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**SENATE COMMITTEE SUBSTITUTE FOR
SENATE, Nos. 2174 and 2226**

STATE OF NEW JERSEY

**Sponsored by Senators VITALE, MATHEUSSEN, SINGER,
ALLEN and Kyrillos**

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 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 high quality health care services
continue to be available and accessible to residents of the State and
that patient safety at health care facilities is maintained and enhanced.

3. 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 the statute of
limitations for medical malpractice for injuries sustained by a minor
shall be tolled until the minor's 11th birthday. An action shall have
accrued when the injured person knew or should have known of the
injury, and this two-year statute of limitations shall not be tolled

because the injured person was unaware that the person's injury may have been caused by a particular person or event.

Notwithstanding the provisions of this section and N.J.S.2A:14-21 to the contrary, an action by or on behalf of a minor who has reached his 9th birthday by the effective date of P.L. , c. (C.)(pending before the Legislature as this bill) that has accrued for medical malpractice for injuries sustained prior to the effective date of P.L. , c. (C.)(pending before the Legislature as this bill) , shall be commenced within four years of the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), except that no such action shall be commenced after the person's 20th 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]** Except as provided in N.J.S.2A:14-2, 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.

(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 of Court.

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 file 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. 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 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 submission of the false objection or inaccurate statement, 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.

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 and the care or treatment at issue involves that specialty or subspecialty, 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 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, the expert witness shall be a specialist or subspecialist who is board certified, by a board recognized by the American Board of Medical Specialties, when applicable, in the same specialty or subspecialty 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 the active clinical practice of that specialty or subspecialty; 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, an accredited medical school, health professional school or accredited residency or clinical research program in the same specialty or subspecialty; 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 and board certification requirements required by this section for an expert testifying as to the standard of care only if the court determines that: despite diligent efforts, no expert meeting the requirements could be obtained to offer testimony concerning the standard of practice or care at issue; and 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 specialty 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. An opinion given in expert testimony or an affidavit as to the appropriate standard of practice or care shall demonstrate the existence of that standard through the production of tangible evidence. For the purposes of this subsection, "tangible evidence" means textbooks, treatises, articles in peer-reviewed journals, written standards, or documented and recognized formulae, customs and practices.

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

g. 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.), who intentionally 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, including a reasonable attorney fee, as a result of the testimony provided or affidavit that was executed. The court shall also refer the matter to the Attorney General and to the appropriate licensing board for further review and to determine if the alleged misrepresentation constitutes grounds for disciplinary action by the board.

h. An individual or entity who threatens to take or takes adverse action against a person who provides expert testimony or has agreed to testify as an expert, or who executes an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.), which adverse action relates to the 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, and in addition, in the case of an

action for medical malpractice, the affidavit shall establish that there was a provider-patient relationship and identify the specific act by the defendant which is the basis for the cause of action against the defendant, or in the event there was no provider-patient relationship, identify the specific act by the defendant which is the basis for the cause of action against the defendant . 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) The 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 and determine whether the award is clearly inadequate, excessive or disproportionate 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. The judge may change the award in accordance with his determination.

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 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. 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.

d. 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.) and a psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

11. (New section) It shall be presumed that a person who signs an informed consent form or document for a medical procedure or other health care has read that form or document.

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) 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)

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, 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 determines that no disciplinary action is warranted, the board shall, within 30 days, notify the health care facility, State psychiatric hospital or health maintenance organization of its determination.

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

14. (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.

15. (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.) and a State psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7.

"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, or in the case of a State psychiatric hospital, to the Department of Human Services, in a form and manner established by the commissioner, every serious preventable adverse event that occurs in that facility.

d. (1) A health care professional or other employee of a health care facility is encouraged to make anonymous reports to the department, or in the case of a State psychiatric hospital, to the Department of Human Services, 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 applicable department pursuant to this subsection. The repository shall function as a clearinghouse for trend analysis of the information collected pursuant to this subsection.

e. Any documents, materials or information received by the department, or the Department of Human Services, as applicable, pursuant to the provisions of subsections c. and d. 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 al.); 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, or the Department of Human Services, as applicable, may be used by the department, the Department of Human Services, as applicable, and the Attorney General for the purposes of P.L. , c. (pending before the Legislature as this bill) and for oversight of facilities and health care professionals; however, the departments and the Attorney General shall not use the information for any other purpose.

f. 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.

g. 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; and the types of events that qualify as serious preventable adverse events. 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.

The commissioner shall consult with the Commissioner of Human Services with respect to rules and regulations affecting the State psychiatric hospitals.

16. (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 that is licensed in the State and offering medical malpractice liability insurance policies on the effective date of P.L. , c. (pending before the Legislature as this bill).

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 that is licensed in the State and offering medical malpractice liability insurance policies on the effective date of P.L. , c. (pending before the Legislature as this bill).

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.

17. (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 bylaws for the operation of the purchasing alliance, which shall be effective upon ratification by a two-thirds majority of the members. The bylaws 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 bylaws 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.

18. (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 premium for the endorsement, which premium shall reflect any 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.

19. (New section) a. Every insurer authorized to transact and writing medical malpractice insurance policies in this State shall offer individual or group medical malpractice liability insurance policies with a deductible, at the option of the insured, in an amount of at least \$10,000 per claim and up to \$1,000,000 per claim.

b. The deductibles offered by an insurer shall be subject to the approval of the Commissioner of Banking and Insurance.

c. 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.

d. In the case of a policy with a deductible of \$15,000 or greater, the insurer shall be responsible for payment of the deductible and shall be reimbursed for that amount by the insured.

20. (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 \$15,000 per covered health care provider.

b. An insurer authorized to transact medical malpractice liability insurance shall, in all policies and contracts issued in the State on or 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.

c. 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.).

21. (New section) Each annual statement, 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-1 et seq.) 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:

- a. adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer; or
- b. not adequate to cover expected losses and expenses of the insurer, but the insurer will create and maintain reserves adequate to ensure the safety and soundness of the insurer.

22. (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.

23. 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 category or subcategory of insureds of 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.

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)

24. (New section) Subject to standards adopted by the National Association of Insurance Commissioners, the Commissioner of Banking and Insurance shall, within 180 days of the effective date of P.L. , 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, 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.

25. (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.

26. (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.

27. 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 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.

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)

28. (New section) Notwithstanding any provision of law to the contrary, every insurer authorized to transact medical malpractice

liability insurance in this State shall, under terms and conditions established by the Commissioner of Banking and Insurance by regulation, permit a health care professional, who has a policy issued by that insurer that is in effect on the effective date of P.L. , c. (pending before the Legislature as this bill): a. to request that the premium for that policy be recalculated to reflect any cost-savings provisions of P.L. , c. (pending before the Legislature as this bill); and b. to cancel the policy with a return of the amount of the gross unearned premium to be returned on a pro rata basis.

Nothing in this section shall be construed to permit an insurer to increase a premium on a policy that is in effect on the effective date of P.L. , c. (pending before the Legislature as this bill), during the term of the policy.

29. (New section) For the purposes of sections 30 through 40 of P.L. , c. (pending before the Legislature as this bill):

"Board" means the board of directors established pursuant to subsection a. of section 31 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 Insurance Excess Fund established pursuant to section 30 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 and 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.

"Insurer" means an entity providing indemnity for health care providers in actions for medical malpractice, including an insurer authorized to do business in the State pursuant to R.S. 17:17-1 et seq., a reciprocal insurer, a captive insurer, or a risk retention group.

30. (New section) a. There is established within the New Jersey Medical Malpractice Reinsurance Facility a Medical Malpractice Insurance Excess 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. The surcharge shall be 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 board. The surcharge may, at the option of the employer, be treated as a payroll deduction to each covered employee.

(2) An annual charge of \$50 shall be imposed by the State Board of Medical Examiners on every physician 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 shall 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 shall be imposed by the State Board of Dentistry on every dentist 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 shall be imposed by the State Board of Medical Examiners on every podiatrist licensed by the board pursuant to the provisions of R.S. 45:5-1 et seq., collected by the board and remitted to the State Treasurer for deposit into the fund;

(6) An annual charge of \$50 shall be imposed by the New Jersey State Board of Optometry 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;

(7) The State Treasurer shall assess an annual fee in the amount of \$50, payable by each person licensed to practice law in this State, for deposit into the fund.

The provisions of paragraphs (2) through (6) of this subsection shall not apply to physicians, chiropractors, dentists, podiatrists 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 (7) 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 this section into the Medical Malpractice Insurance Excess Fund created pursuant to this section. Monies in the fund shall be

invested by the State Treasurer in accordance with the requirements set forth in Title 17 of the Revised Statutes for investments by insurers writing property-casualty insurance in this State. The State Treasurer shall adopt rules and regulations relative to the collection and deposit of the moneys collected pursuant to this section, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

31. (New section) a. The fund shall be governed by a seven-member board of directors consisting of the Commissioners of Banking and Insurance and Health and Senior Services, the Attorney General and the State Treasurer, or their designees, who shall serve ex officio, and three members representing insurers writing medical malpractice coverage in this State, which insurers shall be designated by the Commissioner of Banking and Insurance and at least two of whom shall be domiciled in this State. The insurer members shall serve for a term of three years, except that of the members first appointed, one member shall have a term of one year, one member shall have a term of two years and one member shall have a term of three years. Insurer members shall serve until their successors are appointed and qualified. Insurer members shall serve without compensation.

b. The board shall administer the fund subject to the provisions of sections 30 through 40 of P.L. , c. (C.)(pending before the Legislature as this bill).

c. Within 60 days after the organizational meeting of the board, unless the commissioner grants an extension not to exceed 30 days, the board shall establish and file with the commissioner for his approval a plan of operation for the administration of the fund and the conduct of its affairs. The plan shall provide for, among other matters: methods of collecting and disbursing revenues of the fund as provided for in sections 30 through 40 of P.L. , c. (C.)(pending before the Legislature as this bill); qualifications for and standards of performance for the administrator of the fund; guidelines, standards and methods for reviewing notices of claims and demands as provided for in section 35 of P.L. , c. (C.)(pending before the Legislature as this bill); methods of tracking claims for which the fund has or may have a liability; determining procedures for evaluating whether the fund is to become a party to an action; and guidelines, standards and procedures for the appointment of counsel to represent the fund and for the establishment of a formula for paying claims in the event the revenue in the fund is insufficient to pay all eligible claims during a calendar year.

d. The commissioner shall review and certify the plan, whereupon it shall take effect. The board may amend the plan at any

time and shall file the amendments with the commissioner for his review. Upon certification by the commissioner, the amendments to the plan shall take effect.

32. (New section) a. The board may:

- (1) Sue or be sued in the name of the fund;
- (2) Indemnify its members for any and all claims, suits, costs of investigations, costs of defense, settlements or judgments against them on account of an act or omission in the scope of a member's duties; provided, however, the board may refuse to indemnify if it determines that the act or failure to act was the result of actual fraud, willful misconduct or actual malice;
- (3) Require the reporting of such statistics or other data by insurers writing medical malpractice insurance in this State as may be necessary for the sound operation of the fund;
- (4) Adopt bylaws for the regulation of its internal affairs;
- (5) Appoint such personnel as may be required for the administration of the fund, with the approval of the commissioner;
- (6) Engage the services of such independent consultants as may be necessary; and
- (7) Monitor the administrator's performance in accordance with the standards of performance established in the plan of operation.

b. The board shall report annually to the commissioner and to the Legislature as to its operations, including disbursements made from the fund in the previous calendar year, total claims filed against the fund, fund expenses, the total revenue deposited in the fund by the State Treasurer pursuant to section 30 of P.L. , c. (C.)(pending before the Legislature as this bill), and the total investment income derived therefrom.

33. (New section) a. The board shall appoint an administrator for the purpose of administering claims against the fund, providing for representation of the fund's interests by counsel pursuant to the plan of operation and subsection b. of this section, providing actuarial services for the fund, if it deems it to be necessary, maintaining statistical data supplied to the administrator or the commissioner pursuant to section 39 of P.L. , c. (C.)(pending before the Legislature as this bill), and providing such other services as the board directs. The fund may appoint an insurer authorized to do business in this State pursuant to R.S.17:17-1 et seq. to administer the fund on an administrative services only basis, which insurer may not be a member of the board, or may appoint a third party administrator licensed pursuant to the provisions of P.L.2001, c.267 (C.17B:27B-1 et seq.). The board shall establish standards of performance for the administrator in accordance with the plan of operation.

b. For the purposes of carrying out its duties under sections 30 through 40 of P.L. , c. (C.)(pending before the Legislature as this bill), the fund may: (1) utilize the services of attorneys employed by the Department of Law and Public Safety and assigned to it by the Attorney General; (2) on its own, or direct the administrator to, negotiate with and employ outside counsel as necessary; or (3) both. The fund shall make a determination under this subsection based on cost effectiveness, the expertise of counsel, which shall have demonstrated substantial experience with medical malpractice litigation, and the necessity of its fiduciary responsibility to protect the fund's assets to the greatest extent possible, consistent with its responsibility to pay valid claims and to ensure that any action or decision by an insurer in administering claims which may result in payment by the fund has a reasonable basis.

c. The board may establish a Claims Advisory Committee, comprised of individuals with experience in medical malpractice claims to review notices of claims or demands filed with insurers and to advise the board with respect to any subsequent action the board may elect to take, including becoming a party to the action.

34. (New section) a. Except as otherwise provided pursuant to sections 30 through 40 of P.L. , c. (C.)(pending before the Legislature as this bill), in any action against a health care provider for medical malpractice, no insurer writing medical malpractice insurance in this State shall be liable for the payment of jury awards or post-jury award settlements for non-economic loss in excess of \$300,000 per occurrence, provided that the insurer has not exercised bad faith in the course of administering the claim, and the fund shall be liable, as provided in sections 30 through 40 of P.L. , c. (C.)(pending before the Legislature as this bill), for payment of jury awards or post-jury award settlements for non-economic loss in excess of \$300,000 per occurrence, but no more than \$700,000 per occurrence, up to the limits of the insured's policy, under the terms and conditions established by sections 30 through 40 of P.L. , c. (C.)(pending before the Legislature as this bill).

As used in this subsection, "bad faith" means a demonstrated lack of any reasonable basis for a pretrial settlement position.

b. Notwithstanding the foregoing, the fund shall have no liability for payment of a jury award or a post-jury award settlement as provided for in this section if there has been a failure to notify the fund pursuant to subsection a. of section 35 of P.L. , c. (pending before the Legislature as this bill).

c. The fund shall have no liability for payment of a jury award or a post- jury award settlement in any case in which an insured

exercises any right provided under a policy of medical malpractice insurance to refuse to settle a claim or demand against the policy.

d. The obligation of the fund to pay claims for non-economic loss shall apply to any award or post-jury award settlement arising from a trial commenced after the effective date of P.L. , c. (pending before the Legislature as this bill).

35. (New section) a. The administrator of the fund shall be notified by each insurer of the initial filing of every claim or demand alleging medical malpractice that may result in liability for payment by the fund pursuant to section 34 of P.L. , c. (C.)(pending before the Legislature as this bill) within 10 business days of the filing, whether filed with a defendant, with an insurer or with a court and subsequently, the fund shall be notified within a reasonable time, as established in the plan of operation, prior to the commencement of any settlement or complementary dispute resolution proceeding or prior to the commencement of a trial in which the demand for damages for economic and non-economic loss, set forth in accordance with subsection a. of section 36 of P.L. , c. (C.)(pending before the Legislature as this bill), exceeds \$300,000 per occurrence and, at its option, may be joined as a party to the action.

Failure to notify the fund of the filing of a claim or demand or the commencement of any settlement or complementary dispute resolution proceeding or trial as provided for herein shall result in no liability either on the part of the fund, any excess insurer of the fund or any health care provider covered by a policy of medical malpractice insurance, for the payment of damages for non-economic loss in excess of \$300,000 per occurrence.

b. Following notice to the administrator of the fund of the filing of a claim or demand pursuant to subsection a. of this section, the insurer shall provide such information as may be required by the fund, which may include copies of any demands, notices, summonses or legal papers received in connection with the claim. The insurer shall assist the fund in obtaining records and other information relative to the claim, cooperate with the fund in any investigation or defense of the claim, and assist the fund, if requested, in the enforcement of any right against any person or organization that may be liable to the insured with respect to the occurrence from which the claim arises.

36. (New section) a. Every claim or demand filed against an insured for damages in excess of \$300,000 per occurrence for economic loss and non-economic loss shall document the economic loss for which relief is sought and shall set forth in detail the economic loss incurred at the time the case is subject to a complementary dispute resolution proceeding, at the time settlement

negotiations are entered into or at the time a case is tried, as well as a detailed statement of claimed prospective economic loss resulting from the allegation of medical malpractice, which documentation shall be updated from time to time as necessary and shall be provided to the court, the complementary dispute resolution agent or, in the case of settlement negotiations, the defendant, as applicable.

b. In every trial in which damages are awarded in an action alleging medical malpractice, the trier of fact shall separately itemize damages awarded for economic loss and damages awarded for non-economic loss and the judge presiding over the proceeding shall review each verdict to determine pursuant to section 9 of P.L. , c. (C.)(pending before the Legislature as this bill) whether the award is clearly inadequate, excessive or disproportionate 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.

37. (New section) a. When any person receives a valid jury award or post-jury award settlement in any court of competent jurisdiction in this State that includes an award for non-economic loss in excess of \$300,000 for any occurrence, the judgment creditor may, upon the termination of all proceedings, including reviews and appeals in connection with the judgment or settlement, apply to the fund for any amount that may be payable pursuant to section 34 of P.L. , c. (C.)(pending before the Legislature as this bill).

To apply to the fund, the judgment creditor shall file an affidavit with the court, presenting such proofs as the court may require, (1) that the amount of any payment in damages for economic loss and non-economic loss has been made by the insurer, and (2) that any amount owed by the defendant by way of a deductible or other retention of risk by the defendant that is attributable to payment for non-economic loss, has been paid. The judgment creditor shall request the court to certify to the fund that such payment or payments have been made and to certify the aggregate amount of the jury award or post-jury award settlement for non-economic loss. The certification by the court shall accompany the application to the fund and shall be made in a form and in a manner provided for by the board in the plan of operation.

b. Once each calendar year, on a payment date established in the plan of operation and in a manner provided by the plan, the board shall calculate the amount of money collected remaining in the fund after the fund's administrative expenses, including, but not limited to, any legal fees incurred in connection with representing the fund in connection with any settlement or complementary dispute resolution proceeding or a trial. The remaining balance of the fund shall be used for payment to plaintiffs for jury awards or post-jury award

settlements attributable to the calendar year preceding the payment date for non-economic loss in excess of \$300,000 per occurrence, but no more than \$700,000 per occurrence, up to the limit of the insured's policy, as provided for in section 34 of P.L. , c. (C.)(pending before the Legislature as this bill).

c. In the event that the fund balance on the payment date is insufficient to disburse the full amount to every plaintiff as provided in section 34 of P.L. , c. (C.)(pending before the Legislature as this bill), the fund shall disburse an amount to each plaintiff for payment for non-economic loss in accordance with a formula that calculates the percentage of the balance in the fund payable to each plaintiff, based on the proportion that each plaintiff's share of the aggregate jury awards and post-jury award settlement amounts, if fully paid in accordance with section 34 of P.L. , c. (C.)(pending before the Legislature as this bill) for the calendar year, bears to the aggregate jury awards and post-jury award settlement amounts to all plaintiffs if fully paid in accordance with section 34 of P.L. , c. (C.)(pending before the Legislature as this bill) for that calendar year.

d. In the event that the fund balance on the payment date is insufficient to disburse the full amount for which the fund is liable under section 34 of P.L. , c. (C.)(pending before the Legislature as this bill), the fund's obligation for payment of non-economic loss shall be deemed to be discharged if payments are made pursuant to the provisions of subsection c. of this section, and the fund shall not be liable for any further payment, nor shall the insurer be liable for any such further payment in excess of the insured's policy limits.

e. The fund shall have subrogation rights against any party other than a defendant eligible for indemnification from the fund in any action in which the fund is liable for payment pursuant to section 34 of P.L. , c. (C.)(pending before the Legislature as this bill).

f. No person shall have the right to join the fund as a party or otherwise bring the fund into a lawsuit asking for damages from a person covered for negligence arising from medical malpractice, under a policy or other arrangement for which the fund has an obligation pursuant to section 34 of P.L. , c. (C.)(pending before the Legislature as this bill).

38. (New section) Notwithstanding the provisions of any other law to the contrary, upon:

a. payment by the insurer of a jury award or a post-jury award settlement for non-economic loss, plus any payment due for economic loss, up to the limit of the policy; or

b. payment by the insurer for economic loss and up to \$300,000 for non-economic loss and payment by the fund of a jury award or post-jury award settlement for non-economic loss pursuant to sections

30 through 40 of P.L. , c. (C.)(pending before the Legislature as this bill), up to the limit of the policy, a health care provider covered by a policy providing medical malpractice insurance shall be deemed to have discharged his full financial liability to the plaintiff receiving the award or post-jury award settlement, and any other civil action in connection with the claim or demand leading to the award or post-jury award settlement for non-economic loss shall be barred, unless the provisions of subsection c. of section 34 of P.L. , c. (C.)(pending before the Legislature as this bill) apply.

39. (New section) a. Every insurer shall, no later than 45 days following the enactment of P.L. , c. (pending before the Legislature as this bill), appoint a statistical agent for the purpose of reporting data, including its loss and expense experience, as such data is provided for in section 16 of P.L. 1982, c. 114 (C.17:29AA-16) . Data shall be submitted in a format established by the statistical agent. The commissioner may impose a penalty of not less than \$10,000 nor more than \$25,000 under the provisions of the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.) for failure to appoint an agent or failure to provide data to the statistical agent.

b. No later than 90 days following the appointment of a statistical agent or, if the insurer reports or has an arrangement to report to a statistical agent as of the effective date of P.L. , c. (pending before the Legislature as this bill), no later than 45 days following the effective date of P.L. , c. (pending before the Legislature as this bill), every insurer for which the fund may be liable for payment pursuant to section 34 of P.L. , c. (C.)(pending before the Legislature as this bill) shall provide the administrator of the fund, or the commissioner, or both, as provided in the plan of operation, with such statistical data as the board may require.

40. (New section) Notwithstanding the provisions of section 5 of P.L. 1982, c. 114 (C.17:29AA-5), every insurer shall file with the commissioner all rates and supplementary rate information and changes and amendments thereto, including special risks, reflecting the provisions of P.L. , c. (C.)(pending before the Legislature as this bill), not later than 90 days following the effective date of P.L. , c. (pending before the Legislature as this bill), and not later than 30 days after becoming effective.

41. (New section) 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, or their designees, who shall serve ex officio;

(2) the Administrative Director of the Courts, or his designee, who shall serve ex officio; and

(3) 13 public members appointed by the Governor, with the advice and consent of the Senate, who include: one representative of the Medical Society of New Jersey; one representative of the New Jersey Association of Osteopathic Physicians and Surgeons; one representative of the New Jersey Dental Association; one representative of the New Jersey Hospital Association; one representative of the New Jersey Council of Teaching Hospitals; one representative of the Association of Trial Lawyers of America-New Jersey; one representative of the New Jersey State Bar Association; one representative of the New Jersey Association of Health Plans; one representative of a medical malpractice insurer; and four persons who represent the interests of health care consumers.

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 its chair 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 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;

(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 State's current affordability crisis 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;

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

(6) the necessity for, and advantages and disadvantages of, reactivating the New Jersey 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 nine months after the date of its initial meeting.

42. This act shall take effect on the 30th day after enactment, except that, sections 14 and 15 shall take effect 180 days after the date of enactment and section 19 shall take effect 90 days after the date of enactment.

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