CHAPTER 187

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

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

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

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

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

2. The Legislature hereby finds and declares that:

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

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

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

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

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

3. As used in this act:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25. Statutory construction and relationship to other laws.

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

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

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

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

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

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

Approved July 30, 2001.