
Public Hearing

before

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

“Testimony concerning the affordability and availability of medical malpractice insurance for physicians practicing in New Jersey”

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

DATE: June 3, 2002
1:00 p.m.

MEMBERS OF COMMITTEES PRESENT:

Assemblywoman Loretta Weinberg, Chairwoman
Assemblyman Herb C. Conaway, Vice-Chairman
Assemblyman Willis Edwards III
Assemblyman Jerry Green
Assemblyman Samuel D. Thompson
Assemblywoman Charlotte Vandervalk

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



ALSO PRESENT:

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

Wali Abdul-Salaam
Sheila Kenny
Assembly Majority
Committee Aides

Tasha M. Kersey
Victoria R. Brogan
Assembly Republican
Committee Aides

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ASSEMBLYWOMAN LORETTA WEINBERG (Chairwoman):

Would everybody please take their seats?

Thank you. Good afternoon, everyone. Welcome to the joint hearing of the Assembly Health and Human Services Committee and the Assembly Insurance and Banking Committee on the important issue of medical malpractice insurance.

The Speaker convened us as a Task Force, the two Committees together, since they have obvious implications for the kinds of issues that each of us considers. Before I make a couple of opening comments and turn it over to my colleague chairperson, can I ask--

David, would you take the role of the Health Committee side?

MR. PRICE (Committee Aide): Assemblywoman Vandervalk.

ASSEMBLYMAN IMPREVEDUTO: Dave, is your mike on?
(referring to PA microphone)

MR. PRICE: Assemblywoman Vandervalk.

ASSEMBLYWOMAN VANDERVALK: Here.

MR. PRICE: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: Here.

MR. PRICE: Assemblyman Edwards.

ASSEMBLYMAN EDWARDS: Here.

MR. PRICE: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Here.

MR. PRICE: Assemblywoman Weinberg.

ASSEMBLYWOMAN WEINBERG: Here.

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

ASSEMBLYMAN D'AMATO: Here.

MS. BEAUMONT: Assemblyman Impreveduto.

ASSEMBLYMAN IMPREVEDUTO: Yes.

MS. BEAUMONT: Assemblyman Conners.

ASSEMBLYMAN CONNERS: Here.

MS. BEAUMONT: Assemblyman Cohen.

ASSEMBLYMAN NEIL M. COHEN (Chairman): Here.

ASSEMBLYWOMAN WEINBERG: Thank you.

I know that we're going to probably be hearing a lot of stories about all the problems that exist, stories and issues that most of us have heard about individually and are probably going to hear about again collectively.

Personally, I would like to hear more about what recommended changes any of you might have to the current system. I have some specific questions about things that are in effect currently. For instance, the affidavit of merit. Does that work? It's been on the books for a while. Has it done anything? Does it need to be improved? Will this crisis abate when the economy improves and the stock market improves? Are current caps sufficient? How does the length of time of exposure for OB/GYNs, in particular, affect the whole issue of malpractice? What, generally, are the changes that can be made?

We're also, because we have a very lengthy list of witnesses -- we'd like to give each and every one of you a chance to testify. We are going to ask that you limit your comments to five minutes. And I'm going to ask the OLS staff to try to help us keep order in that and not to go over that length of time so that you have time to speak and Committee members will have time to ask questions.

Thank you for your attendance today.

I'd like to now turn it over to my colleague, Chairperson Neil Cohen.

ASSEMBLYMAN COHEN: Thank you.

Chairwoman Weinberg has already set forth some of the areas of concern. I know there's going to be some war stories. If we could, maybe keep that to a limited basis.

What we do understand from our meetings individually with physicians and insurance companies is that for the last 15 or 20 years, there has been stability in the medical malpractice insurance market and that only over the last year has there been a problem in spiking of premiums, particularly for those involved in obstetrics and gynecology and those in high-risk surgery, where their premiums have skyrocketed pretty high.

So, we're going to want to know what areas of tort reform are necessary, if any; which areas, in terms of the economy and the investment market -- how that has played a part over the last 12 months, of course, what the impact of 9/11 was with regard to companies being able to earn interest on their reserves.

We also want to know and discuss how claims are handled, how premiums are set. We wanted to talk about what is the underwriting criteria where claims are carried against a physician for, let's say, five, ten, fifteen years. There are a number of areas that we want to go into. This is a complex area.

What we are aware, at least I am, to some extent -- and that is that there's been a problem with medical malpractice awards outside of the State of New Jersey, where insurance companies have gone into the market in Texas, Pennsylvania, and other states jury awards under their system have been high,

and that's what the impact has been, even though in New Jersey awards and settlements have been relatively stable for decades.

The Chair and I want to thank everyone for coming here. There will be questioning by the Chairs and also by members of the Committee. We're looking for as much information as necessary to see what we need to do immediately and what needs to be some type of long-term cure, if any, that may be needed.

I want to thank you for your attendance.

Thank you.

Assemblyman Impreveduto.

ASSEMBLYMAN IMPREVEDUTO: Just to the Co-Chairs, if you would, for the sake of time, could we ask that anybody that has written testimony not read it, just summarize it and then hand it out to us?

ASSEMBLYMAN COHEN: You've heard Assemblyman Impreveduto. If there is rather lengthy written testimony that's been provided, it should be provided to all the members of the Committee, in accordance with our rules, and then you'll be able to summarize because there will be questions being asked probably during the course of your testimony that the Chairs may want to ask or that members on both Committees may want to ask.

And if we could have the first witness, Dr. Bernard Saccaro.

Doctor, do you want me to give you a prescription for that water?

ASSEMBLYWOMAN WEINBERG: And two aspirin.

ASSEMBLYMAN COHEN: Take two Tylenol and call my mother in the morning.

ASSEMBLYMAN IMPREVEDUTO: You got to pay a rate for that, you know.

BERNARD SACCARO, M.D.: Good afternoon, Co-Chairpersons.

ASSEMBLYMAN COHEN: You'll have to push the red button.
(referring to PA microphone) In Trenton, the red button means speak.

DR. SACCARO: Good afternoon Co-Chairpersons Weinberg and Cohen and members of the Banking and Insurance and Health and Human Services Committee.

I'm Dr. Bernie Saccaro, and I appear today to represent not only the Medical Society of New Jersey's 8000-member physicians, but all practicing physicians and our patients. My specialty is rheumatology, and I live and work in Bergen County. In these difficult times, it's my privilege to chair the Medical Society of New Jersey's Medical Liability Insurance Task Force.

As background, MSNJ, the Medical Society of New Jersey, is highly committed to quality and patient safety. We are the only State medical society to have a nationally funded quality of care program and the only State medical society to audit thousands of physicians' practices for compliance with rigorous national standards.

I thank you for holding hearings on the availability and cost of medical malpractice insurance. Six months ago, the medical society formed its task force after hearing of how some high-risk specialists were not being renewed or were being quoted astronomical insurance premiums. The Task Force's goal was to gauge the problem's severity and to estimate its potential for worsening. And we sought to develop, with your involvement, solutions to ensure that sick patients maintain access to highly skilled physicians.

By now, we more fully understand the scope of this developing problem, especially as it pertains to specialties such as OB/GYN, emergency medicine, and surgery, and the surgical subspecialties. Even more disconcerting

is the evidence that physicians in other specialties report high double-digit premium increases and fewer companies willing to write coverage.

As the problem has grown, physicians and the entire New Jersey medical community have entered into a full-fledged state of crisis. When that happens, patients are in crisis.

Of course, the liability insurance problem is not unique to New Jersey. The AMA reported in March that physicians in more than 20 states are confronted with such high premiums. Across the nation, high jury awards have forced some insurers to raise their premiums to unaffordable levels. We have these same problems in New Jersey, which I expect the insurance industry representative to present in greater detail during their testimony.

Who is writing insurance in New Jersey? For all practical purposes, Saint Paul, Zurich, and PHICO are gone. One of the State's two primary physician insurers, the MIIX Groups, as we know, is undergoing solvent runoff in anticipation of creating a new, albeit smaller, reciprocal organization.

I wish to offer just one example of the malpractice insurance crisis on medical practice. A colleague of mine in Bergen County with a six-member OB/GYN group, of which there were no malpractice insurances and one judgements -- only one small settlement over the last 10 years-- This year, their malpractice premium in this practice jumped 71 percent up to nearly \$64,000 per physician.

That represents one-third of each of these physician's incomes. How many individuals in other fields, who require insurance as a condition of employment, can readily forego 33 percent of their income for insurance? In addition, these physicians incomes have dropped 17.5 percent over the last two years. And as a result, two of the partners have left OB.

Not coincidentally, in May, the American College of OB/GYN named New Jersey one of its nine hot states where liability insurance premiums threaten the ability of physicians to deliver babies. While I use just one example, I'm sad to report that thousands of other examples like this exist across the state and in other specialities.

Physicians just cannot afford higher premiums. Managed care has devastated our practices. Medicare slashed physician reimbursements by 5.4 percent, with additional cuts approaching 14 percent anticipated over the next three years. And we have a large senior citizen population on Medicare. Medicare reimbursement in this state is outrageously low: 49th out of 50 states.

Physicians are small business people. We pay rising employee salaries and benefits, mortgages, supplies, and a myriad of other expenses. We want to invest in new technology to replace outdated diagnostic equipment. Given all this, where will any of us find the money to improve our practices when liability insurance is so expensive? One effect of skyrocketing premiums is that physicians give up performing riskier procedures.

There can be no doubt that New Jersey's malpractice system has run amok. The stable insurance business climate of only last year has disappeared. Too many cases go to trial that should not. And juries that find for the plaintiff in this state deliver multimillion dollar awards that are out of proportion with the circumstances. One medical liability provider in New Jersey reported that in 1997, they had five \$1 million settlements in their cases. This year they are averaging one a week.

We know that doctors win approximately 70 percent of the cases that go to court. I use this term loosely. Most likely, they've spent hundreds

of hours away from their practice to be deposed and sit in court, and their reputations are besmirched, and they're charged much higher premiums.

With that in mind, I offer some suggestions on what legislators can do in order to stabilize New Jersey's physician liability insurance market.

The Legislature should adopt a cap on damages. The weight of the literature is that noneconomic damage caps work. Twenty-one states that have them attest to this, and they reduce premiums. Physicians need statute of limitation protection so we don't face claims many years after the alleged incident occurred. Our suggestion is two years from the event for adults and the establishment through discussion of a reasonable time period for babies.

Expert witnesses should be required to practice medicine in New Jersey and should practice in the same specialty as the physician against whom they're testifying. They should only be allowed to offer opinions that are supported by the medical literature.

Claims should, again, be brought before an expert panel of attorneys and physicians to decide whether a suit should go forward. The current certificate of merit system weeds out a good number of frivolous cases, but some questionable ones still proceed to trial, driving up the expenses.

Effective immediately, create a mechanism to provide coverage to high-risk clinicians and to encourage more insurance competition in this state.

In addition to this, we have been working with the state associations representing hospitals and nursing homes on reforms that would reduce their premiums, also.

By the way, it's not just the medical community that thinks change is needed. Consider these figures from a national poll conducted in April of 2002: 73 percent of Americans favor guaranteeing economic awards to injured

patients and placing reasonable limits on pain and suffering awards; 71 percent agree that medical liability litigation is a primary force in driving up health-care costs; and 78 percent believe skyrocketing medical liability costs could limit their access to care.

Let me offer an intriguing thought. Quality of care cannot be improved through a strategy of punishment, intimidation, and fear.

ASSEMBLYMAN COHEN: Doctor, if we could end on the intimidation, punishment, and fear issue.

DR. SACCARO: Okay.

ASSEMBLYMAN COHEN: Are there any questions from the Committee to Dr. Saccaro?

Dr. Conaway.

ASSEMBLYMAN CONAWAY: Let me just try to help the members of the Committee crystallize or focus on why it's so important that legislation in this area take place. You mentioned some of them.

There is a tremendous economic pressure on physicians now, managed care driving down costs, Medicare driving down cost -- administrative cost through the roof -- imposed mostly by -- at the demands of managed care. There are -- the Medicaid system -- shambles in this state -- 49th out of 50 states in a high-cost state. It is-- Well, I won't characterize how terrible that is, but it is rotten.

I know, as a physician practicing, and certainly talking with my colleagues, that a lot of these costs-- People on this Committee need to understand that this is not a question of people shifting costs and making it up by making increased income elsewhere. The spiking costs of medical malpractice really comes right out of the bottom line of the physician who's

already seen his ability to raise or her ability to raise income, being very much decreased -- indeed, quite the opposite, a lot of downward pressure being placed by these other factors.

Is that what folks out there -- our colleagues are finding, that all of the inputs out there, in terms of income, are going one way, and all the costs are going the other, and medical malpractice being an important one of them?

DR. SACCARO: That's correct, Assemblyman. The pressure of increasing insurance rates and increasing costs to run our offices is counterbalanced by decreased revenue.

As you know, the medical malpractice crises in the past has been a cyclic problem. I think it last occurred in the 1970s. But at that time, we didn't have such a downward trend on our fees so that right now, in order to make it in our practices, we would have to see more patients, which, of course, can generate errors if you're forcing a lot of patients through. So this is a real problem, and I agree with you.

ASSEMBLYMAN CONAWAY: Direct input on quality care. You can't increase volume really.

DR. SACCARO: Right.

ASSEMBLYMAN COHEN: Any other members of the Committee? (no response) Chairwoman Weinberg?

ASSEMBLYWOMAN WEINBERG: No.

ASSEMBLYMAN COHEN: Based upon what Dr. Conaway said, it seems like part of the problem is your loss -- not your loss, but the loss of revenue from managed care and HMOs and from reimbursements, which has nothing to do with the malpractice insurance issue except you have less revenue. Would that be safe to say?

DR. SACCARO: If my medical malpractice insurance costs are 30 percent or 40 percent or 50 percent of my income, it becomes a problem. If I own a store, and my liability for slip and fall insurance on things goes up 200 percent, I can raise my prices. Physicians are in a position now where we can't. And that's the major problem. We're caught.

ASSEMBLYMAN COHEN: Would you agree, as I indicated early, and as I've heard at meetings -- and that is, until this last year, there was stability in premiums?

DR. SACCARO: Yes, I agree with that.

ASSEMBLYMAN COHEN: So one has to look at-- And during those years and decades of stability, there didn't exist a cap on pain and suffering, yet the rates were still stable in Jersey.

DR. SACCARO: That's correct.

ASSEMBLYMAN COHEN: Would you agree that we need to focus, at least in great part, on what happened during the past year to find out what indicators have caused -- I know surgeons and those in OB/GYN to have their rates dramatically increased. Would that be a good starting point?

DR. SACCARO: Yes, it would, to examine what happened this year. That was one of our proposals, to look into the insurance problems. As you are well aware, Assemblyman Cohen, this is a very complex issue, what has happened in the last year with the insurance industry. And I suppose, and I don't want to talk for them -- but I suppose that their actuaries had something to do with raising their rates -- but it's a very complex problem, as you well know.

ASSEMBLYMAN COHEN: As I understand, in the information that we've begun to digest, certain business decisions were made to expand

markets. Everyone wants to capture the greatest part of the market in their area on the theory that they want to make as much money as possible, and that by expanding into other states and seeking all commerce -- get covered -- that there are certain business decisions that went awry, coupled with the economy and coupled with 9/11, that caused investment problems and losses that generated higher premiums in certain particular areas. Would that be relatively safe to say as in a general statement?

DR. SACCARO: Without commenting on specific companies, what I would say in general is that all the companies doing business in this particular state looked at that bottom line. And some of the major companies ran for the borders or just stop writing insurance. That's the fact. Princeton, for example, is still writing in this state, but their rates are going up also.

ASSEMBLYMAN COHEN: Are there any types of mechanisms? You mentioned before, in the statute of limitations issue--

DR. SACCARO: Right.

ASSEMBLYMAN COHEN: --a need for reform there.

Now, the statute of limitations is two years, except where there is a discovery issue, that is two years from date of discovery. For instance, if a scalpel is left inside a patient, and it's not noticed for five years, and then it becomes a problem, and someone finds out that a scalpel's been left inside because it's turned over during that time, and now a patient knows there's a problem, then it's two years from the date of discovery of that. You understand that?

DR. SACCARO: I understand that.

ASSEMBLYMAN COHEN: Do you think that should be changed?

DR. SACCARO: I think that should be looked into whether that's being enforced or not and when the actual discovery was. I would like to see that enforced.

ASSEMBLYMAN COHEN: Well, it's enforced in court when someone makes a motion to dismiss based upon a failure to meet the statute of limitations, and they say, "You should have known about this three years ago." I mean, that's how it's dealt with in court.

You mentioned also about putting some limitation in terms of statute of limitations on babies. Right now, it's 18 years old and two years past your age of majority, which brings it up to 20.

I mean, if you're looking for something earlier, that may be a two-edged sword because you may be generating more law suits now in order to get a case in where it involves a child. In many cases, an injury that has occurred to a baby or a small child at age six or seven, may improve by the time they're 18 years old. So you may be generating more malpractice cases in court by having attorneys and patients file earlier. I just point that out. It's something you may not want to wish for.

DR. SACCARO: I see that point, but the thing is, that would bring the tail down for obstetricians to a tolerable period of time.

ASSEMBLYMAN COHEN: And in dealing with that area, I think what we'd all like to know is whether or not, in the high-risk areas -- that is OB/GYN and in neurosurgery and other types of high-risk surgery that patients have to undergo -- wasn't there something that we could address in those particular areas to protect -- for physicians and, ultimately, the patient because our concern is obviously to make sure that there is a physician pool so our health consumers have someone to go to to survive?

DR. SACCARO: Right.

ASSEMBLYMAN COHEN: Whether that's something that can be addressed in the high-risk surgeon areas within the insurance company, whether it's how policies are underwritten, what the criteria may be, whether there's a reinsurance that we have to reestablish -- we already have a reinsurance statute -- whether we need to look at that statute to deal with reinsurance in the higher risk only, that's something I think members of the Committee -- I know that Chairwoman Weinberg and I would like to know about.

DR. SACCARO: Yes, I agree with that.

ASSEMBLYMAN COHEN: Rather than changing the world -- whether we can change portions of it to address the most prominent problems.

DR. SACCARO: Thank you.

ASSEMBLYMAN COHEN: Chairwoman Weinberg.

ASSEMBLYWOMAN WEINBERG: Are there any other questions for Dr. Saccaro?

ASSEMBLYMAN SMITH: Yes, I have a question.

Have you found that there's any type of correlation between the reduction or stabilization of Medicare reimbursement and HMO reimbursement and the quality of medical care? And I'm not talking about access but the actual quality. The bottom line being, if doctors are being forced, and they're not making as much money, is it possible that they are cutting corners and not spending as much time, for example, and therefore overlooking problems that may rise to the level of medical malpractice?

DR. SACCARO: I have no expertise of whether that's actually happening, but I can say that that is a concern -- that in order to continue with our overhead and things, as our fees are cut-- And, yes, you're right. The

HMOs do peg their fees frequently to Medicare fees. The Medicare cut over three years will be between 15 and 20 percent. I'm not sure of the exact figure. So that's a problem. Reimbursements are coming down. And then the natural tendency would be to try and squeeze in more patients, and we all know what that could lead to.

ASSEMBLYMAN SMITH: Okay. The second question is, and this is completely anecdotal-- I don't want to make any suggestions with the question, but I had a conversation with our medical examiner about a month ago in Gloucester County. He said that the average person would be shocked and appalled by the number of medical mistakes that are out there. Are there any types of statistics that follow medical mistakes and therefore has some type of impact on the cost of medical malpractice insurance?

DR. SACCARO: I can quote a study done by Harvard on 30,000 patients in New York state. About 4 percent -- they examined the records -- were found to have medical injuries. Of those, probably 1.5 percent were due to negligence by health-care workers, medication errors, things like that. So it is a problem which we are, as physicians and hospitals and nurses and health-care workers, beginning vigorously to investigate.

ASSEMBLYMAN SMITH: Okay. Was that study a snapshot, or was it conducted over time, and did you see any trends?

DR. SACCARO: It was conducted over time.

ASSEMBLYMAN SMITH: Were there any types of trends that were discerned from that study?

DR. SACCARO: That I can't answer. Not in that study. No.

ASSEMBLYMAN SMITH: Okay. Just third and last question. On Page 4 of 4 of your testimony, there is the assertion that 71 percent agree that

medical liability litigation is the primary force in driving up health-care costs. Who are the people that are agreeing?

DR. SACCARO: They're a representative cross section of the country. It's a national poll.

ASSEMBLYMAN SMITH: Okay. So what you're essentially doing is your interviewing, randomly, a cross section of people, whether they're auto mechanics or neurosurgeons.

DR. SACCARO: Yes.

ASSEMBLYMAN SMITH: Okay. Thank you.

DR. SACCARO: Thank you.

ASSEMBLYWOMAN WEINBERG: Before I call the next witness, I just want to make sure I heard you correctly. Under the current tort system, medical malpractice insurance premiums remain stable until this year.

DR. SACCARO: I believe that's correct until this year.

ASSEMBLYWOMAN WEINBERG: Okay. I just wanted to, as I said, make sure that I heard that.

Thank you very much, Dr. Saccaro.

DR. SACCARO: Thank you.

ASSEMBLYWOMAN WEINBERG: Oh, I'm sorry.

Before you leave, Assemblyman Thompson-- I'm sorry.

ASSEMBLYMAN THOMPSON: Last week, the Supreme Court issued a ruling that our Good Samaritan statutes should not apply to a physician who volunteers his services in a hospital setting. Would you anticipate that this would have any significant impact on future malpractice rates?

DR. SACCARO: That it should not apply in a hospital setting?

ASSEMBLYMAN IMPREVEDUTO: Could you put your microphone on, please?

DR. SACCARO: Oh, sure. I'm sorry.

Did I hear you correctly that they said it would not apply in a hospital setting?

ASSEMBLYMAN THOMPSON: Yes, to a physician whose services were volunteered in a hospital setting. They said the current statute would not apply, as far as the Good Samaritan--

DR. SACCARO: And the question was, would I think that would affect malpractice--

ASSEMBLYMAN THOMPSON: Rates and costs.

DR. SACCARO: --rates.

ASSEMBLYMAN THOMPSON: That is the cost of the policy. If now, physicians are also going to be liable when they're doing Good Samaritan work in the hospitals--

DR. SACCARO: I wasn't aware that that Good Samaritan law applied to the hospitals, so I really can't comment on that. I'm sorry.

ASSEMBLYMAN THOMPSON: Well, previously, it was (indiscernible).

Madam Chair, in regards to your questions and comments made by Chairman Cohen-- I know we were given some kind of-- I don't know where it came from, but it was out of one of the newspapers. It does show that in 2001, one insurance company's rates are raised 50 percent. This year, they raised them 19 percent. A second one last year raised them 37 percent and 50 percent this year. So this problem may have been going for about two years rather than just one, if this is accurate information on here.

ASSEMBLYWOMAN WEINBERG: I'm not sure where this came from either. It was on our desk.

ASSEMBLYMAN IMPREVEDUTO: It came from *Bucks County Courier Times*, Pennsylvania.

ASSEMBLYMAN THOMPSON: That's where it's printed. I'm saying I don't know--

ASSEMBLYMAN IMPREVEDUTO: Again, it's not in New Jersey, Sam.

ASSEMBLYWOMAN WEINBERG: Assembly D'Amato had a question, and then we'll go to the next.

ASSEMBLYMAN D'AMATO: Thank you very much, Madam Chairman.

Doctor, as I understand your testimony, you're asking this Committee to consider, as one of the solutions to lowering the the premiums, that physicians of your society pay -- that we should pass legislation that would limit the noneconomic damages of patients that are legitimately agreed by the negligence of the physician. Is that your point?

DR. SACCARO: We believe that patients that have been injured by a malpractice action should be compensated to the fullest extent for their economic damages. We would like to see some cap to be decided by the Legislature on the noneconomic part of that, yes.

ASSEMBLYMAN D'AMATO: Doctor, if I were to tell you that these caps would not lower the premiums and would not prevent them from increasing-- If I were to document that to you, would you change your position?

DR. SACCARO: It would fly in the face of everything that I've read. Twenty-one states now have caps of some form. California, for example, is a very stable environment. But I would always be open to listen to your--

ASSEMBLYMAN D'AMATO: Well, I'm going to send you, when I get back to my legislative office, an article about the announcement in March of 2002 by the American Insurance Association, which I'm advised is a major insurance industry trade group that said that their study has indicated that lawmakers who enact tort reforms, such as caps on noneconomic damages, should not expect insurance rates to drop. This is a rather impressive article. It's written by -- or it was released by the American Insurance Association. So I suggest not only you but the other witnesses that are here today talk about caps. We ought to rethink that and read this article.

DR. SACCARO: I'd be happy to look at. Thank you.

ASSEMBLYMAN D'AMATO: Thank you, Mr. Chairman. Madam Chairwoman, thank you.

ASSEMBLYWOMAN WEINBERG: Thank you, Dr. Saccaro.

The next witness is Patricia Costante, President-CEO of the MIIX Group.

Again, let me reiterate, please, if you've gotten written testimony, please summarize it for us and give us copies because at this rate, we're not going to get through all the witnesses.

Ms. Costante.

PATRICIA A. COSTANTE: Thank you.

I would like to thank the Chairs and the members of the Assembly Health and Human Services and Assembly Banking and Insurance Committees for the opportunity to appear before you today.

I appear before in my role as Chairman and Chief Executive Office of the MIIX Group of Companies. You are getting right now a prepared statement from us. So what I will do is talk most specifically to you about the fact that, as most of you are aware, MIIX Insurance Company is now in voluntary solvent runoff, a business plan that was approved by the New Jersey Department of Banking and Insurance.

We have asked the Department for permission to move forward with the creation of a physician-supported company, and that company would be the MIIX Advantage Insurance Company of New Jersey. We are in day -- I guess we have 63 or 62 days left of a 90-day time period to raise \$30 million from New Jersey physicians in an attempt to be able to continue to provide medical malpractice coverage and stabilize both the availability and affordability of coverage in this market.

What I will do in the interest of time is really refer to your questions rather than continue with a prepared statement.

Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Vandervalk.

ASSEMBLYWOMAN VANDERVALK: Thank you.

Thirty million dollars would allow you to continue in business and would solve the crisis. The State already has, and I'm sure you're aware of this-- The State already has had a fund that has not been used for a number of years, but there is still \$15 million sitting in that fund for medical malpractice reinsurance. The Governor has indicated that he plans to take that money to solve the budget crisis.

Now, I know there is a budget crisis, but I think it's imprudent to take the \$15 million that could be used to solve this very serious crisis. In other

words, if that \$15 million were not taken to balance the budget, it could be used for its original purpose for medical malpractice reinsurance.

MS. COSTANTE: Let me explain to you what we're hoping to--

ASSEMBLYWOMAN WEINBERG: Press your button, please.
(referring to PA microphone)

MS. COSTANTE: Let me explain to you what we're hoping to accomplish with our \$30 million campaign. We are looking to establish a physician-funded company, a company in which every member who is insured is also an owner of the company. And that's a very different objective. We have set our goal at \$30 million because we believe that is the amount of capital we need to responsibly support an infrastructure. With additional funding, we would be able to insure additional physicians. I don't believe that \$30 million is the magic number to solve the crisis. It's a crisis of far-reaching proportions.

ASSEMBLYWOMAN WEINBERG: Assemblyman Impreveduto.

ASSEMBLYMAN IMPREVEDUTO: Thank you, Chairwoman Weinberg.

When MIIX began, it began as a private, nonprofit malpractice insurance facility, correct?

MS. COSTANTE: Correct.

ASSEMBLYMAN IMPREVEDUTO: What happened? Give us the story from that point.

MS. COSTANTE: There are several parts of this story. MIIX was founded in 1977 as part of the malpractice crisis. It was established as a reciprocal company founded with physician dollars, the dollars of New Jersey physicians. About 15 years after it was established, the original subordinated loans were repaid to physicians. And we had sufficient capital to move forward

with insuring the original members and physicians we had added to the roster since that time.

We operated as a New Jersey only company until 1991, at which point we began to write coverage in Pennsylvania. In the mid '90s, we began to move outside of New Jersey and Pennsylvania to write in approximately 25 additional states.

We became a stock company with the approval of 83 percent of our physician insured members in 1999, and then had a public offering and became a public company at that time.

ASSEMBLYMAN IMPREVEDUTO: Okay. Let's go back to 1991, when you were a New Jersey only company.

MS. COSTANTE: Yes.

ASSEMBLYMAN IMPREVEDUTO: How were the-- What were the economics of the company? How well did MIIX do? How badly did MIIX do? Were you making money, losing money?

MS. COSTANTE: For MIIX's 25-year history, we have done very well in New Jersey. We have always been -- had a profitable business plan in New Jersey.

ASSEMBLYMAN IMPREVEDUTO: So in 1991, when you were New Jersey only, you were making a lot of money.

MS. COSTANTE: I don't know a lot of money. I wasn't with the company at that time. But we were always a profitable company.

ASSEMBLYMAN IMPREVEDUTO: So it would seem to me that when you began to expand outside of New Jersey, your problems began.

MS. COSTANTE: Market conditions changed dramatically in the mid to late '90s.

ASSEMBLYMAN IMPREVEDUTO: Would you define what market conditions are?

MS. COSTANTE: Surely. And they changed from several different perspectives.

The first was, it was a different environment that we moved outside of New Jersey to begin to provide insurance. But at the same time, the New Jersey market went from primarily two carriers, to as many as 12 to 18 carriers competing within New Jersey. So rate competition occurred across the country, not only in one isolated market.

ASSEMBLYMAN IMPREVEDUTO: Okay. Now, back to my question, which was, what happened when you moved out of New Jersey? You were making money here. Now, you moved out of New Jersey, and obviously something happened that stopped you from making the kinds of money.

Is MIIX still making money -- as of last year, still making money in New Jersey?

MS. COSTANTE: Yes, we are.

ASSEMBLYMAN IMPREVEDUTO: But losing money outside of New Jersey.

MS. COSTANTE: Correct.

ASSEMBLYMAN IMPREVEDUTO: So with all of the high-priced jury awards in New Jersey, you were still doing okay.

MS. COSTANTE: New Jersey is a volatile environment, but clearly not as volatile as markets outside of New Jersey. The tort reform that was put in place in the mid '90s has served us well. We've seen a decrease in frequency of cases. It's a market where we believe we defend cases very successfully.

However, many of you have heard me say that in the middle '90s, we probably saw five awards a year -- or five payouts a year of \$1 million or more for New Jersey physicians.

By last year, that was one every two weeks. And by this year, that's one a week.

ASSEMBLYMAN IMPREVEDUTO: In New Jersey.

MS. COSTANTE: In New Jersey.

So severity in New Jersey has changed, and clearly severity outside New Jersey has changed. And that becomes the major concern of every carrier as we need to responsibly set aside money for reserves.

ASSEMBLYMAN IMPREVEDUTO: So are you telling me that the financial problems that MIIX has is not for any other reason but the \$1 million a week that you're losing -- that you're paying out in insurance decisions?

MS. COSTANTE: What I'm telling you is that the financial problems that we have experienced have been related to having to set aside reserves differently based on the severity and awards.

ASSEMBLYMAN IMPREVEDUTO: Have you made any poor investments?

MS. COSTANTE: Have we made more investments?

ASSEMBLYMAN IMPREVEDUTO: Poor. P-O-O-R investments.

MS. COSTANTE: We have an investment portfolio, which represents our loss reserve dollars at \$1.2 billion. That is a AA rated portfolio, and the investment yield, even last year, which was a very challenging investment year, was about 6.9 percent.

ASSEMBLYMAN IMPREVEDUTO: So you've not lost any money in your investments for your portfolios?

MS. COSTANTE: Our overall investment portfolio has performed well.

ASSEMBLYMAN IMPREVEDUTO: And the only problem you've got then is these so-called large jury payoffs.

MS. COSTANTE: Let me explain, if you have the time to hear a very brief explanation of how that works. We work with several outside actuarial firms to help us determine how many dollars need to be placed in reserves.

Traditionally, how actuarial firms have dealt with that in medical malpractice is they look at cases that they define as high exposure cases, cases with the potential to pay out \$1 billion or more, as outliers or anomalies within our caseloads. And they remove them from the actuarial formulas.

They then run the formulas, determine an amount of dollars that needs to be put in reserves, and adjust that or tweak it in some way for the number of anomalous cases that they're looking for.

What happens when -- and I'll use New Jersey as an example because it's what we care about here-- When you get to the point where you're seeing one case a week, paying out at \$1 million or more, you can no longer treat that as an outlier. You need to treat that as part of the normal course of business.

If you look at our adverse loss development across the country on a \$1.2 billion reserve allocation for 2001, we only experienced a total of \$11 million in adverse outcome. But when you take that and calculate it over the long payout that we expect to see from medical malpractice cases, the reserve adjustment that's warranted from that is \$150 million. And for MIIX, net of reinsurance -- that was a \$68 million adjustment to reserves for us for the year

2001, and created the impetus for the financial setbacks that we experienced as a result.

ASSEMBLYMAN IMPREVEDUTO: Could we just come back to that \$11 million? What was that again? The \$11 million was--

MS. COSTANTE: Adverse development for 2001. We saw \$11 million more in payouts than we projected in our actuarial studies for the year.

ASSEMBLYMAN IMPREVEDUTO: And you were projecting \$1000 a week -- \$1 million a week rather, I'm sorry.

MS. COSTANTE: We weren't expecting it. We weren't anticipating \$1 million a week because that was an unprecedented development.

ASSEMBLYMAN IMPREVEDUTO: Okay. So the \$1 million a week brings you to \$52 million.

MS. COSTANTE: Correct. But I'm saying that our \$11 million in adverse development was nationwide. It's not just in New Jersey. When we do our actuarial studies, they have to be for all the business the company writes in every state.

ASSEMBLYMAN IMPREVEDUTO: So let me summarize what I think you said, and correct me if I'm wrong. You're investments are doing well.

MS. COSTANTE: Correct.

ASSEMBLYMAN IMPREVEDUTO: The company's made good business decisions, but because of the high payouts, jury awards, MIIX has a problem.

MS. COSTANTE: What we saw was increases in severity, which caused us to move money into loss reserves. And that came as a result of the size of the awards and the settlements that we were approaching and the fact

that we were righting business in many markets that are volatile, not just New Jersey.

ASSEMBLYMAN IMPREVEDUTO: So there's no other problem but the jury awards. That's what I'm hearing. I want you to say that to me.

MS. COSTANTE: What I'm telling you is that our reserve calculations never included the number of high-severity payouts that we have seen more recently.

ASSEMBLYMAN IMPREVEDUTO: If you were not in New Jersey -- I mean, if you were not outside of New Jersey, if you were just in New Jersey -- and I'm sure you have those numbers somewhere -- would you be in this bind right now?

MS. COSTANTE: If we were just in New Jersey, we would be adjusting loss reserves, but clearly not to the magnitude because we wouldn't have the premium base that we have.

ASSEMBLYMAN IMPREVEDUTO: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you very much, Madam Chairwoman.

I'd like to go through with you and review, for the benefit of the members of this Committee who are not a trial attorney, as I am, the process by which MIIX evaluates whether a medical malpractice claim has merit. Now, let's take the situation of where you learn, through your insured physician, that he or she has received a letter from an attorney indicating that the attorney believes there's been some negligence on the part of that doctor. What's the process you go through to determine whether or not the doctor deviated from the standard of care, the applicable standard of care?

MS. COSTANTE: There are a variety of processes that we go through. In some situations, the cases are reviewed internally by our claims staff that have extremely good background and know both legal and clinical aspects of a case. And based on their evaluation of the case, they assign a rating to the case -- a severity rating to the case, and then according to the severity rating, that is how the case is tracked.

In some situations, we use a peer review process, where physicians of the same specialty come in and look at the case and work with the physician who had the case to both review the medicine and review the likelihood that this case will be successful as we move forward to trial.

And in extreme cases, we have both a claims committee, which is a multispecialty group of physicians that look at very difficult cases and help us to think about how to try those cases. And then we have a high exposure committee that only looks at cases that we believe will pay out \$1 million or more. All of them include physicians.

ASSEMBLYMAN D'AMATO: Before MIIX agrees to make a settlement as opposed to having to pay a jury verdict, MIIX must obtain the consent of the insured physician. Is that correct?

MS. COSTANTE: That is correct.

ASSEMBLYMAN D'AMATO: And if you do not obtain the consent of that insured physician, you will not pay, voluntarily, a settlement, correct?

MS. COSTANTE: Correct.

ASSEMBLYMAN D'AMATO: Now, what percentage of the claims that come to your attention -- the company's attention are paid before a lawsuit is filed? Do you have that information?

MS. COSTANTE: I don't have that statistic with me, but it's a relatively small percentage.

ASSEMBLYMAN D'AMATO: So when there's a settlement, most of the time it's after the lawsuit's been filed, there's been deposition of the parties, depositions of all the experts. Is that correct?

MS. COSTANTE: Correct.

ASSEMBLYMAN D'AMATO: And would you say that about the information I have -- is what-- Is it 85 or 90 percent of the lawsuits that MIIX insures a defended doctor ourselves before trial?

MS. COSTANTE: No, I don't think it's that high. But again, I don't have that exact number.

ASSEMBLYMAN D'AMATO: Is it 60 percent, 70 percent? Do you have any idea?

MS. COSTANTE: It's probably in the 60 or 70 percent range.

ASSEMBLYMAN D'AMATO: And when that case-- And when you settled that case, that case went through that entire review process that you shared with the committee. Is that correct?

MS. COSTANTE: Some parts of it.

ASSEMBLYMAN D'AMATO: Let's talk about the affidavit of merit. You think it's worked, don't you?

MS. COSTANTE: The affidavit of merit has resulted in a decreased frequency of cases. We have seen fewer cases since the affidavit of merit went into place.

ASSEMBLYMAN D'AMATO: You also indicated that the number of lawsuits being filed against physicians has substantially dropped. Is that correct?

MS. COSTANTE: The frequency has gone down. Correct.

ASSEMBLYMAN D'AMATO: And just for the record, you're correct because the administrative director of the courts confirms that the filings are substantially down. Do you know why? Is it just the affidavit of merit -- as to why the filings are down?

MS. COSTANTE: I have no information other than that.

ASSEMBLYMAN D'AMATO: Thank you very much.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: You know, the knob of this-- I'm sure you're aware of this. There's going to be-- As part of this debate-- Whether or not there is a crisis in medical malpractice here is going to revolve around, I think, the question of -- one, how much of this is the fact that MIIX is in trouble and that all of a sudden, some 7000 physicians are going to find themselves on the market. Is that where the crisis is coming from? Two, to what extent that MIIX might be involved in their own troubles with the decision they made is going to involve itself in people's view of this?

What I thought I heard you say, and please correct me if I'm wrong, you have seen an increase in the number of high-damage awards in the State of New Jersey. I thought you said that just in New Jersey alone, it went from one a month, perhaps or -- five a year-- I'm sorry, you said five a year to where you're going once a month now or more of these high claims.

ASSEMBLYMAN IMPREVEDUTO: Once a week. It's \$1 million a week.

MS. COSTANTE: Correct.

ASSEMBLYMAN CONAWAY: In your view-- And I'd like to also know to what extent did you think-- MIIX's experience is generalizable to the

other insurers in the State of New Jersey. Isn't that going to put an upward pressure on the insurance rates you're going to have to charge physicians to be insured on rates? Isn't that going to have to do that?

MS. COSTANTE: Clearly, loss development impacts the rates -- the rate setting process. As we have done our actuarial studies for New Jersey physicians-- Because we have a 25-year history of pricing our insurance coverage appropriately, while we have seen a steady increase in rates, you have not seen, in New Jersey, the same double digit increases that you see throughout the -- in other places in the country. So, as we filed our rates that we would anticipate charging from MIIX advantage if we move forward with that company, the aggregate rate increase is 10 percent.

ASSEMBLYMAN CONAWAY: The aggregate rate increase is 10 percent for? I'm sorry.

MS. COSTANTE: For physicians across the board, it averages 10 percent. There's some variability among specialties.

ASSEMBLYMAN CONAWAY: And, of course, people are going to have to decide for themselves whether this is a crisis or not, I think, as been brought out, at least by myself from my own personal experience and from other people, I'm sure, who are going to come forward. We are not seeing increases in reimbursement rates. The Federal government, indeed, is decreasing its rates. And so as a cost, certainly for physicians to be in practice, an increase of 10 percent is certainly an increase that's not going to be, as other businesses can do, passed off on the people who buy their products, let's say, or use their services. Is that right?

MS. COSTANTE: That's correct. And it's very difficult for physicians to face this situation.

ASSEMBLYMAN CONAWAY: Now, you mentioned that you have people who go through and review cases -- and it comes up, because we're going to-- Part of our discussion in the future is going to revolve around this aspect of physician profiling. This is going to be something that we're going to face.

Since you mentioned the fact that you have folks that go through these cases, are you in a position to say that when you look at these various cases -- whether or not they've gone to trial or not -- what percentage of those cases actually involve physician negligence? But when you look at the physicians who get themselves involved in these cases -- because my understanding, looking at some data produced by the New England Journal of 1996 -- I'll get you the citation -- but that if you look at those cases across the board, only maybe a quarter of those cases actually involve physician negligence. Is that consistent with what you know, or do you not have any information on that?

MS. COSTANTE: I don't have specific statistical information about that. Clearly, as we look at cases, what we pay a lot of attention to is the fact that in many situations, what's most readily identifiable is poor physician communication. So we work very hard in our risk-management programs to help physicians develop both written and verbal communication skills to avoid some of these difficult situations.

ASSEMBLYMAN CONAWAY: Now, you mentioned that-- It was mentioned earlier that the use of a reinsurance fund might help MIIX with what it's doing. As I understand it, they're trying to create sort of a new physician mutual.

MS. COSTANTE: Correct.

ASSEMBLYMAN CONAWAY: Is it possible to use those funds and still have a physician's mutual? Is there either some sort of legal or other impediment to using those funds in that way?

MS. COSTANTE: Our plan right now is for it to be a fully physician-supported company. We believe that that is a good plan because it allows physicians to actually make decisions about how the company is run, something that physicians have expressed a tremendous amount of interest in being able to do.

ASSEMBLYMAN CONAWAY: You mentioned also, if I may, characterizations of the market here. Again, since you're involved in this -- and you might tell that -- because my own insurance company actually is pulling out, so this is very personal to me-- How would you look at, or how would you characterize the market here in New Jersey in terms of costliness. I mean, if I've understood your testimony, certainly there are reasonable increased costs that people are going to -- the cost of a growing business always goes up. Our fees don't, or our salaries don't, but the cost of doing business always goes up.

Can you say whether or not -- or what's happening here in New Jersey as it regards that? Do you expect to see more volatility? Do you expect to see people -- your colleagues, your co-business -- or whatever you call yourselves -- other insurers leaving the State of New Jersey? Are people going to stay -- or people -- I was told in a meeting not too long ago that people are fighting to get into New Jersey because there's so much money being made here. Who would you characterize that statement?

MS. COSTANTE: What we have seen is very different than that. What we have seen is, up until about the middle of 2001, there were many companies vying to write coverage in New Jersey. With the exception of MIIX

and Princeton, the two long-time carriers in the market, there was a tremendous amount of competition on price. I would get calls from our long-time physician insureds all the time saying, "I've been with MIIX for 20 years, and X company now wants me to come to them. They will offer me a 20 or 30 or 40 percent discount to do that."

Clearly, what has happened since that time was the very well-publicized failure of PHICO, I think, really forced everyone writing business in this region to step back and look very carefully at their pricing practices. So we had no longer the availability of PHICO, which, especially in South Jersey, was considered a major insurer.

We had Zurich make the decision to leave this market. We had the very wellpublicized withdrawal of Saint Paul from medical malpractice throughout the country because of their concerns about volatility and severity. So, very quickly, I believe New Jersey physicians found themselves faced with a much smaller number of companies to choose from, and all of those companies are beginning to talk about increases in premiums.

I have spent the last several weeks going back and forth across the state speaking to physicians at specialty society meetings, medical society meetings, hospital staff meetings, and the story that I hear again and again is that it takes a very long time to get quoted for a policy, that the price increases are almost always double digit price increases, and that if there are four or six physicians in a group, very often the company will take some of the physicians in the group, but not all of the physicians in the group.

ASSEMBLYMAN CONAWAY: Would you use the term crisis to describe what's going on? One insurance executive told me that he felt that

indeed the situation in New Jersey was at crisis stage. Would you use that term, or do you think that's an overstatement?

MS. COSTANTE: No, I don't think that's an overstatement, and I think that the last time there were hearings, I would have been less likely to use that word because I think that is a word that's best applied when there is difficulty with availability. I think that if MIIX were not to continue writing coverage in this market, impacting 37 percent of the State's physicians, that would qualify as a crisis.

ASSEMBLYMAN CONAWAY: And one last question. I'm almost done.

I apologize, Neil, because I'll call it the Neil question.

And that is, do you-- What suggestions would you have for treating those in high-risk specialties, perhaps, different from a fellow like me who is just a country doctor?

ASSEMBLYMAN COHEN: It's a big country.

ASSEMBLYMAN CONAWAY: (laughter) It's a big country.

The neurosurgeons, obstetricians -- and my own neighbor's obstetrician now is not going to deliver babies anymore. She told me yesterday it's a real difficult question. This is her first child, so she's going to have to find-- She plans to have more children. She's going to have to find another doctor.

Do you have any suggestions for treating these high-risk specialties and how to handle them in terms of insurance?

MS. COSTANTE: This is an issue that we have looked at very, very carefully because, clearly, for the OBs and the neurosurgeons that we insure, they have seen the highest rate increases, not just from us, but from companies across the country that quote them. And in terms of our own capital

contribution campaign, they would have to make the highest contribution to a new company going forward.

I know, a lot of the time, what's discussed is some way to do almost a community rating or a cost sharing for high-risk specialties. I think one of the things that makes that very difficult though is your very point that all physicians are experiencing tremendous revenue pressure within their practices. And contributing additional premium to cover other specialties is a very hard place to get them to.

We certainly look at, with all due respect, Assemblyman D'Amato -- we look very carefully at issues like caps on noneconomic damages because, especially in what we refer to as bad baby cases, what you see is a very high emotional component to those cases. And while we always approach those cases with the expectation that we will pay full life care costs and compensation to families, the pain and suffering components of those cases are what almost always takes them into the multimillion dollar category.

ASSEMBLYWOMAN WEINBERG: Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: In your written comments, you point out that you've received approval for a new business plan from the Department of Banking and Insurance, which places MIIX Insurance Companies into voluntary solvent runoff, but also indicate that you "continue to renew New Jersey physician business in MIIX Insurance company as we move ahead with the formation," etc. These renewals that you're-- Well, currently, you're renewing any physician who is currently a client as they reapply. Is that correct?

MS. COSTANTE: Any physician who is currently a MIIX insured will be renewed within the MIIX Insurance Company if they apply for renewal. We will be able to do that through the end of August.

ASSEMBLYMAN THOMPSON: Well, if tomorrow somebody applies for renewal, are they getting a renewal that's in the current MIIX Company or in the projected MIIX Company?

MS. COSTANTE: In the current MIIX Company.

ASSEMBLYMAN THOMPSON: And they will automatically move into the new one if and when it is established.

MS. COSTANTE: They will move into the new company at the next time their renewal comes up.

ASSEMBLYMAN THOMPSON: Oh, okay. So they remain under the current terms and conditions until then.

MS. COSTANTE: Correct.

ASSEMBLYMAN THOMPSON: In the discussion with Dr. Conaway, I think it was, you mentioned something about 10 percent. The renewals that you're doing currently, are they being renewed at about a 10 percent increase or much larger, or what?

MS. COSTANTE: Our current fee schedule, which is a 10 percent increase, went into effect on May 1 for the current company, the MIIX Insurance Company. That would be the same fee schedule that we use to write business at MIIX Advantage.

ASSEMBLYMAN THOMPSON: So for the next 60 to 90 days, before the new company gets formed, any physician renewing during that time, who's currently with you, can renew and can renew at approximately a 10 percent increase in premium.

MS. COSTANTE: Correct.

ASSEMBLYMAN THOMPSON: Okay. One other thing. Relative to the formation of the new company, which is to be basically physician-sponsored and so on, I also noted a recent news article. I believe it was OB/GYNs were attempting to organize a self-insurance firm separate from yours where you'll be competing for essentially the same potential clients that are customers, or was there any problem with the two of them trying to get formed at the same time?

MS. COSTANTE: My understanding is that there is more than one company right now trying to raise capital, or more than one startup trying to raise capital. I know that the OBs, very specifically, are looking to do something only within their own specialty. I have been told that their concern is that MIIX, for example, would not want OB business going forward, and that's not true. Our plan is to write business across all specialties in New Jersey.

ASSEMBLYMAN THOMPSON: Do they constitute as a substantial portion of your customer base?

MS. COSTANTE: They do not at this time, because when Zurich first came into the market, Zurich did very favorable pricing for OB/GYNs, and a fair amount of the OB/GYN population that we insured moved over to Zurich.

Again, what I know from crisscrossing the state is that many of those OBs, with the departure of Zurich, are now interested in coming back to MIIX, and we will offer them all the opportunity to be underwritten for a policy.

ASSEMBLYMAN THOMPSON: One final question about your discussion with, I think, Assemblyman Impreveduto -- seemed to indicate that relative to New Jersey, your business isn't bad. That is, it comes along, it may

be somewhat profitable, etc. We have all these other companies pulling out of Jersey and so on. Would you attribute their movement -- while you're saying it's not a bad market here in New Jersey, really, to -- that they are suffering in other states, and that's why they're pulling out of New Jersey?

MS. COSTANTE: I guess I'll respond to that in two ways. First, we have a 25-year history in New Jersey. So when we actually price a policy in New Jersey and then look at a physician's underwriting record in New Jersey, we do that with a 25-year history of data. And that's very helpful to us to both price appropriately and insure doctors that we believe we can defend successfully.

As other companies came into this market and were faced with the fact that there was a MIIX and a Princeton that insured almost all the physicians successfully for a long period of time, the way to begin to build market share is to offer discounted pricing. And I think that it may be some of the pricing policies that created difficulty for other companies in this market.

ASSEMBLYMAN THOMPSON: I do want to offer the last comment. As I look over the list of speakers we have here, it appears you are the only malpractice insurance company that is testifying today.

Thank you for being here to answer our questions.

MS. COSTANTE: Thank you very much.

ASSEMBLYWOMAN WEINBERG: Assemblyman Cohen, questions?

ASSEMBLYMAN COHEN: Thank you, Madam Chair.

I guess part of this whole thing is why should we give MIIX another shot at the apple?

By starting a second MIIX and seeking to capitalize it with \$30 million from physicians-- As the physicians choose to make this investment again, that is obviously their consumer choice.

One of my concerns is, what restrictions will there be? Where else you will go write policies? Are you going to be writing policies only in New Jersey and not writing in Delaware or any other states?

MS. COSTANTE: The plan for MIIX Advantage is to write policies only in New Jersey and only for physicians. The bylaws would require that if at any point the company wanted to move beyond writing physician business or beyond writing business in New Jersey, it would require the approval of the supermajority of its physician shareholders, which for our purposes would be defined as 75 percent.

ASSEMBLYMAN COHEN: Well, here's my problem. When you decided to go public and write everywhere, the vote was 83 percent, and that's when you had your problem.

Now, one suggestion that I may have is whether or not the Commissioner of Banking and Insurance, either by regulation or the Legislature by statute, will stop you unless you have some other kind of approval, either from a regulatory agency or from the Legislature. We don't want to have the same problem 10 years from now.

You've got a supermajority the last time you went public. And you went to Texas. And I don't mean you personally. You went to Texas. You went to Mississippi. You went to other states. And that's where your problem was -- because of this price where everybody underprices to try to capture the market. You had that problem when you had 18 companies a couple of years ago writing insurance.

Supposedly, when you have 18 companies a couple of years ago writing medical malpractice insurance, that's supposed to stimulate competition. That's what I'm told every day in car insurance ads. We need to bring more companies into New Jersey to lower the costs for car insurance people. But all it does is creates a price war. And when you start offering services too low to capture a bulk of the market, when the economy goes down, and your investments are reduced, you have a problem.

Now, you mentioned before earlier-- Now, I need to know, and this Committee needs to know, one, why we should give you another shot. And number two, whether we need to build in for the protection of doctors and, ultimately, their patients, who are our constituents, so that this thing doesn't happen again. We may not want you to write anywhere but New Jersey.

And you told Assemblyman Impreveduto, you told Assemblyman D'Amato, you told Assemblyman Thompson that you make a profit in New Jersey. Business was good in New Jersey. Doctors have testified they had stable premiums until last year. So the system must have been working if the doctors acknowledge a stable system despite no caps that exist on pain and suffering. You said that your company was fine. In fact, your Web site showed last year that you guys were flush with money. You were doing very well. But something happened during the last 12 months to cause a problem. And I believe it was from out-of-state verdicts in Texas and other states that caused this problem, not New Jersey's physicians, because they're competent.

Now, you mentioned you have a \$1 million award a week in New Jersey. In New Jersey, a \$1 million award a week.

MS. COSTANTE: One million dollar payout a week. And that's a combination of jury verdicts and settlements.

ASSEMBLYMAN COHEN: All right. Well, let's go through that because I want to know. And I want provided to this Committee claims history from 1998 through the end of the year. I want to have provided to this Committee information concerning the claim, how much was paid, whether it was a structured settlement, whether it was a jury award, how many cases have been dismissed, how many cases have been a finding of no cause of action before the jury, and how many cases got reversed on appeal. Because if you had a \$1 million reward last year, you already set aside a reserve three years ago, four years ago, when the case was first filed -- when you first opened a file and your adjusters looked at it. That wasn't last year. That wasn't two years ago. That was three or four years ago. When the claim came in, you set aside a reserve, and you analyzed it. You also had the ability, as the case went on, to adjust the reserve.

So this Committee wants information and wants data showing that there's been a \$1 million a week award or \$1 million a week settlement. If that was last year, that's 52 cases. Over \$52 million was paid out. Is that correct?

MS. COSTANTE: Last year, we paid out 26 cases for 2001 of \$1 million or more.

ASSEMBLYMAN COHEN: And what kind cases were they?

MS. COSTANTE: They were a variety of cases.

ASSEMBLYMAN COHEN: Were they higher risk OB/GYN cases?

MS. COSTANTE: There were OB/GYN cases. There were ophthalmology cases. They were orthopedic cases. They crossed a spectrum. They were internal medicine cases. They crossed a spectrum of cases. For the first quarter of 2002, we are now on track to pay out \$1 million a week in either jury verdicts or settlements. For the first quarter, we saw one a week.

ASSEMBLYMAN COHEN: And this is from cases from three years ago.

MS. COSTANTE: It could be from cases from 10 years ago. We have a long tail on the product that we write.

ASSEMBLYMAN COHEN: But you set aside reserves over the course of the years on these cases.

MS. COSTANTE: We certainly have set aside reserves over the course of the years. However, when the severity spikes so quickly, what happens is you're adjusting reserves upward at a very rapid pace, and that is very difficult for actuaries to see that kind of change, and it forces them to recalculate or retune or fine tune the formulas they use to calculate our reserve needs going forward.

An example is, if we look at our 25-year database and adjusted for the net present value of a dollar, a left leg amputation that was determined to be as a result of malpractice would be worth about \$350,000. We paid out \$3.5 million, \$4 million on more than one occasion last year for that same case.

ASSEMBLYMAN COHEN: Do you think that's an inappropriate award for an amputation that went wrong?

MS. COSTANTE: What I'm saying is that you can't use the data that you have to necessarily predict what the award will be. That's the volatility in the market and what causes us to adjust reserves.

ASSEMBLYMAN COHEN: You have reinsurance on your insurance, correct?

MS. COSTANTE: Correct. However, we're reinsured after the first \$10 million. That's how we're reinsured, after the first \$10 million. For the new company, that would be very different because you can't reinsure that way

with this kind of volatility. You can't hold to the first \$10 million in risk in the current environment.

ASSEMBLYMAN COHEN: What do the reinsurers say? Do the reinsurers want to do business in New Jersey?

MS. COSTANTE: Yes, they are.

ASSEMBLYMAN COHEN: So, if they want to do business in New Jersey, they're not coming to Jersey to reinsure and lose money. They would reinsure because they think they can make a profit.

MS. COSTANTE: Well, they come to New Jersey charging rates that are different than the rates they would have charged two or three years ago.

ASSEMBLYMAN COHEN: My question is, they want to stay in New Jersey and reinsure for you, correct?

MS. COSTANTE: Correct, at higher rates than before.

ASSEMBLYMAN COHEN: Now, are you going to cherry pick doctors in this new company that has turned down physicians that you had before?

MS. COSTANTE: No, the commitment that we have made is every physician we currently write, we will write in the new company. And for anyone who is not a current MIIX insured, we will underwrite them according to our current underwriting guidelines.

ASSEMBLYMAN COHEN: What happens if we do get more companies who want to write medical malpractice insurance in New Jersey? Is that going to create a price war to see who is going to capture the market the best, which is basically a basic business premise?

MS. COSTANTE: I think everyone's expectation, including mine, is that over the next 48 to 72 months, you are going to see an unprecedented hard market in malpractice. You will not see a price war.

The companies have learned some very painful lessons from the '90s, where probably we will not forget them quickly. And I think physicians have also been sensitized to the fact that going with the least costly carrier doesn't necessarily ensure them stability over the long haul.

ASSEMBLYMAN COHEN: Will your company be able to provide the information? Because I'm going to ask that Committee staff prepare a letter request.

MS. COSTANTE: We can certainly provide the information for the physicians we insure. You should probably look to get that from all companies so that you can have a full picture of this market.

ASSEMBLYMAN COHEN: Well, if another company comes in and says that they're paying out \$1 million awards a week, we'll gladly ask them for that information. So far, we've only heard from MIIX. And we're going to ask for information and details of all those claims.

MS. COSTANTE: And my sense is that our experience is not different from the experience of other companies writing in this market.

ASSEMBLYMAN COHEN: Well, what we've understood to be the climate is that a lot of this problem emanates out of the writing of insurance in other states, which I understand you want to stop doing, correct?

MS. COSTANTE: We no longer write insurance in any state but New Jersey.

ASSEMBLYMAN COHEN: And writing in another state is too volatile, correct? Writing in other states is too volatile, correct?

MS. COSTANTE: We don't believe we know those markets as well as we know New Jersey.

ASSEMBLYMAN COHEN: And you had a bad experience in Pennsylvania, bad experience in Texas, correct?

MS. COSTANTE: Yes, we insured hospitals in Pennsylvania, and that's a very difficult market.

ASSEMBLYMAN COHEN: Who insures hospitals in New Jersey?

MS. COSTANTE: Primarily, Princeton.

ASSEMBLYMAN COHEN: So you're not going to write hospitals either?

MS. COSTANTE: No.

ASSEMBLYMAN COHEN: Do you think it's unreasonable for the Legislature to make sure that all you can do is write in New Jersey?

MS. COSTANTE: Our business plan is only to write in New Jersey.

ASSEMBLYMAN COHEN: Right, except where you have a supermajority, which numbers less than what you previously voted on when this thing went public the first time, correct?

MS. COSTANTE: I think there are two-- Can I separate those two issues though?

The expansion efforts that MIIX underwent were starting in 1991 and continuing until maybe '97 or '98. They were different than the public offering, which happened in 1999. And it was the public offering that required a supermajority vote. In this situation, it would be geographic expansion that would require a supermajority vote.

ASSEMBLYMAN COHEN: Who would comprise-- First of all, I have a real problem with that because ultimately it comes back on our laps when we get calls from -- when we get form letters from consumers who've been contacted by their doctors to send letters to legislators. When we go to meetings that become extremely hostile -- and then when everyone is asked the question, how were your rates for the last 20 years, they say fine, okay, that their only problem that has existed is for the last 12 months.

At least for myself, I have real problems with any vote which allows you to write outside New Jersey since that outside New Jersey atmosphere has been extremely hostile from what we can gather. And the Commissioner of Banking and Insurance is going to have to have a very hard look because, quite frankly, until you're rehabilitated, I don't think that you should write outside of New Jersey at all under any circumstances, unless there is some other objective approval process. And that doesn't mean the members of your board who are investors. I've got a problem with that because it's going to come back to us, ultimately, to deal with, whether it's in two years or three years or five years or in 90 days.

MS. COSTANTE: These are two very different companies, though. There is a public company that has investors. This would be a private company that sits outside the public company structure and have different governance. It's a whole new entity and certainly a startup company, not a company in rehabilitation.

ASSEMBLYMAN COHEN: Who would be on the board?

MS. COSTANTE: We are working right now to recruit board members.

ASSEMBLYMAN COHEN: Physicians?

MS. COSTANTE: We will use both physicians and insurance and finance professionals. As I speak to physicians throughout the state, they have asked us to look beyond the physician-only board.

ASSEMBLYMAN COHEN: Well, from what I understand from the last meeting I went to in Hudson County, a physician stood up and said, “We’re not great business people. A lot of people made a bad decision having it being run completely by physicians.”

I just want you to know I’m not directing this at you personally. But we don’t mind a second chance, but if it’s going to create the same kinds of problems, we do have some profound issues. And I have some real issues about allowing anybody to write out of the state and have the same problems that are going to affect New Jersey physicians and then, ultimately, the consumer patient. I have real problems with that. I’m asking that to be reviewed by legislative services now, as to what can be looked at to prevent the company from making the same mistakes it did.

It’s not like, “Well, you lose business, and you don’t get your dividends.” The end result is physicians can’t be covered. They reduce their practice, or they eliminate a specialty, put a soggy amount of money they may make. There’s also a joy by the physician in being in a certain specialty. The end result of that is that patients have someone they can go to who are competent to provide them with a service to make their lives more comfortable.

So I’m less concerned about your profit motive and more concerned about the physicians’ ability to be covered and the patients’ ability to be protected.

MS. COSTANTE: And I share your concern in that regard. I have more than a 20-year history in New Jersey health care, most specifically working

with physicians. I have been with MIIX for six years. I spent my beginning years with MIIX working with New Jersey physicians in its consulting business and then running its New Jersey book of insurance business.

When MIIX Insurance Company went into voluntary solvent runoff, we ensured that there would be a return to our shareholders, many of our shareholders being New Jersey physicians -- but more importantly, sufficient assets to protect the claims of physicians that we would see going forward for 25 years or 20 years.

We have no responsibility beyond that. Our wish to move forward with a business plan for MIIX Advantage comes from our concern that for 25 years, we helped to protect New Jersey physicians. And without some iteration of a company having a role in the future of New Jersey, we believe that New Jersey physicians will face a very destabilized market. And we believe that we do not have a business responsibility, but that we have an ethical and moral responsibility to address that. And that's why I'm here today to talk about MIIX Advantage.

ASSEMBLYMAN COHEN: I understand that the company did very well over the years.

MS. COSTANTE: Correct.

ASSEMBLYMAN COHEN: I also understand-- And no one disputes that. I also understand that over the last two years, when they decided to do an IPO and go national and grab up states to write in Texas, Pennsylvania, Iowa, Michigan, Mississippi, Alabama to capture the market to make more money without engaging in price wars to capture the world for medical malpractice insurance-- It was an ill-fated and flawed mistake.

The end result was that New Jersey doctors and New Jersey patients are at risk. So, we're willing to work with you, but we can't forget the past. And that's how we move forward. We have to be tempered by what happened. That's all I'm saying to you.

MS. COSTANTE: And I agree with you.

ASSEMBLYMAN COHEN: Thank you.

ASSEMBLYWOMAN WEINBERG: Does somebody have their hand up over here?

Assemblyman Connors.

ASSEMBLYMAN CONNERS: I did.

I just wanted to clarify something. Earlier, when Assemblyman D'Amato was talking about the process -- when the letter arrives from the attorney, you had indicated there's a claims committee and a high exposure committee. I heard something about some doctors being on the committee. But who sits on each committee?

MS. COSTANTE: We have a combination of our own claims people, defense counsel who will be trying the cases, and then physicians that we select from various specialties that sit on those committees. There is a claims committee that looks at cases that we believe are difficult to defend from a medical perspective and require the intervention of a team to build a defense strategy. And then we have high-exposure cases that we expect to pay out more than \$1 million, and so we put the best combined resources together to develop a defense strategy for those cases.

ASSEMBLYMAN CONNERS: And then you indicated the percentage -- I guess it was 60 -- there was a number -- 60 percent are settled before trial.

MS. COSTANTE: I said that I needed to look at that. Assemblyman D'Amato asked me if I thought that was about right. I agreed that it was about right, but I would need to get a precise number.

ASSEMBLYMAN CONNERS: Which means then that only 40 percent of them could be defended successfully. I was just trying to do the math with the \$52 million. That meant only 31 one of them are settled before trial, and the remainder was considered that they couldn't be -- you couldn't successfully defend them.

MS. COSTANTE: One of the things you have to keep in mind is that we do have a consent to settle clause in our policies. So there are situations where we believe that a case is not defensible but it's the physician's preference that we try that case. And in those situations we try the case.

ASSEMBLYMAN CONNERS: Thank you.

And then Chairman Cohen -- I guess the last question I had -- and I think he spoke to it was the-- When we were talking about \$52 million, approximately \$1 million -- but I know it was a combination of different situations--

Is there a specific breakdown? Is there a redundancy in one -- was it obstetrics or surgery-- Is there one group that stands out in those \$52 million?

MS. COSTANTE: Clearly, we see a high number of those cases being impaired infant cases, so they would be OB cases. We see neurosurgery cases, we see orthopedic cases, multiple trauma cases. So they come from a fairly broad spectrum -- radiology cases.

But one of the things that's certainly changing in medical malpractice right now is that a lot of our payouts are related to failure to

diagnose cases. So what you're seeing are more cases coming from your primary care physicians. And when it's a failure to diagnose breast cancer, that's a large dollar amount for a family practice physician or an internal medicine physician that probably never had that exposure much before the last few years.

ASSEMBLYMAN CONNERS: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Green.

ASSEMBLYMAN GREEN: Yes. Listening to the different testimonies of my colleagues, I just want to be a little more specific because I think Assemblyman Cohen asked you a question, but I don't think I really got an answer from it.

In terms of the reason why we have the problem that we have now -- is because you went outside of the State of New Jersey. Now you're coming back, and you're basically saying that, "We're just going to insure New Jersey doctors." If we had a language in law to stipulate that, would you have a problem with that?

What I'm trying to say is, I never heard you say, "Yes, we're definitely not going to do this." And I heard the Assemblyman make it clear that we want to give you another chance. But like anything else in life, to give a person another chance, you want to make sure they understand that that other chance means it can't happen. Would you have a problem if we had that decision drawn up and make it very clear in the language that you cannot go outside the State of New Jersey to insure anybody else?

MS. COSTANTE: I think one of the things that I need to tell you is that for right now our only goal is to be able to insure New Jersey physicians. However, it's very hard for me to tell you today what the medical malpractice market will look like five years from now. And one possibility that we could

encounter is that we cannot be successful without a larger base of insureds. And if we were the only company that was restricted in how we wrote business, it may make it very difficult for us to continue to survive. And you may be facing this situation for a different set of circumstances. But our intention is to only write New Jersey physicians at this time.

ASSEMBLYMAN GREEN: So it's a possibility that you can go back and do what you have done before. Am I correct?

MS. COSTANTE: What we were able to do before was expand geographically with no requirement to discuss that plan with anyone. At this point, it would require the approval of 75 percent of our owners -- physician owners -- New Jersey physician owners.

ASSEMBLYMAN GREEN: Whether it's your company or the other company, if we stipulated in the law that you could not go outside of the State of New Jersey, would you feel that would be a legal problem, or that would be a problem that you could not support?

MS. COSTANTE: That's not my feeling at this time.

ASSEMBLYMAN GREEN: My second question is in terms of -- you owned up to -- because you went outside of the market, like other insurance companies -- it's not really the State of New Jersey, it's not really the laws -- the courts award to the individuals, but it's more being rather (indiscernible). Would you say-- Is that the only problem that we're having, or do you feel the court system in the State of New Jersey basically needs to look at that at the same time?

I'm moving to another area now. I'm trying to figure out exactly whether it's just the insurance companies who got hurt outside of the State of

New Jersey, or we really need to look at the system as a whole here in the State of New Jersey.

MS. COSTANTE: I think that insurance companies got hurt both inside and outside of New Jersey. You have companies that are leaving New Jersey because they do not believe that it is a good place to do business.

So I don't think you can say that New Jersey is a good state and other states are bad states. I do believe that the tort reform from the mid '90s was beneficial in stabilizing this market. I also concur with the Medical Society's testimony that now is the time to look at tort reform again so that we can continue to provide a stable insurance market for our physicians.

ASSEMBLYMAN GREEN: Can you be a little bit more specific when you mention the fact that there are still problems in the State of New Jersey without going into a lot of different areas? I'm just concerned about what problems we really have.

As an individual, I'm not like the Assemblyman who happens to be a doctor, or Mr. Cohen, who happens to be an attorney. I would like to just find out from you what some of the problems you're talking about that exist in the system presently are right now.

MS. COSTANTE: In terms of tort reform? Is that what you're speaking about specifically?

ASSEMBLYMAN GREEN: That's correct.

MS. COSTANTE: Okay. I think that what you would hear is that the major concerns are erosions in tort reform. When we talk about things like statutes of limitations, they were very, very helpful when they were originally enacted. But as more and more case law develops, there are a lot of exceptions made to how long after the fact a case can be tried. That makes it very difficult

to anticipate how many cases you might see at any given point because your window is different. So you need to charge premiums differently to accommodate that. That's one example.

Noneconomic damages is another issue that we all talk about -- what an appropriate cap on noneconomic damages is. When we value a case, I understand what the economic damages are. I can value that case appropriately.

However, I have this other part of the equation that can go anywhere from zero to the multimillions. And to be able to reserve appropriately for that is very difficult. And I think that's where you see the volatility, and that's where you see some of the erratic results of insurance companies is in their ability to reserve appropriately for those components of a case.

ASSEMBLYMAN GREEN: Madam Chair, I would just like to make a comment to the Chair in terms of listening to the testimony today. I don't think this is something that we should really rush into. There's more to it than just giving them a rubber stamp and coming back. I'd like to feel that no matter what bill we're trying to put together, we should safeguard the State of New Jersey from revisiting the same problems, especially when we're not getting a commitment that it's not going to happen, which it can happen.

At the same time, I've dealt with hospitals, as well as some doctors, dealing with the (indiscernible) surgery at Muhlenberg Hospital. And I come to find out that at the end of the day, either the doctors are saying that they're priced out of business or vice versa. Insurance companies are saying they're not making money. But listening today, they are making money. It's just a question now of--

You need to come up with a formula that's fair to everyone, but at the same time, the reality is that doctors are giving up practices because of insurance. And it's obvious that it's more just in the fact of them coming back or any other insurance company coming back and saying, "Okay. We made a mistake." We have to find ways to make sure that this mistake doesn't happen again.

Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Green, thank you. I don't think anybody plans to rush into quick solutions here. And what I neglected to mention is that this is the first in a series of three hearings that we're going to be holding, hopefully, soon.

But before I go to the other questions, I'd like to point out -- and Assemblyman Thompson just brought this to my attention -- that in the background paper that we received from the Department of Banking and Insurance, which I think came out at the end of March of this year-- They did a background paper on medical malpractice insurance problems. And they say, "MIIX has now announced plans to shut down a subsidiary, Lawrenceville Property and Casualty, and stop doing business in 19 of 24 states where it now operates."

"MIIX is also pulling out of the hospital malpractice insurance market. MIIX is rapidly withdrawing from those malpractice insurance markets which are not profitable and is going to concentrate on it's core business in New Jersey, Connecticut, and Delaware."

Now, this is at least a month old. I would just like to hear from you that, in fact, it's not only a month old, it's no longer accurate.

MS. COSTANTE: It is no longer accurate. We have revised the business plan that went to the New Jersey Department of Banking and Insurance, and we will only be writing physician business in New Jersey.

ASSEMBLYWOMAN WEINBERG: Okay. Thank you.

I just have one more quick question. The 10 percent increase that you talked about for those currently insured, they will get an average of a 10 percent increase upon renewal. Then, when they move into the new company, the MIIX Advantage, will there be another 10 percent increase on top of that?

MS. COSTANTE: No.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: I'm tempted to ask if the world's coming to an end tomorrow -- but let me ask it this way. You mentioned that you're seeing claims of \$1 million -- why can't I remember this?

ASSEMBLYMAN IMPREVEDUTO: One million dollars a week.

ASSEMBLYMAN CONAWAY: It's hard for me to get that. That's why I can't remember, I think.

Do you see that there's going to be a change in that trend all of a sudden -- to see less of those claims unless some intervention is taken by policy-makers, this Legislature, this executive in New Jersey?

MS. COSTANTE: We believe that what we're seeing now, despite the severity we're seeing now, will continue unless there's some intervention, some tort reform. So when we did our reserve adjustment, we took into consideration that we will expect to see these kinds of awards, and we need to set money aside to pay them.

ASSEMBLYMAN CONAWAY: As I heard the question in the interrogation over setting aside reserves, it sounded-- I mean, if the trend line

that you don't see changing, if I heard you right -- without any kind of intervention to do tort reform -- that you would expect to see continued multimillion settlements at one week going forward. So therefore you're going to have to raise the reserves into the future.

The world's not ending tomorrow. You're going to see these reserves going forward in the future. You can see what's happening -- that MIIX and MIIX's problems are going to be sort of morphed into the crisis. It's going to be laid on MIIX, and it's going to be a reason not to move forward with any look at the medical malpractice system, the tort reform system.

So, what I would like to ask you to do, because it sounds like it's getting fuzzy to me-- How would you characterize the situation with MIIX and it's cost and what's happened with your company -- weighing -- putting on the scales -- the out-of-state business that you're involved in and the medical malpractice environment here that--

(tape malfunctions)

--would have risen, regardless of what happened with your out-of-state business. Is that a fair statement? Regardless of what happened with your out-of-state business, you're going to see very significant business in the premiums that you would have to charge in the reserves you had to put aside because you're seeing \$1 million a week settlements going forward, and without intervention. You don't see any reason for that trend to change. Is that right?

MS. COSTANTE: Correct.

ASSEMBLYMAN CONAWAY: All right.

One last thing because we're hearing a lot about -- well not a lot about-- There's been some suggestion that you ought to be restricted to the State of New Jersey. I don't know how I feel about that. I'm hearing about

that today. As much as leadership of business leaders here in New Jersey and, indeed, this Legislature -- executive-- It might be, in the future, that New Jersey is not such a great place to be. And if you're invested in MIIX, it might be that you need to go outside in order to offset losses here. I mean, is that a scenario that could happen, perhaps?

MS. COSTANTE: Yes, it could.

ASSEMBLYMAN CONAWAY: So that if we had--

(tape malfunctions)

--you ran into a very difficult business climate here and would not be able to offset losses here in the State of New Jersey by business outside of New Jersey-- That's something that could happen.

MS. COSTANTE: Correct.

ASSEMBLYMAN CONAWAY: All right.

ASSEMBLYMAN IMPREVEDUTO: Loretta, just one last question.

Thank you, Madam Chairwoman, just one last question.

This is being broadcast across over the Internet, so for those out there who are as simpleminded as I am, maybe you can just clarify this for me.

Right now, if we don't do this secondary MIIX group -- I forget -- MIIX alliance or MIIX -- whatever it is--

MS. COSTANTE: Advantage.

ASSEMBLYMAN IMPREVEDUTO: --MIIX Advantage, your rates are going to increase for New Jersey physicians by 50 percent?

MS. COSTANTE: No. If we do not move forward with MIIX Advantage, beginning with August 31, we will no longer write insurance in New Jersey. The current company, MIIX Insurance Company, will only exist to

handle the claims for the policy's it's written for the last 25 years. It will not write any more premium.

ASSEMBLYMAN IMPREVEDUTO: In New Jersey or throughout the country?

MS. COSTANTE: Anywhere.

ASSEMBLYMAN IMPREVEDUTO: Rates, right now, are going up not just for MIIX, I suspect, because you're not going to be in business in August -- but I'm seeing your rates going up 50 percent this year from, I suspect, other malpractice insurers, not you.

MS. COSTANTE: The way insurance companies charge rates is pretty much on a state-by-state basis. So, you can see-- I know someone referred to a *Bucks County Courier* article before that I'm assuming is referring to the Pennsylvania.

ASSEMBLYMAN IMPREVEDUTO: It doesn't say. I suspect it is, though.

MS. COSTANTE: Rates in the Pennsylvania market for the last two years have increased somewhere between 35 and 60 percent.

ASSEMBLYMAN IMPREVEDUTO: Well, it's showing MIIX, in 2002, going up 50 percent.

MS. COSTANTE: Because in the beginning of 2002, MIIX was writing insurance in Pennsylvania. We no longer do.

ASSEMBLYMAN IMPREVEDUTO: Okay. I'm just curious to know you'll be able to, in this new company, write insurance for those who currently have MIIX as their carrier for only a 10 percent increase--

MS. COSTANTE: Correct.

ASSEMBLYMAN IMPREVEDUTO: --maintaining the \$1 million a week payout loss ratio.

MS. COSTANTE: Correct.

ASSEMBLYMAN IMPREVEDUTO: Well, increasing it 50 percent-- I mean, we're looking at increases of 50 percent, 45 percent, 40 percent. How can you only say that it's going to go up 10 percent with all this new -- with these great jury verdicts that are going out?

MS. COSTANTE: What I can tell you is our rate indication for 2002 is 10 percent. What I tell physicians, and they ask me this every time I go out to speak is, "What will my rates be in 2003 and 2004?" I can't answer that question. I need to see what the environment is like as we get closer to 2003.

ASSEMBLYMAN IMPREVEDUTO: So, is it possible that we could be back here in 2004, and you'll be sitting before us, and the MIIX rates for New Jersey physicians are going up 40 percent?

MS. COSTANTE: I have no way of knowing what they'll be. I can only show you that for our 25-year history in New Jersey, our rate increases have never been that erratic. They've usually be 7 percent, 9 percent, 2 percent, because we're building year after year on a stable premium base.

ASSEMBLYMAN IMPREVEDUTO: Do you know what the rate hike was in 2001?

MS. COSTANTE: It was just about 7.9 percent aggregate.

ASSEMBLYMAN IMPREVEDUTO: So you've been increasing it 7.5 and single digits up until now.

MS. COSTANTE: Correct. We may have had other years in our 25-year history where it was higher than 9, but never 35 or 25 or numbers like that.

ASSEMBLYMAN IMPREVEDUTO: Since you seem to think that this entire problem rests on the shoulders of the jury awards, what's your suggestion?

MS. COSTANTE: I think that one of the things we need to look at is a cap on noneconomic damages. I think that that will be the next tort reform that will make a difference in how we--

ASSEMBLYMAN IMPREVEDUTO: Okay. Now, define for me, and for those that are listening, what you mean by noneconomic damages.

MS. COSTANTE: Pain and suffering. For example, loss of consortium, and things like that, as opposed to lost wages, medical expenses.

ASSEMBLYMAN IMPREVEDUTO: Okay. Thank you.

MS. COSTANTE: Thank you.

ASSEMBLYMAN D'AMATO: Madam Chairwoman.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you.

Just a few follow-up questions. Do you have a figure in mind for a cap on these noneconomic damages, which would also include permanent impairment, loss of a limb? Is that correct? Do you have a figure in mind?

MS. COSTANTE: I don't have a recommended figure in mind. We've looked at a range of figures to see what their impact would be on our payouts. And, clearly, depending on how the figure was set, that's how our payout patterns would be different, and it would impact how premiums were calculated.

ASSEMBLYMAN D'AMATO: You come here today, and you've been asked some very difficult questions, appropriately so.

Let's say there are some good things about MIIX. From the day this company was established, it was your intent to have, as your attorneys, the best attorneys in the State of New Jersey. Would you agree with that?

MS. COSTANTE: I would agree with that.

ASSEMBLYMAN D'AMATO: And you also said to your insurers, "We're going to get the best experts. If we have to go to Harvard or Yale or to John Hopkins, we're going to get the best experts." And you have, in fact, done that, haven't you?

MS. COSTANTE: Correct.

ASSEMBLYMAN D'AMATO: Now, let's talk about this consent to settle. Do you have any statistics available to the Co-Chairs, if they would wish it, to show us how many times MIIX receives, from its insured, a consent to settle, but instead you go to trial and go the jury verdict?

MS. COSTANTE: We have those statistics available. I don't have them with me.

ASSEMBLYMAN D'AMATO: Do you have any statistics as to what the plaintiff's demand for settlement was pretrial or during the trial and what the eventual verdict was?

MS. COSTANTE: We have that information.

ASSEMBLYMAN D'AMATO: So if the Co-Chairs wanted that, you could provide that for them?

MS. COSTANTE: Correct.

ASSEMBLYMAN D'AMATO: What is troublesome to certain members of this Committee is that you have the best attorneys, you have the

best experts, you have a review process that no other liability carrier has, and yet, ultimately, you're agreeing to voluntarily pay a large sum of money because you determined and your experts determined that your physician you insured was, in fact, negligent, and that negligence caused serious harm. Is that not a fair fact?

MS. COSTANTE: I'm sorry. I didn't follow your question.

ASSEMBLYMAN D'AMATO: The point being, ultimately, yes, you're paying these sums of money because your best attorneys and your best experts and all those wonderful people in the review process are saying to you, "We have a doctor that deviated from the standard of care, and we should pay money." Would you agree to that proposition?

MS. COSTANTE: We have situations where we look at a case, and we know we can't defend the medicine. Correct.

ASSEMBLYMAN D'AMATO: Thank you.

Thank you, Mr. Chairman and Co-Chair.

ASSEMBLYWOMAN WEINBERG: Let me follow up on what Assemblyman D'Amato just raised because I received a very lengthy letter from a physician in my area -- an OB/GYN, which -- albeit it's long -- I thought really outlined some of the problems. And I had it xeroxed with his permission. It's been distributed to the Committee.

But what he seems to say is that cases are settled often not because of the actual economic damage or even pain and suffering, but because the insurance companies are afraid of what will happen emotionally in a courtroom.

MS. COSTANTE: That relates to noneconomic damages. So there are situations--

ASSEMBLYWOMAN WEINBERG: No, no. What I'm saying is that if you -- if a case was worth X, but you present before a jury with emotional arguments, that jury will make a decision based upon the emotional aspects of the case rather than the actual pain and suffering or the economic damages.

ASSEMBLYMAN D'AMATO: Madam Chairwoman, I can clarify the question.

ASSEMBLYWOMAN WEINBERG: Well, obviously I'm not expressing this, but my colleague, Assemblyman Smith, seems to understand what I'm talking about.

ASSEMBLYMAN SMITH: I think the Chairwoman is referring to jury nullification.

MS. COSTANTE: To jury nullification. I don't know how to comment to that.

ASSEMBLYWOMAN WEINBERG: Well, I don't even know what that means, but that didn't help me at all, Bob.

If a baby is injured -- delivery -- and the baby is scarred, and it's something worth X, in terms of economic damages to repair that, and X in terms of pain and suffering that this child will have to go through in order to get it repaired. But if this baby is presented before a jury, that award might go way up because of the emotional reaction of the jury, rather than the legal aspects of the case. Therefore, the insurance company urges the physician, "Let's settle it here because we don't know what's going to happen when we get into the courtroom." Is that clearer?

MS. COSTANTE: That's clear, and that's also correct -- that especially in cases where the plaintiff is a young child -- it's very difficult for a jury to look at whatever injuries have been sustained by that young child and

not want to give the maximum amount of money available. In those situations, we will look very carefully at whether it makes sense to move to settle that case or to take that case to trial. However, if we believe the case is best settled, but the physician prefers trial, then we go to trial.

ASSEMBLYWOMAN WEINBERG: And can you tell me precisely when we move from this one a month or one every couple of months settlement to once a week -- \$1 million settlements?

MS. COSTANTE: For 2001, we saw, I believe, 28 cases that paid out at \$1 million or more -- just about one every other week. For the first quarter of 2002, we were seeing one a week, and that trend continues. So we're on track to do that for this year unless something dramatic changes in the second half of the--

ASSEMBLYMAN COHEN: Are these jury verdicts?

MS. COSTANTE: Not always.

ASSEMBLYMAN COHEN: What percentage are jury verdicts?

MS. COSTANTE: I looked at that the other day. My sense is about a third of them are jury verdicts, and the rest of them are settlements on high-exposure cases.

ASSEMBLYMAN COHEN: So probably close to 70 percent of them, a jury never makes a determination to have that emotional peak to award something based on emotional bases, correct?

MS. COSTANTE: And for some of those cases, we would try them if we knew there were a cap on noneconomic damages that would protect the physician from an excess verdict. But because we don't have -- and the implications of an excess verdict are so severe, we move to settle those cases within policy limits.

ASSEMBLYMAN COHEN: Who pays beyond what the coverage is?

MS. COSTANTE: The physician would be at risk for what is beyond the coverage. So if you have a--

ASSEMBLYMAN COHEN: Do you have any suggestions in that area?

MS. COSTANTE: That's a very difficult area because clearly there have been concerns that perhaps the insurance companies should be at risk for what goes beyond the policy limits, but then, essentially, there's no value. They're saying, "Do you want \$1 million worth of coverage or \$3 million worth of coverage?" You know that for every case, you have maximum coverage, and premiums would have to reflect that. So that's difficult.

ASSEMBLYMAN IMPREVEDUTO: Neil.

ASSEMBLYMAN COHEN: Have you had any litigation where the plaintiff has demanded the policy, you've not paid the policy, and then the jury award or the settlement is beyond the policy?

MS. COSTANTE: Yes, we have.

ASSEMBLYMAN COHEN: And what do you do in terms of that with regard to the doctors?

MS. COSTANTE: The first thing we do is bond the case to protect the doctor, and then we appeal.

ASSEMBLYMAN COHEN: And after that?

MS. COSTANTE: If there's still an excess verdict, the physician is at risk for the balance.

ASSEMBLYMAN COHEN: Is that because the physician has refused to sign off on a consent to settle?

MS. COSTANTE: That can be the situation, yes. In other situations, the plaintiff is unwilling to move away from the case unless they know the physician is personally going to bear some financial responsibility.

ASSEMBLYMAN COHEN: Do you have any suggestions on the consent to settle issue so that the doctors are not going to face any kind of exposure beyond the policy limits?

MS. COSTANTE: I think consent to settle is a very difficult issue because in many cases, we believe that it would be easier to move forward with the cases if the decision as to whether or not to settle the case rested with the claims experts and the defense counsel. However, when you're talking about medical malpractice coverage, you potentially are interfering with a physician's ability to earn a living going forward. And therefore, we continue to believe very strongly that it's important for the physician to come to the table and have the right for a trial if that's what they believe is appropriate.

ASSEMBLYMAN COHEN: Assemblyman Impreveduto first, and then Assemblyman D'Amato, and then we'll end the questioning.

ASSEMBLYMAN IMPREVEDUTO: I just want to ask you this. A case happens. It's a lawsuit. How does that work? Do your experts get together and look at it and say, "Okay. What's our downside here? We can lose \$2 million or our exposure is \$2 million." Do you then put \$2 million in some loss reserve fund to protect against that case?

MS. COSTANTE: Yes.

ASSEMBLYMAN IMPREVEDUTO: Okay. Now, let's assume that that happens, and you determine that \$2 million is going to be your downside. You put that \$2 million into some loss reserve fund, which doesn't just sit there. You're investing that, and it's making money.

MS. COSTANTE: Correct.

ASSEMBLYMAN IMPREVEDUTO: The case is settled for \$1 million. What happens to the other \$1 million? Does that stay in the lost fund?

MS. COSTANTE: Pretty much. In today's environment, it stays in the lost fund. There was a time, and I would say that probably no one has done this since maybe the middle '90s -- but there was a time where your actuaries could come in and, as part of their year-end certification, say that there was redundancy in your loss reserves, that you were over reserved. And based on that, you could take money out of your reserves and put it back into your surplus account. But because of the current volatility in the market, it is very, very unlikely that any company has done that within the last five years.

ASSEMBLYMAN IMPREVEDUTO: How is the insurance company-- I mean, do you consider that to be a lost amount of money? I mean, that's not part of your profits -- so that when your coming -- I guess you don't come to us and ask for your rate increases, but--

MS. COSTANTE: How are your loss reserves treated?

ASSEMBLYMAN IMPREVEDUTO: Well, you've got that loss reserve account. You paid out \$1 million. You've still got \$1 million in there that's being invested. Plus, that \$2 million was being invested over a series of years. Is that money counted as loss, and you don't count that as part of your profit?

MS. COSTANTE: It's not put into your profitability calculations.

ASSEMBLYMAN IMPREVEDUTO: So you're not paying taxes on any of that money.

MS. COSTANTE: It's held separate.

ASSEMBLYMAN IMPREVEDUTO: So that becomes untaxable dollars.

MS. COSTANTE: Correct.

ASSEMBLYMAN IMPREVEDUTO: Even the amount that you raised -- dollars that you've raised and profits in investment.

MS. COSTANTE: In terms of investment, there's--

ASSEMBLYMAN IMPREVEDUTO: Capital gains investments.

MS. COSTANTE: You're investments are not tax free. And I could get you those calculations.

ASSEMBLYMAN IMPREVEDUTO: I would just be curious because it seems to be rather profitable that you would look at a number and just calculate it high and then put that high number into your loss fund and settle for half of it and just keep growing that money and not pay your fair share of anything.

MS. COSTANTE: Part of why you wouldn't do that is, first of all, you have your rating agencies, but also your Department of Banking and Insurance looking very closely at your reserves to make sure that they are calculated appropriately, not under or over calculated.

Secondly, the money that you get to keep in surplus is what allows you to continue to write more premium. So if you move too much money into your surplus accounts and keep your -- into your reserve accounts and keep your capital and surplus accounts very small, you're very restricted in terms of how much premium you write. And even if you want to raise rates, you have to raise rates by not renewing some of your policy holders to keep you numbers black.

ASSEMBLYMAN COHEN: Assemblyman D'Amato, last question.

ASSEMBLYMAN D'AMATO: Thank you, Chairman.

Let's talk about an excess verdict, where the jury awards damages in excess of your insurance policy limits. It is my understanding, by virtue of my experience with constituent physicians in my district that when they're about to go to trial, they'll come to me and say, "Paul, I want to sign that consent to settle form." We sign the form. We send it to the attorney and to the claims rep. And during the trial, defense counsel says, "You know, it's iffy. We might get hit." That physician comes back to me, and I write that stand we call the bad faith letter. "Dear insurance company. Please settle this case within the policy limits on behalf of my client."

Now, I am told, and I really have no statistics on this, that where there's been an excess verdict above the policy limits, MIIX -- and where there's been a consent to settle and where there's been a bad faith letter -- that MIIX will pay that excess verdict. Is that correct?

MS. COSTANTE: We will, in circumstances such as that. However, I would say we probably haven't done that three times in our career.

ASSEMBLYMAN D'AMATO: Now, are you familiar with an organization called ATRA?

MS. COSTANTE: Yes, I am.

ASSEMBLYMAN D'AMATO: For those listening on the Internet, that's the American Tort Reform Association.

Their president -- and I have it right in front of me here -- has said that that organization that is in favor of tort reform will candidly admit that passing caps by a state legislature will not guarantee that (a) insurance premiums will go down, or (b) that they won't go up.

Now, are you telling the insured physicians in New Jersey that if this this State Legislature passes caps that you'll guarantee that you won't raise your premiums, in fact, you'll reduce them?

MS. COSTANTE: No, I'm not telling you that.

ASSEMBLYMAN D'AMATO: All right. Thank you.

ASSEMBLYMAN IMPREVEDUTO: Did you think they were?

ASSEMBLYMAN D'AMATO: No.

ASSEMBLYMAN COHEN: Oh, because I thought I heard a collective holding of breath by physicians in New Jersey a moment ago.

Any more questions? (no response)

Seeing none, thank you for your testimony.

MS. COSTANTE: Thank you very much.

ASSEMBLYMAN COHEN: We'll probably be back in contact with you.

Thank you. I'm sure you're looking forward to that.

MS. COSTANTE: I am, very much.

ASSEMBLYMAN COHEN: Michael Berger, Dr. Lee Goldsmith, and Abbot Brown may come forward, sit behind the plexiglass.

LEE S. GOLDSMITH, M.D., ESQ.: I assume this microphone is still on.

ASSEMBLYMAN IMPREVEDUTO: The red light's got to be on.

DR. GOLDSMITH: The light's got to be on. I've got a red light. It's on.

Good afternoon, ladies and gentlemen of the combined Committees.

My name is Lee Goldsmith. I'm here today on behalf of ATLA New Jersey, an organization which represents the trial lawyers practicing law in this state, as well as the thousands of citizens of the state who have been and will be injured by acts of medical negligence.

With me to my immediate right is Abbot Brown, a member of the board of governors and an adjunct professor of law at Seton Hall University School of Law, and Michael Berger, a member of the firm of Anderson Berger and a past president of the Association.

The material to be presented has been divided between the three of us because of its complexity and the need to provide accurate information to the Committee. Obviously, we are available to answer any and all questions either during the presentation or thereafter.

As full disclosure is in order, I'm a physician as well as an attorney and a senior partner in the firm of Goldsmith, Richman, Levinson and Harz of Englewood Cliffs, in Edison. I'm also a medical provider.

I'm the Chairman of the Board of American Health Centers Incorporated, a Delaware Corporation that provides medical services in the states of New Jersey, New York, New Hampshire, Vermont, Massachusetts, and Maine.

I think that I'm fully aware of the problems of the patients that I have represented, the physicians in hospitals that I have defended, as well as the providers whose complaints this Committee has heard and which have brought us here today.

We know that medical malpractice litigation has had a beneficial affect in reducing malpractice. As a result of litigation and as a result of bad practice, there have been various events that have been going on constantly

within the health care profession to reduce health care claims. Specifically, the American Society of Anesthesiology has a committee which reviews all anesthetic malpractice claims. And as a result of the work of this committee -- has seen a reduction in the amount of anesthetic malpractice suits over the last 10 years.

Significantly, the state of New York, in reviewing laparoscopic malpractice claims in the early '90s, found that the results and causes of the malpractice were lack of training by the physicians who were doing laparoscopic surgery. They altered the training required of physicians who are going to be doing laparoscopic surgery, and the number and amount of claims significantly dropped relating to that type of surgery.

A simple example: In a hospital that I represent, we found, at the time that we took over the defense of that hospital, they had had a number of claims of individuals who had fractured their legs falling down a flight of steps -- part of the total defense of the hospital. We found out that the ophthalmology clinic was on the top of the stairs. The pharmacy was at the bottom of the stairs. Patients were getting their eyes dilated and being sent with their prescriptions to fill them. We changed the location of the ophthalmology clinic, and we have not had a fracture since that time. That was a very simple example, but one of the types of things that can be done to prevent medical malpractice recurrence.

What we'll hear from Mr. Brown is that the current problem of increased premiums are unrelated to malpractice cases brought within the state. We know that caps on awards do not lower premiums or stop the amount of malpractice and patient injury that is occurring. Therefore, what can be done?

At the initial hearings, we recommended -- and these were hearings that were before Banking and Commerce in the Senate. We recommended the dissolution of MIIX as constituted with a reorganization to allow for a new mutual company to be formed. The mutual company was so successful in this state, created such a surplus of income, that it became the incentive for the formation of a stock company, which was mismanaged and has really failed.

Their bold attempt to regain profitability by increasing the premiums of their insureds in this state is what has brought us here today. It appears that the actions of the insurance commissioner, coupled with the reorganization of MIIX may well have corrected the situation.

However, we have an additional recommendation as it relates to MIIX. We are requesting that this body call for an SCI investigation of the Department of Banking and Insurance to the manner in which MIIX, a successful and profitable insurance company, was allowed to become a public company in 1999, resulting the present problems. Therefore, that is our recommendation, number one.

Number two, medical malpractice carriers cannot operate without accountability. There should be some form of regulatory review when drastic rate increases are to be implemented. Malpractice carriers should not be permitted to retaliate against doctors who have simply switched companies because they got lower rates and wish to come back. Rates should be based on something other than loyalty to an insurance company.

Malpractice carriers should not give doctors complete control over the decision to settle or not settle a case. Policy changes should be implemented immediately to reduce costs for everyone. What we're saying is that when a physician takes on the control of whether or not a case should or

should not be settled and ignores the advice of the attorneys supplied by the insurance company or the insurance company, you can lead to verdicts which are far in excess of what should normally be expected.

I have been in that seat. I have defended in that sort of situation. The physicians reasons for defending may be unrelated to the facts of the case. If it's a bad case, if there's liability, if the physician cannot testify well, you want to see that case settled. You don't want to be exposed to an excessive verdict because somebody will not agree to testify.

So part of our recommendations is that policies written for physicians in the State of New Jersey should not be permitted to include the right of the physician to make a decision over what would be done in that insurance.

Mr. Berger is going to clearly point out the advantages of the Veterans' Administration Program. He will define that program for you. It is our recommendation, as you will hear from Mr. Berger, that the Veterans' Administration Program for the handling of medical negligence claims should be instituted in the State of New Jersey.

We must institute a patient's safety program. This is not a program that's going to be run within an insurance company, but it has to be run, managed, operated, and reviewed by the State of New Jersey. Each and every malpractice suit and adverse incident is to be reviewed to determine the cause for the filing of this suit and an evaluation of events. A determination must be made as to why the adverse event occurred and what can be done to prevent its recurrence. No information gathered by the patient's safety program would be made available to the plaintiff in any malpractice litigation.

However, any and all recommendations as to changes and

procedures of the future care and treatment of patients must be public knowledge. The purpose is to identify recurrent medical errors, providers who make recurrent errors, and circumstances that can lead to errors and take appropriate corrective measures.

As with the Veterans' Administration Program, the result would be less litigation, less patient injury, and lower costs for the State and the practitioner.

Recommendations: full and prompt disclosure of medical errors should be required. Experience has shown that this will result in approved care systems, fewer lawsuits filed, and faster resolution of those suits filed. The State Board of Medical Examiners and the Health Department must function in a manner so that patient complaints as to the quality of care can be reviewed and promptly evaluated. A response must be given to the patient and appropriate recommendations made to the provider. The purpose is to reduce patient dissatisfaction with health care and thereby reduce potential malpractice litigation.

We know, and as I think Ms. Costante said, one of the major reasons that patients go to see attorneys is because they're dissatisfied with the care, the treatment, and the information that they have received from their health-care provider. We want to see patient satisfaction increased, patient dissatisfaction decreased.

We should direct the departments to actively investigate and react to patient complaints. In addition, the board of medical examiners should create a better system for the review of physician actions where malpractice is found. It is in the best interest of patients and good doctors to have an improved system of disciplinary review in place.

We recommend that the New Jersey Division of Consumer Affairs should permit members of the public who have filed a complaint against a physician with the Board of Medical Examiners to learn that status of their complaint.

We frequently see a problem with medical records. Alteration of medical records would tend to subvert an effective patient safety program. Any health care provider, including physician or hospital personnel who alters record to subvert either the litigation process or the work of the panel in reviewing adverse events, shall have their license suspended for a period of no less than six months. The act of altering medical records should be criminalized.

Having continually functioned as an attorney on both sides of the fence, as well as plaintiff, as well as defense council, I know that the management of claims has to be handed like a business. Therefore, as we recommended earlier, the physician should not have the right to decide when a claim should be decided.

We also recognize the problems facing the obstetricians. The era of managed care has resulted in insurance company control of much of the practice of medicine. For those physicians who are in high-risk areas of practice such as the OB/GYNs, the problem has hit them at both ends of their practices. We therefore recommend that this Committee, as well as it may be, look into the reimbursement rate that physicians are receiving for the care that they are rendering.

We know that the State has looked into the amount of time that a woman would be allowed to stay in the hospital after she delivers a baby. Similarly, we have to look at what physicians are receiving for payment of the services that they are being rendered. When, in some instances, and we feel

that it's true with the OBs who are delivering babies, that sum is insufficient and inadequate. There must be some way of altering that system of compensation so as to allow the physicians to receive an appropriate return for the time, effort, and energy and care that they have rendered.

ASSEMBLYWOMAN WEINBERG: Excuse me a minute.

DR. GOLDSMITH: Yes.

ASSEMBLYWOMAN WEINBERG: Do we have a copy of your written testimony?

DR. GOLDSMITH: What I did, Assemblywoman, is to reduce it and redact it as I heard earlier information being given. What I will do is reprepare it and submit it to the Committee. It is part of the recommendations that is being submitted by ATLA-New Jersey.

ASSEMBLYWOMAN WEINBERG: Thank you.

DR. GOLDSMITH: If I may now turn over the program -- our presentation to Mr. Abbott Brown.

ABBOTT S. BROWN, ESQ.: Thank you very much.

ASSEMBLYMAN COHEN: Are you going to read from a statement, redacted or unredacted?

MR. BROWN: I'm not. I realize it's very late. I'd like to give a couple of facts because I feel there's been a lack of factual information in the discussion, and I have some concrete proposals. I will be very brief.

ASSEMBLYMAN COHEN: Thank you.

MR. BROWN: The first fact I'd like to give to the Committee is the fact that there is no large volume of medical malpractice cases in New Jersey. The number of malpractice cases has declined from an even 2200 in

1994 to 1613 cases in 2001 out of 105 lawsuits filed. So in 2001, there were only 1600 malpractice cases in the entire state.

Princeton is not here, but if you look at Princeton's annual report on their Web site, you'll see that they tried -- these numbers are confirmed by Princeton -- 366 malpractice cases to a conclusion in 1998, 347 cases in 1999, and only 274 cases in the year 2000. There's a strong trend of a decrease in the number of malpractice cases.

I also want to establish the fact that there really is a myth of these jackpot jury awards. I see this in the paper all the time. By the way, those initial statistics were from the AOC, the Administrative Office of the Courts. MIIX published a study in the *Annals of Internal Medicine*, a very prestigious publication, where they determined that the amount of payment correlated closely with the severity of injury and that unjustified payments were uncommon. That data is supported by the National Practitioners' Data Bank, run by the United States government, which shows that over the last 10 years, the median payment in New Jersey for malpractice is \$115,000. In 2000, the last year we have available, it was \$175,000 -- is the median payment.

So, there's a myth that there's an explosion of what the doctors or what some of the advocates call jackpot jury awards, but factually, that's not correct.

ASSEMBLYMAN IMPREVEDUTO: Can I just stop and ask a question?

MR. BROWN: Yes, please.

ASSEMBLYMAN IMPREVEDUTO: We just heard, 20 minutes ago, that it's \$1 million a week.

MR. BROWN: Total settlements.

ASSEMBLYMAN IMPREVEDUTO: In New Jersey.

MR. BROWN: Right.

ASSEMBLYMAN IMPREVEDUTO: So you're saying that that is not the fact.

MR. BROWN: No, what I'm saying is the median payment in New Jersey for last year was \$175,000. That was the median payment on a per case basis. The point is, we see in the paper sometimes -- I read this weekend -- average payments of \$3.5 million. That's simply not correct. The median payment in New Jersey for 2000 was \$175,000. For the last 10 years, it was \$115,000. That comes from the National Practitioners' Data Bank.

Every malpractice case that is settled must be reported to the Federal government. They keep detailed statistics. They will be in the information that ATLA provides to this Committee.

ASSEMBLYMAN IMPREVEDUTO: I'm confused though.

MR. BROWN: Okay. I'll try to clear it up.

ASSEMBLYMAN IMPREVEDUTO: The CEO of MIIX is talking about being at an average of \$1 million a week. No matter how you figure that out, it's \$52 million.

MR. BROWN: That's true.

ASSEMBLYMAN IMPREVEDUTO: Now, if you had an average payout of \$175,000 on -- how many cases?

MR. BROWN: We don't know. But if they're paying \$1 million a week, that would be approximately six or seven cases a week that they're settling or having judgements.

ASSEMBLYMAN IMPREVEDUTO: Now, if that were, in fact, so, what we're looking at is-- How many cases were tried last year?

MR. BROWN: Last year, there were-- Last year, Princeton tried 274. That's one insurance company that tried 274 cases to a conclusion. Last year, there were only 1600 cases filed in the entire state for all insurance companies.

ASSEMBLYMAN IMPREVEDUTO: Let's assume that MIIX had all 1600 of them. At \$175,000 average, it still does come out to \$52 million. So, somebody's doing something with numbers that I can't figure out.

MR. BROWN: Well, my only point is that when I look at some of the things that are published in the papers, we see statements that the average award is \$3.5 million. The fact of the matter is-- My concern is that there hasn't been any hard statistical data. This data comes from the Federal government. There's a lot of data out there that I think is simply erroneous.

ASSEMBLYMAN IMPREVEDUTO: I tend to agree with you.

MR. BROWN: Now, because I--

ASSEMBLYMAN COHEN: Maybe I misunderstood. I thought that MIIX represents that the awards were \$1 million a week.

ASSEMBLYMAN CONAWAY: That's right, award and/or settlements.

ASSEMBLYMAN COHEN: Was she saying cumulatively?

ASSEMBLYWOMAN WEINBERG: Yes.

ASSEMBLYMAN IMPREVEDUTO: No, she was saying it was an average of \$1 million a week. My question was--

ASSEMBLYMAN CONAWAY: No, she did not say that.

ASSEMBLYMAN THOMPSON: She was saying at least one case a week gets an award of \$1 million or more.

ASSEMBLYMAN COHEN: That's right.

ASSEMBLYMAN IMPREVEDUTO: Right, and it's \$52 million.

ASSEMBLYMAN THOMPSON: She was not saying the average award every week was \$1 million. There was at least one case that had an award of \$1 million or more every week.

ASSEMBLYMAN IMPREVEDUTO: Okay. So is that \$52 million?

ASSEMBLYMAN THOMPSON: In past years, they only -- every two weeks that that was those cases.

ASSEMBLYMAN IMPREVEDUTO: But is that \$52 million?

ASSEMBLYMAN THOMPSON: But she wasn't saying all cases. That's just one case a week.

ASSEMBLYMAN IMPREVEDUTO: Is it \$52 million?

ASSEMBLYMAN THOMPSON: It might have been 20 cases a week.

MR. BROWN: It was my understanding from the testimony--

ASSEMBLYMAN THOMPSON: And also, you're mixing it up. You keep jumping from average to median.

ASSEMBLYMAN CONAWAY: Thank you, Sam.

ASSEMBLYMAN THOMPSON: A median and average are not the same.

ASSEMBLYMAN CONAWAY: They're certainly not.

ASSEMBLYMAN THOMPSON: An average is a mean. A median is the halfway point in between.

ASSEMBLYMAN IMPREVEDUTO: So we're still looking at \$52 million.

MR. BROWN: We will make the data available for both.

One other point I want to make, factually, is Princeton is not here. If we go to the Princeton Web site, Princeton has done -- as well as MIIX has in New Jersey-- In fact, Princeton, in the last year available -- 2000 -- reported a profit of \$30 million. Princeton is not a public company like MIIX, so it's harder to get their numbers. But Princeton, in fact, in their annual report, says that they've had three stellar years in a row. This is the most recent annual report that's available on-line.

So, the malpractice business in New Jersey-- MIIX, we've already covered. I have the numbers, but I'm not going to get into it because I think we've discussed that quite extensively. But Princeton and MIIX have both made a lot of money in New Jersey and have always made a lot of money in New Jersey. Any problem in New Jersey with MIIX results, as we've established -- from out of the state.

I think the real issue is the amount of malpractice in New Jersey. It's been eluded to before. There are studies in other states. In West Virginia, 40 doctors accounted for 25 percent of all the malpractice in the entire state. In Cook County-- We will be submitting this in written information so we have the cites for all these studies. In Cook County, 2 percent of the physicians committed 36 percent of the malpractice. And in Florida, 4 percent of the physicians were responsible for 45 percent of all paid claims.

The real issue, I think, in New Jersey is that a small number of doctors are probably disproportionately responsible for the amount of malpractice, but virtually nothing is done about it.

Things can be done. We've heard a statement from Dr. Goldsmith, and we'll hear, perhaps, from Dennis Donnelly-- The anesthesiologists have cut the amount of anesthetic deaths by 95 percent by instituting policies and

procedures to reduce medical malpractice. This should be the focus of the Committee. If these kinds of policies and procedures were instituted in and enforced, we could dramatically reduce the amount of malpractice, and that would dramatically reduce the cost of malpractice insurance.

So my first proposal would be that that's where we should be looking. We need to dramatically reduce the amount of malpractice. And nothing in New Jersey, as far as I'm aware -- and I study and write about this frequently -- is being done.

The second point Mr. Berger is going to discuss -- but we need to avoid the secrecy that involves malpractice. We need full disclosure. And I'll defer to Mr. Berger on that. If we really want to reduce the cost of malpractice insurance and the number of doctors that are being sued, one thing that we should do, which has been done in some other states, is to stay the statute of limitations -- to toll it when there's a possibility of a claim.

The way this mechanism would work would be an attorney would send a letter to all of the involved doctors and indicate they're investigating a potential malpractice case. In Florida, this stops the statute of limitations for a year. The doctors must then produce their records, which they have to do anyway under New Jersey law, and give statements if necessary. The discovery is done before a lawsuit is filed, and that allows the attorneys in Florida to focus in on (a) was there, in fact, malpractice, and (b) who are the right individuals who should be sued. A system like that would greatly reduce the amount of malpractice cases and the number of malpractice defendants.

The problem with the statute of limitations is, if somebody comes to me and asks me to file -- to investigate a malpractice claim, and they come within, say, six months of the statute -- because many people in the first year

are focusing on recovery-- I then have got to say, "I'm not going to file suit." Sometimes I may have to file suit before I have all the information. And now, a doctor's brought into a suit-- Maybe it's a good suit. Maybe it's not a good suit. What I do, personally, is I won't take a case if there's less than six months to investigate.

But the simple solution that has been done in other states and has worked very well and really is not an extension of New Jersey law because under New Jersey law, doctors are obligated to provide the records and provide all the patient information that a patient needs.

We could dramatically reduce the number of suits and the number of defendants sued if we would stay the statute of limitations and allow attorneys to do basic pretrial discovery before the filing of the suit. By that I mean simply -- let us get the records, and let us speak to the doctors and do an interview.

My last comment I'm going to make is that I've read a lot about California-style tort reform. There was a study published by the Center for Justice and Democracy -- this will also be in the papers we submit -- May 29, 2002, which was a few days ago -- which demonstrates that malpractice rates in California have increased at a faster pace than in the rest of the country. So this should put a lie to any thought that caps were some of the malpractice proposals -- were really, in fact, reduced medical malpractice rates.

I know it's late. I promised I would be brief. I'm available to do answer any questions, obviously, but I would conclude with that thought.

ASSEMBLYWOMAN WEINBERG: Just before we go to the third speaker, thank you, both.

My understanding of what Ms. Costante from MIIX said was, \$1 million a week -- a combination of settlements, as well as jury awards.

I would like to get clarification so that we're all working on the same set of circumstances. Do you disagree with that number? That's the first quarter of 2002.

MR. BROWN: My understanding was that the \$1 million represented the sum of all settlements and judgements on a weekly average. It was not per case, but it was the total of all cases. So perhaps we can clear that up. But that was my understanding of the testimony.

ASSEMBLYMAN COHEN: I don't know. I mean, I heard the way Sam Thompson heard it. All this is going to be reduced in transcript form. Callback of witnesses may occur.

ASSEMBLYWOMAN WEINBERG: She definitely said a sum of case per settlement.

ASSEMBLYMAN COHEN: Go ahead.

MICHAEL S. BERGER, ESQ.: I'll be brief, as well. I just wanted to point out some important studies which have been done across the country.

Starting in 1992, Harvard School of Public Health spent \$3 million studying the malpractice crisis and concluded that 100,000 people die, per year, nationally--

ASSEMBLYWOMAN WEINBERG: We're still arguing among ourselves. I'm sorry.

MR. BERGER: I'm sorry.

ASSEMBLYMAN COHEN: Go ahead.

MR. BERGER: I was just saying in 1992, Harvard School of Public Health did a study which concluded that 100,000 people die each year as a

result of medical malpractice, nationally. That \$3 million was spent carefully studying what went on in New York hospitals.

Last year, in 2001, the Institute of Medicine from the National Academy of Sciences spent several million dollars. They concluded it was approximately 50,000 people -- I'm sorry -- who die each year as a result of medical malpractice.

Now, last week-- So, we have 1992, 2001-- Last week, the Harvard School of Public Health published another independent study of 800 hospitals in 11 states. They concluded that hospitals would skimp on nursing care, cause more in-hospital deaths from cardiac arrest, internal bleeding, shock, pneumonia, infections, and blood clots. I'm not aware of any study which has been conducted in this state, but all studies agree that many thousands more of people are injured, as well.

From our point of view, you don't have to really look at the Harvard studies or look at the Institute of Medicine because we know patients in each of your home counties who have been injured as a result of medical malpractice.

You should know, also, presently, New Jersey ranks 28th in the nation in taking disciplinary actions against doctors. And as we saw from a recent 2001 series of articles in the *Asbury Park Press*, these investigations of dangerous doctors or dangerous procedures can take years because of inexcusable policies which encourage secrecy rather than public disclosure.

One other fact, which is important, I believe, is that medical mistakes cost taxpayers millions of dollars. That's because when someone is injured -- for example, if someone is paralyzed from the waist down or from the neck down or if a baby is brain injured as a result of medical malpractice,

millions of dollars are needed in order to medically take care of these injured patients. Many of these millions are paid by taxpayers. Medicaid is saddled with hospital bills where there's no insurance or whether -- when the insurance runs out, I should say.

I called the Department of Human Services a couple of months ago and found out that over the last 10 years, taxpayers have shelled out \$75 million for medical bills for citizens injured by medical mistakes. Hundreds of millions have been paid out by private health insurance carriers.

There is an answer, we believe. And that's the answer that the Veterans' Administration came up with and has been documented. Very concerned about the injuries that the Veterans' hospital doctors and health-care providers were causing to veterans-- They were not satisfied with simply saying, "There's a malpractice crisis. What are we going to do?" They said, "How are we going to solve it?"

What they decided to do was study exactly what the roots of malpractice were. They made a determination as to how patients were being injured. As a result of that requirement, they decided that what they really needed was honesty and reporting -- getting the root of the problems, requiring, unlike private hospitals in our state, requiring a doctor's -- explain factually exactly what happened to the patients. This is what they found as a result of the policy of honesty and disclosure.

They found that the number of malpractice cases were greatly reduced. This is a published study from the Veterans' Administration. They found that the costs of malpractice litigation have been reduced. They found that malpractice itself, as a result of finding the root causes of malpractice, was reduced.

This is a solution which, I think, although not a short-term solution, is a long-term solution which, I think, this honorable Committee should take a look at because we want to solve these problems, as you've said earlier, on a long-term basis.

So, we would propose, as a method of dealing with malpractice in New Jersey and the cost of malpractice litigation, looking at the Veterans' Administration study, looking at the regulations that they've promulgated, looking at the success of this program. And if you feel that it is as successful as the Veterans' Administration feels, I think it would be a very admirable program to adopt, disclosure rather than secrecy.

And when you consider that the lives of our families are at stake every day and that malpractice has been a fact of life that, for some reason, we've come to accept. Rather than talking about patient safety and curing the malpractice problem, we're talking about rates and caps and further restricting patients who are already restricted by the injuries that they've suffered.

I'd like to thank this honorable Committee for the opportunity to come here today.

ASSEMBLYMAN COHEN: Assemblyman Green.

ASSEMBLYMAN GREEN: I just want -- clarification -- just revisit what the second speaker said earlier in terms of-- I know we're going to research to find out whether it's \$52 million a year or whatever might be the case. It's obvious an insurance carrier in your position is totally different.

What I'm more concerned about is the fact that -- when you mentioned a lot of problems exist with the doctors-- Do you have documentation to back that up in terms of a handful of doctors are the reason why these sums of money are being paid out?

MR. BROWN: No research in New Jersey. I'm not aware of any research that's ever been done in New Jersey. The studies I sighted are all from out of the state. We do know, however-- There's extensive literature which demonstrates that the amount of malpractice in the country is extremely large, between 50,000 and 100,000 people a year. That's 1000 to 2000 people a week. And there's no reason to believe that New Jersey is any different than Chicago, West Virginia, or Florida. What I'm suggesting is, that is the root cause of this problem, and New Jersey should do a similar study.

I've seen cases where I've handled -- where they've had wrong-site surgery. The doctors operated on the wrong limb. I'm not aware that either the hospital or the State of New Jersey has ever done anything in terms of a corrective measure to make sure that doesn't happen again.

I have a case -- I don't want to get into war stories -- where you're supposed to mark the limb. The doctor did not. He operated on the wrong limb. And even after this, he continued to refuse to follow that simple protocol of marking the leg that you're going to operate on to make sure it doesn't happen again.

So, what I'm suggesting is that we should study this. And there are ways that can be, I'm sure, created to dramatically reduce the amount of malpractice. The anesthesiologists, as I indicated, have reduced malpractice by 95 percent -- the amount of death due to anesthesia by 95 percent. That's out citizens. That's our neighbors whose lives could be saved.

ASSEMBLYMAN GREEN: At the beginning of your presentation, you mentioned the numbers are -- some other states where a handful of doctors, basically, happen to be a problem.

DR. GOLDSMITH: There's two things--

ASSEMBLYMAN GREEN: I would just like to concentrate on the State of New Jersey. I'm pretty sure you should be familiar with some of the things that (indiscernible) of the doctors here in the State of New Jersey. Would you say that same scenario exists here in the State of New Jersey in terms of a handful of doctors are really the problem because of the--

MR. BROWN: I'm personally aware of doctors who've been sued 10 times. I think it's logical to conclude that that same scenario does exist in New Jersey, but I'm not aware that the Board of Medical Examiners have ever studied that.

It would be interesting to ask MIIX in Princeton if they have statistics that indicate that certain doctors have been sued time and time and time again. I know that when I sue a doctor, I go on a Web site, which tells me all the lawsuits that have been filed against that doctor. And it's not surprising to see the physicians have had -- the defendants in my cases -- multiple lawsuits against them.

So it's logical to assume that's true. I think the State should look into that. I think the studies should be done, and information should be requested. And then, perhaps, we can start thinking about how do we fix the problem.

DR. GOLDSMITH: There are two things we can look at, Assemblyman, if I may. One, the type of malpractice is recurrent. In other words, different physicians make the same error over and over again because the methods to prevent the error are not put into place. And two, again, it's not from the State of New Jersey -- the same physicians are involved in malpractice litigation over and over again.

ASSEMBLYMAN GREEN: Thank you.

ASSEMBLYMAN COHEN: Any questions?

Dr. Conaway.

ASSEMBLYMAN CONAWAY: Let me say that I agree with you. You're surprised to hear that, aren't you?

ASSEMBLYMAN COHEN: Can I have that replayed back?

ASSEMBLYMAN CONAWAY: In some respects.

ASSEMBLYMAN IMPREVEDUTO: That was qualified quickly.
(laughter)

ASSEMBLYMAN CONAWAY: And that is that we need to look at the area of medical error reduction. I think that some of the initial studies that have come out that scared people half to death in the country, I think, were unfortunate. There have been some unfortunate-- There have been some rejoined or other studies that have been done to suggest that those numbers were very much inflated.

At any rate, we certainly know that there is a problem and that efforts do need to be made on this area of medical error reduction because I do believe that as we bring those numbers down, we will see an improvement in the climate.

I'll ask you, when I get done some other questions, to comment on the kind of agency -- who should be on an a medical error review kind of a board? Who should constitute it? Where should it be housed? Has any other state done it? Well, you maybe might as well answer it now. What the cost to this kind of review agency would be. Is there a possibility of self-funding? Should the State of New Jersey pay for this because I think it's a very interesting idea?

MR. BROWN: I think that it would be best suit, perhaps, for an academic institution. I am an adjunct faculty member of Seton Hall. They have a health law policy program. I think it's an academic project. I think that all of the parties who are involved: patient representatives, academics, physicians-- It would be something that everybody would want to work. I think we have common ground here. Everybody would be interested in reducing the amount of malpractice. The exact mechanism -- I don't know. But I'm sure we could, certainly, all work together on that.

DR. GOLDSMITH: I'm going to give a slightly different answer to that. I think the initial very good project was done under the New York State Health Department with Commissioner Axelrod, who was then Commissioner of Health in the state of New York. I'm going back to, I believe, the early '80s when he started doing it. As a result of the reporting system that he set up -- is where that laparoscopic surgery study came out because they found so many cases coming in regarding laparoscopic surgery in the early '90s, and they wanted to know why they were getting so many cases and to find them as a problem.

They also instituted, which we now have here in the State of New Jersey, the monitoring of the success versus failure rate -- morbidity versus mortality in cardiac surgery units throughout the state of New York. And the reporting of that became part of the Web site. So that information became public knowledge.

So I think as a model, I would probably want to look first at what New York state is doing and what the Health Department has done since Axelrod instituted that work. It's combined between the New York state Health Department and what they call the OPMC, the Office of Professional Medical

Conduct, which basically takes over the work of the State Board of Medical Examiners. But it does go through the Health Department.

I think with that with the physician availability to do competent reviews. I think that would be one source. It may be academic, as well, but I'd also want to see very welltrained, knowledgeable physicians involved.

MR. BERGER: There is a reporting requirement for anesthesia deaths and serious injury now within the Department of Health. The problem is nothing is being done with the information. There's an absolute requirement that within 24 hours of an anesthesia of serious proportions, whether it's death or brain injury, the Department of Anesthesia is required to contact the Department of Health and report that injury. What's missing in this investigation and disclosure requirement is doing something with the information. So we have a reporting mechanism, which is mandatory, in place now in the state with respect only to anesthesia.

ASSEMBLYMAN CONAWAY: Now, you mentioned the need for a protection of this information of this work product because one of the things -- suggested reforms-- I agree. There needs-- NASA, when it goes -- there's a problem with an O ring-- They've checked this thing back. Everybody knows about it. They get their O rings fixed, and we get people into outer space without blowing them up near the ground.

Would you agree-- Is it a true statement to say that one of the reasons we don't have this kind of thorough review of medical error reporting is the fear on the part of hospitals and physicians that if they engage in this kind of a process, they will expose themselves to liability? And if I heard you -- and maybe I heard the wrong this and misunderstood it-- But I thought you

suggested that this kind of thorough review ought to take place in an atmosphere that prevents liability.

DR. GOLDSMITH: What I said-- And I think it is true at the present time. The information that is developed through morbidity and mortality committee -- which should be developed in morbidity-mortality committees in the hospital is never available to the plaintiff's attorney at this point in time for litigation.

The fact that they use this as an excuse is totally fallacious. What should be done is not being done. What we have is risk management in hospitals, which occurs to look at the risk after it has occurred rather than risk prevention, prevention of future risk based on the knowledge that is obtained from the risk that has occurred.

What is occurring now is that we, as plaintiffs' attorneys, cannot get the information from these morbidity and mortality committees. We do not have it available in the litigation that we process. And there's no reason why the hospitals shouldn't be doing the job to prevent future injury. They are not.

ASSEMBLYMAN CONAWAY: My question is -- because having sat in them-- I guess I'm glad to know now that what's said in there stays in there. But do hospitals have the same kind of protection? Do they have the same--

DR. GOLDSMITH: They don't need it. The courts give it to them.

ASSEMBLYMAN CONAWAY: The courts give it to them.

DR. GOLDSMITH: The courts give it to them. We cannot get that information.

ASSEMBLYMAN CONAWAY: Now, you mentioned that you could get on the Internet, I guess, and look up the cases because this relates to other legislation that's been suggested -- the physician profile. And you mentioned that you can get on and find the cases of physicians that are there.

Do you believe that a physician profiling legislation which -- and I will tell you I'm very concerned about the kind of data that would go in there -- whether or not the data that would go there, in fact, speaks to any actual negligence on the part of the physician.

But one of the criticisms of that is that it is just a waste for plaintiffs' attorneys to find out about physicians. But you really get all this-- You get-- Will the physician profile provide information to you that you could not otherwise obtain?

DR. GOLDSMITH: I don't think we're talking about me, the attorney. I think we're talking about the people in the State of New Jersey who don't know how to get that information and who feel they should have that information. I think that if I, as an attorney, went into the AOC records, and I look up a physician, and I see that that physician has been sued 10 times, and I have that information at my disposal and someone calls me and says, "Lee, who would you recommend to do my back surgery?" And I go in, having had back surgery, and I look up that this individual has been sued 10 times, I say, "Wait a second. I think I can find somebody else, other than this individual, who's been involved in this much litigation." I don't know why his name is on the docket 10 times. It may be that he's been in fights with his partners 10 times. But that disturbs me.

I think we have a duty to the public out there who want to know about the quality of physicians. We can go in and find out that a physician is

board certified or not. We can go in and find out whether that physician has been trained or not. Should we not know that this individual has been having problems?

ASSEMBLYMAN CONAWAY: Well, problem individuals certainly ought to be identified. The question that I didn't ask -- it's for another time -- is whether or not the information that goes there-- I mean, my understanding is that there are studies which show that the actual negligence of the physician is not involved in a great majority of these cases. So if you put a case in there tagging a physician as a bad actor when, in fact, the case in question he was not, in fact, negligent, then that physician is -- his reputation is damaged, and it shouldn't be.

Let's move on because that's not really the subject.

Now, one of the things that was mentioned here, and it keeps coming up -- I guess it's unfortunate it does -- is the question of capping noneconomic damages. I agree, incidentally, again, with you that we ought to be very careful treading into that area, that we should not have situations at the end of the day where people who have been injured are not properly compensated.

But what I would like you to do, while you're here, is to discuss some of the other things that might be involved in a reform. And I'm just going to mention some things, and I invite your comments.

One, is the fair share rule. This is something which comes to me because a very good -- one of my best friends practices down the shore. He had a case where he was roped into this thing, saw the patient -- breathed on the patient, and basically, he carried more insurance than the other people who were in the case. There were three other sets of doctors on the case. This poor

guy ended up in a settlement where he's paying a third when, certainly, his liability -- his involvement with the patient would not have suggested that he ought to be liable for a third of the damage. It was a fair shared -- one.

Two, how do you feel about this issue of court supervision of damages. There are some reforms that suggested that we ought to be looking at how -- at damages and things when they're paid out -- how that ought to be parceled out.

Two, how should-- Three, rather. The issue of collateral source benefits-- Are there reforms and things that we ought to be doing in that area? As I understand it, collateral source benefits, I guess, would be a disability policy, I guess, my count as that -- they're going to be paid out to a person who's injured -- and how might that -- how ought that to be involved in medical malpractice litigation and how ought we to accommodate that?

And fourth, and this is again a question a of punitive damages and compensatory damages. I'm just trying to think about how these awards get whooped up into these high numbers. It's been suggested that if there are no compensatory damages paid, there should not be punitive damages paid.

Now, maybe that's already the law in the State of New Jersey, but you could just sort of touch on those things so we can get off this caps issue because I agree that caps may be very problematic or for folks that have very serious injuries that the cap may leave them really not properly compensated for their injury. But there are other ways of reform, and I'd like you to mention some of those, if you can.

DR. GOLDSMITH: Well, you've thrown out a lot of things all at once, Assemblyman, and I will try to respond to them.

I certainly agree with you that caps are not a way to go. Just as a simple example, caps on noneconomic injuries would make the elderly who are injured suffer the most because they don't have economic injuries, they just have suffering. So you take a large segment of our population, which is growing all the time -- who are retirees, who sometimes receive the most onerous medical care. And they would not receive any award because they would not have any economic damages, or it would be very limited, notwithstanding how badly damaged they are.

The fair share award you mentioned to me when we had a meeting in your office. And you mentioned that as a problem that this colleague of--

ASSEMBLYMAN COHEN: Talk about disclosure. You didn't tell us that. (laughter)

DR. GOLDSMITH: I still have a decent memory.

ASSEMBLYMAN COHEN: Move to strike.

DR. GOLDSMITH: But in any event. We, as the plaintiffs' attorney, make no determination as to how the money comes out of the insurance company or companies. We make a demand to settle a claim, and we attempt to settle the claim for a reasonable sum for our client to get them to be whole as a result of that injury.

The insurance company, in its own machinations, may have Doctor A, B, and C. And they say, "This claim, as caused by the three of them, is worth \$1 million." But I'm getting more heat from Doctor A, who won't consent to settle. And B consents and C consents, so I'm going to get the money out of the two of them, even though A may be the most responsible because we want to resolve this claim.

So, we, as plaintiffs' attorney, have no control out of which pocket or how the money comes from. We just sit back and say thank you. We have settled this claim on behalf of our client. We're getting the money for our client. We're taking care of them. Your physician colleague is walking away saying, "Hey, look. That's unfair. I may have been 10 percent responsible. They charged me for a third." But the mechanism there may be that the other doctor didn't want to settle at all, and they wanted to settle this claim, and he walks away a hero when he should not have been.

ASSEMBLYMAN CONAWAY: If we were to acquire a fair share rule statutorily, that's not going to effect, then, you folks at all.

MR. BROWN: We actually have such a rule. The comparative negligent statute in New Jersey says that if a defendant's less than 20 percent at fault, their damages are limited. And if they're less than 60 percent, they're limited in other ways. So we actually have a fair share rule enacted in law in New Jersey which is really the comparative negligence statute in New Jersey.

DR. GOLDSMITH: That's if the case goes to a trial.

ASSEMBLYMAN COHEN: And a jury reward is made.

DR. GOLDSMITH: That's right. And the insurance company was trying to avoid that in this particular case.

MR. BROWN: We also have collateral source rule in New Jersey. So, if the medical bills are being paid by an insurance company, they're not part of the damages.

ASSEMBLYMAN CONAWAY: They're not part of the damages.

MR. BROWN: So those two areas have actually already been addressed.

And the last area, punitive damages, has been addressed because recently there was an enactment of a statute which controlled punitive damages -- capped punitive damages to five times compensatory damages. And in reality, in my experience at least, the number of-- I've never had a medical malpractice case in 23 years where punitive damages have been awarded. So I don't think the punitive damages in the malpractice field are a very substantial factor.

DR. GOLDSMITH: And I'll say this, in 32 years of practice -- I hate to say 32 years -- but in the 32 years of practice, I've had one instance where an amount above was awarded because they were afraid of punitive damages.

ASSEMBLYMAN COHEN: Any other members.

Assemblyman Smith.

ASSEMBLYMAN SMITH: Irrespective of the specialities, is there any common denominator between those physicians that -- that small percentage of physicians that make mistakes?

MR. BROWN: I'm not aware of any of the studies which indicate that there is such a common denominator. I can't think of one offhand. I think it's almost like drivers or any other profession or any other segment of society. There's always a small few, perhaps, who are not up to par. But I'm not aware of any way to say we can focus on this group in particular.

ASSEMBLYMAN SMITH: It wouldn't have to do with training, medical school, substance abuse, alcoholism?

DR. GOLDSMITH: Well, if you start throwing into the mix that somebody has substance abuse problems, that-- When that gets reported to the State at this point in time, there's pretty severe and rapid reaction on that

physician so that that license may very well be suspended immediately. And that's pretty good.

Dr. Canavan, if I remember correctly, is the physician who's in charge of the State program through the Medical Society for handling the substance abuse physicians. My understanding is he's done an excellent job over the years.

If there would be one thing that I have seen over the years in defending, as I have done, is that the individual physicians have a breakdown in interpersonal relationships because if there's one thing that drives a patient to see a lawyer it's the reaction of the physician to a problem that arises. So when a problem arises and the physician is there and sits with the family and talks with the family, families very often don't even want to sue because that physician's been responsive. But when that same problem arises, and the physician doesn't show up or is hostile or, in some way, creates-- The breakdown of interpersonal relationships-- I think Ms. Costante referred to that very clearly. That's one of the things that they have been trying to do in MIIX, work with the physicians in this regard. That may have nothing to do with the bad acts of the physician, but it does have to do with his tendency to be involved in malpractice litigation.

MR. BERGER: With respect to common denominators, the trends that we've been seeing really are inadequate training before new surgical techniques are attempted. For example, when laparoscopic surgery became -- or was introduced, there was a very high learning curve, and a lot of mistakes were made, and a lot of injuries were caused. And as a consequence, further training was required. When further training was implemented, you saw a drop in mistakes in laparoscopic surgeries.

Another aspect of common denominators, I think, is communications between doctors and hospitals. Because a number of doctors may see a patient at the hospital, a lot of information is not communicated concerning X-ray results, lab results, clinical findings of the patient. And when those communications fail, then the patient is at risk for injury. Those are two of the common forms of malpractice we see.

ASSEMBLYMAN COHEN: Assemblyman Impreveduto, reluctantly. (laughter)

ASSEMBLYMAN IMPREVEDUTO: Just a last question.

We have heard that there really was no problem up until this year. Malpractice insurance premiums were relatively stable. What do you perceive to be the problem now, all of a sudden?

MR. BROWN: Actually, it's interesting because I've been surveying all of the doctors I know. And in the surveys I've done for the vast majority of doctors, malpractice premiums are still stable and low. In fact, in this weeks -- this month's New Jersey medicine, on one page, there's an editorial about malpractice reform, and on the next page, there's an advertisement for malpractice premiums, which has, for example, for anesthesiologists, \$7600 a year. Now, these are doctors who've not had any other claims. Pediatricians are \$4900. Radiologists are \$12,000 a year. I think MIIX has clearly demonstrated that their rates are going up by no more than 10 percent. They've never gone up by more than 10 percent. I don't think that the doctors who are insured by Princeton have experienced dramatic increases.

This is why I started out with the facts, because you hear these stories about doctors who are claiming their rates are dramatically increased. But all of the doctors that I've surveyed, including one this morning, who's an

ophthalmologist, is paying \$14,000 a year. So I believe that there's a perception that these rates are increasing dramatically. But when I ask the individual doctors, and I deal with a lot of doctors for me, against me, friends, I don't get that, on an individual basis, I hear these horror stories. But it doesn't seem--

ASSEMBLYMAN IMPREVEDUTO: Assemblyman Cohen and myself and a number of legislators attended a meeting Wednesday night at the Hudson-Bergen County Medical Society Consortium or whatever they were. There were a number of doctors -- OB/GYN folks saying that she's paying \$50,000, and it's going to \$110,000 in August.

MR. BROWN: From what carrier?

ASSEMBLYMAN IMPREVEDUTO: New Jersey.

DR. GOLDSMITH: The problem--

MR. BROWN: No, no. Who's the insurance company?

ASSEMBLYMAN IMPREVEDUTO: I don't recall.

DR. GOLDSMITH: The problem that we saw--

ASSEMBLYWOMAN WEINBERG: Excuse me a minute. We are going to be hearing from an OB/GYN doctor next if we get through this.

ASSEMBLYMAN IMPREVEDUTO: We heard this time and time and time and time again at this meeting -- that our rates are going. "I'm a surgeon. I was paying \$30,000. Now I've got to pay \$90,000."

DR. GOLDSMITH: The problem that we saw -- because, again, is that individuals who left MIIX and went to other carriers such as Zurich, which is pulling out of the state or PHICO -- then want to come back into the fold-- They're the ones who've been given outrageous premium quotes, not those who have stayed within the system.

MR. BERGER: And there could be no justification for those outrageous increases. Doctors are getting gouged by those particular insurance companies because if you look at the history of malpractice claims and the history of profits of MIIX and Princeton over the past 20 years, the profits have been high, they payouts have remained stable, and the only thing that happened last year was MIIX went to Texas, they went to Ohio, they went to al the other states. And because of other losses, they lost \$200 million in one year.

The malpractice justice system has proved to be stable and profitable because those companies, Princeton and MIIX, know what they're doing. And their charges have not been, as you've heard, 100 percent, 150 percent increases.

ASSEMBLYMAN COHEN: Dr. Conaway will have the last question.

ASSEMBLYMAN CONAWAY: It's just really more of a comment. I called my insurance broker on the way down. As I mentioned, I'm up for renewal -- it's a lot of personal information here -- but I'm up for renewal in July. My carrier is pulling out of the State of New Jersey. She got on the phone -- just when I was back in the corner talking to her. Ten thousand is what I pay for my own-- I'm an internal medicine physician with no claims against me ever.

She tells me to expect to see an increase of 50 to 100 percent in my own premium. She told me that of the other physicians that she has that are in her portfolio or book of business that she's seeing-- I said, "Am I unique?" And I've got no claims. She said, "No, I'm seeing 50 to 100 percent across. For some of those in the high-risk specialty areas, some of those it's 300 percent."

The New Jersey Hospital Association is probably going to come up and say they've done their own survey. They've got OB/GYN-- This is, let's see -- "hospitals reporting specific physician specialties experiencing sizable medical malpractice insurance rate increases." It's a small number -- 43 it says here. But OB/GYN -- and they're going to come up and talk -- 87 percent; surgeons, 82 percent -- 83 percent of the specialists--

ASSEMBLYMAN IMPREVEDUTO: Herb, put your mike on.

ASSEMBLYMAN CONAWAY: I raise the point because it appears that what you've just said regards malpractice rates and what's happening not to my own personal experience or to what the New Jersey Hospital Association is saying.

DR. GOLDSMITH: Then what we heard earlier -- you and I all heard earlier doesn't give with what is being said.

ASSEMBLYMAN COHEN: Let's go.

Thank you very much.

We have a very unique situation. We have malpractice complaints being less than was filed before. We have an insurance company that ran its business out of the state that now wants to come back because it's profitable. We have less terms of insurance awards. And this has become an extremely unique crisis and all done within the last 12 months.

ASSEMBLYMAN COHEN: We have currently here Dr. Hernberg, Dr. Bochner, and Dr. Silverberg. Please, if you could come forward? I feel like I'm at a hospital -- "St. Barnabas calling Dr. Silverberg, Dr. Hernberg. Please come to OR." (laughter)

ASSEMBLYWOMAN WEINBERG: Dr. Silverberg represents the OB/GYN Associates.

FRED SILVERBERG, M.D.: Yes.

ASSEMBLYWOMAN WEINBERG: Dr. Bochner, the New Jersey Citizens United for Health Care Access, also OB/GYNs. And who is our third? I'm sorry.

SCOTT HERNBERG, D.O.: Dr. Hernberg.

ASSEMBLYWOMAN WEINBERG: Right. And you are from?

DR. HERNBERG: I represent the New Jersey State Society of Anesthesiologists that we've heard a lot about.

ASSEMBLYWOMAN WEINBERG: Okay, let's start with the OB/GYNs, on my left.

DR. SILVERBERG: Thank you very much for the opportunity to address this important issue. Without changes in current law, we will not have enough doctors delivering babies in the next two or three years. Already, because of the extremely high cost of medical malpractice coverage, many doctors are dropping obstetrics or moving out of state.

Just last week, my colleague, Dr. Peter Bippart, a fine obstetrician, has announced to me and to the medical community that he is closing his practice in Morristown, New Jersey. Briefly, let me tell you about Dr. Bippart. His ancestry in New Jersey goes back over 150 years with five continuous generations of obstetricians. His great, great grandfather founded St. Barnabas Medical Center. He was a professor of Obstetrics and Gynecology at Columbia University. His grandfather was an obstetrician, and until a few years ago, his father was a gynecologist practicing in Morristown, New Jersey.

Peter was raised here, and he was very eager to work in his father's practice after residency. He worked in that practice tirelessly for over 18 years. He was never even deposed in a malpractice claim. Because of the difficulties

in managed care and increasing costs of medical malpractice insurance, he has decided to leave the state and take a position with another obstetrician in Maine. Maine has gained a wonderful obstetrician, and New Jersey has lost and will continue to lose good doctors. Once someone leaves practice, he or she rarely returns to his or her chosen profession.

What can you, the Legislature, do to avert losing our best doctors? And for that, we need to look at the problem. The bills that are pending in the Legislature -- Senator Anthony Bucco put forth three bills to address this issue. S-1570 limits the statute of limitations to two years from the date of discovery or four years from the date of actual occurrence. We believe this is still too long. California's MICRA laws put a one-year limit from discovery of an injury and three years from the date of occurrence, and we concur with this statute of limitations. There would still be plenty of time to file a claim.

S-1571 sets a \$500,000 cap on noneconomic damages. However, there is a bill in Congress that would set a \$250,000 cap. We believe this is a much fairer amount and ask that the cap be lowered to 250,000. It is important to remember that pain and suffering awards are noneconomic awards, and as such, are not affected by fluctuations in the economy. They are not equivalent to medical bills and wages, which do increase over time and which we agree should be paid to their fullest. Only a few civil justice systems in the world allow any recovery for noneconomic damages. Those that do leave the decision concerning damages with a trial judge. None allow the jury to award unlimited recovery.

S-1572 establishes expert witness standards in physician negligence actions that require the witness to be substantially familiar with the appropriate standard of care, practiced in the same specialty as the defendant, and be board

certified by the same licensing board as the defendant. We believe this does not go far enough. In our midst are board-certified physicians who make a living by giving any testimony that will pay them a handsome fee. We need to put an end to the profit motive that allows these hired guns to pocket such large sums of money. I suggest that the State Board of Medical Examiners appoint, without fee and on a rotating basis, board-certified physicians to review claims for merit and provide expert testimony in such cases. New Jersey physicians should consider it an obligation to perform this service without remuneration. There are other bills that we would like to see enacted.

Binding arbitration of disputes: With this law, patients and their health-care providers could agree that any future dispute may be resolved through binding arbitration. The statute would require specific language for such contracts and provide that such contracts be revocable within 30 days. In California, Kaiser Permanente insures over 6 million people, everyone of them signs a binding arbitration agreement.

Periodic payment of future damages and payment for actual damages only: This statute would allow a health-care professional to elect to pay a claimant's future economic damages if over \$50,000 in periodic amounts. Also, the damages would be actual damages and not actuarially determined. This avoids a claimant's wasting of an award prior to actual need and would more accurately pay the claimant for his or her loss. Also, it would allow the injured patient to receive more of the award and the attorney less.

Advance notice of a claim: To further the public policy resolving meritorious claims outside the court system, this law would require a claimant to give 90-day notice of an intention to bring a suit for alleged professional negligence. If the notice were given within 90 days of expiration of the statute

of limitations, the statute of limitations would be extended to allow the full 90 days of advanced notice.

Evidence of collateral source payments: A defendant in a medical liability action should be able to introduce evidence of collateral source payments, such as for an insurance policy, personal health insurance, or a family member. Reform of the collateral source law would halt double recovery and dramatically reduce unnecessary medical treatment that is stimulated by abuses of the legal system leading to increased costs of the health-care system.

And finally, establishment of a neurological fund for newborns: This law would establish a fund that would provide medical payments for babies born with neurological injuries, such as cerebral palsy and Erb's Palsy. This law would also allow patients to receive payments more quickly and save on attorney fees.

The above bills, if enacted together, would go a long way toward solving our medical malpractice crisis. I plead with this Committee, don't enact ineffective bills as Pennsylvania did in March of this year. That state is losing physicians at a faster rate than we are, and patients, especially in rural areas, those underserved, are not getting the care they deserve. Only by your actions in this legislature can this crisis be averted.

Thank you very much.

ASSEMBLYWOMAN WEINBERG: Thank you.

Dr. Bochner.

R O N A L D B O C H N E R, M.D.: Ron Bochner. I'm an Obstetrician-Gynecologist in practice in the New Brunswick area. I'm a representative of New Jersey Citizens United for Health Care Access, a grassroots organization of OB/GYNs that didn't exist until eight weeks ago.

Eight weeks ago, several of our colleagues at St. Peter's Hospital dropped out of obstetrics simply because of unavailability or unaffordability of professional liability insurance. This created a local health-care crisis for our patients in that remaining practices had to absorb these patients as they had no where else to go.

We formed this grassroots organization and quickly came to realize, as we went across the state -- and we currently have spoken to three-quarters of the obstetricians-gynecologists in the state -- that 20 percent or 25 percent of them anticipate giving up obstetrics by the end of this year. I have a background in the public health service in this country. I served for two years in an underserved area, and I can tell you that this is a health-care crisis that is here and now.

Whatever this body decides or it discusses or you'll hear expert testimony from many different individuals. There is a crisis that's about to hit our shores in a way we've never seen in the State of New Jersey to the extent that, as I go across the state and speak to physicians, they are speaking to patients who traveled from over a hour away, specifically from Philadelphia, because they cannot find obstetrical practices to take care of them in that state. On April 1, when the renewals came, several of our colleagues couldn't meet those renewals. They dropped off. July 1 is the next renewal bout, October 1, and then December 31.

I, myself, have been in practice for 20 years. I've never been sued. I have nothing in the horizon, and I do a lot of high-risk work. My premiums went from \$32,000 to \$75,000 on October 15, a month and four days after my insurer, which is a major insurer for the World Trade Center, Zurich Kemper, sent me a letter attesting to the fact that they were just increasing me. No

warning whatsoever. They sent it to me on October 15, less than two months before the increase was to take place. I scrambled. I found another company to take me. I have no suits against me. It wasn't difficult. But even that company has now told me that come December 31, they're increasing me to \$70,000. And in my small business, in my small practice, a practice where I cannot pass on my increased expenses to the consumer, as you would in a bakery where the cost of milk, sugar, and eggs goes up, you pay more for cake.

That's the difference between my deciding to do obstetrics and to not do obstetrics. I've been listed in the *Best Physicians* in New York state, a New York magazine, *New Jersey Monthly*, and this is the second year in a row I'll be listed there, and I'm contemplating dropping out of my chosen profession, not because I'm a bad doctor, because I'm practicing bad medicine, but because I can't get or afford professional liability insurance. I'm the bottom line. I'm a physician who is in the trenches. I take care of sick people. Anyone who comes into my door, I take care of them. And if it's affecting me, it's affecting many others. Whatever you decide here, whatever you talk and banter about, you'll hear expert testimony from many different people and different professions.

The bottom line is the health care of the public is about to be severely impacted. I can assure you -- this case (indicating briefcase) is half filled with postcards from the public, your constituency, asking you to do something about this crisis because our patients, in my case specifically women, pregnant women and nonpregnant women, like to have a choice as to who they go to. On May 8, I lectured in the Atlantic City Medical Center about this very topic. I've been going around the state organizing my colleagues so they could organize their patients.

We learned an important lesson five years ago when HMOs were kicking our patients out of the hospital 12 to 24 hours after a vaginal delivery. We went to a body such as this, and we told them we didn't think it was appropriate for babies to leave the hospital so soon after birth. They told us, "The only ones complaining about this are you. We haven't heard from the constituency that elected us." Fine. So we go back to a patients. They start writing letters. They start making phone calls. A few months later, New Jersey became a leader in this country and passed -- mandated a stay for patients in the hospital after a vaginal birth. Can you imagine? We had to mandate a stay in the hospital. I commend this branch of government that did that, because New Jersey was the first state in the nation to do that.

The lesson we learned from that is the lesson I'm presenting you with here today. The public is about to get very angry and concerned about what's about to befall them because physicians like myself are going to give up their profession and just do gynecology at a time when the infant mortality rate in this state is nothing to be proud of -- or this country for the matter.

Denmark, which enjoys one of the lowest infant mortality rates in the world, is the leader in this. New Jersey is not anywhere close to it. So, at a time when our infant mortality rate is high, obstetricians in this state are going to be leaving at an alarming rate. What do you suppose the lack of adequate prenatal care is going to do to those numbers? You're going to be hearing from the public. I'm here to tell you that in this briefcase I have postcards collected over one week from three practices. You multiply that by the 1100 OB/GYNs, three-quarters of whom I now speak on behalf of, and I can fill several mail bags of postcards from patients who are very concerned about who will take care of them when they get pregnant.

Whatever you decide here, it has a tremendous impact on public health. I'm here on behalf of all the obstetricians I represent and our patients, and I ask you to do something and do something quickly, whatever it is, because these practitioners are leaving the state, and they're doing so by December 31. That's not very far in the future.

I, myself, may have to make that decision, and I have never been sued. It's just a business decision. Do I pay my employees health benefits and provide them with a profit share plan, or do I send more money to my professional liability insurance carrier? That's a decision I never hoped to make from my chosen profession. If I leave, it's not because I've done something bad, it's because I can't meet my expenses, and I can't pass them on. So start thinking and start talking, because the public awaits what you decide. We want to hear something quickly. We want to hear how you're going to keep medical care available to the public, maintain their access. That's why they've been sitting here for four hours waiting to tell you.

And I hope that whatever comes out of this it's rapid, it's decisive, because physicians are going to leave. This is a certainty, and the public will have to do what two patients from Philadelphia had to do on May 8, which is the day I lectured at Atlantic City Medical Center. On April 1, their physicians gave up obstetrics. They couldn't find a carrier. It took those women until May 8 to find an appointment with a physician one hour away from where they live, out of state, who saw them in the middle of their pregnancy. These are women who have had babies before. They've got a one hour and fifteen minute drive to get to Atlantic City, and I hope they don't deliver on the highway.

Are you prepared to have the State Police do the same for patients on the New Jersey Turnpike as they scramble? They won't be able to go to

Pennsylvania. There's no practice there that will accept them. And at a time when you seek to reduce medical errors, what are physicians going to do to try to meet increasing expenses? What is the only thing that we can do? See more patients? Well, as you correctly said, Mr. D'Amato, the more patients a physician sees, the greater the chance he's going to make an error.

I am not interested in making errors. That's not what I'm about, and that's not what the people I'm here representing are about. We're here about quality medicine. We have a real concern about the public. You're going to hear all kinds of things. You have to decide something, and you have to decide it quickly because we're watching and the public is watching. We're very concerned. I hope you are, too.

Thank you for this opportunity.

ASSEMBLYWOMAN WEINBERG: Dr. Bochner, I think everybody here is very concerned, which is why we're here also. The issues that you touched upon, particularly with OB/GYNs are the issues I'm hearing the most about in my office from doctors who are calling and telling me that they are giving up the obstetric portion of their practice. Obviously, this is something, as a woman, that I am particularly concerned about, as I am sure my males colleagues and other professions here are also. Would you just tell me once again, your insurance went from--

DR. BOCHNER: Certainly. In case you wish, I've made copies from several physicians indicating what their premiums are and what their increases are.

ASSEMBLYWOMAN WEINBERG: Right.

DR. BOCHNER: My policy increase went from \$32,500 to \$75,000 with Zurich Kemper. I couldn't afford to pay that, given that my

income is limited by the HMO plans I participate in. I found another carrier who will only increase me by \$3000 per year because of my record. However, this December 31, even that carrier has told me that my rates will approach \$70,000.

ASSEMBLYWOMAN WEINBERG: And they are currently?

DR. BOCHNER: ProNational.

ASSEMBLYWOMAN WEINBERG: Thank you.

Any questions?

Assemblyman Green.

ASSEMBLYMAN GREEN: I know it's getting late, so I'll be rather quick.

ASSEMBLYWOMAN WEINBERG: And we do want to hear from the anesthesiologist, too, so--

DR. HERNBERG: From Atlantic City.

ASSEMBLYMAN GREEN: Okay. I guess you sat through the testimony of the insurance carrier, sat through the testimony of the trial attorneys, am I correct?

DR. BOCHNER: Correct.

ASSEMBLYMAN GREEN: What's your feeling in terms of if there's a small group of doctors, but you can tell me what the appeal -- if true or not -- is the reason why the premiums are skyrocketing because these are the same individuals over and over? They get sued and have no respect for the system.

DR. BOCHNER: Is this directed towards me?

ASSEMBLYMAN GREEN: Yes, it is. I just want to get a general feeling, since you represent so many doctors and you have a feel-- I'm just

trying to get some kind of idea in terms of -- this is the third entity which is important -- insurance carriers, attorneys, and doctors.

DR. BOCHNER: I can tell you it appalls me when I hear of colleagues who keep making the same mistake over and over again that winds up in a litigation situation. I'm not privy to this sort of information, but I can tell you that as a practitioner, it's not a good thing.

ASSEMBLYMAN GREEN: Would you have a problem in terms of them getting exposed, because again like what Assemblyman Connors said earlier, it can hurt a doctor's reputation, but the reality is that we have to set up some system in terms of if the bad ones are hurting the good ones, then somewhere along the line we have to weed out the bad ones? But again, do you feel that this is the reason why insurance has skyrocketed because of the handful of bad doctors who get sued, or do you think there's another reason?

DR. BOCHNER: I can't answer that fully, because I'm not privy to whatever it is that causes insurance companies to decide their expenses have gone up, and then they have to pass that on to consumers like myself. But I can tell you that anything that reduces professional liability insurance is a good thing for the profession and is a good thing for the public.

ASSEMBLYMAN GREEN: Just like when the Chairman asked you earlier and says, well, how much did your insurance go up, you mentioned it doubled. I'm pretty sure all of us should have a right to know why. And when you do ask why, what kinds of answers do you get?

DR. BOCHNER: They tell me that their expenses have gone up. They're paying more in jury awards. They're paying more for the defense of physicians. They've lost money here or there. I suppose the stock market is the usual place companies lose money. But be it as it may, I have no control over

that. I'm sure they don't tell me the truth, and I end up paying the increased expenses that they have. I shoulder that burden. I can't do it to anyone else.

DR. SILVERBERG: Assemblyman Green--

ASSEMBLYWOMAN WEINBERG: Dr. Silverberg, yes.

DR. SILVERBERG: Yes. We did compile that information. We have data on over 300 physicians, obstetricians/gynecologists in the state, and I can tell you for sure that the pattern is not a few bad doctors, but sprinkled throughout the entire profession. Essentially what happens is doctors are practicing throughout their careers and just get hit with an unfortunate circumstance, such as an Erb's Palsy, that seems to be a very popular one. Cerebral palsy, there is a few that seem to merit huge, huge awards. And that's what's causing and driving some of these settlements.

Unfortunately, when you have a baby with a neurologic injury, what happens is they figure out actuarial data and sue you for maybe \$8 million, \$10 million. If your policy goes up to 1 million, well, you could fight it, and you could possibly lose, in which case you lose everything, or you can ask that the insurance company settle for within the policy limits. I think most people, when faced with that tremendous dilemma of perhaps losing a multimillion dollar case, will ask the insurance company to settle. That's the problem that we have. We can't really fight when it comes to multimillion dollar cases.

ASSEMBLYMAN GREEN: Thank you, Madam Chairwoman.

ASSEMBLYWOMAN WEINBERG: Okay, thank you.

Dr. Hernberg from the New Jersey Association of Anesthesiologists.

DR. HERNBERG: Good afternoon. I'd like to thank both the Co-chairs and the members of the Committee for the opportunity to provide testimony.

Assemblyman Green, you raised a very good question, and I think anesthesia has been referenced many times this afternoon. Perhaps I can share with you before I start my brief prepared statement, the State of New Jersey has an anesthesia related incident form, that semantics has been much debated. It has nothing to do with anesthesia errors, and I would have to correct my colleagues in the trial lawyer field. It has to do with deaths in the perioperative environment. We have been reporting on information for many years, and the attorneys are correct, and information has not been evaluated. But what's interesting is that the mortality, and as I'll mention later, morbidity, both the side effects of unfavorable reactions from the anesthesia have decreased. And it's interesting, they have decreased without anyone looking at the so-called mortality related to anesthesia.

It is called mortality related to anesthesia because when the State wrote the rules, and I sat on the panel that revisited this, we could not agree on a better terminology. So there is information out there. Sometimes we don't look at it. Sometimes things get better, and there's a variety of reasons why things improve, and perhaps, you can ask me about that later.

But let me address why I came here today and, perhaps, answer some more questions. My name is Scott Hernberg. I am an Osteopathic Physician. I'm board certified in anesthesia. I've been practicing anesthesia for almost 19 years, or actually over. I would welcome the opportunity to get a tape of this proceedings, because I would like to play back for my mother the nice things the trial attorneys have said about anesthesia.

We have worked very hard to provide and increase patient safety. Since 1992, I have been a chairman at the Department of Anesthesia and Perioperative Medicine at Atlantic City Medical Center in Atlantic City. Again, it's refreshing to hear that people come to Atlantic City for things other than going to the beach and gambling. For the past several years, I have served the New Jersey Board of Medical Examiners as a member of the Expert Advisory Panel. Additionally -- and this is who I represent today -- I am President of the New Jersey State Society of Anesthesiologists and represent over 750 practicing anesthesiologists in the state.

Our scope of services are quite broad and include general operating room services, outpatient and office-based anesthesia, as well as anesthesia for cardiac surgery, neurosurgery, pediatrics, and neonatal surgery. We are also involved in the management of trauma patients and critical care patients. Additionally, we routinely provide acute and chronic pain management services for a very diverse patient population, from those with ordinary pain to those with lethal cancer. Lastly and importantly, we are also in the delivery suite with my colleagues, to the right, either providing labor epidurals or preparing for cesarian sections.

Although the specialty of anesthesia is not currently in the crosshairs of this malpractice crisis, we are concerned that it is only a matter of time. Clearly, if one follows our scope of services, which anyone would describe as high-risk and the twisted path of the liability crisis, we too can expect increases in our premiums and issues of insurability. Already I'm aware of several distinguished colleagues in this state who, given the choice of significant increases in their premium, have opted for early retirement.

For most of the medical specialties, medical liability insurance ranks as one of the third highest practice expense. For anesthesia, it is the single largest practice expense. This cost cannot be easily and timely shifted to the payors. Eventually, the out of control, skyrocketing malpractice premiums will result in reduced health-care provider accessibility. As the economic pressures on the practice of medicine increases, physicians may be forced to choose early retirement, relocate out of state, or modify their scope or practice. Even worse, young, bright, well-trained and gifted physicians will avoid New Jersey entirely in the decision to where to choose a medical career. I think that will be one of the saddest things to occur in this state, if we lose the young physicians to other states that are more user-friendly.

Many recent news articles have well-documented the critical shortage of medical personnel nationwide. I can tell you, as a chairman of anesthesia, I have five or six open spots in my department. There are many chairmen around the state that are actively trying to recruit anesthesiologists. Anesthesiologists, like other professionals that are in shortage, will opt to go to those states that provide them the best lifestyle. And unfortunately, in New Jersey it is becoming increasingly more difficult to provide services in the operating room. We have delays. We have accessibility issues.

Because of physician fears of liability health-care costs, I believe that there will be an increased use of defensive medical tactics. It is widely recognized that unnecessary costs related to the practice of defense in medicine add more than 5 percent to a patient's hospital bill. As I indicated previously, in the short term, physician fees are unlikely to increase. Eventually they will, and they must.

As a result of the Balance Budget Act, Medicare physician fees are declining. And since many managed care contracts are indexed to the Medicare fee schedule, physicians have limited ability to offset significant unplanned practice expenses. This economic imbalance will further disrupt New Jersey's already fragile and stretched health-care system. The quality of care will be impacted under the double threats of diminished access and the always present efforts to achieve cost efficiencies.

I think I'll address a little bit some of the comments made earlier about the technology and improvement of morbidity and mortality. In 1989, the New Jersey Department of Health and the New Jersey State Society, together as partners, led the nation in creating anesthesia standards for hospitals. This significantly reduced morbidity and mortality in our state. Those standards were later applied to licensed facilities, namely ambulatory surgery centers and now recently are trying to be applied to office-based standards. They're being held up in court. These initiatives were implemented over, I must tell you, a very serious debate, that which is similar to what we're seeing today in this room. However, it was good social policy and it did -- as my colleagues will tell you and as the trial lawyers will also say -- improve the safety and care of our patients in New Jersey. Other states soon followed, but we were the leaders.

We now face a similar challenge and need a similar partnership and leadership from all parties to create an environment for the provision of reasonably priced, readily accessible, and high-quality care. These objectives require a stable medical malpractice environment and a commitment from all parties to above all do no harm to the patient.

To improve the health of our communities and to achieve the aforementioned goals, I am asking the panel to consider the following recommendations when they deliberate about future legislation: One, a cap on noneconomic, unquantifiable damage at 250,000. The panel should also allow periodic payments on settlements greater than its specified threshold, that our health-care providers be allowed to use binding arbitration; that a statute of limitations that is predictable and definable will be implemented. And that limits on contingency fees be established in similar fashion as recommended in the federal legislation, HR-4600, by Congressman Greenwood of Pennsylvania; that damages be allocated fairly in proportion to an individual's degree of fault, and that the search by the plaintiff's attorneys for deep pockets be defeated. Additionally, we believe that there should be limits on punitive damage to make the punishment fit the offense. And finally, we would ask that expert witnesses hold a valid New Jersey license and also participate in the same speciality as the defendant.

I thank you and would like to take any questions.

ASSEMBLYWOMAN WEINBERG: Have the anesthesiologists seen the same kind of spike in insurance premium costs as have happened with OB/GYNs?

DR. HERNBERG: As mentioned, the rates have been reasonably stable over a couple of years. We're beginning to see an increase anywhere from 5 percent to 10 percent. In the last year, we're expecting -- to those that are in MIIX, they are having problems finding insurance, particularly if they have any claims. It is common in our business -- and I do not have any claims after nearly 19 years of practice -- it's common in our business because of the high risk, to be roped in at any time there is a perioperative event. So it is not

uncommon for us to have been named in a suit and not necessarily go to litigation and be in a quagmire now of finding new coverage.

Because of the safety features that we implemented years ago, we did see it diminish the reduction in our cost because the outcomes were much better. What's interesting, and I haven't seen the information in the state, but I can tell you nationally, being the experience, as suggested, there is a decrease in mortality. What we're beginning to see is an increase in claims and the cost of claims for events unrelated to deaths -- some neurological injury, nerve injury, aspiration, dental injuries. We're seeing an escalation, the cost of doing business for all the things that there are no monitors to prevent.

ASSEMBLYWOMAN WEINBERG: Assemblyman Impreveduto.

ASSEMBLYMAN IMPREVEDUTO: Yes. Just quickly. Your rates are not going up by more than 10 percent for your personal--

DR. HERNBERG: Correct. My personal came out in January, so I kind of beat the rush. But we're told by -- and I work at Atlantic City Medical Center -- we were told to expect at least a 10 percent increase in our rates, and we're in a high-risk area. We're a trauma center. We provide a fair amount of indigent care, and we expect a significant increase.

ASSEMBLYMAN IMPREVEDUTO: Can I ask the same of your two colleagues?

DR. BOCHNER: Our increases are over 100 percent.

ASSEMBLYMAN IMPREVEDUTO: So you're paying what now and what are you going to?

DR. BOCHNER: I'm going from -- right now, I'm paying-- I was paying 32. They wanted to increase me to 75. I'm now paying 35. I found

another carrier, but that carrier has told me that I will probably pay close to \$70,000 come December 31, which is 100 percent increase for me.

ASSEMBLYMAN IMPREVEDUTO: Okay. So you're paying 30, and who were you with that was going to raise you to 75?

DR. BOCHNER: Zurich Kemper was going to increase me from 32 to 75, and ProNational, which is the company I'm currently with now, is going to raise me from 35 to 70 come December 31.

ASSEMBLYMAN IMPREVEDUTO: So you're doubling it.

And you?

DR. SILVERBERG: My rates were at \$30,000 last year. The renewal was \$50,000, and now they told me to expect about 80 to 100 with no new claims.

DR. BOCHNER: If you look at the papers we submitted to your Chairperson, you'll see quotes from around the state, and they range as high as a quarter of a million dollars.

ASSEMBLYMAN IMPREVEDUTO: Were any of you with MIIX?

DR. BOCHNER: Yes, I was with MIIX some years ago. When they increased their premiums, we were one of the groups that went to Zurich Kemper who offered a more attractive rate. We've now been informed that they're leaving the state and, well, it leaves us without them as an option, doesn't it?

DR. SILVERBERG: We also were insured with MIIX, several of us, and unfortunately we are very concerned right now about that tail that they were discussing because I feel that within the next two years, that tail may be gone, despite what they say regarding the amounts that is in that reserve.

DR. HERNBERG: I think it's a critical point about the difference between claims made in current policy. I think the rate that was quoted as an anesthesiologist, \$7600, that is probably for someone just getting out of residency and a claims-made policy, meaning that any lawsuits brought the year of the policy -- and it's unlikely you'll have an occasion to cause an incident and go to court within the year. So insurance companies typically write very low premiums the first year. And then by your third year, the policies escalate. The problem is if you have a claims-made policy, when you move out of state or change jobs, you're stuck for paying the tail, which is anywhere for two and a half times a mature policy. It's extraordinarily high. So those that are in companies that have claims made, physicians are kind of locked into, particularly now if they have a claims made, as to whether they're going to continue in a practice, move out of state, or if they have occurrence.

ASSEMBLYMAN IMPREVEDUTO: Why would you move out of state when we see that New Jersey has probably one of the best records around the country for lawsuits when we notice in Texas and Pennsylvania and all the other states are awarding higher?

DR. HERNBERG: Well, I could tell you that I wouldn't necessarily move to Texas or Pennsylvania, but there are people moving to South Carolina and other states where this malpractice crisis is not as bad and managed care is not as penetrated. I think it's a two-sided coin here. As mentioned, my colleague here said if we were making cakes, we could increase the cost of the flour, and we would pass along that cost.

When I try to recruit physicians, I have so many dollars of resources to attract qualified, good young doctors. If I'm putting 30 percent of it and in Atlantic City it's not that high, so I'm not suggesting that -- but other

specialties, I can tell you. My colleagues in OB need to expand their practice. They're shrinking. The poor lady that drove from Philadelphia to Atlantic City is going to have to take the Parkway up and go somewhere else because I can tell you the guys in ACMC are under the same pressure they are in the rest of the state. I had a conversation with my OB chief just the other day. His premium went from \$60,000 to 85. He can't afford it.

DR. BOCHNER: I wanted to tell you that one of my colleagues, sitting behind me in the audience, is part of the 10-men group, and they were quoted an increase from their \$1.4 million for the group of 10 to \$4.1 million for the group of 10. That's an increase of 325 percent.

ASSEMBLYMAN IMPREVEDUTO: What company was that?

DR. BOCHNER: I can't hear him, sorry.

ASSEMBLYWOMAN WEINBERG: If it's not on the microphone, it doesn't get on the transcript, so--

ASSEMBLYMAN IMPREVEDUTO: I'd like to know what company that was.

ASSEMBLYWOMAN WEINBERG: Dr. Bochner, while he's coming up, did you say you sent information up to us?

DR. BOCHNER: Yes, I handed it to your staff right here.

This is Dr. Danny Beim.

DANIEL BEIM, M.D.: Hi.

ASSEMBLYMAN IMPREVEDUTO: Put your mike on. Hit the button. (referring to PA microphone)

DR. BEIM: To be more accurate, our group rates went from 265,000 last year, when we were told by Zurich that we couldn't get insurance, we shopped around. We were declined by five companies. Finally, we were told

that we could get rates for our group, which is a six-position group, three midwife group, of 890,000. The group that he was talking about is a group called Life Line, which represents 35 obstetricians. They were quoted 1.4 million for their entire group, then they were requoted for the end of this year, 4.7 million.

ASSEMBLYMAN IMPREVEDUTO: Are these groups that have had cases against them that were won, or were there large settlements?

DR. BOCHNER: It doesn't matter. All they have to do is be named in a suit. That's the way the premiums go. You don't have to have lost a suit to see a premium increase. All you have to do is be named. I can tell you that when we do high-risk work, if there's five of us working on a case desperately, everyone is getting named. The nurses are getting named. The doctors are getting named. If you look in on a case just to say, "Hey, what's going on here," for five minutes, you're getting named. And suddenly, when you reapply for professional liability insurance, your premiums are shooting up just because of that.

ASSEMBLYMAN IMPREVEDUTO: But how does that stop with economic caps and how does that stop with some other carriers? Is it that the insurance company is taking advantage of you?

DR. BOCHNER: I think there has to be some review process before a case finds its way into the tort system. I can't think of any other way to do it. There has to be some sort of a filtering process so that the individuals are named properly.

ASSEMBLYMAN IMPREVEDUTO: I agree. I don't disagree with that, but what I'm saying to you--

DR. BOCHNER: I just don't know how to do it. I'm not an attorney, but I know the trial lawyers association here will probably tell you how to do that.

ASSEMBLYMAN IMPREVEDUTO: But what I'm saying to you is that by pulling you out -- and I agree with that -- I mean, if you had nothing to do with it, you shouldn't be in the case. But how does that stop the large awards supposedly? Well, what the insurance company is saying to you is we're raising your rates because you were named, even though you were thrown out later on, we're still raising your rates. We don't care.

DR. BOCHNER: It costs them money to defend me. As soon as I get named--

ASSEMBLYMAN IMPREVEDUTO: I see they've got you brainwashed. (laughter)

DR. BOCHNER: --I have to hire a attorney which they will supply me with. It costs them money to defend me. It sometimes costs as much money to defend someone as it does to settle them, because there are multiple people named.

ASSEMBLYMAN IMPREVEDUTO: But nine of the ten times, you're thrown out early, aren't you?

DR. BOCHNER: I have no idea. I've never been named.

ASSEMBLYMAN IMPREVEDUTO: Thank God.

DR. BOCHNER: Assemblyman, in their database, we have one particular case that comes to mind. A doctor went through labor and delivery in order to go to the bathroom. The nurse had asked the doctor to just check on a patient, which was not his, who was uncomfortable. The patient was four or five centimeters dilated, up to 10 is full dilatation. Everything looked fine,

and he went to his bathroom and everything was okay. The other doctor, the attending, came back and several hours later, a bad baby was delivered. That doctor who had gone to the bathroom and checked that patient had to settle for \$1 million. There's something wrong with that.

ASSEMBLYMAN CONAWAY: Yes. Yes.

DR. HERNBERG: In response to, I think, a couple of questions about the information regarding the quality of care. A good part of my career has been behind the scenes looking at those things in my institution. I can tell you that hospitals and physicians and administrators do take these things seriously, that there are corrective actions, that care is change. I would point to the attention that in anesthesia both in the state and on a national level we do this. I see it happening in other fields. I think if you agree with a number, whether it's Assemblyman D'Amato's number of 90 percent, or 70 percent in favor of physician, clearly good medicine is being practiced. But it doesn't stop us from being named in suits, and it takes three years to clear your name. In those three years, you spend an inordinate amount of time, you certainly spend costs that are coming from somebody, and your own costs. And you're smeared. So for that information to be out before it's litigated or it's proven one way or another, there is a concern.

And medicine is a practice of sciences, not an exact science. I think all of us have an obligation, both you as legislators, us as practitioners, the health-care and business folks, lawyers, to work together to find a better system. We are headed for a crisis. I see it. I see it not just in the specialties that are targeted now. It's in a lot of other specialties. We're in a crisis for recruiting physicians. If we want to look where we're going to be in 10 years, hopefully, it won't be back in this room where we were 10 years ago. We need a bold

initiative to solve this problem. It's not just about one company doing poorly in the stock market.

DR. SILVERBERG: It's about public health. The public expects quality medicine.

ASSEMBLYWOMAN WEINBERG: Assemblyman Cohen is going to have to leave, and he has the prerogative, as the Co-chair, to ask some questions here.

ASSEMBLYMAN COHEN: Thank you.

We have to look at a couple of things. Just in terms of your situation, we've had questions about underwriting criteria. There's a question raised before to look at a procedure where once a claim is made, that is, a complaint's not filed but the claim is made, that there's a one-year tolling of the statute of limitations until the matter can be reviewed before a complaint is filed. There's a benefit to that but there's also a downside to that. That means that you just get earlier on your underwriting and your claim against you, which is stretched out an additional year before someone can determine whether to file.

One concern that I have is the underwriting criteria, whether or not a claim that's been made against someone has to stay in the record for three years, whether some kind of adjustments can be made on that claim that's been included in the premium, whether that can be adjusted retroactively when the case is dismissed, because there's always a shotgun approach that's done. You have to do it that way or else you face malpractice, thus naming John and Jane Doe nurses and physicians and hospitals and anybody else who has consulted on the case. Because when you do file, you have very little information. At

best, you have the patient. You may have some medical records that the patient gets that you can review and send to an expert.

These cases are very expensive. Attorneys just don't rush into them because more than likely, if the case does not prove productive, the attorney does it on a contingency fee. They can put in 80, 100, or 400 hours and come away with nothing, but they're paying their own secretaries and work staff and putting out money for costs. So you look at this thing very carefully because most of your clients are not going to have the cost to reimburse you when the case is lost, either when you decide you can't pursue it any further, based upon expert testimony that may come out, so there's a risk on everybody's part.

The question becomes -- after everybody enters into the risk and a case is dismissed or someone is let out of the case, the underwriting criteria then kicks in where you may be paying more money over a couple of years because you've had a claim whether it had merit or it didn't have merit, or a couple of claims that didn't have merit. You're still named.

So, if you have any suggestions that you could submit to the Chairs and to the Committee on ideas that you may have with regard to -- on underwriting issues, we'd like to know them. You see, they deregulated insurance in New Jersey several years ago. So really all the commissioner's office does on this kind of line is deal with solvency issues. It doesn't deal with the underwriting criteria. We may well have to get involved again in dealing with underwriting criteria so that certain claims don't stay with you for a protracted period of time. If you have any ideas of how to deal with--

I mean, I'm assuming you guys may go into MIIX. You're physicians. They're looking for physicians to kick in between \$6000 and

\$10,000 and \$15,000 into MIIX 2 -- the remix -- and you may well want to invest in that.

Now, as a potential shareholder, I don't know if you were shareholders in MIIX before -- you don't have to answer that -- but you may want to decide also that you may want to have us, as legislators, restrict what MIIX can do so that they don't go outside of New Jersey over the next couple of years. Because they're going to come to you, obviously, and say, "Can you kick in \$10,000 to help capitalize MIIX so that we can provide insurance for you?" And a lot of doctors, not to my amazement, will say that they will give MIIX a second shot. Well, our obligation is maybe to protect everybody from each other. We may have to look at restricting them, and I would like to know -- and the Committee may want to know your ideas in terms of how we can do that so that as part of a rehabilitation plan--

DR. BOCHNER: Assemblyman, I'm also concerned about the underwriting issue, specifically with regards to some of the neurologic injuries that babies have at birth -- cerebral palsy, Erb's Palsy, and those things. Automatically, a plaintiff's attorney will see that as a high-risk case which potentially can settle for millions of dollars, and so would be willing to put out, even before looking at it, just to hear somebody has cerebral palsy or Erb's Palsy, that they will accept it. It's a gold mine.

ASSEMBLYMAN COHEN: The question gold mine, you know, first of all, an attorney is going to have-- Before they file, the attorney is going to have their own expert take a look at the medical records. That doesn't give you the complete view, but it gives you some view. The majority of attorneys are not going to just say, "Oh, cerebral palsy, I'm going to go file."

DR. BOCHNER: Unfortunately, we have, as I've testified, in our midst, obstetricians/gynecologists who will testify essentially to anything as long as the fee is decent. We have to stop that. I think one of the things that we have to do as physicians is to be obligated towards giving expert testimony, serving on panels without fee. We have to take the profit motive away from those physicians who are not making money in obstetrics and gynecology, but are making \$50,000, \$100,000, \$150,000 being plaintiff's experts and sometimes defense experts.

ASSEMBLYMAN COHEN: In a lot of cases, defense experts.

DR. BOCHNER: They have to sort of do both sides in order to be more credible.

ASSEMBLYMAN COHEN: I mean, you wouldn't agree that you would only have physicians who are from New Jersey to testify as experts.

DR. BOCHNER: I would like to see a rotating panel of physicians, for example. Ordinary citizens are picked on a jury. I don't see any problem with board certified physicians being selected by the State Board of Medical Examiners saying, "Listen, you have to give this time, and you have to look at these cases." I see no problem with that, and I think most doctors would agree that that would be a fine way of dealing with a lot of these situations.

ASSEMBLYMAN COHEN: Are you talking about a review panel?

DR. BOCHNER: Yes, a review panel which does not involve monetary compensation. And also an expert witness panel.

ASSEMBLYMAN COHEN: Are you talking you'll have expert witnesses who will testify before a jury?

DR. BOCHNER: That's correct. You shake your head no, but honestly, I don't see any problem with doctors who have been selected by the

State Board of Medical Examiners on a rotational basis to serve as experts. After all, if I'm a board certified obstetrician/gynecologist, I should be able to testify in those cases.

ASSEMBLYMAN COHEN: Hired by a particular party. You never get to know exactly who knows who and who has relationships with which doctors.

DR. BOCHNER: You could easily ask.

ASSEMBLYMAN COHEN: That's why you go hire your own experts. I've heard one suggestion about no one being able to testify as an expert in New Jersey's courts unless they've practiced in New Jersey, of course, which belies the question that's asked by Assemblyman D'Amato of MIIX, who said, you get the best experts no matter where you can find them. If you can find them at Harvard, you bring them in as a defense. They don't practice in New Jersey. And what happened years ago that evolved certain rules was that there was a wall of silence. No one could get a doctor from New Jersey to testify against another doctor in New Jersey.

DR. BOCHNER: It's very easy now, unfortunately.

ASSEMBLYMAN COHEN: But those issues are weighed in terms of credibility by a jury. We began with the caps. I'll just say this and go. My brother is a doctor. My brother is an internist. He's a fine diagnostician. Early on in his life, he decided he was going to get away from OB/GYN because of getting up at 2:00 or 3:00 in the morning to delivery babies, which is difficult and extremely stressful. So I have a sympathy to physicians. But I asked some doctors at a meeting, I said, I almost hear the same thing with car insurance. It's like, well, if your daughter or child or yourself were injured in a car accident, and it would impact on your livelihood, and it would impact on your pain and

suffering, do you go to your attorney and say, "Please, don't get me any money?" We all take one position in one part of our life and another position in another part of our life.

If you were in a car accident and your arm was crippled and you couldn't do surgery any more, you wouldn't tell your attorney, "If they offer me a million, five, take \$50,000." Is that would you would do? I don't think so.

DR. BOCHNER: As far as pain and suffering is concerned, I believe we have to distinguish between the claims that are low payout up to, let's say, \$500,000 and the claims that are potentially millions. I believe that the limit on pain and suffering would probably not have much of an effect on those claims with a potential of high payouts. It doesn't matter.

ASSEMBLYMAN COHEN: Well, there may be one thing more that you're talking about or something that some of us talked about a couple of days ago, and that is that there may be cases that determinations could be made in terms of what the limitations of damages might be. Every case is not worth \$3 million. Every case is not worth \$250,000. There may be some process that we could go through, either through arbitration or some other kind of process, that may deal with the higher threshold cases and the lower threshold cases. But I think -- I don't know about this Committee -- and I get a sense that there's no interest in capping pain and suffering, as there would be to no interest in capping pain and suffering on a car accident case that may involve some family member.

DR. SILVERBERG: If you would like to convene a committee that specifically speaks to physicians and addresses their issues, rather than have a public hearing of this forum, I'm sure that you'd get lots of opinions about lots

of specific situations. However, in this particular venue over the course of these several hours, you've heard lots of opinions from lots of different people. We could provide you with experts who can quote statistics and give you all sorts of suggestions for how they see the medical profession integrating with the insurance industry and with the plaintiff's attorney association. I don't think anyone can take away the right of an individual to sue.

However, in the course of the work we do, we sometimes take care of some very high-risk situations in which there is no malpractice, there is simply maloccurrence. In the fraction of a nanosecond, things can go horribly wrong for someone despite everything otherwise going well. Physicians carry the burden for that, very often for things they cannot control. I can tell you, I've been in many situations over the past 20 years where that is the case. How do you underwrite that, which was your original question to us? I don't know. I'm not in the insurance industry. I deliver babies. But I know people who are in the insurance industry, and they could help you with that.

ASSEMBLYMAN COHEN: Well, I don't know how much they can help, since they seem to be part of the problem, but it is an area that we have to deal with, particularly in the underwriting area, so that doctors are not carrying around claims which have been unfounded or dismissed or as part of a settlement another doctor's carrier pays and the other cases are dismissed. That has to be dealt with because that affects your yearly premium.

DR. SILVERBERG: Yes, it does.

ASSEMBLYMAN COHEN: I think that's a legitimate area that we can deal with. But understand, no one is dealing with that because of deregulation that occurred years ago with the State on commercial lines of insurance. All the State really deals with is solvency issues. What we're saying

is that we may have to jump back in and get involved in order to deal with underwriting issues that we can't get involved with just yet.

I spoke to a doctor at length at the Hudson County meeting that Assemblywoman Quigley was so kind and gracious to invite me to, and I spoke to some doctors about the claims issue with cases that won away or were dismissed or they were part of the shotgun to begin with until the facts sorted out. The doctors were still carrying those claims and, therefore, effectively increasing their premiums based upon that. I just think that may be an issue that the Committee is going to have to deal with.

DR. SILVERBERG: You're on target with that. You can do things about underwriting because the commissioner of insurance and banking stepped in when Zurich Kemper wanted to leave the--

ASSEMBLYMAN COHEN: But not on underwriting.

DR. SILVERBERG: No, but they wanted to leave the state, and she had them remain. She said, "You didn't give enough notice." So this Committee does have a tremendous amount of power with underwriting.

ASSEMBLYMAN COHEN: But let me just say so it's clear. That's a solvency issue. That's what the commissioner was doing. The commissioner doesn't have the authority, because of deregulation years ago, to get into the underwriting criteria and approving rates. We may well have to do that.

That's all I'm saying. Thank you.

Madam Chair, thank you for your time. I want to thank the Committee for their participation.

ASSEMBLYWOMAN WEINBERG: Thank you, Assemblyman Cohen.

What the Co-chair just alluded to is an area that I think we might be able to get some agreement, and that is the fact that all the names are put in the shotgun approach, and then it's carried against your claims for however long it takes to settle these. I have heard that from physicians, as he did on the Hudson County group. I've certainly heard that from the Bergen County physicians that I've met with over the last month or so on this issue. So I think that there might even be some common agreement here between the trial lawyers and the physicians. Something we are exploring. But if there are no further--

Assemblyman Thompson.

ASSEMBLYMAN THOMPSON: Dr. Silverberg, again, I saw the articles referred to earlier about OB/GYNs working to form their own malpractice insurance company. Have you been involved in that? Do you know anything about it, a status and so on?

DR. SILVERBERG: Yes. We started that initiative late December. We got approximately 50 people together so that we could-- Because we saw the malpractice crisis on the horizon. What happened was we thought that we could then take those 50 doctors, package in a single group and then market that group with good physicians to the different insurance companies. Unfortunately, they weren't interested because we're a high-risk industry. We were turned down by all the major carriers. And so, sometime in late February, early March, we decided to form our own captive insurance company. We went from hospital to hospital in northern and central New Jersey. We started accumulating physicians. But then, of course, the MIIX fiasco occurred, and then we saw that we needed to act rather quickly. We then sent a mailing every obstetrician/gynecologist in New Jersey, and we got over 300 physicians who--

We've compiled a database, and we are in the process of forming our own captive insurance company.

ASSEMBLYMAN THOMPSON: Do you see that if you're successful there, that this will go a long ways to resolving the problem for the OB/GYN (indiscernible)?

DR. SILVERBERG: I think legislation is definitely needed. However, we need other things as well. In fact, the plaintiffs' attorney have alluded to policies and procedures. I think we need to implement some form of policies and procedures. We need positive feedback. We need counseling for our physicians. We need newsletters. We need certain periodic training that the insurance companies will provide, and all of these things will help lower, hopefully, some of the claims. I think it's very, very important not to delude ourselves. This problem is not going to go away just by the formation of an insurance company. However, I think having a captive where we all, as obstetrician/gynecologists throughout the state, police ourselves, we regulate ourselves as far as the rates are concerned. We don't have to make a profit. We don't have to pay brokerage fees. We have decreased the administrative costs, and we also administer policies and procedures to lower those costs. That will help and go a long way towards stabilizing some of the OB fees that we see on the horizon.

ASSEMBLYMAN THOMPSON: And what would you say is the timetable on this thing, your directive?

DR. SILVERBERG: We would like to be up and running by September -- August, September.

ASSEMBLYMAN THOMPSON: That would provide some temporary relief, although you need the legislative things that you speak of. I

mean, obviously, you'll be up long before we get the legislation enacted, I mean, through both Houses and the governor signing and everything else.

DR. SILVERBERG: However, I don't think we have much choice. So many of my colleagues, including myself, have expiration dates of December 31 on their policy. Thereafter, the rates are going to be going up to \$100,000 to \$120,000 per doctor. You have no other choice but to either get out of the business or drop managed care plans. Several physicians have talked about dropping managed care plans. What that will do is raise fees to employers. Unfortunately, patients will suffer. They won't get the prenatal care they need. It will push employers to force more of the dollar on individuals working for them. There will be more uninsureds. People in rural areas will not be able to get patient care, as they've already started having difficulty right now.

ASSEMBLYMAN THOMPSON: Obviously, you anticipate that your rates, if you come in with September, will be lower than those that you'd be facing in December without your (indiscernible)?

DR. SILVERBERG: We've been looking at rates of approximately \$50,000 to \$60,000 or \$70,000, which is still not cheap, but sound a lot better than \$100,000 or \$120,000.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chairperson.

Doctors and Committee members, I was provided with the April 2002 issue of *New Jersey Medicine*. And before I tell you, there was an advertisement in this magazine. It was from the Joseph A. Britton Agency. I don't know where they're located. And keep in mind that as a sole practitioner from my professional liability policy of a couple of million dollars, I think I pay

\$9000 to \$10,000 a year. Now let me just show you what it says here. For anesthesiologists, the quoted premium is \$7600.

Now, Dr. Hernberg, who is one of the most respected doctors from Atlantic County, my district, is that figure the figure that you're--

DR. HERNBERG: It's hard to believe that that would be for a policy that someone out three or four years would be able to obtain. That's characteristically low. I would have to know what type of policy it is. I would most likely tell you that's claims made. If it's not claims made, it's the best bargain there is. In which case, it is essentially a come-on policy, because within a year, your premium is going up. It's a claims experience -- broaden. So I would be very suspicious, as looking for something too good. So without knowing more about that and knowing who the company is and what the details-- The difference between MIIX and Princeton is that a couple of things in the terms of policy, occurrence, or claims made and whether you as a physician have any input as to whether a case is settled.

ASSEMBLYMAN D'AMATO: What does the average anesthesiologist pay in the south Jersey area where you and I come from?

DR. HERNBERG: Anywhere probably from \$11,000 to \$20,000, depending on your claims basis.

ASSEMBLYMAN D'AMATO: Look, I intend to follow up on this. Because very quickly, I know the time is late, let me just tell you the other quotes here: Family practice, \$5200; gastroenterology, 9500; general surgeons, 21,000; internists, 7000; orthopedics, 20,000; pediatricians, 5; radiologists, 12; urologists, 12,000. Now, the sad thing is, for the OB/GYN, they are, in fact, quoting 43,000. The reason I'm bringing this to your attention and to my colleagues on this Committee is that some of these figures seem in line with

what I'm paying for malpractice as an attorney. I wonder if we have to study what the malpractice carriers are -- how they're handling these OB/GYN claims? Because there's such a difference here -- 43,000 versus some of these other figures.

DR. BOCHNER: One of the answers that I can give you is this could be a poorly rated company. Also, this could be, perhaps, a claims made in the first year. Oftentimes, what happens is claims made are very cheap, maybe a quarter or a third of the price of a mature claims made policy. So, if it's a third the price, 40 times -- yes, I think that's pretty accurate. Mature being approximately \$120,000. So I totally agree.

ASSEMBLYMAN D'AMATO: The ad says -- and again I'm going to follow up with this company. It said that these companies -- that these quotes are from companies excellent by A. B. Best Company. But again, I just wanted to share that with you, because I saw it in that magazine.

DR. BOCHNER: Sure, but first year claims made may be that way, but mature claims made, probably never.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway, and then we do have a couple of more speakers. I'm asking the Committee's patience and forbearance, those of you who are left, please try to stay so we can get through this.

ASSEMBLYMAN CONAWAY: Britton was the first insurance agent I went to when I went to get my own insurance, and I got quoted about that price. It turned out not to be that. I was the first year in practice, and that was not a price I was able to get. The information has been that those are, again, first-year prices, sort of come-on prices. I didn't end up staying with them, after all that. My insurance which was -- we looked around all over the

place -- somewhat higher than that. But still, as I said, my own broker just told me I'm looking at 50 percent to 100 percent of an increase over my current rate.

The question that I had related to something that Sam had asked earlier, and that was this Supreme Court case, because we've got that in our office, and I'm very concerned about this person who was pitching in and was all of a sudden finds himself in a terrible position in terms of liability, when he was there to help out in a situation that was already difficult, particularly for the chief of the department there being in the surgical suites all the time, I guess both of you are. How often does that happen?

It seems to me that there is a real risk that that particular court decision is allowed to stand. That we're going to have people deciding and if we don't change the underwriting and other things, then we're going to have people deciding. If there's a problem, don't tell me about it. I don't want to hear about it. I'm getting out of here lickety-split, because I cannot afford in this current environment to take the risk of a judgment on a case where I'm not even the attending physician, the physician of record. Is that your concern as well?

DR. HERNBERG: Absolutely, as we're really at the crossroads of all intersections of medicine. Typically, we'll carry higher limits in the minimum of one and three, because of our exposure, whether it's OB or doing general surgery, neurosurgery, or cardiac surgery. If I'm in a room with a podiatrist who I know is not going to carry more than one and three, and there's a nerve injury and I did a spinal, I'm going to be roped in on that. If that gets reported to the data bank, we may figure a ways to mischievously change the underwriting, but my name is still going to appear on the data bank three years

later, even if I'm dismissed, and I'll be allowed two or three lines to respond back to the data bank, which will follow me throughout my career.

ASSEMBLYMAN CONAWAY: And these data banks, and just for the information of this Committee, they are fraught with error. They're talking about creating a data bank here in the state of New Jersey and run by an organization of the Board of Medical Examiners which, as I don't need to tell you again, is fraught with problems in handling their own responsibilities. There are folks who are going to heap even more responsibilities on them with some of these things.

DR. HERNBERG: I'd like to compliment the board, actually. They are the ones who are actually trying to bridge the anesthesia standards which exist in licensed at two-tier facilities, both hospital and surgery centers and put them in the office. We're current -- the guidelines were devised by the board with the assistance of our society. They are being opposed by many groups with parochial interests. They are in the courts now. It will change the standard of care and it will, we believe, improve patient care. These things are not done without a great deal of frustration and conflict on all sides of the equation.

The Board of Medical Examiners is doing a fine job, but it is tough. It is tough for them to do this stuff. The follow-up on the information regarding the incidence of anesthesia deaths, again, is information sitting out there and nothing is being done. I'm a little concerned about creating panels and other bodies of oversight without really involving the physicians in this.

And in answer to Assemblyman D'Amato's question about the low malpractice, the thing you have to consider in addition to whether it's claims made or occurrence is when you're coming out of a policy, whether you need a

tail or nose. If you're coming out of a policy and your claims made, you either got to cough up, literally, depending on what special you're in, you're talking minimum 50 to over a couple \$100,000 to cover your previous acts or you're going to pay a new company to cover what you've been exposed to. So that rate -- I would tell you I know a lot of my colleagues would love to have that rate if it was for someone who was a mature practice. This is a very complicated scenario. There's not a simple answer.

ASSEMBLYWOMAN WEINBERG: Thank you very much, doctors. Thank you for taking the time to appear here.

DR. BOCHNER: Thank you.

ASSEMBLYWOMAN WEINBERG: You can see this is a varied Committee that runs the gamut from doctors to trial lawyers on this side of the podium, as well as on that side. Thank you again.

I would like to call on Peter Guzzo, Consumers for Civil Justice, and there are some of us up here who are just plain old consumers.

P E T E R G U Z Z O: For civil justice.

Thank you, Madam Chair, members of the Committee. The hour is late. We will be brief. I'm Peter Guzzo, Director and Legislative Agent for Consumers for Civil Justice, which is a coalition of citizen, labor, civil rights, victim rights, environmental, and public health organizations. We are the face of the other side of the equation, those who are impacted by changes that are made that restrict the rights of victims and consumers to the civil justice system.

I have a couple of handouts on CCJ's position and also a position statement from the Hemophilia Association that asks for hemophilia victims,

etc., not to have their rights restricted because of this. There's also positions from Citizens Actions and New Jersey PIRG that support this.

Dennis Donnelly, on my left, is counsel to CCJ, who will be giving testimony, and on my right, is Jayne Santasiere, President of Consumers for Civil Justice.

But let me just begin by saying something briefly. I think when MIIX finished their presentation, Madam Chair, the issue became very clear. This is an insurance industry driven crisis. I've been in the halls of Trenton in one capacity or the other for the past 30 years. You can just about track these crises. With the stock market, they're cyclical. They pop up like the locusts every 7 years. When MIIX finished its testimony, Madam Chair and members of the Committee, I think it was very clear that this crisis is something that even MIIX can't explain for New Jersey.

With that, I'd like to ask Dennis Donnelly to give a position statement for the group.

DENNIS DONNELLY, ESQ.: Three very prompt and, hopefully, commonsense points. The first one is this.

ASSEMBLYWOMAN WEINBERG: I don't think your microphone is on? (referring to PA microphone)

Peter, turn yours off.

MR. DONNELLY: Okay, better?

Three quick points, perhaps, and the first is this: Listening to Dr. Hernberg and Dr. Bochner, who are obviously excellent physicians and practice in high-risk specialties and yet have never had a claim against them, I think underscores this real issue of underwriting claims experience, and perhaps, unfortunately, the Legislature having to get back into some regulation in terms

of claims based experienced underwriting. Take two groups of doctors, take one group of obstetricians who maybe have 10 claims against them, and they're getting renewals at \$60,000. And then take Dr. Bochner who has had no claims against him and was at 30,000, and he's also getting a \$60,000 renewal rate, you obviously want to encourage the rate to be raised for those people who are creating the claims and you also at the same time want to make it impossible, perhaps, for MIIX, in this case, to punish people who left them.

I know what Zurich was doing. Zurich wanted to get out of the State of New Jersey, so they deliberately sent increased, very high rates, to anybody they were going to renew. The same way someone comes to your house, and they really don't want to do work, so they give you a high estimate. So I think the underwriting field is crucial. The idea of encouraging and rewarding physicians who practice in high-risk specialties who have not had claims against them and the idea of sorting through the real claims from the unreal claims, or maybe where people get out early, is crucial. And then you're going to have good physicians encouraged to stay here and, perhaps, bad physicians encouraged to leave, and that wouldn't necessarily be such a bad thing.

Secondly, let me help you out with the statistics from MIIX about the first quarter and the million dollars every week. What she said was that in the first quarter of this year, in settlements or in verdicts, they were averaging one case a week during the first quarter. We all know what first quarters are. That's when the courts are pushing cases to be reached. That's when backlogs from three or four years ago are finally being forced to trial, and that's when cases are getting settled. She did not, by any means, really substantiate for you that that's going to be a 52-week event, but it probably was a 13-week event.

So that data you're getting shouldn't be interpreted by you as saying necessarily that you are going to have 52 million dollar cases over the next year. She gave you data from the first quarter. The first quarter traditionally -- and I'm a trial lawyer -- is always a busy quarter and a quarter when cases are getting moved.

Another point about the elderly--

ASSEMBLYWOMAN WEINBERG: Excuse me, he can be a trial lawyer and also represent consumers for civil justice.

MR. GUZZO: They are our best friends.

MR. DONNELLY: Well, if I couldn't, that would be a bad thing, and certainly, the position could be as well.

ASSEMBLYWOMAN WEINBERG: Turn your microphone back on? Whenever I push this button, that goes off. (referring to PA microphone)

MR. DONNELLY: Okay. If I could, that would be a bad thing, and certainly I should be able to do both without any conflict.

And by the way, last month I spoke at Dr. Bochner's institution and gave a grand rounds presentation as a trial lawyer about ways of trying to prevent repetitive errors and adopting a system's approach. And that really leads to my third area. And that is that CCJ -- one of our members is AARP. I think the point has been made and the point has been made well. When you think about caps on noneconomic damages, unfortunately, the elderly are the largest consumers of medical care. Unfortunately -- and it's on the AARP Web page -- a very well done study, they probably have the largest percentage victims, therefore, of injuries from negligent care. And at the same time, they don't have economic damages. They only have noneconomic damages because they've retired from the work force. So I think it would unfairly penalize them.

The last thing I have to say is this, and again, I'm trying to be prompt and I know it's been a long day. I practice and try cases, and I can tell you that the people of New Jersey who serve on juries are doing their job. They're not giving away the store. They are deciding cases fairly, and I can look at them and know that if my case is not strong, they're not going to decide it in my favor. But conversely, and if I can really prove that there was negligence in the medical care, that they are going to decide the case fairly.

I think there's a lot of fear on all sides and a lot of misunderstanding, and I think there is a legitimate insurance issue that needs to be addressed. I think most of the other issues are being dealt with fairly and appropriately.

Jayne.

ASSEMBLYWOMAN WEINBERG: Yes. Go ahead.

J A Y N E S A N T A S I E R E: As we get older, elderly, our needs for medical care get greater. Therefore, the chance for a mistake to be made is greater, due to the sheer number of doctor visits, procedures, extended care. I'd like to just personalize this, and again, it's been a long day, and I'm sorry for that.

Personally, if you put cost of insurance aside for a moment, bring the victim of medical malpractice to the forefront, what's that individual to do? Now add to the situation that the victim is an elderly person, 65, 85, 100 years old, your mother, your father, somebody elderly. Their health has been compromised and maybe this person again is your mother, 82 years old. Now she needs extensive care and treatment. She taught school and was able to retire after 30 years. Again, she did not earn the right to have a medical malpractice suit. However, if she brings this lawsuit forward because of medical

malpractice, removing the wrong breast, and she's 85 years old, or a man who is given too much anesthesia suffers a neurological problem, you're saying a medical malpractice suit is bought on -- is brought on -- I'm as tired as you are, and I'm sorry -- and he can only realize a \$500,000 recovery for pain and suffering. It doesn't cover anything.

Eighty-five year old people are living to 100. They're going into a nursing home because their health has been compromised. Nursing home facilities require a minimum of \$100,000 a year. That's without extra care because they've suffered a neurological problem. I don't see how this is possible. I don't think it's fair. I don't think it's reasonable to even consider putting a cap on something like that. Our elderly have to be protected. They cannot speak for themselves again if their health has been compromised.

The real issue is not the high cost of insurance. It's practicing safe medicine. I need to know I can go to a doctor and have him be responsible. I look to doctors to be responsible and take care of me. I don't want medical malpractice to happen to anyone of us here, but if it does, to recover and have it capped, it just seems unfair. Again, the elderly cannot and aren't able to be heard and spoken for after something tragic has happened.

Now, I heard MIIX earlier say, and correct me if I'm wrong, that they were founded in 1977 because of the medical malpractice crisis in New Jersey. It's not in New Jersey. It was perhaps across the board. I don't believe our lawsuits are frivolous. I do believe there are real, real tragedies. What does it say other than let's have doctors not make mistakes? The insurance industry needs to be corrected, needs to be overseen, but basically, we just cannot afford mistakes. We need, when those mistakes are made, to protect the people that

can't speak for themselves or need extended care. The elderly need to be recognized.

Thank you. And again, it's been a long day. There was a lot we all wanted to say, and we're getting older, as well.

ASSEMBLYWOMAN WEINBERG: Thank you.

MR. GUZZO: Madam Chair, just one other recommendation--

ASSEMBLYWOMAN WEINBERG: Yes, Peter.

MR. GUZZO: --in terms of what can be done. I would bring to your attention a bill that I don't think there's an Assembly counterpart, but it's Senate 1408, sponsored by Senators Vitale and Matheussen. This allows for the formation of purchasing alliances by physicians. I think this would be a very competitive practice, in addition to what you heard today where doctors are forming their own companies. If this bill would be enacted and would authorize and legitimize purchasing alliances, doctors would have a powerful bargaining tool for approaching medical malpractice insurance companies for and at rates that they would be able to negotiate as a unit, not as individual doctors.

ASSEMBLYWOMAN WEINBERG: Any questions?

ASSEMBLYMAN CONAWAY: Just one, I think one. You mentioned the noneconomic damages and that if someone is elderly, those noneconomic damages, are they-- Is the life of the person ever at issue in any case when noneconomic damages are brought to bear? Say someone has the same amount of noneconomic damage, if you could determine that, and they're 30 on the one hand, and they're 80 on the other hand, are those damages or the amount of the award there ever different because one is 30 and the other is 80?

MR. DONNELLY: Absolutely. Every time there's a claim made, it's a claim based on time and on life expectancy. In a litigated case, you'll have a life expectancy table, you'll have experts indicate. The cases are sometimes defended on the premise that, yes, there was a mistake. Yes, it was a serious injury. Yes, there's extensive pain and suffering, but you're only going to survive another year. So it's always factored in. The key point we were trying to make is this, and that is that, basically, children and the elderly are always going to be the ones who don't have "the economic loss," but in contrast they have a tremendous personal, individual pain and suffering loss, and they would be the people you'd be capping.

ASSEMBLYMAN CONAWAY: Well, I'm trying to--

MR. DONNELLY: And let me explain why.

ASSEMBLYMAN CONAWAY: What I'm trying to figure out is whether this is a seesaw kind of a thing or not? If you lose one, do you gain the other, or is it--

MR. DONNELLY: Now, let me explain, Doctor. First of all, as the point has been made, lawsuits are expensive to bring, let's say, a medical negligence case. If an elderly person comes to a lawyer and pain and suffering has been capped at \$500,000, and the lawyer says, "Look, it's going to cost \$200,000 by the time we get to trial to present your case," the chance may be the lawyer says, "I cannot take your case. Because when all is said and done, even if I were successful, the maximum I could recover for you is this." Instead, what we have now is we have juries who are told that they can only award for the life expectancy of the person. We have juries that in -- no one is giving you data that there are 10s or 20s or 30s, let alone 100s, of New Jersey jury verdicts where New Jersey juries have suddenly said, "We want to give away a lot

money.” It does not happen. They respond to overwhelming catastrophic cases.

I mean, I represented a young girl who was left blind and brain damaged for the rest of her life, and she was 18 years old. That’s a lot of pain and suffering.

ASSEMBLYMAN CONAWAY: Yes. Which is why I’m concerned about the cap -- by capping it.

But I have two other questions and that is: Was this sort of just a make up kind of a thing that the president of MIIX was saying? I mean, do you believe in your experience that we are seeing and are likely to see an increase in the number of these million dollar either adjudicated cases, settled cases--

MR. DONNELLY: The answer is that is has been consistent over the last several years and it will remain consistent, subject only to basically the way our society changes its attitude. And after all, that’s what this country is all about. It could be next year that we see fewer verdicts because juries feel as a social decision, that okay, this year we think less of this. It could be the year following, but over the course of five years, it’s been static. It’s been consistent. It’s been regular. Essentially, what we have is two problems or three problems during this year. We had some bad business decisions made by MIIX that hurt people. We had 9/11 that hurt people. We had a stock market reverse, that hurt people, and we had a business which for the last five years was underselling itself and now has to make up for that. And finally, we have a business, and this is the point, I think, the qualitative point that has refused to make decisions between doctors as to pricing.

They’ve looked at Dr. Bochner and they’ve looked at another doctor, and they’ve said, “Well, you’re just two obstetricians.” And they said,

“Okay, \$70,000.” But instead of looking at the one obstetrician who maybe has 10 claims against him and help create some of the problem and said, “Okay, you’re \$100,000,” and looked at Bochner and said, “Wait a minute. You’ve been practicing 20 years in a high-risk speciality, and you have no claims. You’re still at \$30,000.” But they don’t want to make those decisions, so they said instead, “We’re just going to raise everybody’s rates across the board, and secondarily, those people who left us, we’re going to punish them when they come back and charge them more.” That’s not right.

ASSEMBLYMAN CONAWAY: And lastly, I mentioned a number of things other than the caps on noneconomic damage that are mentioned, and you made. You might not want to stick your head in a noose, but are there things that you could-- Because we’re hearing costs-- Certainly my colleagues are saying that we need to reform something about the way cases are either entering the system, about the way they’re adjudicated by the courts, how money is distribution, etc. Are any of those things things that we ought to be doing or none of them? I mean, are we just going to ride merrily along without any kind of intervention?

MR. DONNELLY: That’s not really a good thing either. You did something four or five years ago called an affidavit of merit, which has worked, and basically has limited the amount of cases. You could consider ways to try and eliminate the so-called shotgun effect. And one of the proposals may have some merit and maybe it requires the medical people, Bochner, and the trial lawyers to sit down and how to figure it out and, that is, how to weed out the fact that a legitimate claim is brought on the one hand versus you’ve got to name 12 people and really only 2 people are the ones you need to name. That

should be a focus because that's going to reduce cost. It's going to reduce defense costs because you're not going to have 12 lawyers running around.

And let me tell you, I do this for a living. I don't want 12 lawyers on the other side of the case, and I don't want 10 doctors who don't belong there. I want the one or two, legitimately, if it's a case, who made the error. But we have this difficulty of getting at the information because there's nondisclosure and there's sort of, like, "Hey, I don't want to tell on my colleague, etc.," and that's a problem. If we're going to look anywhere, that's where we should look.

MR. GUZZO: Assemblyman, may I also just interject something. You're asking what can we do, where can we look? I think Assemblyman Cohen hit it on the head, in my opinion. Look at the industry. They threw the grenade. They caused the problem, and then they walk away. This is something that MIIX said. They said, "The problem we have today is the result of a decade-long industry price war." This problem was created because of poor business practices, poor investment practices, and they walk away leaving the rest of us fighting among ourselves -- consumer fighting doctor fighting lawyer. It's the industry that needs to be regulated and be reined in in this situation with this crisis.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

We've heard from the insurance people, the doctors, the trial lawyers, the consumers, and now I'd to call Elizabeth Ryan who is General Counsel for the Hospital Association.

And hopefully, unless somebody I didn't call is still here and has waited five hours, hopefully this will be near the end of our testimony.

Is there anybody else here who has signed up that we haven't called? Okay, so there will be one more after Elizabeth Ryan, and the remaining Committee members get rewarded somehow.

Go ahead.

ELIZABETH RYAN, ESQ.: Good afternoon. Thank you for staying to hear my testimony. There's been a lot of interesting input this afternoon, and I just briefly would like to comment on the medical malpractice crisis from the hospital industries perspective. And I have with me, Margie Davino, who is the General Counsel from St. Joseph's Hospital in Paterson, and she'll briefly upon what she's seeing within the four walls of St. Joseph's.

I've submitted written testimony, and I'm not going to read from it, but I did want to bring the Committee back to the MIIX problem, and then just comment briefly upon sort of the idea that this entire crisis has been brought about by MIIX. I don't own stock in MIIX. I have no allegiance to MIIX, but I just do want to point out that other insurance carriers in this state are having difficulty: PHICO, which did a lot of business particularly in southern New Jersey is in liquidation; Zurich wants to leave the state; St. Paul's pulled out. Obviously, we've gone over the MIIX problems, so it's not just one medical malpractice insurance company in this state that's having financial difficulties. Many are. My research shows that according to a company called A. M. Best, in terms of premium dollars brought in and paid out, for every dollar of premium that medical malpractice insurance companies brought in in New Jersey last year, they paid out \$1.39. So something is askew.

But what I really want to spend my time devoted to this afternoon is to ask you to look at the problems that may be caused by MIIX. Pat Costante testified, and I think she is very articulate and knows what she's

doing, but one thing that was sort of glossed over is this. MIIX insures 9000 out of 20,000 physicians in the State of New Jersey. MIIX Advantage, the new company that she's seeking to form, is only seeking to insure somewhere between half or a third of the positions insured by MIIX. So that means we are going to have literally thousands of physicians currently insured by MIIX without medical malpractice insurance in the coming months.

Now, MIIX insures. They do renewals on a monthly basis, so it's not going to be immediate that all the MIIX insured physicians are going to be without medical malpractice insurance, but it will happen. That's if MIIX Advantage is sort of a going concern, if it can find financial backing from physicians in the State of New Jersey. If not, we will have 9000 doctors insured by MIIX without medical malpractice insurance creating, as others have indicated, a huge public health crisis and an access to care crisis, I think, which New Jersey has never seen before.

A few comments on MIIX Advantage. It is seeking capitalization from individual physicians. They have to invest in order to get medical malpractice insurance in MIIX Advantage. The average investment is \$11,000, but the range is between \$5000 probably for, like, a family practitioner, a general practice physician, to \$25,000, probably for OB/GYNs and neurosurgeons. So that's the up-front money that Pat Constante is seeking going around the state. Query whether or not physicians in this state who have already invested in MIIX will want to recapitalize a company that is, frankly, going to be managed by the same people who managed MIIX.

NJHA, you have a copy of the one survey we've already done, and Assemblyman Conaway quoted from it. We're doing a second survey to find out whether or not physicians in this state are interested in MIIX Advantage,

because we think it's really important to know sooner rather than later if MIIX Advantage will be a going concern. So physicians are going to have to make this initial investment. They're going to have to pay their premium.

Now, Pat testified, too, that the premium increase will be 10 percent in the aggregate. That in the aggregate is very important, because again, I think OBs, neurosurgeons, ER physicians, are going to have significant premium increases from MIIX and if it's predecessor, if MIIX Advantage is successful, that new company MIIX Advantage.

The other thing I just wanted to ask you to consider in your oversight capacity is whether or not the reserves that MIIX has put aside, the \$1.2 billion is sufficient to pay all the claims filed to date and claims that haven't been filed yet. That's significant because if it is not sufficient, and I'm not saying it's not. I'm not an actuary. But if it is not sufficient, then claims in the future would go the New Jersey Guarantee Fund, and the maximum payout there is \$300,000. Anything over and above that, individual physicians would have to pay. They're personally liable. So I think that's a very important point that the Committee must look into.

We at NJHA have established a task force, and we are studying what other states have done with respect to the medical malpractice insurance crisis, and hopefully, at your second hearing, we'll be able to come up with some tangible recommendations. But I did take the liberty of copying for you and distributing this chart. And I know the idea of tort reform hasn't met with great success to the Committee from listening to the testimony for the four or five hours we've all been here. But this chart, which was done by the National Association of Insurance Commissioners, shows that the reforms enacted by the state of California in 1975 have worked to keep down medical malpractice

insurance premiums in the state of California. You can see that they have gone up. They haven't held them absolutely stagnant, but as compared to the rest of the United States, they have kept them down. And I think it is something that the Committee should look at. Look at California. Look at the MICRA law that was enacted there. I think it's worthy of your time and attention.

And then finally just to comment on affordability. You've heard from physicians in the state. Affordability is an issue regardless of the MIIX crisis. Put MIIX aside, and I think what I've just told you is very sobering about the 9000 physicians who may go bear very shortly. But the other carriers in the state are hiking premiums so much that affordability is actually pushing people out of the practice of medicine. I get calls each and every day from physicians who are saying, "I'm thinking of leaving the practice of medicine. Do you think the Legislature will do a real tort reform? What should I do?" It's reached that crisis, and I think you're all getting similar calls.

So I would just direct your attention to California. We'll come back at the second hearing with more specific recommendations, and I'd like to turn it over to Margie for her comments.

Thank you.

MARGARET DAVINO, ESQ.: Thank you for listening to me at this late hour. My name is Margaret Davino. I am the General Counsel of St. Joseph's, and I just wanted to mention a little bit about the impact of this medical malpractice crisis and insurance crisis on hospitals and also on access to care, specifically access to care for the medically underserved who don't have the money to necessarily shop around for another doctor or to pay out of pocket.

St. Joseph's is located in Paterson, New Jersey, which is, as you all know, a very urban area and one of the areas in the state with a higher poverty level. We, therefore, employ a number of our physicians to provide care for our patients because many physicians don't want to take care of patients in their offices if those patients have no insurance, regardless of the fact that they may be working, but their jobs don't provide insurance for them, or the fact that they have Medicaid, because Medicaid pays about \$18 per office visit, and that doesn't even cover the doctor's overhead. So, therefore, the only way a lot of these patients get medical care is we employ the physicians to provide insurance for them.

We, therefore, as the hospital, are responsible for carrying the cost of the doctor's malpractice insurance, and the increase has been staggering. Last year on our doctor's malpractice policy, it was approximately \$750,000. This year we're paying close to \$1.4 million just for those limited amounts of doctors who are on that policy, not including the doctors whose insurance we reimburse part of.

For example, St. Joseph's has almost 3000 deliveries a year -- babies delivered a year. Of those almost 3000 deliveries, over half of them are what we call "service patients," patients who don't have a primary care obstetrician because they can't afford one. They don't have insurance, whatever reason. When we contracted with our obstetrician to provide care for those service deliveries this year, the obstetricians told us that the only way they could afford to do so was if the hospital would pay the percentage of their malpractice premium that was attributable to covering the service patients, because they perceived the service patients as being more litigious. They are a higher risk medically, because most of these patients don't have any access to care

beforehand and haven't received prenatal care. And therefore, because we didn't want over 1500 patients to come into the hospital and not have an attending physician be available to deliver their baby or to supervise the residents, we were in a position where, indeed, we as the hospital had to pay the malpractice premiums for the doctors.

We have a situation right now where the chief of our perinatology area -- perinatology, as you probably know, is the area of OB that delivers all the high-risk babies -- has one malpractice claim that he has ever had against him. He's never had a claim in private practice, but when he was in his residency program, he was named in a lawsuit. He was at University of Tennessee, and they decided that they were going to apportion a part of the settlement to his name. So that was 23 years ago. And because he has one malpractice case in which he was named -- he is with MIIX -- he's tried to leave MIIX because of the concern that MIIX is going to go under. Princeton won't take him because he has a claim. ProNational won't take him because he has a claim. Another three insurance companies won't take him because he has a claim. The only insurance company that will take him has told him that his premium will be approximately \$220,000. Well, \$220,000 is maybe a little less than he makes after taxes, but not a lot. And so, he is waiting until the end of this year to see what happens with MIIX or whether or not the OBs are able to form their own practice to determine whether he's going to move out of state or whether he's just going to stop practicing OB.

That creates a huge problem for us as the hospital, who feel as though our mission is to care for people who don't have other ways to access care. Because what are we going to do in terms of providing care for high-risk deliveries if this gentleman leaves? We have no idea.

I just wanted to mention a couple of things that were brought up earlier. The gentleman from the American Trial Lawyers Association talked about New York, that there was a reporting statute that was passed there that requires hospitals to report different incidences. I want to comment on that since I worked in New York as a lawyer for 16 years, and I was in New York while that statute was passed and over the past number of years. New York has a very strong peer review protection for information that's discovered in the peer review process or, specifically, for hospitals as part of their quality assurance risk-management program. So, when hospitals make reports, they know that nobody else is going to be able to access that information. When hospitals in New York come up with peer review material or risk-management material, they again know that nobody else is going to be able to access the information.

New Jersey is one of the two states in the nation that does not have that kind of statute to protect hospitals information in terms of providing--

ASSEMBLYWOMAN WEINBERG: When you say nobody else, are you talking about the general public?

MS. DAVINO: I'm sorry. I'm talking both about the general public and about the plaintiffs bar. In New York, New York has two separate statutes, one is specifically for peer review information under the education law, and the other one is specifically under the public health law for hospitals and nursing homes that provide quality assurance and risk-management review. It specifically states that any quality assurance or risk-management material that's generated as part of the hospital's risk-management process is not discoverable in any type of civil litigation.

ASSEMBLYMAN CONAWAY: We're one of only two in the whole country that lacks this protection?

MS. DAVINO: New Jersey and Kentucky. So, therefore, hospitals are very concerned that when we provide what we do, when we do a peer review process, and when we come up with the written information, we think who's going to be able to access that? Is the plaintiffs lawyer going to be able to subpoena that, and if they are, are they going to be able to subpoena successfully? So, I would ask this Committee to please look at that in terms of possibly other avenues that may be able to have some success in this area.

The second thing I wanted to comment on was the question as to whether or not there's really been an increase in medical malpractice verdicts and settlements. And speaking from a hospital standpoint, the answer is there is absolutely has been an increase, both in verdicts and settlements. It hasn't just been this year. It's been ongoing over the past two, three years. And, in fact, we've seen our premiums increase because of that. It's gotten worse this year. It's gotten much worse, but it's been increasing steadily over the past couple of years. It's really to the point where, unfortunately, because - at least the perception in the medical field is that if you lose a case, you could really lose it big and have a lot of responsibilities for a payout that, even if you don't think that the case is really meritorious, if it's a case where there's a very sympathetic plaintiff, you'd better seriously consider settling.

ASSEMBLYWOMAN WEINBERG: I'm going to ask our OLS staff if -- since we hear such divergent testimony on this particular issue -- if you could find out any real statistics from the Administrative Office of the Courts on exactly what's happened over the last three to four years.

ASSEMBLYMAN CONAWAY: You mean, with cases and amounts?

ASSEMBLYWOMAN WEINBERG: Right. Right. Whether there has been a spike over the last year or the first quarter, whatever, if that's available.

So, thank you very much.

MS. DAVINO: Thank you.

MS. RYAN: Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you for your patience.

The last speaker, if I'm correct, are you Dan Strauch?

DANIEL W. STRAUCH: Yes.

ASSEMBLYWOMAN WEINBERG: Medical Group Management Associates.

But just before you speak and before everybody leaves, I would like to take a moment to thank the OLS staff, David Price and Mary Beaumont, for helping to put this together, as well as our office staff, Sheila Kenny, while we were doing all the work on this and then managing to stay here during the last -- about five hours.

So you are the curtain call, hopefully, Mr. Strauch.

ASSEMBLYMAN CONAWAY: You'd better be good. (laughter)

MR. STRAUCH: Hi. My name is Dan Strauch. Is this on? (referring to the PA microphone)

ASSEMBLYWOMAN WEINBERG: Yes.

DR. STRAUCH: I'm the Executive Director of ID Associates, an infectious disease group practice. I appreciate the opportunity to speak to you. I appreciate your considering this important issue, and I just want to share a

very short, brief story about our group. I'm the manager of a physician practice. We have 10 physicians. We practice infectious diseases, which is a specialty of medicine treating all kinds of infections -- Lyme disease, HIV, hepatitis, hospital infections.

We were previously insured by PHICO, and we were forced to change late last year. As you know, PHICO is now in receivership. Our physicians feel personally exposed. We appreciate the coverage with the New Jersey guarantee fund, but there's obviously a potential shortfall if those cases would be settled for anything over \$300,000. Our physicians have some personal liability and exposure that makes them very uncomfortable.

I would encourage the Committee to consider increasing that maximum case settlement amount to above \$300,000. Most policies are written for at least a million dollar coverage, and that might make some sense. We changed companies, not of our own choice, but we had to. We solicited quotes from five companies, through brokers. Three companies opted not to quote at all to us, even though we were very low in terms of the number of claims. Of the two quotes, I wanted to make you aware that our premium costs increased 120 percent from last year to this year. It's a huge jump, and this increase in our cost comes from no other place other than the amount people get paid, the amount we can spend on supplies, equipment, and our overall overhead is increasing. I feel little control to do anything about that cost.

We have been concerned about the increase in insurance costs. We're concerned about next year's premium jump. If it goes up again, it may jeopardize our ability to serve patients or recruit another doctor to our practice or to serve patients most in need. I'm not sure what the right solution is. I appreciate your concern about it, because I think it's going to continue, as

you've heard from other physicians and other physician groups, it's going to continue to be a very hot issue.

I'm a believer in tort reform in terms of having some kind of statutory limits on what pain and suffering should be worth. It shouldn't be worth millions and millions of dollars just because juries feel sorry for somebody who got hurt. Unfortunately, there are bad outcomes. Our doctors see patients who are very sick, a lot of ICU cases and patients who have blood-borne illnesses and infections that can be fatal and sorry that there are sometimes bad outcomes. It's tragic. We don't want to see it. We practice good medicine. But just bad outcomes don't mean that awards should always be there for cases that go to trial.

We also feel that there should be some kind of either rate control on premiums or some ability for government to have an impact on these increases, because it will have an impact. I used to practice in Philadelphia. I managed physician services there. I know doctors who have left the state. We don't want to have in New Jersey what Pennsylvania is going through, and I encourage your continued efforts to control the rate of increase and to provide more accessible malpractice insurance for physicians.

That's all I have to say.

ASSEMBLYWOMAN WEINBERG: Thank you.

ASSEMBLYMAN CONAWAY: And, of course, a lot of folks are here, but just for the record. It's a point that I tried to make earlier. You're not able, in the current environment, to increase the amount of revenue that you can gain through increases in what you charge for services in order to meet the increased insurance premium that you're going to pay? There's no place to go.

DR. STRAUCH: That's correct.

ASSEMBLYMAN CONAWAY: HMOs, we can do nothing with them. We can't negotiate with them. We can't raise our premiums. Medicare is cutting there costs, right?

DR. STRAUCH: Our rates are set by outside forces.

ASSEMBLYMAN CONAWAY: You've got insurance companies with mandate after mandate for paperwork and all sorts of nonsense. You've got to hire people who have salaries that need to be paid, insurances and other things that -- you have to be paid. So all of those things are there, and we can't do anything about them. You certainly can't raise the revenue in your group. You don't see any way to do that?

DR. STRAUCH: We just have to do more volume, that's all. It's the only way.

ASSEMBLYMAN CONAWAY: So this increased premium on medical malpractice is going right against your bottom line--

DR. STRAUCH: That's it.

ASSEMBLYMAN CONAWAY: --and your ability to pay physicians, who currently can't work any harder than they're doing and even to get somebody else to join the group, because they're not going to come for the kind of salary that you're able to pay in the current environment. Is that right?

DR. STRAUCH: Exactly. That is very true. It also affects our ability to recruit physicians. They hear about the costs, and they know that New Jersey's, already cost of living is higher than other surrounding states or other parts of the country, and we're competing with that. So, as malpracticing increases grow as well, that makes it even more difficult to attract good candidates.

ASSEMBLYMAN CONAWAY: Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Mr. Strauch.

I also neglected to thank Linda Brokaw for sitting at the machine for five hours. I think you only got up once. I kept my eye on you, Linda. (laughter) So congratulations. Yes, I'm going to have to go take lessons from her.

Well, to the vast audience out there, thank you very much for sticking with us and particularly to my colleagues, Assemblyman Jack Connors and Assemblyman Herb Conaway.

ASSEMBLYMAN CONAWAY: Burlington and Camden Counties all the way, boy.

ASSEMBLYWOMAN WEINBERG: We're terrific.

Thanks.

ASSEMBLYMAN CONAWAY: Thanks.

(HEARING CONCLUDED)