ASSEMBLY, No. 3198

STATE OF NEW JERSEY

210th LEGISLATURE

INTRODUCED JANUARY 23, 2003

Sponsored by:
Assemblyman ERIC MUNOZ
District 21 (Essex, Morris, Somerset and Union)

SYNOPSIS

Revises laws concerning medical malpractice claims, procedures and liability insurance.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning medical malpractice claims and procedures and revising various parts of the statutory law.

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

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

a. The high cost and lack of availability of medical malpractice insurance has threatened the integrity of the State's health care system and the ability of the residents of the State to maintain access to a full spectrum of health care services and highly trained physicians in all specialties;

b. While a significant factor affecting the cost and availability of this insurance is the general disruption in the commercial insurance market caused by reduced investment income, instability in the reinsurance market, and the lack of capacity to write new business because of reductions in insurers' surplus, all of which lie beyond the State's ability to address, other factors contributing to the problems are within the purview of the State, including the increasing severity of claims experience, medical errors that lead to litigation, the statute of limitations affecting claims of minors, and high defense and settlement costs;

c. A person who has sustained injury or dies because of medical negligence by a health care provider must be afforded prompt access to the judicial system and must receive fair compensation, but measures need to be taken to ensure that physicians and other health care professionals named in litigation but not involved in any incident involving the alleged malpractice must be permitted to be removed from the case in the most expeditious and least expensive manner through a procedure established for that purpose;

d. While New Jersey's affidavit of merit requirement has been effective in reducing the number of frivolous suits, stringent standards must be put in place governing experts who prepare this affidavit or who testify at trial, and defendants must be given the opportunity to present their own affidavit of meritorious defense, if they so choose;

e. The State must provide more flexibility in terms of the ability of physicians to use alternative means to procure insurance coverage, such as purchasing alliances and risk retention groups, and must require that insurers provide more policy deductible options to physicians to permit them to reduce the cost of their coverage, and insurers must give physicians the option to lower their premiums by eliminating the right-to-consent-to-settle provisions in their policies if they choose to do so;

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.

f. In recent years, jury awards for noneconomic loss have, in the aggregate, increased substantially both in terms of the number of awards and the amount of the awards, some of which have been disproportionate to the degree of illness or injury resulting from medical malpractice, but the courts have limited discretion to modify awards, even though there may be a perceived inequity;

g. The increasing aggregate amount paid out each year in large awards has had a significant adverse effect on physicians' medical malpractice premiums, to a degree not found in other lines of commercial insurance because of the proportionally smaller base of insureds over which the costs must be spread;

h. The recent substantial increase in malpractice premiums has affected the medical community to a more profound degree than the large premium increases that caused a similar crisis in the State in 1975, as physicians are now required to maintain insurance in order to continue to practice, eliminating the ability to reduce or drop coverage altogether, and the method of physician reimbursement has changed substantially with the advent of managed care, limiting their income, increasing their expenses, and precluding them from passing on part of the higher cost to their patients;

i. While it is the public policy of the State to permit persons injured as a result of medical negligence to be awarded payments for noneconomic loss, it is essential that the State be ever mindful of the necessity of making premiums affordable and insurance coverage available in order to ensure the ability of physicians to practice medicine in this State, and it is also essential that the awards be proportionate to the severity of the illness or injury caused by medical negligence, rather than primarily a reflection of the respective abilities of plaintiffs' and defense counsel, the quality of the jury making the award, or other factors extraneous to the nature of the illness or the injury itself;

j. Accordingly, the policy of the State shall be to place limitations on awards for pain and suffering to control the overall cost of medical malpractice insurance, and to establish limitations that are equitable and consonant with the nature of the illness or injury, recognizing that persons injured by medical negligence, including those grievously injured, are not subject to any limitation on awards for economic damages, so that their future medical care, living expenses, and other needs will continue to be sufficiently met;

k. In establishing limitations on awards for pain and suffering, the Legislature sees fit to place a lower limit for injuries neither permanent nor serious so that in the future there will be recoveries for noneconomic loss equably apportioned among all claimants with like injuries, and to place a higher limit for recovery for noneconomic loss with respect to those illnesses and injuries that are those for which the claimants have experienced a more significant illness or injury that

palpably disrupts their lives in the long term;

l. The elements contained in this act, while a partial solution to the problem facing the State and its health care providers, are essential to maintain the public health, safety, and welfare of all of the citizens of this State.

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

"Health care provider" means any person licensed in this State to practice medicine and surgery, chiropractic, podiatry, dentistry, optometry, psychology, pharmacy, nursing, physical therapy or as a bioanalytical laboratory director, or a hospital or other health care facility or health care agency.

"Medical malpractice" means a negligent act or omission to act 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, provided that such services are within the scope of services for which the health care provider is licensed and which are not within any restriction imposed by the licensing board or licensed hospital.

3. (New section) a. In any action alleging medical malpractice against a health care provider in this State, the person filing the action shall, no later than 30 days following the filing of the action, file an affidavit as required pursuant to section 2 of P.L.1995, c.139 (C.2A:53A-27) provided by a person whom the plaintiff's attorney reasonably believes meets the requirements for an expert witness pursuant to section 2 of P.L.1995, c.139 (C.2A:53A-27) and section 6 of this act. A notice of the filing of the complaint and a copy of the affidavit shall be mailed to the last known professional business address or residential address of the health care provider who is the subject of the claim. Proof of the mailing of the notice required pursuant to this subsection shall be prima facie evidence of compliance with this section. If, in the case of a physician or other health care provider, no last known 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 action was rendered.

b. No later than 60 days following the filing of the affidavit pursuant to subsection a. of this section, the defendant may file an affidavit by a person whom the defendant's attorney reasonably believes meets the requirements for an expert witness as set forth in section 6 of this act, which states:

(1) the standard of practice or care that the health care provider named as defendant asserts is applicable to the proposed action, and that the health care provider that is the subject of the claim complied with that standard;

(2) the manner in which it is claimed by the defendant health care provider that there was compliance with the applicable standard of

practice or care; and

(3) the manner in which the defendant health care provider contends that the alleged negligence was not the proximate cause of the claimant's alleged injury or damage.

c. If a defendant elects to file an affidavit pursuant to subsection b. of this section, the affidavit may be filed not later than 90 days following the filing of the affidavit by the plaintiff pursuant to subsection a. of this section in any case in which the plaintiff has failed to allow access to medical records as required pursuant to section 4 of this act.

4. (New section) a. Not later than 60 days after filing an affidavit pursuant to section 3 of this act, the claimant shall allow the health care provider receiving the notice access to all of the medical records related to the claim that are in the claimant's control, and shall provide releases for any medical records related to the claim that are not in the claimant's control, but of which the claimant has knowledge.

b. Not later than 60 days after receiving a copy of the affidavit pursuant to subsection a. of section 3 of this act, the health care provider shall allow the claimant access to all medical records in its possession that are related to the claim, provided that this shall not restrict a health care provider that receives notice of a claim from communicating with other health care providers and acquiring medical records as may be necessary or pertinent to the claim.

5. (New section) a. A person who has commenced an action alleging medical malpractice shall be deemed to waive, for the purposes of that claim or action, any right of confidentiality with respect to any medical records relating to the claim or action, as well as any other similar privilege established in law with respect to any person or entity who was involved in the acts, transactions, events, or occurrences that are the basis for the claim or action or who provided care or treatment to the claimant for the condition that is the subject of the claim or action or a condition related to the claim or action, either before or after those acts, transactions, events, or occurrences, whether or not the person is a party to the claim or action.

b. Pursuant to subsection a. of this section, a person: (1) who has received a copy of the affidavit under section 3 of this act; or (2) who has been named as a defendant in an action alleging medical malpractice, or that person's attorney or authorized representative, may communicate with a health care provider, or any business entity of which the foregoing are a part, or any employee or agent thereof, in order to obtain all information relevant to the subject matter of the claim or action and to prepare the person's defense to the claim or action.

c. Any person who discloses or releases information pursuant to

subsection b. of this section to a person who has received a copy of the affidavit under section 3 of this act or to a person who has been named as a defendant in an action alleging medical malpractice or to the person's attorney or other authorized representative shall not be deemed to have violated any law regarding the privacy or confidentiality of records or any other similar duty or obligation to the claimant otherwise provided by law.

6. (New section) a. In an action alleging medical malpractice, no person shall give expert testimony or execute an affidavit pursuant to section 3 of this act unless the person is licensed as a health care provider in the same profession as the defendant health care provider. In order to qualify as an expert, the person shall meet the following qualifications:

(1) If the person against whom or on whose behalf the testimony is offered is a specialist, 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 as the person 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, the expert witness shall be a specialist who is board certified in the same specialty, 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, the active clinical practice of that specialty; 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 profession in which the defendant is licensed, and, if that defendant is a specialist, an accredited medical school, health professional school or accredited residency or clinical research program in the same specialty; or (c) both.

(2) If the person 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; or (b) 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 (c) both.

b. In determining the qualifications of an expert witness in an action alleging medical malpractice, 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's testimony.

c. Notwithstanding the provisions of subsection a. of this section, the court may permit a specialist who is board certified, but not board certified in the same specialty as the defendant, if a procedure that is the subject of the malpractice action, including, but not limited to, surgical procedures, are within the specialized scope of practice of both the proposed expert witness and the defendant.

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. Violation of this subsection shall be a disorderly persons offense.

7. (New section) a. In an action alleging medical malpractice, a scientific opinion rendered by an otherwise qualified expert is not admissible unless the court determines that the opinion is reliable and will assist the trier of fact. In making that determination, the court shall examine the opinion and the basis for the opinion, which basis shall include the facts, technique, methodology, and reasoning relied upon by the expert, and shall consider all of the following factors:

(1) Whether the opinion and its basis have been subjected to scientific testing and replication;

(2) Whether the opinion and its basis have been subjected to peer review publication;

(3) The existence and maintenance of generally accepted standards governing the application and interpretation of a methodology or technique and whether the opinion and its basis are consistent with those standards;

(4) The known or potential error rate of the opinion and its basis;

(5) The degree to which the opinion and its basis are generally accepted within the relevant expert community. As used in this paragraph (5), "relevant expert community" means individuals who are knowledgeable in the field of study and are gainfully employed applying that knowledge on the free market;

(6) Whether the basis for the opinion is reliable and whether experts in that field would rely on the same basis to reach the type of opinion being proffered;

(7) Whether the opinion or methodology is relied upon by experts outside of the context of litigation.

b. A novel methodology or form of scientific evidence may be admitted into evidence only if its proponent establishes that it has achieved general scientific acceptance among impartial and

disinterested experts in the field.

c. In an action alleging medical malpractice, the provisions of this section are in addition to, and do not otherwise affect, the criteria for expert testimony provided for in section 6 of this act.

8. (New section) a. In an action alleging medical malpractice, a party named as a defendant in the action may, instead of answering or otherwise pleading, file with the court an affidavit certifying that he was not involved, either directly or indirectly, in the occurrence alleged in the action. Unless the affidavit is opposed pursuant to subsection b. of this section, the court shall order the dismissal of the claim, without prejudice, against the party providing that certification.

b. Any party to a medical malpractice action may oppose the dismissal of any claim pursuant to the filing of an affidavit in accordance with subsection a. of this section or may move to vacate an order of dismissal, and the court may reinstate as a party the person filing the affidavit, if it can be shown that the party was involved in the occurrence alleged in the action. 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. The person opposing the dismissal of the claim pursuant to this subsection shall have standing to obtain discovery regarding the involvement or noninvolvement of the party filing the affidavit, which discovery shall be completed within 90 days after the affidavit is filed.

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.

d. 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.

e. 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.

9 (New section) a. Subject to the provisions of subsection b. of this section, in an action alleging medical malpractice, the plaintiff shall have the burden of proving that in light of the state of the art existing at the time of the alleged malpractice: (1) the defendant, if a general practitioner, failed to provide the plaintiff with the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury; or (2) the defendant, if a specialist, failed to provide the plaintiff with the recognized standard of practice or care within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available in the community or other facilities reasonably available under the circumstances, and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

b. In any action alleging medical malpractice, the plaintiff shall have the burden of proving that he suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants.

10. (New section) a. Following the filing of a complaint with the court, an action alleging medical malpractice may, upon agreement by both parties or upon order of the court, be mediated pursuant to this act. Upon that agreement or order, the judge to whom an action alleging medical malpractice is assigned shall refer the action to mediation by written order not less than 90 days after the filing of the answer or answers in a court action.

b. A mediation conducted pursuant to subsection a. of this section shall be conducted by a panel of neutral mediators, which shall be composed of three voting members selected in a manner determined by the court from a list maintained by the Administrative Office of the Courts. One of the neutral mediators shall be an attorney admitted in this State whose practice is other than the representation of plaintiffs or defendants in personal negligence cases, including medical malpractice negligence cases, and one shall be a licensed board certified physician. If a defendant is a specialist, the physician on the panel shall specialize in the same, or related, relevant area of health care as the defendant. The third member shall be selected from a pool of active or retired Superior Court judges, active or retired administrative law judges, active or retired workers' compensation judges, or other individuals as may be determined appropriate to qualify as neutral mediators by the Administrative Office of the Court pursuant to the Rules Governing the Courts of the State of New Jersey. An active judge of the Superior Court may be selected as a member of a mediation panel but may not preside at the trial of any action in which he served as mediator.

c. The grounds for disqualification of a neutral mediator in an action shall be the same as the grounds for the disqualification of a judge from an action. A person serving as a neutral mediator shall comply with ethics standards established by the Supreme Court governing conflicts of interest, professional relationships, and such other issues as the Court may establish. A proposed neutral mediator shall be disqualified from service in any case in which a judge determines that the ethics standards established by the Court would preclude his service on the case, and a neutral mediator may disqualify himself if he determines an affiliation with any party to the dispute that would preclude his service under the ethics standards.

11. (New section) a. In any mediation proceeding, the judge to whom the medical malpractice action has been assigned shall designate a person, who may be the clerk of the court, the assignment clerk, or another person, to serve as the mediation clerk. The mediation clerk shall set a time and place for the mediation hearing and send notice to the neutral mediators and the attorneys of record in the case at least 30 days before the date set for the mediation hearing. Adjournments of mediation hearings shall be granted only for good cause, in accordance with the Rules Governing the Courts of the State of New Jersey.

b. Not later than 14 days following the mailing of the notice of the mediation hearing pursuant to subsection a. of this section, each party to the mediation shall pay a fee as prescribed by the court.

c. Not later than seven days before the mediation hearing date, each party shall submit to the mediation clerk three copies of the documents relating to the issues to be mediated and three copies of a concise brief or summary that sets forth that party's factual or legal position on issues presented in the malpractice action. In addition, one copy of each shall be provided to each attorney of record in the case. Failure to submit the materials required by this subsection shall result in a fine to be determined by the judge to whom the medical malpractice action has been assigned.

12. (New section) a. A party to a case being mediated pursuant to this act may attend a mediation hearing. If scars, disfigurement or other pertinent conditions exist, they may be demonstrated to the mediation panel by a personal appearance of the party alleging malpractice, but testimony shall not be taken or permitted from any such party. The Rules of Evidence shall not apply in proceedings of the mediation panel but factual information having a bearing on damages or liability shall be supported by documentary evidence if possible or practicable.

b. Oral presentation shall be limited to fifteen minutes per side unless multiple parties or unusual circumstances warrant additional

time, which may be granted by the mediation panel. The panel may request information on applicable insurance policy limits and may inquire about settlement negotiations unless objected to by any party. Statements by the attorneys during the hearing and the briefs or summaries presented pursuant to this act shall not be admissible in any subsequent court or evidentiary hearing.

13. (New section). a. Except as otherwise provided in subsection b. of this section, not later than 14 days after the mediation hearing, the panel shall make an evaluation and notify the attorney for each party of its evaluation in writing. The evaluation shall include a specific finding on the standard of care provided. The mediation panel shall indicate in its evaluation if a determination or award of the panel is not unanimous.

b. If the mediation panel unanimously determines that a complete action or defense is frivolous as to any party, the panel shall state this to that party. If the action proceeds to trial, the court may order the party determined to have a frivolous action or defense to post a surety bond. If the court has so ordered, and judgment is entered against the party who posted the bond, the bond shall be used to pay all reasonable costs incurred by the other party or parties in the frivolous action, as well as any costs allowed by law or by court rule, including court costs and reasonable attorneys' fees.

c. The evaluation of the mediation panel shall include a separate determination or award as to each cross-claim, counterclaim or third-party claim that has been filed in the action.

14. (New section) a. Each party shall file a written acceptance or rejection of the mediation panel's evaluation with the mediation clerk not later than 30 days after service of the panel's evaluation. The failure to file a written acceptance or rejection within the time limit prescribed shall constitute acceptance of the evaluation. A party's acceptance or rejection of the panel's evaluation shall not be disclosed until the expiration of the time limit prescribed herein, at which time the mediation clerk shall send a notice indicating each party's acceptance or rejection of the panel's evaluation.

b. With respect to mediation involving multiple parties, the following rules shall apply:

(1) Each party shall have the option of accepting all of the determinations or awards covering the claims by or against that party or of accepting some and rejecting others; provided, however, that as to any particular opposing party, the party shall either accept or reject the evaluation in its entirety;

(2) A party who accepts all of the awards may specifically indicate that he intends the acceptance to be effective only if all opposing parties accept. If this limitation is not included in the acceptance, an

accepting party shall be considered to have agreed to entry of judgment as to that party and those of the opposing parties who accept, with the action to continue between the accepting party and those opposing parties who reject;

(3) If a party makes a limited acceptance under paragraph (2) of this subsection and some of the opposing parties accept and others reject the evaluation, for the purposes of the cost provisions contained in section 15 of this act, the party who made the limited acceptance shall be considered to have rejected as to those opposing parties who accepted.

(4) If any party decides to proceed to trial, no findings of the mediation panel shall be admissible.

15. (New section) a. If all of the parties accept the mediation panel's evaluation, judgment shall be entered in that amount, which shall include all fees, costs and interest to the date of judgment. In a case involving multiple parties, judgment shall be entered as to those opposing parties who have accepted the portions of the panel's evaluation that apply to them. Except as otherwise provided in this act with respect to cases involving multiple parties, if all or part of the evaluation of the mediation panel is rejected, the action may proceed to trial.

b. The mediation clerk shall place a copy of the mediation evaluation and the parties' respective acceptances and rejections in a sealed envelope for filing with the clerk of the court. In a nonjury action, the envelope shall not be opened and the parties shall not reveal the amount of the evaluation until the judge has rendered judgment.

c. If a party has rejected an evaluation and the action proceeds to trial, that party may, if the court so orders, pay the opposing party's actual costs, unless the verdict is more favorable to the rejecting party than the mediation evaluation; provided, however, that if the opposing party has also rejected the evaluation, that party is entitled to costs only if the verdict is more favorable to that party than the mediation evaluation. For the purposes of this subsection, a verdict shall be adjusted by adding to it the assessable costs and interest on the amount of the verdict from the filing of the complaint to the date of the mediation evaluation. Following this adjustment, the verdict shall be considered more favorable to a defendant if it is more than 10% below the evaluation, and is more favorable to the plaintiff if it is more than 10% above the evaluation. The court shall determine the costs pursuant to this subsection, including reasonable fees for attorney services necessitated by the rejection of the mediation panel's evaluation. No costs shall be awarded if the mediation determination or award was not unanimous.

16. (New section) In awarding damages in an action alleging medical malpractice, the trier of fact shall itemize damages into damages for economic loss and damages for noneconomic loss.

17. (New section) a. In any action for damages alleging medical malpractice by or against a health care provider, the total amount of damages for noneconomic loss recoverable by all plaintiffs, resulting from the negligence of all defendants, shall not exceed $250,000, except in any case in which the negligence of a defendant or defendants, whether individually or collectively, is the proximate cause of:

(1) severe and permanent illness or injury that renders the person incapable of independently performing the essential activities of normal daily living and functioning and which cannot be significantly remediated by medical or surgical treatment;

(2) severe chronic and permanent disability which is expected to give rise to a long-term need for specialized health, social, and other services and which makes the person with such a disability dependent upon others for assistance to secure those services;

(3) injury resulting in blindness;

(4) injury resulting in the loss of an organ, permanent loss of a bodily function or system, or loss of a body member;

(5) injury resulting in severe malformation or significant disfigurement, significant scarring, or significant disfigurement that cannot be remediated by medical or surgical treatment;

(6) injury resulting in any significant and permanent degree of paralysis other than paraplegia or quadriplegia which will result in making the person permanently incapable of independently performing the essential activities of normal daily living and functioning;

(7) injury resulting in the person being rendered hemiplegic, paraplegic or quadriplegic, resulting in a total permanent functional loss of one or more limbs caused by injury to the brain or injury to the spinal cord, or both;

(8) injury resulting in permanently impaired cognitive capacity, including, but not limited to, an impairment rendering the person incapable of making independent, responsible life decisions and permanently incapable of independently performing the activities of normal, daily living; or

(9) injury resulting in a permanent loss of or damage to a reproductive organ, resulting in the inability to procreate.

In the case of an illness or injury set forth in paragraphs (1) through (9) of this subsection, the total amount of damages for noneconomic loss recoverable by all plaintiffs, resulting from the negligence of a defendant or defendants, collectively, shall not exceed $500,000.

b. The Supreme Court shall annually adjust the limitations on damages for noneconomic loss established in subsection a. of this

section by an amount determined by the Court to reflect the cumulative annual percentage change in the Consumer Price Index for All Urban Consumers issued by the United States Department of Labor.

18. (New section) a. A judge presiding over an action alleging medical malpractice shall review each verdict to determine if the judgment or settlement is in accordance with the provisions of this act. If the verdict exceeds the limitations on noneconomic loss set forth in section 17 of this act, the court shall set aside any amount of noneconomic damages in excess of the amounts provided therein.

b. A judge presiding over an action alleging medical malpractice shall review each verdict and shall: (1) concur with the award; or (2) upon motion by any party, within 21 days of entry of the judgment of the court, grant a new trial to all or some of the parties, on all or some issues, whenever their substantial rights are materially affected because: (a) the judge determines a verdict to be clearly inadequate, excessive, or disproportionate in view of the nature of the medical condition or injury that is the cause of action; (b) the judge determines excessive or inadequate damages to have been influenced by passion or prejudice; (c) the judge determines a verdict to have been against the great weight of the evidence or contrary to law; (d) the judge determines that there is newly discovered material evidence which with reasonable diligence could not have been discovered and produced at trial; or (e) the judge makes any other determination otherwise provided by law or court rule.

c. Within 21 days after entry of a judgment, the court on its own initiative may order a new trial for any of the reasons set forth in subsection b. of this section, which order shall specify the grounds upon which the order is based.

d. If the court finds that the only error in the trial is the inadequacy or excessiveness of the verdict, the court may grant a new trial unless, within 14 days, the nonmoving party consents in writing to the entry of judgment in an amount found by the court to be the lowest or highest amount the evidence will support, as appropriate. If the moving party appeals, the written consent provided for in this subsection shall in no way prejudice the nonmoving party's argument on appeal that the original verdict was correct. If the nonmoving party prevails on appeal, the original verdict may be reinstated by the Appellate Division.

e. Notwithstanding the foregoing provisions of this section for the granting of a new trial, on application for additur or remittitur by any party to the action on the issue of the amount of damages, the judge may review the amount of damages awarded pursuant to the standards established in this section and may increase or reduce the amount of that award, as he determines to be appropriate.

19. (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 under section 130 of the federal Internal Revenue Code, 26 U.S.C. s.130;

"Future damages" means damages for economic and noneconomic loss which may arise or be incurred after the date on which a judgment or settlement is entered into in an action involving medical malpractice, which shall include future medical treatment, care or custody, loss of earnings, loss of bodily function, or damages for noneconomic loss;

"Judgment creditor" means a plaintiff who is the recipient of an award for economic or noneconomic loss that is as 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 plaintiff an award that is subject to the provisions of this section;

"Plaintiff" means a person bringing an action against a health care provider for medical malpractice;

"Structured settlement" means an agreement made to settle a claim or lawsuit or respond to a judgment in a lawsuit 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 plaintiff, in accordance with the needs of the plaintiff 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. In any judgment or settlement resulting from any medical malpractice action brought by a plaintiff for personal injury or death which is in excess of $1,000,000, or such different amount as agreed upon by the parties with the approval of the court, the court shall enter a judgment ordering that money damages for economic and noneconomic loss, or its equivalent for future damages, shall be paid in the form of a structured settlement by any person, organization, group, or insurer that is contractually liable to pay the judgment or settlement. The sum of $1,000,000 as provided herein shall be adjusted annually, in increments of at least $10,000 and rounded off to the nearest $10,000, by the Supreme Court to reflect the cumulative annual percentage change in the Consumer Price Index for All Urban Consumers issued by the United States Department of Labor.

c. The structured settlement agreement shall be approved by the court and 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, the court that rendered the original judgment shall, upon application of any party in interest, modify the judgment to reduce the amount of payments required under the structured settlement agreement by any amounts attributable to the future medical treatment, care or custody, loss of bodily function, or pain and suffering of the deceased judgment creditor. 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. 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 or settlement shall cease.

20. (New section) If the plaintiff in an action alleging medical malpractice enters into a settlement agreement with a defendant concerning the action, regardless of whether the settlement agreement was entered into under court supervision, and the defendant was a health care provider licensed under Title 45 of the Revised Statutes, the plaintiff's attorney and the defendant's attorney or, if the plaintiff and defendant are not represented by attorneys, the plaintiff and defendant, shall jointly file a complete written copy of the settlement agreement with the professional board in the Division of Consumer Affairs in the Department of Law and Public Safety not later than 30 days after the settlement agreement is entered into. Any such information filed with a professional board shall be confidential except for use by the board, and shall not be subject to disclosure under the provisions of P.L.1963, c.73 (C.47:1A-1 et seq.).

21. (New section) a. A health care facility or health care agency shall not discharge or discipline, threaten to discharge or discipline, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment, or against the privileges of a person who is not an employee of a facility or agency because the employee, other person, or an individual acting on their behalf: (1) reports in good faith or intends to report, verbally or in writing, the medical malpractice of a health care provider; or (2) acts as an expert witness in a civil or administrative action involving medical malpractice.

b. A health care facility or health care agency that violates the

provisions of subsection a. of this section shall be subject to a fine of not less than $5,000 nor more than $10,000 for each violation.

22. (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, shall not be liable for civil damages as a result of an act or omission in the rendering of emergency assistance. 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.

c. The provisions of subsection a. of this section shall 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.).

23. 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)

24. 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, podiatrist or medical resident or intern, the board requests information from a health care facility or health maintenance organization regarding that individual, 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)

25. (New section) a. 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.

b. The report shall include:

(1) the number of complaint files against physicians that were opened in the preceding calendar year;

(2) the number of complaint files against physicians that were closed in the preceding calendar year; and

(3) 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.

c. The report issued in the first year shall contain the information required in this section for the preceding three years.

26. (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 and 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.

27. (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 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 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 the 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.

28. (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 orintentional 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 a group basis or otherwise, 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, except that this prohibition shall not apply to policy deductibles, retrospective rating plans, or other sharing of risk provided for in the policy form;

(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.

29. (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. (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.

30. (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.

31. (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: (1) the claim results in a medical malpractice claim settlement, judgment, arbitration or mediation award against the insured; or (2) the cost of defending the claim with respect to the insured exceeds $10,000 and there is no cause of action against that insured.

b. An insurer authorized to transact medical malpractice liability

insurance shall, in all policies and contracts issued in this State on and after the effective date of P.L. , c. (C.) (now 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.).

32. (New section) Every filing, made after the effective date of P.L. , c. (C.) (now 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, within a reasonable probability, anticipated to be, adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

33. (New section) a. Notwithstanding the provisions of section 8 of P.L.1975, c.301 (C.17:30D-8) to the contrary, if the Commissioner of Banking and Insurance determines that there is insufficient capacity among insurers writing medical malpractice insurance in this State to ensure the availability and affordability of coverage to health care providers in this State, he shall activate the New Jersey Medical Malpractice Reinsurance Association created pursuant to the provisions of P.L.1975, c.301 (C.17:30D-1 et seq.), for the purpose of issuing policies of medical malpractice liability insurance to any category or subcategory of insureds to which that act applies, on a direct basis or otherwise, subject to the provisions of this subsection.

(1) The association shall issue policies only to insureds who have been denied coverage by two or more insurers in the voluntary or surplus lines market.

(2) The reinsurance association shall make available six month and twelve month policies, which shall be issued at the option of the insured.

(3) Cancellation of a policy issued by the association shall not be subject to any cancellation penalty, including, but not limited to, a short-rate cancellation penalty, and any return of unearned premium

shall be made on a pro rata basis.

b. The commissioner shall cause to have developed a rating and classification plan for categories and subcategories of risks. Rates shall be established for policies issued on or after January 1, 2003 on a prospective basis, and shall not reflect any obligations payable by the association for policies issued prior to that date.

(1) The rates charged for association policies may vary by category or subcategory of risk, giving consideration to past and prospective loss experience. Rating systems established by the association shall not be unreasonably high or excessive, shall be adequate to pay the anticipated claims of the association for policies issued on or after January 1, 2003, plus expenses of the association, and shall not be unfairly discriminatory between like risks insured by the association.

(2) The rating plan adopted by the association shall not provide for either a surcharge or a premium increase applicable to any insured named as a defendant in a legal action for medical malpractice if the action was dismissed or if it was determined that there is no cause for action.

(3) Every policy issued by the association shall provide that if the commissioner determines that premium income, together with investment income and other revenues of the association are not adequate, the commissioner may impose a surcharge on policies issued by the association during the policy term. Such surcharges may be assessed in equal amounts among all policyholders or, at the option of the commissioner, may vary in accordance with the loss exposure ascribed to specific categories or subcategories of risks.

c. Not later than the last day of the fourth month following the issuance of the first policy pursuant to this section and on the last day of the two ensuing four-month periods, the actuary engaged by the commissioner to formulate the association's rating plan and commissioner shall certify that the premium rates in effect are adequate to pay the projected losses of the association on a prospective basis.

d. No policy of medical malpractice liability insurance shall be issued or renewed by the association on or after the first day of the thirteenth month following the issuance of the first policy following activation of the facility under subsection a. of this section.

34. 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)

35. 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)

36. Section 2 of P.L.1959, c.90 (C.2A:53A-8) is amended to read as follows:

2. Notwithstanding the provisions of **[**the foregoing paragraph**]** section 1 of P.L.1959, c.90 (C.2A:53A-7), any nonprofit corporation, society or association organized exclusively for hospital purposes or any of its agents or employees, other than licensed physicians, shall be liable to respond in damages to such beneficiary who shall suffer damage from the negligence of such corporation, society or association or any of its agents or **[**servants**]** employees, other than licensed physicians, to an amount not exceeding $250,000, together with interest and costs of suit, as the result of any one accident and to the extent to which such damage, together with interest and costs of suit, shall exceed the sum of $250,000 such nonprofit corporation, society or association organized exclusively for hospital purposes, or any of its agents or employees, other than licensed physicians, shall not be liable therefor.

(cf: P.L.1991, c.187, s.48)

37. 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**]** 30 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 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.**]** Notwithstanding the foregoing, in the case of a physician licensed in this State, the affidavit shall be executed by a person meeting the requirements of an expert witness as set forth in section 6 of P.L. , c. (C.) (now before the Legislature as this bill).
(cf: P.L.1995, c.139, s.2)

38. This act shall take effect on the 90th day next following enactment.

STATEMENT

This bill modifies procedures for the disposition of medical malpractice claims and provides for optional mediation of claims against health care providers. "Health care provider" is defined by the bill as any person licensed in this State to practice medicine and surgery, chiropractic, podiatry, dentistry, optometry, psychology, pharmacy, nursing, physical therapy or as a bioanalytical laboratory director, or a hospital or other health care facility or health care agency. "Medical malpractice" is defined as a negligent act or omission to act 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, provided that such services are within the scope of services for which the health care provider is licensed and which are not within any restriction imposed by the licensing board or licensed hospital.

The bill defines the burdens of proof that the plaintiff in a medical malpractice action must meet; specifically that the defendant, if a general practitioner, failed to provide the plaintiff with the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury; or (2) the defendant, if a specialist, failed to provide the plaintiff with the recognized standard of practice within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available in the community or other facilities reasonably available under the

circumstances, and as a proximate result of the defendant failing to provide that standard the plaintiff suffered an injury. In any action alleging medical malpractice, the plaintiff shall have the burden of proving that he suffered an injury that more probably than not was proximately caused by the negligence of the defendant.

The bill requires the plaintiff in a medical malpractice action to file an affidavit of merit pursuant to P.L.1995, c.139 (C.2A:53A-26 et seq.) 30 days following the filing of the complaint, contrary to the provisions of that law generally. The plaintiff would be required to send a copy of the affidavit to the defendant, and the defendant has the option of filing his own affidavit in response, by an individual that the defendant's attorney believes meets the qualifications for an expert witness as established by the bill. Essentially, to qualify as an expert or to execute an affidavit, the bill requires that the individual be in the same type of practice and possess the same certifications, as applicable, as the defendant. Other requirements for expert and scientific opinions are also spelled out in the bill.

Under the bill, all actions alleging malpractice may be mediated by panel of three neutral mediators, which shall include an attorney that does not do personal negligence work, a health care provider licensed by the same board as the defendant and an active or retired judge, selected in a manner determined by the court. Procedures for the mediation of the complaint are enumerated in the bill. A party to the mediation is permitted, but not required, to attend. If scars or disfigurement exist, they may be demonstrated, but testimony shall not be taken. The Rules of Evidence will not apply and each side shall be limited to a 15 minute oral presentation. The panel's evaluation of the complaint shall be completed and submitted to the parties in writing within 14 days of the hearing. Each party must file an acceptance or rejection of the evaluation. If all of the parties accept the evaluation, judgment shall be entered in that amount. If any party rejects the evaluation, the action may proceed to trial. Costs and interest are also allocated under the bill according to the outcome of the mediation and evaluation process.

Noneconomic damages in medical malpractice actions for injuries that are neither serious or permanent are limited by the bill to $250,000, and serious and permanent injuries or illnesses, as enumerated in the bill, would have a $500,000 limitation. The trier of fact must itemize damages into economic and noneconomic loss. The presiding judge must review each verdict or settlement and set aside any amount of noneconomic damages in excess of the limits specified by the bill. In cases in which the judgment or settlement exceeds $1,000,000, the bill requires structured settlement of money damages for economic and noneconomic loss. In the case of both this amount, and the limits on noneconomic damages, the Supreme Court shall adjust the amounts annually based on the Consumer Price Index. The

bill also amends the current statute of limitations on the filing of suits as it affects minors; suits on behalf of minors would have to be filed for injuries sustained at birth before the minor's tenth birthday.

The bill requires that, in any settled action, the plaintiff and defendant shall jointly file a copy of the settlement agreement with the appropriate professional board in the Division of Consumer Affairs within 30 days of the execution of the agreement. A provision prohibiting retaliation by a health care facility or agency against an employee who reports malpractice or acts as an expert witness in a malpractice action is also included.

Presently, nonprofit hospitals, under the doctrine of charitable immunity, have a $250,000 cap on awards for both economic and noneconomic loss. This bill amends that law to extend the cap to hospital employees other than physicians. The bill also 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 and who, in good faith, nevertheless responds to a request for emergency assistance in a hospital or other licensed health care facility. The bill also provides that health care professionals will not be liable for civil damages for injury or death caused in an emergency situation occurring in the health care professional's private practice on account of failure to inform a patient of the possible consequences of a medical procedure under certain conditions. The bill also establishes a medical error reporting system for health care facilities. These facilities would have to develop and implement a patient safety plan that is designed to reduce or eliminate avoidable medical errors, which are often the cause of medical malpractice lawsuits. Facilities would also have to report adverse events to the Department of Health and Senior Services, which would not be discoverable in any civil action.

To assist physicians in obtaining medical malpractice insurance coverage at the most reasonable price, the bill permits the establishment of purchasing alliances and permits groups of physicians to enter into risk retention agreements. To ensure that insurers writing medical malpractice insurance do not market coverage at inadequate rates to gain market share, as some have in recent years, the bill requires that the chief financial officer attest that, to the extent it can be known, the rates being charged are adequate to pay claims.