P U B L I C H E A R I N G

before

SPECIAL SUBCOMMITTEE OF THE ASSEMBLY INSURANCE COMMITTEE

"On the issue of private automobile insurance
with regard to personal injury protection (PIP)
as it relates to the medical claims process"

August 14, 1991
10:40 a.m.
Moot Court Room
Seton Hall Law School
Newark, New Jersey

MEMBERS OF THE SUBCOMMITTEE PRESENT:

Assemblyman Louis J. Gill, Chairman
Assemblyman Bernard F. Kenny, Jr.
Assemblyman Gerald H. Zecker

ALSO PRESENT:

Carolyn S. Mealing
Office of Legislative Services
Aide, Assembly Special Subcommittee of the Insurance Committee

* * * * * * * *

Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

New Jersey State Legislature
ASSEMBLY INSURANCE COMMITTEE
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625-0068
(609) 984-0445

NOTICE OF PUBLIC HEARING

A special sub-committee of the Assembly Insurance Committee will hold a public hearing on the issue of private automobile insurance with regard to personal injury protection (PIP) as it relates to the medical claims process.

The hearing will be held on **Wednesday, August 14, 1991 at 10:30 a.m. in the Moot Court Room (2nd Floor) of Seton Hall Law School, Newark, New Jersey.**

The public may address comments and questions to Thomas K. Musick or Carolyn S. Mealing, Committee Aides, and persons wishing to testify should contact Cynthia D. Petty, secretary, at (609) 984-0445.

Those persons presenting written testimony should provide 10 copies to the committee on the day of the hearing.

DIRECTIONS TO SETON HALL LAW SCHOOL:

From Northern New Jersey (Via New Jersey Turnpike):
Exit 15E -- follow signs for Newark which bring you onto Raymond Boulevard.
School is approximately 2 miles West on Raymond Blvd on the right-hand side.
(Just pass Penn. Station and Gateway Hilton).

From Northern New Jersey (Via Route 3):
Take Route 3 to Route 21 South (McCarter Highway)
School is about 4 miles South on Route 21 on the corner of Raymond Blvd.
Enter either through Main Entrance at 1111 Raymond Blvd or through the parking lot at the rear of the building.

From Western New Jersey (Via Garden State):
Take Garden State Parkway - Exit 145 for Route I-280 East.
Take I-280 to Exit 14A Newark (Martin Luther King Jr. Blvd).
At traffic light at end of exit ramp, make a right and quick left.
Go 2 blocks to Broad Street and make a right.
Stay in far left hand lane.
About 6 lights bear left onto Park Place.
Third light is Seton Hall Law School's Parking Lot.

From Southern New Jersey:
Follow directions from the Garden State Parkway Exit 145 or
the New Jersey Turnpike Exit 15E as listed above.

Issued 08/05/91

TABLE OF CONTENTS

	Page
Robert J. Weierman, M.D. Chairman Committee on Utilization and Review Systems, and Past Chairman Third Party Review Committee Medical Society of New Jersey	5
Kenneth Lucianin Private Citizen	24
Carol J. Kientz, R.N., M.S. Executive Director Home Health Assembly of New Jersey	34
Elmer M. Matthews, Esq. Clapp and Eisenberg Counsel American Insurance Association	40
Verice M. Mason Assistant Commissioner Legislative and Regulatory Affairs New Jersey Department of Insurance	43
Ronald W. Pott Regulatory Officer New Jersey Department of Insurance	55
Thomas G. Smith Supervising Investigator Division of Enforcement and Consumer Protection New Jersey Department of Insurance	64
Robert R. Levinson, Esq. Levinson, Feinson, & DeFillippo President Association of Trial Lawyers	74
Gerald H. Baker, Esq. Baker, Garber, Duffy, & Pedersen Association of Trial Lawyers	81
Glenn A. Malmberg Member Board of Directors Jersey Association of Medical Equipment Suppliers	96

TABLE OF CONTENTS (continued)

APPENDIX:

	Page
Medical bills and other material Submitted by Kenneth Lucianin	1x
Statement submitted by Carol J. Kientz, R.N., M.S.	4x
Statement submitted by Glenn A. Malmberg	8x

* * * * * * * * *

hw: 1-27
tca: 28-53
mjz: 54-82
bgs: 83-103

ASSEMBLYMAN LOUIS J. GILL (Chairman): Good morning, ladies and gentlemen. I think it is about time we started. We're about 15 minutes late, which is not bad according to New Jersey Assembly time. I'll ask that the smoking rule be waived for this room because we have a few smokers on the panel, and those of you who want to light up, feel free.

I'm Assemblyman Lou Gill. I'm Chair of this Special Subcommittee to examine the medical claims process under the auto insurance policies issued in this State.

I'd like to welcome everyone here this morning. Today we will specifically focus our energies on those portions of the Fair Automobile Insurance Reform Act relating to Personal Injury Protection benefits, and the claims payment process procedure.

Serving with me on this Special Subcommittee are Assemblyman Kenny from Hudson County, and Assemblyman Gerry Zecker from Passaic and Essex. At the outset, I would like to express my deep appreciation to Assemblyman Michael Adubato, who is the Chairman of the Assembly Insurance Committee. When I brought this issue to the attention of Assemblyman Adubato after having been contacted by several of my constituents, he was quite supportive and instrumental in establishing this Special Subcommittee that begins hearing testimony today. Furthermore, I thank those of you who have taken the time to contact my office with your concerns.

The cost of auto insurance has traditionally been a dominant concern for both New Jersey residents and the State Legislature. That is why the current Legislature and the Governor took early and definitive action on the issue of auto insurance when the legislative session began in January of 1990. In just two months into the session, the Fair Automobile Insurance Reform Act was enacted in a bipartisan fashion, representing the most comprehensive overhaul of the insurance industry in our State's history.

I wish I could sit here today and tell you that the FAIR Act has corrected all of the ills within the auto insurance industry, but we know that is not the case, nor did we reasonably expect it to be when we passed the law. Still, the FAIR Act represented a significant step forward.

Bearing in mind the density of population, the traffic, medical claims, litigation, and the desire to maintain a comprehensive benefits package for residents, auto insurance rates in New Jersey will never be among the cheapest in the nation. Still there remains much room for improvements.

Clearly, the FAIR Act has been helpful to many New Jerseyans. Thousands of drivers have already seen their insurance costs drop by almost $200 per vehicle with the elimination of the JUA surcharges. Others are discovering that it pays to be a good driver, as the FAIR Act provides reduced rates for those without violations or accidents. There have been, and will be, additional benefits as other portions of the FAIR Act become effective, but as is the case with any new law -- especially one as complicated as the FAIR Act -- there are problems which only can be solved after the law is implemented and we see how it works. We have seen this in the area of photo inspections and certain regulations, and the Assembly has moved in a bipartisan fashion to correct these problems. As I have suggested, the legislative process is one of continual refinement.

We should also be cognizant that insurance goes beyond the issue of dollars and cents. It is also a matter of providing adequate benefits to be assessed and accessed when absolutely necessary.

Today, after an influx of public concern, we begin to look at the issue of payment of medical claims for those involved in auto accidents under the current law: How does this procedure operate; how successful it may be.

As part of our efforts to contain auto insurance costs, we made a number of adjustments through the PIP Benefit Program and the medical claims process under the FAIR Act. Let me spend a moment to review these changes.

First, the Legislature moved to reduce insurance premiums by limiting the amount of medical expenses an individual can be reimbursed for under his or her auto insurance policy, and we set that limit at $250,000. This should cover most every accident. This cap is higher than most other states. For example, Colorado limits medical expenses to $50,000, Minnesota at $20,000, and Hawaii at just $5000.

Additionally, the FAIR Act established uniformity in terms of how much can be charged for medical treatments provided for certain injuries. This was actually adopted in the form of a Medical Fee Schedule regulation. It simply did not make sense to reimburse doctors at such varying rates for similar injuries. The Medical Fee Schedule promulgated by the Department of Insurance has rates which should be reflective of the basic prevailing fees charged by doctors within the regions of the State.

I have heard from constituents concerned with long delays in the payment of their claims, as well as the level of reimbursement. Some have had significant out-of-pocket expenses, or have had to lay out their own money and await reimbursement. Furthermore, some have said that certain doctors may be denying coverage altogether, because of the fee schedule.

Finally, the quality of service and adequacy of benefits have been a concern. As I stated earlier, no law is perfect, and the FAIR Act is no exception. Still, the law is designed to reduce rates, but if there are problems with the law, it is essential that the Legislature address these issues promptly.

I do not pretend to be an insurance expert. That is why we need all of you to participate in this process. Your input, your ideas, and suggestions are crucial. Today's hearing is a fact-finding mission, and to paraphrase Assemblyman Adubato, whose idea it was to create the Special Subcommittee, the purpose of this hearing is to shed light and not heat.

As part of this reform effort, the practice of balance billing was terminated. In simple terms, doctors cannot seek payments from patients in excess of those fees permitted in this schedule.

Next, we gave people the option of using their health insurance to cover auto related injuries. Under this optional "PIP switch," drivers should realize a savings.

Finally, the FAIR Act gives insurance companies an additional 30 days to pay their claims. This extra time should allow insurers to more thoroughly investigate claims and reduce fraud, a major expense in the insurance system.

Since these changes have become recently enacted, the Department of Insurance has probably received a record number of inquiries relating to this law. Such dramatic changes take time to be accepted. We are here today to listen to those concerned with the insurance industry: insurance companies, doctors, lawyers, the Department of Insurance, and most important, the public. We need your input.

I expect to take testimony from as many people as possible today, and this Committee will spend whatever time is necessary to resolve those issues raised. A second hearing will probably be necessary.

I am optimistic that with the help of those here today, we can address and resolve those issues raised and work toward improving the insurance in New Jersey.

Before we begin, however, I would like to offer Assemblyman Zecker and Assemblyman Kenny the opportunity to make a statement.

Assemblyman Zecker?

ASSEMBLYMAN ZECKER: Mr. Chairman, I'll hold back on my comments, but I would like to take this opportunity to thank you for asking me to serve on this Committee, and to thank Assemblyman Adubato for allowing you to create this Committee. I think it is something that has been necessary, and I hope we will accomplish what has to be accomplished for the people of the State of New Jersey.

Thank you.

ASSEMBLYMAN GILL: Thank you, Mr. Zecker.

Assemblyman Kenny?

ASSEMBLYMAN KENNY: Likewise, I'll reserve any comments till the end, but I would also like to thank you for asking me to serve on the Committee. This is an issue that is very important to my constituents in Hudson County, and of course, to the people in the State of New Jersey.

ASSEMBLYMAN GILL: Thank you very much.

I know some of the people in the audience have a very pressing schedule, and I know we have Dr. Weierman, from the Medical Society. I know you have a very busy morning. I would appreciate any testimony you can shed on this at present.

R O B E R T J. W E I E R M A N, M.D.: Thank you, Mr. Chairman. Can you hear me?

My name is Dr. Robert Weierman. I'm a practicing orthopedic spinal surgeon from South Orange, New Jersey, and I'm here representing the Medical Society of New Jersey. I also am past Chairman of the Third Party Review, which is the Fee Review Committee from Essex County. And presently I am the Chairman of the Committee on Utilization and Review Systems--

ASSEMBLYMAN GILL: Can you speak louder, please?

DR. WEIERMAN: Okay. It's not a--

ASSEMBLYMAN GILL: The microphone is not for auditory, so you will have to speak up.

DR. WEIERMAN: Okay.

ASSEMBLYMAN GILL: It's strictly to allow our staff here to make a tape of this and then prepare testimony.

DR. WEIERMAN: Okay. I am past Chairman of the Third Party Review Committee from Essex County. I am presently Chairman of the Committee on Utilization Review Systems in the State of New Jersey Medical Society, and am Secretary of the Hospital Medical Staff Section of the A.M.A., on a national basis.

I'm here to make comments concerning some of the problems that, as a private doctor, we have seen concerning the fee schedule under the FAIR Act. As a taxpayer of the State, I must say that I am pleased to see some of our insurance costs going down, but as someone who is supposed to collect under the fee schedule, I can only tell you--

I brought my Assistant Office Manager with me, just in case you ask questions that I can't answer, because she is the one who deals with this everyday.

ASSEMBLYMAN GILL: Would you like her to sit with you?

DR. WEIERMAN: If she could?

ASSEMBLYMAN GILL: Positively. Is that Michele?

DR. WEIERMAN: This is Michele--

ASSEMBLYMAN GILL: Good, Michele Deo.

DR. WEIERMAN: --who deals with this everyday.

Some of the problems we run into: One particular insurance service-- It's not so much the insurance company as it is the review services that they hire. Even though we have a no balance billing, and a fee schedule, some of these companies have taken a position that any bill over $2000 is automatically audited, which in essence, basically, puts off payment for at least three to six months. Which, in today's day and age, as you know, physicians are dealing with a cash flow problem as it is, with Medicare and everything else, and there is just no rational reason that I can see why all of these things have to be audited.

I am well aware, and so are all physicians in the State, if you read the recent series of articles in The Star-Ledger, concerning fraud. Believe me, I worked too long and too hard to get where I am, to go to jail, and I have no intention of putting myself in that position. So, I would not submit bills that aren't correct, and yet this is automatic.

The other thing that happens is that when you call the representative who is handling the case on a regular basis, they change. They no longer work for the company, they work for a different department, the file is, "Not available," "We don't have a copy of your bill," the, "Bill is illegible" -- even though ours are computer generated, which are quite legible.

They want more and more information, such as: operative notes, progress notes; they want narrative reports in great detail for which they are not willing to pay, and yet I have to review charts from the hospital and my office records to provide this to them, or else they won't pay. And these are not big bills.

The other problem that we have run into is that they pay according to the patient's zip code, rather than the area where the service was provided. Now, doing spinal surgery and scoliosis as I do, I have patients that not only come from different parts of the State, but even out-of-state. And when you start paying on a zip code, even though I'm providing a service, let's say, in Orange, I'm-- They are paying based on South Jersey, and then to try to rectify it becomes a major, major problem. It takes months and months and months before they pay.

ASSEMBLYMAN GILL: Dr. Weierman, to understand you correctly: You are telling me that people from a particular zip code get paid far more sooner than others? No?

DR. WEIERMAN: No. It's not payment sooner. What they do is, they base their fee schedule-- There are three

different levels in the State, the region. What they do is, they base it on the patient's zip code, and not the physician's billing area. That's basically becoming a routine.

When you call-- Again, you call and try to get the supervisors to try to get these things rectified, and they never call back. It's multiple, multiple phone calls: "So and so doesn't work here anymore." "It's been reassigned to someone else." "I don't have the file in front."

What's even worse is, they come to the office they audit, and the auditor says, "Everything is fine. You should be paid within two weeks." And we're still waiting three and six months later, and still receive no payment, even though the auditor says it's okay.

ASSEMBLYMAN GILL: Dr. Weierman, again--

DR. WEIERMAN: Yes?

ASSEMBLYMAN GILL: --do you find this to be a frequent occurrence, or is this--

DR. WEIERMAN: This is frequent.

ASSEMBLYMAN GILL: This is--

DR. WEIERMAN: This is almost routine. She spends more time on the phone trying to hunt these things down on a regular basis than I could even count.

One of the problems we run into-- You mentioned the no balance billing. With no balance billing, you understand, the patient has no incentive to make sure that bill gets paid. I do not ask for money up front, okay? I am one of the few, but I do not, okay? What happens, basically, is, you ask the patient to call the insurance company and they say, "Hey, Doc, that's between you and the insurance company. There is a fee schedule. What do we want to get involved with this for?" And they have no incentive. I can't threaten them, okay?

And if I recall, there is another law in the State of New Jersey that I can't charge for filling out forms if it is to reimburse me. Most patients will not put money up front.

If I do sophisticated surgery -- which I do, with rods and fusion and things like that of the spine -- they will not come up with that money ahead of time. That's a lot of money. I can't expect people to go to the bank and borrow money to do this. And yet, why should I wait six months and longer to get paid?

I can't balance bill. I mean, the insurance company is telling me what it is. The fee schedule is clear, and yet it is putting a terrible problem on my office staff, and really on Michele, because she is spending all the time on the phone. It's routine for the patients to tell her, "Look, that's none of our concern." And they won't write. Of all the patients that we are dealing with, we have had one, recently, who wrote to the Insurance Commissioner complaining. To date, there has been no answer, and that's been a couple of months ago.

The other issue that has come up is the multiple surgeries. There is a section in the bill which concerns where multiple procedures are done in the same area of the body. Our understanding at the Medical Society, and my understanding, was that this referred to surgical procedures. If you did one procedure in a certain area, you would be paid at 100%. If you did a second procedure in the same area at the same time during the surgery, you would be paid at 50%, and then 25%.

One particular insurance company has extrapolated that out to physical therapy modalities in a doctor's office. Now, the problem with that is, that it is the only insurance company that has done it. I wrote a letter to the Insurance Commissioner a couple of months ago, and I received a letter back from the insurance company, who said the letter was referred to them by the Insurance Commissioner, and that the Insurance Department agrees with their interpretation. And yet I have nothing from the State Insurance Department that says that -- that they agree with that interpretation.

Now, understand that these are not simultaneous procedures that are being done. A patient receives one modality -- for example heat, or hot packs -- which takes 20 minutes to a half hour with the therapist checking, then receives traction, let's say, to the neck. That's another 20 minutes to 30 minutes, and then receives ultrasound and electrical stimulation to relieve spasm. It may take an hour or more of the therapist's time. Now, it's not the same as when someone operates and happens to do something and takes the appendix out at the same time. It's not the same. And yet, I find this one insurance company has interpreted it that way.

What I am afraid is, as someone mentioned before, that patients are being asked to pay up front, and then get reimbursed by the insurance company. I think they are the ones who are going to complain, because they are the ones who aren't getting reimbursed.

I would hate to see this happen, especially with my practice, only because of the fact that I believe in treating patients and I don't want to see patients mistreated, or maltreated. And, you know, we just keep treating them, but meanwhile, it's hurting me financially, to a point where we may have to look at whether we want to provide physical therapy to the patients. We may decide that they will have to go to an outside therapist, or go to a hospital for physical therapy. And then what could occur is the fact that they are not going to get treated there because of that issue, because it does take time.

I've looked at what the costs of physical therapy are in our office, and it's basically a break-even issue. So, I don't make money on physical therapy. I know there are doctors who do, I am sure, but in my particular setting, I don't. And now, when it is starting to cost me money, I have to really look at the whole issue of whether I want to provide it.

Basically, we work around a patient's schedule, so that they can come in and our therapist works with them so they don't have to take too much time off from work. That would be a service that would not be provided, and if you go to private settings, you may find that you have to be there at certain times, take time off from work or whatever, to get it done.

Those are the fears that I have in what's occurring.

ASSEMBLYMAN GILL: But, Doctor, just to interrupt you, you can require your patients to pay you up front. You don't have to--

DR. WEIERMAN: I understand that, but if I have a bill-- You know, I do spine surgery, so if I put a couple of rods in a patient and fuse them at the same time, for a fracture of the spine, you know, I'd be asking them to put up approximately $8000. I don't know too many people-- She's telling me $12,000. I was being conservative, $12,000 (indicating Ms. Deo, seated with him at witness table)-- I don't know too many people who are going to have $12,000 to give me, and quite frankly-- Maybe I'm in the wrong profession, but I'm not a businessman, and I can't force my patients to do that.

If a patient comes in and tells me that they have to take a loan out, I'm not in the business of forcing them to do that. I think most physicians are not in that business. But with cash flow problems as they are now with everybody-- I mean, it isn't just the automobile insurance; it's everybody who is bringing this to us. It is becoming more and more difficult for physicians to continue to practice, because as you know, people in the office need to get paid. My suppliers have to get paid, and if I don't pay them, I don't get supplies. I pay insurance premiums, too, so I know. I mean, health insurance and etc., so I am well aware of that.

So, it is a problem, and I think that what is going to happen is that you may find that more and more physicians are going to take a tact that you have to pay up front.

One of the other things -- as long as we're talking about insurance-- You mentioned that you can switch over to your private insurance. I was at a meeting about a year-and-a-half ago with the Department of Insurance, and one of the questions that was asked was, "How do we know who your primary carrier is when you walk into my office and say that you were in an automobile accident?" And the answer that the Insurance Department representative gave was that if the private insurance company gets the bill, they should assume they are the primary carrier.

Now, if I'm the private insurer, and I see checked off, "automobile," the first thing I do is say, "We're not paying that until we find out if they have private insurance through their automobile carrier." And that puts off payment at least three to six months. It's like kiting a check, you know. They keep bouncing back and forth.

The other thing is, we have no way of knowing what their deductible is, whether it is $250 or $2500. Now, it seems to me that the insurance industry can at least provide an identifier, so that you have a card that is given to each patient that says, "This covers automobile; this does not."

I had a patient who walked into my office who had an identification card from an insurance company that was two-sided. You flipped it over and it very clearly said, "There is a $250 deductible, 80% of the next $2000" -- or whatever it was -- "and 100% after that." It was very clear what it was covering, so I believe that can be done. I think that would be very helpful, not only to the physicians, but to the patients. Patients don't understand what's covered and what's not covered. They check off things.

If you read the questionnaire from the automobile coverage of what you want covered and what you don't want covered-- To this day, I don't understand what "threshold" means. Every year I get that questionnaire, and all I want to

do is-- I don't want the lawsuit. I just want, you know, major injuries. And everybody in my family asks me, everybody in my office asks me, "Which box do you check off?"

It seems to me it ought to be clearer. It's the same thing: "Do you want your private insurance to pay, or your automobile to pay for medical?" It ought to be clear. They ought to make it in English; it's not. It is not clear. And the same thing with deductibles.

I think once that decision is made, the private insurer ought to be notified and they ought to provide an identification card. It seems to me that's relatively easy. It makes more work for us, and like I say, more work for the people in the office is eventually going to lead to a thing where physicians are going to say, "Time out. We can't continue to do this and just keep getting bounced around, bounced around, bounced around."

Like I say, as you know, the Medical Society is against no balance billings, because that has nothing to do with the premium, quite frankly. But with no balance billing, you basically have no patient incentive to help the doctor get paid unless he's paid up front, and then they're really not helping the doctor get paid, they're helping themselves get reimbursed.

I would hate to see that happen, because I believe that puts wedges between doctors and patients, and it shouldn't come down to dollars and cents. I personally don't believe in that. I know most people in the Medical Society do not believe that we should have that kind of a relationship.

So, that's really all I want to say, other than I would like to make mention of the $250,000 limit. I know that's one of the higher in the--

ASSEMBLYMAN GILL: In the country.

DR. WEIERMAN: --in the State, and I know that physiatrists, and people who deal with spinal cord injured patients like I do, have a problem with that limit, because a

$250,000 limit on a spinal cord injured patient from an automobile accident is used up very quickly, and then suddenly those patients are put on Medicaid, and you know, it becomes a major problem for them to get care. Whereas, the previous no-fault automobile covered them the rest of their lives, so they did get care.

ASSEMBLYMAN GILL: Doctor, were you or the Medical Society involved in forming the fee schedule, at all?

DR. WEIERMAN: We were questioned about it. We made comments about it. I know, personally, I wrote letters concerning it, about the fee schedule. Some of the fees, I think, are a little bit out of line with what our experience is, but the comments were made. I don't know if they were acted on favorably.

ASSEMBLYMAN GILL: Overall, you feel that they are adequate?

DR. WEIERMAN: It depends on where you look. Some fees are adequate; some fees are not adequate. You know, for example-- I'll give you an example of what happened to me on one. We put in a fee for an office visit and x-rays, and after three months I got paid for the x-rays, and they are "auditing" a $107 bill for a comprehensive exam that was for a back patient, you know, which took anywhere from 30 to 45 minutes to an hour with the examination, plus sitting down and talking, etc., to the patient. It just seems to me that auditing $107 is beyond me, because I'm sure it's not being audited. I'm sure somebody is just sitting there with a chart sitting on the desk, just to hold the money, but the problem is that it seems to me that it costs more money to audit that $107 bill than it would be to just go ahead and pay it.

You know, but, they want all sorts of things: They want this, they want that, they want office notes, they want narratives, and it becomes very time-consuming. It's really a type of harassment, as far as I'm concerned.

ASSEMBLYMAN GILL: Doctor, according to your experience, do you find that patients have been denied service due to the fee schedule, at all?

DR. WEIERMAN: They haven't in my office, and I would say that, at the present time, I don't know of any -- at least in the Essex County area -- or, no one has mentioned to me, at least on a State level, that anyone has done that. I firmly believe that physicians generally still take care of patients first. I don't agree with the articles that were in the paper -- in The Star-Ledger -- the last few days about the fraud and all. I think that to convict by innuendo, by mentioning, "I can't mention the doctor's name, but these kinds of things happen." I don't think is fair to the medical community.

If there is fraud going on, or something like that, the Medical Society would be first and foremost, ready to go to the Board of Medical Examiners and take care of it.

I can-- If you don't mind, I'll give you a little anecdote. I testified about 10 years ago on two physicians, for unnecessary surgery. In fact, it was about 12 years ago. Both lost their license through the Board of Medical Examiners. A year-and-a-half ago I was served papers on a Sherman Antitrust lawsuit, which, by the way, is six years over the statute of limitations. At the present time it has gone through the courts and the Appellate Division to a point where this man no longer has an attorney representing him, and he is representing himself. He is now petitioning the Supreme Court of the United States, and he continues in this hopefully -- hopeless quest.

So physicians -- at least I am -- are willing to go out on a limb and go after people who are not acting accordingly. But to have this one over my head, with a triple damage situation that I could end up having no money to pay this off, is frightening. And he is not even questioning the fact that he was found guilty. The whole question is, "I'm

competing with him." I'm 30 miles from the man. I don't even know him. I testified against his partner, and he happened to get sucked in because he was an assistant, but I mean, that's the situation.

So, physicians are not afraid to tackle problems, and I think that if there are problems committing fraud, I think you will find the Medical Society would be more than willing to help solve that situation. We have Judicial Committees, etc. And when I was Chairman of the Third Party Review of Essex County, and we found that physicians were abusing the system, we had no qualms, after investigation-- If it was reportable, we would report it to the Board of Medical Examiners. I think that physicians will do that. We're just as happy to get rid of people, too, who are abusing the system.

ASSEMBLYMAN GILL: I'm sure you are. Thank you.

Any questions, Assemblyman Kenny? Assemblyman Zecker?

ASSEMBLYMAN ZECKER: Doctor, we have been advised that you serve on the Fee Review Committee, and you are in Essex County?

DR. WEIERMAN: I was past Chairman of that; yes, sir.

ASSEMBLYMAN ZECKER: In past hearings, and after the hearings in the hallways, it surprised me, but insurance companies had said that by having a fixed plan of payments that they felt that insurance companies would wind up paying more. That surprised me.

But with the fee schedule-- In other words, insurance companies felt that statewide they did not even argue about the fees that were being paid, other than the ones that were fraudulent. But that insurance companies feared a fee schedule, because they felt that rates would go up. I'd like you to comment on that.

And I'll tell you this: Doctors after 5:00 -- that means, "off the record" -- have told me, "Gerry, that's exactly what's going to happen." I think it was an accepted fact that

in northern New Jersey, where the operating costs were higher, you know, you tended to have higher fees than in southern New Jersey, and maybe in western New Jersey. And what wound up happening is that fees wound up being raised in some areas of the State where they really were higher than the prevailing rates.

Now, I know you probably feel uncomfortable in addressing something like that, but is there any merit to those comments?

DR. WEIERMAN: I would say that, first of all, I'm not uncomfortable in answering the question. I think that part of the problem is that one of the things you always have to fear is that people will start overutilizing the system if they see what -- or start doing something they may not have done because of a higher payment rate, okay, or seeing patients more frequently. As a matter of fact, that's one of the things that, with the Medicare fee schedule that's coming up in January, that the government has decided that because they are dropping the rates, the doctors will overutilize the system, and therefore, see the patients more frequently. There are studies around -- and I can get them for you if you like -- that show that that's not the case where fixed fee schedules have been put in, either by the government or other agencies, where doctors have started to see patients more frequently, have them come back three times instead of once, etc. So, there was no basis in fact of overutilization.

As far as the fee schedules go, all I can say is that fee schedules were set up by the State. I think there is one payment in here for artificial insemination. For the life of me, I can't understand how that is involved with an automobile accident, unless something was going on when the car was moving, and--

ASSEMBLYMAN ZECKER: You were never a claims representative?

DR. WEIERMAN: No, I have a real problem with that. As an orthopedic surgeon I don't understand that one at all, because I don't put that claim in. But, you know, if this is the 75th percentile of what doctors are charging in areas, I would think it's perfectly natural for a physician to say, "Hey, if this is what 75% of my colleagues are charging, why shouldn't I get paid that, if that's what the State has said?" I mean, certainly, you know, there are physicians who charge very little. I know some older doctors who haven't changed their fees in years and years and years. And you know, is it fair? Is it fair to have someone who was undercharging not to be paid what the service is worth?

Certainly, anyone else in this country-- As far as I know, it's free enterprise. If you were to say that so and so is selling widgets down the street for $10 and you're selling them for $2, you might very seriously consider at least raising your price to $5, okay? I mean, you're still underselling him, but why should you--

ASSEMBLYMAN ZECKER: You're answering the question like an attorney, and you're a doctor. The question is, by having a fee schedule, in instances, did fees wind up going up? That's the question.

DR. WEIERMAN: I honestly don't know of any studies that show that. I would be interested in finding out. I'm sure the Insurance Department -- or the insurance representatives -- could tell you. I think putting a fixed fee schedule-- The question I always asked is, putting a fixed fee schedule -- a Medical Fee Schedule -- in the automobile law, how much did that save the client who bought it? To my recollection, I think it's about $16. And the question you have to ask is, as a person who wants automobile insurance, who wants the automobile carrier to cover my medical expenses, "Am I willing to pay the $16 to go back to the old system where the doctor is paid in full and I'm taken care of?" I think most

people in the State would pay the $16. I think that's what it comes down to. I don't think it's much more than that, to have a fixed schedule. I mean, if somebody has other statistics--

ASSEMBLYMAN ZECKER: All right. I have one other question, or comment. Many professionals -- doctors, dentists -- have said that if they could get their money within 7 to 14 days, they could almost provide services at 10% less, because they have to have office administrators; one, two, or three secretaries. In particular, dentists, who-- They have office staff that is not coming cheap these days. That is not included in their medical billing. They have to carry that onto their cost of doing business.

I see firsthand, through my own dentist's office-- He has two to three girls in the office, along with an office administrator just working on the billing process. I guess the lead-in is: If many doctors have said that they can provide the same service for 10% less if they were provided for, and if, in fact, there are different programs being sold today, where if the patient pays cash up front, there is a 10% reduction--

You know many doctors have signed up for that program, that if the patient pays-- Maybe not in your particular-- Your fee schedules are-- I mean, your fees are higher. There are not many people with $12,000 in their checking account. But many professionals have signed up for programs where if the patient comes in and pays cash, the doctor will provide an immediate 10% reduction off of his prevailing fee. The lead-in into that is that if doctors or dentists were provided-- Is there a consideration of discounts? In other words, if the insurance carriers pay the bill within 14 days, that they get a 5% discount, 30 days, a 3% discount. Is there a lead-in to that type of possibility?

DR. WEIERMAN: Well I always like to--

ASSEMBLYMAN ZECKER: I know it sounds like a corporation doing business--

DR. WEIERMAN: Right.

ASSEMBLYMAN ZECKER: --with 1% off at 30 days.

DR. WEIERMAN: Right. I always-- I never say "No," to anything. I believe that's-- Any subject is discussable.

I will speak personally at this point.

ASSEMBLYMAN ZECKER: It sounds like you would take a 5% discount off your bill if it were paid within 30 days, rather than have the 90- or 180-day lag time.

DR. WEIERMAN: You're right.

ASSEMBLYMAN ZECKER: As your accountant, I would recommend that you take it, yes.

DR. WEIERMAN: My accountant would definitely recommend that. One of the problems we see right now is that you put loopholes in these laws. The first no-fault law had an interest charge after 30 days of billing. But there was a loophole in that. All that the insurance company had to do was say it was under investigation, and immediately it went to 45 days. I have never charged an interest charge or finance charge until about two or three years ago, when suddenly I found that everyone was putting me on the back burner. We now have "a finance charge," which I think is 8% this year -- something like that. It is written by the State, whatever.

The problem is they get laughed at. There is not an insurance carrier around that pays it. They just pay the bill, take all the finance charges off, so it's worthless.

Somebody did a questionnaire that said if doctors did not have to fill out insurance forms and got rid of the paperwork, that they would be willing to take a 10% cut. I think that if you were to ask--

ASSEMBLYMAN ZECKER: I saw that questionnaire.

DR. WEIERMAN: If you were to ask that of most physicians right now, I would venture to say that you would get about 99% of the doctors saying, "Just get this paperwork out of my hair--"

ASSEMBLYMAN ZECKER: I think it was about 85% that responded in the affirmative.

DR. WEIERMAN: Right. "--and we would be very happy just to get paid."

Someone has interpreted that, by the way, to say that 85% of doctors want national health. That's not quite a regular finding. That's not-- That doesn't follow. But indeed, I think that if the hassles were less, and the paperwork was less--

I have to say that I think insurance carriers do know who some of these physicians are; who are abusing the system, and who are not. It used to be that an insurance company would call me and say, "Oh, okay. Take care of it and it's all-- Don't worry about it. We know you." It doesn't work that way anymore, and it becomes a real problem. And it's not just this. Compensation is doing the same thing, and they are just automatically taking 10% off, by the way.

ASSEMBLYMAN ZECKER: But you haven't answered the question.

DR. WEIERMAN: Yeah, I know.

Would the doctors do it? I would say I think it is something we would be willing to sit down and talk about. I think that the Medical Society would be very happy to sit down, and if that was proposed, to see if we could work out something.

I think if it's guaranteed that it is going to be paid within 30 days, that's one thing. I think there should be some penalties if it's not, and I think you should take loopholes out where it says that, just by the quirk of somebody's pen, "Well, we're going to look at it." I think there should be definite reasons if a bill is being looked at; not just automatically, every bill over $2000 is audited. I don't think that's fair.

And I think the phone calls have to stop. One of the problems, too, we run into, is, these review organizations call

the office, and they want all this sensitive information about patients. When we ask, "Do you have permission?"-- I got a questionnaire. About a third of them did not have permission from the patient to ask the questions, and then got incensed over the fact that I wouldn't answer their questions. And they literally admitted that they did not have permission from the patient to get this information. And I don't have any way of knowing who that is on the phone. Anybody could be calling, and that's not fair, because there are some questions-- As you know, AIDS-- And people do get tested.

I don't think any of you here would want me to release information concerning that that might affect not only your livelihood, but everything else concerning your life, you know, by someone just asking a simple question, and we don't know who it is.

And if a doctor asks the question, "Do you have permission?" or, "Send us in writing, something," you immediately become an uncooperative doctor. Your patient gets told, "Your doctor is not cooperating with us; therefore we are not paying."

It's not fair, either. They call at strange hours of the day. I'm a surgeon. Call me at 10:00 in the morning, I'm in surgery. Because I don't answer your phone call-- I had one in particular I remember, where this was a supervisor, who was only there until 1:30, and after that was unreachable. You know, you work in the OR all morning; you don't get to the office until 1:30 or 2:00, you can't call them. And then all of a sudden you're an uncooperative doctor; you didn't answer their calls, and, "No one else knows the case."

So, I mean, I think there are problems. I mean, I would hope that, you know, perhaps the Medical Society or something like that could sit down and we could iron out some of these problems, and you know, maybe we could come up with an agreeable-- I mean I'd like to sit down and talk with

everybody, because I happen to believe that insurance problems are everybody's problem, and we can't keep pointing fingers and saying, "It's this one's fault or that one's fault." I think it's time to sit in a room together with everybody and say, "Look, here are our problems. Tell us your problems." And we should iron them out.

I mean, I'm also spokesman for the Health Access America from the A.M.A. trying to get everybody covered, and all that. That's one of our big pleas. We say, "Look, it's time to stop pointing fingers." We should sit down in a room, everybody involved, and tell everybody what the problems are. Let's work this out. I mean, we should not have 31 million or 37 million people in this country uninsured. That's unacceptable, totally. We should work on it.

So, I think it's really time to talk, and that's what I'm here to say.

ASSEMBLYMAN GILL: That's what we're doing.

Just one other question, Dr. Weierman: Do you charge a different rate for your regular patients who may come through than those injured in an automobile accident?

DR. WEIERMAN: Yes.

ASSEMBLYMAN GILL: You do?

DR. WEIERMAN: My fees are higher for the other patients--

ASSEMBLYMAN GILL: Higher for the other patients?

DR. WEIERMAN: I'm being paid at the 75th percentile, so--

ASSEMBLYMAN GILL: --and lower for those involved in the auto accidents?

DR. WEIERMAN: --I don't have a separate-- Let me put it this way: I do not have a separate fee schedule for my automobile insurance. I charge my regular fee, but I don't balance bill. In other words, I charge my regular fee, whatever the fee schedule pays me, then it gets written off.

You see, I have this fear. According to the law it says the Insurance Commissioner is to make the rate 75%, you see, at the 75th percentile. If I put in the 75th percentile as my fee schedule this year, he will pay me next year at the 75th of the 75th, and that will go on ad infinitum, you see? So, my regular fee goes in. I do not balance bill. So, if I have to raise my fees, I just raise my fees, but I just don't balance bill, which is what the law says.

ASSEMBLYMAN GILL: Anyone else? (no response)

Thank you, Doctor.

DR. WEIERMAN: Thank you.

ASSEMBLYMAN GILL: Thank you very much for your time and your testimony.

DR. WEIERMAN: Thank you.

ASSEMBLYMAN GILL: At this time I see, Mr. Kenneth Lucianin. Mr. Kenneth Lucianin? You are here as a victim; as a consumer of insurance?

K E N N E T H L U C I A N I N: I am here as a person involved in an automobile accident who was wronged by my insurance company, and I am here as an office manager for a physician in the City of Clifton, who has a physical therapy practice.

I would first like to discuss my own problem. In May of 1989, while driving my auto, I was involved in an automobile accident with an unlicensed driver -- an uninsured driver -- who came through a red light and smashed into my car. I sustained injury to both of my shoulders, and was treated by a physician; saw an orthopedic surgeon who sent me for an MRI which confirmed the fact that I had a torn rotator cuff of the left shoulder, and suspected in the right shoulder.

The bills were sent to my insurance company in October of 1989. The bills for the orthopedic examination and the MRI were sent at the time that they were done.

None of my bills were paid by the insurance company. I started getting notices from the people who did the MRI. I'll just read you what it says. This is the final notice. I got one every month, but this is the final notice:

"Upon auditing your long overdue account, I find your account with this office has been unpaid for several months and we have exhausted all attempts to aid you in settling your debt. Because of rising overhead costs, and in fairness to our patients who have paid their bills, our accountant will not allow us to carry your unpaid balance any longer. From date of this service, this bill has remained the responsibility of the patient. Therefore, please be advised that if the balance is not paid within 10 days, I may have no alternative but to refer this account to our collection agency.

"We sincerely hope that you will contact us to clear up your unpaid bills so that you can maintain a good credit standing.

"Thank you."

With having no other recourse, my attorney filed a lawsuit against the insurance company for payment of my bill. I also demanded interest. So, as opposed to what this doctor just said -- he said they don't pay it -- I received my interest, and my bill was paid. They paid for the MRI; they paid the orthopedic surgeon.

Thirteen months went by before they even considered my bill. I have a letter for all of you from the insurance company. This is June 28, 1990. Remember, my accident was in May of 1989. This is to the doctor:

"We are writing you in regard to your bill for services rendered to Kenneth Lucianin. A check in the amount of $1360 will be forthcoming for services deemed reasonable and appropriate from 5/24 to 7/24.

"Our decision was based upon recommendations from Intra Corps, a medical review service organization. Intra

Corps is a nationwide company, and as such, utilized hundreds of qualified consultants, including: practicing physical therapists, physiatrists, chiropractors, neurologists, etc. in their bill review service."

Now this was done-- Someone decided that after July 24, I no longer needed any treatments. Nobody saw me; nobody questioned me; nobody talked to me. But they have all these hundreds of specialists on their board, and they decided I no longer needed any treatments, so that's all they were going to pay. When I got this letter, that's when I contacted my attorney to file suit.

ASSEMBLYMAN GILL: When you say, "No one advised you"-- You had seen no doctor; no one else?

MR. LUCIANIN: No one from the insurance company.

ASSEMBLYMAN GILL: No one?

MR. LUCIANIN: No one from the insurance company.

After that, a year and some later, they sent me to an orthopedic surgeon for what they call an "independent medical examination." They call it an IME.

The doctor asked me two questions: He said, "Are you on disability?" And I said, "No." He said, "Are you still being treated?" I said, "No." He said, "Why are you here?" I said, "Because I'm complying with the request of the insurance company for an examination."

Now, had the insurance company paid my bill when it was originally submitted, it would have ended. But, of course, they chose not to. They paid for an audit. They paid me three-hundred-and-some-odd dollars in interest. They paid my attorney $750 in legal fees. Now, I'm sure-- This case never went to court. It was all done on telephones as far as I know, because I know I never went to court. I just got a phone call from my attorney telling me, "Your case is settled. Your check will be in the mail, plus your interest."

Now, they had to have a legal fee someplace. They sent me for an orthopedic examination, for whatever reason I don't know. He confirmed all of my injuries, and I got a beautiful report from him stating that I do have a torn rotator cuff in the left shoulder. I have a possible torn rotator cuff in the right shoulder.

Now, if we're going to worry about inflated insurance costs, I think here is one insurance company that could have saved themselves an awful lot of money, in excess of $1500, by just paying the consumer, who has paid his insurance bills faithfully for over 40 years, never made a claim, never looked for anything. So, this is my experience.

Now, just to say that the bill from the doctor was reasonable--

ASSEMBLYMAN GILL: Mr. Lucianin, just to interrupt you, what company are you insured with?

MR. LUCIANIN: At that time, that was with CIGNA.

ASSEMBLYMAN GILL: CIGNA.

MR. LUCIANIN: I have-- My doctor charged me-- He gave me hydrocollator ultrasound and massage, which is three modalities. With the fee schedule, it comes out to $105. He charged me $50 a visit. They had that audited.

ASSEMBLYMAN GILL: They had that audited?

MR. LUCIANIN: Fifty-five dollars less than the fee schedule, just six months before the fee schedule came in. They had this bill audited and chose not to pay it.

I have a letter here that I'd like to give you all a copy of. It's not a letter, it's a bill. It's from one of Mr. Zecker's constituents, who I'm sure he'll know the name when he sees it. This is a 75-year-old woman who just lost her husband. They were in an automobile accident prior. The accident had nothing to do with his death, by the way. But this is from an orthopedic group who says: "If we do not receive payment within 10 days, your account will be forwarded

to a collection agency." Across the thing, they have: "Last notice." I have copies for all of you. It says: "This $275 bill is over 90 days." So I'll leave this here so that you can look at that.

ASSEMBLYMAN GILL: Now with an overdue bill of 90 days, what happens, Mr. Lucianin? What takes place at that point? How does that affect the consumer?

MR. LUCIANIN: Well, now they're saying that they're going to turn it over to a collection agency, which then can call TRW and affect your credit rating. You go to apply for a credit card or something and they'll tell you, "I'm sorry, we can't give it to you. You have bad credit. You have outstanding debts."

ASSEMBLYMAN GILL: So therefore, that person's entire creditability or credit rating is affected because the insurance company did not pay this bill on time.

MR. LUCIANIN: That's correct. This is what they were threatening me with.

Now, I'd just like to discuss something, as Office Manager for Alphonsus L. Doerr, M.D., in the City of Clifton. I disagree, again, with what the Doctor said, when he made comment that, "One insurance company is interpreting the fee schedule with that 100%/50%/25%." I find that half of the insurance companies are interpreting the fee schedule in that manner.

Now let's just take my case as an example: If I were to be treated today at the fee schedule -- and let's say we're talking about Allstate, who is one of the companies who does interpret the fee schedule to be 100% for the first modality, 50% for the second, and 25% for the third -- I would have been charged $61. But the fee schedule says, "You can bill for each part of the body treated." So it could have been $61 for the left shoulder, and $61 for the right shoulder, or $122.

So we have Hanover and Amgro paying the regular way -- the way they always paid -- one modality, two modalities, three modalities. Then we have other insurance companies that are paying at 100%, 50%, and 25%. So you have two different standards. Then you have insurance companies -- I should say insurance services -- plus once we went into CSC, MDA, EDS, HEM, Pike Adjusting, Delaware Claims, Rely and Fleming, everything went to a halt. I used to have one file cabinet for bills in the office, now I have four -- unpaid bills.

Now, I have copies of the fee schedule here for you, which I don't think you really need. But here you can see -- I underlined in yellow -- where the fee schedule calls for $34, the fee approved was $25. Dr. Doerr billed $22, the fee schedule calls for $37 and they approved $22. He billed-- The fee schedule calls for $33, he billed $33, and they approved $25. Now, for each one of these visits the patient has to pay the balance, because you can't charge over the fee schedule, but you can collect up to the fee schedule.

Now if this particular patient has a sharp attorney a PIP suit will be started. They'll file a suit against the insurance company and 99 out of 100 times the insurance company will not defend. They'll pay. They'll pay the bill 100% and they'll pay the legal fees.

ASSEMBLYMAN GILL: How does that increase the rates, Mr. Lucianin, or does that increase the rates?

MR. LUCIANIN: It's increasing the insurance costs if an attorney is going to get $750 every time an insurance company cuts a bill, and he files a suit. That cost may be $50 to file, and a secretary to push the button in the computer to print out the PIP suit.

ASSEMBLYMAN GILL: And you're saying that this is the modus operandi? This happens as a rule?

MR. LUCIANIN: This company has been told, six months ago, that their fees are wrong in their computer. They claim that they have no one to change the numbers in the computer.

Now, I have-- Over 80% of the bills in our office are over six months old. Forget about 30 days; forget about 90 days. Eighty percent of the bills are over six months old, and all of this happened since we got involved with these computer companies: the MDA, HEM, EDS, Pike, and those companies. They do not pay their bills.

ASSEMBLYMAN GILL: Is this, at all, affected by the deductible involved?

MR. LUCIANIN: The deductible has nothing to do with the payment of what has to be paid. Now I can see why this doctor might have a problem. If he's billing his regular rates, and is waiting for someone in the insurance company to adjust what he's billing, he could have a problem. We bill according to the fee schedule. Each and every item is according to the fee schedule. There's not $1 over the fee schedule.

Now if you have a fee schedule, and you're applying the fee schedule, why would the bill go for audit? Why would it need an audit? And I also agree with the good doctor when he said that, "Doctors do not refuse treatment." He's true. They don't refuse treatment, but they want payment up front -- I'm talking about specialists, orthopedic surgeons, and neurosurgeons. They no longer want to wait for their money, due to the fact of what I just said to you, that the bills are in excess of six months old. They feel that they're providing that kind of specialty -- a specialist service. They don't feel they have to wait for their money. I don't, honestly, think they're wrong.

They will never say, "No, we don't want it." They'll say, "Please, tell the patient they have to pay up front, and I'll be happy to give them a paid bill, which they can then submit to their insurance company." Now, he also said, "People don't have the money," which he's correct. You go to a specialist, people may not have the money to pay up front,

which means one thing: You might have to go down two or three notches in someone's reputation to find someone who's going to wait, someone maybe who is new in the field who will take the time to wait for their money. I think that's depriving the person of the number one man, just because the insurance company won't pay on time, won't pay within the law.

I think that's about all I have to say. I got most of it off my chest.

ASSEMBLYMAN GILL: From what I could see here, from your testimony, Mr. Lucianin, the cost of insurance is highly increased, in fact, because of the lawsuits involved, number one. Not only to the consumer or to the insurance company, I think it's bad all the way around.

MR. LUCIANIN: Well, Mr. Gill, like I said, I'll just take (witness coughs) -- excuse me -- my case, in and of itself. Let's just review that again. After my treatments were terminated -- was all finished, everything was finished, the bills were sent in -- I had to file a suit against them. They sent it out for an audit, so they paid the auditors. They then sent me for a medical examination, almost a year after I was done treatment. For what reason? They had to pay the doctor. Then there was the suit that I had to institute to collect my moneys, which they had to pay their legal fees. They had to have attorneys on their side. I know they paid $750 to my attorney, because I asked him what he got. And they paid me $310 in interest.

I would say, roughly, we're talking probably $2500. Now, how many times does this happen in the State? I know how many times it happens in my office.

ASSEMBLYMAN GILL: Could you give us a guesstimate?

MR. LUCIANIN: I'd say, probably, 30% of the cases. Every CSC case that's there, has a PIP suit on it, every one. The attorneys are not going to make the people pay the money that the insurance companies are suppose to pay. See, that's

only one page. This girl might have had four pages. So if you're going to see that there's eight or nine, times $9, and then multiply that by four pages it comes out to maybe $250 to $300. Now why should the consumer have to pay that amount that is supposed to be paid by the insurance company?

And as I said earlier, if my memory serves me correct, it only cost like $40 or $50 to file a PIP suit, and I know that most of them are in a computer, so it's just pushing a button. You type in the name of the insurance company, and the name of the person suing, and out it comes, and if there's going to be a $750 bill attached to that, and the insurance companies are not going to go to court, they're going to settle it over the telephone--

ASSEMBLYMAN GILL: Mr. Kenny, any questions?

ASSEMBLYMAN KENNY: No, Mr. Chairman.

ASSEMBLYMAN GILL: Assemblyman Zecker, any questions?

ASSEMBLYMAN ZECKER: Mr. Lucianin, it's no great secret that two years ago I had hearings, and even when computer companies were brought into the insurance scenario, I didn't think I was a wizard in insurance, but, I predicted that once computer companies came in, as much as you may hate an insurance company, you're going to hate computer companies even more. You've mentioned CSC.

Now, also, we in the Legislature have a way of reacting. If 10% of the people are doing something bad, we'll pass a law that punishes 100% of the people. You've told us the bad news, but could you, and not specifically naming companies-- I think we all know the major companies. You've probably been dealing with them for years, and I'd like to think that many of them are responsible in what they do. Could you give me a percentage of the problems you have with the major companies that you deal with, and I'll say Allstate, Prudential, State Farm?

MR. LUCIANIN: Allstate is number one. They're the best.

ASSEMBLYMAN ZECKER: No, no, wait.

MR. LUCIANIN: No, no, I'm going to tell you. If we're going to talk about companies--

ASSEMBLYMAN ZECKER: Well, when you're talking about companies in general, and then dealing with computer companies, what percentage of your problems are with the insurance companies, and what percentage of your problems are with the computer?

MR. LUCIANIN: Twenty and 80.

ASSEMBLYMAN ZECKER: Twenty percent with the insurance company--

MR. LUCIANIN: Twenty with the established insurance companies, and 80% with the computer companies.

ASSEMBLYMAN ZECKER: So, in other words, the insurance companies, in your experience, are about 10% away from almost being "A" students?

MR. LUCIANIN: Yes.

ASSEMBLYMAN ZECKER: The computer companies are--

MR. LUCIANIN: Forget about it.

ASSEMBLYMAN ZECKER: Okay.

ASSEMBLYMAN GILL: Mr. Lucianin, one other question. Have you contacted the Department of Insurance with any of your problems, at any time?

MR. LUCIANIN: Yes.

ASSEMBLYMAN GILL: And what was their reaction?

MR. LUCIANIN: They said that, "No decision has been made as far as the interpretation of the fee schedule is concerned." See, the doctors that I deal with have the same feeling as the doctor who sat here, that the wording in the fee schedule is strictly for surgical procedures and not for physical therapy. The companies-- Certain companies have interpreted that to take in physical therapy.

Now the doctor was 100% right when he said, if you're going to bring someone in, let's say with a cervical spine

injury, and you give them ultrasound hydrocollator treatments -- which is heat treatments, massage -- which takes, again, 30 or 40 minutes, and put them on a traction table for 30 more minutes, and then have a company say, "We're going to pay you $34. We're going to pay you half of $33. We're going to pay you 25% of $30, and we're not going to pay you anything for the last modality." Then the doctor has to say, "Well, maybe this person doesn't need all of these modalities. Maybe they can get better without them." Of course, you're asking the doctor to provide services for free.

I think somebody just misread that, because if you really read the wording, it says, "When two practitioners are participating at the same time--" Where are you going to have two doctors giving physical therapy on someone at the same time?

ASSEMBLYMAN GILL: Yeah, that's true.

MR. LUCIANIN: You could have two surgeons there though, at the same time.

ASSEMBLYMAN GILL: That's it? (no response) Thank you, Mr. Lucianin.

MR. LUCIANIN: Thank you.

ASSEMBLYMAN GILL: Carol Kientz? (witness gives copies of statement to Committee) Carol, thank you for preparing written testimony. Carol is with the Home Health Assembly of New Jersey.

C A R O L J. K I E N T Z, R.N., M.S.: That's right. Good morning.

ASSEMBLYMAN GILL: Good morning, Carol.

MS. KIENTZ: Thank you for the opportunity to testify. I appreciate this. I'll try to summarize the testimony, rather than bore you with reading all of it. Our problems may seem relatively minor and confined, but they are significant, and we fear they may be growing. Therefore, we do want to present those issues to you.

I am Carol Kientz, the Executive Director of the Home Health Assembly of New Jersey which represents home care providers throughout the State, traditional Visiting Nurse Associations, hospital home care departments, some visiting homemaker agencies, private proprietary home care providers, IV therapy companies -- the whole gamut of home care providers throughout this State.

We have, traditionally, been used to cost caps and limited limitations to our rates in home care. Most of our reimbursement, in truth, is from Medicare and Medicaid, well over 50%, and in some case perhaps as much as 75% from those payment sources, and they have cost caps and we're used to accepting that limitation.

Many of our providers in New Jersey are not-for-profit agencies and companies, and they operate within that not-for-profit cost structure and charge cost also. So the rates did not, initially, I suspect, seem a major concern. And in all honesty, to the best of knowledge -- and I was not in my position at the time that the rate schedule was developed last year -- our industry did not participate, specifically, in the setting of home-care rates. But in honesty, we're also happy that there was some home-care rates included, because often home care is kind of neglected and people forget that it is often a necessary service, particularly in the areas of rehabilitation and posttraumatic acute care.

When we try to get an individual out of a hospital or a rehabilitation facility quickly -- because that's where the most expensive care generally is -- we try to get them home where we believe a well managed home-care program can be much more cost-effective and can provide therapy, nursing, and homemaker-home health aide services, and the like. So when we try to do that, we believe that that can be a very cost-effective modality of health care. And therefore, as I say, we were pleased to have rates included in the fee schedule for home care.

However, what we realized was that the rates-- Home care did not have region-specific rates, as opposed to some of the other professional-service rates. We do not have North, Central, South Jersey rates for home-care. There is one rate. There are two types of home care rates established, however: one for private duty care, the other list is for home health visits -- per visit -- as opposed to per hour; is the easiest way to look at it, because much of home care is provided on a per visit basis. A physician-- And all of it is provided under physicians' orders.

A physician may order three nursing visits a week to change a wound dressing, for example. And the visiting nurse goes to the home, changes that wound dressing, whether it takes half-an-hour, an hour, or an hour-and-a-half, depending upon the patient's problems, family needs, and teaching a patient, and so on. That is a per visit charge.

The per visit rates that were set in this fee schedule are, honestly, reasonable we feel at this point in time. Although, each year we have concerns of just how the adjustments will be made, because we're dealing with increasing cost and nurses, physical therapists, occupational therapists, and so on, are costing us more and more each year to employ and to provide adequate benefits to keep them in the field of home care.

The per visit rates at this point, we feel, are manageable. The per hour rates are our concern at this point, because there were single rates set for registered nurse, licensed practical nurse, home health aide, and a live-in attendant, which would be a 24-hour type of home health aide attendant.

Where private duty care is required -- and that's often in the early stages of the most acutely injured individuals -- where they might need, for instance, eight hours of a nurse at home, just as an individual might need that kind

of care in an institution. Or they might, for a few days or even a few weeks, require a couple of shifts or different shifts. There might be someone at home who can assist them during the day but may not be able to help them all night or every weekend. So we have complex hour schedules. Just as you may have a nurse around the clock in a hospital, someone might require a nurse around the clock, or an evening shift, or a night shift, or a holiday, because home care is 24-hours a day, seven days a week, in terms of availability.

If a nurse has to provide care on Christmas Day, so be it. We will have a nurse in that home, under the physician's orders, on Christmas Day. But home care providers have to pay a different rate, just as a hospital or any other employer or professional staff would pay that professional at a higher rate for evening, night shift, or holiday work. However, we're dealing with a single rate in the fee schedule. That single rate, we feel, is at this point appropriate for daytime, Monday through Friday care in the home on an hourly basis, but at this point it is not meeting the needs of professional care on those evening, night, holiday schedules where we have to pay more, and it winds up being more than the per hour rate.

There also are some concerns around the State because, as I said, there was not a differentiation in terms of locality; not a north, central, or south variation in home care fees. In our suburban and rural areas of this State it's often more difficult to get home health aides. Certified homemaker-home health aides are trained, and there's oversight by the Board of Nursing here in New Jersey, of those individuals. They must operate under the supervision of a registered nurse who must visit and establish their care plan and see that they're properly caring for the patient.

Those home health aides are costing more and more because of increasing regulation, and the training, and supervision that we're providing to them. And it's also, in

all honesty, not the most desirable job for an individual, and we often cannot provide all of the benefits that a McDonald's or a Burger King could, at the rates that we're getting reimbursed for those homemaker-home health aide hours. So we have to pay more and more to try to attract individuals, particularly if you're talking about Suburban Essex County, Morris County, Suburban Monmouth County where there are fewer individuals, perhaps, hard enough up, let's say, to need a job that pays at a lower rate, so we're paying higher and higher rates.

One of our big visiting nurse associations is now offering a $1000 sign-on bonus to try to attract home health aides in one of our rural areas because they are so scarce. So that per hour home health aide rate, even during the day -- Monday through Friday -- and some of our suburban or areas of more scarcity of that particular person, that's a problem too. So what we're really asking for is a review of those rates for home care, particularly the per hour rate, and a consideration of some alteration. Just a few dollars an hour can make the difference for us.

We're not asking for 10% more or 50% more. But we feel at this point, at least on a year by year basis, right now, just a few dollars an hour for those off hours, weekends, holidays, and in that home health aide rate, could make the difference between losing money on the home care of an auto injured patient and at least breaking even.

We have been very gratified by the response of the Department of Insurance, and no way am I saying that that was a problem for us. We did write to them and they have indicated a real concern and interest with our problem. They're asking, at this point, for some more statistics and information to help them, which we're in the process of compiling.

Unfortunately, New Jersey does not really provide much in the way of statistical information in home care. They don't

gather it very extensively, from home care providers. So we're trying to come up with some good solid information that's usable to the Department, and we hope that that will continue.

So my purpose here this morning is really to reinforce our concern and to hope that as you're considering the problems, you will consider this as one of the problems and urge the Department to continue to look at this.

ASSEMBLYMAN GILL: Carol, I'm happy to hear that you have such good reports on the Department of Insurance, and that they've been so cooperative. How large is your organization?

MS. KIENTZ: We have about 120 members. Over 100 of those are direct home care providers. In terms of figures of volume of home care, because some of those providers-- We're talking about home care providers that are between $5 million and $10 million a year in budget -- a very large, multiple counties, hundreds of thousands of visits a year. Others may be smaller, local; serving one town.

We have local municipal health department home care providers as part of our organization. The Hoboken Public Health Department is a small provider but, nevertheless, they're out there trying to meet the needs of the people of Hoboken, so that's variable. But the most recent, solid, State collected statistics on home care, in terms of volume -- and this is from the State Health Department -- indicated well in excess of two million visits in 1988, provided to New Jerseyans in home care. Those are statistics only collected from the certified licensed home care providers through the State Health Department.

There's also a whole volume of home care providers, proprietary private duty home care providers licensed under the Division of Consumer Affairs. There is no statistics, at this point, kept on that segment of the industry, but they're certainly involved in this, sometimes through subcontract with those Health Department licensed providers. So there's a bit of meshing of statistics.

We know over 150,000 patients a year are cared for in home care, and with those that are not tabulated it may be well over 200,000, and the visit total might be as much as three million visits a year.

ASSEMBLYMAN GILL: Thank you, Carol. Assemblyman Kenny?

ASSEMBLYMAN KENNY: No questions.

ASSEMBLYMAN GILL: Assemblyman Zecker?

ASSEMBLYMAN ZECKER: No, thank you.

MS. KIENTZ: Thank you.

ASSEMBLYMAN GILL: Thank you. Elmer Matthews, American Insurance Association? Elmer? Good to see a friendly face.

E L M E R M. M A T T H E W S, ESQ.: I appreciate being identified as a friendly face. (laughter) For those of you who don't know me, my name is Elmer Matthews, the New Jersey Counsel for the American Insurance Association, a trade association representing the major stock insurance carriers, licensed and doing business in New Jersey. We have approximately 235 members who are writing in New Jersey.

We are the industry that FAIRA is all about, the legislation that this Legislature passed in the first two months of the Florio administration. I have a copy of it in front of me, and I was prepared to tell you some of the things that FAIRA asked us to do under its terms, and most of those things were commented upon by Lou Gill. But basically -- and I don't think that I'm exaggerating when I start out by saying that -- we are an industry, and as such we are a member of the profit making community, but we are very very highly regulated by the State of New Jersey.

I think you could sum it up by saying that we are told what to write. We are told how to write it. We are told how much we can charge for what we write. We are told whom to write. We are told how much to pay for what we write, and when

we have to pay it -- as far as a time period is concerned. We also are told, by the way, when you pay things, don't pay any fraudulent claims. That sort of puts one on the horns of a dilemma.

You look at the business of property casualty insurance, and the way that you keep premium cost down is by taking costs out of the system. Now one of the intentions of the Legislature, in FAIRA, was to face problems that did arise in the PIP area. For example, you did put a cap on PIP at $250,000. You left in place that provision of the law where payments between $75,000 and $250,000 are paid by the company but they are reimbursed by the Unsatisfied Claim and Judgment Fund, and ultimately are assessed against all of the companies on a share of the market basis.

So there was a limiting in FAIRA. It's not something that the companies asked for. It's something that the Legislature did. You capped the responsibility for PIP payments at $250,000. That was a political judgment by the Legislature.

I recognize that there are, out there, cases that will exceed the $250,000 figure. I've heard varying estimates as to how many cases there are, but it is probably in the realm of between the 94th and 100 percentile, so about 6% of cases may fall in that category. Those cases were always covered by the industry, throughout the history of no-fault, albeit through the UCJF procedure.

So there is some animosity -- and I might use the word a little bit to strongly -- out there among people who are not being reimbursed for that, but that's the system that we have been given, and we've been given it by you, and that's the system that we have to live with.

Another item that you gave us under FAIRA was the "PIP switch," and that's the ability to use your health coverage for personal injury protection payments on your auto policy. I'd

like to lay claim to the origin of that statement. When I testified before the Ad Hoc Committee, I referred to it as the PIP switch. That apparently stuck.

You have to understand that even under the PIP switch, costs that aren't covered by your health insurance policy in accordance with the terms of FAIRA, are still paid by your auto policy, and to make sure that the companies didn't overcharge for PIP payments, there is a specific provision in FAIRA that says, "If you have to reduce your premiums, in the event of a PIP switch, by 25% of the base rate, up front -- for policies during calender 1991 and for policies issued after 1992 -- there has to be a filing with the Department of Insurance to justify the payment."

So there again, the Legislature has acted and asked us to do something and we're doing it, and complying with it. We're also under the stricture by the Department and by this Legislature, "Don't pay any fraudulent claims."

ASSEMBLYMAN GILL: Mr. Matthews, just to interrupt, how many participants -- I don't know if you have this number or not? -- have taken advantage of the PIP switch?

MR. MATTHEWS: That number I don't have, but I'm sure that the Department people who are here can give you that answer. I can only speculate. See, one of the problems of a trade association is that we can deal with legislation as it moves through the Legislature, or regulation as it moves in and out of the Department, but when you get into the cost and the participation, we run straight into the antitrust provision of the law, so we really can't share that information. And I, as a representative of a trade association, can't codify that. You can ask that question directly of an individual company, and they can answer it, but, of course, as a member of a trade association, or Counsel for a trade association, I can't do it.

ASSEMBLYMAN GILL: I just thought you might have had some information.

MR. MATTHEWS: No, I don't have it off of--

ASSEMBLYMAN GILL: I was just wondering, are you aware of any states which have a higher cap than we do?

MR. MATTHEWS: I believe that-- Verice is it Illinois or Michigan that still has unlimited?

A S S T. C O M M. V E R I C E M. M A S O N: Michigan.

MR. MATTHEWS: Michigan still has unlimited. Michigan and New Jersey were the only states that had an unlimited fee schedule and we took that away in FAIRA. Now another improvement of "FAIRA" that you gave us was the Medical Fee Schedule. I think part of the problems that are the reasons for these hearings probably grow out of problems that have been caused by the Medical Fee Schedule.

It was a terribly hard job for the Department to do, when you figure that they have to run the whole gamut of medical procedures, put dollar figures on them reflective of 75% of the average cost in various sections of the State, and recognize the variation in sections of the State, and use separate zones. That is the basis upon which we pay.

But you have to understand that when a charge comes in for a medical fee -- for a medical procedure -- we just can't say, "Well, Dr. Swartzen (phonetic spelling) in Weehawken says that he provided these four procedures." In looking at them you say, well, it may seem odd that these four procedures were all done at once, or were done on the same day. So you look at the file and you review it and you question the doctor about it. The Department says, "Watch out for overpayment. Watch out for fraud." We do that.

FAIRA, in fact, encouraged us on PIP -- as you indicated at the start of the hearing -- by saying that these payments did not have to be made in 30 days, but now they had to be made in 60 days, and the specific reason for that, as testified to by the Department at the Ad Hoc Committee hearings, was so that the companies would have more time to

look at fraud. There always was the provision in the law to give you the additional time to investigate a case that you thought had a problem.

ASSEMBLYMAN GILL: Mr. Matthews, just to interrupt you a second. Do you have any idea of the percentage of cases which are investigated by the insurance companies? I mean, do they actually go out and do an investigation in most cases, or are they just settled over the phone, like Mr. Lucianin pointed out?

MR. MATTHEWS: There is a requirement of FAIRA that we present a plan to approach fraudulent claims. Within that plan there is a procedure laid out whereby we use medical auditors to make sure that what we're doing is paying valid claims, and not just paying everything that comes in the door.

We could be everybody's hero by paying every claim that came in the door, but your insurance premium would be insurmountable, and I think the Department would be the first one to agree with us.

It's interesting, when the Committee called and asked me if I might come and testify before you, I made some inquiries around the industry from claims people as to what the complaints they were getting under FAIRA, more specifically under PIP. Because of the fact that the subject matter of this hearing is a little bit esoteric the way it was framed, I didn't know exactly what you wanted to hear. But the interesting thing was that promptitude of claim payment is not a universal complaint, and it seems strange in light of the testimony of the first two witnesses at least.

Promptitude of payments is not the subject of complaint. Neither to the companies nor in inquires to the Department, is promptitude a problem. One of the problems is the utilization of the Medical Fee Schedule and the melding -- if I can use that word -- of different sections of the Medical

Fee Schedule to recoup payment for medical treatments of the same injury. The Medical Fee Schedule -- and I don't mean this critically -- is a rather convoluted schedule, as you can see--

ASSEMBLYMAN GILL: I have a copy.

MR. MATTHEWS: You have a copy. --and it treats different procedures -- it treats different approaches to various parts of the body, and there is a tendency, on some health care providers, to lump together two and three parts of the body in the reimbursement for treatment and when you see that, our job is to make sure we're not overpaying. Now we still have to pay within 60 days, and if we don't pay within 60 days we have to give the reason why we're not paying, the policy numbers, and all of the information that's specifically called for in FAIRA and in the regulations. I just can't fathom the universality of complaint that has been elicited this morning.

ASSEMBLYMAN GILL: Mr. Matthews, you're pointing out that you must pay within 60 days; however, should an investigation take place, there now is an additional time period extended, is there not?

MR. MATTHEWS: That's specifically in FAIRA--

ASSEMBLYMAN GILL: Yeah, that's right.

MR. MATTHEWS: --right here in section 5 of the bill it says, "Additional time not to exceed 45 days."

ASSEMBLYMAN GILL: Right.

MR. MATTHEWS: And there's very specific information that you have to provide.

ASSEMBLYMAN GILL: But yet we've heard testimony from more than one person -- we've only had three or four people testify -- that in some cases these cases take nine months and longer to reach some type of settlement, causing an increase all the way around.

MR. MATTHEWS: Yeah. I can understand that. I understand the problems of the last witness. The computer

companies were the bane of everyone's existence, and they became known as the insurance industry. A lot of their sins have been transferred to the industry.

ASSEMBLYMAN GILL: I think that's a very valid point.

MR. MATTHEWS: I like to refer to the computer companies -- and I don't mean any disrespect to our former Commissioner -- but they came on the scene to solve all of the problems of the JUA as sort of Merin's Commandos, and they ended up as the gang that couldn't shoot straight.

ASSEMBLYMAN GILL: While we're talking about investigations--

ASSEMBLYMAN ZECKER: Are you saying he was an idiot?

MR. MATTHEWS: Who? The computer companies.

ASSEMBLYMAN ZECKER: Oh, okay.

ASSEMBLYMAN GILL: As a representative of the industry, have you any idea of the amount of fraudulent claims your investigators turn up after doing an investigation? Is this a prevalent thing in the industry? Is there as much fraud that is perceived out there or is it--

MR. MATTHEWS: I think we're finding a lot of fraud. I think we are. I think that the fraud plans requirement of the Department of Insurance were an excellent idea. I think it caused people to reanalyze their procedures. I think it's been very helpful. The problem is that its got a downside -- that when you investigate a claim you don't pay it until it's fully investigated.

ASSEMBLYMAN GILL: Mr. Matthews, we also have-- I've seen people who make a living from the insurance companies. Some people never go to work, they just fall on somebody else's property or happen to get bumped in their back while they're sitting at a red light -- whatever it may be. Do you do any kind of a follow-up on these people who are always collecting money from the insurance companies? Do you list them in any way? Is that allowed? Do you have a record?

MR. MATTHEWS: There is a central index system that is nationwide, that has been in operation for quite some time. Some of the prosecutions within the last two or three years in New Jersey, some of the very important or most notorious ones, have been the result of cross name checks in that system. There are people on those lists like the 47 passengers on the 20 passenger bus, those kinds of people.

ASSEMBLYMAN GILL: I'm not just talking about the automobile insurance -- the automobile injuries -- I'm talking about people who habitually collect.

MR. MATTHEWS: Oh, yeah. There's no question about that. About 18 months ago, one of our domestic carriers in northwest New Jersey -- an alert claims examiner -- saw the same name on two files, ran a cross check and turned up seven claims under that person's name, in three years. He's doing time now.

ASSEMBLYMAN GILL: I find that to be a very interesting way to make a living, if nothing else, and yet I do know of people who, believe me, are driving around in new cars, take a couple of vacations a year, and just don't bother to go to work. They just can't wait for another accident.

MR. MATTHEWS: You know, I'm driving around in a new car that's only about three weeks -- four weeks old -- because about a month ago, and I have gray hair--

ASSEMBLYMAN GILL: Sporadic though.

MR. MATTHEWS: --I had the first auto accident I ever had since I was 17 years old. Somebody ran a stop sign, hit me broad side, turned me around, and almost turned me over. It did $17,000 damage to my car. I had my seat belt on and wasn't scratched. I said to myself, if I was in the business, I could probably make something on this.

ASSEMBLYMAN GILL: Mr. Matthews, again, as a representative of the insurance industry, do you find that the

new FAIR Act is in any way-- Do you find that the payment process is in any way leading to a reduction in payments or in premiums by the consumer?

MR. MATTHEWS: Well, they're two separate things of course. Whether the actual PIP--

ASSEMBLYMAN GILL: Do you think it's working?

MR. MATTHEWS: Whether the actual PIP will lead to a reduction in premiums, it was created by the statute itself. Whether the long-term effect will be true, will be based upon the filings that are made in the coming year, in 1992. That will be the test of PIP savings under FAIRA.

ASSEMBLYMAN GILL: That will also go for the cap, am I correct? In other words, the cap ceiling hasn't caused any reduction in payments in premiums? That will be part of the same thing?

MR. MATTHEWS: It's attributable to this, yeah.

I apologize if my remarks to you aren't really fulfilling. As I say, I was sort of troubled as to exactly what you were driving at this morning, and the subject of the hearing.

ASSEMBLYMAN GILL: I think, maybe, after listening to the testimony you'll have a better flavor of what's been going on.

MR. MATTHEWS: I do want to reiterate to you one thing: Insurance regulation in New Jersey is very very strict. It's perhaps one of the strictest states in the nation. We have had cooperation from the Department of Insurance since FAIRA has come on the scene. The doors are open. We are able to discuss our problems with them, and I don't think that I sense, strongly, from the Department any attitude that we are not paying claims promptly or that we're overpaying fraudulent claims. Of course there are those examples out there, but I don't think that that's the universal statement that could be made.

ASSEMBLYMAN GILL: Mr. Matthews, we are very fortunate to have three representatives from the Department of Insurance with us this morning, and I'm going to listen to their testimony right after you're finished -- and my colleagues have any questions for you -- because I think that they can all shed a lot of light on this.

MR. MATTHEWS: I'll read the transcript, because I have an appointment in a half hour up in Roseland. I can't stay.

ASSEMBLYMAN GILL: Mr. Zecker, any questions of Mr. Matthews?

ASSEMBLYMAN ZECKER: No. Elmer, I'd just like to say, your testimony was excellent today. A brand-new suit-- Your hairline is excellent. I'm practicing my election year rhetoric here. (laughter)

I'm really surprised that your association hasn't done surveys on the PIP switch. I think the Department of Insurance -- and I don't know if they're going to testify to it today -- they've mailed out approximately 88 surveys. I think 25 companies have yet to respond, so the numbers are meaningless. They're only showing that 2% switched so far. I've done surveys among the major companies, both through agents and companies, and we find it to be in the area of 12% to 15% are switching over. So the majority of them are keeping their PIP carriers.

I think that information is going to be very important, and I'm surprised your organization doesn't have the button on that particular figure. Do you think they might?

MR. MATTHEWS: See, we have problems when you're talking about reduction of rates, as a trade association.

ASSEMBLYMAN ZECKER: No, I'm not talking about reduction of rates. I'm talking about the PIP switch, people that are switching from--

MR. MATTHEWS: You mean, just the bland statistic, whether people have done it or not?

ASSEMBLYMAN ZECKER: Yeah. What percentage are switching?

MR. MATTHEWS: I know some of the individual companies have indicated to me, in conversation, that it's very very low, less than 15%.

ASSEMBLYMAN ZECKER: Maybe at our next-- Maybe you could check back with your association and find out if any surveys have been taken in New Jersey. You don't know of any surveys?

MR. MATTHEWS: Not beyond what the Department is doing.

ASSEMBLYMAN ZECKER: Okay. So you're going to accept the numbers that the Department comes up with, when they come up with it?

MR. MATTHEWS: Well, if you'd like to I'll make some inquires of-- I'll do a cross section of my companies and see if I can't come up with some figure for you by the time of your next hearing. I'll do it by mail.

ASSEMBLYMAN ZECKER: Okay. I think at a future Committee hearing, which probably will be -- Mr. Chairman--

ASSEMBLYMAN GILL: Yes?

ASSEMBLYMAN ZECKER: --within a month?

ASSEMBLYMAN GILL: Yeah. We'll be meeting within a month, yes.

ASSEMBLYMAN ZECKER: Within a month. Those kind of numbers would be interesting to this Committee.

MR. MATTHEWS: I'll furnish that information to Ms. Mealing.

ASSEMBLYMAN ZECKER: Thank you.

MR. MATTHEWS: Thank you, gentlemen.

ASSEMBLYMAN GILL: Assemblyman Kenny?

ASSEMBLYMAN KENNY: Nothing.

ASSEMBLYMAN GILL: All right. We do have the Department of Insurance with us, and they've been sitting with us so patiently. We have Verice Mason, and Ronald Pott, and

Thomas Smith, from the Department of Insurance. Would you all care to come up together, or separately?

ASSEMBLYMAN ZECKER: To a standing ovation, Verice. Three people from the Department of Insurance.

ASSEMBLYMAN GILL: Which I think is a credit to the Department, especially in the summer months. It's not easy to get the people out.

ASSEMBLYMAN ZECKER: Michael Adubato would be so proud. (laughter)

ASSEMBLYMAN GILL: I think you've heard some of the concerns addressed here this morning, and of course we still have other people to testify, but I wanted to get the Department's input on this so that anyone else who wishes to add in may have a better overview of what's been going on.

ASSISTANT COMMISSIONER MASON: Thank you.

ASSEMBLYMAN GILL: Verice, will you be doing the--

ASSISTANT COMMISSIONER MASON: Yes, I will, thank you. I'm Verice Mason, Assistant Commissioner for Legislative and Regulatory Affairs at the New Jersey Department of Insurance.

ASSEMBLYMAN GILL: Will you please speak up, I don't think everyone can hear you? You have such a soft voice.

ASSISTANT COMMISSIONER MASON: I'm Verice Mason, Assistant Commissioner for Legislative and Regulatory Affairs at the New Jersey Department of Insurance. I have with me today, Ronald Pott, a Regulatory Officer on my staff, who is intimately familiar with the Medical Fee Schedule inasmuch as he did draft the regulation that you have before you, and I also have at my side Thomas Smith, Supervising Investigator with our Division of Enforcement and Consumer Protection. He's familiar with complaints that have come in with regard to any PIP claim issues.

We welcome this opportunity to talk to you today about the Medical Fee Schedule. This is the first opportunity that we've actually had since we've implemented the schedule,

pursuant to the FAIR Act. I'd just like to take you back a second to tell you what the Department has done in this regard.

As you know, the FAIR Act required that we promulgate a Fee Schedule, on a regional basis, for the reimbursement of health care providers providing services or equipment for medical expense benefits for which payment is required to be made under the PIP portion of automobile insurance policies. We first promulgated this Fee Schedule in July-- We first purposed it on July 16, 1990 of last year. At that time we were interested in obtaining comments from the public. We obtained over 90 comments from interested parties, and those comments resulted in a reproposal and actually an adoption of the regulation on November 26, 1990, via emergency regulation. Those regulations were effective on January 1, 1991.

Basically, what they did is, they established a Medical Fee Schedule, and we tried to implement the FAIR Act by requiring that the schedules incorporate the reasonable and prevailing fees of 75% of the practitioners within a region. We didn't set out special fees for specialty doctors. Instead, we subsumed that within our Fee Schedule ranges.

We also implemented the no balance billing requirement. Specifically, we established a series of fee schedules. Those schedules established different schedules for different kinds of practitioners -- those who provide medical services -- including: medical doctors, osteopathic physicians, medical laboratories, etc., a separate schedule at that time for chiropractors, a separate schedule for dentists, a separate schedule for providers of ambulance services, and a separate schedule for providers of durable medical equipment and prosthetic devises.

We also provided, lastly, a separate schedule for nurses and other providers of allied health professional services, including: registered nurses, physical therapist,

speech therapist, occupational therapist, licensed practical nurses, and home health agencies, some of which have testified before you today.

We then, after that, believe it or not, got more comments on the regulation, and as we get comments we realize that we do not have a corner on the market of what is the best way to approach this. When we did this, initially, we looked at a series of billings -- $500,000 just for medical services alone -- and for each of the various schedules we looked at billings made by doctors so that we could determine the 75th percentile.

When we adopted the emergency regulations, to be effective on February 19, 1991, we made some changes in the schedule already. We had originally separated out chiropractors. We subsequently merged their charges into the normal charges for medical services. So we already have made some changes in the Medical Fee Schedule. Since that time we have circulated the Medical Fee Schedule to all county medical societies, specialty societies, and we have been working with a number of provider organizations as well as insurers.

As you know, the Medical Fee Schedule requires that the Department conduct a biannual -- meaning twice a year -- review of the Medical Fee Schedule. In the first year, as you have said, this needs to be an ongoing process, principally because when you create a new baby, you have to keep refining it to make sure that it makes sense, and that it's not inconsistent, and that we're not killing some profession out there. That is not our aim.

The aim of this whole fee schedule, in accordance with the legislative intent, is to try and control costs. I do not think that means they're going to come down immediately. I think that the aim is to have a control factor over time.

The groups we have met with-- The first group, of course, was the Medical Society. We met with trauma surgeons,

rehabilitation facilities, chiropractors, physical therapists, nurses, insurers, and insure -- claims audit companies. I think our last meeting with one of these groups was probably the two insurer groups we met with on the 18th and 19th of July. So this really has been an ongoing process since we first put the reg out, back in November.

We have learned some things from this. There are some changes that will need to be made in this process, and we will be proposing a regulation recommending some changes to be taking effect January 1, 1992. We have already seen-- Some of the people have testified to some of the quirks of this particular -- the schedule. We have already found, for instance, that physical therapists have developed a problem because-- I cannot recall the person who spoke on this, maybe Mr. Lucianin. They described the problems that physical therapists are having with insurance companies charging modalities for different procedures. They will chop the bill down: after the first procedure, they pay 100%; the second procedure, they pay 50%; the third procedure and for subsequent procedures, they pay 25%.

When we first drafted this, we really meant for this kind of concept to really be applied to surgical procedures. Our language is a little bit unclear. We recognize that, so we have been meeting with physical therapists and the Therapy Association to determine how we might address this. They have come up with a proposal, which we are now reviewing. Their proposal, basically, recommends that we go to an hourly charge on our Fee Schedule. That is something we are looking at now. We anticipate that there may be some changes in how we go about this. So, to a certain extent, Mr. Lucianin -- Mr. Lucianin, I believe -- is accurate that we could not--

ASSEMBLYMAN GILL: Lucianin. (corrects pronunciation)

ASSISTANT COMMISSIONER MASON: Lucianin? Thank you.

We could not accurately explain to him, at the time he may have written the Department, what our position was, because this is an ongoing process, and we are trying to figure out what the bugs are.

We also anticipate that we will be updating the Durable Medical Equipment Schedule, because that schedule was based on the Medicare schedule, which has been updated since we proposed the regulation. So, we anticipate that there will be some changes in that area.

I might ask Ron Pott, of my staff, to go briefly through some of the issues that have been raised by some of the various organizations, just to give you an idea of the kinds of matters that have been coming before us. I think that would be quite enlightening. Ron?

R O N A L D W. P O T T: Thank you, Verice.

You have already heard testimony this morning referring to the particularly troublesome provision in our regulation having to do with multiple procedures. That paragraph on multiple procedures contains a number of sentences, all of which we consider to be important. One of them has to do with the 100/50/25% reduction formula that applies to multiple procedures. There is another sentence in there which defines body parts, for example, and there is also an important reference which -- actually, it is found all through the regulation -- emphasizes the importance of coming in, not necessarily at the upper limit that the Fee Schedule reflects in a given case, but at what is the usual, customary, and reasonable fee for that particular service. That principle is basic to the entire regulation. I was interested to note that I didn't hear any of the previous witnesses even refer to that factor.

Getting back to the multiple procedures situation, I would say that at least half of the inquiries we get at the Department relate to difficulties that that language produces,

particularly, for example, for physical therapists. We have addressed those concerns. I think I can say this much: Probably within the next week or two, we will be issuing a bulletin which will be intended to clarify a number of the problems which other witnesses have already indicated to you exist. That is in final draft form. It needs to be approved by the Commissioner before it is sent out, so to comment specifically on what that will accomplish, would probably be inappropriate at this time. But we are pretty confident that it will resolve a number of the problems that have been referred to this morning.

I think it is fair to say that the multiple procedures formula was-- Well, let me say this: When the entire multiple procedures language was first written, it was not necessarily intended to apply across-the-board equally to everyone. Particularly the body parts language was probably intended to apply to surgical and operational proceedings. And yet it has been, in some cases we think wrongly, applied to physical therapy type proceedings, as well.

ASSEMBLYMAN GILL: How do you mean, "wrongly applied," Mr. Pott?

MR. POTT: Well, I'm getting in over my head at this point, really, with very complicated information. Let me read to you, in draft form, the explanation which refers to the multiple procedures language, which, as I indicated, includes several sentences which all tend to operate together.

In the first sentence of the subsection, the Department interprets the phrase, "at the same time," to be synonymous with "at the same visit," or, "at the same operative session." Note that the reference to operative session appears in the very next sentence. The second reference to "at the same time" appears in the last sentence of the subsection. In this context, the phrase, "at the same time," is interpreted by the Department in a more literal sense to include services

performed simultaneously, since specific reference is also made to multiple services provided during the same medical visit.

One problem we have experienced is an interpretation that some people have taken -- and it was referred to earlier in testimony -- whereby interpreting the multiple procedures language to mean simultaneously, they would like to avoid altogether the application of the multiple procedures formula -- the 100/50/25% reduction. The Department does not agree with that interpretation. We hope to clarify the fact that reference to -- at the phrase "at the same time" not only can mean simultaneously, but more precisely means during the same office visit; during the same period of treatment, as far as that particular patient is concerned. Therefore, the multiple procedures formula can be appropriately applied in those cases.

Now, one problem we experienced with respect to the application of the multiple procedures formula-- There are various interpretations that have been given to this language by various insurers, and I am not necessarily suggesting that there is only one that is appropriate. In many cases, there may be more than one that is appropriate. This language -- the paragraph on multiple procedures -- is very flexible, and allows for a number of legitimate interpretations.

We at first, for example, in dealing with physical therapists-- Insurers had the problem where some offices would automatically increase their fees to the upper limits actually permitted by the schedule and reflected in the schedule. Those upper limits, of course, were intended to set up a whole range of limits that providers could charge, depending on what their usual, customary, and reasonable fee was. The result of charging at the upper limit was not only to increase that office's fees beyond the usual, customary, and reasonable level, but also to inflate a given billing of a given patient per visit, maybe by as much as $100 or $150. That is where the multiple procedures formula of 100/50/25% began to be applied

to that type of billing, in order to reduce it down to a point which was more akin to the usual, customary, and reasonable fee.

The Department has not disagreed with that interpretation, or with that procedure, because the result of that is to get that practitioner back to what is recognized as his usual, customary, and reasonable fee for those procedures. The best indication for that often is, what was that provider charging for those same services maybe a year ago, before the Medical Fee Schedule came into existence?

Now, there are other providers -- I think by far the majority of the providers -- who have taken a very honest, conscientious approach to the Medical Fee Schedule, and they have continued to bill much as they had before, certainly in terms of the total amount that they submit for services rendered to a given patient on a given day. They have also, when required to break down their services on a procedure or modality basis-- They have shown amounts which have come in well below the upper limits that are reflected for those procedures on the Fee Schedule.

Their frustration comes from the fact that the insurer, or the audit review claims company, will then take that billing, which probably should be paid at face value, and apply the multiple procedures formula to it, with the result that the provider is substantially undercut in terms of what his fair and reasonable fee should be. That is one of the problems which we hope our bulletin will resolve.

ASSEMBLYMAN GILL: That is the bulletin which will be coming out shortly, in a week or two?

MR. POTT: Will be coming out shortly, yes.

ASSISTANT COMMISSIONER MASON: Before we even take action to revise the regulation.

MR. POTT: The proposal, as it stands right now, as to that particular example, is to encourage insurers to apply the multiple procedures formula to the upper limits that are the

actual dollar amounts in the Fee Schedule for the particular procedures that are stated. If that total, as a result of application of the 100/50/25% to those upper limits-- If that total results in an amount that is more than the total of the particular billing, then it would have, in effect, no application. If, in fact, it is less than the amount of the individual billing that we happen to be talking about, then the billing would be reduced to reflect the multiple procedures reduction.

So, we feel that once we get the bulletin out and it is widely circulated -- and we intend to send it to all of the medical societies in New Jersey and all the specialty societies, as well as to all the insurers; give it as wide a circulation as possible -- we feel that the problems that are being experienced now will largely disappear. That certainly is our hope.

ASSISTANT COMMISSIONER MASON: Ron has raised a very important point that we have had to repeatedly explain to the parties with whom we are meeting. Before the Fee Schedules came into existence, medical bills were paid by insurance companies based on: First, a determination by the insurance companies that the bills were medically necessary; and then second, that they fell within the usual, customary, and reasonable fee of that particular provider.

What the Medical Fee Schedule did on top of that is-- They have set a maximum limit that is then compared against the usual, customary, and reasonable fee of that particular provider. Unfortunately, I think some providers have thought that the Medical Fee Schedule is actually the amount. The Medical Fee Schedule is the ceiling. If your UCR is lower than that, that is what the insurance company should be paying. I think that has probably been the source of some concern. Based on what I have heard today, and based on our conversations with a number of providers, that is something that definitely needs

clarification. To a certain extent, if that were more readily understandable, then people would understand why there is a delay sometimes in their claim payments. If, in fact, the individual provider submitting the bill is submitting a bill that is not in line with his UCR rate, that will cause the insurance companies, undoubtedly, because of the emphasis that the Department and the Legislature and this administration has placed on ferreting out fraud-- They will be looking at that to find out if there is a problem.

Now surely there will, over time, be what we call "Fee Schedule creep" within our Department, because UCRs will go up over time. There is no question about that. But if after the Fee Schedule all of a sudden a provider that used to charge -- I don't know -- $22 for a visit is now charging $44 for a visit because the Fee Schedule says $44 even though that particular provider has charged $22-- When they put in their $44 fee, an insurer is probably going to challenge it, want to see records, and many of the insurers that we met with said that they have UCR information on doctors. I guess some of them have admitted that they do not. It may be a new doctor to the region. It may be someone they haven't dealt with before. I don't know what the particulars are. That is something you might want to ask the insurance companies. But that causes them, at differing times, to conduct audits or come in and look at claim records and that kind of thing.

We do have certain procedural requirements that insurance companies are required to meet in terms of time frame. I think if they go over a certain amount of days-- They have 60 days. It used to be 30 days. The FAIR Act has given them that additional 30 days to conduct appropriate investigations where necessary. But after they go beyond that, they are supposed to give notice to the party of the delay. The party is entitled to interest on the claim payment. We have tried to resolve those kinds of issues.

We don't have a perfect animal here, but I think we are getting to the point where it will be better than it was when it first started. I can't stress enough that whenever you start a new system, there are going to be glitches in the system. What we are trying to do is educate ourselves and, of course, an undertaking like this is also an education to the Department. We are here to learn as much as we can about this process also. We think we have learned a lot since January 1, or November 26, when we first put this out, but there will legitimately be some changes, as Ron has said, some clarifications in certain instances, and in other instances, just a general update of the schedule. We anticipate that general update will be proposed soon, to be implemented and effective on July 1 -- January 1, 1992.

ASSEMBLYMAN GILL: Verice, I'm hoping that the Department is taking into consideration some of the problems causing, say, the consumer -- credit problems because of the delays in getting some of these things paid, where we are really putting some people's lives at -- I can't say "at stake," but ruining their entire credit rating and putting them under excessive strain and jeopardy for, I think, a problem that we can resolve at this point. I'm sure you are addressing this, but--

ASSISTANT COMMISSIONER MASON: That is a major concern of ours. Now, we are encouraging people to file information with the Department, so we can track the companies that are basically screwing up.

ASSEMBLYMAN GILL: Yes.

ASSISTANT COMMISSIONER MASON: Ron Pott, on my staff, is taking phone calls every day from providers and insurance companies to explain the actual implementation of the Fee Schedule, but the actual complaints are handled by Enforcement and Consumer Protection, and that is Tom's duty. If they involve instances of fraud, the insurance companies are

required to submit that information to the Fraud Bureau. So, we are beginning to track this on a number of fronts. I do not know--

ASSEMBLYMAN GILL: Just to interrupt you for one second-- I know you are doing this, and I am happy to hear that you are. I hear mention of the insurance companies -- everyone but the billing companies. Are you also addressing their involvement in this entire process, because some of the problems appear to be stemming, or originating from the billing procedures by these companies?

MR. POTT: By the providers.

ASSISTANT COMMISSIONER MASON: By the providers.

ASSEMBLYMAN GILL: The providers and their billing companies--

ASSISTANT COMMISSIONER MASON: Are you talking about the audit companies that they--

ASSEMBLYMAN GILL: --their computer companies.

ASSISTANT COMMISSIONER MASON: No. I'm not--

MR. POTT: The computer companies represent the insurers.

ASSEMBLYMAN GILL: Right.

MR. POTT: Redo billings for the insurers.

ASSEMBLYMAN GILL: Right.

MR. POTT: We have met with them. They were included in the meetings we had with the insurers back in July.

ASSEMBLYMAN GILL: Because that appears to be part of the problem here. If you have met with them, I am satisfied with that.

MR. POTT: They are the first to agree that because of the fact that we now have a Medical Fee Schedule and it's new and people are getting used to it, and it is subject to varying interpretations -- or it has been up until now -- that they have experienced delay that is even greater than what they were experiencing before. I think partly that is a natural result

of a new regulation which people are getting used to. I think one of the effects of solving key problems which we recognize -- which we referred to earlier -- will be to lessen that delay. We certainly hope so.

ASSISTANT COMMISSIONER MASON: Based on our meetings with them, the key issue seems to be this multiple procedures issue. Once there is an understanding of that, we're hoping that at least the delay, if there is a delay in claims pursuant to audits on that issue, will be somewhat resolved. We're hoping.

Now, if you are talking about computer companies that are serving as insurance companies for the residual market, that is a different issue. You are talking about individual insurance companies. That, I really can't speak to. We're talking about the claims audit functions that are serving insurance companies; that are auditing these particular medical bills.

ASSEMBLYMAN GILL: Okay, Verice. Thank you.

ASSISTANT COMMISSIONER MASON: All right. You also asked a question about just the number of people taking the PIP switch, as Elmer Matthews referred to that.

ASSEMBLYMAN GILL: Yes, I did ask that question before. Do you have any numbers on that?

ASSISTANT COMMISSIONER MASON: Basically I was going to say the same thing that Assemblyman Zecker said, which is: We do require, by regulation, that insurance companies provide us with information twice a year -- the most recent time being June 30 -- as to the options that consumers are taking, and we have not gotten a very good response to this. I do not know why. That is something we are checking into. So, we don't have a good number.

The other thing, though, that you should be alerted to, is that these changes will be taking place as policies expire, so many people, you know, may not have made this

changeover yet because their policies are just beginning to expire.

ASSEMBLYMAN GILL: Verice, can State employees opt for the PIP switch? Do they have that option?

T H O M A S G. S M I T H: Yes.

ASSISTANT COMMISSIONER MASON: Yes, I believe--

ASSEMBLYMAN GILL: Yes, they do? Other public employees also? In other words, this is inclusive of all public employees? They have that option?

ASSISTANT COMMISSIONER MASON: I think State agencies. The reason I am equivocating is, I am not sure about quasi-public authorities like the Turnpike Authority. Those I am not sure of. I just don't know off the top of my head.

ASSEMBLYMAN GILL: But State agencies--

ASSISTANT COMMISSIONER MASON: But State agencies and public employees which are covered by the State Health Benefits Program-- The answer to that is, "Yes."

ASSEMBLYMAN GILL: Since we have this $250,000 cap, do you have any idea of the amount of people involved in auto accidents who have exceeded that cap? Do we have any data on that at all?

ASSISTANT COMMISSIONER MASON: I don't have good data right now. That is something I could get back to the Committee on, and could provide you with that data, probably.

ASSEMBLYMAN GILL: I would like that for our next meeting, if you can. Also, if you could give me some idea of what the cap saves in terms of insurance premiums---

ASSISTANT COMMISSIONER MASON: All right.

ASSEMBLYMAN GILL: And also tell me, does that cap apply only to each-- Does it apply to each individual accident, or is that a cap that applies to an individual's record and accidents, or both?

ASSISTANT COMMISSIONER MASON: Per person, per accident.

ASSEMBLYMAN GILL: Per person, per accident. Okay.

Now, are we getting many complaints with the schedule as it is at present?

ASSISTANT COMMISSIONER MASON: The Medical Fee Schedule?

ASSEMBLYMAN GILL: Yes.

ASSISTANT COMMISSIONER MASON: They are coming at different points. Maybe Ron can answer that. He takes the phone calls on that, and the letters.

MR. POTT: What I am finding -- and I think this, too, is a natural result of a new regulation-- As time goes on, we are getting more instances where communication between the providers' offices and insurers about given situations are breaking down. We're finding that we are sending out more complaint forms the Department has for such things, let's say in the past month, than we were a month prior to that. I think that will tend to increase for a period of time, and then perhaps level off.

But generally speaking, I have to say as a result of talking literally to hundreds of providers' offices and, to a lesser extent, insurers, that things have worked out pretty well so far, and that most-- A large percentage of cases have been resolved on the basis of communication--

ASSISTANT COMMISSIONER MASON: From the Department trying to explain. Now, Ron has been speaking primarily to providers. I mean, those are the kinds of telephone calls that we have been taking. Tom's unit has been taking complaints from consumers, so maybe he could speak on that.

MR. SMITH: Yes, as far as the Medical Fee Schedule itself. The number of complaints-- I am personally handling them as they come in. It is a very small number. I would say you could count them on both hands. I think it is partly due to Ron's efforts in communicating with the providers. See, there was a misinterpretation, or a misunderstanding about what

the multiple procedures was all about, and as we address each provider and clarify it to them, the resulting complaints that we receive from the public diminishes.

ASSISTANT COMMISSIONER MASON: But I also believe that it would not generally be the consumers who would have the concern, because there is the "no balance" billing concept in the Medical Fee Schedule. It will probably be the providers who will be concerned about delay in payment or possibly not appropriate payment, those kinds of issues.

MR. SMITH: Now, one thing I would like to interject, if I may-- Earlier, we heard testimony whereby the only recourse that individual had was to seek legal advice to get claims paid. One of the functions of the Department in the Enforcement and Consumer Protection area is to field these types of complaints and to track the companies that have these types of problems. Once we can track a certain company that is not handling things in a proper manner, we can then step in to correct that situation. But without that feedback coming in from the public, vis-a-vis--

ASSEMBLYMAN GILL: You are exactly right.

MR. SMITH: --the complaint, you know, it is unfortunate--

ASSEMBLYMAN GILL: Tell me, in your opinion, does this Medical Fee Schedule-- Is this, say, a move toward socialized medicine in any way?

MR. POTT: Is this what?

ASSEMBLYMAN GILL: A move toward socialized medicine?

ASSISTANT COMMISSIONER MASON: I don't think I would say so, principally because the basis for this is still the usual, customary, and reasonable fee of the provider, and that is an individual fee. It is assumed that they don't all talk to each other and set the same fee, for competitive reasons I would assume. So, when you consider that we are taking into account the UCRs of all the providers within the region, and

merely setting it at a particular percentile, our aim is more, not socialized medicine, as it is controlling costs.

MR. POTT: There has not been widespread concern from the providers concerning where the upper levels were set. So, by and large, they are happy with those upper limits. That is the impression that we have gotten anyway.

ASSEMBLYMAN GILL: Mr. Kenny -- Assemblyman Kenny?

ASSEMBLYMAN KENNY: No questions, no.

ASSEMBLYMAN GILL: Assemblyman Zecker?

ASSEMBLYMAN ZECKER: Verice, just a couple of comments: I would like to compliment the Department of Insurance, and I think you just hit it on the head. I get many complaints and I am in constant contact. People don't have to get lawyers to alleviate a lot of the problems.

ASSISTANT COMMISSIONER MASON: Right.

ASSEMBLYMAN ZECKER: Sometimes the questions aren't answered as quickly as the constituent would want, but ultimately they are all answered, sometimes not even to the person's satisfaction. So, I compliment the Department of Insurance in their responsiveness to the complaints that at least I forward them, which are numerous.

ASSISTANT COMMISSIONER MASON: Thank you.

ASSEMBLYMAN ZECKER: Verice, I checked with Blue Cross/Blue Shield, looking to see on the PIP switch if they had any numbers yet. Blue Cross/Blue Shield -- and Rick Lloyd was here; I guess he left-- He commented that they do not have any measurable statistics even with Blue Cross/Blue Shield. They haven't seen any huge switch over to the -- you know, to a company like Blue Cross/Blue Shield. They haven't put anything in writing. I was wondering if the Department of Insurance has done any monitoring with Blue Cross/Blue Shield to see if there is any tremendous, you know, jump over from PIP to, let's say, the Blues?

Do you think you could do that in the next 30 days? You know, they are reluctant to put anything in writing to me, which is understandable. I am only one legislator. I would tend to think that your inquiry might result in a written response.

The other thing is -- and you have heard testimony from Mr. Lucianin--

ASSISTANT COMMISSIONER MASON: Do you mean to all commercial insurers, or just to the Blues?

ASSEMBLYMAN ZECKER: Well, the Blues, and all of them. I think if you hit the majors, you're getting the general-- You don't have to check with every health provider. I think that if you get a good cross section, you are going to get some number.

The other thing is -- and you heard testimony by Mr. Lucianin, at least answering my question -- there are many insurance companies that act responsibly and pay their bills quickly, and I think sometimes legislatively we take action that, in fact, punishes the companies that are doing business the right way; you know, that are being good to the consumers and the providers.

I know you have statistics down there -- maybe not as much as you would like -- as to who exactly, or where exactly are the problems arising from. I think what you are going to find is that computer companies have caused a great deal of the problems that we see today. I know some companies use a computer company as their back room operation. Other companies have on-line-- You know, they handle all of their own claims. So I wonder if there are any kinds of numbers that you could come back to this Committee with just relating to PIP claims, to show specifically where the problems are coming from? You know, with the multiple procedures billing, you said that that problem will be clarified with your memo and probably eliminate a lot of the problems.

Generally, the calls that I get are legitimate claims, because I-- If I smell something, I mean, I have a tendency to, you know, not put as much effort into it. But I get a lot of constituents with legitimate complaints, and I forward them to you. Many times, I just make one phone call and the bill is paid, because I tell them what I am going to do next. I am going to call in the Department of Insurance and ask for an audit of your company.

I think you will find that a lot of the computer companies, whether it is from inexperience-- I don't know what the reasons are, but that is where the generation of complaints seems to be. And by the way, there are some good computer companies that are handling-- I am not out to even penalize the good ones, but you will find that there are just going to be a few bad ones. I am interested in seeing what your numbers produce in terms of complaints. I assume you take action and go out to visit these people. Maybe what this Committee could do is, through finding out, you know, what companies are doing things the right way, you know, find out what procedures they are using, and maybe implement those legislatively into some direction for the Department of Insurance, if you know what I am saying.

ASSISTANT COMMISSIONER MASON: Yes, I do. When you say "computer firms," do you mean the audit firms that insurance companies hire?

ASSEMBLYMAN GILL: No, the billing companies.

ASSISTANT COMMISSIONER MASON: The actual billing companies.

ASSEMBLYMAN GILL: That's what I spoke about before.

ASSEMBLYMAN ZECKER: I am not going to mention any names, Verice, but it's always the same names that come up in the majority of complaints I get.

ASSISTANT COMMISSIONER MASON: Okay.

ASSEMBLYMAN GILL: That seems to be the problem I've been hearing also, Assemblyman Zecker. You're on the money with that; there's no question.

ASSEMBLYMAN ZECKER: When Mr. Lucianin-- I didn't check with any numbers, but you heard what he said. In dealing, like, with the Prudentials and the Allstates and the State Farms, et al, you know, he is talking about 80%, which is, you know, not great, but that is something that could be worked on. But any time providers have to deal with a computer company, that is the beginning of the end. And by the way, it goes into body shops, too. I think we all know that, but that is not for this Subcommittee to address.

The numbers you could come back with are probably going to be more meaningful than the numbers that I could get. It is basically looking over the complaints you have down in Trenton and identifying to this Subcommittee, you know, who the people are who are creating the majority of the problems, unless that is confidential information; then we will have to subpoena it from you. Is it confidential information?

ASSISTANT COMMISSIONER MASON: It is until the complaint is closed. Not every complaint that is filed is a real complaint, so when the complaint is closed, it is public.

ASSEMBLYMAN ZECKER: Okay.

ASSISTANT COMMISSIONER MASON: Before then, when it is ongoing, it is considered to be confidential.

ASSEMBLYMAN ZECKER: We're looking for, basically, if there is a source of this problem that just takes it into--

ASSISTANT COMMISSIONER MASON: Right, I get you.

ASSEMBLYMAN ZECKER: That is what we want to know, and then maybe we will look into why they have problems. I think many of the computer companies went into this business thinking, "Oh, this is going to be easy," and then they found out it wasn't so easy.

Just as a point of clarification, a previous witness testified that artificial insemination is covered under the Fee Schedule. My aide and I have looked through this list numerous times, and we cannot find that, but there are a couple of things like, DILAT URET STRICT, W/SOUND, MALE, you know, so we just--

ASSISTANT COMMISSIONER MASON: Yes. We chuckled when he said that, but there is actually a method to that madness. Maybe Ron can explain it to you.

No, it is not in the schedule now. It was originally.

ASSEMBLYMAN ZECKER: It was this young lady who wanted the information. (laughter) She was embarrassed to ask for it, so I am just--

MS. MEALING (Committee aide): No way.

MR. SMITH: She didn't want to say anything, so she got you to say it.

ASSISTANT COMMISSIONER MASON: No, seriously--

MR. POTT: Let me just explain that when we made certain changes to the physicians' schedule back in February -- effective February 19 -- the procedure having to do with artificial insemination was deleted from the schedule at that point. But since then, I have been told by at least one physician that having that on the Medical Fee Schedule relative to auto accident injuries--

ASSEMBLYMAN ZECKER: Was legitimate.

MR. POTT: --was not a bad idea.

ASSEMBLYMAN ZECKER: No, it was legitimate.

MR. POTT: Right, exactly.

ASSEMBLYMAN ZECKER: You don't know how many claims we used to get where the males would say that they couldn't perform anymore. You know that.

MR. POTT: Right, or where they still wanted to have children when that would be necessary in order to do it, which

makes it a very legitimate-- It might find its way back on the schedule.

ASSEMBLYMAN ZECKER: Well, it was said with tongue in cheek, but--

MR. POTT: That's right.

ASSEMBLYMAN ZECKER: We just wanted to see where it was in the Fee Schedule. It was deleted from the Fee Schedule that was presented to this Committee. Is that what you're saying?

MR. POTT: It was deleted, and it is not on the schedule now. But, you know--

ASSEMBLYMAN ZECKER: My staffer gets perplexed when he can't find information.

MR. POTT: That's in--

ASSISTANT COMMISSIONER MASON: It was originally for quadriplegics who wanted to have children, as we understand it.

MR. POTT: That raises another question.

ASSEMBLYMAN ZECKER: I don't want to dwell on that for a half hour.

MR. POTT: Well, I will leave that.

ASSEMBLYMAN ZECKER: Do you know the information this Committee would like back, though, in order to, you know, possibly take some action in the future? We want to know specifically, you know, is this a narrow area of complaints? Are all the complaints coming from certain areas? Then we may address legislation to that certain area, rather than punish everybody, and make your life more miserable, because the more laws we pass, the more things you are going to have to enforce.

ASSISTANT COMMISSIONER MASON: That's true. I just want to add one last thing, and that is: I was surprised to find that many of the providers that have written us have requested that we increase the number of CPT codes, or basically things on the Medical Fee Schedule. That is

something that we are looking at now and will probably do in our next proposal.

There seems to be a concern that the more things you have on the schedule, the more things will be paid more easily by insurance companies. That is not necessarily our aim, but if we missed a lot of procedures, that becomes our concern. So, we are looking at that.

ASSEMBLYMAN GILL: What happens if an item is not on the Fee Schedule?

ASSISTANT COMMISSIONER MASON: If an item is not on the Fee Schedule, the insurance company is supposed to: First, look at medical necessity, as they do anytime; and second, they would pay -- once they find it is medically necessary -- the usual, customary, and reasonable fee of that particular provider.

ASSEMBLYMAN GILL: Verice, one of the prior witnesses-- I am going to try to get this-- We are running a little late already, but I have-- Something is on my mind. One of the previous witnesses testified that they want to be paid up front. Is that legal?

ASSISTANT COMMISSIONER MASON: There is nothing that prohibits that in our Fee Schedule.

ASSEMBLYMAN GILL: In other words, pay me first for the operation, and then we go after the insurance company. I find that a very bizarre way to operate, for some reason or other.

MR. SMITH: See, we don't regulate insurance-- Excuse me. We regulate insurance companies, and there is nothing in the insurance statutes which prohibits, you know, or allows us to regulate what a doctor does.

ASSEMBLYMAN GILL: What happens if the person doesn't have the money? Or, what happens if the insurance-- I mean, there are a lot of complications that could arise from this.

If a doctor is asking for payment up front before he performs an operation, or performs surgery, whatever it may be, I find that a very strange way to go in medical practice, and that has been testified to this morning.

ASSISTANT COMMISSIONER MASON: Yes.

MR. POTT: There is one point at which a provider's office that takes up that practice of requiring payment up front is going to run into trouble sooner or later, and that is with actually the balance billing prohibition that appears not only in our regulation, but in the FAIR Act. The very first phrase says: "No health care provider may demand or request any payment from any person in excess of those permitted by the Medical Fee Schedules." And right away you are going to get into trouble -- sooner or later -- with that provision.

ASSEMBLYMAN GILL: I want to thank you for coming down and testifying. We will be having another meeting on this, and I would appreciate it if the Department of Insurance could send this august body once again to help us to clarify some of our problems.

ASSISTANT COMMISSIONER MASON: Certainly, and we will try to get back to you with some of this information. Thank you very much.

ASSEMBLYMAN GILL: Thank you very much.

ASSEMBLYMAN ZECKER: Thank you.

ASSEMBLYMAN GILL: We have with us Robert Levinson from the Association of Trial Lawyers, and Gerry Baker. Good afternoon, gentlemen.

R O B E R T R. L E V I N S O N, ESQ.: Good afternoon, folks.

ASSEMBLYMAN GILL: Sorry we're running a little late, but there is a lot of testimony here.

MR. LEVINSON: That's okay. I'm Robert Levinson. I am President of the Association of Trial Lawyers. To my right

is Gerry Baker, who is our person in charge of automobile insurance, and also my Cochairman in legislation.

Before I turn this testimony over to him, I would just like to point out a couple of things to this Committee. I guess I have practiced now for around 17 years, and I have only practiced in personal injury work. Over the last two years, the number of PIP problems that have developed in my office has been voluminous. We have problems with deductibles; we have problems with copay; we have problems with whether or not there is any health care coverage for those deductibles and for those copays. We have problems with the insurance companies sending people for PIP exams and cutting them off improperly. We have problems with the insurance companies -- and when I say "insurance companies," I mean insurance companies, not just the computer companies -- not making payments properly in a timely fashion. And I have to tell you, not one of those cases has been because there has been a fraud investigation.

In 17 years, specifically in recent time, I have not lost one of those PIP cases, and to be honest with you, I know very few attorneys who have.

ASSEMBLYMAN GILL: Is it a good source of income?

MR. LEVINSON: Well, no. To be honest with you, it is a source of income that I would rather not have. It is not worth my aggravation, but more importantly, it is not worth what I see my clients going through, because they are the ones who are affected. Yes, their credit is affected. But even more importantly, they go through an awful lot of emotional distress at a bad time for them.

I'll give you an example: Right now I have a woman who needs an MRI done. She hasn't met her deductible. That means of an $800 bill for the MRI, she has to come up with $500, and she has no way to come up with that $500. There is very serious evidence that she, in fact, needs that MRI, and

the distress she is experiencing is terrible, and I see no justification for it.

I would much rather see these claims processed in an orderly fashion, than for me to have to get involved. My average fee in one of these cases is $750, give or take a few dollars here and there. The cost that the insurance companies then have to turn around and reimburse me for, is another $200. After all is said and done, basically you are talking about another $1000 that is being added on to what they would otherwise have to pay, and I can't see how that is helping insurance rates in this particular State.

ASSEMBLYMAN GILL: And you say you haven't lost one of these cases in 17 years?

MR. LEVINSON: In 17 years, I have lost one.

ASSEMBLYMAN GILL: You've lost one in 17 years. Was that your first case?

MR. LEVINSON: No, it was not my first case. As a matter of fact, it was a case that probably should have been lost. The doctor was at fault in terms of his billing.

ASSEMBLYMAN GILL: Now, tell me: How many of these cases do you do a year? Do you do 1, 10, 20, 50, 100?

MR. LEVINSON: It used to be that I would have maybe 10 a year that I would have to deal with. I am probably filing, on an average this year, two PIP claims a week.

ASSEMBLYMAN GILL: That's over 100 cases.

MR. LEVINSON: It's an awful lot, and I win them all. I'll give you an example: Right now I have a situation with New Jersey Manufacturers where they are refusing to pay a bill based upon an examining doctor's report. The examining doctor's report is based on a faulty supposition. It is based on the supposition that my client wasn't treated for a certain condition for over a year after the accident. That wasn't true. The client was. I submitted to New Jersey Manufacturers proof that the client was, and they still wouldn't pay the

bill. So now we are in arbitration, and New Jersey Manufacturers is going to have to pay that bill. They are going to have to pay me a fee, and they are going to have to pay the costs, and the situation is really getting out of control.

Something has to be done about it, not so much because of the chaos that it creates in the doctors' offices, but because of what it does to the people of New Jersey. One of the best pieces of testimony that I heard here this morning was: "This is a problem that is a problem for all of us, and we should try to deal with it as all of us." Even though this is the FAIR Act, this is just a modification, slightly, of what was initially passed into law by Governor Kean. I have to tell you-- I testified before Assemblyman Zecker before, and I have to tell you, I was there when that law came into effect. That was a law that was designed to lessen insurance companies' problems and, from my perspective right now, that is being-- I don't even know that it is lessening their problems, but it is being done on the backs of the consumers, the people in this State, and that just isn't fair. We have to come to a solution for everyone.

ASSEMBLYMAN GILL: Mr. Levinson, don't these costs normally get passed onto the consumer and eventually raise insurance rates for everyone? Is that not--

MR. LEVINSON: Not if it is done in an orderly process. If you don't have an insurance company, or insurance companies, having to pay out much more money than they otherwise would have if these claims were properly handled, then there would be nothing to pass on. There would be no problem.

ASSEMBLYMAN GILL: But at present, they are being passed on. They have to be passed on. Somebody has to pay for them.

MR. LEVINSON: Somebody has to pay for them; somebody does, so we all end up paying for them in many different ways -- in many different ways. In terms of the cap of $250,000, in terms of the deductibles and the copays, if this is really going to be a consumer-oriented State -- and I think it should be -- if a person wants to have more than $250,000 in coverage, he should be allowed to purchase that. If a person doesn't want to have the deductible, if a person doesn't want to have a copay, he should be allowed to contract otherwise.

I would also indicate to you that I found it very interesting that a doctor testified here this morning and told you that neither he nor his family could understand the questionnaire that comes to them every year from the Insurance Department. I have to tell you that I am a lawyer. I may not be a "Philadelphia lawyer," I may not have graduated from Harvard Law School, but I have a difficult time understanding that questionnaire, and--

ASSEMBLYMAN ZECKER: As do I.

ASSEMBLYMAN GILL: I think that was a very valid point.

MR. LEVINSON: --despite many reassurances that we have had from the Insurance Department that that questionnaire would be modified, it never has been. I mean, just a simple thing like, "No, I want the 'no threshold'"-- What does that mean: "No, I want the 'no threshold'"? I mean, that is a questionnaire that was designed to have people choose the lawsuit or the verbal threshold, or whatever-- The lawsuit threshold is even misleading. The lawsuit threshold would seem to mean to somebody -- if it were me -- "Well, a lawsuit. That means I can sue." Well, it means that it becomes much more difficult to sue. That is another thing that has to -- that I think is appropriate for the Subcommittee to look into.

But now I would like to turn this testimony over to Gerry Baker, my expert.

ASSEMBLYMAN GILL: Thank you, Mr. Levinson.

ASSEMBLYMAN KENNY: Mr. Chairman, I have a question.

ASSEMBLYMAN GILL: Yes, Mr. Kenny?

ASSEMBLYMAN KENNY: We heard testimony from the Department of Insurance that they are set up to investigate the types of problems that you bring suit on. Is that correct? If a client comes into your office-- If one of your clients comes in and he has this problem with having his bills paid -- his or her bills paid -- do you have that client call the Department of Insurance, the group that is set up to investigate these problems?

MR. LEVINSON: I have had that done on occasion, without any satisfactory result to the client. Quite frankly, I don't do that anymore. I find it to be an exercise in futility, and I have my client's credit to be concerned about. I have to be concerned about getting bills paid for him at a time when he needs it, and I just, at this point, go about and do what I have to do. At this point, I think I am the best vehicle to do it for them.

ASSEMBLYMAN KENNY: So, you do not feel that the Department of Insurance is equipped to produce results for consumers to have their bills paid?

MR. LEVINSON: I don't think they are equipped to do that. I don't think they have the type of staff that would be necessary to effectively do that. That is not to say that they couldn't if they did have the staff. But I think we are all familiar with the budgetary problems that are in existence in the State of New Jersey, and I think one of the departments that has felt that particular problem has been this Department. They have an overwhelming job to do with the staff they have. I just don't think they can do it.

ASSEMBLYMAN KENNY: Your PIP suits are resolved through arbitration?

MR. LEVINSON: I try to. One of the problems with the PIP arbitration process, is that that only deals with the bills

that are in existence at the time that I go into arbitration. So, if bills come along afterwards, I very well likely will have to go back into that same procedure again. I still choose to do it that way because I find it to be more expeditious than going into court, particularly with the backlogs we face in court right now. I also find it to be much less expensive for the client in the long term. They don't have to bring doctors in to testify, and very often, you know, unless the insurance company asks for it -- I know I usually don't -- we don't even have to have an oral hearing. We can do it on the papers.

ASSEMBLYMAN KENNY: If it were possible to establish in the Department of Insurance a way to resolve this problem of payment of bills for your clients, do you think that would be preferable to pursuing the legal remedies that you are forced to take, now?

MR. LEVINSON: I would always prefer the most expeditious way to resolve their problems, particularly at this time in their lives. And very often-- You know, you can talk about those people who may make a living by trying to be hurt. That may diminish the intensity and seriousness of the problem.

I have a young man who, two weeks ago, was operated on to remove rods from his legs after very bad leg fractures. When Assemblyman Zecker talked about hearings he had two years ago dealing with auto body problems, I, in fact, appeared and testified at a hearing about this young man and the Warner Insurance Company. His problems continue to linger on with Warner Insurance Company. In fact, his surgeon would not operate on him until his surgeon could get confirmation from me that Warner Insurance Company was committed to paying his bill. That is how long it took to get that surgeon's bill paid. We are not talking about muscle injury here; we are talking about very serious fractures, and a very serious situation for a young man, who right now is only 20 years old.

What I had to do to even get a return call from Warner Insurance Company was astronomical. I had a secretary who basically spent the better part of two days trying to get to somebody at Warner Insurance Company. When Dr. Weierman testified this morning about what the young lady seated next to him had to go through, I could understand, because I have people on my staff who tear their hair out with some of these companies.

ASSEMBLYMAN KENNY: Mr. Chairman?

ASSEMBLYMAN GILL: Yes, Mr. Kenny?

ASSEMBLYMAN KENNY: Through you, I would like to request that at our next hearing the Department expand upon its ability to have these payments made to the consumers. We heard some testimony earlier from one of the gentlemen from the Department, who has left already. He said that this was the way people should pursue these payments. So I would like to hear further testimony at the next hearing on that issue.

ASSEMBLYMAN GILL: I think that is a good suggestion, Assemblyman. Thank you.

ASSEMBLYMAN KENNY: Thank you.

ASSEMBLYMAN ZECKER: Excuse me, Mr. Chairman. Before Mr. Baker begins, we thought this would be over about 12:30. I'm sorry, but I had to make an unbreakable appointment. Actually, my son and I are going to the Giants' training camp this afternoon. He'll kill me if I don't show up. (laughter)

Gerry, you know I agree with 92.5% of what you say. I will read your testimony with great interest, but I didn't want you to think that I was running out on you. My staffer will fill me in on everything you have to say.

G E R A L D H. B A K E R, ESQ.: I am going to work on the other 7.5% while you are gone.

ASSEMBLYMAN ZECKER: Okay.

ASSEMBLYMAN GILL: Assemblyman Zecker, thank you.

ASSEMBLYMAN ZECKER: I apologize for having to leave. I didn't want you to think that I was walking out on you.

MR. LEVINSON: I just want to know if Pepper Johnson has come back?

ASSEMBLYMAN ZECKER: I don't know. We are going to find out this afternoon. My son would kill me if I didn't show up.

ASSEMBLYMAN GILL: Thank you, Assemblyman.

MR. BAKER: I, as some of the other people, didn't receive the notification until about 4:30 this afternoon (sic), and I wanted to try to figure out what you meant by, "the PIP statute as it relates to the medical claims process." Listening to the other people testify, I have tried to map out a couple of specific items. As I talk about them, I want to gear them to the two consumer issues which I think you have asked questions about, if I can glean it from the various questions you have asked.

Consumer question number one is: How do consumers get access to quality medical care, and also necessary medical care? Probably those are two different subparts. Quality medical care and necessary medical care are not necessarily the same thing. Secondly, how do consumers get their bills paid without creating credit problems for them? I think those are consumer issues, and when I say, "consumer issues" -- and I testify before governmental committees -- I guess that means constituent issues, and that means what people vote on. It may also mean what people get upset about at some later date when they find out they are not properly being taken care of. That's, I guess, what "consumer issues" means.

What we have to look at as attorneys is what happens to our clients. Our clients are the accident victims that you are trying to compensate. We come before you as the people who speak for your constituents who are injured in accidents. Now, with that in mind, one of the problems that I can perceive with

the medical claims process, and what kind of legislation is necessary to resolve some of them-- I've heard very few people, maybe nobody, talk about legislation, and I guess that's what you're here for.

1) Caps. You put into the law a cap of $250,000 on the payment of medical bills. As an organization representing accident victims, we have always taken the position that caps on innocent accident victims is absolutely the wrong way to go. It is totally unjustifiable to say to someone who may be only part of the 6% of the people in the State of New Jersey who have catastrophic injuries that, "Your injuries are so severe that we're not going to take care of you." But what happens to the head trauma person, the quadriplegic, the person who's in a vegetative state, after they run out of their $250,000 worth of coverage? How in the world can our legislators have any conscience to say to these people, "We're capping you with $250,000 because we want to save some more profits for the insurance industry, because we want to reduce the cost of automobile insurance on your backs"? Totally unjustifiable. So, as far as I'm concerned, absolutely, legislation should be adopted to remove that $250,000 cap.

Elmer Matthews was not telling you the whole story when he comes here and says, "Well, you are the ones who gave us the system, and we have to live with it." That's bull. The insurance companies testified before you, and I heard them. They wanted caps. They wanted limitations on PIP. They wanted health insurance primary. They wanted Medical Fee Schedules. That's not the part of the system that you foisted upon them; that's what they want. And I think that's wrong. Now, if you can't go the whole way and take off the cap, there are at least two different things you can do as responsible legislators to relieve some of the problem.

Number one is to make a mandatory offer of unlimited PIP. The statute as it reads today says, "Insurers may -- may

also make available to named insureds coverage under section 4 at higher limits--" and so forth and so on. That is outrageous. It should say, "Must offer to the named insureds." It should be a mandatory offer. Now, if you don't want to buy it, that's fine; but if we're going to protect the consumers in this State, then we must make that coverage available to them -- at a price. I don't have any problem with the insurance companies coming up with a fair price. Let them submit their rate applications and let them charge us for it, but I want to have the right to purchase unlimited PIP in this State. I've had it for the last 20 years based upon a system that the insurance companies wanted us to have, which was no-fault. They're the ones who proposed it in 1972, and now I want to have the right to purchase unlimited PIP. There are only two companies now, that I'm aware of today, that are accepting this offer of-- They may offer additional coverages. It should be a mandatory offer.

Again, as an alternative, if you don't require that, what happened to the discussions about a Catastrophic Loss Fund? When the insurance industry first started to talk about limiting our unlimited medical coverage, every legislative proposal had a section or statute that went along with it for a CAT Fund, so that people had the right to purchase additional coverages. What happened to that stuff? We're letting people drive around in dangerous vehicles, causing damage to our brothers and sisters -- catastrophic injuries -- and not providing protection for them.

So, I give you at least three suggestions; Number one, get rid of the cap; number two, make a mandatory offer of unlimited PIP; or number three, put in a Catastrophic Loss Fund. Those are three specific things that I think you should consider.

Second point, deductibles and copay. You put in a $250 deductible; you put in a 20% copay. Has anyone yet told

you how much money the insurance industry is saving because of those deductibles and copay? Do you have the vaguest idea what it has done to reduce the cost of our premiums? I can tell you that it creates an administrative hazard for every single person in the State of New Jersey who's injured in an accident. Anyone who's injured in an automobile accident automatically has unpaid medical bills, because the first $250 comes off and then 20% of the next 4750 bucks. You're guaranteed to have $1200 worth of unpaid medical bills if you're hit in the rear while stopped at a red light, by a drunk driver who's going 60 miles an hour, and you've got to pay the first 1200 bucks out of your own pocket. Now, if you can tell me why that's justified, then maybe I can live with it.

But the insurance industry-- Elmer says, "Well, it's reduced costs." They haven't given you-- When you adopted the bill we came before you and said, "Tell us before you adopt this bill how much it's going to save the consumers." We didn't get that information, but you adopted it anyway. Now we've had it for a couple of years, let them come in and tell you how much money they're saving, and how they're passing it on to the consumer. I haven't seen it. And I would go on to say again, if you're not--

I think you should get rid of the deductibles and the copay, but if you don't get rid of them, at least give the consumer a mandatory option to purchase total coverage without deductibles and without copay. Let the insurance industry set the price with the approval of the Department, and then if I choose to buy it, I should have the right to buy it, and if I choose not to, then it's my own fault if I'm not properly covered. But to take away people's rights without knowing what it's saving the consuming public -- the automobile public -- is absolutely wrong. So, that's point two.

Point three: Now, we talked about Medical Fee Schedules. As a representative of people who are injured in

accidents, I have no problem with the concept of Medical Fee Schedules. I think they can work effectively. I only have some adjustments. First of all, they have to be set at a rate where the medical providers are properly paid so that they do not choose to withdraw service. Did you hear the first doctor who testified? He said some comment about, "Well, whether we want to provide service"-- I mean, he's a nice man, and he said it nicely, but wasn't he, in a sense, threatening -- that if the Medical Fee Schedules are not set at adequate rates, that medical providers will choose not to provide service to people who are injured in accidents? How do you justify that? An innocent victim in an automobile accident cannot go to the doctor of his choice, because the doctor's not being paid appropriately.

Now, we don't disagree, and I don't think the medical profession disagrees, with maybe 90% of the Medical Fee Schedule. There are things missing in the Medical Fee Schedule, and I've written three letters, myself, to the Department of Insurance, and I know other people have. There are certain things missing under the Physical Therapy Schedule. There are certain things missing-- Some of the Radiology Schedules have a CAT Scan of the neck, but they don't have a CAT Scan of the back, or they'll have an MRI of the back, but not of the-- Those are things that will have to be worked out through the Department.

The major problem that I have with the Medical Fee Schedule, which was addressed by Verice very generally, is the fact that they are lumping all medical providers into one group for the provision of initial office visits and follow-up office visits, and initial consultations, and follow-up consultations. What they're saying is, the general practitioner and the specialist should charge the same thing. Now, that's great for the general practitioner because there are a lot more people in that category. Because what happens

is, it raises the fees higher than the general practitioner would normally charge, but it lowers the fee substantially less than the specialists charge. And I would suggest -- and I have numbers and my own opinion on this, and I've addressed it in writing before -- that the figures for general practitioners are maybe as much as 50% higher than most of them will charge, but are probably half of what specialists will charge. Where specialists may charge $250 or $200 or $300 for the first visit, the Fee Schedule may allow them $127.

So, by lumping them all into one group, what has happened is that the Department has artificially lowered the amount of money that will be allowed to be paid a specialist. And a Dr. Weierman, who's an orthopedic specialist, comes in and says, "For the Physical Therapy Schedule, when I treat people with diathermy and whatever, I follow that schedule, but you're not paying enough money for my specialty service, for my office visits and my consultations. And then what happens?

I'm not here to defend the medical profession, but what does that do to the consumer when this nice doctor comes in and says, "The fees for my initial office visit and my follow-up care are set too low"? They may be the 75 percentile of all medical providers in the State, but they are not in the 75 percentile of orthopedic specialists, and I think a critical problem to people who are injured in automobile accidents. This is not a minor point, this is a critical problem. If you break your arm, you want to go to an orthopedist; you want to go to the specialist in rehabilitation; you want to go to the neurologist; you want to go to the psychiatrist.

If someone is board certified in the State of New Jersey where they have the certification requirements -- I have to distinguish it some way -- there should be a separate Fee Schedule for those people who are certified. What will happen is, it will provide a higher level for people who are specialists. It will lower still, the amount for general

practitioners, and in my opinion, will resolve one of the two really critical areas -- multiple procedures you've heard too much about -- will resolve the major problem that I see in the Medical Fee Schedule.

All the Department has said to me in their regulations is that we've lumped everyone because specialists provide specialty services and they are separately taken care of under the Fee Schedule. That means if you operate on a broken arm -- which the general practitioner doesn't do -- that's scheduled. And I agree with that. The error in the reasoning, in my opinion, is that it doesn't solve the problem of what happens when the specialist gives you your initial office visit and each follow-up office visit. There they're providing the same type of service as any other physician, but they're providing it with their specialty knowledge. And you may not want to go to the general practitioner; you may want to go to your specialist, and if these nice doctors come in and say to you, "Whether we want to provide the service--" they're telling you that something's wrong in the schedule.

And if the Department would address-- This is the first chance I even knew who the-- After two years, maybe three years -- because I've written one letter each year -- of writing letters to the Department of Insurance and supposedly their meetings with all the medical societies, this is the first time I even knew the name of the gentleman who wrote that Medical Fee Schedule, never once, am I aware of, consulting with the attorneys who represent the people who are injured. And now that Verice has heard what I've had to say -- the first time I've had a chance to meet her -- maybe that particular problem will go away; maybe not, and we'll have to worry about it next time.

ASSEMBLYMAN GILL: Nothing goes away, but it can be resolved.

MR. BAKER: Okay. This leads into what is really the epidemic. The real crisis right now, in the administration and medical claims process, is in the payment of bills. And it is totally disingenuous for the representative of AIA to come in and say, "Well, we don't know. We're not aware of any problems with the payment of bills." And this is not for him to say, that it's the sins of the servicing carriers that are visiting upon the legitimate insurance companies in the State of New Jersey in just, you know, sidestepping. The fact of the matter is that medical providers -- not even attorneys and not even the poor innocent victims-- The medical providers are being backed up and taken advantage of by the fact that the insurance companies are simply not paying the bills. They're arbitrarily sending out any amounts of money that they want, and in many cases, they're not sending out an explanation of benefit forms, which the regulations require. They're not telling you what they're paying or why. They're not properly applying the Medical Fee Schedule.

I'm going to tell you that almost every single case in my office involving automobile accidents has a problem with the PIP carrier. I can tell you, almost every case in the office, and I've been doing this for 24 years, and up until the last -- really, up until the FAIR Act -- I don't know that I ever filed a PIP claim. And now I am filing them on almost every case, either because they're cutting my people off in treatment, or my treating doctors still say they need treatment, or because they're not paying the bills. And I have never had one single PIP case claim denied for fraud, and I have never lost a PIP claim, and I don't expect that I ever will. Maybe I'll lose one here or there, but the bottom line is that the problem is not the problem with the claims or the doctors. The problem is the problem with the insurance companies, primarily the service carriers.

I agree with, I guess it was Mr. Lucianin, or whatever: We really don't have as much of a problem with the insurance companies who've been in this business for time immemorial, who have good claims departments. It is not an epidemic problem with Allstate and Liberty Mutual and State Farm, and whatever, although we do have problems with them. It is an epidemic problem with the servicing carriers because you get nothing out of them. Zero. You can't get them on the telephone. They don't respond to letters. They don't pay their bills. You probably have hundreds of millions of dollars of outstanding medical bills that are due and owing today that can sink the system, and you don't even know about it because the PIP carriers are not paying the bills. I know individual doctors who have over half-a-million dollars of unpaid medical bills, and if all these doctors got together and started filing suits to get their medical bills paid, it wouldl shake the roots of the system. That's where the problem is.

Now, how you resolve it is not so easy. We do not want to file PIP suits or PIP arbitration. We don't enjoy it. We don't make money at it. It doesn't solve-- That's not what people hire us for. We are personal injury lawyers. We represent people who are injured in accidents, who want to get compensated for their injuries. None of us, you know-- Maybe there are a couple of people, but truly, as a profession, we are not in the business of wanting to sue PIP carriers to recover on unpaid medical bills. I waive my fee on almost any case if the PIP carriers will pay the bills and the cost of filing the arbitration, immediately. I don't want to get paid for it. I just want them to pay the bills and get out of my hair so I can get on to business.

My business is representing people who are injured in accidents, not fighting insurance companies. I don't want to do that. There is no profit for attorneys in that business.

That is not why we are here, plus the fact that it's no fun, because we're not going to lose. There's no battle to it, because the doctors will always come in with a sound explanation as to why they provided the service and why the service was necessary. And once we have a chance to sit down with the carriers and apply the schedules properly, the doctors will get paid, and we get reimbursed the cost of filing the arbitration, and we are entitled to interest, and we're entitled to a counsel fee. All of that, as you've heard from several different people, has increased the costs.

I think I have maybe two other points to talk about: health insurance primary, the PIP switch we've heard a bunch about. It is a disaster to people who are injured in accidents. I daresay that if you look through the legislation itself, you will find that the legislation does not provide the correct picture as to coverages. The legislation specifies, by terms, those areas of health insurance programs which can be made primary to PIP. The legislation is wrong. Look at comments eight and nine from the Department of Insurance in the December 17, 19-- Oh, by the way, I found artificial insemination. It's 5583-- It's CPT Code No. 58310, and you'll find it in the December 17, 1990 issue of the "New Jersey Register." They also have vasectomy, 55250, and a variety of procedures involving women, that's, you know, equal in its approach. But, it was there.

Health Care Primary: It lists Medicare and Medicaid in the statute. They cannot be made primary to New Jersey PIP. It lists State-- Let me find my notes. A lot of people who work in New Jersey are insured out-of-state. Strike that. A lot of people who live in New Jersey work out-of-state. I'm speaking too fast. A lot of people who live in New Jersey work out-of-state. New Jersey can't require a New York or a Pennsylvania health insurance carrier to make them primary to

New Jersey PIP. Any New Jersey residents who are insured out of the State of New Jersey can't make health insurance primary. Self-insured employee welfare benefit plans-- Those are those types of plans that are covered under Federal law, ERISA. New Jersey, it so happens, can't make their State automobile insurance laws primary to Federal legislation.

I would suggest to you that 50% of the people in the State of New Jersey -- this is my number -- 50% of the people in the State of New Jersey with health insurance coverage do not have plans that permit them to be made primary to PIP. Now, what does that mean for you? You've got a plan and you say, "I'm going to select that primary." And then you find out, you can't do it. Do you all remember what your statute says happens to the nice person who made that error? PIP has to pick up the payment. But what happens to the consumer? Do you recall? A $750 penalty on top of the $250 deductible and 20% copay. So, if you select health care primary because you've got a plan through your employer and it turns out that your employer's plan doesn't provide coverage for you, you'll get socked with another 750 bucks on top of the $250. I'm looking forward to the first constituent that I find has that problem, because when I give him the name of his Assemblyman and State Senator, he might be a little bit upset with the statutory protection -- or lack of protection.

What if you have a nice plan that does provide coverage but it doesn't provide coverage for your spouse or your children, say, an adult child who's living with you? And you honestly put down health insurance primary because you thought you had it, but it's your kid who has an accident, and then you find out that there's no coverage for the kid. You know what happens? You get hit with another $750 penalty on top of the $250 deductible because there's no coverage. Now, do you want to make that choice? State health insurance-- The State Employees' Health Benefit Plan can be made primary,

comment nine to the same note. No one's ever going to read these comments. There isn't anybody who pays attention to that much detail. Do you want to take a chance-- It is estimated by the insurance industry that you would save $40 if you selected health insurance primary.

On the basis of what I've just asked you, when you think about your own policy, are you going to take a chance that your health insurance plan-- I don't understand those health-- Did you ever try to coordinate benefits? Blue Cross/ Blue Shield Major Medical is going to provide you protection? And worse than that, The New York Times, in an article -- I have it here someplace or other. Not so long ago; it was in January -- asked Blue Cross whether or not they could be made primary in New Jersey, and Blue Cross said, "Yes." They said, "Well, are you going to do anything about your rates to reflect the fact that you may have to come in and pay primary to PIP?" and they said, "Yes." And they said, "How much of your recent requests for rate increases will go to the PIP primary, health insurance primary?" They said, "6.9%." How much does that work out to? One-hundred-and-seventy-one dollars on an individual policy will be the increased cost to save 40 bucks. Now, I don't have to be a legislator to understand there's something wrong with that mathematics. And, there was someone else who testified that the $40 savings isn't even real -- 25% of the premium. Mr. Castelano, I think was his name. He came in and he testified that the actual savings will probably be $20.

And how can anyone really make a choice of putting health care primary and take a risk-- I know somewhere down the line, if I pick health care primary, that I'm going to lose money on it as soon as someone has an accident. I just can't recommend it to people. I don't know why it's in the statute, and unless someone comes in and gives you real hard dollars about how much money the consumers of the State of New Jersey

are saving, and how much exactly this goes into the reduction of cost in automobile insurance, it would be-- Thank God only 2% of the people are selecting it. It would be catastrophic. And then, not only don't you get the coverage, you get hit with a $750 penalty. And by the way, since you've made the wrong selection of coverage, the insurance can then ask you for the premium back -- the money that you saved, the 40 bucks supposedly. They can ask you to pay that premium, and if you don't pay them the premium, they can cancel your policy. It's in the regulations.

So -- you might have gathered -- I'm not a big fan of health care primary. You call it PIP switch, or Elmer Matthews did, but it's health care primary -- is really what it is; not a smart choice.

PIP suits I covered. I guess two last points: While we're talking about medical claims processing -- everyone talks about medical expenses -- a very minor suggestion to you about funeral expenses. This current no-fault statute provides a PIP benefit of $1000 for a funeral expense benefit. You have just increased the funeral expense benefit in Workers' Compensation claims to $3500. Since you've already accepted that as being a reasonable fee for reasonable cost for funerals in the State of New Jersey, you really should modify the PIP statute to match the limit. That is a medical claims issue and it really should be $3500 on the basic PIP, and probably higher, like $7500 under additional PIP.

Do I have a last point? The last point: What happens if you put a PIP claim in and the insurance company says to you, "We want to have you examined"? There is a provision, 39:6A-13d, that gives the PIP carriers the right to have you examined by their physician. No one objects to that. And the statute says you should be examined in the municipality where you reside. That's fair enough, too. And, if you can't find a competent physician in the municipality where you reside who

can do a defense examination -- misnamed independent medical examination-- IMEs are medical examinations paid for by PIP carriers. Doctors who perform the examinations for insurance companies are not any more independent medical examinations than doctors who where consulted by injured people to represent them. Neither one of them are independent. But when insurance companies ask you to be examined by their physician, if they can't find a doctor in your municipality, supposedly they can then ask you to go to another municipality.

There is a case that has come down in the Appellate Division called Benyola, which creates a problem in that. It says if there's a dispute as to whether there's a doctor available within the municipality-- Who should have the burden of proving whether or not there is such a doctor? In my opinion, the legislation should say that the burden of proving that there is no physician available within the municipality to examine, should really be on the insurance company. This case, Benyola, says that the burden is upon the injured person to prove there's no doctor available, and he has to file a separate cause of action called a Summary Proceeding, in order to go before the court and prove that there is no doctor available in the municipality. Completely backwards. Completely backwards.

The statute clearly says, "the examination shall be in your municipality." It should be amended if this case is-- It's only in the Appellate Division level and it's on its way up. It should be amended to make clear the fact that, if there's any dispute as to whether or not there's a doctor available, the burden of proving should be on the insurance company, not upon the innocent accident victim: you know, the constituent, the consumer.

That runs through a whole lot of items. I'm sorry I only heard about it at 4:30 yesterday afternoon, because I've only come up with about seven, or so, items. If I had heard

about it, you know, a little bit more in advance, I might have been able to limit it down to two or three -- or maybe 70 or 80. (laughter)

ASSEMBLYMAN GILL: Mr. Baker, we'll give you another opportunity in a couple of weeks, or a month, to come down and give us some more information. I enjoyed your testimony.

Mr. Kenny, any questions or comments?

ASSEMBLYMAN KENNY: Not really. I've enjoyed the hearing. I learned a lot about the issue.

ASSEMBLYMAN GILL: We have someone else, yet.

ASSEMBLYMAN KENNY: Oh, pardon me. There is another? Oh, I didn't realize that. Okay, fine.

That was a very good testimony.

MR. BAKER: Thank you, folks.

ASSEMBLYMAN GILL: Thank you, gentlemen, and we will look forward to having you at the next hearing.

MR. LEVINSON: We'll be back.

ASSEMBLYMAN GILL: You are enlightening, to say the least.

MR. BAKER: If we could know more than a day in advance?

ASSEMBLYMAN GILL: You certainly will know. We'll get you a card and you'll have a week; at least a week's notice.

Now, our final witness for this afternoon is Glenn Malmberg from the Jersey Association of Medical Equipment Suppliers.

G L E N N A. M A L M B E R G: Thank you. That's a tough act to follow.

I don't know why, but our organization also found out about this quite late.

We have a lot of concerns as well. Our problems are not as critical as -- are just as critical as physicians, but because our total volume is lower, I'm not sure it gets as much attention.

I'm here today not only as the representative of the Jersey Association of Medical Equipment Suppliers, but also as an owner of a small, durable medical equipment company, and, in fact, one that specializes in custom medical equipment and works with very severely involved, severely disabled persons.

Some comments were made earlier about the $250,000 cap. That's a lot of my customers. It's not unusual for me to provide a customer with a wheelchair costing $20,000, and that's approaching 10% of the cap, for severe spinal cord injuries and head injuries, and so forth. So we're real concerned with how our reimbursement is. The work we do is very labor-intensive. It involves the purchase of products that we resell where we really don't control the price.

Our first concern is with the Fee Schedule. The Fee Schedule currently used to reimburse suppliers for durable medical equipment and for prosthetic and orthotic supplies is based on Medicare allowables from 1986. Now, some testimony was given earlier that there would be some adjustments made to reflect more recent Medicare allowables, but I have to tell you, the medical suppliers are having really profound and serious problems with Medicare allowables, right now. Most of us have stopped being Medicare providers. We no longer participate in the Medicare program. If a patient comes to us, we ask them for payment, and then we'll submit the paperwork and they're on their own with Medicare. I can see that happening with this. Some of the codes for Medicare are below our cost.

I started my company four years ago with a lot of real good intentions, and when we started we signed up and became providers in everything. Then I got burned on a couple of big cases where we provided something that was medically necessary. There was no question with regard to documentation and we waited a year, or more, to get paid, and we got paid below our cost. And, we have a real problem if the current fee

structures are going to be based on Medicare and not based and not updated on what it actually costs us to provide services. What it's going to force my industry to do is to move away from these types of cases, because it's just not cost-effective to run a business and to be able to provide that. Most of my industry is small business -- corner drugstores, mom and pop businesses. We care a lot about what we do. We work with very severely involved accident victims. Our margins are not that great, but when we're hooked into a Fee Schedule that doesn't make any reflection of our actual costs, it's really a disaster. And it makes it very difficult for us to provide equipment that really makes a difference in a patient's life; whether they're going to be confined to bed, whether they're going to have mobility -- they're going to get out of the house, they're going to have ways to get in and out, possibly ways to drive.

The current Fee Schedule also doesn't address the area of customized equipment. Other testimony was given a bit earlier that these are addressed on a case-by-case basis. The experience of most of our members, and mine as well, we've been told by-- Each insurance company seems to interpret it in a different way, but we've been told that if it's not in the codes, it's not covered. Again, it's not uncommon for me to provide a wheelchair that's made up of 40 separate identifiable components that might come from five or six different manufacturers, and then I look at a code screen that says: "wheelchair with removable arms and swing-away leg rests, 'X' number of dollars," when I'm providing a product that is nowhere like that coded product, but that's the only reimbursement there is for it. So, the reimbursement might say $1500 for that wheelchair, and I have a product that would sell for $7500. But the codes don't give me an avenue to bill it properly, and quite often the claims examiners don't understand and don't want to address that, even though I can provide

medical documentation for each and every component that goes into that medical equipment and why that's so critical for this individual's recovery and rehabilitation. So custom items, as far as we're concerned, are not adequately addressed.

There are many items that do not contain codes. This is-- Again, when you lift the whole chunk out of Medicare, a lot of those problems come with the Medicare codes that's frought with problems. Our industry has been struggling with that for a number of years now, and some of these problems have carried right over. At least Medicare provides a proper avenue for where there's not a proper code, and there's still a timely resolution of the claim. Just because it wasn't coded, it shouldn't take six more months to pay because no one thought of a code where this quadriplegic needs this particular type of equipment. So we're really concerned that that point be clarified.

In addition, we've found that some insurance carriers are using this Fee Schedule across-the-board, and not just for PIP claims. A physician mentioned earlier that he has really two levels of charges, one that he charges other patients, and one that he charges PIP patients. Well, we sort of have that situation, too, except we're going to some of the insurance companies with non-PIP claims and they're saying, "Well, we're going to pay on these rates because these are rates we use for PIP claims, and they're lower than, maybe, what the prevailing rate might be, so we're going to go with that particular rate."

So we're not only suffering with inadequate, inappropriate Fee Schedules for PIP patients, but also for non-PIP patients, as well, and it's inappropriate that they should be applying that Fee Schedule to other areas of their insurance that have nothing to do with auto accidents. But a number of them are because they realize we can save a lot of money here.

I've submitted claims on behalf of families for very, very customized, powered wheelchairs that cost $13,000 -- that

I sell for $13,000 -- and the insurance company says: "This is only worth $4000." Well, I know it cost me more than $4000 to buy. I put a lot of labor into it, yet they only feel that's a $4000 product because of this code, and that code, and whatever. In some cases, the family can pay the money and I'm off the hook, and then they hire an attorney and they get paid in full. In other cases, it's my receivable that hangs out for six, or nine months, or twelve months. It seems to me kind of self-serving for the insurance companies to say that they need extra time to investigate claims. Well, that's great. I wish the people that sent me bills-- I could say, "Well, I'm going to investigate that invoice from you, and I'm going to put it in a pile for six months."

We've heard about piles and about preferred suppliers that get put to the top of the pile and other providers that get put somewhere else. I'd love to have a business where I could decide which bills I want to pay right away and which bills I want to put off, and all I've got to do is say it's in review, and I don't have to pay it for awhile.

You know, physicians have to buy supplies, too. A lot of their work, however, is service. We buy products and we sell products, very complicated products, to people with severe disabilities, and my suppliers want to be paid in 30 days. They don't care if PIP has 60 days and then 45 days and then who knows what else. We've just had so many valid claims that turn up in the end to be fully paid, dragged out for months with all these concerns, and then it all gets worked out in the end anyway. But in the meantime, all these months have been lost and it just seems self-serving because the insurance companies preserve their cash flow for those months, basically at my expense. So that's a real big problem.

What we're afraid of-- We're concerned as much as everyone else with the cost of this equipment. Our industry is working hard to try and get our members to follow certain codes

of ethics and to try to expose individual companies that are improperly billing or creating fraudulent situations. We feel that, as a whole, our industry is billing appropriately for necessary equipment, but what I think a lot of us are going to do, because we're small businesses, is we're just going to walk away from this area of coverage because to continue with it will make us bankrupt. And, as a result, if a PIP client comes to us, we're either going to turn it down or we're going to have to say, "You pay us for the equipment, and then you're on your own to collect, because we can't carry that receivable for you." We don't usually do that because we sell expensive products. We usually deliver, we bill, and then we wait, because people can't pay out of pocket. When you have a catastrophic illness you have all kinds of-- You have financial problems; you have emotional problems; your family's been disrupted. The last thing we want to do is say, "Well, you can't have that wheelchair for your child because you don't have $5000." So we give it to them, and then we wait, and a lot of us can't continue to do that.

That's why everybody walked away from Medicare. Medicaid is much better right now. We'd rather all these people get bumped over their caps and go into Medicaid. At least the Medicaid program recognizes our costs and equipment, and that's really critical for us.

That's really all of my comments, except that I don't feel-- We don't feel as an industry -- the durable medical equipment suppliers -- that we've really had adequate involvement in this process. We're kind of formally asking, at this point, that we be involved more in the future. Again, maybe our dollar volume isn't anywhere near the physicians' and other types of industries like that, but we still play an important role, and we really want to be involved in the future hearings and provided with the opportunity to give the

Department input when they come up with these Fee Schedules -- Fee Schedules that just have no basis in reality.

ASSEMBLYMAN GILL: Mr. Malmberg, thank you for your testimony.

MR. MALMBERG: Thank you.

ASSEMBLYMAN GILL: You will be involved in the future, hopefully, and we appreciate your taking the time to come down and express your interests.

Assemblyman Kenny, do you have any questions?

ASSEMBLYMAN KENNY: No questions, Assemblyman.

ASSEMBLYMAN GILL: Any comments before we adjourn? Any other witnesses, by the way?

UNIDENTIFIED SPEAKER FROM AUDIENCE: When is your next scheduled meeting?

ASSEMBLYMAN GILL: We've got to review the testimony we've received today. I guess it will be within a month, hopefully.

UNIDENTIFIED SPEAKER FROM AUDIENCE: How will you announce it?

MS. MEALING: There is usually a standard list of people that notification is sent out to. Obviously not everyone receives that. Also, if you'd like to be involved, please leave me your name. I'll be sure that you get a notification. It is also in newspapers as a public notice.

UNIDENTIFIED SPEAKER FROM AUDIENCE: The notice was-- I would like to testify, but it's too late. I was advised yesterday at 4:30--

ASSEMBLYMAN GILL: You will have another opportunity.

MS. MEALING: Yes.

ASSEMBLYMAN GILL: If there are no other people who wish to testify, I would like to thank Assemblyman Kenny, Assemblyman Zecker who was here, Carolyn, Mark, and Gary, for your help.

Gentlemen, ladies, thank you. We look forward to seeing you at our next meeting. Thank you very much.

(HEARING CONCLUDED)

APPENDIX

Hearing of the

ASSEMBLY INSURANCE COMMITTEE

August 14, 1991

TESTIMONY

by

Carol J. Kientz, R.N., M.S.

Executive Director

HOME HEALTH ASSEMBLY OF NEW JERSEY

760 Alexander Road, CN-1
Princeton, N.J. 08543-0001
(609) 452-8855

4x

I am Carol J. Kientz, Executive Director of the Home Health Assembly of New Jersey, a state-wide association of over 100 home health care providers. Our Members include every type of in-home care including traditional non-profit Visiting Nurse Associations, municipal health department home care services, private for-profit home health providers, hospices, and in-home "high-tech" home care services.

Last year over 150,000 New Jerseyans received our home care services. These include nursing, home health aide, therapist and social work visits as well as per-hour care by registered nurses, licensed practical nurses, and certified aides, and, finally, "live-in" care by nurses and/or aides. "High tech" services by professional nurses with advanced skills are also provided for such needs as intravenous therapy and respirator-dependent infants, children and adults.

While the largest portion of home care here in New Jersey and throughout the country is reimbursed by government programs including Medicare and Medicaid, a significant portion is paid for through private insurance, including automobile personal injury protection plans. Although there are no solid state or national statistics for our industry as yet, some estimates indicate about 10% of home care is provided through private insurance coverage of various types.

The industry is accustomed to capped rates, having worked within caps for the Medicare and Medicaid programs for many years, and we appreciate the need for regulation of both health care and insurance costs. The rates set for home care earlier this year by the Department of Insurance in relation to personal injury protection (PIP) in private automobile insurance coverage are largely reasonable. However, they failed to take into consideration certain common home care situations. These situations involve the per-hour nursing rates for registered nurses, licensed practical nurses, and home health aides (Sec.11:3-29.6).

5X

The rates set in that section would be roughly appropriate base-line for Monday through Friday daytime care of a patient with routine nursing needs. However, many patients, especially in the initial post-injury period, need care 7 days/week, nights and /or evenings, including holidays. And if they have specialized needs such as intravenous therapy, respirator care, or intensive infant/child services, they must be provided with a nursing professional with appropriate specialized experience and/or training to meet those needs. The rate schedule simply does not allow for the cost of evening/night/weekend/holiday care - which has always been at a higher rate in the field of nursing. Nor is there provision for specialty nursing services, which also command higher rates. Because the supply of nurses is extremely limited, home care agencies must pay these rates or they simply will not have any professional staff for auto-injured patients.

The same is true in relation to certified homemaker-home health aides. New state and federal training and supervision requirements for home health aides, while very appropriate for safety and consumer protection, have added to the cost of these services. Shortage of supply has also raised the cost to home care providers. The per hour rate set in PIP regulations is below the cost for aides, particularly in the suburban and rural areas of our state.

Therefore we urge a review and revision of these rates by the Department of Insurance as soon as feasible, as well as promulgation of a method by which rates can be periodically adjusted to at least keep pace with basic cost-of-living raises. The increases we recommend, it should be noted, are not major. Just a few dollars per hour can make the difference between a home care agency absorbing a loss and breaking even when caring for a patient. I would also like to commend the Department of Insurance for being receptive and willing to listen to these concerns when our organization recently wrote to the Department.

6x

We believe home care can be a cost-effective alternative to in-patient acute and rehabilitative care. It maximizes the assistance of family and friends, and promotes the independence of the patient in his or her familiar home surroundings. New Jersey's home care providers hope to continue assisting in the care and rehabiliation of auto accident victims, and we look forward to working out a reasonable solution to the current rate problem.

7X

ASSEMBLY INSURANCE COMMITTEE
Public Hearing 8/14/91

The Jersey Association of Medical Equipment Suppliers (JAMES) is pleased to have the opportunity to testify before this committee. Unfortunately, training seminars relating to the transition of carriers under the Medicaid Program conflict with this hearing and many of our members are attending those seminars today. In representing the group the following is of vital importance in order for the supplier community to continue to provide the much needed services currently available. The following comments and questions are respectfully submitted:

1. The Fee Schedule currently used to reimburse suppliers for Durable Medical Equipment (DME) and Prosthetic and Orthodic Supplies (P & O) is based on Medicare allowables of 1986. Reimbursement reductions are industry wide in an effort to achieve cost containment. Current fee structures are making it impossible to provide not only inexpensive items, but certianly more sophiscated rehabilitation equipment which is custom to the patient's particular need. The current fee schedule does not address the area of customized equipment. Many items provided today, do not have a code and suppliers are advised by insurance carriers that the items not listed are not covered. Under Medicare guidelines, items not listed are not necessarily not covered, but provided on an individual cost consideration. This point must be clarified.
2. Insurance carriers are using this fee schedule across the board rather than for personal injury protection(PIP)

8x

claims only, for which it was intended. This has created an atmosphere where suppliers must selectively choose to bill an insurance company or leave that to the patient. This is a transparent service that was provided routinely, prior to the cost containment measures enacted recently by the State as well as the Federal government. Billing services are expensive and payment can be delayed for much longer than supplier creditors can wait. Therefore, the demands of cash flow create the policies used by individual suppliers in accepting assignment and the responsibility for billing those services on behalf of the patient.

3. While we understand the reason for current legislation, we believe that governing bodies have gone too far, thus making much needed equipment and supplies unavailable.
4. Suppliers who choose not to accept assignment and the responsibility for billing services on behalf of the patient do so in order to survive economically. We consider this a retail transaction. Many in the supplier community have experienced cases where the patient submits a PIP claim only to have the insurance company contact the supplier requesting a "refund" of overcharged services. This falls into the catagory of "no balance billing". When a supplier accepts assignment, he is in fact agreeing to accept the allowed payment. This is understood. However, retail transactions should occur just as any other retail transaction. It should not be the responsibility of the supplier to interrogate each customer before making a sale.

9x

CONCLUSION:

DME suppliers provide much needed services which are the least expensive patient preferred method of recuperating from an illness or living with a permanent disability. To structure reimbursement at at inadequate levels impacts availability dramatically. We do not believe it was the intention of law makers to create this atmosphere. Therefore, reimbursement levels must be reviewed. Insurance carriers must be regulated so that intended legislation is not taken beyond the areas for which it was enacted. And industry involvement in the policy making of the State and Federal agencies should be utilized in order to protect the people for which legislation is intended. Technology has afforded Americans with the best possible techniques in healthcare. Over regulation will serve only to make this technology unavailable for many, or at best rationed. Therefore, we respectfully request the opportunity to provide industry input in the future.

10x