CHAPTER 17

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

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

C.2A:53A-37 Short title.

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

C.2A:53A-38 Findings, declarations relative to medical professional liability, insurance reform and patient protection.

2. The Legislature finds and declares that:

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

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

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

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

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

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

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

Actions for injury caused by wrongful act, appointment of guardian ad litem.

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

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

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

Disabilities affecting limitation; action on behalf of minor.

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

C.2A:53A-39 Judge may refer medical malpractice action to complementary dispute resolution mechanism.

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

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

C.2A:53A-40 Affidavit of noninvolvement.

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

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

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

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

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

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

C.2A:53A-41 Requirements for person giving expert testimony, executing affidavit.

7. In an action alleging medical malpractice, a person shall not give expert testimony or

execute an affidavit pursuant to the provisions of P.L.1995, c.139 (C.2A:53A-26 et seq.) on the appropriate standard of practice or care unless the person is licensed as a physician or other health care professional in the United States and meets the following criteria:

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

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

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

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

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

(c) both.

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

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

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

(3) both.

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

d. Nothing in this section shall limit the power of the trial court to disqualify an expert

witness on grounds other than the qualifications set forth in this section.

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

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

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

C.2A:53A-27 Affidavit of lack of care in action for professional, malpractice or negligence; requirements.

2. In any action for damages for personal injuries, wrongful death or property damage resulting from an alleged act of malpractice or negligence by a licensed person in his profession or occupation, the plaintiff shall, within 60 days following the date of filing of the answer to the complaint by the defendant, provide each defendant with an affidavit of an appropriate licensed person that there exists a reasonable probability that the care, skill or knowledge exercised or exhibited in the treatment, practice or work that is the subject of the complaint, fell outside acceptable professional or occupational standards or treatment practices. The court may grant no more than one additional period, not to exceed 60 days, to file the affidavit pursuant to this section, upon a finding of good cause.

In the case of an action for medical malpractice, the person executing the affidavit shall meet the requirements of a person who provides expert testimony or executes an affidavit as set forth in section 7 of P.L.2004, c.17 (C.2A:53A-41). In all other cases, the person executing the affidavit shall be licensed in this or any other state; have particular expertise in the general area or specialty involved in the action, as evidenced by board certification or by devotion of the person's practice substantially to the general area or specialty involved in the action for a period of at least five years. The person shall have no financial interest in the outcome of the case under review, but this prohibition shall not exclude the person from being an expert witness in the case.

C.2A:53A-42 Procedure to evaluate award by judge following verdict.

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

C.2A:62A-1.3 Immunity from civil liability for certain health care professionals, certain situations.

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

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

c. The provisions of subsection a. of this section do not diminish a general hospital's responsibility to comply with all Department of Health and Senior Services licensure

requirements concerning medical staff availability at the hospital.

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

(1) the patient was unconscious;

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

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

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

e. As used in this section:

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

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

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

C.45:9-19.16 Physicians, report out-of-State disciplinary, criminal actions.

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

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

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

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

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

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

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

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

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

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

C.45:9-19.13 Notification to health care facility of status of license, permit, registration of licensee.

13. a. In any case in which the State Board of Medical Examiners refuses to issue, suspends, revokes or otherwise conditions the license, registration, or permit of a physician, podiatrist or medical resident or intern, the board shall, within 30 days of its action, notify each licensed

health care facility, psychiatric hospital operated by the Department of Human Services and listed in R.S.30:1-7, and health maintenance organization with which the person is affiliated and every board licensee in the State with which the person is directly associated in his private medical practice.

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

C.17:30D-18 Conflicts of interest; violations; penalties.

13. a. On or after the effective date of P.L.2004, c.17 (C.2A:53A-37 et al.) and except as provided in subsection d. of this section, no person who is an officer, director or board member of a professional association for health care providers shall serve concurrently as an officer, director or board member of a State-domiciled medical malpractice liability insurer that is licensed in the State and offering medical malpractice liability insurance policies on that effective date.

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

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

d. In the case of an officer, director or board member of a medical malpractice liability insurer who is an officer, director or board member of a professional association for health care providers on the effective date of P.L.2004, c.17 (C.2A:53A-37 et al.), the officer, director or board member shall have 180 days to comply with the requirements of this section.

C.17:30D-19 "Medical Malpractice Liability Insurance Purchasing Alliance;" definitions.

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

a. As used in this section:

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

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

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

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

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

alliance; and

(2) procedures for the qualifications and admission of the members of the alliance. The bases for denial of membership shall include, but not be limited to:

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

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

(c) previous expulsion from the alliance;

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

(4) procedures for the expulsion of members from the alliance. The bases for expulsion shall include, but not be limited to:

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

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

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

(5) procedures for the termination of the alliance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C.17:30D-20 Provisions concerning settlements of medical malpractice liability insurance policy.

15. a. A medical malpractice liability insurance policy, which is made, issued or delivered pursuant to Subtitle 3 of Title 17 of the Revised Statutes in this State on or after the effective date of P.L.2004, c.17 (C.2A:53A-37 et al.), may contain a provision that provides a person

insured under the policy with the exclusive right to require the insurer to obtain the consent of the insured to settle any claim filed against the insured; except that, if the policy contains that provision, the insurer shall offer an endorsement, to be included in the policy at the option of the insured, providing the insurer with the right to settle a claim filed under the policy without first having obtained the insured's consent. The insurer shall establish a premium for the endorsement, which premium shall reflect any savings or reduced costs attributable to the endorsement.

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

C.17:30D-21 Offering of deductibles in medical malpractice liability insurance policy.

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

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

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

C.17:30D-22 Increase of premium prohibited, certain circumstances.

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

C.17:30D-23 Certification as to adequacy of rates.

18. Each annual statement made after the effective date of P.L.2004, c.17 (C.2A:53A-37 et al.), pursuant to the provisions of section 16 of P.L.1982, c.114 (C.17:29AA-16), by an insurer writing medical malpractice in this State, shall include a certification by the chief executive officer or chief financial officer that the rates for every category, subcategory, or risk classification are adequate to cover expected losses and expenses of the insurer and to ensure the safety and soundness of the insurer.

C.17:30D-24 Mailing of notice of renewal, nonrenewal.

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

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

C.17:29AA-13 Rate policy from noncompliance; order of commissioner; provisions for medical malpractice.

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

b. If the commissioner finds, after a hearing, that a rate in effect for any insurer writing medical malpractice liability insurance is not in compliance with the provisions of P.L.1982,

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

C.17:30D-25 Annual review of capitalization, reserve requirements.

21. Subject to standards adopted by the National Association of Insurance Commissioners, the Commissioner of Banking and Insurance shall, within 180 days after the effective date of P.L.2004, c.17 (C.2A:53A-37 et al.) and annually thereafter, review the current capitalization and reserve requirements applicable to insurers authorized or admitted to transact medical malpractice liability insurance in this State, as those requirements are established by statute or regulation, or both.

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

C.17:30D-26 Option of installments for premium payments.

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

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

C.17:30D-7 Insurer to notify Medical Practitioner Review Panel of malpractice settlement, judgment, award.

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

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

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

c. The form of notification shall be prescribed by the Commissioner of Banking and Insurance, shall contain such information as may be required by the board and the review panel, and shall be made within seven days of the settlement, judgment or award or the final action for a termination or denial of, or surcharge on, the medical malpractice liability insurance. Upon request of the board, the review panel or the commissioner, an insurer or insurance association

shall provide all records regarding the defense of a malpractice claim, the processing of the claim and the legal proceeding; except that nothing in this subsection shall be construed to authorize disclosure of any confidential communication which is otherwise protected by statute, court rule or common law.

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

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

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

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

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

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

C.17:30D-27 Definitions relative to medical malpractice judgments; payment.

24. a. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

C.45:9-19.17 Medical malpractice liability insurance, letter of credit required for physician, regulations.

1. a. A physician who maintains a professional medical practice in this State and has responsibility for patient care is required to be covered by medical malpractice liability insurance issued by a carrier authorized to write medical malpractice liability insurance policies in this State, in the sum of $1,000,000 per occurrence and $3,000,000 per policy year and unless renewal coverage includes the premium retroactive date, the policy shall provide for extended reporting endorsement coverage for claims made policies, also known as "tail coverage," or, if such liability coverage is not available, by a letter of credit for at least $500,000.

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

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

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

d. The State Board of Medical Examiners shall notify all physicians licensed by the board of the requirements of this section within 30 days of the date of enactment of P.L.2004, c.17.

C.17:30D-28 Definitions relative to Medical Liability Insurance Premium Assistance Fund.

26. For the purposes of sections 27 and 28 of P.L.2004, c.17 (C.17:30D-29 and 17:30D-30):

"Commissioner" means the Commissioner of Banking and Insurance.

"Fund" means the Medical Malpractice Liability Insurance Premium Assistance Fund established pursuant to section 27 of P.L.2004, c.17 (C.17:30D-29).

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

"Practitioner" means a physician, podiatrist, dentist and chiropractor and a nurse employed by a licensed hospital, long-term care facility or assisted living facility in this State.

C.17:30D-29 Medical Malpractice Liability Insurance Premium Assistance Fund.

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

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

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

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

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

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

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

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

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

The provisions of paragraph (6) of this subsection shall not apply to attorneys who: are constitutionally or statutorily barred from the practice of law; can show that they do not maintain a bona fide office for the practice of law in this State; are completely retired from the practice of law; are on full-time duty with the armed forces, VISTA or the Peace Corps and not engaged in practice; are ineligible to practice law because they have not made their New Jersey Lawyers' Fund for Client Protection payment; or have not practiced law for at least one year.

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

d. The fund shall be administered by the Department of Banking and Insurance in accordance with the provisions of P.L.2004, c.17 (C.2A:53A-37 et al.).

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

(1) $17 million shall be allocated annually for the purpose of providing relief towards the payment of medical malpractice liability insurance premiums to health care providers in the State who have experienced or are experiencing a liability insurance premium increase in an amount as established by the commissioner by regulation and meet the criteria established pursuant to section 28 of P.L.2004, c.17 (C.17:30D-30);

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

(3) $1 million shall be allocated annually for a student loan expense reimbursement program for obstetrician/gynecologists, to be established pursuant to section 29 of P.L.2004, c.17 (C.18A:71C-49); and

(4) $1.2 million shall be allocated annually to the Division of Medical Assistance and Health Services in the Department of Human Services for the purposes provided in section 30 of P.L.2004, c.17 (C.30:4J-7).

f. The fund and the annual surcharge, charges and fee provided for in subsection b. of this section shall expire three years after the effective date of P.L.2004, c.17 (C.2A:53A-37 et al.).

g. The commissioner, in consultation with the Commissioner of Health and Senior Services, shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to carry out the purposes of sections 26 through 29 of P.L.2004, c.17 (C.17:30D-28 through C.17:30D-30 and C.18A:71C-49); except that, notwithstanding any provision of P.L.1968, c.410 to the contrary, the commissioner may adopt, immediately upon filing with the Office of Administrative Law, such regulations as the commissioner deems necessary to implement the provisions of sections 26 through 29 of P.L.2004, c.17 (C.17:30D-28 through C.17:30D-30 and C.18A:71C-49), which shall be effective for a period not to exceed six months and may thereafter be amended, adopted or readopted by the commissioner in accordance with the requirements of P.L.1968, c.410.

C.17:30D-30 Responsibilities of commissioner.

28. a. In order to carry out the purposes of section 27 of P.L.2004, c.17 (C.17:30D-29), the commissioner shall, at a minimum:

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

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

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

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

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

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

(1) In order to be eligible for a subsidy from the fund, a practitioner shall have received a medical malpractice liability insurance premium increase in an amount as determined by the commissioner by regulation, for one or more of the following: upon renewal on or after January 1, 2004, from the amount paid by that practitioner in calendar year 2003; upon renewal

on or after January 1, 2005, from the amount paid by that practitioner in calendar year 2004; and upon renewal on or after January 1, 2006, from the amount paid by that practitioner in calendar year 2005; or

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

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

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

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

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

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

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

g. For the purposes of section 29 of P.L.2004, c.17 (C.18A:71C-49), the commissioner, in consultation with the State Board of Medical Examiners, shall provide to the Higher Education Student Assistance Authority the names of obstetrician/gynecologists licensed by the board who may qualify for the student loan reimbursement program established pursuant to P.L.2004, c.17. A physician who has been subject to a disciplinary action or civil penalty by the board, as provided in subsection c. of this section, shall not be eligible for the program.

C.18A:71C-49 OB/GYN student loan expense reimbursement program.

29. a. There is established a student loan expense reimbursement program within the Higher Education Student Assistance Authority for obstetrician/gynecologists who agree to practice in State designated underserved areas as established pursuant to section 1 of P.L.1999, c.46 (C.18A:71C-35). Any loans provided through the NJCLASS Loan Program pursuant to P.L.1999, c.46 (C.18A:71C-21 et seq.) or a student loan program of the federal government shall be eligible for reimbursement under this program.

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

b. (1) An obstetrician/gynecologist who receives a payment under the student loan expense reimbursement program shall be required to practice as an obstetrician/gynecologist in an underserved area in this State for a period of at least four years after receipt of the payment.

(2) An obstetrician/gynecologist who fails to comply with the provisions of paragraph (1) of this subsection shall be required to repay to the Higher Education Student Assistance

Authority the amount of the payment, in whole or in part as determined by the authority.

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

C.30:4J-7 Eligibility for Family Care Health Coverage Program, women, certain.

30. Within the limits of funds appropriated pursuant to section 27 of P.L.2004, c.17 (C.17:30D-29) and such other funds as may be available for this purpose, the FamilyCare Health Coverage Program established pursuant to P.L.2000, c.71 (C.30:4J-1 et seq.) shall enroll into the program women whose eligibility under the Medicaid New Jersey Care pregnant women program or the "New Jersey Standardized Parent Service Package," Demonstration Population 3, Medicaid expansion for uninsured pregnant woman, has expired and whose family income does not exceed 100% of the federal poverty level.

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

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

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

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

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

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

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

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

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

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

force.

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

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

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

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

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

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

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

C.17:30D-31 Rules, regulations.

32. The Commissioner of Banking and Insurance shall adopt rules and regulations, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to carry out the purposes of sections 13, 16 through 19, 21, 22 and 24 of this act.

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

Approved June 7, 2004.