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# *Public Hearing*

before

ASSEMBLY BANKING AND INSURANCE COMMITTEE  
and  
ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

*“Testimony on a proposal to provide medical malpractice insurance  
premium assistance for New Jersey physicians”*

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**LOCATION:** Committee Room 4  
State House Annex  
Trenton, New Jersey

**DATE:** May 1, 2003  
10:00 a.m.

**MEMBERS OF COMMITTEES PRESENT:**

Assemblyman Neil M. Cohen, Chairman  
Assemblyman John F. McKeon, Vice-Chairman  
Assemblyman Jack Connors  
Assemblyman Anthony Impreveduto  
Assemblyman Robert J. Smith II  
Assemblyman Christopher “Kip” Bateman  
Assemblyman Paul R. D’Amato

Assemblywoman Loretta Weinberg, Chairwoman  
Assemblyman Herb Conaway, Vice-Chairman  
Assemblyman Upendra J. Chivukula  
Assemblyman Jerry Green  
Assemblywoman Nellie Pou  
Assemblyman Sean T. Kean  
Assemblywoman Charlotte Vandervalk



**ALSO PRESENT:**

Mary C. Beaumont  
David Price  
*Office of Legislative Services  
Committee Aides*

Sheila Kenny  
Wali Abdul-Salaam  
*Assembly Majority  
Committee Aides*

Marianne L. Ingrao  
Tasha M. Kersey  
*Assembly Republican  
Committee Aides*

***Meeting Recorded and Transcribed by***  
The Office of Legislative Services, Public Information Office,  
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

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**ASSEMBLYWOMAN LORETTA WEINBERG (Cochair):** Good morning, ladies and gentlemen, and welcome to the Joint Hearing of the Assembly Banking and Insurance Committee and the Assembly Health and Human Services Committee.

David, would you please take the role for the Assembly Health Committee.

MR. PRICE (Committee Aide): Assemblyman Kean.

ASSEMBLYMAN KEAN: Here.

MR. PRICE: Assemblywoman Pou.

ASSEMBLYWOMAN POU: Here.

MR. PRICE: Assemblyman Chivukula.

ASSEMBLYMAN CHIVUKULA: Here.

MR. PRICE: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Here.

MR. PRICE: Assemblywoman Weinberg.

ASSEMBLYWOMAN WEINBERG: Here.

Assemblyman Green is here.

MR. PRICE: And Assemblyman Green.

A quorum is present.

ASSEMBLYWOMAN WEINBERG: Take the role for the Insurance Committee.

MS. BEAUMONT (Committee Aide): Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Here.

MS. BEAUMONT: Assemblyman Bateman.

ASSEMBLYMAN BATEMAN: Here.

MS. BEAUMONT: Assemblyman Smith.

ASSEMBLYMAN SMITH: Here.

MS. BEAUMONT: Assemblyman Impreveduto.

ASSEMBLYMAN IMPREVEDUTO: Here.

MS. BEAUMONT: Assemblyman Connors.

ASSEMBLYMAN CONNERS: Here.

MS. BEAUMONT: Assemblyman McKeon.

ASSEMBLYMAN McKEON: Present.

MS. BEAUMONT: Assemblyman Cohen.

**ASSEMBLYMAN NEIL M. COHEN (Cochair):** Yes, here.

ASSEMBLYWOMAN WEINBERG: Just to lay out the outline of this hearing this morning: We are not going to be taking official action this morning, because we have not officially received the Senate version of the medical malpractice bill, because our board has not been open since the Senate passed its bill. The discussion, we hope, mainly will be on the issues that we are going to put into our bill -- of the direct premium assistance, and the method of funding to come up with that premium assistance. So that's the gist of our conversation this morning, although we will, certainly, give people some latitude in what they want to testify for.

So, with that as the parameters, I would like to first call on our Majority Leader, Assemblyman Joseph Roberts, who has some comments he'd like to share with us.

**A S S E M B L Y M A N J O S E P H J. R O B E R T S J R.:**  
Assemblywoman Weinberg, thank you very much; Assemblyman Cohen, and to the members of the Committee -- it's a pleasure to be with you. I want to

begin by thanking each and every member of this Joint Committee for the time that you have devoted to this issue. It is clear that this is an issue that has appropriately dominated the public debate, because it affects so many healthcare providers and so many people who depend upon them. And you are all to be commended, and on behalf of myself and Speaker Sires and your colleagues in the General Assembly, I want to say, irrespective of where you are on this issue, thank you for the commitment that you have made to tackle this.

I want to particularly thank Assemblywoman Weinberg and Assemblyman Cohen, as the Chairs of this joint effort, and Assemblyman John McKeon, who is one of my cosponsors on Assembly Bill No. 50. They particularly have distinguished themselves by devoting countless hours to this issue in meetings, that many of you recognize occur sometimes out of the glare of the television cameras and the media, where a lot of the real hard work is done. They've been great, great credits to the General Assembly. So, Loretta and Neil and John, particularly, thank you so very much for the work that you've done.

As the Chairwoman said at the outset, this is not official consideration of Assembly Bill No. 50, or any specific piece of legislation today, because it's not technically been received by the Assembly yet. But I wanted to just take a few moments to talk about the concept of premium assistance and why we think that is meritorious, and why we believe that is, in fact, the way to go. Assembly Bill No. 50, in the manner that it is currently proposed by the sponsors, would create a five-year, \$150 million fund for direct, immediate premium assistance.



The Department of Banking and Insurance, the Department of Health and Senior Services would establish criteria to ensure that the hardest hit physicians would be entitled to this assistance. The criteria in order to participate would include whether the physician practices in a certain high-risk speciality, whether his or her premium increase exceeds certain threshold percentages, whether the increase will have an adverse impact on the physician's ability to practice, whether the physician has been subject to any disciplinary action, and whether the overall impact of premium increases, when patient access to medical care in the applicant's geographical area or region--

The intent of this is that physicians in high-risk specialities and sub-specialities, such as obstetrics and neurosurgeons, will directly, immediately benefit from this subsidy. Our proposal will be fashioned in a manner similar to what the Senate has advocated: namely, a modest, \$3 assessment per employee; a \$50 annual surcharge on doctors, lawyers, and certain other professionals. Approximately \$30 million will be generated per year through these assessments. And as you know, the fund would sunset at five years.

Assembly Bill No. 50, as amended by the Senate, also allows the courts to overturn jury awards that are "clearly inadequate, excessive, or disproportionate." This is very, very important for those who are concerned about the occasional inappropriate jury verdict that in many cases has had an adverse impact on premiums. That approach gives the courts flexibility to overturn these unfair awards, and is, in my judgment, superior to imposing a harsh and subjective ceiling on compensation for victims of substandard medical care.

In contrast to what is currently contained in the bill, as amended, in the Senate, there is simply no way of knowing whether or not the Senate fund will provide the sufficient relief to med-mal victims. We have heard that the fund, which appropriates \$30 million annually, may conceivably need upwards of \$80 million per year in order to meet its obligations, thus creating a potential \$50 million per year shortfall.

In my judgment, it is reckless to take such a risk, especially given the lack of evidence establishing the correlation between caps on noneconomic damages and a reduction in medical malpractice premiums. The Senate legislation establishes a task force to examine the caps issue, which we support in order to gather more information on this very important issue. But the information we have now does not justify imposing a cap on noneconomic damages.

California is often cited as a state where caps on noneconomic damages have worked, but the Foundation for Taxpayer and Consumer Rights reports that between 1991 and the year 2000, the average premium increase in California was 3.5 percent, and it actually grew more quickly than the national average, which was 1.9 percent. Caps on damages have been declared unconstitutional in seven states: Alabama, Florida, Illinois, New Hampshire, South Dakota, Texas, and Washington.

Let's take a minute and discuss who gets hurt by caps. Caps disproportionately impact our elderly, which is why the AARP has spoken out, as recently as this week, against caps. Our older citizens are victims of medical mistakes and may not suffer economic damages, but they do suffer tremendous pain and suffering. The sad truth is, if there are caps on noneconomic damages,

many attorneys will not pursue cases on behalf of older victims in New Jersey.

Caps on noneconomic damages also discriminate against low- and middle-income workers who do not receive large economic damages that are attributable to their lost earning capacity.

Caps in medical cases discriminate, as well, against women, who are more likely to be the victim of medical malpractice than men, and who are more likely to suffer the types of injuries, such as miscarriage or loss of reproductive capacity, that simply may not translate into lost wages, but certainly take a tremendous toll on victims. Caps on noneconomic damages discriminate against our children, who will suffer for a greater number of years than adult med-mal victims, but who will run the risk of not being fully compensated for their disability before being capped at an arbitrary amount.

Most persuasive of all is that caps simply are not fair. A victim of medical malpractice does not “win a jackpot.” These are individuals who may be paraplegic, blind, disfigured, or brain-damaged because of a medical error. In my view, Assembly Bill No. 50 preserves our system of allowing jurors to determine the appropriate level of damages for victims, but allows courts unprecedented latitude to correct the occasional egregious misjudgment. It is a balanced and appropriate way to achieve medical malpractice insurance reform, without doing so on the backs of seriously injured victims in New Jersey.

My colleagues, let me just conclude, again, by thanking you for your efforts. It is our job, on important public policy issues like this, not, frankly, to choose one side or the other, but to search for that middle ground, to search for that balance that protects all the parties, the interested parties, in an appropriate fashion -- and, if you will, doesn't take the easy way out. It

would be very easy to side with the Medical Society, or the trial bar, or the patient advocates and give any group anything that they wanted.

Your work has been to work on that middle ground, and I compliment you for that. I know that you have many important witnesses to hear from today, and I want to thank you again for the hours that you have devoted to this matter.

Thank you very, very much.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Majority Leader -- and, I neglected to mention, the prime sponsor of A-50.

ASSEMBLYMAN ROBERTS: Thank you, Assemblywoman.

ASSEMBLYMAN COHEN: Physicians and Patients for Quality Care. If each of you could state your names and the organizations you represent, and you have to press the red button to speak.

**ROONEY SAHAI:** Good morning, Madam Chair, Mr. Chairman, and honorable members of the Committees. My name is Rooney Sahai, and I serve as the Executive Director for Physicians and Patients for Quality Care. I have here three of my colleagues: Dr. George Ciechanowski, he's on my right side. He's a pulmonary medicine specialist in Hudson County. Dr. Delores Lao is an OB/GYN from Secaucus, New Jersey. Dr. Juliano is an orthopedic surgeon from Bergen County. We would like to thank you for the opportunity to come before you and state our position.

A lot of debate has occurred on caps. We feel that any position that compromises the rights of patients should be carefully considered. We have looked at evidence from California. In our opinion, what we saw was, in 1975, they passed their caps. It was not until 1988, when Proposition 103 was

passed, that physicians were able to see any rollback or reduction or containment in their medical malpractice premiums.

More recently, states like Missouri, Minnesota, Nevada, and Ohio have passed their caps, and physicians have yet to see any reduction or containment in their medical malpractice premiums, nor is any reduction or containment in these premiums in sight.

Having said that, I would like Dr. Ciechanowski to say a few words on this issue.

**GEORGE CIECHANOWSKI, M.D.:** Thank you very much.

Madam Chair, Mr. Chairman, honorable Committee members, I am a practicing pulmonologist. I also do critical care. I've been in practice since 1986 in Hudson County. I am here, really, to tell you that we do not see capitation as a solution, as an immediate help, for physicians. Physicians' practices -- I see my colleagues on a daily basis in the hospital. They are really drowning, in this day and age, due to the high, escalating costs of maintaining a practice, an independent practice, outside of the hospital, and not being an employee.

We really need a life raft in order to support ourselves and to continue to help our patients. This is really about saving individual practices and helping patients in the interim.

Thank you.

MR. SAHAI: A lot of physician practices are drowning, according to Dr. Ciechanowski. They're looking for life rafts. These political debates on caps and reform have not presented any viable solution that benefits physicians or patients. What we've heard from Majority Leader Roberts -- and let me

loosely call it the subsidy fund -- gives us some hope that physicians can benefit without compromising patient rights in the near future.

I would like to draw your attention to an OB/GYN from Hudson County, New Jersey. I've had the privilege of knowing Dr. Delores Lao for over two years. As I enter her office, I find my demeanor changing to a more softer, more comfortable one. Her office has been a very kind office, a very sweet office. Dr. Lao, as she tells me, has been in practice for about 24 years. It was not until the last five years that she first experienced a malpractice suit, which was ultimately dropped. And it was not until recently she has a case open. There is no evidence of any malpractice whatsoever.

Her premiums last year were approximately \$45,000. Being close to retirement, that was at the height of her budget. This year the premiums, from \$45,000, were escalated to \$130,000. The reason I would like to draw your attention to Dr. Lao is because she has decided -- I believe, and I can speak for her, with quite a bit of pain and suffering -- to close her doors to her patients. I believe this is not just Dr. Lao's loss. Her patients who she cared for, for a number of years, lose a lot more. They lose a caring physician and the community loses her as well.

A life raft is what we're seeking, and the subsidy package offers some hope. Dr. Lao, like other physicians in the last 10 years, have experienced reimbursements cut in the neighborhood of 30 to 50 percent. In the same time period, practice costs and inflation have escalated 30 to 50 percent. Twelve years ago, an OB/GYN was reimbursed approximately \$4,000 for nine months of care and delivery of a child. Today, that \$4,000 is down to approximately, on average, \$2,000. And if you factor in the ravages of inflation on top of that,

there isn't a whole lot left. And on the heels of all this, we have huge premium escalations in medical malpractice insurance, which are forcing physicians to close their doors, and again, compromising patient care.

And on that disappointing note, I would like to hand the microphone over to Dr. Lao.

**DELORES LAO, M.D.:** Hi. I'm Dr. Lao. I'm an OB/GYN practicing in Hudson County. I've been in practice for 24 years. Last month I had to close my office because I cannot afford my malpractice insurance, which goes from \$45,000 to \$130,000. I had a case, five years ago, which was dropped, and recently I have an open case, but it has not been settled yet. With this increasing malpractice, a lot of my colleagues are suffering from pain -- and because they could not afford the malpractice. And soon, more OB/GYNs are going to be dropping out of practice because of the escalating malpractice insurance.

MR. SAHAI: Thank you.

I would like to also try and draw the attention of the Legislature to the overall picture. As I pointed out earlier -- that reimbursements have fallen almost up to 50 percent or more in the last 10 years. And the question one asks, had reimbursements remained steady would there be a crisis today, or would there be a crisis in the magnitude that we have today?

As we turn our attention to the reimbursements, we seek the support of the Legislature and other groups to support patient-friendly physicians that we represent in seeking solutions that will benefit physicians and will not compromise the rights of patients.

The minimum wage-- May I ask what the minimum wage is these days, if someone can please volunteer, approximately?

I'm sorry?

ASSEMBLYMAN BATEMAN: Seven-forty-five, 7.50.

ASSEMBLYMAN McKEON: The Democrats want to move it to 10.

MR. SAHAI: Seven dollars. Okay. All right.

ASSEMBLYWOMAN WEINBERG: I don't believe it's that high, but-- It's \$5.35, I think.

MR. SAHAI: What is half of \$7? Three dollars and fifty cents. Well, I got to tell you something. Almost every physician has been working at 50 percent of the minimum wage, and I use this as an analogy. And with this rise in malpractice premiums, there is no room to absorb that. And it's time to focus our attention on the larger picture of reimbursements.

And with that, I'd like to hand the floor to Dr. Ciechanowski.

DR. CIECHANOWSKI: I would like to reiterate what Rooney just said. Physicians are really caught at this present time between a rock and a hard place. The declining reimbursements that we are facing and the escalating costs that we are facing, at the other end, has really provided a very big, short squeeze, and many physicians really cannot maintain their practices in this type of an environment. If we are seeking to lessen the burden of malpractice, this is not the way to do it. By making physicians work harder, longer hours, seeing more patients per day will not lessen the episodes of malpractice. It will, rather, escalate them. I think that we need to be reimbursed at a fair level in order for



us to spend more time with our patients and provide them the quality care that they deserve.

Thank you.

MR. SAHAI: Dr. Juliano, would you like to offer any comments?

**A. B. JULIANO, M.D.:** Well, I agree with what you and Dr. Ciechanowski--

ASSEMBLYWOMAN WEINBERG: Excuse me, Dr. Juliano, you must use a microphone. (referring to PA microphone)

Thank you.

DR. JULIANO: Well, I agree with what you said, Rooney, and what Dr. George has said. I have nothing else to add at this point.

MR. SAHAI: Okay.

Thank you for listening.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Yes, Mr. Sahai. You're the Executive Director of Physicians and Patients for Quality Care. How old is your organization?

MR. SAHAI: Your question is how is the organization--

ASSEMBLYMAN CONAWAY: How old is your organization? When was it formed, and do you collect dues from members? How many members do you have?

MR. SAHAI: The organization was founded in July of 2002. The organization, currently, has the support of approximately 3,000 physicians throughout New Jersey. We are very strong in Hudson County. This organization continues to grow every week.

ASSEMBLYMAN CONAWAY: What is your dues structure? They pay you a salary, I guess.

MR. SAHAI: There is a dues structure, sir.

ASSEMBLYMAN CONAWAY: Now, you mentioned that you did some analysis of, I guess, caps or something like that. I mean, are you an actuary yourself, or what's your professional background, if you don't mind my asking?

MR. SAHAI: I'm a manager of physician practices with an insurance background, and I don't believe I need an actuarial background or an underwriting background to analyze the situation. I have analyzed the situation together with a bunch of physicians. From among other perspectives, from a commonsense perspective, we have tried to be analytical. We have looked at a lot of research from actuaries and other research that most folks here have been privy to. And the conclusions were drawn from those researches.

ASSEMBLYMAN CONAWAY: Madam Chair, if I may.

I have looked at-- I mean, I'm not an actuary myself, but people who bring testimony and who are experts, I think, would disagree that caps won't provide any benefit.

You mentioned that, and I agree with you, that caps won't provide any immediate benefit. No one has asked that, but what do you think of this statement? Many of us feel that without underlying reform we're not going to achieve long-term stability in the marketplace for medical malpractice insurance, and that we physicians will always be subject to these forces which drive our costs, costs that we can't recoup in terms of reimbursement, and that putting money into a system that is fundamentally flawed is, one might argue, a waste

of money. Well, not a waste of money, because there will be some immediate help for physicians, who otherwise would be out of business. But don't you think that it is inappropriate for lawmakers to think about the long-term health of the healthcare delivery system, to think 10 years down the road or more, to bring the kind of fundamental structural reforms that will prevent this kind of hearing from taking place in five or 10 years. What kind of reform do you think we ought to do, other than just throwing money in a system that we're not prepared to change?

MR. SAHAI: Thank you.

Dr. Conaway, when we analyzed California's situation, our analysis has the perspective where these physicians need immediate relief, which, unfortunately, has to be of a monetary nature. As we analyzed the California situation, we have not been able to see any evidence of rate reduction or containment. Up until Proposition 103 came to pass in 1988, states like Missouri, Minnesota, Nevada, and Ohio have all passed caps, and we have not yet seen any indication of rate reduction or premium containment. Nor is any expert out there making a prediction or call on that.

ASSEMBLYMAN CONAWAY: Well, that's not quite true. Because there are experts that are saying that caps will bring relief. And as I said to you, and I think there's general agreement, that caps won't bring any immediate relief. So when you mentioned these states who have recently passed their caps and you tell me there's no rate reduction -- of course there's no rate reduction. There are a lot of cases in the pipeline that are still going to continue to drive those insurance rates in those states for some time to come. Many people say three to five years. And so there is a time line involved here. And so,

for the future, because people are going to come up here and talk about the caps that aren't working in these states, I just want, for the record, for everyone in here to know that, of course, those caps are not going to bring immediate relief on the premiums, and that we are talking about a time line that is three to five years or, perhaps, more. So, perhaps, we won't hear that with every witness that comes up opposing caps.

ASSEMBLYWOMAN WEINBERG: Any other questions here?  
Go ahead, Mr. Sahai.

MR. SAHAI: I just want to put in my last word on that, please.  
There are other measures--

Dr. Ciechanowski, would you like to point them out.

DR. CIECHANOWSKI: I think your comments are very well taken, Dr. Conaway. However, as a fellow colleague of yours, I think we look across the state and we see physicians whose practices are dying today. Waiting three to five years is not an option for those physicians out there. I think while we seek the long-term solution, I think we really do need a life raft or a stop-gap measure in the immediate future for those practices and those physicians and those patients today.

ASSEMBLYMAN CONAWAY: I agree.

DR. CIECHANOWSKI: Thank you.

MR. SAHAI: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Vandervalk.

ASSEMBLYWOMAN VANDERVALK: Thank you.

I've listened closely to what you said, and you say we need life rafts and stop-gap measures, but you don't say what they are. The only thing you

mentioned in a positive way, as to what you would like, would be increased reimbursements, which is something we really can't deal with at this table, certainly not today. So, if you could spell out -- is there something more specific you could say as to what you're looking for in the way of a life raft?

MR. SAHAI: Sure. For the first time in 18 months, Majority Leader Roberts's proposal of -- if I can loosely call it a subsidy fund -- offers hope. It offers hope because it is a simple plan. It offers hope because the benefit appears to be immediate. What we have heard is, if a physician qualifies for relief based on the percentage increase in premium costs, this fund intends to refund to the physician approximately 50 percent of the increase. That could make the difference between staying in practice or closing the door. And that would be my answer.

ASSEMBLYWOMAN VANDERVALK: In Dr. Lao's case, I don't think that would be sufficient to-- If it was 50 percent of the increase, we would be talking about \$45,000 or \$50,000. I don't know if that would be enough to keep her in business.

MR. SAHAI: We don't know that. However, it's a step closer to keeping physicians, like herself, in business. The reason we support it is because it looks like an immediate benefit to physicians, which comes at no cost to the patients or anyone else.

ASSEMBLYMAN COHEN: Thank you very much. Thank each of you for coming down.

MR. SAHAI: Thank you.

DR. JULIANO: Thank you.

DR. CIECHANOWSKI: Thank you, Mr. Chair.

ASSEMBLYWOMAN WEINBERG: The next witness is Catherine Fulton.

**R O N A L D G O L D F A D E N, E S Q .:** Good morning, ladies and gentlemen. My name is Ronald Goldfaden, and I want to thank you for inviting us to speak today. I am a personal injury attorney specializing in medical malpractice, and I'm proud to represent the family of Richard Fulton, along with his wife, Catherine Fulton, who will be sitting next to me and will be speaking to you in a few moments.

I'm here today to, hopefully, put a human face on some of the victims of medical malpractice, so that you can see that some of the things that you hear in the press about victims looking for a jackpot or a payday is not always what we actually see -- those that handle medical malpractice claims. I'm here today to tell you about the wrongful death of a beloved member of our community, a treasured husband and father of two children, a man in his late forties who had everything to live for. His life was destroyed by a total disregard of hospital protocol and procedure, as well as an act of astonishing negligence by a doctor.

One year ago, Richard Fulton was 49 years old when he felt a lump on his neck. He was diagnosed as having a Burkitt's lymphoma, and he was started on chemotherapy. He was to receive four medications; three of them were to be infused intravenously into his veins, and one of them was to be put into his spine intrathecally. On July 25, 2002, eight hours after it had been administered, the hospital realized that they had put the wrong medication into his spine. When they checked the medical literature, they realized that this had

only been reported to have happened 14 times ever before, and that in each instance the person died.

When they told Mr. Fulton of his mistake, they told him that he was certain to die. Over the next day, he called in his 12-year-old son, Ryan, and he told him to take care of mommy. He called in his 4-year-old daughter, Katie, and hugged and kissed her goodbye for the last time. And over the next four days, he died an excruciatingly painful death with ascending paralysis up his legs, to his waist, to his chest. He lost his hearing, and he lost his gag reflex, and he was in such pain that they started a morphine drip until he died four days later.

The only thing that is more horrible than the actual malpractice, or the death that Mr. Fulton sustained, is the fact that this was so easily preventable. The medication that Mr. Fulton received is called Vincristine. And as you can see (indicating bottle), the bottle has a clear warning on the outside of the package which indicates “fatal if given intrathecally. For intravenous use only.” In addition to that, the medication comes with a whole host of additional package inserts and warnings. The package insert, also, has a warning that this medication should be administered by individuals experienced in the administration of Vincristine, it is extremely important that the intravenous needle be properly positioned, and that it will be fatal if given intrathecally.

In addition, there are additional warnings on the package inserts. And as you can see (indicating bottle), there is, actually, on the bottle itself, another warning that indicates that this is for intravenous use only, and that this is a potent drug that is potentially fatal if given in the wrong administration. In

addition to all of those warnings, there is also a warning that is supposed to go directly on the syringe itself, which, as you can see again, gives the clear warning to the doctors. And finally, and almost unbelievable with all of these warnings, the medication actually comes with plastic baggy overwraps where the syringe goes inside this overwrap. And as you can see, there is a clear warning that says, "Don't remove this syringe until the moment of injection. Fatal if given intrathecally." The medications that Mr. Fulton received, which are indicated here, also clearly indicated that this medication was not for intrathecal use.

Let me just tell you, very briefly, about the kind of man that Richard Fulton was. In addition to his wife and two children, he had worked for the last 15 years as the Director of Special Education Services for Monmouth and Ocean County Services. He was the director responsible for providing all special ed services to nonpublic schools. These included things such as English as a Second Language, home instruction, compensatory education. He had programs for pregnant teens, prior to school and after school. He was a Eucharistic minister and religious education teacher at his church. He formerly was the principal at Mt. Carmel Guild School in Jersey City, and before that, the director of the Holy Rosary Day Care Center.

I'd just, rather than speak about him any further myself, want you to hear from a nun who worked with Richard and who was with him the day before he died.

(runs program on Richard Fulton)

Ladies and gentlemen, I know you have a difficult task. Please don't forget the victims of legitimate medical malpractice when you undertake your difficult responsibility.



I'd like, at this time, to introduce Catherine Fulton, who has a few remarks that she would like to make, very briefly.

Thank you.

**CATHERINE FULTON:** Good morning.

I am here today to speak to your about how my husband became a victim of malpractice and how it has affected our family and me. I call those last days of Richard's life *the nightmare weekend*. Nine months later, our 12-year-old son, Ryan, and 4-year-old daughter, Katie, and me are still living in this nightmare.

These months have been very difficult for Ryan. I have been told the most devastating and traumatic time for a child to lose a parent is that of a 12-year-old boy. Not only is Ryan dealing with adolescence, he is grieving the loss of his dad. To make things even more devastating, he is extremely angry with the doctor for being so careless as to not read the label of his dad's chemotherapy. It is mind-boggling to him, and for that matter beyond anyone's comprehension, why this tragedy ever occurred in the first place. Ryan is taking out his anger on Katie and me. He's being treated for depression and is on medication.

Katie, on the other hand, let's her thoughts and feeling out all the time. She is constantly saying that she wants to see daddy's real eyes, not the ones in the picture. She tells me that daddy died because he got the wrong chemo and that the doctor doesn't know how to read. Katie doesn't sleep through the night anymore. Like clockwork, she comes into my room each night around 2:00 in the morning. Katie is very clingy and tells me numerous times a day that she loves me.

The children's psychologist tells me they are both afraid that I am going to leave them. They are both expressing the same fear in different ways. For Ryan, his anger is a way of saying, "Why bother loving mommy, because she's going to leave, too, just like daddy did." Katie feels, if she showers me with affection and makes sure I'm there at 2:00 in the morning, I won't leave her. I am concerned about the long-term psychological effects this tragedy will have on our children.

My husband paid the ultimate price of medical malpractice. The absurdity of this tragedy cries out for justice. Arbitrarily capping the amount of damages our family can recover would be monstrous. How do I tell our children their government has put a price tag on their daddy's life because some medical malpractice lawsuits are considered frivolous? How do I tell them that we might not be able to live in our house anymore? How do I explain to them that the country that comes to the aid of the world is turning their back on them?

MR. GOLDFADEN: Thank you very much.

ASSEMBLYWOMAN WEINBERG: I thank you, Mrs. Fulton.

Are there any questions? (no response)

Thank you both for coming forth this morning.

ASSEMBLYMAN CONAWAY: Cochairpersons, I want to raise a point of order, please, about these proceedings going forward. Now, my understanding from the remark relayed from the Majority Leader and from our own discussions -- that we were dealing with the specific aspects of this bill as relates to whether or not we were going to have a subsidy to deal with the medical malpractice premium crisis that physicians face. I would think,

accordingly, that the testimony that we hear today should be directed toward that end. And so I'm just going forward. I'd like to know whether or not our discussions are going to be limited to the question of the subsidy or not?

ASSEMBLYWOMAN WEINBERG: I think I explained at the outset that that was, definitely, what was before us today, although we would not be able to take any official action; that we were going to be giving some latitude to people to go beyond that subject in testimony. But we would like to hear a concentration on the issue of the direct medical malpractice premium subsidy. That would be helpful to this Committee, but people will be free to go beyond that subject.

ASSEMBLYMAN COHEN: Dr. Delores Williams. Dr. Delores Williams. Okay, fine.

Good morning.

**RAYMOND E. CANTOR:** Good morning, and thanks for allowing us to be here. My name is Ray Cantor. I am with The Medical Society of New Jersey, and with me is Dr. Delores Williams. I have a few things I would like to say from the Medical Society, specifically on the subsidy issue. But Dr. Williams has a patient who is in labor and she has to leave soon, so I'm going to let her talk first and then I--

ASSEMBLYWOMAN WEINBERG: As soon as I heard about the patient in labor, we moved her up on the list.

Dr. Williams.

**DELORES WILLIAMS, M.D.:** Okay, thank you.

Yes. My name is Dr. Delores Williams, and I'm an obstetrician/gynecologist in private practice in the County of Mercer, New

Jersey, in Trenton. I have been in this area since 1989. I specifically came here today because I know that the subsidy issue, while it may actually alleviate some short-term suffering on the part of physicians, will not do anything, really, in the short or the long run.

At the end of last year, it became very clear to me that the liability crisis had put me out of business. I elected, in December of last year, to stop practicing obstetrics. At the time I decided to stop, I had patients due into July, and I paid my malpractice premium so that I wouldn't have to abandoned any of my patients. It's very clear to me that this particular environment will not allow me to stay in practice, and again, many of the doctors in my department -- about five so far -- have also elected to stop delivering babies.

I think the issue of the subsidy, while good in intentions, certainly doesn't offer me any hope in the short or the long run. I think without effective tort reform, even in the long run, there would be no hope for many of us staying in practice, especially one- and two-person and three-person groups. I only deliver seven to 10 deliveries per month. And I figured out, in order for me to afford these huge premiums, I'd have to double or triple my volume, resulting in loss of quality care to my patients and also loss of quality of life for myself, and so I didn't have any other choice except to stop the obstetrical portion of my practice.

Thank you.

ASSEMBLYMAN COHEN: Assemblyman Green.

ASSEMBLYMAN GREEN: Initially, what type of premiums were you paying?

DR. WILLIAMS: Well, originally, before this so-called crisis here, I was paying about \$30,000 a year. And my premium then escalated to \$50,000 a year. At this point, if I had not dropped obstetrics, I would be facing at least -- I was told the good-driver discount is about 72,000. Because I deliver seven to 10 babies a month, in order for me to come up with that kind of money, I'd have to double, and maybe triple, the volume. And I couldn't do that. Also, my problem also is, as insurance companies have gone out of business--

For instance, when I made a decision to stop practicing obstetrics, I had FICO insurance at that time. The actual problem, that we're not really dealing with, is the stability of the insurance industry. I received a certified letter from the State of New Jersey that -- any cases I have during my FICO tenure -- I may have personal liability, because the statute of limitations is 20 years for delivering a baby in New Jersey, which means FICO is now out of business. Any cases would be referred to the State Guarantee Fund, which has a limit of 300,000. Therefore, I have been already notified that I may have personal exposure for any case resulting from those FICO years that settles in excess of 300,000. So, again, there are some tremendous problems facing doctors that we're not even beginning to address here.

ASSEMBLYMAN GREEN: My next question is that, have there been any claims against you in terms of malpractice?

DR. WILLIAMS: Actually, there are two claims that I've been named in that I don't know the patients. In one claim, there's one line with my name on the chart where I examined the patient for a nurse/midwife. I have never met the patient. And the other claim is a patient I've never met, but my

previous partner was involved in her care. So, yes, those claims count against physicians. Even though you are eventually dropped, your insurance company incurs an expense to “defend you,” whether you have anything to do with the case or not. So, for me, the decision was a very complex decision. It was based on possibly losing my home, my assets, my ability to fund my children’s college tuition, and based on this liability crisis -- the statute of limitations at 20 years, insurance companies out of business, 17 more years before I can rest assured that there is no FICO claim that I may be personally liable for.

The other issue is just, physically, being able to afford the liability insurance. We were already sweating every month to pay for financing the liability insurance premium over 10 months. And every month, with the decreasing insurance reimbursements, there were times I did take my college savings for my children to pay my liability payments. So we’re already struggling to pay liability insurance.

ASSEMBLYMAN GREEN: Listening to your testimony, the thing that’s very frightening is that, if I’m listening to you correctly, even if you go out of business and you have no income, you and your family are still going to be exposed to the fact that over the last 20 years you have basically brought children into this world. Yet still, there’s no insurance coverage. There’s nothing to basically protect you and your family. Is this what you’re saying to me?

DR. WILLIAMS: I’m saying exactly that. As a matter of fact, one of the physicians who stopped delivering babies in my department, the end of last year, he calculated his life expectancy, and he says, “I want to outlive my risks.” We do face 20 years of further risk from the last baby we deliver. And

again, this wasn't a big issue before liability insurance companies were going bankrupt and to State receivership. But I've received a certified letter from the State of New Jersey. All of us who had FICO insurance received that letter notifying us that we may have a personal exposure if any case during those FICO years were to settle for more than 300,000. And as you know, 300,000 is a pittance in terms of the kinds of awards that are being awarded in the majority of "bad baby cases." So, you're right, even if I go bankrupt today, I still have 20 years of exposure from the last baby I deliver.

ASSEMBLYMAN GREEN: Thank you very much.

This question to the Chair. As we sit here, we listen to all the different testimonies. It's obvious this thing is getting all kinds of twists. I'm hoping that a testimony of this magnitude should shed some light on the fact that no one, including a doctor or a person in life, should not be protected, especially when they feel they have insurance and the insurance company says they're either belly up or go out of business, and just leave the person hanging out there -- like this can happen to her. So I just want to hope that, during the course of our discussion of these types of issues, that we can talk about further discussion.

ASSEMBLYWOMAN WEINBERG: Assemblyman Green and Dr. Williams, let me point out that some of the very basic problems that you raised are addressed in our bill. The statute of limitations is lowered. There is a method to get out of the types of lawsuits where, you said, your name was just on the stationery, but you didn't actually see the patient. There is a method in the bill so that you can get extricated from such a lawsuit. So although, again, the subject is about premium assistance, if this legislation passes, those issues

that you raised would be lessened somewhat. And in addition, you would receive the direct premium relief.

DR. WILLIAMS: However, that doesn't really address what happens to you after an insurance company loses its license in your state. In other words, if the insurance company goes bankrupt, you still have some risks. And therefore, I heard one young lady ask a question, what do we think some, possibly, interim measures could be? Many physicians in the state, we've discussed the fact that, at this point, this is such a severe crisis, many of us are having to close our doors. I think the Legislature and certainly doctors, like myself, are thinking that there should be an alternative in the state to liability insurance, just as the state of Florida has an alternative to liability insurance. I don't see any "short-term" solutions that would help many of us stay in business. However, I think if physicians in the State of New Jersey were allowed to post a bond in lieu of liability insurance, as already exists in the state of Florida, that would keep some specialists from going out of business.

ASSEMBLYMAN COHEN: No questions.

Thank you, Doctor. I know you've got to go to handle a patient, which is more important at this point.

DR. WILLIAMS: Thank you very much.

MR. CANTOR: Thank you, Doctor.

Can I do my testimony?

ASSEMBLYMAN COHEN: We took Dr. Williams first because she has to handle a patient, so--

MR. CANTOR: That's fair.



ASSEMBLYMAN COHEN: The Administrative Office of the Courts, unnamed but, yet, present.

ASSEMBLYWOMAN VANDERVALK: I don't know if I should say Madam Chair or--

ASSEMBLYWOMAN WEINBERG: Whichever you prefer.

ASSEMBLYMAN COHEN: We're doing a gender neutral.  
(laughter)

ASSEMBLYWOMAN VANDERVALK: Can I just ask if there's anybody here who can give us a follow-up on posting a bond. I mean, that would have a cost to it as well. You don't get that -- you have to pay for that coverage as well.

ASSEMBLYMAN CONAWAY: And it's not enough, the bond by itself.

ASSEMBLYWOMAN VANDERVALK: So I don't know what that really means.

ASSEMBLYMAN CONAWAY: Well, the bond issue is-- I mean, \$500,000 is not enough protection for these "bad baby cases." I wish there was another name for it. But that is slim -- that's a fig leaf protection, considering the environment that we're in now.

ASSEMBLYMAN COHEN: Thank you.

If you could state your names.

**D A N I E L P H I L L I P S, ESQ.:** I'm Dan Phillips, from the Administrative Office of the Courts, and I have with me Kevin Wolfe, who is an attorney with the Civil Division in the Administrative Office of the Courts. We're appearing today at the request of the Committee to explain a couple of

tables that we have put together, at the request of Senator Vitale, for the Senate Health and Human Services Committee, regarding jury verdicts and some case-flow trends on medical malpractice cases. And we have no position at this time on any of the bills and specific bills, but we're taking the opportunity to explain the table again at the request of the Committee.

We provided two tables. One is a table showing a six-year trend -- it's one page -- on the filings and terminations of medical malpractice cases in the courts. And the other one is the detail on the terminations, the cases that were terminated by juries, and also showing the jury award amounts. We'll explain both tables.

The first table, the one-page table, that's entitled New Jersey Medical Malpractice filing/termination data. Again, it's a six-year trend. First, it shows the number of cases filed in 2002. There were 1,656 cases filed with the courts for medical malpractice. There's also, generally, about 1,500 cases pending in the courts. So, for example, at this time at the end of March, there were about 3,200 cases pending in the courts, medical malpractice.

The terminations that you see, with the detail of the method of disposition, they don't necessarily relate to the cases filed in those years. The medical malpractice cases, the average case, takes about two years to be terminated in the courts, and that's compared to an average civil case, all civil cases, which is about 11 months. Obviously, the medical malpractice cases are more complex and take additional time. So when you look at the terminations, the terminations are not the terminations of the cases that were filed in 2002. They were filed in some earlier year. So you should look at the terminations separately from the filings.

As far as the terminations go, in 2002, there were 1,700 terminations. About 43 percent of them were resolved by settlement, about 37 percent were dismissed. And we don't always know the reason for dismissal. Some of those may be procedural, meaning they were involuntary, and some of them may be voluntary, meaning the parties may have settled or decided to dismiss the case and file the stipulation of dismissal with the court. In those cases, we don't know the reason for the request for dismissal by the parties. We just get a stipulation of dismissal, and the court dismisses.

Twelve percent of them went to trial; 200 were trial by juries, and five were trial without juries. And that's what I'm going to have Kevin explain the detail on, the-- The other table is the detail of the 205 cases.

**KEVIN WOLFE, ESQ.:** What we're talking about on the second table is the cases that were tried to completion in the year 2002. That's the calendar year. What we did was, we used our automated computer case management system to generate the cases that went to trial in 2002, and then we asked our staff in each one of the 21 counties to go in and physically look at the file to give us the information as to how that case was disposed of.

And you'll see that approximately three out of four cases were no cause. In other words, it was a verdict for the physician; and one-quarter of the cases were a verdict -- a jury award on behalf of the plaintiff. We have run the numbers of the approximate 56, 57 cases that resulted in a jury award. The total amount came to 59,423,000, for an average number of 1.1 million. And the median number was, I believe, \$350,000. That is on Page 7 of the table.

We also have -- you'll see that there is a column marked additur and remittitur. That column was used for comments, but it was also -- notice

that cases where there was a jury verdict, and then there was a decision by the judge on a motion for a new trial -- to change the amount that the jury awarded in that particular case, because of the evidence in the case.

MR. PHILLIPS: We've given, with that table, an explanation of some of the terms that are used on the tables: no cause, additur/remittitur, and high/low. If you need further explanation, Kevin can explain what those terms mean.

I'd be happy to answer any questions.

ASSEMBLYWOMAN WEINBERG: Just before you do, let me ask, would you please go over again the three cumulative figures on the bottom of Page 7, and slowly explain what each of those figures -- starting with the 59 million -- mean?

MR. WOLFE: The \$59 million was simply the column -- that was the total in that column of jury award amounts. So that column was added up, and it amounts to \$59 million. We then ran the average number for the cases that went to jury award, and that came to 1.1 million. And then, finally, we ran the median, \$350,000 -- half were above that, half were below that \$350,000.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chairwoman.

ASSEMBLYWOMAN VANDERVALK: We don't have that page, Madam Chair.

ASSEMBLYWOMAN WEINBERG: It's the very last page. Oh, all right. Sheila will try to get more. Apparently, we gave you an amended version.

ASSEMBLYMAN D'AMATO: May I ask a couple questions?  
Thank you.

May I take you to the first page of the chart there. Now, if you look at the year 2002, you have there 732 cases settled. When you mean settled, you mean a payment was made by the defendant, through the defendant's carrier to the plaintiff, correct?

MR. WOLFE: That indicates that -- the communication to the courts was that that case was settled, and we assume it was settled for a monetary amount.

ASSEMBLYMAN D'AMATO: Now, let's go to the category where it says *dismissed*.

MR. WOLFE: Correct.

ASSEMBLYMAN D'AMATO: How many of those dismissals were voluntary? Do we know?

MR. WOLFE: We do not have -- we can't look behind that number. So that category could involve involuntary dismissals because of some procedural problem, or it could mean that the case was settled and, simply, the attorneys, rather than communicating to the court that the case was settled, simply communicate to the court that they want the case dismissed.

ASSEMBLYMAN D'AMATO: Now, if the settlement was sealed, then in all probability the court would not know that money has, in fact, been paid, because that was negotiated between the parties. That is, there'll be no disclosure to anyone about the fact that a dollar settlement was made, correct?

MR. WOLFE: You're going beyond my expertise. I don't want to answer that.

ASSEMBLYMAN D'AMATO: Okay. Well, I can tell you, that's the case. All right.

Now, let's talk about this for a minute here, because of the 638 cases, theoretically there could have been a payment made by the carrier to the plaintiff, correct?

MR. WOLFE: That's correct. As I indicated, if the case was settled but it was communicated to us as a dismissal--

ASSEMBLYMAN D'AMATO: Then let's assume that's the case. So if we add those two figures together, the 732 and the 638, working on the premise that settlement was made, there were settlements in 1,370 cases of the 1,656 that were filed.

MR. WOLFE: Based upon the way you've characterized it, yes.

ASSEMBLYMAN D'AMATO: All right. Thank you.

MR. PHILLIPS: It's not of the file cases. It's of the terminations for that year.

ASSEMBLYMAN D'AMATO: Okay.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Just in carrying on with what Assemblyman D'Amato said, your data is incomplete in that there are sealed settlements -- figures that are probably not contained here that are likely to make these numbers even worse than they are. Isn't that right? Isn't that a fair assumption?

MR. WOLFE: The numbers that we're giving you are simply information that was communicated to the court and put into the courts ACMS

system. If, in fact, there are settlements outside of the court system, obviously we would not have that information.

ASSEMBLYMAN CONAWAY: Now, just so that I understand it--  
Now, the global number is, whatever it was--

MR. WOLFE: Approximately 1,700 cases filed a year.

ASSEMBLYMAN CONAWAY: I'm talking about the cash. You're talking about a million dollars spread across all the cases. We're at a million dollars that insurance companies are paying out to clients on average. Is that right?

MR. WOLFE: These are the jury verdicts.

MR. PHILLIPS: These are jury verdicts only, not settlements.

MR. WOLFE: The second table is jury verdicts.

ASSEMBLYMAN CONAWAY: Those are jury verdicts.

MR. WOLFE: Those are jury verdicts.

ASSEMBLYMAN CONAWAY: And there has been a lot of testimony here, and a lot of dispute and gnashing of teeth over the statements that we have heard in this committee room, from the insurance industry, who has said that they are seeing increases in the amounts that they're paying. And they threw a number out of a million dollars of these -- in the multimillion dollar verdicts. It seems to me, now, what you presented to us today seems to support rather than to refute what -- the testimony that we heard from insurance executives. If I'm misunderstanding, please let me know. But this average number of a million strikes me as very significant. I mean, if he has an answer, I'd love to hear it.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: The point I was trying to make, and I thought it was obvious, and once again, I should have thought that, is that in the year 2002 there was a disposition of 1,656 cases, as they went out of the court system. And theoretically, there could have been a payment of 1,370 cases. So, I suggest, respectfully, that what this indicates, or should indicate to us, is that there is a problem. That doctors, physicians are deviating from the standard of care. Because why would the company pay on 85 percent of the cases that were disposed of. That's the point I was trying to make.

ASSEMBLYMAN CONAWAY: Well, I have an answer.

ASSEMBLYWOMAN WEINBERG: Well, apparently, you're able to answer each other's questions, but we do have--

ASSEMBLYMAN CONAWAY: The reason these settlements get paid is because of the fear of going in the court system and having to deal with these very high jury awards, and so you get a settlement. And it's one of the underlying -- the difficult things to get your fingers around here, because of the fear of exposing yourself in that court-- You know, you get out and wipe the sweat off your brow that you're getting away with a million bucks, if you settle for the maximum amount of policy, which happens very often. I think there is a lot of data there that's tough for us to get at. That's my answer.

ASSEMBLYWOMAN WEINBERG: I would like to put a question to you. Is there a possibility of actually getting the information on settlements in terms of dollar figures? Is there any way that that can be gleaned?

MR. PHILLIPS: That's not reported to the courts, and often, they are also, as Assemblyman D'Amato said, they are sealed. So that information is not recorded, and it's confidential among the parties. We do not have it in



our system. We don't record any settlement information, only that there was a settlement and the case was disposed.

I'd also like to clarify that we give you two measures of central tenancy, here, of the jury verdicts where there was a monetary award. We give you the mean and we also give you the median. The mean, obviously is affected by the much higher awards. There are some very high award in here, which affects the mean. The median, for your purposes, may be a better measure of the central tenancy, which is \$350,000, which is pretty much the middle-of-the-road award. So you have to consider which average you want to use for your discussions, whether you want to use the mean, which is affected by excessive highs and lows, or the median, which is \$350,000.

But to answer your question, we wouldn't have the information on settlements. It's just not reported.

MR. WOLFE: And just one further nuance. That \$59 million includes -- is the jury award. That is not necessarily what was ultimately paid out, because there is-- You'll see in the statistics some cases that were actually reduced by the court.

MR. PHILLIPS: Or that there was a high-low agreement, which means the attorneys agreed to hedge their liability by agreeing to arrange the award before it goes to the jury.

ASSEMBLYWOMAN WEINBERG: Are there any other questions?  
(no response)

Thank you for putting this information together.

MR. WOLFE: Thank you.

MR. PHILLIPS: If we could be of any other help, please let us know.

ASSEMBLYWOMAN WEINBERG: We have the consumer group as a panel: Peter Guzzo from CCJ, Marilyn Askin from AARP, Dena Mottola from PIRG, Paul Amitrani from the Hemophilia Association, and Dennis Donnelly.

Welcome all of you.

Peter.

**PETER GUZZO:** Yes. Good morning, Madam Chair, members of the Committee. I was just informed by the hearing person -- what we'll have to do is play musical chairs, because there's no microphone working in the back. So when we finish, if you would allow us, we'll bring the two gentlemen in the back up front.

I'm Peter Guzzo, Executive Director of Consumers for Civil Justice. And what you see before you this morning, members of the Committee, is the broadest coalition of consumer, patient advocates, victim advocates, healthcare advocates, senior advocate organizations.

I have, to my right, Marilyn Askin, President of the New Jersey AARP, which represents 1.3 million seniors; Dena Mottola, from New Jersey PIRG; Paul Amitrani, from the New Jersey Hemophilia Association; and Dennis Donnelly, who is our counsel for the consumer issues. I'm also speaking on behalf of the Health Professionals and Allied Employees this morning, and Citizen Action.

So I think you see before you an array of consumer organizations that have a common message here. And the common message is, if ever there

was a cause for consumers and victim advocates to draw the line in the sand, medical-mal reform that penalizes the victims, the innocent victims of medical malpractice, is it. No way in the world will any other consumer organizations that you see before you today approve of victims being penalized by having awards capped, especially after you see the horrendous pain that a family goes through because an innocent victim goes into a hospital, trusting a facility, a doctor and dies four days after he goes in -- and that life is going to be trivialized at 250, 300, 400.

Before I hand over to Marilyn Askin, let me just mention a statement that I was asked to read on behalf of the Health Professionals and Allied Employees, which is a union of 9,000 nurses and healthcare workers.

ASSEMBLYWOMAN WEINBERG: Excuse me one moment, Peter. We do have a lot of lengthy written testimony from your witnesses here.

MR. GUZZO: Right. This is one sentence.

ASSEMBLYWOMAN WEINBERG: So I am going to ask each of you, if you could, to summarize rather than -- since you've given us copies -- rather than go through a reading of all the testimony.

Go ahead.

MR. GUZZO: Right. And this is just going to be one sentence from the HPAE. "Health Professionals and Allied Employees believe that doctors have chosen the wrong enemy, the wrong ally, and the wrong solution. Patients are not the enemy, and limiting awards to patients who are victims of malpractice is not the answer." And they support the subsidy as proposed by Assemblyman Roberts, also.

And just one final comment. Throughout all these hearings for the past year, this is like a wedding without a groom or a wedding without a bride. Where is the insurance industry? That is who should be at this table. That is who should be asked the questions of, and they should be the ones to have to respond. It's a sad day when doctors and patients and consumers are opposing each other. We are common allies. It is the insurance industry that has much to answer for.

And with that, I'll hand it over to Marilyn Askin.

ASSEMBLYMAN CONAWAY: I have to make one comment.

ASSEMBLYWOMAN WEINBERG: Can I say no? (laughter)

ASSEMBLYMAN CONAWAY: Well--

We physicians are the only ones who by oath and by temperament stand with patients every step of the way. And I can't sit here and have you say, in public, that physicians are pitting themselves against their patients. It's just not true. And what we are trying to do is to come up with a solution that serves everyone, to find a middle ground to make sure that, at the end of the day, that we have a healthcare system that works for everybody -- if you're a woman, that you have an obstetrician to go to; if you're traumatized on the road, there's a neurosurgeon or a trauma surgeon or an orthopedic surgeon to take care of you. We're trying to balance the needs of the many, as opposed to the needs of the few. That's what we're trying to do. But to sit here and say that we physicians don't stand with patients and walk with them every step of the way is absolutely wrong, and it should not be said in public.

MR. GUZZO: Well, I commend you, Assemblyman, because you are one of those physicians who is standing with patients and consumers.

Thank you.

ASSEMBLYWOMAN WEINBERG: Ms. Askin.

**M A R I L Y N A S K I N:** Chairwoman Weinberg, my name is Marilyn Askin. I'm the New Jersey State President of AARP. We have 1.35 million members in New Jersey. I'm sure some of you -- I know Assemblyman McKeon is not yet a member, but he'll get there.

Majority Leader Roberts so eloquently articulated our concerns, and I'd love you to study his testimony on that, because it really does represent the concerns of AARP. Why is AARP interested in this? We're interested because most of our members, if they were a victim of medical error, would never have a day in court whatsoever, because they don't suffer economic damages. The only damages they suffer are noneconomic damages. And with the cost of litigation these days, it would be very hard for them to find an advocate who would be willing to put the up-front money involved and to vest so much energy into a case in which there would be only noneconomic damages.

So that the caps proposed, any kind of caps proposed, in this legislation are unreasonable, they're unacceptable, and they're unwarranted. Because caps on noneconomic damages denigrate the great value that retirees and others provide to our society, just because they are currently not earning economic damages or significant income.

We had a press conference the other day and, Assemblywoman Weinberg, one of your constituents came down to testify. You probably know him. His name is Lou Schwartz (phonetic spelling).

ASSEMBLYWOMAN WEINBERG: I certainly do.

MS. ASKIN: He's 90 years old.

ASSEMBLYWOMAN WEINBERG: Plus.

MS. ASKIN: That's true. He's going to be 91 very soon. And he has been retired since the age of 65. He retired as a plumber. Well, since '65, his life has taken on such meaning, such advocacy. He's been a councilman. He's on the SHIP program helping people get through the Medicare maze. He's on the Martin Luther King board. He's on the Fair Housing Commission, and I'm sure there are a host of other things. His attitude was, when he heard that his life is only worth, maybe, 250,000 -- if he gets that, maybe 100,000, if there is some egregious error -- really makes him feel that this trivializes the value of his life.

And so that-- Caps on noneconomic damages could result in an unequal legal and medical system where wealthy, wage-earning patients who suffer from medical malpractice will have far greater access to the legal system and far greater medical concerns. And they are freer from medical malpractice because physicians and others would become a bit more circumspect in the kind of care. Maybe they'd read the labels a little better.

So I know there are a lot of people testifying. In behalf of our members, let me say that we are absolutely opposed to unreasonable caps. All these caps are unreasonable because it would deny our constituents their day in court.

Thank you.

**DENA MOTTOLA:** Good afternoon. My name is Dena Mottola. I'm the Executive Director of the New Jersey Public Interest Research Group, and I'm also here today to strongly support the direct subsidy approach, which we believe is the best solution to the medical malpractice problem. We think that

New Jersey needs an immediate solution to this crisis. We think that we need immediate relief. From the point of the view of the patients and patient care and access to patient care, we need direct subsidies because we need our doctors to have immediate relief to the crisis so that they don't leave the state, so they stay here and take care of us.

So I implore the members of this Committee to take a serious look at this issue. I know Assemblyman Roberts made the case very well. This is something that we've been advocating, and we think this is the right solution. We're tired of hearing the Medical Society say that caps are the only way to protect a patient's access to care. Caps are not the magic bullet. Direct subsidies are the magic bullet. Even the Medical Society's own report, released in March, acknowledges that caps are not an immediate solution. And I quote from Page 16, "We would not recommend an immediate rate reduction, as a result of a cap on noneconomic damages, because of the uncertainty as to the amount of the benefit resulting from the reform, the apparent current rate level inadequacy, and uncertainly as to whether the reforms will be upheld in the courts."

So I think that -- even many consumer groups have put out research saying that caps won't work and won't solve the problem, and this is, in fact, the own New Jersey Medical Society's research.

Direct subsidies are money in the doctor's pocket -- 50 percent. Dr. Williams just spoke. I understand she's experiencing a lot of difficulty in her practice. A 50 percent subsidy brings her rate down to almost what it was when she said 30,000, when she was practicing, when she didn't think that there was a particular problem. It would be retroactive. So, again, money in the doctor's

pocket, back to the time when rates started to increase. I think that the physicians in this state are just foolish not to support this approach as the best to solving the problem.

There's another reason, from my point of view, why I think this is the right approach, and that is it acknowledges that this is an insurance crisis and that it's cyclical. That right now we're at the high end of the cycle where rates are high. We're coming back. Eventually, we'll come back around, and this subsidy can -- we can sunset it as the problem goes away and naturally attenuates. So we think this is the right solution.

You're going to hear, or you already did hear a lot why caps are not right for consumers. I just want to add my voice, New Jersey PIRG's voice, to why we think caps are anticonsumer. And just in general, access to the civil justice system when injured is an important civil right afforded to members of our society. Even when the injury is the result of a physician's negligence, that right must be upheld. Doctors are not exempt from accountability. From the point of view of the victim, a disability caused by medical negligence and a disability caused by anything else -- a reckless driver, you name it -- is still a disability. They live with it for the rest of their lives.

So, as we go forward in this debate, let's finally reject this whole conversation about caps and move onto the solution that we think can actually solve the problem. You heard Assemblyman Roberts talk a little bit about why caps won't solve the problem. I think that's the practical reason. It certainly isn't the most compelling reason why we should abandoned caps as a solution. We heard from the victims. That's the most compelling reason. But just to quote some research that just recently came out from the Center for Justice and



Democracy, a report they released last month, that says that in the three states where lawmakers recently enacted caps -- that would be Nevada, Mississippi, and Ohio -- doctors are still struggling to find affordable insurance.

We're going to see doctors coming back clamoring for a solution, if the only solution that we're going to be looking at is caps, because-- And I would guess that the solution that they'd be coming back for is a subsidy, because we have a crisis and we have to deal with it now.

I just want to conclude by talking a little bit about the long term, because we need to get out of the short-term crisis. We also need to do what we can to prevent the crisis from coming back around again, and getting the cyclical problem. So how do we prevent a future crisis, and what else does New Jersey PIRG advocate, besides the direct subsidy now? This is what we do for a crisis. And we probably, in the next 10 years, will be back where we are today, where we can give consumers the ability to have more power in the market -- consumers meaning doctors who purchase medical malpractice insurance -- and give doctors the ability to form purchasing alliances to negotiate with malpractice insurers to get lower rates. We can do insurance reform like California did, where we can actually ask insurers to open up their books. If they want to increase over 15 percent, they have to justify it.

So there are long-term solutions out there, that are not caps, that would help solve the problem tremendously. But I think, right now, in the short term, the direct subsidy's, the right way to go. Let's help doctors ride out the crisis.

Thank you very much for allowing me to speak today.

**DENNIS M. DONNELLY, ESQ.:** Madam Chairwoman, it's not just because you're my Assembly person that I thought you did a nice job in responding to Dr. Williams about the positive aspects of your bill, in other words, the decrease in the--

ASSEMBLYWOMAN WEINBERG: Excuse me, would you just identify yourself, even though I know you're a constituent.

MR. DONNELLY: Thank you very much.

I'm Dennis Donnelly. I'm counsel to CCJ, and I wanted to just add to your statement to Dr. Williams that, in actuality, A-50 -- although some of the changes in the Senate version were for the worse -- also contains in Section 20 a limitation on the rate of increase that any one insurance company can charge. That's actually Section 22. And, in Section 20, contains an additional safeguard or protection, and that is that the type of case that Dr. Williams mentioned, where she's a peripheral defendant, could not be included in increasing the rates. So I think those are examples of positive things that you're trying to do.

I also want to point out to you that the presentation from the AOC gives a very specific example of why, perhaps, your addition, to the remittitur standard, also dealt well with the problem. Although, frankly, judges are already dealing with the problem. Because in the data you were given, there was a \$9 million verdict, which you will see was remitted by the judge to a \$1 million verdict. So that, actually, \$8 million of the data you were presented from the AOC was eliminated from the mix. So when you're looking at their median numbers and when you're looking at their average numbers, you can

also back out that \$8 million, because the judge did the remittitur. And I'm sorry, I don't have it in front of me, but it's in there, and you will see it.

ASSEMBLYMAN CONAWAY: No, it's 1.4. I'm fine.

MR. DONNELLY: Am I frustrating you? Okay. The last point that I would make is this, and it is an important point. When consumers speak to you about -- on behalf of AARP, on behalf of senior citizens, or on behalf of minors who are the opposite end of the spectrum -- they talk about the two parts of our society who, I think, we've always protected the most. And the legal term that you can apply to that is equal protection. There are real issues about the constitutionality of caps. And the reason why many states have had a legislature pass an arbitrary and unreasonable cap, and then had the courts come and reverse them, is that equal protection means that all parts of the society -- the children, the elderly -- are protected the same. And if you apply something based on noneconomic loss, you are unequally treating a large number of people.

Actually, the AARP Web site has an excellent series of articles, the last time caps came around, and they had one other disturbing statistic. The elderly are the largest percentage of the unfortunate recipients or victims of medical negligence, because they need more medical care and there are more medical mistakes that are made in that care. So, if you deal with this in the way it's been presented and the unfair way of "noneconomic damages," you are visiting on the people who are going to have the most errors made the most restrictive access to justice. And that's just not the right way to go.

Thank you.

**P A U L D. A M I T R A N I:** Good morning, Madam Chairwoman, members of the Committee, my name is Paul Amitrani, and I'm the Past President of the Hemophilia Association of New Jersey. The Hemophilia Association of New Jersey opposes any law that limits an individual's access to the courts. By access, we mean anything that impedes the ability of an individual to bring suit, or to be fully compensated for their injuries. A-50 does not specifically target the hemophilia community. But our struggle with major pharmaceutical companies in the early '90s, over HIV contaminated blood products, has made us extremely vigilant of anything that might deny an individual's right to legal redress in the courts.

I know many of you were very helpful to us during that crisis period, and I would just like to thank you, again, for the assistance that you did provide at that time.

Rather than caps, the Hemophilia Association of New Jersey favors the traditional means of determining damages -- the jury system. In this way, all parties to the action get a fair hearing of the facts of their specific injury, and the jury makes a case-by-case determination as to the amount of damages. It is our position that this is the only fair way to determine compensation.

Thank you.

ASSEMBLYMAN CONAWAY: Madam Chairman?

ASSEMBLYWOMAN WEINBERG: Yes, Assemblyman.

ASSEMBLYMAN CONAWAY: A couple comments and questions. Any time you put a dollar value on human life, I would say, that it's being trivialized. Whether you are talking about \$20 million or \$30 million, you're

still putting a value on someone's life. And that, I think, in any scenario, represents trivialization.

Someone commented that we're focused on this cap issue. One of the reasons why we're talking about caps is because there's general agreement on many of the other things that are there. Caps is the most controversial one, and sorry that we are discussing it and people are bringing it up, but unfortunately, that's the big rub in the legislation that's being proposed. And if you look at my own legislation and even the legislation we're considering here today, we are talking about comprehensive solutions that are aimed at various aspects of the problem.

Now, one question that I have, and of course, there are more than one ways to get at someone. Because one of the issues that has been raised is the access to folks, generally, to the courts. And some believe -- I haven't made up my own mind about this -- is that we do -- that perhaps our system ought to do a better job at getting people who are injured into court, so that there's not this sort of income bar -- so much is driven by how much the lawyer is going to get out of the case that many people who have been injured don't get to court at all. And that we -- and I don't know if the AARP is saying this or whether PIRG is saying this -- some kind of a system, whether you call it a workmen's comp-like system, or some kind of a system, to get folks who have been injured some kind of compensation, whether you're looking at that.

Because when you talk about fairness -- and I'm a Democrat, I don't mind saying so -- having people who have been injured get some kind of compensation is very important. We don't have that now. My understanding is that only a small percentage of people who actually have injury are able to go

to court and get any kind of recovery. And maybe when we start talking about reform and thinking about fairness and equality, as has been raised, we ought to think about whether or not this kind of a litigation-driven system is the best way to get people all they need.

So my question is, have you folks been studying the most comprehensive reform, and that is some kind of workmen's comp system that makes sure that everybody who is injured gets some kind of a judgment and determination to give them some redress.

MR. AMITRANI: Dr. Conaway, there's never--

ASSEMBLYWOMAN WEINBERG: Excuse me, before you answer.

Assemblyman McKeon would like--

ASSEMBLYMAN McKEON: Thank you very much.

I've been -- and I will continue to keep -- quiet and, hopefully, stay on message and listen to the testimony we're supposed to today. But I have to say to my colleague -- and I know you probably didn't mean what you said, and maybe you did -- that the same way that you took umbrage relative to that, that the doctors are in opposite with the views of their patients-- To say that litigation is driven by attorneys not because it's in the best interest of the people that they're duty-bound to represent, but because of the money there is, well, I think that's just insulting. I know many, many lawyers, of which you are one, a member of the bar, who move and proceed in the best interest of their clients, often at their economic peril relative to them taking the case on contingency.

Now, I'm going to tell you the farce that all this is, relative to us talking about jury verdicts. The bottom line is that if the Senate version or any

type of cap go through, that's all we're going to see is jury trials. Because the bottom line is that jury trials in the State of New Jersey, relative to medical malpractice, work very well. Take a look at what the AOC gave you. Look at the number of cases tried and look at how many resolve in the favor of the doctor. So let's all keep in mind, if we go forward with any type of cap, modified, what have you, that that is going to result in the insurance companies going forward and trying 90 percent of the cases. Those numbers, of 700 resolved, you'll see go down to about 50, and then you'll have 10 other pages attached for the next year, relative to cases getting tried and juries making those decisions. And that will be the effect of that kind of cap.

ASSEMBLYMAN CONAWAY: Well, let me just respond.

ASSEMBLYWOMAN WEINBERG: Excuse me, but we are going to have a lot of time to discuss among ourselves what we're going to be doing with this bill in the future. We're kind of even. We've insulted the doctors and the lawyers now (laughter), so I'd like to go back to Mr. Donnelly.

ASSEMBLYMAN McKEON: Both of us deserve it.

MR. DONNELLY: That's equal protection, actually, and that's a good thing.

Dr. Conaway, I think that is a different debate. I will tell you this. That no one who has ever been involved in a workers' compensation claim is satisfied with their claim. So you're suggesting a relief that's worse than the disease. But in any event, that's for another day, and I do appreciate being here.

Thank you.

MR. AMITRANI: I'll defer to Assemblyman McKeon any day, because he did a better job than I could.

ASSEMBLYMAN CONAWAY: Can I comment on his testimony?

ASSEMBLYWOMAN WEINBERG: Okay. Are there any other questions for this panel, because we do-- We have another doctor who's waiting to see a patient, and we have the Medical Society, who I'm sure is getting a little antsy about the length of time they're waiting, but go ahead.

Assemblyman.

ASSEMBLYMAN CONAWAY: Oh, I was just going to say that counsel for CCJ makes my point. When you have a \$9 million verdict that comes out of the box, in that case, the judge did happen to remit that award. But the concern is that a different judge wouldn't do that, and you have \$9 million sitting there that needs to be paid. So the fact of the verdict itself, I think, is concerning. It might have been appropriate. That judge happened to think that verdict was not. You might get another judge, or many other judges, who think that that's perfectly fine and that will have, in our view, a very detrimental effect on our cost structure, because it affects the cost structure of the people who insure us.

MR. DONNELLY: But again, your own bill has modified and even strengthened the judges ability to do that--

ASSEMBLYMAN CONAWAY: True.

MR. DONNELLY: --so that seems highly unlikely.

Thank you very much.

ASSEMBLYWOMAN WEINBERG: Thank you.



We have another physician who has asked to come forth, who also has a patient waiting, Dr. Stephan Lomazow, is it?

**STEPHAN M. LOMAZOW, M.D.:** Lomazow. Thank you.

ASSEMBLYWOMAN WEINBERG: Lomazow, thank you.

And then he'll be followed by the New Jersey Medical Society.

DR. LOMAZOW: Thank you very much.

Madam Chairwoman, thank you. My name is Dr. Stephan Lomazow. I created the concept of the fund that recently passed the Senate, introduced and refined by your honorable colleague, Senator Raymond Lesniak. I have no personal agenda. Being a neurologist, I am not in a high-risk speciality.

My concern is for the future of medicine and how an unfavorable environment to practice, contributed to by skyrocketing liability premiums, will impact upon the health and welfare of the people of this great state and country. I have had extensive and substantive conversations with leadership of the medical, osteopathic, legal, political, and insurance communities in an attempt to better understand their positions and find an equitable solution to this exceedingly complicated problem.

The essential question is, how can moneys raised by the State be best utilized to beneficially impact the system of medical liability insurance? The present legislation proposes a subsidy for physicians in high liability crisis specialties. I would urge you not to adopt this approach. First of all, it would be an administrative nightmare and vastly more expensive than the Senate proposal. The needs of a pediatrician or a senior part-time clinician, for want of a few thousand dollars, who would ordinarily stay in practice and then retire,

is equal to that of a neurosurgeon whose premiums may be elevated by 75 to \$100,000 a year.

There is no equitable way to distribute a subsidy of insurance premiums. Moreover, it does nothing to affect a long-term solution to the problem, and it is not what the organized medical community wants. Politically, my mentor, Senator Lesniak, has told me on numerous occasions, “Don’t give people something they don’t want,” citing the billions of dollars to education by former Governor Florio, only to have the teachers demonstrating in Trenton the next day.

Organized medicine is focused on caps on liability. They have commissioned studies which show a relationship between caps on liability and stabilized cost of premiums. They are not interested in Band-Aid approaches, even those which may have an obvious and immediate benefit for high-risk specialists.

The Senate bill is not a cap. Most of the testimony you hear today is against caps. The Senate bill is not a cap. It is a limitation on the personal liability of physicians against large awards for noneconomic damages. A cap is not on the table. Senator Lesniak is opposed, in any form, to a cap.

The legal profession feels that the insurance industry is primarily to blame. Fortunately, both the medical and legal professions are in favor of needed reforms to protect doctors against frivolous litigation and against penalizing them for being named in an action in which they were not involved, as you heard earlier. Neither the doctors nor the lawyers are wrong. The crisis is multifactorial, precipitated by greedy insurance companies that artificially lowered rates to get market share in a favorable economic environment, and now

have to bear the consequences after a fall in investment income. It's about a small percentage of incompetent lawyers who will bring wrongful and poorly prepared litigation. And yes, a small percentage of physicians, who overreached their capabilities.

The essence of the dispute about the fund, as it is created, is whether or not it would encourage or discourage litigation, as Assemblyman McKeon so clearly spoke. Some would then argue, why wouldn't insurance companies then not settle any cases and wait for the State to pay their bills after a trial. Senator Lesniak believes that the strong bad faith language in the Senate bill will afford protection against this. I agree, but I also feel that there is even greater potential to encourage early settlement of cases, by applying a portion of the fund to the noneconomic portion of cases that settle rapidly and expeditiously.

Everyone agrees that prolonged litigation adds undue expenses that raise premiums and are passed along to the physicians. Another very major point of contention between the interested parties is the ratio of economic to noneconomic damages in malpractice awards. The Medical Society, in some degree, citing the AOC report, believed that the noneconomic damages in cases settled last year totaled about \$175 million, which is 70 percent of the total. The trial lawyers believe this number is grossly inflated. Obviously, the greater the percentage of noneconomic damages, the greater the effect on rates by any limitation or subsidy of them. An accurate determination of the true number is absolutely critical. I would urge the Assembly to obtain this information from the carriers and carefully analyze it.

Also, one thing that's been overlooked here is the implications of concurrent Federal legislation -- have been overlooked. It is stalled in the United States Senate, but if passed, any cap on damages imposed would be applicable to New Jersey unless some preemptive measure, presently lacking in the New Jersey legislation, is enacted.

The creation of a streamline, fair, and efficient system of medical liability is a daunting task requiring innovative, bold, and well-thought-out ideas. The Senate bill, in my opinion, is an excellent foundation. I would urge the Assembly to build upon it.

Thank you.

Any questions?

ASSEMBLYMAN COHEN: Thank you, Dr. Lomazow.

DR. LOMAZOW: Thank you very much.

ASSEMBLYMAN COHEN: The New Jersey Medical Society.

MR. CANTOR: Thank you, Madam Chairman, Mr. Chairman.

Again, my name is Ray Cantor. I am with the Medical Society of New Jersey. I do have a few comments I do want to make about the issue of subsidies. But first, I want to introduce James Hurley, from Tillinghast-Towers Perrin, who is here today to talk about the report he did on behalf of the Medical Society.

We've heard many people testify today about what are the drivers, what are the causes, why are rates going up, and what can we do about that. There are a lot of nonexperts who are posturing their opinions. There are people who say that they know the answers. The Medical Society of New Jersey, representing the physician community in New Jersey, was, and remains,

dedicated to finding out what the truth is. But it's really our members who are being impacted most severely by this crisis. We have no interest in coming up with a solution that is false, and it's not going to help our members. We have no intention of trying to fight battles that don't have to be fought, if they're not going to result in substantial premium relief for our members.

It is with that emphasis in mind that we determined to find out what the truth is and to find out the possible solutions to solve this crisis. In order to do that, we engaged the services of Mr. Hurley, who is a nationally renowned actuary. And what we did then was negotiate with Princeton Insurance Company and MIIX Advantage, or MIIX Insurance Company, to release to Mr. Hurley their proprietary data over the last 10 years. We, as the Medical Society, have not seen this data. It remains confidential. We had to sign confidentiality agreements. But this data was turned over to Mr. Hurley for his analysis and his report.

Princeton and MIIX, I believe, represent, maybe, 70 or 80 percent of insurance policy coverage of the physician community in New Jersey. So we think their data really is telling as to what is going on in New Jersey. Now, having said that, I will turn it over to Mr. Hurley to present his findings.

**JAMES D. HURLEY:** Good morning, Madam Chairwoman, Mr. Chairman, and members of the Committee. I think Ray is probably describing in greater detail and with greater glory than I deserve, so I'll not mention anything about what I do. But I have spent the last 20 years, believe it or not, looking at med-mal problems as a consulting actuary. I am an actuary by training, which means my tendency is to try and figure out the score. So some

of my comments are going to focus on that score-keeping process and how we see the score at this moment.

I guess, it's fair to say, that it's anticlimactic to say there's a financial problem as it relates to medical malpractice in New Jersey, as there is in many other jurisdictions. Our task was to find out what that problem was and what some of the drivers are. First is, it seems clear that the payments that are being made by these companies are in excess of the premiums that they're collecting. There is actual paid data that is indicated by these companies that is exceeding the premiums that they're collecting. So clearly, from their standpoint, the economic proposition is not working very well.

The data that we were provided indicated that there was roughly \$1.36 or so in paid expense and loss dollars relative to the premium they collected, and that's on a paid basis. Unfortunately, you're not providing paid coverage in this state. You're not providing claims-paid coverage, you're providing occurrence coverage, which means if trends continue at the rate they are, that number will not be \$1.36 or \$1.40. It will be something closer to \$1.70 or \$1.80. And no amount of investment income is going to offset that inadequacy.

These studies are based on several sources of data, including the information that the two companies that Mr. Cantor described provided to us, as well as published data. In fact, most of our work was done based on not just the two companies' data, but on the broad medical malpractice industry data that we were able to collect in conjunction with the study that we did.

So a couple of findings about why that's happening. It's our conclusion that the primary reason for these needed higher rates and the loss

statistics that we see is an increasing severity. There is data that shows clearly that there's a higher severity in current periods relative to prior periods. There's an increase in the percentage of claim dollars that are being paid relating to very severe claims, and those are claims of over a million dollars. If you go back four or five years, the data says that, roughly, 15 percent of the claim dollars that are paid to claimants were related to claims that cost more than a million dollars. Today, or in 2002, that percentage now has exceeded 25 percent, based on the data that was provided to us. So more severe claims are occurring, more claim dollars are being paid on those severe claims.

A second reason that contributes to the increase is the level of investment income that companies can make. And that doesn't mean that companies lost money on their investments and are recouping that. And I'll touch on that in a moment. What it means is that interest rates out there, which is the way most companies invest their assets, are lower. Interest rates dropped 250, 300 basis points over the last several years, and we all know that's true. We all feel that in our investments. Well, insurance companies feel that, too. And when you change the rate of interest that you can earn on assets -- because these companies reflect investment income and reduce the rates, in response to that level of investment income, when interest rates are lower -- rates will be higher. It's a calculation that gets done whenever rates are determined. And when interest rates go down, rates will, generally, go up. And that's where we are today -- in a lower interest rate environment.

I mentioned that stock market loss -- sometimes it's mentioned that stock market losses are a cause for increases in rates, and, in fact, that's not the case. These companies invest very little of their assets in the stock market. And

while they have-- To the extent they did invest them, they have separate losses they are not able to recoup that -- and I'll come back to that in a moment -- in the rates that they file.

Our study indicated that the rate increases that have been taken so far are justified. We have reviewed rate filings of the companies, that were made with the Insurance Department. We have analyzed the data that we have available to us, provided by the companies and in the general industry, and we conclude that not only are those rates justified, we fear that the rates are not adequate at this moment. In fact, there may be need for greater rate increases.

One reason for the timing of this, and one reason for the difficulty in identifying these needed rate increases, is the fact that it's hard to identify these changes in trend levels. And you'll see in our report that we show you some graphs of the level of changes in severity of claims. That's the average cost of a claim over time. And you'll see that that number doesn't go in a nice smooth line over extended periods of time. It will shift. It's those shifts and those turning points in the data that are most difficult for anyone to identify. And even when you study it persistently, over time, you may not be able to identify it. It's those shifts, and recognizing those shifts, that are difficult; and it's partly those shifts that we're seeing affecting the level of the increases that are being implemented at this point in time. As I say, to the extent that that rate of increase has not been arrested somehow, it's possible that there will be further increases needed as we go forward.

Just a couple more thoughts. I just wanted to discuss a couple of misconceptions. First is that insurance companies recoup investment or



underwriting losses in rates that they charge prospectively. That is not done. That is not allowed. The law, in general, in most states will prohibit you from doing that. Rate making, as it is called, the setting of rates, is a prospective exercise. It is a forward-looking exercise. You set rates based on what your experience has been, but you're not able to go back and say, "Well, I lost money in underwriting last year. That's my insurance operations." Or, "I lost money in the stock market." That doesn't get into the rate-making process. It's a forward-looking exercise.

The second misconception is that insurance companies report bad results to justify higher rates. Again, not done. A clear example of that is very close here -- is the fact that if MIIX reported bad financial results to get higher rates, it didn't work, because they're in runoff. And there's several other companies that were mentioned. FICO, for example, didn't report bad financial results to be put into liquidation. And there are other companies who have suffered that same fate.

And St. Paul, a major writer, the top writer of business in the country, withdrew entirely from medical malpractice. Not because they wanted to make the money back -- because with increased rates in medical malpractice, they'll never make the money back. They're out of the business. So this, in the words of St. Paul and the published statements they made, is that the business is too unpredictable -- "We cannot adequately predict these losses and, therefore, we want to deploy our capital in more prudent ways on behalf of our stockholders."

Lastly, I just wanted to talk for a moment about the issue of cycle. And certainly, I don't think we would argue that there is not a cycle, an

economic cycle out there that somehow dovetails into and affects the insurance business, and so, as such, part of the cycle for the insurance business. Unfortunately, where we are is not going to get much better. The losses that we have today, the level of investment income needs to be reconciled with the premiums, and that's the process that we're going through right now. In other words, those loss levels and those investment income levels are being reconciled to premium. And the premiums that are being charged today are functions of those losses and those investment income levels. Unless you do something to change those, these rates are not going to go down prospectively. At least, you should have no expectation that they're going to do down prospectively. And so the changes in the financial environment are not likely to change, substantially, the level of the rates that are being put into place.

And with that, I'll conclude and answer any questions you would have for me. I know you have a very thick piece of paper or set of papers in front of you, and I apologize for that.

ASSEMBLYMAN COHEN: Assemblyman McKeon.

ASSEMBLYMAN McKEON: Yes. Thank you.

And thank you for your testimony.

My question is relative to the -- I don't know how familiar you are with the current Senate bill -- but it is the way it's drafted. It applies retroactively. Meaning that if it was to be passed, every lawsuit that's currently filed and not yet disposed of, it would apply to. Now, there's a cause for concern for those proponents of that bill that that provision will be challenged with the court. There's a very good chance that at least that provision will be deemed unconstitutional. If that was to happen -- let's not talk about if it

would or wouldn't -- if that was to happen, what would be the effect, if any, on premiums over the next five years, if the cases currently in the pipeline were affected by the modified cap, and as a matter of fact, if there was maybe a ton that would be filed, out of the hope that one wouldn't be affected by the cap?

MR. HURLEY: If I understand the question, you're saying that the cap that would be put in place would apply to claims currently in process.

ASSEMBLYMAN McKEON: That's what the proposal is. There's a school of thought that that's going to be -- if it was passed, that the courts would have a final say on that, as it may be unconstitutional. So, if that was declared unconstitutional, would there be any effect on premiums? As a matter of fact, they'd go up, wouldn't they?

MR. HURLEY: It's quite possible they would go up. I don't know to what extent the loss estimates, at this point, would reflect some expectation of favorable results due to the change in the law. I don't think they would, at this point, if the law hasn't been passed. I think what would have to happen is, you'd have to sort out those claims over time and see what happened. But it's quite possible that-- As I say, the loss experience we've projected here anticipates no changes in the environment. And so \$1.70, \$1.80 is what we're looking at for underwriting results, which cannot be offset by investment income. So the results could get worse. I doubt, seriously, it would get better.

ASSEMBLYMAN McKEON: And as we all know, the doctors do need some relief. And going forward in that direction, that relief is, at least, five years off, as opposed to the current bill that the Assembly is proposing, and that's immediate relief.

MR. HURLEY: As I understand these bills, the so-called subsidy bill that's been described would represent an immediate reduction, I guess, in certain circumstances to be defined. And that would give immediate relief to the physicians. I guess the question for you folks to deliberate about is, what is the long-term solution? That's a more difficult question. Certainly I could see the desirability of a bill that would give some sort of immediate, short-term relief. But as time goes on, there's no signals in this data, and if you do nothing to affect it, there's no signals in this data that these losses are going to go down. They are, in fact, where they are.

ASSEMBLYMAN McKEON: And the last question -- relative to the comprehensive, all the other changes, even as they relate to both frequency and severity, as actuaries should look at all the other changes in the proposed law -- if they're given a chance to percolate over four years, will then, from an actuary perspective, would that lead to improvement?

MR. HURLEY: I don't know that I could articulate exactly all the provisions of the bill. I think it's one that we had looked at. My recollection was that the bill, if it was AB-50. Is that--

MR. CANTOR: Yes, A-50. I assume you're referring to the bill that came out of the Senate.

ASSEMBLYMAN McKEON: Yes.

MR. HURLEY: With the \$300,000 in excess liability fund.

ASSEMBLYMAN McKEON: I am referring to that bill, but the point is, and it seems the witness has answered the question, that he's not analyzed all of the bill to understand, when given five years for all those reforms to percolate, whether or not that will improve the environment, therefore

resulting in the ability to stabilize rates from the insurance industry's perspective.

MR. HURLEY: If it was a bill that the Medical Society asked us to review, it was our conclusion that that bill probably would have a net effect of increasing costs slightly.

MR. CANTOR: Excuse me, excuse me. You're--

ASSEMBLYMAN COHEN: No, let him finish. Let him finish.

MR. CANTOR: I think he's referring to the wrong bill.

ASSEMBLYMAN COHEN: Maybe you don't understand, let him finish.

MR. HURLEY: I think that the right solution would be-- We were asked to look at one version of the bill, in fact, several versions of the bills over time. And I think, in order to provide a proper answer to the question, perhaps I could submit something after we're done here, so I'm looking at the right version of the bill. We had looked at several versions, and there was one that looked to us like it would actually increase costs, rather than decrease costs. I should look at the exact bill you're referring to and give you a written response to that, if you don't mind.

ASSEMBLYMAN McKEON: All right. And I'll appreciate that.  
Thank you, Mr. Chairman.

ASSEMBLYMAN COHEN: Thank you.

Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you, Mr. Chairman.

Sir, if I could direct your attention to Page 2 of your report, where you talk about reliances and limitations. You say, in part, and I'll quote it, "We

have also relied, without audit, on information contributed to the Medical Society of New Jersey study by MIIX Insurance Company, MIIX Advantage of New Jersey, and Princeton Insurance Company.” Did you write a letter, or did the Medical Society of New Jersey write a letter, to MIIX and Princeton, itemizing the data that you needed in order to do an objective and an intellectually honest analysis?

MR. HURLEY: The way the process worked was, the Medical Society of New Jersey retained us, and we defined a data request that was provided to the companies.

ASSEMBLYMAN D’AMATO: And did you get all the data that you wanted?

MR. HURLEY: No. We never get all the data we want.

ASSEMBLYMAN D’AMATO: Tell us what you asked for that you didn’t get?

MR. HURLEY: I don’t know that I could articulate exactly what we didn’t get that we asked for, sitting here at this moment, but there were some details of data, breaking it down into coverage year -- that type of information -- that we were not able to obtain from the companies, and therefore, we did not use those types of analyses.

ASSEMBLYMAN D’AMATO: Now, the fact that you relied on information without an audit, in simple English for everybody’s comprehension, what does that mean?

MR. HURLEY: That means that the data was provided to us by the companies without having, for example, an accounting firm review the data to match it against, exactly, their records. So, for example, what we get is a data

run or a list of claims that was not reconciled by an auditor or an accountant to the individual claim records within the company.

ASSEMBLYMAN D'AMATO: So, if the data that was supplied to you by the two insurance companies, MIIX and Princeton, was intentionally or negligently skewed a certain way, then the conclusions of your report would, perhaps, be different.

MR. HURLEY: Well, clearly, if the data was biased in some way by the companies, it would affect our conclusions. However, I would comment that that was not the only data that we used in doing our analysis.

ASSEMBLYMAN D'AMATO: As part of your analysis, did you do a study of the investment practices of MIIX and Princeton over the last 10 years?

MR. HURLEY: No.

ASSEMBLYMAN D'AMATO: Why not?

MR. HURLEY: We didn't think-- Well, actually, that wasn't the focus of our analysis. Our focus of analysis, on their particular information, was on the claim or the loss side. We did look at the relative proportion of assets that they had in equities versus bonds, fixed income, interest, and that sort of thing, but did not review the investment practices of these companies over the last 10 years.

ASSEMBLYMAN D'AMATO: Have you ever investigated an insurance company, particularly medical malpractice insurance company, regarding their investment practices, as to whether they were reasonably prudent in their investments?

MR. HURLEY: I am not in the business of reviewing companies' investment practices. That's sort of outside my area of expertise. But I am familiar with how these companies invest their assets, having looked at them over the last 20 or so years. So I think I'm familiar with it, but I don't investigate it. No.

ASSEMBLYMAN D'AMATO: In order for this combined legislative Committee to do something that's fair, would you recommend to us that we study the investment practices of the two companies to see how this crisis evolved?

MR. HURLEY: While I'm not comfortable with advising the Committees about what they should or should not do--

ASSEMBLYMAN COHEN: Feel free. (laughter) It's an open invitation.

MR. HURLEY: It would be my observation, based on past experience, that looking at companies' experience over time, it has typically not been investments that have been the cause of problems. So my experience is that in looking at the investment practices of these companies, over the time I've dealt with them, the problems do not emanate from the investment side. And I can tell you that if they did emanate from the investment side, as I mentioned earlier, relief in the form of increased rates would typically not occur, as a consequence of that.

ASSEMBLYMAN D'AMATO: Okay.

Thank you, Mr. Chairman.

ASSEMBLYMAN COHEN: Dr. Conaway.



ASSEMBLYMAN CONAWAY: Just to reiterate a point on that, with your experience looking at these insurance companies -- not only in the State of New Jersey, but across the country -- that-- Because the claim is that all of these huge increases that we're seeing are due to their losses in either their interest income or to their stock market income. And I think you testified -- or losses -- that there is not much of a correlation between those factors and the premiums that are paid. Isn't that right? Is that a fair statement?

MR. HURLEY: I believe it is, but let me state it again, just so I'm clear. Rate increases today are not a function of investment losses from yesterday. Companies are not increasing their rates because they lost investments or they lost money in the stock market or anything like that. It is partly a function of the fact that they cannot invest the premium flows they're going to collect next year in interest instruments that are going to generate 6 percent yields; rather, they're going to generate 3 or 4 percent yields. So rates are higher as a consequence of that, but not because they lost money in prior investments.

ASSEMBLYMAN CONAWAY: And so, one would wonder then about the value of some of the explorations that have been suggested as -- in terms of how they run their business. But moving on from that, you seem to suggest in your comments, if I understand them, at least in your study of what goes on in New Jersey, that there has been a trend toward higher awards. Because this has been one of the big bones of contention here from the one time we were able to get one of the insurance company executives to come in, that they're seeing higher and higher payouts which is affecting -- which is a second question, because of a following question -- which is affecting the premiums that

they have to charge. I mean, they're looking at what their liabilities are, going forward, and trying to make a prediction about what it's going to be, in setting a rate. So, did you say, and from your analysis, did you see or are you seeing evidence which supports their contention that the awards, in fact, are higher than they had been in previous years?

MR. HURLEY: Yes. The awards are higher, and correspondingly, the settlements that they make, which are not awards, to distinguish between jury findings and payouts, are likewise moving up. So the combined effect of those is increasing and, therefore, driving up rates.

ASSEMBLYMAN CONAWAY: Very good. That's what I had thought. And it is true to say that those awards have to affect the premiums they charge the physicians, or is that-- I mean, I know there's some other factors going in there, but what would you say is the principle driver of the premiums they have to charge us?

MR. HURLEY: The key driver is lost costs. Most of the dollars that these companies spend money on is on lost costs and defending claims. That's where most of the money gets spent.

ASSEMBLYMAN CONAWAY: That's what I thought.

Now, one of the-- To go back to Assemblyman McKeon's point, because I think what he was trying to get at-- And I read your initial report to the Medical Society, and you did say, and your comments on the bill before you, that you were concerned that some of the provisions might actually be cost drivers. I think that what the Assemblyman was getting at -- who is not here -- was looking, specifically, at the limitation on liability to insurance companies of \$300,000, and whether or not that limitation to their liability, hopefully,

translated to us in terms of a lower premium, whether or not that particular provision would lower the premiums they have to charge we physicians.

MR. HURLEY: It would be my expectation that it would reduce the losses that the companies will be responsible for, but I would caution you in drawing the conclusion that that will translate immediately into lower rates. And the reason for that is, that the rates need to be adequate. In other words, they need to be reflective of the current loss level before you can start thinking about the impact of having lower loss costs reduce them. So the first step in the process is to get the rates to be adequate. And as I alluded to earlier, they may not be adequate at this point.

ASSEMBLYMAN CONAWAY: And that's the problem. What now, what you're saying is that we have an inadequate rate structure for the costs right now, which may obliterate, perhaps, all of the savings measures in this legislation.

MR. HURLEY: Quite possible, yes.

ASSEMBLYMAN CONAWAY: Now I wanted to get to a point that has been raised here time and time again by folks regarding the experience in California, because I think the graph is pretty clear -- over 25 years, and what has happened there. And it's been a combination of things, which I've said in all of my comments -- which keeps being missed -- and that is that it's a combination of the cap and the tough regulations they have on insurance companies. Can you comment on the effect of the proposition in California as regards insurance reform, and comment, generally, on the method of a cap and strong insurance regulation in affecting the kinds of premiums that physicians pay in those jurisdictions?

MR. HURLEY: How long have you got? I guess, a couple of comments on Proposition 103 and MICRA, which I guess are the two subjects. It took a while for MICRA to have some impact. And MICRA, which was a package of reforms, not just a 250 noneconomic cap, it was a package of reforms that was passed -- was implemented in '75. The companies didn't know how it was going to impact their losses over time. It wasn't quite tested in the courts until the middle '80s. You may recall, in the early part of the '80s, and California was no exception, we had 20 percent inflation rates. In the medical malpractice trend, we had plus-25 percent per year trend rates. So, you could imagine, we were running hard just to keep up with that rate of increase. But that's the rates of increase we were seeing in the frequency and severity of claims, in that time frame, in the early '80s.

California, despite that law at that point in time, was not immune from those types of pressures. So their rates went up during the early part of the '80s. Their loss costs were going up, driving the rates up. Toward the end of the decade, there were, roughly-- In the middle part of the decade, there were, roughly, 200 pieces of legislation passed throughout the country in the middle '80s. Various ones throughout the states. California, obviously, had already had MICRA, and I don't know if they had passed anything at that point in time, but many other states passed many other types of tort reform. And you may recall that trend rates and inflation rates and the rate of inflation declined as we got to the latter part of the '80s. Where our prime rate had reached almost 20 percent in the early part of the decade, it fell off.

Trends, amazingly, fell over. You're going into the early part of the '80s, and you're seeing 20 percent or more per year. The frequency and severity

of claims rolled over, went flat, and, in fact, declined in the latter part of the '80s. Well, as that happened, companies reacted to that, learned what was going on, reduced their rates, and California likewise saw that's where the benefit in its loss costs-- And incidentally, at or about that time, MICRA was confirmed. In other words, it was upheld in the courts -- the 250 noneconomic cap was upheld.

In 1988 and 1989, I think, Proposition 103 was passed. It was finally determined that Proposition 103 would be upheld in 1991. In the meantime, the medical malpractice companies who wrote business in California had already started to take down their rates in response to the confirmation of MICRA and in response to the improving loss environment that became apparent in their data. They, actually, voluntarily made agreements with, as I understand it -- and this is second hand -- voluntarily made agreements with the insurance department to give one-time dividends as a consequence of the rollback provision in Prop 103, and did so, 20 percent. They were already paying dividends at that point in time, which means they were paying back premiums that they thought were excessive, as a consequence of the improvement in the loss experience. So they were paying back dividends, and part of it, at that point in time, they paid an extraordinary dividend that was satisfactory of their requirements under the Proposition 103 rollback provision.

Proposition 103 guides, as I mentioned -- confirmed in 1991. We come into the middle '90s, trends flatten out. And in California, the data had stabilized in the latter part of the '80s and coming into the '90s, and has remained relatively flat since that time. My comment to you about Prop 103 and its effect on the rate filings that companies make in California is that losses

drive rates. No rate regulation is going to make losses go away. If the losses are continuing up, as they are in other jurisdictions, rates will need to go up or companies will leave or go broke.

In California, the loss costs have been more stable. I cannot tell you it's cause and effect of MICRA, but it coincides in its occurrence. The companies have not had the same problems that there have been in other jurisdictions, and therefore, there has not been a problem as far as Prop 103 needing to hold the rates down. To me, rate regulation is not the answer there. The loss costs being more stable, more predictable, and increasing at a lower rate is the answer to why the California rates haven't gone up.

ASSEMBLYMAN CONAWAY: And that part of MICRA, of course, which affects directly what the losses are, is the cap portion of it, isn't it?

MR. HURLEY: That is generally viewed as the cornerstone, yes.

ASSEMBLYMAN CONAWAY: And so, if a state or a legislature is looking at getting a handle on a problem that's driving physicians out of the State of New Jersey and Pennsylvania -- they lost a thousand, we're losing them here -- preventing people from staying in the state, interfering with our recruitment of bringing physicians here to the state, because of this environment, wouldn't you say that policy makers, as they look out across the country, would make the laws more like California, rather than less?

ASSEMBLYMAN COHEN: You may answer that leading question.  
(laughter)

ASSEMBLYMAN CONAWAY: I'm just trying to be a good counsel, that's all that counts.

MR. HURLEY: I think that my goal here is not to be a policy maker or not to advocate for or against reform. What I'm really trying to do is tell you what I think I've seen over time, and what seems to work, and what doesn't, and what the experience has been. So I'll defer answering that question, if you don't mind.

ASSEMBLYMAN CONAWAY: Fair enough.

MR. HURLEY: I think you folks are the folks who are going to have to face the challenge of that question.

ASSEMBLYMAN COHEN: Oh, this jury will rule on that, but--

MR. HURLEY: I'm sure. You don't need my help, I'm certain.

ASSEMBLYMAN COHEN: Assemblyman Chivukula.

ASSEMBLYMAN CHIVUKULA: Thank you, Mr. Chairman.

Just looking at some of the charts, one chart that says *Model of New Jersey Malpractice Results without Changes*, somehow it seems to stop at 2001 for earned premium.

MR. HURLEY: Which chart are you referring to, sir? I'm sorry.

ASSEMBLYMAN CHIVUKULA: It's Exhibit *F*.

MR. HURLEY: Exhibit *F*, okay.

ASSEMBLYMAN CHIVUKULA: It stops at 2001, and also there is an earned premium drop from year 2000 to 2001. I'm just curious, I mean, why did it stop there? Also, the Exhibit *G*, you have a model of potential results with reforms. It looks like the losses and expenses with reforms starts at year '98, or '99.

MR. HURLEY: First, taking Exhibit *F*. Exhibit *F* reflects some data from a company called A.M. Best, which collects industry data for all lines of

business and all types of coverages. This is data, from that data source, which collects information from all the companies. The data for 2002 was not available. In fact, I don't believe it's necessarily available even at this point in time. They're still assembling that information, which will be available later in the year. So 2001 was the most recent year we had available.

ASSEMBLYMAN CHIVUKULA: Also, do you know why the earned premium dropped from 2000 to 2001?

MR. HURLEY: I do not know why it dropped. I can't tell you that.

ASSEMBLYMAN CHIVUKULA: Any, maybe -- to continue that--

MR. HURLEY: To be honest with you, it looks relatively flat to me, but it dropped a little bit, I guess, yes.

ASSEMBLYMAN CHIVUKULA: Now, if you look in the hundreds of thousands, definitely there's a drop there.

MR. HURLEY: I cannot explain the decline.

ASSEMBLYMAN CHIVUKULA: It's in the millions, or it is-- Okay.

And Exhibit G, I have a question on it. How did this -- losses and expenses, they start diverging with reforms and without reforms. How did this start in '98? We don't have any reforms right now.

MR. HURLEY: Yes. The idea of this graph is, you may remember at the early -- at some early comment, I mentioned that the way you provide coverage in New Jersey is generally occurrence-type coverage, as opposed to claims-made coverage. The implication of this graph is that -- and I think it was mentioned by one of my dear colleagues a moment ago -- the implication of this



graph is, if you implement tort reforms, it's likely to have an effect that goes back and affects claims that haven't been reported or claims that haven't been settled. So the beneficial effect you're seeing, reaching back, is the effect on the claims that are still open or the claims that haven't been reported for those prior coverage years. And that's why it affects those.

ASSEMBLYMAN CHIVUKULA: Thank you.

MR. HURLEY: Sure.

ASSEMBLYMAN COHEN: Assemblywoman Nellie Pou.

ASSEMBLYWOMAN POU: Thank you, Mr. Chairman.

Sir, I'd just like to go back to your testimony earlier. You mentioned something with regards to the premium increase. You've made two statements that I'd just like you to just clarify for my benefit. One was that there is an increase in the severity of claims and rate increases are justified. Would you say that the awards are higher due to the severity of the cases that-- Is that what your comment is based on, that number? Is it because of the -- the increase of the severity of the cases has led to the higher awards?

MR. HURLEY: Yes. That's probably a terminology problem, and I apologize for that. When I was talking about severity, I slipped into actuarialese (*sic*) on you. I'm really talking about the average cost of a claim, not the severity of the injury.

ASSEMBLYWOMAN POU: Okay.

MR. HURLEY: So when I'm talking about changes in severity, I'm really talking about the change in the average cost of a claim over time, not the severity of the injury or something like that. Does that clarify?

ASSEMBLYWOMAN POU: Well, that helps, yes. No, that certainly makes a world of difference in my mind in terms of what I understood you to mean, in terms of increase and severity of the claim. What was your statement?

MR. HURLEY: It is an average claim cost. And what it means is, it's the dollars paid divided by the number of claims associated with those payments. It's the average claim cost. We do not see data in sufficient detail to determine, for example, whether there are different injuries in a given year. Our assumption is that there's a fairly consistent distribution of injury types in a given period, so that averages can be compared from one year to the next. We're not evaluating the individual severity of claims. We're looking at the overall average of claims. Is that fair?

ASSEMBLYWOMAN POU: All right. Thank you very much.

ASSEMBLYMAN COHEN: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you.

Were you here when the representatives of the Administrative Office of the Courts testified, AOC?

MR. HURLEY: I think I was in the room. I don't know that I could quite hear them.

ASSEMBLYMAN D'AMATO: Have you seen the data that they've submitted to our combined Committee here?

MR. HURLEY: No.

ASSEMBLYMAN D'AMATO: Why didn't you contact the Administrative Office of the Courts as part of your analysis?

MR. HURLEY: I didn't think that it was necessary. My intent was to evaluate the reasonableness of what the rate structures -- rate changes were. And part of my purpose was to make a determination about that, rather than to, in some way, gather data that I couldn't then compare to any premiums, or number of doctors, or something like that. I need something to compare it to.

ASSEMBLYMAN D'AMATO: Because this -- the combined Committees here are going to have to deal, I would hope, with the information supplied by the Administrative Office of the Courts of the State of New Jersey. And if my math is right -- and I didn't use my calculator -- it seems that the median jury verdict, in 2002, I have as 300,000, not 350, 300,000. If I counted right, there were only 18 verdicts in excess of 1 million, and one was remitted, as we heard before, which is not reflected on here. And it seems that there is a downward trend in our state in the number of med-mal verdicts. Is that something that should have been considered by you?

MR. HURLEY: Well, certainly it would be if it were data that were evaluated or structured or organized in a manner in which we could evaluate it. We did look at the severity of claims in several ways in the report, both on a closure-year basis and on, what we call, a report-year basis, which means, sort of, on a claims-made basis. And we determined from that data that, in fact, the severity of claims is increasing. I can't easily reconcile that data to your data without some pretty extraordinary efforts with individual claim information.

ASSEMBLYMAN D'AMATO: As I gather, from quickly going through your report and your testimony, you did not study the underwriting practices of MIIX and Princeton over the last five, seven years, did you?

MR. HURLEY: I did not study the underwriting practices, no. I just evaluated their experience.

ASSEMBLYMAN D'AMATO: But we've been told by legitimate commentators, who profess to have no stake in this debate, that these two companies insured physicians at below fair market value and physicians who had a history of med-mal claims against them. Is that something that should have been considered by you as part of your fair and objective analysis?

MR. HURLEY: My analysis was to determine the reasonableness of the necessary -- or the premiums relative to losses, and whether there was a legitimate and real driver of what those increases were. It was not to evaluate their underwriting practices. It was not to evaluate what they may or may not have charged for an individual physician. It was intended to say, in the broad aggregate of things, when you compare the premiums they collected to the losses they have -- and more broadly, beyond MIIX and Princeton, to the data for medical malpractice, in general, within the state -- do the losses make sense relative to premium? The answer to that is no. The losses exceed the premium by a substantial margin. Does that imply that there needs to be rate increases? And the answer is yes.

ASSEMBLYMAN D'AMATO: Okay. Finally, I have to share with you a personal experience. I decided to make Italian sauce this past weekend, because I said I could make it better than my wife. I made it, and I said to her, "What do you think?" She says, "It seems to be better than what I make." In your report, you say that caps seemed to be working in states that have the caps, as opposed to states that don't have any. You use the word *seemed*. Is that something that this legislative body should rely upon -- this report where you do

not conclusively state that caps work? Rather, you say it seems that rate level can be controlled better.

MR. HURLEY: Let me see if I can put that in perspective. I don't have any sauce to mix, but I'll see if I can sort through that. Our view on caps is that they will reduce the loss payouts. But there are many other dynamics that go on in a given jurisdiction that affect what's going to happen to loss costs. Caps in their singular and absolute -- only by themselves may not actually arrest the increase in losses, if there are other things that change, that make the losses go up.

So, for example, you shouldn't assume that if you implement a noneconomic damage cap that there will not be any increases in rates, because the other major aspect of things is the economic damages, which do have upper pressure. So for me to sit there and tell you, well, rates won't go up after you implement a noneconomic cap, or we can take rates down because we implement noneconomic caps, ignores the reality of the economic damage aspect of the equation that is a very significant contributor to that.

You're reading, I think, a little, probably, too literally what we're trying to get at there, but it is true that there can be no guarantee until such time as the caps have been confirmed and that you actually see the benefit and the losses. You really don't know what the impact is going to be. But one thing is clear, and that is that if you implement caps, even to the extent it doesn't stop rates from going up, it will make the losses lower than they would otherwise be, and it will make rates, as a consequence, lower than they would otherwise be. So it may not make them go down, it will slow the rate of increase. That's what I'm trying to say in my report.

ASSEMBLYMAN D'AMATO: Thank you.

Thank you, Mr. Chairman, Madam Chairman.

ASSEMBLYMAN COHEN: Thank you.

Did you read the A.M. Best reports on MIIX from April 2002?

MR. HURLEY: I can't say that I have, no.

ASSEMBLYMAN COHEN: What was the last A.M. Best report you reviewed either for Princeton or MIIX?

MR. HURLEY: Let me clarify. When I say we used A.M. Best data, sir, what we were using was data that they collect for all companies reporting to them that wrote business, for example, in the State of New Jersey. So we did not individually get information from A.M. Best on MIIX or on Princeton. What we collected was the aggregated data that included all companies writing medical malpractice data in the State of New Jersey.

ASSEMBLYMAN COHEN: All right. But A.M. Best issues reports that are also three or four pages long, correct?

MR. HURLEY: Yes, they do. Yes, sir.

ASSEMBLYMAN COHEN: And you can make certain assumptions from their findings on information that they've gathered, correct? They're a respectful organization, are they not?

MR. HURLEY: I think they're recognized as a good organization that summarizes the data for the insurance company and financial results, yes.

ASSEMBLYMAN COHEN: Okay. And in April 2002, A.M. Best issues a report that says that MIIX -- the keystone to MIIX's financial problems was its out-of-state business, where it was being hit strong by losses in Pennsylvania, Ohio, Texas. Do you recall that? Do you recall that issue?

MR. HURLEY: Actually, I do recall the issue, yes.

ASSEMBLYMAN COHEN: And in black and white, in A.M. Best's report in April 2002, it says that the problem with the company and its rate increases was generated by a loss history sustained out of state. Now, if you're going to come in-- I mean, you're very good at your craft. I'll give you that. That's very good. But one would think that before you wrote a report in April 2003, you would have looked at, or someone would have shown you, the A.M. Best reports, because New Jersey physician premiums in that report, in that report, were being used to pay the claims created out of state. It's right in A.M. Best's report. It provided us with very easy reading that the losses that were being sustained, through MIIX, were being paid because of New Jersey physician premiums, collected in New Jersey.

I suggest that you, if you're going to continue with this, that you take a look at the A.M. Best reports after 2002. I'm not sure-- In fact, let me ask you this. What A.M. Best report did you read?

MR. HURLEY: These are data that are provided, called A.M. Best executive--

ASSEMBLYMAN COHEN: Listen to my question. The A.M. Best reports -- that is, A.M. Best's final product -- what was the last A.M. Best report that you used as part of your report?

MR. HURLEY: May I answer?

ASSEMBLYMAN COHEN: Yes.

MR. HURLEY: Is it okay for me to answer the question?

The A.M. Best report we used was the A.M. Best Executive Data Service, which provides data summarized for the companies. And let me

address just the question you mentioned. In our analysis, we limited our review, as far as it related to the MIIX experience, to only its experience in the State of New Jersey. We did not look at states outside of New Jersey, because it was not relevant to the study.

ASSEMBLYMAN COHEN: Well, if MIIX were taking money from MIIX and paying the claims to Texas, isn't that relevant to how their financial situation is?

MR. HURLEY: It's certainly relevant to how their financial situation is. I'm not telling you that MIIX's problems or the fact that MIIX had to go into voluntary runoff is a consequence of its New Jersey business. And if you've interpreted that as my comment, then I apologize. My comment was, as it relates to MIIX, is that it went into voluntary runoff because it charged inadequate premiums relative to the losses that are emerging. It could have been in Pennsylvania. It could have been in Virginia. It could have been in Texas. But as far as my analysis and the conclusions I've given you from the numeric standpoint in this report, it is New Jersey-only data. As it relates to MIIX, it is New Jersey data only, not Pennsylvania, not Texas, and not Florida. But I would agree with you.

ASSEMBLYMAN COHEN: The money that's paid out of New Jersey MIIX -- we'll use that name -- that's paid out of their funds to go pay a Pennsylvania or Texas claim, isn't that part of its financial picture in New Jersey, since it's taking New Jersey physician premiums? And it's right in A.M. Best's report in April 2002 -- taking New Jersey physician-collected premiums, being used to bolster and protect cases in Texas and out of state. Isn't that part of New Jersey MIIX financial picture? It's the same checkbook.



MR. HURLEY: I would agree that it is the same checkbook from which they are writing their claim checks. However, in our analysis and in the conclusions I have given you, it is irrelevant. The fact of the matter is that the rate structure that was used in New Jersey is inadequate to meet the loss costs that are emerging in New Jersey.

ASSEMBLYMAN COHEN: When did that begin? When did the inadequate pricing begin?

MR. HURLEY: It appears that it would probably have started -- oh, I don't know -- during the late '90s, 1999 or so, something like that. But the problem, as I mentioned earlier, is that it's difficult to determine that the rates are inadequate as of that point in time, in part because of the coverage that's provided here, which is occurrence-type coverage. It's very difficult to identify these turning points in the data.

ASSEMBLYMAN COHEN: Now, whether or not it's going to be an occurrence or claims made is a decision made by the insurance company when they offer it to those who wish to be insured, correct?

MR. HURLEY: The company decides what coverage it will provide.

ASSEMBLYMAN COHEN: Correct.

Now, in terms of that, which of those benefits the insurance company, more so, than the consumer it serves?

MR. HURLEY: Which of what, sir?

ASSEMBLYMAN COHEN: In other words, on an occurrence or claims-made basis, that they determine what they're going to offer to a physician or anyone else, which of those benefits the insurance company more?

MR. HURLEY: I'd have to give interpretation to your word *benefit*.  
So I'll use my interpretation--

ASSEMBLYMAN COHEN: Sure.

MR. HURLEY: --and perhaps you'll correct me if I make a mistake there. Benefit to me would be, it's less risky for the insurance company to write one coverage form rather than the other. Would that be a correct interpretation?

ASSEMBLYMAN COHEN: Okay. Which would be more expensive to the one who's being protected -- occurrence or claims made?

MR. HURLEY: I'm sorry. You changed the words.

ASSEMBLYMAN COHEN: In other words, what I'm trying to get to, maybe, and I'm not phrasing it exactly correctly--

MR. HURLEY: Okay.

ASSEMBLYMAN COHEN: --but if you have two options, you can either offer a claims-made policy or an occurrence-based policy, correct?

MR. HURLEY: Yes, those are two options.

ASSEMBLYMAN COHEN: If I'm a consumer, like a doctor or nurse or a hospital, would I prefer to have it claims made or would I prefer to have occurrence protection?

MR. HURLEY: It depends on what your criteria for preference are. If you prefer to pay less, perhaps you'd like a claims-made product. If you prefer to pay more, you might want an occurrence product. If you prefer--

ASSEMBLYMAN COHEN: Okay. Now, on a claims made -- if you would pay less on a claims made as a doctor, physician, a nurse, or a hospital, and you would have to pay less in premiums on a claims made, if the

insurance company only offers occurrence that means that the cost to you is going to be higher in good times and bad times, correct?

MR. HURLEY: Incrementally higher, yes. It would be higher, generally.

ASSEMBLYMAN COHEN: Now, do you think that those who are covered should have the option of either picking a claims made or an occurrence?

MR. HURLEY: I don't know that I have an opinion on whether they should have an option or not. I think companies are not required to offer both, so therefore, apparently, we don't think it's appropriate for them to have a choice. A company decides. Now, if companies in the State of New Jersey are precluded from writing one form versus another, then you've made it -- then the law makes it that way.

ASSEMBLYMAN COHEN: No one's precluded. But when the -- that which is offered is, of course, determined by the insurance companies. And the ones that they offer, obviously, are the occurrence, which means that those who are being protected are going to pay something higher than what it would be in a claims-made basis, as you just indicated.

MR. HURLEY: But the tradeoff, which I don't think I quite got out before you asked your next question, is that you're buying different protection. Under an occurrence policy, you buy the policy and, forever, any claim that gets reported is covered by that occurrence policy. Under a claims-made policy, you buy the policy and only those claims that are reported during that policy period are covered. So you're buying a different coverage, and therefore, the price is correspondingly different.

ASSEMBLYMAN COHEN: Which will -- and the claims made is less than what the occurrence is?

MR. HURLEY: As generally is the view that the coverage provided is also less.

ASSEMBLYMAN COHEN: Now, the data that you received from Princeton and MIIX, in terms of losses, that information -- was there a breakdown to you in terms of how much represented, let's say, on a jury award, how much represented noneconomic and how much was economic and medical and wages? Did you have that background on jury verdicts?

MR. HURLEY: No.

ASSEMBLYMAN COHEN: Did you ask for it?

MR. HURLEY: We discussed whether or not we could get any breakdowns in terms of noneconomic and economic damages. I believe, and as is true of most companies, they were not able to provide it. So, no, we didn't get that.

ASSEMBLYMAN COHEN: So on any jury verdict, whether it's 500,000 or 3 million, you don't know how much represented pain and suffering, correct?

MR. HURLEY: That is correct.

ASSEMBLYMAN COHEN: Now, on matters that were settled, on the information that was provided to you from MIIX and from Princeton, on the matters that were settled, was there a breakdown provided to you in terms of pain and suffering -- that is, not economic damages and wages, medical bills?

MR. HURLEY: There was no breakdown of the indemnity payment--

ASSEMBLYMAN COHEN: So you don't know, even in the settled cases, whether or not the noneconomic represented 3 percent of the settlement or 80 percent of the settlement?

MR. HURLEY: As is true of most companies, they were not able to provide that detail, correct.

ASSEMBLYMAN COHEN: Did you ask them for it?

MR. HURLEY: I believe, as I said earlier, we asked for what would be available in that regard, and we did not even include it in the data request, I do not believe, because we were told that, as is true in most companies' case, was not available.

ASSEMBLYMAN COHEN: Well, in viewing whether or not noneconomic damages should have a cap, whether it's 250 or a million or 7 million, isn't it important to look at, for purposes of history, exactly how much is being paid out for noneconomic damages in a settlement or in a trial? I mean, that's actual data. Isn't that important in looking at?

MR. HURLEY: I think it would be helpful to have that sort of breakdown. It is my understanding, from talking to claims people, that that's a very difficult thing to get your arms around. And, in fact, when they make claim payments, it's not clear what portion is noneconomic and what portion is economic. For example, if a payment is made at policy limits, and they are presented with information that says the economic damages are 2 million and we want noneconomic damages of a million, and the policy limit is a million and that's the amount they pay, I'm not sure what the portion of economic and noneconomic damages are. So there are difficulties in getting that information.

There are judgments. It's somewhat subjective, and companies tend not to keep that information, unfortunately.

ASSEMBLYMAN COHEN: They don't keep the information.

MR. HURLEY: They don't keep information in the detail of economic and noneconomic, because they don't know exactly what that is, and it's very subjective.

ASSEMBLYMAN COHEN: So they're devoid of any information on it.

MR. HURLEY: They aren't able to split their data into economic and noneconomic damages.

ASSEMBLYMAN COHEN: Now, did you look at the jury verdict sheets on the jury awards?

MR. HURLEY: I do not have any data from jury verdicts that say this is -- if I understand your question -- the jury verdict on this particular claim, no.

ASSEMBLYMAN COHEN: Did you ask for it?

MR. HURLEY: No.

ASSEMBLYMAN COHEN: Did they offer to give it to you?

MR. HURLEY: No, they didn't. I didn't feel I needed it.

ASSEMBLYMAN COHEN: You know, on jury verdict awards, it says, nonec pain and suffering award and economic damages, there's a check off as to each count. Were you aware of that?

MR. HURLEY: No.

ASSEMBLYMAN COHEN: Did you speak to any of the defense attorneys in terms of the jury award verdicts in MIIX and Princeton for the last couple of years?

MR. HURLEY: No, I have not spoken to the claims defense attorneys at MIIX or Princeton.

ASSEMBLYMAN COHEN: So that when interest rates go down, that has an impact on the rate of return that a company may have with investments. Is that correct?

MR. HURLEY: I believe that's correct.

ASSEMBLYMAN COHEN: Okay. Anybody who has their certificate of deposit knows that they were making more money at 8 percent than they are now at 1.1 percent, correct?

MR. HURLEY: Yes.

ASSEMBLYMAN COHEN: Okay. So can you tell us, on a percentage basis -- and I know a lot of expert opinion report is trying to draw an opinion, but it should be based on the factual predicate. What percentage of our problem in Jersey deals with the interest rates, which have gone from 8 and 9 percent down to 1?

MR. HURLEY: I'd have to do a calculation that reflected that order of gap, but I think, in our report, we provided you an assessment or a rough estimate of what the impact would be. For example, going from 6.5 percent interest down to, roughly, 4 percent interest, and we said that in rough terms that was probably somewhere between 10 and 15 percent of rate level. So dropping the interest rate assumption by 250 basis points, from 6.5 to 4 we

(indiscernible) something between 10 and 15 points of rate level, given the payout pattern that exists in New Jersey.

ASSEMBLYMAN COHEN: All right. But what percentage of an impact on what the rates would be -- 15 percent, 20 percent, 30 percent -- on interest rates dropping 250 basis points?

MR. HURLEY: I think, I just--

ASSEMBLYMAN COHEN: Fifteen percent.

MR. HURLEY: Between 10 and 15 percent. I think the actual number was 11 percent.

ASSEMBLYMAN COHEN: Did they give you computer-driver data, MIIX and Princeton, or did they give you hard copy files?

MR. HURLEY: It was electronic information.

ASSEMBLYMAN COHEN: They had this information on a computer, that you're aware of?

MR. HURLEY: The data they provided to us was on -- in electronic form. So, I mean, I don't know what their data system issues are. I just know they provided us information in electronic form.

ASSEMBLYMAN COHEN: Are you aware, or did you take into consideration, that by virtue of -- and I'm going back to the A.M. Best reports -- that by virtue of out-of-state losses, paid for out of the New Jersey checkbook, that as a result of that, there had to be rate increases to make up for those losses out of state. Is that correct?

MR. HURLEY: I cannot speak to what impact their out-of-state-- I assume we're talking about MIIX, first of all?

ASSEMBLYMAN COHEN: Correct.



MR. HURLEY: I cannot speak to what decisions and what rate changes were implemented by MIIX in New Jersey as a consequence of its losses from out-of-state business. I cannot speak to that question.

ASSEMBLYMAN COHEN: Now, an insurance company, as we understand, obviously as it gets more claims in and sustains more losses, unless it has tremendous investments, either in the bond market or elsewhere -- right now, nobody does -- the only thing that an insurance company can do to make up for those losses is adjust the rates upward to recapture revenue. Is that correct?

MR. HURLEY: I would disagree with your characterization.

ASSEMBLYMAN COHEN: Would you disagree with the premise that if my losses are larger, I'm going to have to increase rates somewhat and make up for those losses so I can stay in business?

MR. HURLEY: I disagree with that.

ASSEMBLYMAN COHEN: You disagree?

MR. HURLEY: Yes. Because, as I said--

ASSEMBLYMAN COHEN: So one would not increase premiums if they were sustaining losses?

MR. HURLEY: Could I amplify?

ASSEMBLYMAN COHEN: Sure.

MR. HURLEY: As I mentioned earlier, the way rates are determined, you learn from the loss experience that you had historically, but you do not get to recoup, which is my interpretation of your comment. Your comment suggests that somehow, if I lose money last year, I'm going to adjust my rates this year to make up for that. That's not what happens. What

happens is you interpret the loss experience that you had in prior years, you adjust it so that you make an estimate of what the losses are you're going to have for next year, on a loss cost basis, and then determine what rates you need to charge for the coverage you're going to be providing in the next year. You do not recoup for the losses you had for prior years, which was my interpretation of your characterization, which is why I said that. I apologize.

ASSEMBLYMAN COHEN: You referenced National Practitioner Data Bank and other national information in your report. You used out-of-state data, also, to look at issues in New Jersey?

MR. HURLEY: There certainly was some countrywide data that we used in our study.

ASSEMBLYMAN COHEN: Which countrywide data, if you can recall?

MR. HURLEY: I believe it was, some A.M. Best data was used in the early part of the discussion to look at the long-term trends over the '75 through 2000 period, or something like that. That's my only recollection of out-of-state data. It was not used directly in the conclusions I mentioned earlier.

ASSEMBLYMAN COHEN: Did you measure the jury awards and settlement awards over the last five or six years in Jersey?

MR. HURLEY: We looked at severity of claims implied by the payments that were made by these companies over the last five or six years, yes.

ASSEMBLYMAN COHEN: I'm not sure if that did or did not answer, but--

MR. HURLEY: I thought it did. I think the answer is--

ASSEMBLYMAN COHEN: Let's try it again. Let's try it again, either for my benefit or for your benefit. But over the last five years, in reviewing the information from, let's say, MIIX, did you review the payout claims on all settlements and all jury awards?

MR. HURLEY: I believe if you-- We received payout information from MIIX and from Princeton and--

ASSEMBLYMAN COHEN: How was the payout information from MIIX provided to you? In what form?

MR. HURLEY: I believe it was--

ASSEMBLYMAN COHEN: Was it a list of 800 settlements, or was it a gross amount?

MR. HURLEY: I believe it was aggregated into coverage year, what we call coverage year detail, either by accident year or report year, is my recollection. And in Exhibit C of our report, we summarized, on a report-year basis, what the severity of claims had been for those companies, based on that data.

ASSEMBLYMAN COHEN: All right. So let's take that so that I know that my question has been answered, or the best that you can do it. What you were presented with was, for each of those years, MIIX paid out \$50 million in claims that year. Is that basically it?

MR. HURLEY: Not exactly. It was in more detail than that. It was by -- I think it gave us accident year, report year, summarizations of the data. And we may, actually, have had some more detailed data. I just don't recollect it off the top of my head.

ASSEMBLYMAN COHEN: But what you were provided with was a gross number? It didn't say, like AOC's report, which is, "These are the 800 cases MIIX had in 2002 that paid out." This was the amount paid out in settlements, this was the amount paid out in jury awards. You did not have that information?

MR. HURLEY: I don't think we got it in individual claim detail, but we got summarizations by, what I call, either calendar period or coverage period.

ASSEMBLYMAN COHEN: So, summarization, so that I understand it, is a gross amount, whether--

MR. HURLEY: It's an amount that would have--

ASSEMBLYMAN COHEN: --it's 10 million or 5 million. That's the amount that you got. You got no breakdown?

MR. HURLEY: That is true in one sense of the data. I think we did get something. I'd have to look back and refresh my memory on the exact detail of the data to answer correctly. But I think we did get some detail about the individual claim detail, but I don't recollect that.

ASSEMBLYMAN COHEN: And that would have been for all those years, correct?

MR. HURLEY: It would have been for, roughly, the last 10 years.

ASSEMBLYMAN COHEN: What was the date that you went up to, in terms of the information provided by MIIX and Princeton?

MR. HURLEY: I believe it was through the latter part of 2002, but not quite through December 31, 2002.

ASSEMBLYMAN COHEN: Okay.

Thank you.

ASSEMBLYWOMAN WEINBERG: Just before you do -- I have a couple of questions.

To understand, when you said the insurance company, based on the data given to you, paid out \$1.36 for every dollar collected. Is that -- did I write that down right?

MR. HURLEY: Yes, you did.

ASSEMBLYWOMAN WEINBERG: Okay.

Does that \$1.36 -- is that only for New Jersey claims, or did it include, as my colleague said, the out-of-state claims to other states?

MR. HURLEY: No. That was only New Jersey data, only New Jersey experience. It did not include out of state.

ASSEMBLYWOMAN WEINBERG: Now, you also said that there was no breakdown of the economic versus noneconomic?

MR. HURLEY: I did say that, yes.

ASSEMBLYWOMAN WEINBERG: Does an insurance company usually keep that?

MR. HURLEY: No, it doesn't. It generally doesn't have it, unfortunately. It may be able to get it, as it was mentioned, in situations where there's a jury verdict, if it actually retains that information. But because most of the claims are settled rather than tried to verdict, it would be, as I mentioned earlier, a very subjective exercise to try and keep track of that information, and they generally don't.

ASSEMBLYWOMAN WEINBERG: So we can't really say that this increase was due to pain and suffering. It could have been due to economic awards.

MR. HURLEY: That is correct. That is correct.

ASSEMBLYWOMAN WEINBERG: And there is nothing in here that could either prove or disprove that?

MR. HURLEY: There is no data in here that would distinguish between economic and noneconomic-- No, it's combined together, and I do not have the ability to separate it, with the information available.

ASSEMBLYWOMAN WEINBERG: So how would an insurance company then decide to lower their-- If this information isn't even available to them -- and I'm a layperson at this obviously -- how would they decide to lower their rates if there was some kind of cap on noneconomic damages, if they don't even know what percentage of what they're paying out is actually for economic damages?

MR. HURLEY: That is a difficult decision for an insurance company to make. Their expectation would be that the loss costs, if they were to do such a thing, their expectation would be that the loss costs would be reduced as a consequence of the implementation of the noneconomic cap, and it would be based on some judgments or some assumptions about what the impact of that would be, if they were actually to prospectively reduce the rates. Hence, part of our observation is that you need to wait until you see what the loss data shows and let the rates respond to the loss data. It's very difficult to make these assessments because, as you correctly noted, the data is not available to do it in an explicit, quantitative way.

ASSEMBLYWOMAN WEINBERG: Okay. All right.

Assemblyman.

ASSEMBLYMAN CONAWAY: Just following on the Chairwoman's comments, the analysis was based on loss data, and that is a global number. Now, perhaps, for the sake of our study, which I think is redundant, on this question of noneconomic damages of impact, perhaps we ought to require them to keep this data so that we can figure out what these impacts are, going forward. But at the end of the day, they're making decisions based on loss data, and that is aggregated. What seems to me that we do know, that if we take steps to reduce that loss data in the form of a cap -- I think if I understand all of your testimony taken as a whole -- that we would, looked in isolation, expect to see some reduction in premium. Now that reduction in premium might be swamped out by poor rate premium, going in the past; poor rate structure; and a number of other factors. But the point that I'm not quite understanding, and some of the questions I'm just hearing, is, you're talking about and your analysis is based only in New Jersey. It is based on loss data only, and we know that if we decrease the losses to the insurance companies, that's going to have -- that, well, it may not be the whole determining factor on what our rates will be. It should have an impact which would serve to reduce the rates that they have to charge to physicians. Isn't that right?

MR. HURLEY: Yes, over the long term, reducing losses will reduce rates.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chairperson.

In June of 2002, this distinguished body took testimony, and the chairperson and chief executive officer of MIIX testified here. There was some dialogue that I had forgotten about, but I think it's very, very important to share this with you. Assemblyman Impreveduto and the CEO of MIIX had the following to say. I'm going to quote this:

"There are several parts of the story of MIIX. MIIX was founded in 1977 as part of a malpractice crisis. We operated as a New Jersey company until 1991, at which point we began to write coverage in Pennsylvania. In the mid-'90s, we began to move outside New Jersey and Pennsylvania to write in approximately 25 additional states." This CEO says, "For MIIX's 25-year history, we have done very well in New Jersey. We have always been at a profitable business plan in New Jersey." The Assemblyman says, "So, in 1991, when you were in New Jersey only, you were making a lot of money." She says, "I don't know about a lot of money, but we were always a profitable company." The Assemblyman -- and I'm almost finished -- "So it would seem to me that when you began to expand out of New Jersey your problems began." And here is her response: "New Jersey is a volatile environment, but clearly not as volatile as markets outside New Jersey. The tort reform that was put in place in the mid-'90s has served us well. We've seen a decrease in the frequency of cases. It's a market where we believe we defend cases very successfully."

Sir, you have the CEO of MIIX saying that for the 25-year history, up until she testified here, that it was a profitable company, but the problem was they went outside of New Jersey, as was explained to you in the dialogue between you and Assemblyman Cohen. Isn't that something, when you have the CEO of MIIX saying we were good in New Jersey? We made a mistake.



We went into 25 other jurisdictions. Because they made that mistake, we ought to have caps in this state?

MR. HURLEY: Is that a question to me?

ASSEMBLYMAN D'AMATO: Yes.

MR. HURLEY: Could you state the question so I can understand it?

ASSEMBLYMAN D'AMATO: You know what, I'll withdraw the question.

Thank you, Madam Chairperson.

MR. CANTOR: Madam Chairwoman?

ASSEMBLYWOMAN WEINBERG: Yes.

MR. CANTOR: I did have a few statements, on the part of the Medical Society, on the issue of subsidies, if you want me to just go through those right now.

ASSEMBLYWOMAN WEINBERG: Sure.

Go ahead, Mr. Cantor.

MR. CANTOR: Again, I know the day is late, so I will just keep it short. One, first of all, there are a number of doctors who would have liked to have been here today, but unfortunately, as I think you know by now, our annual conference is going on. So we apologize that we could not be here -- our leadership could not be here.

The doctors of MSNJ are very thankful that you are taking this issue seriously, and I think the fact that you are proposing subsidies show that you recognize it's a problem and that there are a number of physicians who are really hurting and need relief. The Medical Society of New Jersey would support

subsidies being given to doctors. However, we do not support a short-term bandage approach of subsidies in lieu of the long-term fix to the liability problem. Now, we believe that a comprehensive system that is contained in the Senate version of A-50 is the best way to go right now.

Again, we would support subsidies, but could not in lieu of. And let me speak, specifically, to the subsidy which I think is being proposed here today. It is very difficult, because we don't have the language before us. But it's my understanding that what you're doing is taking the funding mechanism of the current Senate version of A-50 and merging it into the A-50 bill that passed initially, but changing the loans into a subsidy program. If I have that right, I think-- I don't have it right?

ASSEMBLYWOMAN WEINBERG: We have not -- I think I explained at the beginning -- we have not officially received the Senate version of A-50, because our--

MR. CANTOR: No, I'm not saying that you've done it. I'm saying that the concept that I think we're talking on today is, basically, I think, the language of A-50, as it passed this House, using the funding mechanism of the existing Senate version.

ASSEMBLYWOMAN WEINBERG: Correct. Correct.

MR. CANTOR: A few points on that. It was mentioned before that you were looking to raise \$30 million per year for the subsidy. It's my understanding, in talking to the Senate staff, that they were really looking to raise between \$20 and \$25 million to do that, and that's before any administrative costs are taken out in order to run any type of program. So we

don't think, in the first instance, you are going to raise the type of money that you're looking for.

Next, under the language of that proposal, it's very uncertain which doctors will be getting any subsidies or any assistance at all. You're talking about leaving the (indiscernible) to determine where you may have geographical limitations, where you may have doctors who can no longer practice, and certain value judgments being made, which I'm not sure if the Department is going to be competent to make those determinations.

I believe we heard from Commissioner Lacy, at one point in time, that, if you were going to do a subsidy idea, that all doctors should be able to get the benefit of that subsidy, not just a select few based on criteria which, again, we're not sure how it's going to apply.

We also think there are two fundamental flaws with the subsidy idea. One, I think there's a belief that there's only a certain limit or amount of physicians who are really being impacted. However, it's not just an OB problem, not just a neurosurgeon problem. This is a problem that is filtering down to all doctors in the state -- obviously, some worse now than others, but it's creeping up. If you go talk to any surgeon in the state right now -- not neurosurgeons, any general surgeon in the state -- they are seeing their premiums increase substantially, and as Mr. Hurley mentioned, the rate increases are only becoming more.

I believe, this year alone, Princeton Insurance imposed a 25 percent rate increase January 1; I think another 18 percent rate increase on April 1. Surgeons are being hit substantially in the state, and no amount of subsidy that you're going to have is going to be able to help them. Even the family

practitioner, who may see only a \$10,000 increase in their premium -- which we may think is not a big deal, but really, practitioners and pediatricians do not make enormous sums of money -- they're maybe making \$90 or \$100,000 a year. And I would suggest to you that a \$10,000 increase on your operating costs, when you're only making 100,000 a year, and you have your other bills and your college loans, is a substantial hardship even on those family practitioners.

Again, and the other problem with the theory is that there's an assumption that this problem is cyclical and, in a couple of years from now, the economy will turn around and that this problem will go away. Therefore, we only need this for three, four -- I believe I heard five years today. I believe, if you listened to Mr. Hurley's testimony today and if you read his report, that this is not a problem that's going around. The trend increases began in 1997, when the economy was good. They're continuing now, and there's no indication that, unless the Legislature acts, that there's going to be anything to change the losses that companies are experiencing into the future.

So, while we may support a subsidy to help some physicians right now, we believe it's not a solution for a long-term problem. If you want to do both, to help out those physicians now, into the future, we would appreciate that. But what doctors in New Jersey are really looking for is a long-term solution, because they want to practice their careers in New Jersey. They want to take care of their patients into the future. We believe we need a long-term solution.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Mr. Hurley. Thank you for your time and patience here today.

The last on my prior sign-up list -- and just a word. I know, and I see Clark Martin standing there, that it was not convenient for the Medical Society today, since your annual meeting is being held, and I appreciate your coming here in spite of those other pressing obligations.

The Trial Lawyers Association.

**BRUCE STERN:** Good afternoon, Madam Chairwoman Weinberg, Chairman Cohen, and members of this Committee. My name is Bruce Stern, and I am the President of ATLA New Jersey. I'd like to thank you once again for the opportunity to testify here this afternoon, as you work to provide medical malpractice insurance assistance for New Jersey physicians.

As you know, debate has been raging in New Jersey and around the country for more than a year now about how to best address the problem within the medical community due to the increasing costs of medical malpractice insurance. We fully appreciate the work, energy, and attention that has been paid to this issue by legislative leaders and the members of the Banking and Insurance, and Health and Human Service Committees.

We support the plan to provide immediate, meaningful, financial support to the physicians who are experiencing cost increases in their medical malpractice premiums that endanger their ability to maintain a medical practice. The subsidy plan developed by the Assembly, and discussed this morning by Majority Leader Roberts, is an immediate solution to an immediate problem. When compared to the cap gap cap fund option, the subsidy plan is a far superior way to address this cyclical problem, which is driven by economic

considerations outside the control of State government. More importantly, this approach does not harm victims, as it strives to help doctors.

With all respect to Dr. Lomazow, this bill passed by the Senate is a cap. It is a \$300,000 cap on doctors' liability. There is a \$700,000's worth of a fund, a cap gap fund, but for every dollar recovered on economic losses, that fund gets reduced a dollar by dollar. So that if a jury returned a verdict of a million and half dollars in pain and suffering, disability and impairment, loss of enjoyment of life, all that could be recovered by the injured plaintiff was \$1 million. This bill is a cap.

Secondly, Dr. Lomazow mentioned that if we have a cap in New Jersey that is higher than the cap being proposed under the Federal legislation, somehow citizens in New Jersey will be protected. That is wrong. The bill that's before the United States Senate is a bill that would preempt all state law. And if that bill were to pass, there would then be a \$250,000 cap.

There are many unknown and unanswerable questions surrounding the creation of a cap gap cap fund that not only limits the liability of the physician who has committed an act of malpractice, but also limits the financial recovery of the injured patient. How much money will the fund need to cover? Who will administer the fund? Will lawyers be needed to defend the fund? How will future dollars be raised if the fund is depleted? If the fund only applies to jury verdicts, how will any cases ever be settled? Will this turn into another failed attempt by State government to run an insurance company? Remember the JUA and MTF disasters.

Responsible professionals on all sides of this issue have admitted, at some point in these discussions, that the problems of high insurance rates will

not be solved by any cap on the damages victims seek. Rather, the problem will be solved by reducing medical errors. Stop the injuries and you will stop the lawsuits. Honest disclosure of medical errors to the patient -- tell the patient what happened to them, as required by the AMA ethics. Impose some regulatory control of the medical malpractice insurance carriers. Appropriate changes to tort law that encourage timely resolution of a case--

For the past year, Dr. Rigolosi and the Medical Society has continually misrepresented the facts, and threatened and extorted this body to destroy the civil justice system here in New Jersey. When this debate began a year ago, the Medical Society alleged that the problem was due to excessive verdicts. When the Administrative Office of the Courts dispelled that argument, the rhetoric changed.

Just yesterday, in an Associated Press story, John Shaffer, spokesman for the Medical Society, admitted that the Medical Society's claims of excessive verdicts was wrong. But now the Medical Society claims that since verdicts are only averaging under a million dollars, well then, caps won't hurt patients that much. We've gone from: Verdicts were way too excessive to, now, verdicts are so small why not enact a cap, no one will be hurt.

Speaker Sires, Majority Leader Roberts, Committee Chairman Cohen have recommended legislation to subsidize the high medical malpractice premiums of those high-risk specialties, which have been especially hit and hurt by the medical malpractice insurance companies. These proposals would put, in some cases, over \$40,000 in tax-free moneys in the pockets of the obstetricians, neurosurgeons, and other high-risk specialists. Yet, the Medical Society has said no to this proposal. Instead, the Medical Society continues to

clamor for caps on noneconomic damages and seeks immunity from responsibility and accountability for its members' cause.

Dr. Williams, who testified here this morning, is proof that a subsidy would work. Let's recall what her testimony was this morning. She testified that, previously, she paid \$30,000 in medical malpractice premiums. Now she pays \$50,000, without the ability to deliver babies. She testified that her malpractice premiums would be \$72,000 if she were to deliver babies. Now, according to the report that Mr. Hurley presented, the first report, his study found that if you enacted caps, perhaps there would be a 5 percent savings in premiums. So, if we take Dr. Williams quote of \$72,000, you enacted caps, there would be a reduction, maybe, of 5 percent. So her premiums would go down to \$69,000. Not very much help for Dr. Williams. Certainly getting a \$3,000 reduction on her premium is not going to be the item that's going to let her practice and deliver children.

However, under Majority Leader Roberts's subsidy program, under the formula that had been expressed before, in which she would be reimbursed one-half of the increase, if you look at her premium quote of 72,000, her previous premium was \$30,000. Therefore, the different is 42,000. She would receive a \$21,000 tax-free subsidy. You subtract the \$21,000 subsidy from her \$72,000 quote and, all of a sudden, she's only paying, out of her pocket, \$50,000. The same \$50,000 she's paying today, but she'd have the ability to deliver children in Mercer County, under the subsidy program, that she's not able to do now and she won't be able to do under a cap.

Recently, before the Senate Health Committee, Paul Anzano, counsel to ProMutual Insurance Company, one of New Jersey's medical



malpractice insurance companies, testified and recognized that the medical malpractice insurance problem was a cyclical and short-term one, requiring a short-term solution. So why then is the Medical Society against legislation which would subsidize its members? Is it the fact that the Medical Society of New Jersey is the third largest shareholder of MIIX and will reap millions of dollars in profits if the compensation to injured people is drastically reduced? Is it the fact that the Medical Society's officers sit on the board of MIIX and that the Medical Society representatives, also, are large shareholders of MIIX? Why was it, when Neal Weissfeld (phonetic spelling), Deputy Executive Director of the Medical Society of New Jersey, issued a report condemning the conflict of interest between the Medical Society and MIIX, he was summarily fired and escorted out of the building, jointly occupied by MIIX and the Medical Society, by guards?

Six months ago, this Joint Committee requested, in writing, documentations and statistics from New Jersey's medical malpractice insurance companies. Yet, isn't it interesting that these same insurance companies, MIIX and Princeton, which have refused to comply with your written request, voluntarily provided data to Mr. Hurley and his company, who is retained by the Medical Society? How is it and why is it that Princeton Insurance Company and MIIX are permitted to snub their noses at this Committee and yet voluntarily comply with the request of the Medical Society to provide its actuarial firm with the same data requested here? Isn't it interesting that the Medical Society brings in an actuarial person?

That's like, if somebody brought into court an expert who never saw the patient, but just did a paper review. Why didn't they bring in MIIX to give

you the real data? They're the third largest shareholder. They own 821,000 shares of MIIX, and yet they don't bring MIIX here to testify before you. Fortunately, here this afternoon is a former Vice President of MIIX, who will be more than happy to supply you with the information you requested, not hearsay information -- firsthand information.

Also interesting is that Mr. Hurley didn't take in the compensation package paid by MIIX, a company that has gone into insolvent runoff, a company that pays its CEO \$750,000 a year, according to its prospectus, and plans to pay her more money next year. Unfortunately, A-50 as amended by the Senate, fails to address or provide any solution to the medical malpractice insurance problem here in New Jersey. Nothing in this legislation will cause medical malpractice premiums to drop. A-50 provides no financial assistance to New Jersey's physicians and hospitals. Rather, it makes injured patients bear the responsibility for the medical malpractice caused by physicians and medical providers.

According to the Institute of Medicine, over 98,000 people a year are killed as a result of preventable medical errors. That's one jumbo jet crash every other day. The legislation passed by the Senate utterly fails to address this public epidemic. The bill drastically changes the statute of limitations in medical negligence cases, which will have a dramatic effect on children, women, and the elderly. And yet, this legislation does nothing to address the ethical requirement that physicians notify their patients when a preventable medical error has occurred.

Dr. Lacy, New Jersey Commission of Health, has testified that it is ethically and morally wrong for a physician to fail to notify a patient that a

preventable medical error has occurred. Even more distressing is the failure of this legislation to address the real cause of this short-term problem, the medical insurance companies themselves.

Over a year ago, Patricia Costante, CEO of MIIX, appeared and gave testimony. She appeared only because MIIX needed government dollars in order to stay afloat and to start up MIIX Advantage. Since that day, she has never returned. Despite all of the hearings before these Joint Committees and the Senate Committees addressing medical negligence, not once has an insurance company, other than Mr. Anzano, ever appeared.

William McDonough, CEO of Princeton, was willing to talk to *Money* magazine, but not to this Committee. *The Star-Ledger*, *The Bergen Record*, the *Asbury Park Press*, the *Courier-Post*, the *Trenton Times*, *The Press of Atlantic City*, and other leading editorial boards have written editorials denouncing this legislation. They have called upon this Committee to investigate medical malpractice carriers and obtain the data before you take any action. We have demonstrated that the civil justice system is not the cause of the arbitrary rise in medical malpractice premiums. We've been honest and straightforward in providing you with the facts.

Donald J. Palmisano, the President-Elect of the American Medical Association, testified, "People who cause harm should be held accountable." Dr. Palmisano gave that testimony before the United States Congress when the AMA urged Congress to enact legislation to hold HMOs accountable for the medical harm caused to patients due to HMOs' bad business decisions. People who cause harm must be held accountable, whether it's the person who runs the

red light, a company which manufactures a defective product, or a physician who commits a medical error.

A-50, as passed by the Senate, is a flawed piece of legislation. It fails to address the real cause of medical malpractice and the real cause for the arbitrary rise in medical malpractice premiums. On behalf of ATLA New Jersey, we oppose that bill. We support the plan to provide immediate, meaningful financial support to the physicians who are experiencing cost increases in their malpractice premiums that endanger their ability to maintain a medical practice. We applaud the efforts of Speaker Sires and Majority Leader Roberts to balance the interests of the parties involved in this debate. More importantly, we applaud their stand on behalf of the injured patients in New Jersey.

Thank you.

ASSEMBLYMAN COHEN: Thank you very much.

Any questions from the Committee? (no response)

Thank you very much.

MR. STERN: Thank you very much.

ASSEMBLYMAN COHEN: Is Mr. Weiss present?

Mr. Weiss.

**HOWARD WEISS:** Thank you.

ASSEMBLYMAN COHEN: Thank you.

MR. WEISS: I'd like to give you a little background. I was one of a team of healthcare consultants that helped form MIIX in late 1976 and early 1977. I stayed on with MIIX as a consultant until October 1978, and I joined them as a Vice President and was subsequently promoted to Senior Vice President. I left MIIX in January of 1992. My responsibilities included

legislative affairs, particularly the passage of tort reform, actuarial statistical analysis, information services, and general troubleshooting.

The tort reform effort that we undertook at that time had about eight different proposals, including collateral source and joint and civil liability, a \$250,000 cap on pain and suffering, revising the statute of limitations, among others. We were successful in enacting an offset for collateral sources and a revised doctrine of joint and civil liability. Those were the two elements of the package that, as data showed, would have the biggest impact on losses. The rest of the package was “window dressing.”

ASSEMBLYMAN COHEN: When was this?

MR. WEISS: We passed this in 1986, and it was signed by Governor Kean, I believe, in January of 1987.

At that time, my data had shown that a \$250,000 cap on noneconomic damages, if it had been enacted -- we would not have been able to cut premiums one dime. The overwhelming majority of indemnity dollars on settlements is for real economic loss, for past and future medical care, past and future lost income, past and future custodial care, renovations for homes for people who are handicapped, and other economic loss. In essence, I can tell you that in the majority of cases settled by MIIX, the settlement doesn't even cover for economic loss.

The medical communities claim that 70 percent, or 75 percent, of dollars paid are for noneconomic loss is really ludicrous. They don't have any data to make that claim, and I can tell you firsthand they don't, because I'm the one who designed their data system. I'm the one that included in their data system places to put how much of the settlement was for past medical bills, how

much was for future medical bills, how much was for past lost wages, how much are for future lost wages, and so forth, and so on. So we had a category for every economic component of the loss. It was decided that it was too burdensome and too cumbersome to input this data into the system, so it was never input.

I've been in medical malpractice now since 1976, and I'm still in it, in terms of evaluating medical malpractice claims. If I was forced to make a bet, I would bet that not 10 percent of dollars paid in indemnity is for noneconomic loss. Another part of the window dressing was a revision to the statute of limitations for minors. We had proposed cutting the statutes of limitations from age 20 to age 11. That also wouldn't have saved a dime. The overwhelming majority of dollars paid out on pediatric claims or for neurologically impaired infants -- the overwhelming majority of those claims are filed within three years of the birth of the child. The parents, basically, recognize when the child is not rolling over, when the eyes are not tracking, when they're not walking when they're supposed to, they're not speaking when they're supposed to. And certainly, the ones that are filed after that are certainly filed once the kid starts going to school and learning disabilities are uncovered in kindergarten, in Grades 1, 2, 3.

The only thing that revising the statute of limitations will do is to keep those kids -- whose parents decided not to file an action -- when they reach the ages of 16, 17, 18, and 19 years old, and they decide that they want to look into what's causing their disability -- it would deny them a cause of action. Also, my 27 years experience in medical malpractice has taught me that frivolous claims is not even a small problem for medical malpractice insurers.

It is virtually an unexisting problem. And I think it's important to make a distinction between an unmeritorious claim and a frivolous claim.

A person who has an encounter with the healthcare system that has an untoward event has the right, if they so choose, to investigate why that event happened. It's called a discovery process. Once that discovery is finished and they decide that, "Gee, there wasn't a real -- no malpractice," most of those cases are dropped. And I can give you some real and accurate statistics. I have a company that evaluates claims for plaintiffs' attorneys. We've been doing it for 11 years. We've evaluated 3,576 claims for 600 law firms in 32 states. Out of those 3,576 claims, our clients have proceeded with only 610 -- only 17 percent. Eighty-three percent, or 2,966, of those claims were dropped after the discovery process.

It's important to also understand that in about 750 of the 2,966 that were dropped, it was our judgment that there was negligence on behalf of the healthcare provider, but there wasn't sufficient cause in terms of damages or there weren't sufficient damages to make it economically feasible to continue with those claims. So even though it was determined that, 750 of those claims, there was negligence, our clients didn't proceed with them.

Statistics were gathered from a prestigious south Jersey law firm over a 19-month period, where 323 individuals had walked into their office saying, "I've been harmed by some healthcare provider." At the time of the study, they had only accepted 12 as clients. Frivolous cases, on the other hand, would encompass those cases in which there were no real injury.

During my time with MIIX, which was from 1977 through 1991, the number of truly frivolous cases -- ones in which there was no untoward

medical outcome -- was minuscule and didn't put any financial burden on the company. MIIX was formed in combination by the Medical Society and Osteopathic Association. It was formed as a reciprocal insurance company, and hence, had a board of governors. It was run by an attorney, in fact, that had a board of directors. Both these boards were "stacked" with physicians who also served on the Board of the Medical Society and the Osteopathic Association, or otherwise politically connected with these organizations. Far and away, the Medical Society had the most representation.

As such, MIIX was always governed with an eye toward what was good for the Medical Society. Premium discounts were given for being a member of the Medical Society, even though there was no data to suggest that such membership reduced the doctor's risk. This was done to encourage doctors to join the Medical Society. In essence, premium dollars were used to subsidize Medical Society membership dues. Outlandish perks were given to board members, including million-dollar life insurance policies.

In the late '80s and early '90s, after Peter Sweetland (phonetic spelling), the President of MIIX, passed away, MIIX hired Dan Goldberg as President. He changed MIIX's philosophy. Up until that time, MIIX's mission was to assure that the doctors in New Jersey would never be without a reasonably priced market for medical malpractice insurance, and hence, one of fiscal responsibility. Dan Goldberg's idea of success was measured in market share. The more insureds the better, even at an inadequate premium rate. The expansion into other states was undertaken with the idea to write as many insured as possible, regardless of whether they were reasonable risks or whether the pricing was adequate. I personally saw Dan Goldberg offer a large reduction



in premium to a large group after Princeton had quoted them a large renewal premium increase based on their experience. The difference in premium was over 50 percent.

I would not leave today without discussing several proposals that could help cut losses and lead to premium stability and even reduction. The first issue relates to the State Insurance Department, which is supposed to monitor rates and make sure that rates are adequate. And I'm going to go a little bit into what the actuary said and respond to some of the things he said. New Jersey, for medical malpractice, is a use and file state. You make a rate, and you use it, you file it with the Insurance Department. In the meantime, it's being used. I don't really know how much time it takes the Insurance Department to get around to looking at the rate filing and making some determination as to whether it's reasonable or not, but all this time the rate is being used.

Premiums for medical malpractice are made by trending individual factors, such as the number of claims that are expected, what percentage of these claims will end up with a payment, what will the average payment be, how many will require extensive defense costs, what will the average defense cost be, and what will be our average investment return over the 15 to 18 years that we're going to hold all or part of this money?

The actuary indicated, and people seem to be interested in the fact that, the loss ratio was 136 percent. In other words, they paid out \$1.36 for every premium dollar they collected. That's the way rates are made. It's made that way purposely, because if they didn't make it that way, then they'd make unconscionable profits. Because over the 15 to 18 years that they're holding the

money, they're going to make 70 or 80 or 90 percent of investment income. So what they do when the rate is made is, they make a loss ratio of 130 to 135 to 140 percent, versus premium, expecting that if they collected 100 million in premium, they're going to end up paying out 140 million. But in the meantime, they're going to make 80 or 90 million of investment income, and therefore, make a 30 percent profit.

One of the factors that are trended is severity. Severity that -- and that means, what was the average payout on a paid claim? And the actuary said, "Well, severity is trending up." Well, you can't take that figure in a vacuum because severity trends up -- it may be trending up or it may not be trending up, based on individual factors. If this year the average case was 250,000 and next year it's 300,000, okay, you really have to look at why. If the 250,000 severity was based on a caseload where you had severity of injuries one through nine being: one, emotional injury only; two, three, four, and five, temporary injuries; six, seven, eight, and nine, various degrees of permanent injury -- nine being death, eight being quadriplegia, coma, seven being paraplegia, and so forth. If the 250,000 severity was because I had an even number of all of these injuries -- one, two, three, four, five, six, seven, eight, and nine -- but the 300,000 was because that particular year I had only one one and eight eights, eight quadriplegia cases, then naturally the severity is going to go up.

What you have to do is, you have to look at severity in terms of the severity of injury. In addition, severity is going to go up because economic costs go up. As wages go up, the lost wages component goes up. As medical costs go up, the economic portion for medical bills goes up. In addition, the actuaries

that work for the insurance companies, or work for me, were “independent actuaries.” They weren’t on our staff. They were independent. But independent actuaries aren’t so independent. Because if they don’t do what you want, you go out and find somebody who does.

When they trend each factor that goes into making up the rate, since there’s such a long-tail line of insurance, they tend to be conservative and put some, what we used to call, “fat” into the rate. And they do it for a number of claims, and they do it for the severity of the claims, and they do it for how many you’re going to have -- expenses, and how what that expense is going to be. And in the end, if you put a little fat here and little fat here and little fat here and little fat there, what you end up is -- you end up with a rate that’s 7 percent higher than it’s supposed to be. And if you do that year after year after year, it gets compounded.

In addition, actuaries are funny people in a way, in the sense that they’re conservative, in that they-- When they see something -- a factor -- go up, it increases, they basically say it’s a trend. When they see it decrease, they basically look at it almost as an aberration, and they say, “Well, it’s got to decrease more than once for me to take it into account as a trend.” So what happens is, you have fat built into the factors. You then have this trending, which is not -- is trending of increases in these factors that don’t fully take into account decreases in these factors.

In addition, insurance is a spreading of the risk. If you have 10,000 doctors insured by MIIX, let’s say, in New Jersey, and 1,000 of them are classified as high-risk doctors -- obstetricians, neurosurgeons, orthopedic surgeons -- and you have 9,000 that are considered either low risk or medium

risk, and your loss data shows that a neurosurgeon's loss ratio is 30 times that of a family practitioner, you just don't go and charge that neurosurgeon 30 times the family practitioner rate. The reason is, you'll price neurosurgeons out of the market. So what you do is, you say, well, there are only 70 neurosurgeons in New Jersey. You make them a reasonable rate. You take the difference, and you spread that difference around the other 9,000 low-risk people, so that the rest pay \$300 more or \$400 more or \$500 more. So, in essence, companies like MIIX and Princeton are already, in their rates, supposed to be subsidizing high risk. Now, we did it when I was there. I don't know whether they're still doing that or not, and the Insurance Department ought to make sure that they are.

The second issue that I'd like to talk about, and a possible solution, is to get the Board of Medical Examiners to be more proactive in terms of looking at doctors that are repeat offenders in terms of medical malpractice. And figures are tossed around -- 5 percent of the doctors account for 60 percent of the medical malpractice losses. And I think you've got to take that into a context, because a lot of that 5 percent are high-risk doctors. But a norm must be established for each speciality, and doctors whose claims' experience are one standard deviation away, or two standard deviations away, should be investigated. And that doesn't mean that everyone of them should be disciplined or sanctioned, but it means that the public is -- at least hold an investigation as to why these doctors are engendering so many malpractice claims.

The third issue really relates to something that I think can save a lot of money in this system. And that is, early settlements of meritorious cases. And there are a number of factors in the system that are working against that.

The first thing that works against that is that the insurance policy contains the consent-to-settle clause. The consent-to-settle clause gives the doctor the right to consent to a settlement or not consent to a settlement. When the insurance company does an in-house peer review and their own peer reviewer says that the doctor was negligent, and the insurer wants to settle the case and the doctor says, no, the hands of the insurer are tied. Now that was put in there -- that consent-to-settle clause was originally put in by MIIX, because they wanted to show the doctors that they were different from the commercial carriers that had been insuring them.

Well, the policy also contains a cooperation clause, saying that the doctor must cooperate in his own defense. He must provide records. He's not going to alter the records. He's going to show up at deposition. He's going to show up at trial. Well, if it's been determined by the carrier that the case really is -- there's liability on the case and should be settled, the consent-to-settle clause really is in contradiction to the cooperation clause. And I know of no other insurance policy -- I certainly don't have to consent to my auto carrier settling a claim on my behalf.

The second element -- and I guess I'm going to make a lot of people mad at me today -- the second element working against early settlement of meritorious claims is the defense attorneys. The insurers pay the defense attorneys such a paltry rate to defend cases -- \$100 an hour, \$115 an hour. So, basically what happens is, the defense attorneys have to tell the carrier that every case is defensible so they have cases to work on to build up their hours. If they were paid a reasonable rate, they could make a living defending the really defensible cases, and the cases with real liability would be settled.

Thirdly, the third issue that works against early settlement of cases is that many, many cases involve more than one insured, and therefore, more than one insurance company. And even though the two insurance companies may know that something was done wrong, they basically argue with one another. They go back and forth with one another, and they -- in terms of trying to say, "Well, my guy was only 20, yours was 80." "No, yours was 80, mine was 20." If there was some mechanism where those cases could be settled early, and then liability apportioned after the fact by some mediation or arbitration or some other mechanism, then cases could get settled earlier.

In addition, the passage of a cap would work against early settlement of cases. Why? If you put a cap on noneconomic damages, the insurer would have no downside in taking everything to trial, and nothing would ever get settled. Now, why is it important to settle cases early? It's important to settle cases early because studies have shown -- studies that I did, studies that I have access to -- that a claim, where there was negligence that could have been settled within 12 months of presentation to the insurance company, that was not settled until between 36 and 48 months, costs 73 percent more in just indemnity. When you add the cost of defending the case, the cost about doubles. So, in essence, a case that could have been settled for \$100,000, and you don't settle it for three or four years, it's going to cost you \$173,000, plus tens of thousands dollars in defense costs. Okay.

I also would like to respond to a comment by the actuary that insurance companies are not allowed to make up for past losses, or rotten investment income, or anything in rates made for the next year. Well, they're not supposed to. But basically what happens is, after you make a rate based on

losses -- and you make that rate, let's say, at 140 percent of premium -- and you now think you're going to make 80 million of investment income, if instead of putting in your actuarial report that, "I think we're going to make 7.5 percent over the next 15 or 18 years while holding this money," if you say, "Gee, I'll put in I'm only going to make 6.5 percent or 5.5 percent." And they can do that, and the Insurance Department will say that's reasonable. The difference between 5.5 percent investment income and 7.5 percent investment income may be the difference between a 15 or 20 percent change in the premium rate. Because that's how much investment income is made over the long term they hold the money.

I also think it's important that you understand why I left MIIX. I left because of a dispute over two issues. Firstly, it was disheartening for me to see a company built on fiscal responsibility to, now, be a company where insured counts, market share was more important than maintaining a strong survivorable market. Secondly, I thought that we should continue our tort reform effort, not because it would save any money, but as a public relations effort for the doctors in New Jersey and our insureds.

Vince Morasa (phonetic spelling), the Executive Director of the Medical Society, and at the time the Chairman of the Board of Directors, said it would just be a waste of money, as additional tort reforms would have no effect on our business.

Thank you.

ASSEMBLYMAN COHEN: All right.

Any questions from the Committee?

ASSEMBLYMAN CONAWAY: I have a couple.

ASSEMBLYMAN COHEN: Dr. Conaway.

ASSEMBLYMAN CONAWAY: You mentioned -- by the way, just for the record, I guess -- the bulk of your income now comes from providing consultants who work to--

MR. WEISS: The bulk of my income comes from consulting with plaintiffs' attorneys.

ASSEMBLYMAN COHEN: You have to hit the red light. (referring to PA microphone)

MR. WEISS: Oh, red.

The bulk of my income -- all of my income comes from evaluating and screening medical malpractice cases for plaintiffs' attorneys.

ASSEMBLYMAN CONAWAY: You've mentioned in your statement that, in your opinion, that you didn't think that the bulk of the awards were driven by noneconomic damages.

MR. WEISS: Correct.

ASSEMBLYMAN CONAWAY: And I guess it begs the question, then what's all the fuss about? I mean, if, in your opinion, and people have different-- I'm sure you don't represent the plaintiff's bar and wouldn't want to do that, but just for yourself, looking at it, if the noneconomic damages don't represent a big portion of the awards, then why should anybody care that we put a cap on noneconomic damages?

MR. WEISS: I think it's a very easy answer. If putting a cap on noneconomic damages is not going to lower lawsuits and is not going to cut premiums, but will, in some cases, deny justifiable compensation to seriously injured people, then why do it? There are people who deserve more than



\$250,000 of pain and suffering. There are people who are so seriously injured that they deserve to be compensated for having-- A neurologically impaired infant who is going to have a normal life expectancy of 82 years, 80 years, 85 years -- okay. If it was going to save some money in the system and there was a benefit to society from that, then maybe it should be considered. But there's no justification for taking justifiable damages from seriously injured people when it will have no effect whatsoever. We could not have cut premiums one-half of 1 percent, one-tenth of 1 percent, if a cap had passed.

ASSEMBLYMAN CONAWAY: Well, obviously, people have differing opinions about that. We look at California. We look at the opinion--

MR. WEISS: Well, if they--

ASSEMBLYMAN CONAWAY: The next question.

You talked about the fact, in some of the bills, about cutting the statute of limitations bringing these cases from 20 years to 11. And I agree with you, I don't think it will help -- and, indeed, my legislation has a lower number, because I think 11 won't work. I thought you said something very interesting -- which I had been arguing in smaller groups -- was that the bulk of parents, of course, bring these claims within any of the limits, that have been set by anybody that I've seen, in the bills that are currently in the hopper.

So, if you had, say, a statute of limitations that was at six years, you would expect that that would reduce, over the long term, your payouts, and should bring savings?

MR. WEISS: This has got to be red, right? (referring to PA microphone)

ASSEMBLYMAN COHEN: Just hit red and it will--

MR. WEISS: The answer to that is no. Bringing it down to six is not going to save any money, and it's going to deny, again, the individual whose parents didn't bring the claim on his behalf. When he now becomes 17 or 18 years old and realizes that he had a cause of action that he could bring by himself-- The overwhelming majority of these cases are all within the first three years. Whether you lower it to six or 10 or 14 or 15, you're going to save no money. So if you're going to save no money, why take rights away from people?

ASSEMBLYMAN CONAWAY: Well, again, those questions are argued. Rights are certainly very important, and some of us are concerned about the system as a whole and making sure that there is somebody there to take care of people. For instance, because of the insurance crisis, we have ophthalmologists who can no longer afford to take care of the eye care of neonates, because they can't afford to do the work. And I think that's a tragedy for those infants that are born and who we must provide for, that they don't now have a provider that can afford to take care of them. So I'm focusing on that tragedy and that problem, as well as the rights of individuals, from my own perspective.

That's all I have for now.

ASSEMBLYMAN COHEN: Let me ask an open-ended, broad question that I wouldn't normally try to do in court. But given the fact-- You see, I find you to be a key witness in these proceedings because you had 14 years of experience at MIIX, which is the key provider in New Jersey to the Medical Society and its members. And the work that you currently do is not advocating -- you review claims, whether or not, in your view, the law firm

should pursue or not pursue. So it's not as if you're testifying in court for either plaintiff or defendant, but you have a good sense of the type of cases that are out there.

My question to you, in a general sense, since you have specific information in terms of how MIIX worked, how it operated, how it viewed the tort system, and everything else, what is your view of all the factors that have occurred that have raised rates in Jersey and elsewhere?

MR. WEISS: I think there was some naivety on the part of the actuary group who spoke, because I think that anybody who thinks that MIIX didn't try to recover lawsuits in Pennsylvania, Texas, and Ohio on the backs of the New Jersey doctors, I think is very naive. And they can do it by filing actuarial reports that increase factors by -- that the Insurance Department is not going to look at. If you go from 5.5 to a 6 percent increase on one factor, and from 6 to 6.5 on another factor, and you go from 7.5 percent to 5.5 percent on anticipated investment income, you could recover all of that. Okay.

Second of all, as I said before, the system has a built-in increasing severity, in that, as wages go up, lost income goes up, as medical care becomes more costly, the medical component of economic damages goes up. So severity is always going to go up a little bit. There's no question in my mind that there's fat in the premium rates in New Jersey. There was fat when I was there, when rates were reasonable. And there's nothing to suggest that the fat has gone away. It's probably increased.

In addition, there's nothing to suggest that if you looked at number of claims filed-- The number of claims filed are going down. Something like 2,200 medical malpractice cases were filed, I believe, in 19--, 2000 -- I don't

know, I don't know the exact years -- and that, last year, was only 1,650. The number of claims is going down. The thing that the insurance companies have to do to cut loses are very simple. They need to get defense costs under control. They need to undertake a program to settle meritorious cases early. That will save them a bunch of money. And they have to stop paying their boards of directors and providing them with million-dollar insurance policies, which they -- I think that they did away with.

The other thing that's interesting is, when I was with MIIX, when we first started out, we wrote an occurrence policy. We found that to be very, very -- after a few years, that that wasn't the best way to control premiums in this State, so we switched from an occurrence policy to a claims-made policy. And when I left, we were still selling a claims-made policy. Now, for whatever reason, they went back to an occurrence policy. It doesn't make any sense. You can buy a first year claims-made policy at 20 percent of an occurrence rate; a second year claims-rate policy at 40 percent of an occurrence rate. You don't actually pay an occurrence rate until you've reached the mature claims-made policy which -- five years, six years, seven years -- I'm not really sure where it falls in the actuarial scale now. But they can save money by going to a claims-made policy and making things more affordable.

The other thing is that the Insurance Department should make sure that the way that they're making rates for specialties is spreading the risk. They need to make sure that they're not charging neurosurgeons and orthopedists and obstetricians their true loss ratio. That would be unconscionable.

ASSEMBLYMAN COHEN: Would that be possible to be -- being done by--

MR. WEISS: But there's a way to do it--

ASSEMBLYMAN COHEN: Could that be happening?

MR. WEISS: It could be happening. I don't know that it is happening. All I'm saying is that, for example, when I was there, the loss data showed that a neurosurgeon should pay 25 times a family practitioner rate. We only charged him seven times. Because you take the difference between the seven times and the 25 times and you spread it across the 9,000 family practitioners and the allergists and dermatologists, so each one is making up a couple of hundred dollars and you're keeping each neurosurgeon from paying an extra \$180,000. Well, isn't that what you're talking about now with this bill? Subsidizing those specials. Well, that's supposed to already have been done. And I think it's a good idea to do it here if -- but first make sure that the insurance company is doing their portion to subsidize those rates.

ASSEMBLYMAN CONAWAY: Which is us doing that subsidization, by the way. Go ahead.

ASSEMBLYMAN COHEN: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you, sir.

I want to make a statement and, maybe, together you can help me frame the question. I've been practicing 28 years as an attorney. I was discussing with my wife, who handles the books in the office, that 10 years ago, when legal malpractice insurance for \$3 million was about \$5,500-- I'm now up to \$13,000 per year, per lawyer. I haven't had one claim against me in 28 years. I'm told by people who are more astute than I am that, simply, that's what the cost of insurance is. The market is going up.

To what extent, with respect to medical malpractice insurance, do we simply see that a component in the higher premiums is simply that the cost of insuring a professional, whether it be an architect, a physician, or a lawyer, is simply going up?

MR. WEISS: Oh, I believe that to be the case. I believe that costs go up and-- It's interesting that you bring up that issue, because professional liability premiums for lawyers have just about tracked those of physicians. Those of accountants have just about tracked those of physicians. And it's interesting to note that those two professions, the losses in those two professions, have no noneconomic component. There's no noneconomic component to an accountant malpractice or a lawyer's malpractice. And, yet, their rates have gone up the same as physician rates.

Another thing that needs to be done is administrative costs in insurance companies. When I was with MIIX, we ran the insurance company at nine cents on the dollar. I'll bet you that that's more than doubled. You can run a company very efficiently if you pay your people liveable wages, you control what they're doing, you control defense costs, you do early settlements of claims, you get the Board of Medical Examiners to at least investigate doctors, you get the State Department of Insurance to really clamp down and look at premiums -- look at the way they're made, look at what it -- (indiscernible) they have been given for investment income. Look at how they're trending each of their factors -- look that their building into the trend decreases in number of claims, decreases in this, decreases in that, and their not holding it out to see whether it happens again and again and again. If you do those things and you go ahead and make sure that the insurance company is

subsidizing high-risk physicians, it's my opinion you wouldn't have to do anything, and premiums would stabilize and maybe even come down.

ASSEMBLYMAN D'AMATO: Thank you, Mr. Chairman.

ASSEMBLYMAN CONAWAY: I would say that, I guess, if you saw -- what -- 100-and-some percent increase over 28 years, I think a lot of physicians would love to see that over 28 years. We're seeing people seeing 100 percent increase in a year or two. So I'm not quite sure I agree with the proposition that the rates of physicians and other professionals are tracking.

You mentioned about this business of having a claims-made policy. It's not one that I would purchase. I'm paying, I guess, more for an occurrence policy, because it gives me more protection. I've talked to folks that have to make claims-made policies or buy those, because they can't afford to get the occurrence plus, and they've gotten quotes that their tail coverage was over 100,000 -- \$200,000, one person told me. You're also telling me that in order to get this rate I have to stay with a company five years. I've been with three different companies shopping for better rates, as we move forward. And of course, in Pennsylvania they've seen companies go out of business. The obstetrician that was here has seen her company go out of business, and now she's going to be exposed to liability in the out years. Why would one-- Is it really a good deal for anybody to get a claims-made policy, and isn't the reason why not a whole bunch of them are written when things are well is because it doesn't provide the same level of protection, and also protection against companies going out of business, and all the vagaries that happen that an occurrence policy gives you?

MR. WEISS: I think the word *protection*, okay-- You asked a number of questions, and I'll respond to each and every one of them. Does a claims-made policy provide the same amount of protection? In essence, yes. It only does it in a different way. What it does is, it lets you save money the first few years that you practice. You save 80 percent of the premium the first year, 60 percent the second year, something like 45 percent the third year--

ASSEMBLYMAN CONAWAY: If I stay with them the whole time.

MR. WEISS: Well, wait a second. And you save that all. And then at the end, when you quit practice, you have to buy a tail, and now you say that tail may cost you a 100 percent, 200 percent. That's true. That's true. But it affords the same level of protection, and you're not paying for it up front. So the obstetricians who are new to the business and, maybe, don't have a flourishing practice, who want to deliver babies their first and second year in practice, can certainly do that by buying a claims-made policy.

The answer to the other part of your question is, that when you change carriers, okay-- When you change carriers, if you buy a tail from the carrier you left, the carrier you are going to will charge you a first year claims-made rate, which is 20 percent. If you don't buy the tail, then the carrier is either going to charge you -- if you were two years with another company -- they'll charge you the third year rate or they will sell you what's called a prior acts policy, saying I'm going to cover you for all your prior acts. And they'll price that based on how many years you were insured with the other company. But to say that an occurrence policy provides you more protection is not true. Both provide you the protection assuming you buy the tail at the end.



ASSEMBLYMAN CONAWAY: I mean, if I'm making a decision about -- assuming, buying a tail-- People are going out in the market to buy the tail and find that they can't afford it. I know that if -- what my premium is going to be in that year, and if I could afford to pay it and make a go of it, I'm going to pay that, and I'm done. What you're saying is that someone in my position is going to say, "Well, look, we're going to stay here, around for a while, and then, hopefully, when it comes time for me to buy the tail, I can afford to buy the tail." That's the uncertainty that I think that, certainly, I wouldn't accept, and I think a lot of people won't accept. And so, as far as from where I sit, I think that's less protection, because I now have to hope that I can afford the tail coverage when it comes time for me to buy it. Right?

MR. WEISS: I think you have a point. I think that's why people should be given choices. Okay. First year doctors who can't afford an occurrence policy should be given the opportunity to buy a claims-made policy. Everybody is in a different position. I can afford to drive a Chevy and you can afford to drive -- whatever you drive. I can afford to buy an occurrence policy, you can afford to buy a claims-made policy. The problem is that they're not giving those people the opportunity to buy the cheaper policy which provides the same protection. Okay. Now, are you taking a chance that, at the end, the price of the tail is going to be exorbitant? Yes. But again, that's where the Insurance Department comes in and the Insurance Department should be made to approve the rates every year, tail rates every year, to make sure that they're not gouging the insureds, to make sure that those rates are not making up for past bad underwriting decisions, bad claims decisions, bad investment decisions, and should reflect the true nature of the losses in the business.

ASSEMBLYMAN CONAWAY: Now you mentioned that -- what sounds like to me is that -- these insurance companies can, basically, do whatever they want with the numbers, which has always concerned me. And that the government really doesn't have enough, either, regulatory authority or power to actually get in there and make sure that the numbers it receives, as part of its oversight responsibility are -- to, in fact, represent a true reflection of what's going on inside that company. You have made some suggestions that we need to step that up, and I was wondering if you could put some more clothes on that. It sounds like we-- In your experience, does the government send its own auditors into these insurance companies to get the data that it needs to find if-- "Well, that's a fad. It sounds like it's been there. It's going to be there in the future if we can't do anything about it." So I'm not sure how it plays on this particular discussion. But are there things we can do, ought to be doing, in terms of independent audits or other things, to make sure that we are getting the truth from these folks?

MR. WEISS: The answer is yes. Medical malpractice is a lot different than other types of insurance. It's a lot different than automobile, where the accident happened this year, you're covered this year, the accident happened this year, and, boom, the whole thing is going to be over shortly, or other types are. Medical malpractice is a very long-tailed line of insurance. If you write an occurrence policy, okay, one-half of 1 percent of the claims you see, and the money you're going to spend, is going to go out the first year. Only 4 percent is going to go out the second year. It's such a long-tailed line, and I'm not sure whether-- And again, I don't want to be disparaging to the Insurance Department, but I don't know what kind of actuaries they have. I don't know

what their understanding is as to the different lines of insurance, and whether they have actuaries that really understand medical malpractice, or any kind of professional liability, where it's going to take that long, where you may see a claim-- You may not see a claim from a-- Let's say the parents didn't file a claim for the kid, and now the kid, at age 18, says, "I've been injured. I want to file a claim." Well, that claim goes back against the policy of 18 years ago. It's very difficult to make rates. It's very easy, because of such a long-tailed line, to -- I don't want to use the word fudge, don't take it that way -- but for medical malpractice actuaries to say, "Well, I'll make this 6 percent rather than 5 percent." Well, the effect of that over 15 or 18 years is 15 or 20 percent in the rate. If the Insurance Department doesn't understand that, and your Insurance Department is not willing to say to this company, "That's not supposed to be six, that's supposed to be five," or "No, you can't say I'm going to earn only 4 percent. You got to say, I'm going to earn 6 percent." The rate will come down 20 percent or 25 percent, or whatever their number is.

But I don't think any of that's done. I don't think anything is done. The other thing is that I firmly believe that a legislator, whether it be State or Federal, should never consider passing any legislation unless they have accurate, valid data upon which to judge what it is they're doing. Okay. What you should do--

ASSEMBLYMAN COHEN: Don't disrupt our system too much.

MR. WEISS: --from this point on is, the Insurance Department or somebody should require the insurers to keep that information on their computer systems as to economic loss versus noneconomic loss. They should be required to keep information about severity of claims, dollars paid by severity

of injury, so that we can see that last year a severity eight was 300,000. This year, it's 297,000. It's about the same. But the reason it went up overall from 250 to 300 is because we got many more eights. But they don't keep this data. And they come to the Legislature and they ask for help with a crisis that's manufactured by the insurance companies, by the way they make rates, by the way they invest their money, by the way they go out and write in other states where they all don't know what the environment is in the other states, because they think success is measured in market share rather than the mission that these companies were created for. And this is not only in New Jersey.

In Pennsylvania, the Pennsylvania company PMSLIC, you can't be insured by them unless you're a member of the medical society. If you're not, they'll almost pay you a dues to make sure you're a member of the medical society.

ASSEMBLYMAN CONAWAY: I was in PMSLIC, before they went out of business or withdrew from the market. I had them, and I didn't have to be a member of the medical society.

MR. WEISS: This is something that's not just in New Jersey. It's all over the place. The truth is, better monitoring of the way premium rates are made, better monitoring of physicians who are repeat offenders, early settlement of claims, everything I've said before, will stabilize the market and maybe even bring it down to a reasonable rate.

ASSEMBLYMAN CONAWAY: The last one for me, anyway.

Do you have any reason to assume that this severity factor is significant in the data that the independent actuary presented earlier today? I mean, any reason -- do you have any sense of, are things more severe and,

perhaps, that's driving these numbers -- or, even, maintain these high numbers, even as cases are coming down? Are things just worse out there in terms of injury, in your opinion, or based on, I hope, some data or knowledge you have?

MR. WEISS: I think the cost to a plaintiff's attorney of pursuing a medical malpractice action is prohibitive. The cost is high. The average cost of pursuing a medical malpractice case on behalf of a plaintiff's attorney is probably between \$30,000 and \$50,000 a case. So they're not going to take cases of low severity. They're going to take cases of high severity where there are high damages. So, basically, what you end up with, okay, year after year after year, you end up with increasing severities of injury, but it doesn't mean that the amount of money paid on those injuries has been going up. There's just more of them.

ASSEMBLYMAN CONAWAY: Or severe, you said. The more severe.

MR. WEISS: More severe injuries. In the cases -- for example, in the 610 cases that we counseled our clients to go ahead with, I'm not aware of any of those cases -- and, of course, they're not all settled, some of them are still going on -- but I'm not aware of any one of those cases where there was a significant settlement or verdict that had an unreasonable noneconomic component. In fact, most of them had no noneconomic component. Most of them were justified by the severity of injury, the age of the patient, the job that the patient had and how much lost income was being generated, and the need for custodial care and others things that go into economic loss.

ASSEMBLYMAN COHEN: Assemblywoman Pou.

ASSEMBLYWOMAN POU: Very quickly. You had mentioned, and I believe very early on into your testimony, and I think the Assemblyman, Conaway, had made reference to it, but -- if you could explain to me, if you have an opinion or any of your data that will show -- you mentioned that there's a decrease in the claims from last year's amount, the yearly claims are lower now than what they were before. Would you say that that may be attributed to the decrease in the specialties?

MR. WEISS: No. I believe that the decrease in the number of malpractice claims that were filed is directly related to the legislation that was passed in 1995 requiring an affidavit of merit before -- in order to proceed with a medical malpractice client. That legislation said that once a claim has been filed, the plaintiff has 60 days in which to provide an affidavit of merit from an expert with at least five years experience in the same speciality. Okay. Now, that has helped decrease cases where, before, there would be claims filed and somebody would go through and, maybe, wait a year or 18 months before they would find an expert. Now you have to find an expert quickly. You have to get that affidavit. And basically, that's why the number of claims dropped from 2,200 to 1,650. I believe there's a direct relationship. You can see the number of claims going down after that legislation was passed.

ASSEMBLYWOMAN POU: As a result of the higher premium insurance, would you say that we have the number of subspecialties currently in place that are going to be able to provide the kind of input and information that you're referring to?

MR. WEISS: Yes. MIIX, for example, has specialties broken down into well over 100 categories. There are surgical categories, nonsurgical

categories. They have orthopedic surgery. They have orthopedics/office practice only. They have -- so they have specialties broken down. They even have specialties broken down into subspecialties. They have more than 100 of them and, basically, data should be kept among those specialties. And I don't know whether you have to break it down that fine. You could certainly combine some like-specialties. Family practice and general practice are pretty much the same thing. Internists that are practicing as general practitioners can be folded in with the same thing. But data should be kept as to the norms for those specialties, in terms of numbers of cases that they get dragged into, the number of cases that end up being paid, the number of cases that end up being closed with no payment, what the average is, let's say-- So you come up with a profile for an average doctor in that specialty. And then what you do is, you say, "Well, somebody is one over that." You certainly don't want to bother with them, but you do a statistical analysis and say, "If they're one standard deviation away or two standard deviations away on this bell curve," then you want to look at them.

Like I said before, you don't want to look at them with an eye toward, that, they should be disciplined, that they should be sanctioned, but you want to look at it to see if you can find out why they are generating these claims and whether something can be done to modify the way they practice.

When I was with MIIX, we had a dog-and-pony show where we would-- We had a whole loss prevention department, and we would send people out to doctor's offices to see the way their office was set up, because we had determined that there was a good portion of claims that were not being generated by the medicine being practiced, but were being generated by the

systems in the doctors' offices, where test results would come back in and the nurse would file them before the doctor would see it. So three days later, somebody who had an abnormal stress test would die of a MI.

So we would go in and we would look at the systems in the doctors' offices and say, "Look, you can't practice medicine this way. What you must do is, you must have a system so that nobody will file anything unless your initials are on the bottom, to make sure you saw that." We also had loss prevention that was very, very specialty specific.

We had, and I'll give you an example of the way it works and can work if it's taken seriously. We had had, from 1979 through '83 -- we had had a whole bunch of claims involving the use of two different kinds of agents in anesthesia -- IV Valium and something else. I forget what it was right now. And we had a whole bunch of claims -- 11, 12 of them -- and they were costing us a lot of money. We went to the Association of Anesthesiologists. We told them what the problems were. They took it seriously. They put it in their newsletters. Every time they had a meeting they told the doctors about this. And lo and behold, in the next six years, we only had one case. We had 11 cases in four years and, boom, the next six years only one case.

Loss prevention works if the societies take it seriously -- if you go to the Society of Orthopedics, and OB/GYN, ACOG, and the rest and you tell them, "This is what's causing your losses and this is the way you can prevent it." I used to go on the road, when I was at MIIX -- I used to go on the road and speak to 400 general surgeons in Las Vegas or 300 otolaryngologists in Phoenix and tell them, this is what's causing your losses and this is the way to prevent them. How much of that is going on, whether they're devoting enough money



to loss prevention, I don't know. We devoted a lot of money to it, and in certain situations, it paid off big.

ASSEMBLYWOMAN POU: Thank you, Mr. Chairman.

ASSEMBLYMAN COHEN: Thank you.

Any other questions from the Committee? (no response)

Thank you very much, Mr. Weiss.

MR. WEISS: Thank you.

ASSEMBLYMAN COHEN: Ed McCreedy and Valerie Brown.

Nice to see you, Ed.

**EDWIN J. MCCREEDY, ESQ.:** Mr. Chairman, members of both Committees.

You all know Valerie, I think.

I'm Ed McCreedy. I'm the First Vice President of the New Jersey State Bar Association, which is the largest professional association in the state representing attorneys. I've also been practicing law doing exclusively litigated matters for approximately 34 years. I've been involved in medical malpractice litigation on both sides, representing doctors and representing plaintiffs as well.

We recognize the extensive debate that has preceded this hearing, and we appreciate being a part of the dialogue on this important issue. We oppose some medical malpractice reform provisions and support others. Let me clarify.

The New Jersey State Bar Association Task Force on Medical Malpractice was formed last year and is actively engaged in review of this critical issue. The task force brings together knowledgeable members of the Bar, who represent clients on all sides of the issue -- doctors, hospitals, the insurance

industry, and injured patients -- because we represent all lawyers. I happen to serve on that task force. We have kept our members abreast of the latest medical malpractice developments through our newspaper, the *New Jersey Lawyer*, and communicated with State print and broadcast media, and met with members of the State Legislature, the Office of the Governor, the Commissioner of Banking and Insurance, and other affected interest groups.

We were pleased to see that the Senate version of the medical malpractice legislation, passed in March, included the State Bar Association on the Medical Care Availability Task Force. We recommend such a task force, and we hope that the Assembly will include us in the task force as well. However, we believe that deliberate study of medical malpractice by the task force should occur before any reforms are instituted.

And if I could just depart from my prepared remarks a moment-- And what I've heard today leads me to that conclusion even more. The idea that the information that's been provided by MIIX, and apparently by Princeton or anyone else doing insurance, is so sketchy-- And listening to the accountant, or the expert, who testified on behalf of MIIX, and listening just now to Mr. Weiss as well, I have to think that the information is available, or can be made available, that would enable the Legislature to determine exactly what noneconomic loss is costing in medical malpractice matters and to tailor legislation based on that. So we believe very strongly that there should be a task force and an investigation, to include the insurance companies providing information that's needed in order to make intelligent decisions.

With respect to the current legislation and the rumored legislation in the Assembly, a couple of comments. First of all, we strongly oppose a \$50

annual assessment on members of the Bar to fund this liability excess fund or premium relief fund. There is no rational basis for taxing thousands of lawyers in New Jersey who do not practice in the medical malpractice area to pay for harm caused by the doctors. In fact, lawyers are beginning to experience, as was earlier alluded to, a similar premium rate crisis. And if you were to carry this proposal to its logical conclusion, we would be back here before you asking that the doctors subsidize our premium increases as well, which makes no sense.

You might, for instance, also say that all accountants in the country should be billed \$50 apiece to bail out the Enron pension plan or something like that. Or, if a newspaper goes under, let's bill all reporters \$50 to help bail out that newspaper. It's makes as much sense. The lawyer who is up in Sussex County doing nothing but closings for his entire practice, and who never sees and never will see a medical malpractice case, shouldn't be paying \$50 for a doctor's negligence. It makes no sense at all.

If you look at the figures provided by the AOC, you can readily see that there are, number one, very few malpractice cases, down something like 1,900, down to 1,600 and change. There are about 110,000 cases filed every year in the Superior Court, so we're talking about less than 2 percent of the litigation to begin with, and we're talking about a very small number of law firms that prosecute and defend medical malpractice cases. So the great, overwhelming majority of lawyers in New Jersey have nothing to do with this issue and shouldn't be subsidizing the doctors' expenses.

With respect to -- we do believe that if there is going to be some type of fund, it should be a fund that's designed for premium relief, rather than trying to pay for settlements or verdicts.

With respect to caps, there was an editorial in *The Star-Ledger* entitled “Doctors have put a cap on the truth,” on February 8. And others have objectively called into question the efficacy of the cap prescription for relief. Assemblyman D’Amato, who is here today, put it directly to Patricia Constante of MIIX, when she was here, “Are you telling the insured physicians in New Jersey that if this State Legislature passes caps you’ll guarantee that you won’t raise your premiums, in fact, you’ll reduce them?” And her answer said, “No, I’m not telling you that.”

The problem is, as you just heard from the last speaker, we really don’t know what the cause of this premium increase is, and there is nothing to indicate that caps is going to solve it. Caps, after all, deals with noneconomic loss, and we have no idea what percentage of the payouts are being for noneconomic loss, as opposed to total payouts.

Just as an aside, there was a *San Diego Times* editorial in January, an op-ed piece by Jamie Court of California’s Foundation for Taxpayer and Consumer Rights, and she was quoted as saying, “Let’s lower auto insurance premiums by stopping lawsuits against drunk drivers, not by preventing drunk driving. And this is the same logic,” she says, “by which insurance companies and doctor lobbies propose to lower the medical malpractice premiums that doctors pay.”

With respect to the proposals for limitations on the statute of limitations, I know that this is a tempting solution, but it is really contrary to the entire jurisprudence of this State. We recognize that people’s claims for rights should not begin to run until they are aware that they have actual or

constructive notice of the injury. And to pass such a provision, which would not continue this concept, runs counter to our system of jurisprudence.

I've indicated why I believe that there should be a study commission. We think that the study commission should have all interested parties present and that there should be no legislation passed until a study commission takes place with all parties present. We are not convinced that there is a malpractice litigation crisis in New Jersey. You've heard the figures of the AOC, and I had planned to make a comment with respect to them, but you've seen them. In essence, there are very few cases that go to verdict. Only 205 cases were juries-issued verdicts. They found for doctors and against plaintiffs on 151 of those cases. Of the 54 cases where there was a verdict, the median verdict was, as the AOC indicated, about \$350,000.

And I know from personal experience that many of the verdicts that get a lot of publicity never wind up being the final result in the case, either because of settlement or because of remittitur. So you can't just accept those figures as saying, this is what is returned in malpractice cases.

We believe that the jury system in New Jersey has worked well to provide justice to all parties on a case-by-case basis. The statistics are, in fact, objective statistical proof that there is not a medical malpractice lawsuit crisis in New Jersey. We ask that both Committees consider these points. We thank you for the opportunity to be heard, and I'll be happy to answer any questions if you have them.

ASSEMBLYMAN CONAWAY: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you.

I wanted to share something with Mr. McCreedy, as well as the members of this Committee. Last week I received a telephone call from my malpractice carrier, who's insured me for 28 years. And he said, "We're not going to renew your policy." I said, "Why? I haven't had any claims against me." "We're getting out of the business." So we're searching for a malpractice carrier now, and I had to sign a form as to the type of cases I handle in my firm. I failed to fill in a certain blank, and the underwriter called me up and said, "We have to know one way or the other, do you do plaintiffs' medical malpractice work? Do you sue doctors?" I go, "No." He said, "Okay, then, we're going to consider you." "What do you mean?" And at which point, I had to get back to a disposition, and I put my office manager on -- also known as my wife -- and she said, "What's going on here?" We went over the whole thing again. And this underwriter said, "We are not going to insure any plaintiffs' personal injury attorney who sues doctors." And my wife made the comment, "So is that your way of handling the medical malpractice crisis?" There was silence on the phone.

I just want to leave that one with you, because I think, before I leave the Assembly, I think we ought to investigate that particular one. And as a representative of the New Jersey State Bar Association, let's see if we have that problem.

MR. McCREEDY: Well, we're beginning to hear complaints about spiraling premium costs for legal malpractice. Dr. Conaway's comment earlier -- that it's not as bad as it is with doctors -- I'm not sure. I bet it tracks a lot closer until the last three or four years, when MIIX went to Texas and Louisiana. Up to that point, I have a feeling that the increases that lawyers and

doctors were experiencing were probably tracking a lot more comparably, but I'm not an expert.

Thank you.

ASSEMBLYMAN CONAWAY: Anyone else? (no response)

Okay. Thank you for your testimony.

MR. McCREEDY: Thank you.

ASSEMBLYMAN CONAWAY: Who's next here? Ms. Clark, you're coming forward.

**L A U R I E C L A R K:** Thank you very much, Mr. Chairman.

Due to the lateness of the hour and the fact that my testimony has pretty much been covered by Mr. Cantor and Dr. Lomazow, I will take the high road and refrain from testifying. I want to thank everyone for the attention they paid to this very important issue this morning. I look forward to working with you.

Take care.

ASSEMBLYMAN CONAWAY: Bless you. (laughter)

MS. CLARK: I got more points doing that, right? (laughter)

ASSEMBLYMAN CONAWAY: I don't see Ms. Ryan, Betsy? (no response) She submitted written testimony. We have that.

Let's see, I have Justin Mattes, perhaps, with Frank Rodriguez? (no response)

Howard Weiss, I think he was called. He was up, that's right.

Colby and Colby? (no response)

Zaccaria, no? (no response)

Is this the right list?

Okay, is anybody else out there who wants to testify? Please come forward, draw near, and be heard. (no response)

With that, I will take a motion for adjournment, unless anybody has any closing comments from the Committee.

ASSEMBLYMAN McKEON: So moved, Mr. Chairman.

ASSEMBLYMAN CONAWAY: Thank you all.

**(HEARING CONCLUDED)**