Committee Meeting

of

SPECIAL COMMITTEE OF THE GENERAL ASSEMBLY TO INVESTIGATE MEDICAL MALPRACTICE INSURER BUSINESS PRACTICES

"Testimony on information related to the business practices of medical malpractice insurance companies"

LOCATION: Committee Room 11
State House Annex
Trenton, New Jersey

DATE: October 2, 2003
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Neil M. Cohen, Vice-Chair
Assemblywoman Loretta Weinberg, Vice-Chair
Assemblyman Herb Conaway
Assemblyman Jack Conners
Assemblyman Willis Edwards III
Assemblyman Jerry Green
Assemblyman Anthony Impreveduto
Assemblyman John F. McKeon
Assemblywoman Nellie Pou
Assemblywoman Joan M. Quigley
Assemblyman Robert J. Smith II
Assemblyman Christopher "Kip" Bateman
Assemblyman Eric Munoz
Assemblyman David C. Russo
Assemblyman David W. Wolfe

ALSO PRESENT:

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

The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

New Jersey State Legislature

SPECIAL COMMITTEE OF THE GENERAL ASSEMBLY TO INVESTIGATE MEDICAL MALPRACTICE INSURER BUSINESS PRACTICES

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COMMITTEE NOTICE

TO: MEMBERS OF THE SPECIAL COMMITTEE OF THE GENERAL ASSEMBLY TO INVESTIGATE MEDICAL MALPRACTICE INSURER BUSINESS PRACTICES

FROM: ASSEMBLYMAN ALBIO SIRES, CHAIRMAN

SUBJECT: **COMMITTEE MEETING - OCTOBER 2, 2003**

The public may address comments and questions to Mary C. Beaumont and David Price, Committee Aides, or make bill status and scheduling inquiries to Vivian A. Todaro and Alice Murphy, Secretaries, at (609)984-0445 and (609)292-1646.

The Special Committee of the General Assembly To Investigate Medical Malpractice Insurer Business Practices will meet on Thursday, October 2, 2003 at 10:00 AM in Committee Room 11, 4th Floor, State House Annex, Trenton, New Jersey.

The special committee will meet for organizational purposes and to receive testimony on information related to the business practices of medical malpractice insurance companies.

Anyone wishing to present written testimony should provide 30 copies to the committee on the day of the meeting.

Issued 9/26/2003

For reasonable accommodation of a disability call the telephone number or fax number above, or TTY for the hearing impaired (609)777-2744/toll free in NJ (800)257-7490. The provision of assistive listening devices requires 24 hours' notice. Real time reporter or sign language interpretation requires 5 days' notice.

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SPECIAL COMMITTEE OF THE GENERAL ASSEMBLY TO INVESTIGATE MEDICAL MALPRACTICE INSURER BUSINESS PRACTICES

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AT: STATE HOUSE ANNEX
West State Street
Trenton, New Jersey 08625
Thursday, October 2, 2003

B E F O R E:

NEIL M. COHEN
Co-Vice Chair

LORETTA WEINBERG
Co-Vice Chair

HERB CONAWAY, MD
Vice Chair

MARY C. BEAUMONT
Office of Legislative Services
Committee Aide

DAVID PRICE
Office of Legislative Services
Committee Aide

ERIC MUNOZ
Assemblyman

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(Continued)

B E F O R E:

DAVID W. WOLF
Assemblyman

NELLIE POU
Assemblywoman

JOAN M. QUIGLEY
Assemblywoman

JOHN F. McKEON
Assemblyman

ROBERT J. SMITH
Assemblyman

JACK CONNERS
Assemblyman

ANTHONY IMPREVEDUTO
Assemblyman

CHRISTOPHER "KIP" BATEMAN
Assemblyman

DAVID C. RUSSO
Assemblyman

Reported by:
RHEA C. VILLANTI, C.S.R.

MS. BEAUMONT: Assemblyman Cohen?

MR. COHEN: Here.

MS. BEAUMONT: Assemblywoman Weinberg?

MS. WEINBERG: Here.

MS. BEAUMONT: Assemblyman Conners?

MR. CONNERS: Here.

MS. BEAUMONT: Assemblyman Edwards?

MR. EDWARDS: Here.

MS. BEAUMONT: Assemblyman Green?

MR. GREEN: Here.

MS. BEAUMONT: Assemblyman Impreveduto?

MR. IMPREVEDUTO: Here.

MS. BEAUMONT: Assemblyman McKeon?

MR. McKEON: Present.

MS. BEAUMONT: Assemblywoman Pou?

Assemblywoman Quigley?

MS. QUIGLEY: Here.

MS. BEAUMONT: Assemblyman Smith?

MR. SMITH: Here.

MS. BEAUMONT: Assemblyman Bateman?

MR. BATEMAN: Here.

MS. BEAUMONT: Assemblyman Munoz?

DR. MUNOZ: Here.

MS. BEAUMONT: Assemblyman Russo?

MR. RUSSO: Here.

MS. BEAUMONT: Assemblyman Wolfe?

MR. WOLFE: Here I am.

MS. BEAUMONT: That's it.

MS. WEINBERG: For the record, Assemblyman Munoz is substituting for Assemblyman Sean Kean and Assemblyman David Wolfe is substituting for Assemblywoman Charlotte Vandervalk. Thank you for filling in.

MR. IMPREVEDUTO: Madam Chairwoman, just for the record, I want to let you know that the Banking and Insurance Committee is present at 100 percent and, Mr. Chairman, we want you to know that we are here for you.

MS. WEINBERG: I did make the announcement that the Insurance Committee would get the gold stars for attendance and punctuality this morning.

MR. McKEON: Neil promised us a hotdog later.

If I might be acknowledged, Mr. Chairman, to the extent that gold stars are to be given out, Chairperson Weinberg has made it here from California, taking herself away from her first grandchild. So we all congratulate her on that momentous occasion.

MS. WEINBERG: Thank you very much. And I have pictures for anybody who wants to look at them during intermission.

MR. COHEN: Mr. Leone, will you be testifying?

MR. LEONE: Aye.

MR. COHEN: It will be marked into evidence. Now we have the roll call. The Committee will go into executive session to discuss the matters of procedure in terms of the operation of the Special Committee. Hopefully it will not be long in discussion and we'll return shortly.

(Break in proceedings.)

MS. WEINBERG: For the record, for the roll call, Assemblywoman Pou and Assemblyman Conaway have joined us. Please mark them present.

And the first order of business is the adoption of the standard operating procedures. The copies have been distributed by David Price so can we have a Motion?

MS. QUIGLEY: Madam Chair, I move that the Committee adopt the standard operating procedures.

MS. WEINBERG: Excuse me one minute. But because we have a new outside reporting service, we have to try to remember to make sure your names are mentioned each time. The regular Office of Legislative Services, their hearing unit, unfortunately there is a funeral today of one of their esteemed members and that's where they all are.

So the Motion was made by Assemblywoman Quigley. Can I have a second?

MR. BATEMAN: Second.

MS. WEINBERG: Seconded by Assemblyman Bateman. Roll call.

MS. BEAUMONT: On the standard operating procedures, Assemblyman Cohen?

MR. COHEN: Yes.

MS. BEAUMONT: Assemblywoman Weinberg?

MS. WEINBERG: Yes.

MS. BEAUMONT: Assemblyman Conaway?

DR. CONAWAY: Yes.

MS. BEAUMONT: Assemblyman Conners?

MR. CONNERS: Here, yes.

MS. BEAUMONT: Yes. Thank you. Thank you.

Assemblyman Impreveduto?

MR. IMPREVEDUTO: Yes.

MS. BEAUMONT: Assemblyman McKeon?

MR. McKEON: Yes.

MS. BEAUMONT: Assemblywoman Pou?

MS. POU: Yes.

MS. BEAUMONT: Assemblywoman Quigley?

MS. QUIGLEY: Yes.

MS. BEAUMONT: Assemblyman Smith?

MR. SMITH: Yes.

MS. BEAUMONT: Assemblyman Bateman?

MR. BATEMAN: Yes.

MS. BEAUMONT: Assemblyman Munoz?

DR. MUNOZ: Yes.

MS. BEAUMONT: Assemblyman Russo?

MR. RUSSO: Yes.

MS. BEAUMONT: Assemblyman Wolfe?

MR. WOLFE: Yes.

MS. BEAUMONT: Thank you.

MR. COHEN: First I just want to read -- we'll read this statement one time so it doesn't have to be read before each witness. "Each witness at a hearing conducted by the Special Committee shall be entitled to the following rights: The right to be accompanied by counsel, who may advise the witness of his rights, the right to receive a copy of his testimony and the right to file a brief sworn statement relevant to his testimony for incorporation into the hearing record.

"In addition, each witness compelled by Subpoena to appear at a hearing shall be entitled to all other rights accorded under the Code of Fair Procedures."

The first witness will be Mr. Howard Weiss. That will be fine, Mr. Weiss. Mr. Weiss, if you could just stand for one moment and raise your right hand.

H O W A R D W E I S S,

S W O R N.

MR. COHEN: Thank you. If you could state your name and location of residence or

business.

MR. WEISS: My name is Howard Weiss and I live and work in Monmouth Junction, New Jersey --

MR. COHEN: You have to hit the red button.

MR. WEISS: Red light on? Howard Weiss. I live and work in Monmouth Junction, New Jersey.

MR. COHEN: Good morning.

MR. WEISS: Good morning. I thank you for the opportunity to appear before you today. I'll take just a few minutes to outline my background.

Back in the mid to late 1970s and early 1980s I was one of a team of health care consultants that worked with state medical societies to form seven captive medical malpractice insurance companies in the States of Illinois, New Jersey, Connecticut, District of Columbia, Minnesota, Utah and Texas.

After the creation of MIIX in New Jersey I remained a consultant to them until October of 1978, when I joined them as vice president and was subsequently promoted to senior vice president. I left MIIX in January of 1992.

My responsibilities included legislative affairs, particularly the passage of

tort reform, actuarial, statistical analysis, informational services, new business development and general troubleshooting. I also served on several national medical malpractice committees through the Physicians Insurers Association of America.

From 1980 to 1991 I led the tort reform effort at MIIX. This effort centered around a number of different proposals, including collateral source offsets, joint and several liability issues, mandatory arbitration of small claims, periodic payment of future damages, a $250,000 cap on pain and suffering and revising the statute of limitations.

We were successful in enacting an offset for collateral sources, a revised doctrine of joint and several liability and mandatory arbitration of small cases, which were subsequently found to be unconstitutional.

Our own data had shown that collateral source offsets and a more equitable approach to joint and several liability would have a meaningful effect on losses and as such on premiums.

The cap bill was part of our "window dressing." Our data showed that had a $250,000 cap on non-economic damages been enacted, we would not have been able to cut premiums by even one-half of

1 percent.

The overwhelming majority of indemnity payments on settlements is for real economic loss for past and future medical care, past and future lost income, past and future custodial care and renovations to homes for those who suffered severe handicaps through the negligence of health care providers.

Not only is the overwhelming majority of indemnity dollars on settlement for real economic loss but in most cases the settlement amount does not even cover full economic loss.

In all the years I was at MIIX, covering thousands of claims, the number of claims where the settlement amount included $250,000 for non-economic loss was miniscule. The medical and insurance communities' claim that a large portion of claim payments are for non-economic loss and that's ludicrous. They have no basis on which to make such a claim.

The insurers do not even keep such data on their systems. If there were such a basis, they would surely share the detail data with you on a case by case basis.

MIIX, in its response to the Assembly's request for data, has indicated that they, "Cannot break out between economic and

non-economic damages."

And in Med Pro's (phonetic) response, which I had just gotten this morning, it says they can give you data and amounts on each payout for bodily injury but they cannot -- they cannot break it out between economic and non-economic. They don't keep the data and they admit in their response, it says, "There would be no objective basis for such a division."

Based on my 28 years' involvement in medical malpractice, I would venture to say that non-economic damages do not and have never reached 10 percent of total loss payouts. If non-economic damages were the driving force in the escalation of medical malpractice premiums, how can we explain the ever increasing premiums of lawyer's professional liability and accountant's professional liability premiums, as losses related to those lines of insurance really have no non-economic component.

Passage of a cap on non-economic loss would not serve to reduce losses or premiums. It would only serve to deny severely injured people just compensation.

My 28 years of experience in medical malpractice has also taught me that frivolous claims are not even a small problem for medical malpractice insurers. It is a virtually

nonexistent problem. You must first make a distinction between what is a frivolous claim and a non-meritorious claim.

While many claims turn out to be non-meritorious, extremely few are frivolous. A person who has an encounter with a health care provider that results in an untoward result has the right, if they so choose, to investigate the sequence of events that led to the untoward outcome. This is called discovery.

The overwhelming majority of cases where no negligence is found are not pursued by Plaintiff counsel. And I can give you some real and accurate statistics that can attest to that.

For the last 11 years I have been with Second Opinion, Incorporated, a company that was created solely to assist Plaintiff attorneys in the evaluation and screening of potential medical malpractice actions.

During this period we evaluated -- and I must tell you this data is about six months old. During this period we evaluated 3576 cases for about 600 attorneys in 32 states. Out of these 3576 cases our clients have proceeded with only 610, or about 17 percent. The other 83 percent, or 2966, have been dropped by our clients.

In 755 of these cases that were dropped it was our judgment that the health care provider was indeed negligent but either the

damages were not sufficient to pursue the matter or the negligence could not be causally linked to any damages. In essence, of the 3576 cases we evaluated, more cases of negligence, 755, were not pursued than pursued, 610.

We did a survey with a prestigious South Jersey law firm that practices in the Cherry Hill area, in the Philadelphia area, and over a 19-month period they had 323 individuals who sought representation for a medical malpractice action. At the time we did the study they only accepted 12 and only one lawsuit had been filed.

Frivolous cases would encompass those cases in which there was no real injury. During my time with MIIX the number of truly frivolous cases, ones in which there was no untoward medical outcome, was again minuscule.

These few -- and I reiterate -- few cases do not put a financial burden on the insurer. While many cases may turn out to be non-meritorious once the discovery process is finished, these cannot and must not be called frivolous. Everyone is entitled to investigate untoward outcomes.

What we can glean from all of this is that Plaintiffs' attorneys have no reason to file so-called "frivolous lawsuits" and, in fact, do not. Why would they want to spend the better part of four to five years of effort and 40 to

$60,000 in out-of-pocket expenses on average on frivolous cases? If they did, they would go broke.

In fact, from what I understand, the New Jersey Courts have had the ability to award court costs and attorney's fees in so-called "frivolous cases" for many years. The instances where such awards have been made are few and far between.

Another part of our "window dressing" was a revision to the statute of limitations for minors. Our own data had showed that reducing the statute of limitations from age 20 to 11 would have no effect on premiums. And this was one of the bills that we have been pushing.

The overwhelming majority of indemnity paid on cases involving minors are on cases involving severe neurological birth injuries. The overwhelming majority of these cases are filed within three years of the birth of the child. Parents notice early on that the child is not developing normally, not rolling over, not following motion with their eyes, not crawling, not walking, not talking.

Most certainly there are some cases filed during the first few years of schooling, grades kindergarten, one, two, three, et cetera, when some learning disabilities are uncovered. These are rather few, however.

Modifying the statute of limitations for minors from age 20 will not lower losses and as such premiums will only serve to deny children whose parents chose not to file an action from filing one when they are old enough to understand the circumstances surrounding the situation.

So why is there a current medical malpractice crisis? The fact is there isn't a real crisis. This is a crisis created by the medical malpractice insurers because of their own ineptness during the 1990s and the collapse of interest rates during the last few years.

The 1990s were a time of diversification and geographic expansion for medical malpractice insurers. Many companies were looking to go public. Market share was prized. The marketplace became extremely competitive. Premium rates were continually slashed so that market share could be obtained.

These decreases in premium rates were solely a marketing ploy. Many different discounts were applied to the base rate in order to attract new business. The companies could not substantiate that these discounts were actuarially sound and, in fact, they were not. In addition to writing insureds inadequate premiums, the insurers lowered their own underwriting standards so that they might increase market share.

In the late 1990s insurers who were already writing insureds that they probably shouldn't have and at inadequate premiums got hit with the so-called "crash" of interest rates. They finally had to stop all the foolishness of the 1990s and get premium rates back to where they should have been all along.

They also decided that they were entitled to recover all the money they had lost due to their bad business decisions and falling interest rates, but by so doing they created a public relations disaster with the medical community.

Their answer was to create a crisis by telling the medical community that they had real non-economic losses that were driving premiums through the roof. At the same time they raised premium rates of high-risk specialties, such as OB/GYNs, orthopedists and neurosurgeons, to astronomical levels and said it was actuarially appropriate. They lied on both fronts.

Insurance is a spreading of the risk and as such high-risk specialties should be subsidized by low-risk insurers. This is feasible because high-risk specialties have many fewer class members than lower-risk specialties.

For example, loss data might show a neurosurgeon to be 30 times the risk of a family practitioner. That does not mean that the insurer

should charge a neurosurgeon 30 times the family practice rate. This would place an undue hardship on neurosurgeons. They should be charged a reasonable rate and the difference made up by marginally increasing the premium of lower-risk specialties.

I'm going to talk a little bit about MIIX now. MIIX was formed in combination by the Medical Society and Osteopathic Association. MIIX was formed as a reciprocal insurance company -- excuse me -- and, hence, had a Board of Governors made up of 17 physicians.

As a reciprocal, MIIX had no employees. It was run by an attorney-in-fact that was fully owned by the Medical Society of New Jersey. It had a Board of Directors made up of five physicians, Vince Maressa, who was the executive director of the Medical Society, and Peter Sweetland, the president of the attorney-in-fact.

Both the Board of Governors and the Board of Directors were "stacked" with physicians who also served on the Board of the Medical Society, Osteopathic Association or otherwise politically connected with these organizations.

Far and away the Medical Society had the most representation. As such, MIIX was always governed with an eye toward what was good for the

Medical Society.

Premium discounts were given for being a member of the Medical Society, even though there was no data to suggest that such membership reduced the doctor's risk. This was done to encourage doctors to join the Medical Society.

In essence, premium dollars were used to subsidize Medical Society membership dues. Outlandish perks were given to Board members, including million dollar life insurance policies.

In the late '80s and early '90s, after Peter Sweetland, the president of MIIX, passed away, Vince Maressa used this opportunity to seize the Chairman of the Board spot. Up until that time the Chairman had always been a physician.

Vince Maressa hired Dan Goldberg as president. He changed MIIX's philosophy. Up until that time MIIX's mission was to ensure that the doctors in New Jersey would never be without a reasonably priced market for medical malpractice insurance and, hence, one of fiscal responsibility.

We were a not-for-profit company who had returned money to the physicians in the form of dividends. Vince Maressa and Dan Goldberg, with an eye toward taking MIIX public, measured success in terms of market share. The more insureds the better, even at inadequate premium rates.

The expansion into other states was undertaken with the idea to write as many insureds

as possible, regardless of whether they were reasonable risks or whether the pricing was adequate.

MIIX underwrote bad risks and inadequate premiums in environments about which they knew nothing. They then chose to pile the consequences of these atrocious business decisions on the backs of the New Jersey doctors.

I personally saw Dan Goldberg take a large group of doctors away from the Princeton Insurance Company by offering them a large reduction in premium after Princeton had quoted them a huge renewal increase because of their adverse claims experience. The difference in premium was over 50 percent.

More and more insureds and more and more premium income, immediate cash, would make it easier to take MIIX public and make several insiders very well off. In essence, the physicians in New Jersey were abandoned by MIIX and the Medical Society because of a few greedy individuals.

And it's ironic that the same people who were screaming for tort reform announce that the first quarter of this year MIIX made a $7.2 million profit and they suggest -- they suggested that this might be related to the new philosophy of best practices. In other words, why

don't we settle meritorious claims quickly, thereby saving both indemnity and defense costs? Why now? Where were they all these years?

MIIX's first president was Peter Sweetland, a true insurance professional with many years of prior medical professional liability insurance experience with the Travelers Insurance Company.

After Peter's death the Medical Society and Vince Maressa hired Dan Goldberg, Ken Koryeva and Patricia Costante to run MIIX. None of them had any experience in insurance, no less a long-tail and complicated line of insurance such as medical malpractice. As such, the Medical Society controlled MIIX and its operations.

It is ironic that in between Mr. Koryeva and Miss Costante they did hire a true insurance professional to run MIIX. He left after only one month on the job. I wonder why?

I would not want to leave today without discussing several proposals that will help cut losses and lead to premium stability and even reduction. A good place to start would be to ensure that insurance professionals are running the insurance companies, not lawyers, not doctors and not Medical Society executives.

An extremely good start was the 1995 legislation requiring an Affidavit of Merit. The number of medical malpractice claims filed in New

Jersey has fallen from 2200 in 1994 to 1613 in 2001, a decrease of over 26 percent, and is directly related to the Affidavit of Merit requirement. The system now disposes of non-meritorious, not frivolous but non-meritorious matters early on, saving everyone significant time and money.

A further good step was recently taken when the Insurance Department reactivated the Reinsurance Authority. I spoke of the need for this action back in May. This will serve to make medical malpractice insurance more widely available.

The next few issues relate to the State Insurance Department. This Department is supposed to be an advocate for insurance consumers but is really an advocate for insurance companies. States should not allow premiums to be used and then file for approval.

New Jersey is a use and file state. Premium rates are made, put into effect by the insurer and filed with the Department. It is anyone's guess as to when and if the Department ever gets around to scrutinizing these files. Even if they do, the rate has been in effect for a long period of time.

The time has come to make New Jersey a pre-approval state. Look what happened in

California after Proposition 103, which was insurance reform and pre-approval of regs, passed in 1988. Medical malpractice earned premiums decreased in six of the next thirteen years and the decreases were more than sufficient to counter the seven years of increases. Earned premiums in 2001 were down 2.4 percent from 1988.

This is in sharp contrast to the experience following the passage of MICRA in 1975, which included a $250,000 cap on non-economic loss. In the first ten years following the passage earned premiums had almost quadrupled.

In 1985 the MICRA legislation was found to be Constitutional by the California Supreme Court and rates still continued to go up. By the time Proposition 103, insurance reform, was passed in 1988, earned premiums of California were five-and-a-half times what they were when the cap legislation was passed in 1975.

Premiums for medical malpractice are made by trending many individual factors. These factors include how many claims are expected, what percentage of these claims will end up with a payment, what will be the average payment, how many will require extensive defense costs, what will the average defense costs be, what will be our average investment return over the 15 years or so we will hold all or part of the money.

Because medical malpractice is a

long-tail line of insurance, meaning that we have many years before all claims from the year are paid, it is prudent to build so-called "fat" into the rate. But because the rate is made by trending many individual factors, fat built into each factor is compounded, when these factors are multiplied, to arrive at a final rate.

In addition, actuaries are funny people in the sense that when a certain component of the rate rises, they immediately take it as a trend. But when the same component decreases, they consider it an aberration. It is not a trend until it decreases several times.

The statistical trending techniques they use, although statistically sound, are only as good as the data they use in trending. Built-in bias, retrends versus aberrations, again, adds fat to the rate.

Many medical malpractice insurance companies will tell you they use "independent" actuaries and as such they have no control over the rate making process.

In reality there is no such thing as an independent actuary. If the actuary does not comply with company wishes, he or she is replaced. Just look at Enron, who had "independent" auditors.

The State Insurance Department has an obligation to assure that any so-called

"contingency" built into the rate is justified. The Insurance Department should also have an obligation to ensure that high-risk specialties are being subsidized by lower-risk specialties.

It is easy for an insurer to abandon this practice and charge high-risk specialties, such as neurosurgery, obstetrics and orthopedics, among others, unreasonable premiums that are substantiated by an actuary's report.

Physicians in this state should always have the choice of a claims made policy. This is especially important for new physicians. The first year cost of such a policy is substantially cheaper than an occurrence policy. Several subsequent years' premiums are also cheaper.

The losses are the losses. Now, that may sound dumb. But whether you buy an occurrence policy or a claims made policy, the ultimate cost should be about the same because the losses are the losses.

Payment of the premium under claims made is just deferred. The insurer may price the claims made product a little higher to make up for some lost investment income, but in general the total cost for a claims made policy should not be substantially higher than for that of an occurrence policy.

The Insurance Department is obliged

to ensure that first, second, third, fourth, fifth and mature claims made rates are properly calculated. My gut feeling tells me they are not.

Insurers are also known to burden their insureds with increased premiums because of bad business decisions, whether they are involving underwriting bad risks, inappropriate claim practices or poor investment decisions.

Premium rates tend to increase when interest rates are low and tend to maintain rather level when interest rates are high. An actuary study has found that amounts charged for premiums do not track losses paid but instead rise and fall in concert with the state of the economy.

When the economy booms and investment returns are high, insurers maintain premiums at modest levels. When the economy falters and interest rates fall, companies increase premiums. The Insurance Department should be charged with ensuring that premium rates are accurately and validly calculated and provide the insureds with sufficient credit for anticipated investment income.

This leads directly into another issue related to investment income. Insurers and actuaries will tell you that for each dollar of premium they collected last year, they paid out $1.38. At first this may seem alarming to you,

unless you know how the rate is made.

A premium collected during a policy year is paid out over many years. During the 15 or so years the premium is held, it will earn investment income. The major portion of the money is not paid out for many years. The insurer makes substantial investment income. The premium rates take this into account. The rate is consciously and deliberately made to expect a loss ratio of between 130 and 140 percent, otherwise the insurers would make unconscionable profits.

The next issue relates to the State Board of Medical Examiners and their failure to take repeat malpractice offenders seriously. Everyone has heard figures tossed about, re 5 percent of the doctors accounting for 60 percent of the malpractice losses.

This figure must of course be taken in context, as many of these doctors are in so-called "high-risk specialties." A norm must be established for each specialty. And the Board of Medical Examiners must at least investigate why physicians who are one or two standard deviations from the norm are generating so many claims.

That does not mean that every one of these physicians should be disciplined or sanctioned but the public is owed an investigation that might result in positive practice changes.

I am aware of Assemblywoman

Weinberg's proposed legislation to encourage more active participation of the Board of Medical Examiners and wholly -- and wholeheartedly endorse her proposal.

The next issue involves loss prevention. Loss prevention programs work. I sat on MIIX's Loss Prevention Committee and the National Loss Prevention Committee of the PIAA. When detail about the causes of medical malpractice is disseminated to physicians, either directly or through organized medical groups such as specialty societies, physicians become better doctors and, hence, better risks.

I have seen many examples of this in practice. One such instance involved anesthesiologists. During a one or two-year period we had received about 15 claims involving the use of two anesthetic agents in combination. After researching what was happening, we disseminated this information to the anesthesiologists through the American Society of Anesthesiologists. During the next five years we saw only one such claim.

Like many professionals, physicians are mandated to take continuing education. Part of their continuing medical education should be mandatory loss prevention. Not only will this serve to decrease losses but most importantly will lead to a significant decrease in patient injury.

The next issue relates to early settlement of meritorious cases. This does not happen for a variety of reasons. First, many malpractice insurer policies contain consent to settle clauses. This prohibits the insurer from settling claims without the consent of the doctor.

The clause was put in to show doctors that the new insurers, companies like MIIX, were different from the old commercial carriers. In the beginning it did not seem to present a problem. With the introduction of the National Practitioner Data Bank, it became a big problem and is extremely counterproductive.

The insurer goes through an internal peer review and decides that the claim should be paid but the insured says no. The insurer's hands are tied and the claim drags on for years. In essence this clause is a direct conflict with the cooperation clause, saying the Defendant must cooperate in his or her own defense.

The Defendant must supply records, not altered records, show up for deposition and trial. Non-cooperation is grounds for non-renewal. Is withholding consent on a case that has been peer reviewed as indefensible really cooperating?

An insurance company is a business that should be run as a business. This clause does not allow for that. I know of no other insurance policy containing such a clause. Such clauses

should be abolished.

The second element working against early settlement is that many cases involve more than one Defendant and, hence, more than one insurer. While insurers are placing blame on each other's insureds, the case goes unsettled. A mechanism should be devised so that a meritorious case involving more than one insured can be settled and then liability apportioned through some other process, such as mediation or arbitration.

Since these meritorious cases are not being settled, the insurer and defense counsel have to do something, so they ask doctors to write reports saying that cases are defensible, even though they know that not to be the case.

As you can imagine, it is much easier for an insurance company to get an expert than for the Plaintiff. The insurer tells the doctor to write the report to help mitigate damages -- it's called a sweetheart report -- and promises the doctor that he or she will never have to show up for deposition or trial.

Why is settling a case early important? What is the effect of the delay in settling meritorious cases? Studies have shown that a claim that could have been settled within 12 months of presentation that was not settled until between 36 and 48 months from presentation, costs

73 percent more in indemnity.

When you add the cost of defending the claim, the cost about doubles. A meritorious case that could have been settled for 100,000 ends up costing 173,000, plus tens of thousands of dollars in defense costs.

Should a cap on non-economic damages become a reality, it would have a devastating and I mean devastating effect on not only early settlement but any settlement of meritorious cases by so limiting the insurer's exposure they would have no reason to settle any claim at any time. They would force everything to trial, as there would be no down side for them.

Finally, let me say that no legislation should ever be enacted without knowing the reality of the situation. Before you consider diminishing the rights of ordinary people, make the insurers provide detailed case by case data of actual indemnity payments broken out by category of damages.

They should, at a minimum, provide total economic loss and substantiate this figure with a breakdown of economic payments into individual categories, such as past and future medical bills, et cetera.

Non-economic damages should also be broken out into individual categories, such as pain and suffering, mental anguish, disfigurement,

et cetera.

Current and past rate filings should be scrutinized to determine the extent of rate subsidies for high-risk specialties, whether claims made factors are appropriate, the extent to which insureds are being credited for investment income, whether more current favorable trends in decreasing claims volume has been adequately trended into the rate.

I have been talking with a fellow by the name of Bill Burns, who is an actuary in New York. He currently works for a reinsurance broker in New York City. He was an actuary for MIIX for several years and after leaving MIIX, he spent several years as an actuary for PHICO, which was a med mal insurer in Pennsylvania, who now no longer exists.

He is a certified actuary with extensive experience as a medical malpractice actuary. In addition, he has extensive experience with New Jersey environment.

My preliminary discussions with him leads me to believe he would be willing to work with the Committee to analyze the -- any data collected by the Committee. He would like to meet with the Committee leadership to discuss this possibility. He wants the Committee to know that he would approach this task with utter

impartiality.

I will be meeting with Mr. Burns tomorrow morning so he might look at the initial data provided by New Jersey's medical malpractice insurers. I have already provided Mr. Burns with a copy of the letter the Committee has sent to these insurers.

In closing, let me refer to the recent testimony of a Mr. Edward Dench of the Pennsylvania Medical Society before the Pennsylvania Senate Judiciary Committee. This was just last week.

He pointed to a new actuarial study by Milliman USA that concluded that a $250,000 cap on non-economic damages would reduce losses by 22 percent and premiums by 18 percent in Pennsylvania. The study used data from the National Practitioner Data Bank and Pennsylvania insurance filings.

I would be the first to admit that I have not seen the study and cannot comment on the statistical methods used but I do know that neither the National Practitioner Data Bank nor Pennsylvania insurance filings break down losses into economic and non-economic categories.

You can use the finest, most accurate statistical methods but if the data with which you are working is not real -- and in this case it was not -- the results are invalid.

Obviously the actuary took total payout data and made various assumptions. This is the only plausible explanation, as the real data is nonexistent. In a study such as this, it would do an injustice to legislators such as yourself. You are attempting to solve a problem in good faith by looking at true data. This study cannot possibly provide such data.

I also would like to read something. This was a news story published September 3rd of this year and it basically relates to California medical malpractice premiums. And this is as a direct result of the passage of Proposition 103 in 1988, which was insurance reform making -- making premiums -- pre-approval of premiums.

The second largest malpractice writer in California, SCPIE, had filed for the rate increase to be effective January 1st. They had asked for a 15.6 percent increase. The State Insurance Department cut that by 36 percent after an eight-month study of the -- of the environment in California and allowed them only a 9.9 percent rate hike. It's exactly this kind of procedure that's needed here in New Jersey.

I will be glad to answer any questions.

MR. COHEN: Thank you, Mr. Weiss. Any questions from the Committee?

Dr. Conaway.

DR. CONAWAY: Thank you for your comments. I can't help but point out, before I go on to a couple questions, a 9.9 percent increase will not be met by -- any kind of an increase by those physicians on the reimbursements from their insurers. So when -- part of the question of crisis for the individual physician out there is what's happening to him or her and their balance of payments.

And when these costs go up and there's no commensurate increase in the amount of reimbursements that are brought in, then -- for that physician is on the edge, particularly if they are practicing in areas of the state where people might have less -- where the prevalence of insurance among your patients are not very high or numbers that affect -- might affect income, that might be a crisis for that person practicing in that area.

I have a couple of questions. I take it from your testimony -- oh, now, you were with MIIX 29 years ago. Can you recall how many million dollar cases on a per month basis you saw 29 years ago? I mean, just as a ballpark.

MR. WEISS: I can tell you this. We were down here at the legislature trying to pass a $250,000 cap from 1980 and we had not had a million dollar loss and I believe we had been writing

policies from February 1st, 1977. I don't believe we had our first million dollar loss until 1987. It could have been '88 but around that -- around that -- around that time. So when I was there --

DR. CONAWAY: Is that ten years? You said '77 to '88?

MR. WEISS: Yeah. It took us ten years to get our first million dollar loss and yet we were down here trying to convince the Senate Judiciary Committee and other Committees of the Assembly that we needed a cap, when our average -- when our average payment was less than $100,000, our median payment was less than that and we hadn't seen any cases that even had $250,000 of pain and suffering and yet we were down here trying to get a cap.

DR. CONAWAY: Well, you raised a point that I was going to say. But since you raised the question of the cap and your advocacy, then when you worked for the insurance company and saying that caps were a wonderful thing, now that you are working for the Plaintiffs' bar, caps are a terrible thing. I just want to sort of note that for the record.

But let me say here, we have a -- I have a -- I guess a printout here from the Office of the AOC looking at medical malpractice cases tried to completion January 1, 2002 to 12/31/2002.

Now, you said in ten years you hadn't seen a million dollar case.

MR. WEISS: That was about the time frame, yes.

DR. CONAWAY: And by the way, do you think that case severity has anything to do with the rates? Are these disjointed factors here, that the severity of cases have no role to play in the --

MR. WEISS: The severity of cases has a big role to play --

DR. CONAWAY: Big role to play.

MR. WEISS: Yeah, the severity of the injury, number one, and plus the severity of the economic loss. You can't look at -- you cannot look at the same injury -- for example, if somebody -- if some doctor committed negligence on me and let's say I lost a leg, I could still do my job.

But if that happened to be Baryshnikov or that happened to be Doc Gooden, okay, the economic loss to that individual is a lot larger than the economic loss to me. So -- so --

DR. CONAWAY: I'm sorry, sir. I mean, is the economic -- look, you have an economic loss in the '70s and '80s and you were there. We have an economic loss now. We have, you know, all sorts of factors in place, you moving up, people are making more money. We're paying more in

premiums, getting a little bit more in the way of reimbursement over the last 20 years.

Are you saying that there's something different about either the kinds of injuries that happened in the '70s and '80s versus the kinds of injuries that happen here in the turn of the century --

MR. WEISS: No. I'm responding to your question that the -- that the value of the claim is based on the severity of the injury --

DR. CONAWAY: Sure.

MR. WEISS: -- and -- and the economic component.

DR. CONAWAY: All things being equal -- okay. So in answer to my question, then, are you saying that the claims are more severe now than they were then? Because I asked the question -- the question was the severity by itself, the severity in the '70s, the severity now that we're -- it's 2003, that has an impact or not --

MR. WEISS: In order to --

DR. CONAWAY: -- on the -- on what insurance companies --

MR. WEISS: In order to determine whether -- whether you are paying more money for the same injury, what you need to do is you need to go back and you need to look severity by severity.

And -- and when I was with MIIX, we coded claims severities one through nine, where one was emotional injury only, two, three, four, five were various escalating degrees of temporary injuries and six, seven, eight and nine were varying degrees of permanent injuries; the most serious of which was severity eight, which was quadriplegia and irreversible coma.

And what you need to do is you need to go and look at what the insurance company was paying on an average severity eight claim back in '85, '86, '87, '88, all the way up until what they're paying for it now.

DR. CONAWAY: My question was, does severity have an impact on rates? Does it or not? I mean, your opinion, you're an insurance adjuster. You're there. Does severity of claim --

MR. WEISS: Severity of injury, yes.

DR. CONAWAY: Severity of injury --

MR. WEISS: I don't understand what you mean by just severity.

DR. CONAWAY: Well, okay. The amounts paid out, I'm saying that if you pay out $200,000, it's less severe than you can pay out a million. And my question is, if you -- if most of your claims, as you said -- in fact, when I asked the question, you said -- you were down here searching for caps for -- at $250,000 and your payouts rarely approached that. Now, that was in

answer to my question -- your first response to my question about severity. So you said -- you didn't mention anything about injury. You mentioned payout, which was -- my question was based on payout.

Now, and -- do the payouts of insurance companies, my measure of severity -- if you want me to use another term, fine -- but severity in terms of what insurance companies have to pay out in claims, do you think that that has an impact on what they charge to physicians for insurance or not?

MR. WEISS: Losses are always a component.

DR. CONAWAY: Good. Now, we got that.

A VOICE: Happy now?

DR. CONAWAY: Yes. I am happy. It took a long time to get through, but I am happy now.

MR. WEISS: Go ahead.

DR. CONAWAY: Now, you mentioned back in the '70s and '80s, of course things were less -- you didn't have those million dollar claims. I am looking at, again, these -- this report from the AOC on the severity -- the amounts paid out of claims for the -- 2002.

And I just counted them up here and

I included the ones where there was a remitter for the claim, I count 14 of these million dollar claims in 2002 alone.

Now, you said in the '80s you didn't see any of these claims. We're seeing in 2002 14 of these things and this doesn't include the impact of these kinds of awards and the settlements that are ultimately there.

So is it fair to say, then, that at least as of 2002 and the data that we do have from the AOC -- I don't think they have an ax to grind in this thing -- that at least -- that these -- and your experience as an executive, that these 14 million dollar claims are arguably more severe than million dollar claims or the lack of them in -- counting for inflation and all of those things, do you feel this is a fairly severe -- that these payouts are fairly severe when we are talking about just the payouts irrespective of the injury?

MR. WEISS: I don't know whether you would consider $14 million in today's environment severe. I think you would have to look at total paid losses.

And the other thing that I just want to clarify is, yes. It's true we did not have a million dollar loss for our first ten years in business, but you have to understand we were not a mature insurance company.

We started writing doctors

February 1st, 1977. Claims didn't start coming in the door until '78, '79, '80. It took three, four, five, six years until those claims matured when we started to see settlements and verdicts. So it's not unusual that we didn't have million dollar verdicts in the 19 -- in -- from 1977 up through '87 because we were a new company.

DR. CONAWAY: Well, you raise another point about lag. And I know you talked about the California case. And of course those of us who support caps understand that there is going to be a lag in the -- in the effect that those caps are going to have in the market.

In the California case, one the -- you noted that the Court didn't pass, said that those caps pass muster until I guess 1988 then the insurance regulations, I think you said, went in 1989.

Of course we don't know what the effect -- we do know that the effects of the caps that were passed in, like, '75 and then given the okay by the Court that -- the impact of those things was going to be in the future.

But, anyway, you mentioned in one of your statements here that -- and it surprised me because I thought your earlier testimony said that the non-economic damages really weren't a very significant portion of the total -- I'm sorry. Oh,

I'm sorry. I'll try to speak slower. I lost my train of thought here. This -- My mind races that fast.

Yes. Yes. You mention that the non-economic damages was not a very important component of the insurance company's payout. I thought that was your earlier testimony. And, therefore, focusing on that didn't make very much sense.

But then you said here at the end on page ten -- and maybe you don't see the contradiction. I -- it just happened to strike me. In the second -- I guess the first full paragraph on that page, you said that should a cap on non-economic damages become a reality, it would have a devastating effect not only on early settlement but any settlement of meritorious cases.

Which suggests to me, that at least insofar as the insurance company's position that these non-economic damages are pretty important to them. And that -- and so I just wondered whether or not you think -- whether you want to reconsider your statement about the impact of non-economic damages on these payouts.

MR. WEISS: Well, I don't think that it's a contradiction at all.

DR. CONAWAY: Okay.

MR. WEISS: Basically the insurers have no data, no data to share with this Committee

to show that a cap of $250,000 would save one penny and no data exists anywhere in the United States, okay, to say that.

Okay. But the one thing that's true -- the one thing that's true and it's common sense, is that any time you restrict and restrain an insurer's liability and you say to this insurer, okay, why should -- why should an insurer go into negotiations on a case where economic loss is $500,000 and say, okay, I'll pay it to you, I'll pay you the 500,000, when their down side if they go to Court is 750? They have nothing to lose.

What they'll do is they'll go to court and they'll say, I'm not going to pay the 500 today. I'd rather wait three years, take it to court, my down side is only another 250. In the meantime, it's possible the jury will find no cause. It's possible they'll come back at $50,000. They have no down side. You'll never see a claim settlement, never.

DR. CONAWAY: But as to the physician of course who is paying for those claims, they might very well see a difference in what they're charged, no?

MR. WEISS: I feel for physicians. I feel for physicians. I ski with physicians. I go to hockey games with physicians. Physicians are my friends.

DR. CONAWAY: I see one every day when I go home.

MR. WEISS: The bottom line is that physicians are not -- physicians are not being put upon by the civil justice system. Physicians are being put upon by insurance companies. That's the bottom line.

DR. CONAWAY: And my last comment -- because I know other people probably have questions -- you mentioned actuaries and you want to bring an actuary in. I gather you didn't trust very much what they said when -- before, but I guess we're going to have to trust this fellow Burns that you are recommending to this -- to this Committee.

Thank you, Mr. Chairman and Madam Chairman.

MR. COHEN: Assemblyman Impreveduto.

MR. IMPREVEDUTO: Thank you. Mr. Weiss, I just really have one question and it's based on the $250,000 cap. You pretty much said that a $250,000 cap is not going to save a physician a penny in premiums. And I think you just recently said that there is no data anywhere in the United States that would show that it will save money in premiums.

We keep hearing about California and how they have saved money there. And please explain, again, if you will -- I know that you have

given your testimony, but please explain again why California is not an example of the $250,000 cap saving premium dollar.

MR. WEISS: Okay. And I agree with the distinguished Assemblyman that there is a lag. I agree with that. But there is not a 13-year lag. What happened was MICRA legislation was passed in California in 1975.

MR. IMPREVEDUTO: And MICRA was?

MR. WEISS: Medical insurance something reform act. And it basically had a $250,000 cap on non-economic loss. Following that premiums continued to go up in California.

I believe by 19 -- there were court fights about the Constitutionality of that legislation. The MICRA legislation was not upheld until 1985, found to be Constitutional. By that time already, even though the cap had been in place for ten years, okay, earned premiums in California had almost quadrupled. I think it was up 273 percent.

MR. IMPREVEDUTO: So it wasn't a matter of just going up because of inflation --

MR. WEISS: They were just going up. The cap hadn't had any effect whatsoever. Then the cap was held Constitutional in 1985 and from '85 to '88 premiums continued to go up another 47 percent. When you put that 47 percent on top of what had

already gone up, earned premiums in California were about 5.5 times what they were in 1975.

Then in 1988 California passed Proposition 103. Now, Proposition 103 was not passed specifically for medical malpractice insurance. It was passed for auto insurance because there was a big auto insurance crisis.

But it so happened that medical malpractice fell under the proposition and all of a sudden instead of insurers being able to make rates, use them, file them with the Department and wait for the Department to look at them, which may be today, may be tomorrow, may be never, meanwhile these rates are being used, instead California now had a system where you needed prior approval of rates.

Since that went into effect -- it also, by the way, mandated a 20 percent return of premiums. Since that went into effect, earned premiums in California -- and I don't know about 2002, 2003, but I do know that the total amount of earned premiums in California near 2001 was only 97.6 percent of what they had been in 1988. In other words, they fell 2.4 percent. Okay? Because of better regulation of the insurance companies. Not because of the cap.

MR. IMPREVEDUTO: So just one more time. What was the rate that the -- what were the premium rate increases in California bearing the

cap before Proposition --

MR. WEISS: I believe -- I believe it was -- I believe it was -- from 1975 to '85 it was 273 percent cumulative increase. I believe from '85 to '88, '85 was when the cap was found Constitutional, there was another 47 percent on top of that. I think that made the total increase about 450 percent.

MR. IMPREVEDUTO: Do you know what premiums went up in a non-capped state during that same period of time? Would you have any idea of knowing what -- in New Jersey, for instance, what was the rate of increase for that same period of time in premiums for malpractice insurance?

MR. WEISS: Well, it certainly wasn't -- it certainly -- I don't know. But I certainly don't believe that from -- that they were that magnitude. I mean, I know they have increased but I --

MR. IMPREVEDUTO: So basically what you're saying is that you have a 400 percent increase in California with a cap?

MR. WEISS: 450 percent.

MR. IMPREVEDUTO: 450 percent increase with a cap?

MR. WEISS: With a cap.

MR. IMPREVEDUTO: And we know that premiums have gone up throughout the United States,

particularly states that didn't have caps, but your feeling is it did not increase nearly that much?

MR. WEISS: I'll -- absolutely. Absolutely not that much.

MR. IMPREVEDUTO: So would you then -- from what you're saying, it would seem to me that the caps actually increase rates?

MR. WEISS: Well, I would say there's other -- I think you got to be careful -- you got to be careful when you -- you got to be careful --

(Many people speaking at once.)

DR. MUNOZ: Get me oxygen.

MR. WEISS: You know --

MR. IMPREVEDUTO: Well, it certainly seems logical that 450 percent -- 450 percent with a cap and not that much without a cap, it seems I'd rather not have the cap.

MR. WEISS: You have to be careful --

DR. MUNOZ: I can't breathe.

MR. WEISS: You have to be careful when you -- when you -- when you look at cause and effect relationships and try to say that two things that are happening at the same time are related because a lot of the times they're not related.

My first year in college I had an economics professor who said to me, one of the things that you have to know in economics, one of

the big things is cause and effect. And he says you got to be careful. You got to be very careful. And he gave the following example -- gave the following example.

He said let's say that the batting averages of the New York Yankees are going up at the same time the price of bananas is going up. He said one can easily conclude that eating bananas makes you hit better; therefore, the Yankees are eating a lot of bananas, driving the price of bananas up.

Now, everybody knows that that's ridiculous. You have to go and examine. There may be other things happening in California. The environment may be different in other ways that drove those premiums up. But the one thing we do know is that the cap didn't stabilize premiums. It didn't stabilize them. They went up despite the cap. That we know.

Why they went up? Hey, is it possible that the -- you know, medical malpractice is a -- is a funny business. There's one year that you get 1,000 claims and the 1,000 claims may all be severity two injuries. And then there's another year where you get 1,000 claims and they may all be quadriplegic injuries. And, therefore, the amount of money you pay out against that policy year is going to be significantly higher.

But does that mean there's a crisis? No. That meant you got more serious injuries. You've got to look at the underlying factors. You got to look at the underlying data. You can't just -- you can't just say that because two things happen at the same time that they're related.

MR. IMPREVEDUTO: The thing I find interesting and worrisome -- and I'm sure we'll hear other testimony -- was your discussion of MIIX and its Board of Directors early on, Mr. Maressa and the others. If this, in fact, is true, it's a very serious accusation that is being made.

MR. WEISS: Well, I'm not accusing -- I'm not saying that anybody did anything criminally wrong. What I'm saying is that they ran the company in a way that best suited the Medical Society. I'm not saying anybody stole any money.

MR. IMPREVEDUTO: No. I'm not going there. But -- well, in fact, if they -- if -- if, in fact, they ran the company as poorly as it seems here, that they cost hundreds of thousands -- hundreds of thousands of dollars of premiums to be paid that didn't have to be paid.

MR. WEISS: They caused the company to go out of business --

MR. IMPREVEDUTO: Well, that's a lot of money.

MR. WEISS: -- because they decided

they were going to go and write in states where they didn't know the environment. The environment, it was not as defense oriented as it was here in New Jersey. New Jersey is a very defense oriented state. New Jersey has full discovery.

There are no surprises when you go into court in New Jersey. Everybody knows what the Plaintiff's expert is going to say, what the Plaintiff is going to say, what the defense expert is going to say, what the Defendant is going to say because everybody has been deposed.

And then you go and you write in other states, where they don't depose experts. They don't depose Defendants. They don't do this. And you walk into court and you don't know what the other side is going to say.

MR. IMPREVEDUTO: When we look at -- when we look at the fact that someone is inflating their book of business with poor doctors -- or doctors that have poor records, just to show that they have X amount of dollars so they can go public with it and get more for their stock, that's a serious accusation.

MR. WEISS: Oh, I believe that happened. I believe that they basically went out to write -- Dan Goldberg told me that what he -- that he measured the success of a company in terms of market share. Before that we measured success

of the company in how many times we could declare dividends and give them back to the doctors.

MR. IMPREVEDUTO: You know, when you talk about not saying something criminal, I'm not so sure that that's not.

MR. WEISS: Well, I don't -- well --

MR. IMPREVEDUTO: Thank you. I have no further questions, Mr. Chairman.

MR. COHEN: Thank you.

Assemblyman Wolfe.

MR. WOLFE: Thank you. Eleven-and-a-half pages of single typed testimony is a lot. I tried to read and listen to what you were saying but at one time I think I heard you say, Mr. Weiss, that the problem seemed to be, according to you, the insurance companies. Is that correct?

MR. WEISS: I believe that.

MR. WOLFE: Now, are you referring to MIIX, Princeton, the reinsurance companies, or are you referring to Travelers, Aetna and those other companies? What --

MR. WEISS: I think every -- I think all the companies that write in New Jersey have to -- you have to look at their rate filings. You have to look at -- I don't know how diverse their rates are.

I don't know how, for example, each

company is rating orthopedists or OB/GYNs or neurosurgeons versus a family practitioner. That should be looked at.

I don't know how each company is -- what kind of credit each company is giving for anticipated investment income. I don't know how each company is determining first, second, third, fourth, fifth year claims made rates.

Somebody should look at it and see, you know -- and I believe it should be the Insurance Department. That's their responsibility, to make sure that rates in the State of New Jersey are being calculated properly.

MR. WOLFE: Let me ask you -- I have two more questions, Mr. Chairman. Are you aware or do you have access to records of any insurance companies relating to judgments or settlements paid for pain and suffering in excess of a million dollars?

MR. WEISS: For pain and suffering?

MR. WOLFE: Yes.

MR. WEISS: No. They don't break out that data.

MR. WOLFE: Why not?

MR. WEISS: Because they don't. All they do -- all they do is keep the total amount of the settlement.

MR. WOLFE: Okay. Should hospitals

be encouraged to create a system to detect medical errors?

MR. WEISS: Absolutely. Also, I believe -- and, again, I am not an expert in this, but I believe that when the -- when the National Practitioner Data Bank was created, one of the uses for that data bank was that hospitals were supposed to inquire of that data bank -- it might have been once every two years when undergoing the recertification process of their doctors. I don't know whether they're doing that. Well, they should be doing that if they're not.

MR. WOLFE: But are they subject to discovery, those records?

MR. WEISS: The National Practitioner Data Bank is not -- is not open for discovery. It's -- the use of it is very limited to specifically for -- like, I can't get information from it.

MR. WOLFE: Right.

MR. WEISS: I know hospitals are supposed to do it. I don't know who else has -- has access to it.

MR. WOLFE: Thank you.

MR. WEISS: You're welcome.

MR. COHEN: Assemblywoman Quigley.

MS. QUIGLEY: Thank you, Madam Chair. First I would like to say that the hospitals with which I am associated do during the

credentialing process.

But you made a recommendation, Mr. Weiss, that said that doctors should have a choice between claims made policies and occurrence policies and you explained why the choice is important, but I don't know the difference between them so could you briefly tell us --

MR. WEISS: Sure.

MS. QUIGLEY: -- what's the balance.

MR. WEISS: Sure. When you buy -- and they're both very aptly named. An occurrence policy covers you for when the occurrence took place. So if you have a policy for, let's say, from January 1st, 2003 to December 31st, 2003 and it's an occurrence policy and you treated a patient during that year and that patient turns around and she sues you for something you did that year, it covers you regardless of when that claim is filed.

Okay. So when you have that type of policy, when you retire, if you've had occurrence policies every year, you're covered. You don't have to worry about retiring because if you're not practicing, you're not generating any -- any more patient visits, you can't possibly generate any more malpractice and, therefore, you don't need any other policy.

A claims made policy does not cover you for when the claim occurred. It covers you for

when the claim is made.

MS. QUIGLEY: Is that what they call tail coverage?

MR. WEISS: Right. So what happens is, if you might have -- you have a claims made policy in the year 2003. Okay? If you buy another claims made policy, you are still practicing, you buy one in 2004, okay, and now a claim comes in in 2004 for something you did in 2003, you're covered because you have a policy.

When you stop buying the policy, unless you buy a tail, when claims are made after that, you're not covered. But in the pricing of the policy, okay -- and I'm going to use some very -- some numbers that I don't know if they are correct. I know when I did -- when I was there, first year claims made rates were about 20 or 25 percent. Now they -- I believe they may be 35 percent or something.

But basically what you are doing the first year is -- is because you are only going to take care of claims that are being presented this year, your premium is a lot less. So you may have a 30 percent first year, 50 percent second year, 65 percent third year, 85 percent fourth year. Then you're mature so you get 100 percent so you are actually paying an occurrence. And then when you retire, you buy the tail.

Now, the tail may cost you two times

your final year's premium but in the meantime you've saved 65 percent and 50 percent and -- and, you know, maybe 30 percent and maybe 20 percent. When you add all that up, it should come out to the same, minus whatever the insurance company may charge you for some lost investment income.

MS. QUIGLEY: Thank you.

MR. WEISS: You're welcome.

MR. COHEN: Assemblyman McKeon.

MR. McKEON: Thank you very much, Mr. Chairman. Thank you for your testimony. I just -- you know, as everyone who testifies, there's a lot of subjectivity to what they have to say so I'd like to get to some of the objective things that I think are important to this Committee's work.

Objectively, under any circumstances, MIIX, when it was a reciprocal, before it went for profit, was a very successful company. Would that be fair to say?

MR. WEISS: Extremely successful, yes.

MR. McKEON: And could you just expound upon what a reciprocal is and how that operates.

MR. WEISS: Sure. A reciprocal insurance company is similar to a mutual in that a reciprocal insurance company, just like a mutual,

are owned by its insureds, owned by its insureds. So MIIX was owned by its doctors.

MR. McKEON: And --

MR. WEISS: Okay. The difference between a reciprocal and a mutual is when a mutual declares a dividend, the mutual goes to the policyholders as of the date that the dividend was declared, okay, the insureds.

In a reciprocal the dividend, when it's declared, goes back to the doctors who were the ones responsible for creating the profit that led to the dividend.

So if in 19 -- so if in 1984 or whenever it was we declared our first dividend against our first year in business, 1977, that dividend went back to the doctors who were insured with us in 1977.

MR. McKEON: And there's no pressure in a reciprocal to give a dividend, so to speak, as if the company has a particular year, with the unpredictability of losses, those dollars can remain in the company to support the losses and see the premiums don't go up?

MR. WEISS: Actually -- actually, the way MIIX was run was that each policy year stood on its own. That if -- because you were a reciprocal it was unfair to ask doctors who created a profit in one year to pick up the slack for other doctors that created a deficit in another year.

Okay. That's why the company had a surplus. The surplus covered years when you -- when you had losses that were -- but when you had -- you wanted to reward the doctors in those years when there was a profit.

MR. McKEON: So -- and thank you for clarifying that in my and the Committee's mind, but the bottom line is with -- that reciprocal way of doing business had proven for a long term to be very, very successful in New Jersey in this environment?

MR. WEISS: Yes.

MR. McKEON: Okay. There are a number of reciprocals. MIIX I guess now has returned and, again, is one as MIIX Advantage and a number of other reciprocals that are popping up in New Jersey. What you're -- can you predict with any reasonable certainty how long it will take those companies to come in to -- to be capitalized to the extent of being able to absorb the market?

MR. WEISS: I couldn't guess. You know, the Insurance Department has requirements for capitalization of these companies. You know, are those requirements sufficient? I don't know. I couldn't say.

MR. McKEON: But the bottom line is when they are capitalized correctly and can absorb the doctors, then that reciprocal, based upon the experience in the state, should be a successful way

to maintain premiums?

MR. WEISS: Yes. But the -- the -- it should be pointed out, however, that if you start eating into your surplus and you eat into your surplus to such an extent, the Insurance Department may step in and say you can't write any more business because you have to maintain a certain level of surplus to the premium that you write. And if your surplus starts going down, down down, down, down, the Insurance Department might step in and say well, you can't write any more business.

MR. McKEON: Well, I guess my premise is -- and using, ironically, MIIX as the example -- that to allow these reciprocals to grow, that we would in the long term be in the position to, again, create a good environment for the insurance market for doctors in the state without having to get into any severe limitations into people's rights?

MR. WEISS: Well, any time you eliminate the profit motive and the money is going back to the reciprocal, to the doctors, you know, it's -- it's -- it's a more conducive environment to success.

The bottom line is that if you had a newly formed reciprocal in the state and that reciprocal was being run the same way MIIX's

reciprocal was run after Vince Maressa and Dan Goldberg took over, there's no way that reciprocal is going to be successful. Okay?

It all goes back to management. It goes back to having insurance professionals run the insurance business and running it like a business.

MR. McKEON: Okay. Thank you very much.

MR. WEISS: You're welcome.

MR. COHEN: Dr. Munoz?

DR. MUNOZ: Thank you, Mr. Chairman. I first want to thank both Committee Chairs, Assemblywoman Weinberg and Cohen, for allowing me to participate. This is obviously a very important issue and I know all of us are interested in solving it.

The bad news is New Jersey in the last year and this year is not producing any obstetricians. I work at the medical school in Newark and last year we had one student go into obstetrics. This year we will probably have none.

So there is a lag of course, you know, in training doctors and we know about that lag. But I am very concerned that if this trend continues, you could argue about a crisis today, but, you know, we can't go on not producing obstetricians.

So I simply make a statement that we can use our very own state as an example of what's

happening. And in all honesty, it's not a growing concern. If somebody showed me a premium price of 190,000 for an obstetrician, add that to a medical student's loan, they would have to work for nothing so it's just impossible for them to do that specialty.

Going back to what you said about the Insurance Department, I am not an expert in insurance but I am concerned that here we are in October of 2003 and we are asking questions about an insurance area and we have government entities that oversee that area. And I would really encourage that, you know, we try to get some data.

Now, speaking of data, there is actually one agency in New Jersey, the Board of Medical Examiners, I think Assemblyman Cohen has heard me say this before, that actually will give us some real simple data.

And from 1990 Senator Dick Cody passed a bill called the Cody Bill that created a practitioner review panel and by law every year we had to collect all the cases in simple tally, we can say how many cases there were and what the payout was for those cases.

And it simply added up. So we could add the Division of Consumer Affairs that overseas the Board of Medical Examiners and then we know these individuals and at least get the count to say

from 1990 to 2000, you know, payouts have improved or increased or haven't increased. And I know that we sometimes argue about that point.

Another issue -- and this is actually a question I have for you relative to the caps. I'm reading your statement and I have to, you know, have a little respite there when you talked about caps might actually be bad. Now, I am a surgeon. I operate on people. And I am using your figure up at -- maybe helps -- maybe contributes to 10 percent. We do know that this is a multifaceted problem, so let's say it's 4 percent or 6 percent.

Now, if I were operating on one of your family tonight and I come out to the waiting room and say, you know, there's four things we want to do for your kid and this is going to help 20 percent and this is going to help whatchamacallit and this is only going to help 6 percent so I'm not going to do it, you would get really excited. I can tell you that. You know what I mean? I mean, you're not going to try to save the life for only a 6 percent chance? So -- and not to debate it. You know what I mean?

I think there has been a lot of data out there of whether it helps or not. Of course I can argue that it probably does. But from your statement simply saying that, you know, if it's net positive, okay -- and Assemblyman Impreveduto was

talking maybe it's net negative when you actually pass the caps. And I don't think -- it just doesn't pass the sniff test.

Let me do -- the last comment is this. I sit on a Commission --

MR. COHEN: Is there a question?

DR. MUNOZ: Yeah. Well, actually, there was a question.

MR. WEISS: I certainly --

DR. MUNOZ: But wait. Wait. Wait. But I answered it myself.

MR. WEISS: Well, I certainly --

DR. MUNOZ: No. No. No. I'm finishing. I'll be brief. I'll be brief.

MR. IMPREVEDUTO: Would you like to testify?

MR. WEISS: Certainly -- certainly --

MR. COHEN: That is not a problem --

(Many people speaking at once.)

MR. WEISS: I would like to respond --

DR. MUNOZ: He wants to respond. Go ahead.

MR. WEISS: No. I would like to respond -- I would like to respond to the Assemblyman because I think that the example -- the analogy you gave is not exactly the same. Because

when you go out to a patient and you say well, this is only going to help your son 6 percent, okay, there's no down side to that. Of course they're going to take it.

But here what you're saying is, if it only helps 4 percent, on the other side, you're taking rights away from people, seriously injured people. People who -- people who -- let's take your OB/GYNs who might have -- who might not have -- who might have waited four-and-a-half hours while there was fetal distress.

And now you have a neurologically impaired infant that is going to have a normal lifespan and -- and is going to live 80 years and now you're saying well, you can only recover -- see, there's a down side here. The down side is taking rights away from people --

DR. MUNOZ: And, actually, you're a great lead in, you know. We got to do a routine together. Let me just now -- my last closing statement is this --

MR. WEISS: I'm available.

DR. MUNOZ: -- closing statement is this. This gentleman says that there's a down side. You're not kidding there's a down side. Let me tell you the down side, one of the issues.

I sit on a Commission that advises the President of the United States and the Congress about health delivery called Health Disparities,

that's Afro-Americans, Hispanics, Indian Americans, which are out West or in New Jersey, and Pacific Islanders, which are Hawaii, if you go there, and it's about what their health is like.

Last week we met two days in Washington. One of the issues that came up was if, in fact, we can't solve this problem -- I won't call it a crisis, a problem -- in fact, the urban kids of the world and all the other areas that have been under served -- that's the language we use in medicine when doctors don't want to work in an area -- they will start to see access. Can they get an obstetrician? Can they get a neurosurgeon effectively?

So that is the big down side that is going to be reported -- it's a public meeting -- to the Congress and to the President. And I simply tell this body because of the fact, I mean, this is not for free if we don't do something.

Thank you. Thank you, Mr. Chair.

MR. COHEN: I guess we'll ask the question later. Any other members of the Committee that haven't gone yet?

Assemblyman Russo?

MR. RUSSO: Thank you. Mr. Chairman, I wanted to ask you first, when I went through the witness letters last night, I saw the first one was Mr. Weiss and it didn't have a title. In fact, I think it was the only one out of

the 30 letters -- I'm not saying -- there were these 30 letters we were given of all the people who received requests to testify.

And it was interesting because I had never met Mr. Weiss or heard of him and I noticed last night that was the only one that wasn't either a health care provider or whatever with a title or an attorney. And I was wondering, either through you or to the staff, what was the basis of having Mr. Weiss here today and what was the history that he would be the first witness that we would call, whether pro or con?

MR. COHEN: I believe Mr. Weiss has a wealth of information. You wouldn't have been here. You weren't on the Committee.

MR. RUSSO: No. He testified before the Committee before?

MR. COHEN: He testified before the Committee before and the information and material he -- he had provided was not only relevant but it was also an individual that had been in the business for all these years and in particular the prior company, MIIX, where we've had -- where problems are acknowledged by virtue of their business failure that precipitated a large problem.

He has a wealth of information in a multitude of areas, specifically with the issues we're looking to address, which is med mal

insurance practices and business, how the company works, how they make a decision, how they go about rating, what kind of factors are put in place.

He is extremely knowledgeable I found and I wanted him to go first to provide a background to the types of issues that were involved. I read his testimony. He has also testified in Pennsylvania as part of a working group acting on behalf of Governor Rendell, trying to resolve a problem there.

MR. RUSSO: Thank you.

Another question before I ask --

MR. COHEN: Is that next question to me? I want to make sure I have counsel --

MR. RUSSO: No. The other question I was wondering -- when I listened to his testimony, it's really more for the Committee. I saw the list today of the four or five witnesses. I assume the Commissioner is not going to testify.

Has the Commissioner testified before -- I don't mean exactly this group, but I know you had previous meetings before at AR 50. Have you had the Commissioner come in?

MR. COHEN: The Commissioner hasn't come in. This is going to be one of several meetings. This one session does not complete dispositive. There is information that witnesses have that more than likely I am going to want back just because of time limitations that we have in

terms of testifying and how long and I don't know if everyone can pay attention. So this is just one of several hearings.

MR. RUSSO: Okay. Thank you. Can I ask several questions of --

MR. COHEN: Absolutely.

MR. RUSSO: Thanks. Mr. Weiss, in your report on page two you talked about that you have an extensive background in the industry and you talked about -- in fact, it says here, you don't believe that the pain and suffering or non-economic damages have ever reached 10 percent of total loss payouts.

My question would be, how do you arrive at that? Because I thought you said the insurance industry doesn't have that information.

MR. WEISS: That's my gut feeling.

DR. CONAWAY: Gut --

MR. WEISS: My gut feeling is that -- I spent -- I spent -- I spent almost 15 years at a medical malpractice insurance company. During those 15 years, okay, year after year after year our average claim payment for a lot of years was under $100,000. It then was a little over $100,000. The median claims payment was under 100,000, then a little bit over 100,000.

There was no basis -- there was no basis on which to say that a cap would save any

money. Okay? I've heard figures thrown out by the medical community, by the insurance community that as much as 70 percent of the losses is non-economic. Okay?

I've been in the business 28 years. If you asked me to take a guess, I'd say it's less than 10 percent. Okay? Can I prove it's less than 10 percent? No. Can they prove it's 70 percent? No. Can they prove it's 15 percent? No. Nobody can. Okay?

But the bottom line -- the bottom line is that if you were to sit down and take a look at individual cases, okay -- and I'm not talking about verdicts because verdicts are not paid. Verdicts aren't paid; settlements are paid.

So when you get a verdict of $3 million and the doctor's coverage is only $1 million and that's all that's paid, okay, don't go about -- on the basis of a $3 million verdict. Go on the basis of a million dollar -- a million dollar settlement.

I've heard the insurance companies take a $3 million verdict in which the jury has said there was a million dollars for economic loss and $2 million for pain and suffering, then settle the case for a million dollars and insist that two-thirds of that million dollars was pain and suffering.

Well, that's ludicrous. The million

dollars covered the million dollars of economic loss. Forget about the $3 million verdict. They didn't pay it. What you want to look at is what they paid and what was that for.

MR. RUSSO: I believe you've stated that you've been working for Second Opinion for about the last 11 years?

MR. WEISS: That's correct.

MR. RUSSO: Do you still work for them?

MR. WEISS: Yes. I do.

MR. RUSSO: Okay. So would it be fair to say that you don't have access to the insurance company statistics, which I guess don't even really exist for the last 11 years?

MR. WEISS: No. I don't.

MR. RUSSO: You talked about California. And when I ask you these questions, understand that many of us, again, we hear testimony from both sides and we read the literature --

MR. WEISS: Sure.

MR. RUSSO: You talked about California. Now, I believe the cap in California was enacted in '75?

MR. WEISS: Correct.

MR. RUSSO: Okay. What would be, in your opinion, the equivalent of a $250,000 cap in

1975 in today's dollars?

MR. WEISS: I think you'd have to look at the -- you know, the inflation figures and make some judgment on what's happened to the cost of living from 1975 to 2003.

The cap in California has never been adjusted. I know that there's been people out there who are fighting to get it up to 350,000 and to get it up higher, but I don't know what it would be in today's dollars.

MR. RUSSO: No. I don't either. I would agree with your analysis, too. I would think it would certainly be in excess of $250,000 in today's dollars, so.

MR. WEISS: Sure.

MR. RUSSO: The reason I ask you that is because in some of the literature it seems to indicate that there have been increases in the California premiums for medical malpractice --

MR. WEISS: Correct.

MR. RUSSO: -- since 1975, but that the opinion was that the increases had been less rapid than nationally and there has been attribution to the statute that went into effect. Now, I know your position I believe was the opposite of that. You thought that MICRA did --

MR. WEISS: I don't have that data but I would -- you know, certainly you can look at that, but earned premiums in California were

five-and-a-half times in 2001 what they were -- the earned premiums were five-and-a-half times what they were in 1975.

That's huge. It went from 100 some odd million dollars to 600 some odd million dollars. Almost $700 million. I mean, that's -- it would be hard for me to believe that that's -- that that -- that that has happened to that extent in other states.

MR. RUSSO: I was going to say when you compare that, are you comparing that with the national increase? Because that's nearly a 30-year period.

MR. WEISS: Yeah. I -- like I said, I don't know what's really happened in other states.

MR. RUSSO: I mean, I would think we would agree that over a period of time of 20 or 30 years, all things being equal, whether it's for accountants or lawyers or doctors, you would expect increases. The question is, what is the rate of increase?

MR. WEISS: Yeah. You would expect the increases in premiums that track increases in losses and increases in losses should track, for example, are you going to have an inflationary impact on economics? Sure.

If somebody is earning more money this year than they earned last year because they

got a 5 percent hike in salary or the fact that the cost of medical care went up, certainly the economic component -- the economic component of the loss is going to be higher in 2003 than it was in 1990 or 1980 or 1975. So there is an inflationary -- a built-in inflationary impact on losses on the economic side.

MR. RUSSO: You testified against the enactment of caps.

MR. WEISS: Correct.

MR. RUSSO: Have you ever considered the factor of, in essence, jury verdicts? I heard you mention that. Now, one of the things we hear are that juries are not competent to handle these type of matters and that I believe the doctors point to the fact that runaway juries sometimes enter verdicts that are way out of kilter.

Have you, from the insurance perspective, when you were -- from the insurance perspective, did you ever consider or did you ever have instance to deal with states that did not use juries in medical malpractice cases?

MR. WEISS: No. I didn't.

MR. RUSSO: So as far as you know they all do?

MR. WEISS: I couldn't tell you what each and every one does but I would assume that

most of them use juries.

MR. RUSSO: Did you ever -- from when you were here as an insurance rep is what I'm talking about. Did you ever have that issue where you were -- I think you said you lobbied for tort reform for years?

MR. WEISS: Correct.

MR. RUSSO: Was part of that -- and I think in your testimony you talk about the Affidavit of Merit passed in '95 in New Jersey.

MR. WEISS: Correct.

MR. RUSSO: Did you ever deal with the issue of judges hearing these cases, the ones that are not settled obviously, rather than having juries?

MR. WEISS: The only difference that we -- the only change we wanted to make is we thought we could improve the system if we could get -- if we could get the small cases out of the system and then be able to put our resources on the more severe injuries.

So we had said -- we had put a bill up that actually passed that said that if the assignment judge had thought that the case was worth less than $50,000, it would go to arbitration. But that was found unconstitutional. That never came into being.

So we tried to do things to speed the system up, okay, but we never looked at what

would happen -- what would happen if we had no jury trials.

I would say one thing. Juries -- juries, for the most part, do a decent job. Are there cases where juries -- are there cases where juries find liability where there's not? Yes. Are there times they don't find liability where there is? Yes.

We offered -- we offered $4 million on a case the last day of trial, 4 million, because we had three doctors in the case, all of which we thought was liable. Three -- three doctors we offered $4 million and the jury came back no cause. We won. Okay? Now, you could never tell what a jury is going to do.

The bottom line is that both sides, the Plaintiffs side and the defense side, gets the best experts they can to explain to the jury, hopefully in layman's terms -- not in big medical terminology, in layman's terms, what happened during the treatment, why it was negligence or why it wasn't negligence. Okay? Why it caused the damage or it didn't cause the damages. What the damages are. Okay? And then the juries make a decision.

Would it be better -- would it be better with just a judge? Your judge is going to hear the same testimony. It's my belief -- it's my

belief that when jurors go to the jury box, they go to the jury box with a bias on -- on behalf of the physician.

And I say this because I sat in on many, many malpractice trials. Okay. I've talked to many, many jurors. Every juror has their own personal doctor and they say to themselves well, Dr. Smith wouldn't make that mistake. Why would I expect this doctor would make the mistake?

The burden really is on the Plaintiff, okay, to persuade that jury, through medical evidence, that this doctor was negligent. Are they successful? They're successful less than -- less than 20 percent of the time.

MR. RUSSO: You've argued strenuously today against caps. In the '80s, when you testified here, what would your testimony have been for them?

MR. WEISS: My testimony -- that's a good question. I don't know.

MR. RUSSO: Well, I don't mean to be facetious --

MR. WEISS: No. I understand -- I understand where you're coming from.

MR. RUSSO: -- because you make a very forceful presentation. That's why I asked the Chairman what your background was --

MR. WEISS: What we did -- the truth was, we put together a package of six or eight

bills -- a couple of which might not have been enumerated here. We put together a package of six or eight bills and as you do in any negotiations with anybody, the goal was that we have six or seven things in the package that were throwaways, that we didn't care about.

So that when the trial lawyers came in and argued strenuously that you shouldn't change the statute of limitations, we would then go and say okay. We'll give that one up. Okay. What we wanted was collateral source and we wanted a change -- a more equitable change to the joint and several liability doctrine and we got it. Okay?

The rest of it is -- was just a negotiating technique. Put all of these packages together, throw it on the table and maybe we'll get two out of eight or three out of eight. I mean, there's no secret to it.

We held -- we held focus groups. We held surveys. We asked the general public what do you think of doctors? What do you think of lawyers? What do you think of insurance companies? And we found out that the general public thought most highly of doctors, then of lawyers, then of insurance companies.

So we said okay. The way to do this fight is to keep the insurance companies out of it and make this a lawyer versus doctor fight. That's

what we did. Make it a lawyer versus doctor fight. Get the doctors all steamed up. Tell them the premiums are going up because of losses. Okay. Because of losses raise their premiums.

Drive OB/GYNs to the brink of giving up delivering babies. Okay. And have them come to the legislature and have these -- these -- these big demonstrations.

And because of that the -- the trial lawyers have to respond because they're trying to protect the rights of these -- these people and it becomes a battle of lawyers against doctors and it's all staged. We did it. It's all staged.

MR. RUSSO: Well, with that, you know, you're not sure what to believe now. I mean -- but with that -- and I'm trying not to --

MR. COHEN: It certainly was a good reply.

MR. RUSSO: So I guess in the '80s he was for caps. Now he's against it.

MR. COHEN: I think you should --

MR. WEISS: If I wasn't for caps -- if it wasn't for caps in the 1980s, I would have been fired.

MR. BATEMAN: As it would be now if you --

MR. COHEN: Follow-up question, Assemblyman?

MR. RUSSO: I don't think we need

any. Okay. Thank you. Thank you.

MR. COHEN: I believe Chairwoman Weinberg has a question and then we will go next to Dr. Conaway.

MS. WEINBERG: Yeah. Well, more of a comment. I would hope that this Committee and the testimony that we hear from witnesses will deal less with gut instincts and a little bit more with facts.

Mr. Weiss, I appreciate the facts that you did give us in your testimony. It's out of questioning that we seem to have members who have already made up their minds and then want to elicit answers to that.

I, for one, have not. I believe in this Committee structure and I believe that we need to get the information and I am looking forward to hearing from the insurance companies.

And I would just like to point out one thing. I want to go to the GAO report, the federal government's own general accounting report. We get lots of questions about economic versus non-economic damages. And, Mr. Weiss, as you said, nobody in the United States of America knows what the breakdown is between economic and non-economic damages except perhaps the insurance companies. I am hoping that they are going to be forthcoming to share that information with us.

And I want to read one -- a couple of sentences from that GAO report, which is dated June of 2003. And they say -- this is the federal government's own report: Interested parties debate the impact of these various -- that these various measures may have had on premium rates.

However -- however, a lack of comprehensive data on losses at the insurance company level make measuring the precise impact of the measures impossible. As noted earlier, in the vast majority of cases existing data do not categorize losses on claims as economic or non-economic damages. So it is not possible to quantify the impact of a cap on non-economic damages on a insurer's losses.

Now, that is not from a report of anybody who had a vested interest. This is from the General Accounting Office of the United States. I would hope, ladies and gentlemen, that we can get to gathering the data that we need.

I think Mr. Weiss gave us an excellent introduction. I would like to hear from the Administrative Office of the Courts, who can give us more information about jury awards. And then I'd like to hear from the insurance companies, who perhaps can answer some of the questions that were raised in this report. Thank you.

MR. COHEN: Assemblyman Dr. Herbert Conaway.

DR. CONAWAY: Just a segue about the government and its truthfulness -- but rather I'll leave that be, but the question of the lack of data. And I agree that we have -- I think one of the important things that we have heard over this past hour or so is that we don't have all the data that we need, but we do have empirical evidence that I think is very weighty.

And Assemblyman Russo I think -- I don't know if -- well, I know he was cogent and I think his point was that there -- that we had to look at rates over time, I think was one of the points that you were making. I have a chart here looking at national data and it showed the difference between California as apart from the rest of the country.

And it runs from 1976 to 1999 and it shows that over that period that you had an increase in premium of 168 percent, while the rest of the country went up 420 percent.

Now, I grant you that we don't have all the data but what do we know about what California did and what their experience has been over time?

They did do tighter insurance reform, which I think there is broad agreement on this Committee that we need to do that. They did tighten up -- they did do a lot of things on

collateral source and all the other things that are in that package but it also included caps.

Now, I will grant that we don't know perhaps what the various weights of the various things that were done but for someone who practices medicine and has seen his own rates go up 20 percent and know the rate increases of my colleagues and see the dislocations that it is causing, if we are going to make a judgment based on empirical data that is imprecise and inaccurate and incomplete and perhaps we'll never know all we need to know, it seems to me that we ought to be making ourselves more like a state which has seen a rate of increase over that period of just 168 percent versus everybody else that has seen their rates go up by 420 percent. So I think there are -- there is empirical data that should guide our deliberations in this body.

Now, my question was whether or not you think that the cases and severity -- the million dollar cases, people know about them. And, sure, they're not paid out, but you want to argue between one and $3 million, that's fine. A million dollars, in my view, is still a lot of money.

Do you think that those kinds of payouts, a million or more, that they have some kind of an impact on the -- on the kinds of settlements that are rendered and those settlements of -- those settlements perhaps have gone up over

time than when you were there in the '70s and '80s?

We don't have settlement data before us, but I think that -- as a physician sitting there and I know that my colleague just got hit with a million bucks or somebody -- reading in the magazine that somebody else got another large settlement.

Do you think that that affects my behavior, as a physician, in assessing the likely outcome of the case or the insurance company assessing their risk? Do you think those jury awards have some, I think, upward impact on the kind of settlements that are rendered?

And I think there's an impact -- well, and the secondary question would be the payouts. There is a relationship between the payouts, I thought you said, and the amount of premiums charged.

MR. WEISS: Oh, losses are always a component of premiums. I mean, you can't get away from taking into account losses. Okay. Each case is looked at -- the insurance company looks at each case individually. Okay. They look at each case individually. The fact that they lost a million dollars on a case in -- in -- you know, really doesn't affect the behavior on another case.

Let me -- let me -- let me back off that a minute. Okay? This is the way it works.

Okay. New Jersey has 21 counties. Each county -- each venue is different. Each venue is different. Each venue is different from the standpoint that the jury makeup is different. You have liberal counties. You got conservative counties. Insurance companies take that into account.

So, for example, there are cases that we would take to trial in Somerset County, in Ocean County that we would never try in Essex County or Camden County. You just wouldn't try them there because we know that the likelihood is that the -- that the jurors are more liberal, the jurors are going to come back on behalf of the Plaintiff.

Okay. If we got hit with a huge verdict, let's say, on a particular type of case in Newark, would we think hard about a similar kind of case in Newark? Yes. Would it change our behavior on that same kind of case in Somerset County? No. Okay.

DR. CONAWAY: Well, my question was --

MR. WEISS: You can't make a generalization.

DR. CONAWAY: Well, my -- well, I -- you're generalizing about something that was somewhat removed from my question. My question was, the severity of the cases in jury verdicts -- because all we really have now -- because we are

talking about the fact that we don't have complete data and we are trying to get some of this -- these judgments that are -- these summary judgments and settlements and things -- rather, settlement data that we don't have. Excuse me.

My point is, does the jury award -- there are 14 cases here in '02 which were a million dollars or more. Now, do you think that the -- that those awards have an impact on what people are willing to settle for? That has an upward pressure on the settlements that -- that -- that are agreed to between the parties?

MR. WEISS: I think that there are lots of factors. Is that one factor? Yeah. I would agree that that's a factor that's taken into account with -- with hundreds of other factors to make a decision as to whether they're going to go into negotiations to settle a case and how much they're willing to settle it for.

DR. CONAWAY: So it might -- one might say that if -- that if insurance companies, at least insofar as the data that we have, are seeing higher payouts and the jury thinks -- the data that we do have that that --

MR. WEISS: I wouldn't make that statement.

DR. CONAWAY: You wouldn't make that statement. You don't -- well --

MR. WEISS: It's a fact --

DR. CONAWAY: -- you disagree with that --

MR. WEISS: It's a factor that they take into account.

DR. CONAWAY: Okay. It's a factor, but it's an upward factor. Is it not? Is --

MR. WEISS: Were there more million dollar verdicts last year than there were the year before? I don't know. If there were -- if there were, then that's one factor they would take into account. Absolutely. But it's only one of many.

DR. CONAWAY: More money means higher premiums?

MR. WEISS: Excuse me?

DR. CONAWAY: More money paid out by insurance companies means higher premiums generally? I mean --

MR. WEISS: I said that -- I said that a number of times, losses are part of premiums. Yes.

MR. IMPREVEDUTO: Mr. Chairman.

MR. COHEN: This is what we're going to suggest to do. We're going to break for lunch 45 minutes. We'll come back around 1:30, 1:35. Think about what you want to ask Mr. Weiss. You will return to the stand.

(Lunch recess is taken.)

C E R T I F I C A T E

I, RHEA C. VILLANTI, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, do hereby certify that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place and on the date hereinbefore set forth.

I do further certify that I am neither of counsel nor attorney for any party in this action and that I am not interested in the event nor outcome of this litigation.

_____

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NEW JERSEY STATE LEGISLATURE
SPECIAL COMMITTEE OF THE GENERAL ASSEMBLY TO INVESTIGATE MEDICAL MALPRACTICE INSURER BUSINESS PRACTICES

IN RE:

MEMBERS OF THE SPECIAL COMMITTEE OF THE GENERAL ASSEMBLY TO INVESTIGATE MEDICAL MALPRACTICE INSURER BUSINESS PRACTICES

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State House Annex
Committee Room 11
4th Floor
Trenton, New Jersey
October 2, 2003
10:00 a.m.

B E F O R E:

ASSEMBLYMAN NEIL M. COHEN, Co-Vice Chair

ASSEMBLYWOMAN LORETTA WEINBERG, Co-Vice Chair

ASSEMBLYMAN HERB CONAWAY, M.D., Vice Chairman

ASSEMBLYMAN JACK CONNORS

ASSEMBLYMAN ANTHONY IMPREVEDUTO

ASSEMBLYMAN JOHN F. MC KEON

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ASSEMBLYMAN CHRISTOPHER "KIP" BATEMAN

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ASSEMBLYMAN DAVID C. RUSSO

ASSEMBLYMAN DAVID W. WOLFE

MARY C. BEAUMONT
Office of Legislative Services
Committee Aide

DAVID PRICE
Office of Legislative Services
Committee Aide

T R A N S C R I P T of the stenographic notes of the proceedings in the above-entitled matter, as taken by and before KATHLEEN F. SIGLE, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, held at the State House Annex, Committee Room 11, 4th Floor, Trenton, New Jersey, on Thursday, October 2, 2003, commencing at approximately 1:45 p.m. in the afternoon, pursuant to notice.

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CO-VICE CHAIR COHEN: Special Committee will resume. Mr. Weiss. Any committee members continue. I mean, just continue.

MR. IMPREVEDUTO: I am just continuing where we left off.

CO-VICE CHAIR COHEN: Yes, sorry.

MR. IMPREVEDUTO: I want to come back, not to belabor the issue, right before we broke we talked about -- well, in my previous questioning, we talked about the 450 percent increase over the 19, whatever it was, '77 to 85 and then Assemblyman Conaway came up with another number that showed almost the reverse, that the rest of the country went up 400 and some odd percent and California only had 168 percent. The thing that confuses me is that whose numbers are right, where do the numbers come from, I mean, how do I know your numbers and how do we know her -- I know where your numbers came from, we got to come to some kind of a conclusion that somebody's numbers have to be a certified set of numbers that we can go by.

MR. WEISS: That's correct, and that's one of jobs is to get data and dig into the number and find out. Go to the California Insurance Department and get the -- get the numbers, don't -- don't listen to my numbers, don't listen to any numbers, go get the numbers
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yourself and see what the real numbers are, make decisions based on real data.

MR. IMPREVEDUTO: Mr. Chairman, I suspect

we'll do that?

CO-VICE CHAIR COHEN: I'll go. Loretta is going to be going out next week.

MR. IMPREVEDUTO: Coming back to what you think we need to do, we know what the problem is now and obviously, there is a problem, how do we fix it in your opinion? How do you fix the problem moving forward?

MR. WEISS: I think the -- the biggest biggest thing you have to do is you got to have some insurance reform in the state. You have to make New Jersey a pre-approval of rate state, so that the -- that the filings can be -- can be scrutinized by the insurance department and hopefully, actuaries that work for the insurance department that understand medical malpractice understand professional liability, that it's a long tail line of insurance, it's not like writing other insurance, okay. To look at the assumptions that it made in these rate filings, the assumptions of -- and a lot of the assumptions that are made when you're -- when you're holding money for 15 years, how much investment am I going to make in holding money for 15 years, well, what portion of the money am I going to hold each year over those 15 years, that's an estimate, how much --- what are the interest rates going to be, that's an estimate, okay. What you have to do is you got to get these actuaries to say are these reasonable estimates, okay, are the trending techniques being used statistically sound, is the data going into it, into these -- into this trendings statistically correct, are

these accurate numbers. One of the problems in making rates for medical malpractice was such a long tail line of insurance, the -- the current years data, current year, maybe last year, there's not enough data available, claims haven't coming in, haven't come in, they haven't been been payments made, so you can't use 20030, you can't use 2002, maybe you can't even use 2001, so you go back to 2000 and you're back up 10 years and now you trend things that are happening from 1990 to 2000 to make a rate for 2004, okay. It's not an exact science. It's not an exact science. What happens is because you're using so many years worth of data the things that are happening in the current years may not be carrying enough weight, so the insurance department should make sure that if the last five years or two years or whatever it is has seen decreases in numbers of claims. Has that been taken into account in rate making, okay. You can't just let insurance companies

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have actuaries who make rates, send a report into the insurance department and put those rates into effect without -- without pre-approval. That's the biggest thing you can do.

MR. IMPREVEDUTO: I guess my question was, if there were going to be caps, and that's a big uncertainty, if there were going to be caps in New Jersey and, in fact, I guess, California did not do this, but would be something that I think is going to be caps we have to look at, would be some kind of escalator

in that cap. For instance, California putting their $250,000.00 cap in 1980 something --

MR. WEISS: '75.

MR. IMPREVEDUTO: '75. So, Between '75 and 2003 it's still a $250,000.00 cap, well, it's not the same $250,000.00, obviously?

MR. WEISS: That's correct.

MR. IMPREVEDUTO: So that 250 is in today's dollars maybe 125, I don't know what the number might be, so certainly that's not a fair count, so if there were a cap I suspect you would recommend that you do an escalated?

MR. WEISS: I wouldn't recommend any cap.

MR. IMPREVEDUTO: Thank you.

CO-VICE CHAIR COHEN: Assemblyman Bateman.

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MR. BATEMAN: Mr. Chairman, it's not so much a question of the witness, I just -- unfortunately I have a T.V. taping at 3:00 which was scheduled before this meeting, procedurally I know that we organized today, do you know what your game plan is? Are we going to meet now on a regular basis, on a weekly basis? I mean, there are doctors in my district, as well throughout the state, that are, you know, are hurting, contemplating closing up their practices, whether you're for caps or against caps and the Chairwoman said we're here to gather testimony, that's very important, but we've been off for three months, we need to solve -- try to solve this crisis. I was wondering if we were going to meet on a weekly basis now --

CO-VICE CHAIR COHEN: We'll be discussing that after the meeting.

MR. BATEMAN: Okay. So, you'll inform the members of the committee --

CO-VICE CHAIR COHEN: In terms of people scheduled, as you know, down the road are doing other things, right now we're trying to work things out, all committee members will be present while we go through this, just go beyond the --

MR. BATEMAN: I would just hope that we make this a priority.

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CO-VICE CHAIR COHEN: Assemblyman, this has been a priority of me and members of this committee, I've spend hundreds of hours of reading, of course, testimony from out of state. It's a been a priority for me, been a priority for Co-Vice Weinberg, as well as members of the committee. You know me, I take this stuff very seriously, I have no life, but I take this stuff -- I take this stuff seriously.

CO-VICE CHAIR WEINBERG: If I may, I'd just like to add to that, I agree with you that there are problems for doctors which is exactly why we passed a premium subsidy in order to get them through this crisis while we gather this information, to come up with what we might consider the best in most appropriate solution, but we all know what happened to our legislation.

CO-VICE CHAIR COHEN: Assemblyman Wolfe.

MR. WOLFE: Yes, I just have a question,

I'm substituting on this committee, so I don't know if I'll be back again, but would you explain in a sentence or so pre-approval?

MR. WEISS: Pre-approval means that the companies must submit their rates to the insurance department and they cannot put them into effect until they get approval from the --

MR. WOLFE: Okay.

MR. WEISS: -- from the insurance department.

MR. WOLFE: All right. Thank you.

MR. SMITH: Mr. Chairman.

CO-VICE CHAIR COHEN: Assemblyman Smith.

MR. SMITH: Do you have a sense of what the fiscal impact would be for making New Jersey a pre-approval state in terms of how much manpower requirements that would be necessary in order to review the applications and the request for certain premiums?

MR. WEISS: Well, the insurance department is supposed to have the manpower now to review these rate requests after the fact. I don't know whether they do or they don't. If they already have the manpower and they're just doing it after the fact, okay, then they can do it before the fact, okay, give approval of the rates and the rates could even be put in retroactive if necessary after they're approved. Nobody is saying that the insurance companies aren't entitled to -- to accurate valid rate increases on the day they need them, so if they need them January 1st and the insurance

department takes up until September and then insurance department says yes, these rates are -- are accurate and should be put into -- then they can make them retroactive January 1st, but -- but as in California, okay, lots of times the insurance department is going to find that the rate is not accurate, that the rate should be cut back a little bit. The insurance department is supposed to already have the manpower to do this. Whether they have or not, I don't know.

MR. SMITH: Thank you.

MR. WEISS: You're welcome.

CO-VICE CHAIR COHEN: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Because it was mentioned for the record and I apologize for not stating before, but the data that they used on the trends comparing California comes from an organization called the NAIC, for the edification of the committee, I believe that stands for National Association of Insurance Carriers.

CO-VICE CHAIR COHEN: Insurance commissioners.

MR. CONAWAY: Excuse me?

CO-VICE CHAIR COHEN: Commissioners.

MR. CONAWAY: Insurance commissioners, thank you, but that's for the record, what the data, you know, the origin of the data and I would just finish with one comment about, you know, the escalator or the point that's interesting on raising the cap on

uneconomic damages, I mean, that would suggest that there's something different about pain and suffering in the '70's as opposed to now. I mean, now --

MR. IMPREVEDUTO: Yes, the value.

MR. CONAWAY: The value.

MR. IMPREVEDUTO: What was 250 in '75, in '75 was not 250 in 2003.

MR. CONAWAY: Got it. Thank you.

CO-VICE CHAIR COHEN: That's it?

Mr. Weiss, I have a few -- few areas. Just a comment -- just a comment on the pre -- pre-approval of rate lines. We have a major problem with the -- the car insurance industry and in terms of availability and cost and we had a regulatory process that was generally a strangle hold. The auto insurance carriers wanted to have what the malpractice carriers have now which is go in, submit the rate, go charge the rate until somebody decides you charge too much. Part of the problems historically in New Jersey unfortunately, is that rates, insurance rates that need a governmental body approving brings into consideration political issues, whether -- whether a car insurance industry that comes in for a rate filing a 15 percent, even though they may need it, but no one from any governor's office, democrat or republican, wants to put a stamp of approval on a 10 or 15 percent rate hike on insurance, car insurance rates that are already high and that caused a regulatory and business harass that hopefully is now has been to some extent removed by non-politicizors, the commissioners' decisions. As a

practical matter we understand that no matter what administration is here no one wants to wear the image of giving your stamp of approval on yet another rate hike for the insurance industry. So that suggestion that there be approval before they be allowed, I think if I'll be asking those questions of the insurance executives as to what that impact would be, will probably be placing us back in same position that we have with car insurance; that is, who wants to hand out a rate hike from a political perspective. The down side of that is by not doing it you're creating under pricing issues again that you already discussed, the impact of under pricing and professional liability can have a devastating impact on physicians or health care suppliers down the road, correct?

MR. WEISS: Correct.

CO-VICE CHAIR COHEN: It can also have a devastating system overall to the entire health care system because under pricing can be a decision factor that can't cured for years, is that correct?

MR. WEISS: Correct.

CO-VICE CHAIR COHEN: In fact, we've seen it with Zurich, correct?

MR. WEISS: Correct.

CO-VICE CHAIR COHEN: We've seen it with PHICO, correct?

MR. WEISS: Correct.

CO-VICE CHAIR COHEN: And we've seen it

massively and almost nationally with MIIX?

MR. WEISS: Correct.

CO-VICE CHAIR COHEN: Would you tell us what the impacting system is by virtue of profoundly under pricing in order to capture a market share?

MR. WEISS: Well, basically you saw -- you saw companies go out of business. I mean, MIIX went out of business, PHICO went out of business, although -- in fact, four companies in Pennsylvania went out of business, although the allegations are that there was fraud involved in the Pennsylvania companies, a number of them --

CO-VICE CHAIR COHEN: Can you explain that here, that situation?

MR. WEISS: Pennsylvania had six writers of malpractice insurance and now they're down to two and from what I understand companies like PHICO and PIE and some others, I know charges have been filed against a lot of the executives in a lot of these companies, I

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don't know exactly what the -- the -- I have two complaints at home that I haven't read yet, but basically I believe that one insurance exec has already been put in jail, but there are allegations of fraud at all four of those companies. I wouldn't necessarily say that there's fraud going on here in New Jersey, I have no knowledge of that and I wouldn't think that was the case, but just like in any business, just like in any business, you can't -- you can't make up for under pricing by volume. The more insurance you get, if

you -- if you price something at a dollar and it cost you a dollar and-a-half to make, the more you sell, the more you lose and that's exactly the same thing in insurance, if you under price your product and you attract more and more insureds -- if you're not getting enough for money for your product now why have twice as many insurers, okay, unless you're looking to do something with the company, unless you're looking to take the company public, unless you're looking to take -- transfer the company from a reciprocal to a stock company and taking it public that there's no reason to attract more insureds at rates that are -- that are, you know, under priced. What do you is you take a market, when you under price something now what you do is you force your competitors in order to keep
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the business they have to under price.

CO-VICE CHAIR COHEN: What is the rippling effect?

MR. WEISS: Well, the rippling effect is everybody starts underwriting the product, everybody starts to lose money, interest rates go into the -- you know, into the toilet and now -- and now rates that were here, that during the '90's weren't here, now they got to get them back here, plus they got to recover everything that was lost, so they go to here. I mean, if you were to take the premiums and again -- and I know you don't like the word, but I'm going to give you my gut feeling, if you took premiums as they existed in

1990 and compared them to what they are now, my guess is that the average premium in New Jersey, the average, if you took total dollars paid and divided by the number of doctors that the average is not that much higher today than it was in 1990, it's just spread differently and it looks like it's spread differently, it's spread to high risk doctors more, it also is -- I just lost my train of thought.

CO-VICE CHAIR COHEN: That's okay, the train is still here, so --

MR. WEISS: It's called -- it's called a senior moment. The -- when you drop the premiums and now you bring them back to here and then to here, it looks like a tremendous increase, go back to what the premiums were before they started slashing, okay. The average premium in the State of New Jersey for a doctor in 1990 might have been about $10,000.00, I don't know if that's correct, would be my guess, today maybe it's $12,000.00, but it's spread differently, they're hurting certain doctors.

CO-VICE CHAIR COHEN: We've asked for, I believe, going back to 1995, what we requested along the lines that you just noted, we want to see what the premiums were, the average premiums. I'm sure it's going to be higher, some with more claims and it's obviously going to be lower, something in the area of let's say an internist, there's no comparison between internist's policy and vascular surgeon's policy, we requested, at least, back to '95, we don't want to know

names, we don't want to know policy numbers, but what we want to do is I would like to see, I would like to know that in each -- by county their listing of their specialties and what their premiums were, what those physicians' premiums were in '95 all the way up to 2003, to try to get some perspective of how the numbers have changed and whether there was a particular spike. Is that the way we should go about getting information --

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MR. WEISS: Sure.

CO-VICE CHAIR COHEN: -- upon that?

MR. WEISS: That's one of the ways. One of the ways is to go back and look at the -- that information should be available from the insurance department in the rate filings. You'll see what -- what their premiums with for each class of business starting with the lowest classes of allergists and dermatologists or to family practitioners, all the way up to doctors who do, you know, minor surgery to doctors who do major surgery to the real high risk doctors. That data is available and that data is available in terms of you'll be able to see how many of each specialty they have, you get a computer program to multiply out the premium times the number of doctors they have, you add them all together, divide by the number of doctors, you get the average premium. At the same time you would be able to see the relativity in premiums between the different classes, a class one doctor versus a class seven doctor or whatever the classes happen to be now. That data

should be available and I would go back and look at it, this is not data that has to be provided, you can get it from the insurance department, go back to 1990, go back to when they first started slashing premiums, and I don't know the exact year, but you may want to go -- the further you go back, I don't think you have to go back into the '80's, but just look at those rate filings and look at the -- what the average premium was back let's say in 1990,'91, '92 compared to what it is today, and I think you'd be surprised.

CO-VICE CHAIR COHEN: In terms of -- you mentioned that there was a color coding at MIIX of claims, I think you mentioned early on in your testimony that there were coded claims?

MR. WEISS: Claims were assigned to severity code.

CO-VICE CHAIR COHEN: All right.

MR. WEISS: They're assigned a severity code of one through nine.

CO-VICE CHAIR COHEN: Was that coded within a computer system?

MR. WEISS: Yes, it was and it was a coding system that was devised by the National Association of Insurance Commissioners, it was their code, one through nine, nine was death, eight was quadraplegia and irreversible coma, seven was paraplegia, loss of limbs, six was other types of permanent injury that were less serious, five, four, three and two were decreasing temporary injuries and one was where the allegation

was -- it was just an emotional injury only, there was no physical injury and, you know, one of the things that -- one of things you got to look at in any particular year is the mix of -- the mix of the type of injuries you're getting. The fact that somebody may come in here and say well, the average payment in 19 -- the average payment in 2001 was 250,000 and the average payment in 2002 was 300,000, you'll say gee, it went up 50,000 on 250, that's a 20 percent increase, but you got to look behind that, you got to look at the mix of claims they're getting, if in the first year they got a lot of ones and twos and threes and fours and in the second year they got a lot of eights and sevens, then maybe the payments really didn't go up, maybe the payments are -- you got to look at the payments versus the severity of injury. If the payment for severity eight was the same in 19 -- in 2002 as it was in 2001, you didn't have any increase, maybe you just got more eights and maybe that's why it went up.

CO-VICE CHAIR COHEN: And that's really when the payout occurred, but not necessarily when the injury occurred, so if you paid out in 2001, the areas that you mentioned, that's -- it's a little misleading. In fact, a lot of information is a little misleading because you have to look at the entire picture. A payout in 2001 the injury may have occurred in 1996.

MR. WEISS: That's right, that's why you got to look at information based on policy years and you

got to look at based on calendar years, you got to look at it two different ways.

CO-VICE CHAIR COHEN: Now, from what I understand and what's been pretty clear is that we're being told -- we're being told that no one can go into their files or in their computer system and determine and tell us how much of a settlement represented economic or non-economic and no one can tell us that as a result of a trial, through appeal how much represented economic and non-economic, is that correct?

MR. WEISS: That's correct.

CO-VICE CHAIR COHEN: Now, it occurred to me that the way you do it, and it may take obviously a lot more time -- let me ask you this, when you were at MIIX did they keep records of economic and non-economic?

MR. WEISS: No, they didn't. One of things I was in charge with everything else was information services and the design of a computer system and what -- and when -- I led a team of people to design one starting in 1977 and one of things that we had in our claims system was we had field in the data records that were set up to collect medical specials, you know, medical bills, to collect loss wages, to collect all the

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different types of economic loss and what happened was we started off assuming when we put this system up that everybody would comply and as they were doing claims and then as they would get information about medical bills that were attached to answers to interrogatories and things like that, they would enter that into the system,

but then the claims vice president of MIIX said that it's too cumbersome a system, it takes too much time, it takes -- it puts too much of a burden on the claims staff and the thing never got done. So, the fields were there, but no data was ever entered. So, the data was never collected.

CO-VICE CHAIR COHEN: But you could really break down into economic and non-economic?

MR. WEISS: If you collected the data.

CO-VICE CHAIR COHEN: Whether as a settlement or as a jury verdict because you all you have to do is call out medical that's got to paid, as you indicated before any changes to a house, based upon either child or the adult having profound injuries where it has to be brought to handicap -- handicap accessible and you back that out, if there is a loss wage claim you back that information out --

MR. WEISS: Yes.

CO-VICE CHAIR COHEN: -- until you come

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down to a number.

MR. WEISS: Yes, certain -- certain components would have to be estimates when they -- you make a settlement and that settlement includes future damages, so there would be estimates of future medical bills, they'll be estimates of future lost wages based on some formula, taking into account, you know, wage inflation, stuff like that, but it certainly could be done to a fairly accurate, not to an exact, but

certainly within a ballpark that would be meaningful. It takes a lot of work to do that.

CO-VICE CHAIR COHEN: So, you would agree that nowhere that you're aware of, in no jurisdiction has anyone ever come forward and say we're able to break it down?

MR. WEISS: No, I don't think -- not to my knowledge.

CO-VICE CHAIR COHEN: What was the effect -- I mean, when we had hearings back, I believe, in May, hearings that we had in 2002 and 2003, testimony at the first hearing indicated that the health care providers, physicians and hospitals indicated that for the prior 20 years that they were not dissatisfied with what their premium costs were, but that over the last 12 to 18 months, this is back in 2002, so really talking

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about this -- being dissatisfied somewhere around the end of '01 and in '02 when this matter exploded due to the public view, that it's that time frame that obviously they were upset because certain numbers went off the roof, would you agree with what their concession was, that for a 20 year period they're relatively not unhappy with the cost approach?

MR. WEISS: Well, certainly they weren't unhappy because all during the 1990's the rates were coming down, okay, and then all of a sudden when -- when the interest rates went into the toilet and all this bad experience started to bite them, they raise rates. So, there's no mystery as to why they got upset in that time

frame, they had every right to get upset.

CO-VICE CHAIR COHEN: When MIIX decided that it was going to leave -- leave New Jersey and go out of state by virtue of the VIPO and then try to capture the market, what followed was a financial disaster and what some have characterized as a bad business plan. Would you characterize what MIIX did in terms of going out and VIPO and going out to other states, would you characterize that decision as a bad business plan?

MR. WEISS: Well, I was there when this all thing was conceived and basically had no business plan,

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they did no research into those states to understand what the environment was in those states, they gave very little thought as to how they would handle claims in those states.

CO-VICE CHAIR COHEN: Did they have offices in those states?

MR. WEISS: I'm not sure 'cause then I left, okay.

CO-VICE CHAIR COHEN: Time is everything.

MR. WEISS: I'm not sure how they actually did it, they had no plan as to how they were going to handle claims in those states, they had no idea about the environment of the state, all they wanted to do is expand geographically, so that they could get -- so they could say they're "a national company" maybe -- maybe be more -- not only to take a company public, but maybe

even to be more attractive as a take over possibility for a company.

CO-VICE CHAIR COHEN: For somebody else via MIIX?

MR. WEISS: For somebody else to come in, yeah.

CO-VICE CHAIR COHEN: Is it more attractive to buy out a company that has a lot of clientele?

MR. WEISS: Oh, sure.

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CO-VICE CHAIR COHEN: The more clientele you have --

MR. WEISS: The more markets you're in, if you could handle that market, if you could handle the market -- when I was with MIIX I was in charge of new business development and my focus when we first decided we were going to want expand our business, our focus was on let's expand and do things that we know how to do. First of all, we know New Jersey, so let's expand on this New Jersey, but up until that time all we did was issue policies to physicians. So, my plan was well, let's see if we can write dentists and let's see if we could write other kinds of health care providers in New Jersey, that will give us some diversification, that will help us, okay, but, at least, we know where we're playing, okay, we know the field here, we know the environment, we're good at doing things here in New Jersey, okay, let's do that, let's start to write some hospitals in New Jersey, okay. The last thing that -- that I had on my agenda, the last thing that I wanted to

do was to expand geographically, certainly not into New York which they didn't do, okay, 'cause the environment in New York is a disaster, certainly not into Pennsylvania because the environment in Pennsylvania is not that great. You know, when I was with MIIX the highest malpractice premiums in the country were in New York, the fourth highest was in Pennsylvania and we sat here in New Jersey, we had the 41st highest premiums in the country. This was back in the '80's, I can't give you the exact year, but it was all during my stay at MIIX, New Jersey has the 41st highest premiums in the country, Pennsylvania had the fourth, New York had the first, the last were in Florida, came in between, I would never have gone into Pennsylvania, I don't care how geographically close it is, okay, the environment just wasn't good, they don't have the discovery rules that they do here in New Jersey.

CO-VICE CHAIR COHEN: When did MIIX first decide it was going to VIPO and go public?

MR. WEISS: Well, I don't know the exact time, but it was certainly -- it certainly was after Peter Sweetland passed away and Dan Goldberg came aboard and Vince Maresser assumed the chairmanship of the exchange.

CO-VICE CHAIR COHEN: What year was that then in, if you remember?

MR. WEISS: 1990 maybe, '91. I guess, it would be '90.

CO-VICE CHAIR COHEN: You reference -- you reference on page five of your testimony, beginning of the last paragraph, missed first quarter of 2003 they announced -- announced 7.2 million dollar profit?

MR. WEISS: That's correct, I read it in the paper. I remember reading it in the paper, they announced that they had a profit for the first quarter.

CO-VICE CHAIR COHEN: That's the new MIIX?

MR. WEISS: No, that was the old MIIX.

CO-VICE CHAIR COHEN: So, that would be first quarter of 2002?

MR. WEISS: No, was 2003, they're still -- they're still running off the business.

CO-VICE CHAIR COHEN: Wait a minute now, I'm confused. The first MIIX has had enormous amount of press that supposedly they stopped doing business and created the new MIIX that's now been in business for approximately 12 months, you're saying that the first MIIX, that is -- that's in runoff has declared 7.2 million profit?

MR. WEISS: I believe that's true, we can get the -- get their annual report, the press -- the press release they had that said that they've changed the way they do things and they -- they had a profit in the first quarter.

CO-VICE CHAIR COHEN: Of the old company?

MR. WEISS: I believe it was the old company. I may be wrong, but I do believe that.

CO-VICE CHAIR COHEN: I mean, in either

event we need -- we need more information on that, they've been in business for 12 months, they got 7.2 million dollars profit, that's a wonderful profit for being in business for 12 months.

MR. WEISS: That's correct.

CO-VICE CHAIR COHEN: If it's a company that has business practices and bad business plan that literally destroyed physicians in this state and the market in this state and they're showing a 7.2 million dollar profit, we need some profound answers on that, wouldn't you agree?

MR. WEISS: Correct.

CO-VICE CHAIR COHEN: Whatever staff is around we can look at that, that area as soon as possible, if MIIX will be coming in to testify before this committee relatively shortly, not necessarily today and maybe we can get some more information on that, perhaps we can expand our request for documents, I know I'm in the middle. Assemblyman Wolfe?

MR. WOLFE: Something that the assemblyman said before, several minutes ago he was talking about the experience apparently, I guess, beginning to go sour, I guess, in 2001, 2002, would that be correct, for the --

MR. WEISS: He said an 18 month period, from 2000 or 2001.

MR. WOLFE: Right, that was just in New Jersey or that was nationally?

MR. WEISS: Well, I think --

MR. WOLFE: The malpractice insurance industry.

MR. WEISS: Well, the industry, the industry in general has undertaken a position where they're -- they're, you know, alleging that there's crises in 17 or 18 or 20 or whatever the states are.

MR. WOLFE: Yeah, but what I'm saying, coming back to what the assemblyman said, is that as a result of this last 18 month period that we're focusing on, is that when this crisis nationally hit us, that now comes down to New Jersey, when this started?

MR. WEISS: I believe so 'cause I didn't see in any newspapers or any --

MR. WOLFE: All right. I'm not trying to sensationalize it, a lot of insurance companies lead the blame or gave as the reason for increased rates in premiums the 9/11 experience where they lost a lot of money under various, I guess, insured. Do you think this may have in some way contributed to the situation we face involving malpractice?

MR. WEISS: It shouldn't have because they should basically -- insurance companies should price products based on the losses of that line of insurance, they shouldn't base -- they shouldn't base doctors' malpractice premiums on hurricane losses or losses that have to do with automobile insurance or losses that have to do with anything, each line of insurance should stand on its own.

MR. WOLFE: 'Cause what I'm saying it was such a jolt, all at once, there was this -- this recoil from this tragedy and the prices the people were forced to pay, you know, would that, in fact, you think impact on the other --

MR. WEISS: There are -- certainly there are -- there are, if a company is not doing well from one line there's always the, you know, the temptation to tack it on to another line or if you're not doing well in one state and you write doctors in Pennsylvania, Ohio and Texas and you're having tremendous losses there there's tremendous temptation to recoup that losses on the back of New Jersey doctors.

CO-VICE CHAIR COHEN: Assemblyman? I guess, I'll move on. Thank you, Assemblyman. What I'm going to do is since we have some other groups that are here I find the information that you have important, so unless there are any questions now we'll excuse you. Is there anything else you want to add now, I'd be more than willing to listen, but I would like to have you back at some later point in time as the hearings continue, as more issues and information may come up. Would you be available in the future?

MR. WEISS: I'll make myself available.

CO-VICE CHAIR COHEN: You make it consistent with your schedule.

MR. WEISS: Sure. Any time.

CO-VICE CHAIR COHEN: Any further questions

of Mr. Weiss? In the absence of any, thank you for your time.

MR. WEISS: Thank you.

CO-VICE CHAIR WEINBERG: Our next witness we're going to hear from represent Princeton Insurance Company. Thank you for your patience. Introduce yourself, please.

MR. PILLION: Good afternoon, ladies and gentlemen of the Special Committee, Madam Chairman, Mr. Chairman. My name is Kieron Pillion, I'm the general counsel for Princeton Insurance Company.

CO-VICE CHAIR WEINBERG: You'll be sworn in by the co-chair.

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MR. PILLION: I would like to make a procedural point, I'm appearing as general counsel, I have appeared earlier with a witness of Princeton who was going to have to testify, Mr. Robert Schultz, he is our vice president of corporate and customers relations. Unfortunately, he had to leave to go to meet somebody at the Philadelphia Airport. With the -- with the Committee's permission, you know, I could read Mr. Schultz' prepared testimony, perhaps try to answer some questions that are in my field of expertise as to general counsel to the company, but I'm not the most qualified person to talk to the same issues that Mr. Schultz was going to discuss.

CO-VICE CHAIR COHEN: That's understood.

MR. PILLION: Okay.

CO-VICE CHAIR COHEN: We will still have to

swear you in.

MR. PILLION: Okay.

CO-VICE CHAIR WEINBERG: Make sure you're reading accurately.

MR. PILLION: Okay. Thank you.

K I E R O N P I L L I O N, Sworn:

MR. PILLION: On behalf of Mr. Schultz, "Good morning, everyone, my name is Robert Schultz and I'm the vice president of Corporate and Customer Relations for Princeton Insurance Company. I currently have responsibilities in the areas of communications, risk management, loss prevention and regulatory compliance. During my 20 years with Princeton I have held positions with leadership in underwriting, marketing and product development. Let me begin by telling you a little bit about Princeton Insurance Company and what we believe to be the facts surrounding today's medical malpractice crisis. Princeton Insurance Company is part of Medical Liability Mutual Insurance Company which is owned and directed by the health care professionals it insures, New York doctors and hospitals. The MLMIC Group which includes Princeton and other MLMIC subsidiaries is the largest medical malpractice insurer in the nation. Prior to MLMIC's purchase of the Princeton Group in 2000, September 2000, for $192,000,000.00 Princeton was owned by the hospitals of New Jersey through the Health Care Insurance

Exchange. Our commitment to New Jersey's medical and health care community spans more than a quarter of a century and is as strong today as it ever was. According to the study conducted by the general accounting office and released in June 2003, losses on medical malpractice claims appear to be the primary
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driver of rate increases. The report stated incurred losses among the insurers analyzed were up 18.7 percent between 1998 and 2001. At Princeton we couldn't agree more that today's medical malpractice crisis is related to a dramatic increase in claims cost. Princeton Insurance Company has experienced a 33 percent increase in average paid losses for hospitals between 1998 and the present. The average paid loss for physicians increased 25 percent from 2001 to 2002 alone. Poor investment results in the bond market have also contributed to rising rates, but in comparison to increase in claim costs it is minor. Princeton has less than five percent of its assets in equities and is not impacted significantly by swings in the stock market. One way to help reserve -- reverse the trend in rising awards and settlement values is to enact meaningful tort reform. Caps, however, are only one component of a comprehensive tort reform effort. Princeton believes it is time to revisit the other components, such as setting and upholding realistic statutes of limitations, better defining who can be an expert witness, giving judges more discretion in reducing extraordinary jury awards and extending the charitable immunity protection to

hospital employees. Further, clarifying the definition of bad faith to limit payouts to policy limits will also help. If enacted, these reforms could add a measure of predictability to claim handling processes. Having a better handle on the maximum value of the claim would help us to better establish accurate rates. While these efforts are directed to helping carriers address the unpredictability of malpractice claims, Princeton also believes that patient safety issues need to be part of any effort to address the malpractice crisis. Patient safety initiatives and staff commitment to risk management protocols can go a long way to prevent the occurrence of malpractice in the first place. Princeton supports those types of initiatives. No one will argue with the fact that New Jersey's malpractice system needs reform and Princeton wants to be part of the solution. While tort reform addresses the cost aspect of malpractice claims there is another facet to the crisis, availability of insurance. Princeton Insurance which has largest market share of any carrier currently writing in New Jersey recently stopped accepting new business. We simply could not responsibly take on any new business without jeopardizing our ability to meet the future claim obligations of our current policyholders. One reason for this is the ever rising cost of reinsurance which Princeton and other insurers depend on to fund losses above a certain level. Following our announcement the New Jersey Department of

Banking and Insurance called for a hearing on the need to reactivate the Medical Malpractice Reinsurance Association. Princeton representatives testified on the benefits of such an action and shortly thereafter Commissioner Bakke ordered the association reactivated to provide reinsurance coverage to the state's insurers. This decision was a positive regulatory development that addresses the growing availability problem. This committee is facing a challenging task in its effort to get to the bottom of the difficult issue. We believe Princeton Insurance Company can provide assistance in obtaining that goal. The Special Committee's request for data and documents, however, presents a challenge for Princeton, too. We need to balance our obligation to protect the confidentiality of our policyholders and preserve patient privacy while fulfilling our desire to work with you towards building a better malpractice compensation system. We respectfully suggest the Committee consider engaging the services of a nationally recognized and independent actuarial firm that specializes in the medical malpractice area, such as Ernst & Young or Price Waterhouse Cooper to collect the data from the insurers in New Jersey. Confidentiality agreements could be executed between the insurance

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companies and the selected firm, thereby preserving a privacy that is so necessary to the policyholders and patients and alike.

CO-VICE CHAIR COHEN: You all agree?

MR. PILLION: No, it wouldn't be our

recommendation. This independent party could analyze the data, maintain its confidentiality and provide the best opportunity for objective evaluation. This Assembly Committee has taken on a very important issue and one that touches everyone in the state. Without a resolution to the mounting medical malpractice insurance crisis access to care will suffer. Princeton believes strongly that meaningful -- that a meaningful tort reform package can help to stabilize the medical malpractice insurance rates and we will continue to work with the legislature as it attempts to gather and analyze insurers' data, while at the same time protect the privacy of the doctors and patients involved. Thank you for allowing me the opportunity to present Princeton Insurance Company's views on this matter and our thoughts on the best way to analyze and collect insurer data.

CO-VICE CHAIR COHEN: Thank you, counsel. How long has Princeton been in business in Jersey, writing professional liability for physicians and hospitals?

MR. PILLION: Princeton, itself, was formed in 1982 by the Health Care Insurance Exchange which itself was formed in 1975 by New Jersey's not for profit hospitals. When the Health Care Insurance Exchange was first formed in 1975 it wrote insurance only for New Jersey's Hospitals and only in the medical malpractice area. In 1982 --

CO-VICE CHAIR COHEN: Since 1975?
MR. PILLION: Yes, since 1975 the ultimate original company was created.
CO-VICE CHAIR COHEN: So, essentially the writing of -- in the area of the med -- physicians' liability it's been approximately 26 years?
MR. PILLION: Yes.
CO-VICE CHAIR COHEN: Okay. I'm assuming Princeton has been in business for 26 years in New Jersey is because you find it an area that we can provide a service and also have a business that does well financially or you would have left New Jersey 24 years ago?
MR. PILLION: Well, the mention of the original company, Health Care and Insurance Exchange in Princeton has been to provide, especially with respect to the New Jersey hospital community, malpractice
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insurance on an at cost basis. We -- it would be very difficult for us to make a decision to not write insurance for hospitals as long as we have the financial capacity to do so.
CO-VICE CHAIR COHEN: But you've been writing for hospitals and physicians for 20 years?
MR. PILLION: That's correct.
CO-VICE CHAIR COHEN: I imagine someone made a business decision to continue to write hospital and physician liability policies for the last 20 years, correct?
MR. PILLION: The board of directors of the

Exchange, yes.

CO-VICE CHAIR COHEN: My point is, and maybe we'll be less coy, but for the last 20 years that you were losing money for 20 years in a row you wouldn't be in business in New Jersey, would you?

MR. PILLION: No, we wouldn't be in business if we lost money for 20 years in a row.

CO-VICE CHAIR COHEN: So, someone has determined that it's a business that should continue as Princeton Insurance for the last 20 years and continued to participate in the business cycle here, correct?

MR. PILLION: We're committed to New Jersey because of the origins of our company, it's a hospital

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formed directed company in Jersey, it's now directed by physicians and hospitals based in New York State.

CO-VICE CHAIR COHEN: And also I imagine because there must have been some profitability in a 20 year period, correct?

MR. PILLION: The profit motive hasn't been a paramount concern to the Health Care Insurance Exchange, that's part of the historic corporate mission of the exchange, is to provide insurance on as near an at cost basis as possible.

CO-VICE CHAIR COHEN: How much was Princeton Insurance bought for?

MR. PILLION: The Princeton Group was purchased for $192,000,000.00.

CO-VICE CHAIR COHEN: So, it must be a --

the Yankees may be just a little bit less, but it must seem that buying someone for $192,000,000.00 that means the company has, at least, a value of 192 on book, correct?

MR. PILLION: At the time, yes.

CO-VICE CHAIR COHEN: So, it had a value to it, correct?

MR. PILLION: Yes.

CO-VICE CHAIR COHEN: So, it was doing good business to get a value of 192 million, correct?

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MR. PILLION: I believe it was.

CO-VICE CHAIR COHEN: Because if it was failing you would no longer be in New Jersey, correct?

MR. PILLION: We wouldn't.

CO-VICE CHAIR COHEN: Unless -- unless you want to operate at a deficit for 20 years in the State of New Jersey I'd say that's as bad business decision as MIIX has gone through. All I'm saying is that if you're doing business in Jersey, you have a book value of $192,000,000.00, you've been doing business for 20 years, sounds like something that is making some money to keep it viable, correct?

MR. PILLION: We certainly have to operate in an effort to maintain financial strengths, so that we can pay the claims that come in on behalf of our policyholders.

CO-VICE CHAIR COHEN: That's what you're able to do in getting a return on an investment over the last 20 years, correct?

MR. PILLION: We've had had some success over the last 20 years, yes.

CO-VICE CHAIR COHEN: There is no paying no salary?

MR. PILLION: Yes, we are.

CO-VICE CHAIR COHEN: When MIIX went through its bad business plan and had to go start a new company, and we'll find out later whether they have a 7.2 million dollar profit with a bankrupt company or whether they had it with a company that's completely in its infancy, when MIIX had its problems what was the impact on Princeton Insurance, if any?

MR. PILLION: We saw a significant increase in submissions of new business at that time and we ultimately, I believe, wrote approximately 3000 new physicians.

CO-VICE CHAIR COHEN: If Princeton had not existed at that point in time what would have happened in all likelihood to the 3000 physicians who left MIIX?

MR. PILLION: I don't know.

CO-VICE CHAIR COHEN: There would be a girth of insurance available for those physicians, correct?

MR. PILLION: That's a possibility.

CO-VICE CHAIR COHEN: And leave those 3000 physicians and health care providers without any type of coverage at all, correct?

MR. PILLION: That's quite possible. We

would -- we were perhaps the only available market, domestic in New Jersey.

CO-VICE CHAIR COHEN: And the savior for them? In my view.

MR. PILLION: It certainly help those physicians, yes.

CO-VICE CHAIR COHEN: Now, as a result of that infusion and that infusion of 3000 physicians, over what time frame was that infusion? Wasn't over a period of 10 years, where you could bring more people in each year? What was the time fame when you got the shock of 3000 new individuals --

MR. PILLION: That, I don't --

CO-VICE CHAIR COHEN: -- needed to be covered?

MR. PILLION: I couldn't give you an accurate answer on that one, Mr. Chair.

CO-VICE CHAIR COHEN: Well, MIIX had its problems when, its disastrous problems, in the year 2000, 2001, end of '99? What we like you to do, at least, what I would like you to do is get that information, talk to your staff --

MR. PILLION: Sure.

CO-VICE CHAIR COHEN: -- and some others who were here also as support, I'd like to know when that 3000 came in all of a sudden, and it was a sudden infusion, correct?

MR. PILLION: Yes, it wasn't something that we would necessarily find very -- 3000 at once is an

awful lot to swallow, yes.

CO-VICE CHAIR COHEN: As a result of that did that have an impact on Princeton Insurance Company which we now have the resurrection of the Reinsurance Association?

MR. PILLION: I don't know if I can answer that with any degree of accuracy or certainty myself, we would have to get back to you on that, that -- the numbers on that issue. It effected our leverage ratios because we were writing more premium dollars, our surplus was not growing, so it was hurting our premium surplus ratio.

CO-VICE CHAIR COHEN: But you took that burden anyway, correct?

MR. PILLION: Yes, that's part of the overall corporate mission of the group.

CO-VICE CHAIR COHEN: Did MIIX ever try to buy out or purchase Princeton?

MR. PILLION: When Princeton -- yes.

CO-VICE CHAIR COHEN: Do you remember when that -- approximately what time frame that was?

MR. PILLION: It would have been before, several years before September of 2000 when our current parent closed on the deal, it would have been

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approximately for the three years before September of 2000.

CO-VICE CHAIR COHEN: Three years prior to September of 2000, so that would be sometime in the fall

of 1997 approximately?

MR. PILLION: Approximately. The process was a fairly lengthy one, an ongoing one and the parties interested in the Health Care Insurance Exchange and the Princeton Group, you know, changed over time, but MIIX was certainly one of the most interested parties as was our ultimate purchaser, the Medical Liability Mutual Insurance Company.

CO-VICE CHAIR COHEN: You may not know, but if and perhaps, you can make an estimate, if MIIX had purchased Princeton in 1997 how much of the market in New Jersey would Princeton have had?

MR. PILLION: I believe -- this is, I believe, going back that was a significant concern that I had at the time as the general counsel that the market share was going to be very high, high percentage. I think it was over 60, maybe 70 percent.

CO-VICE CHAIR COHEN: If MIIX had its own market, plus the acquiring concerns --

MR. PILLION: Yes, I believe -- I mean, I'm not the most knowledgeable one in those percentages, but

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I believe MIIX maybe had 40 percent of the market, we had 30 percent of the physician market, it was getting very close to almost all the market, 70 percent would be my best guess.

CO-VICE CHAIR COHEN: You know, I'll come back.

CO-VICE CHAIR WEINBERG: Assemblywoman Quigley.

MS. QUIGLEY: Thank you, Madam Chair. I have two separate questions. You had read that one reason for Princeton declining to accept new claims was the ever rising cost of reinsurance. Could you speculate on what creates the ever rising cost of reinsurance and I stress ever rising 'cause that's what you read.

MR. PILLION: Yes, I did read it, and again I'm reading the words of my associate Mr. Schultz whose involvement and responsibility is much greater than I in those areas. Reinsurance has become difficult for medical malpractice insurance companies and costs to buy it, if its available, is very high.

MS. QUIGLEY: Are you talking New Jersey specifically or are you talking nationwide in general that reinsurance is ever rising?

MR. PILLION: I -- again, I'm speaking from a limited foundation of knowledge and information, but it's anecdotal and it deals with us in New Jersey, what I read in the trade papers is that it's a problem that is not just limited to New Jersey.

MS. QUIGLEY: Would you assume then that the cost of reinsurance is ever rising in California, as well?

MR. PILLION: I couldn't really answer that question. I haven't studied the California market, was never a market that we took a look at.

MS. QUIGLEY: Well, I would respectfully

suggest to the chairs then that one of the things perhaps we should look at is not only the insurance premium rates, but the reinsurance premium rates to see if New Jersey is being significantly effected in ways that other states are not and then if I may switch to my second subject, anyway, you had said that, clarifying the definition of bad faith to limit payouts to policy limits would also help. Would you interpret that in plain English, please?

MR. PILLION: Yes, that I have a little bit of understanding of. Again, nemesis, perhaps a little. When an insurance company issues a policy of insurance it has stated limits in the contract for the person that purchased it. If the damages that are presented by the

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plaintiff exceed the policy limits you may have a situation develop where the plaintiff attorney makes a demand, a formal demand upon the insurance carrier to tender the policy limits. Under New Jersey case law if you were given the opportunity as the insurance company whose directing the defense to settle the claim against the insured within or for the policy limits, if they don't take it and then the case goes to trial and the jury verdict comes in beyond the policy limits, the interpretation and ruling of the New Jersey courts is that you have rewritten your policy limits up to whatever the jury verdict is.

MS. QUIGLEY: I didn't know that. Thank you.

CO-VICE CHAIR WEINBERG: Assemblyman Munoz.

MR. MUNOZ: Thank you, Madam Chair. I wonder if I could ask, in the middle of the first page you talk about -- it says according to a study, the study conducted by the General Accounting Office released in June 2003 losses appear to be the primary driver of rates, so then we have this study we prefer, that's the study out of Washington, D.C., right?

MR. PILLION: That's what I believe Mr. Schultz was referencing, yes.

MR. MUNOZ: Okay. But then towards the back of that paragraph it says -- now talks specifically about Princeton, Princeton Insurance Company has experienced a 32 percent increase in average paid losses for hospitals, that talks about doctors, the average paid loss for physicians increased 25 percent from 2001 to 2002, that's Princeton's data?

MR. PILLION: That's Princeton's experience, yes.

MR. MUNOZ: Okay. 'Cause we've heard various testimony, well, one of the testimony, but yeah, there is some differences of what's actually happening, are we going up, are we going down, but let me go to the next paragraph, and I will maybe ask the attorneys on the next page on the Committee, I'm just a dumb surgeon, it says here if you want to work with us and cooperate, however, there is certain changes, I always get concerned with that, however, and it says the Special Committee's request for data and documents presents a

challenge, we need to balance our obligation, blah, blah, blah, confidentiality, and that sort of means to me like we're looking at years, maybe I'll ask the attorneys, and I think we talked about that earlier, oh, yeah, it said attorney, doctor, attorney, yes, but I'm talking -- I mean, that sounds like a negotiation, sometimes lawyers get long winded, and there's all kinds of negotiations. I mean, it doesn't sound like that will happen next week, right, I mean, you come forward with your committee and present all the data confidentially or is that a deliberation we have to get into that might go on and on?

MR. PILLION: Let me take the opportunity to perhaps give a little historical perspective to that issue. Last year a different committee of a different house, a senate committee, had made a fairly extensive data request of Princeton Insurance Company. Through our counsel at the time, Courter, Kobert we attempted to negotiate a confidentiality agreement so that we could provide the information they wanted and at the same time be assured that the information, if it became public or we didn't want it to become public because it could be used to cast in a false light our doctors or perhaps violate the patient privacy issues of the patients that the doctors had treated, we were not able to reach an acceptable agreement, we had a document that was presented and discussed, and I think some of the issues that were brought back to us through counselor to that committee there were some concerns about did -- did the

committee have the ability to insure confidentiality given some of the states statutes and there was also some discussion whether or not the full senate by resolution would have to take action to insure the confidentiality information. There was never a final resolution with respect to that request, so --

MR. MUNOZ: Just as a follow up, so the notion that I can ask you or we can ask you for information and come to some agreement is to go to the recent past is we'll probably never reach an agreement, we'll never get the information, we can't make you do that?

MR. PILLION: No, I don't want to create the impression that we're not, you know, trying to provide the information. If there is an adequate confidentiality agreement or a framework set up so that the information can be protected from either inadvertent or improper disclosure which could cast certain, you know, parties in unfavorable lights, then we would like to cooperate. I mean, that's -- you know, we would like to get to the bottom of the issue also. At the same time we do not want to expose, you know, our customers, our doctors or our hospitals to, you know, being cast in a false light because information or on a piecemeal basis may become known in the public, you know, environs about them. So, it's a valid concern, I believe, and as the general counsel for the company I've advised them to act cautiously in that regard.

CO-VICE CHAIR WEINBERG: Let me -- if I may continue on that road. What would -- why would it be considered confidential information to provide us with an aggregate figures on how much is paid for economic damages, how much non-economic damages, how much you paid out in an aggregate fund for out of court settlements and for X number of doctors without releasing anybody's name? Why would that be considered confidential information?

MR. PILLION: Some of the settlements, themselves, may be bound by a confidentiality agreement so the very numbers in the settlements could not be disclosed to anyone.

CO-VICE CHAIR WEINBERG: So, even if names and geographic areas and so on were not released, you couldn't add up all the numbers that you paid out in the course of a given calendar year and divulge that information to this committee?

MR. PILLION: That's a little different than what I was saying, I think. I mean, if you're talking about aggregate numbers, you know, I'm not so sure, you know, there's a confidentiality issue in that regard, but some of the data that has been requested gets down to things such as the specialty and the location of where the specialist practices and given

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that some counties don't have a lot of specialists in one particular field, there is a concern, if we were to give all that was asked for they could inadvertently identify the party who the information relates to.

CO-VICE CHAIR WEINBERG: Well, I guess, I have a little difficulty with that because this is an industry that is asking us to become involved with regulating or setting a cap on what your losses might be, but while we're being requested to cap potential losses we're being told we can't get the information to make a rational decision on that because of these confidentiality agreements, but again, if we asked for aggregate figures for out of court settlements, aggregate figures for jury settlements, the numbers of doctors involved, you would be able to supply that without breaching any confidentiality --

MR. PILLION: I think there is -- there are -- there is common ground where I think we can provide the information you need. However, the first initial request that we got asked for a level of detail which I honestly had concerns could identify parties inadvertently, but it doesn't mean that the information in a meaningful way can't be identified and provided. One of the things that we had suggested is that it be provided to a -- an outside independent nationally

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recognized actuarial firm. We engaged in a similar type of undertaking where I also had some very serious concerns with our competitor, the Medical Society of New Jersey approached us and asked if we'd be willing to participate in a study conducted by Telehast, whereby we would provide very detailed data that an actuary needed to give a comprehensive rate study over a period of

time. We had serious concerns about the fact that the Medical Society commissioned them, that our data would be going into their hands, you know, we were told MIIX's data would be contributed to it also. It took several months of negotiations for Princeton to get comfortable and accept the confidentiality agreement that Telehast provided to us, but we provided them with an enormous amount of data which along with MIIX which did form the basis of the report prepared by Telehast and presented, I believe, before one of the committees, I think it was the Banking and Insurance Committee, but although I do believe, Madam Chairman, you were there also, Mr. Hurly testified. That was a concern that I had even then, sharing it with a competitor, you know.

CO-VICE CHAIR WEINBERG: Do you know if Princeton has a breakdown of economic versus non-economic damages paid out?

MR. PILLION: I know that they don't. They don't, except for the jury awards where you have a jury verdict that breaks it down because the jury has asked -- answered questions, if a matter has been resolved by settlement, you know, it's not -- it's not the type of data that is needed by the company or its actuaries and it's not -- we just never captured it.

CO-VICE CHAIRMAN WEINBERG: Well, if it's not the type of data that is needed by the company, how can somebody come up with the idea that a cap on non-economic damages will somehow hold down premium rates, if it's not data that you even considered

important to capture?

MR. PILLION: I think what happens is the actuaries, they develop mathematical models, the methodologies to apportion the settlement amounts to economic and non-economic and I honestly can't tell you how they do that because I don't understand it, but I know that when I've read reports done by the actuaries that attempt to establish a value or attempt to establish a number, that a cap at a certain level will have in either preventing malpractice rates from increasing or reducing them they make certain assumptions and do certain mathematical modeling, but that's beyond my expertise.

CO-VICE CHAIR WEINBERG: Can you find out for us if it is possible for Princeton to recapture some of that information based on whatever mathematical models the actuaries used?

MR. PILLION: The raw data with respect to the jury verdicts would require us to manually go into the files and try to read through the files to see what the -- what the jury's findings were. You know, that -- that -- that's out there, but the vast majority of the cases are settled without a jury verdict and then you're faced with a dilemma of how you develop an agreed upon or reliable apportionment between economic versus non-economic, if you're looking at a limited or a sampling of the jury verdicts and then trying to extrapolate that back over all the other settlements.

You have to have somebody, I belief, you know, with experience, qualifications in the actuarial field to do that and have them discuss it with other actuaries who are taken a -- for taking the devil's advocate position and trying to challenge the accuracy of their methodologies and modeling, it's not something I would feel comfortable doing or even suggesting that anybody at Princeton who is not an actuary could do.

CO-VICE CHAIR WEINBERG: Assemblyman Conaway.

MR. CONAWAY: You raised some points here that -- I'm going to stick with this question, because one of the problems that we're having, it seems to me, is that you have jury awards on the one hand and where you often have these awards that are precisely laid out, I don't know if it's in every case, but I guess it would depend on the questions to the jury, but is it fair to say that in most cases you do get an apportionment between the economic and non-economic portions of the award or that half the cases or what on that matter, the breakdown? Do you get the breakdown most of the time or rarely when a jury verdict is rendered in these medical malpractice cases?

MR. PILLION: I believe you get the breakdown. I'm not involved with the claims department on a daily basis, I do get involved on appeal matters. What I've been involved, I've seen a breakdown.

MR. CONAWAY: So, we have data on the one hand and that's -- and that's data that I tried to put

on the record on the experience of insurance of New Jersey, in the New Jersey court system on these verdicts of 14 million or more here, of most of those awards are going to have some kind of breakdown, economic versus non-economic, we've had -- and there's a lot of concern here, and was a concern that I had raised, is that the verdicts, themselves, that are, of course, public,
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published, that are known about in the medical community, known about to other insurers, has a impact on what happens in -- when cases are settled; that is, and so my question is, do you think, do you agree with me, that that -- that the experience in the -- in the market place of information, if you will, when a lot of these awards are out there effects what people are willing to settle for, it effects their decision making, go to trial, not go to trial, it-- it -- that a physician might say, you know, if I'm going to be risking a $3,000,000.00 verdict or a verdict that's above limits of my policy, whatever happens in the case law now gets worked out in the end, I'm more likely to settle for the limits of my policy and I believe that over time that has put an upper pressure on the amount that the insurance companies has to pay out, is that a defensible statement that I'm making?

MR. PILLION: I believe that's an accurate portrayal of what exists in the real world. The jury verdicts drive the settlement values.

MR. CONAWAY: No question about it. Now --

now, is it fair to say because we're going to get into an argument over this, so as we try to get this data out, 'cause you're going to be asked time and time again to try to get into the settlements, I think the
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settlements are -- can -- that the jury awards can be a good surrogate for what happens in the settlement area, particularly I think the amounts of the cases that are settled are trending -- trend along with what's happening in the jury awards, now, they'll be an argument about that, unquestionably, but perhaps it is just the wrong question to ask, can we apportion these various settlements among all these things because the process is different? I don't know, but -- but is it appropriate to even ask the question when a case settled how much is economic versus non-economic in your opinion?

MR. PILLION: Well, you'd be looking to be asking the claim adjuster or --

MR. CONAWAY: Well, because the data -- what's trying to be extracted here by some members of the committee as I am able to glean is to try to find out how much of this problem is related to the non-economic damage question. I mean, that's why we're here really today. Now, the -- some of us -- and so the settlements, in getting at and getting behind the settlements is important to a lot of folks now, and so you were talking about methodologies and things -- thank you -- just a second. So, we're trying to get at these settlements. Now, the question I have is, is it fair,

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is it appropriate to try to apportion these things among -- among the non-economic or economic damages? Is that an appropriate question to ask? Can it reasonably be done? I think you suggested that there are a number of factors in here which makes that process a difficult one, some of us think that the jury awards are probably -- can probably serve as an adequate surrogate for the information we need to find, but we're going to go and try to get this information, anyway. I'll set aside for Assemblyman Russo. I think you -- I hope elucidate, maybe answer my question, I don't know.

CO-VICE CHAIR WEINBERG: Yes, go ahead.

MR. RUSSO: It's an excellent question and in a perfect world if it were done that way, okay, whether, and remember these are medical,malpractice cases we're talking about today, it's a good question for slip and fall cases, it's a good question for divorce settlements, it's a good question for automobile accidents.

MR. RUSSO: That's right, and what happens is rarely, except in the one percent of the cases, in any of those cases the one or two percent that yeah, that get tried, he's exactly right, there you're going to have apportionment because the jury or in some of the case like divorce, the judge will do it piecemeal
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because that's what he or she will do because he or she is making that decision. That is the one or two percent of the cases that don't get settled at some point in the

system. It's -- it's an amalgamation where it's a give and take and what happens is I can understand why they don't put that in their books, there is no way to exactly do it on a settlement, of course, those are all factors that are done on the fly and it ends up with one number and, of course, in some cases you take into account and again, you can't take in quotes the pain and suffering in account but, of course, you, but things like medical bills, lost wages, future lost earnings, those things are a little easier to quantify, whether an auto accident or malpractice case, but you're not going -- we're not going to get from them, even if they -- I don't even think they can do it if they reopen the files because that's again a kid going to a surgeon and only a surgeon who is a professional on the fly, as Dr. Munoz says before, I think he gave the example look, well, if I told you it's six percent of this and twelve percent of that you'd walk out of my office. Well, that's why he's the professional, he makes those decisions as you do on the fly and you do them and that's the way those things are done. So, the problem here is I don't think this committee, even if we

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subpoena, will ever get the data we would actually need to decide whether or not the caps will do exactly what we think they're going to do.

CO-VICE CHAIR WEINBERG: A very interesting observation. Assemblyman Conaway.

MR. CONAWAY: Now, so -- so, I think the question has been raised of whether or not -- 'cause

there's a lot of heat being generated around this question, whether or not in practical terms we're going to be able to get the settlement data. I think that's the long and short of it. Moving on, you mentioned -- well, I understand, it makes sense to me, that there are confidentiality issues that -- that are in brought into question when we try dig into that data. You can imagine because I read the questions, people -- the severity question keeps coming up, the other witness -- and every time something goes up it's all due to severity when you're looking at something in a particular year at a particular time and I kept wondering for myself why aren't we looking at severity over time and putting a question line on that as we do for everything else, but there are -- it is certainly possible that if we say that X happened to this mythical patient, not this mythical patient in this area, that you're going to be able to identify who that patient is and who the doctor is and that presents problems for your company.

MR. PILLION: Yes, it does.

MR. CONAWAY: Okay. Now, moving on to a question that was asked by Assemblywoman Quigley, I wanted to get more into that, the question of the definition of bad faith and limited payouts. Can you put more clothes on -- what do you suggest we should do in that area and if you could be specific I'd appreciate it. What we ought we do with that bad faith problem?

MR. PILLION: Well, what we would suggest is to be considered is that they enact legislation to give clear direction to the court that says if an insurance company has any reasonable basis, and you can define what constitutes reasonable basis, if you want it in great detail or leave, any reasonable basis, very broad, to make the decision to defend the doctor in a malpractice case and the judgment comes back after they have the opportunity to settle within policy limits, but didn't that that will not constitute bad faith and the concept of bad faith is -- goes back, I'm sure everybody in the legal profession knows the Roe Farms case, the swim club down in Jackson Township right off of Route 571 where the insurance company had the opportunity to settle a serious injury against a swimmer who dove in

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and got injured, could have settled the case within the policy limits, didn't, took it to trial, the judgment came back beyond the policy limits, the insurance company said we're only going to pay up to policy limits, it was appealed and the New Jersey Supreme Court says you can't gamble with the insured's money. You know, but I don't know, I don't recall specifically if the carrier had a reasonable basis, but I think since then insurance companies have been very hesitant to take any case where there's a possibility of bad faith all the way to the top court and try to have a finding that they acted in good faith, there's just -- there hasn't been a good track record with respect to even if you have the best reason and rationale for trying to defend

a case that had a very bad outcome, if you had the opportunity to settle the case within the policy limits within the industry, there's a very great reluctance to take those cases to trial.

MR. CONAWAY: Which -- and I think that strengthens the hand, I guess, or the plaintiff's burden that particular --

MR. PILLION: And you know what, they're very capable in utilizing it to the benefit of the client, yes.

MR. CONAWAY: And after this particular provision, is there a down side to the position, therefore, involved in this case, are they going to be then liable for those amounts which -- which then come in over their policy limits? I know there's some question about whether or not when these high awards come in how much the -- the financial assets of the physician personally might come into play, what are the down sides to this proposal, please, particularly as regards to the physician.

CO-VICE CHAIR WEINBERG: The down side to the benefit?

MR. CONAWAY: Yes, I mean, if we do his provision I want to know is, you know, all of a sudden people are going to start losing their homes.

MR. PILLION: Well, I think to approach it from a comprehensive -- in a comprehensive way, it may require that the legislature come to a consensus in a

finding that the physician's exposure is limited also to the policy limits, you know, then you get into, you know, should you mandate a certain level of limits for different physicians based upon the potential injury that a bad outcome or malpractice could have in their field, the type of discussion and issues that you really have to address is -- many facets to that issue.

MR. CONAWAY: My last question, if I may?

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MS. QUIGLEY: May I ask a question?

CO-VICE CHAIR WEINBERG: Yes. Assemblywoman Quigley.

MS. QUIGLEY: I want to, if I may get a clarification of that, are you saying in that case if the policy limit is say half a million dollars and a jury award is a million dollars that neither the doctor nor the insurance company would have to pony up that other half a million, we would be saying to the patient tough luck?

MR. PILLION: I don't know if that's the outcome that you would want and I don't know if that's the outcome, no.

MS. QUIGLEY: Not the outcome I would want, no, but would that be the outcome that would almost inevitably result?

CO-VICE CHAIR WEINBERG: Assemblyman McKeon.

MR. MC KEON: You give me more credit than I had, but -- and it doesn't directly answer your question, but I'd like everybody to -- God bless you,

'cause what I'm about to say is the truth. I want everybody to appreciate what they're hearing here and first off, I'd like to say that Mr. Pillion, I've known for 20 years and he has the upmost of my respect and credibility relative to what he says today, he happens to be a good democrat, too. What this insurance executive is telling you is that they want to try their cases, that the jury system works and that if they were able to try all of their cases in light of what the statistics show that justice would be done. He's telling one of the reasons they don't is because of the specter of going beyond policy limits and, therefore, they settle the vast majority on the basis of worrying about exposing them to a verdict that goes beyond those limit. So, therefore, I think we should all think about that, that the insurance companies, themselves, are telling you, we try every case because we win 80 percent of them, but what we fear is going beyond the policy limits and, of course, the doctors, in their best interest, force these cases to settle not wanting to expose their personal assets beyond that, vis a vie the case of Roe Farms. So, going a long way to get to your point, my colleague from Hudson County and affiliated with Christ Hospital, another great place, if the insurance coverage was adequate for the -- for the victim, three million dollar limits, I have no problem with limiting those numbers to policy limits, I'm using three million as a number that maybe it's two, but if

the policy limits were adequate, then limiting the policy limits would -- would may be be a potential solution and something that I think that we, as a Committee, should explore, but would have to have an adequate amount.

MS. QUIGLEY: May I ask through the chair, if the policy limits are not adequate in that case, what happens?

MR. MC KEON: Can I answer?

CO-VICE CHAIR WEINBERG: Yes.

MR. MC KEON: I mean, it would be a case for example of a 25 year old that's through some problem is incontinent for their entire life, what might a reasonable jury do to that, what's that worth beyond whatever it might due in keeping him from working or conducting themselves in an ordinary way and, you know, that verdict is an unknown, so -- you know, so, therefore, usually a case like that, even that liability might be questionable, will settle for close to policy limits because of the catastrophic exposure that might be there. At the end of the day, though, the plaintiff's attorneys, on behalf of their clients, are taking those policy limits, it's rare, if ever, that you see attorneys go after the personal assets of physicians or any other insured for that matter, that rarely happens in our tort system, whether it be medical malpractice or otherwise.

CO-VICE CHAIR WEINBERG: Since you're waiting patiently, well, please, go ahead and finish.

MS. POU: I do have a question.

MR. CONAWAY: Of course, the question is how much often those policy limits have been reached or breached lately as opposed to many facts. My last question was on -- in the area of regulation because there's -- there -- there -- and if this is beyond your purview, that's fine, but I'll have to ask somebody else, but there are going to be proposals, as you probably heard to -- to move us toward California and in terms of rationing out the regulation insurance companies, there sounds like there is a proposal out there which would require you to -- to start collect data that, I guess, currently you don't collect. Can you give some assessment of the impact of some of the regulatory things that are in the current proposals? I mean, current assembly and the senate proposals on what -- on business?

MR. PILLION: I recall that there are some fairly burdensome requirements that are in both the senate and the assembly version. I'm drawing a little bit of a blank a what they were --

CO-VICE CHAIR WEINBERG: I think, if I can

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help you out here, if you look at the last paragraph, your first page where you say caps are only one component and we need a comprehensive tort reform effort, my understanding is that most of what is outlined in that paragraph is in in the tort reform package, in A50, that we originally passed when we

separated out a premium subsidy. It's this the last paragraph on page one of the testimony and I believe most of that in is our legislature, am I correct?

MR. PILLION: The issue of increased regulation on the insurance industry is -- I can make a general statement about -- I'm just more referencing back to prior testimony from Mr. Weiss with respect to making the use of a filing system that's currently in place versus the prior approval, my recommendation, although I don't know what senior management would do, but my recommendation would be not to impose a change to use in files to prior approval. As a matter of, you know, practicality, there is somewhat of an informal dialogue between carrier and the department even under the user file has been my experience, I've advised our company to be very cautious about taking any type of rate increase where you might be forced to go back and give the money back due to the administrative burden, the embarrassment of doing that, so as a practical

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matter we -- you know, we don't just, you know, make a pronouncement issue, a press release and say this is the new rate, that's not the way it works, at least, with my experience. So, I wouldn't be recommending that we engage in a big battle with the regulatory issue of prior approval to be honest with you.

CO-VICE CHAIR WEINBERG: Assemblywoman Pou.

MS. POU: Thank you very much, Madam Chair. I'd like -- in your testimony there's -- or in the prepared testimony, there is an area on page two which

refers to, from the fourth paragraph that talks about the Medical Malpractice Reinsurance Association and you made reference also -- it's also stated in the testimony that the Princeton Insurance felt that this was a very positive position taken by the Commissioner of the Department of Banking and Insurance, I'd like if you would, please, explain and there's a reason why I need you to do that, but if you would explain what does the Medical Malpractice Reinsurance Association does and then I'm going to ask you how it relates to the Princeton Insurance Company, but if you would describe very -- as quickly as you can or as detailed as you want that particular procedure.

MR. PILLION: Again, I'm a little rusty in that area, but I think I have a working knowledge of it,

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the Medical Malpractice Reinsurance Association, as I think it's intended to be utilized going forward after this recent reactivation is to provide reinsurance only to the medical malpractice carriers in New Jersey who have had trouble finding reinsurance at certain levels of exposure. In Princeton's case, our testimony indicated we were having trouble finding reinsureds below the one million dollar attachment point. You know, you would be sharing some of your premium with the Medical Malpractice Reinsurance Association, seeding it to them to pay for the reinsurance, the concept of an insurance company buying insurance from another company. Currently, the commercial market is not very good in our

opinion for reinsurance for medical malpractice at certain levels in New Jersey.

MS. POU: Let's go back to your -- the statement just before the last one, that it's a series of different companies providing insurance, that together -- that one half to those other insurance, for those individuals that do not have insurance. Now, in order for you to do that as a company, are you not required to come up with some basis of how you are going to sell your insurance half or part thereof to those other insurance carriers, mainly the Association and if so, how are you -- how are you coming up with that

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estimated amount if in earlier in your statement you talked about how Princeton Insurance is not in the position of having any or conducting any actuaries, if you're not in the position of doing that, how are you coming up with an estimated dollar amount in terms of selling off whatever part thereof to those other insurance carriers when you're not using any basis of that?

MR. PILLION: What I believe the procedure will be is that Medical Malpractice Reinsurance Association which is an entity created by the legislature going back to 1976, they will be hiring actuaries to advise them with respect to what part of primary premium at Princeton or any other carrier that engages in a reinsurance transaction with the Reinsurance Association should give to the Reinsurance Association for the protection it is affording to the

primary carrier. There will be a group of professionals hired and paid for by the New Jersey Medical Malpractice Reinsurance Association, it will be operating, you know, as if it were a commercial reinsurer, it just happens to be a state created entity that is acting in the capacity of a commercial reinsurer. It will be hiring professionals to give it advice and to negotiate on its behalf.

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MS. POU: If I may just interject, I understand that's -- you're describing a responsibility that would fall under that of the Association, am I understanding you correctly?

MR. PILLION: Yes.

MS. POU: Okay. I guess, my question is on your part and on the part of the Princeton Insurance Company, am I to assume then that you would take that information as prepared by those -- by the professionals that you talked about that's been hired by the Association and accept whatever packet or price index dollar amount that would come before and present it to the Princeton Insurance and accept those dollars -- that amount from them directly or is Princeton Insurance not engaged in any part of that decision making process?

MR. PILLION: It is, I believe, because in order for the Reinsurance Association to become informed and to make a good business judgment about what type of reinsurance contract to enter into with any primary carrier, that primary carrier, including Princeton,

would have to provide them with lost data and certain information, just like I understand we do when we go out to the commercial market for the higher layers that are still available.

MS. POU: But my understanding was that you do not currently provide that information?

MR. PILLION: To who?

MS. POU: Or that you don't have the where with all or that you do not maintain that type of information based on those actuary figures?

MR. PILLION: The breakdown between economic and non-economic are we discussing?

MS. POU: No, just in the overall dollar amount that estimates what -- if I was Insurance A and wanted to sell insurance, a part to Insurance B, Company B, how would I be able to do that if I am not providing as a Company A any form of data that will allow for me to come up with a cost, an actuary cost for me to be able to say to Company B that in order for Company B to provide insurance to 20 different physicians or -- that needed medical malpractice insurance, how do I come up with a figure if I'm not providing -- that I'm not maintaining that data and how does Company B come up --

MR. PILLION: We have -- we have the data that the reinsurance companies need. They look at, you know, aggregate data --

MS. POU: Okay. Well, if you have the data that the company needs then why is the data not available to us as a Committee to provide and come up

with an understanding of what that cost would be?

MR. PILLION: There is a vast amount of data that would be available to the Committee in which we want to give to the Committee provided we can enter into some type of an agreement that protects its confidentiality, the level of detail is such that it would inadvertently disclose individual identities of hospitals or doctors or patients, so the data is there.

CO-VICE CHAIR WEINBERG: Okay. Wait. I'm going to ask everybody to hold this because we're going to take a five minute break or the court reporter will no longer be able to work her hands to continue doing the transcription of this. I tried to wait for an automatic break, but it doesn't seem to be happening. So, we are taking a five minute break. We hope you will stay and continue.

MS. POU: It's okay, Madam Chair. I waited all day to ask my question and thank you very much.

CO-VICE CHAIR WEINBERG: She's really having a problem. Hold the thought, you will be the first when we come back, just five minutes.

MR. PILLION: Thank you.

(Whereupon, recess was taken.)

CO-VICE CHAIR WEINBERG: Assemblywoman Pou. She's all refreshed and ready to take down every word.

MS. POU: Thank you, Madam Chair. Hi, I don't know if you remember the question, but if you would, please, try to respond to our -- my earlier

question.

MR. PILLION: Yes, let me take the opportunity to try to be clear about what Princeton is suggesting with respect to the data that we know is available and we do want to give the Committee, the framework that we think that works to protect the confidentiality, the same information we would give to our reinsurers when we go to them to purchase reinsurance so they know how to price the reinsurance for our exposure, when we give it to the reinsurer we know that it is staying confidential and is not going to become part of a public record subject to the Open Public Records Act. The framework that we're suggesting may work for this Committee is to let us give that data to an outside independent party who uses the data, gives the confidentiality agreement that actuaries customarily give to clients when they provide data, so that the raw data does not become part of the public record. The findings that the actuaries may, you know, have with respect to analyzing the data in whatever way this Committee would ask them to analyze it, certainly, you know, are part of the public record, but the raw information that we would be giving them, similar to the
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raw information we would be giving to our reinsurer, you know, would be, we think, the framework, we think would work, we think would enable the insurance carriers to be comfortable that the raw data about our individual customers, patients, minors would stay confidential because it is going into the hands of professional

actuaries who will analyze it pursuant to the direction of this Committee and that's a framework we think may enable this Committee to get the data it needs, the professional actuarial analysis that it wants, so that it has a very informed understanding of, you know, this very complex area, medical malpractice insurance, but I think that's, you know --

MS. POU: Okay. Let me -- I think I understand, hopefully, but, please, correct me if I'm -- if I'm saying the wrong thing. So, is it my understanding that if we were to just -- I'm just going to go along with what you said, if we were to consider -- do -- provide that information to a professional actuary insurance provider or is that -- am I using the right term here?

MR. PILLION: Yeah, the actuaries -- the actuaries that analyze insurance loss and premium data, investment income data --

MS. POU: That information then would then

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be shared and you're suggesting that that -- that that would be okay to have that information shared with this body?

MR. PILLION: The information would go to the independent actuarial firm that this body agreed to retain and hire. We'd send the data from Princeton Insurance Company to that actuary, they would analyze it in whatever manner you deemed appropriate to get the kind of analysis and detail that you need.

MS. POU: Okay.

MR. PILLION: They would also be agreeing with us, Princeton, that they wouldn't disclose the information in a fashion that could impinge upon the confidentiality of a particular hospital or a doctor or a patient. We think that's a good framework, we're not 100 percent certain, we just had some preliminary discussions with this Committee's professional staff in that regard.

MS. POU: Let me -- let me just mention that the reason why I led to this point now is that earlier in your comment when you even considered proposing that, as part of your statement you also said although I am concerned of what some of our other competitors having this information available -- you know, our competitors, so we come back to the question

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what kind of data, be that wrong or -- and certainly that's not -- obviously, I understand clearly what you're saying or be that through a professional actuary analyzing -- analyzer that's going to provide that information, at what point do we receive information that's going to be helpful to us to come up with an understanding as to what the actual estimated cost for medical malpractice premium dollars would be?

MR. PILLION: It would be, I believe, that it would be presented in a report issued by the actuarial firm that this Committee decided to hire, is how I would envision it.

MS. POU: Thank you, Madam Chair.

CO-VICE CHAIR WEINBERG: Assemblyman Wolfe.

MR. WOLFE: Yes, I have one question, I must say that my knowledge of this issue is related to John Grisham's books, I never read anything about medical malpractice, but frequently you read in the paper the jury has awarded a certain amount of money and yet that money is never ever collected, so to speak. So, what is the typical practice in a medical malpractice, is the total money paid or is a portion paid or is some of it written off, I mean, how usually does it work out?

MR. PILLION: If there's adequate policy limits to cover the judgment --

MR. WOLFE: Right.

MR. PILLION: -- you know, unless the judgment -- because there might be appealable issues, there may be a negotiation between the plaintiffs and the defendants that they settle after a jury trial for something less than the jury awarded because there may have been appealable issues at the trial, as long as the policy limits are available the companies, you know, have to pay up to the policy limits under the contract.

MR. WOLFE: And if it's above the limit?

MR. PILLION: I think Assemblyman McKeon kind of addressed that issue better than I could, he's a practicing defense attorney and well versed in what happens in that area.

MR. WOLFE: Okay. Thank you very much.

CO-VICE CHAIR WEINBERG: Any other questions? All right. Just to sum up, I'd like to find out, does Princeton have in aggregate how much you pay out in out of court settlements?

MR. PILLION: Yes. Yes.

CO-VICE CHAIR WEINBERG: Is that information that you could supply to this Committee?

MR. PILLION: It's information we can provide to the Committee depending upon the level of
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detail that you're actually looking for. If there's -- if I have a concern that it might reflect that a certain hospital in a certain county was involved in settlements that summed up to seven million dollars, I would advice that we not disclose it in that format.

CO-VICE CHAIR WEINBERG: But if I just asked you for the aggregate number, the numbers of doctors and/or institutions that that aggregate number represented, would you not be able to give that to us without worrying about confidentiality rules?

MR. PILLION: Very likely I could, I mean, I could recommend that we do that, yes.

CO-VICE CHAIR WEINBERG: I have one closing question and, I guess, this continues to mystify me since nobody seems to be able to give a breakdown or ever bothered to capture economic versus non-economic data, where did $250,000.00 come from?

MR. PILLION: I think what -- there were different numbers that I saw in the different -- those are numbers, I guess, that come from studies that were

done trying to analyze at what level would a cap yield a potential savings in the malpractice premium. I would have to refer you to whatever actuarial reports were used when they gave those numbers.

CO-VICE CHAIR WEINBERG: I'd be very

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interested in finding out where this -- I don't want to use the word myth because it's too pro-jargon, but where $250,000.00 emanated from, it was put in in California 20 some odd years ago, it is still being used as the magic number in New Jersey today, but so far from everything I've heard nationally, as well as in the State of New Jersey, nobody has any idea of if you've paid out $100,000,000.00 in the course of a year, I'm just making up a figure, whether 90,000,000 could be economic damages and 10,000,000 non-economic damages, nobody has any idea of which portion of those payouts are the magic non-economic damages which somehow will hold down premiums if we decide that 250,000 or 300,000 is the cap. So, if you've got any actuary studies or anything that would lead us to believe that this $250,000.00 magic figure that is talked about nationally, as well as statewide, has any basis in fact, I'd really be interested in seeing that.

MR. PILLION: I do have a study that I can provide you, it is based upon New York claim experience, it was commissioned by our parent company Medical Liability Mutual several years ago, it is -- because of that it's based upon all claim values and I believe from

recollection that they did an analysis that making assumptions that if a cap on non-economic damages was set at different levels what they projected saving in reduction in the malpractice premium would be and it's a fairly -- a fairly detailed actuarial analysis. I think it's a good starting point to get, at best, from my standpoint, gave me a bit of a working knowledge of how these actuaries seem to approach this issue. Again, it's based on New York data, but the methodologies could be similar to any type of study that would be done with specific to New Jersey data, so I can provide that to the Committee.

CO-VICE CHAIR WEINBERG: I, for one, would appreciate that, and if we can have the beginning of the aggregate that Princeton has paid over the course of the last five years on out of court settlements, the numbers of doctors and/or institutions that that covered, that would be a beginning for us to start sorting out some of this information and I would hope -- I mean, I know that there might be some more questioning, it's almost four o'clock, we are not going to hear from anymore witnesses today, that this is a long arduous road that we're on, but I'm determined, and I think with the co-cooperation certainly of my Co-Chair of this Special Committee, that New Jersey might be among the first states to actually find out the information it needs to find out to come up with a rational plan to help keep doctors practicing in an appropriate manner, particularly obstetricians and gynecologists who seem to be having the most problem and

I would hope that this Committee is going to gather all of the information it needs to make those decisions and we're all going to give up on the slogans.

CO-VICE CHAIR COHEN: When you're gathering the information that -- and I'm sure our staff is going to be in contact with, you know, your office and, you know, some other carriers, the gross -- the gross payout that Chairwoman Weinberg referenced, you can have a gross payout in a case of $2,000,000.00, but the individual payout on the individuals, it could be 50,000 for the nurse, 200 for the hospital, 300 for the one physician, 150 for another physician, 100,000 for the radiologist, I would like to see how those things break out in terms of the -- in terms of the liability.

MR. PILLION: I'll have to get back to the Committee.

CO-VICE CHAIR COHEN: We don't need a -- you know, we're not going to get it by tomorrow, obviously and as the Co-Chair has so wisely indicated, it's an arduous process and the process is not ending on November 3, so that everyone should be aware. This is -- this is not generated by an election year, this has been a two year process of trying to get

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information, to be intelligent and thoughtful about this issue.

MR. MUNOZ: Just for information, I'm told that the Telehast Report has something about the $250,000.00 or rather and, so, I mean, I would like to

look at it, too.

CO-VICE CHAIR WEINBERG: That has been provided to this Committee, so certainly we'll ask, have to get you a copy of that.

CO-VICE CHAIR COHEN: I'm not sure, you wouldn't have been at the last meeting since you're not on the Health Committee or Insurance, two meetings ago the actuary for the New Jersey Medical Society testified and when asked how did he come up with the 250 he had no idea 'cause he had no underlying data at all and we're being told that that underlaying data doesn't even exist. So, I now know why he didn't know where it came from, and right now no one knows where 250 came from, except some artificial number that has been chosen several years ago and it's been carried forward. You really didn't know that because you wouldn't have been on the Committee.

MR. MUNOZ: You know, it's interesting that 25 years ago, whenever it was the state imposed that limit which would be, you know, how much does a Hershey Bar gone up in price, would be a lot more now.

CO-VICE CHAIR COHEN: Well, since my father worked for Hershey for 40 years I could probably discuss that with you probably as to why the cost of that is --

MR. MUNOZ: Makes my day.

CO-VICE CHAIR WEINBERG: Thank you for your patience and thank you for those that -- the Insurance Committee started out promptly, but I will say it was the Health Committee who lasted through the day.

CO-VICE CHAIR COHEN: That's true.

MR. PILLION: Thank you members of the Committee.

CO-VICE CHAIR WEINBERG: Yes, we are adjourned.

(Proceedings adjourned 4:00 p.m.)

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C E R T I F I C A T E

I, KATHLEEN F. SIGLE, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, certify that the foregoing is a true and accurate transcript of the stenographic notes of the deposition of said witness who was first duly sworn by me, on the date and place hereinbefore set forth.

I FURTHER CERTIFY that I am neither attorney nor counsel for, nor related to or employed by, any of the parties to the action in which this deposition was taken, and further that I am not a relative or employee of any attorney or counsel employed in this action, nor am I financially interested in this case.

_____

KATHLEEN F. SIGLE, C.S.R.
LICENSE NO. XI00682

APPENDIX

Howard P. Weiss
NJ Assembly Testimony – October 2, 2003

I thank you for the opportunity to appear before you today. I will take just a few minutes to outline my background. Back in the mid to late 1970's and early 1980's, I was one of a team of health care consultants that worked with state medical societies to form seven captive medical malpractice insurance companies (Illinois, New Jersey, Connecticut, District of Columbia, Minnesota, Utah, Texas). After the creation of MIIX in New Jersey, I remained a consultant to them until October 1978, when I joined them as Vice President and was subsequently promoted to Senior Vice President. I left MIIX in January 1992. My responsibilities included legislative affairs (particularly the passage of tort reform), actuarial, statistical analysis, information services, new business development and general troubleshooting. I also served on several national medical malpractice committees through the Physicians Insurers Association of America (PIAA).

From 1980 to 1991 I led the tort reform effort at MIIX. This effort centered around a number of different proposals including collateral source offsets, joint and several liability issues, mandatory arbitration of small claims, periodic payment of future damages, a $250,000 cap on pain and suffering, and revising the statute of limitations. We were successful in enacting an offset for collateral sources, a revised doctrine of joint and several liability and mandatory arbitration of small cases (which was subsequently found to be unconstitutional). Our own data had shown that collateral source offsets and a more equitable approach to joint and several liability would have a meaningful effect on losses and as such on premium rates.

The cap bill was part of our "window dressing". Our data showed that had a $250,000 cap on non-economic damages been enacted we would not have been able to cut premiums by even ½ of 1 percent. The overwhelming majority of indemnity dollars on settlements is for real economic loss for past and future medical care, past and future lost income, past and future custodial care, and renovations to homes for those who suffered severe handicaps through the negligence of health care providers. Not only is the overwhelming majority of indemnity dollars on settlement for real economic loss, but in most cases the settlement amount does not even cover full economic loss. In all the years I was at MIIX, covering thousands of claims, the number of claims where the settlement amount included $250,000 for non-economic loss was miniscule. The medical and insurance communities claim that a large portion of claim payments are for non-economic loss is ludicrous. They have no basis on which to make such claim. The insurers do not even keep such data on their system. If there were such a basis they would surely share the detail data with you on a case by case basis. MIIX in

its response to the Assembly's request for data has indicated that they "cannot break out between economic and non-economic damages".

Based on my 28 years involvement in medical malpractice, I would venture to say that non-economic damages do not and have never reached 10% of total loss payouts. If non-economic damages were the driving force in the escalation of medical malpractice premiums, how can we explain the ever increasing premiums of lawyer's professional liability and accountant's professional liability premiums, as losses related to these lines of insurance have do not have a non-economic component. Passage of a cap on non-economic loss would not serve to reduce losses or premiums and would only serve to deny severely injured people just compensation.

My 28 years of experience in medical malpractice had also taught me that frivolous claims are not even a small problem for medical malpractice insurers. It is a virtually non-existent problem. We must first make a distinction between a frivolous claim and a non-meritorious claim. While many claims turn out to be non-meritorious extremely few are frivolous. A person who has an encounter with a health care professional that results in an untoward result has the right, if they so choose, to investigate the sequence of events that led to the untoward outcome. This is called discovery. The overwhelming majority of cases where no negligence is found are not pursued by plaintiff counsel. I can give you some real and accurate statistics that can attest to that.

For the last 11 years, I have been with Second Opinion, Inc. a company that was created solely to assist plaintiff attorneys in the evaluation and screening of potential medical malpractice actions. During this period we evaluated 3576 cases for about 600 attorneys in 32 states. Out of these 3576 cases our clients have proceeded with 610 or about 17%. The other 83% or 2966 have been dropped by our clients.

In 755 of these 2966 cases which were not pursued it was our judgment that the health care provider was indeed negligent, but either the damages were not sufficient to pursue the matter or the negligence could not be causally linked to any damages. In essence in the 3576 cases we evaluated, more cases of negligence 755 were not pursued than pursued 610.

Other statistics gathered from a prestigious law firm who practices in the Cherry Hill area of New Jersey and in the Philadelphia area of Pennsylvania are quite revealing. Over a period of 19 months 323 individuals sought representation as plaintiffs in a medical malpractice action. As of the time of this study only 12 had been accepted as clients and only one lawsuit had been filed.

Frivolous cases would encompass those cases in which there was no real injury. During my time with MIIX the number of truly frivolous cases, ones in which there was no untoward medical outcome were again miniscule. These few and I reiterate few cases do not put a financial burden on the insurer. While many cases may turn out to be non-meritorious once the discovery process is finished, these cannot and must not be called frivolous. Everyone is entitled to investigate untoward outcomes.

What we can glean from all of this is that plaintiff attorneys have no reason to file so called "frivolous lawsuits" and in fact do not. Why would they want to spend the better part of four to five years of effort and $40,000 to $60,000 in out of pocket expenses, on average, on frivolous cases? If they did they would go broke.

New Jersey courts have had the ability to award court costs and attorney fees in so called "frivolous cases" for many years. The instances where such awards have been made are few and far between.

Another part of our "window dressing" was a revision to the statute of limitations for minors. Our own date showed that reducing the statute of limitations from age 20 to age 11, would have no effect on premiums. The overwhelming majority of indemnity paid on case involving minors are on cases involving severe neurological birth injuries. The overwhelming majority of these cases are filed within three years of birth of the child. Parents notice early on that the child is not developing normally – not rolling over, not following motion with their eyes, not crawling, not walking, not talking etc. Most certainly there are some cases filed during the first few years of schooling grades kindergarten, 1, 2, 3 etc. when some learning disabilities are uncovered. These are rather few, however. Modifying the statute of limitation for minors from age 20 will not lower losses and as such premiums, but will just serve to deny children whose parents chose not to file an action from filing one when they are old to enough to understand the circumstances surrounding their situation.

So why is there a current medical malpractice "crisis"? The fact is there isn't a "real" crisis. This is a "crisis" created by the medical malpractice insurers because of their own ineptness during the 1990s and the collapse of interest rates during the last few years. The 1990s were a time of diversification and geographic expansion for medical malpractice insurers. Many companies were looking to go public. Market share was prized. The market place became extremely competitive. Premium rates were continually slashed so that market share could be attained. These decreases in premium rates were solely a marketing ploy. Many different discounts were applied to the base rate in order to attract new business. The companies could not substantiate that these discounts were actuarially sound and in fact they were not.

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In addition, to writing insureds at inadequate premiums, the insurers lowered their own underwriting standards so that they might increase market share.

In the late 1990s, insurers, who were already writing insureds they probably shouldn't have and at inadequate premiums, got hit with the "crash" of interest rates. They finally had to stop all the "foolishness" of the 1990s and get premium rates back to where they should have been all along. They also decided that they were entitled to recover all the money they had lost due to of their bad business decisions and the falling interest rates. But by so doing they created a public relations disaster with the medical community.

Their answer was to create a "crisis" by telling the medical community that they had "real" non-economic losses that were driving premiums through the roof. At the same time they raised premium rates of high risk specialties such as OB/GYNs, orthopedics and neurosurgeons to astronomical levels and said it was actuarially appropriate. They lied on both fronts.

Insurance is a spreading of the risk, and as such, high risk specialties should be subsidized by low risk insureds. This is feasible because high risk specialties have many fewer class members than lower risk specialties. For example, loss data might show a neurosurgeon to be 30 times the risk of a family practitioner. That does not mean that the insurer should charge a neurosurgeon 30 times the family practice rate. This would place an undue hardship on neurosurgeons. They should be charged a reasonable rate and the difference made up by marginally increasing the premium of lower risk specialties.

MIIX was formed in combination by the Medical Society and Osteopathic Association. MIIX was formed as a reciprocal insurance company and hence had a Board of Governors made up of 17 physicians. As a reciprocal, MIIX had no employees. It was run by an attorney-in-fact that was fully owned by the Medical Society of New Jersey. It had a Board of Directors made up of five physicians, Vince Maressa, the executive director of the Medical Society and Peter Sweetland, the President of the attorney-in-fact. Both the Board of Governors and the Board of Directors were "stacked" with physicians who also served on the Board of the Medical Society, Osteopathic Association or were otherwise politically connected with these organizations. Far and away the Medical Society had the most representation. As such, MIIX was always governed with an eye toward what was good for the Medical Society.

Premium discounts were given for being a member of the Medical Society even though there was no data to suggest that such membership reduced a doctor's risk. This was done to encourage doctors to join the Medical Society. In essence premium dollars were used to subsidize Medical Society membership dues. Outlandish perks were given to Board members including

million dollar life insurance policies. In the late eighties and early nineties after Peter Sweetland, the President of MIIX passed away, Vince Maressa used this opportunity to seize the Chairman of the Board spot. Up until that time, the Chairman had always been a physician.

Vince Maressa hired Dan Goldberg as President. He changed MIIX philosophy. Up until that time MIIX's mission was to assure that the doctors in New Jersey would never be without a reasonably priced market for medical malpractice insurance and hence one of fiscal responsibility.

We were a not-for-profit company, who had returned money to the physicians in the form of dividends. Vince Maressa and Dan Goldberg, with an eye toward taking MIIX public, measured success in terms of market share. The more insureds the better, even at inadequate premium rates.

The expansion into other states was undertaken with the idea to write as many insureds as possible regardless of whether they were reasonable risks or whether the pricing was adequate. MIIX underwrote bad risks at inadequate premiums in environments about which they knew nothing. They then chose to pile the consequences of these atrocious business decisions on the backs of the New Jersey doctors. I personally saw Dan Goldberg take a large group of doctors away from Princeton Insurance Company by offering them a large reduction in premium after Princeton had quoted them a huge renewal increase because of their adverse claim experience. The difference in premium was over 50%.

More and more insureds and more and more premium income (immediate cash) would make it easier to take MIIX public and make several insiders very well off. In essence, the physicians in New Jersey were abandoned by MIIX and the Medical Society because of a few greedy individuals.

It is ironic that the same people who are screaming for tort reform announced that MIIX's first quarter of 2003 resulted in a $7.2 million profit. They suggest that this might be related to their new philosophy of "best practices." In other words, why don't we settle meritorious claims quickly thereby saving both indemnity and defense costs? Why now? Where were they all these years? MIIX first President was Peter Sweetland, a true insurance professional with many years of prior medical professional liability insurance experience with the Traveller's Insurance Company. After Peter's death, the Medical Society and Vince Maressa hired Dan Goldberg, Ken Koryeva and Patricia Costante to run MIIX. None of them had had any experience in insurance, no less a long tail and complicated line of insurance such as medical malpractice. As such, the Medical Society could control MIIX and its operations. It is ironic that in between Mr. Koryeva and Ms.

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Costante, they did hire a true insurance professional to run MIIX. He left after only about one month on the job. I wonder why.

I would not want to leave today without discussing several proposals that will help cut losses and lead to premium stability and even reduction.

A good place to start would be to insure that insurance professionals are running the insurance companies. Not lawyers, not doctors and not Medical Society Executives.

An extremely good start was the 1995 legislation requiring an affidavit of merit. The number of medical malpractice claims filed in New Jersey has fallen from 2200 in 1994 to 1613 in 2001. This is a decrease of over 26% and is directly related to the affidavit of merit requirement. The system now disposes of non-meritorious (not frivolous) matters early on, saving everyone significant time and money.

A further good step was recently taken when the insurance department reactivated the Reinsurance Authority. I spoke of the need for this action back in May. This will serve to make medical malpractice insurance more widely available.

The next issue relates to the State Insurance Department. This department which is supposed to be an advocate for insurance consumers is really an advocate for insurance companies. States should not allow premiums to be used and then filed for approval. New Jersey is a "use and file" state. Premium rates are made, put into effect by the insurer and filed with the department. It is anyone's guess as to when and if the department ever gets around to scrutinizing these filings. Even if they do, the rate has been in effect for a long period of time. The time has come to make all New Jersey a pre-approval state. Look what happened in California after Proposition 103 (insurance reform and pre-approval of rates) passed in 1988. Medical malpractice earned premiums decreased in six of the next 13 years and the decreases were more than sufficient to counter seven years of increases. Earned premiums in 2001 were down 2.4% from 1988. This is in sharp contrast to the experience following the passage of MICRA in 1975, which included a $250,000 cap on non-economic loss. In the first 10 years following passage, earned premiums had almost quadrupled. In 1985 the MICRA legislation was found to constitutional by the California Supreme Court and by the time Proposition 103 passed, medical malpractice earned premiums in California was five and one-half times that of 1975.

Premiums for medical malpractice are made by trending many individual factors. These factors include: How many claims are expected? What percentage of these claims will end up with a payment? What will the

average payment be? How many will require extensive defense costs? What will the average defense cost be? What will be our average investment return over the 15 or so years we will hold part or all of this money?

Because medical malpractice is a long tail line of insurance, meaning that it will be many years before all claims from a year are paid, it is prudent to build so called "fat" into the rate. But because the rate is made by trending many individual factors, "fat" built into each factor is compounded when these factors are multiplied to arrive at a final rate. In addition, actuaries are funny people in the sense that when a certain component of the rate rises they immediately take it as a "trend', but when the same component decreases they consider it an aberration. It is not a trend until it decreases several times. The statistical trending techniques they use although statistically sound, are only as good as the data they use in trending. This built in bias re trends vs. aberrations, again adds "fat" to the rate. Many medical malpractice insurance companies will tell you they use "independent" actuaries and as such have no control over the rate making process. In reality there is no such thing as an "independent" actuary. If the actuary does not comply with company wishes, he/she is replaced. Just look at ENRON who had "independent" auditors. The state insurance department has an obligation to assure that any so called "contingency " built into the rate is justified.

The insurance department should also have an obligation to ensure that high risk specialties are being subsidized by lower risk specialties. It is easy for an insurer to abandon this practice and charge high risk specialties such as neurosurgery, obstetrics and orthopedics among others, unreasonable premiums that are substantiated by an actuary's report.

Physicians should always have the choice of a claims made policy. This is especially important for new physicians. The first year cost of such a policy is substantially cheaper than an occurrence policy. Several subsequent years premiums are also cheaper. The losses are the losses. That may sound dumb, but whether you buy an occurrence policy or claims made policy the ultimate cost should be about the same because the losses are the losses. Payment of the premium under claims made is just deferred. The insurer may price the claims made product a little higher to make up for some lost investment income, but in general the total cost for a claims made policy should not be substantially higher than that of an occurrence policy. The insurance department is obliged to ensure that first, second, third, fourth, fifth and mature claims made rates are properly calculated. My gut feeling tells me they are not.

Insurers are also known to burden their insureds with increased premiums because of bad business decisions, whether involving underwriting bad risks,

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inappropriate claim practices or poor investment decisions. Premium rates tend to increase when interest rates are low and tend to maintain rather level when interest rates are high. An actuarial study has found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, insurers maintain premiums at modest levels, when the economy falters and interest rates fall, companies increase premiums. The insurance department should be charged with insuring that premium rates are accurately and validly calculated and provide the insureds with sufficient credit for anticipated investment income.

This leads directly into another issue related to investment income. Insurers and actuaries will tell you they for each dollar of premium they collected last year they paid out one dollar and thirty-eight cents. At first, this may seem alarming to you, unless you know how the rate is made. The premium collected during any policy year is paid out over many years. During the 15 or so years the premium is held, it will earn investment income. The major portion of the money is not paid out for many years. The insurer makes substantial investment income. Premium rates take this into account. The rate is consciously and deliberately made to expect a loss ratio of between 130 and 140 percent. Otherwise, the insurers would make unconscionable profits.

The next issue relates to the State Board of Medical Examiners and their failure to take repeat malpractice offenders seriously. Everyone has heard figures tossed about re 5% of the doctors accounting for 60% of the malpractice losses. This figure must of course be taken in context, as many of these doctors are in so called high risk specialties. A 'norm" must be established for each specialty and the Board of Medical Examiners must at a minimum investigate why those physicians who are one or two standard deviations from the norm are generating so many claims. That does not mean that every one of these physicians should be disciplined or sanctioned, but the public is owed an investigation that might result in positive practice changes. I am aware of Assemblywoman Weinberg's proposed legislation to encourage more active participation of The Board of Medial Examiners and whole heartedly endorse her proposal.

The next issue involves loss prevention. Loss prevention programs work. I sat on MIIX's loss prevention committee and the national loss prevention committee of the PIAA. When detail information about the causes of medical malpractice is disseminated to physicians, either directly or through organized medical groups such as specialty societies, physicians become better doctors and hence better risks. I have seen many examples of this in practice. One such instance involved anesthesiologists. During one two year period we had received about 15 claims involving the use of two anesthetic

agents in combination. After researching what was happening, we disseminated this information to the anesthesiologists through the American Society of Anesthesiologists. During the next five years we saw only one such claim. Like many professionals, physicians are mandated to take continuing education. Part of their continuing medical education should be mandatory loss prevention. Not only will this serve to decrease losses, but most importantly will lead to a significant decrease in patient injury.

The next issue relates to early settlement of meritorious cases. This does not happen for a variety of reasons. Firstly, many medical malpractice insurance policies contain consent to settle clauses. This prohibits the insurer from settling claims without the consent of the doctor. The clause was put in to show doctors that the new insurers were different from the old commercial carriers. In the beginning it did not seem to present a problem.

With the introduction of the National Practitioner Data Bank it became a big problem and is extremely counter productive. The insurer goes through an internal peer review and decides that this claim should be paid, but the insured says no. The insurer's hands are tied and the claim drags on for years. In essence this clause is direct conflict with the cooperation clause saying the defendant must cooperate in his/her own defense. The defendant must supply records, not alter records and show up for deposition and trial. Non-cooperation is grounds for non-renewal. Is withholding consent on a case that has been peer reviewed as indefensible really cooperating? An insurance company is a business that should be run as a business, this clause does not allow for that. I know of no other insurance policy containing such a clause. Such clauses should be abolished.

The second element working against early settlement is that many cases involve more than one defendant and hence more than one insurer. While insurers are placing blame on each other's insured, the case goes unsettled. A mechanism should be devised so that a meritorious case involving more than one insured can be settled and then liability apportioned through mediation or arbitration.

Since these meritorious cases are not being settled, the insurer and defense counsel have to do something, so they ask doctors to write reports saying the cases are defensible even though they know that not to be the case. As you can imagine it is much easier for the insurance company to get an expert than for the plaintiff. The insurer tells the doctor to write a report to help mitigate damages (called a sweetheart report) and promises that doctor that he/she will never have to show up for deposition or trial.

What is the effect of this delay in settling meritorious cases. Studies have shown that a claim that could have been settled within 12 months of

presentation that was not settled until between 36 and 48 from presentation cost 73% more in indemnity. When you add the cost of defending the claim, the cost about doubles. A meritorious case that could have been settled for $100,000 ends up costing $173,000 plus tens of thousands in defense costs.

Should a cap on non-economic damages become a reality, it would have a devastating effect on not only early settlement, but any settlement of meritorious cases. By so limiting the insurer's exposure, they would have no reason to settle any claim at any time. They would force everything to trial, as there would be no downside for them.

Finally, let me say that no legislation should ever be enacted without knowing the reality of the situation. Before you consider diminishing the rights of ordinary people, make the insurers provide detail, case by case data of actual indemnity payments broken out by category of damages. They should at a minimum provide total economic losses and substantiate this figure with a breakdown of economic payments into individual categories such as past and future medical bills, past and future lost wages, past and future custodial care, etc. Non-economic damages should be broken out into individual categories such as pain and suffering, mental anguish, disfigurement and loss of consortium, etc.

Current and past rate filings should be scrutinized to determine the extent of rate subsidies for high risk specialties, whether claims made factors are appropriate, the extent to which insureds are being credited for anticipated investment income, whether more current favorable trends in decreasing claims volume has been adequately trended into the rate, etc.

I have been talking with Bill Burns. Bill is an actuary currently working for a reinsurance broker in New York City. He was an actuary for MIIX for several years and after leaving MIIX spent several years as an actuary for PHICO in Pennsylvania. He is a certified actuary with extensive experience as a medical malpractice actuary. In addition, he has extensive experience with the New Jersey environment. My preliminary discussions with him, leads me to believe he would be willing to work with this committee to analyze the data collected by the committee. He would like to meet with the committee leadership to discuss this possibility. He wants the committee to know that he would approach this task with utter impartiality. I will be meeting with Mr. Burns tomorrow morning so that he might look at the initial data provided by New Jersey's medical malpractice insurers. I have already provided Mr. Burns with a copy of the letter this committee has sent to these insurers.

In closing let me refer to the recent testimony of Mr. Edward Dench of the Pennsylvania Medical Society before the Pennsylvania Senate Judiciary Committee. He pointed to a new actuarial study by Milliman USA that concluded that a $250,000 cap on non-economic damages would reduce losses by 22% and premiums by 18% in Pennsylvania. This study used data from the National Practitioner Data Bank and Pennsylvania insurance filings. I would be the first to admit that I have not seen the study and can not comment on the statistical methods used, but I do know that neither the National Practitioner Data Bank nor Pennsylvania insurance filings break down losses into economic and non-economic categories. You can use the finest most accurate statistical methods, but if the data with which you are working is not real, and in this case it was not, the results are invalid. Obviously the actuary took total payout data and made various assumptions. This is the only plausible explanation as the real data is non-existent. It is studies such as this that do an injustice to legislators such as yourselves. You are attempting to solve a problem in good faith by looking at true data. This study can not possibly provide such data.

I would be happy to answer any questions you may have.

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Princeton Insurance

Princeton Insurance Company Princeton Risk Protection, Inc.

Good morning everyone.

My name is Bob Schultz and I'm the Vice President of Corporate and Customer Relations for Princeton Insurance Company. I currently have responsibilities in the areas of Communications, Risk Management and Loss Prevention, and Regulatory Compliance. During my twenty years with Princeton, I have held positions of leadership in Underwriting, Marketing and Product Development.

Let me begin by telling you a little bit about Princeton Insurance Company and what we believe to be the facts surrounding today's medical malpractice crisis.

Princeton Insurance Company is part of Medical Liability Mutual Insurance Company, which is owned and directed by the health care professionals it insures. The MLMIC Group, which includes Princeton and other MLMIC subsidiaries, is the largest medical malpractice insurer in the nation. Prior to MLMIC's purchase of the Princeton Group in 2000 for $192 million, Princeton was owned by the hospitals of New Jersey through the Health Care Insurance Exchange. Our commitment to New Jersey's medical and health care community spans more than a quarter century and is as strong today as it ever was.

According to the study conducted by the General Accounting Office and released in June 2003, losses on medical malpractice claims appear to be the primary driver of rate increases. The report stated incurred losses among the insurers analyzed were up 18.7% percent between 1998 and 2001. At Princeton, we couldn't agree more that today's medical malpractice crisis is directly related to a dramatic increase in claim costs. Princeton Insurance Company has experienced a 33% increase in average paid losses for hospitals between 1998 and the present. The average paid loss for physicians increased 25% from 2001 to 2002 alone.

Poor investment results in the bond market have also contributed to rising rates, but in comparison to increasing claim costs, it is minor. Princeton Insurance Company has less than five percent of its assets in equities and is not impacted significantly by swings in the stock market.

One way to help reverse the trend in rising awards and settlement values is to enact meaningful tort reform. Caps are only one component of a comprehensive tort reform effort. Princeton believes it is time to revisit the other components, like setting and upholding realistic statutes of limitations, better defining who can be an expert witness, giving judges more discretion in reducing jackpot jury awards and extending charitably immunity protection to hospital employees. Further, clarifying the definition of Bad Faith to limit payouts to policy limits would also help.

If enacted, these reforms could add a measure of predictability to the claim handling process. Having a better handle on the maximum value of a claim would help us to better establish accurate rates.

While these efforts are directed to helping carriers address the unpredictability of malpractice claims, Princeton also believes that patient safety issues need to be part of any effort to address the malpractice crisis. Patient safety initiatives and staff commitment to risk management protocols can go a long way to prevent the occurrence of malpractice in the first place. Princeton supports those initiatives.

No one will argue with the fact that New Jersey's malpractice system needs reform. And Princeton Insurance Company wants to be part of the solution.

While tort reform addresses the cost aspect of malpractice claims, there is another facet to the crisis: availability of insurance. Princeton Insurance Company, which has the largest market share of any carrier writing in New Jersey, recently stopped accepting new business. We simply could not responsibly take on any new business without jeopardizing our ability to meet the future claim obligations of our current policyholders. One reason for this is the ever-rising cost of reinsurance, which Princeton and other insurers depend on to fund losses above a certain level. Following our announcement, the New Jersey Department of Banking and Insurance held a hearing on the need to reactivate the Medical Malpractice Reinsurance Association. Princeton representatives testified on the benefits of such an action and shortly thereafter Commissioner Bakke ordered the Association reactivated to provide reinsurance coverage to the state's insurers. This decision was a positive regulatory development that addresses the growing availability problem.

The Committee is facing a challenging task in its effort to get to the bottom of a difficult issue. We believe Princeton Insurance Company can provide assistance in attaining the desired goal.

The Special Committee's request for data and documents, however, presents a challenge for Princeton, too. We need to balance our obligation to protect the confidentiality of our policyholders and preserve patient privacy with fulfilling our desire to work with you toward building a better malpractice compensation system.

We respectfully suggest the Committee consider obtaining the services of a nationally recognized and independent actuarial firm that specializes in the medical malpractice area, such as Ernst & Young or PricewaterhouseCoopers to collect the data from the insurers in New Jersey. Confidentiality agreements could be executed between the insurance companies and the selected firm thereby preserving the privacy that is so necessary to the policyholders and patients alike. This independent party could analyze the data, maintain its confidentiality and provide the best opportunity for objective evaluation.

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Princeton Insurance

Princeton Insurance Company Princeton Risk Protection, Inc.

This Assembly Special Committee has taken on a very important issue and one that touches everyone in the state. Without a resolution to the mounting medical malpractice insurance crisis, access to care will suffer. Princeton believes strongly that a meaningful tort reform package can help to stabilize med-mal insurance rates.

And, we will continue to work with the Legislature as it attempts to gather and analyze insurers' data, while at the same time protect the privacy of the doctors and patients involved.

Thank you for allowing me the opportunity to present Princeton Insurance Company's views on the origin of the crisis and our thoughts on the best way to collect and analyze insurers' data.

I will be happy to answer any questions you may have on the areas of my responsibility at Princeton.