Public Hearing

before

ASSEMBLY POLICY AND REGULATORY OVERSIGHT SUBCOMMITTEE ON AUTOMOBILE INSURANCE

"Continuation of testimony concerning the proposed rules to implement the 'Automobile Insurance Cost Reduction Act'"

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

DATE: December 1, 1998
1:00 p.m.

MEMBERS OF SUBCOMMITTEE PRESENT:

Assemblyman Paul DiGaetano, Chairman
Assemblyman Jack Conners

ALSO PRESENT:

David L. Sallach
Office of Legislative Services
Subcommittee Aide

Jarrod C. Grasso
Assembly Majority
Subcommittee Aide

Tim Clark
Assembly Democratic
Subcommittee Aide

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TABLE OF CONTENTS

dmt: 1-24

ASSEMBLYMAN PAUL DiGAETANO (Chairman): Folks, I sincerely apologize to all of you who came on time. I can assure you that I was in the building long before the start of this hearing, but I was involved in a meeting with the Chief Counsel, the Governor, and President of the Board of Public Utilities on another very important issue, as this one is. It was my understanding that one of my Assembly colleagues would be here. Unfortunately, his schedule did not permit him to do so to chair this meeting.

So again please accept my sincere apology. I do not have a reputation for starting meetings late, but I guess that changed today. As you are aware, I'm sure, continuing our hearing-- This is the Oversight Subcommittee on the regulations pursuant to the Automobile Insurance Cost Reduction Act, and we have two witnesses signed in to testify. If you have not signed in and wish to testify, please do so now.

The first of those is Ken Andres, who is President of the Association of Trial Lawyers. And I'd like to have Ken come up now and address the Committee.

K E N N E T H G. A N D R E S JR.: Thank you, Mr. Chairman.

ASSEMBLYMAN DiGAETANO: Make sure that red light is on, Ken. (referring to PA microphone)

MR. ANDRES: Thank you, Mr. Chairman and members of the Committee. In the legislative debate surrounding the Automobile Insurance Cost Reduction Act of 1998, the Association of Trial Lawyers of America of New Jersey urged the elimination of no-fault insurance as the proper way to reduce automobile insurance premiums for the drivers of our state. ATLA-New Jersey produced evidence documenting the fact that the no-fault system is the

most expensive system in the country. As the record reflects, we still believe that the no-fault system is the real culprit and the reason why 38 other states have rejected or repealed no-fault.

Nevertheless, throughout the debate, New Jersey continued to require mandatory automobile insurance in the no-fault fashion. The Legislature chose to retain the no-fault automobile insurance system and specifically indicated that the principle underlying the philosophical basis of the no-fault system is the trade-off of one benefit for another, in this case, continuing to provide high-quality first-party medical benefits without regard to fault in return for a limitation on the right to sue.

In the Act, the Legislature did limit the right of injured automobile accident victims to sue and delegated the responsibility of drafting guidelines for medical treatment to the Department of Banking and Insurance. It is clear that in the legislative history this philosophy was to be continued, trading off first-party benefits for medical treatment for individuals in exchange for a limitation on the right to sue. That is not what happened with the regulations that were promulgated.

In our view, the proposed rules dealing with medical treatment and care do not meet the legislative intent and are, in fact, arbitrary and capricious. We believe it is self-evident that medical decisions must be made by doctors. They should not be made by insurance carriers or their representatives or well-intentioned individuals in the Department of Banking and Insurance. Only doctors have the knowledge and the ability to decide what is best for their patients.

The proposed treatment rules call for managed care, and it is bad managed care at that. You only have to look at the "care paths" attached to the regulations to understand just how medically and realistically inadequate they are. The Department of Banking and Insurance, through these regulations, would have injured individuals treated like commodities rather than people.

The regulations give total control of treatment to the automobile liability insurance carriers. That is a clear conflict of interest. All medical tests require preapproval. That was never intended, and the Act clearly indicates that is not the case. All medical treatment beyond four weeks essentially requires insurance carrier approval. Most patients will be discharged after twelve weeks, even when they are still symptomatic. And the few patients permitted to have treatment after a minimum period of twelve weeks are under the total management of the automobile insurance carriers.

One of the issues that I know that this Committee is vitally interested in is the fact that it has often been said that you cannot do by regulation what was not done by legislation. This legislative body has consistently rejected the concept of managed care, in total control care for automobile accident victims by liability insurance carriers, yet that is exactly what these regulations do. Many, many bills have appeared before this legislative body, and they have all been shot down indicating that managed care is not what we want. The public does not want it, the Legislature has voiced on multiple occasions that it is not what it wanted here.

The Act requires that medical treatment, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly

accepted protocols and professional standards of practice. That is what the Act requires. Those standards are to be acceptable to the health care-providing community of the State of New Jersey and commonly accepted as being beneficial for the treatment of the covered injury. Protocols, standards and practices which are deemed to be commonly accepted pursuant to this section are those recognized by national standard-setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the Commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Public Safety.

The Act did not indicate that the accounting firm of Pricewaterhouse Coopers should be deciding what is appropriate medical care for our citizens. If you have an accounting problem you go to Pricewaterhouse. If you have a medical problem you go to the medical community. Unfortunately, the Department went to Pricewaterhouse.

It is admitted by the Department, and in the documentation that we have provided to this Committee, these regulations were drafted by Pricewaterhouse Coopers. They do not reflect commonly accepted medical standards and practices. In the documentation that we have given you are two memoranda from Pricewaterhouse Coopers indicating that it consulted people in the medical community. However, as you know from previous testimony from the Academy of Neurology, the folks at Pricewaterhouse Coopers represented to the Department that they consulted the Academy of Physical Medicine and Rehabilitation and a Dr. Brown, who is a leading authority in the area of rehabilitation medicine in New York City.

And Pricewaterhouse told the Department that they consulted these people and they assisted in the drafting of the regulations. Well, lo and behold, we have provided you with documentation from the Academy of Physical Medicine and Rehabilitation and from Dr. Brown indicating that these regulations were not drafted in consultation with them. They do not comply with medical standards. And, in fact, two other authors that were cited by Pricewaterhouse Coopers have completely repudiated these proposed treatment regulations as being invalid and being bad medicine.

But I don't ask you to take the trial lawyers' word on this. I understand that certain members of the public feel that we have a vested interest in this, and that is why we are addressing these issues. But we have a vested interest in high-quality medical care. And I ask you not to take the word of ATLA-New Jersey as to whether or not these medical treatment standards are appropriate. I ask you to take the word of the New Jersey medical community.

At the previous hearing, on October 27, 1998, a who's who of the New Jersey medical community appeared before this Committee and told you that these proposed regulations are dangerous for the health and well-being of injured individuals. They are bad medicine and they do not reflect the accepted standard of care for treatment of injury victims of any type, much less people who have traumatic, acute injuries suffered in car crashes. Not only do these regulations not meet medical standards, they will create adverse long-term health consequences causing people to suffer chronic pain and disability because they are denied timely and appropriate medical treatment.

It doesn't take a brain surgeon to figure out, when you deny people medical care early on in the medical process when they need it, that it's going to hurt them down the road, and it's going to hurt consumers directly in their pocketbook. It's robbing Peter to pay Paul in the first instance. And not only is this bad medicine that the New Jersey Medical Society, the American Osteopathic Association, the Academy of Orthopedic Surgeons, the Neurological Association, the Chiropractic Board of the State of New Jersey -- they were all here -- if you look at our submission, you will see exhibits from 20 of the leading medical organizations in the state and in the country saying that this is bad medicine.

And worse yet, these regulations established financial disincentives built right into the regulations which will cause doctors not to treat patients. They violate the New Jersey Health Care Quality Act by telling doctors, "Can you imagine this Act mandates that if a doctor provides medical treatment to an injured individual that is appropriate treatment, that is found to be appropriate treatment, that those doctors will only be compensated 50 percent if they do it during one of the breaks in the health-care process, which is mandated by the decision review process."

People will go to their doctors because they are hurt, and the doctor will say, "You need this. You need it now." And the caring physicians will provide that medical care, and these regulations, because it didn't happen at the right time, with the right approval, with the right insurance adjustor sitting behind a desk saying, "It's okay, Doctor" -- the doctors will only be compensated 50 percent.

The medical community was here to tell you that it will stop doctors from treating people when they need it and how they need it. That's bad. Because we require the people of this state to purchase automobile insurance, and we require them to purchase PIP coverage, and we are now requiring them to purchase second-class medical coverage through this PIP treatment.

The Department's reliance on cost of treatment statistics in New Jersey to justify their drastic proposals is misguided and incorrect at best. The statistics relied upon deal with the old act, and they deal with the strict verbal threshold of *Oswin vs. Shaw*, when diagnostic tests were required. Now those statistics no longer apply based upon the changes in the threshold where an individual now requires a permanent injury. Now there is a list of permitted tests. Those lists are predetermined regardless of whether or not the treating physician, who is the person in the best position to know, decides that it's necessary to help his or her patient.

We agree that part of the problem pertaining to medical costs is overutilization. These proposed rules, to the contrary, limit initial treatment rather than addressing any problems of long-term abuse -- the Legislature's directive to draft treatment guidelines or sufficient authority to remedy this situation. What the Department has done is drastically limit all treatment to New Jersey accident victims to the detriment of every patient.

Sufficient cost containment can be achieved through the enactment of proper guidelines with the input and cooperation of the New Jersey care-providing community. It is those physicians, the men and women who treat you, me, and our families, who know what is right here. It is not

necessary for the Department to propose the worst health-care system in the United States to achieve cost control. As I've said to you before, you don't have to take our word for it, the whole medical community was here. We have all been dealing with this issue throughout our professional careers. I suggest to you that you have never seen the type of unanimity within the medical community like you have seen on this issue.

There are many things which divide the professionals in this world, but on this issue the entire medical community was here to tell you that this is not right and it can be solved so simply. It can be solved by going to the New Jersey medical community to have appropriate guidelines drafted rather than intentionally bypassing our physicians. The Department chose to go to Pricewaterhouse Coopers, and we provided you the documentation showing that the rules and regulations, literally treatment by a computer flowchart, is not done anywhere, anyhow, anytime in the United States.

Only an accountant could love that picture, and the citizens of this state are the ones that are going to be injured. And the bad news is not only our people going to be denied medical care, it's going to increase costs because the additional levels of bureaucracy, the additional litigation is all going to the same end: bad treatment, bad results, more costs, and another disaster in this unfortunate saga of automobile insurance in New Jersey.

In addition, there are problems with the alternative dispute resolution process. The alternative dispute resolution process contains two very serious errors involving the confidentiality of individuals involved in the medical review organizations and the award of counsel fees. Historically, the New Jersey No-Fault Act has permitted a prevailing claimant, the injured

individual, to be compensated for his or her costs of proceedings, including reasonable attorney fees. What that means is, when the policyholder is forced to sue his or her insurance company for medical care, the insurance company has had to compensate the attorney for medical fees and the legal fees for getting those medical fees compensated.

Under the regulations promulgated by the Department of Insurance, unbelievably, it allows for insurance companies to get their attorney fees from an injured individual if the medical bills are not found to be reasonable and necessary under the circumstances.

This scenario is such that a working person who is injured in a car crash could go to his or doctor, the insurance company could deny payment, the individual could be denied treatment, and if he or she losses the arbitration, could suffer the additional personal and financial indignity of having to pay his or her insurance company's legal fees. That was never even raised in the legislative debate, yet it's now in the regulations.

Could you imagine trying to explain to an injured client, "Well, ma'am, well, sir, we are not going to financially pursue you getting medical treatment because you may not have the finances to pay the insurance company's legal bill if you lose." What are the working people of this state going to do when they are faced with that issue? Get medical treatment and take the chance of being denied treatment, not having their doctor bills paid, and pay the insurance company's lawyers on top of it.

And keeping secret the identity of the individuals involved in the medical review organizations serves no purpose other than to allow insurance companies to stack the deck. Arbitrators and individuals must know the

identity of the people involved in the medical review organizations to determine their qualifications, whether or not they are biased, and whether or not their credibility is an issue. It would be like hiring a witness and having that witness come testify and not even know who he or she is, put them behind a wall, just hear their voice. Don't determine what their qualifications are, where they come from, or where their bread is buttered, and it's wrong. It's the approval of the entire MRO process as well. Who are the folks that have the financial incentives? That needs to be aired out in public.

And the last major concern that we see deals with what we have referred to as the basic policy. The basic policy was supposed to be a bare-bones policy enabling persons currently illegally operating motor vehicles without automobile liability insurance to become part of the insurance system. As you know, under the basic policy, people are permitted to be street legal without buying bodily injury liability insurance coverage. That exposes people to financial judgments if they injure someone, which could haunt them for the rest of their lives.

We know that the intent of the Legislature was to bring in folks who were on the periphery of the economic zone for insurance. But under the rules and regulations promulgated by the Department, it now permits folks to get comprehensive and collision coverage on those vehicles, which it was never intended to do. So you are going to have people who are capable of affording new vehicles, purchased or leased, who are going to be running around without bodily injury insurance coverage. And it was never intended to be that way. We provided you with the specific statements in the Committee hearing on March 23, 1998, where it specifically said that "mandatory coverages not

included in the minipolicy, or the basic policy, would be no uninsured or underinsured coverage, no collision or comprehensive coverage."

These problems are significant. We all sat through and labored with this problem on the legislative side for almost a year, and I know how hard the Joint Committee worked. And it would be a darn shame to have that Act fall flat on its face because of regulations that are not up to snuff. Because we will be back here again, next year, two years, three years, facing the same problem, and that's okay for us. And when I say us, there are people in the industry, there are legislators who can deal with that issue.

But the real problem is it's the people who are going to pay the price here. They are going to continue to pay high insurance premiums. Sure, they may be reduced by 15 percent, but they are going to pay premiums that provide them with medical coverage which is effectively meaningless. You would be so much better, better off falling out of a tree and hurting yourself than you would being injured in a car crash in the State of New Jersey, and that's a darn shame, because the Legislature made a decision that we are going to limit your right to sue, but we are going to continue to give you high-quality first-class medical care. And you delegated that responsibility to the Department of Banking and Insurance to make sure that happens, and these regulations do not do that.

We know how terribly charged this political issue is, but we strongly suggest that we still have an opportunity to get it right now through the oversight process. And we ask you to exercise legislative oversight and correct the rules now so that people don't get hurt, so that we are not back here doing this all again at a later time. Don't take our word for it, take the

word of the medical community, the same people that we go to when we are sick and when we are hurt. It was unanimous.

I thank you for your time and the opportunity to address this Committee.

ASSEMBLYMAN DiGAETANO: Assemblyman Conners, any questions? (no response)

Thank you very much, Ken.

We'll next hear from Gerald Baker and Walter Kowalski of the New Jersey Bar Association.

I'll repeat again, if anyone has come to testify and has not signed in, please do so at this time.

G E R A L D H. B A K E R, ESQ.: This may not look like Walter Kowalski, but--

ASSEMBLYMAN DiGAETANO: I was not going to go there, but I'd be happy to have you introduce--

MR. BAKER: This is Valerie Brown, Legislative Counsel for the New Jersey State Bar Association.

ASSEMBLYMAN DiGAETANO: Thank you.

MR. BAKER: It's my privilege to testify today on behalf of the New Jersey State Bar Association. Let me remind you that the State Bar has a membership made up of over 19,000, almost 20,000, attorneys from all areas of the law. These particular regulations were analyzed by a committee on automobile reparations, of which I was the Chairman, our health and hospital law section, made up of attorneys who represent medical providers throughout the State of New Jersey, and a special committee on tort reform that was

established several years ago when there was other tort legislation before the Legislature.

The position of the State Bar, which has been submitted to you in two letters prior to today's hearing, was reviewed, debated, and approved by our board of trustees consisting of over 40 attorneys who represent the Bar Association in each of the counties of the state, as well as our sections dealing with specialized areas of the law, as well as two minority members of the board of trustees representing a wide variety of interests of attorneys in the State of New Jersey. Only a small percentage of the members of the New Jersey State Bar Association are engaged in litigation and a smaller percentage of those engaged in personal injury litigation and a smaller percentage of those representing plaintiffs.

So the position that you have from the New Jersey State Bar Association represents a cross section of views all attorneys of the state representing a wide variety of interests. That doesn't mean it was unanimous point of view, there is always disagreement, but it is the strong position of the State Bar which you have had presented to you.

The position which is set forth in the letter, which I am just going to summarize because you have heard this from many witnesses prior to my testimony, falls into six areas, and I'm just going to give you the topic headings because you have heard the testimony in great detail set forth in the letters.

And that is that the proposed regulations, first, interfere with the ability of a physician to practice medicine under the license granted to the physician by our Board of Medical Examiners.

Second, that the regulations violate the Heath Care Quality Act by creating financial disincentives for doctors, meaning that it is more expensive for them to practice, to have to comply with the regulations. That it is easier not to treat people who are involved in accidents.

Third, that the care paths were not derived in consultation with New Jersey physicians and do not comply with accepted standards of treatment in the State of New Jersey.

Fourth, that the protocols, or the regulations, do not define precertification or provide a clear standard for what precertification means for medical tests and treatment. It just uses the term and kind of leaves it somewhere out in the Netherlands as to what it means.

Fifth, that there is an increased risk of physician liability for malpractice as a result of the regulations.

Sixth, the regulations limit access of patients to physicians willing to treat victims of automobile accidents.

Now, those are six themes that have recurred from the testimony of a variety of physicians and the testimony of Mr. Andres from ATLA-New Jersey, so I am not going to repeat all of the details. You're familiar with the arguments.

I am concerned, however, with the testimony of the Commissioner of Insurance during your first hearing of October 27, 1998. And I don't know if you have a transcript of it or not, I haven't seen it, but I was here and I took very careful notes. And I am very disturbed by the comments that she made when she started off by saying certain special interest groups have created an air of misinformation. And I want to go through and remind you about the

five things that the Commissioner said. I want to suggest to you that it was, in fact, the Commissioner who was misinformed, and that the regulations that she is trying to convince you comply with the legislative intent do not do so, and so I'd like to go through those five items briefly with you.

I'd like to remind you as you are listening to my comments about these five items that you sit here not just as legislators, but also as consumers. So each one of these items may very well someday have a personal effect on each one of you if, God forbid, you or one of your family members are injured in an accident and you have to sit back and say whether or not you are happy with what this legislation has done as it has been enforced or implemented by the Department of Insurance.

First of all, the Commissioner started by saying that one chiropractor of thousands of doctors in the State of New Jersey sent around some petitions that suggested that the regulations would deprive patients from the right to choose their own doctor. Now, it is clear that the regulations do not mandate -- do not mandate -- who the treating doctor is. You can go to any doctor you want. But the Medical Society testified -- the President-elect of the Society and a dozen doctors -- before you that the regulations may induce physicians not to treat people who are involved in motor vehicle accidents because of the fact that the financial compensation is not adequate, because the problems of administration become so burdensome, because of the difficulty in getting approval for treatment -- that they may just decide not to treat people who are involved in motor vehicle accidents.

So while the regulations do not, in words, tell a patient which doctors they can go to, in effect the regulations may stop the doctor that you

choose to go to from being available to treat you. And that is tantamount to saying that under these regulations doctors may not be available for patients to go to at the choice of the patient. And I believe that is a misstatement by the Commissioner. In effect, these regulations do make it difficult for people to choose the doctors that they want to treat.

Secondly, the Commissioner claims that all medical decisions will be made by doctors. She objected to statements that suggest that the regulations allow insurance companies to dictate the course of treatment. I believe that statement is incorrect, and you have heard it from doctor after doctor and again from Mr. Andres, who just testified from ATLA-New Jersey. In effect, what the protocols do are establish courses of standard treatment, not guidelines, but standardized courses of treatment, which tell the doctors exactly what kind of treatment they can render.

During the first four weeks, they have to follow a conservative course of therapy that is established by the regulations. A certain number of visits to the doctor, a certain number of visits to physical therapists, certain kinds of medication. After that, the doctor has to give prior notice to the PIP carrier of any requests for additional treatment or diagnostic tests. The PIP carrier will then determine whether or not to authorize reimbursement. Now, what the Commissioner is suggesting to you -- and I think it's slight of hand-- The Commissioner is suggesting that all the PIP carriers are doing is determining whether or not a doctor will be reimbursed, that means get paid, and that they are not dictating medical care. But that's not in reality what happens.

If the doctor is not going to get paid, then the doctor can't afford to treat; otherwise they will go out of business. No one is going to pay for their treatment if the PIP carrier doesn't do so. So by mandating whether or not treatment will be reimbursed that is tantamount to determining whether or not care will be rendered. So the power to determine payment is, in fact, the power to determine whether or not treatment will be rendered. And accordingly, it is a fact that under these regulations the approval of medical treatment and tests after the first four-week period of time will be turned over to the PIP carriers and taken out of the hands of your doctors and the doctors of your constituents.

Third, the Commissioner stated before you a month ago that disputes with respect to medical care will be resolved by dispute resolution with the advice of individual physicians provided by MROs, medical review organizations. I wrote it down almost word for word, that's what she said. Don't worry about it, disputes will be determined by medical professionals with medical review. That's wrong. It doesn't work that way.

PIP arbitration, what's now called dispute resolution, which is in your statute, is a process for the payment of outstanding bills. After a period of nonpayment, which will be a minimum of 60 days and can be as long as two years after the treatment is rendered, a physician or patient or a physician on assignment can file a demand for arbitration. As part of that process, the arbitration process -- and I'll call it the dispute resolution process -- you have provided that either party may request a medical review of medical issues. That report will then be submitted to the dispute resolution professional, the

arbitrator, and will be presumed to be correct unless rebutted by a preponderance of the evidence.

PIP arbitration is not designed for the purpose of determining whether future treatment should be rendered. It's not within the mechanism, and even if it was, it would take much too long for disputes with respect to future treatment to get into the hands of the arbitrator. The problem in the regulations is, what does the treating doctor do once a denial of reimbursement has been made by the PIP carrier?

Think of what your intention was, Assemblyman. What did you expect would happen after the PIP carrier denied authorization? What does the treating doctor do? How do you protest? How does your doctor who says, "Mr. DiGaetano needs to have an MRI," but the PIP carrier won't authorize it -- what does your doctor do? There is nothing in the regulations to provide any remedy whatsoever -- well, except perhaps pick up the telephone and try to get the PIP carrier on the phone which is a process that we have been attempting to do for years and what you get is a series of answering machines and rarely can find a live person. There is nothing within this system, despite what the Commissioner testified to, to provide for an immediate review of medical decisions once the request for reimbursement has been denied.

The only thing that the doctor could possibly do, I suppose, is treat you on the arm and hope that some day in the future, maybe after six months or a year of arbitration, they may get reimbursed. But why should you or your constituents be forced to sit and wait while PIP carriers and doctors fight over whether or not you should be treated. If your doctor thinks you need the treatment, you should get it. If you want to have something in the

system to allow the PIP carriers to review it and deny authorization, then there must be something in the system to provide your doctor with a remedy. These regulations don't provide any such remedy, and I believe the Commissioner was incorrect in her statements to you.

Fourth, the Commissioner stated that the PIP system will provide reimbursement for all expenses that are determined to be medically necessary. It's not true. Mr. Andres just referred to it a few moments ago, the co-pay provisions. Even if the doctor renders treatment and it is ultimately determined that the treatment is medically necessary, the PIP carrier can reduce the payments to the doctor by 50 percent, a 50 percent co-pay, if the doctor did not comply with each and every administrative procedure within the decision point review plan of each insurance company, which may vary. Every company may have a decision point review.

So if you haven't complied precisely with the plan, or a precertification plan, and it is subsequently determined that your treatment was proper and was medically necessary, you still don't get paid in full. All the doctor gets is 50 percent. And the insurance company, of course, keeps the other percent, which makes it more profitable for them at the expense of your treating physician.

Now, is that what you intended? I can't believe that is so. I can't believe that the mere failure to comply with the terms of a decision point plan should empower your insurance company to automatically cut your doctor payments in half.

Fifth, and finally, the Commissioner stated that the regulations do not deprive doctors from the ability to order tests. That's what she said. Well,

the care paths as you've heard from doctors only provides for one test. It provides for a cervical X ray, four views during the first month. Any other diagnostic test of any nature you have to give prior notice to the PIP carrier after the four-week period of conservative therapy, and you must get approval. And even if you get approval, you still have to comply with the protocols that have been set forth in the list of valid tests from each of the medical societies. But the key issue is that contrary to what the Commissioner said, the regulations do not permit doctors to obtain diagnostic tests that they think is reasonably necessary.

What's the prevailing standard in New Jersey? The New Jersey Supreme Court, in a case called *Allstate vs. Thermographic Diagnostics*, has said that the standard for determining whether or not a test should be paid under the No-Fault Act is the reasonably objective opinion of the treating doctor as to whether or not those tests will aide in the diagnosis and treatment of the patient. Now, if you were a patient, I think that's what you would like to see happen. You would like your own doctor to be able to exercise his or her reasonably objective expectation to determine whether a test, an MRI, a CAT scan, an EEG, an EMG, whatever it may be, will assist in your diagnosis and treatment. That's the prevailing law in the State of New Jersey, and the Commissioner is completely wrong when she says that the regulations don't deprive doctors from the ability to order tests. You can't do anything for the first four weeks except order a cervical X ray, and after that, you can only order tests if the PIP carrier approves it.

So I wanted to concentrate on those five areas, recognizing that a month has passed and that you may or may not have taken accurate notes as

to exactly what the Commissioner had said, but I do believe that those are areas in which her testimony was incorrect.

I would conclude by commenting that I have a very strong objection to almost the first words that came out of the Commissioner's mouth when she started to testify. She said, "Certain special interest groups have created misinformation." Now, who is she talking about? Who are the special interest groups? Are the special interest groups the legislators? Do you have a special interest because you're concerned about constituents? Are you more concerned about what you think is right for your constituents or getting your constituents' votes? Are doctors more concerned about getting paid for treatment or properly treating their patients? Are lawyers more concerned about getting paid for their services or seeing to it that people's legal rights are being protected?

I think when you talk about special interests you have to look at the injured consumer. You have to look at your constituents, our clients, the doctor's patients. The only special interest that are important to this Committee and are important to the Legislature should be the special interest of the consumers of the State of New Jersey who are injured in motor vehicle accidents. And those are the interests that you have to speak out for.

Insurance companies have special interests, too. And I think the Commissioner of Insurance, before she comes before a Committee such as this and talks about special interests and points the fingers at doctors and lawyers, also has to look at the special interest of the insurance industry and recognize that they are in it for a profit, too, and they are concerned about paying the

salaries of their executives and paying the payrolls of their employees, and that they also have an obligation to deal with the public in good faith.

I conclude by reminding this Committee that there is testimony and we do have experience in the fact that insurance companies engage in bad faith, that they fraudulently deny claims. We have an Unfair Claim and Settlement Practices Act that sets forth standards for insurance companies. The Commissioner of Insurance, who represents all the people of this state, should not come before a committee of our Legislature and point fingers at people who are representing those who are injured in accidents, whether they are doctors or lawyers.

The Commissioner has an obligation to be fair to all people in this state. And where we have claims and testimony and evidence to show that insurance companies have special interests she must recognize that. And when we have evidence that show that insurance companies engage in fraudulent practices and in bad faith, she has to recognize that, too. Her testimony has to be broad enough to recognize that you don't point the fingers at lawyers and doctors, especially if she wants to get along with us. Because if she wants to work together to come up with regulations, as Ken Andres has suggested, that we work together to try to come up with something that will benefit the consumer -- we are willing to do that. But we are not going to do that if we are being singled out as being the culprit of a system where there is more than enough blame to go around.

And that blame has to be shared not just by lawyers and doctors, but by insurance companies, probably by legislators, probably by members of the executive branch of our government. There is more than enough work to

be done without calling names at one another. So I'm not going to stand here and listen to someone to talk to lawyers and doctors as having special interests when they themselves have their own interest.

With that in mind, we would like to continue as representatives of the State Bar to work with this Committee. We especially would like to work with the Commissioner of Insurance. We had a very productive meeting with her two weeks ago in which some proposals were discussed in a very evenhanded and well-balanced meeting, and we hope to continue to work with her.

In the meantime, these regulations do not represent what the Bar of the State of New Jersey feels is a proper method for taking care of people who are injured in motor vehicle accidents. It actually will drive the consumer of the State of New Jersey backwards.

Mr. Andres had made a comment about, "You would be better falling out of a tree than having an automobile accident." Well, frankly, the lesson that these regulations are is you're better off not having an automobile accident in the State of New Jersey. Pay your premiums, buy your insurance here, but if you have an accident in New Jersey, these regulations are going to make it very, very difficult for you to get the quality of care that our Legislature has suggested that our consumers should have.

So thank you again for the opportunity to testify. We don't suspect this will be the last time we are heard from. We will probably be back again, but hopefully we will make progress as time goes on.

Questions?

ASSEMBLYMAN DiGAETANO: Assemblyman Conners, any questions? (no response)

Thank you very much.

Valerie, do you wish to add anything to that? (no response)

We appreciate you being here to testify.

Ladies and gentlemen, we have no other witnesses signed up to speak today, so this concludes today's Hearing of this special Subcommittee. Thank you for your attention.

(HEARING CONCLUDED)