PUBLIC HEARING

before the

New Jersey Legislature.

SENATE, LABOR, INDUSTRY AND PROFESSIONS COMMITTEE

on

Assembly, No. 1552

(Medical Malpractice Liability Insurance).

Held:

Senate Chamber
State House
Trenton, New Jersey
April 8, 1975

Committee Members Present:

Senator Edward J. Hughes, Jr., (Chairman)

Senator James H. Wallwork

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I N D E X

I N D E X (Continued)

[SECOND OFFICIAL COPY REPRINT]

ASSEMBLY, No. 1552

STATE OF NEW JERSEY

INTRODUCED APRIL 16, 1974

By Assemblymen SALKIND, FLYNN, VAN WAGNER, WORTHINGTON, Assemblywoman CURRAN, Assemblymen RYS, FITZPATRICK, KOZLOSKI, D'AMBROSA, GALLO, RUANE, Assemblywoman CROCE, Assemblymen HERMAN, BAER, NERI, NEWMAN and KEEGAN

Referred to Committee on Commerce, Industry and Professions

AN ACT concerning *[the practice of medicine and surgery and supplementing chapter 9 of Title 45 of the Revised Statutes]* *medical malpractice liability insurance, requiring certain licensed medical practitioners and health care facilities to maintain such insurance, and creating a New Jersey Medical Malpractice Reinsurance Association, a New Jersey Medical Malpractice Reinsurance Recovery Fund and a New Jersey Health Care Facility Insurance Deductible Fund*.

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

[1. No license to practice medicine and surgery shall be issued by the board unless the applicant therefor shall submit proof satisfactory to the board that he has or will have on the effective date of his license a professional liability insurance policy with minimum limits of coverage as shall be specified by the board in its rules or regulations, but in no event shall such coverage be less than $100,000.00 for any one claimant.]

[2. No annual certificate of registration shall be issued or renewed, and any such certificate may be revoked or suspended, by the board with respect to any licensee who fails to maintain professional liability insurance as required in section 1 of this act.]

*1. *This act shall be known and may be cited as the "Medical Malpractice Liability Insurance Act."*

2. a. The purpose of this act is to assure that the public is adequately protected against losses arising out of medical mal-

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

practice by requiring licensed medical practitioners and certain health care facilities to carry medical malpractice liability insurance, to make such insurance readily available to licensed medical practitioners and health care facilities by requiring certain general liability insurance carriers to write medical malpractice liability insurance and establishing a reinsurance association to equitably spread the risks for such insurance, to provide for recoupment of losses resulting from the operation of the association through surcharges on insureds and establishing a health care facility deductible fund to permit substantial deductibles in the coverage for such facilities without severe budgetary hardship.

b. This act shall apply to medical malpractice liability insurance as defined herein.

3. As used in this act:

a. "Association" means the New Jersey Medical Malpractice Reinsurance Association established pursuant to the provisions of this act.

b. "Commissioner" means the Commissioner of Insurance.

c. "Licensed medical practitioner" means and includes all persons licensed in this State to practice medicine and surgery, chiropractic, podiatry, dentistry, optometry, psychology, pharmacy and as a bioanalytical laboratory director.

d. "Medical malpractice liability insurance" means direct insurance against loss or damage resulting from accident to or injury suffered by any person arising out of or in connection with the practice of any licensed medical practitioner or the operation of any health care facility for which the practitioner or facility is liable.

e. "Health care facility" means and includes all hospitals within this State, and any other health care facility as defined in the "Health Care Facilities Planning Act" (P.L. 1971, c. 136) (C.26:2H-1 et seq.) whose inclusion hereunder is deemed necessary by the commissioner, after consultation with and upon the advice of the Commissioner of Health and the Health Care Administration Board, to adequately effectuate the purposes of this act and is provided for by rule or regulation of the commissioner.

f. "Plan of operation" means the plan of operation of the association approved or promulgated by the commissioner pursuant to the provisions of this act.

4. There is hereby created an unincorporated, nonprofit association to be known as the New Jersey Medical Malpractice Reinsurance Association consisting of all insurers authorized to write, within this State, on a direct basis general liability insurance which

have written during the 24 months preceding the effective date of this act medical malpractice liability insurance of the type subject to the provisions of this act anywhere in the United States of America. Every such insurer shall continue to be a member of the association and shall be bound by the plan of operation thereof so long as the association is in existence as a condition of its authority to continue to transact general liability insurance in this State. Any other insurer may become a member of the association if the commissioner is satisfied that such insurer is willing and able to provide the necessary services to policyholders and claimants for the type of insurance required under this act and approves its membership in the association.

5. The association shall, pursuant to the provisions of this act and the plan of operation, have the power:

a. To assume 100% reinsurance or a lesser percentage on any policy of insurance or binder subject to this act;

b. To provide for separate accounts of reinsurance assumed for all categories and subcategories of insureds;

c. To maintain relevant loss, expense and premium data relative to all risks reinsured in the association and to require each member to furnish statistics in connection with insurance ceded to the association at such times and in such form and detail as may be deemed necessary;

d. To establish fair and reasonable procedures for the sharing among the members of profit or loss on risks reinsured in the association and other costs, charges, expenses, liabilities, income, property and other assets of the association, and to assess members for their appropriate shares in accordance with participation ratios to be established in the plan of operation on the basis of the ratio of the members' direct premiums written to the total direct premium written by all members in this State for the coverages subject to this act;

e. To receive and distribute all sums required by the operation of the association;

f. To establish procedures for reviewing claims procedures and practices of members and in the event that the claims procedures or practices of any company are considered inadequate to properly service the risks ceded by it to the association, the association may establish a claims program that will undertake to adjust or assist in the adjustment of claims for the company on risks ceded by it, and in such event shall charge such company a reasonable fee for establishing and operating such claims program;

g. To audit the operations of member companies to such extent as the Board of Directors determines to be necessary to assure compliance with this act, in a reasonable manner and at such reasonable time or times prescribed by the Board of Directors;

h. To sue and be sued, provided that no judgment against the association shall create and direct liability in the individual member companies, and the association may provide for the indemnification of its member companies, members of the Board of Directors and officers and employees and such other persons acting on behalf of the association to the extent permitted by law;

i. To review the market for insurance subject to this act throughout this State to make certain that eligible risks can readily obtain such insurance and to provide in the plan of operation a reasonable means for achieving this objective by requiring all members, in a fair and equitable manner, to discharge their responsibilities under this act.

6. Within 30 days after the effective date of this act, the commissioner shall call an organization meeting of the association for the purpose of constituting a board of directors. Every member of the association shall be a member of the board of directors if the number of association members does not exceed nine. If the number of association members exceeds nine, the commissioner shall appoint nine members to serve as members of the board of directors after consultation with all the members of the association, and in making such appointments he shall give due consideration to the various methods of operation and the distribution by class of risks among the members.

The commissioner shall appoint three representatives of producers to be members of the board of directors.

Each member of the board of directors shall be entitled to one vote. The producer representatives on the board of directors shall be eligible to vote on all matters not directly involving the association's budget and personnel administration.

The plan of operation shall provide for rotation of the membership on the board if the membership of the association consists of more than nine insurers companies.

Except as may be delegated to others in the plan of operation or reserved to the members, the board of directors shall have full power and responsibility for the establishment and operation of the association.

7. a. Within such time as shall be prescribed by regulation of the commissioner, the directors shall submit to the commissioner, for

his review and approval, a proposed plan of operation. Such plan shall provide for economical, fair and nondiscriminatory administration and for the prompt and efficient provision of medical malpractice liability insurance throughout the State. Such proposed plan shall include: preliminary assessment of all members for initial expenses necessary to commence operations; establishment of necessary facilities; management of the association; assessment of members to defray losses and expenses; underwriting standards; procedures for acceptance and cession of reinsurance; and such other provisions as may be deemed necessary by the commissioner to carry out the purposes of this act. The plan of operation shall provide that the premium charged for reinsurance shall be the primary premium charged for the coverages and limits ceded less the expense allowances. The expense allowances shall consist of the amounts actually incurred by the member on the ceded risk for commission and brokerage, taxes, licenses and fees as determined in ratemaking for general liability lines of business, and an allowance for other acquisition and general administrative expenses based on the member's countrywide insurance expense exhibit and determined in the manner used in ratemaking, and an allowance for unallocated loss adjustment expenses as determined in relation to the definition of allocated loss adjustment expenses in the statistical plan used by the member. No expense allowance shall be permitted in excess of the total expense allowances provided in ratemaking for medical malpractice liability insurance in the latest rate revision or experience review for a rating organization.

b. The proposed plan shall be reviewed by the commissioner and approved by him if he finds that such plan fulfills the purposes of this act. In his review of the proposed plan the commissioner may, in his discretion, consult with the directors and other members of the association and any other individual or organization. If the commissioner approves the proposed plan he shall certify such approval to the directors and said plan shall take effect 10 days after such certification. If the commissioner disapproves all or any part of the proposed plan of operation he shall return same to the directors with a statement, in writing, of the reasons for his disapproval and any recommendations he may wish to make. The directors may accept the commissioner's recommendations, or may propose a new plan, which accepted recommendations or a new plan shall be submitted to the commissioner within 30 days after the return of a disapproved plan to the directors. If the

directors do not submit a proposed plan of operation within 90 days after the effective date of this act, or a new plan which is acceptable to the commissioner, or accept the recommendations of the commissioner within 30 days after the disapproval of a proposed plan, the commissioner shall promulgate a plan of operation and certify same to the directors. Any such plan promulgated by the commissioner shall take effect 10 days after certification to the directors.

c. The directors of the association may, on their own initiative, amend the plan of operation at any time, subject to the approval by the commissioner.

d. The commissioner may review the plan of operation whenever he deems evpedient, and shall review same at least once a year, and may amend said plan after consultation with the directors and upon certification to the directors of such amendment.

8. On and after the date that reinsurance is available from the association:

a. No member of the association shall refuse to issue to any eligible risk a policy of insurance of the type normally afforded by such insurer to the public, utilizing the rates, rating plans, rules and classification systems then in effect for such insurer; provided, however, that the coverages and coverage limits to be afforded may be ceded to the association; and provided further that nothing herein contained shall require any insurer to accept any risk if such insurer's policy forms or rates do not provide for the acceptance of such risk, unless the association or the commissioner determine that such forms or rates are unfairly discriminatory or are otherwise inconsistent with the public policy of this State;

b. No duly licensed insurance agent, broker or solicitor regularly engaged to solicit general liability insurance shall refuse to furnish to any eligible risk quotations of premiums for any insurer with whom such agent, broker or solicitor places medical malpractice liability insurance policies, or shall fail to submit any eligible risk to such insurer selected by the applicant when requested directly to do so by such applicant;

c. No company shall terminate any agent or restrict the authority of any agent, directly or indirectly, or in any manner whatsoever, solely by reason of the volume of such agent's business it cedes to the association or the experience produced by such ceded business. Neither shall any company make any distinction in remuneration to the agent between business retained and business ceded, or use any promise of reward or threat of penalty, present or

future, or any device whatever, related to certain classes of risks or other classes of business, which would tend to induce the agent to avoid certain classes or types of risks.

[*9. On or after the date the commissioner declares that medical malpractice liability insurance is available for the various categories and subcategories of licensed medical practitioners and health care facilities subject to the provisions of this act, each licensed medical practitioner and health care facility shall maintain medical malpractice liability insurance in amounts at least equal to the minimum limits prescribed by rule or regulation of the commissioner for the category or subcategory of such practitioner or facility. Failure to maintain the insurance coverage required herein shall be grounds for revocation or suspension of the license of a licensed medical practitioner or health care facility, and no license for a licensed medical practitioner or a health care facility shall be issued or renewed unless adequate proof of the insurance required hereunder is submitted to the appropriate board or agency in the form and manner prescribed in the rules and regulations thereof.*]

[*10.*] **9.** *There are hereby created two funds, one to be known as the New Jersey Medical Malpractice Reinsurance Recovery Fund (hereinafter referred to as the recovery fund) and the other to be known as the New Jersey Health Care Facility Insurance Deductible Fund (hereinafter referred to as the deductible fund). The purpose of the recovery fund is to provide a financial backup for the plan of operation of the association and shall be used to reimburse the association for losses sustained in excess of premiums ceded and expenses incurred in the operation of the association. The purpose of the deductible fund is to provide a financial backup for that portion of incurred losses under policies issued to health care facilities that are within the deductible limits of such policies and shall be used to reimburse a health care facility for 75% of the loss not covered because of a deductible provision for any claim which is paid by an insurer. Both funds shall consist of all payments made to them by insurers as hereinafter provided, of securities acquired by and through the use of moneys belonging to the funds, moneys appropriated to the funds, together with interest and accretions earned upon such payments or investments. The funds shall be administered by the commissioner and the State Treasurer in accordance with the provisions of this act.*

[*11.*] **10.** *For the purpose of providing moneys necessary to establish the recovery and deductible funds in amounts sufficient to meet the requirements of this act, the commissioner*

shall establish reasonable provisions in the rates for policies of all categories and subcategories of medical malpractice liability insurance. Such provisions in the rates may vary by category or subcategory of risk in reasonable relationship to the loss experience of the association attributable to such category or subcategory.

[*12.*] ***11.*** *The funds created by this act shall be separate and apart from any other fund and from all other State moneys. The State Treasurer shall be custodian of the funds and all disbursements from said funds shall be made by the treasurer upon vouchers signed by the commissioner. The moneys in the funds shall be invested and reinvested by the Director of the Division of Investment as other trust funds in the custody of the State Treasurer in the manner provided by law.*

[*13.*] ***12.*** *The commissioner, after consultation with and upon the advice of the boards or agencies responsible for licensing and regulating the medical practitioners subject to the provisions of this act, and with respect to health care facilities, the Commissioner of Health and the Health Care Administration Board, shall establish categories and subcategories of risks for medical malpractice liability insurance based upon accepted insurance principles, and shall prescribe reasonable minimum limits of coverage for each category and subcategory. The commissioner may establish minimum deductibles to be applicable to policies subject to this act, which deductibles may vary by category or subcategory of risk, and shall give due consideration to such deductibles in ratemaking by appropriate premium discounts.*

[*14.*] ***13.*** *The commissioner may promulgate reasonable rules and regulations to carry out the purposes of this act, and may suspend or revoke, after reasonable notice and a hearing, the certificate of authority to transact insurance in this State of any insurer which fails to comply with the provisions of this act, rules or regulations promulgated thereunder or any plan of operation.*

[*15.*] ***14.*** *If any provisions of this act or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and for this purpose the provisions of this act are decluared to be severable.*

[*16.*] ***15.*** *This act shall be liberally construed to effectuate its purposes, and all laws or parts of laws of this State inconsistent with this act are hereby superseded to the extent of such inconsistency.**

[3.] **[*17.*]** ***16.*** This act shall take effect *[90 days after its enactment]* **immediately**.

ASSEMBLY COMMERCE, INDUSTRY AND PROFESSIONS COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1552

STATE OF NEW JERSEY

DATED: FEBRUARY 10, 1975

This bill makes malpractice liability insurance compulsory for all medical practitioners and health care facilities and makes provisions for making such insurance available through licensed New Jersey insurance companies.

Since it is realized that different medical practitioners require different limits of liability coverage, such as surgeons compared with nurses, the minimum required limits of coverage will be determined by regulation after consultation between the Commissioner of Insurance, the Commissioner of Health and the Health Care Administration Board.

The act contemplates the use of deductibles which may vary by category of risk; this feature will reduce the cost of insurance for those who maintain a claim free record.

In order to assure complete availability, the act provides for the establishment of a reinsurance facility. Those companies that are licensed to write general liability insurance in New Jersey and that have the expertise in providing appropriate policyholder service for this type of insurance, companies that write medical malpractice insurance anywhere, will form a panel of companies that will accept every applicant for medical malpractice insurance. Any risk that such insurer does not wish to carry on its own account can be ceded to the reinsurance facility. Funds to absorb any deficit of the reinsurance facility will be obtained through periodic premium adjustments to be determined by the Commissioner of Insurance on the basis of appropriate ratemaking procedures.

SENATOR EDWARD J. HUGHES, JR. (Chairman): Good morning, ladies and gentlemen. I want to apologize for the public hearing not getting underway. I am Senator Hughes and to my left is Senator Wallwork.

This public hearing has been requested by Senate President Dodd, relative to malpractice insurance.

I would like to have everyone observe what I would term a brevity approach on their talks. In the event there is repetition, the Chair will request that this be deleted from any statements. Now, if there is more than one individual from a group that wishes to speak, we will allow you five minutes to get your heads together and decide on who is going to be the spokesman, because we don't want this to go into a lengthy hearing which becomes again, as I say, repetitious information as far as the Committee is concerned. So we will wait for five minutes so that any groups who are here can get together and decide on who will be the spokesman.

All right, I will open the meeting with Assemblyman Salkind.

I would like everybody called upon to identify themselves so that the Court Reporters can record same.

M O R T O N S A L K I N D: Mr. Chairman and members of the Committee. I thank the Senators for scheduling this meeting today.

My name is Morton Salkind, I am State Assemblyman from the 11th Legislative District elected from Monmouth County.

I am going to try to follow the Chairman's instructions of a few minutes ago, not to duplicate in any way the testimony which will be given later today by our Commissioner of Insurance of the State of New Jersey and, therefore, I will avoid some of the specific detail and some of the specific reasons for advocacy. But

I would like to start by reviewing briefly the legislative history of this bill which is now before this Committee of the Senate.

On April 16, 1974, Assembly Bill 1552 was duly introduced in the Lower House. It was a bill which had the sponsorship, together with me, of the members of the Committee on Commerce, Industry and the Professions, as well as other Assemblymen and Assemblywomen.

The bill basically, in its original form, required the carrying of medical malpractice liability insurance as a requirement for licensure, by medical doctors in the State of New Jersey. The bill was released, unanimously, as obviously it would be as a Committee-generated bill, to the floor where opposition to the concept developed. The bill was then referred back to Committee by myself and, as the problem of the availability of medical malpractice liability insurance developed it became a serious problem in New Jersey, in New York State, and throughout the United States, as far away as California, it was decided by me, as the chief sponsor, and by several of my colleagues that the correct procedure would be to expand the framework of the bill to try to solve the problems for New Jersey.

With that in mind, I went to the Commissioner of Insurance who, of course, as our leading Administration official in this area, had already developed solutions to the problem in anticipation of the problem becoming a crisis, and I met with the Commissioner and with the then Chief Counsel for the Assembly Committee, as well this Committee, Tom Bryan, who is now one of the Senior Researcher in the Legislative Services Agency, and the bill that is now before you, previous to floor amendment in the Assembly, was the result of that work, together with the Commissioner of Insurance and his staff, including Mr. Stern, the Chief Actuary for the Department.

The bill was duly considered at several meetings by the Assembly Committee and was released to the floor. At that time, it was considered to be far-reaching, landmark legislation. We had not yet reached the crisis stage in New Jersey.

I might add, parenthetically, that the bill was filed in its entirety under the number of Assembly 3094 on February 4, 1975, but it was the decision in the wisdom of the Committee that the bill would be released as an amended version of A-1552, which is the number of the bill before you. The two bills are, of course, identical.

Mr. Chairman, during the period just prior to the recess, a crisis situation developed in New Jersey which for the first time placed us in the same situation as our sister states. We found that one of the large insurers, the largest company providing this insurance nationally, Argonaut of California, which is a subsidiary of Teledyne, decided for various reasons, various fiscal reasons, both stated and misstated, - which will be discussed after a while - that it would demand great rate increases, as much as 410%, or it would threaten or indeed would get out of the business of providing this kind of coverage in the various states.

Each state that has been involved has considered various methods of solving this problem. When the 30 hospitals in New Jersey found their insurance cancelled, including one of the great institutions in my county, The Medical Center commonly referred to as Fitkin, in Neptune, Monmouth County, - when these cancellations occurred, for the first time everyone understood what a crisis could be as hospitals and doctors could not get insurance. And many doctors in our State find themselves unable to get medical malpractice liability insurance,

not only at reasonable prices but in some cases at any price. And despite various allegations to the contrary, testimony before the Assembly Committee during the hearings on this bill developed official numbers from the companies involved admitting to charging individual doctors in the past year as much as $35,000 for policies. And, of course, in the press we have seen allegations of as much as $80,000 being charged to individual doctors.

Hospital charges, as these costs have escalated, have increased twofold and threefold and fourfold.

This bill would do one thing which would have two effects. One thing it would do, it would set up a medical malpractice liability reinsurance facility, which means in layman's terms, and I am not a lawyer and I am not an insurance agent of any kind, and I will speak in layman's terms as the citizens of our State would speak, - it says, just as you do in the automotive assigned risk field, that if someone isn't going to get insurance in the regular manner that he can be assigned to this facility and the companies must share in providing the coverage. All of this under the direct responsibility and control of our Commissioner of Insurance.

Now the effect of this, in simple layman's terms, is, number one, it would force the competition and eliminate monopoly. In the long run, anytime you have monopoly it's going to cost more and do less. And I think that the history of the United States so clearly proves that that I would be insulting the Senators if I took any time on that subject. We all understand it. But it's so essention that no one should ignore it.

The second part of the effect is that it would make it readily available to people under a control of

the State situation as far as price goes. So that doctors and hospitals alike wouldn't find themselves faced with a company being able to say, if you don't want to take it at our rates, which are outside of the standard schedule, and our rates which may be two or three or four times the standard schedule, then you won't have it at all. Because under this circumstance, the Commissioner of Insurance would be able to protect the people of New Jersey by setting the rates fairly and equitably in all categories, which is not the case today. The Commissioner can speak about that in detail later.

So what we have here in Assembly 1552, as adopted in our House, is a bill that protects the people of New Jersey. And the criticism that has been given by some who are in opposition to the bill, for various reasons including personal and fiscal, is that it doesn't do what they would like it to do in other areas.

Well, my concern, Senators, is to protect the people. And this bill does protect the averate man and woman who goes into a doctor's office or into a surgical situation or similar visit to a hospital and, God forbid, has something happen. And when I hear people who talk about revising the system, whether it's to take it away from juries and have it go into a compensation type of board or an arbitration type of panel; when I hear people talk in terms of limiting the amounts of awards that can be gotten, as some have suggested; when I see people talking in terms of, let's limit the statute of limitation so that if it doesn't come to the surface in two or three or five years it's too late for the citizen to sue, I begin to wonder what we're all about.

Basically, any one of us who has watched nationsl television or read the national news media over the course of the last three or four months has been exposed to the various illustrations - some of which

have come from our own and nearby states - of people who have gone -- young people as well as those of greater life experience -- who have gone into hospitals in a surgical situation and found themselves coming out as - I don't like to use the word but it's true - total vegetables. Intelligent, good-looking, nice, fine, young men and women have had their lives totally and irreparably destroyed in various ways. And I won't bore all of us and I won't frighten all of us by telling the ways, but I do recall seeing a CBS-TV national coverage graphically illustrate that problem, young people going into the hospital and coming out forever ruined. And when you talk about a maintenance figure to keep them alive, that maintenance figure must be supplied somewhere. It's beyond the ability of any family of even affluent means to do. Then the jury award system seems still to work in our country.

But that's not the point of this bill and that's not before us. Whether the basic system should be revised or not should be the subject of other legislation, just as New Jersey took the lead in a recent session of the Legislature when it passed far-reaching legislation, indeed the best in the country in my opinion, limiting greatly the amount of contingency fees that the attorneys of our State were allowed to receive for awards of this type. And New Jersey is the leader, nationally, in that field.

In the same way, this bill gives Nes Jersey the opportunity to be the leader, nationally, in providing effective medical malpractice liability insurance for all people in the State who need it.

It's interesting to note that bills exactly like this are being prepared in six other states at the present time. The most recent of these is in the State of Florida, which has received no publicity in our area. I

have before me the Miami News of April 1, 1975, and on the front page of that publication, in this Associated Press story, the headline says: "Require Hospital Malpractice Policy". It's datelined Orlando: "'The Florida Hospital Association will ask the upcoming Legislature to force insurance companies to write malpractice policies' the organization's Executive Director said today. Jack Monyhan outlined the proposal following a decision by Argonaut Insurance Company" - I think I've heard that name somewhere - "one of the nation's largest malpractice insurers to cancel the policies of 60 Flordia hospitals." It seems like they did the same thing here, didn't they? "Monyhan said, 'the legislation recommended by the Association would create an assigned risk pool to be funded by premiums paid by the hospitals and require all insurance companies to share in the risk. This is the same kind of thing that's done now in Workmen's Compensation and Automobile Insurance' Monyhan said. 'It creates a market at rates determined by the insurance commissioner.'" That's exactly this program. And Florida, as I say, and all six states are ready to follow our lead. And the Commissioner can detail some of the experiences that he's had with his colleagues nationally who are looking to New Jersey and looking to this House of our Legislature to see what they can expect in their own states.

Mr. Chairman, on April 4, 1975, last Friday, WNBC-TV, Channel 4 in New York, produced an editorial on this bill which I would like to read into the record. I have a copy for the Committee. This was fortunately telecast at prime time, at approximately 7 PM on Friday night, where it was able to be seen by millions of people in New York and New Jersey and the greater metropolitan area, hopefully in Pennsylvania as well:

PUBLIC HEARINGS WILL BE HELD IN TRENTON NEXT WEEK BY THE NEW JERSEY SENATE'S LABOR, INDUSTRY AND PROFESSIONAL COMMITTEE ON A BILL THAT OFFERS A NEW CONCEPT IN PROVIDING MALPRACTICE INSURANCE COVERAGE FOR DOCTORS AND HOSPITALS.

THE BILL, SPONSORED BY ASSEMBLYMAN MORTON SALKIND, HAS BEEN PASSED OVERWHELMINGLY BY THE ASSEMBLY AND HAS THE FULL SUPPORT OF STATE INSURANCE COMMISSIONER JAMES SHEERAN WHO SAYS IT WOULD PROTECT CONSUMERS, DOCTORS AND MEDICAL FACILITIES FROM THE EFFECTS OF SOARING PREMIUMS FOR MALPRACTICE INSURANCE.

THE MEASURE WOULD REQUIRE ANY INSURANCE COMPANY OFFERING MALPRACTICE COVERAGE IN OTHER STATES TO ALSO PROVIDE COVERAGE TO NEW JERSEY PHYSICIANS AND HOSPITALS IN ORDER TO DO ANY OTHER KIND OF BUSINESS IN NEW JERSEY.

A REINSURANCE RECOVERY FUND WOULD BE ESTABLISHED UNDER THE BILL, SIMILAR TO THE ASSIGNED RISK POOL FOR AUTO INSURANCE. INSURANCE COMPANIES COULD THEN PLACE ANY POLICY CONSIDERED EXTREMELY RISKY INTO THAT POOL. FUTURE CLAIMS WOULD BE PAID FROM THAT POOL.

IT IS A UNIQUE CONCEPT AND ACTUARILY, IT IS SOUND. THIS BILL SHOULD BE ADOPTED INTO LAW.

That is the opinion of WNBC-TV. It is also my opinion.

I have read in the last few weeks in national business publications how medical malpractice liability insurance throughout the United States is a dilemma. Indeed, in the March 31, 1975 issue of Barron's Magazine, which is published by Dow-Jones, The Wall Street Journal, it was the lead story, continuing in the current issue. It was interesting to read and, of course, one can popularize this by talking about the unethical sex case award in New York, or things like that which really have no bearing on the day-to-day problems, but this is a patient's dilemma, not just a businessman's dilemma, certainly not a doctor's dilemma, it's a patient's dilemma. And I suggest that everyone take the time to read how the insurance companies that are involved all say, give us more rates, double, triple, quintuple the rates, or we

are not going to do it. And it goes into it in the nth degree of detail, talking about St. Paul, talking about the other companies who are anxious to get out of the business and talking about how only, according to Barron's, 10 companies nationally are still able to offer insurance policies of this kind.

I think, Mr. Chairman, that when a citizen goes into a hospital, when a citizen visits his or her doctor in his or her office, he should have every right and she should have every right to expect that if, God forbid, statistically the patient falls into one of those cases that has trouble that he or she will have protection. He shouldn't be able to see the doctor going behind the professional - the PA concept to be able to walk away without recourse to the patient in a situation where the insurance company is unable to fulfil or where there is no insurance company. He shouldn't be able to have a hospital just point to bankruptcy and say, we can't do it. And, above all, he shouldn't be able to find that doctors, as has happened in some specialties in our State right now, recognizing their inability to get this kind of coverage in certain narrow specialties, their inability to afford the coverage which exceeds, as I say, in some cases the $50,000 mark going up to allegations approaching $100,000, that it has forced doctors in these specialties to give up their private practice and take employment on a salary from hospitals, receiving their expenses and so on, because the end result of that, Mr. Chairman and Senators, is that we're going to end up with socialized medicine, a bugaboo that those who speak in opposition to this bill would speak in even greater opposition to but have not thought through the end product Because what this medical malpractice liability crisis has done in now a few cases is it has pushed doctors in these specialties, such as the nth degree of neurosurgery, out

of the private practice field and into working for a salary, which is not what they want to do, which is not the American way.

How much longer, Mr. Chairman, will we have to read editorials and will we have to see headlines of the type that we saw just in March - and I have here one of our Monmouth County papers, the Asbury Park Press for March 27 with a headline which says - an AP story our of Trenton - "Malpractice Insurer Asks 410% Hike." That's not the way to do it. It's not right to see our hospitals threatened and there's no reason for it.

Mr. Chairman, the Legislature of New Jersey is in the unique position of being able to act with existing legislation that's before it at a time when there is not a day-to-day crisis but an overall one. It doesn't have to act in haste; it can act with reason. The people of our State are watching us and they're watching us for a particular reason that goes far beyond medical malpractice and the pool concept of this bill.

I've had the privilege, with deference to my seniors who are sitting on this Committee, of serving, having been elected three times to local or State office. I have been interested in politics all my life, and I guess I've read heavily on it and watched it, both from afar and, more recently, close up. Yesterday the Assembly passed a bill sponsored by one of my colleagues from Bergen County, the so-called Sunshine Bill, which your House will consider in due course and will decide yea or nay. And supposedly that's to be an answer to opening up our system. Well, I've watched the results on this bill until now; I've watched the pressure on this bill until now; I've looked at stories, such as the article in the Journal of Commerce of March 27 referring

to the actions which resulted in the removal from the floor to this Committee under a headline: "New Jersey Insurers' Doctors Win Delay on Creation of Malpractice Pool" which has talked about the lobbying effort in opposition to this bill in both Houses.

I might say, Mr. Chairman, through my political experience I have never seen a greater, more flagrant lobbying effort against a proposed piece of legislation than has occurred in this particular one, going back to the original movement in the Assembly Committee when lobbyists almost succeeded by going to various people in removing a bill that was duly posted on an agenda from that agenda. Fortunately, that did not occur.

Mr. Chairman, this bill should stand on its own feet, and I know it will. And thank God it's before a Committee that has a group of Legislators on it who are concerned about consumers and concerned about public interest above all. And I feel quite secure in that knowledge.

But the people of New Jersey, as this bill proceeds through this Committee and to the floor itself, with any modification that in the wisdom of the Committee is necessary, - the people of New Jersey are looking beyond this bill. The question that is before it today in this hearing and, indeed, in the whole action on this bill is whether the people of New Jersey run the State through their duly elected Legislators or whether the special interests of New Jersey run this State through their various lobbying interests in the private sector.

I'm for education and I'm for public interest information, as the lobbyists love to call themselves, but I think that once and for all the people of New Jersey have to come first. This is our test. A-1030 is not our test. All the other bills we've talked are not our test. Assembly 1552 is our test in 1975 as

to whether or not the people of New Jersey are going to come first. And I thank God that we're in the hands of an intelligent Committe under the leadership and chairmanship of a very fine, outstanding Senator who understands the whole problem.

I will be glad to answer any questions on the bill. I thank you for hearing me at this time.

SENATOR HUGHES: Is there a good reason for individual doctors and/or hospitals not being able to get insurance? Do you have any input on that?

ASSEMBLYMAN SALKIND: Let me illustrate some of the reasons that are offered as good reasons. I don't think they're good reasons but some of the companies take them as good reasons. For example, sometimes a person --

SENATOR HUGHES: Are they valid reasons in your opinion?

ASSEMBLYMAN SALKIND: Senator, in my opinion, the public interest is served if no one is denied this type of insurance. And, therefore, any reason which is offered by the companies in denying that insurance should not be allowed to continue. Perhaps it should have to go into an assigned risk pool kind of setup such as this bill offers. But at no time should a medical doctor licensed in our State, and even those few who practice without licensure in our State, be allowed to not have medical malpractice insurance available for the protection of his patients when he wants it. And no health care facility, hospital or otherwise, should be denied the opportunity to have this type of protection to protect their patients when they want it. Anytime a company is able to effectively either deny the insurance totally or in practice deny the insurance by charging rates outside the standard schedules as approved by the Commissioner of

Insurance, set by the companies themselves. Then I don't think the public interest is being served, so my answer to your second question would be no. It should never be possible for a doctor or a hospital to not obtain this coverage if it wants to.

SENATOR HUGHES: No. I think you misinterpreted my question. My question was, is there a good or valid reason for individual doctors and/or hospitals not being able to get insurance. If so, how is this established.

ASSEMBLYMAN SALKIND: At the present time the companies cite the following reasons for not making available such insurance:

A. A doctor is brand new to the profession and is not a member of the society in some cases, therefore, they deny it;

B. A doctor has been in a particular specialty where he is considered high risk by the actual nature of the specialty, such as some of the specific areas of neurosurgery and, therefore, they deny it.

C. A doctor operating in such a narrow specialty who has a statistical history of problem, as the insurance companies in their cold, businesslike fashion would look at it, tends to have a problem getting a continuation of that insurance, for example, a brain surgeon who statistically has had problems over a period of time, even though he may be an excellent practitioner.

A fourth reason is often used in the denial of such protection to public and semipublic institutions. For example, the Public Health Service facilities run both for the benefit of our State and New York State at Staten Island, is an example of what I am talking about. And sometimes, last, but certainly not least, patients who are in other health care facilities, other than what we would normally refer to as hospitals, in various nursing homes and related type facilities, cannot

have this protection and just arbitrarily the other companies side.

Now, many times the company will say - particularly in the last case - okay, we will insure you, but we won't do it through the standard rates. You will have to pay a rate, and they will name something four or five times the standard rate, and it is take it or leave it to the facility, which I don't think is fair, either.

SENATOR HUGHES: You mentioned the statute of limitations. Do you feel that this should be made a part of the bill? My question there would be, what if another illness affects the original sickness or injury? How would this be determined under -- for example, as I understand, you believe the statute of limitations should not be invoked or included.

ASSEMBLYMAN SALKIND: On that, I think it is a very basic question, and I have two different answers. The first part of my answer dealing with the question at hand is that I personally do not believe that the statute of limitations section should be abruptly and markedly reduced, because I think that a patient can find a defect of magnitude showing up after a period of time, which,if one narrowed it to three years from the original illness or five years from the original surgery or something of that sort, might not show up during that period, and it is unfair to the patient.

I do recognize, however, that there is a problem that is worthy of review in this field. The second part, therefore, of my answer is this: I don't think that the question of changing the statute of limitation on medical malpractice awards should in any

way be part of this legislation. I think this legislation deals with availability and pricing to the consumer, to the public interest. That is really what this bill is about. I think there should be separate legislation if it is the will of the Senate and the Assembly to change the statute of limitations provisions. That is an entirely separate although related program, and if it is to be done, it should be the subject of a separate piece of legislation.

My own personal opinion at this point is, I would not promptly support such a change, although I recognize the fear of both doctors in the field and the companies serving the field, that they could get hit in a lengthy period of time later. There has to be something that protects the patients and at the same time meets their goals. I think that should be separate legislation.

SENATOR HUGHES: Well, supposedly, for the sake of discussion, the individual didn't have any problems with the original illness or injury, and somewhere within the statute of limitations something happened that precipitated - from a diagnostic standpoint now, because I am not a doctor - incapacities within the individual, how would this be determined? This is one of the things I am trying to ask. I am not asking you as a professional individual, but, I mean, there is nothing in the bill that would cover this type of -- other than the reinsurance poll.

ASSEMBLYMAN SALKIND: At this time, this bill does not address that problem as a separate problem at all. All this bill does is cover the area providing

the availability of insurance, and, as I say, the pricing control through the Commissioner.

In reality, the question that you address is a valid question pertaining to today's existing law outside of this entirely, and I think it is a worthy subject for review legislatively. I don't think it belongs in this bill. That is the point I am making, that the matter of the extension of time of the secondary effect, which is really what you are talking about, of the various things up to and including lawyer's contingency fees - which I feel have already been covered - but all of those things are each worthy of study in their own right, and should not be in any way taken as part of this program and should not be allowed in the lobbying efforts to divert our attention from the specific problem that this entails.

For example, in all of the areas that have been covered by the various opponents to the bill, with the single exception of companies directly involved, they don't deal with the subject of the bill. What they deal with are what I might call the collateral or peripheral areas of concern in the field of medical malpractice. Those are all worthy of study and are all worthy of investigation and are all worthy of consideration of amendments to the present law. I am not denying it. Whether or not I support specific amendments would be beside the point. I don't think they should be allowed to interfere with the deliberations on this particular piece of legislation.

SENATOR HUGHES: Didn't you say that

some insurance companies provide this insurance in other states and not in New Jersey?

ASSEMBLYMAN SALKIND: Yes, sir.

SENATOR HUGHES: If so, do you have any documentation of this?

ASSEMBLYMAN SALKIND: I would like, on that particular question, to yield to the Commissioner of Insurance who can document it completely for the committee. It is a known fact that that is the case, and I could specifically name companies, but I think he should do that. I would state to you that,on the company's side, that is one of the areas of their greatest concern with the bill, since part of the heart of the bill is to say that any company which has offered or offers this program anywhere in the United States - has offered it during the past two years or offers it currently in any other state - must offer it in New Jersey as a condition of doing general writing in New Jersey. That is the heart of this bill, as far as I am concerned.

The Commissioner can give you specific examples later in the program, Senators. It is a very valid question.

SENATOR HUGHES: Thank you. Senator Wallwork.

SENATOR WALLWORK: Assemblyman Salkind, is there a crisis now in the medical malpractice field in New Jersey?

ASSEMBLYMAN SALKIND: In my opinion, we have a crisis situation that is in an embryonic-development stage. We have been able, by having a step-in, if you will, and some high premium charges

to avoid what would have been a crisis of the month of March, and that crisis has temporarily been avoided also by the litigation of the Hospital Association.

SENATOR WALLWORK: How was that crisis avoided?

ASSEMBLYMAN SALKIND: The company that indicated that it would completely step out of the field, cancelling all existing policies to hospitals,

A. Was prevented through the court injunctive process.

B. Was stepped into in a lurch by another company who said that as part of their effort - in my opinion, with no slur intended as part of their lobbying effort against the bill - decided that they would step in and serve, I believe, twenty-nine -- I said thirty before, but I believe it is twenty-nine -- hospitals that had their insurance cancelled throughout our state. But, of course, you recognize, Senator, that many of the costs of these facilities have now gone up astronomically, and I cite you, and I know the Commissioner will refer to it, the example of our State College of Medicine and Dentistry, on the subject of mere premium experience in 1975.

So I think we have two crises that are developing fast in New Jersey, although not as fast as in other states. I think that is because of our Commissioner of Insurance. He has been able to keep us from having a crisis situation that we have elsewhere.

The first one is an availability crisis. The second one is a cost crisis. There are two different crises.

SENATOR WALLWORK: How is your bill going to hold down the cost to the consumer?

ASSEMBLYMAN SALKIND: Two ways. First, by creating competition. I think it is a fundamental axiom of American business that when you have competition that the cost to the consumer in the long-run is lower. Secondly, by ---

SENATOR WALLWORK: How does it create competition?

ASSEMBLYMAN SALKIND: I think that the reference to the earlier question from Senator Hughes, as far as companies that provide insurance elsewhere in the United States, have tried or successfully do not offer it in New Jersey will force competition. I think if this bill is not adopted, we will end up where in a year from now in New Jersey there will be no more than one or, at the maximum, two companies offering this type of coverage in the State, probably one. And I think that is the worst monopolistic situation.

If this bill is adopted, and does become law, I think that you will find somewhere around a dozen to eighteen companies offering this kind of protection. There are approximately close to two dozen offering it right now in the United States.

SENATOR WALLWORK: Well, what is going to prevent any of these companies from dumping all of the insurance that they write into the pool?

ASSEMBLYMAN SALKIND: Well, first of all, under the control of the Commissioner, if they ended up doing that very thing which has been threatened, as we both know, I think in the longrun that would have no effect, because the Commissioner would end up controlling the cost and setting the scales in such a way that it would equalize out across the State.

SENATOR WALLWORK: Does the Commissioner have the ability to set these rates? Does he have the expertise and the staff to set these rates?

ASSEMBLYMAN SALKIND: Senator, I think he does. If he doesn't, we have a problem in New Jersey that we better understand very quickly. I think he does have that, but the Commissioner should answer that himself.

To answer one thing that you had said a moment ago, I think -- and I am reading from the Barron's article, although we have independent data at the state level -- the ten firms that are currently offering malpractice policies - and these are the ones currently, not the ones that have offered it over the past two years, which would actually more than double that figure - are Saint Paul, which has gotten out of New Jersey; Travelers, Argonaut, Chubb, Aetna, Hartford, CNA, Medical Protection Company, Signal Imperial Insurance Company, and Shelby Mutual.

Now, of these companies - and I will only pick a couple as an illustration - Hartford Insurance, Aetna, CNA, are the three that I will

pick. I could have picked others. These three companies cannot get out of the general insurance business in New Jersey without adversely affecting their overall economic situation. They are all big, national, general insurance carriers. If they were to get out of that business in New Jersey, their stockholders would obviously be very unhappy. So I think that what this says is,whereas they cannot offer this today in New Jersey, if they wish - or tommorrow - that this would require them as a matter of business practice to have to participate.

I am convinced, very sincerely convinced, that if this is done, and if it is placed under the direct control of the Commissioner of Insurance so that all rates are under his control, as they are not today, in the long-run not only will the doctors and hospitals benefit, but, after all, it is the consumers who pay for it. They increase hospital charges and they increase medical charges, and therefore they would end up saving money in the long-run. The scare tactics that have been used in one particular case, where the one company that has a virtual in-house situation with the Medical Society of our State, insuring only those members of the Society until the recent addition of the hospitals, they are saying that they can do it cheaper than anybody else. I think that over a period of time we will end up with the greatest maximum efficiency. Either that, or, you know, it is a whole system that is the question. It is not anything to do with this particular field. We are talking about basic economics.

SENATOR WALLWORK: Well, your legislation would mandate that Argonaut, for instance, be in this pool; would it not?

ASSEMBLYMAN SALKIND: Yes, sir. Unless they wanted to get out of the insurance business, totally, in our State.

SENATOR WALLWORK: Say Argonaut was maintained in this pool and it went bankrupt. What would happen then to the pool?

ASSEMBLYMAN SALKIND: Well, let's go back a step. First of all, if Argonaut is only in the medical malpractice liability business - and I can't speak with knowledge on that - but if that is their only business, and they want to get out of that business, they can do so, even under the pool set up. Because if they want to drop out of the general insurance business in New Jersey, they can do it.

Remember, the bill only says -- it doesn't force someone to continue to do business in New Jersey. It forces them to offer this kind of protection if they want to do any business in New Jersey. That is the point. Now, I don't think that there is a chance in the world of any of these large companies going bankrupt, unless it is a manipulative situation, quite frankly, and I can speak with some knowledge on that subject.

SENATOR WALLWORK: What incentives are there in your bill to make sure that the insurance companies that are in this pool will operate economically and efficiently? What if they just throw up their hands and say, well, we are

in the pool; we will just not worry about our costs and the Commissioner can come in and audit our books and he sees this is the amount of money we have expended, so that is the rate. And it is a wash transaction, so far as they are concerned. How is your bill going to prevent that?

ASSEMBLYMAN SALKIND: I think the Office of the Commissioner of Insurance is going to prevent that. I think, if you go back to the fundamentals of the present insurance business in New Jersey, and the best illustration -- we do have an experience factor with the assigned risk program in the automobile field that has worked.

SENATOR WALLWORK: But you can't compare automobile experience with medical malpractice.

ASSEMBLYMAN SALKIND: Only the numbers change, Senator. The theory doesn't change. The numbers in specific award cases can change. The numbers of participants can change. The numbers of companies involved can change, but theoretical aspects don't change. The practical situation is this, what this bill does is give a greater control over pricing policies to the Commissioner of Insurance. It removes the present structure of, if you will, policies that are outside his area of ability to regulate for the benefit of New Jersey citizens. It removes those as a practical matter, placing those policies either in regulated areas directly or in what I will call the assigned risk pool. So that in any event, either way, we

find that the Commissioner is able to do his job better. Now, as far as the actual formulas, as far as the ability of the Commissioner to keep businesses operating economically, operating fairly, I think we have that exact situation today. All you are doing is giving him a tool to be able to do it all the way, instead of being limited as he is today by covering some aspects of the field and not other aspects through what I call the exempt situation.

SENATOR WALLWORK: Does Fitkin Hospital have insurance now?

ASSEMBLYMAN SALKIND: Fitkin Hospital has insurance as of today. I am quite concerned, and I was concerned about this subject before Fitkin was cancelled, but as far as Fitkin goes, as of this moment they have insurance. I would like to know they are going to have insurance in May and June and July. And I would like to know they are going to have that insurance at a fair rate regulated by the Commissioner of Insurance of New Jersey.

By the way, Senator, I served on a hospital board of directors and board of trustees. I am intimately familiar with this particular problem, and I am concerned that we could bankrupt our hospitals if we don't protect them in this area. That is a separate subject.

SENATOR WALLWORK: I have no further questions, thank you.

SENATOR HUGHES: One further question, and maybe you can answer this. I understand that there is Federal legislation going through along these lines at the present time. How does this compare with the Federal legislation?

ASSEMBLYMAN SALKIND: In broad strokes, there is a similarity between this and the Federal legislation. Certainly the conceptual parts of the Federal legislation are similar. I think as far as the individual regulation by the State Commissioner there are obvious differences. I think that Commissioner Sheeran is better equipped to talk about that particular subject than I, but again, I would like to see the Federal legislation, but I don't think we should wait for it. I think it is important for New Jersey to continue its normal position of leadership for our nation.

SENATOR HUGHES: I have no further questions. Thank you, Assemblyman.

ASSEMBLYMAN SALKIND: Thank you, Senator.

SENATOR HUGHES: I will now call on Senator Mc Gahn, please.

J O S E P H L. M c G A H N: Mr. Chairman, Senator Wallwork, good morning and thank you very much for the opportunity. I was late in getting here.

SENATOR HUGHES: Senator, will you identify yourself.

SENATOR MC GAHN: My name is Joseph L. Mc Gahn. I am a self-employed physician licensed in the state of New Jersey in the specialty of obstetrics and gynecology. For the record, I would like to say there is no conflict of interest. I am not employed by a hospital. That is in case any of the Senators in this chamber would like to question this later on. I am not employed by a hospital and I am not employed by any pharmaceutical firm. I have no interest in them and receive no remuneration from them in that particular respect.

I would like to address myself today from a dual standpoint both as a physician and as a legislator. I was somewhat late in getting here this morning because I had surgery. The sponge count was correct, but after closing up I noticed that the malpractice policy was missing, and we had to X-ray the patient. Thank God it had a long tail on it. I went back again and, of course, got it out. In reading it, I see that the contract terminates the first of November, so I figured I better get up here. Enough with being facetious.

I did not hear all the remarks, of course, that Mr. Salkind made. One question I think that Senator Wallwork brought up, which to me is basically the crisis of the situation as it stands today, and that is, I would like to compliment the Commissioner of Insurance for the alacrity with which he proposed this bill at the time there was an unavailability crisis, as far as the twenty-nine hospitals in the State of New Jersey were concerned. That was, I believe, March the twenty-seventh. Had that bill come over to this house after the deletion of Section Nine, I believe it was, I would have supported it at that point in time.

However, despite what Mr. Salkind says, there is no crisis in the State of New Jersey at the present time. There may be an embryonic crisis, but it takes nine months of gestation before something basically happens.

We are confronted with the possibility of Chubb, Incorporated, as far as the physicians of this state are concerned, renewing our contract on November the first. I think this is an extremely important thing.

I think, however, one cannot take an extremely narrow viewpoint as far as this is concerned. There have been a lot of myths and a lot of misunderstanding which has occurred in the press. We are not in the same position as California, New York State, Indiana, Florida, Maryland. I do not think that we have a sufficient amount of factual data to make a determination of what is going on. I, myself, do not know basically which is the best policy, a monopolistic type of insurance, vis-a-vis,competetive carriers.

From the medical standpoint as a physician, the important thing is that malpractice coverage. I think that we can pay a reasonable rate for that. Let me say, from the standpoint of physicians in New Jersey, the rates are much more reasonable than they are in the surrounding states of Pennsylvania and certainly New York.

I think here, we have to take again - as I mentioned before - into consideration -- I have read letters from the Commissioner. I have read letters from the Medical Society, and I think there is to some degree overreation, because we must recognize, of course, that there is a crisis impending. I agree with Mr. Salkind concerning that. But I think we must recognize a very important factor, that the situation is completely different in each and every state. And the solution is going to be different in each and every state.

The Federal Reinsurance Program and some of the Federal bills introduced - and the Commissioner may want to speak more about these - are fine. The answer, however, to a state's problem is not Federal legislation. The answer to a state's problem is state

legislation. Actually, involved in this thing is not only actually the cost. Number one, the conventional policy today that is written is on an occurrence basis. This means that there is a long tail to the policy, and actually from the date of discovery by the patient, there is a statute of limitations of basically two years. In the instance where you have a juvenile, the statute of limiations does not run until age eighteen, so somebody can bring suit against the obstetrician who delivered them for something that happened twenty years ago, minus one day. These are all problems that, I think, basically have to be addressed from a legislative standpoint.

The best I can say without attempting to get into the merits - because I did not honestly anticipate that this was going to be a debate on the basis of a monopolistic-type of insurance, vis-a-vis, the other type of situation, but probably this is what it is going to turn out to be - but nonetheless, I think we must come up and face as a legislature the possibility that we have to simply change the traditional form of tort liability under which this is being operated at the present time, under the court and jury type of system, and consider, if you will, the reparation type of system, simply compensating the individual for injury that has occurred, whether it is on a no-fault basis or whatnot. These are concepts that have to be basically considered.

The approach to this will vary in different states. In California there may be one approach; in New York it may be one. As a matter of fact, in

New York State, for example, the physicians themselves are considering establishing their own insurance company, because this is the only way they feel this thing can be dealt with. In a number of states throughout the country, it is JUA, Joint Underwriting Associations. But one point finally I would like to emphasize, at the moment there is absolutely no crisis in the State of New Jersey as far as availability of insurance is concerned. The cost is basically another thing. The cost of everything is going up.

Certainly, if the insurance companies were to have their way and actually go on a claims made basis rather than the occurrence basis upon which the policies are written at the present time, meaning that they would have some idea from an actuarial standpoint of basically what it would cost, and the only insurance company responsible for me would be the insurance company that is covering me this year for any claims that are made against me. This would help prevent anyone suing me eight years after I retire.

In the insurance business, this is basically why it is necessary for the companies to keep reserves, for the potential liabilities that may occur as much as six or eight years later.

I think that there is insufficient information available. I would honestly suggest that we obtain in-put from physicians; we need in-put from the attorneys in this state; we need in-put from the insurance firms, and this is primarily the basis of Senator Greenberg's bill, SCR-3001, I believe it is, setting up a commission to investigate this and make determinations as to what

would be the better way to handle the malpractice situation in New Jersey. We have time to accomplish it in this way. This is basically what I think should be done.

I would assume at that particular time this type of legislation would be one of the alternatives considered but might not necessarily, basically, be the best. But you cannot consider only the availability of coverage. You must also consider some of the factors that have gone into the high cost of malpractice insurance, the increased number of malpractice suits.

Physicians are probably more to blame than anybody. There actually must be much more strict monitoring, as far as physicians are concerned. The attorneys are getting a black-eye, because if it is the attorney's fault, I think it is a bum rap. I think we must all share our equal blame on this, but we must work together to come up with what basically is a good program.

Frankly, at the moment there is not a good program in any state in the union. Senator Wallwork, again, I will conclude by saying that at this time there is no crisis as far as the availability of coverage in this state, either for hospitals and/or for physicians. Thank you. I will be happy to answer any questions.

SENATOR HUGHES: Would you have any idea how it would affect the consumer, as a physician now?

SENATOR Mc GAHN: I think Assemblyman Salkind was entirely correct in stating that. Number one, if it is costing me more money to do business, this must be automatically passed on to the consumer. I did make

a statement at a South Jersey Hospital's Association meeting, and I said, that there comes a saturation point beyond which the consumer cannot afford basically to pay higher costs. I think there is no doubt about it, that simply, as far as the rate-setting structure is concerned, that the Commissioner of Insurance should have a more definitive control over this. Largely, I think, Senator, this is going to be implemented to a degree by mechanisms that presently the Federal government is setting up, the PSRO, the Professional Standard Review Organization, as far as physicians are concerned; and budget review audits, as far as hospitals are concerned. Certainly, as the Federal government becomes much more involved in health care services, where they are paying a larger degree of cost, they are going to also exercise a larger degree of control.

SENATOR HUGHES: I have no further questions. Senator Wallwork.

SENATOR WALLWORK: Well, I don't think you addressed yourself, Senator Mc Gahn, to the basic question of how this specific bill is going to hold down costs to the consumer. Will it hold down the costs to the consumer or will it not?

SENATOR MC GAHN: Senator, I don't think I have sufficient information to be able to honestly answer that. That is why I said I thought the commission approach -- Now, there are probably some individuals here, insurance men and the Commissioner who can address themselves to that. I frankly cannot in that particular respect.

SENATOR HUGHES: Thank you, Senator Mc Gahn.

SENATOR MC GAHN: Thank you for your courtesy in calling on me.

SENATOR HUGHES: Doctor John J. Mc Guire.

J O H N J. M c G U I R E, M. D. :

Mr. Chairman, members of the Committee, I am John J. McGuire, M.D., President-Elect of The Medical Society of New Jersey, Secretary of the State Board of Medical Examiners, 15-year member of the Essex County Insurance Committee, a practicing Thoracic Surgeon and consequently a physician who is paying a sizeable professional liability insurance premium.

The Medical Society of New Jersey, numbering 8900 New Jersey physicians, is opposed to A-1552 for the following reasons:

1. Although Section 9 of the bill which required proof of insurance was deleted in the Assembly, Section 2 of the bill declares that public policy requires that such insurance be a requirement which is to be effected by regulation. As we have maintained time and again before this Legislature, proof of insurance, in no way, should be a criteria for licensure or practice. In fact, any insurance company that would be foolish enough to insure an unlisenced physician, would find itself in trou

2. This same section of the bill also declares that the Commissioner may recoup losses through a surcharge of insureds.

It is not clear whether this is to apply prospectively or retrospectively. To leave such a decision to the discretionary rule making authority of the Commissioner sets a very dangerous precedent and can quite easily result in economic distress for insured professionals.

3. Section 6 dealing with the governing body of the statutorily imposed "facility" does not provide for representation by any providers. Interestingly enough "three producers" (not defined in the bill) are to sit on the Board, but they may not vote on issues of budget and personnel administration. This in effect grants the Commissioner and Board the ability to proliferate a titanic and costly bureaucracy which would have to be paid for by the insureds and ultimately the consumers that you represent.

The Medical Society of New Jersey has been maintaining a comprehensive and continuous professional liability insurance program since 1920. We are convinced that there is no crisis in regard to the availability of such insurance in New Jersey. The primary problem that we see is one of rates at a reasonable cost to the physicians.

While there are many statistics and allegations flying about, I can assure you that we are not aware of any physicians licensed to practice in this State that are unable to purchase insurance.

This bill would make both the insurance companies and the health providers subordinate to the whim and caprice of the Insurance Commissioner. I am sure you can understand our concern in this regard when the Newark Star Ledger on November 5, 1974, quoted the Commissioner as saying, "I am not really concerned about the physicians. They have a problem, sure, but they have a lot of money as well." On March 11, 1975, the Commissioner stated that 7,000 physicians were insured through surplus lines carriers in an article appearing in the Newark Star Ledger. Then on March 28, 1975, that same paper carried an article stating that the Commissioner, assumptively by emergency regulation, had prohibited anyone from securing coverage on the surplus lines market unless they proved they could not get insurance elsewhere.

The logic involved in such an approach certainly escapes us at this time.

Finally, you should appreciate that there isn't a single item in this bill to assure cost containment nor is there any guarantee that rates will not rise precipitately. What then is the legitimate purpose of this bill? Frankly, we don't know. While we have twice written to the Insurance Department about this, we have yet to receive a response. Thus, The Medical Society of New Jersey representing 8900 New Jersey physicians -- consumers of professional liability insurance -- have not been

given the courtesy of a reply to these most important issues nor has its offer of cooperation been accepted.

We urge you, therefore, to reject A-1552 and to continue your support of SCR-3001 which calls for a deliberative study. In this regard we offer you, as we have the Commissioner and the Governor, our fullest support and cooperation.

If I may make a few addenda, Mr. Chairman, with regard to what has been said earlier, I have been on the Committee in Essex County for fifteen years. I have been co-chairman for the past six years. We changed our name from the Loss Control Committee to an MRAC, Medical Review and Advisory Committee. Every malpractice suit that is instituted in the county of Essex goes before our committee for a thorough study and is reviewed by a specialist in the particular field wherein this occurred. For example, if it is a gynecological procedure, it will be reviewed by an OB-GYN man. If it is an orthopedic procedure, and orthopedist will review it. If it is a thoracic procedure, it will be reviewed by a thoracic man. If it is a medical problem, dermatology, cardiology, whatever, we have a cracker-jack specialist in every field who reviews that and reports back to our committee, and then we decide what can be done, or what should have been done differently.

In this regard, by the way, we have our own Peer Review Committee, actually, for professional liability in the county of Essex. I don't know about the other twenty counties, but we do have this and it works very well. The man involved is always interviewed by the specialist to find out why he deviated this way or that way.

We have in New Jersey, as you now know, compulsory continuing education, 150 hours every three years which the man must document. Now, arrangements have been made through the American Medical Association and through the Academy of Medicine of New Jersey, so that you can get the credits in your own hospital. We have in Essex County on the county level a committee and then on the state level a council, the Grievance Ethics Committee known as the Judicial Committee in the county and the Judicial Council on the state level.

Cost-wise, New Jersey at the moment is eighteenth of the fifty states with regard to per annum cost. On January the 24th, 25th, and 26th I was in Chicago for the annual meeting of the American Medical Association Leadership Workshop. On Saturday, the 25th, there were five panels, one of which was on malpractice. There were over 600 physicians involved in malpractice activities - such as I would be on our committee - from the 50 states, District of Columbia, and Puerto Rico.

At the evening dinner it was announced that the state with the best malpractice protection program of all the units was New Jersey, not the least expensive, that is eighteenth, but the best program for indoctrinating the doctors, for policing the doctors, and for protecting

the consumers, we are first in the country. Now, why should we try to sabotage a program like that?

As far as competition is concerned, I cannot see how so-called knocking out competition is going to change the per diem rate. We will have a monopoly if the Commissioner himself sets the rates and everybody must abide by that. Is that not a monopoly, his one action, rather than the action of the various insurance companies?

As I said before, I am speaking to you not only as a practicing physician for many years, but also as one who has been actively involved in the professional liability committee of our particular county, and amongst the doctors we have seen no problem. Now, we have over 8900 physicians practicing in the State of New Jersey who are members of the state society. Many of them have their insurance other than through Chubb. They are not with us.

There was a discussion about protecting the consumer with regard to, let's say, unlicensed physicians. There are physicians practicing in New Jersey illegally. As you know, I am secretary of the board that is going after them, and if you read the Ledger the beginning of January, you saw where over 70 doctors and some 19 hospitals were heavily penalized for having these unlicensed doctors against whom the patient has no protection - the consumer, if you will, has no protection. We are fighting this and are doing a very thorough job. It is quite interesting to note that once you go after one, the word gets about. So that has to do with the illegal practicing

physician. We are gradually ferreting him out.

Secondly, there are unlicensed doctors who are eligible for protection in the hospital. I am speaking now of the interns or residents in the approved training programs throughout the state of New Jersey.

The constitution and bylaws of our state society, the Medical Society of New Jersey, are being changed to get them in as members at a minimal amount of dues, and if they wish extra protection over and above what the hospital affords them, we will be glad to accept that part of the situation.

Of course, then you have the doctors who are under 45921-M, the exemption for county and state institutions. They are covered by the county-- I'm sorry, by the State of New Jersey or the county by which they are employed for any malpractice or professional liability violations.

I appreciate very much your letting me say these few words. Thank you. Do you have any questions?

SENATOR HUGHES: I have no questions, Dr. Mc Guire. You have been very comprehensive. Senator Wallwork.

SENATOR WALLWORK: Yes. Dr. Mc Guire, how many medical malpractice suits have there been, say, in the last year in Essex County?

DR. MC GUIRE: There have been approximately forty-six.

SENATOR WALLWORK: How many would you estimate in the state?

DR. MC GUIRE: I can't answer that. May I ask you to hold that question for someone from

Chubb and Sons. They are here this morning and they can give you an absolute answer.

But, Senator Wallwork, may I interject a point here? There has been a discussion about some doctors who have had to pay higher premiums than others, a so-called surcharge. Five years ago we had forty-five members of our organization, the Medical Society of New Jersey, on a surcharge. Through our policing, we are down to only twenty-one. I will grant to you that two have died and one has retired, but nevertheless we are down 50% on the number of those with surcharges.

After a certain number of surcharges, we report these people, not only to their hospital, but also to a state board of medical examiners for a review of their competency. I can't answer your question exactly for the state.

SENATOR WALLWORK: Have any of these doctors been disciplined?

DR. MC GUIRE: Yes. We have one in Essex County that has been disciplined, and his privileges were suspended for three months, and he was also notified that the next time it happened -- he was at fault. There is no question about it. There was not a good professional approach on his part. We, with our heads hanging, will be the first to admit to you that this has occurred. If it happens again, he will be dismissed from his staff.

We also now have a regulation in New Jersey that any hospital -- this man got in under the wire -- But if it happened to him today, we have a regulation through the State Board of

Medical Examiners and the Attorney General's Office that any doctor who is suspended or dropped from the staff, it is the duty of the administrator of that hospital to notify the State Board of Medical Examiners for their review -forgetting about malpractice insurance - of the competency of that particular man.

I might tell you, Mr. Chairman and Senator Wallwork, in the last six months, three doctors in New Jersey have been offered the opportunity of voluntarily retiring from practice with a notarized letter to the State Board of Medical Examiners where the license would be revoked because of ineptness, a so-called disabled doctor. There was one in Hudson County, one in Passaic County and one in central New Jersey.

SENATOR WALLWORK: When did you write to the Commissioner of Insurance, Doctor?

DR. MC GUIRE: The very last time we had written to him was March 11th, 1975.

SENATOR WALLWORK: You said you had written to him twice.

DR. MC GUIRE: I don't have the first date, but I can get it for you. I can give that to you before I leave this morning.

SENATOR WALLWORK: You received no response?

DR. MC GUIRE: No, sir. I can also get you copies of both letters if you wish them, Senator Wallwork.

SENATOR WALLWORK: I would like copies for the record.

DR. MC GUIRE: Surely, I will see that you get a copy of each one.

SENATOR WALLWORK: Of the 8932 doctors in the Medical Society of New Jersey, how many would have insurance at the regular reasonable rates that prevail today, if they are reasonable?

DR. MC GUIRE: Primarily there are six categories, and the two rough categories are neurosurgery and orthopedics. The reason they are high is that every complication that occurs in neurosurgery or in orthopedic surgery - or I should say everyone - in the majority of them there is some sort of litigation instituted. This requires investigation by the carrier, and the costs are increased. One other thing that has increased our rates, Senator Wallwork, is the fact that we are not just placidly settling suits. If this MRAC Committee we have in Essex feels that what happened was, let's say, an unavoidable complication, or the like, then we pursue that right through into court. This is very expensive. This has also helped to keep the rates up.

I must say, I am not going to pick on the legal profession. I am going to tell you that it was laxity on the part of some of our leaders in the past and also on some of the insurance companies. Going back to 1946 through 1950 when they would rather settle than go through the expense of going to court, the number of nuisance claims was absolutely fabulous at that time. It was amazing. That is being cut down very gradually. That is what has caused much of the cost of our premiums. Of course, the other has been some complications, and in certain fields -- the complications of neurosurgery are rough. Well, if it's the brain, it

can cause a vegetable, which is a term that is being used today. If it's the cervical cord, the person could be a quadriplegic, paralyzed from the neck down for the rest of his life. And, as I pointed cut earlier, these are expensive situations for any family. So their penalties are high.

SENATOR WALLWORK: Do you feel the Medical Society doesn't support this legislation because if this legislation were to pass, then there would be less interest on the part of the public, shall we say, and less interest on the part of various people who are dealing with the malpractice insurance to get to root problems and solve root causes for the high cost of insurance?

DR. MC GUIRE: It would take it completely out of our hands and the Peer Review, which Dr. Mc Gahn had referred to earlier, would be strictly on a hospital basis until such time as the HEW comes out with its national program, which it is presently studying. Does that answer your question?

SENATOR WALLWORK: No, it doesn't. If this bill were to pass and become law, do you think that that then would eliminate or at least give it less impetus to solve other problems that are creating the high cost of medical malpractice? Is that the reason the Medical Society is against this type of legislation?

DR. MC GUIRE: Our primary reason for opposing is the fact that we would lose our complete impact, our ability to put a little sledgehammer over our people. On that basis, we would have to go back to just the slap on the

wrist. The Medical Society of New Jersey, per se, has no judicial action it could really take. It can merely - if a member comes before the Judicial Council, let's say the MSNJ, and is found to be grossly wrong, the only thing our state society can do is to report him to the State Board of Medical Examiners for any punitive action that is to be included.

We do have a little in-put with regard to the man through our professional liability insurance. That would be lost. We would have no control over that at all, because that would come, again, through the Commissioner of Insurance Department and not through us. We have our own review committees now, but they would be valueless under this new program.

SENATOR HUGHES: Thank you, Dr. Mc Guire.

DR. MC GUIRE: I have here copies of both letters.

SENATOR WALLWORK: Fine, thank you.

DR. MC GUIRE: I appreciate greatly the giving of your time here this morning.

SENATOR HUGHES: Is there someone here representing Chubb Insurance Group?

N E W E L L G. A L F O R D, JR.: I am Newell G. Alford, Junior, the General Counsel for the Chubb Insurance Group. Mr. Chairman, and members of the Committee, I want to thank you for the opportunity to present to your committee the views of our Chubb Insurance Group on Assembly Bill 1552.

We are here in opposition to Assembly Bill 1552. Briefly, in our view, A-1552 is a prescription directed at one of several symptoms but not at the disease, and it is going to aggravate the illness.

There is an illness: the steadily increasing costs of medical malpractice claims and the great difficulty in pricing the insurance at rates which will cover the costs.

We think something should and can be done about this in New Jersey in a deliberate and constructive way: A way which gives primary attention to the interests of the patient, and has appropriate concern for the interests of the medical care providers. We have made clear our own willingness and interest in cooperating with the Commissioner of Insurance, the Legislature, and the medical and legal professions in solving the underlying problems. That effort should also involve the providers of health and medical insurance, and others, including patients, who finally bear the cost.

Before discussing Assembly Bill 1552 further, I wish to give the committee a bit of background information. With me are those of our staff who are most familiar with our medical malpractice insurance operations in New Jersey. They will do their best to help answer specific questions which the committee may have.

Also with me today to testify before you on our behalf is George K. Bernstein. Mr. Bernstein is a lawyer who was until December of last year Federal Insurance Administrator in the Department of Housing and Urban Development - responsible for the development and administration of the Federal Flood Insurance Program, the Federal Riot Reinsurance Program, etc. He has written many articles on the Federal programs, on a program for certain lines of insurance often referred to as "Full Insurance Availability", and recently on medical malpractice insurance.

I appreciate the committee's permission to have Mr. Bernstein speak to you about his views on Assembly Bill 1552.

Now to explain why we are so greatly interested in the matter before you.

The Chubb Insurance Group

The Chubb Insurance Group has long-standing and close ties to the State of New Jersey. Our oldest and principal company, Federal Insurance Company, is a New Jersey company organized here in 1901. Its home office is in Short Hills. We have offices throughout the United States, but our combined offices in Short Hills and Summit are the largest. We have a small office in Moorestown. We have over 1750 employees at those New Jersey offices.

These ties to the New Jersey community mean that we have a special interest in the state's well-being and general welfare, including, of course, the quality and cost of its medical care and hospital services. Indeed, that interest was a primary consideration when we agreed less than four years ago to write medical malpractice insurance for the Medical Society of New Jersey.

We write property/casualty insurance throughout the United States and in many foreign countries, but New Jersey is one of our most important insurance markets.

Medical Malpractice Costs and Insurance Rates

Our statements on the medical malpractice situation in New Jersey pointed out that the New Jersey climate is relatively better than that in a number of other states which indeed have right now critical problems

in medical malpractice costs and in the directly related costs of its insurance - New York, California and Florida. Those problems are the key to the availability crises in those states. Compared to those other states, there is indeed a healthier situation in New Jersey.

Our background memorandum (March 18, 1975) which each member of your committee received, pointed out that premium rates in New Jersey compare favorably with those in the problem states of New York and California. (Memorandum appears in the appendix on page lx.)

Nevertheless, we do believe that the costs of malpractice insurance claims are going to continue to rise in New Jersey - however those claims are handled. We are certain that our rate review for the current year will show that further rate increases are necessary. We expect to enter into the necessary discussions of experience and rate with the experts and representatives of MSNJ in due course this spring and to make an appropriate filing for increased rates with the Insurance Department. That rate revision would affect renewals in November of this year.

Federal's rates for malpractice insurance for physicians and surgeons are based upon New Jersey experience and data. They do not reflect what happens in other states. I am told by our actuaries, however, that they anticipate an increase in the rate of medical malpractice claim frequency in New Jersey, and that appears to be a countrywide phenomenon, although recently more severe in California and New York.

Our Relationship to the MSNJ Program

The sponsored program of the Medical Society of New Jersey (MSNJ) was actually started ten years or more before we agreed to become its insurer in the summer of 1971.

There is nothing mysterious or uncommon about such professional group sponsored programs. The New Jersey Bar Association has long had such a program for Lawyers' Professional Liability Insurance and perhaps for other coverages as well. That's just one example.

One reason why such programs work, when they do, is that the professional association (whether we are talking about doctors, lawyers, or other professionals) has a responsibility for maintaining standards of professional conduct. It is actively concerned with maintaining and updating its members' competence.

This I understand to be the case with MSNJ. Obviously, the best source for information about it is MSNJ itself.

When such a program works well, as we believe the MSNJ program does, it has efficiencies and economies of scale which make it significantly less costly to the doctors insured than would be the case in a diffused market where such a program does not exist. Again, we discussed this in our background memorandum on March 18th.

As I understand it, one of the purposes of Assembly Bill 1552 is to destroy that very program. That's not a step which should be hastily taken.

I mentioned that we expect that our malpractice insurance rates in New Jersey will continue to rise. What has been our rate history in connection with this program?

November 1971 actually marked our first participation in the sponsored program of the MSNJ. Our rates which took effect then were 10% higher than the rates previously charged by the insurance company which we replaced. That insurer had been asking for a 40% increase. The rates involved are reviewed annually in the light of most recent experience. After our evaluation is completed, any proposed change is reviewed with the insurance agency which administers the program and with representatives of the Medical Society and submitted as a rate filing to the Insurance Department.

In November 1972, there was no rate change. In November 1973, the rates were increased 25% on the average, and in November 1974, 20% on the average. Some classes of physicians and surgeons (particularly the neuro and orthopedic surgeons) bore a larger increase than others.

These rate increases are not insignificant, but they are also not the dramatically staggering figures of hundreds and hundreds of percent which have been making headlines in other states.

We believe this is testimony to the effectiveness of the MSNJ program, as well as to the comparatively stable legal climate in New Jersey.

Assembly Bill 1552

We have already summarized our views on Assembly Bill 1552. Before saying more about that or answering questions which you may wish to put to us about it, I would like to call on Mr. George Bernstein to give you his views.

SENATOR HUGHES: All right, Mr. Alford, we will listen to Mr. Bernstein now.

MR. ALFORD: Thank you.

G E O R G E K. B E R N S T E I N: Mr. Chairman, Senator Wallwork, thank you for the opportunity of appearing before your committee today.

I testify as an attorney and former state and federal insurance regulator with some background in medical malpractice insurance and in the reinsurance facility principle which is incorporated, to some extent, in Assembly Bill 1552. The views I express are my own, but with respect to Assembly Bill 1552, they fully coincide with those of my client, the Chubb Insurance Group.

During the peric I served as Federal Insurance Administrator in Washington, D. C., I also represented the U. S. Department of Housing and Urban Development on the Interdepartmental Committee on Medical Malpractice. This advisory committee worked with the Commission on Medical Malpractice of the Secretary of the Department of Health, Education and Welfare (HEW) during its study of the problem from 1971 until the issuance of its report in January 1973. Subsequentl I continued to advise the Department of HEW on medical malpractice insurance issues and I also served as a member of the National Academy of Science's Ad Hoc Committee on Medical Malpractice, which recommended further action to resolve what in 1973 was already developing into a national problem of crisis proportions.

I applaud the efforts of the Committee, the legislature and the New Jersey Insurance Department, under the leadership of its able Commissioner, James J. Sheeran, for their appreciation of the problem and their desire to bring about a solution. Moreover, I am somewhat flattered that the approach urged by the Insurance Department incorporates the reinsurance facility approach which, as Federal Insurance Administrator, I proposed to resolve residual market problems in such key lines as automobile, fire, homeowners and small commercial insurance. I submit, for your information, a copy of the 1974 report of the Federal Insurance Administration which culminated more than four years of study and advocacy and recommended the reinsurance facility concept for appropriate lines of insurance, under the title of Full Insurance Availability.

Unfortunately, any pride I might feel in witnessing my proposal introduced in legislative form in this State is dissipated by the knowledge that the reinsurance facility proposal is being applied to a line of insurance where it is totally inappropriate. The reinsurance facility concept will not and can not work in medical malpractice insurance.

The reinsurance facility approach as introduced in Canada for automobile insurance and as refined and extended in the Full Insurance Availability proposal, involves a complex system of checks and balances geared to achieving equity both for the consumer and the insurer. These checks and balances are structured to complement a statutory mandate to write insurance and to create incentives on the part of all insurers writing the line of business to make their product and

services available efficiently and to distribute the cost of the system fairly among all such insurers. Essential to such checks and balances, and to the system itself, is that the line of insurance involved be broad based in terms of numbers of insurers and insureds and in spread of risk. Equally vital to the reinsurance facility approach is that the carriers desire to continue to write the line on a voluntary basis even through such writing compels them to accept certain business which they would not otherwise accept.

All of these factors apply to automobile, fire, homeowners, and many other lines of insurance. None of them applies to medical malpractice. In medical malpractice, very few insurers write the business, on either a relative or absolute basis. In New Jersey, for instance, there are less than 10 insurers writing medical malpractice insurance for doctors and hospitals. By contrast, 147 insurers write automobile insurance in New Jersey.

In automobile insurance, there are more than 4.4 million vehicles in the State, developing $750 million of annual premiums. There are only 9300 doctors practising in New Jersey and approximately 150 hospitals. The total medical malpractice premium for doctors and hospitals is only about $21 million.

Automobile and the other lines contemplated as appropriate for the reinsurance facility approach involve a broad spread of risk, with a high volume of insured incidents as contrasted with a relatively low severity factor. The medical malpractice business develops just the reverse result.

Moreover, the reinsurance facility concept was conceived to

deal with a residual market situation. By definition, there cannot be a residual market unless there is a primary market. In plain terms, this means that insurers voluntarily and enthusiastically compete for the vast majority of business in a given line, such as automobile or homeowners, and for any number of reasons avoid a small remnant, perhaps from five to ten percent, which is designated as the residual market.

Reinsurance facility, under which an insurer must accept every insurable risk at the same rate which that insurer would charge all other risks with the same objective characteristics, is grounded on the desire of the insurers to retain the 95 percent of the business which they consider profitable.

In medical malpractice, we have the anomalous situation where most carriers have decided that there is no desirable business and that they wish to avoid the line in its entirety. Coupling this with the minimal number of carriers who started off with a medical malpract capability in terms of service and claims handling, we find that the relatively few insurers who were ever prepared to write medical malpractice are now reduced to a handful who are capable and willing to service this business in the State.

To the advocates of reinsurance facility, a basic advantage over the joint underwriting association approach is that a small number of unwanted, but objectively good risks can be absorbed at little cost within the existing market structure which voluntarily serves the vast majority of risks, without creating a separate and distinct premium rate, servicing mechanism and claims structure.

In medical malpractice, this goal is not even theoretically attainable as it is the lack of any voluntary market which is the defect to be addressed.

The necessity to a successful reinsurance facility system of a healthy, competitive structure which manifests itself not only in a large number of insurers competing for the majority of the business, but also in the carriers being willing to absorb the undesired business as the quid pro quo for their continuing to write the line in the State, has other basic implications which must be carefully considered. Accordingly, in structuring a reinsurance facility system for such lines as automobile and fire insurance, the Federal Insurance Administration in its Full Insurance Availability report, recognized the need to protect the respective insurers against the possibility of a particular carrier aggressively writing more business than it was able or willing to handle and then "dumping" all or a portion of it in the reinsurance pool underwritten by its competitors. The carrier in such case might be motivated by a desire for cash flow, the expectation of skimming better business, or the attempt to retain excessive expense dollars while ceding the loss exposure to the pool. Not only does Assembly Bill 1552 fail to incorporate any of the recommended safeguards against such skimming and dumping, but the absence of such protective measures is an admission that the principles of a reinsurance facility or Full Insurance Availability system have no application to the medical malpractice situation.

With this brief background, I would like to address myself to some of the most basic specific deficiencies of Assembly Bill 1552

which not only make it unworkable, inequitable and counterproductive to a solution to the medical malpractice problem, but also promise to develop a record of failure for the reinsurance facility approach which may well prevent its application in such areas as automobile insurance where it holds so much promise.

Under Section 4, a company which writes no medical malpractice in New Jersey and which, therefore, has no trained staff or expertise in this line in the State, will be forced to staff up to accept medical malpractice business merely because it writes even a single policy of medical malpractice anywhere in the United States. Aside from the Constitutional implications of not merely requiring an insurer to share in the profits and losses of a line of insurance as a condition of its license, but also to issue policies and service a line of insurance which it does not write and may never have written in the State of New Jersey, the financial and physical burdens imposed on such a carrier are staggering.

The bill would require an insurer with no capabilities, experience or know-how in medical malpractice in New Jersey to start from scratch and expend the time and money to hire staff, develop policy forms, promulgate rates, and involve itself in a field where loss control is a significant factor and where the carrier is totally unequipped to provide this service. Too little real expertise already exists. Too much business has been written without the care and knowledge required of so complicated a line of insurance. Too few companies have compiled the quality and quantity of statistics which are essential to an understanding of the business, no less to an ability

to make rates with any degree of assurance that, even with all the variables present in medical malpractice, the best available methodology has been utilized.

Yet Assembly Bill 1552 would require unqualified insurers to write medical malpractice, thereby intensifying the dilemma of non-expertise. The consequences will be increased losses, paid in many cases on unworthy claims, to the wrong persons, with the general public and the innocent health provider bearing the cost of such inequities through lost recoveries and increased premiums, passed on, of course, to patients through higher health care fees.

With respect to a unique line such as medical malpractice, with limited scope in terms of numbers of carriers and insureds, a joint underwriting association could operate more efficiently, equitably and effectively. A central office could be staffed with the limited expert personnel now handling medical malpractice in New Jersey for private carriers, or qualified servicing carriers with experience in the field could be appointed to handle the business. In effect, a new medical malpractice insurance carrier would be created, representing all of the appropriate carriers who could contribute needed expertise in loss control, servicing and claims handling. Whatever the pros and cons of a joint underwriting association for such mass lines as automobile insurance, it is a superior vehicle for medical malpractice.

Section 5a of the bill authorizes up to 100 percent of any policy issued by a member company to be reinsured with the association. Section 5d of provides that assessments on members to make up for deficits be based on the relationship between a given member's

"direct premium written" and "the total direct premium written by all members in this State for the coverages subject to this act". Even overlooking the unanswered question as to just what lines of insurance are covered by Assembly Bill 1552, these two provisions actually constitute an incentive to an insurer dumping all medical malpractice business into the reinsurance pool.

Any constructive reinsurance facility system must include some penalty on an insurer which inhibits its dumping all business in the pool, particularly when the amount is in disproportionate ratio to that ceded by other insurers. In the absence of such penalty, it is certain that any voluntary market will be destroyed by reactive, defensive dumping by all carriers. To the extent that there is a limited or non-existent voluntary market for medical malpractice in the first place, it is further evidence of the inapplicability of the reinsurance facility approach to this line. If the bill intends that no voluntary market continue, if it exists at all, there is no rationale for utilizing a reinsurance facility system (which is predicated on eliminating a relatively small residual market) as opposed to a joint underwriting association which can better be tailored to a non-competitive market.

Section 8b is another example of the tendency of the bill to fail to increase markets for medical malpractice. To utilize a reinsurance facility for automobile insurance and to require a company to accept business from any agent or broker with whom that company has previously had a relationship is a significant accomplis in a line where agents and brokers operate broadly and write substan

insurance. To make the same offer to the handful of producers who have been involved in medical malpractice is to make an empty gesture. Under this bill only those producers currently writing medical malpractice can participate in the reinsurance facility. The vast majority of agents and brokers will have no more access to a medical malpractice insurer than they do today. In contrast, a joint underwriting associaton for medical malpractice insurance will make available a market for this unique line of insurance that is currently unavailable.

I shall not address myself to other deficiencies in the bill although many of them are also basic and promise extended litigation over issues of coverage contemplated, the types and number of insurers covered by the bill and the very Constitutionality of its specific provisions. I would point out, however, that to the extent the legislature is concerned about a lack of competition in medical malpractice insurance in the State, not only does this bill do nothing to increase competition, but it imposes a heavy and unreasonable penalty on those few insurers who are now providing that needed coverage. If New Jersey despairs of revitalizing the medical malpractice market, there are far better ways than through a reinsurance facility whose attributes are inappropriate to this unique line of insurance.

In fact, the legislature and the Insurance Department have a real opportunity to make a valuable contribution, not only to the citizens of the State but to the development of a nationwide model for resolving the medical malpractice dilemma. Because of the voluntary action by Chubb, the immediate crisis has been avoided. Passage of Senator Greenberg's resolution, providing for a special commission to deal

with the underlying problems which precipitated the crisis, will permit the newly available time to be used to develop a comprehensive solution which cannot be structured on a piecemeal basis.

Thank you for the privilege of appearing here today. I will try to answer any questions you may have about the bill or other aspects of the medical malpractice dilemma.

SENATOR HUGHES: Thank you, Mr. Bernstein. I have one question. I would like to confirm your figures of 9300 physicians and 21 million dollars.

MR. BERNSTEIN: Those are the figures that the Chubb technical people have come up with. I understand from previous testimony that only 8932 doctors are members of the State Medical Society, and Chubb itself only insures about 6300 of those doctors. The others obtain their coverage elsewhere.

SENATOR HUGHES: If that is true, then your average premium would be approximately $2,250 per year, per doctor, exclusive of hospitals; is that correct?

MR. BERNSTEIN: May I have permission to ask Mr. Hartmann, our actuary, who actually worked with the New Jersey doctor's program, to answer your question?

SENATOR HUGHES: Yes, certainly.

D A V I D H A R T M A N N: My name is David Hartmann. I am with Chubb and Sons. The 21 million dollar figure includes an estimate of 3 million dollars premium for hospitals, leaving approximately 18 million dollars for medical doctor premiums.

SENATOR HUGHES: In other words, then, that figure would change roughly to, I would say, about $2500 per doctor?

MR. HARTMANN: No, to about $2,000.

SENATOR HUGHES: Oh, I'm sorry, it would go in the reverse. Those are the only questions I have. Do you have any questions, Senator Wallwork?

SENATOR WALLWORK: No questions.

MR. ALFORD: You asked Dr. Mc Guire one question, which I would like to supplement the answer to, if I may, about the number of claims last year in his county.

Based on the 6700 doctors, I think it is, that we insure in New Jersey, we had approximately 700 claims statewide. I would say roughly 10% of the total number of doctors had claims.

SENATOR WALLWORK: What would be the cost of those claims?

MR. HARTMANN: If our pricing is correct, it would be about 80% of the premium that we collected.

SENATOR WALLWORK: How many people do you have on your staff dealing with medical malpractice, so far as working on the costs and getting the figures and the information?

MR. HARTMANN: In our actuarial department we have four people working on reviewing the numbers that are produced by our data processing department, which would include a lot of people. I am not clear on what number we are looking for.

SENATOR WALLWORK: Well, I am looking for a scope of what your company is doing, if it is not going to violate any corporate internal information,

as to how many people are you employing and about what is it costing you, because I would then like to have the Commissioner respond later on as to whether he has the capabilities to do this type of sophisticated insurance analysis in medical malpractice. Do you understand the point of the question?

MR. HARTMANN: Clearly, the work that we do in the actuarial department is reviewed by our underwriters, with in-put from our claim department for reasonableness, so that the number involved is certainly greater than the four in our own department. There is certainly a large number of claim adjusters and claim examiners involved who are specialists in this class of business who handle only medical-professional liability claims who do not get into automobile or home owners or general liability claims.

SENATOR WALLWORK: What financial incentives do you have now to keep your rate of claims payments down and balance the amount of charges that you make for your insurance? What incentive do you have to keep insurance rates in malpractice, in other words, as economical as possible, which you would lose under the pool plan?

MR. BERNSTEIN: Under the pool, Senator, companies could write the business and the consequences of their poor handling of that business would be spread among all insurers. Here, if Chubb does a bad job, Chubb eats it, and that premium is what Chubb gets at the beginning and it doesn't get a penny more for that year. It may ask for rate increases prospectively, but it must eat any loss, so the

profit motive is what keeps Chubb trying to be an efficient claims carrier and servicing business.

SENATOR WALLWORK: How many years have you been in medical malpractice?

MR. HARTMANN: One of our companies first wrote major medical malpractice account in 1963; Federal Insurance Company entered medical malpractice in 1971, with the Medical Society of New Jersey Program, but we have had people within our insurance group who have accumulated years of experience.

SENATOR HUGHES: Thank you, gentlemen, for appearing before the Committee. There are no further questions. I appreciate your taking the time to appear before us.

MR. ALFORD: Thank you for giving us the opportunity.

SENATOR HUGHES: I am going to call a break for ten minutes.

(Whereupon there was a ten-minute recess.)

SENATOR HUGHES: Gentlemen and ladies, the testimony that the Committee has heard so far has been very, very comprehensive, and I believe that in most cases, except for Commissioner Sheeran's remarks, I would like each individual, in the interest of brevity, to hold their statements to five minutes. Now, there have been several doctors who spoke here. Now, Dr. Wilson, if you have a prepared statement -- if anyone else has a prepared statement of their talk before the Committee, we would appreciate receiving it. I think that these people, I'm sure, would be repetitious, and we would appreciate it very much if they would not testify, or if they want to, they can condense

their talk and give us a brief summary of it. We would accept that.

Doctor Wilson, we will hear you next.

H A R V E Y W I L S O N: Thank you, Senator. I am Doctor Harvey Wilson, immediate past president and chairman of the legislative committee of the New Jersey Optometric Association, representing over 80% of all optometrists licensed to practice in the State of New Jersey.

THE NEW JERSEY OPTOMETRIC ASSOCIATION IS OPPOSED TO A-1552, THE MEDICAL MALPRACTICE LIABILITY INSURANCE ACT. TO OUR KNOWLEDGE, NOTHING SO FAR HAS BEEN PRESENTED THAT WOULD JUSTIFY THE PASSAGE OF SUCH PERMISSIVE LEGISLATION. THE URGENCY WITH WHICH THE BILL HAS BEEN PUSHED HAS US WONDERING WHAT IS THE UNDERLYING MOTIVE FOR SUCH HASTE.

EVERY OPTOMETRIC PRACTITIONER IN THIS STATE HAS IMMEDIATE ACCESS TO ANY NUMBER OF RECOGNIZED INSURANCE CARRIERS, WILLING TO WRITE ADEQUATE PROFESSIONAL LIABILITY INSURANCE COVERAGE. THIS HAS NEVER BEEN A PROBLEM FOR MEMBERS OF OUR PROFESSION. WE HAVE ALSO BEEN ADVISED THAT NO OTHER HEALTH CARE PROVIDERS IN THIS STATE ARE EXPERIENCING DIFFICULTY IN SECURING SUCH COVERAGE, THEREFORE, WE MUST LOGICALLY QUESTION WHY THE INSURANCE DEPARTMENT IS OVER-REACTING TO A SITUATION THAT DOES NOT EXIST AND FURTHER, WHY THE HEALTH CARE PROVIDERS, WHO ARE DIRECTLY AFFECTED BY THIS ACT, WERE NOT CONSULTED PRIOR TO ITS INTRODUCTION.

WE VERY SERIOUSLY QUESTION THE NEED FOR SUCH LEGISLATION IN VIEW OF THE FACT THAT OTHER THAN THE WHIM OF THE INSURANCE COMMISSIONER, NO VALID STATISTICAL DATA INDICATES THAT ANY PROBLEM EXISTS.

IT IS ALSO INTERESTING TO NOTE THAT EVEN IF A PROBLEM EXISTED, THE ANSWER CERTAINLY WOULD NOT BE THE PASSAGE OF A-1552. THE ENTIRE BILL IS RIDDLED WITH INCONSISTENCIES AND PERMISSIVE WORDING, ALLOWING THE COMMISSIONER TO CREATE AN UNWIELDY AND COSTLY BUREACRACY WHICH WOULD EVENTUALLY BE PAID FOR BY THE CONSUMER WHICH YOU ARE ATTEMPTING TO REPRESENT. THERE IS NOT A SINGLE REFERENCE IN THE BILL TO ASSURE COST CONTAINMENT OR A GUARANTEE THAT RATES WILL STABILIZE. THE BILL WOULD SIMPLY MAKE BOTH THE INSURANCE CARRIERS AND HEALTH CARE PROVIDERS SUBORDINATE TO THE DIRECTIVES OF THE INSURANCE COMMISSIONER WITH NO REQUIRED PROVIDER INPUT TO HIS DELIBERATIONS.

WE HONESTLY BELIEVE THAT YOUR SUPPORT OF SCR 3001 WHICH WOULD INITIATE A THOROUGH STUDY OF THIS ENTIRE AREA IS WARRANTED. TO PURPORT THAT THIS HASTILY SO-CALLED "PUBLIC HEARING" WILL GIVE YOU SUFFICIENT INFORMATION ON THIS COMPLEX AREA TO MAKE A LOGICAL DECISION,IS A DISSERVICE TO THE CONSUMER OF HEALTH CARE SERVICES.

WE URGE THE NEW JERSEY SENATE TO REJECT A-1552 AND SUPPORT SCR 3001. OUR ASSOCIATION STANDS READY TO ASSIST THE COMMISSIONER'S OFFICE AND THE LEGISLATURE IN THE DEVELOPMENT OF A REALISTIC SOLUTION, IF IN FACT A PROBLEM EXISTS.

Thank you, gentlemen. If there are any questions, I will be happy to answer them.

SENATOR HUGHES: I have no questions, Doctor. Senator Wallwork.

SENATOR WALLWORK: Just one comment. I don't really consider this a hastily so-called hearing, all right.

DR. WILSON: Could I just make one more statement? In optometry the cost of malpractice insurance is $140 for a three-year coverage for a one-hundred and three-hundred thousand, plus an umbrella, if they want it, for $70 a year which carries the liability up to one million dollars. So, really, there is not a problem in our profession, thank you.

SENATOR HUGHES: I thank you, Doctor. We are going to go a little out of sequence here. I would like to hear from Mr. Jack Owens. Is there anyone else from the Hospital Association here, hospital representatives or administrators?

All right, it will be noted that Mr. Jack Owens has offered his testimony for the record.
(Prepared statement appears on page 7x in the appendix.)

Also for the record, Mr. Gary Shenfeld of the New Jersey Dental Association has submitted his testimony for the record.
(Prepared statement appears on page 5x in the appendix.)

Mr. William Owens will be our next witness.

W I L L I A M O W E N S: Mr. Chairman, members of this committee, my name is William Owens, a licensed New Jersey Insurance Broker. I have narrowly specialized in providing medical liability insurance coverages in our state, at low rates, and at a profit to the industry for over ten years.

On selling my brokerage last year, I then formed the Association of Professionals for Economic Defense, Incorporated of Bordentown. A.P.E.D.'s mission is to advance and defend the economic interests of its M.D. members. The maintenance of a viable state-regulated private insurance market in New Jersey is our only advocacy. It is the public who is clearly entitled to effective protection against malpractice by health care providers and it is the public who will have to pay the huge costs which current conditions and your deliberations generate. Please remember that such costs will be "passed-along" to your constituents with higher payments, increased loadings on Medicare/Medicaid, the Blues, the unions', corporate and private health insurance plans; the premiums of which will have to be recast to compensate the hospitals and practitioners.

I have spent the past several months in Washington, testifying before Congress, consulting with and frankly trying to influence our Federal authorities to step in and partially support the State-regulated medical liability insurors, somewhat comparable to riot coverage, with Federal reinsurance by the Department of Health, Education and Welfare.

Senator Gaylord Nelson has introduced just such a bill numbered S. 188 (and this is tracked by House of Representatives Bill #2884 introduced by Congressman Gonzalez). Our Senator Williams chairs the Senate Committee whose Sub-Committee, under Senator Kennedy, will conduct hearings this week on this and other related health care matters. Washington is aware of the urgency and is moving to ameliorate if not to correct it. Our Senators

Williams, Case and Congressmen Thompson, Helstoski and Florio are all actively engaged in addressing this national problem. The Nelson/Gonzalez bills, with our proposed modification, would restore a competitive private medical liability insurance market under State regulation at a fair cost based on local conditions.

Incorporated with and attached to your copy of my statement is, marked Appendix "A", the recent testimony I gave to the House Ways and Means Committee - Health Sub-Committee on March 5th. To conserve time, I shall only read that portion dealing with the proposed Federal reinsurance by HEW and a note regarding staggering costs.

"The important feature of the bills authorizes the Secretary of HEW to offer reinsurance to the hospital and medical malpractice insurance industry. It is gathered that, like floods, riots in urban areas, et cetera, our national interest requires Federal intervention to solve a problem with which private industry cannot be fairly expected to cope.

My proposed modification of the Nelson and Gonzales bills has to deal with the areas requiring Federal support of private industry. I submit that there are only three basic obstacles standing in the way of our State-regulated insurance industry to competitively re-enter the market and willingly provide viable and adequate medical liability insurance protection at fair cost. I suggest that these three are, in descending order of importance:

1. The incalculable exposure to unforeseen claims arising under the liability "tail" whereby insurers and their reinsurers cannot properly promulgate rates today to provide adequate reserves from their assets for uncertain future payouts.

2. The dramatic increased exposure to the catastrophic million dollar-plus awards, or "shock" losses, which simply cannot be evalued in the jury climate under existing and unforeseen future conditions.

3. A minor, but very dangerous, block of uninsurable, volatile or loss-prone risk in certain areas which cannot be written profitably at standard rates and probably cannot be written profitably even if the good risks were compelled to subsidize their premium by paying an additional amount. Both a careless practitioner and a very careful, highly trained urban anesthesiologist could qualify.

Propose therefore that Senate Bill S. 188 and House of Representatives Bill H.R. 2884 be amended to provide that:

a. The Secretary of HEW be authorized to reinsure the future "tail" of 3-year term, deferred premium payment annual installment, occurrence insurance policies for hospitals and practitioners as issued by private insurance carriers under our existing State regulatory machinery, with reinsurance premiums to be established by the Secretary and

b. The Secretary of HEW be authorized to reinsure all properly licensed carriers against the catastrophic or "shock" malpractice loss using the following formula:

(1) Carriers' primary insurance to pay all specific damages that can be documented and promptly, with a time frame to be developed as standard by the Secretary.

(2) Carriers' primary insurance to pay for "pain and suffering" but limited to a maximum amount equal to that documented for specific damages and under existing tort liability processes, with any excess in HEW reinsurance -- at reinsurance premiums to be established by the Secretary, and

(3) The proposed HEW Federal medical malpractice advisory board, or State committees thereof, acting in conjunction with each State insurance commissioner, develop a Federally-reinsured primary special risk program by State as recourse for the naturally volatile, loss-prone or "uninsurable" risk under the foregoing Federal umbrella thereby providing effective blanket occurrence insurance protection to the public based on fair local rates and local conditions. "

This note deals with cost and it was part of my testimony in Washington.

" In answering Congressman PIKE, American Hospital Association's DR. GEHRIG estimated that $4.00 per day-per hospital bed would have to be added for increased insurance cost this year. The A.H.A. formal testimony indicated that 1.4 million hospital beds are affected. $1456 per bed-per year would produce a loading of OVER $2.03 BILLION just for hospital insurance, excluding all other institutions, clinics, nursing homes etc., providing health care to the public nationally.

"To that large figure must then be added the high cost of insuring all of our Medical Doctors and all other practitioners.

In view of the foregoing, I refine my March 5th testimony to aver that OVER FOUR BILLION DOLLARS of insurance cost, passed-along, will be pumped into our national health care pipeline this year and that this message is not getting across.

Irrespective of the "distress" Joint Underwriting Assn. approach or other patchwork actions taken to preserve insurance coverage by states or groups if Congress fails to act to Federally-reinsure our malpractice insurers, I submit that the above cost will still have to be squarely-faced by the nation and that it will quickly spiral upward. "

This figure is apparently already outmoded because Dr. Roger O. Egeberg, Special Assistant for Health Services to the Secretary of HEW, testified last week to the National Association of Mutual Insurance Agents that $10.00 a day insurance loading per bed was being reported by major quality hospitals. If this is even remotely true then our national health care insurance bill can approach or exceed TEN BILLION DOLLARS - this year!

Everyone is rightly concerned with availability of protection, but I ask that you Senators not forget the cost to the public - your constituents, on the "passed-along" basis. I also ask that you carefully consider the efficacy of a panic punitive action whereby the State could be effectively resisted (as Aetna recently did on auto insurance) or otherwise overturned by the courts. In this vein, please read two clippings attached as Appendix "C" regarding Maryland and its attempt to punish the St. Paul Insurance Company. Maryland's own Court of Appeals found for the company and it is rumored that Federal Constitutional issues loomed too large for the court to ignore when trying to mandate the assets

of a national company without statute of limitations safeguards with potential exposure to rising million-dollar awards which cannot be reserved actuarily now for an uncertain future. There is also a local grey area of discrimination, boycott, etc., because our citizenry is served by health care practitioners including the highly trained, board-certified M.D. specialist as well as osteopaths, chiropracters, optometrists, and others who may not belong to a county or state medical society. Fifty percent of the public may be affected.

(Appendix "C" may be found on page 11x.)

Per Appendix "D" and "E", our New Jersey Commissioner has stated and restated that a monopoly has been created and that companies withdraw coverage if they don't get premium increases.

I am happily in a position to document our Commissioner's serious charge to the extent of attaching, as Appendix "F", a photocopy of a letter which the huge Aetna Casualty and Surety Company circulated to its local agents on September 17, 1974. Your very careful attention is invited to the third paragraph thereof. Aetna is a member of the Insurance Services Office mentioned by our Commissioner in the Inquirer article and was a principal New Jersey beneficiary of a recent medical malpractice rate increase of up to 200-plus percent without ever having demonstrated its "need" based on New Jersey loss experience for same.

(Appendix "D" may be found on page 12x.)
(Appendix "E" may be found on page 13x.)
(Appendix "F" may be found on page 14x.)

To revert to the subject of Federal reinsurance of our malpractice insurance industry, the method proposed offers something for almost everyone:

(1) The public, nationwide, would be fully-protected and would shoulder a lower passed-along cost.

(2) The health care providers, hospitals and practitioners, would be fully protected and at a fair insurance overhead cost.

(3) The attorneys would be able to continue participating in the tort liability arena.

(4) The insurance industry would have no reason whatever not to offer competitive occurrence coverage at much lower rates being able to actuarily guage their exposure.

(5) State Insurance Departments would retain control of carriers doing business in the states as in the past.

(6) The reinsurors would be equally well-served and would have no reason to restrict or pressure the primary carriers. Parenthetically, they possibly triggered this crisis for all of us.

(7) The spectre of Socialized Medicine would be blunted if not dispelled as an immediate threat to mongrelize the quality of health care at a prodigious cost to the national economy.

(8) Semi-retired and incoming new practitioners would be able to practice privately and serve the public instead of opting

for retirement or employment with industry or government because their cash flow cannot contemplate paying premiums in the five figures.

The only vested-interest sector which will not be served are these groups or associations that dominate entire states through monopolies as charged by our Commissioner in Appendix "D". Medical Society or Hospital Association insurance plans may be very convenient to the favored members, but nobody should try to justify holding an umbrella over them at the expense of the public welfare at this late date.

Respectfully submit that few malpractice insurance carriers are willingly interested in serving New Jersey if only because they fear that your punitive, unilateral legislative action will nail them to the wall. In the interest of all, I urge that you do nothing arbitrary but rather consider tracking the proposed Federal solution pending national relief from Washington. In other words, propose that the State of New Jersey, under existing State-regulation, reinsure only those three sensitive areas as outlined in my foregoing testimony at a reinsurance premium to be determined by our Commissioner based on local New Jersey loss experience as developed by the American Mutual, Employers of Wausau and Federal Insurance Companies who insured the Medical Society of New Jersey. A temporary committee would be appointed by the Commissioner similar to the proposed Federal Medical Malpractice Reinsurance Advisory Board to operate the State program pending relief from Washington. Senator Nelson's Bill #S. 188 is attached as Appendix "G" to this statement.

(Appendix "G" begins on page 15x.)

To conclude, I should be happy to try to answer any questions and to work in any capacity as requested by the New Jersey Legislature or our Insurance Commissioner. I also volunteer to advance New Jersey's viewpoint, if compatible, in my future testimony or representations in Washington.

Thank you and your Committee for receiving me, Mr. Chairman.

SENATOR HUGHES: I have no questions. Senator Wallwork.

SENATOR WALLWORK: No questions.

SENATOR HUGHES: I thank you, sir. I call Mr. Augustus Nasmith.

A U G U S T U S N A S M I T H: Good afternoon, Mr. Chairman and Senator Wallwork. My name is Augustus Nasmith. I am an attorney representing the National Association of Independent Insurers.

I would merely like to record our opposition to this bill before your committee, and also indicate that we would not prefer any type of joint underwriting association because we think, as indicated by Senator Mc Gahn, and by Doctor Mc Guire, there is no crisis. We think attention should be addressed to the basic problems rather than a cure of the symptoms and hope that such study will be made through SCR-3001. Thank you.

SENATOR HUGHES: Thank you, Mr. Nasmith. I have no questions.

SENATOR WALLWORK: I have no questions.

SENATOR HUGHES: Thank you. Mr. Frank Siracusa or Stanley Braddock.

F R A N K J. S I R A C U S A: Thank you, Senator. My name is Frank Siracusa. I appear here

today on behalf of the Mutual Insurance Agents of New Jersey representing some 2,000 licensed agents. Our testimony is in written form, and much of it deals with our position that a crisis as such does not actually exist today.

We feel that the near crisis that did approach us was adequately taken care of by the insurance carriers who have responded. As such, we are not particularly opposed to Bill 1552. We think, however, there is too much haste being generated in trying to rush through with the passage of the bill into law.

Really, we feel that we can offer something different by suggesting immediate formation of an industry task force to study the problem in depth and report back to the legislature at some reasonable time in the future with recommendations for lasting, long-range solutions to the underlying causes of the problem.

As an interested party, we would like to work together with the rest of the industry to develop these recommendations, and we are offering our services herewith, as a catalyst to draw the various segments of the industry together to pursue the subject.

In keeping with this suggestion, we additionally recommend that any further action on Bill 1552 be deferred until such time as the industry task force has filed its recommendations for a long-range solution to a basic problem. It is our judgment, a voluntary market solution built upon the premise that insurance companies will voluntarily underwrite the medical malpractice business at reasonable

but adequate rates, coupled with appropriate remedial legislation to correct the shortcomings of the present tort system will best serve to treat the underlying cancer, as opposed to merely addressing the symptoms of the disease.

If our suggested task force is not formed, and if no other solution to the malpractice problem is arrived at within a reasonable period of time, we would then be willing to support Assembly Bill 1552, essentially, but not exactly as presently written.

To conclude, we don't oppose the bill, but ask that a reasonable time be allowed so that private industry can approach the problem as it exists. Thank you very much.

SENATOR HUGHES: Are there any questions?

SENATOR WALLWORK: No.

SENATOR HUGHES: Thank you, sir.

(Prepared statement begins on page 34x in the Appendix.)

SENATOR HUGHES: Mr. Frank O'Brien or Mr. William Fox.

F R A N K O' B R I E N: Senator, my name is Frank O'Brien. I am a representative of the American Mutual Insurance Alliance. We are a national trade organization of over 100 mutual casualty companies. We write approximately 19% of the property and casualty business in New Jersey. We have previously submitted a statement to your committee and, therefore, I will be very brief.

It is our contention that A-1552 is no longer necessary. In any event, A-1552 would not have corrected any of the underlying causes of the malpractice problems, but would have aggravated them.

We feel that New Jersey now has the opportunity to study and evaluate the overall malpractice situation; therefore, we endorse Senate Concurrent Resolution 3001, which would create a special committee to investigate medical malpractice insurance costs and availability.

We don't believe anyone has all the answers at this time, but the Alliance stands ready to work cooperatively with other segments of the insurance industry, with the medical profession, and with the legislature in dealing with this problem. Thank you.

SENATOR HUGHES: Thank you, Mr. O'Brien. Are there any questions?

SENATOR WALLWORK: No questions.

(Prepared statement begins on page 36x in the appendix.)

SENATOR HUGHES: Mr. James Byrne.

J A M E S B Y R N E: I am James Byrne of Wildwood, New Jersey, President of the New Jersey Association of Independent Insurance Agents.

Members of the Senate. I appreciate this opportunity to speak before you toda on the matter of Medical Malpractice. I am here representing the New Jersey Associ tion of Independent Insurance Agents. Our organization is composed of 1400 indivi independent insurance agencies with more than 5000 licensed agents.

Our concern is for the Malpractice insurance market which has certainly been l than dynamic in recent years. Although there has been a means of placement of som sort, usually available, I certainly would have to say that the very few companies writing in the Hospital Malpractice Market, and even less in the Doctors Malpracti Market, did not create an atmosphere of encouraging competition. In the doctors m practice area it was usually necessary for the local independent agent to refer th coverage to an association and the single agent who writes this coverage for the entire state. Competition hardly! Monopoly, yes!

We are convinced that through Bill Number A1552, and the reinsurance facility it establishes, a broader market base for the consumer will be established. More companies will become involved, even if nothing more than ceding all their risks to the pooling mechanism. We do believe that through this increased participation by more insurers, an open market will again be established. Our hopes are that if this occurs, we will have a limited need for a residual mechanism of any type for the future in New Jersey.

At this juncture, I would like to say that we are examining here an insurance problem and not the underlying causes. It is up to you gentlemen not to stop when this legislation is passed. You must consider the entire problem confronting the medical men and facilities of this state. I would hope that a study committee will be formed immediately to look into facets of this underlying cause, such as; a statue of limitations; contingent fees; the court mechanism that deals with malpractice claims, eying arbitration and peer review groups.

Gentlemen you can easily infer that we are in favor of the pending legislation, but you can also easily infer that we feel you must go further to investigate and remedy the underlying causes in the early future. Thank you for this opportunity. Are there any questions?

SENATOR HUGHES: I have no questions. Do you have any questions, Senator Wallwork?

SENATOR WALLWORK: No.

SENATOR HUGHES: All right, I thank you, sir. Mr. Grover Czech.

G R O V E R C Z E C H: Mr. Chairman, Senator Wallwork, my name is Grover Czech. I am Mid-Atlantic Regional Manager of the American Insurance Association. AIA represents 138

property-casualty insurance companies, most of which write insurance in the state of New Jersey and also throughout the United States. My statement is being presented in their behalf. I appreciate this opportunity to appear here before you today on this very important subject of medical malpractice.

I am here specifically to put AIA on record in the Senate in opposition to Assembly Bill 1552. The reasons for AIA's opposition have been stated very competently by the witnesses for Chubb and Son who preceded me, particularly George Bernstein, and I will say that we agree basically with everything he did say in his statement. So to avoid being repetitive, I won't repeat them in detail.

Briefly, however, the basis of AIA's opposition is as follows: We feel the bill is intended to meet what is called an availability crisis, and it has been stated by several witnesses before me, There simply is no crisis for availability of medical malpractice insurance in New Jersey as of today, either to the doctors or to the hospitals.

I know that we all realize that this situation could change sometime in the future and there may well be such a crisis; someone called it the crisis in the embryonic stage. This, however, is an unknown, and it is not likely to occur for sometime, due to the timely and very responsible action of Chubb and Son, who is an AIA member company, who has agreed to step in and maintain a market for the hospitals.

Now, if such a crisis does occur, we feel very strongly that a reinsurance facility is simply not the answer. The primary weaknesses of the proposal are the narrowness of the base, whereby a few companies would be

subject to absorbing the bulk of any losses that would be incurred by the facility. This would further exacerbate the problem by driving those companies out of the voluntary market.

In addition, the bill does nothing to control cost. Further, AIA feels there may be problems going to the constitutional validity of the bill, which was addressed in Mr. Bernstein's statement, specifically the requirements that all companies, having written medical malpractice insurance anywhere in the country in the last two years must participate in the pool. This invites challenge. I don't think anyone would want legislation that is legally questionable. I think it would be eminently preferrable to have legislation that everyone can agree on.

The malpractice problem is a complex one, and I don't know anyone - and I have talked to a lot of people in this area in the last several months - that proposes to have a single answer or answers that will solve the problem at this time. It has come on us too fast, and no one is adequately prepared with enough necessary facts, figures, and well-thought-out legislative proposals.

What we in AIA are proposing is a dual approach to the problem. First, where there is or may soon be an availability problem, we would support the creation of a temporary market mechanism to maintain the availability of insurance. The insurance industry recognizes this as a significant social problem, and our member companies and legal staff have been hard at work for sometime now in an effort to find solutions. We have had a special subcommittee of AIA,made up of high level company executives, working on this problem. And to approach the short term solution,

on a nationwide basis, they have developed a Joint Underwriting Association facility model bill which has been officially adopted by the AIA as of sometime in March. We are advocating the JUA approach rather than the reinsurance facility approach proposed in A-1552 for several reasons: We feel that it is a more desireable answer to the short-term problem of availability. It is a more effective method of creating a pooling device and it will not intensify the problem as will the reinsurance facility, but it will stabilize the problem while a long-term solution to the problem can be sought. This is the second part of our effort; that is, the development of some long-term, comprehensive, overall solution that can be generally agreed to by all those numerous parties involved.

Now, as I stated earlier, no one presently knows the answers to the problem. What is needed is time. Time to study its causes, and develop sound, long-term answers. We feel - and this has been repeated several times through the other witnesses - that there is simply no present crisis. However, if the Legislature or the Insurance Department - or whoever - feels that there is a present need to provide some standby legislation to meet an unexpected or future availability crisis, we would support a JUA law for this purpose. And this, again, I emphasize, "only if there becomes an availability crisis, we would support a JUA bill." If there is no availability crisis, there simply is no need. This will insure the time that would be needed to review the situation and determine what can be done to resolve it on a long-term basis.

We strongly support Senate Concurrent Resolution 3001, which has been sponsored by Senator Greenberg. This would establish a legislative study commission in order to arrive at a legislative proposal

that would go toward a long-term solution. As I have indicated, AIA companies and staff have been hard at work on the problem. We have developed a great deal of useful information regarding both the causes and possible solutions to the medical malpractice problem. We have worked with various states. We have been working heavily with the Federal government. We have been working with the HEW and also we are involved with the Special Study Committee of the National Association of Insurance Commissioners, so we have become very, very familiar with the problem.

We are offering to you, the Legislature, the Insurance Commisioner, and the Legislative Study Commission -- if it is adopted - all the information that we have developed, and AIA would be glad to work with you and others in an effort to seek a solution to this problem.

In summary, then, what we are saying is that no one really knows the dimensions or the answers to the problems at this time. It is simply too soon to approach a complex problem like this by jumping in and passing such a bill as we are talking about here today. So rather than enact any legislation now when there is no need - and especially A-1552, which would not solve the problem - wait; study the problem. There is no immediate crisis. Let's look and propose responsive, adequate legislation that will solve this on a permanent and long-term basis, and one, again, I emphasize, that all of the various people involved, the doctors, the agents, the insurance companies, the Insurance Commissioner can agree on. I think this is the approach we have to take. It is simply too soon to jump in and pass any kind of legislation. That is

the basis of my statement. If you have any questions, I would be glad to answer them.

SENATOR HUGHES: I have no direct questions relative to your statement, but I do have a question which would interst our committee, inasmuch as there is another bill before our committee. Would you, as representative or carrier, insure acupuncturists?

MR. CZECH: I don't represent an insurance company. I represent the American Insurance Association, which is a trade association. We represent the companies in a legislative capacity. I really wouldn't be in a position to answer a question for an individual company.

SENATOR HUGHES: Is there anyone representing the carriers in the chamber that might be able to answer that question?

MR. HARTMANN: If the individuals are medical doctors, Federal Insurance Company does insure those who do acupuncture.

SENATOR HUGHES: Thank you. Do you have any questions, Senator Wallwork?

SENATOR WALLWORK: No.

SENATOR HUGHES: Dr. Mc Guire, do you have a comment?

DR. MC GUIRE: Yes. They are put in the same category as anesthesiologists. In other words, their premium category is the same as an M. D. acupuncturist, as would be an anesthesiologist.

SENATOR WALLWORK: Where does that fit on the scale of malpractice charges?

DR. MC GUIRE: Category four.

SENATOR WALLWORK: There being six categories, one is the highest?

MR. HARTMANN: No, one is the lowest and six is the highest.

SENATOR WALLWORK: I think you have the neurosurgeons and the orthopedic surgeons as the highest.

DR. MC GUIRE: That's right.

SENATOR WALLWORK: And then right underneath that you have the anesthesiologists.

DR. MC GUIRE: That's right.

SENATOR WALLWORK: And the acupuncturists would be underneath them.

SENATOR HUGHES: If I understand your answer correctly, then, if it is a medical doctor who is practicing acupuncture, you would give him malpractice insurance?

MR. HARTMANN: That's correct.

SENATOR HUGHES: But he would have to be a medical doctor?

MR. HARTMANN: That's correct.

SENATOR WALLWORK: What if he is not?

MR. HARTMANN: I'm not sure whether we have been faced with that question.

SENATOR HUGHES: Well, we as a committee have been faced with that problem, and this is one of the questions that we wanted to try and clarify.

Dr. Mc Guire, do you have a further statement?

DR. MC GUIRE: As you know, the Governor appointed an ad hoc commission to study the legislation for acupuncture, and until such time as that comes to fruition in New Jersey, only plenary licensed physicians - that is, M. D.'s and D. O.'s - may practice acupuncture legally in New Jersey at the present time. All others who practice it are doing it illegally. We are looking for them, by the way.

SENATOR HUGHES: Thank you, Doctor. We recognize that fact.

Our next witness will be Mr. Irving J. Tecker.

I R V I N G J. T E C K E R: Mr. Chairman, Senator Wallwork, my name is Irving J. Tecker, and I am the Executive Director of the New Jersey Podiatry Society. While the podiatrist is a physician practicing within a limited area of the human body, just as a dental practitioner, he shares the same concerns as any other physician regarding professional liability insurance where premiums have escalated in the last few years as much as 500% in the State of New Jersey.

In commenting on Assembly Bill 1552, we wish to state at the outset that we recognize this bill to be an earnest attempt at solving the professional liability insurance crisis facing health care practitioners in the State of New Jersey, but we feel that it addresses the problem only obliquely, and it does not directly attack the causes which have generated and aggravated the problem to its current dimension.

We feel this bill earnestly attempts to assure that professional liability coverage will be available in the State of New Jersey for all practitioners, but we believe that the crisis is essentially the cost of professional liability insurance as well as its availability.

We recognize, too, that insurance carriers intend to operate their business at a profit. When claims, a substantial number of which could be labeled as opportunistic, result in defense costs and awards of such magnitude that the carrier is hard-put to cover them adequately, we can understand their difficulty. When the length of time permitted to elapse from the date of alleged occurrence, past the

time of discovery is so extensive that years pass before a claim surfaces and more years pass before it is tried, we can understand the problem of the carrier in trying to amass sufficient reserves to cover the defense and possible awards of almost limitless amount. We can understand when the carrier states that he must continually stockpile reserve funds to cover almost unpredictable future costs. These are the factors, we believe, which cause the cost of professional liability insurance to rise to the point where the carrier is unwilling to sell it and the practititoner who buys it is forced to pass this exhorbitant expense onto his patients. This bill does not attack these root causes, while it might provide for the availability of professional liability insurance, it does not provide any limits or control to the cost of such insurance.

Additionally, we feel that it is not wise that there is no provision for practitioner representation on the Board of Directors of the proposed New Jersey Medical Malpractice Reinsurance Association and its accompanying reinsurance fund. We find highly objectionable the provision in the proposed bill which would have unequivically mandated that every health care provider carry professional liability insurance as a prerequisite to maintaining his license. Providing evidence of his insurance has absolutely no relevance to competence and professional behavior, which are the qualities which statutory regulation and licensure attempt to insure.

We believe that it must be recognized that the practice of medicine in any of its disciplines or specialties is still both an art and a science. To

call medicine a science recognizes it exactness. To call medicine an art recognizes the unexplained enigmas of many of its applications and results. The combined effect of both art and science must be considered when evaluating the legitimacy of a claim for the possibility of award.

From a variety of sources comes an even wider variety of suggested solutions, and while no single one of them may be a total answer to the problem we face, we earnestly believe that each and all of them should be given the deepest and most detailed examination and evaluation, for perhaps by a combination of them we may find the answers we are seeking.

We recommend serious consideration of the following suggestions:

1. Establishment of screening committees to evaluate the legitimacy and worthiness of a claim before it is permitted to go to court. Such committees could consist of a jurist, an attorney, a member of the medical discipline involved, and a public representative.

2. The type of compensation board arrangement which would review claims and allegations an make awards in accordance with a pre-set schedule.

3. The imposition of a mechanism for compulsory arbitration.

4. A special pool of carriers to accept assigned risks.

5. Reduction of the tail. A shorter period of time from the date of alleged occurrence to the date until which a claim may be entered.

6. No fault insurance for medical mishaps is another possibility.

And we assure that study will reveal additional possible solutions.

We do endorse and support the concept of Senate Concurrent Resolution 3001, which would create a special committee to investigate medical malpractice insurance costs and availability and their effect upon the delivery and cost of medical care services to the citizens of New Jersey.

Thoughtful solutions to this problem of professional liability insurance would have direct and beneficial effects both upon the standard of health care and the cost of health care to the citizens of New Jersey. It is common knowledge that many practitioners practice what is popularly termed defensive medicine, designed not so much to protect the patient as it is to protect the practitioner against the possibility of a malpractice action. There is no question but that this increases the cost of medical care to the patient.

We must point out also that the word "malpractice" has been overused. We are not defending the incompetent or restraining the patient's right to redress. We do recognize that inadvertencies or untoward results do sometimes occur. We are really talking about protection for professional liability, for malpractice connotes a measure of incompetence or willful professional misuse or wrongdoing. Evidence shows that the majority of cases filed are not such, but rather a patient's reaction to a real, or fancied, less than perfect result which could not have been guaranteed in the first place.

We urge that deep and sympathetic study be given all aspects of this problem, and every possible solution, for professional liability insurance coverage is a practical necessity for every practitioner. Without it, he cannot practice, unless he wishes to risk his all. Without adequate protection at a bearable cost, most practitioners are unwilling to practice. If uncorrected, this could lead to a flight of health care practitioners from the state of New Jersey and a real crisis, not for the medical community, but for the health and welfare of the men, women and children of our state.

SENATOR HUGHES: I have just one question, sir. What dollar amount of premium do you call or consider exhorbitant?

MR. TECKER: Well, that is a relative term, Senator. I am not in practice myself. I am the Executive Secretary of the Association.

SENATOR HUGHES: Well, you used that terminology in your statement.

MR. TECKER: I did, because I was expressing to you the attitude and the feeling of my Society.

SENATOR HUGHES: Well, how can this be brought into your text without documentation or figures that would substantiate it?

MR. TECKER: I'm sorry, I didn't understand your question.

SENATOR HUGHES: Well, I will go back to my original question. What dollar amount of premium would you consider exhorbitant?

MR. TECKER: All right, that question is difficult for me to answer, since I am not a man

in practice. And I can't evaluate that dollar figure toward a directly related income.

SENATOR HUGHES: All right, thank you. Commissioner Sheeran.

J A M E S J. S H E E R A N: Mr. Chairman and Senator Wallwork, and all those in attendance today, I have a statement that I will read from. It won't be too long, although I do believe that the subject at interest is sufficient to take your time, which I know you have done, and it is deeply appreciated.

I do think that I have to try to focus in on the issue that is really before the Senate, and cut away the chaff. I have heard substantial discussion today from what I consider the organized interest involving the matter of medical malpractice. The reason I say the organized interest is because the citizen of this state who is walking up and down the streets of Trenton, Newark, south Jersey, regardless of where it is, does not have the ability to either organize the technical, nor even the vocal staff to represent their position before the Senate Committee. And I consider you, the Senators, and me as the Commissioner of Insurance, the representatives of that public interest, the broad public interest involved that cannot prepare for such a hearing.

The presentation that was given this morning by Assemblyman Salkind was accurate, well-stated, and I think focused on the very important issue that not only faces the State of New Jersey, but I believe almost every state in the nation; that is, the matter of the monopoly that has grown in the medical malpractice business that has prevented us from either reasonably pricing or protecting the interest of all medical providers.

The question that you are asking has been asked many, many times today, and that is, is there a crisis today? And my answer is, yes, there is a crisis today. There is a crisis until such time as we can make an available insurance market for those who need medical malpractice in order to practice their profession in a reasonable way, in addition to those people who may be injured, and many are injured through the fault of those providing medical care to the citizens of this state. That can be in no way interpreted by me as indicating that I believe that doctors or medical providers are not doing an excellent job. By and large those doctors are excellent. They do a fine and dedicated job for our citizens.

But we know, and we would be blind if we were not willing to accept the fact that there are many who should be policed by the industry and thoroughly policed before we think one minute about depriving one citizen of what is that person's tort right.

Now, as far as the crisis is concered, I say there is a crisis today, and at the very best - no matter how you analyze this problem - we are no further than thirty days away from a major crisis.

The company that had just assumed some of the medical malpractice coverage for hospitals, Chubb and Sons - a New Jersey company that I have a great deal of respect for. I know its officers and the individuals involved. I do not consider this to be a matter of personalities, including corporate personalities or indiviudal personalities. It is a matter of crisis, again.

Before Argonaut Insurance Company cancelled out its insurance -- and if you recall, you must recall that they gave thirty days notice under the terms of our own statutory provision. They gave a thirty-day notice and said, we are walking out of the state of New Jersey. We moved with a bill that was not presented in a crisis situation, but was a "reason" bill because we saw a crisis that developed throughout the nation, so that we in New Jersey would not be the victims of that crisis. Even moving with haste, we were the victims of that crisis. Argonaut said, we are pulling out of the state of New Jersey. They cancelled out twenty-nine hospitals and left us without an available market.

I dare say that had we not introduced this legislation, had we not moved rapidly, that Chubb and Sons would not have been the volunteer that picked up that business, but the fact was that if that crisis existed, we would have gone to the root-core problem involved here, and that is, an attack on the monopoly that exists.

I'm going to give you an example and support for the position that I have taken as Commissioner of Insurance in this state, and I must tell you that I have had a number of states that have written to me, have called me, have even asked us to appear in their states to testify, because they see this same problem, and they are studying our legislation, I think, as the answer for getting into the fundamental issue of availability.

I am going to talk about our neighboring state of New York, and I am going to give you an example of what happened. In New York, the Argonaut

Insurance Company, a year ago, received 100% increase for malpractice insurance. This year, and December of last year, which carried the problem into this year, they sought a 197% rate increase for malpractice insurance.

When they did, the Commissioner of Insurance said, we will not allow that increase. It appears to be out of order. We are going to have hearings. The Argonaut Insurance Company - which was involved there and was involved here - said, we will not go to your hearings. We will not present testimony. We simply refuse to write any further business in New York, and we are getting out of the medical malpractice business. That left New York without a market.

Now, let me just try to focus in on that problem, and assume that they had a reinsurance facility as we have proposed here. Had Argonaut taken that position, there would have been a fully available market in New York, and everyone of those medical practitioners or health care providers could have gone to many substantial companies, such as we have in New Jersey. We have Argonaut, Aetna, St. Paul, Hartford, Travelers, INA, Chubb, and we are getting lists of many more that write medical malpractice business in many other states, but not in New Jersey. The reason they don't do it in New Jersey - I will try to cover that in my statement a little more carefully. But what I am saying there is that when they pulled out of New York, or threatened to pull out of New York, there would have been an available insurance market, and the threats that they levied would not have come through.

Now, let me just show you what happened in another state that tried to handle the problem just a little bit differently. The state of North Carolina, John Ingram, Commissioner. They were covered by - not Argonaut, but St. Paul Insurance Company. St. Paul, at the beginning of this year, said we want an 82% increase. John Ingram, being a reasonable Commissioner, concerned about the interests of the citizens of his state said, no, we will not give you that increase. We are going to have hearings.

They held hearings. At the conclusion of the hearings, the Commissioner found that they were entitled to a 5 1/2% rate increase. The company said, we are not going to accept that, Commissioner. We are pulling out of your state.

I am going to read a statement, very briefly, that he made. "The medical malpractice hearing began under the cloud of a threat of non-renewal and termination. It ended under the same cloud. The insurance company writing almost all of this coverage stood on its original position that it would not renew physicians policies after January 1, 1975, unless granted an 82% rate increase. Evidence was clear that reserves for pending claims were grossly overstated. Hard historical evidence proves that this company had actually paid out in dollars for claims and loss adjustment expense less than 20% of the premium dollars collected over the past seventeen years. The 82% increase is therefore excessive."

I want you to know that they were talking about claims payed as against premiums over a seventeen-year period. I don't know the accuracy of it, but it is

his statement, a public statement made by him. I have not seen any counter-statements to this. "Malpractice insurance," he goes on, "is just as essential to the people of North Carolina, as automobile liability insurance. Since there is no reinsurance law for malpractice requiring the companies to write this insurance, I am forced to enter a temporary order allowing the 82% increase." Why did he do it? Because he had to provide an available market for the people in the state of North Carolina. And I am saying that we in New Jersey, if we are not wise enough, if we don't have the strength, in spite of the outcry of some special groups, to give us an available market, I think we fail the citizens of this state, because they are the victims of the lack of availability of medical malpractice insurance market.

Now, we have heard this morning the testimony of the AIA and Mr. Bernstein, concerning a proposed JUA in substitute for the kind of action that we have tried to develop here for an available medical malpractice insurance market. I told you about the 97% increase in New York and the threat to walk out. There was a proposed solution in New York by the New York Department to create a JUA in New York. I am now going to quote from the Journal of Commerce on Tuesday, January 7, 1975,"The American Insurance Associations expressed strong opposition Monday to a proposal being set forth by New York State Senator John Dunn, which would establish a Joint Underwriting Association." The president goes on and he is quoted throughout the entire article.

Summing up, Mr. Jones who is the president said, "AIA member companies believe the Joint Underwriting Association approach to medical malpractice insurance problems is self-defeating and unsound." It goes on, "In our judgement, the most immediate productive step which could and should be taken is for the Insurance Department to permit a justifiable increase in current medical malpractice insurance rates. This would temporarily alleviate the heavy burden on the present carrier." They are talking about Argonaut, the one that got 100% the year before and was looking for 198% this year. "And could attract offers of additional reinsurance. That certainly would not be a permanent resolution to the problem, but it would at the very least provide some time to determine what major changes have to be made in the current system of providing reparation for those who suffer as a result of medical malpractice."

I say that that is an inconsistent position. I think, had I offered the JUA position here there would have been opposition to the JUA. Had I offered a reinsurance facility as I did, there is opposition to that, and it depends, it seems to me, on what the forum is.

Now, let me try to again focus in on whether or not we have a crisis or not. In this state, and in every other state affected by medical malpractice, there is a standard market and there is what we call a non-standard market. In the standard market, they are the companies that are approved to do business in our state, make substantial deposits, who we check for financial stability, we check their policy forms,

and we make sure that they are reasonable. Those companies are very thin, as far as medical malpractice is concerned. But let's talk about those who do not qualify by the standards of the standard companies to be insured for medical malpractice. We have heard the testimony of the Medical Society, and it is true, they do not have a problem, because they have a deal. They have an agreement with the insurance company that their members will be provided. But there are over 15,000 medical practitioners in the state of New Jersey, and there are other people who provide medical care in the state of New Jersey, either para-professional or otherwise, who do not belong to that association and who are not covered by that agreement. Those people, in my judgement, to the largest extent are thrown into the non-standard market.

What does this non-standard market mean? It means that we don't control rates. We don't examine rates. It means that if there is an insolvency of the carrier - and I have at least ten insolvencies involving non-standard carriers presently being considered by my office, and most of those are out of the state or out of the country -- but if there is an insolvency, you pass the guaranteed fund that protects the citizens who are injured. That guaranteed fund is not operable. Those people, if they were caught in that trap, would not be covered.

Let me just try to really show you what it all means. Let's talk about the state of New Jersey and the people we represent who pay taxes. Are they affected by the lack of an available malpractice insurance for the medical providers of this state? I say, yes, they are. I have here, and I am going to

make available to the members of this committee, first, a letter that was delivered to the State Supervisor, Bureau of Special Services, Division of Property and Purchase, on November 21, 1974, State of New Jersey General Liability Malpractice, Bellefonti Insurance Company. This is a company only licensed to write the surplus lines market.

In this case they are writing the insurance for the New Jersey School of Medicine and Dentistry. "We, the state facility, do not have an available market. We cannot purchase insurance from a standard insurance carrier, and our own State Medical and Dental School has to go into the surplus market, and there is no coverage in the event of an insolvency."

That in itself is a disgrace, not to us, but I think to the industry and the providers of insurance in this state which provides many billions of dollars to an industry. The policy in one year was raised from $213,000 to $546,000. There was no justification for that increase; there was no proof that it was needed. As a matter of fact, there was no proof of anything except the demand that there be payment made in two stages, an immediate payment of $262,000 and a second payment on April first of $262,000.

Let me try to really show you where the problem lies. If you remember, when the so-called crisis developed, we were covered for the twenty-nine hospitals. We were contacted by Frank M. Papale, who was the Director of Purchase, and through his office, Mr. Arthur Livney, State Insurance Manager - he manages our state insurance program - wrote this letter. I am going to read it because it is important.

"The above-captioned policy in the amount of 3 million dollars written through the Reserve Insurance Company at an annual premium of $228,574 expired in October, 1974. The carrier was unwilling to renew the policy, despite loss ratios of 37% the first year, 7% the second year, and 12% the third year of coverage. Brokers were only successful in obtaining coverage with the Bellefonti Insurance Company admitted to do business in New Jersey as a surplus lines carrier for a period of one year at a premium of $546,314. The new carrier agreed to accept the deposit of $284,083 on or before 12/12/74 with the remaining $262,231 payable by 4/1/75."

The Insurance Director says, "I personally contacted more than twenty carriers in the hope that coverage might be placed elsewhere, but all efforts proved fruitless. Mr. Philipp Stern of your Department" - who is with me today - "phoned this morning and suggested that I contact Chubb and Son, in view of their recent public pronouncements concerning medical malpractice insurance. I immediately contacted Mr. Robert Rusis of Chubb, and briefly mentioned the problem of the New Jersey College of Medicine and Dentistry, and I said I would welcome a quotation from his company. He said he was only acting as a spokesman but would have Mr. Calperwaite, a company underwriter, contact me.

"Mr. Calperwaite phoned this afternoon. I briefly reviewed the situation with him and told him that while we have coverage, we would prefer placing the insurance with an admitted company and at a more realistic premium, rather than proceed with the payment

of a second installment due shortly. He explained that his people were simply so busy trying to handle the twenty-nine hospitals that could obtain no coverage, that he could do nothing for us at this time. He was also unable to advise me as to when such a possibility might arise. His only suggestion was that in view of our experience we might consider self-insurance."

The New Jersey Hospital Association presented me with a copy of a report that they made concerning the Argonaut Insurance Company. The Argonaut, as you know, wrote many of the companies through an agreement with the Hospital Association. They had agreed that they would cover all hospitals. Then about December of this year they took the position that they would not renew, and when they would not renew, they were specifically zeroing in on the more urban hospitals where our problems, as you know, are always most difficult, and those hospitals went out into the field trying to get coverage. Some coverage was provided by the St. Paul, but there were increases involved.

Now, I think it is important to know that as long as we have a surplus lines market, that a company or a type of insurance is listed on what we call the exportable list, which means that there is not an available market. Even standard insurance companies can charge more than the amount of insurance that we permit as a reasonable charge. What I am saying is that a standard company, even if we say that you can't charge more than $96 a day for a hospital bed, if it wants, can charge more than that, as long as the company, or as long as that type of insurance

is not available, fully available, and is placed on what we call the exportable list which permits non-admitted companies to do business in our state.

The Hospital Association - I do not and will not try to support these figures, because we have not been able to get anything by way of reliable statistics from Argonaut Insurance Company as long as they have been writing here, because they do have the monopoly and we have the threat of them leaving the state, and they will not support their pricing of insurance with reliable statistics.

Mr. Stern, who I consider the finest actuary that I have ever met in my life, has called them garbage statistics, and rightly so, I believe. But here is what the Hospital Association found:

1. Argonaut has not considered the investment income that could have been earned over the years on the available funds not used to pay claims.

2. Argonaut has consistently overstated their claims' reserves. Our study indicates that 377 claims were reserved and then subsequently settled during the period of August 31, 1971 to June 21, 1974. The total reserves were 2.68 times greater than the settlement amounts. And what it is saying is that there was a 268% over-reserve, according to their figures. And you must know that if we have nothing, we have no support for fixing rates, that when they over-reserve, they are really hiding, in my judgement, a substantial amount of money in their development, and we use those figures in rate making. In other words, this is the so-called tail. They are reserving for that so-called tail, but when that tail seems to be developing, according to the Hospital Association figures is 268% greater than actually is paid out.

Now, a question was asked, will Argonaut be insolvent? I took a great interest in the Argonaut Company, and this is a cursory examination, but it comes from their own records. They submitted their annual report, and they show an underwriting loss of $83,000,700. I thought, well, that titillates me at least to look into whether or not it really is so that they are in this bad position. I looked at it and I found, first of all, in their pay outs a dividend to policyholders of over 6 million dollars. In addition to that, a dividend to stockholders of over 10 and a half million dollars. More interesting than that, I found that during the year 1974 loss reserves were increased by 135 million dollars plus, and loss adjustment expenses were increased by almost 35 million, which, simple calculation says to me that they took and placed into their reserves over 170 million dollars, while they show an underwriting loss of some 86 million dollars and also show dividends of close to 17 million dollars. I think that it ought to be looked into carefully. We are going to do that. I can assure you that we are going to look carefully into every case that was handled by the Argonaut Company.

We are very short in personnel, but we are not short, in my judgement, in the initiative that it is going to take to get to the bottom line of what's going on with medical malpractice. Every statistic I see, time and time again, does not seem to support this long tail. I have information from New York. I have the statement from the Commissioner of North Carolina that shows a 20% pay out. There is

nothing there that even points to reason to me. It may be so; it may not be so. But I think we have to look and look very carefully. A lot can be said about the reserve position.

Now, we had a gentleman speak from the ---

SENATOR HUGHES: Commissioner, could we have a copy of that, if you would please, if it is not privy information?

COMMISSIONER SHEERAN: I will give you a copy of my summary which is -- do you mean the Argonaut information?

SENATOR HUGHES: Yes.

COMMISSIONER SHEERAN: Yes, I would be glad to give you that. The New Jersey Podiatry Society spoke here, and I had the privilege of examining their problem with them when John J. Miller, former Senator representing the Podiatry Society, came to my office with what, in my opinion, was one of the most disgraceful problems that I have seen in the medical malpractice area.

Frankly, I am a little bit concerned about the fact that the initiative wasn't taken to see that the problem that they are really dealing with is one of a lack of availability of insurance, and until its available, the root-core problems that the gentleman spoke of cannot be attacked until we can make companies cover our people and give us coverage.

Let me just show you how disgraceful the prblem has gotten in this state. This is a letter from John Miller, the attorney, to the insurance company, and I am quoting part of it. The whole file is available. I have no private documents in my office.

It says, "The purported notice" - they had

given them a notice that they were not going to renew their policy, and you have to listen carefully to this. "The purported notice would be better described as a directive that unless the assured agreed to pay $1,000 instead of the current annual rate of $125 and give up the professional liability coverage under the umbrella, the company would not renew. A unilateral directive is readily distinguished from the bilateral negotiation of a new premium."

What the company did here is say, we are not going to renew your insurance, and we are not going to give you a professional coverage unless you pay us $1,000 per person, rather than $125. There is no support for that whatsoever, no statistical. This is a non-admitted carrier - the one I am talking about - that covers most podiatrists in the state of New Jersey. They do not have a standard market.

Then it goes on, "a directive that the assured must forfeit the most important feature and provision of his policy, in fact, the very feature for which he originally sought the policy is incomprehensible in light of the foregoing. The directive to the insured that the company will not renew unless the insured would pay $1,000 annual premium instead of the $125 annual premium currently in effect, and to forfeit his professional liability coverage seems like a clear case of bad faith dealings by the company."

Now, I went further and I got a copy of the policy that is involved. Again, a disgrace to the state and a disgrace, in my judgement, to the association that exists between the industry and the people that it is supposed to cover. All Starr Insurance Corporation, on the face of the policy it shows

a coverage, professional liability $100,000 each, $300,000 aggregate, an aggregate professional umbrella coverage of 1 million dollars.

You won't believe this, I know. I could not believe it myself, except that I have the documents. Under exclusions in this policy, a policy that is not examined, approved for use in this state by our department because it is a surplus line item, "This policy shall not apply to the rendering of any professional service or the ommission thereof by the insured."

Now why in the world would a company sell medical malpractice insurance and then exclude the very coverage that it is supposed to be covering, and then demand on top of that a 700% increase? I think, as I said, it is a disgrace.

Let's go further and find out whether or not all doctors really support the position of the Medical Society. Is every memeber of the Medical Society in agreement? I don't believe that they are. I have talked to many doctors. I have here the New Jersey Neurosurgical Society - and I think we all know that is the group that is most heavily hit by the escalating or the high cost of medical malpractice - Press Release by H. Lieberman, M. D. It says,

"The New Jersey Neurosurgical Society is in favor of the passage of bill A-1552 concerning malpractice insurance. This bill which is now before the State Senate will provide coverage by a pool of insurance companies and would eliminate the monopoly presently held by the state's sole carrier, Chubb and Son. It is significant that such legislation would prevent the imminent closure of numerous hospitals which are now threatened with loss of their coverage. A takeover of this insurance by Chubb would only result in a disasterous rise in hospital costs and must be prevented if our hospitals are to remain as viable institutions.

"Admittedly, this bill is but a temporary stopgap. It will, however, provide for a continuity of coverage for those unfortunates in need of compensation. It would also permit medical and particularly surgical care in the state to continue without interruption, and it will, above all, provide us with the time to search for a more permanent solution to this problem."

This is signed by that society and its officers. Now, we have progressed, I think, in this with procedures and so on. We are prepared to move ahead to make an available market. I do not agree with anyone that it either denies those who are presently covered insurance; it denies Chubb and Son of its present clients. I see no reason why they can't insure the same people. I see no reason why there should be an increased cost.

When they talk about a bureaucratic set up, it is a very simple mechanism. It simply is a pooling device. It is a paper transaction, and there is no large company sitting there. There are not fifty employees. It is merely an accounting at the end of the year. It's a change in movement of premiums. It works in the automobile insurance business, and as Commissioner Ingram from North Carolina said, it's too bad we don't have it here for medical malpractice.

I don't think I should overburden your Committee with my signed statement, unless you feel it would be of help to those who are here, so they can respond to whatever I have to say. I can read this signed statement and further amplify upon what I have said. Unless you so wish that I do, I would

simply end by saying that the ---

SENATOR HUGHES: Commissoner, I would like you to make your statement for the record.

COMMISSIONER SHEERAN: Fine. The plight of the twenty-nine ---

SENATOR HUGHES: Commissioner, I didn't mean that you should read it, but I would like you to turn it over to the court stenographer, so she can include it in the record. (Statement begins on page 51

COMMISSIONER SHEERAN: I have a copy for the court stenographer, and I have copies for all who are present here today. Among other things, I think in that statement it is important to know that we have no objection, and we will support, of course, an examination into some of the underlying problems in the costing of malpractice insurance. But I will say, Senator, there is no question in my mind that the day we will be able to know there is an insurance market and deeply look into the cost problems and know that the only company or companies - two or at the most three - who are writing any kind of business will not walk out of our state and leave us void of a market is the day we will get to the bottom line of what is right and what is wrong by way of costing.

If they are charging too much for the market, then we are going to know it. I can show you statistics from all areas of the country which do not necessarily support this proliferation of medical claims. There is a relationship between the numbers of doctors practicing and the number of claims. In New York I can give you very specific detailed information that would belie this idea that there is proliferation. I don't believe it exists. I think we have to get to the core, and that is what I want to do.

I would be pleased to answer any questions you may have in this regard. Again, I think Assemblyman Salkind said from the viewpoint of the problem, we do not in this Department, and I do not object to looking into the heart issues. I think we have to look very carefully and be very sure of ourselves before we do what is being asked of us by denying the

I have some information here which to me is
51r rather heart rendering. There is a boy -- this is the one case that is probably cited by the insurance companies and those delivering health care to our people as the largest malpractice case that has ever been passed in medical areas, and award of 4 million dollars. The fact is it involved what appears to be a rather blatant case of malpractice. It involves an eleven year old boy named Kelly Niles of California who suffered an injury. He now can move his mouth, his eyelids, and a couple of fingers.

I want you to compare that kind of recovery - and you know that our courts provide that if there is an excessive award that that award by the jury can be overturned, if it is determined to be excessive. In other words, there is a review by the court - to Indiana where they have a $100,000 limitation on medical malpractice recovery.

It becomes obvious to me that the poor family of that very, very unfortunate child, who is that vegetable we talked about, cannot live long under any kind of care for $100,000.

SENATOR HUGHES: Commissioner, from the testimony that I have heard today, the medical profession seemed satisfied with the existing conditions.

COMMISSIONER SHEERAN: That is the Medical Society. That does not mean all professionals. There are

some 15,000 in New Jersey and there are some 6,300 covered by the Medical Society's policy. The others, many of them, are in the surplus lines market and are not satisfied, but they are not organized.

SENATOR HUGHES: Well, you did mention the neurosurgeon which is the smaller group. In essence, the neurosurgeons - just to clarify my thinking - they undoubtedly receive the highest compensation for their work. And in turn, I am wondering whether their premiums aren't in line with their compensation, or parallel their compensation?

COMMISSIONER SHEERAN: I would say that is true, and there is no question that in the medical profession, the idea of a classification system and so on probably has some merit.

SENATOR HUGHES: What I am trying to point out is, the minority group here would reap the most benefit from the reinsurance facility.

COMMISSIONER SHEERAN: Senator, I think there is a misunderstanding, then. The reinsurance facility does not aim at giving level premiums. There is nothing that changes the classification system. The neurosurgeons' pricing structure calls for $14,000 and he would have to pay $14,000. So that any idea that this would change the pricing mechanism with this legislation is not correct.

SENATOR HUGHES: What is their reason for objecting to it then?

COMMISSIONER SHEERAN: The reason for supporting it is that they recognize that there is a monopoly; that there is only one available company in the market. And I think they also realize that when you break that monopoly we will be able to see whether or not the pricing structure is in fact correct.

SENATOR HUGHES: Well, we have heard in previous testimony that there are ten companies offering this insurance to doctors of New Jersey.

COMMISSIONER SHEERAN: That is not so.

SENATOR HUGHES: You did mention five or six names yourself, though; is that correct?

COMMISSIONER SHEERAN: Yes. There are nine or so that are immediately off that are doing hospitals. We are getting that information now. I would say that we probably have over thirty, or thirty to forty, who are writing other business in this state that also write medical malpractice insurance in other states. It will substantially open the market, which is really the purpose of this legislation. It in no way means that we will not look further into it. It simply makes an available market, and then from there I think we can attack the basic issues involved.

SENATOR HUGHES: How would this affect the consumer?

COMMISSIONER SHEERAN: It will affect the consumer because it will assure: One, any insurance or any person dealing with any medical facility, even our State College of Medicine and Dentistry who have a malpractice problem, will be insured through a standard market company, and if in fact there were, for example, an insolvency of the standard market company, they would be insured.

I think it will insure us the right to examine for lower rates. Let me give you an example of that. In California, the rate for hospital day for medical malpractice in 1969 was 10¢ per day. Today it is $3.60 per patient day in a California hospital. Now, California isn't so far from us and it isn't so different from us. But I think it is inconceivable that

there is such a proliferation of medical malpractice cases or increases in awards in California that it could possibly have increased that much. I don't think that there would be any supportable data for that kind of increase. I think we have been powerless to really attack the problem.

SENATOR HUGHES: Relative to California - I don't like to degrade our state - but would you say that we are comparing apples with oranges from a population standpoint? What is the ratio of doctors in California per capita?

COMMISSIONER SHEERAN: I really don't know that answer, but what I mean is that assuming we just look at California and look at a ten-cent per day cost for medical malpractice insurance, and assuming it was absolutely the worst bunch of doctors that were ever put together on this earth, and it went from 10¢ a day per patient day to $3.60 per patient day ---

SENATOR HUGHES: How long a period of time?

COMMISSIONER SHEERAN: From 1969 until the present date. That is a fantastic increase. We would all be out of business at that kind of a rate increase. And that is what the consumer is picking up. And each year we find through the threats that exist in all of these states that are all interrelated -- you know, we can't separate or draw lines around our state. What I am saying is, that the monopolies that exist, exist state by state, territory by territory, and until we as state officials can break that, saying that it was created by design or otherwise, but it was created and the fact does exist.

SENATOR HUGHES: Would this effect in any way premiums of Blue Cross and Blue Shield?

COMMISSIONER SHEERAN: Well, it is affecting it right now. As these costs go up, they are directly related to the per hospital day costs. Now, as far as reductions in, for example, tort liabilities and so on, to reduce premiums, I don't know whether the doctors would reduce their fees. I haven't heard them say that.

SENATOR HUGHES: I don't have any further questions. Do you have any questions, Senator Wallwork?

SENATOR WALLWORK: Yes. Commissioner, you said you were powerless to attack the problem. Why are you powerless to attack the problem?

COMMISSIONER SHEERAN: For the same reason that Commissioner Ingram and the Commissioner from New York and the Commissioner in Maryland -- as soon as these Commissioners attacked the problem and looked into rates and so on, the companies said they were pulling out of the state and left them with no available market. This happens, Senator. It just happened in Florida, I understand, the same problem.

SENATOR WALLWORK: Can't you get the figures from the companies, or do you have the legislative power to audit the company's books?

COMMISSIONER SHEERAN: My Chief Actuary can answer that. He has been trying for how many years now to get it?

P H I L I P P K. S T E R N: Yes, sir, we do have the power to get the data, but they are hard to get, because the organization responsible for obtaining the data is lax.

Let me give you an example. In 1972, the rating organization, ISO, put through a 50% increase in rates for hospitals. Somehow, through some combination

of circumstances, I didn't see it when it went through. When the Commissioner asked me to look at that, I started to exaimine the data. And I called them to my office and I pointed out the discrepancy, and I asked them if there was anything wrong with my reasoning or are these figures wrong. They said, yes, the figures were wrong, and there must be something wrong there.

I went through a lot of work with the whole staff actually comparing the reported number of beds and the reported number of written premiums as used in those rate-making data with the bills which the hospital supplied. It was a very limited area where you could make a complete survey, and we compared these two sources, and there was absolutely no correspondence between those two figures. The two sets of data looked like telephone numbers.

I wrote a report which was sent to the rating organization, and on the basis of that report, the Commissioner ordered the rating organization to roll back the 50% increase. Now, normally that rating organization would have gone to court, because they never allow any commissioner to roll back their rates, and justly so. But our case was so strong that they did it. They later on made another filing, and they still did not satisfy me that they had corrected the errors. Most of these errors came from Argonaut, and I am still looking at some more data. As a matter of fact, we have a filing from ISO now for a 250% increase. Let me see what your companies reported to you in terms of number of beds insured. We further are looking into the losses - the comparison the Commissioner referred to before - comparing paid losses with loss reserves. We have reams of work papers. We have to do it by hand, because we don't have

computers as the other companies have. We are using these data to see whether that huge loss development they talk about is justified. It may be justified, but I want to see the numbers.

I want to mention to you that the two filings, the Argonaut filing and the ISO filing will be subject to public hearings. And in addition to the question of justifying the reported losses or the estimated losses, we are going to raise many, many issues affecting rate making. The Commissioner's point was that in the past and without an alternative, if we ask too many questions the answer is, well, if we don't get these rates our companies are going to pull out.

For example, Chubb, every year for a number of years they come down to the Department with the broker who handles the entire business, the sole broker, with a secretary of the Medical Society and says, here are the rates we agree to. And that's what they want. We do scrutinize them, and generally I would say that the Chubb requests have not been excessive, and as Mr. Alford said this morning, their increases have not been excessive and there is no comparison to what Argonaut has done.

We really have no choice, because if the Commissioner does not approve what the Insurance Committee and the broker and the company agree to, then there is no alternative, because that is the only carrier providing the coverage today.

I also want to mention to you this, and picture this, every doctor in New Jersey who is a member of the Medical Society has to go through the door of one broker. If I don't like the check-out clerk in the A&P, I can go to Shop-Rite, but if a

doctor doesn't like the broker, he still has to go to his store to get insurance, and that is the monopoly Mr. Byrne of the Agents Association referred to. The whole thing is unsound. It is atypical of the insurance industry. The insurance industry is regulated as a competitive business, but here you have a monopoly. The power of the Commissioner is simply not designed to meet a monopoly.

SENATOR WALLWORK: Well, with this reinsurance pool, what assurance can you give this committee that you are going to, in effect, break the monopoly that you allege and that there will be competition?

COMMISSIONER SHEERAN: Senator, I have named some of the companies involved who do substantial business in our state. They supply another part of the market. They selectively have not gotten into the medical malpractice business, because they have some other state, very frankly, and our supplier isn't interfering in that state. So that these companies want the business in New Jersey. It is profitable. We are a fair state and they will stay here. We have already had meetings, and I asked at the meeting, if anyone had anything they would like to say, any objections to the basic concept, and at that meeting which was with nine other companies involved, I don't recall any position that was in opposition to it.

SENATOR WALLWORK: Are you implying that Aetna and St. Paul and these other carriers would definitely come in and participate in this reinsurance pool, and they expressed that they would approve that and do it basically ---

COMMISSIONER SHEERAN: They have already met with us, yes.

SENATOR WALLWORK: What did they indicate?

COMMISSIONER SHEERAN: They indicated that they would work with us towards accomplishing what we hope to be the framework of the operative parts of the reinsurance facility, which you will see in there calls for the formation of a reinsurance facility with a board of directors and so on.

SENATOR WALLWORK: I think that we should, Mr. Chairman, get an expression from these individual companies as to what their recommendations specifically are, so we have it on the record. I would be very interested in that.

Let's say that they came in and you had ten or twelve companies in this program. Is that what you visualize?

COMMISSIONER SHEERAN: It's hard to say. I would say that there could be a larger number. We are getting that information now. We have written to all the companies.

SENATOR WALLWORK: Approximately how many would you visualize?

COMMISSIONER SHEERAN: I would say anywhere from ten to thirty. But that is more than one or two.

SENATOR WALLWORK: All right, now, what if all of these companies were to ---

COMMISSIONER SHEERAN: Excuse me, to be more clear, they worked with us on the plan of operation for a reinsurance facility generally very cooperatively, but they did reserve within themselves the right to oppose it.

SENATOR WALLWORK: That was reinsurance specifically on medical malpractice or on a different type of insurance?

COMMISSIONER SHEERAN: On medical malpractice. They

worked with us on the assumption that if the measure is passed, then we will need a mechanism to have it work. In fairness, to be precise in that statement, they worked with us in developing that, but reserved the right to oppose the concept, and I think you have probably heard that opposition expressed here today.

SENATOR WALLWORK: I didn't hear it from ten or twelve of the companies.

COMMISSIONER SHEERAN: You probably heard that from their associations, the AIA being one, and I think the mutual companies had a spokesman.

SENATOR WALLWORK: So I understand correctly in my own mind, are you saying in effect then that they said they would be cooperative, but they don't support the program?

COMMISSIONER SHEERAN: I would say that that's probably a more precise statement, and they generally are cooperative when there is legislation.

SENATOR WALLWORK: Now, what if these ten or fifteen or twenty companies came in and they said, well, here we are, and they dumped everything into the pool? What would you do?

COMMISSIONER SHEERAN: Well, we would proceed with it. They will handle those claims, and there is no reason - there is absolutely no reason - why that should be a catastrophe. There is a pure premium development, and that pure premium would be devoted toward the reinsurance facility for the purpose of paying claims and claims expenses. Now, if they do this, I don't consider it a disaster. I think the more they put in, the better result we will find in the reinsurance facility itself. If the companies are selective and they pick out what they consider the

bad risks, we will probably find some bit of bad experience in there, because they will pick out those practitioners that should have been policed probably by their own profession or those that should not have been practicing, and will not keep them as their own risk but put them into the facility. I do think that the more people that go in, the better the experience.

Our rate will be calculated so that a company can make a reasonable, fair profit under the terms of the statute.

SENATOR WALLWORK: Well, who would end up then doing this calculation, and who would end up then handling the facts and the figures and seeing that everything was being operated properly?

COMMISSIONER SHEERAN: The board of directors as set forth in the statute, which is made up mainly of industry people.

SENATOR WALLWORK: If the board of directors did that, which in effect would be the industry people policing themselves - the way I can understand it from this legislation - how will you be able to check and see that they are policing themselves properly?

COMMISSIONER SHEERAN: We do that now with the fair plan. We do it with the assigned risk plan and so on. They have a board of directors, but we check that. As a matter of fact, I have just finished with the fair plan and made a very careful analysis of that. We would analyze it very carefully.

SENATOR WALLWORK: Well, how many people do you have available to do that? Because you are talking about checking on accident insurance with automobiles and other types of insurance, but this is a very difficult field, from what I can gather here today, to do this.

COMMISSIONER SHEERAN: I think I will ask my actuary. We are fortunate. We have, I think, the best available actuary.

MR. STERN: Sir, the rate-making process would be the same as today. The normal process is that the rating organization or an individual company presents the experience and the rate filer's interpretation of the data. They bring the data to us, and we check them to the best of our ability. It doesn't mean going into every detail. Under certain circumstances, like in this case of the hospital filing, we do go into great details; otherwise, we usually can accept the data and only make overall checks, and they are valid and reliable.

We would not need more personnel than we have today. We would handle their rate filings the way we always do. The same people would decide on what kind of rates they want. The only difference would be that the experience would be broken down into two pieces. The business voluntarily retained by the companies would be the basis for rate making, and that should become a profitable line of business, the business seeded to the reinsurance facility that should reflect the residue, the undesireable business The deficit would be calculated and it would be determined how that deficit would be spread out as an addition to the otherwise calculated rate

Now, we have a precedent for that in our fair plan. In 1968, the Legislature established a mechanism to provide fire insurance to people who can't get the insurance. At the same time, of course, because this is a broad-based line of insurance, a surcharge was placed on all fire insurance policies and property insurance policies, including home owners.

The money went from the insured to the company, from the company to the department, to the treasury, and it is kept there. Then the fair plan was established, which provides insurance for those people who cannot get it from the voluntary market. The fair plan divulged a deficit over a period of time. From time to time the fair plan manager applies to the Commissioner for a reimbursement, supported by data. We do a clerical checking of the request. The Commissioner passes around to the treasury the request to make out a check for so many thousands or hundreds of thousands of dollars and the money goes back to the fair plan and makes the plan whole again so it can continue to operate. It is a very simple bookkeeping transaction. It does not involve hiring of more people. It is our facility.

The difference between the fair plan and what we are talking about here is the fair plan operates like an insurance company or joint underwriting association.

SENATOR WALLWORK: I basically understand the mechanics of it, but are we not talking about a system here on medical malpractice that is much more complex than handling automotive problems or fire insurance problems, and therefore you are unable -- what is the average length of a claim? How long is it on the books?

MR. STERN: Well, the figures I have seen recently look like four or five years would be the bulk of it.

SENATOR WALLWORK: Well, isn't it more like ten or twelve years? How long is the tail?

MR. STERN: Well, some hang on up to ten years.

SENATOR WALLWORK: What is the average?

MR. STERN: I would say most cases are settled between the sixth and the eighth year or so. That is taking into account today's rate making. There are actuarial techniques which I use with some success. I don't say it is sure fire, because six or eight years is a long time, but you have the same problem with automobile insurance where some claims hang on for three, four or five years. We get the proper data and we are able to measure the change in losses and the number of claims and project it and apply it to the more recent immature experience. It is not an insurmountable problem. It does not require additional personnel, either here in our department, or in the insurance companies.

SENATOR WALLWORK: How many people would you have available for this? I am concerned about the expertise. How are you going to actually hold down costs to the consumer? That is what we are all concerned about. How will you make sure that everyone has reasonable insurance at reasonable rates? That is the bottom line that concerns me. How will you do it through this mechanism?

MR. STERN: This mechanism will in no way affect the rate-making process except that you would separate the residue, which is a very simple matter.

SENATOR WALLWORK: Well, what if the residue is 90% or 95% or 100%?

MR. STERN: If it goes that far, then we have a new problem which would have to be dealt with, in terms of rate-making, somewhat differently than what I explained right now to you. But it still could be handled. I see no problem in dealing with the statistics on either basis for rate making.

SENATOR WALLWORK: I asked the people from Chubb and Company earlier how many people they have just working on medical malpractice. How many people do they have; do you know?

MR. STERN: Well, Mr. Hoffman said he has about four people in the actuarial department, and then he mentioned the fact that when they do some work, they check back with underwriters and claims people to review their work.

Now, of course, if he says he has four people, he is probably talking about doing work for many states for many more subdivisions of malpractice and I'm not even sure that all four of them work all year long on malpractice only. But again I want to stress that our work would not change substantially. The only difference would be that when we sit down with the rate filer, we would sit down in the same relationship as we do, for example, when we get a filing for a private passenger rate revision. We can sit down as equals. We know that we have to take care of the company's justified demands, but we don't have to worry about the company walking out if they don't get their increase.

SENATOR WALLWORK: Now, because it is a New Jersey based company, I assume they wouldn't be able to walk out. Have you had an opportunity to check Chubb and Sons medical malpractice program?

MR. STERN: If you say program, are you talking about statistics for rate making?

SENATOR WALLWORK: Yes.

MR. STERN: We have not so far looked into their detailed statistics. I have a great deal of confidence that their statistics are a great deal better

than, for example, the Argonaut statistics, because they are a well-staffed company, and Mr. Hoffman is a very good actuary. I don't expect to find any great surprises. Chubb has been handicapped in using rate-making statistics, because in all rate making you have to use old data. In malpractice, that's even older normally than liability insurance, and to a great extent we have to rely on statistics accumulated from the time when Warsaw and American Mutual were the carriers, and they don't seem to have the best statistics.

As a matter of fact, Chubb makes all kinds of judgement allowances for differences in conditions reflected by the old experience by the employers of the American Mutual and their own. Now we are coming out of that period. They are going to have more genuine Chubb data, and I think they are going to be better than the old data.

SENATOR WALLWORK: Who checks on Argonaut then, for instance? That's a California based company?

COMMISSIONER SHEERAN: Yes.

SENATOR WALLWORK: Are they in a financial problem here? Is that the reason for their pulling out of medical malpractice and is that why they are trying to raise rates in certain areas so high? Has the California Insurance Commissioner inspected them and given detailed information on that so we would have that available as a cross-check on other carriers?

MR. STERN: If you are talking about the solvency of the company, that is one kind of check. That is based on a document called the Annual Statement and supporting information.

SENATOR WALLWORK: I'm talking just on their medical malpractice.

MR. STERN: You are talking about their rate-making experience?

SENATOR WALLWORK: Yes.

MR. STERN: No, I do not believe that the California Insurance Department checks, because California is one of the states that does not even require the reporting of statistics, but within New Jersey we can check on their own data. As a matter of fact, the Commissioner has approved my plans to make a very exacting check of the Argonaut statistics. We plan to check their records before we go to a hearing on their file.

SENATOR WALLWORK: Don't you think that it would be important to have this factual information and all of the information, so far as what the financial conditions are of these various companies in their experience ratings in medical malpractice, before we plunge into a program of this nature, which, it would seem to me, would be rather difficult to disband, if sometime in the future it could be disbanded?

MR. STERN: Well, I don't think there is a direct relationship between the solvency of the companies, their method of collecting and reporting statistics and this program. Any rate-making program requires good statistics. The effort would be exactly the same, whether we have our present system, whether we have an underwriting association, or whether we have the reinsurance facility. The requirements of the solvency are the same, so that the adoption of this program will have no effect on the mechanics of rate making or the

mechanics of collecting statistics or checking on statistics. It will only give us an alternative. That is if a company didn't want to go out of business, they would not be compelled to hold the business. If they don't want to insure -- let me correct that. If they don't want to assume the risk of insuring a certain hospital or a certain doctor, they would be able, by a simple bookkeeping transaction, to transfer the risk to the reinsurance facility. They would continue to service the risk, that is, to issue endorsements, issue the policy, investigate claims, and they would be paid for that function out of the normal provisions for expenses in the rates.

SENATOR WALLWORK: Would they really be in a position to handle these cases in a routine manner and handle the paperwork, because they would be reimbursed for all costs plus make a small profit?

MR. STERN: Senator, are you asking if they can do it as efficiently as they could do it otherwise?

SENATOR WALLWORK: In effect, yes.

MR. STERN: Well, that question came up in many meetings before in connection with other situations, and I think the answer of a responsible company is that they don't have different standards when it comes to dealing with one type of insured versus another type of insured or one type of claimant versus another type of claimant. Their claims personnel is trained to respond in a certain manner, and they always try to do the best possible job for the company and the claimant. I don't see any reason why a claims adjuster would be less careful in settling a malpractice claim than he would settle a product liability claim. I think responsible companies

have made that statement to me, that they see no reason.

There is a fear expressed, and I think Mr. Bernstein referred to that when he said that some companies may enter the field recklessly and provide poor service and try to make money on the expense provision in the rates. I don't think there is a real danger of that happening, because, as you yourself noted before, there are only a limited number of companies who will be writing that business, and they are companies of the responsible type. They are not gateways or companies like the foreign-based companies. These are responsible companies, and I don't think anybody should expect that they will act in any way less responsibly than they do in their regular business.

SENATOR WALLWORK: Well, won't the Commissioner of Insurance in effect under this legislation then become the main person in determining the actuarial costs if a good percentage of the companies end up dumping it into the reinsurance program?

MR. STERN: No; no, it would not.

SENATOR WALLWORK: In other words, I visualize that if this doesn't go the way you think it is going to go, and if 80% or 75% or 90% of the claims go into the reinsurance pool, you are going to have four people there that are going to be trying to do something that is practically an impossible task.

MR. STERN: Sir, the reinsurance facility will have no actuaries, no claim adjusters, no underwriters. It is a bookkeeping transaction. They would receive the premiums and credit the company with

the premiums received and they would receive parts of losses paid and parts of losses incurred and credit the insurance company for it.

SENATOR WALLWORK: Yes, but how will you know that the claims are accurate? How will you be able to project for a ten-year period? How will you know that you are going to be covering all these contingencies? Somebody is going to have to make those judgements and those decisions.

MR. STERN: The company writing the risk would still keep the statistics. Let's assume Chubb insures a Dr. Brown, and they decided to seed that business. As soon as the doctor's premium is $1,000, Chubb says, $800 is for losses and $200 covers our expenses. Chubb would notify the reinsurance facility,which is just a bookkeeping place, that Dr. Brown is seeded and give the parties the number and transmit $800, which is the loss portion of the rate, and retain the $200. Chubb will now perform all the functions it performs on any other risk, including settling a claim if it comes up.

If a claim report is made, the company would establish a loss reserve and investigate and eventually pay. Chubb would keep the records. When the payment is made, they would notify the facility that they paid $2000.

Now, taking these two transactions one against the other, they send the facility $800 and they paid out $2,000. The facility owes them $1,200. And now picture that as a function carried out in bulk, with, let's say, quarterly accounting between the companies and the facility. The whole thing becomes a bookkeeping transaction. All other functions, underwriting, policy service, claims investigation and payment are performed by the company.

SENATOR WALLWORK: Yes, I understand that. But say I am and insurance executive - which I am not - and I know that it is in the pool. The profit motive is then removed in effect, is it not?

MR. STERN: No. For the pool business, yes, sir.

SENATOR WALLWORK: And say the pool business becomes 100%. Am I going to have my best people working in this area? Am I going to be giving my full attention or a portion of my executive attention to make sure that that is going to operate efficiently and effectively, or are they going to say, "Well, there it is; dump it in the pool." And who ends up paying? In my opinion what happens is, it is just a mechanism that becomes a shell, because I could see then that there would be no one but the Insurance Department setting up the program and operating in effect the pool and there would be no balance. So I see no assurance that there would be a savings to the consumer. On the other hand, I see that it could run away and the responsible companies will move out of the field and say,"Well, there it is. You handle it."

That is the problem. Would you explain to me how that isn't going to happen, because that is what I have a grave doubt about.

MR. STERN: Well, first, there would be a saving, actually, an expense saving in handling business through the pool. Because if companies do dump everything into the pool, the pool would accumulate the funds and invest them, and these investment returns and loss reserves are very substantial on medical malpractice, so ---

SENATOR WALLWORK: Excuse me, would you give me that sentence again?

MR. STERN: Well, today a company may hold a loss reserve for six to eight years. If rate levels are adequate, the company can reap a very substantial profit out of the investment of these loss reserves, but if rates are inadequate, the loss portion is absorbed very quickly and spent and therefore nothing is available.

If the companies seed all the business in the pool, the pool will become a very big investor. So that will increase the pool's facility.

SENATOR WALLWORK: Who does the investing in the pool? Who sees that the investments are put in the pool?

MR. STERN: The underwriting association would have to have some part-time personnel. They would have a general manager, some computer personnel and a treasurer who has to take care of the money.

SENATOR WALLWORK: Who supplies that?

MR. STERN: Well, there is already in existence an organization which handles similar activities for automobile reinsurance facilities in three states. We contacted that organization and asked whether they would be able to assume - it is a company supported organization - the additional work for the medical malpractice pool. Their answer was a cautious, "We will cooperate and then review what we have to do later on." If you really have a reinsurance facility for medical malpractice, the additional work could easily be absorbed by that organization with existing personnel, with a minimum of additional requirements.

SENATOR WALLWORK: But isn't that the crux of the problem, and why we are here? Because if you could equate the way you can with fire insurance

or forms of casualty insurance, there is no real problem, because most companies have that expertise. But how many companies, in your opinion, really have the expertise to move and are knowledgeable and can solve the problems in medical malpractice?

MR. STERN: Probably about ten companies in the state. May I address myself to this point now? I realize that some companies may not have the expertise to handle it. When we discussed the plan of operations with the group of companies, it was not even a committee. I suggested that if there is a company that does not have personnel in New Jersey, arrangements could be made for a designated carrier to assume that workload for that company. The designated carrier approach is a part of the reinsurance facility on automobiles in North Carolina, South Carolina, and Massachusettes. Again, it is a device which can be applied, and the plan of operations, which will be much more specific than the proposed statute, will fill in in those areas. So that if a company that does not have the expertise in New Jersey should get an application, they could have a designated carrier and simply transfer their business to that carrier - let's say, like Chubb or St. Paul - and they would do the work for them for the same compensation.

SENATOR WALLWORK: Well, I would say that it would be safe to say that the pool would have a shortage somewhere along the line.

MR. STERN: A deficit.

SENATOR WALLWORK: A deficit. How then would you raise the deficit to fund the pool and make it hold?

MR. STERN: It would become an addition to the otherwise established rate.

SENATOR WALLWORK: Specifically who pays it?

MR. STERN: The insured. Just as you and I have been paying for the insurance development fund over a number of years, through an additional line in our home owner's policy for the insurance development fund, and the charge was 3%.

SENATOR WALLWORK: But then how can you guarantee to us that under this program and this legislation you will be able to have the medical malpractice at a lesser rate? Because if the pool becomes so large, don't you then possibly have a tiger by the tail, which you are not able to control? That is the point. I don't know -- in my mind the question is, when shortages come up, how is the program going to be made solvent? Who is going to pay it, and what guarantee is there that this legislation will do the job more efficiently than some other program?

MR. STERN: Well, first, the establishment of a reinsurance facility or an underwriting association or any other device will not change the cost of insurance. The same number of claims will be made. The same dollars will be paid out. And the same expenses will be incurred, plus possibly some additional expense in handling the reinsurance facility, which should not be significant.

This proposal does not in any way change the cost of insurance. All it does is provide a secondary source of obtaining coverage. That is the only effect of this proposal.

COMMISSIONER SHEERAN: I would like to comment on that. Mr. Stern said that this in no way will change the cost of insurance, Senator, and I do not subscribe to that. I say it will have a monumental change

on the cost of insurance. And I will give as an example our own State Hospital Medical and Dental School. Obviously, the 560 some thousand dollars that is being charged to them does not square with fact. As I read the letter from our own state insurance person that indicates a 34% loss, a 7% loss and a 17% loss in three years, and on top of that, those three years of experience, they got an increase of some 560 some thousand dollars. If that were a standard carrier, it would have to be in accordance with our established rate system, and it would not be by a non-admitted carrier whom we have no control over. We do not control those people.

The podiatrists who received the notice that they were going to be increased from $125 to $1,000, I guarantee you that there will be no support for that kind of an increase. The ridiculous position that we got from -- at least in my judgement and at least on its face ridiculous -- the Argonaut Company who came in with what is an artful statement asking for 410.8% increase, I am so curious to find out what that .8% on the 410 was. I just can't wait until I get that answer. These are the kinds of things that we are going to be able to attack.

When you talk about the pool itself -- our fair plan took care of the houses in our own county of Essex in the Newark area, the down neck areas and so on, that no other company would write. When we started the fair plan, it was thought that it was going to operate at a terrific deficit. All of that business was thrown into the pool. Well, it wasn't long before the companies found it to be very profitable, and they reduced the amount of business substantially. They used about one-third of the space

that was necessary to run the fair plan before, because the companies will not give away good business. And when they get in and our rates are fair, they are going to find that many doctors do not have malpractice problems. Many hospitals have nominal malpractice problems, and they are going to keep the good business. What really is going to happen is that the companies are now going to do their work. They are going to sharpen their pencils, and their underwriters are not going to send good business in, because they want to make money on the good business.

And I still say that our rate making, if it is calculated correctly, and they threw 100% of the business into the pool servicing the accounts, we will find that it will operate as a business. The pool will end up making money, because our rates are so calculated.

But all of these thousands of health care providers, who now do not have an available standard market will have it. That is the only difference here. And I say that our rate-making capabilities will be increased by many, many fold.

Do you disagree?

MR. STERN: I agree, and I am glad to stand corrected, because I was thinking of the legitimate, honest kind of insurance business, and I forgot all about this big area which is really a rip-off on the public, and that is the non-admitted insurers. That will make a big difference on the overall payments by the medical profession.

SENATOR WALLWORK: I know time is getting along, and you have been very patient, and I think the committee is quite interested that we get all

the facts on the table. We have been talking about concepts. I am not going to go into a great deal of detail on the specifics in the bill, if the committee supports the bill, but I do want to ask a couple of quick questions.

What kinds of insurance does this bill apply? Isn't this definition of medical malpractice liability insurance rather open-ended? It could almost be construed that the practice of any licensed medical practitioner or the operation of any health care facility -- would that include patients that slip on the floor or injured in an automobile accident? I think it could be construed, could it not?

MR. STERN: Well, whenever the person is a medical practitioner and the liability is based on either what he did or what he failed to do, his medical policy will pick up.

COMMISSIONER SHEERAN: Senator, I can give you an example of what you have just said. There is a person with a fractured leg, and he has a need to be serviced in his bed, a bedpan problem, and the nurse in the hospital, for example, were to say, "Now, you go take care of yourself. There is a facility there." I think the chances are that if he wasn't shown how to walk with a cane or crutch or something that that could possibly fall into the area of a medical malpractice, because he hadn't learned how to use that crutch. But generally speaking, you are talking about an automobile liability. That is not a medical malpractice. Or the ordinary slip on the floor, if you went to visit in the hospital, that would not be a medical malpractice. That would be another kind of negligence that they would have to prove.

SENATOR WALLWORK: What I am suggesting is that maybe there ought to be a tightening up of the definition and specifically say "rendering of those professional services." I think that that is one of the points I wanted to make.

You don't know how many insurance companies, then,would actually issue medical malpractice insurance in the state based on this?

COMMISSIONER SHEERAN: I would say a minimum of ten, but we have a questionnaire out now that is making specific inquiry of every carrier that writes general liability in our state as to whether or not they write medical malpractice and to what extent in any other state.

SENATOR WALLWORK: Do you have sufficient staff to supervise them?

COMMISSIONER SHEERAN: Yes. We work thin, but I would tell you that there is no question in my mind that we will be better able to do our job in this area, which we are now responsible for doing anyhow . If we have this kind of facility, it will give us better control.

SENATOR WALLWORK: Once this association becomes operative, if the legislation passes, can it ever be terminated?

COMMISSIONER SHEERAN: Yes. I would say so. I think if we normalize this market, and it develops into a normal, functioning market, which it is not today, here, or any other place that I know, that it could be terminated simply by legislation. Although, I can tell you that a residual market problem in insurance is not only confined to medical malpractice - and I have spoken to the legislature before. I think that not 5% as was suggested by George

Bernstein and the automobile market, but probably closer to 30% of the people in New Jersey are rejected in the standard market. We have secondary market companies that feed, in my judgement, on the selectivity or the creaming of the market by the major companies, so that a reinsurance facility has a broader base. It makes an essential product - which I consider medical malpractice, as well as automobile or home insurance - and an essential market available to all of the citizens who need that insurance in this state, without the selectivity of the insurance industry, in other words, the creaming of the market, and leaving many people without an available market.

The conept in itself, I think, is fundamentally right. It doesn't take any of the rights away from the companies, but it does not permit them to selectively pick the people whom they will or will not insure. Our pricing mechanism will be so calculated, because we believe that your responsibility as you will assign it to us, to make sure that the companies make a resonable profit but not an excessive profit, is to be observed by us. I don't believe it is in the consumer interest, for example, for a company to not make money. I think that is the worse thing we could probably do for a consumer, because they start cutting corners. They start cutting claims. They start failing to service that person. But I think we also have to make sure that they don't get an excessive amount of money.

I believe that George Bernstein, who was here today and spoke in opposition to this, is one of the leaders in this country, in my judgement, in recognizing the failures of the industry as it dealt with the residual market physician. Now, George has taken the

position today that is apparently in opposition to what I am trying to do for this State. But George has the responsibility today that is different than mine. He was the Federal Administrator. Today he is representing a company who has the market in New Jersey. I am not saying there is anything wrong with that. I don't imply that or say it. However, my responsibility, as I see it, is to have an available market of insurance, a normalized market for the people of the State of New Jersey. There isn't one of us sitting here, either in the Senate or otherwise, that had anything to do, in my judgement, with the abnormal market that we have today. And any response from industry which, today, is purely defensive, because they did not take the initiatives they should have taken when they knew this problem existed. And now when we are taking that initiative, as I said before, in New York you find that the AIA has opposition to the JUA and here they support it. I say that is the way it goes. We have to fight our problems, it seems to me, as they arise. And we have to do it, and once we do, I don't think we can or should be taken out of the problem.

SENATOR WALLWORK: One final question. I had a few others, but just one final question. You say there is a crisis today and other speakers have said there isn't a crisis.

COMMISSIONER SHEERAN: Yes, there is.

SENATOR WALLWORK: Would the Senate Concurrent Resolution, which sets up the group to do the study to come back with recommendations, would that be a better vehicle, in light of the actions in New Jersey today, to get at the root cause and to do something to make sure that people can afford malpractice, so

far as the practitioners, and therefore protect the patients. Would that be a better route to take over the short-term as compared with A-1552.

COMMISSIONER SHEERAN: Senator, I think they are two different problems. That is why I tried to say at the outset that we are talking about availability of insurance. Now we are talking, I think, through that hearing - and I talked to Senator Greenberg about it, and we are going to, of course, give whatever input we can - about the change in the tort system, a change in the statute of limitations, and considerations of those changes which are very, very deep problems, but it does not reflect upon this issue of the availability. I think if we have a fully available market, we are going to be stronger as we address ourselves to the issues that involve the root question of cost.

We still can't tell you, and no state in my judgement can tell you, the real facts on cost. It is just not available to us, because under this monopolistic system, when you try to get to the root problems of cost, they can tell you they are pulling out, they are not going to give you the information, and you may think you have power, but you don't, just like John Ingram in North Carolina didn't. He said they were only entitled to 5%, and they said, "Goodbye, Commissioner, we are leaving your state with no available market." And he had to give them 82%, knowing that is was wrong, knowing that they were getting an excessive profit. That is what we are really talking about here. I say we are thirty days away from a real crisis, because just as we walk out of here today, if Chubb and Sons gave us a thirty-day notice that they were leaving, we have the same problem

we faced with Argonaut. It goes on, and St. Paul could do the same thing. So that it's not something that is far away from us, and we are not immuned, and there is no line drawn around the State of New Jersey.

SENATOR WALLWORK: Commissioner, would Argonaut be in this pool?

COMMISSIONER SHEERAN: Argonaut would be in this pool, and they should be in this pool. Right now they are looking for a 410.8% increase. They are capable of handling the cases. They have the capabilities by way of personnel in handling these cases. All they are doing is using the power of the monopoly again to force us to give them a rate increase.

I looked at their statement. I told you that it is available to you. I can show you, one, what our Hospital Association described as a 268% over-reserve by Argonaut; and, two, I can show you their own statement showing that this year they have pumped 170 million dollars into their reserve, while they are saying that they are having an underwriting loss of 80 some million. It doesn't make sense, and it doesn't add up.

SENATOR WALLWORK: Well, does this type of legislation then penalize a good operating company when it is trying to be honest and fair and get the fly-by-nights off the hook?

COMMISSIONER SHEERAN: No, I don't think any company we named is a fly-by-night company here. And I don't think that in our standard market that we are going to be talking about fly-by-night companies. The only way we get fly-by-night companies in this state, and the only way any state gets fly-by-night companies is when you have a market to be serviced which is the unwanted insureds by the standard company. I am talking

about the kinds of things that the podiatrist had to face here with a demand for a 700% increase. They are fine people. But they can't be and were not written on the standard market, because nobody wanted them. That is really where it is.

SENATOR WALLWORK: Well, what I really meant by that was I get the impression from you that you feel that Argonaut is not being fair.

COMMISSIONER SHEERAN: Yes, I beleive that to be true. And I'll say, if you go around the country, you will find company after company after company that sits in that position of being the carrier. They use the same mechanism for getting additonal rates.

SENATOR HUGHES: One or two further questions, Commissioner. The statistics which I had asked of Mr. Salkind earlier, he said some insurance companies provide them in other states, but not in New Jersey. I asked him if he had documentation of this, and he said that you have the statistics.

COMMISSIONER SHEERAN: Yes. We have circulated a questionnaire to every company writing general lines of business in this state, asking them if they write medical malpractice ---

SENATOR HUGHES: This is not available at the present time, though?

COMMISSIONER SHEERAN: No, but it is being developed rapidly. I think we will have it in a few days. We have to analyze that, because it was suggested here that if a company wrote one medical malpractice,in one hospital,in one state, would we want them or not. I think the bill refers to a "substantial" number.

SENATOR HUGHES: I notice in the statistics that the Committee received from Chubb and Son that from the approximate seven thousand doctors insured by them only nineteen are in what you call the high risk or the surcharge field. Now, that seems like an infinitesimal percentage. Also, my question is, the average fee, according to what has been pointed out and stated is $2,000 a year. Now the medical profession doesn't seem to think that that is exhorbitant, yet, Chubb and Son did admit that they were, on an 18 million dollar premium from the medical profession, in turn operating at a profit.

Now, if this is true, why is it that the pools would be necessary. I mean, to me, wouldn't you say that it would be more than necessary to make a pre-survey of the insurance companies who are going to issue medical malpractice insurance by your office?

COMMISSIONER SHEERAN: We will set the rates.

SENATOR HUGHES: Well, by setting rates, wouldn't it be a little bit more advanced if you would, say, determine whether or not they were capable, and we'll say, solvent companies that could handle the business?

COMMISSIONER SHEERAN: We will do that. I think I named about nine companies or so that we know are involved, and they are all substantial, and they all have the expertise and the ability to function in this area.

SENATOR HUGHES: If they do have the expertise, then, their rates are going to be controlled theoretically by your department, if this bill were to pass?

COMMISSIONER SHEERAN: That's correct. And as soon as we have a fully available market, a company, whether it be standard or non-standard, will not have the ability to simply fix rates on their own, unless they

use what we call the consent to rate mechanism. I can tell you that right now, from the standpoint of the osteopaths, they are being written, or there is an attempt to write them, on the consent to rate basis, where their premium was being raised 45%, and the company asked us to sign an approval of a consent by that practitioner to have a higher rate than our standard permits. And our position was that until we fix the rates, we are not going to have rates set through that mechanism. We have no proof that there should be a distinction between them and the regular medical doctors.

SENATOR HUGHES: I have no further questions. Senator Wallwork, do you have anything further?

SENATOR WALLWORK: I would like to ask the Chubb people, if they are still here, how many people, and what their payroll costs would be if they figure administering the malpractice insurance for New Jersey?

R O B E R T R U S I S: I am Robert Rusis, Counsel for Chubb, and it is our estimate that it would be about 100 people, if you take into consideration people working full and part time, and you take into consideration our claims people actuaries, clerical staff and so forth, but it is an estimate. We certainly would be willing and able to provide you with a more detailed report.

SENATOR WALLWORK: Is that just for doing New Jersey business.

MR. RUSIS: Yes, sir.

COMMISSIONER SHEERAN: Sir, can I talk on that issue? We regulate the Prudential Insurance Company.

Prudential has over 200 actuaries and thousands and thousands and thousands of people. We can't measure our ability to do our job or to regulate on the number of people who are operating in the malpractice field.

We regulate automobiles, and there are thousands and thousands and thousands of people who are employees of the company. There is no relationship between those two.

What we do as an Insurance Department is check the credibility of their statistical data and determine from that by actuarial analysis and a demand of information which we are entitled to, is set rates. That is really what we are talking about. There is no relationship between those two, or our budget would be out of sight.

SENATOR HUGHES: This was all brought about by one company, correct?

COMMISSIONER SHEERAN: No, I think it is brought about by the entire industry and its failure to come to this state or any other state and to service the malpractice market. It is a selective group of people who are covered by malpractice insurance, not all. The Medical Society people have no problem. I agree with the doctor that his constituency has no problem. They have an available market. But doctors who are not members of the medical society do not have that available market. The podiatrists don't; the osteopaths have a special problem. Tney have all been in to see us.

SENATOR HUGHES: Well, then, wouldn't you say that the Medical Society would be exploited to some degree?

COMMISSIONER SHEERAN: Not exploited. I think that they ---

SENATOR HUGHES: Well, why wouldn't the other doctors be able to get the insurance?

COMMISSIONER SHEERAN: Well, because they are not members of the Medical Society, and the agreement between the company and the Medical Society only goes to its membership. And they go through the one agent that does all the business in the state.

SENATOR WALLWORK: But the point is, if this were a profitable area, I should think that there would be maybe 30 or 40 insurance companies competing for the business, but it appears to me that because the profitability is so questionable that companies are pulling out, and the insurance departments in the various states really don't have the financial data to support the charge that consumers are being charged too much indirectly because of the fees for the medical practitioners. I don't really think that we have gotten the full information. This is an area that we really don't know.

COMMISSIONER SHEERAN: Senator, I say that what you are doing here is accepting something that there is no creditable proof of, and that is, that it is not a profitable business. I say it is profitable and it is selective. Why is it a company, that you say will not write in this state because it is not profitable, finds it profitable and does write in another state? I say that you have selectivity and the monopolistic kinds of tendencies that are guarded.

I hate to make this analogy, but we have been through it, and you know, Senator, that you and I talked about it before with reference to problems involving Essex County, when I was the Mayor of West Orange. We tried to control the rates for garbage collection, for

example in that town. What was it underlying the whole problem, other than the fact that there was only one person who got that business. It wasn't the fact that it wasn't profitable. It was the fact that there was a monopoly created by one means or another. And I say that we have to get to the heart of it. We have to open the market up, and when we open the market up, we will find out whether it is profitable or not. It has to be profitable. That is in the best interest of everyone, but it should not be excessive. That is in the best interest of everyone as well.

This doesn't change that problem. It just gives us greater capability, in my judgement.

SENATOR HUGHES: Thank you, Commissioner. Yes, Dr. Mc Guire, do you have something further?

DR. MC GUIRE: I'm sorry. I know it is very late. I have four points. First, all the M. D.'s in the Medical Society of New Jersey are not under Chubb. Of the 8932, approximately 6400 are under Chubb. The others, which would be almost 35%, have other forms of malpractice coverage. They all have malpractice coverage, but certain organizations have their own malpractice. For example, the OB-GYN people have their own and many other specialty groups have their own, so that in a sense -- I am sure Mr. Stern didn't mean what he said. It sounded like we were a captive audience.

It is true that Chubb will only take members of our Soceity. But all the members of our Society are not covered by Chubb, roughly 65%.

Secondly, I would like Commissioner Sheeran to write to the President of the neurosurgeon's surgical group and tell them that their premium would not change. They

are under the impression that all would have the same premium. In other words, the family physician, the chest surgeon, the orthopedist all would, with the pool, come under the same premium.

I have met with the officers of the neurosurgical group, Dr. Liebman, Dr. Robert Greene and the others, and they want this, because they feel that their premium will go down to about $2,000. Now, I think the policy of the podiatrist was All Star - and it would be on page three or page five when you were turning - where the medical care was excluded. It would have to be excluded, Commissioner, because there are two different acts. They don't come under the Medical Practice Act. They come under the Podiatry Act. They are not allowed to administer drugs, for example, by mouth, by vein, or by subcutaneous measures. So that policy would have to exclude medical actions. That really isn't semantics; that is quite important.

Now, the statistics that the Commissioner used, I'm sure, the 15 thousand M. D.'s in New Jersey, were published last year by Dr. Louis Dars. He is a Ph. D. working for the Department of Higher Education. And, indeed there were 14,100 M. D.'s who are licensed in New Jersey, but only 8400 were practicing in New Jersey.

For example, very few doctors have a license for one state. They will have one for New Jersey where they are practicing, but they will also have one for New York and Pennsylvania. So if you are getting statistics for Pennsylvania, you will include doctors who are only practicing in New Jersey but have a Pennsylvania license. A tremendous number of doctors have a license in New Jersey and California, but they are not practicing in California. So these are the figures of Dr. Louis Dars, and I must confess to you that they

are misleading, but that is where the 15,000 comes in. At that time, 1972, there were 8400 licensed physicians practicing in New Jersey.

I'm sorry to take your time. I thought these four points should be clarified, that M. D.'s in the Medical Society of New Jersey are not necessarily covered, and only 6400 out of 8900 are covered. The neurosurgeons are misled. I would appreciate it very much, Commissioner, if you would contact their president and tell him that and see what his reaction would be to it. They won't believe us. As I say, in the contract, it should have said "medical." That is correct, because they are a podiatry group under a different act entirely. I'm sorry to take up your time.

SENATOR HUGHES: That's quite all right.

COMMISSIONER SHEERAN: I just want to say that as far as podiatry is concerned, the fact is that they are rendering medical service in this state. It's true. I'm sure the doctor will agree with that.

SENATOR HUGHES: How about nurses?

COMMISSIONER SHEERAN: Nurses as well. They are a provider of health care, and they are the kind of people, too, I think Dr. Mc Gahn would tell you so of the nurses that he has talked to, have a problem getting medical malpractice. They are included.

SENATOR HUGHES: Thank you very much, Commissioner. I thank all of you for taking the time to appear before this committee.

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HEARING CONCLUDED

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CHUBB & SON INC.

51 John F. Kennedy Parkway, Short Hills

March 18, 1975

Medical Malpractice Insurance in New Jersey

This memorandum sets out the medical malpractice insurance situation in New Jersey, the reasons why the pending legislation to deal with that situation is unsound, and what Chubb proposes to do to prevent medical malpractice insurance problems in New Jersey in the future.

The Situation

In New York and several other states, medical malpractice insurance is a serious problem -- for health care providers, insurers, insurance regulators and ultimately for patients and the public.

It is a problem for two reasons. First, the interval between setting the premium rate and paying the last loss is one of the longest in any line of insurance. Hence, it is extremely difficult, especially in a time of inflation, to determine what a proper rate should be. Second, the legal rules of medical malpractice are changing in many states, with liability becoming stricter, proof of liability easier and damage awards larger. For this reason, too, it is extremely difficult to know what a proper rate should be.

For those two reasons, New York and several other states have problems with medical malpractice insurance, problems so serious that the legislators of some of them have concluded that it is necessary to compel the provision of such insurance, a step which damages the private insurance mechanism in many respects and obviously should not be taken if any socially acceptable alternative exists.

The situation in New Jersey is not comparable to that in New York and those ›ther states. The two reasons for trouble -- rating difficulties and an extremely un- ›redictable legal climate -- are not as critical here. Premium rates in New Jersey ompare favorably with those in the problem States of New York and California. The ›llowing table shows typical one-year insurance premiums for comparable, sub- tantial limits (1 million/3 million) of coverage in the urban areas of those states:

	New York	California	New Jersey
nesthesiologists	9,433	6,302	4,319
eneral Practitioners	1,534	1,297	901
›spital (Premium $ per bed)	504	818	98*

* The $98 annual rate was established in 1969. We understand that the Insurance partment is considering the need to increase this rate.

While Chubb believes that the legal rules and practices determining medical malpractice liability for hospitals and doctors could and should undergo a deliberate process of change throughout the country, New Jersey already has in place significant improvements over such states as New York and California.

For instance:

Supreme Court sub-panel review by competent jurists and doctors to foster early determination of fault, if any.

Peer review for doctors' cases.

Two year statute of limitations.

Court control of lawyers contingent fees.

Limitation of liability for hospitals (but not for doctors).

These laws tend to stabilize the malpractice situation in New Jersey. Chubb would, of course, be happy to work with the appropriate legislative committees and others concerned in developing still further improvements.

On March 18 Chubb announced that it would assure a market for the 29 hospitals cancelled by the Argonaut Insurance Company of California. Chubb believes that the insurance markets for hospitals and doctors in New Jersey, including its own programs, offer a fair and socially useful solution to the malpractice issue with strong possibilities of future stability.

Unsoundness of the Pending Legislation

The main reason why the pending bill (A-1552) is unsound is that it is not necessary. As explained above, the situation here is not comparable to that in New York and some other states. Any legislation to coerce the provision of insurance, with its damaging effects on the insurance mechanism in general, should not, as a matter of sound public policy, be undertaken unless it is necessary. It is not necessary here. The problems, such as they are, can be dealt with in a far less disruptive way as will be described in the next section of this memorandum.

In addition, even were coercive legislation needed, the pending bill is unsound for a number of reasons. Most important, medical malpractice loss handling is the most sophisticated, difficult and time-consuming process in the insurance world.

Only a few insurance carriers are fully equipped and capable of handling this kind of loss situation. It is utterly different from the handling of, say, automobile liability claims. The pending bill would undermine the by-and-large excellent loss services now provided for the people of New Jersey.

Another unsoundness of the pending bill is in the highly technical area of statistics, classification, rating and rate regulation. The essence of the proper pricing of medical malpractice insurance is the compiling of the detailed, accurate and comprehensive statistics and the making of adequate loss reserves. Under the bill, the statistical system would be scattered and thus inherently unsound. Since proper rating depends on proper reserving, and since reserves in medical malpractice insurance are for claims which may not be paid for many years so that the reserve is a matter of judgment for a long time, even the most dedicated insurance regulator would feel pressure to discount reserves. The result would be the inadvertent subsidizing of the medical and legal professions by the stockholders and the other policyholders of insurance companies.

A third serious fault in the pending bill is the narrowness of the base of participation in the underwriting association. Participation would be in proportion to a company's writing of general liability insurance and only those companies which have heretofore written medical malpractice insurance would be required to participate at all. Hence the bill would paradoxically penalize the very insurers which have been trying to make a market for this insurance in the past. Moreover, it would allocate malpractice insurance, surely on a losing basis, in proportion to premiums in a larger class, general liability, on which the insurance industry last year sustained the largest underwriting losses it has ever had on any line of insurance. The pending bill would thus have a strong tendency to discourage the writing of general liability insurance in New Jersey.

Fourth, the inefficiency of the system required by A-1552 can only produce additional costs.

The foregoing four serious weaknesses of the pending bill, as well as many others, follow from the fallacy on which the bill is based. The bill is patterned on legislation in other states which seeks to cure their automobile assigned risk plan problems. These automobile insurance facilities were set up in the response to a proven need of long duration. In some instances, these facilities may work tolerably well, but they do so because of the essential simplicity of automobile insurance pricing and claims handling. Medical malpractice insurance is at the extreme other end of the spectrum of complexity in insurance. There is no reason to believe that so simple a facility as that contemplated by the bill would work in so complex a line of insurance as medical malpractice.

Action Taken

As to hospitals, many are insured by the St. Paul Fire and Marine and by other highly competent and financially strong insurance companies. The only problem is that the Argonaut Insurance Company has cancelled the malpractice insurance on 29 hospitals. We understand that several insurance companies are prepared to write that insurance. If for any reason any of the hospitals cannot obtain coverage effective when the Argonaut's coverage ends, Chubb will insure it.

As to doctors, most practicing physicians in the state buy their malpractice insurance from Chubb under a program sponsored by the Medical Society of New Jersey. That program was ten years old, when Chubb entered it in 1971. We went into it then because we felt that we had some degree of special capability in this difficult field and that we could render a useful service in our home state. The program appears to be a success from the point of view of doctors, claimants and ourselves. All of our financial records on this program have always been available to the New Jersey Department of Insurance and we would be happy to provide them to members of the Legislature. In the unlikely event that Chubb makes any "excess profits" on this program, we can work out some way to return them to the Medical Society, its members or its designee, for the benefit of the profession.

As for the physicians who are not covered through the Medical Society program, the Medical Society just last week pointed out that the numbers are not large and that other sources of coverage are active. While Chubb's capacity to increase its malpractice insurance exposure in New Jersey is limited, we will do our part in providing the necessary insurance if, for any reason, other companies do not.

Conclusion and Recommendation

The pending bill (A-1552) is unnecessary. It is an overreaction to a problem, not in New Jersey but in a neighboring state, and to the abrupt action of one company in cutting back its exposures. The bill is also unsound and would work against the public interest both in malpractice and in other lines of insurance.

The bill, therefore, should not pass. Instead, the private insurance business should be allowed to continue to provide this coverage on an independent, competitive basis and to cooperate, as it is certainly willing and able to do, with the legislature and the Insurance Department and the professions involved in solving the underlying problems.

NEW JERSEY DENTAL ASSOCIATIC

STREET ADDRESS: 2675 U. S. HIGHWAY ONE, RFD 4, NORTH BRUNSWICK, N. J. 0
MAILING ADDRESS: P. O. BOX 1715, NORTH BRUNSWICK, N. J. 08902 (201) 821-

To: New Jersey Senate Standing Committee on Labor, Industry and Professions

From: New Jersey Dental Association

The New Jersey Dental Association sees no crisis in professional liability insurance involving the dental profession in this State.

The Association opposes Senate Bill 1552, feels it should be reconsidered in Committee and suggests that all aspects of professional liability insurance be studied before the Legislature passes into law any broad sweeping proposal that alleges to have all the answers to a so called crisis.

Dentists in this State have access to markets for their insurance needs. Under this Bill, the risk would be spread and it appears dentistry, a relatively low risk profession would be included with high risk speacialties. This Bill ignores cost and any process that would bring down the cost of professional liability insurance. All this Bill would do is to interpose a State agency where none exists. This Bill would put the State in the insurance business and the

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Statement to be read before the Senate Labor, Industry, and Professions Committee public hearing on Medical Malpractice Liability Insurance, April 8, 1975.

taxpayers would be required to pay for the personnel, equipment and supplies, the administration of this business.

This Association considers it imperative that the Legislature with the Commissioner of Insurance authorize a broad review of the entire professional liability area.

Evidence has been given that there is no immediate emergency. A reasoned study is necessary in order that a system can be developed that is best for consumers, practitioners and insurance companies.

Carrying liability insurance has nothing to do with rendering care. This Bill presents the possibility that a dentist could be forbidden from practicing his profession if he does not have liability coverage.

The definition of medical professional liability insurance in this Bill is too broad and not limited to the professional aspects of any profession. This Bill would allow the Commissioner of Insurance and the Commissioner of Health to set up categories of risks for malpractice.

A provision of this proprosed Bill calls for procedures "for reviewing claims." Would this be a lay panel of non-professional State insurance executives? Professional judgement must be used to review claims.

The Association urges that a review of the entire professional liability problem, including unlimited statute of limitations, a no fault potential and the amounts of recent awards be reviewed carefully.

New Jersey Hospital Association

RESEARCH PARK, 1101 STATE ROAD • PRINCETON, NEW JERSEY 08540

Jack W. Owen, President

Telephone (609) 924-4124

Hearing on A-1552 Before the Labor, Industry and Professions Committee of the New Jersey Senate--Senator Hughes Presiding
April 8, 1975

My name is Jack Owen, and I am President of the New Jersey Hospital Association which represents 108 private profit and nonprofit hospitals, all of whom are purchasers of malpractice insurance. As buyers and users of malpractice insurance we are vitally interested in the kinds of coverage available and the cost of such insurance.

We would like to express our appreciation to Commissioner Sheeran for galvanizing action which initiated action on the part of more companies to propose coverage for our hospitals. At a time when 29 hospitals were threatened with cancellation of policies, the action by licensed companies in New Jersey to underwrite these hospitals is a welcome relief to the hospitals and the patients they serve.

We believe the proper way to approach the problems of malpractice insurance for hospitals and professionals can be best handled through Senator Greenberg's Resolution which will provide for a thorough study of the problems associated with malpractice and legislative action to address those problems.

We would like to see some legislation ~~which~~ such as is currently proposed in New York State, backed by the Administration with bi-partisan support. This is New York Senate Bill S-5007 and Assembly Bill A-6969. Some of the problems addressed in the New York bill, which have application here are as follows.

1. Action for medical malpractice must be commenced within two years, except where treatment is continuous or where the action is based on discovery of a foreign object in the body of a patient which is not discovered or could not reasonably have been discovered within the two-year period. Action must then be taken within one (1) year of discovery.

This would have the effect of reducing the amounts of reserves which must be held by the insurance company under the present system where action may be taken two years after discovery of any medical malpractice.

2. The doctrine of res ipsa loquitor in medical malpractice actions is abolished.

3. The admissability of collateral sources of payment in any action for medical malpractice where the plaintiff seeks to recover for the cost of medical care.

4. Partial abolition of medical malpractice action based on lack of informed consent limitations. Right of action for recovery for malpractice based on lack of informed consent is abolished except:

   (a) non-emergency surgery
   (b) use of experimental drugs
   (c) diagnostic procedures which necessarily involved disruption of the integrity of the body.

For action it must be established that a reasonably prudent person in the patient's position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought. However, no judgment shall be recoverable against the defendant if it is established either: (1) the risk not disclosed is too commonly known to warrant disclosure; (2) the patient assured the person administering the treatment or diagnosis he would undergo the same regardless of the risk involved; (3) consent by or on behalf of the

patient was not possible making disclosure not necessary; or (4) the person rendering the treatment made a professional judgment to withhold disclosure because he reasonably believed disclosure would adversely affect the patient.

All of these proposals will not only assist in making the malpractice market more competitive, they will in effect help to control the costs of malpractice insurance and in the long run will provide a decided benefit to the patient in the cost of his care.

In addition to these recommendations which appear in the New York bill there are several others which should be considered.

1. Arbitration--In order to reduce friction and costs some thought should be given to the development of an arbitration system which would respond more quickly to legitimate malpractice cases and provide an objective determination of awards rather than the present system of emotional determination.

2. Sinking fund concept--Where awards are substantial a method should be devised for payout to be made over a period of time, i.e., the life of the plaintiff.

We would like to see a commission appointed which would take these and other recommendations and develop a law which would not only insure that malpractice carriers would be available but would also tackle some of the inherent problems in the present system.

To just insure that hospitals will have malpractice coverage is not enough. We believe this can be accomplished by developing a self-insured group or a captive company of some kind. With the help of the insurance industry and

the approval of the Department of Insurance a hospital controlled program could provide statistics and information on New Jersey malpractice which is currently not available.

We cannot support legislation which does not address itself to problems other than just coverage of hospitals.

LIFE & CASUALTY

Casualty & Surety Division
41 South Haddon Avenue
Haddonfield, N. J. 08033
428-7000

APPENDIX "F"

September 17, 1974

ALL AGENTS OF THE HADDONFIELD OFFICE

RE: PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

You were previously informed about our Company's position as respects renewal of Physicians and Surgeons Professional Liability policies. There has been some misinterpretation.

Our Company position is that, effective January 1, 1975, we will not renew Physicians and Surgeons Professional Liability policies upon expiration. Three-year policies will remain in effect until their normal expiration date; they will not be cancelled on the mid-term anniversary date. Contracts expiring between now and January 1, 1975 will be renewed for one year only. Effective immediately, no new business will be issued.

On three-year policies, any rate increases will be applied on the interim anniverrary date. If we are unable to obtain needed rate adjustments, our Company's policy as respects three-year contracts will have to be reconsidered.

I appreciate the interest a number of you have shown in this matter and hopefully the above has clarified the issue.

D. M. Stayton, Jr.
General Manager

94th CONGRESS
1st Session

H. R. 2884 (ALSO SENATE BILL # S.188 - GAYLORD NELSON, Wis.)

IN THE HOUSE OF REPRESENTATIVES

February 5, 1975

Mr. Gonzalez introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To authorize the Secretary of Health, Education, and Welfare to establish a medical malpractice reinsurance program, and to conduct experiments and studies on medical malpractice.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Medical Malpractice Insurance Act".

AUTHORITY

SEC. 2 (a) The Secretary of Health, Education and Welfare (hereinafter referred to as the "Secretary") is authorized to offer to any insurer or pool, subject to such rules and regulations as he may prescribe. reinsurance against

1-0

liability for damages resulting from acts of medical malpractice

(b) In carrying out the medical malpractice reinsurance program authorized by subsection (a) of this section, the Secretary shall arrange for--

(1) appropriate financial participation and risk sharing in the reinsurance program by insurance companies or other insurers, and

(2) other appropriate participation on other than a risk-sharing basis by insurance companies or other insurers, insurance agents and brokers, and insurance adjustment organizations.

(c) The Secretary shall make reinsurance available in such amounts as he determines to be necessary, based upon actuarial studies by the Department's actuaries or retained independent actuary services based on criteria as prescribed by the Secretary, ~~but shall make available initially such insurance in amounts in excess of $25,000.~~ DELETE

PROPOSED CHANGES BY APED INC (OWENS)

(d) The Secretary of HEW be authorized to reinsure the future "tail" of a 3-year term, deferred premium payment annual installment, occurrence insurance policies for hospitals and practitioners as issued by private insurance carriers under our existing State regulatory machinery, with reinsurance premiums to be established by the Secretary and

(e) The Secretary of HEW be authorized to reinsure all properly licensed carriers against the catastrophic or "shock" malpractice loss using the following formula:

(1) Carriers' primary insurance to pay all specific damages that can be documented and promptly, with a time frame to be developed as standard by the Secretary.

(2) Carriers' primary insurance to pay for "pain and suffering" but limited to a maximum amount equal to that documented for specific damages and under existing tort liability processes, with any excess in HEW reinsurance -- at reinsurance premiums to be established by the Secretary, and

CONT PROP CHAN BY A

WT'O
OPOSED
ANGES
APED, INC.

(f) The proposed HEW Federal medical malpractice advisory board, or State committees thereof, acting in conjunction with each State insurance commissioner, develop a Federally-reinsured primary special risk program by State as recourse for the naturally volatile, loss-prone or "uninsurable" risk under the foregoing Federal umbrella thereby providing effective blanket concurrence insurance protection to the public based on fair local rates and local conditions.

CLAIMS AND JUDICIAL REVIEW

SEC. 3. (a) All reinsurance claims for losses under this Act shall be submitted by insurers in accordance with such terms and conditions as may be established by the Secretary.

(b) (1) Upon disallowance of any claim under color of reinsurance made available under this Act, or upon refusal of the claimant to accept the amount allowed upon any such claim, the claimant may institute an action against the Secretary on such claim in the United States district court for

The district in which a major portion (in terms of value) of the claim arose.

(2) Any action under paragraph (1) must be begun within one year after the date upon which the claimant received written notice of disallowance or partial disallowance of the claim.

(3) The district courts of the United States have exclusive jurisdiction to hear and determine actions brought under this subsection without regard to the amount in controversy.

USE OF EXISTING FACILITIES AND SERVICES

SEC. 4. In carrying out his responsibilities under this Act, the Secretary may utilize--

(1) insurance companies and other insurers, insurance agents and brokers, and insurance adjustment organizations, as fiscal agents of the United States, or

(2) officers and employees of any executive agency (as defined in section 105 of title 5, United States Code) as the Secretary and the head of any such agency may from time to time agree upon, on a reimbursement or other basis.

ESTABLISHMENT OF AFFORDABLE RATES

SEC. 5.(a) In establishing the rates for various reinsurance coverages offered from time to time under this Act, the Secretary shall consult with appropriate State insurance

authorities and other knowledgeable persons and is authorized to take into consideration the nature, geographical source and degree of the risks involved, the extent of anticipated losses, the prevailing rates for similar coverage in adjacent or comparable areas and territories, the economic importance of the various types of coverage, and the relative abilities of the particular classes and types of insurers to pay the full estimated costs of such coverage. Nothing in this section shall be construed to prohibit or require either the adoption of uniform national rates or the periodic modification of currently estimated affordable rates for any particular line or subline of coverage, class, State, territory, risk or procedure on the basis of additional information or actual loss experience, including expenses on the net written premium basis.

(b) For purposes of this section, the term "rate" means such premium rate as the Secretary determines would permit the purchase of a specific type of insurance coverage by a reasonably prudent person in similar circumstances with due regard for the costs and benefits involved.

REPORTS AND STUDIES

SEC. 6 (a) The Secretary shall--

(1) conduct a comprehensive study to determine the direct and indirect costs of medical malpractice claims including litigation and expenses arising out of such claims, in all federally supported health care programs;

(2) explore alternative methods of selecting, classifying and rating in-

dividual medical practitioners and institutions for medical malpractice reinsurance ratemaking purposes;

(3) study and recommend methods of changing the system and minimizing the cost of claims settlement including litigation, expenses and reserving insurance company assets against claims excluding the "incurred but not reported" basis;

(4) Study the contingency fee system and recommend changes if indicated;

(5) develop a contingency plan to provide primary medical malpractice insurance if such insurance were to become unavailable through private insurance companies.

(b) (1) In carrying out his functions under this Act, the Secretary is authorized to provide financial assistance to persons for the purpose of studying and evaluating new and alternative methods of providing and improving malpractice insurance coverages and of settling medical malpractice claims, including but not limited to studies and demonstration projects of no-fault insurance and compensation plans, prelitigation screening programs, arbitration programs, and mediation of disputes.

(2) Assistance may be provided under paragraph (1) under such terms and conditions as the Secretary may by regulation prescribe.

(c) The Secretary shall annually report to the President and the Congress on his operations and activities under this Act together with such recommendations as may be appropriate.

RECORDS, ANNUAL STATEMENT, AND AUDITS

SEC. 7. (a) Any insurer, or pool, acquiring reinsurance under this Act shall furnish the Secretary with such summaries and analyses of information in its records as may be necessary to carry out the provisions of this Act, in such form as the Secretary in cooperation with the State insurance authority, shall, by regulation, prescribe. The Secretary shall make use of State insurance authority examination reports and facilities to the maximum extent feasible.

(b) Any insurer or pool acquiring reinsurance under this Act shall file with the Secretary a true and correct copy of any annual statement, or amendment thereof, filed with the State insurance authority of its domiciliary State, at the time it files such statement or amendment with such State insurance authority. In addition, any such insurer or pool shall file any information filed with any State insurance authority pertaining to medical malpractice insurance as the Secretary may determine is necessary for carrying out the provisions of this Act.

(c) Any insurer or other person executing any contract, agreement, or other appropriate arrangement with the Secretary under this Act shall keep reasonable records which fully disclose risk acquisition data, claims experience including expense, reserving of assets against claims and total costs of the programs undertaken or the services being rendered, and such other records in the form prescribed by the Secretary as will facilitate an effective audit of liability for reinsurance payments by the Secretary.

(d) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of investigation, audit, and examination to any books, documents, papers, and records of any insurer or other person that are pertinent to the costs of any program undertaken for, or services rendered to, the Secretary. Such audits shall be conducted to the maximum extent feasible in cooperation with the State insurance authorities and through the use of their examining facilities.

ADVANCE PAYMENTS

SEC. 8 Any payments which are made under the authority of this Act may be made, after necessary adjustments on account of previously made underpayments or overpayments in advance or by way of reimbursement. Payments may be made in such installments and on such conditions as the Secretary may determine.

RECOVERY OF PREMIUMS: STATUTE OF LIMITATIONS

SEC. 9. (a) The Secretary in a suit brought in the appropriate United States district court, shall be entitled to recover from any insurer the amount of any unpaid premiums lawfully payable by such insurer to the Secretary.

(b) No action or proceeding shall be brought for the recovery of any premium due to the Secretary for reinsurance, or for the recovery of any premium paid to the Secretary in excess of the amount due to it, unless such action or

proceeding shall have been brought within five years after the right accured for which the claim is made, except that, where the insurer has made or filed with the Secretary a false or fraudulent annual statement or other document with the intent to evade, in whole or in part, the payment of premiums, the claim shall not be deemed to have accrued until its discovery by the Secretary.

PAYMENT OF CLAIMS

SEC. 10. The Secretary is authorized to issue orders establishing the general method or methods by which proved and approved claims for losses may be adjusted and paid for any liability which is covered by medical malpractice reinsurance made available under the provisions of this Act.

NATIONAL INSURANCE DEVELOPMENT FUND

SEC. 11. (a) To carry out the programs authorized under this Act, the Secretary is authorized to establish a National Medical Malpractice Reinsurance Development Fund (hereinafter referred to as the "fund") which shall be available without fiscal year limitations--

(1) to make such payments as may, from time to time, be required under reinsurance or direct insurance contacts under this Act;

(2) to pay such administrative expenses as may be necessary or appropriate to carry out the purposes of this Act; and

(3) to repay to the Secretary of the Treasury such sums, including interest thereon, as may be borrowed from him for purposes of such programs under this Act.

(b) The fund shall be credited with--

(1) reinsurance premiums, fees, and other charges which may be paid or collected in connection with reinsurance;

(2) interest which may be earned on investments of the fund;

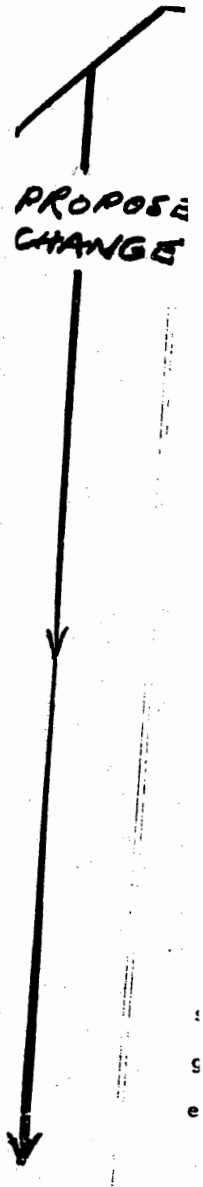
(3) such amounts as may be advanced to the fund from appropriations in order to maintain the fund in an operative condition adequate to meet its liabilities;

(4) such amounts which are hereby authorized to be appropriated as may be necessary from time to time to reimburse the fund for losses and expenses (including administrative expenses) incurred in carrying out the program;

(5) receipts from any other source which may, from time to time, be credited to the fund; and

(6) funds borrowed by the Secretary and deposited in the fund.

(c) If, after any amounts which may have been advanced to the fund from appropriations have been credited to the appropriation from which advanced, the Secretary determines that the moneys of the fund are in excess of



current needs, he may request the investment of such amounts as he deems advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

SEC. 12. (a) (1) There is established a Federal Medical Malpractice Reinsurance Advisory Board (hereinafter called the "Board") consisting of nineteen members appointed by the Secretary. Members of the Board shall be selected from among representatives of the general public, medical practitioners and other providers of health care services, the legal profession, the insurance industry, State and local governments including State insurance authorities, and the Federal Government. Not more than two members of the Board

As the general public is paying, urge that at least 4 Public Members be appointed if only for regional input:

Northeast
South
Middle West
Southwest } COMBINE
Far West }

PROPOSED A.P.E.D. CHANGE TO "BOARD"

Suggest that 2 representatives is plenty for the legal profession as their interest is uniform but 5 should be allocated health care providers - considering that hospitals, nursing homes, clinics, M.D.s, other practitioners, etc., all have varying interests and viable contributions to make. The 4 from Industry, 2 from the Government and 2 from States makes the 19. Further suggest that this Board should be specifically authorized by legislation to spin-off splinter State Sub-committees (to be chaired by the respective State Insurance Commissioners) with the Sub-committee Secretary and composition Board-appointed. These Sub-committees would be the actual mechanisms to devise and oversee Federally-reinsured "special risk" State programs as proposed. They would meet as directed by the Board Chairman or on request of the State Commissioners. They would report back to the Secretary of HEW through the Board Chairman and these state programs would be subject to the approval of the Board. It is suggested that each Sub-committee appointed consist of one representative of each of six sectors including the Sub-committee Secretary plus the State

CONT'D PROPOSED CHANGE BY A.P.E.D. INT

Commissioner as a voting Non-Member Sub-Committee Chairman or seven in number.

shall be regular full-time employees of the Federal Government; not more than three shall be representatives of the general public; not less than four shall be representatives of health care providers; not less than four shall be representatives of the legal profession; not less than four shall be representatives of the insurance industry; and not less than two shall be representatives of State insurance authorities.

(2) The Secretary shall designate a Chairman and a Vice Chairman of the Board.

(3) Each member shall serve for a term of two years or until his successor has been appointed, except that no individual who is appointed while a full-time employee of a State or the Federal Government shall serve in such

position after he ceases to be so employed, unless he is reappointed.

(4) Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of that term.

(b) The Chairman shall preside at all meetings, and the Vice Chairman shall preside in the absence or disability of the Chairman. In the absence of both the Chairman and Vice Chairman, the Board may appoint any member to act as Chairman pro tempore. The Board shall meet at such times and places as it may fix and determine, but shall hold at least four regularly scheduled meetings a year. Special meetings may be held at the call of the Chairman or any three members of the Board.

(c) The Board shall review general policies and shall advise the Secretary and perform such other functions as he may require.

(d) The members of the Board shall not, by reason of such membership, be deemed to be employees of the United States, and such members, except those who are regular full-time employees of the Government, shall receive for their services, as members, the per diem equivalent to the rate for grade GS-18 of the General Schedule under section 5332 of title 5, United States Code, when engaged in the perform-

ance of their duties, and each member of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of such title for persons in the Government employed intermittently.

AUTHORIZATION OF APPROPRIATIONS

SEC. 13. There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this Act.

94th CONGRESS H. R. 2884
1st Session

A BILL

To authorize the Secretary of Health, Education, and Welfare to establish a medical malpractice reinsurance program, and to conduct experiments and studies on medical malpractice.

By Mr. Gonzalez

February 5, 1975

Referred to the Committee on Interstate and Foreign Commerce

29x

A.P.E.D., Inc.

The Association of Professional for Economic Defense, Inc.

P.O. Box No. 675
Bordentown, New Jersey 08505

APPENDIX "H"

April 10, 1975

Statement of : William Owens,
N. J. Insurance Broker #30513000
and
President, The Association
of Professionals for
Economic Defense, Inc.
Bordentown, N. J.

To : U. S. Senate Sub-Committee
on Health of the
Committee on Labor and
Public Welfare
Washington, D. C.

Incorporating : His testimony given before
U. S. House of Representatives
(Annex "A") Health Sub-Committee of the
Ways and Means Committee on
March 5, 1975 (with cost effect note)

His testimony given before the
New Jersey Senate Committee
(Annex "B") on Labor, Industry and the
Professions, in Trenton on
April 8, 1975

April 10, 1975

TO: U.S. Senate Health Sub-Committee
(Committee on Labor and Public Welfare)

This is the statement of William Owens, President of The Association of Professionals for Economic Defense, Inc., of Bordentown, N. J. A.P.E.D., Inc. is a group formed of 150 selected M.D.s practicing in New Jersey and Pennsylvania.

The crisis in availability and cost of hospital and medical liability insurance must be dealt with quickly while other long-range solutions can be effected involving fifty states. States are facing loss of protection for the public against medical malpractice while increased insurance cost loaded on our national health care system can easily exceed Five Billion Dollars this year. This has to adversely affect Medicaid, Medicare, Blue Cross and Shield, union and corporate health plans and, as always, cruelly militate against the elderly, poor and minorities. Dr. Roger Egeberg, Special Assistant for Health Services to the Secretary of HEW, has very recently testified to the National Association of Mutual Insurance Agents that a large leading hospital has estimated its 1975 insurance cost now to be at least $10.00 per bed per day. There are about 1,400,000 hospital beds nationally, excluding all the nursing homes, clinics and many other health care facilities. To this massive cost projection must then be added the cost of insuring all of our M.D.s and the other many practitioners ranging from osteopaths to nurses and para-medics.

I strongly support Senate Bill #S.188 printed in the Congressional Record on January 16, 1975 as introduced by Senator Gaylord Nelson of Wisconsin with three basic modifications. See Annex "A" which is attached and made a part of this Statement. The modifications basically provide that the Secretary of HEW be authorized to reinsure our private hospital and medical malpractice insurance carriers at premiums to be determined by him and as follows (pending any fundamental changes in the tort liability climate):

(1) HEW to fully reinsure the future "tail" of primary 3-year term Equal Annual Payment occurrence insurance policies so that private industry could actuarily promulgate proper premium on a current basis of need in each local market nationwide.

(2) HEW to fully reinsure the excess over losses paid by the carrier from the above primary policy including -

(a) All specific damages (to be paid promptly) combined with

(b) any awards or settlements for "pain and suffering" (limited to the amount paid by the primary carrier for "specific damages"). All excess would be fully reinsured by HEW and would eliminate the catastrophic or unpredictable "shock" loss to the carrier.

(3) HEW to fully reinsure the "uninsurable" or volatile risks who would receive a standard policy from the private carrier after being classified and surcharged by the state in a manner to be specified by the Secretary.

If this minimal and partial HEW support is forthcoming, there would then be no reason whatever for any carrier not to willingly reenter the competitive market for hospital and medical liability insurance to protect the public at a lower cost to our health care delivery system.

Included, as part of this Statement, is testimony given March 5, 1975 with amplifying note on cost-effect to the House Ways and Means Sub-Committee on Health plus testimony before the New Jersey Senate on Labor, Industry and the Professions on April 8, 1975 to counteract fragmentary, divergent and unilateral state actions.

To conclude, we oppose relying on actions, subject to court delays, by the several states to meet an urgent national catastrophe-type health care crisis simply because an acceptable partial Federal solution, as for riot or flood insurance, could be quickly and easily implemented as proposed to you. Such a partial support by HEW would:

I. Preserve the availability of public protection against malpractice by hospitals and practitioners and at lower cost - nationally, in a uniform manner and now - when it is needed;

II. Enable the Secretary of HEW to finally build a credible body of nationwide statistical data for loss incidence and severity- something which nobody has ever had;

III. Permit Doctors and hospitals to resume practicing the best health care - not the best "defensive" health care;

IV. Halt early retirement and stimulate new practitioners to start up in our communities across the land;

V. Enable our nation's attorneys to continue in the tort liability sphere to obtain just awards and settlements for the public;

VI. Solve an insurmountable present economic problem for private insurance carriers;

VII. Ditto (VIabove) for their reinsurors - whose panic and pressure contributed greatly to this crisis;

VIII. Preserve state regulation of the private insurance industry under the control of our respective State Commissioners (and legislatures).

My Statement is concluded with the offer to try to answer any questions and to assist the Committee or the Department of HEW in any way deemed useful to resolve the problem.

* * *

William Owens
N.J. Broker #63513000
and
President
A.P.E.D., Inc.

Enclosures:
Annex "A" 3/5/75 Testimony to U. S.
H.R. Health Sub-Committee,
Washington, D. C.
"B" 4/3/75 Testimony to
New Jersey Senate Committee,
Trenton, N.J.

STATEMENT RE: Assembly Bill 1552--An Act concerning medical malpractice liability insurance.

BY: Independent Mutual Insurance Agents Association of New Jersey

TO: Committee on ~~Commerce~~ Labor, Industry and Professions, New Jersey State Senate; Trenton, New Jersey; April 8, 1975.

My name is Frank J. Siracusa. I am an independent insurance agent from Atlantic City, New Jersey, and I am testifying today as a member of the Executive Committee of Independent Mutual Insurance Agents Association of New Jersey, a professional trade Association representing approximately 2,000 independent insurance agents currently doing business in this state. I am a member of the Board of Directors of the association and Chairman of its Legislative Committee.

Our primary concern is not with Assembly Bill 1552, as such, but with the long-range implications of the problems associated with availability of medical malpractice liability insurance. To place our comments in proper perspective, please note two things:

1. While we recognize the growing seriousness of the problem, we do not think it has reached crisis proportions as yet in the State of New Jersey. In fact, the most immediate near-crisis--the termination of coverage for a number of New Jersey hospitals by the Argonaut Insurance Company of California--has already been averted by the court order obtained by the State Insurance Department against Argonaut, backed by the promise of the private insurance industry to fill the gap, if necessary.

2. The reinsurance facility proposed by Assembly Bill 1552 should be viewed as a stopgap measure only, not as a long-range solution to the basic problem.

Expanding upon our second comment above, the entire medical malpractice insurance situation is not primarily an insurance problem. It is a combination of social and legal problems, tied to increasing awareness on the part of the patient of his right to sue doctors and hospitals and to the increasing size of malpractice awards granted to claimants by our courts. Possibly the only aspect of the problem directly related to insurance is the question of whether rates are adequate for this type of coverage.

Hence, any attempt to solve the problem by merely manipulating the insurance mechanism, whether by the establishment of a reinsurance facility or by any of the other frequently suggested means, is doomed to early failure.

Instead, someone must analyze all aspects of the problem, from actual underwriting costs to the tort laws themselves and come up with long-range answers. We are not technically equipped to provide those answers or even to suggest any remedies.

However, in lieu of such direct recommendations, we do suggest instead the immediate formation of an industry task force to study the problem in depth and report back to the legislature at some reasonable time in the future with recommendations for lasting, long-range solutions to the underlying causes of the problem. As an interested party, we would like to work together with the rest of the industry to develop those recommendations, and we herewith offer our services as a catalyst to draw the various segments of the industry together to pursue this project.

ing with the above suggestion, we additionally recommend that any further action mbly Bill 1552 be deferred until such time as the industry task force has filed commendations for a long-range solution to the basic problem.

judgment, a voluntary market solution, built upon the premise that the insurance ies will voluntarily underwrite all medical malpractice business at reasonable but te rates, coupled with appropriate remedial legislation to correct shortcomings in esent tort system, will best serve to treat the underlying cancer, as opposed to addressing the symptoms of the disease.

suggested task force is not formed, and if no other solution to the malpractice m is arrived at within a reasonable period of time, we shall then be willing to t Assembly Bill 1552 essentially as presently written.

you for hearing our thoughts on this very vital subject today. If we can be of rther service to you, please feel free to call upon us.

Statement of

The American Mutual Insurance Alliance

Submitted to
New Jersey Senate Labor, Industry and Professions Committee

Re: Assembly No. 1552

April 8, 1975

The American Mutual Insurance Alliance is the national trade association of mutual property and casualty companies. Our companies write about 19 percent of the property and casualty business in New Jersey.

Our members are vitally concerned with the current medical malpractice situation in New Jersey and particularly with its underlying causes. Your hearing today centers on Assembly Bill 1552. We have had an opportunity to present our views on this bill before the Assembly in February. A copy of our testimony is attached for your review. Since our original testimony, the Chubb Insurance Group and other insurers have offered to insure the 29 hospitals that had received cancellation notices from Argonaut thereby alleviating any temporary market problems that may have existed. Also the Supreme Court has granted a temporary injunction against Argonaut thus preventing the planned cancellations.

It is our contention that A. 1552 is no longer necessary. In any event, A.1552 would not have corrected any of the underlying causes of the malpractice problems, but would have aggravated them.

Enacting A.1552 without basic reforms of the law results in no incentives to reduce the number of incidents giving rise to malpractice suits. Claim costs would continue to soar with doctors and hospitals paying higher, if not prohibitive, premiums.

We'd be no better off than we are today. In fact, we'd be worse off because the reinsurance pool scheme contains no time limit after which it would expire. It is therefore being offered as a long-term solution to malpractice insurance price and availability problems. Ironically enough, the only long term result it will produce is higher insurance premiums for doctors and hospitals. The cure is worse than the disease.

Also, the reinsurance pool mechanism is probably the worst of all available pooling mechanisms that could have been chosen for New Jersey. Reinsurance pools are not magic answers to insurance problems. A reinsurance pool scheme was mandated in North Carolina in 1973 to replace the state's risk sharing plan for hard to place automobile insurance. It now turns out that the reinsurance association there is incurring expenses 27.6 percent higher than the auto insurance plan it replaced.

We would also like to point out inconsistencies in A-1552 itself. It requires that participation in the reinsurance pool mechanism be limited to liability insurers. Since the problem of medical malpractice involves the medical care system and not automobile or general liability, shouldn't all the accident and health insurers in New Jersey as well as Blue Cross and Blue Shield be included to carry their fair load? And shouldn't assessments on liability insurers be based only on that portion of their premium that goes for medical care of individuals? This would seem more equitable.

To enact A-1552 is therefore unsound and illogical. It will result in higher malpractice insurance premiums. It will result in higher premiums for automobile, homeowners and workers' compensation insurance. It will increase the already high cost of health care since increases in medical malpractice premiums will be passed on to patients in the form of higher medical bills.

Study Commissions on malpractice insurance claims have discovered that patients who considered their medical bills to be excessive, retaliated by filing a malpractice claim. Passage of A-1552, together with present skyrocketing increases in medical and hospital costs, could increase those bills even more and result in a greater number of malpractice claims.

We feel that New Jersey now has the opportunity to study and evaluate the overall malpractice situation, therefore we endorse Senate Concurrent Resolution 3001 which would create a special committee to investigate medical malpractice insurance costs and availability.

We don't believe anyone has all the answers at this time, but the Alliance stands ready to work cooperatively with other segments of the insurance industry, with the medical profession and with the legislature in dealing with this problem.

A PROPOSED SOLUTION

For

NEW JERSEY'S MEDICAL MALPRACTICE INSURANCE PROBLEMS

Statement of
The American Mutual Insurance Alliance

Submitted to
New Jersey Assembly Standing Committee

on

Commerce, Industry and Professions

Re: Assembly Bill A-1552

February 10, 1975

The American Mutual Insurance Alliance is the national association of policyholder-owned companies who account for nearly 19 percent of the property and casualty insurance market in the state of New Jersey.

Our members are vitally concerned with the current medical malpractice insurance situation in New Jersey and particularly with its underlying causes.

Unless the situation is corrected, there will be an adverse effect not only on the quality of medical care available in the state, but also on the cost of personal and business insurance to our present policyholders.

Property and liability insurance companies are large consumers of

medical and hospital services. If these services become more costly because malpractice insurance rates escalate, it means that the price of workers' compensation insurance, automobile personal injury insurance and other personal lines medical coverages become more costly. This added expense would not go well with our customers, especially when unemployment and inflation are already taking their toll.

THE PROBLEM - AVAILABILITY AND COST

Much has been written and said over the last several weeks concerning the crisis in medical malpractice coverage. It's become a front page item in most of our newspapers and has received extensive attention from the broadcast media. However, as with most crises -- this one didn't materialize overnight nor is it confined to New Jersey. Other states -- New York, Maryland, North Carolina, Ohio, Indiana and California are experiencing similar problems. But a careful review of medical malpractice problems indicates they are due to multiple causes --- which do not lend themselves to simplistic solutions.

Consumerists blame the doctors, the doctors blame the lawyers. Unfortunately, the medical malpractice insurers are caught in between. Claims settlements over the years tell part of the story. In 1965 insurance companies collected $30 million in malpractice premiums from American doctors and made a profit on the business. In 1974, insurers collected $300 million in malpractice premiums and experienced no profit on the business.

Moreover, comparing malpractice premium income in any one year to claims paid out in the same year, can be very deceiving. It's just the tip of the iceberg. What appears to be a surplus for that specific year may be insufficient to cover future claims. The profit and loss balance in malpractice insurance can be struck only after the passage of eight years or more. A case reported today can be settled for nothing or for millions of dollars, which makes it difficult for the malpractice insurer to know how much to set aside for settlements.

It's that kind of claims experience that has helped create the medical malpractice insurance cost and availability problems we are now faced with.

UNDERLYING CONTRIBUTING CAUSES

Adverse claims experience, however, is a symptom -- not a cause -- of the medical malpractice insurance problem. There are in fact several underlying causes which significantly influence the initiation and outcome of malpractice claims and suits and have an ultimate adverse effect on malpractice insurance premiums.

The underlying causes also effect the way the malpractice insurance premium dollar is distributed. About 55 cents out of every premium dollar goes for legal fees with only 15 to 20 cents ending up in the pocket of injured parties. The rest goes for overhead and claims adjustment expenses. As we said before, there is no profit.

In New York State, for example, most of the malpractice insurance was written by Employers of Wausau -- an AMIA member. From 1949 to 1972 the company received $212 million in premiums and investment income while it incurred losses of $332 million. Net loss came to $120 million. The company was forced to withdraw from the market.

Here is a list of those underlying contributing causes.

First: We have seen more of a willingness on the part of patients to sue a physician if they feel the physician has maltreated them. This is a sociological phenomenon over which no one has control. Many people regard good health as though it were a commodity, something that a doctor can dispense at will. But good health is not a purchasable commodity. It is a matter of heredity, personal responsibility, choice and self-discipline. Unfortunately, the failure to achieve ideal health has caused great disappointment on the part of some patients.

And they have turned with greater and greater frequency to the lawsuit as a means of resolving their disappointments. The best hope here is for an improvement in the doctor-patient relationship.

Also, an impersonal atmosphere of hospitals may contribute to the malpractice potential. The hospitalized patient's loss of privacy, the sense of captivity, the depersonalized attitudes of some personnel, understandable patient fears and anxieties, the family and patient's inability to secure an explanation of diagnosis and treatment, may contribute to complaints about the final outcome.

Second: Patients may sue a doctor many years after treatment --- creating an almost never-ending commitment for the medical malpractice insurer. Ten thousand dollars in premiums collected from a doctor today could result in a ten million dollar loss years from now. This open-ended commitment has resulted in an upward cost push on the medical malpractice insurance premium. There are remedies available which can equitably help alleviate this condition and hopefully reverse the rising cost spiral.

Third: In malpractice cases, the doctrine of res ipsa loquitur (latin for "the thing speaks for itself"), can be applied. When it is, the burden of proving that the physician was negligent is lifted from the complaining party. Instead the law permits an inference of negligence on the part of the physician who must now prove he is not negligent. We feel this area is one which can be beneficially reformed.

Fourth: It has been shown that the contingent fee arrangement provides a means by which a claimant can obtain legal counsel for little or no charge is he losses his malpractice case. If he wins, he pays his lawyer some fraction of the recovery amount, usually between one-third and 40 percent, but occasionally as high as 50 percent. We feel that modification -- not abolition -- of the contingency fee would still guarantee the claimant his day in court, but would also help reduce total loss costs for malpractice cases to doctors -- with a corresponding reduction in malpractice insurance premiums. Important steps to accomplish this end have already been taken in New Jersey.

Fifth: Patients, with increasing frequency, have been suing for injuries arising out of medical malpractice, alleging an oral guarantee by the physicians of successful outcome of treatment. In these cases the plaintiff does not have to prove the physician was negligent. We believe that this area of existing malpractice law could also be beneficially reformed. 2.

PROPOSED SOLUTIONS TO UNDERLYING CAUSES

Unless and until these underlying causes are corrected no proposed solution, be it a Reinsurance Association, an insurance company run by doctor's themselves or federal legislation, will solve the problems of cost and availability of medical malpractice insurance.

We therefore urge the immediate enactment of remedial legislation to make sure:

1. That no claim of any kind, whether in contract or tort, alleging the malpractice of a health care provider shall be commenced, unless said action is filed (1) within two years of the act, omission or failure complained of, or (2) within one year of the date when the act, omission, failure, or the resulting injury was discovered, whichever is longer. In no event shall such claim be commenced more than six years after the act, omission or failure complained of, except for a claim alleging the 3.

failure to remove a foreign object left in the claimant during the course of medical treatment, in which case the claim must be commenced within one year of the object's discovery.

2. That in professional liability actions against licensed health care providers there shall be no presumption or inference of negligence on the part of any defendant. In professional liability actions against licensed health care providers, the jury shall be instructed that the plaintiff has the burden of proving, by a preponderance of the evidence, the negligence of the defendant or defendants. The jury shall be further instructed that injury alone does not raise either a presumption or an inference of negligence.

3. That attorney contingent fees be regulated. The schedules of charges adopted by the New Jersey Supreme Court in 1972 is an important development towards solving the malpractice problem. The schedule is as follows:

The first $25,000 recovery - one-third
The next $25,000 recovery - one-fourth
The next $50,000 recovery - one-fifth
Ten percent of the portion over $100,000.

It has been estimated that such a schedule could eventually help reduce total loss costs for malpractice claims for doctors by as much as 20 percent.

4. That any promise, guaranty, warranty or other representation of a licensed health care provider to effect a cure or improve the health or condition of a patient by provision of health care or service, shall be void and unenforceable unless in writing duly signed by or on behalf of the health care provider to be charged.

I can't emphasize enough the need for this remedial legislation if we are to solve once and for all the medical malpractice insurance problem in New Jersey or anywhere else. Enactment of any other proposed solution, without this necessary remedial legislation, would be cosmatic reform, at best.

THE PROPOSED MEDICAL MALPRACTICE REINSURANCE ASSOCIATION

(A.1552)

Among other proposed solutions is the creation of a New Jersey medical malpractice Reinsurance Association. Such a proposal is now pending before your Committee in the form of Assembly Bill 1552.

This legislation makes no attempt to resolve the underlying cause of the unavilability and high cost of medical malpractice insurance.

What then, will the proposed Reinsurance Association solve? We think very little. In fact, if the Reinsurance Association is enacted without effecting remedial changes in the malpractice tort law --- the current situation will be further aggravated. Enacting A-1552 without basic reform of the law results in no incentives to reduce the number of incidents giving rise to malpractice suits. Claim costs would continue to soar with doctors and hospitals paying higher, if not prohibitive, premiums.

We'd be no better off than we are today. In fact, we'd be worse off because the resinsurance pool scheme contains no time limit after which it would expire. It is therefore being offered as a long-term solution to malpractice insurance price and availability problems. Ironically enough, the only long term result it will produce is higher insurance premiums for doctors and hospitals. The cure is worse than the disease.

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We would also like to point out inconsistencies in A-1552 itself. It requires that participation in the reinsurance pool mechanism be limited to liability insurers. Since the problem of medical malpractice involves the medical care system and not automobile or general liability, shouldn't all the accident and health insurers in New Jersey as well as Blue Cross and Blue Shield be included to carry their fair load? And shouldn't assessments on liability insurers be based only on that portion of their premium that goes for medical care of individuals? This would seem more equitable.

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We do not believe the legislature or the citizens of New Jersey would want to see this happen.

Thank you.

STATEMENT BY COMMISSIONER OF INSURANCE

JAMES J. SHEERAN

BEFORE THE SENATE COMMITTEE ON LABOR, INDUSTRY AND PROFESSIONS

APRIL 8, 1975

Senator Hughes and members of the committee:

The plight of 29 New Jersey hospitals was apparent after Argonaut's precipitate action in cancelling their policies made it necessary for this legislation to be considered by the Assembly on an emergency basis. It should be noted, however, that this bill came out of committee in the Assembly before the emergency occurred.

What confronts you now is the need to find a long-term solution, one that will assure both the public and medical practitioners of the availability of malpractice insurance in a market that is subject to state regulation and with all the safeguards that state regulation provides.

I think that A-1552 and its provision for a Reinsurance Association or Facility, to be comprised of only those companies with expertise in malpractice insurance, is the long-term solution.

A major problem with the market, as it exists today, is the so-called exclusive agreement between the carriers and professional organizations. Argonaut, for instance, was the insurer for members of the New Jersey Hospital Association through agreement with the association. The Chubb Group, similarly, is the carrier for the members of the Medical Society of New Jersey through an exclusive agreement.

I regard this use of exclusive agreements between the carriers and professional societies as essentially monopolistic, which leads to an unhealthy, if not unlawful, stifling of competition. The result is that there are few companies available to write malpractice insurance, each apparently content with the territory it has acquired and unwilling to engage in the kind of competition we have a right to expect in a supposedly free market.

Let me explain how these exclusive agreements not only stifle competition but actually tie the hands of the insurance commissioner. Every year, representatives of the Medical Society, the broker and the company come to the department and hand us a filing and say "these are the rates on which we agree." If I refuse to accept the filing, I'm cast in the role of villain.

The insurance commissioner is depriving the doctors of malpractice insurance at a price the doctors are willing to pay! So I'm up against a fait accompli---and the fact that we can't be sure that there's a carrier willing to step in and pick up the coverage if the exclusive carrier drops out.

The department is thus limited in its ability to examine other evidence relevant to rate, and particularly to develop a means of distributing large losses.

can draw an analogy in this regard from the practice in fire insurance, which is similarly susceptible to catastrophic losses as malpractice insurance is. The fire industry simply distributes its catastrophic losses country-wide by adding five per cent or so loading into the rates. That's not unusual at all. It's a calm, ordered approach that contrasts with the panic that large malpractice losses induce in the industry.

As long as these monopolies persist, there is little the commissioner of insurance can do to assure availability of insurance and to provide a reasonable distribution of the loss costs among classes of insureds.

The existence of monopolies has led to a proliferation of the surplus lines market and, indeed, to an abuse of this market, which was originally intended as a means whereby unusual and otherwise hard-to-place risks could obtain coverage.

Forced to go to a surplus lines company because the standard market won't have them, medical practitioners, whether they be individuals or institutions, are faced with exorbitant rates. For instance, the malpractice insurance bill of our own College of Medicine and Dentistry this year is more than half a million dollars, up from two hundred thousand last year.

The surplus lines insureds also have another problem if their companies face insolvency. The insureds do not have the protection against insolvency that the standard market provides through the Property-Liability Insurance Guaranty Association. The insolvency of a surplus lines company with heavy malpractice writings could mean a very real disaster for the New Jersey public.

I have recently taken a step to reduce the indiscriminate use of the surplus lines market by promulgating an emergency regulation that requires proof that hospitals and physicians employed by hospitals have been refused by three carriers in the standard market before they will be permitted to purchase surplus lines insurance. If a hospital has to go to surplus lines, I will know about it.

I have also taken steps to prevent a "consent-to-rate" device from being used to bring about an increase in rates. The Chubb Group, for instance, has filed a revised rate schedule for osteopathic physicians, which is now being reviewed. In the meantime, the company started to submit "consent-to-rate" forms, on which osteopaths are being asked to agree to an increase of 45 per cent in their rates. The company's excuse is that it anticipated a favorable action on its rate filing. But I have disallowed the "consent-to-rate" filings on the ground that they are an inappropriate means of bringing about what is really a general increase in rates.

Those are some of the problems I am faced with because of the lack of an available market for malpractice insurance. Let me describe, briefly and simply, what A-1552 would do, even though I know you are familiar with it.

The bill would make malpractice insurance readily available for all medical practitioners, including doctors, dentists, chiropractors, podiatrists, and others as well as hospitals and other health care facilities. The insurance would be available from certain liability companies---those with experience in malpractice writing either here or elsewhere in the country. This limitation is necessary because malpractice insurance is not a popular line and requires expertise that only can be acquired through experience.

These companies together would constitute the Reinsurance Association or Facility.

Under this legislation, each company would be required to accept any medical practitioner applying to it for insurance. Each company would then be free to retain the risk or to cede it in whole or in part to the reinsurance pool. If a company decided to cede a risk, it would retain only the expense portion of the premium and would service the policy just as if it continued to be the insurer. The remainder of the premium would be paid into the reinsurance facility. Out of that fund, losses on the ceded policies would be paid. If the facility showed a deficit, assessments would be made against the individual companies. Ultimately, the losses would be passed onto the insureds through additional charges

The facility itself would be not much more than a bookkeeping operation and its costs would only be minimal.

Unfortunately, and somewhat strangely, the hospitals and the doctors do not like the solution I have proposed. Perhaps, they are afraid of the wrath of the companies, which don't like it either. That's what happens when you don't have competition. Perhaps, they favor a change in the system of tort liability. No-Fault, or some such, such as the Legislature decreed in the matter of auto insurance.

But that is a question that requires long and careful study so that the rights of the people are fully protected and not frittered away. What we need is a solution that will solve existing problems now by breaking the monopoly and insuring full availability of insurance.

The Reinsurance Facility will make readily available the insurance that is needed to protect the public against the mistakes of the medical and allied professions. That is what the public needs.