examiners, or a physician who is an applicant for a license from the State Board of Medical Examiners, shall notify the board within 10 days of :

(1) any action taken against the physician's medical license by any other state licensing board or any action affecting the physician's privileges to practice medicine by any out-of-State hospital, health care facility, health maintenance organization or other employer;

(2) any pending or final action by any criminal authority for

violations of law or regulation, or any arrest or conviction for any criminal or quasi-criminal offense pursuant to the laws of the United States, this State or another state, including, but not limited to:

(a) criminal homicide pursuant to N.J.S.2C:11-2;

(b) aggravated assault pursuant to N.J.S.2C:12-1;

(c) sexual assault, criminal sexual contact or lewdness pursuant to N.J.S.2C:14-2 through 2C:14-4; or

(d) an offense involving any controlled dangerous substance or controlled substance analog as set forth in chapter 35 of Title 2C of the New Jersey Statutes.

b. A physician who is in violation of this section is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).

c. The State Board of Medical Examiners shall notify all physicians licensed by the board of the requirements of this section within 30 days of the date of enactment of this act.

(cf: P.L.1995, c.69, s.1)

12. Section 13 of P.L.1989, c.300 (C.45:9-19.13) is amended to read as follows:

13. a. In any case in which the State Board of Medical Examiners refuses to issue, suspends, revokes or otherwise conditions the license, registration, or permit of a physician, podiatrist or medical resident or intern, the board shall, within 30 days of its action, notify each licensed health care facility, psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7, and health maintenance organization with which the person is affiliated and every board licensee in the State with which the person is directly associated in his private medical practice.

b. If, during the course of an investigation of a physician, the board requests information from a health care facility, psychiatric hospital operated by the Department of Human Services or health maintenance organization regarding that physician, and the board subsequently makes a finding of no basis for disciplinary action, the board shall, within 30 days of making that finding, notify the health care facility, State psychiatric hospital or health maintenance organization of its determination.

(cf: P.L.1989, c.300, s.13)

13. (New section) a. On or after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill) and except as provided in subsection d. of this section, no person who is an officer, director or board member of a professional association for health care providers shall serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that is licensed in the State and offering medical malpractice liability insurance policies on that effective date.

b. As used in this section, "health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes, and a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

c. A person or professional association who violates the provisions of this section shall be liable for a civil penalty of $10,000 for each violation. The penalty shall be sued for and collected by the Commissioner of Banking and Insurance in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

d. In the case of an officer, director or board member of a medical malpractice liability insurer who is an officer, director or board member of a professional association for health care providers on the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), the officer, director or board member shall have 180 days to comply with the requirements of this section.

14. (New section) Physicians may join together, by means of a joint contract under the procedures established by this section, to form a "Medical Malpractice Liability Insurance Purchasing Alliance" for the purpose of negotiating a reduced premium for its members in the purchase of medical malpractice liability insurance. The joint contract shall be executed by all members of the purchasing alliance.

a. As used in this section:

"Board" means a medical malpractice liability insurance purchasing alliance board of directors provided for in this section.

"Commissioner" means the Commissioner of Banking and Insurance.

"Medical Malpractice Liability Insurance Purchasing Alliance," "purchasing alliance" or "alliance" means a purchasing alliance established pursuant to this section.

"Member" means a physician who is a member of a medical malpractice liability insurance purchasing alliance as provided for in this section.

b. The purchasing alliance, which may be a corporation, shall be governed by a board of directors, elected by the members of the purchasing alliance. No person may serve as an officer or director of an alliance who has a prior record of administrative, civil or criminal violations within the financial services industry. The directors shall serve for terms of three years, and shall serve until their successors are elected and qualified. Each director shall serve without compensation, except for reimbursement for actual expenses incurred by that director.

c. The board shall adopt by-laws for the operation of the purchasing alliance, which shall be effective upon ratification by a

two-thirds majority of the members. The by-laws shall include, but not be limited to:

(1) the establishment of procedures for the organization and administration of the alliance; and

(2) procedures for the qualifications and admission of the members of the alliance.

The bases for denial of membership shall include, but not be limited to:

(a) performance of an act or practice that constitutes fraud or intentional misrepresentation of material fact;

(b) previous denial of membership in the alliance; or

(c) previous expulsion from the alliance;

(3) procedures for the withdrawal of members from the alliance;

(4) procedures for the expulsion of members from the alliance.

The bases for expulsion shall include, but not be limited to:

(a) failure to pay membership or other fees required by the purchasing alliance;

(b) failure to pay premiums in accordance with the terms of the medical malpractice liability insurance policy or the terms of the joint contract; or

(c) performance of an act or practice that constitutes fraud or intentional misrepresentation of material fact; and

(5) procedures for the termination of the alliance.

d. In addition to the other powers authorized under this section, a purchasing alliance shall have the authority to:

(1) set reasonable fees for membership in the alliance that will finance reasonable and necessary costs incurred in administering the purchasing alliance;

(2) negotiate premium rates for medical malpractice liability insurance with insurers on behalf of the members of the alliance, provided that negotiations are conducted by a person other than a member of the alliance or an employee of a member of the alliance;

(3) provide premium collection services for insurance purchased through the alliance for members;

(4) contract with third parties for any services necessary to carry out the powers and duties authorized or required pursuant to this section; and

(5) establish procedures for keeping confidential all communications between the members of the purchasing alliance and for prohibiting the dissemination and discussion of pricing information and other business-related information between and among members of the alliance.

e. A purchasing alliance established pursuant to the provisions of this section shall not:

(1) assume risk for the cost or provision of medical malpractice liability insurance;

(2) exclude a member who agrees to pay fees for membership and

the premium for medical malpractice liability insurance coverage and who abides by the by-laws of the alliance;

(3) engage in any trade practice or activity prohibited pursuant to P.L.1947, c.379 (C.17:29B-1 et seq.);

(4) represent more than 35% of the physicians in a county or other relevant geographic service area; or

(5) require a member to purchase medical malpractice liability insurance only through the alliance.

f. Within 30 days after its organization, the purchasing alliance board shall file with the commissioner a certificate that shall list: the members of the alliance; the names of the directors, chairman, treasurer and secretary of the alliance; the address at which communications for the alliance are to be received; a copy of the certificate of incorporation of the alliance, if any; and a copy of the joint contract executed by all of the members. Any change in the information required by the provisions of this section shall be filed with the commissioner within 30 days of the change.

g. The commissioner, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the provisions of this section.

15. (New section) a. A medical malpractice liability insurance policy, which is made, issued or delivered pursuant to Subtitle 3 of Title 17 of the Revised Statutes in this State on or after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; except that, if the policy contains that provision, the insurer shall offer an endorsement, to be included in the policy at the option of the insured, providing the insurer with the right to settle a claim filed under the policy without first having obtained the insured's consent. The insurer shall establish a premium for the endorsement, which premium shall reflect any savings or reduced costs attributable to the endorsement.

b. The Commissioner of Banking and Insurance, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt rules and regulations necessary to effectuate the provisions of this section.

16. (New section) a. Every insurer authorized to transact medical malpractice liability insurance in this State shall offer medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1,000,000 per claim, and may require the insured to provide collateral for the deductible amount to the insurer.

b. Every insurer authorized to transact medical malpractice liability insurance in this State shall provide an appropriate premium reduction for any deductible chosen pursuant to subsection a. of this section.

c. In the case of a policy with any deductible, the insurer shall be responsible for payment of the deductible and shall be reimbursed for that amount by the insured.

17. (New section) Notwithstanding any other law or regulation to the contrary, an insurer authorized to transact medical malpractice liability insurance in this State shall not increase the premium of any medical malpractice liability insurance policy based on a claim of medical negligence or malpractice against the insured if the insured is dismissed from an action alleging medical malpractice prior to the close of discovery.

18. (New section) Each annual statement made after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill), pursuant to the provisions of section 16 of P.L.1982, c.114 (C.17:29AA-16), by an insurer writing medical malpractice in this State, shall include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory, or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

19. (New section) Notwithstanding the provisions of section 1 of P.L.1968, c.131 (C.17:29C-1) to the contrary, each notice of renewal or nonrenewal by an insurer authorized to transact medical malpractice liability insurance in this State shall be mailed or delivered by the insurer to the insured not less than 60 days prior to the expiration of the policy and, in the case of a nonrenewal, shall contain the reason for the nonrenewal.

20. Section 13 of P.L.1982, c.114 (C.17:29AA-13) is amended to read as follows:

13. a. If the commissioner finds, after a hearing, that a rate or policy form in effect for any rating organization or insurer, whether or not a member or subscriber of a rating organization is not in compliance with the standards of this act, he shall issue an order specifying in what respects it so fails, and stating when, within a

reasonable period thereafter, such rate or form shall be deemed no longer effective. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

b. If the commissioner finds, after a hearing, that a rate in effect for any insurer writing medical malpractice liability insurance is not in compliance with the provisions of P.L.1982, c.114 (C.17:29AA-1 et seq.), the commissioner shall issue an order specifying in what respects it so fails, and stating when such rate shall no longer be deemed effective. The order may provide for the retroactive adjustment of rates and require the payment or credit of interest to insureds covered during the adjusted rate period. Interest shall be calculated at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.

(cf: P.L.1982, c.114, s.13)

21. (New section) Subject to standards adopted by the National Association of Insurance Commissioners, the Commissioner of Banking and Insurance shall, within 180 days after the effective date of P.L. , c. (C. ) (pending before the Legislature as this bill) and annually thereafter, review the current capitalization and reserve requirements applicable to insurers authorized or admitted to transact medical malpractice liability insurance in this State, as those requirements are established by statute or regulation, or both.

Based upon the findings of that review, the commissioner shall adopt regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to modify those requirements, as the commissioner determines necessary in order to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in this State. If the commissioner determines that legislation is necessary to effect any such modification, the commissioner shall notify the Governor and the Legislature within the 180-day period provided in this section.

22. (New section) Every insurer authorized to transact medical malpractice liability insurance in this State shall offer its insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance by regulation.

23. Section 2 of P.L.1983, c.247 (C.17:30D-17) is amended to read as follows:

2. a. Any insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the Medical Practitioner Review Panel established pursuant to section 8 of P.L.1989, c.300 (C.45:9-19.8) in writing of any medical malpractice

claim settlement, judgment or arbitration award involving any practitioner licensed by the State Board of Medical Examiners and insured by the insurer or insurance association. Any practitioner licensed by the board who is not covered by medical malpractice liability insurance issued in this State, who has coverage through a self-insured health care facility or health maintenance organization, or has medical malpractice liability insurance which has been issued by an insurer or insurance association from outside the State, shall notify the review panel in writing of any medical malpractice claim settlement, judgment or arbitration award to which the practitioner is a party. The review panel or board, as the case may be, shall not presume that the judgment or award is conclusive evidence in any disciplinary proceeding and the fact of a settlement is not admissible in any disciplinary proceeding.

In any malpractice action against a practitioner, a settlement prohibiting a complaint against the practitioner or the providing of information to the review panel or board concerning the underlying facts or circumstances of the action is void and unenforceable.

b. An insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the review panel in writing of any termination or denial of coverage to a practitioner or surcharge assessed on account of the practitioner's practice method or medical malpractice claims history.

c. The form of notification shall be prescribed by the Commissioner of Banking and Insurance, shall contain such information as may be required by the board and the review panel, and shall be made within seven days of the settlement, judgment or award or the final action for a termination or denial of, or surcharge on, the medical malpractice liability insurance. Upon request of the board, the review panel or the commissioner, an insurer or insurance association shall provide all records regarding the defense of a malpractice claim, the processing of the claim and the legal proceeding; except that nothing in this subsection shall be construed to authorize disclosure of any confidential communication which is otherwise protected by statute, court rule or common law.

An insurer or insurance association, or any employee thereof, shall be immune from liability for furnishing information to the review panel and the board in fulfillment of the requirements of this section unless the insurer or insurance association, or any employee thereof, knowingly provided false information.

d. An insurer, insurance association or practitioner who fails to notify the review panel as required pursuant to this section shall be subject to such penalties as the Commissioner of Banking and Insurance may determine pursuant to section 12 of P.L.1975, c.301 (C.17:30D-12). In addition to, or in lieu of suspension or revocation, the commissioner may assess a fine which shall not exceed $1,000 for

the first offense and $2,000 for the second and each subsequent offense, which may be recovered in a summary proceeding, brought in the name of the State in a court of competent jurisdiction pursuant to **[**"the penalty enforcement law," N.J.S.2A:58-1 et seq.**]** the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

e. A practitioner who fails to notify the review panel as required pursuant to this section shall be subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 45:1-22 and 45:1-25).

f. An insurer or insurance association shall make available to the review panel or the board, upon request, any records of termination or denial of coverage to a practitioner or surcharge assessed on account of the practitioner's practice method or medical malpractice claims history, which occurred up to five years prior to the effective date of P.L.1989, c.300 (C.45:9-19.4 et al.).

g. For the purposes of this section, "practitioner" means a person licensed to practice: medicine and surgery under chapter 9 of Title 45 of the Revised Statutes or a medical resident or intern; or podiatry under chapter 5 of Title 45 of the Revised Statutes.

h. Any insurer or insurance association authorized to issue medical malpractice liability insurance in the State shall notify the Commissioner of Banking and Insurance, in a form and manner specified by the commissioner, of any medical malpractice claim settlement, judgment or arbitration award involving any practitioner licensed by the State Board of Medical Examiners and insured by the insurer or insurance association. The notification shall include the specialty or area of professional practice of the practitioner and the amount of the settlement, judgment or arbitration award, but shall not include the name or other identifying information of the practitioner.

(cf: P.L.1989, c.300, s.4)

24. (New section) a. As used in this section:

"Annuity" means an annuity issued by an insurer licensed or authorized to do business in this State which is a qualified assignment under section 130 of the federal Internal Revenue Code of 1986, 26 U.S.C. s.130.

"Judgment creditor" means a claimant who is the recipient of an award for economic or noneconomic damages, or both, that is the result of an action filed against a health care provider for medical malpractice, which award is subject to the provisions of subsection b. of this section.

"Judgment debtor" means a health care provider who, as a defendant in an action brought for medical malpractice, is required to pay the claimant an award that is subject to the provisions of this section.

"Noneconomic damages" means damages for physical and

emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

"Structured payment agreement" means an agreement made to settle a claim or lawsuit or respond to a judgment in an action brought for medical malpractice by an injured person whereby a series of periodic payments, rather than a lump sum payment, is made over time to a claimant, in accordance with the needs of the claimant or the claimant's family, either through the purchase of an annuity or the establishment of a trust fund, or by another means approved by the court.

b. (1) Unless otherwise agreed to by the parties, in any judgment resulting from a medical malpractice action brought by a claimant for medical malpractice in which the noneconomic damages are less than or equal to $1,000,000, the court shall enter a judgment ordering that all of the money damages, both economic and noneconomic, be paid immediately.

(2) Unless otherwise agreed to by the parties, in any judgment resulting from a medical malpractice action brought by a claimant for medical malpractice in which the noneconomic damages exceed $1,000,000, the court shall enter a judgment ordering that 50% of the noneconomic damages be paid immediately, with the costs and attorney's fees to be paid from that amount. The remaining 50% of the judgment shall be paid over 60 months in the form of a structured payment agreement by any person, organization, group, or insurer that is contractually liable to pay the judgment.

c. The structured payment agreement shall specify: the recipient of the payments; the dollar amount of the payments; the interval between payments; the number of payments or the period of time over which payments are to be made; and the persons to whom money damages are owed, if any, in the event of the judgment creditor's death.

d. In the event of the judgment creditor's death, any amounts due and owing pursuant to subsection b. of this section shall be paid to the judgment creditor's estate.

e. The judgment debtor or the judgment debtor's insurer shall be required to: post a bond or security; or, as otherwise provided by regulation of the Department of Banking and Insurance, assure full payment of the noneconomic damages awarded. A bond shall not be deemed adequate unless it is written by a company authorized to do business in this State and is rated A-, or better, by A.M. Best Company or such other company as is approved by the Department of Banking and Insurance. If the judgment debtor is unable to adequately assure full payment of the judgment, the judgment, reduced to present value, shall be paid to the claimant in a lump sum. No bond may be

canceled or be subject to cancellation unless at least 60 days' advance written notice is filed with the court and the claimant. Upon termination of periodic payments, the security, or so much as remains, shall be returned to the judgment debtor.

f. Upon the purchase of an annuity, establishment of a trust, or approval of another arrangement for periodic payments by a court, any obligation of the judgment debtor with respect to the judgment shall cease.

25. Section 1 of P.L.1997, c.365 (C.45:9-19.17) is amended to read as follows:

1. a. A physician who maintains a professional medical practice in this State and has responsibility for patient care is required to be covered by medical malpractice liability insurance in the sum of $1,000,000 per occurrence and $3,000,000 per policy year, with extended reporting endorsement coverage for claims made policies, also known as "tail coverage," issued by a carrier authorized to write medical malpractice liability insurance policies in this State, or, if such liability coverage is not available, by a letter of credit for at least **[**the minimum amount required by the State Board of Medical Examiners**]** $500,000 .

The physician shall notify the State Board of Medical Examiners of the name and address of the insurance carrier or the institution issuing the letter of credit, pursuant to section 7 of P.L.1989, c.300 (C.45:9-19.7).

b. A physician who is in violation of this section is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).

c. The State Board of Medical Examiners **[**shall**]** may, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), **[**adopt regulations which**]** establish **[**the**]** by regulation, minimum **[**amount of a line**]** amounts for medical malpractice liability insurance coverage and lines of credit **[**that is**]** in excess of those amounts required pursuant to subsection a. of this section.

d. The State Board of Medical Examiners shall notify all physicians licensed by the board of the requirements of this section within 30 days of the date of enactment of **[**this act**]** P.L. , c. (now before the Legislature as this bill).

(cf: P.L.1997, c.365, s.1)

26. (New section) For the purposes of sections 27 and 28 of P.L. , c. (C. )(pending before the Legislature as this bill):

"Commissioner" means the Commissioner of Banking and Insurance.

"Fund" means the Medical Malpractice Liability Insurance Premium Assistance Fund established pursuant to section 27 of P.L. , c.

(C. )(pending before the Legislature as this bill).

"Health care provider" means a physician, podiatrist, dentist and chiropractor licensed pursuant to the provisions of Title 45 of the Revised Statutes, a nurse licensed pursuant to the provisions of Title 45 of the Revised Statutes who is employed by a licensed hospital, long-term care facility or assisted living facility in this State and any person who purchases professional liability insurance on behalf of or for a practitioner, including professional liability insurance protection which is provided for hospital employed physicians through hospital funding supplemented by purchased commercial insurance coverage.

"Practitioner" means a physician, podiatrist, dentist and chiropractor and a nurse employed by a licensed hospital, long-term care facility or assisted living facility in this State.

27. (New section) a. There is established a Medical Malpractice Liability Insurance Premium Assistance Fund within the Department of the Treasury as a nonlapsing, revolving fund.

b. The fund shall be comprised of the following revenue:

(1) an annual surcharge of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law," R.S.43:21-1 et seq., collected by the comptroller for the New Jersey Unemployment Compensation Fund and paid over to the State Treasurer for deposit in the fund annually, as provided by the commissioner, which surcharge may, at the option of the employer, be treated as a payroll deduction to each covered employee;

(2) an annual charge of $50 to be imposed by the State Board of Medical Examiners on every physician and podiatrist licensed by the board pursuant to the provisions of R.S.45:9-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund;

(3) an annual charge of $50 to be imposed by the State Board of Chiropractic Examiners on every chiropractor licensed by the board pursuant to the provisions of P.L.1989, c.153 (C.45:9-41.17 et seq.), collected by the board and remitted to the State Treasurer for deposit into the fund;

(4) an annual charge of $50 to be imposed by the New Jersey State Board of Dentistry on every dentist licensed pursuant to the provisions of R.S.45:6-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund;

(5) an annual charge of $50 to be imposed by the New Jersey State Board of Optometrists on every optometrist licensed by the board pursuant to the provisions of R.S.45:12-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund; and

(6) an annual fee of $50 to be assessed by the State Treasurer and payable by each person licensed to practice law in this State, for deposit into the fund.

The provisions of paragraphs (2) through (5) of this subsection shall not apply to physicians, podiatrists, chiropractors, dentists or optometrists who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; or have not practiced their profession for at least one year.

The provisions of paragraph (6) of this subsection shall not apply to attorneys who: are constitutionally or statutorily barred from the practice of law; can show that they do not maintain a bona fide office for the practice of law in this State; are completely retired from the practice of law; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment; or have not practiced law for at least one year.

c. The State Treasurer shall deposit all moneys collected by him pursuant to this section into the fund. Monies credited to the fund may be invested in the same manner as assets of the General Fund and any investment earnings on the fund shall accrue to the fund and shall be available subject to the same terms and conditions as other monies in the fund.

d. The fund shall be administered by the Department of Banking and Insurance in accordance with the provisions of P.L. , c. (C. )(pending before the Legislature as this bill).

e. The monies in the fund are specifically dedicated and shall be utilized exclusively for the following purposes:

(1) $20 million shall be allocated annually for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established pursuant to section 28 of P.L. , c. (C. )(pending before the Legislature as this bill);

(2) $8 million shall be allocated annually to the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58) for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.);

(3) $1 million shall be allocated annually for a student loan expense reimbursement program for obstetrician/gynecologists, to be established pursuant to section 29 of P.L. , c. (C. )(pending before the Legislature as this bill); and

(4) $1 million shall be allocated annually to the Division of Medical Assistance and Health Services in the Department of Human Services for the purposes provided in section 30 of P.L. , c. (C. )(pending before the Legislature as this bill).

f. The fund shall expire three years after the effective date of P.L. , c. (C. )(pending before the Legislature as this bill).

28. (New section) a. In order to carry out the purposes of section 27 of P.L. , c. (C. )(pending before the Legislature as this bill), the commissioner shall, at a minimum:

(1) establish a program to provide medical malpractice liability insurance premium subsidies to health care providers from monies that are contained in the fund;

(2) establish a methodology and procedures for determining eligibility for, and providing subsidies from, the fund;

(3) maintain confidential records on each health care provider who receives assistance from the fund;

(4) take all necessary action to recover the cost of the subsidy provided to a health care provider that the commissioner determines to have been incorrectly provided; and

(5) provide for subsidies to all practitioners who are members of specialties and subspecialties who qualify for relief under subsection b. of this section, including those whose professional liability insurance protection is provided by hospital funding supplemented by purchased commercial insurance coverage.

b. The commissioner shall certify classes of practitioners by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount per year as determined by the commissioner by regulation. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, as applicable, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

(1) In order to be eligible for a subsidy from the fund, a practitioner shall have received a medical malpractice liability insurance premium increase in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in calendar year 2005; or

(2) In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding

supplemented with purchased commercial insurance coverage, in order to be eligible for a subsidy from the fund, that provider shall have increased its total professional liability funding obligation in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that provider in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that provider in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that provider in calendar year 2005.

(3) The amount of the subsidy shall be an amount, as determined by the commissioner by regulation, of the increase from the preceding year's premium or self-insured professional liability funding obligation; except that no health care provider shall receive a subsidy in any year that is greater than an amount as determined by the commissioner by regulation.

c. A practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's respective licensing board pursuant to sections 8, 9 or 12 of P.L.1978, c.73 (C.45:1-21, 22 or 25), when that action or penalty relates to the practitioner's provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

d. (1) A practitioner who receives a subsidy from the fund shall be required to practice in that practitioner's specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy.

(2) A practitioner who fails to comply with the provisions of paragraph (1) of this subsection shall be required to repay to the commissioner the amount of the subsidy, in whole or in part as determined by the commissioner.

e. The commissioner may waive the criteria for eligibility for a subsidy established pursuant to this section, if the commissioner determines that access to care for a particular specialty is threatened because of an inability of a sufficient number of practitioners in that specialty or subspecialty to practice in a geographic area of the State.

f. The State Board of Medical Examiners, the State Board of Chiropractic Examiners , the New Jersey State Board of Dentistry and the New Jersey Board of Nursing shall each provide to the commissioner, on a quarterly basis, the names of the practitioners who have been subject to a disciplinary action or civil penalty by the practitioner's respective licensing board.

29. (New section) a. There is established a student loan expense reimbursement program within the Higher Education Student Assistance Authority for obstetrician/gynecologists who agree to practice in State designated underserved areas as established pursuant

to section 1 of P.L.1999, c.46 (C.18A:71C-35). The authority shall implement the program in consultation with the Commissioners of Banking and Insurance and Health and Senior Services.

b. (1) An obstetrician/gynecologist who receives a payment under the student loan expense reimbursement program shall be required to practice as an obstetrician/gynecologist in an underserved area in this State for a period of at least four years after receipt of the payment.

(2) An obstetrician/gynecologist who fails to comply with the provisions of paragraph (1) of this subsection shall be required to repay to the Higher Education Student Assistance Authority the amount of the payment, in whole or in part as determined by the authority.

c. The authority shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of subsection a. of this section, including, but not limited to: eligibility for the program, procedures for application, selection of participants, establishment and nullification of contracts established with participants under the program, reports to the program by participants, and recruitment of participants.

30. (New section) Within the limits of funds appropriated pursuant to section 27 of P.L. , c. (C. )(pending before the Legislature as this bill) and such other funds as may be available for this purpose, the FamilyCare Health Coverage Program established pursuant to P.L.2000, c.71 (C.30:4J-1 et seq.) shall enroll into the program women whose eligibility under the Medicaid New Jersey Care pregnant women program or the "New Jersey Standardized Parent Service Package," Demonstration Population 3, Medicaid expansion for uninsured pregnant woman, has expired and whose family income does not exceed 100% of the federal poverty level.

The Commissioner of Human Services shall establish a presumptive eligibility process to provide for an efficient transition into the FamilyCare Health Coverage Program from the Medicaid program pursuant to this section.

31. There is established the "Medical Care Availability Task Force."

a. The task force shall consist of 17 members as follows:

(1) the Commissioners of Banking and Insurance, Health and Senior Services, and Human Services, and the Director of the Administrative Office of the Courts, or their designees, who shall serve ex officio; and

(2) 13 public members, who shall include: one person appointed upon the recommendation of an organization that represents physicians; one person appointed upon the recommendation of an

organization that represents osteopathic physicians and surgeons; one person appointed upon the recommendation of an organization that represents dentists; one person appointed upon the recommendation of an organization that represents hospitals; one person appointed upon the recommendation of an organization that represents teaching hospitals; one person appointed upon the recommendation of an organization that represents trial lawyers; one person appointed upon the recommendation of an organization that represents attorneys; one person appointed upon the recommendation of an organization that represents medical malpractice insurers; one person appointed upon the recommendation of an organization that represents managed care carriers; and four persons who represent the interests of health care consumers.

Of the 13 public members, five shall be appointed by the Governor, with the advice and consent of the Senate; four shall be appointed by the President of the Senate; and four shall be appointed by the Speaker of the General Assembly. The Governor, the President of the Senate, and the Speaker of the General Assembly shall consult with each other on the appointment of the public members.

b. Vacancies in the membership of the task force shall be filled in the same manner provided for the original appointments. The public members of the task force shall serve without compensation but may be reimbursed for traveling and other miscellaneous expenses necessary to perform their duties, within the limits of funds made available to the task force for its purposes.

c. (1) The task force shall organize as soon as practicable, but no later than the 30th day after the appointment of its members, and shall select a chairperson and vice-chairperson from among the members. The chairperson shall appoint a secretary who need not be a member of the task force.

(2) The task force may meet at the call of the chairperson and hold hearings at the times and in the places it may deem appropriate and necessary to fulfill its charge. The task force shall be entitled to call to its assistance, and avail itself of the services of, the employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for its purposes.

(3) The Department of Banking and Insurance shall provide staff services to the task force.

d. The purpose of the task force shall be to study the following issues:

(1) the advantages and disadvantages of establishing limitations on noneconomic damages for medical malpractice judgments and on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

(2) the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

(3) the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

(4) the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits; and

(5) the advantages and disadvantages of establishing a pre-suit procedure.

e. The task force shall present a report of its findings and recommendations to the Governor and the Legislature no later than 24 months after the date of its initial meeting, and shall be authorized to periodically issue a summary of its deliberations prior to the presentation of its report.

32. This act shall take effect on the 30th day after enactment and shall apply to causes of action for medical malpractice that accrue on or after that effective date; except that sections 14 through 16 and section 22 shall take effect on the 180th day after the date of enactment**,** sections 17 and 19 shall take effect on the 90th day after the date of enactment, and the amendatory provisions of sections 3 and 4 shall apply to injuries sustained at birth on or after the effective date of this act. Section 29 shall expire three years after the effective date.

STATEMENT

This bill, which is designated the "New Jersey Medical Care Access and Responsibility and Patients First Act," is designed to implement a number of reforms relating to tort liability as it concerns medical malpractice, as well as health care system and medical malpractice liability insurance reforms.

Specifically, the bill provides for the following:

**Tort Liability Reforms:**

The bill amends N.J.S.2A:14-2 and N.J.S.2A:14-21 to provide that actions by or on behalf of a minor that have accrued for medical malpractice for injuries sustained at birth must be commenced prior to the minor's 13th birthday. These statutory changes would not affect the discovery doctrine in any way. The bill also provides that in the event that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth is not commenced by the minor's parent or guardian prior to the minor's 12th birthday, the

minor or a person 18 years of age or older designated by the minor to act on the minor's behalf would be permitted to commence such an action.

The bill provides for court referral of a medical malpractice action to a complementary dispute resolution mechanism if the judge presiding over the action determines, within 30 days after the discovery end date, that the referral may encourage early disposition or settlement of the action. If the judge makes that determination, the matter is to be referred to complementary dispute resolution pursuant to Rule 1:40 of the New Jersey Rules of Court.

The bill also provides that a health care provider named as a defendant in a medical malpractice action may file an affidavit of noninvolvement with the court. The affidavit of noninvolvement is to set forth the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant. The bill also provides penalties for false statements made in the affidavit or in challenging the affidavit.

The bill establishes qualifications for expert witnesses in medical malpractice actions and for the purpose of executing an affidavit of merit, and provides that an expert must have the same type of practice and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court. The bill prohibits expert witnesses from testifying on a contingency fee basis. The bill also provides for penalties for an individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit of merit, which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure.

With respect to the payment of medical malpractice judgments, the bill provides that in any medical malpractice judgment in which the noneconomic damages (those for pain and suffering) are $1 million or less, unless otherwise agreed to by the parties, the court is to enter a judgment ordering that money damages be paid immediately. In any judgment in which the noneconomic damages exceed $1 million, unless otherwise agreed to by the parties, 50% of the money damages are to be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50% of the judgment is to be paid over 60 months in the form of a structured payment agreement.

Further, in order to provide the court with discretion to modify jury awards, the bill modifies the standard of review to be used by the court in reviewing the amount of a jury award to require the court to consider the evidence in the light most favorable to the non-moving

party and to allow the court to determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury.

**Health Care System Reforms:**

The bill expands the State's "Good Samaritan" law to provide immunity from civil damages to licensed health care professionals, emergency medical technicians and mobile intensive care paramedics whose duty does not require a response to a patient emergency situation, who, in good faith, respond to a life-threatening emergency or respond to a request for emergency assistance in a life-threatening emergency within a hospital or other licensed health care facility or a State psychiatric hospital operated by the Department of Human Services. The immunity shall not apply: to acts or omissions constituting gross negligence, recklessness or willful misconduct; if a provider-patient relationship existed before the emergency; if consideration in any form is provided to the health care professional for the service rendered; or if a general hospital has not reasonably and adequately staffed its emergency department.

Further, the bill provides that a health care professional is not liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility or State psychiatric hospital on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

- the patient was unconscious;

- the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

- the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The immunity provided is applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

The bill strengthens reporting requirements by physicians to the State Board of Medical Examiners (BME) to ensure that the BME is promptly informed of any pending or final action by any criminal authority in this State or any other state or federal jurisdiction or any arrest or conviction for a criminal or quasi-criminal act, by requiring

that a physician report, within 10 days, the action or his arrest or conviction, for crimes that include, but are not limited to, criminal homicide, aggravated assault, sexual assault, criminal sexual contact or lewdness, or an offense involving any controlled dangerous substance or controlled substance analog.

The bill also ensures that health care facilities, State psychiatric hospitals and other physicians affiliated with a physician who has been disciplined by the BME, are notified of its action, within 30 days of the action. Similarly, the bill ensures that a health care facility, State psychiatric hospital or health maintenance organization is promptly notified by the BME if, during the course of an investigation of a physician, it requests information from that facility or health maintenance organization regarding that physician, and subsequently determines that no disciplinary action is warranted.

**Medical Malpractice Liability Insurance Reforms:**

To avoid the appearance of any conflicts of interest, the bill prohibits any person who is an officer, director or board member of a professional association for health care providers to serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that issues policies in the State.

For the purpose of negotiating a reduced medical malpractice liability insurance premium, the bill would permit physicians to join together, by means of a joint contract, to form a "Medical Malpractice Liability Insurance Purchasing Alliance."

The bill provides that a medical malpractice liability insurance policy may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; but, if the policy contains that provision, the insurer would be required to offer an endorsement to the policy that permits the insurer to settle a claim filed under the policy without first having obtained the insured's consent. The insurer would be required to establish a premium for the endorsement which reflects any savings or reduced costs attributable to the endorsement, and the insured would have the option of accepting or refusing the endorsement.

Another provision to provide premium relief to health care providers is the requirement that every medical malpractice liability insurer offer individual or group medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1 million per claim, with the insurer being permitted to require the insured to provide collateral for the deductible amount to the insurer. The deductibles offered by an insurer are subject to the approval of the Commissioner of Banking and Insurance. For policies with any deductible, the insurer would be responsible for payment of the deductible and would be reimbursed for

that amount by the insured.

To provide increased oversight of medical malpractice insurers, the bill requires that every annual statement filed by a medical malpractice insurer in this State with the Department of Banking and Insurance include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

The bill requires insurers authorized to transact medical malpractice liability insurance in this State to provide at least 60 days' notice to the insured for policy renewals and nonrenewals. Also, in the case of a nonrenewal, the insurer must provide the reason for the nonrenewal.

The bill provides that if the Commissioner of Banking and Insurance finds, after a hearing, that a rate in effect for any medical malpractice insurer is not in compliance with the provisions of N.J.S.A.17:29AA-1 et seq., the commissioner is to issue an order specifying in what respects it so fails, and stating when the rate will no longer be deemed effective. The order may provide for the retroactive adjustment of rates and require the payment or credit of interest to insureds covered during the adjusted rate period. Interest is to be calculated at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.

The bill also directs the commissioner, subject to standards adopted by the National Association of Insurance Commissioners, to review the current capitalization and reserve requirements applicable to medical malpractice insurers, and to modify those requirements, as necessary, to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in the State.

Also, the bill requires medical malpractice liability insurers to offer their insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance, by regulation.

In addition, N.J.S.A.17:30D-17, which requires all medical malpractice insurers to notify the BME of every medical malpractice judgment, settlement and award involving a physician or podiatrist licensed in this State, is amended to also require notification to the Commissioner of Banking and Insurance of these payments. The notification to the commissioner is to enable the commissioner to compile statistical data about medical malpractice payouts, and would not include the name of or other identifying information about the practitioner.

The bill removes from the BME the authority and discretion to set the minimum amounts of medical malpractice liability insurance that a physician who maintains a professional medical practice in this State and has responsibility for patient care is required to carry, and instead

establishes those minimum amounts by statute. The bill sets the limits at those currently in effect by virtue of regulations promulgated by the BME, that is: medical malpractice liability insurance in the sum of $1 million per occurrence and $3 million per policy year, with extended reporting endorsement coverage for claims made, also known as "tail coverage;" or, if liability coverage is not available, by a letter of credit for at least $500,000. The BME may, however, increase these minimum amounts by regulation.

The bill establishes the Medical Malpractice Liability Insurance Premium Assistance Fund in the Department of the Treasury to provide relief towards the payment of medical malpractice liability insurance premiums to certain health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the Commissioner of Banking and Insurance by regulation. The fund will be administered by the Department of Banking and Insurance, and will expire three years after the effective date of the bill.

The bill provides that the Commissioner of Banking and Insurance will certify classes of health care practitioners, by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount determined by the commissioner, or in the case of health care practitioners whose professional liability insurance protection is provided through self-insured hospital funding supplemented with purchased commercial insurance, the total professional liability funding obligation has increased in excess of an amount determined by the commissioner. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

In order to be eligible for a subsidy from the fund, a practitioner must have received a medical malpractice liability insurance premium increase in an amount determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in 2005. The amount of the subsidy will be determined by the commissioner by regulation.

In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding supplemented with purchased commercial insurance coverage, that provider must have increased its total professional liability funding obligation in an amount as determined by the commissioner by

regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that practitioner in calendar year 2005.

The Medical Malpractice Liability Insurance Premium Assistance Fund is to be comprised of the following revenue:

-- an annual surcharge of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law";

-- an annual charge of $50 imposed on each licensed physician, podiatrist, chiropractor, dentist and optometrist by the appropriate professional licensing board; and

-- an annual fee of $50 imposed on each licensed attorney by the State Treasurer.

The above charges and fees will not apply to physicians, podiatrists, chiropractors, dentists, optometrists or attorneys who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; have not practiced their profession for at least one year; or, in the case of attorneys, are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment.

The bill also specifies that a practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's licensing board, when that action or penalty relates to the practitioner's provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

The bill requires that a health care practitioner who receives a subsidy from the fund practice in that practitioner's specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy; and a practitioner who fails to comply with this requirement must repay the Commissioner of Banking and Insurance the amount of the subsidy, in whole or in part as determined by the commissioner.

The monies in the Medical Malpractice Liability Insurance Premium Assistance Fund are specifically dedicated and to be utilized exclusively for the following purposes:

-- $20 million is to be allocated annually for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and

meet the criteria established under the bill;

-- $8 million is to be allocated annually to the Health Care Subsidy Fund established pursuant to N.J.S.A.26:2H-18.58 for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to N.J.S.A.26:2H-18.51 et al.;

-- $1 million is to be allocated annually for a student loan expense reimbursement program for obstetrician/gynecologists (as described below); and

-- $ 1 million is to be allocated annually to the Division of Medical Assistance and Health Services in the Department of Human Services to expand the NJ FamilyCare program (as described below).

The bill establishes a three-year student loan expense reimbursement program within the Higher Education Student Assistance Authority for obstetrician/gynecologists who agree to practice in State designated underserved areas as established pursuant to N.J.S.A.18A:71C-35. An obstetrician/gynecologist who receives a payment under the program is required to practice as an obstetrician/gynecologist in an underserved area in this State for a period of at least four years after receipt of the payment; and an obstetrician/gynecologist who fails to comply with this requirement must repay the authority the amount of the payment, in whole or in part as determined by the authority. The authority is to implement the program in consultation with the Commissioners of Banking and Insurance and Health and Senior Services, and to adopt rules and regulations, pursuant to the "Administrative Procedure Act," to effectuate the purposes of this new program, including, but not limited to: eligibility for the program, procedures for application, selection of participants, establishment and nullification of contracts established with participants under the program, reports to the program by participants, and recruitment of participants.

The bill provides that, within the limits of funds appropriated pursuant to the bill and such other funds as may be available for this purpose, NJ FamilyCare is to enroll into the program women whose eligibility under the Medicaid New Jersey Care pregnant women program or the "New Jersey Standardized Parent Service Package," Demonstration Population 3, Medicaid expansion for uninsured pregnant woman, has expired and whose family income does not exceed 100% of the federal poverty level. The Commissioner of Human Services is to establish a presumptive eligibility process to provide for an efficient transition into NJ FamilyCare from the Medicaid program pursuant to this provision.

Finally, the bill establishes a 17-member "Medical Care Availability Task Force" to study the following issues:

-- the advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and on

extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

-- the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

-- the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

-- the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits; and

-- the advantages and disadvantages of establishing a pre-suit procedure.

# SENATE, No. 551

# STATE OF NEW JERSEY

## 211th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2004 SESSION

**Sponsored by:**
**Senator JOSEPH F. VITALE**
**District 19 (Middlesex)**

**SYNOPSIS**

"New Jersey Health Care Access and Patient Protection Act."

**CURRENT VERSION OF TEXT**

Introduced Pending Technical Review by Legislative Counsel.

**AN ACT** concerning medical professional liability, insurance reform and patient protection and revising parts of statutory law.

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

1. (New section) This act shall be known and may be cited as the "New Jersey Medical Care Availability and Patient Protection Act."

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

a. One of the most vital interests of the State is to ensure that high-quality health care continues to be available in this State and that the residents of this State continue to have access to a full spectrum of health care providers, including highly trained physicians in all specialties;

b. The State's health care system and its residents' access to health care providers are threatened by a dramatic escalation in medical malpractice liability insurance premiums, which is creating a crisis of affordability in the purchase of necessary liability coverage for our health care providers;

c. One particularly alarming result of rising premiums is that there are increasing reports of doctors retiring or moving to other states where insurance premiums are lower, dropping high-risk patients and procedures, and practicing defensive medicine in a manner that may significantly increase the cost of health care for all our citizens;

d. The reasons for the steep increases in the cost of medical malpractice liability insurance are complex and involve issues related to: the State's tort liability system; the State's health care system, which includes issues related to patient safety and medical error reporting; and the State's regulation and requirements concerning medical malpractice liability insurers;

e. It is necessary and appropriate for the State to take meaningful and prompt action to address the various interrelated aspects of these issues that are impacted by, or impact on, the State's health care system; and

f. To that end, this act provides for a comprehensive set of reforms affecting the State's tort liability system, health care system and medical malpractice liability insurance carriers to ensure that health care services continue to be available and accessible to residents of the State and that patient safety at health care facilities is enhanced.

3. (New section) As used in sections 3 through 9 of P.L. , c. (C. ) (pending before the Legislature as this bill):

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

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

"Health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse, pharmacist or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes, and a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Medical malpractice" means a negligent act or omission by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death**.**

4. N.J.S.2A:14-2 is amended to read as follows:

2A:14-2. Every action at law for an injury to the person caused by the wrongful act, neglect or default of any person within this **[**state**]** State shall be commenced within 2 years next after the cause of any such action shall have accrued; except that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 10th birthday.

(cf: N.J.S.2A:14-2)

5. N.J.S.2A:14-21 is amended to read as follows:

2A:14-21. If any person entitled to any of the actions or proceedings specified in **[**sections**]** N.J.S.2A:14-1 to 2A:14-8 or **[**sections**]** N.J.S.2A:14-16 to 2A:14-20 **[**of this title**]** or to a right or title of entry under **[**section**]** N.J.S.2A:14-6 **[**of this title**]** is or shall be, at the time of any such cause of action or right or title accruing, under the age of 21 years, or insane, such person may commence such action or make such entry, within such time as limited by **[**said sections**]** those statutes, after his coming to or being of full age or of sane mind. Notwithstanding the provisions of this section to the contrary, an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth shall be commenced prior to the minor's 10th birthday, as provided in N.J.S.2A:14-2.

(cf: N.J.S.2A:14-21)

6. (New section) a. A person shall not commence an action alleging medical malpractice against a health care provider, unless the person has given the health care provider written notice of that proposed action at least 180 days before the action is filed.

b. The notice of intent to file an action shall be mailed, by certified or registered mail, to the last known professional business address or residential address of the health care provider who is the subject of the proposed action. Proof of the mailing of the notice required pursuant to this section shall be prima facie evidence of compliance. If no professional business or residential address is known, notice may be

mailed to the health care facility where the care that is the subject of the proposed action was rendered.

c. A notice given to a health care provider pursuant to this section shall contain, at a minimum, a statement of the following:

(1) the factual basis for the proposed action;

(2) the applicable standard of practice or care alleged by the claimant;

(3) the manner in which it is claimed that the applicable standard of practice or care was breached by the health care provider;

(4) the alleged action that should have been taken to achieve compliance with the alleged standard of practice or care;

(5) the manner in which it is alleged that the breach of the standard of practice or care was the proximate cause of the injury that is the subject of the proposed action; and

(6) the names of all health care providers that the claimant is notifying pursuant to this section in connection with the proposed action.

d. No later than 90 days after receipt of the notice pursuant to this section, a health care provider who is a recipient of the notice shall furnish to the claimant a written response that contains a statement of the following:

(1) the factual basis for the defense of the proposed action;

(2) the standard of practice or care that the health care provider claims to be applicable to the proposed action and that the health care provider complied with that standard;

(3) the manner in which it is claimed by the health care provider that there was compliance with the applicable standard of practice or care; and

(4) the manner in which the health care provider contends that the alleged negligence was not the proximate cause of the claimant's alleged injury.

e. No earlier than 60 days, but before 180 days, after the notice is mailed, the claimant and health care provider notice recipient shall conduct a pre-suit information session to determine the appropriate parties to the proposed action and such other issues as the parties may agree to discuss.

(1) The session shall be conducted by a neutral third party, to be called a "discovery master," who shall be selected from a list of qualified discovery masters that is maintained by the Department of Banking and Insurance. The claimant shall initiate the session and make any necessary arrangements to hold the session, at a time and place that is acceptable to all parties. If necessary, multiple sessions may be scheduled.

(2) The claimant shall request from the department a list of three discovery masters, from which one master shall be chosen. The selection of a master shall be pursuant to the written agreement of the

parties. If the parties cannot agree on a master from the list of three masters provided by the department, the parties may submit the names of other masters to each other for consideration. If the parties cannot agree on a master from that list, the master shall be selected from the next available master on the list maintained by the department.

A person serving as a master shall comply with neutrality standards established by the Commissioner of Banking and Insurance, which shall include ensuring against conflicts of interest, professional relationships and such other issues as determined by the commissioner.

(3) Attorneys and parties to the proposed action have an obligation to participate in the pre-suit information session in good faith in accordance with department regulations.

(4) The discovery master and parties to the proposed action shall review the notice of intent to file an action, the health care provider's response and such other documents that the master or a party deems relevant to the issue.

(5) If the session results in the parties' total or partial agreement concerning which health care provider shall be named and which shall not be named in an action, or any other issues, it shall be reduced to writing and a copy thereof furnished to each party.

(6) Any necessary fees and expenses of the master with respect to the information session shall be shared equally by the parties to the proceeding.

(7) The outcome of the information session shall be filed with all parties to the proposed action, including the health care provider's medical malpractice insurer, within 10 days of the date of completion of the session.

(8) The department shall adopt such rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), necessary to administer information sessions.

f. No later than 90 days after notice pursuant to this section is mailed, a party seeking to investigate the matter may serve process to compel both written and oral discovery, which shall be limited to factual information directly related to the proposed action, including, but not limited to, the production of medical records, test results, films, videos and other items, as well as serving written interrogatories and taking oral depositions. The claimant shall allow the health care provider receiving the notice to have access to all of the medical records related to the proposed action that are in the claimant's control, and shall provide releases for any medical records related to the proposed action that are not in the claimant's control, but of which the claimant has knowledge.

g. No later than 90 days after notice pursuant to this section is mailed, the health care provider who receives the notice shall allow the claimant to have access to all medical records in his possession that are related to the proposed action, but nothing in this subsection shall be

construed to restrict a health care provider who receives notice from communicating with other health care providers and acquiring medical records as may be necessary or pertinent to the proposed action.

h**.** The statute of limitations is tolled for 270 days, beginning on the date the notice of intent to file is mailed, for all potential parties to the proposed action.

7. (New section) a. A health care provider named as a defendant in a medical malpractice action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth, with particularity, the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant.

b. A codefendant or claimant shall have the right to challenge an affidavit of noninvolvement by filing a motion and submitting an affidavit that contradicts the assertions of noninvolvement made by the health care provider in the affidavit of noninvolvement.

c. If the court determines that a health care provider named as a defendant falsely files or makes false or inaccurate statements in an affidavit of noninvolvement, the court, upon motion or upon its own initiative, shall immediately reinstate the claim against that provider. Reinstatement of a party pursuant to this subsection shall not be barred by any statute of limitations defense that was not valid at the time the original action was filed.

In any action in which the health care provider is found by the court to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court shall impose upon the person who signed the affidavit or represented the party, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the filing of the false or inaccurate affidavit, including a reasonable attorney fee.

d. If the court determines that a plaintiff or his counsel falsely objected to a health care provider's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a health care provider's affidavit, the court shall impose upon the plaintiff or his counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other party or parties the amount of the reasonable expenses incurred as a result of the false objection or inaccurate statement, including a reasonable attorney fee.

8. (New section) a. In an action alleging medical malpractice, a

person shall not give expert testimony or execute an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.) on the appropriate standard of care or practice unless the person is licensed in the United States as a physician or other health care professional and in the same profession as the defendant.

In order to qualify as an expert witness, the person shall meet the following qualifications:

(1) If the party against whom or on whose behalf the testimony is offered is a specialist, the person providing the testimony:

(a) shall have specialized at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered,

(b) shall be board certified in the same specialty as the party against whom or on whose behalf the testimony is offered, and

(c) during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his or her professional time to:

(i) the active clinical practice of the same health care profession in which the defendant is licensed, and, if the defendant is a specialist, the active clinical practice of that specialty;

(ii) the instruction of students in an accredited medical school, other accredited health care professional school or accredited residency or clinical research program in the same health care profession in which the defendant is licensed, and, if that party is a specialist, an accredited medical school, health care professional school or accredited residency or clinical research program in the same specialty; or

(iii) both; and.

(2) If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, shall have devoted a majority of his professional time to:

(a) active clinical practice as a general practitioner;

(b) the instruction of students in an accredited medical school, health care professional school or accredited residency or clinical research program in the same health care profession in which the party against whom or on whose behalf the testimony is provided is licensed; or

(c) both.

b. In determining the qualifications of an expert witness the court shall, at a minimum, evaluate all of the following:

(1) the educational and professional training of the expert witness;

(2) the area of specialization of the expert witness;

(3) the length of time the expert witness has been engaged in the active clinical practice or instruction of the health care profession or

specialty; and

(4) the relevancy of the expert witness' testimony.

c. The court may waive the requirements in subsection a. of this section if it determines that, upon representation by an affidavit by the plaintiff or defendant, as applicable, no witnesses are reasonably available that meet the criteria set forth therein, and the person testifying possesses sufficient training, experience and knowledge to provide credible testimony. Under the provisions of this subsection, with respect to a physician, the court may allow an expert who is board certified in a specialty area of medicine to serve as an expert or sign an affidavit when the medical service, procedure or care being addressed is one that is performed by both the specialty of the defendant physician and the specialty of the expert witness.

d. Nothing in this section shall limit the power of the court to disqualify an expert witness on grounds other than the qualifications set forth in this section.

e. In an action alleging medical malpractice, an expert witness shall not testify on a contingency fee basis.

9. (New section) In any civil action for damages sustained as a result of the death or injury of a person caused by medical malpractice in which the jury has rendered a verdict in favor of the complaining party, if there is a motion for additur or remittitur on the issue of the quantum of non-economic damages, the court shall consider the evidence in the light most favorable to the non-moving party and determine whether the award constitutes palpably unreasonable compensation to the complaining party for damages sustained as a result of the medical malpractice.

10. (New section) a. For the purposes of this section:

"Annuity" means an annuity issued by an insurer licensed or authorized to do business in this State which is a qualified assignment agreement under section 130 of the federal Internal Revenue Code of 1986, 26 U.S.C. s.130;

"Judgment creditor" means a claimant who is the recipient of an award for economic or non-economic damages, or both, that is the result of an action filed against a health care provider for medical malpractice, which award is subject to the provisions of subsection b. of this section;

"Judgment debtor" means a health care provider who, as a defendant in an action brought for medical malpractice, is required to pay the claimant an award that is subject to the provisions of this section;

"Structured payment agreement" means an agreement made to respond to a judgment in an action brought for medical malpractice by an injured person whereby a series of periodic payments, rather than

a lump sum payment, are made over time to a claimant, in accordance with the needs of the claimant or his family, either through the purchase of an annuity or the establishment of a trust fund, or by another means approved by the court.

b. (1) Unless otherwise agreed to by the parties, in any judgment resulting from a medical malpractice action brought by a claimant for medical malpractice in which the damages are less than $1,000,000, the court shall enter a judgment ordering that the money damages shall be paid immediately.

(2) Unless otherwise agreed to by the parties, in any judgment resulting from a medical malpractice action brought by a claimant for medical malpractice in which the damages exceed $1,000,000, the court shall enter a judgment ordering that 50% of the money damages for economic and non-economic loss shall be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50% of the judgment shall be paid over 36 months in the form of a structured payment by any person, organization, group or insurer that is contractually liable to pay the judgment.

c. The structured payment agreement shall specify the recipient of the payments, the dollar amount of the payments, the interval between payments, the number of payments or the period of time over which payments are to be made and the persons to whom money damages are owed, if any, in the event of the judgment creditor's death.

d. In the event of the judgment creditor's death, any amounts attributable to the future medical treatment, care or custody, loss of bodily function, or pain and suffering of the deceased judgment creditor and any money damages awarded for loss of future earnings shall not be reduced, nor payments terminated, by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to the judgment creditor's death, or if none, to the judgment creditor's estate.

e. The judgment debtor, or his insurer, shall be required to post a bond or security or otherwise to assure full payment of the damages awarded. A bond is not adequate unless it is written by a company authorized to do business in this State and is rated A-, or better, by A.M. Best Company or such other company approved by the Department of Banking and Insurance. If the judgment debtor is unable to adequately assure full payment of the judgment, the judgment, reduced to present value, shall be paid to the claimant in a lump sum. No bond may be canceled or be subject to cancellation unless at least 60 days' advance written notice is filed with the court and the claimant. Upon termination of periodic payments, the security, or so much as remains, shall be returned to the judgment debtor.

f. Upon the purchase of an annuity, establishment of a trust or approval of another arrangement for periodic payments by a court, any

obligation of the judgment debtor with respect to the judgment shall cease.

11. (New section) a. If an individual's actual health care facility duty, including on-call duty, does not require a response to a patient emergency situation, a health care professional who, in good faith, responds to a life-threatening emergency or responds to a request for emergency assistance in a life-threatening emergency within a hospital or other health care facility, is not liable for civil damages as a result of an act or omission in the rendering of emergency care. The immunity granted pursuant to this section shall not apply to acts or omissions constituting gross negligence, recklessness or willful misconduct.

b. The provisions of subsection a. of this section do not apply to a health care professional if a provider-patient relationship existed before the emergency, or if consideration in any form is provided to the health care professional for the service rendered.

c. The provisions of subsection a. of this section do not diminish a general hospital's responsibility to reasonably and adequately staff its emergency department.

d. A health care professional shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

(1) the patient was unconscious;

(2) the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

(3) a medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The provisions of this subsection are applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

e. As used in this section:

(1) "Health care professional" means a physician, dentist, nurse or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes and an emergency medical technician or paramedic certified by the Commissioner of Health and Senior Services pursuant to Title 26 of the Revised Statutes; and

(2) "Health care facility" means a health care facility licensed by the Department of Health and Senior Services pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

12. Section 1 of P.L.1995, c.69 (C.45:9-19.16) is amended to read as follows:

1. a. A physician licensed by the State Board of Medical Examiners, or a physician who is an applicant for a license from the State Board of Medical Examiners shall notify the board within 10 days of :

(1) any action taken against the physician's medical license by any other state licensing board or any action affecting the physician's privileges to practice medicine by any out-of-State hospital, health care facility, health maintenance organization or other employer;

(2) the arrest or conviction of the physician for any of the following offenses in this State or another state:

(a) criminal homicide pursuant to N.J.S.2C:11-2;

(b) aggravated assault pursuant to N.J.S.2C:12-1;

(c) sexual assault, criminal sexual contact or lewdness pursuant to N.J.S.2C:14-2 through 2C:14-4; or

(d) an offense involving any controlled dangerous substance or controlled substance analog as set forth in chapter 35 of Title 2C of the New Jersey Statutes.

b. A physician who is in violation of this section is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).

c. The State Board of Medical Examiners shall notify all physicians licensed by the board of the requirements of this section within 30 days of the date of enactment of this act.

(cf: P.L.1995, c.69, s.1)

13. Section 13 of P.L.1989, c.300 (C.45:9-19.13) is amended to read as follows:

13. a. In any case in which the State Board of Medical Examiners refuses to issue, suspends, revokes or otherwise conditions the license, registration, or permit of a physician, podiatrist or medical resident or intern, the board shall, within 30 days of its action, notify each licensed health care facility and health maintenance organization with which the person is affiliated and every board licensee in the State with which the person is directly associated in his private medical practice.

b. If, during the course of an investigation of a physician, the board requests information from a health care facility or health maintenance organization regarding that physician, and the board subsequently determines that no disciplinary action is warranted, the board shall, within 30 days, notify the health care facility or health maintenance organization of its determination.

(cf: P.L.1989, c.300, s.13)

14. (New section) The State Board of Medical Examiners shall report annually, by March 1 of each year, to the Senate Health, Human Services and Senior Citizens and the Assembly Health and Human Services Committees, or their successors. The board shall make the information provided in the annual report available to the public by posting the information on its web site.

The report shall include:

a. the number of complaint files against physicians that were opened in the preceding calendar year;

b. the number of complaint files against physicians that were closed in the preceding calendar year; and

c. the number of disciplinary sanctions imposed upon physicians in the preceding calendar year, including the number of licensure revocations and suspensions imposed, voluntary license surrenders accepted, license applications denied and license reinstatements denied.

The report issued in the first year shall contain the information required in this section for the preceding three years.

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

a. Adverse events, some of which are the result of preventable errors, are inherent in all systems, and the health care literature demonstrates that the great majority of medical errors result from systems problems, not individual incompetence;

b. Well-designed systems have processes built in to minimize the occurrence of errors, as well as to detect those that do occur; they incorporate mechanisms to continually improve their performance;

c. To enhance patient safety, the goal is to craft a health care delivery system that minimizes, to the greatest extent feasible, the harm to patients that results from the delivery system itself;

d. An important component of a successful patient safety strategy is a feedback mechanism that allows detection and analysis not only of adverse events, but also of "near-misses";

e. To encourage disclosure of these events so that they can be analyzed and used for improvement, it is critical to create a non-punitive culture that focuses on improving processes rather than assigning blame. Health care facilities and professionals must be held accountable for serious preventable adverse events; however, the current punitive medical malpractice environment, with its focus on assigning blame and fixing liability, is not particularly effective in promoting accountability and increasing patient safety, and is actually a deterrent to the exchange of information required to reduce the opportunity for errors to occur in the complex systems of care delivery. Fear of sanctions induces health care professionals and organizations to be silent about adverse events, resulting in serious under-reporting; and

f. By establishing an environment that both mandates the confidential disclosure of the most serious, preventable adverse events, and also encourages the voluntary, anonymous and confidential disclosure of less serious adverse events, as well as near misses, the State seeks to increase the amount of information on systems failures, analyze the sources of these failures and disseminate information on effective practices for reducing systems failures and improving the safety of patients.

16. (New section) a. As used in this section:

"Adverse event" means an event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

"Anonymous" means that information is presented in a form and manner that prevents the identification of the person filing the report.

"Commissioner" means the Commissioner of Health and Senior Services.

"Department" means the Department of Health and Senior Services.

"Event" means a discrete, auditable and clearly defined occurrence.

"Health care facility" or "facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Health care professional" means an individual, who, acting within the scope of his licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse, pharmacist or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes.

"Near-miss" means an occurrence that could have resulted in an adverse event but the adverse event was prevented.

"Preventable event" means an event that could have been anticipated and prepared against, but occurs because of an error or other system failure.

"Serious preventable adverse event" means a preventable adverse event that results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility.

b. In accordance with the requirements established by the commissioner by regulation, pursuant to this section, a health care facility shall develop and implement a patient safety plan for the purpose of improving the health and safety of patients at the facility.

The patient safety plan shall, at a minimum, include:

(1) a patient safety committee, as prescribed by regulation. The commissioner may permit a facility to use its existing quality improvement committee for this purpose if the existing committee meets the requirements established for a patient safety committee;

(2) a process for multi-disciplinary teams of facility personnel with appropriate competencies to conduct ongoing analysis and application

of evidence-based patient safety practices to reduce the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures;

(3) a process for multi-disciplinary teams of facility personnel with appropriate competencies to conduct analyses of near-misses, with particular attention to serious preventable adverse events and adverse events; and

(4) a process for the provision of ongoing patient safety training for facility personnel.

c. A health care facility shall report to the department, in a form and manner established by the commissioner, every serious preventable adverse event that occurs in that facility.

d. A health care facility shall assure that the patient affected by an adverse event, or, in the case of a minor or a patient who is incapacitated, the patient's parent or guardian or other family member, as appropriate, is informed of the adverse event, no later than the end of the episode of care, or, if discovery occurs after the end of the episode of care, in a timely fashion as established by the commissioner by regulation. If the patient's physician determines, in accordance with criteria established by the commissioner by regulation that the disclosure would seriously and adversely affect the patient's health, then the facility shall notify the family member, if available. In the event that an adult patient is not informed of the adverse event, the facility shall assure that the physician includes a statement in the patient's medical record that provides the reason for not informing the patient pursuant to this section.

e. (1) A health care professional or other employee of a health care facility is encouraged to make anonymous reports to the department, in a form and manner established by the commissioner, regarding near-misses, preventable events and adverse events that are otherwise not subject to mandatory reporting pursuant to subsection c. of this section.

(2) The commissioner shall establish procedures for and a system to collect, store and analyze information voluntarily reported to the department pursuant to this subsection. The repository shall function as a clearinghouse for trend analysis of the information collected pursuant to this subsection.

f. Any documents, materials or information received by the department pursuant to the provisions of subsections c. and e. of this section concerning preventable adverse events, serious preventable adverse events and near-misses shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding;

(2) considered a public record under P.L.1963, c.73 (C.47:1A-1 et seq.) or P.L.2001, c.404 (C.47:1A-5 et seq.); or

(3) used in an adverse employment action or in the evaluation of

decisions made in relation to accreditation, certification, credentialing or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information in accordance with this section.

The information received by the department may be used by the department and the Attorney General for the purposes of this act and for oversight of facilities and health care professionals; however, the department and the Attorney General shall not use the information for any other purpose.

g. Any documents, materials or information developed by a health care facility as part of a process of self-critical analysis conducted pursuant to subsection b. of this section concerning preventable events, near-misses and adverse events, including serious preventable adverse events, shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding; or

(2) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information in accordance with subsection b. of this section.

h. The commissioner shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt such rules and regulations necessary to carry out the provisions of this section. The regulations shall establish: criteria for a health care facility's patient safety plan and patient safety committee; the time frame and format for mandatory reporting of serious preventable adverse events at a health care facility; the types of events that qualify as serious preventable adverse events; and the circumstances under which a health care facility is not required to inform a patient or the patient's family about a serious preventable adverse event. In establishing the criteria for reporting serious preventable adverse events, the commissioner shall, to the extent feasible, use criteria for these events that have been or are developed by organizations engaged in the development of nationally recognized standards.

17. (New section) a. On or after the effective date of P.L. , c. (pending before the Legislature as this bill) and except as provided in subsection e. of this section, no person who is an officer, director or board member of a professional association for health care providers shall serve, simultaneously, as an officer, director or board member of a State-domiciled medical malpractice liability insurer.

b. On or after the effective date of P.L. , c. (pending before the Legislature as this bill) and except as provided in subsection e. of this section, no more than one person who has been an officer, director or

board member of a professional association for health care providers shall serve as an officer, director or board member of a State-domiciled medical malpractice liability insurer.

c. As used in this section, "health care provider" means an individual or entity, which, acting within the scope of its licensure or certification, provides health care services, and includes, but is not limited to, a physician, dentist, nurse or other health care professional whose professional practice is regulated pursuant to Title 45 of the Revised Statutes, and a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

d. A person or professional association who violates the provisions of this section shall be liable for a civil penalty of $10,000 for each violation. The penalty shall be sued for and collected by the Commissioner of Banking and Insurance in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

e. In the case of an officer, director or board member of a medical malpractice liability insurer who is an officer, director or board member of a professional association for health care providers on the effective date of P.L. , c. (pending before the Legislature as this bill), the officer, director or board member shall have 180 days to comply with the requirements of this section.

18. (New section) Physicians may join together, by means of a joint contract under the procedures established by this section, to form a "Medical Malpractice Liability Insurance Purchasing Alliance" for the purpose of negotiating a reduced premium for its members purchasing medical malpractice liability insurance. The joint contract shall be executed by all members of the purchasing alliance.

a. As used in this section:

"Board" means a medical malpractice liability insurance purchasing alliance board of directors provided for in this section.

"Commissioner" means the Commissioner of Banking and Insurance.

"Medical Malpractice Liability Insurance Purchasing Alliance," "purchasing alliance" or "alliance" means a purchasing alliance established pursuant to this section.

"Member" means a physician who is a member of a medical malpractice liability insurance purchasing alliance as provided for in this section.

b. The purchasing alliance, which may be a corporation, shall be governed by a board of directors, elected by the members of the purchasing alliance. No person may serve as an officer or director of an alliance who has a prior record of administrative, civil or criminal violations within the financial services industry. The directors shall serve for terms of three years, and shall serve until their successors are

elected and qualified. The directors shall serve without compensation, except for reimbursement for actual expenses.

c. The board shall adopt by-laws for the operation of the purchasing alliance, which shall be effective upon ratification by a two-thirds majority of the members. The by-laws shall include, but not be limited to:

(1) the establishment of procedures for the organization and administration of the alliance;

(2) procedures for the qualifications and admission of the members of the alliance.

The bases for denial of membership shall include, but not be limited to:

(a) performance of an act or practice that constitutes fraud or intentional misrepresentation of material fact;

(b) previous denial of membership in the alliance; or

(c) previous expulsion from the alliance;

(3) procedures for the withdrawal of members from the alliance;

(4) procedures for the expulsion of members from the alliance.

The bases for expulsion shall include, but not be limited to:

(a) failure to pay membership or other fees required by the purchasing alliance;

(b) failure to pay premiums in accordance with the terms of the medical malpractice liability insurance policy or the terms of the joint contract; or

(c) performance of an act or practice that constitutes fraud or intentional misrepresentation of material fact; and

(5) procedures for the termination of the alliance.

d. In addition to the other powers authorized under this section, a purchasing alliance shall have the authority to:

(1) set reasonable fees for membership in the alliance that will finance reasonable and necessary costs incurred in administering the purchasing alliance;

(2) negotiate premium rates for medical malpractice liability insurance with insurers on behalf of the members of the alliance;

(3) provide premium collection services for insurance purchased through the alliance for members; and

(4) contract with third parties for any services necessary to carry out the powers and duties authorized or required pursuant to this section.

e. A purchasing alliance established pursuant to the provisions of this section shall not:

(1) assume risk for the cost or provision of medical malpractice liability insurance;

(2) exclude a member who agrees to pay fees for membership and the premium for medical malpractice liability insurance coverage and who abides by the by-laws of the alliance; or

(3) engage in any trade practice or activity prohibited pursuant to P.L.1947, c.379 (C.17:29B-1 et seq.).

f. Within 30 days after its organization, the purchasing alliance board shall file with the commissioner a certificate that shall list the members of the alliance, the names of the directors, chairman, treasurer and secretary of the alliance, the address at which communications for the alliance are to be received, a copy of the certificate of incorporation of the alliance, if any, and a copy of the joint contract executed by all of the members. Any change in the information required by the provisions of this section shall be filed with the commissioner within 30 days of the change.

g. The commissioner shall adopt such rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), as are necessary to effectuate the provisions of this section.

19. (New section) a. A medical malpractice liability insurance policy made, issued or delivered pursuant to Subtitle 3 of Title 17 of the Revised Statutes in this State on or after the effective date of P.L. , c. (pending before the Legislature as this bill) may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; except that, if the policy contains that provision, the insurer shall offer an endorsement, to be included in the policy at the option of the insured, providing the insurer the right to settle a claim filed under the policy without first having obtained the insured's consent. The insurer shall establish a reduced premium for the endorsement, which premium shall reflect savings or reduced costs attributable to the endorsement.

b. The Commissioner of Banking and Insurance shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to effectuate the provisions of this section.

20. (New section) a. Every insurer authorized to transact medical malpractice liability insurance in this State shall offer, to groups of 50 or more insureds, group medical malpractice liability insurance policies with a deductible, at the option of the insureds, in amounts of at least $50,000 per occurrence and up to $1,000,000 per occurrence.

(1) Physicians in the same specialty, or in different specialties, may purchase the policies jointly, whether or not they are members of the same practice group, and may elect to treat the deductible amount under the policy as a self-insured retention, in which claims filed under the policy are managed by either the insurer issuing the policy, on an administrative-services-only basis, or by an independent third party administrator approved by the Commissioner of Banking and

Insurance and the insurer issuing the policy.

(2) A physician group purchasing a policy issued pursuant to the provisions of this section shall do so pursuant to a written agreement, subscribed to by all of the participating physicians. The agreement shall include provisions regarding the selection of an administrator, allocation of contributions to the self-insured retention under the policy, procedures for investment and management of the contributions, allocation of the cost of the policy premium among physician members of the group and such other matters as to the administration of the program as may be necessary.

b. Every insurer authorized to transact medical malpractice liability insurance in this State shall offer to individual physicians or practice groups such deductibles on those policies as they may require, for a commensurate reduction in premium, which deductibles shall be straight deductibles and shall not be treated as self-insured retention.

21. (New section) Notwithstanding any other law or regulation to the contrary:

a. An insurer authorized to transact medical malpractice liability insurance in this State shall not increase the premium of any medical malpractice liability insurance policy based on a claim of medical negligence or malpractice against the insured unless the claim results in a medical malpractice claim settlement, judgment or arbitration award against the insured or the cost of defending against the claim exceeds $10,000.

b. An insurer authorized to transact medical malpractice liability insurance in this State that provides medical malpractice liability insurance to a health care provider who is a recipient of a notice of intent to file an action pursuant to section 6 of P.L. , c. (C. ) (pending before the Legislature as this bill), which health care provider is not subsequently made a party to an action, shall not consider the notice or investigation therefrom as part of the insured's claims experience or for the purposes of underwriting or establishing a premium for the health care provider.

c. An insurer authorized to transact medical malpractice liability insurance shall, in all policies and contracts issued in the State on and after the effective date of P.L. , c. (pending before the Legislature as this bill), define the term "claim" to mean any demand received by an insured seeking damages that results from a medical incident, or an insured's notice to the insurer of a specific professional services act or omission that an insured reasonably believes may result in a demand for damages.

d. An insurer who violates this section shall be subject to a penalty of up to $25,000 for each violation unless the insurer knew or reasonably should have known it was in violation of this section, in which case the penalty shall not be more than $250,000 for each

violation. The penalty shall be sued for and collected by the Commissioner of Banking and Insurance in a summary proceeding in accordance with the "Penalty Enforcement Law of 1999," P.L.1999, C.274 (C.2A:58-10 et seq.).

22. (New section) Every filing, made after the effective date of P.L. , c. (pending before the Legislature as this bill), pursuant to the provisions of section 16 of P.L. 1982, c. 114 (C.17:29AA-16) by an insurer writing medical malpractice in this State, shall include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory, or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

23. (New section) a. There is established in the Department of the Treasury the "New Jersey Health Care Access Fund" as a nonlapsing, revolving fund.

The State Treasurer shall credit to the fund, in addition to any sums appropriated thereto, all monies designated in subsection b. of this section. Monies credited to the fund may be invested in the same manner as assets of the General Fund and any investment earnings on the fund shall accrue to the fund and shall be available subject to the same terms and conditions as other monies in the fund.

b. Monies from the following sources shall be credited to the fund: monies collected by the State Board of Medical Examiners pursuant to section 25 of P.L. , c. (C. )(pending before the Legislature as this bill); monies collected by the State Board of Chiropractic Examiners pursuant to section 26 of P.L. , c. (C. )(pending before the Legislature as this bill); and monies collected by the State Treasurer pursuant to section 27 of P.L. , c. (C. )(pending before the Legislature as this bill).

c. The fund shall be administered by the Department of Banking and Insurance in accordance with the provisions of section 24 of P.L., c. (C. )(pending before the Legislature as this bill).

d. The monies in the fund are specifically dedicated and shall be utilized exclusively for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to physicians, podiatrists and chiropractors in the State who have experienced or are experiencing a liability insurance premium increase of 30% or greater and meet the criteria established pursuant to section 24 of P.L. , c. (C. )(pending before the Legislature as this bill).

e. The fund shall expire on December 31, 2005.

24. (New section) a. In order to carry out the purposes of section 23 of P.L. , c. (C. )(pending before the Legislature as this bill), the Commissioner of Banking and Insurance shall, at a minimum:

(1) establish a three-year program to provide medical malpractice liability insurance premium subsidies to physicians, podiatrists and chiropractors from monies that are contained in the fund;

(2) establish a methodology and procedures for determining eligibility for and providing subsidies from the fund;

(3) maintain confidential records on each physician, podiatrist and chiropractor who receives assistance from the fund; and

(4) take all necessary action to recover the cost of the subsidy provided to a physician, podiatrist or chiropractor that the commissioner determines to have been incorrectly provided.

b. The Commissioner of Banking and Insurance shall certify classes of physicians, podiatrists and chiropractors, by specialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after August 2002, is in excess of $50,000 per year. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of physicians, podiatrists or chiropractors, as applicable, in a particular specialty, to continue practicing in a geographic area of the State.

(1) In order to be eligible for a subsidy from the fund, a physician, podiatrist or chiropractor shall have received a medical malpractice liability insurance premium increase of 30% or greater, upon renewal on or after January 1, 2003, from the amount paid by that practitioner in 2002. In 2004 and 2005, the premium increase shall be calculated using the preceding year's premium as the base-year premium.

(2) The amount of the subsidy shall be 35% of the amount of the increase from the preceding year's premium; except that no physician, podiatrist or chiropractor shall receive a subsidy greater than $25,000 in a year.

c. A physician, podiatrist or chiropractor who has been subject to a disciplinary action or civil penalty by the practitioner's respective licensing board pursuant to sections 8, 9 or 12 of P.L.1978, c.73 (C.45:1-21, 22 or 25), or who has been found by a court to be liable for the payment of a medical malpractice judgment within the last five years is not eligible for a subsidy from the fund.

d. The Commissioner of Banking and Insurance may waive the criteria for eligibility for a subsidy established pursuant to this section, if the commissioner determines that access to care for a particular specialty is threatened because of an inability of a sufficient number of practitioners in that specialty to practice in a geographic area of the State.

e. The State Board of Medical Examiners and the State Board of Chiropractic Examiners shall each provide to the Commissioner of Banking and Insurance, on a quarterly basis, the names of the practitioners who have been subject to a disciplinary action or civil

penalty by the practitioner's respective licensing board.

f. The Commissioner of Banking and Insurance may reduce the amount of the assessment pursuant to sections 25, 26 and 27 of P.L. , c. (C. )(pending before the Legislature as this bill) in the second and third years of the assessment if the commissioner determines that sufficient monies are available in the fund to permit a reduced assessment and still meet the purposes of this section.

g. The Commissioner of Banking and Insurance shall, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt such rules and regulations as are necessary to carry out the provisions of this section.

25. (New section) The State Board of Medical Examiners shall assess an annual fee in the amount of $175 payable by:

a. each physician licensed in this State pursuant to the provisions of R.S.45:9-1 et seq., except that physicians holding a certificate of registration as a retired physician pursuant to section 1 of P.L.1971, c.236 (C.45:9-6.1) shall not be required to pay the fee; and

b. each podiatrist licensed in this State pursuant to the provisions of R.S.45:5-1 et seq.

Fees imposed pursuant to this section shall be payable on or before July 1 of each calendar year, for three years, from 2003 through 2005. Payments are to be remitted to the board and credited by the State Treasurer to the "New Jersey Health Care Access Fund" established pursuant to section 23 of P.L. , c. (C. )(pending before the Legislature as this bill).

26. (New section) The State Board of Chiropractic Examiners shall assess an annual fee in the amount of $175 payable by each chiropractor licensed in this State pursuant to the provisions of P.L.1989, c.153 (C.45:9-41.17 et al.).

Fees imposed pursuant to this section shall be payable on or before July 1 of each calendar year, for three years, from 2003 through 2005. Payments are to be remitted to the board and credited by the State Treasurer to the "New Jersey Health Care Access Fund" established pursuant to section 23 of P.L. , c. (C. )(pending before the Legislature as this bill).

27. (New section) The State Treasurer shall assess an annual fee in the amount of $175, payable by each person licensed to practice law in this State who has engaged in the practice of law for at least one year. Fees imposed pursuant to this section shall be payable on or before July 1 of each calendar year, for three years, from 2003 through 2005. Payments are to be remitted to the State Treasurer and credited to the "New Jersey Health Care Access Fund" established pursuant to section 23 of P.L. , c. (C. )(pending before the Legislature as this bill).

28. This act shall take effect on the 30th day after enactment, except that sections 15 and 16 shall take effect 180 days after the date of enactment and section 20 shall take effect 90 days after the date of enactment.

STATEMENT

This bill, designated as the "New Jersey Medical Care Availability and Patient Protection Act," provides for a comprehensive set of reforms affecting the State's tort liability system, health care system and medical malpractice liability insurance carriers to ensure that health care services continue to be available and accessible to residents of the State and that patient safety at health care facilities is enhanced.

**Tort Liability Reforms:**

The bill amends N.J.S.2A:14-2 to provide that actions by or on behalf of a minor that have accrued for medical malpractice for injuries sustained at birth shall be commenced by the minor's 10th birthday.

The bill provides that a person who intends to commence a medical malpractice action shall notify all health care providers, who may be party to the action, at least 180 days prior to filing the action. The notice shall contain, at a minimum, a statement of the following:

(1) the factual basis for the proposed action;

(2) the applicable standard of practice or care alleged by the claimant;

(3) the manner in which it is claimed that the applicable standard of practice or care was breached by the health care provider;

(4) the alleged action that should have been taken to achieve compliance with the alleged standard of practice or care;

(5) the manner in which it is alleged that the breach of the standard of practice or care was the proximate cause of the injury that is the subject of the proposed action; and

(6) the names of all health care providers that the claimant is notifying pursuant to this bill in connection with the proposed action.

The health care provider then has 90 days after receipt of the notice to furnish the claimant with a written response. The bill provides that after the response is received, a party seeking to investigate the matter may serve process to compel both written and oral discovery, which shall be limited to factual information directly related to the proposed action.

In addition, the bill requires all parties to the proposed action to participate in a pre-suit information session, in good faith, to determine the appropriate parties to the proposed action and such other issues as the parties may agree to discuss. The session will be conducted by a neutral third party, to be called a "discovery master,"

who shall be selected from a list of qualified discovery masters that is maintained by the Department of Banking and Insurance. At the session, the notice of intent to file an action, the health care provider's response and such other documents that the master or a party deems relevant to the issue shall be reviewed. If the session results in the parties' total or partial agreement concerning which health care provider shall be named and which shall not be named in an action, or any other issues, it shall be reduced to writing and a copy thereof furnished to each party. Any necessary fees and expenses of the master with respect to the information session shall be shared equally by the parties to the proceeding. The bill provides that to allow for the proper conduct of the notice of intent and pre-suit information session procedures, the statute of limitations for filing a complaint is tolled for 270 days, beginning on the date the notice of intent to file is mailed, for all potential parties to the proposed action.

The bill also provides that a health care provider named as a defendant in a medical malpractice action may cause the action against that provider to be dismissed upon the filing of an affidavit of noninvolvement with the court. The affidavit of noninvolvement shall set forth the facts that demonstrate that the provider was misidentified or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant.

The bill establishes qualifications for expert witnesses in medical malpractice actions and for the purpose of executing an affidavit of merit and provides that an expert must have the same type of practice and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court.

Further, the bill modifies the standard of review to be used by a court in reviewing the amount of a jury award for non-economic damages to require the court to consider the evidence in the light most favorable to the non-moving party and to allow the court to determine whether the award constitutes palpably unreasonable compensation to the complaining party for damages sustained as a result of the medical malpractice.

Finally, the bill provides for structured payment agreements for judgments in excess of $1,000,000. Specifically, the bill provides that in any medical malpractice judgment in which the damages are $1,000,000 or less, and unless otherwise agreed to by the parties, the court shall enter a judgment ordering that the money damages shall be paid immediately. In judgments in which the damages exceed $1,000,000, unless otherwise agreed to by the parties, the court shall enter a judgment ordering that 50% of the money damages for economic and non-economic loss shall be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50%

of the judgment shall be paid over 36 months in the form of a structured payment by any person, organization, group or insurer that is contractually liable to pay the judgment.

**Health Care System Reforms:**

The bill expands the State's "Good Samaritan" law to provide immunity from civil damages to licensed health care professionals, paramedics and emergency medical technicians whose duty does not require a response to a patient emergency situation, who, in good faith, responds to a life-threatening emergency or responds to a request for emergency assistance in a life threatening emergency within a hospital or other licensed health care facility. The immunity shall not apply: to acts or omissions constituting gross negligence, recklessness or willful misconduct; if a provider-patient relationship existed before the emergency; or if consideration in any form is provided to the health care professional for the service rendered.

Further, the bill provides that a health care professional shall not be liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

- the patient was unconscious;

- the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

- a medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that a medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The immunity provided is applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

The bill strengthens reporting requirements by physicians to the State Board of Medical Examiners to ensure that the board is promptly informed of a physician's arrest or conviction for certain crimes, by requiring that a physician report, within 10 days, his arrest or conviction, in this State or any other state, for criminal homicide, aggravated assault, sexual assault, criminal sexual contact or lewdness, or an offense involving any controlled dangerous substance or controlled substance analog.

The bill also ensures that health care facilities and other physicians

affiliated with a physician who has been disciplined by the State Board of Medical Examiners, are notified of the board's action, within 30 days of the action. Similarly, the bill ensures that a health care facility or health maintenance organization is promptly notified by the board if, during the course of an investigation of a physician, it requests information from a that facility or health maintenance organization regarding that physician, and subsequently determines that no disciplinary action is warranted. The bill enables the Senate Health, Human Services and Senior Citizens and the Assembly Health and Human Services Committees, and the public, to be kept informed of Board of Medical Examiners disciplinary actions by requiring the board to report annually to the committees and post on the board's web site information about actions on complaint files and the number of disciplinary sanctions imposed upon physicians in the preceding calendar year.

The bill establishes a medical error reporting system for health care facilities that seeks to minimize the occurrence of errors, as well as to detect those that do occur, and to incorporate mechanisms to continually improve the performance of facilities to enhance patient safety by minimizing, to the greatest extent feasible, the harm to patients that results from the delivery system itself. In this regard, the bill establishes a system that both mandates the confidential disclosure to the Department of Health and Senior Services of the most serious preventable adverse events, and also encourages the voluntary, anonymous and confidential disclosure to the department of less serious adverse events, as well as near-misses.

Specifically, the bill requires all licensed health care facilities in the State to develop and implement a patient safety plan, which includes a patient safety committee, for the purpose of improving the health and safety of patients at the facility. Components of the plan would include a process for multi-disciplinary teams of facility personnel with appropriate competencies to conduct: ongoing analysis and application of evidence-based patient safety practices to reduce the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures; and analyses of near-misses, with particular attention to serious preventable adverse events and adverse events.

A health care facility would be required to report to the Department of Health and Senior Services, in a form and manner established by the Commissioner of Health and Senior Services, every serious preventable adverse event that occurs in that facility. The bill defines "serious preventable adverse event" to mean a preventable adverse event that results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility.

The bill also provides that a health care professional or other

employee of a health care facility is encouraged to make anonymous reports to the department, in a form and manner established by the commissioner, regarding near-misses, preventable events and adverse events that are otherwise not subject to mandatory reporting

A health care facility would be required to assure that the patient affected by an adverse event, or, in the case of a minor or a patient who is incapacitated, the patient's parent or guardian or other family member, as appropriate, is informed of the adverse event, no later than the end of the episode of care, or if discovery occurs after the end of the episode of care, in a timely fashion as established by the commissioner by regulation. "Adverse event" is defined as an event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

The bill provides that any documents, materials or information received by the department concerning preventable adverse events, serious preventable adverse events and near-misses shall not be:

(1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding;

(2) considered a public record under P.L.1963, c.73 (C.47:1A-1 et seq.) or P.L.2001, c.404 (C.47:1A-5 et seq.); or

(3) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information.

Similarly, any documents, materials or information developed by a health care facility as part of a process of self-critical analysis conducted pursuant to this bill, concerning preventable events, near-misses and adverse events, including serious preventable adverse events, shall not be: (1) subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding; or (2) used in an adverse employment action or in the evaluation of decisions made in relation to accreditation, certification, credentialing or licensing of an individual, which is based on the individual's participation in the development, collection, reporting or storage of information.

**Medical Malpractice Liability Insurance Reforms:**

To avoid the appearance of any conflicts of interest, the bill prohibits any person who is an officer, director or board member of a professional association for health care providers to serve, simultaneously, as an officer, director or board member of a State-domiciled medical malpractice liability insurer. The bill also provides that no more than one person who has been an officer, director or board member of a professional association for health care providers shall serve as an officer, director or board member of a State-

domiciled medical malpractice liability insurer.

For the purpose of negotiating a reduced medical malpractice liability insurance premium, the bill would permit physicians to join together, by means of a joint contract, to form a "Medical Malpractice Liability Insurance Purchasing Alliance".

The bill provides that a medical malpractice liability insurance policy may contain a provision that provides a person insured under the policy the with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; but if the policy contains that provision, the insurer would be required to offer an endorsement to the policy that provides the insurer the right to settle a claim filed under the policy without first having obtained the insured's consent. The insurer would be required to establish a reduced premium for the endorsement, which premium shall reflect savings or reduced costs attributable to the endorsement, and the insured would have the option of accepting or refusing the endorsement.

Another provision to provide premium relief to health care providers is the requirement that every medical malpractice liability insurer to offer, to groups of 50 or more insureds, group medical malpractice liability insurance policies with a deductible, at the option of the insureds, in amounts of at least $50,000 per occurrence and up to $1,000,000 per occurrence. Insurers are also required to offer to individual physicians or practice groups such deductibles on those policies as they may require, for a commensurate reduction in premium, which deductibles shall be straight deductibles and shall not be treated as self-insured retention.

In addition, the bill provides that an insurer shall not increase the premium of any medical malpractice liability insurance policy based on a claim of medical negligence or malpractice against the insured unless the claim results in a medical malpractice claim settlement, judgment or arbitration award against the insured or the cost of defending against the claim exceeds $10,000. Further, the bill provides that an insurer that provides coverage to a health care provider who is a recipient of a notice of intent to file an action pursuant to this bill, which health care provider is not subsequently made a party to an action, shall not consider the notice or investigation therefrom as part of the insured's claims experience or for the purposes of underwriting or establishing a premium for the health care provider. The bill also provides a uniform definition of the term "claim," that all medical malpractice insurers would be required to use. "Claim" would mean any demand received by an insured seeking damages that results from a medical incident, or an insured's notice to the insurer of a specific professional services act or omission that an insured reasonably believes may result in a demand for damages.

To provide increased oversight of medical malpractice insurers, the

bill requires that every filing by a medical malpractice insurer in this State shall include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

Finally, the bill establishes the "New Jersey Health Care Access Fund" to provide relief towards the payment of medical malpractice liability insurance premiums to physicians, podiatrists and chiropractors in the State who have experienced or are experiencing a liability insurance premium increase of 30% or greater and meet criteria established in the bill. The fund will be administered by the Commissioner of Banking and Insurance, and will expire on December 31, 2005.

The bill provides that the Commissioner of Banking and Insurance will certify classes of physicians, podiatrists and chiropractors (practitioners), by specialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after August 2002, is in excess of $50,000 per year. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, in a particular specialty, to continue practicing in a geographic area of the State. In order to be eligible for a subsidy from the fund, a practitioner shall have received a medical malpractice liability insurance premium increase of 30% or greater, upon renewal on or after January 1, 2003, from the amount paid by that practitioner in 2002. In 2004 and 2005, the premium increase shall be calculated using the preceding year's premium as the base-year premium. The amount of the subsidy will be 35% of the amount of the increase from the preceding year's premium; except that no practitioner shall receive a subsidy greater than $25,000 in a year.

A practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's licensing board, or who has been found by a court to be liable for the payment of a medical malpractice judgment within the last five years, is not eligible for a subsidy from the fund.

In order to provide sufficient monies for the fund, the bill provides that licensed physicians, podiatrists and chiropractors, as well as attorneys, will be assessed an annual fee of $175, for three years. This amount may be reduced by the Commissioner of Banking and Insurance if the commissioner determines that sufficient monies are available in the fund to meet the purposes of the bill.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR

**SENATE, Nos. 50 and 551**

# STATE OF NEW JERSEY

DATED: MARCH 22, 2004

The Senate Health, Human Services and Senior Citizens Committee reports favorably a Senate Committee Substitute for Senate Bill Nos. 50 and 551.

As amended by committee, this substitute, which is designated the "New Jersey Medical Care Access and Responsibility and Patients First Act," is designed to implement a number of reforms relating to tort liability as it concerns medical malpractice, as well as health care system and medical malpractice liability insurance reforms.

Specifically, the substitute provides for the following:

**Tort Liability Reforms:**

The substitute amends N.J.S.2A:14-2 and N.J.S.2A:14-21 to provide that actions by or on behalf of a minor that have accrued for medical malpractice for injuries sustained at birth must be commenced prior to the minor's 13th birthday. These statutory changes would not affect the discovery doctrine in any way. The substitute also provides that in the event that an action by or on behalf of a minor that has accrued for medical malpractice for injuries sustained at birth is not commenced by the minor's parent or guardian prior to the minor's 12th birthday, the minor or a person 18 years of age or older designated by the minor to act on the minor's behalf would be permitted to commence such an action.

The substitute provides for court referral of a medical malpractice action to a complementary dispute resolution mechanism if the judge presiding over the action determines, within 30 days after the discovery end date, that the referral may encourage early disposition or settlement of the action. If the judge makes that determination, the matter is to be referred to complementary dispute resolution pursuant to Rule 1:40 of the New Jersey Rules of Court.

The substitute also provides that a health care provider named as a defendant in a medical malpractice action may file an affidavit of noninvolvement with the court. The affidavit of noninvolvement is to set forth the facts that demonstrate that the provider was misidentified

or otherwise not involved, individually or through its servants or employees, in the care and treatment of the claimant, and was not obligated, either individually or through its servants or employees, to provide for the care and treatment of the claimant. The substitute also provides penalties for false statements made in the affidavit or in challenging the affidavit.

The substitute establishes qualifications for expert witnesses in medical malpractice actions and for the purpose of executing an affidavit of merit, and provides that an expert must have the same type of practice and possess the same credentials, as applicable, as the defendant health care provider, unless waived by the court. The substitute prohibits expert witnesses from testifying on a contingency fee basis. The substitute also provides for penalties for an individual or entity who threatens to take or takes adverse action against a person in retaliation for that person providing or agreeing to provide expert testimony, or for that person executing an affidavit of merit, which adverse action relates to that person's employment, accreditation, certification, credentialing or licensure.

With respect to the payment of medical malpractice judgments, the substitute provides that in any medical malpractice judgment in which the noneconomic damages (those for pain and suffering) are $1 million or less, unless otherwise agreed to by the parties, the court is to enter a judgment ordering that money damages be paid immediately. In any judgment in which the noneconomic damages exceed $1 million, unless otherwise agreed to by the parties, 50% of the money damages are to be paid immediately, with the costs and attorney's fees paid from that amount. The remaining 50% of the judgment is to be paid over 60 months in the form of a structured payment agreement.

Further, in order to provide the court with discretion to modify jury awards, the substitute modifies the standard of review to be used by the court in reviewing the amount of a jury award to require the court to consider the evidence in the light most favorable to the non-moving party and to allow the court to determine whether the award is clearly inadequate or excessive in view of the nature of the medical condition or injury that is the cause of action or because of passion or prejudice by the jury. This provision shall take effect upon action by the court.

**Health Care System Reforms:**

The substitute expands the State's "Good Samaritan" law to provide immunity from civil damages to licensed health care professionals, emergency medical technicians and mobile intensive care paramedics whose duty does not require a response to a patient emergency situation, who, in good faith, respond to a life-threatening emergency or respond to a request for emergency assistance in a life-threatening emergency within a hospital or other licensed health care facility or a State psychiatric hospital operated by the Department of Human Services. The immunity shall not apply: to acts or omissions

constituting gross negligence, recklessness or willful misconduct; if a provider-patient relationship existed before the emergency; or if consideration in any form is provided to the health care professional for the service rendered. The immunity does not diminish a general hospital's responsibility to comply with all Department of Health and Senior Services licensure requirements concerning medical staff availability at the hospital.

Further, the substitute provides that a health care professional is not liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice or in a health care facility or State psychiatric hospital on account of a failure to inform a patient of the possible consequences of a medical procedure when the failure to inform is caused by any of the following:

- the patient was unconscious;

- the medical procedure was undertaken without the consent of the patient because the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient; or

- the medical procedure was performed on a person legally incapable of giving informed consent, and the health care professional reasonably believed that the medical procedure should be undertaken immediately and that there was insufficient time to obtain the informed consent of the person authorized to give such consent for the patient.

The immunity provided is applicable only to actions for damages for an injury or death arising as a result of a health care professional's failure to inform, and not to actions for damages arising as a result of a health care professional's negligence in rendering or failing to render treatment.

The substitute strengthens reporting requirements by physicians to the State Board of Medical Examiners (BME) to ensure that the BME is promptly informed of any pending or final action by any criminal authority in this State or any other state or federal jurisdiction or any arrest or conviction for a criminal or quasi-criminal act, by requiring that a physician report, within 10 days, the action or his arrest or conviction, for crimes that include, but are not limited to, criminal homicide, aggravated assault, sexual assault, criminal sexual contact or lewdness, or an offense involving any controlled dangerous substance or controlled substance analog.

The substitute also ensures that health care facilities, State psychiatric hospitals and other physicians affiliated with a physician who has been disciplined by the BME, are notified of its action, within 30 days of the action. Similarly, the substitute ensures that a health care facility, State psychiatric hospital or health maintenance organization is promptly notified by the BME if, during the course of an investigation of a physician, it requests information from that facility or health maintenance organization regarding that physician, and subsequently determines that no disciplinary action is warranted.

**Medical Malpractice Liability Insurance Reforms:**

To avoid the appearance of any conflicts of interest, the substitute prohibits any person who is an officer, director or board member of a professional association for health care providers to serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that issues policies in the State.

For the purpose of negotiating a reduced medical malpractice liability insurance premium, the substitute would permit physicians to join together, by means of a joint contract, to form a "Medical Malpractice Liability Insurance Purchasing Alliance."

The substitute provides that a medical malpractice liability insurance policy may contain a provision that provides a person insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; but, if the policy contains that provision, the insurer would be required to offer an endorsement to the policy that permits the insurer to settle a claim filed under the policy without first having obtained the insured's consent. The insurer would be required to establish a premium for the endorsement which reflects any savings or reduced costs attributable to the endorsement, and the insured would have the option of accepting or refusing the endorsement.

Another provision to provide premium relief to health care providers is the requirement that every medical malpractice liability insurer offer individual or group medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least $5,000 per claim and up to $1 million per claim, with the insurer being permitted to require the insured to provide collateral for the deductible amount to the insurer. The deductibles offered by an insurer are subject to the approval of the Commissioner of Banking and Insurance. For policies with any deductible, the insurer would be responsible for payment of the deductible and would be reimbursed for that amount by the insured.

The substitute prohibits a medical malpractice insurer from increasing the premium of a policy based on a claim of medical negligence or malpractice against the insured if the insured is dismissed from an action alleging medical malpractice within 180 days of the filing of the last responsive pleading.

To provide increased oversight of medical malpractice insurers, the substitute requires that every annual statement filed by a medical malpractice insurer in this State with the Department of Banking and Insurance include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

The substitute requires insurers authorized to transact medical malpractice liability insurance in this State to provide at least 60 days' notice to the insured for policy renewals and nonrenewals. Also, in the case of a nonrenewal, the insurer must provide the reason for the nonrenewal.

The substitute provides that if the Commissioner of Banking and Insurance finds, after a hearing, that a rate in effect for any medical malpractice insurer is not in compliance with the provisions of N.J.S.A.17:29AA-1 et seq., the commissioner is to issue an order specifying in what respects it so fails, and stating when the rate will no longer be deemed effective. The order may provide for the retroactive adjustment of rates and require the payment or credit of interest to insureds covered during the adjusted rate period. Interest is to be calculated at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.

The substitute also directs the commissioner, subject to standards adopted by the National Association of Insurance Commissioners, to review the current capitalization and reserve requirements applicable to medical malpractice insurers, and to modify those requirements, as necessary, to ensure the solvency of those insurers and the availability and affordability of medical malpractice liability insurance in the State.

Also, the substitute requires medical malpractice liability insurers to offer their insureds the option to make premium payments in installments, as prescribed by the Commissioner of Banking and Insurance, by regulation.

In addition, N.J.S.A.17:30D-17, which requires all medical malpractice insurers to notify the BME of every medical malpractice judgment, settlement and award involving a physician or podiatrist licensed in this State, is amended to also require notification to the Commissioner of Banking and Insurance of these payments. The notification to the commissioner is to enable the commissioner to compile statistical data about medical malpractice payouts, and would not include the name of or other identifying information about the practitioner.

The substitute removes from the BME the authority and discretion to set the minimum amounts of medical malpractice liability insurance that a physician who maintains a professional medical practice in this State and has responsibility for patient care is required to carry, and instead establishes those minimum amounts by statute. The substitute sets the limits at those currently in effect by virtue of regulations promulgated by the BME, that is: medical malpractice liability insurance in the sum of $1 million per occurrence and $3 million per policy year, with extended reporting endorsement coverage for claims made, also known as "tail coverage," (unless renewal coverage includes the premium retroactive date); or, if liability coverage is not available, by a letter of credit for at least $500,000. The BME may, however, increase these minimum amounts by regulation.

The substitute establishes the Medical Malpractice Liability Insurance Premium Assistance Fund in the Department of the Treasury to provide relief towards the payment of medical malpractice liability insurance premiums to certain health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the Commissioner of Banking

and Insurance by regulation. The fund will be administered by the Department of Banking and Insurance, and will expire three years after the effective date of the substitute.

The substitute provides that the Commissioner of Banking and Insurance will certify classes of health care practitioners, by specialty and subspecialty for each type of practitioner, whose average medical malpractice premium, as a class, on or after December 31, 2002, is in excess of an amount determined by the commissioner, or in the case of health care practitioners whose professional liability insurance protection is provided through self-insured hospital funding supplemented with purchased commercial insurance, the total professional liability funding obligation has increased in excess of an amount determined by the commissioner. In certifying classes eligible for the subsidy, the commissioner, in consultation with the Commissioner of Health and Senior Services, may also consider if access to care is threatened by the inability of a significant number of practitioners, in a particular specialty or subspecialty, to continue practicing in a geographic area of the State.

In order to be eligible for a subsidy from the fund, a practitioner must have received a medical malpractice liability insurance premium increase in an amount determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in 2003; upon renewal on or after January 1, 2005, from the amount paid by that practitioner in 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in 2005. The amount of the subsidy will be determined by the commissioner by regulation.

In the case of a health care provider providing professional liability insurance protection through self-insured hospital funding supplemented with purchased commercial insurance coverage, that provider must have increased its total professional liability funding obligation in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the professional liability funding obligation paid by that practitioner in calendar year 2003; upon renewal on or after January 1, 2005, from the professional liability funding obligation paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the professional liability funding obligation paid by that practitioner in calendar year 2005.

The Medical Malpractice Liability Insurance Premium Assistance Fund is to be comprised of the following revenue:

-- an annual surcharge (for three years) of $3 per employee for all employers who are subject to the New Jersey "unemployment compensation law";

-- an annual charge (for three years) of $75 imposed on each licensed physician, podiatrist, chiropractor, dentist and optometrist by the appropriate professional licensing board; and

-- an annual fee (for three years) of $75 imposed on each licensed attorney by the State Treasurer.

The above charges and fees will not apply to physicians, podiatrists, chiropractors, dentists, optometrists or attorneys who: are statutorily or constitutionally barred from the practice of their respective profession; can show that they do not maintain a bona fide office for the practice of their profession in this State; are completely retired from the practice of their profession; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; have not practiced their profession for at least one year; or, in the case of attorneys, are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment.

The substitute also specifies that a practitioner who has been subject to a disciplinary action or civil penalty by the practitioner's licensing board, when that action or penalty relates to the practitioner's provision of, or failure to provide, treatment or care to a patient, is not eligible for a subsidy from the fund.

The substitute requires that a health care practitioner who receives a subsidy from the fund practice in that practitioner's specialty or subspecialty in this State for a period of at least two years after receipt of the subsidy; and a practitioner who fails to comply with this requirement must repay the Commissioner of Banking and Insurance the amount of the subsidy, in whole or in part as determined by the commissioner.

The monies in the Medical Malpractice Liability Insurance Premium Assistance Fund are specifically dedicated and to be utilized exclusively for the following purposes:

-- $17 million is to be allocated annually for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established under the substitute;

-- $6.9 million is to be allocated annually to the Health Care Subsidy Fund established pursuant to N.J.S.A.26:2H-18.58 for the purpose of providing payments to hospitals in accordance with the formula used for the distribution of charity care subsidies that are provided pursuant to N.J.S.A.26:2H-18.51 et al.;

-- $1.0 million is to be allocated annually for a student loan expense reimbursement program for obstetrician/gynecologists (as described below); and

-- $ 1.2 million is to be allocated annually to the Division of Medical Assistance and Health Services in the Department of Human Services to expand the NJ FamilyCare program (as described below).

The substitute establishes a three-year student loan expense reimbursement program within the Higher Education Student Assistance Authority for obstetrician/gynecologists who agree to practice in State designated underserved areas as established pursuant to N.J.S.A.18A:71C-35. An obstetrician/gynecologist who receives a payment under the program is required to practice as an

obstetrician/gynecologist in an underserved area in this State for a period of at least four years after receipt of the payment; and an obstetrician/gynecologist who fails to comply with this requirement must repay the authority the amount of the payment, in whole or in part as determined by the authority. The authority is to implement the program in consultation with the Commissioners of Banking and Insurance and Health and Senior Services and the State Board of Medical Examiners, and to adopt rules and regulations, pursuant to the "Administrative Procedure Act," to effectuate the purposes of this new program, including, but not limited to: eligibility for the program, procedures for application, selection of participants, establishment and nullification of contracts established with participants under the program, and reports to the program by participants.

The substitute provides that, within the limits of funds appropriated pursuant to the substitute and such other funds as may be available for this purpose, NJ FamilyCare is to enroll into the program women whose eligibility under the Medicaid New Jersey Care pregnant women program or the "New Jersey Standardized Parent Service Package," Demonstration Population 3, Medicaid expansion for uninsured pregnant woman, has expired and whose family income does not exceed 100% of the federal poverty level. The Commissioner of Human Services is to establish a presumptive eligibility process to provide for an efficient transition into NJ FamilyCare from the Medicaid program pursuant to this provision.

Finally, the substitute establishes a 17-member "Medical Care Availability Task Force" to study the following issues:

-- the advantages and disadvantages of establishing limitations on non-economic damages for medical malpractice judgments and on extending current limitations on liability that apply to nonprofit hospitals to employees, other than physicians, of those hospitals;

-- the impact of third party reimbursement policies by insurers and health maintenance organizations on access to health care services in the context of the current affordability crisis in the State affecting health care providers in the purchase of necessary liability coverage;

-- the advantages and disadvantages of adopting additional changes to the statute of limitations regarding medical malpractice actions;

-- the advantages and disadvantages of establishing additional procedures for mediation of actions alleging medical malpractice and for screening for frivolous medical malpractice lawsuits; and

-- the advantages and disadvantages of establishing a pre-suit procedure.

This committee substitute is identical to the Assembly Committee Substitute for A-50 (1R)(SCA)(Roberts/Cohen/Weinberg/McKeon), which the committee also reported favorably on this date.

PO BOX 004
TRENTON, NJ 08625

Contact: Micah Rasmussen
609-777-2600

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# Office of the Governor

## News Releases

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### McGreevey Signs Landmark Law Providing Access to Quality Health Care for New Jersey's Families

***Comprehensive Medical Malpractice Reform Puts Patients First***

(TRENTON) – Today Governor James E. McGreevey signed into law the "New Jersey Medical Care Access and Responsibility and Patients First Act" (A50), enacting comprehensive medical malpractice reform. The legislation provides for tort reform, health care system reform, and insurance reform, all in an effort to stem skyrocketing malpractice insurance premiums and ensure New Jersey's families have access to quality health care from the physicians they trust.

"Health care is one of the most important quality of life issues for New Jersey's families. That is why we have made access to quality health care a top priority," said Governor McGreevey. "Today is another good day for the health of New Jersey's families. Thanks to a focused commitment from all parties, this medical malpractice law is comprehensive, providing short-term relief and long-term reform. Our overriding priority is to ensure that patients have access to doctors and quality health care and this bill meets that objective in several ways."

The act reforms the Health Care System through the following: expanding the "Good Samaritan Law" to provide immunity from civil damages to a licensed health care professional who, in good faith, responds to a life threatening incident even though their duty does not require a response; strengthening reporting requirements of physician misconduct to the Board of Medical Examiners and to the health care facilities affiliated with physicians who have been disciplined.

The new law enacts Insurance Reforms by: prohibiting individuals from dual membership on the boards of medical malpractice insurers and professional trade associations; allowing physicians to form medical malpractice liability insurance purchasing alliances in order to negotiate a reduced medical malpractice liability insurance premium; requiring insurers to provide a reduced premium for policies that do not include a "consent to settle" provision; requiring insurers to offer policies with deductibles of at least $5,000 per claim and up to $1,000,000 per claim; prohibiting a carrier from increasing the premium of an insured if the insured is dismissed from an action alleging medical malpractice within 180 days of the filing of the action; requiring all medical malpractice insurers to certify to the DOBI as to adequacy of their financial reserves as a way to ensure the safety and soundness of insurers; allows the Commissioner to order a rate roll back if it is determined that a carrier's medical liability rates are not in compliance with the law.

In regards to Insurance Reforms, it also: requires medical malpractice insurers to offer its insureds the option to make premium payments in installments; requires medical malpractice insurers to notify the Medical Practitioner Review Panel and the commissioner of the Department of Banking and Insurance, in writing, of any medical malpractice claim settlement, judgment or arbitration award involving any practitioner licensed by the State Board of Medical Examiners and insured by the insurer or insurance association; requires physicians to maintain medical malpractice insurance coverage in the sum of $1 million per occurrence and $3 million per policy year; creates a 17-member task force to review relevant issues related to the medical malpractice affordability crisis and requires them to issue a report 24 months after the effective date of the bill; creates a 3-year, $78 million fund to provide direct premium relief to doctors and self-insured hospitals, relief to hospitals, and a student loan forgiveness program for doctors in high risk specialties - the fund would be based on a $75 assessment on certain professionals, such as doctors, dentists, lawyers, and a $3 surcharge on all employers who are subject to the New Jersey "Unemployment Compensation Law."

Lastly, the law enacts Tort Reforms by: reducing the statute of limitations for birth injuries to age 13; providing for complementary dispute resolution to encourage early disposition of medical malpractice lawsuits; creating an affidavit of non-involvement mechanism to allow defendants who are misidentified or otherwise not involved in the care and treatment of the claimant to seek dismissal of action; establishing qualifications for expert witnesses for persons executing an affidavit of merit and for testimony in a malpractice action, providing for penalties for intentional misrepresentation; granting the court greater discretion to review awards; allowing for structured judgments – awards less than $1 million dollars must be paid immediately, and awards exceeding $1 million may be paid 50% immediately with 50% annuitized over 60 months.

"This new landmark law will ease the crisis in medical malpractice insurance rates that has forced doctors from the State, while keeping intact protections for injured patients," said Senator Joseph F. Vitale, D-Middlesex. "It represents a year and a half of negotiations to come up with the best compromise to get something done without overly burdening one group over another. This law will help doctors without unduly hurting someone else."

"The high malpractice insurance rates were causing a crisis in the access to health care, and we needed to act to protect patient safety," said Senator Raymond J. Lesniak, D-Union. "This law will provide the necessary relief to stem the exodus of specialty doctors from our State, and will ensure the high quality of health care that New Jerseyans have come to expect."

"This law represents nearly two years of efforts by the Assembly Democratic Caucus to provide doctors and patients with a fair and balanced solution to the medical malpractice crisis," said Assembly Majority Leader Joseph J. Roberts Jr.. "Doctors will get the financial relief they deserve and patients will get the quality care they need."

"The many constructive and progressive elements in this law will keep doctors on the job while protective a patient's right to sue," said Assembly Deputy Majority Leader Neil M. Cohen. "Our reform measure recognizes that doctors are under tremendous financial strain

because of the paltry reimbursement policies of health maintenance organizations (HMOs) and the Medicare and Medicaid programs."

"We're striking a constructive balance between competitive professional interest groups while ensuring continued protection of patients," said Assembly Majority Conference Chair Loretta Weinberg. "These tort reforms will enable doctors to stop practicing defensive medicine and aggressively provide quality care to patients."

"Serious consequences await consumers, physicians, hospitals, insurers, and our state economy if the medical malpractice insurance issue goes unattended much longer," said Assemblyman John McKeon."This law will be good for patients and the doctors who provide their care. It will promote stability in the medical malpractice insurance marketplace and our health-care system."