
Committee Meeting

of

JOINT COMMITTEE ON AUTOMOBILE INSURANCE REFORM

*"Testimony regarding personal injury protection (PIP) reforms
and related issues"*

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

DATE: January 22, 1998
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Senate President Donald T. DiFrancesco, Co-Chairman
Senator John O. Bennett
Senator Gerald Cardinale
Senator Joseph M. Kyrillos
Senator Richard J. Cody
Senator John H. Adler
Assemblyman Paul DiGaetano
Assemblyman E. Scott Garrett
Assemblywoman Clare M. Farragher
Assemblyman Joseph Charles Jr.



ALSO PRESENT:

Thomas K. Musick
*Office of Legislative Services
Committee Aide*

Laurine Purola
Barbara S. Hutcheon
*Majority Staff
Committee Aides*

Tom Hastie
Tim Clark
*Democratic Staff
Committee Aides*

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ASSEMBLYMAN DiGAETANO: We would like to get started. Ladies and gentlemen, can I have your attention please.

Elmer, we need this one for the Gipper. Why don't you take a seat, Elmer. Thanks. Just one for the Gipper, Elmer.

Ladies and gentlemen, thank you for being here with us today in, what I guess, is our fourth Committee meeting on auto insurance reform. Today we will be taking testimony on personal injury protection reforms and related issues. We have a list of some 12 witnesses. I would ask that each of the witnesses be as brief as possible, and I'm sure the Committee members will do the same.

The Speaker, Jack Collins, will not be with us today. He is attending a funeral. Senate President DiFrancesco will be here, but he has been delayed, so we will begin the testimony.

Assemblyman Charles, did you have something that you wanted to say before we begin?

ASSEMBLYMAN CHARLES: No.

SENATOR BENNETT: Actually, Paul led a cuop; that is, that Senator DiFrancesco and Speaker Collins are lost somewhere in the fields of South Jersey, and that's how you have the two of us here today.

We look forward to it being very enlightening. We are anxious to continue on the time focus that has been set by the Senate President and the Speaker. In an effort to move ahead, we continue to need to gather this information to be able to come forward with what will be an appropriate program for automobile insurance in the State of New Jersey.

With that, I guess, Paul, to you.

ASSEMBLYMAN DiGAETANO: Our first witness is Dr. Eugene Cianciulli, Chairman of the Insurance Committee, New Jersey Chiropractic Society. Not a bad chiropractor either.

EUGENE P. CIANCIULLI, D.C.: Good morning.

ASSEMBLYMAN DiGAETANO: Good morning. Would you please press the button on your microphone.

DR. CIANCIULLI: Good morning, honorable Chairman, members of the Committee. Let me introduce myself. I am Dr. Eugene Cianciulli. I'm a practicing chiropractor in Elizabeth, New Jersey. I'm the Insurance Chairman for the New Jersey Chiropractic Society. I'm on their Board of Trustees. I serve on the State Board of Chiropractic Examiners, recently elected as President. I am a member of the ACA and a national delegate to our national organization. I received my graduate education from Georgetown University, my D.C. from New York Chiropractic College, and I have a master's degree in human nutrition from the University of Bridgeport.

I really want to thank you for the opportunity to present our input into the critical issue of auto insurance reform. We all know New Jersey's automobile insurance premiums are among the highest in the nation. However, the causes and the reasons are vigorously argued. You may have heard substantial testimony from insurance carriers, and I will now attempt to present our views and to offer our solutions to some of these urgent problems.

Number one, fraud. My profession has been opposed to fraud since the humble beginnings in 1895. Our Society has been in a forefront of every effort to contain and eliminate fraud. Our code of ethics, our bylaws, our ethics committee actively pursue any allegation or appearances of

impropriety. At every meeting of the NJCS Board of Trustees, as well as every general membership meeting, discussion on the ethical conduct and procedures to eliminate and contain fraud are presented. This is a continuing professional effort. Fraud, however, comes in many flavors; over billing, over utilization, padding of treatments, procedures, up coding of services, unbundling of codes are some of the examples of fraudulent practices that need to be exposed and eliminated.

The New Jersey Chiropractic Society is at the forefront to eradicate these deceptive practices. Our past record indicates that our Society had cooperated with Mr. Parisi, the State head of insurance fraud. It was our President who sought the assistance of Mr. Parisi when we were the object of insurance harassment. With Mr. Parisi's intervention, several problems were amicably resolved. In fact, it was the NJCS who, because of the cooperative efforts with Mr. Parisi, awarded him a distinguished service award.

I believe that we have been the only professional society to ever have done so. While many of the headlines attribute fraud as the chief reason for the escalating cost, I believe that this really needs to be put in its proper perspective. Mr. Parisi's testimony and data state that probably no more than 5 percent of the cost and not less than 1 percent were attributed to our profession alone. Yet, we still remain committed to eliminating any and all fraud, but 1 percent is hardly significant contribution to the escalating auto costs.

Diagnostic testing. This particular area can be fraught with overuse, but not necessarily of a fraudulent nature but of a desire to perform

more tests for defense or litigation. The question of medical necessity as it relates to the patient should be determining factor, not the litigation.

Soft-tissue injuries. This is the most seriously maligned area by the insurance carriers. In their view, there is no such entity as soft-tissue injuries. Nothing could be further from the facts or realities. Analyze any injury, contusion, concussion, myocardial infarcts, synovial problem, myositis, neuritis, GI problems, whiplash syndrome, or headaches. In fact, they are all soft-tissue injuries.

Really the only hard-tissue injuries are bone and crush injuries. The point here is that it is invasive on the part of the insurance carriers. Pain is mediated by the nervous system. The resulting disability is as great, if not more so, than from fractures. In fact, the pain of a fracture is in fact due to nerve stimulation or a disruption. Nerve, muscle, ligament damage is far more difficult to diagnoses, treat, rehabilitate, and heal than any other trauma. Why then should soft-tissue injuries be stigmatized as being fake, or not real? Is death or paralysis the only criteria for real injuries?

A very famous medical physician by the name of Dr. Paul Williamson, in his outstanding text "Office Procedures," states very clearly the dilemma of soft-tissue damage, and I quote.

"There are a number of fallacies about the locomotor system that seem quite prevalent in the medical profession. To me, the most important is the seeming concept with which we treat soft tissue. Ligament and cartilage injuries may be many times more serious than fracture, but they don't show in X rays, so we ignore them. Disability from fracture of the femur rarely last for more than a few weeks or months, but a crack in a tiny semilunar cartilage can

cripple for life even in spite of the best surgery. You can pop the tip off the external malleolus with monotonous regularity and get along fine if properly treated. Tear the internal ligaments of an ankle and let the physician say you've just got a sprain, put ice and Ace bandage on it, and wear it for a few days. You have an excellent chance of being hindered for life by a weak ankle. I know fractures are more dramatic, but this is a plea, please watch out for soft-tissue injury. There is just as much, if not more, chronic morbidity related to soft injury as there is for fractures."

It's interesting because this text and this dialogue that I quoted from was written in 1960, and here we are almost 40 years later arguing the fact of whether it exists or whether it has any relationship to disability, and it's clearly documented if someone does any search of the medical literature or does any search on the various sites that refer to it. You will see it well documented.

Many times it has been stated that the chiropractor profession is the only primary involvement in a treatment of automobile accident trauma cases. In fact, trauma is treated by orthopedists, chiropractic physicians, physiatrists, general practitioners, and physiotherapists. So one may ask the question, whom do you expect to treat trauma? Certainly not a pediatrician or gynecologist. So again the hype and the facts are skewed. Yes, we treat more because this is the essential part of our practice. Chiropractic care is intimately concerned with the osseous system, spine, and nervous system, as well as muscles and viscera -- all soft tissue.

The bias and prejudice against my profession borders on a conspiracy. The documented referred to studies, both national and

international, have attested to the superiority of chiropractic intervention and neuromuscular problems. No other profession has overwhelming volume of outcome data to support their treatment protocols. Yet, in spite of their scientific credibility, harassment restrictions are placed on out treatments but not on valueless procedures. It is not uncommon for chiropractic services to be unjustifiably reviewed and even terminated when medical and physiotherapeutic services are reimbursed at unrestricted levels with no limitations. The AHPCR guideline monogram on acute low-back injuries stated the only effective treatment was chiropractic care, spinal manipulation.

If one analyzes the direct premium costs, it would appear that auto theft is the singular largest contributor to auto insurance costs. The fact that in New Jersey we have two of the top ten municipalities in the nation in terms of auto theft is a blight on the citizens of our state. A review of my own recent premium was quite enlightening. Of the total semiannual premium of \$797 PIP protection, including tort, no threshold, full coverage amounted for \$119, while comprehensive and collision amounted for \$235. Apparently, we prefer to have well-treated autos than well-treated humans. The PIP medical portion is approximately 15 percent of the premium, while the collision and theft portion accounted for 30 percent of the premium. I ask you, are cars worth more than the quality of human life?

Finally, in an effort to pose some constructive solutions, I draw your attention to the following. With the implementation of the 21-day notification law the insurance carriers can track treatment profiles and abuse patterns. They presently have the ability to utilize independent medical or chiropractic examinations to determine the clinical necessity of ongoing care.

The cost of using independent examiners is incidental relative to costs of diagnostic testing or treatment. This will allow for fair and professional judgement as to the quality and duration of care rather than making judgement based solely on dollars.

Also, we need to change the municipality clause to permit examinations anywhere within the same county and not only where the patient lives. Many times patients treat 20 or 30 miles removed from their home but refuse to be examined 2 miles away from the home because it is in a different city. This, there is no reason for in 1998.

Eliminate no-fault and return to the tort system. In studies across the nation have documented that in those states with no-fault have higher premiums than those states without. Also, that the premiums in no-fault states are raising at about a 25 percent faster rate. In the 1970s, 16 states adopted no-fault, but now Nevada, Connecticut, Georgia repealed no-fault, Pennsylvania repealed it and then reenacted it, and Massachusetts at last had it, appeal session passed the Senate. No-fault was based on a 1965 paradigm but has proven to be an absolute failure. In Colorado, the costs were declining prior to the implementation of their no-fault managed care policy.

Last, investigate the true operating cost of insurance carriers. A recent Jenks Health Care Business Report study on September 26, 1997 showed that health care CEOs compensation rose 25 percent.

Let injured persons freely choose their own physicians. Again, studies have shown that individual fee for service achieves the best results. I thank you for the opportunity to speak today.

ASSEMBLYMAN DiGAETANO: Thank you very much.

Senator Adler.

SENATOR ADLER: Doctor, we have had statistics over the last few weeks of hearings suggesting that New Jersey's PIP costs are rising much faster than the national average over the last five or six years. In your position as the leader of the New Jersey Chiropractic Society, can you give us suggestions as to how we might slow the rate of growth and eliminate, or at least reduce, unnecessary or excessive medical and chiropractic treatment in this context?

DR. CIANCIULLI: Yes, I think the answer to excessive treatment is relatively easily handled. I think the wisdom of this Legislature to pass the 21-day law really puts it-- I think I can identify every aberrant physician in this state. I certainly can identify every aberrant chiropractic physician. I'm sure some of my medical friends can identify every aberrant medical practitioner. So the insurance companies, with their vast database and searches, certainly know treatment profiles.

So if you have a 21-day notification law and you know the diagnosis submitted-- When you know the reasonable profiles of what would be a normal or unusual customary treatment profiles, at the end of that period of time use professional judgement. Send them to a reviewer. Reviewers are incidental in cost. Cost to review is probably, maybe, the cost equatable to two office visits. At that point in time, you have a valid professional opinion which predicates the judgement on a treatment of the patient predicated on real incidents and real information, not phony data. At that point you can say, "Well, this case is terminated," which reduces your cost or, "No, this is in fact the 1 percent or 2 percent or 10 percent of cases that require more care."

We tend to view injuries in a textbook mentality. The patient has a cervical sprain; therefore, that should resolve in 10 visits. If I took everybody in this room and I examined everybody clinical in this room, there would be no one in this room who would probably meet treatment protocols that are published. The reason why is human beings are individuals, their bodies react individually, different. Therefore, the way to make an evaluative judgement is to assess them. You have that all in place. You know who the bad guys are, you can track them, you have early notification, you can get the qualified, bona fide, intelligent, ethical doctors, and you can put it on the record. That could save you many dollars.

Originally, I was for the ICE rule, which said that you shouldn't be examined outside of your city or municipality. That was a good rule because 30 years ago when that was implemented -- or whatever the exact date -- what happened was they used to take a patient from North Jersey and send them down to South Jersey. That was clearly discretionary and clearly, clearly violative of their rights. So it became very restrictive, you need to pick a doctor in your own municipality.

What happened was now in some municipalities you may not have a doctor who can make the judgement, or in some municipalities they may only have two doctors. So you think the one doctor is going to-- It's the old adage, when there is one lawyer in town, no one makes a living. When there is two, they both make a living. Quite frankly, today with a mobile society, if the patient was being treated 30 or 40 miles away from their home, then why would it be inconsistent to be examined within 30 or 40 miles of their home? I don't think that is valid. If you live across the street--

SENATOR ADLER: Let me followup on a dovetailing issue. Do you think the implementation of a professional arbitrator system would help eliminate some of the aberrations that seem to come up in the PIP suit context?

DR. CIANCIULLI: It would depend on what scope the professional arbitrator has. Some of the proposals that I saw that he made the absolute decision it would then depend on their qualifications. I see no reason why he can't make recommendations. I don't know if he would have the ability to make absolute judgements. You would then have to have an arbitrator which would have to be knowledgeable in every single case and every single venue that came before it.

I wouldn't want to be evaluated for a brain tumor by a chiropractor, nor would I want a brain surgeon to evaluate my spine for my problems. So I would guess that answer to your question depends on how the arbitrator was setup, what his qualifications were, what he was going to be arbitrating, and what absolute authority he had verses what discretionary authority. I am not against the concept; I would have to see the dynamics of it.

SENATOR ADLER: One more question on the same line. How do you think the Chiropractic Society would react to implementation by the State of some sort of medical protocol of standard medical care that should be the normal course of conduct for medical providers?

DR. CIANCIULLI: We already use standard protocols within our profession. The standard protocols, if you use our guidelines, are fine. If you use someone else's arbitrary guidelines, they are not fine. We also feel that

within the guidelines there always has to be the room for the exception. This is where it has to come back to being clinically based.

If we have a guideline, that for this particular CTP or -- I strike that -- ICD code problem that exists, we are going to have *X* number of visits, that's cookbook. What happens to the patient who has legitimate injuries, who doesn't fall within those perimeters? How does that person seek getting better and seek getting reimbursement? Those are the problems.

Guidelines, fine. If you use them as relative, absolute -- not absolute -- cutoffs, I have no problem with them. If you use them as, at this particular junction this person should be pooled for review and should be pooled for a professional evaluation, I have no problem with them. If they become absolute, then I don't think anybody that I know in this planet can make that decision upfront.

ASSEMBLYMAN DiGAETANO: Thank you.

Assemblyman Garrett.

ASSEMBLYMAN GARRETT: Just one question. Your testimony is that we have the 21-day rule right now, so we already have a system in place for the carriers to address the problems of aberrant treatment.

DR. CIANCIULLI: Absolutely.

ASSEMBLYMAN GARRETT: The testimony that we also received prior to today's hearing is that despite that, carriers find that the system that we have in place is not able to terminate the treatment. The majority of cases, when the carriers contest the treatment, whether it's within 21 days or 2 years later, they are not successful in the majority of the cases in questioning it.

DR. CIANCIULLI: To answer that, number one, if they do their job right, the method is in place. If they use the right consultants and they get the people with the professional expertise, they shouldn't be losing arbitration cases.

I mean, there is a defensible area which more care is required, and there is an indefensible area where unjustifiable care should not be rendered. That's an argument of professional expertise of the two professions. The answer to them is, number one, they need to identify who the good guys are and start using them. Number two, I find that, contrary to what you tell me, they are very lax in trying to get to this. I find that my experience with that industry for dozens of years has always been -- and this is my personal experience -- whenever I told them in cases that I personally adjudicated in which I thought there was fraud, the answer came back we'd rather pay the claim than fight it. That's disingenuous because that disenfranchises the good people, and at the same token, why do you want me to go out and be a good guy if you don't want to do what I ask you to do to begin with?

So there is a little bit of a latitude here. I see many cases in which they pay for things that they should not have. I recommend to the supervisors not to pay. Why did you pay? Why didn't you contest it? For them it's an economic decision; for us it's a professional decision. I'm not into their economics. They may find it cheaper to pay the claim than to fight it, I don't know that.

ASSEMBLYMAN GARRETT: Let's finish with what Senator Adler asked you, a couple of questions on proposals. The proposal that was out last year based on a peer review system with not a professional arbitrator,

but just a medical writer, which includes chiropractors in the peer review system. Your opinion on that.

DR. CIANCIULLI: The one that I saw last year had given the arbitrator tremendous discretionary powers, and my objection was that -- as I said before -- I'm not against having a peer review panel or arbitrators who would decide. It really depends on whether or not their decision becomes one that is absolute, that you would have to appeal that they are making the clinical decision. If they are going to make the decision and that clinical decision doesn't leave an available avenue for the doctor who is treating to make a professional judgement, then it would be wrong. I guess I'd have to see how tight their protocols are and where they were going with it.

SENATE PRESIDENT DONALD T. DiFRANCESCO (Co-Chairman): Senator Cardinale, you have a question?

SENATOR CARDINALE: Yes, I have a couple of questions, Mr. President.

You mention this AHPCH monogram.

DR. CIANCIULLI: It's spelt wrong, there is a mistyping. It's AHPCR. I apologize for the typographical error.

SENATOR CARDINALE: Would you tell the Committee what that shows.

DR. CIANCIULLI: Well, the Committee is a federally funded committee, which really is practice guidelines and treatment profiles. What they do is they review all kinds of treatments for all kinds of things. For instance, they may want to look at the quality of care for minor cartilage injuries, so they will set up all the criteria by which the diagnosis is made, how

to diagnosis it, what treatments were rendered, and what the outcomes were for that diagnosis.

SENATOR CARDINALE: I'm really only asking what their findings were in this particular study that you cite.

DR. CIANCIULLI: Sorry. Their findings were very clear that in acute low-back situations, which is musculoskeletal injuries, they found that the most significant treatment of choice was spinal manipulation and over-the-counter aspirins and Advils. All other treatment, at that particular level, they found to be relatively ineffective, so that was the treatment of care. That was their findings of their guidelines. Is that what you're asking me?

SENATOR CARDINALE: Yes. Wasn't there a second part of it, where they said, if you have the chiropractic care and it extends over a certain period of time and has not resulted in relief, you are in the wrong ballpark?

DR. CIANCIULLI: Okay, they always extend the care. They did not address chronic problems. The focus of that guidelines report was only acute problems, and yes, the answer is, if there was a period of time that there was no treatment benefits, obviously they would call to other interventions. The guidelines--

SENATOR CARDINALE: What was that period of time?

DR. CIANCIULLI: They had a period of time of approximately 12 to 14 visits, and I believe it was about six to eight weeks. However, in their guidelines they were not absolute. Also, Senator, they were also discretionary in terms of, if there were reasons to treat that were valid and just, then obviously ongoing treatment would be continued.

SENATOR CARDINALE: Yes, therefore, when the insurance company comes before this panel and says, "Look, you've been treating this fellow for two years and you're still treating him," the panel says, "Oh, continue the treatment," do you think there is something wrong?

DR. CIANCIULLI: I would say if the clinical data didn't support his treatment, yes, it's absolutely wrong.

SENATOR CARDINALE: Well, doesn't this study, which is done by the Federal government in a somewhat impartial way, say if it's more than 60 days for this acute incident being treated by a chiropractor, it's being treated in the wrong way?

DR. CIANCIULLI: No, it's not what it said. You read it wrong. What it said was clearly that-- A majority of the cases they would respond-- They didn't say in all cases. It only picked acute cases, and it said their guidelines. Apparently, you are not aware of the definition of guideline.

A guideline means that this is something you look at and you look at it with discretionary value. So a guideline can be something that could be moved up or down. They are saying that in a majority of times this occurs. They are not saying that absoluteness occurs. There is no Federal study that ever sets a protocol that says that everybody is going to conform to the treatment guidelines and you will reach that level of benefit within that protocol. It's impossible.

SENATOR CARDINALE: Thank you, Doctor. I think everyone on this Committee is conversant with the fact that, and understands, in common sense -- not even with professional judgement -- there are going to be exceptions to every rule. I'm posing the question 60 days verses 2 years verses

what we hear from insurers, who are providing this stuff, is that it is routine that people are treated more than 60 days by chiropractors after an auto incident. It is routine, it is not exception. Now, would you think that there is something wrong with the routine treatment of people longer than the 60-day period by a chiropractor for an acute incident after an auto trauma?

DR. CIANCIULLI: Again, I'll answer it very specifically. If the injury was an acute injury, then maybe 40 to 60 days may be the treatment profiles. I don't know what they are alleging they are saying that over-treatment-- Two years obviously would not be normal for acute sprain. But if it were an injury which required major problems and had the clinical documentation, I could justify that exception.

Do I believe it's the norm? No, I don't believe it's the norm.

SENATOR CARDINALE: I agree with you, by the way.

DR. CIANCIULLI: Okay.

SENATOR CARDINALE: I agree with what you've just said.

DR. CIANCIULLI: Do I believe that 12 visits is the norm? No, I don't either.

SENATOR CARDINALE: You don't have to defend it anymore to me.

DR. CIANCIULLI: Okay.

SENATOR CARDINALE: I agree with what you've just said, that there are exceptional circumstances, but the routine should be the 60 days.

Now, you've confused me on something else.

DR. CIANCIULLI: Go ahead.

SENATOR CARDINALE: In your written statement, you talked about who should be doing these treatments. Should it be a gynecologist, I think--

DR. CIANCIULLI: No, I didn't say that.

SENATOR CARDINALE: --you tried to be a little bit funny.

DR. CIANCIULLI: Very funny. But who else would treat trauma other than chiropractors?

SENATOR CARDINALE: And I agree with that, by the way. I'm not challenging that statement.

But, in evaluating the treatment, should lawyers evaluate chiropractic care or a brain injury?

DR. CIANCIULLI: Of course not. Doctors should evaluate their--

SENATOR CARDINALE: But I understood from the appearance of your Society before my Committee when we were reviewing peer review that you didn't want to have peer review being done because you didn't want to have medical people -- now maybe you have changed your position and I would welcome that -- but you didn't want to have medical people looking at the injury and evaluating whether the injury was being overtreated or not being overtreated. You preferred the present system where we have lawyers doing that.

DR. CIANCIULLI: No, I never said that. I was the one who testified in front of your Committee, and that's not what I said. What I said was, clearly, that--

SENATOR CARDINALE: Well, you confused me then.

DR. CIANCIULLI: Thank you. What I said is that peer review should be done by like professionals. I think chiropractic doctors should evaluate chiropractors, neurosurgeons should evaluate neurosurgeons. I don't think a proctologist should evaluate what I do or brain surgery. So I am very clear with what I said. I was never against the concept of being equitable peer review by professionals, dependent on which professional was chosen.

Historically, the relationship between political medicine and chiropractic medicine has never been one that is amicable, so therefore, that alone would not want us to be adjudicated by them. The second thing is I don't think they have an area of expertise that clinically relates to what we do, as I do not have an area of expertise that clinically relates to what they do. So I would not want to peer review them, nor would I want them to peer review me. That's what I said.

SENATOR CARDINALE: You cleared up my confusion.

DR. CIANCIULLI: We've been on record--

SENATOR CARDINALE: The bill that we had under review, by the way, accomplished what you were talking about.

DR. CIANCIULLI: --of saying my position for a long time, but what you're saying was a little bit different than what I'm saying.

PRESIDENT DiFRANCESCO: Anyone further?

Gerry, are you finished?

SENATOR CARDINALE: Well, I have one other question. You talk about your profession being very much interested in getting rid of fraud, and I know from all the prior conversations I've had with chiropractors that they all say the same thing, so that you're not unique.

How many chiropractors' licenses have been lifted by the board in the last year?

DR. CIANCIULLI: In the last year, I couldn't give you that number because I don't have access to it. I do know that there are many, many pending investigations.

Let me just clarify--

SENATOR CARDINALE: How about in the last 10 years?

DR. CIANCIULLI: --something because I think I know where you're going with it, but I think the answer should be said.

We have taken a lot of hit because of an issue that happened to involve two chiropractors -- two aberrant chiropractors -- the famous V and K people that probably gave birth to this hearing. But what's not said, ever--

PRESIDENT DiFRANCESCO: That's not true, so don't say that again.

DR. CIANCIULLI: --is that it was the chiropractic profession who identified the aberrant chiropractors. It was the chiropractors who brought him to the Board, it was the Chiropractic Board that adjudicated, and it was the Chiropractic Board that was on record asking for criminal penalties. I'll let it end there.

We never got what we wanted, we never got any credit for doing it. We spent five years -- and if you care to talk to me privately, I'll tell you how much dollars we spent on it. We were the lead people, and the investigation of prosecution could never have happened without us.

PRESIDENT DiFRANCESCO: Okay.

DR. CIANCIULLI: End of conversation.

PRESIDENT DiFRANCESCO: You made your point.

DR. CIANCIULLI: The point is simple.

PRESIDENT DiFRANCESCO: You made the point, I think. I would stop while you're ahead here.

Anything else of this witness?

SENATOR CARDINALE: Senator Adler is asking me to ask a question.

PRESIDENT DiFRANCESCO: Senator Adler?

SENATOR CARDINALE: Has asked me to ask a question.

PRESIDENT DiFRANCESCO: Senator Adler asked you to ask a question. This is unique.

SENATOR ADLER: I'm too afraid. (laughter)

SENATOR CARDINALE: You referred, in your answer to him, that there are bad chiropractors out there that you want to get rid of.

DR. CIANCIULLI: Absolutely.

SENATOR CARDINALE: Would you give us a list of them? (laughter)

DR. CIANCIULLI: I'll tell you what's coming down.

PRESIDENT DiFRANCESCO: He's not looking for an answer to that question, okay.

DR. CIANCIULLI: I know. But I think there are published records -- and I'm being serious about this. They do publish the disciplinary action--

PRESIDENT DiFRANCESCO: Well, you guys are being too serious right now, why don't we get on with this.

Do you have anything further?

DR. CIANCIULLI: Sorry to take your time.

PRESIDENT DiFRANCESCO: Anything further of this witness?

(negative response)

I've never been a Chairman of a Committee before -- I just want you to understand that -- so I like doing this.

You don't have to respond to that either.

SENATOR KYRILLOS: Is that true, Mr. President?

PRESIDENT DiFRANCESCO: That's the truth.

ASSEMBLYMAN DiGAETANO: Do you guys want to make him Chairman next time?

PRESIDENT DiFRANCESCO: All of you have, I think except for me and Senator Adler. We are the only two people.

SENATOR ADLER: Nothing.

PRESIDENT DiFRANCESCO: Let's see, we now have Nancy Pinkin, New Jersey Society of Physical Medicine and Rehabilitation and also the Council of New Jersey Chiropractors.

NANCY J. PINKIN: Good morning.

PRESIDENT DiFRANCESCO: What do you have this fellow on your right here for?

MS. PINKIN: This is my assistant of Bartlett. (laughter)

PRESIDENT DiFRANCESCO: He's your assistant. Oh, that's a new one.

Go ahead, Nancy.

MS. PINKIN: Good morning, and thank you for hearing my testimony today. As you said, I'm here on behalf of the New Jersey Society of Physical Medicine and Rehabilitation, which represents physicians who are specialists in rehab medicine, and also the Council of New Jersey Chiropractors.

At present, New Jersey offers one of the best systems of coverage for its drivers and other citizens. At the same time, insurance rates have been heavily impacted by the most densely populated state with the highest number of drivers per mile. Each part of this system has an impact on our rates, including patients, insurers, providers, legislators, and lawyers. New Jersey has taken many steps to reduce the costs such as the 21-day notification law, the fraud reform laws, and numerous other reforms. We have yet to see the impact of all these changes, but we look forward to data from the Department of Insurance and insurers regarding the effects on New Jersey insurance premiums as a result of the already enacted changes.

In regard to PIP, the purpose of PIP was instituted to provide coverage of medical care required because of injuries from an automobile accident. Before the implementation of PIP, individuals could not obtain medical care until their court cases were settled. Previous patients and providers had to wait five to six years for payment of cases until cases were settled in court. PIP has improved the access to early intervention and improved the outcomes for injured persons and should be preserved.

Soft-tissue injury is frequently raised as a problem in increasing the cost of insurance. However, soft-tissue injury is real and requires real care. About 90 percent of injuries from automobile accidents cause soft-tissue

injuries rather than trauma, major trauma. Soft-tissue injuries are harmful to the routines of daily living for patients. Asking for the elimination of treatment of soft-tissue injury is similar to asking for treatment for stroke but not for hypertension, or treatment for coma but not for diabetes.

Many patients do not file claims for soft-tissue injuries. Others settle claims, yet they still have problems resulting from those accidents. Damage to soft-tissue injuries happen to sports players, and they have lifelong problems. The same thing happens when people have car accidents. Their injuries may last for years or may be permanent after that injury. We frequently have heard of people saying that they have never been right ever since they had a car accident.

Despite the difficulty diagnosing soft-tissue injury as easily as you would diagnose a fracture does not eliminate the reality of the impact of these injuries on people. Some people would even say that's it cheaper not to treat people at all, but unfortunately, people do have injuries and need that care.

In regard to the PIP fee schedule, we have had discussions about reducing the rates. Tying the medical fee schedule to the Medicare rate is inappropriate for numerous reasons, they include the fact that Medicare is a subsidized program in which providers are forced to treat the elderly for the set rates. Unfortunately, those rates are not adequate to cover all of the care. In fact, AARP right now is suing the Federal government to be able to go outside of the system so that patients can receive care when they can afford to pay.

There are many treatments that are not included under the Medicare fee schedule, but are important components of care. These items have been included in the PIP schedule to correct for that factor, and we would

like to see that preserved. In addition, the fee schedule has not been adjusted in six years, so reducing the rates seem inappropriate.

Inadequate reimbursement will substantially reduce the quality and range of care that is available to injured patients. In addition, providers have an increasingly difficult time in obtaining reimbursement for services rendered. The amount of times that they are required to rebill, send additional documentation, require prior authorization is escalating and is sometimes bordering on harassment. This is dramatically increasing the cost of billing for legitimate care.

There was discussion in regard to the PIP coverage about reducing that coverage. The idea of creating higher deductibles is problematic because the provider is forced to carry the burden of providing services for which he or she cannot be paid. Providers are required to collect co-payments from patients, yet many patients and lawyers are asking the providers to waive that co-payment and added it on at the back end of the bill, or wait until a settlement for that. That is inappropriate for the providers.

That goes on every day. I heard discussion about -- I think Senator Cardinale had mentioned the other day that it is illegal to do that. That's true, but people are still asking the providers to do that on a daily basis.

SENATOR CARDINALE: Can I ask her a question on that point?

PRESIDENT DiFRANCESCO: See what you did. You mentioned his name, so now--

MS. PINKIN: I'm sorry, I shouldn't have mentioned that.

PRESIDENT DiFRANCESCO: Okay. Senator Cardinale.

SENATOR CARDINALE: You say that people are asking this to be done on a regular basis. Who are the people asking that be done?

MS. PINKIN: Individuals.

SENATOR CARDINALE: The individual patient?

MS. PINKIN: Or the lawyers as well.

SENATOR CARDINALE: The lawyers.

MS. PINKIN: Suggesting that the physicians should set an acceptable rate and not expect any for their payment.

SENATOR CARDINALE: If the lawyer asks someone to do something that's illegal, isn't that a very serious offense on the part of a lawyer?

MS. PINKIN: I'm sure the lawyers know the laws.

PRESIDENT DiFRANCESCO: Gerry, she's doing this secondhand, I think, or thirdhand.

MS. PINKIN: It used to be also that--

PRESIDENT DiFRANCESCO: Why don't you skip over this.

MS. PINKIN: Okay. Traditionally people did used to waive the co-payment, and the Federal government said that you can't do that any longer. But the problem is that people don't want to have to pay that co-payment. It's as simple as that.

If you go to the doctor and they are asking you for--

PRESIDENT DiFRANCESCO: But the statement that you say, however patients are frequently advised to request their co-pays be waived and billed at the end of the case to avoid deductibles, that is something that you've heard about, correct?

MS. PINKIN: Yes.

PRESIDENT DiFRANCESCO: Okay, go on.

MS. PINKIN: Peer review. Peer review is not the answer for overtreatment. Peer review and second opinions have been utilized in hospitals for many years. The health care system has been moving away from peer review and from second opinions because these systems are just adding additional waivers of administration and paperwork without reducing the costs. They may even increase the cost because you are adding that extra work and the second opinions.

Unfortunately, with peer review, frequently what happens is the doctors or the providers who are working within the system are forced to do this extra work, but the doctors who are working or the providers who are working outside of the system and who are outliers do not change their practice at all.

The only acceptable peer review system would be one that is totally -- and we mean totally -- independent of the insurers. All practitioners would need to take a turn doing peer review on a rotating basis. They would have to have some way where they wouldn't be paid through the insurers. Practitioners would have to participate from a rotating pool and would have to have the majority of their business coming from private practice as opposed to from doing IMEs and the like.

In regard to managed--

PRESIDENT DiFRANCESCO: We want to stop, I guess because you raised this issue of peer review. We are going to stop there, and I think Assemblyman Garrett would like to ask you a question.

ASSEMBLYMAN GARRETT: Just a quick question on that proposal. We heard testimony previously from attorneys, as far as the fee structure is concerned. Where you have a rotating system of attorneys out in the arbitration system that these attorneys realize that one day they may be a plaintiff's attorney and, then, the other day they may be in the position of defense attorney. There is a hesitancy by the attorneys to give a negative result to them because they know that someday they may be in the position of being reviewed by the other attorney.

Don't you have the same situation here if you have a total rotating system of all the chiropractors going through the system of serving on the panel, that they know that someday-- Today they are the arbitrator, but tomorrow they may be in the other seat, and they may be in the situation of being reviewed by one of their colleagues.

For that reason, today, when they are an arbitrator, they are not going to give the honest opinion, of saying I want you to terminate the benefit, today because tomorrow the tables will be turned. So don't you really want a-- When you say that you want a neutral party, somebody outside of that system, that can actually make that determination--

MS. PINKIN: I'm unclear of what you're suggesting.

PRESIDENT DiFRANCESCO: What she's suggesting: not attorneys.

ASSEMBLYMAN GARRETT: I understand. I used attorneys as an example, that we heard testimony on where there is a problem when you have a total rotating system. If you're going to suggest a rotating system all the chiropractors serve on--

MS. PINKIN: Any provider--

ASSEMBLYMAN GARRETT: Or any provider.

MS. PINKIN: --would be reviewing their speciality.

ASSEMBLYMAN GARRETT: But for your case, it's going to be a rotating system of chiropractors reviewing other chiropractors.

MS. PINKIN: Or physiatrist.

ASSEMBLYMAN GARRETT: Or physiatrist, right.

Don't you run into the problem that: today I'm the arbitrator; tomorrow I sit on the other side of the table and I will be in the situation of trying to defend my position of why I'm treating after the 60 days or the 2-month period, so for that reason I may be a little less willing -- as the arbitrator -- to terminate the benefits today?

MS. PINKIN: Well, I believe that's the system in the United States for the jury by peers. As a citizen, if you are chosen to be on a jury, one day you could be a criminal, the next year you could be-- Well, I suppose it would have to be the opposite. You could be on a jury one year but in court the next for your own problem.

ASSEMBLYMAN GARRETT: Right, but in the jury system, you're not suggesting that everyone -- the 12 members sitting on a jury -- is looking at it from a possibility that they are going to be a criminal someday, so they want to protect their rights.

In this case, you're suggesting that every day the chiropractor is going to be a chiropractor providing benefits, and he is going to want to protect his ability to continue to provide treatment.

MS. PINKIN: Well, he's going to want to uphold the standards of practice that he has warranted to as a chiropractor or as a physiatrist. I mean, the alternative-- What's the alternative? The alternative is IMEs, where somebody is employed by insurer and they give the opinion that they feel the insurer needs so that they can keep their job and keep continuing to get cases referred to them. That's what we don't want to see.

PRESIDENT DiFRANCESCO: We understand that. I think his point was the suggestion you made about the process. You're throwing out a process that is generalized. It's like me being assigned cases as a lawyer, correct?

MS. PINKIN: That would be acceptable to me.

PRESIDENT DiFRANCESCO: Except in my case it's usually malpractice, so I don't take those cases.

If you were to work off the entire membership of the Chiropractic Society, how would you, in any way, develop any expertise in a system of peer review?

MS. PINKIN: Well--

PRESIDENT DiFRANCESCO: I like the fact that you're now suggesting something different and that there ought to be peer review. I think you ought to rethink that.

MS. PINKIN: We said all along that we would be in favor of true peer review that was total independent from the insurers. We've always said that.

PRESIDENT DiFRANCESCO: Right, okay. I think that is consistent with what other people have said. I don't know that anybody up here would argue with that.

What is the correct system? Who should do it? How professional should it be? How much experience should they have? I don't know the answers to those questions. My view of what you suggested on peer review -- it's good that you're suggesting it be independent. I'm just concerned that you involve so many people in the process who are not usually involved in these things, and you need some form of expertise, I would think, in an arbitration system or in a peer review system in order to deal with the case that you may be sitting on.

MS. PINKIN: I think the training of any health professional requires continual reviewal of cases. Hospitals have grand rounds where they review cases, they have teams where they are reviewing cases of patients. Whether it's someone in the hospital and the whole team is reviewing how they are going to handle that care -- that's done on an everyday basis.

PRESIDENT DiFRANCESCO: Okay, I understand what you're saying now.

Senator Cardinale has a question.

SENATOR CARDINALE: You talked about your next paragraph, and you say that you would like one that is totally independent of the insurers. Have you had an opportunity to review the bill from last year, S-2252, which was the last of the various peer reviews that was introduced?

MS. PINKIN: Well, I don't remember the specifics of that particular bill. What points are you speaking about?

SENATOR CARDINALE: Well, let me then make it prospective. I'm going to give you a copy of the bill and ask you -- not now, perhaps you can send us a little note later -- of whether this bill and the independence aspect of this bill satisfies your statement of independent of the insurers. It's a very elaborate process in here. I don't want to go into it and take the time of the Committee doing that at this time. But I will give you a copy of this bill when your testimony is concluded and ask you to later report to us whether this satisfies your desire for independence.

MS. PINKIN: Okay, I'd be happy to do that.

In regard to managed care. One of the key features of managed care is to provide preventative care in an effort to prevent the need for more expensive care, which results from not treating illnesses and injuries early and thoroughly. The principle was not to deny care. California is now establishing an oversight committee to deal with the many problems that have resulted from the managed care system that has developed there. They have been the leaders, but they have also been the leaders in the problems.

Insurers already do case management of claims. Further managed care will reduce the access to care for patients. In addition, managed care companies are moving away from networks to providers to point of service plans, which allow patients to receive care from their provider of choice. Patients have had greater success of treatment under the concept of a medical home where they received their care from their home doctor who knows their history and needs. Quality and the outcomes have not improved under the system of sending patients to just any doctor in a managed care network

without regard for the relationship that has been established between the doctor and the patient.

In fact, today on the radio they were talking about First Option and how First Option was reducing the rates to the anesthesiologist and forcing them to accept lower fees. It's those types of things that make us very afraid of adding a managed care system when we have so many problems going on every day in the health care market.

In regard to verbal threshold, we agree with the efforts to tighten the verbal threshold. However, one concern is, when you're tightening it, is the gamesmanship going to continue with whatever new level you establish? That's something that we can't really answer.

I heard somebody mention the other day, in regard to the question of why the insurance rates are going up for those people who have picked the zero threshold, why they are one-third higher-- Many of the providers that I asked about this issue-- They were concerned about why the rates are so high if they pick it. It almost seems like it's a penalty for picking the zero threshold. Also, we have concerns about the fact that when individuals file a medical claim and their rates automatically go up, this doesn't seem fair either.

In regard to our suggestions overall, I do have some suggestions. We would like to see the State undertake a thorough study of automobile insurance coverage and benefits in each state to determine exactly what aspects of the New Jersey system would require reform. I would do that myself if I had the wherewithal, but I am unable to do that.

Eliminate the pass through of losses by insurers to policyholders. This would increase the incentive of the insurers to prevent various types of

fraud from slipping through the system. We agree with the efforts to aggressively attack the V and K type cases rather than trying to reduce the care to the average citizen. There is still a lot of problems with the insurance system. There was someone on the radio, last week, on 101.5--

PRESIDENT DiFRANCESCO: Do you want to continue now with what--

MS. PINKIN: Should I?

PRESIDENT DiFRANCESCO: That's up to you.

MS. PINKIN: Okay.

PRESIDENT DiFRANCESCO: Well, let me just say this, Nancy, that you have given a complete transcript of what you are going to say. You may say it any way in which you would like. You can shorten it if you want, you can summarize, or you can read it verbatim.

MS. PINKIN: Okay.

The last thing that I wanted to say is that we had a lot of impacts, again, on the health insurance system. The providers have been asked to accept lower rates, to accept longer waits to get paid, to meet the 21-day notification, to do peer review, they pay \$100 surcharge for the uninsured drivers, they have difficulty calling the insurers and getting through on the phones, they are having difficulty getting the insurance companies to work with them in reviewing care. We are wondering where the end of this system is.

The point of the insurance is supposed to be to provide a helping hand for those people who need it at the time they have an accident, so that they can get their care and be returned as a productive citizen.

Are there any other questions? (no response)

We are not going to address fraud today. We thought we would address that on the day that you will be dealing with fraud.

PRESIDENT DiFRANCESCO: Any questions?

Assemblyman Charles.

ASSEMBLYMAN CHARLES: Does your organization support the repeal of no-fault as it pertains to PIP?

MS. PINKIN: You know, I really don't have anything on that. I did try to get information from them either way. We are not clear what the ramifications would be of that.

ASSEMBLYMAN CHARLES: I asked that question because the representative of the Chiropractic Association testified just before you that his organization represents the -- or recommends the elimination of no-fault. I understood that to mean the doing away with the PIP aspect of the policy, also.

MS. PINKIN: There actually are separate groups. The Council of New Jersey Chiropractors represents primarily the chiropractors that do mostly manipulation as opposed to additional modality, so there is a difference between the groups. The physiatrists are a totally different group. They are a group of physicians.

I don't really have a definitive answer. I would have to do a little more research before I can really answer that. I have been trying to gather information on it, though.

PRESIDENT DiFRANCESCO: I think your statement reads like -- although it doesn't say -- that you support keeping PIP. That's the way I read it.

MS. PINKIN: Yes, we do want to maintain PIP because we believe that PIP provides the coverage upfront rather than waiting until the court cases are settled. We don't want to wait for the court cases to be settled and then be paid. What happens with that is that providers have to treat the patient and they won't get paid. They don't know for five or six years whether or not they are going to get paid. What businessman can go out and treat somebody or provide a service -- sell something -- and not get paid for five or six years, if they are going to get paid at all? I think that was the purpose of PIP in the first place.

PRESIDENT DiFRANCESCO: Yes. I wasn't here, I don't know.

ASSEMBLYMAN CHARLES: That's what her statement says. That's correct. The testimony of the first witness included a recommendation that no-fault be eliminated.

PRESIDENT DiFRANCESCO: Is that right?

ASSEMBLYMAN CHARLES: Yes.

MS. PINKIN: We are not related in any way.

ASSEMBLYMAN CHARLES: I understand that. You've answered it. I was talking to the Chair.

PRESIDENT DiFRANCESCO: I guess we mostly know that there are two different organizations of chiropractors.

ASSEMBLYMAN CHARLES: Yes, she clarified that point.

PRESIDENT DiFRANCESCO: There are actually three now. As the years go on, more and more, I suppose.

I would assume that's difficult for them in terms of PIP, no-fault, no no-fault.

Anyone else? (negative response)

Thank you very much. I appreciate it, you were very helpful.

MS. PINKIN: Thank you for hearing our testimony.

PRESIDENT DiFRANCESCO: Ken Andres. Am I saying that properly, Ken? President-elect, Association of Trial Lawyers of America.

K E N N E T H G. A N D R E S J R., E S Q.: Senate President DiFrancesco and Majority Leader DiGaetano and members of the panel. The system of no-fault insurance is a failed experiment which has plagued the good drivers of this state for the past 25 years and resulted in the highest--

PRESIDENT DiFRANCESCO: Ken, I don't think the mike has picked it up well as it could. We want these insurance company representatives to hear you. (laughter)

MR. ANDRES: I am certain that they will hear, but I doubt that they will listen. (laughter)

PRESIDENT DiFRANCESCO: We didn't plan that. Don't blame me for that statement.

MR. ANDRES: Mr. Senate President, Majority Leader, and members of the Committee. The system of no-fault automobile insurance is a failed experiment which has plagued the good drivers of our state for the past 25 years and resulted in the highest insurance premiums in the country.

In the ultimate irony, this no-fault system requires our citizens to buy an expensive automobile health policy which duplicates their current health coverage and Medicare and limits the rights of injured drivers to be compensated for their injuries by the verbal threshold on top of it. We have heard that we have a Cadillac of coverage. That is not the case. I would liken it more to a lemon which is overpriced.

My name is Kenneth G. Andres Jr., and I appear today as the President-elect of the Association of Trial Lawyers of America-New Jersey. With me today is the President, Michael S. Berger, and Richard H. Wildstein, who is the Chair of the ATLA-New Jersey Automobile Insurance Committee. We sincerely thank this Committee for the opportunity to express the views of our members who have extensive experience in representing the injured citizens of negligent drivers.

Any fair analysis of the statistical data dealing with automobile insurance rates throughout this country mandates one, and only one, conclusion, and that is, that no-fault insurance and the verbal threshold must be repealed in order to lower automobile insurance premiums.

During this presentation, I will refer to actuarial data and facts obtained from the insurance industry, as well as our State government, including the Department of Insurance. I will not merely hypothesize as certain representatives speaking on behalf of insurance industry have done. During the past five years, ATLA-New Jersey has consulted three independent actuarial companies, all of which have confirmed the indisputable fact that no-fault insurance does not work.

AIS Risk Consultants, Inc. prepared an actuarial analysis of the repeal of no-fault private passenger automobile insurance in New Jersey, dated January 13, 1998, which was submitted to this Committee last week. That data was interpreted by Mr. Rick Boer, who spent 19 years with our Department of Insurance, including 6 years as the Chief of the State's Rating Bureau, and Mr. Allan Schwartz, who was the Assistant Commissioner of Insurance during the Kean administration. They unequivocally concluded that the repeal of no-fault and the institution of a tort liability system without a verbal threshold limitation would reduce the cost of automobile liability insurance between 10 percent and 20 percent per vehicle.

Based upon an average premium in New Jersey of approximately \$1000, the projected savings from the repeal of no-fault and the elimination of the verbal threshold is between \$100 to \$200 per insured automobile while still giving our citizens access to the courts when they need it for injuries.

One of the basic components, four problems, of the failed no-fault system in New Jersey is the requirement that a driver purchase an automobile health insurance policy, which includes personal injury protection benefits, which we all know by the acronym of PIP. I call this automobile health insurance because that is, in fact, what we are dealing with, and it duplicates the health insurance coverage or Medicare coverage that the vast majority of the citizens of our state already have and has already paid for.

SENATOR CARDINALE: Mr. Chairman, may we ask a question on this point?

ASSEMBLYMAN DiGAETANO: Yes, Senator Cardinale.

SENATOR CARDINALE: Mr. Andres, you've said it twice now, and I just think you need to know what the law is in New Jersey. The law in New Jersey does not require that you duplicate your health care coverage. We have an option for any consumer to make their health coverage primary. There is not any requirement in the law, and every time you say it you are misstating what the law is.

Now, I'm not a lawyer, but when a lawyer misstates the law, it sort of colors everything else that he says -- when I'm listening at least -- and so I would appreciate it if you would limit yourself to facts.

ASSEMBLYMAN DiGAETANO: Please continue, Mr. Andres.
Thank you, Senator Cardinale.

MR. ANDRES: The law requires that the automobile liability insurance company pay for medical costs that are reasonable, necessary, and causally related to the accident in question up to a maximum of \$250,000. Worse yet, the \$250,000 medical benefits coverage, which is supposed to be available, is unnecessarily high because we know that 85 percent of the people injured in automobile collisions have medical bills which are less than \$10,000. New York mandates benefits in the amount of \$50,000 and Pennsylvania at \$5000.

The total cost for PIP, which is comprised mostly of medical expenses as distinguished from the modest income continuation of benefits, has risen to \$266 per car in New Jersey. That constitutes more than 26 percent of the average automobile insurance premium. One of the primary components of the cost for PIP is the exorbitant overhead expense of this wasteful system. The overhead costs of the automobile liability carriers in

administering no-fault are approximately three times that of health care carriers.

AIS Risk Consultants, Inc. has advised that approximately 45 percent of the collected premium, or \$353 million, goes to overhead expense. More than half of that amount is expended for claims supervision, administrative expenses, such as legal fees, documenting the adversarial nature of PIP. Make no mistake about it, it's adversarial between the insurance companies and the people that they are supposed to be providing coverage for.

More, in fact most, disturbing are the hidden costs of PIP. Nearly \$200 million of claim payments are made in excess of premiums collected for this coverage. When that sum is added to overhead costs, the true cost of PIP exceeds premiums collected by \$109 per car. You might ask, where does that money come from? In order to meet this additional expense, the automobile insurance carriers have been permitted to charge 50 percent more than the necessary premium for first-party automobile physical damage.

What this means is that all of us who pay for collision and comprehensive coverage, the physical damage coverage for vehicles, are subsidizing the failed no-fault system without even knowing it. On top of that we are, then, charged an additional 4 percent of the liability premium, or approximately \$25 per car, to pay for PIP claims above \$75,000, which go through the Unsatisfied Claim and Judgement Fund.

This supposed \$250,000 coverage is illusory as each insured individual must pay out of his or her own pocket a minimum deductible of \$1200, and the insurance companies routinely deny medical benefits to injured persons. Medical expense benefits are required by law to be paid within 60

days after written notice of the expense is furnished to the insurers. That is certainly not the case in the real world.

To the contrary, the automobile insurers boost their profits by withholding payment to medical providers or offering to pay an amount less than the statutory fee schedule in exchange for prompt payment to the medical providers, all of the while realizing additional monies by syphoning off the interest generated from those payments wrongfully withheld.

The automobile insurance carriers take unfair advantage of their insurers and the busy medical practitioners and force them to compromise their medical bills below the fee schedule so as to not to have to take time off from work or their busy medical practices to attend court or arbitration proceedings and testify regarding the nature and extent of injuries and the medical treatment provided.

In addition, the automobile insurance carriers routinely hire the same physicians over and over and over again to examine their injured insured and make the determination that no treatment is necessary, despite the fact that the treating physicians who are attempting to heal their patients know that services are needed to help their patients. It is not a coincidence that the same physicians are routinely retained by the insurance carriers. They do insurance medical examinations. The term independent medical examination is a misnomer at best and is certainly disingenuous.

We know this to be true because last year more than 16,000 injured people in our state had to either sue their insurance company in court or file a formal arbitration claim with the American Arbitration Association simply to get their medical benefits paid for. That's outrageous. It shouldn't

happen, but it does so routinely. Automobile insurance companies routinely deny the payment of medical bills and benefits for two reasons. One, they simply want to limit the amount of money that they are paying out for medical treatment to injured people. Two, they want to limit the amount of damages that will later need to be paid to compensate the injured victims of negligent drivers. The system that we have--

PRESIDENT DiFRANCESCO: Just a minute, Ken.

Senator Adler.

SENATOR ADLER: I don't want to break up the rhythm in his testimony. What can we do legislatively to reduce this practice that you're describing of carriers allegedly denying payment of medical benefits to the providers?

MR. ANDRES: Get them out of the business by eliminating no-fault. We provided a proposal to this Committee which documented, in exemplary fashion, the savings that could be made. This system immediately sets up an inherent conflict of interest. You have the insurance carriers who may have to later foot the bill because of what a negligent driver did, covering the medical care.

They are saying you do not need medical care for the reason that they will simply limit the payout right then and there. Then later on down the road when their insured is sued for crashing into someone, they will turn around and say, "You're not injured, you didn't get enough medical care, you don't have the right test, you don't have a herniated disk, sir, despite the fact that an MRI study would show it." That is exactly what happens.

SENATOR ADLER: Let me ask you. Hypothetically, the Legislature chooses not to repeal no-fault -- hypothetically. I understand that you are advocating the repeal of no-fault. What other steps would you recommend this Committee to take if we are not going to repeal no-fault in order to reduce or eliminate this practice -- you described we have carriers not paying medical expenses?

MR. ANDRES: First of all, Senator Adler as you know our position is the repeal of no-fault.

SENATOR ADLER: Let's take a leap here and say hypothetically that we don't pass a repeal of no-fault. What else would you recommend that we consider?

MR. ANDRES: A \$10,000 med pay provision. The med pay provision would take care of approximately 85 percent of the claims. Those claims that are not covered by medical payments of \$10,000 would fall into that gap between the amount of money that is required once you reach the UCJ, \$75,000 or more.

You could then simply shift to the private health carriers and to Medicare, those injuries. It's interesting. We find of about 8 million drivers, there is about 80,000 injuries for which claims are made. Since we know that 85 percent of the medical bills fall under \$10,000, what we are really shifting is that 15 percent or so between \$10,000 and \$75,000. So it works and our actuarial data shows that.

What you want to do is get the insurance industry, from an automobile perspective, out of the medical benefits business. They have an inherent conflict of interest. This is really giving the keys to the fox to the

chicken. It's real problems. The insurance industry sits there and says, "You don't need this medical care," knowing full well that they will limit medical care right now which a treating doctor says this person needs. Then what happens is, if that person is injured and wants to seek compensation, as he or she is lawfully entitled to do, they turn around and say, "You don't have the medical care to back it up."

I call it a double whammy. It's a squeeze play. The automobile insurance industry gets you coming or going. They're squeezing you when you need care to get better, and then if you are in fact injured, they are squeezing you by saying, "You haven't documented your injury, you must not be hurt because you weren't going to the doctor." That's what happens here.

PRESIDENT DiFRANCESCO: Did he answer your question?

SENATOR ADLER: Part of it. Let me followup on the flip side of it. We've heard testimony over the last couple of weeks from individuals and entities suggesting that there is overtreatment and there is fault in system. Again, assuming that we are not going to repeal no-fault -- and I'm not hinting on behalf of this Committee -- I'm just asking you what steps would we take to eliminate fraud and to eliminate unnecessary or excessive medical treatment?

MR. ANDRES: Several things, Senator Adler. First, I think you should eliminate the verbal threshold. The verbal threshold sets a standard that says you must have a certain type of injury in order to make a claim. That's what the insurance industry wanted in 1988. They said that if you set an arbitrary standard, you will eliminate claims. That has not proven to be the case. They also told us that it would lower insurance premiums.

Well, guess what, we know that we are sitting here as No. 1 in the world, not No. 1 in the country, because of that verbal threshold. We find that every state in the union that has a verbal threshold, not surprisingly, pays out more per claim.

The insurance industry set, in 1988, a program in motion where the verbal threshold set an arbitrary standard, and then, when people meet that standard and physicians document the nature and extent of injury, then they turn around and cry fraud. Well, you can't get it both ways. When you set the standard to require a certain proof and you meet that proof, that's not fraud, that's complying with the law. It's a shame.

We find, also, that if you have the \$10,000 med pay it will take care of more than 85 percent of the claims. You can pass on the difference to private health carriers and Medicare. The dollars work.

SENATOR CARDINALE: Mr. Chairman, I have a question.

SENATOR ADLER: One more question.

PRESIDENT DiFRANCESCO: Senator Adler.

SENATOR ADLER: We've heard some discussion about the value of standardizing the arbitration system with professional arbitrators rather than with lawyers making the decisions -- practicing lawyers making the decisions. What benefits can you see from our instituting a professional arbitration system as opposed to the ad hoc system that now exists?

MR. ANDRES: Without looking at the specifics, Senator, I would be hesitant to commit. We would certainly be willing to look at that. We are willing to look and work with this Committee and do everything that we can--

PRESIDENT DiFRANCESCO: Would you do that?

MR. ANDRES: Absolutely.

SENATOR ADLER: Maybe as a follow-up to that, maybe speak to your counterparts in New York State which has, I understand, a professional arbitration system in place in the automobile insurance context and maybe get your sense of how that has worked from a consumer point of view, from a litigation point of view, and from a cost point of view.

MR. ANDRES: We'll be happy to do that. Right off the top of the head, though, there is a couple of things that I do know. It takes a heck of a lot longer when you have the professional arbitrator system because you--

SENATOR ADLER: Well, that's the sort of thing I think the Committee would want to hear.

MR. ANDRES: You're limiting the number of--

SENATOR ADLER: The cost in terms of time--

MR. ANDRES: --people who can do it.

SENATOR ADLER: --and expense.

MR. ANDRES: If you look at the statistics that we know about, the American Arbitration Association last year -- I think the ballpark number was give or take 13,000 claims that injured people had to file against their insurance companies. They used attorneys from all over the state. Knowing that this question is coming, they used attorneys who represent plaintiffs and who represent the insurance industry as well.

This is not a system which is skewed. In fact, when we had the hearings in the springtime, we learned that the response rate from both the injured victims and the carriers was that they were fully satisfied with that system. They told us that some 90 percent--

PRESIDENT DiFRANCESCO: Assume that it's skewed. Make the assumption that it is skewed, and if you have a proposal for change, let us have it. We're going to assume that it's skewed today, at this moment, when I ask you this question.

I understand what you're saying, but if we are going to make change, I would assume that you would want input into that change, so I think Senator Adler's question is right on target.

SENATOR ADLER: And I think we have to make some change somewhere in the system, whether it's repeal no-fault-- The status quo isn't good enough, so there is going to be some change. We would like to have your input on each potential change, so we understand what will work as a comprehensive reform for the state.

MR. ANDRES: As you know we want a seat at this table on all of these issues. We feel that our members are the ones who have a great deal of expertise in representing the injured people, and we are, in fact, the voice on behalf of the little guy in opposition to the insurance industry. We want to work with this Committee so that it is best for the citizens of our state.

If I may return, Mr. Senate President.

PRESIDENT DiFRANCESCO: Just one thing. I think Senator Cardinale on that point wanted to ask a question.

SENATOR CARDINALE: Yes.

MR. ANDRES: Yes, Senator.

SENATOR CARDINALE: You've raised a couple of issues here that I think I would like a little expansion of the information available for the Committee. You've mentioned that if you had this \$10,000 med pay -- and

that presumes getting rid of no-fault -- that the amounts that were not covered by that \$10,000 med pay would be covered by health insurance.

MR. ANDRES: Correct, and/or Medicare.

SENATOR CARDINALE: About 50 percent of the people in New Jersey are ERISA insured. What happens if--

MR. ANDRES: They have subrogation rights.

SENATOR CARDINALE: What happens if their policy will not pay for the kinds of injuries that occur in an automobile accident or if they have a complete exclusion from their coverage for events that flow from an automobile accident? Now, I know the answer for the other half, we could pass legislation that mandated coverage for the other companies. We would probably have to do that. But what would happen if-- And we have no power over ERISA to mandate that they cover that -- what would happen to those people?

MR. ANDRES: Senator, you're half right and half wrong. I agree with what you told us about the necessity for additional legislation being passed on the state level. I would suggest to you that we would do exactly what the 38 other states do who have lower premiums. In that instance, if you were injured in an automobile crash as the result of a negligent driver and your health insurance company would not pay for it because of ERISA or anything else, you would sue the other driver and do exactly what they do in the other 38 states and make it the right way. The right way is the wrongdoer pays.

SENATOR CARDINALE: I'm assuming that-- I am the negligent driver. I am assuming that in every one of these two car accidents, one of the drivers is going to be negligent and one is not. They are not both negligent.

What happens to the negligent driver? Today that negligent driver's bill is paid.

The fellow who hits a tree-- I mean, he's not going to sue the tree. He may sue the town where they planted the tree, but he can't sue the tree. What happens to those individuals? You give the impression that there is no problem, but there is a major problem because a lot of accidents occur where there is no one to assume that liability. What happens to those people?

Sure, you can sue the negligent party, and you're good at that, and you do that. But what happens to the rest of the people?

MR. ANDRES: I believe, Senator, that the numbers that you're talking about are statistically insignificant and that we could fashion some sort of remedy to take care of that. There are not a lot of people running out and simply running into trees willy-nilly. That's not what happens in the real world.

SENATOR CARDINALE: Aren't there most accident involving two cars?

MR. ANDRES: Yes.

SENATOR CARDINALE: Okay. One of those cars is going to be deemed negligent.

MR. ANDRES: Yes.

SENATOR CARDINALE: What happens-- Now you've got the other half. The value of no-fault is that whether you are at fault or not your medical expenses are paid and they aren't a burden on society, they are not shifted to society. What happens to those other half of the people?

MR. ANDRES: First, Senator, I disagree with your assumption that ERISA excludes in these instances. What it does do, in most instances, is make it secondary. For instance, the discussion that we had last week when you discussed Medicare. Medicare in New Jersey is secondary only because of the fact that we have a no-fault act. The New Jersey Legislature passed 39:6A, which is the no-fault act. It said that we are going to make Medicare, worker's comp, TDP primary. After that act was passed there was a Federal statute passed which preempts New Jersey law, which says, "No, if you folks do have no-fault, Medicare will be secondary."

That's why we lose the benefit of Medicare to all of the senior citizens in this state. We know that with the greying of America that population percentage is going to increase. The thing that really is a darn shame is we're paying for it. We're paying to subsidize an addition of 38 states who take advantage of Medicare that we don't get.

SENATOR CARDINALE: I would submit to you that someone pays for it, even when Medicare pays for it. That someone pays for it, and it's the taxpayers who would pay more under your scheme. You've made that point.

MR. ANDRES: It's the entire country that pays for it.

SENATOR CARDINALE: You talked about the verbal threshold, and you said repealing it would lower insurance rates.

MR. ANDRES: Yes.

SENATOR CARDINALE: And you justified that by comparing us to other states. Why do you not compare New Jersey to New Jersey? We have a zero threshold, as well as a verbal threshold, in New Jersey. We get lots

of complaints from your group that the zero threshold costs more. Well, it is a fact that the zero threshold costs more, about 40 percent more. Why don't you accept the fact that if everyone was a zero threshold -- which happens if you repeal the verbal -- everyone is at a zero threshold, doesn't everyone-- That 88 percent of the drivers go up 40 percent.

MR. ANDRES: No, that is not, in fact, what happens. The people who have zero thresholds in New Jersey would be the equivalent of the 38 other tort states where there are no thresholds. What we find, in fact, is that those premiums are significantly lower.

SENATOR CARDINALE: There are many other variables, come on, counselor. There are many other variables. In New Jersey, we can have the same variables, everything is evened off, the demographics are evened off, the cost of medical care is evened off. The fairest comparison is comparing New Jersey to New Jersey, we have a dual system. Why don't you compare our system?

You are suggesting that we have one system, not a dual system. I would maintain to you -- and I guess you can't accept it and we can leave it there -- that the 88 percent of the drivers go up 40 percent if you repeal the verbal threshold, you make that option no longer available to them.

PRESIDENT DiFRANCESCO: Is it 40 percent of the bodily injury portion that you are referring to?

SENATOR CARDINALE: Yes.

PRESIDENT DiFRANCESCO: Do you want to finish your statement and then continue the questions after that.

MR. ANDRES: Yes, I certainly would, Mr. Senate President.

PRESIDENT DiFRANCESCO: Let me just clarify. You suggest that medical claims -- that 85 percent of the medical claims -- I'm saying that properly -- are less than \$10,000. In 85 percent of the cases--

MR. ANDRES: Correct.

PRESIDENT DiFRANCESCO: --the medical claims are less than \$10,000. Is that correct what you suggest?

MR. ANDRES: Yes.

PRESIDENT DiFRANCESCO: Now, if anyone who's in the room disputes that, who is going to testify, I would like to hear that. That is basically in line with the information provided to us.

Go on.

MR. ANDRES: That's data that we have obtained from the insurance industry and the Department of Insurance.

The problem with the system, in addition to the immediate conflict of interest, is that it's used, as I referred to previously, as the double whammy. Frequently the very same insurance company that is responsible to pay medical bills uses that power to later limit the rights of the individual not only to obtain treatment, but that person's right to access to the courts in compensation for permanent injuries. That's wrong, it's costly, and it creates unnecessary litigation.

Peer review is not the answer for a multitude of reasons. First, the elimination of no-fault would eliminate any consideration for peer review, and I fail to see why we would want to build in yet one more system of review and have all of those administrative costs. Peer review unfairly shifts the burdens of the cost of proceedings and counsel fees back upon the injured insured or

the medical provider and would, of course, result in an additional incentive to the insurer to deny payment of the medical bills.

If you have peer review consistent with due process, you're then going to have to allow the injured people access to the courts, and you're going to increase costs in another way that we don't want the fund because that will simply be a flat out tax on the citizens of the State of New Jersey.

There is no question that there is a real danger of insurer bias in the selection of the peer review panelist. The problem exists today, and since most of the physicians who are now qualified and willing to do peer review work currently for the carriers, that problem would continue to be pervasive.

Lastly, the doctors are not trained triers of fact. Doctors are trained individualists to treat injured people. Judges and attorneys, who are trained to serve as dispute resolution individuals, are in the best position to make factual determinations based upon conflicting evidence. There appears to be a misconception that lawyers are making medical decisions, they are not. They are weighing and evaluating evidence because what happens in the current system is the treating physician, who is in the position to know, comes in and says here is what is going on. A physician hired by the insurance company comes in and says no. The attorneys and the judges are evaluating conflicting evidence. We further find that frequently the issues that are in dispute extend far beyond the propriety of medical treatment. Frequently, they involve a whole host of legal issues.

It's clear that automobile liability insurers back the peer review notion because, if it is enacted, it would allow them to continue to deny, delay, or reduce payment of medical bills without any real exposure for their wrongful

acts. Why do you think the insurance industry lined up against the bad faith bill that was put in by Majority Leader DiGaetano?

Thirty-eight other states have recognized that people who are hurt in collisions should have their medical coverage administered and bills paid by real health insurance companies or Medicare. These companies have the expertise and ability to provide proper care in a cost efficient manner without unfairly limiting necessary treatment and without being placed in this conflict of interest.

Our senior citizen population, which is growing, loses the benefit of Medicare which would pay for medical expenses for treatment rendered as the result of an accident if no-fault is eliminated. As I explained to Senator Cardinale, even though our statute says that PIP is primary to Medicare, there was a Federal statute passed which said that Medicare will be secondary. I point you to 42 U.S.C., Section 1395y(b)(2)(A)(ii).

There are 8 million people who live in our state, and there are approximately 80,000 automobile injury claims per year. The only shift to alternative health care sources is 1 percent of the general population who have medical bills from accidents in excess of \$10,000 and less than \$75,000 of our recommendation regarding medical payments coverage is accepted.

Medical health care plans and the Federal medical system that have already been paid for will absorb these costs. The 38 non-no-fault states have turned to these other sources, and they have saved their citizens significant dollars on their insurance premiums.

A study by the Roscoe Pound Foundation conducted in May of 1997 reached the following conclusion. It interprets the data and it is what we

have been saying all along, it's not hypothetical projection. During the five-year period from 1992 to 1996, the level of personal injury costs has been highest for no-fault states, less for add-on states, lowest for tort states. The rate of inflation in personal injury costs has been highest for no-fault states, less for add-on states, lowest for tort states. Furthermore, personal injury costs are higher and have increased faster in verbal threshold states than in monetary states. You can look to Michigan for that documentation.

Before 1972, when New Jersey adopted this no-fault insurance scheme, our average insurance rates were within \$24 of the national average. Today, after 25 years of this failed experiment, our rates are \$350 above the national average. The no-fault system itself is expensive because it generates extensive litigation. It drives up the cost per claim and requires the purchase of duplicative automobile health insurance coverage.

When you compound the problem with the system with the unique demographics to our state, you have a clear explanation as to why New Jersey has the highest automobile insurance premiums in the country. But there's only one thing that's changed during the past 25 years, and that's the addition of more stringent thresholds. Our demographics have not changed, so we keep upping the threshold, which limits the rights of injured individuals, and driving up the costs at the same time. Respectfully, it's backwards.

The annual report prepared by the National Association of Insurance Commissioners ranks the cost of the average policy for the top five states or jurisdictions as follows: New Jersey, Hawaii, Washington, D.C., New York, and Massachusetts. It is not a coincidence that these states with the highest insurance premiums share one common denominator -- they're all

no-fault states. In fact, only 13 states in the nation have no-fault at this time, and the trend is to eliminate no-fault, as we know with Massachusetts and Georgia.

Thirty-eight states have rejected the no-fault experiment and rewarded their citizens with lower automobile insurance premiums and provided access to the courts for injured drivers at the same time. Our state is the most expensive in the country, requires duplication all over the place, and limits the rights of the innocent victims. Worse yet, good drivers are made to pay for the negligence of bad drivers not only with their pocketbooks, but with their health.

PRESIDENT DiFRANCESCO: Ken.

MR. ANDRES: Yes.

PRESIDENT DiFRANCESCO: Are you going to finish reading-- I was going to just mention to you that one of our State House reporters would obviously have done some research on this question of who has the highest rates. So that in terms of affordability, and I guess when you bring per capita income into it, we are fourth or fifth? You would agree with that, I would assume?

MR. ANDRES: Mr. Senate President, I believe that to be true. We're ranked highest in terms of premiums--

PRESIDENT DiFRANCESCO: Right.

MR. ANDRES: --but we are not ranked highest when you factor in cost of living, salaries, things of that nature. I agree with the reporter, and I agree with you.

PRESIDENT DiFRANCESCO: All right.

Just so members that have questions--

Did you want to-- I know you have two paragraphs left.

MR. ANDRES: Yes.

PRESIDENT DiFRANCESCO: Good.

Senator Codey.

SENATOR CODEY: Let me ask you a question about that. I was reading something about-- I don't know if-- In regards to the type of vehicles we're buying in New Jersey. We're tending to buy these big "Explorer type"--

PRESIDENT DiFRANCESCO: Like you have -- sport utility.

SENATOR CODEY: No. No. I turned my wife down.

The sport utility vehicles, which when they're in an accident, tend to do more damage to the other vehicle than other cars. And, as opposed to other states, we have probably one of the highest percentages of those types of vehicles. And I wondered if anybody has some stats on how that factors into our auto insurance.

MR. ANDRES: I would certainly believe that since we rank very high in per capita income that we drive more expensive vehicles. And if you look at the charts that were attached to our actuarial statement, you will see that what, in fact, is happening here is that we're robbing from Peter to pay Paul. What is going on is our folks are being charged almost twice what they should be for the physical damage because the costs are being shifted over into no-fault. So we have more expensive vehicles, they are more costly to repair, we have more accidents because of the fact that more people are driving on more congested roadways, and we see situations where certain vehicles certainly add insult to injury in that they are not truly crashworthy.

The repeal of no-fault together with the repeal of the verbal threshold--

SENATOR CARDINALE: Mr. President, on this -- on the same point that you asked, can I--

PRESIDENT DiFRANCESCO: Yes, except he has one paragraph left and I want him to finish--

SENATOR CARDINALE: All right.

PRESIDENT DiFRANCESCO: --and then--

MR. ANDRES: I'm trying so hard, Mr. Senate President.

The repeal of no-fault and the verbal threshold and the creation of a \$10,000 medical payments provision will reduce the insurance bill for our drivers between \$100 to \$200 per year. We've already discussed the cost shifting -- the fact that the claims are less than \$10,000 on average, specifically 85 percent, and the cost shifting to private health insurers will be minimized particularly when we take advantage of Medicare, health care insurance industry cost efficiency and payment controls, the removal of the inherent conflict of interest with liability considerations vis-à-vis the verbal threshold, and the fact that most underwriting considerations for health care carriers are formulated on a regional or national basis will limit any impact on health insurance costs.

It is true that our insurance premiums for automobiles will always rank high on the national scale due to the unique demographics that we have. But there is no reason for us to occupy the position that we have now -- that is because of the failed no-fault experience.

The most exciting part of the proposal that we have put forward is not only that it avoids duplicative coverage and keeps premiums down, it also restores the full civil rights to our citizens at the same time.

Mr. Senate President, if I may, I know that Speaker Collins is not here today. But when we discussed this last week, Speaker Collins questioned whether or not routinely medical benefits were provided. And I know that you have a busy schedule today, but we have produced today attorneys from Gloucester, Camden, Monmouth, Essex, Ocean, and Atlantic, together with clients to tell you firsthand -- and it can be done through writing or documentation--

PRESIDENT DiFRANCESCO: You mean they're here today?

MR. ANDRES: Yes.

--to tell you about what happens in the real world. In fact, claims are routinely cut off. There are people who will tell you that in order to get surgery at the University of Pennsylvania that they have to go to the Appellate Division and file multiple claims year after year, and in certain instances insurers don't even show up for the hearings. We want to document--

PRESIDENT DiFRANCESCO: Well, you know what, it's not just auto insurance, too -- just look at the front page of today's paper.

I don't know. I don't know where we stand in terms of letting a whole bunch of people talk because we have such a long list--

MR. ANDRES: I understand that, Mr. Senate President, and I'm not trying to--

PRESIDENT DiFRANCESCO: Do you have anybody from Union here? No, just kidding.

I think we have a number, if it's okay with you-- We have a number of people who would like to ask you some questions since they have you right now, and you've said a lot, expressed a lot of opinions, so I would hope you would be able to do that.

MR. ANDRES: Very good.

PRESIDENT DiFRANCESCO: Scott, did you have -- want to start? You were the first person that asked, and then Senator Cardinale, Senator Adler, I believe, also.

ASSEMBLYMAN GARRETT: Good morning.

Just a couple of questions. First of all, I want to make sure I understand your proposal; I think I do. Is your proposal that we have a \$10,000 med pay, and then the same policy would pick up again through the UCJF75?

MR. ANDRES: Yes.

ASSEMBLYMAN GARRETT: Okay.

MR. ANDRES: That's requiring at present a 4 percent of the liability premium, or about \$25 per vehicle.

ASSEMBLYMAN GARRETT: And your numbers, also. And I think that we've heard this the other day about 16,000 cases that are going through arbitration right now. Do you have a number -- and I don't recall -- a number of those cases that fall within the 10,000 and in that area -- range with carriers are contested?

MR. ANDRES: Assemblyman Garrett, I do not have those numbers. I don't know whether or not we can do that. Perhaps the American

Arbitration Association maintains statistics in that regard, but I simply don't know and don't want to misrepresent anything to you or this Committee.

ASSEMBLYMAN GARRETT: With regard to the studies that you speak of in the beginning, did they look at the 4 percent figure on the UCJ charge? And did they determine whether or not that is an adequate rate for the UCJ payment?

MR. ANDRES: They did not look at the number in terms of whether it's an adequate rate. The savings does not include the elimination of that. If you eliminate that, and that's if you eliminate coverage over \$75,000, you will have a \$25 to \$30 more car per savings. The costs of that are estimated between \$125 million and \$200 million a year. And there's been some questions as to whether the 4 percent is adequate.

ASSEMBLYMAN GARRETT: That's it. And I don't know the answer to that. Maybe someone from the carrier -- the industry can answer that question later on. Is--

MR. ANDRES: Those are the catastrophic-type plans that we need to deal with.

ASSEMBLYMAN GARRETT: Right. And is there enough to know whether that 4 percent figure is adequate? I've heard the same thing, that it isn't. Whatever system we come up with, if you were going to go down that way, you would want to make sure that that figure is an appropriate figure--

MR. ANDRES: We agree.

ASSEMBLYMAN GARRETT: --and what I'm just hazarding a guess is, is that figure is not adequate -- the 4 percent is not adequate -- and so

you may see 8 percent or 10 percent. In which case, the apparent end result savings might be less than what we're speculating. Okay, so it's the number--

MR. ANDRES: When you're talking about the catastrophic-type issues, I agree with you. And we will be happy to have our people look at that and again come back to you, and we'll let you know.

ASSEMBLYMAN GARRETT: Okay. With regard to the 1600 (*sic*) cases, and I could ask as to why there are so many, you know-- There's two sides to every story. The one side that you present is that the carriers are being the mean ogres and forcing people to go through the system. The testimony that we received from two hearings ago was that there are, believe it or not, cases of fraud out there, and that sometimes people do make fraudulent or excessive claims of need is a testimony that we've previously received.

MR. ANDRES: Of course, they do, and we believe that reasonable legislation to combat fraud is necessary. We support it. You have to understand that it hurts the legitimate--

ASSEMBLYMAN GARRETT: Right.

MR. ANDRES: --injured people when they go to court and they think that there are people out there committing fraud.

ASSEMBLYMAN GARRETT: Right.

MR. ANDRES: We want it eliminated and steps have been taken. The 21-day notification and what recently happened--

PRESIDENT DiFRANCESCO: Ken, he was leading up to his question.

ASSEMBLYMAN GARRETT: Yes, thank you.

Senator Adler gave you the suggestion of what would happen if we don't go with your proposal and we still need peer review. I'm wondering -- and that's why I asked how many -- what percentage of the 1600 (*sic*) cases are under the \$10,000 threshold. I'm wondering if a significant percentage of the cases that are going into arbitration today are in the \$10,000 range. That means that there's still, in the minds of the carriers at least, a dispute as to legitimacy of those claims. And so even if we adopt your plan completely and just have the \$10,000 med pay, the carriers will look at this and say, we're paying out up to \$10,000 on average now on these cases, we still have a dispute on a significant percentage of these cases. The carriers will say that they still believe that there is fraud or excessive treatment in those cases. And so they will be in a position to say we want to have something like Senator Adler suggested, a peer review system to handle those cases. But I don't know what percentages of those cases there are, but since 85 percent of the cases are coming in, it's got to be significant cases that they're going to have a dispute with. So should we adopt your plan, still have some form of a peer review system, or the \$10,000 med pay?

SENATOR ADLER: I'm not sure I used the words peer review.

PRESIDENT DiFRANCESCO: Well, no. It's going to be known as the Adler plan.

SENATOR ADLER: I think I talked about -- just for -- the record has some of -- I think I used the term professional arbitrators. I don't think I used the term peer review.

MR. ANDRES: I believe we've learned in the last round of hearings in the springtime that what you are postulating really didn't work in

Pennsylvania. I remember specifically when Majority Leader DiGaetano was asking questions of the individual here from the insurance commissioner's office in Pennsylvania that what it really turned out to be was a very, very modest amount of money with great administrative expenses. And I believe that our Auto Chair can add to that as well.

RICHARD H. WILDSTEIN, ESQ.: The reason you have the 13,000 disputes is because of -- the system is adversarial because of the verbal threshold. There's a policy to be adversarial because you want to, as an industry, limit the treatment so that you don't make the verbal threshold. If you eliminate the verbal threshold, you eliminate the adversarial nature. Then you're left with a true review system like in the health care system that only focuses on cost. The reason we have so many disputes is because there's another policy in effect. So if you adopt our plan, all of the adversarial nature will go down, and you will have only a fraction of disputes.

PRESIDENT DiFRANCESCO: But the litigation will go up.

MR. WILDSTEIN: No. The litigation will not go up because--

PRESIDENT DiFRANCESCO: The litigation is going to go up, the number of cases are going to go up.

MR. WILDSTEIN: --it will allow the resolution of the claims without any artificial barriers. So they--

PRESIDENT DiFRANCESCO: I understand that. I understand that.

MR. WILDSTEIN: We don't have cases being resolved now in the claim stage.

PRESIDENT DiFRANCESCO: But you will admit that if you eliminate no-fault, the number of cases instituted in a court will go up?

MR. WILDSTEIN: No. No.

PRESIDENT DiFRANCESCO: You don't admit to that?

MR. WILDSTEIN: No. I'll tell you why. The number--

PRESIDENT DiFRANCESCO: You sure?

MR. WILDSTEIN: The number of claims may go up. The number of people who recover may go up, but not the litigation.

PRESIDENT DiFRANCESCO: You think the number of lawsuits instituted will not necessarily rise?

MR. WILDSTEIN: When we adopted the monetary threshold, the early claims went out the window. When we adopted the verbal, the claims for litigation stopped, because the verbal requires you to file a suit in the superior court and have it reviewed first by a judge, as to whether you have the basic prima facie qualifications. And then it goes on to the final litigation. There's more litigation in a no-fault threshold--

PRESIDENT DiFRANCESCO: Well, you're not going to do that unless you have some reasonable belief that you are going to be successful. Am I correct? I mean, if you don't file the suit-- Unless you believe--

MR. WILDSTEIN: What happens in the tort states, the claims are resolved early and for less money. So that while there's more--

PRESIDENT DiFRANCESCO: Sure of that?

MR. WILDSTEIN: --claims resolved, the total payout is far less. And that is why--

PRESIDENT DiFRANCESCO: So you mean there will be a lot more claims, but not necessarily more litigation?

MR. WILDSTEIN: A lot more recovery.

PRESIDENT DiFRANCESCO: That's what you believe anyway.

MR. WILDSTEIN: We use the word claims, but we--

PRESIDENT DiFRANCESCO: Or recovery. Yes, whatever.

MR. WILDSTEIN: --mean people will be compensated for injuries--

PRESIDENT DiFRANCESCO: Yes.

MR. WILDSTEIN: --but the total payout will be less because the threshold drives the claims value up. After four or five years of litigation, test after test required, argument after argument, the people do not take a lower amount.

PRESIDENT DiFRANCESCO: I don't think we dispute the fact that that definitely drives-- For those successful cases, it drives the value up. Assemblyman Garrett.

ASSEMBLYMAN GARRETT: Just one final question along that line. Is-- Does your study also address -- as a matter of fact, this was a question by Senator Cardinale from two sessions ago -- the issue of the nature of the treatment in the verbal threshold cases, where the argument you just made is that that drives up the nature of the treatment and in the long term drives up the time and the cost of the claim? But compare that to the zero option right now wherein you would think that the nature of the treatment would be less, and yet, as the Senator made the observation the last time, that the nature of the treatment continues to be the same in each instance.

MR. ANDRES: I have never seen data making the delineation between folks who have verbal and folks who have the unlimited right to sue. But the national data is very clear. Whenever you have a threshold with no-fault, it skyrockets. Everybody wants to go to Michigan, but when you look at Michigan you find that the cost per claim is the greatest in the country. And then, when you put the Michigan system in New Jersey, where there are more accidents, it's a prescription for disaster.

ASSEMBLYMAN GARRETT: I'll just conclude by saying-- I think that we have our study area right here in the state, and I think we should be able to -- if you've done three studies already that someone should have looked along the line as far as what the comparisons are between the two right here in the State of New Jersey. And I think that would be very telling as to what would actually result, as the President states, as far as the nature and number of claims that we'll see if we adopt this system, whether they will rise or not.

Thank you.

PRESIDENT DiFRANCESCO: Senator Cardinale.

SENATOR CARDINALE: Yes. A number of times you've made the claim, and others have made it, that we are the highest premium per car on an average. And you're correct. I mean, I don't challenge that. It's been documented. But when you compare us to the non-no-fault states, tort states, are you making that comparison deducting what we pay for PIP, or are you making that comparison including what we pay for PIP?

MR. WILDSTEIN: Both.

SENATOR CARDINALE: Both. And in both instances are we disadvantaged by having PIP?

MR. WILDSTEIN: In both instances, we're disadvantaged by having no-fault. If you look--

SENATOR CARDINALE: So that we're higher--

MR. WILDSTEIN: There's two--

SENATOR CARDINALE: --even if you deduct what we pay for PIP, we're higher than the tort states?

MR. WILDSTEIN: Yes. Very much so.

SENATOR CARDINALE: Okay. PIP is subsidized as a matter of fact by collision and comprehensive. If you would deduct the PIP's subsidy, deduct the whole of PIP, where would we stand relative to the tort states?

MR. WILDSTEIN: In a lot of cases, we would still be higher.

SENATOR CARDINALE: In many cases, would we be lower?

MR. WILDSTEIN: I would have to go back over the data and check every state to see whether we would be--

SENATOR CARDINALE: I think the Committee should have--

MR. WILDSTEIN: The average--

SENATOR CARDINALE: --your opinion with respect to that.

MR. WILDSTEIN: --of total claims paid out is 13,000-- The highest is 13,000 in the tort states. The average is about 9000. Ours is 26,000. So if you eliminate what we pay for the PIP, I believe we pay \$18,000 a claim. So that's the answer. We're paying double what the tort states pay.

SENATOR CARDINALE: Well, I'm looking at it from the premium side and how that affects the consumer.

MR. WILDSTEIN: The premium would go--

SENATOR CARDINALE: It's obvious -- I think, we should all agree on one point -- that if you don't buy a particular coverage, the policy is cheaper. And if we are going to compare ourselves to places where they have different coverage, we should compare the cost of the coverage -- that analogous coverage -- in New Jersey as it would be in any of the states that you have used in your comparison. Take Connecticut and compare us on an equal basis.

MR. WILDSTEIN: There is a 5 percent reduction of premium attributable to abolition of the verbal threshold in the AIS studies based on the national comparison and what happened in New Jersey. On top of that, there is the reduction of the elimination of the PIP costs, which are 50 percent above the \$10,000 level.

SENATOR CARDINALE: Now, I appreciate--

MR. WILDSTEIN: So it is a combination.

SENATOR CARDINALE: --what you've done and the position you've taken that there is a way to reduce costs and there are factors that would reduce costs. If there were factors that we could introduce that would reduce those same costs even more, would you be supportive of those?

MR. WILDSTEIN: There is no factors you could introduce.

SENATOR CARDINALE: I'm going to give you one. It's been introduced in this Legislature.

MR. WILDSTEIN: Every time the Legislature in good intent -- and you have good intent, sir, I'm sure -- tries to intervene with the normal relationship of people in the market, you cause chaos. That happened with the

JUA. It happened with the adoption of the verbal, and it happened with the adoption of no-fault in 1972. We're only \$24 above the rest of the nation, the national average, in 1972. Within 10 years of adopting no-fault, we were \$180 above. Now we're \$355. You can't--

SENATOR CARDINALE: There are people who have maintained that we've never adopted no-fault.

MR. WILDSTEIN: Why not allow the system to be the free market? And as somebody in your party who advocates a free market type of economy, that is what a tort state is. No-fault is government intervention.

SENATOR CARDINALE: I agree with you.

MR. WILDSTEIN: Thank you, sir.

SENATOR CARDINALE: No-fault is government intervention, and government intervenes all the time in the lives of people, and that's what we do as a professional.

MR. WILDSTEIN: Yes, but when we do it wrongly, we should withdraw.

SENATOR CARDINALE: Now-- And when we do it wrong, we should change it. Now suppose we made all insurance in New Jersey -- all auto insurance in New Jersey -- first party. Would we not correct all of these ills that you're talking about?

MR. WILDSTEIN: No, because you would have to put a fair schedule. Once you put a fair schedule of adequate compensation, you would then have to compensate the careless, reckless, and negligent drivers along with the safe drivers, and you would bankrupt the system. The only way you could do it is if you put the schedule such that the safe driver hardly gets any

compensation, because those would be the numbers. You cannot give a fair methodology. The fair methodology is the system that existed with the adoption of our constitution, and that is, a jury reviewing a case, analyzing it, and trying to decide what would fairly compensate this individual, rather than a schedule that says for a certain type of injury you get \$1500 or \$1200, where the actual compensation is justified at much more.

SENATOR CARDINALE: I would submit just two facts, just for your examination and consideration. Compensation was driving employers out of New Jersey at one time. We changed the system long before I was here. But this Legislature changed the system, and worker's comp now works. There is a suggestion not for an arbitrary schedule, but for a schedule that is created by a closed-claim study of what is actually happening, what is actually being given to the injured party, and if that were adopted-- We have testimony from an insurance company that they would love to cut rates 25 percent. And the bill called for them to cut it 30 percent, and they said they could live with that. That's a record that has been made in this Legislature last year of a particular bill making-- And it cures all of the problems from a different direction that you have been talking about in terms of the incentives to milk PIP.

I don't need any further comment from you because the Senate President is really--

MR. WILDSTEIN: I'm not going to comment on that.

PRESIDENT DiFRANCESCO: No, I don't either. I know that you'll be here religiously throughout the hearings. I know that we'll have this opportunity to continue to talk after we've finished everything, and I know you would want further input as we deliberate. So I'm cutting you off, but I'm

not really going to be cutting you off, because you'll have plenty of input. Whatever additional information you want to provide to us in the future you know that you can do that.

I forgot you. Okay.

Clare, I'm sorry. I didn't see your hand go up.

That's Paul's fault.

ASSEMBLYWOMAN FARRAGHER: Sorry.

ASSEMBLYMAN DiGAETANO: Guilty.

ASSEMBLYWOMAN FARRAGHER: Somebody-- We have too many mikes on.

PRESIDENT DiFRANCESCO: Too many mikes on.

Are all the mikes off?

Try again.

ASSEMBLYWOMAN FARRAGHER: Now I've got it.

PRESIDENT DiFRANCESCO: Okay.

ASSEMBLYWOMAN FARRAGHER: Thank you.

Thank you, Mr. President. I know it was because I'm so timid and quiet over here.

PRESIDENT DiFRANCESCO: Yeah.

ASSEMBLYWOMAN FARRAGHER: I have some questions that really have to do with the report that was generated and some of the numbers that were stated on Page 2 of your testimony, which I thought was really interesting. In one respect, it does refer to the fact that the cost for the PIP has risen to 266 per car -- that's an average -- constitutes more than 26 percent of the average automobile insurance premium. In information that has been

provided to the Committee in our binder, we do have sort of a pie chart here on New Jersey private passenger auto direct losses incurred 1995 and PIP claims 26 percent. So that's pretty much on the money.

The problem I have, though, is in the next paragraph where there is reference that approximately 45 percent of the collected premium, or \$353 million, goes to overhead expenses. More than half of that amount is for claim supervision, and so on. The 26 percent pie chart came from the Department of Insurance.

We have here another one that comes from The New Jersey-- The information was from The New Jersey Insurance News Service. The data came from triple I -- Insurance Information Institute -- AM Best, Insurance Services Office, NAIC -- the insurance commissioners -- and National Association of Independent Insurance, an insurance research council. And it said that 970.072 million of auto premiums on the PIP went to pay for medical benefits; wage loss and other economic claims, 878.46 million; other direct costs, 91.615 million.

All right, I find that that does not fit in with the numbers that are in your report. Now, these numbers are admittedly 1995 total year. I'm totally confused by the differences in those numbers given that we seem to be looking at, in another pie chart, in terms of where the premiums went in 1995. When it's broken out, general operating expenses is \$4. Agent commissions for those companies that use agents, \$14. Dividends to policyholders or shareholders, \$1. Claims settlement costs, \$8. So the total spent on claims and expenses would be \$108 under this-- And that was the same general groups.

I'm totally confused by all of the numbers not matching up. And those kinds of things trouble me, because those are the things that I look at to see where are we out of balance, where can we make the improvements. And AIS Risk Consultants testified here at the last meeting and now we've been provided with the report today-- We just-- We haven't had time to go through this. I think that we need an explanation of where are these differences, why are these differences. Given the fact that companies are, number one, not all the same. Companies are different. Companies are mutual. There are shareholder companies. There are reciprocals.

I want to compare like to like. It makes it so much easier for us here, especially for those members who are being exposed to these issues for the first time. I think it would be more-- It's important for us to know that there are cases -- some 16,000 cases-- I don't know if that's a lot. I don't know what percentages are in other states. I'd like to know that -- that wind up having to be litigated.

I would like to know more about a comparison on the medical costs. Given the fact that while in New Jersey the reason we went-- I believe, because I wasn't here when they went to PIP. I believe they went to that because we have so many uninsured, and you have auto insurance mandatory, health insurance not. We have a large number of uninsured -- many young people. I would guess that the thinking was that the PIP benefits are probably, in most cases, the only benefits that a young person might need. They tend to be healthier than us old fogies.

So I would say what we need to know is why is this difference between this collection of insurance information and your consultant, and also I would like comparisons of like to like.

I am a policyholder of a mutual company. Was a recipient of not one, but two checks last year. The performance of the company is outstanding. There are other companies that are perhaps not as efficient, but then again, there are differences.

Also, we should keep in mind that, for example, State Farm is a mutual company in every other state but New Jersey. In New Jersey, they are an indemnity company. So we need to start looking at like to like. Why is State Farm an indemnity company in New Jersey and a mutual every place else? I know why. It's interesting, too, that Allstate had to create a New Jersey subsidiary to insulate their policyholders in other states from losses incurred in New Jersey.

There have been so many things that have been wrong in New Jersey. We need to look at those things, factor that into the conclusion, and not just look at the statements of what the hidden costs are in PIP and all that. Because companies differ between themselves, they are not all the same. They're not all going to come in here and share information. Why their information is proprietary, can't be shared, can't be shared under-- We have to rely on accurate sources like Insurance News Service, like ISO, like the NAIC, who has captured all of the information because everybody files with them. So they can extrapolate things in a different way. And if you're not able to get that, I may be able to reach out to the NAIC and get some more information.

So while I say it is very important that we know of the problems that you experience or your clients, it is not as helpful to us as some of the other information. We can help in instances where things need to be referred to the Insurance Department, Unfair Claims Settlement Practices, and so on. But we need to know factually where actually we can make a real difference by comparing apples to apples.

I didn't really have a question, did I?

PRESIDENT DiFRANCESCO: I guess not.

ASSEMBLYWOMAN FARRAGHER: I'm sorry.

PRESIDENT DiFRANCESCO: And since she never questioned, there's no answer. Right? (laughter)

Assemblyman Charles would like to ask a question.

ASSEMBLYMAN CHARLES: Your proposal includes eliminating, repealing no-fault or PIP and substituting some med pay \$10,000. I think during the questioning at one point -- the extensive questioning by Senator Cardinale -- there was a point where you talked about the people in the gap between \$10,000 and \$75,000 UCJ. I'm concerned about the people in the gap, and I think that maybe the Legislature ought to know a little bit more about the numbers of people who are in this gap and whether there's any way that these gap people can be protected or helped in some way in this reform that we're now considering. Is it a possibility that-- And does it make sense from a financial point of view, dollar point of view, total payout in the different ways to reduce the UCJ coverage from 75,000, for example, down to begin at 10. What does that mean in terms of the dollars, for example, that we now pay in our policy toward UCJ? Is that going to go up? Is there some way

that we can handle that gap situation? I would need to know numbers there, people who would be involved, and how much it would cost to cover that.

ASSEMBLYMAN DiGAETANO: Just one quick question I have, since I am not an attorney as has been said before, but you are. One of the Committee members at the last hearing or the hearing before stated rather emphatically that Federal law prohibits Medicare from being the primary coverage. You in your testimony in almost the next to last full paragraph address Medicare being the primary payor for our senior citizens. So could you explain that, please?

MR. ANDRES: After our no-fault act was passed, there was a Federal statute which was passed. Our no-fault act said Medicare will be primary as would worker's compensation. There was a Federal act which was passed after that that said no, and it preempts us. And that was the statutory citation that I gave you, 42 U.S. Code, Section 1395.

ASSEMBLYMAN DiGAETANO: So how would your proposal provide for Medicare being the primary payor then?

MR. ANDRES: We get rid of no-fault.

ASSEMBLYMAN DiGAETANO: Oh. So simply removing no-fault would then remove that Federal bar.

MR. ANDRES: Yes.

MR. WILDSTEIN: Yes.

ASSEMBLYMAN DiGAETANO: Thank you very much.

MR. ANDRES: The Federal act specifically references no-fault states.

PRESIDENT DiFRANCESCO: Thank you.

MR. ANDRES: Thank you.

MR. WILDSTEIN: Thank you.

PRESIDENT DiFRANCESCO: Alex Archimedes, President of Parkway Insurance Company. Alex, you're still here?

ALEX C. ARCHIMEDES: Yes, sir.

PRESIDENT DiFRANCESCO: Good afternoon, Alex.

MR. ARCHIMEDES: Good afternoon.

PRESIDENT DiFRANCESCO: Did you give us a statement, Alex?

MR. ARCHIMEDES: Yes.

PRESIDENT DiFRANCESCO: Okay.

Who do you have with you?

MR. ARCHIMEDES: I have Dean Vintch with me, who is our Vice-President of Parkway Claims, and also to his right is Linda Reina, who is the Manager of our PIP Unit at Parkway.

Mr. Chairman, other members of the Committee, good morning. I am Alex Archimedes, President of the Parkway Insurance Company, and I've already introduced the people next to me.

I would first like to commend this special legislative Committee for addressing the issues surrounding automobile insurance in such an open and forthright manner. It seems that in the past years, the tendency has been to treat symptoms rather than the root causes of problems. The work of this Committee should provide an excellent opportunity to make needed revisions to a system that is sorely in need of change.

The purpose of our testimony today is to encourage you to address the problems relating to personal injury protection coverage, so called PIP. As you know, New Jersey mandates the second highest level of PIP coverage in the nation, second only to Michigan where there is unlimited coverage. For the purpose of this discussion today, we are not disputing that coverage limit. What we would like to talk about is PIP abuse, overutilization, and fraud which occurs at levels much less than the maximum provided.

The majority of PIP claims are clearly legitimate. People are injured in automobile accidents and need medical attention -- sometimes for an extended period of time. Unfortunately, a number of claims result in clear abuse of the system. Parkway, as well as any other major insurer in the state, can cite many examples of fraud and abuse, particularly as it relates to whether medical treatment being claimed is necessary or appropriate. In a few minutes, I will ask Dean and Linda to talk about some actual Parkway files and provide an overview about the abuse that I've described.

We need the tools today to be able to fight fraud and abuse in a cost-effective manner. This will ultimately provide a benefit to the New Jersey driving public. Over the past two decades, the cost-effectiveness of PIP has eroded through factors such as an ineffective arbitration process, increases in experimental diagnostic procedures and duplicative and unnecessary medical treatment. These excessive and unnecessary treatments provide financial advantage to those who seek nothing more than personal gain.

There are measures we can take to improve the system. One effective weapon we could institute to fight this abuse is PIP peer review. This would require that disputes regarding medical necessity and appropriateness

be submitted to a peer review panel of qualified New Jersey doctors who specialize in the same field as the services under review rather than attorneys, as is currently the practice in the arbitration system. This peer review process would not reduce coverage for legitimate medical treatment and would not impact the vast majority of New Jersey citizens. It is a focused approach to attacking fraud and abuse related to unnecessary and inappropriate medical treatment. Numerous safeguards could be built into this peer review process including licensing procedures, regulation, and oversight by the State, and a process to ensure impartiality.

The most important point is that doctors should decide what is appropriate medical treatment and not attorneys. This has worked well in Pennsylvania and can work effectively in our state also. This is a commonsense approach to a very serious problem in New Jersey. Additionally, we should institute a comprehensive medical fee schedule to better control PIP costs and to streamline the evaluation and payment of claims.

We look forward to working with this Committee over the next few months to bring about meaningful, long-lasting change to New Jersey's PIP system, change that will help make PIP more cost effective and begins to reduce the waste, excessiveness, and abuse that characterizes the current system. Hopefully, people will look back at this Committee's efforts as a major turning point in making New Jersey's auto insurance more affordable, equitable, and efficient in providing medical treatment in a legitimate manner.

I would like now to ask Linda and Dean to just talk about a couple of examples of actual claims that really describe what I've talked about.

Dean.

DEAN VINTCH: Okay.

Before we get into our examples, I think it's very important to explain our claims handling philosophy, which can be stated in three parts.

1. Our objective is a fair and timely settlement of claims. When our insureds pay their premiums, we truly believe that they are paying for claim service in the event they are involved in an accident. We want this customer satisfied at the time they have a claim.

2. We will complete, as a claim department, a thorough and timely investigation of what are questionable claims, if these claims are found to be valid. And again we want to pay these fairly and in a very timely manner.

3. We will deny and defend claims which are proven to be unreasonable or fraudulent including complete cooperation with the Fraud Division and law enforcement agencies.

As you will see in our examples, the unreasonableness of some claims is very obvious. In others, claim representatives must walk a very fine line between providing the customer service we expect and at the same time investigating questionable claims with what we find to be very limited tools.

The examples you have been given are very detailed including summaries of the bills received, as well as explanation of benefits. Linda and I will limit our presentation to a brief discussion of the highlights of three of the examples. If you would like additional details or have questions, we will go through the rest of the examples also.

Even though the majority of claims we receive are valid, our examples are of grossly exaggerated and possibly fraudulent billing practices by providers. And we don't think this is unusual.

Now, the first six examples involve very minor impacts. The property damage involved in these claims totals \$338. The medical bills submitted for these same claims totals over \$229,000. I would like to draw your attention to Example No. 1, which you have before you. What I will do is quickly summarize the facts of the loss. And then Linda will go through some of the more interesting information regarding the actual medical aspects of the claim.

In our Example No. 1, our insured backed out of a parking space in a parking lot. When he was nearly finished backing up, another car struck him in the right rear quarter panel. If you look on Page 4 of the package you have, you'll see a photograph of the damage. The damage, which was an estimate completed by the other carrier, totaled \$330. As you will see as we go through this claim, the total medical bills submitted including testing now total \$54,942. There was only one person, which was an occupant of our car, who complained of any injuries at the scene of the accident. But the police report indicates that there were no injuries. One month after the accident, we found out that all four parties in our car were claiming soft-tissue neck and back injuries. The driver of our car is also claiming chest injuries. We find this very difficult to believe when you look again at the photograph and see the right quarter panel impact. It's hard to understand how anybody could be thrown around the car and let alone hit the steering wheel. None of the PIP

claimants have lost wages even though we know that our driver was employed at the time of the accident.

Linda.

L I N D A R E I N A: All four of the PIP claimants in this accident were treated with the same provider. They all have the exact same diagnosis. They are all receiving the same treatment. The amount of treatment does vary. The first two people involved in this claim do have verbal thresholds. I'd like to call your attention to the amount billed per claimant, especially claimants two, three, and four. They all had in excess of \$15,000 of medical bills billed to the insurer. The first claimant had \$10,000 in testing. The other 6200 is treatment. The second claimant has the same amount of testing as treatment, which is in excess of \$7000. And the third claimant has \$11,000-plus in diagnostic testing, and the other 5800 is for treatment. Again, the total amount that we were billed for on this claim for these four individuals was nearly \$55,000 -- a \$333 impact to the car.

We did pay approximately \$8000 of the bills received on the file when they initially came in again. We want to pay these claims timely. If we feel the claim is valid, we will pay it. It got to the point where we realized there were problems, there was extensive treatment and testing. We started to have the bills reviewed, getting a second opinion. We also had independent medical exams conducted. And as a result of that medical investigation, we decided to deny the balance of the bills, and we do anticipate arbitration being filed.

Another point I want to bring out is that there were five different diagnostic facilities utilized to perform the various diagnostic tests on these four claimants. They are located in Morristown, Matawan, Staten Island,

Union, and Newark. It seems odd the chiropractor wouldn't utilize the services of a diagnostic facility within the municipality of the PIP claimant's home. It also seems odd that they would use more than one facility to perform these MRIs. One of the claimants had to go to Morristown for an MRI, and the same person had to go to Union for the other. It also seems odd that the chiropractor would order CAT scan of the spine in a facility in Newark after MRIs were done on this patient. It has been proven that MRIs are a much more reliable method of detecting soft-tissue disk injuries of the spine than CAT scans.

MR. VINTCH: As Linda stated, we've paid approximately \$8000. Once we've found that the bills were very questionable, we sent them out for review by another chiropractor. We were told that these bills for testing were not appropriate. We've since denied the rest of the claim. But because of the current system, we expect an arbitration demand probably any day, and unfortunately, we expect to lose because of what we have found in the past. It is very difficult to question these types of tests even though they seem to be extremely overutilized even to a layperson.

MS. REINA: I just wanted to point out the last two claimants. There's four. The first two have verbal threshold. Claimants three and four have zero threshold. And as you can see, the amount of treatment and diagnostic testing is not that much different. In fact, it's sometimes heavier.

MR. VINTCH: I'd like to draw your attention now to Example No. 2.

ASSEMBLYMAN DiGAETANO: Before you do that--

MR. VINTCH: Yes.

ASSEMBLYMAN DiGAETANO: --there may be some other questions here. I have one. On this example, are you questioning the results of these tests, or are you just questioning the fact that the tests were performed?

MR. VINTCH: At this point in time, we are questioning whether they should have been performed at all.

ASSEMBLYMAN DiGAETANO: Yes, but not the findings?

MR. VINTCH: No.

ASSEMBLYMAN DiGAETANO: Any other questions from the Committee?

Senator Cardinale.

SENATOR CARDINALE: Do you find-- I know you have a number of cases you want to go through, I don't want to belabor this. But do you find that there are patterns that a particular lawyer will have a particular group of chiropractors or other medical providers who work with that particular law firm and provide similar kinds of tests case after case, similar kinds of testimony from this same medical providers in case after case?

MR. VINTCH: Absolutely. In fact, when we take statements under oath, most of these patients, we ask them how they ended up at this certain provider. In most cases, they were referred by the attorney or in many cases, I would say.

SENATOR CARDINALE: Okay. So the person who's in the accident is just not going to his own doctor. He's going to his lawyer, and then from the lawyer he goes to the doctor.

MR. VINTCH: Correct.

SENATOR CARDINALE: Have you in the suspicious cases reported any of these things to the Department of Insurance, the Fraud Division?

MR. VINTCH: Yes, we have.

SENATOR CARDINALE: And what's the typical result that you get?

MR. VINTCH: They send us a reply card on every loss. They have discussions with our SIU investigators. Our SIU investigators give them more information, and we are made aware of the providers that they are so-called monitoring. And at some point in time, we're told that more action will be taken, but we do feed information back and forth to each other.

SENATOR CARDINALE: Do you find over the year -- now, you've been doing this for a number of years, I suppose -- that ultimately they take action against any of these providers?

MR. VINTCH: Not on any of the cases we've been involved, but we do know they're working on them. Because, again, very often there-- We know they're gathering information because they ask for it all the time.

SENATOR CARDINALE: Do you monitor whether or not the individual patient is, in fact, paid the co-pay?

MS. REINA: I can answer that question. We have been asking that question of the patients in the examinations under oath that we've conducted when they're treating with a provider that we have a little bit of problem with their treatment and testing. I have yet to find a patient who has -- can prove to us that they've been billed or have paid the deductible and co-pay to their provider.

SENATOR CARDINALE: Have you had any of them tell you that their attorney or the doctor has suggested that the co-pay needn't be paid?

MS. REINA: No, they are just never asked for it.

SENATOR CARDINALE: They're never asked for?

MS. REINA: No.

MR. VINTCH: And, again, that's on a very few cases that we actually have what we call fraud suits on. These cases and most of the cases it's very difficult to do that. We can't get that information without actually going to suit.

SENATOR CARDINALE: Thank you.

ASSEMBLYMAN DiGAETANO: Senator Adler.

SENATOR ADLER: Would it help at all if the State had a standard medical protocol for treatment of accident victims? Would that help reduce costs for carriers and, therefore, for the system?

MR. VINTCH: I'd have a hard time answering that without looking at it, but it's very possible.

Example No. 2 -- again it's another very minor accident. If you go to Page 5, you'll see the picture. Again, our insured was rear-ended by another vehicle. Both vehicles were driven from the scene of the accident. No injury was reported to the police officer. As you can see, our insured vehicle is a full-size van. The total estimate to the van was \$55, as indicated in the photograph. The two claimants in the accident, which were husband and wife, in total have received medical treatment in excess of \$69,000 for soft-tissue injuries. There's a slight twist to this loss in that the spouse to our insured was

not indicated on the police report, but after approximately 30 days, said that she was in this loss also.

MS. REINA: The diagnosis for both--

SENATOR KYRILLOS: Mr. Chair.

PRESIDENT DiFRANCESCO: Senator Kyrillos.

SENATOR KYRILLOS: I'm looking at the photograph that you're alluding to, and I'm having trouble of even finding this car injury so to speak.

MR. VINTCH: It's that black little scuff you find on the bottom of the bumper on the left-hand side. There's brackets on the top picture.

SENATOR KYRILLOS: Toward the bottom of the bumper?

MR. VINTCH: Right. I mean, the estimate is really for cleaning the bumper more than anything.

PRESIDENT DiFRANCESCO: What was the estimate?

MR. VINTCH: Fifty-five dollars.

PRESIDENT DiFRANCESCO: Fifty-five dollars.

MR. VINTCH: Yes.

MS. REINA: Okay, the diagnosis for the injuries sustained to the husband and wife are sprains and strains and other unspecified parts of the back, sprains and strains of the sacroiliac region, myalgia, myositis, neurotic depression, psychic factors associated with diseases, other isolated and simple phobias and persistent disorder of initiating or maintaining sleep. This diagnosis is identical for the husband and for the wife. The treatment rendered -- therapy exercises, myofacial release, unlisted modalities -- some of this stuff I can't even pronounce -- hot and cold packs, injections, local anesthesia for a procedure of percutaneous electric stimulation. Testing -- data analysis,

performance testing, nerve conduction studies. The nerve conduction studies were performed on two separate occasions three months apart. This is just for the rehab facility. They rehab facility billed us \$19,000.

On the chiropractor -- had the exact same diagnosis as the rehab facility word for word. The treatment of the chiropractor was manipulation, joint mobilization and traction, neuromuscular stimulator, as well as providing other medical equipment including all kinds of supports, electric heating pads, cervical pillows, ice cap, and a jar of mineral ice, which by the way, we were charged \$12 for. I think they cost about 2.50 in the drug store. The billing, including the testing done by the chiropractor, was nearly \$18,000 for claimant No. 1. Other testing included two MRIs. The interesting one--

ASSEMBLYMAN DiGAETANO: Excuse me one moment.

Senator Adler has a question on the area that you are addressing right now.

SENATOR ADLER: Well, maybe not on the specific area. I would assume that you would demonstrate there has been excessive medical costs in these instances based on small physical damage to vehicles. And I know you talked about peer review as a possible solution. Let's assume, hypothetically, that this Legislature or at least this Committee is not going to support peer review. Can you recommend any other changes, other than peer review, that would reduce the number of instances or maybe eliminate instances such as the ones you're testifying about in such detail?

SENATOR CARDINALE: A guillotine in front of the courthouse.

MR. ARCHIMEDES: Senator, I wish I had the magic bullet to really answer how we could get rid of fraud and abuse without having doctors

judge what's medically necessary and appropriate. But the bottom line answer is it really is the commonsense approach to solving these problems.

SENATOR ADLER: We've heard testimony that there are doctors that are likely to do excessive treatments, and we've heard testimony from other witnesses that there are doctors that are likely to deny that a death in the car is related to the accident. We've heard both extremes -- that people are healthy even if they are dead from an accident. I want to assume that there are doctors that will do good things, and there are doctors that won't, just as there are human beings in all capacities.

Other than peer review, what would you recommend we consider as other options to reduce the level of fraud and the level of excessive or unnecessary medical treatment?

MR. ARCHIMEDES: Well, I think some of the things have been done already with recent legislation that's been passed.

SENATOR ADLER: From today forward, what other forms would you recommend we consider instituting other than peer review to move the situation--

MR. ARCHIMEDES: Well, medical fee schedule should be reviewed. We should examine whether a non-New Jersey-type, Medicare-type fee schedule should be instituted in this state. This has been done in Pennsylvania -- has been very effective in conjunction with peer review. That's one area we should look at. Today's New Jersey fee schedule is very complicated, very convoluted. It's one of a kind. It does not include all the different procedures that are available, and I believe it's very costly to try and

keep it updated; so some type of standardized Medicare-based fee schedule, I believe, would be very effective.

SENATOR ADLER: Do you have any written documentation or have you seen any written documentation that you could share with the Committee as a proposed new fee schedule for New Jersey?

MR. ARCHIMEDES: A Medicare-based fee schedule?

SENATOR ADLER: Could you provide us?

MR. ARCHIMEDES: Yes, we could.

SENATOR ADLER: Thank you.

ASSEMBLYMAN DiGAETANO: I'm not sure the way you're proposing, though, deals with the problems created in the Examples 1 and 2.

MR. ARCHIMEDES: No, it doesn't.

ASSEMBLYMAN DiGAETANO: I mean, 1 and 2 seem to be outright fraud -- their cases where there's minimal or no damage to the vehicle and claims for injuries. Now, you said earlier, you didn't dispute the results of the tests. So I think we're going to agree that there was some problem there, but it was not necessarily due to the accident. Peer review isn't going to solve that, and I haven't heard you propose something that's going to resolve that. What resolves the problems in Examples 1 and 2, which deal with negligible or no damage to the vehicle, yet claims? What resolves them?

MR. VINTCH: Well, first of all, it does resolve a very large portion of this because peer review would tell us that this treatment and amount of testing, which is most of the bills here, are unnecessary and unreasonable, whether it's a very large accident or a very small accident. So that's step one. That would reduce most of the bills. The next step is really

some type of process that allows us to show the peer review pictures and everything else we have so they can make a decision based on all the facts. Right now in the arbitration process, we can go in and show these pictures and they're basically ignored. And based on the provider saying he needed to do these tests, they're awarded the dollars. So it would help a great deal, though.

MR. ARCHIMEDES: The degree to which this testing is being performed is a judgment by a professional whether it's necessary or unnecessary, and that's exactly what peer review is intended to look at.

ASSEMBLYMAN DiGAETANO: Senator Cardinale.

SENATOR CARDINALE: A few years ago when Parisi was heading this division, we have mixed reviews about his efficacy, but he did a number of sting operations. Have the insurers-- I'm sure you get a history and you have an idea of which law firms are working with which chiropractors, and you could do sting operations. You could send an investigator in claiming that they were in an automobile accident. And-- Are you doing that? And, if you're not, why are you not doing that?

MR. ARCHIMEDES: Are we as companies doing that individually?

SENATOR CARDINALE: Yes.

MR. ARCHIMEDES: Well, I guess the question is what is our own level of authority to be able to conduct a sting operation. We would love to be able to have enabling legislation to do something like that. And if this Committee would consider that as part of legislation--

SENATOR CARDINALE: So you don't feel that you have a legal authority to send an uninjured party to the lawyer claiming that they were in

an automobile accident to find out where the lawyer refers them, what he says to them--

MR. ARCHIMEDES: No.

SENATOR CARDINALE: --and you don't have the authority within the law to do that?

MR. ARCHIMEDES: No.

SENATOR CARDINALE: Thank you.

ASSEMBLYMAN DiGAETANO: Senator Adler.

SENATOR ADLER: If we had professional arbitrators making the decisions about whether to continue treatment -- not peer review, but professional arbitrators from the American Arbitration Association or some other group -- would that serve to reduce costs of excessive or unnecessary medical treatment veering into the fraud area that Assembly Majority Leader described earlier?

MR. ARCHIMEDES: Although it's probably a step forward from what we have today, here again, I think it's treating the symptom and not the root cause of the problem. A professional arbitrator, once again, is not a medical professional. And for their ability to be able to judge what's medically necessary or not, they would need to have some kind of ongoing training relating to new diagnostic tests, new procedures-- And I know. I was at a meeting a couple of months ago where a New York arbitrator-- We asked that very question -- how do you keep up to date? And the comment was that through their own experience. Well, I think this goes beyond experience because you have to have some type of ongoing medical training to have you

understand whether this, in fact, is necessary or not. So I guess a quick answer to your question -- step forward but not the answer.

ASSEMBLYMAN DiGAETANO: In Examples 1 and 2, do you have the ability and if not what prevents you from bringing an action against the claimants with your contention that while they may have an injury and they may need some treatment, whatever injury they have is not related to these \$55 and \$300 accidents.

MR. VINTCH: We are bound to go through the arbitration process if they demand arbitration. But we have done exactly what you said on several cases where we have filed direct actions against the claimants to attempt to prove that they are fraudulent. The arbitration process continues to move along, but we are hoping we can prove in a court of law that, in fact, these claims were fraudulent. Our problem is that we have a lot of these, and it would be very difficult to do it on all cases. A lot of these are exaggerations, and what we call soft fraud. Now, these are very, very exaggerated examples. But we have ones where \$20,000, \$30,000 versus \$60,000, and to take all of those to court would be very difficult. But we have done so.

ASSEMBLYMAN DiGAETANO: Senator Cardinale.

SENATOR CARDINALE: You know, looking at these-- These sort of jump off the page that you have iontophoresis being done twice on a given date and then being repeated the next day. Now, I don't know if there's any medical protocol that would indicate that that kind of time frame for doing that kind of procedure is at all indicated. It would seem to me that for that kind of treatment to have any kind of efficacy you would have to do it at staged intervals. You have to let the tissue recover and then do it-- Perhaps

if you need to repeat it, you would repeat it on a -- certainly less frequent than twice a day.

When you take those before the current arbitration panels, do they routinely approve treatments that are as blatant as this?

MR. VINTCH: I'd say in most cases, yes. I must admit, however, that if they're really, really blatant like two treatments on the exact same day, every once in a while they will deny one of those payments. It does happen. The problem is, however, that even if they deny \$500 for an extra test, they still award the attorney fees for the plaintiff, which could be \$15 to \$3000. We've paid our 275 filing fee, and we've paid our attorney about \$1500. So net net, we're really in the loss position. So it's very difficult. So sometimes we have very minor wins, but the expenses are so great in going to arbitration that it makes it very difficult.

ASSEMBLYMAN DiGAETANO: Anything else?

MR. VINTCH: Okay. In the interest of time, we would like to jump to No. 7, because this is an example of an actual impact. The damages here were \$331. The insured vehicle was in the process of making a left turn, when the other vehicle ran the stop sign. There were no injuries reported at the scene, and the claimant did not go to the hospital. The claimant was also-- We don't know if he was employed, but there was no lost wages. We've paid much of this claim. Again, this is one of those situations where a lot of the claim was valid, but there were several tests that we feel, and our second opinions told us, were not usual and customary. The reason we wanted to show you this case is that it's an example of the arbitration process because

there's a very obvious bill that should not have been paid according to our doctors if the arbitrator found for the plaintiff.

I'll let Linda tell you about that.

MS. REINA: Okay. As Dean said, we didn't have a question as to whether this individual was injured. We did allow him to treat without questioning it until we started getting the diagnostic tests that were administered directly by the chiropractor, which included electromyographies on several occasions, a number of muscle tests, two paraspinal EMGs-- I mean, just test after test after test after test. All of these tests were given within a seven-month period, so it wasn't like the test was given and then there was an ample amount of time given to see if the tissue had improved.

The chiropractor also recommending \$1123 worth of durable medical equipment, which we did not question. Then, for whatever reason, the chiropractor referred the patient to a neurologist for more electromyographies, which the chiropractor had already performed twice, and a number of other tests. At that point we said, "Well, wait a minute. What's going on here?" We asked that a second opinion be given by a doctor of the same specialty as the treating physician to review the records and the treatment of the patient. We, in fact, had two experts review the records and had someone examine the patient. So we had three different physicians in the same discipline as the treating doctors.

One of the tests, in fact, is called spinal ultrasound, and spinal ultrasound was found -- and I have the minutes of the physical therapy board meeting for the New Jersey Physical Therapy Board -- that it's an experimental test and should not be reimbursed. We did accompany that with the doctor's

report who found that much of this testing was unnecessary. There was no medical necessity that could be found by any of these physicians, and we forwarded their reports, along with the minutes of this New Jersey Physical Therapy Board, regarding spinal diagnostics -- gave that to the American Arbitration Association who awarded the entire amount being claimed by the petitioner.

I can't understand it. It was \$3700 in tests. We did not question the treatment. We did not question the durable medical equipment, which we could have, we didn't. We said, we just want to know why we're paying for these tests if three people are saying it's not reasonable or necessary, and a New Jersey Physical Therapy Board finds that one of the tests is unreimbursable and experimental. Yet, the arbitrator and attorney appear to have ignored the information that we supplied for our defense and awarded the entire amount to the petitioner and the chiropractor.

Oh, one additional thing, the neurologists who administered the tests was given an examination under oath, and under oath testified that the use of these tests in no way would have changed the treatment pattern of the patient, whether they were negative or positive. He himself, under oath, said these tests were unnecessary. Again, that was included with the submission -- his testimony -- and again, the arbitrator chose to ignore that testimony and awarded the full amount to the petitioner and the chiropractor.

MR. VINTCH: In addition to the award, they also awarded \$1000 to the provider's attorney for taking the case.

ASSEMBLYMAN DiGAETANO: Assemblywoman Farragher.

ASSEMBLYWOMAN FARRAGHER: Yes. I just have a question, because I'm looking at this list of tests and I don't even know what some of them are. I've had an EEG, but what's a paraspinal EMG? What is that?

MS. REINA: A paraspinal EMG, I believe, is the-- There's service EMGs and there's needle EMGs. I am not a doctor, but I am pretty sure the paraspinal EMG is the needle EMG, and they are performed on a number of occasions.

ASSEMBLYWOMAN FARRAGHER: This person actually put himself through quite a lot of discomfort, if my experience with MRIs and such is anything to go by. I can't imagine why the person even went through all this. I'm looking at what happened. I've been in a couple car accidents, and, yes, you get hurt, you get banged a little bit, but I don't understand why all of these kinds of tests would have been necessary for what's described as the diagnosis, and it's confusing to me. Do you have any leeway at all in denying payment for a test when it doesn't seem related to the possible diagnosis or the--

MS. REINA: Well, what we will do is, like I said before, we will refer whatever tests we see appear to be-- Again, we are not doctors, we are claim--

ASSEMBLYWOMAN FARRAGHER: I understand that.

MS. REINA: --representatives. So when we have a question, we can't just deny it. We need an expert opinion. If the expert tells us it's not necessary or reasonable, then we are in a position to deny it. But when we deny it, it is inevitable that an arbitration will be filed.

ASSEMBLYWOMAN FARRAGHER: For example, let me-- Where I'm going with this-- A car accident, I obviously hurt my knee and my hip. They x-rayed my knee and my hip. I had no complaint with my head and my neck; therefore, they didn't x-ray that. So that if you saw somebody come in complaining-- The claim was that, you know, some injury to the hip, then you shouldn't have to pay for neck X rays if that's not part of the-- You know what I'm saying?

MS. REINA: Absolutely.

ASSEMBLYWOMAN FARRAGHER: Are you allowed to do that at all?

MS. REINA: Yes, we do that.

ASSEMBLYWOMAN FARRAGHER: Oh, okay. I was just-- I just was confused about that.

MS. REINA: Unless they can support it. We'll deny it and ask them to please support the charges and the treatment rendered. It's not-- It doesn't fit in with the facts that we have presented. If they can support it, we'll consider it. If they can't, I don't think they're going to argue with the denials.

ASSEMBLYWOMAN FARRAGHER: Oh, okay. If they can support that like-- Okay, maybe the neck injury wasn't apparent the first day. I know that sometimes those things don't show up for a day or two. So that if it can be supported, then you would pay.

MS. REINA: Then we would consider.

ASSEMBLYWOMAN FARRAGHER: All right. Okay. I was just -- wanted to know about that.

Thank you.

PRESIDENT DiFRANCESCO: Anyone further?

Gerry. (no response)

Did you present the solution?

MR. ARCHIMEDES: We could go through other cases. As we said, in the interest of time--

PRESIDENT DiFRANCESCO: Very good.

MR. ARCHIMEDES: --we just wanted to give you a flavor for some of the cases that we do see. And, as we said, although these aren't the majority of the cases that we deal with, these do happen day in and day out. And I would welcome any member of this Committee to come visit our company, and we could go to any examiner's desk, and you could see cases just like this.

PRESIDENT DiFRANCESCO: Alex, have you presented a written form of testimony?

MR. ARCHIMEDES: Yes, I did.

Our position is that we think the time to act is now. Peer review is an effective way to be able to combat some of this overutilization, excessiveness. This is a very focused solution to a huge problem in New Jersey. And this does not affect anybody's benefits, anybody's coverage. It's a very focused way to take fraud and cost out of the system. And we would hope that this Committee would recommend peer review as a solution for legislation.

PRESIDENT DiFRANCESCO: Thank you.

MR. ARCHIMEDES: Thank you.

PRESIDENT DiFRANCESCO: Okay. Bob Clinkscale, Director of Corporate Development, PRO New Jersey.

ROBERT CLINKSCALE: Good afternoon.

PRESIDENT DiFRANCESCO: Good afternoon, Bob.

MR. CLINKSCALE: I just learned of this late yesterday afternoon, so I have no prepared written testimony.

PRESIDENT DiFRANCESCO: Okay. It's being transcribed. Is the red light on, on your microphone?

MR. CLINKSCALE: It's on now.

PRESIDENT DiFRANCESCO: Okay.

MR. CLINKSCALE: Okay.

As I said, I'm just going to speak extemporaneously.

PRESIDENT DiFRANCESCO: Okay.

MR. CLINKSCALE: I didn't have time to prepare anything.

I understand what you would like for me to do. This will tell you a little bit about the Peer Review Organization of New Jersey, how they do peer review, and then answer any questions that you may have.

The Peer Review Organization of New Jersey is a nonprofit, physician-governed peer review organization, and we're also a quality improvement organization. In the State of New Jersey, we have been in business for about 25 years. I think to describe what we do in terms of peer review is to tell you a little bit about the sponsors of what we do.

First, I'll tell you something about the staff. We have a staff of about 100 people. On that staff, we have physicians, nurses--

PRESIDENT DiFRANCESCO: Bob, let me interrupt you.

I have asked the witnesses 5, 6, and 7 to come back Monday morning to testify. That's why this is out of order.

This is Bob Clinkscale, Director of Corporate Development, Peer Review Organization, New Jersey. He's going to outline how his organization works. He started doing that, and then he'll take questions on it.

We will then go to Barbara Geiger-Parker and her group. They'll come up together. The final group -- they'll come up together, and they'll talk about it also. So then we will be finished. The other three people will start off first thing on Monday.

Go ahead, Bob.

MR. CLINKSCALE: Also, Mr. Chairman, for the record, can I get my name spelling correct? It's S-C-A-L-E -- Clinkscale. I think it's S-D on your--

PRESIDENT DiFRANCESCO: Yes, it is.

MR. CLINKSCALE: Okay.

As I was saying, we have a staff of about 100 people: physicians, nurses, medical records technicians, economists, statisticians, epidemiologists -- several physicians on our staff have held principle positions at our State Health Department. So that's the type of people that we have. We have offices in East Brunswick and in Cherry Hill.

Okay, to our clients. One of principle clients is the Medicare program. We have been for many, many years the Federal government's agent in New Jersey to oversee the quality of health care for our some 1.4 million Medicare beneficiaries. And we do that work in several ways. The way I think that that's of most interest to you today is peer review.

We, by various avenues, receive information about either utilization or quality problems that come up in the Medicare program. Most of the traffic in that regard comes from the beneficiaries themselves, because we investigate beneficiary complaints. Some of the requests for our peer review come from other physicians, from hospitals, they come from the Medicare insurance carrier who profiles physicians and the utilization patterns by certain physicians. We monitor utilization patterns by hospitals and some physicians. We monitor things at hospitals like infection rates; obviously deaths we're concerned with. We monitor a great number of clinical factors having to do with measuring what hospitals are, and are not, doing.

So the peer review process that we follow is that we receive notice from one of those particular avenues about a case. And what we do is, we ask the -- these are usually inpatient hospital stays -- hospitals to turn over to us all the medical records, all the clinical information, the identity of everyone who had anything to do with the care of that patient, and we have a team of nurses that examine that information. If the team of nurses, after having examined the information, feel that there's some merit in either a utilization or a quality issue, they will then pass that along to one of our physicians. And one of our physicians will usually team up-- We have a network of a couple of hundred physicians in the state -- that's peer review. We couldn't possibly have a peer to every physician on our staff. So we have physicians out there in the state.

So we ask one of those physicians to sit in on the review. So our physician reviews it, the peer review physician reviews it -- and this by the way is with complete impartiality. We're not-- We're just concerned as to whether

this is or is not a quality problem or whether medical care was necessary or not necessary. If in that investigation it appears that there was a quality problem, then we call in either the hospital or the physician and we counsel them, and we discuss the case, and we try to educate them as to how something like that would not happen again. And we may ask them to take certain education courses. We may provide education information ourselves, and we may ask them to write a corrective action plan on how they plan to assure us, the Medicare program, the patients that this kind of thing wouldn't happen again.

That's how we conduct peer review. It's completely impartial. We don't work for any providers.

PRESIDENT DiFRANCESCO: Bob, let me ask you this question because I don't know very much about this. I just asked Laurine this very same question. For the record here now-- You've outlined your organization. Who pays for this?

MR. CLINKSCALE: Oh, in this case, Medicare pays for it.

PRESIDENT DiFRANCESCO: Okay.

MR. CLINKSCALE: I'm describing to you-- We do several types of peer review. So the payor is Medicare when I'm talking about Medicare peer review. We do another kind of review I'll tell you about that's paid for by the State.

PRESIDENT DiFRANCESCO: Okay.

MR. CLINKSCALE: None of this is paid for by-- We have no relationships whatsoever to insurance companies, never had, as far as I know, and don't. In fact, the way we maintain our impartiality is by not having any relationships with any providers. So we're not, for example, for managed care.

We're not against managed care, we're only for good health care and wherever you find it and in whatever form it's delivered. So Medicare is the payor there. I'll stop there. That gives you sort of an idea of how we do peer review.

We also do quality improvement studies of hospitals and among providers, and they're collaborative. I mean, we may, for example, notice that infection rates for osteopathic surgery at some hospitals is high relative to the State average or some sort of outlier. We do a lot of computer work. And we may get those hospitals together and say, "Look, perhaps the reason your postop infection rates are high is because your physicians aren't administering the prophylactic antibiotics appropriately. Let's look into it." And we're doing it not as a kind of a gotcha thing, we're doing it to try to help them. First of all is to let them know their rates are really high, and then help them figure out why, and then help them correct it. Or we may know of some guidelines that aren't being followed that have been developed by NIH, the Federal government, the Health Department, whatever. And we'll let people know those guidelines exist, and we encourage them to read it. So that's the kind of thing we do for the Medicare program.

In Medicaid, which is our State program for the poor, as you I'm sure all know -- we're moving more and more people into Medicaid. And we've moved our TANIF (phonetic spelling), or AFDC, moms and kids -- most of them are now on Medicaid managed care. And next year, we're going to-- Medicaid is going to be moving the SSI population, the H-blind and disabled into managed care. And we'll be moving a lot of our people who are receiving mental illness and substance abuse services. That, too, will become part of managed care.

So the State Health Department has retained us to be the external quality reviewer of that whole program. And that's really important because you're talking about a very vulnerable population and they have special needs. So we are quite external to the-- We are the external reviewer. We oversee the quality of care, for the access to care, and the quality of care within that Medicaid managed care program. And we produce independent reports, collect data. We do studies. We oversee the operations of the HMOs or the managed care plans that provide those services. We work with the HMOs to help them improve the quality of care, and we collect statistics on virtually all encounters that anybody has with the health care system in that population. That is paid for by the Department of Human Services.

PRESIDENT DiFRANCESCO: Any questions?

Senator Adler.

SENATOR ADLER: For your system, you have some sort of medical protocols that you follow in judging the quality of care, for excess of care, or for inadequate care. Is that right?

MR. CLINKSCALE: Yes, sir.

SENATOR ADLER: Would it be feasible for the State of New Jersey to have medical protocols instituted for the treatment of auto accident victims?

MR. CLINKSCALE: I don't know a lot about the auto accident victim issue. I mean, mainly I know most of what I learned today sitting here. But, yes, there are medical guidelines and protocols that have been developed for practically any type of trauma or illness. And some of them are developed by, let's say, scientifically through clinical trials -- like the work that the FDA

does. A lot of them are developed by expert panels such as pulled together by NIH, and others are developed by special societies. So, yes, I think there is probably as many medical guidelines as there are recipes for chili.

SENATOR ADLER: We've heard testimony from some people that carriers don't pay for legitimate medical treatment. We've heard testimony from other people that there have been very expensive reimbursements for excessive or even fraudulent treatment. Do you have a sense as to whether or not a standard set of medical protocols in the auto accident context would in any way reduce costs? And if you think it would reduce costs, can you give us any sort of estimate of what dollar figures we are looking at for reducing costs?

MR. CLINKSCALE: I think I can safely say it would reduce costs, but I couldn't tell you by how much. I mean, that would be-- I wouldn't even venture a guess. What happens when you tend to use medical guidelines is people get better care, and better care is actually cheaper than bad care. Bad care involves hospital readmissions and complications, and that's really expensive. So if you follow-- So if providers tend to try to follow good medical guidelines -- I don't mean like a cookbook -- but I mean use them as references, use them appropriately, follow good guidelines, then they take better care of people -- and it is less expensive. And it does screen away a lot of the unnecessary treatment and unnecessary diagnosis that we've seen in other parts of health care.

SENATOR ADLER: Thanks.

PRESIDENT DiFRANCESCO: Joe? Scott? (no response)

So that forgetting about the fact that you deal strictly with Medicare, if you were to -- as Senator Adler, I think, was driving at -- perhaps get involved or advocate involving this same kind of review in automobile claims, you would deal with, for example, overutilization? Would you look into that-- Is that an area that you look into?

MR. CLINKSCALE: We do that now with Medicare and Medicaid and some of the others.

PRESIDENT DiFRANCESCO: Where the diagnosis appropriate or not?

MR. CLINKSCALE: Yes, we do that.

PRESIDENT DiFRANCESCO: You do that, too.

MR. CLINKSCALE: Yeah. I mean, I guess you're just talking about, in this case, it's an auto accident.

PRESIDENT DiFRANCESCO: Right.

MR. CLINKSCALE: And in another case, it's the emergency room. We deal with every aspect of preventive treatment.

PRESIDENT DiFRANCESCO: Joe.

ASSEMBLYMAN CHARLES: Are you suggesting that your organization is an organization that would be available to do the kind of peer review in this area that we've been considering?

MR. CLINKSCALE: I don't want to make an independent-- No, I'm not offering us as being able to do that. We'd like to think-- We'd certainly think about it. We could do it. I know there's a volume. I heard somebody say 16,000 cases a year. Did I hear that?

ASSEMBLYMAN CHARLES: Right.

PRESIDENT DiFRANCESCO: But 16,000 that now go to arbitration, right?

ASSEMBLYMAN CHARLES: Now the cases that go to arbitration -- yeah. My question is this. If you were-- You've heard some of the testimony today about the problems in this automobile insurance area. If you were putting together some sort of peer review system to deal with the problems we're discussing, what kind of system would that be? What would you suggest to us that we do to put together a peer review organization that really can handle the issues that we've been talking about?

MR. CLINKSCALE: I think I would-- I was going to try to be brief, so I skipped a lot of things. One of the other things that we do is that we hear appeals under our State HMO regulations. We are the organization that when somebody has a problem with an HMO they can't resolve, it comes to us and our physicians. And I think I would set up something like that. I think what we do for Medicare is probably a little overly elaborate. I think that you're talking about conflict here or a situation where somebody feels that they've either been overtreated or undertreated or mistreated and they can't resolve that. Instead of going maybe to the courts or to the lawyers who may or may not have the objectivity and the expertise to sit down and look at the facts and decide what really should have happened-- That's the way we deal with the HMO appeals. They come to us, we study them--

ASSEMBLYMAN CHARLES: They come to you from whom?

MR. CLINKSCALE: From the HMO. If somebody has a complaint with an HMO and they can't resolve it or the HMO, let's say, says as a medical denial, you're not entitled to this service or if they feel in any way

that they have been wronged by an HMO and they can't resolve that with the HMO, then the HMO must surface it to us -- the peer review organization and that is per the Department of Health and Human Services.

ASSEMBLYMAN CHARLES: Is that referral to you-- That disagreement that underlies, is that generally involving an attorney representing the insured, or is that something that comes from just individual laypersons? In the majority of cases or the usual cases, is that an attorney involved on the side of the insured, or is it a situation where normally it comes up where the insured is unrepresented by an attorney?

MR. CLINKSCALE: I don't have the statistics. We've done about 35 of these. And we've only been doing this a couple of months. We've done about 35 appeals. And I asked the other day before I left, about half of our judgments had been for the managed care plan and about half of them had been for the patients. Now, I do believe that there are some cases where patients are represented by attorneys.

ASSEMBLYMAN CHARLES: And what's the forum? You get written reports from one side, written reports from the other side, and your review people make a call or just -- is there some examination? Just what's involved in your making that determination?

MR. CLINKSCALE: Our review physicians get all the information, all the facts from every side, and sit down and look at it and make a call -- an independent call.

ASSEMBLYMAN CHARLES: That doesn't involve any sort of hearing at all. It's just on the record, on the medical reports that are submitted. So you allow each side to put together whatever medical reports,

whatever statements they want to make, whatever contentions they want to make -- all that is submitted along with medical records? If that's the case, then the review people make a decision?

MR. CLINKSCALE: That's the way it generally works. I think they are entitled-- I think, if they want to, there is some flexibility there. If they want to have -- if we want to actually meet with a provider -- you know, other than talking to them on the telephone to clarify things -- I think we'll have the provider come in. We can talk to the medical director at the HMO, and I believe that the patient is entitled to come in and talk to us, if they like. We let them know that, and I think there have been times when they have.

ASSEMBLYMAN CHARLES: In these 35 cases that you've talked about, has there been anything that you could call a hearing, some sort of adversarial hearing or a hearing where parties were present in the presence of their legal representatives?

MR. CLINKSCALE: No.

ASSEMBLYMAN CHARLES: Has that been involved in these 35 cases?

MR. CLINKSCALE: We don't let it get adversarial. It's not about that. It's about whether or not we think that the patient and their physician have a case or not.

ASSEMBLYMAN CHARLES: Can you do these things in the absence of an examination of the patient? I mean, aren't there situations where a real evaluation -- before a decision could be made, there should be or it would be helpful to have an actual physical or other kind of medical examination of the person whose claims are in issue?

MR. CLINKSCALE: We have access to all the medical information available, and it would be-- All that examination information is there. We don't want to subject patients to that again. However, if our physicians feel that they want to collect independent medical evidence or make independent observations, we're free to do that. And I think there may have been some cases when we did.

ASSEMBLYMAN CHARLES: Thank you.

SENATOR DiFRANCESCO: Is that it? Anything else you want to add?

MR. CLINKSCALE: I would-- No, I think not. I said I'd be brief, I'm being brief.

SENATOR DiFRANCESCO: Well, I mean, if there is something else that the Committee thinks could be helpful to us, we'll contact you. I think that we need a little time to digest what you have said.

I guess we kind of understand that in the area of the HMOs, we're dealing specifically with new regulations and new laws that allow that right of appeal, as I had understood it, by the doctor on the advice of a physician. It's a little different, with auto, right now anyway, because that structure isn't necessarily in place.

So we appreciate your being here with us, and your patience.

SENATOR ADLER: I think he said something which is fascinating. He said that we -- if we standardize medical procedures, it would actually both reduce costs and improve care. That's a pretty stunning win-win, if you can do it that way, somehow.

SENATOR DiFRANCESCO: It sure is, yes.

MR. CLINKSCALE: Senator, there is no question that good quality care costs less. We can demonstrate that over and over again.

SENATOR DiFRANCESCO: Even dental care? (laughter)

MR. CLINKSCALE: Especially dental care.

SENATOR DiFRANCESCO: Especially dental care.

SENATOR CARDINALE: More so. (laughter)

MR. CLINKSCALE: I know that, personally.

SENATOR DiFRANCESCO: Thank you.

Joe?

ASSEMBLYMAN CHARLES: Just one question. Is there any-- Soft tissue -- the soft-tissue injury, that's what is involved in a lot of cases where a lot of disputes come up. Is there anything unique about that that either helps or hinders the standardization of treatment and the development of a standard treatment protocol? Would that be the same degree of complexity or simplicity involved in developing a protocol for soft tissue as it is for other kinds of injuries or illnesses?

MR. CLINKSCALE: I don't see anything different about soft-tissue trauma from any other kind of trauma.

SENATOR DiFRANCESCO: Since Assemblyman Charles had asked that question, Senator Cardinale has thought of something he would like to ask.

SENATOR CARDINALE: Well, I think this is an important issue in these kinds of cases. We hear, all the time, and I've had radiologists call me since these hearings have been going on and told me that many times -- or the way they put it is, "If we take enough pictures, if we take enough MRIs, we can

find something wrong with almost everyone, whether or not they've been in an accident."

Now, would your organization have the capacity to take -- to review those documents, those medical records and pictures and actually differentiate -- because I understand that radiologists can do that -- between old injuries and injuries of a more recent nature?

MR. CLINKSCALE: Absolutely. There is no question that we can do that. I mean, we have access to all of our consultant physicians all over the state -- specialists, including radiologists.

SENATOR CARDINALE: In the cases -- the kinds of cases that you've had occasion to review, have issues like that been resolved as a result of your review and determination that this injury was something that was from years ago, rather than more recent? Have you had any actual experience of having--

MR. CLINKSCALE: I don't know about that. I don't know if that has come up or not. That's a good question. I'll get the answer for you.

SENATOR CARDINALE: Thank you very much.

SENATOR DiFRANCESCO: Thank you. Thank you again for your patience today.

MR. CLINKSCALE: You're welcome.

I did think of one other thing I want to say before I leave. I think that, in listening to some of the comments made earlier about peer review, peer review can work if it's done right. It's a perfectly acceptable way for a lot of issues to get resolved, and we get it out of our jury system.

I think the importance of doing peer review well is to have somebody do it who has got the competence, that's got the commitment to quality, and that has the impartiality. I think that if you can find those three ingredients, you'll find peer review working very well.

SENATOR DiFRANCESCO: Well, you know, the problem that exists in this area is that last word you mentioned, is the allegations of impartiality -- you know, who is paying for the process lends itself to whether or not there is impartiality in the automobile accident area, as opposed to what you're doing now. So that's what we're struggling with, is impartiality.

MR. CLINKSCALE: Well, I can tell you, in the case of the HMO regs that we have in the state, the payer is the HMO -- not in this case--

SENATOR DiFRANCESCO: What kind of control do they have over the process, I guess? According to you, none, right?

MR. CLINKSCALE: No, regulations make it-- We have good health care regulations in this state. The HMO regs make it very clear that we're free to investigate the case in any way that we see fit, and the HMO has to pay for it, period. They have no influence over us, whatsoever.

As I said, about half of our cases, so far, have seemed to go-- We've agreed with the determination made by the medical director at the HMO, and in about half we didn't.

SENATOR DiFRANCESCO: Okay, thank you.

MR. CLINKSCALE: You're welcome.

SENATOR DiFRANCESCO: Okay, Barbara. The final group of witnesses may come forward -- Barbara Parker.

It was their request to come up together, so you'll know--

And, Barbara, you'll introduce who you have with you?

BARBARA GEIGER - PARKER: Yes.

Good afternoon, Senate President DiFrancesco and members of the Committee. I'm Barbara Geiger-Parker, the Executive Director of the Brain Injury Association of New Jersey. I'm joined here by Scott Gebhard, by Dr. Becker, and by Evie Bird. I will introduce them a little bit more formally at the end of my remarks.

The Brain Injury Association is a nonprofit organization dedicated to providing services, advocacy, and information to people with brain injury, their families, and professionals in the field of brain injury.

Each year in New Jersey, more than 10,000 people are hospitalized with traumatic brain injury. Over 2000 of these injuries are moderate to severe, many times resulting in lifelong disability. About half the individuals who are hospitalized are injured in motor vehicle crashes and access the care that they need through automobile insurance's personal injury protection. We believe that PIP provides the most important benefit in auto insurance -- immediate access to medical services needed by an injured individual.

Today I am not only speaking for the Brain Injury Association, but also as a representative of the Coalition to Preserve Personal Injury Protection.

The Coalition to Preserve Personal Injury Protection was established in 1993 in response to proposals calling for a reduction in the amount of PIP that automobile insurers must offer, and we've closely monitored various reform proposals over the past several years. The Coalition is comprised of more than 20 statewide organizations including consumer advocacy groups, as well as health care professional associations and provider

groups. Our paramount objective is ensuring patient care to appropriate levels of medical treatment and rehabilitation care required to recover from the effects of a motor vehicle crash. While individual member organizations may differ on their views toward various aspects of auto insurance reform, each has an unwavering commitment to the preservation of the current mandatory \$250,000 PIP.

We appreciate the Committee's deliberate approach to collect evidence on all sides of the auto insurance problem. We understand that you have a very difficult task with many competing interests involved in the auto insurance debate. We also understand that the Legislature has been asked to lower rates, but we ask that you do not sacrifice the often unknown benefits of personal injury protection as a means of lowering coverage premiums. We urge the Committee to maintain the needed medical and rehab care New Jersey citizens can now access through their mandatory \$250,000 worth of PIP. We know that many citizens of New Jersey are grossly underinformed on the benefits of PIP until they or a loved one is injured in an automobile crash and needs to access the essential care, often only offered by personal injury protection.

Today, we hope to show you how PIP works, after a car crash, to provide injured individuals with the excellent trauma and rehabilitative care currently available in our state. When an individual is injured in an automobile crash, he or she might require extensive rehab, medical care, and other services to recover from injury. Many times these services are not paid for under regular health insurance -- as Senator Cardinale was referring to earlier -- no matter what coverage an individual might have, if they have any

health insurance coverage at all. Those with no health insurance coverage would be shifted to State-sponsored charity care. However, charity care does not cover rehabilitation that is often necessary to have crash victims cared for at the State's comprehensive rehab facilities. Even under a typical health insurance plan, one may be limited to just a certain number of visits to a practitioner such as a physical therapist.

Health insurance was designed for acute medical care: the flue, an appendectomy, heart attack, cancer. Personal injury protection was designed specifically for recovery from physical trauma received due to an automobile accident. PIP benefits provide needed services to ensure good health recovery to all but the most seriously injured citizens in our state.

Many individuals who suppose they have good health insurance plans are surprised to find that rehabilitative services that they or a loved one need are out of reach, when they didn't realize that. As stated, actually by Assemblywoman Farragher in a statement that she submitted in opposition to some of the changes in the FAIR Act-- She stated that "shifting medical coverage from automobile insurance to health insurance may leave certain catastrophic costs, including rehabilitation, unpaid. Health insurance policies do not provide the same breadth or extent of coverage as automobile insurance." The \$250,000 worth of PIP often represents an individual's only source of funding for rehabilitative services and home modifications.

When a person is seriously injured, they need services regardless of the funding source. By maintaining PIP, the State fulfills its goal of providing care to those who are injured, while at the same time offering the only hope that these individuals may have for returning to a normal and

productive life. Furthermore, PIP benefits also help accomplish what Governor Whitman recently outlined as one of her primary objectives for real auto insurance reform, which was to minimize the cost shift to health insurance.

Preserving the \$250,000 worth of the PIP benefit also accomplishes another one of the Governor's stated goals for real auto insurance reform. It eliminates the need for additional lawsuits parties would have to file in order to pay for the costs for basic medical care and rehabilitation that otherwise would be covered by PIP.

Although there are no numbers available to us on the shifting of costs to the private health insurance, which would occur if you eliminated PIP, common sense dictates that health insurance premiums would rise if you take the \$1 billion cost of PIP, as was presented in prior testimony, and shift it to the health care system. Not only would costs increase to the private health insurers, but also increased costs would be anticipated among the government's State-worker health benefits funds and Medicaid.

Automobile crashes do not discriminate. They don't check and see if you carry insurance. Crashes happen every day to anybody, as I think was illustrated at our last hearing when the question was posed on how many people in the audience used their car insurance benefits. Almost every single person in the room raised his or her hand. Anyone of us, at some point in our lives, may realize the need, personally, for the benefits of preserving mandatory \$250,000 PIP.

Following me today are three people who will advise the Committee about the care system in New Jersey and PIP's influence on that care system. We will hear from Dr. Becker, Director of Trauma at Jersey Shore

Medical Center, who knows, firsthand, that the people brought into his trauma center did not plan on that trip, nor did they have any knowledge of the long road ahead of them.

We will hear from someone representing what is many times the next step in the rehabilitation system, Scott Gebhard, who is Chief Executive of JFK Johnson Rehabilitation Institute. JFK and the many rehab centers around the state begin to work with injured individuals in the many different kinds of rehab that injured folks need to get back to work and to achieve the highest quality of life available to them.

Finally, we will hear from Evie Bird, a parent of a then 20-year-old son who was injured in a car crash when unlimited personal injury protection was still an option. She knows, firsthand, the devastation an injury can bring to a family. She counts herself among the lucky ones. Her son had the coverage he needed, but she met others throughout her days of long rehabilitation that were not so lucky.

Listen to these people. They have a different perspective than any of the other persons who have testified before you. They live, day in and day out, with the havoc that a car crash can bring to injured individuals and to their families.

Thank you very much for your time today.

STEPHEN A. BECKER, M.D.: My name is Dr. Stephen Becker, and I'm the director of one of the nine trauma centers that exist in the State of New Jersey. I don't have any typewritten testimony, so I'm just going to say a bunch of stuff, and hopefully you will ask questions, and I can offer you,

also, some very concrete suggestions as to how to make some of these problems go away.

The State of New Jersey has nine trauma centers. You pay one dollar with your car registration renewal so that the State Police can provide you with a helicopter that can get you to any trauma center within 15 minutes. So everyone within the State of New Jersey has access to the best chance of survival after a car crash of anyplace in the entire world. Why is it surprising that that costs more money?

So I first ask you to think about, when you don't want to fund PIP and you want to change the coverage that everybody has, that you are going to destroy, subsequently, the best trauma system in the entire world. In the United States our mortality rates, when compared to only eight other states that have statewide trauma systems, are the best in the United States, thus, the best in the world.

I would remind you that the most effective way of limiting the cost of medical care to patients who have accidents is for the patient to die quickly. That is the best way to limit costs. Dead patients do not consume money to pay for hospital or physician care. But if we can all agree that we still want to maintain the best trauma care system for the unfortunate instance where something happens, then I would ask you to maintain the PIP coverage that we have.

The average age-- We've treated now more than 25,000 patients in the nine centers since the system was organized in 1991. The average age of all trauma patients is 39.8 years. Thirty-nine point eight years means they have 25 years left before Medicare kicks in. So the patient-- Some of the stuff

you've heard today here is just, to me, totally embarrassing, about how Medicare is going to pick up all of these costs. Average age, 25,000 patients, 39.8 years, okay, so there is no Medicare. The average age is 39.8 years.

The randomness of trauma: Some of you on this panel have had experience with how random that is -- so has the deceased coach of the Yankees, Billy Martin, so has Gloria Estefan, so has Willy Shoemaker, so has Bob Hurley, so has Tommy John's son, so has Teddy Pendergrass, and so has the son of the United States' Vice President, Al Gore, when four years ago his son stepped off the curb in Baltimore, after seeing a ball game, and was waffled by a car.

Trauma doesn't care what race you are, how much money you make, and what the color of your skin is. It can happen to anyone, and that's why we have insurance, because it can happen to anyone.

Three months ago, a 32-year-old State Trooper, on the New Jersey Turnpike, pulls over a motorist for speeding. He took the motorist information, went back to his car, and because he was so well trained, sat in his seat after restrapping his seat belt to fill out the form to give the automobile driver a ticket. The pickup truck driver, who fell asleep at the wheel, that crashed into the back of him transmitted energy to his automobile, which then, through the seat belt, transmitted energy to both of his chest cavities, both of which were crushed.

Now the bottom line is, in the old days, he dies. He doesn't consume any health care benefits. He dies because the general community hospital doesn't know how to take care of this patient. But the other issue is

that what happened to him was totally random, and because you can't control these events, you've got to provide the coverage to protect those it happens to.

Where is the outcry? Right now you can-- You know, if everybody has all this health insurance that all these previous speakers talked about, how come you don't opt out of your health insurance? There is a clause, you just opt out for your private health insurance, and only 4.5 percent of New Jersey drivers do that. Why? Because the health insurance stinks, and because there are limits on rehabilitation, and because you have to fight harder with health insurance, now that the HMOs have come along, to get the care you need than you have to with the insurance industry.

SENATOR DiFRANCESCO: Do you think that's why they don't opt out? Is that what your opinion is?

DR. BECKER: I'm asking you all, what do you think your opinion is?

SENATOR DiFRANCESCO: I don't know why. I don't know that that's the reason why they don't opt out, but--

DR. BECKER: Well, I think it's a little odd that you can opt out of your PIP coverage right now, save more than is proposed by many of the changes in the PIP cap, and nobody does it. So where's the outcry?

SENATOR DiFRANCESCO: I don't know how many people know that.

DR. BECKER: Excuse me.

SENATOR DiFRANCESCO: I don't know how many people really know that. I'm going to suggest that not a lot of the members of the public even know that.

DR. BECKER: You can increase your deductible from \$500 to \$2500 and save more money than if you were to reduce the PIP cap from \$250,000 to \$15,000. Nobody does it. So where is the outcry? Where are the people marching around the capital? Just because one radio station is out of control, we shouldn't lose our heads here, okay.

The No. 1 payor -- the No. 1 payor for trauma patients who have exceeded their PIP cap is Medicaid. I'll say that again: The No. 1 payor for trauma patients who exceed their PIP cap is Medicaid. The No. 1 payor for patients who don't have automobile insurance, because they're driving irresponsibly without paying their premium, is Medicaid. So all you are going to do is shift all these costs to charity care or to the Medicare rolls, and then somebody is going to have to raise taxes, and they will vote you all out of office because you raised taxes.

The denied payments that this guy is talking about -- 16,000 denied payments-- We have treated, our surgical group, 5385 patients. We have not had one patient, who had properly paid for insurance at the time of injury, had their payment denied. So who are these people? Who are these 16,000 people who have arbitration and litigation because the insurance industry doesn't pay their fees? I know, because I also send bills for services, and we don't have any denied payments. So apparently, if you're injured, you get payments made. I would like to know the level of injury of the 16,000 claims that are up for arbitration.

SENATOR DiFRANCESCO: Apparently, a lot of them are soft tissue. I assume a lot of them are soft tissue.

DR. BECKER: Right. Soft tissue is next on my list.

You know, we're all concerned about soft tissue here today, and I would like to get the focus back where it belongs, and that is, on saving your life. Saving your life is a much more significant issue than the issue of the soft tissue.

The sting operations should have started years ago. You should look into how many of the MRIs purchased in the State of New Jersey in the last three years have been by lawyer consortiums. You should be looking at the solution to the peer review is the Governor's Choice Plan. Once you take the engine out of that mill machine, all these soft-tissue bologna cases will go away. The Governor's Choice Plan takes care of a lot of the problems that the no-fault industry has today.

So trauma is random. We have the best system in the world in the State of New Jersey. Why do we want to trade down from being a first-class organization to a third-world organization, with who knows whether you're going to get the care that you need? And I'm not talking about soft tissue. I'm talking about saving your life.

We've saved thousands of lives in the seven years that we've been in New Jersey, and I think that we should continue to do that.

All right, what should you do? You should stop repairing automobiles. It's very simple. How can we sensibly talk here today about not repairing people, and yet we continue to repair the automobiles? Put in a clause that if you're seriously injured, the money that you paid for your automobile -- leave the car wrecked, but we'll repair you.

Shut down the shake-and-bake operations. The workmen's compensation IME has taken care of all of those shake-and-bake, bologna

soft-tissue stuff that used to go on in the workmen's compensation industry. I'm not sure -- I think the Governor's Choice Plan addresses most of these, but you need independent medical examination to supplement that.

Tort reform: As a trauma surgeon and a trauma director, I am deluged by requests from lawyers for reports -- medical reports on patients who have essentially no injuries. I do this every single day -- send back lawyers' requests for reports saying that they have a modest amount of injury. They have an indeterminate amount of injury. They have a minimal amount of injury, and the lawyer, of course, is all ticked off, because now he has a formal medical report that says his patient is not that injured. So reforming the motivation behind the legal system's pursuit of one-third of the fee of what they settle for, it will take a lot of the wind out of the engines that have been created to milk this no-fault system.

Sting operations: Remembering that Medicaid is the principle payor if you don't have insurance, transferring the money from the paid for system to the public coffers are all reasons why, in the trenches, which I am, the no-fault system that we have makes sense. It should not be surprising it costs more, because it's a Cadillac program, and it's probably the best that any group of people can provide for in the world.

So we pay a dollar to get the helicopter to get you to the trauma system, and then we can save your life, if you continue to support the personal injury protection.

I hope there are quite a few questions on some of the purposely inflammatory statements that I've made.

SENATOR DiFRANCESCO: Do we want to hear from--

MS. GEIGER-PARKER: Yes.

Scott, do you want to go?

J. SCOTT GEBHARD: I was going to say, perhaps I should rest my case.

Good afternoon, and thanks to Senate President DiFrancesco and members of the Committee for the opportunity to present my thoughts, and my condolences to House Speaker Collins.

My name is Scott Gebhard. I'm the Senior Vice President for Solaris Health, which is the newly formed parent company of JFK Health Systems in Edison and the Muhlenberg Regional Medical Center in Union County.

Among my various capacities, I also serve as the Administrator and Chief Executive Officer of the JFK Johnson Rehabilitation Institute. Much of the care we deliver involves the treatment and rehabilitation of victims of catastrophic injury, things like multiple trauma, spinal cord injury, and brain injury. And I have to tell you that many of these are the direct result of motor vehicle accidents.

Our JFK Center for Brain Injuries represents New Jersey's largest and most comprehensive provider of head injury-related care. Over the last 20 years, we've literally treated thousands of patients who were victims of closed head injury.

Our range of care extends all the way from the point of injury, where we will work with skilled specialists like Dr. Becker, through comprehensive rehabilitation, long-term care, outpatient care, and all the way

to community reentry, and by that I mean the point at which the patient is able to return directly to the home, the school, or the workplace.

As a health care professional, I've witnessed, firsthand, the detrimental impact that changes in motor vehicle insurance practices have had on the victims, particularly the victims of catastrophic injury and their families. I don't mean to say by that that health care costs should not be reduced and that the providers do not have a responsibility. It simply means that our efforts should not be at the expense of the patient.

At the JFK Johnson Rehab Institute, for example, during the last five years of operation, we've actually managed to lower or reduce -- not increase, but reduce -- the average cost per case of our inpatient care by 26 percent.

I'd like to emphasize that during that process, we did not achieve those decreases through layoffs of personnel or by denying our patients and their families access to necessary health and rehabilitative care services. Rather, our clinicians and others around the room, like Dr. Becker, and including members of the insurance industry, worked successfully to improve our utilization of testing and the use of other expensive resources. We also worked very carefully in developing protocols, or clinical pathways, specific to each injury or illness, thus, permitting us to better bring the right resources to bear at the right time during the patient's recovery process.

And lastly but not least, we continue to advance the use of alternative delivery services designed to limit the patient's stay in the very costly inpatient acute settings and costly rehab settings, and make better use of skilled nursing, outpatient, and home care-related environments.

What I would ask is that the same thought process and the incentives to pursue cost reduction need to be carefully and deliberately built in to our reform of the motor vehicle insurance system, and to date, they have not. Motor vehicle insurance premiums can and certainly should come down but not at the expense of the victims of catastrophic injury and the families of these victims and not in such a way that simply shifts the cost, as Dr. Becker suggested, from one pocket to another.

As each of you wrestle with the various proposals to lower automobile insurance rates, please consider the following:

- * Because of the catastrophic and chronic nature of spinal cord injury and traumatic brain injury, the length of time an individual requires treatment and care often extends through their entire lifetime -- Dr. Becker mentioned 25 years and beyond.

- * Even the current amount of coverage is insufficient to comprehensively and cost-effectively treat and rehabilitate those motor vehicle injuries that include closed head injury and spinal cord injury. The victim's need for care isn't altered by the fact that they survived and continue to live for 25 years. The cost of the needs are simply shifted elsewhere. They still need to be taken care of.

- * For every dollar spent on PIP rehabilitation, \$7 or \$8 is ultimately returned through increased productivity of the patient by returning to work sooner, paying taxes, and receiving a more comprehensive recovery, since much of the PIP system does focus on the specialized rehabilitative needs of these patients and what it requires to get them back into productive society.

* Attempts to lower the caps and allow insurers to purchase up, which I believe was mentioned earlier, have not been successful in other states. Fewer than 5 percent of those afforded the opportunity to purchase up actually do so. Even less likely to purchase up are those folks most likely to be involved in these types of accidents -- severe accidents -- and those are the males aged 18 to 24 years old. They don't have the alternative insurance in most cases to opt over to.

* Managed care does not necessarily mean better utilization of health care resources. More often, in the care of catastrophic injuries, it means the denial of necessary services -- health care rationing based on finances. For example, rehabilitation beyond 30 days and X number of treatments is common. That's fine with some injuries. It's not fine with catastrophic injuries. Cognitive therapy and other vital components such as specialized wheelchairs and adaptive equipment that allow, again, these same patients to return home, get them out of institutionalized settings -- very expensive settings -- and back to work are often denied, because it's not part of the covered package.

* It also means that the patient is unable to maintain continuity with the provider and access less expensive, more appropriate levels of care such as skilled nursing, outpatient programs, and home care. And again, the burden is simply shifted.

The dangers of altering the PIP system and its limits are that these alterations may not represent cost savings, but rather a dramatic cost shift, one that New Jersey's current health care system and tax structure cannot handle.

I would ask that you carefully consider the impact of each of these proposals to lower health insurance premiums for the people of New Jersey.

Senators and Assemblymen, help us build a system so those relatively few that suffer very significant catastrophic injuries don't have to give up their jobs, divorce their spouses, and spend every cent that they've earned throughout their lives simply to access Medicaid, which is the next course of recourse. Help us develop a system whereby a patient is not taken away from the caregiver who is most qualified to make them better simply because their managed care company has an exclusive contract with another provider. Help us develop a system, where at the end of a long 16-hour day the clinician physician who has been caring for that patient doesn't leave in tears, not because the patient didn't necessarily get better or they died, but because they didn't see that patient that day. They spent the entire day on the phone trying to convince a bureaucrat to allow them even to render the care that that patient needed.

Thank you very much.

SENATOR DiFRANCESCO: Thank you.

E V I E B I R D: Good afternoon. Thank you very much for this opportunity to speak. As Barbara mentioned, I'm the mother of a young man who was catastrophically injured, and you are looking at a person who will never complain about the cost of auto insurance.

Why? Because I understand and know from experience what PIP coverage means. We certainly did not comprehend the value of our auto insurance 10 years ago when our then 20-year-old son, Jay, crashed his car into a tree along River Road in Piscataway, but we certainly know now.

At the Robert Wood Johnson Trauma Unit, where our son was taken following the accident, they said, “Critically injured.” They said, “Traumatic injury.” They said our son was young and strong and that he would probably survive. He did. He did survive.

My husband and I were thrown into the world of head injury, faced with a whole new vocabulary. Luckily for us -- and I say those words with bittersweet irony -- we had unlimited personal injury protection and an insurance company that provided us with a rehabilitation nurse. From the very beginning, he was-- You don’t often think of nurses as he, probably, but ours was a he, and from the very beginning, he was our liaison between the services our son received and the insurance company.

I do not believe that we could have managed in the beginning or until this day without him. He was and is an essential part of our lives. His hands-on monitoring of our son ensured that Jay was given the appropriate, necessary services throughout his rehabilitation. He translated the often confusing rehabilitation process to us and was able to keep an eye on how and where Jay’s funding went. Again, I say, we were very lucky.

Jay remained in a coma in intensive care for eight weeks. During this time, physical therapies were begun to prevent his body from contracture, which, if left unattended, would cause crippling effects that might be impossible to repair later.

I hope that’s right.

DR. BECKER: That’s correct.

MS. BIRD: Jay came out of his coma and was then transferred to a nursing care facility where he began intensive therapies, which included

further physical therapy, speech therapy, cognitive therapy, and other medical treatments. After three months in this facility, he was able to talk with impediments to his speech. He could manage a wheelchair and could feed himself with supervision, but at the same time, he was not cognizant of his impaired condition, nor did he remember what happened to him.

He demanded that he finish his college application, which he was working on at the time of the crash. You see, even though Jay still had to learn to dress himself, brush his teeth, and do all the other daily living tasks that you and I take for granted, he still didn't understand the extent of his injury. He thought, I guess, that he would just get better and go back to life, the one he lost and was looking for, back to all of the things a 20-year-old does. But he didn't. Instead, he went to a rehab facility, where he gradually became more and more aware of his condition and his limitations. The awareness of his condition brought new frustrations that he would never return to the life he once had. This realization created new psychological problems, as he attempted to understand his new life.

Once again, we were so fortunate. Jay could access the care he needed through his personal injury protection, and with the help of the rehabilitation nurse, we could find the specialized care he needed during this very difficult time. In spite of this good care, we, as our son's caregivers, often felt sad and helpless. Information about head injury was hard to find in 1988. Even though my husband is a physiologist and could access the medical school library, there was very little to be found there at that time. The Brain Injury Association of New Jersey was a great source of information, and for them we will always be grateful.

We used the Association for resources, information, and to meet other families just like ourselves. We are not alone. There are more families just like us out there, but unfortunately, many are not receiving the support and services of a rehabilitation nurse or the funding to rehabilitate their loved ones.

I have met many of these families throughout the last 10 years; for example, one young man who was in a hospital bed just down the hall from Jay in the nursing care facility. This man had been in a motorcycle crash and did not have insurance coverage. As many of you know, motorcyclists do not have to carry PIP. This young man was in contracture, the very thing Jay was avoiding because of the availability of physical therapy early on. Contracture is when muscles contract and fail to relax, a very painful cramp, and are eventually frozen in place if measures are not taken to release them.

I have also become aware of others who were discharged from rehab facilities because of a lack of funds before their rehabilitation was completed, as Scott had mentioned so forcefully before. Facilities have to pay their bills, too. At the same time, this early leaving often leaves the injured with nowhere to go but home, if there is a home, or a nursing home, perhaps. Whatever rehab they have received can be easily lost as they go without needed therapies. This situation becomes a drain on society and their families.

PIP allowed our family to avoid, to a large degree, that drain, but where would we be today without that unlimited PIP? Would our son be lying in a nursing home, still unable to walk? Would he be financially and emotionally devastated? Would our health be so diminished that we could no longer help ourselves? Would our family still be together? Many, many

families do not survive the tragedy of injury. And what about the emotional tasks of just caring for our son? We care for him a lot, believe me, but not as much as the rehab places did. Would our spirits be broken because we could no longer help our son?

Injuries happen to families every day, and not everyone is as lucky as we have been. Jay was a single-car accident, as are 40 percent of motor vehicle crashes today in the United States. A single mistake, and his life and all of us around him have changed. I would assert that PIP was there so that he could recover his life, the most important recovery of all. Even if we had someone who was at fault, many times it takes years to settle suits. Who would have paid for Jay's care then?

The immediate care he got after his injury was so important, I do not believe that sacrificing that care is worth any amount of money in the long run.

Jay is now living in an apartment close to our home and still receives some therapy care. He works as a volunteer in the community and is pleased with his ability to give to others. We love him deeply, as we have always loved him. Being close to our home, he is now a real part of our family activities.

Please do not make it harder for those injured and their families than it already is. We need it. We need appropriate care. We need it immediately at the time of the accident. Please think of Jay and the thousands of individuals like him that are injured each year in motor vehicle crashes when you design and decide what you want.

SENATOR DiFRANCESCO: Thank you very much. We do appreciate your being here and waiting patiently all day, and understand -- fully understand -- your concern. I think all the members of the Committee, including those who are not here, recognize that there are traumatic accidents that occur, catastrophes in some cases. We know that. It is not our intent, in any way, to diminish the care for those unfortunate individuals in any way. I think I speak for everybody when I say that. It is not our intent to eliminate either the availability or the need for these trauma centers or the means by which we get people to the trauma centers.

I think that you outlined very well and very quickly, you know, the need for these services, particularly in a state that can well afford it. But we're charged with a responsibility to oversee and look through these laws to see if we can, perhaps, help people with the high costs -- rising costs -- of auto insurance premiums, and that's our job. And if there is some way that we can continue to have these services available, to maintain our high degree of quality care for auto accident victims and, at the same time, perhaps provide some savings to the premium payers, to the citizens, we're going to try to do that. That's basically our charge.

Do you want to say something else?

MS. BIRD: I just would like to add that I think it really is important that the public gets educated fairly about what they have to gain by any kind of change in coverage and what they have to lose. I think it's really important that people understand that.

SENATOR DiFRANCESCO: Well, as you can imagine, that's a difficult process to go through, to communicate to the public, when you

haven't been through it. Barbara knows that and has been here a few times and I think keeps the Legislature aware of its responsibility to a few people who are, unfortunately and accidentally, in circumstances that can happen to anybody, as was outlined.

So I understand your point, but it's hard to communicate that, and it's hard to find a process to communicate that in some way to the public.

But thank you, again. I think that concludes the hearing for today.

Does anyone have any questions that they would like to ask any of the people who have testified?

Yes, Scott, and then, Joe.

ASSEMBLYMAN GARRETT: Two quick questions. One, I guess, is more an observation on the number that you said was -- 40 percent cars are single-car crashes?

MS. BIRD: Yes.

ASSEMBLYMAN GARRETT: I guess that goes back to the-- My comment there that goes back to a question that was raised earlier about what happens in those automobile cases if you take the proposal that was put on the table before, about having a \$10,000 med pay policy, and then what happens to the people who don't have insurance. What happens to the cases, of the individual accident cases-- I was not aware that that was that high a percent of the cases. So in those cases, I suppose, there would be no negligent party to recover from.

My question, though, is, the proposal that we heard from the Trial Attorneys earlier was to have a med pay policy on the bottom -- of 10 and then

allow for the 75 above to go through the UCJ. Wouldn't that system be satisfactory for you, inasmuch as you would be still-- The cases that you're talking about here are cases that would incur costs of \$75,000 or more. So those cases would all be covered under the UCJ, would they not, under their proposal?

MS. GEIGER-PARKER: Well, we are talking about-- I mean, Evie's experience has been with a very catastrophic brain injury. But not all injuries are brain injuries, and even not all brain injuries are as catastrophic as her son, who was in a coma for eight weeks. You then get back into the differences of coverage between health care and PIP, with the health care system not being responsive to the rehabilitative needs of persons who have been injured.

MR. GEBHARD: Assemblyman Garrett, just one last response to that: It may be a double-edge sword. That would impact less on the population that we described here, the catastrophically injured. What it would also possibly do is all of these patients are going to go through that level of needing that \$10,000 worth of care. Anybody who reaches to the catastrophic level we described could be conceivably bare for that component of the care.

What might be more appropriate, and I think it was talked about earlier, is I would say 80 percent of all of the expenditures fall under that \$10,000 cap, that where the ability to have the case management structure that Evie talked about -- the focus there so that the fraud and abuse does not occur in that arena -- would probably produce the greatest savings. Simply going without it might have some other consequences.

ASSEMBLYMAN GARRETT: Can I just have one fast question, then, and that is, we hear criticism on the other side -- I guess, not thinking of managed care type arrangements, but what you were talking about with -- and I'm familiar with what you're talking about, having a nurse assigned to your case-- Did you ever have or do you see in your hospital situations where that turns into an adversarial situation, where either the nurse says, "We don't think your son should be having this type of treatment," and it becomes a managed care arrangement, where now they block you from getting what you think, or your doctor thinks, is the appropriate treatment?

MR. GEBHARD: When the system changed about seven years ago, that was actually a component of the system that wasn't always without argument or conflict -- but was actually a part of the system that had matured to the extent where good decisions were being made regarding utilization. The insurance company had a hand in it. That professional interacted with other professionals in the hospital. And, again, they didn't always agree, but typically good decisions were made, and we were watching the costs of care for that patient go down, and they were going into appropriate settings.

The managed care component, very few have that level of oversight or that level of professional oversight at these type of cases. So what you tend to get is denials based on the "it's not covered" or denials based on "it doesn't cover that component." Again, the argument that a person only gets 30-days worth of rehabilitation care, X number of treatments, that doesn't work when you average it all out. That hurts a large number of patients.

So we left a system that actually worked pretty well, was bringing down costs, and then we went away from it when we went that managed care route in motor vehicle.

ASSEMBLYMAN GARRETT: Thank you, all.

SENATOR DiFRANCESCO: Senator Kyrillos.

SENATOR KYRILLOS: Thank you, Mr. President.

I just want to say that I've seen Dr. Becker at work, Jersey Shore Medical Center. I've seen him and his people try to piece people back together that are on their -- literally, their last breath.

So I know how important your work is, and I congratulate you.

I wanted to ask -- because, I think it was you, Dr. Becker, that said, we're not talking about the soft-tissue issues here, but the save-your-life issues -- whether or not, beyond your concern about lowering the \$250,000 threshold, if you advocated any tightening of PIP for excessive or frivolous claims at the lower end of the scale. And I believe that Dr. Ross, in his response to Scott Garrett, may have said, in fact, that the answer is yes.

Is that the case for this panel?

DR. BECKER: Yes, I strongly support Mr. Cardinale's concept of sting operations, of-- To me, as a committed career professional, it's embarrassing that other professions look at this money that's available in a completely self-centered aspect. I'm hearing, at cocktail parties, about lawyers who just purchase their own MRI facilities to create the soft-tissue injuries that are identifiable in all of us, whether they occurred in relation to that accident or not.

SENATOR KYRILLOS: I hear you. We may have gone too far over to one side with HMO-style cost controls on the health insurance side, but as I understand it, on auto insurance -- PIP -- there are no constraints -- virtually no constraints whatsoever on what the policy offers. So if this Committee wanted to make some changes to PIP that didn't affect the patients that you treat, the catastrophic situations, didn't necessarily touch the threshold, they fell into the kind of category that you're talking about, you wouldn't necessarily object to that. I want to make that clear--

DR. BECKER: Not at all.

SENATOR KYRILLOS: --so if people hear us talking about PIP, that they're not all of a sudden or necessarily startled.

DR. BECKER: You're correct, and if 80 percent have this \$10,000 and under, like Willy Sutton said, "That's where the money is." It seems that that's where you would go to save the most amount of money, not take away the protection that the randomly injured person needs -- randomly, seriously injured person needs.

SENATOR KYRILLOS: I know I'm going to meet with some people next week from your group, and rather than take up the time of the panel today, unless they want to hear it, I'd like to hear what you have to say about New York, where the threshold, I guess, is \$50,000--

DR. BECKER: Yes.

SENATOR KYRILLOS: --and Pennsylvania, where it's \$5000, and find out what happens there.

DR. BECKER: What happens-- Because we are a recreational or a tourist area, especially in the summertime, we treat patients from New York.

And when they break the \$50,000 cap, we're right back to the Medicaid discussion.

So our experience has been -- is that the patients who come down to the shore and get into an accident, who have New York-based insurance, get in -- we put their Medicaid application in the first day they come in the door if they're seriously injured, because they're going to go through that \$50,000 very quickly.

SENATOR KYRILLOS: Regardless of their economic means?

DR. BECKER: Yes. There is no-- Remember, the average age is 39.8 years. The people coming to the shore are usually young people, who do not have secondary insurance, and Medicaid is the fall back.

MR. GEBHARD: The individuals who can afford it, in New York, and have alternative insurance, not the motor vehicle insurance, actually, many of them come here for treatment. Part of that rationale is that the health care systems in New York have not necessarily bought it all to the extent and, in part, because the money wasn't there to treat the catastrophic rehabilitative needs of the patient. So where they can afford it, they come here. Where they can't, they tend to go into systems that are more based on Medicaid support and aren't necessarily geared toward getting the patient home and independent as rapidly.

SENATOR KYRILLOS: We'll talk more about it. Thank you.

SENATOR DiFRANCESCO: Thank you very much.

On Monday, I guess, January 26, we'll continue with Wayne Dean, Anthony LoCastro, and Hank Strawn, who were witnesses on today's

list, and then we will continue on to the threshold, for anyone who wishes to talk about the threshold.

Thank you very much.

(MEETING CONCLUDED)