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

before

SPECIAL SUBCOMMITTEE OF THE ASSEMBLY INSURANCE COMMITTEE

"Private automobile insurance with regard to personal injury protection (PIP) as it relates to the medical claims process"

September 4, 1991
10:30 a.m.
Passaic City Hall
Passaic, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Louis J. Gill, Chairman
Assemblyman Gerald H. Zecker

ALSO PRESENT:

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

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Hearing Recorded and Transcribed by
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New Jersey State Legislature
ASSEMBLY INSURANCE COMMITTEE
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625-0068
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NOTICE OF PUBLIC HEARING

A special subcommittee of the Assembly Insurance Committee will hold a second public hearing on the issue of private automobile insurance with regard to personal injury protection (PIP) as it relates to the medical claims process. This meeting will focus on the effect of the changes to that process which were instituted under the FAIR Act. Specifically, the committee is interested in ascertaining whether those changes enacted under the FAIR Act have served to improve the medical claims process.

The hearing will be held on **Wednesday, September 4, 1991 at 10:00 a.m. in the City Council Chambers, Passaic City Hall, 330 Passaic Street, Passaic, 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.

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ASSEMBLYMAN LOUIS J. GILL (Chairman): I'd like to welcome everyone. Good morning, I'm Assemblyman Lou Gill, and I would like to welcome everyone to the second hearing of the Assembly Insurance Committee Special Subcommittee on private automobile insurance medical benefits. I would also like to take this opportunity to welcome everyone, including my Committee member, Gerry Zecker. Bernie Kenny, who serves on this Committee, couldn't make it today. He has to be with the Governor, so we'll be working as a very nonpartisan group: Assemblyman Zecker representing one side, and myself the other side.

We are here to do the people's business today. The purpose of this bill is not Democratic or Republican, but to forge a bill which will ultimately benefit the consumers in New Jersey. The purpose of this meeting will also be to further discuss those issues relating to personal injury protection and the medical claims process as instituted under the Fair Automobile Insurance Reform Act, commonly known as the FAIR Act. Today, our Committee is specifically interested in determining the effectiveness of these changes made to the auto insurance medical claims process under the FAIR Act.

As I noted at our last meeting, no law or legislative action is ever perfect, and certainly the FAIR Act is no exception to this. So, bearing in mind that the Legislature moved in a bipartisan fashion almost 18 months ago to enact a comprehensive overhaul of New Jersey's auto insurance industry, today we are here to examine the effectiveness of certain aspects of this new law.

In essence, Assemblyman Michael Adubato, the Chairman of the Assembly Insurance Committee, created this Subcommittee so that we could first examine those problems regarding the auto insurance medical claims process, and then formulate recommendations based upon the testimony and the content of our public hearings.

Back on August 14, this Committee first convened at Seton Hall Law School, taking several hours of testimony from members of the public, representatives of the auto insurance industry, and the medical and legal professions, as well as the State Department of Insurance. I think all Committee members will agree that the hearing provided compelling testimony which revealed several concerns regarding medical payments and PIP benefits. The hearing also left many unanswered questions regarding the effectiveness of many of the changes made to the auto insurance system in this State.

Today I'm hoping that the industry professionals and the Department of Insurance will be able to supply this Committee with more detailed information concerning the effect of these changes. I'm also hoping that we can develop suggestions for changes to better the auto insurance system in New Jersey. I want to spend some time today discussing how we can improve the auditing and timeliness of medical payments resulting from auto accidents, personal injury protection benefits and caps, the PIP switch, and clarifying insurance questionnaires and insurance questionnaire cards -- the identification cards, that is.

I'll say it one last time: The FAIR Act represented a comprehensive overhaul of this State's auto insurance system. Many of these changes have helped to improve the system; some changes may need further refinement. It is in this vein that we are here today, to work together to improve upon a product first conceived some 18 months ago.

I'll now ask Assemblyman Zecker if he would like to offer some brief comments before we begin to take testimony from some of our witnesses. I would also like to add that other members of the Special Committee, in particular Assemblyman Kenny, had some pressing business matters this morning and cannot be with us right now, but hopefully he can be with us later in the day.

Assemblyman Zecker?

ASSEMBLYMAN ZECKER: Thank you, Mr. Chairman.

I think your opening remarks encompass just about everything that can be said as to the intent of the Subcommittee. I would particularly like to repeat, as I did down at Seton Hall, that I'm very happy that we're moving forward in a bipartisan fashion to address one of the many problems that plague the insurance industry in New Jersey today. I would hope that this is going to be the beginning of many years of bipartisan work, because insurance is not a Republican or a Democratic or an Independent's problem; it's the problem of seven million-plus people in the State of New Jersey. I feel the only way that the problems can be properly addressed is through bipartisan efforts by Republicans and Democrats.

I'm particularly proud to serve on this Committee with you. As I told you, I had some difficulty getting through Passaic. They kept stopping a Republican Assemblyman, but I showed them my birth certificate; that I was born less than two hundred yards away from here, on Fourth Street. Lou and I go back more years than we'd care to admit, and I'm particularly proud to serve on this Committee with you.

Thank you.

ASSEMBLYMAN GILL: Mr. Zecker, I'm very happy to have you on this Committee, and I know your expertise in the field of insurance -- auto insurance, and insurance in general -- is surpassed by very few in this State, and your expertise and your comments are well-appreciated.

ASSEMBLYMAN ZECKER: Thank you.

ASSEMBLYMAN GILL: I would like to call upon the Department of Insurance. I'm very happy to have representatives Bob King and Ron Pott. I'm happy to see that they take their valuable time to be with us and provide valuable testimony. So, gentlemen, if you would, please proceed.

ASSEMBLYMAN ZECKER: Verice Mason couldn't make it today?

R O B E R T M. K I N G: Unfortunately, she couldn't.

ASSEMBLYMAN ZECKER: Okay. You'll send her our regrets?

MR. KING: I certainly will.

ASSEMBLYMAN ZECKER: Thank you.

MR. KING: Good morning, Assemblyman Gill, and Assemblyman Zecker.

ASSEMBLYMAN GILL: Good morning.

MR. KING: My name is Bob King, and this is Ron Pott. We're here on behalf of the Department of Insurance. We're here to address some questions that were presented to the Department in a memo dated August 27, 1991, that requested certain information for this Subcommittee. With your indulgence, I'll-- The response was delivered yesterday, and I realize you haven't had an opportunity, probably, to review it. With your indulgence I'll read it into the record, and when I've finished, I'll try to answer any additional questions you might have.

ASSEMBLYMAN GILL: Please proceed.

MR. KING: Due to time constraints, we are unable to provide complete responses to all of the questions contained in your memo of August 27, 1991. Nevertheless, we are attempting to provide responses to those questions where information is readily available. The following responses follow the sequence of questions contained in your August 27 memo.

Question number 1: Attached to our response is a printout of the 25 largest private passenger automobile insurers showing how many insureds have selected their health insurance as primary PIP coverage. It should be noted that 3 of these 25 carriers have not completed the survey. Furthermore, this survey only covers the period from January 1, '91 through June 30, '91. Therefore, some insureds whose

policies do not renew until after June 30 have not yet had the opportunity to select the "PIP switch" option.

Auto insurers were ordered to reduce the PIP premium by 25% for those insureds who selected their health insurer as primary. The average PIP premium in New Jersey is $165, making the reduction worth slightly more than $40. Note, however, that this is an average figure. The actual PIP premium varies from insurer to insurer, as well as by territory, so that an individual's savings could be greater or less than the $40 average.

Blue Cross/Blue Shield was contacted and informed us that they would only be aware that an insured has selected it to be primary if the insured were injured in an auto accident and submitted a claim. Since this option only became available on January 1, 1991, there is insufficient data available.

In response to question 2, the Department is unable to provide the requested information at this time. However, the Unsatisfied Claim and Judgment Fund which reimburses insurers when medical expense benefits on an individual exceed $75,000. (small portion inaudible due to tape malfunction) We are attempting to develop a computer program that will show when an individual excess claim reaches or exceeds $250,000.

While the impact of the $250,000 medical expense cap is not yet quantifiable, it should be reflected in the claims experience of an insurer. It should be noted that auto insurers were given the option under the FAIR Act to offer medical expense benefits in excess of $250,000, and that four insurers -- New Jersey Manufacturers, State Farm, Amica Mutual, and Home Insurance Company -- are currently offering such excess benefits.

In response to question number 3, the Department does not yet have sufficient data to respond to this request. The Fraud Prevention Division is currently altering its computer system to better monitor this for future reports.

Finally, in response to question number 4, although it is impossible to quantify, savings to insureds have undoubtedly resulted from the balance billing prohibition, which is set forth both in the FAIR Act and the Medical Fee Schedule rules. Additional savings to insureds should result in reduced insurance premiums due to the anticipated decreases in medical expense payments by insurers. Such decreases will be reflected in the overall annual claims paying experience of insurers.

The dollar amounts shown on the Fee Schedule are upper limits beyond which providers are prohibited from charging. It is true that providers, in many instances, will be tempted to automatically increase their fees to these upper limits. This practice is specifically discouraged by the rules, which provide that nothing shall compel a PIP insurer, "to pay more for any service or equipment than the provider's usual, customary, and reasonable fees, even if such fee is well below the automobile insurer's limit of liability as set forth in the Fee Schedules." It is incumbent on insurers and claim review organizations to recognize abuses and avoid making payments that are in excess of usual, customary, and reasonable amounts.

The Department has endeavored to be as responsive as possible within the time allowed, and hopes that the information provided proves useful to the Subcommittee.

If there are any additional questions, we will certainly attempt to answer them.

ASSEMBLYMAN GILL: Thank you, Mr. King.

Your statement notes that auto insurers were ordered to reduce the PIP premium by 25% for those selecting the PIP switch. Is there any data as to how one's health insurance premiums may be affected by that move?

MR. KING: I don't believe there is any data available yet.

ASSEMBLYMAN GILL: Nothing at all? Are you working any of that data up?

MR. KING: I will certainly check on that and get back to you and the Subcommittee.

ASSEMBLYMAN GILL: Please do that.

I think you also noted in your testimony that Blue Cross and Blue Shield do not yet have sufficient data regarding the PIP switch. But isn't it true, however, that in their last rate filing, they attributed a portion of their rate request to the PIP switch?

MR. KING: That I'll have to check on. I'm not personally aware of it.

ASSEMBLYMAN GILL: I think you also note that certain insurers are offering excess of medical expense benefits coverage, over $250,000. Do we know how much companies are charging for this?

MR. KING: It would vary from company to company. Again, we'd have to give you a breakdown on that. It would also vary according to the territory, and a number of other factors.

ASSEMBLYMAN GILL: At our last hearing several concerns were raised relating to the Medical Fee Schedule and suggested revisions. Has anything been done to address these concerns, as of yet?

R O N A L D W. P O T T: At the last hearing I mentioned the fact that we had prepared a bulletin which will go a long way toward solving what we consider to be the major problems with the Medical Fee Schedule. I touched base with Verice Mason yesterday afternoon, knowing that we were going to be here this morning, and she assured me that within a week that bulletin will be released. It's just pending final approval.

The Medical Fee Schedule, apparently, is subject to litigation with the Medical Society of New Jersey, and review by the Attorney General's Office is necessary.

ASSEMBLYMAN GILL: What issue, specifically, will be reviewed by that bulletin?

MR. POTT: Well, I explained at some length at the last hearing; I don't want to repeat my testimony. And actually at the last hearing, because it was at the stage of being a proposed solution of problems, I really hadn't anticipated speaking about the bulletin at all. But, of course, we got into it, because you can't very well talk about problems without referencing possible solutions. But I think the main problem that it will tend to clarify is the one having to do with multiple procedures, and particularly the multiple procedure reduction formulas, which the rules set out; specifically, where multiple procedures are involved calling for 100% payment on the principle procedure: 50% and 25% thereafter, in descending order. That has caused problems, particularly in the area involving physical therapists and other physiotherapy type services.

The one problem that we hope to resolve is where a particular physical therapist's office, for example, submits a very straightforward, honest billing which may not be that much different from what they were submitting before, and having approved and reimbursed by insurance companies before the Medical Fee Schedule ever came into existence. And then, all of a sudden, unknown to them, that formula is applied, and instead of getting something like $65 for services to a particular patient on a particular day with three or four modalities involved, all of a sudden they are down to $35. It's just basically an unfair situation which we want to resolve, and we think we can resolve it.

ASSEMBLYMAN GILL: Okay.

MR. POTT: I might also mention that one other major clarification, I think, would be to underscore the fact that the body parts definition in the regulation is really intended for surgical procedures, and not nonsurgical procedures. We feel that language was prepared with surgical procedures in

mind at the outset. It's-- Some people have interpreted it to go far further than what it really should, and that has led to certain problems, too.

So, with this bulletin, hopefully, if it's approved, and we can get it out -- and we'll try to circulate it as broadly as possible, both to the providers and also to the insurers and to the audit companies -- things should be a lot better, and the phones at the Insurance Department should ring a lot less.

ASSEMBLYMAN GILL: We're looking forward to receiving a copy of that bulletin.

MR. POTT: We'll see that you get it as soon as it's approved.

ASSEMBLYMAN GILL: To what do you attribute the small amount of people who have been doing the PIP switch? I think it's only 3% of the people who have taken advantage of the switch. Is there any reason that the Department has developed, or any concept or theory as to why that number is so low?

MR. KING: We really haven't-- As I say, it's only been in operation for six months. It would be pure speculation as to why certain people haven't opted. There may be a certain amount of hesitancy on anybody to change what they currently have, but again, it's pure speculation at this point.

ASSEMBLYMAN ZECKER: Mr. Chairman, continuing on that thought, may I ask a question?

ASSEMBLYMAN GILL: Please do.

ASSEMBLYMAN ZECKER: The sheet that we have here is undated. The survey results-- You advised us that as of June 1, policies that do not renew-- You are going to have the June 30 until the end-of-the-year figure. Are these numbers all totaling-- Are these accurate as of, say, June 30?

MR. KING: To the best of our-- Yes, they are, as of June--

ASSEMBLYMAN ZECKER: When were the questionnaires mailed out?

MR. KING: I believe that may have been February, or something like that -- March.

ASSEMBLYMAN ZECKER: March? Bob, if some of them responded real quickly, then this would not really be an accurate June 30 figure. They were mailed out June 30, and these are the responses as of July 1 through August, aren't they?

MR. KING: No. They were the actual responses that came in after June 30 that represented survey results from those companies.

ASSEMBLYMAN ZECKER: So, most of the companies waited until June 30 before they responded? (no response)

Do you understand what I am saying? If these were mailed out in March and returned immediately in March, then you would have -- like Aetna Casualty and Surety has 250 as health primary, and 48,942. That's a very small number. Allstate, on the other hand, shows 40,000 on 445,000 insureds. They show a six-month-- If that was sent in, you know, June 30, it shows like a 10% figure. Because this number -- 82,000 on 2.2 million -- I mean-- Let me see, 10%-- Five percent would be 100,000-plus, so this is coming in, Louie, at what?

ASSEMBLYMAN GILL: Three percent.

ASSEMBLYMAN ZECKER: Three percent. It makes you wonder, you know. Allstate, so far, for a half year is approaching a 10% transfer to a health primary, right? New Jersey Manufacturers has high numbers. State Farm has very low numbers, you know. Is it confusion over the forms, or are all of their mailings consistent?

I've looked at a lot of the information that was sent out from different companies, and I'll tell you-- For 23-and-a-half years I worked for an insurance company, and I had to carefully read the information that was sent out. It was thoroughly confusing. Just about when I understood the

forms of my company, I had constituents come in with their company's forms, which were, in some instances, very confusing. I didn't see one that was really simple.

My point is, and you know, Assemblyman Gill alluded to it, some companies seem to have a higher success rate of conversion to health as a primary than other companies. I'm not going to mention them, but you see 70 to health as primary on 31,000 insureds, you know. Another company, 3000 on 388,000 insureds, and then you look up at Allstate, which is 40,000 on 445,000, right? It's still not that big. It will give you a projection of possibly approaching 20% to health as primary. Are their transfer forms-- Are their information sheets more readable, more understandable? Is the information being put out more confusing by some companies? Does the Department of Insurance review the various letters that are sent with the insurance billings?

MR. KING: Yes, we do.

ASSEMBLYMAN ZECKER: You do?

MR. POTT: The "Buyer's Guide," and the Coverage Selection Form, were completely revamped as a result of the FAIR Act as part of the regulatory process, and yet it is up to each individual company to take that material and adapt it to their own purposes. So you are going to have quite a bit of variation, in terms of what goes out.

ASSEMBLYMAN ZECKER: So, you would agree with me that some companies have tried to simplify it, and other companies -- it's not as simple?

MR. POTT: Yes.

ASSEMBLYMAN ZECKER: Are you going to be doing any research into that area, that at least the public full well understands their options?

MR. KING: I think that's what this survey result is an attempt to indicate: which selections are being chosen by individuals, and then to eventually focus in on why people are

selecting them. And maybe, as you pointed out, it could be due to some confusion in the way it is presented to the public. Some companies may be doing a better job of advising their insureds as to their options. That certainly will be something that we would look at in the future.

ASSEMBLYMAN ZECKER: The Department of Insurance is going to pursue it, or did you just get that idea today?

MR. KING: No, we are pursuing it.

MR. POTT: No.

MR. KING: The survey was published-- The forms for this survey that you are alluding to, were published in the "New Jersey Register" back in February. Most of the results were received by July 12. We asked them to turn in half a year's report. We're continuing to receive some of those because there was some confusion on the companies' behalf as to filling out our forms. We sent out a couple of surveys. They overlapped, and there was some confusion there. So, we will be looking at this area again. As I indicated, it only represents a half year's results. And with any new system, I suppose there are going to be glitches, and maybe some of the results here will turn out to be glitches.

ASSEMBLYMAN ZECKER: Bob, do you do your review on a continuing basis, or do you wait for a six-month period to go by? Is it a daily type of review for this type of information?

MR. KING: For the information on the-- I'm not sure I understand specifically what--

ASSEMBLYMAN ZECKER: In other words--

ASSEMBLYMAN GILL: On the Fee Schedule?

ASSEMBLYMAN ZECKER: No, I'm talking about health as primary and auto insurance as to the auto primary -- health to auto primary. Do you keep a continuing survey going on this? Do you stay on top of the companies, or do you just wait for six-month cycles to pass?

MR. KING: I believe the idea on this one is to go with a six-month cycle. Any complaints, we would-- Another area of our Department would handle any complaints as far as misinformation being provided, or we do have the "Buyer's Guide," and the "Drivers' Bill of Rights," that were publications put out to try to explain certain aspects of the FAIR Act, and to better inform them. Those are readily available at the Department.

ASSEMBLYMAN ZECKER: Has the Department received many complaints as to confusion that is created by these choice forms being mailed out?

MR. POTT: Not to my knowledge.

ASSEMBLYMAN ZECKER: Not to your knowledge?

MR. POTT: No.

ASSEMBLYMAN ZECKER: I have received -- not complaints, but confusion. People call me-- My constituents call me up, and I really don't mind giving them the-- It's a job that probably their agent should be doing, but I think many of the agents are confused. You know, the agents, obviously, are there to protect their premium base. And they are going to tell the person, "Look, don't switch over to your health insurance. Keep paying your PIP premium." And at times, that's good advice, because there could be an erosion of their health benefits. But when you see patterns like this developing-- Allstate must be doing something, or have a simpler form, because they have a higher success rate of people taking health insurance.

So, your next real survey into this is going-- You're going to be waiting until January or February of next year after a six-month cycle is completed?

MR. KING: Probably.

ASSEMBLYMAN ZECKER: Okay. Thank you.

ASSEMBLYMAN GILL: Thank you, Assemblyman Zecker.

Did you have a comment? (addressing a member of the audience)

E V A N B E L O S M E G A R I O T I S, M.D.: (speaking from audience) Yes. You're not considering the fact that some people may be switching because -- or not switching -- because the product they can switch to is inferior. If you have a health care product that is not going to give you something better than PIP, then why switch? So, it sounds as if you are saying that Allstate is doing something in a positive vein. I don't know if it's better or worse. I would have to look at it, because if their product is-- If another company's product is inferior, then why switch?

None of you are considering the fact that most patients have no idea what is going on. It's just too short a period of time. I'm a physician, and they come in and have no idea of what's going on with their insurance. They don't know what we mean when we say, "Well, who's first; your private insurance or your PIP insurance?" The time span is too short for any kind of valid data, I think.

ASSEMBLYMAN ZECKER: I'm not trying to get to any point. I'll tell you this: I have Blue Cross/Blue Shield and I did not opt to make them primary. I'm still carrying my PIP, because I personally want that protection, and I'm advising anyone who comes to me, "Be very, very careful before making your Blue Cross/Blue Shield primary." But, Blue Cross/Blue Shield does have a lot of insurance in the State of New Jersey, and possibly a person would not be that troubled in going with Blue Cross/Blue Shield as a primary.

It's just that my point is, the forms that are mailed out are confusing, and I think the consumer has the right to make an educated decision. And I don't think they are being given that opportunity, at least with the forms that I've seen.

ASSEMBLYMAN GILL: To the Department: What further evidence does the Department have that would reflect a decrease in the premiums?

MR. KING: At this point it would be-- As far as--

ASSEMBLYMAN GILL: Nothing.

Do we know what the average insurance premium is in the State?

MR. KING: I'm afraid I don't.

ASSEMBLYMAN GILL: I would like if you could get a written response to some of the questions which have been raised of the Department, so that we can incorporate some of those comments and some of that data into whatever we do with this bill. I'm sure some of these things would be helpful.

Any further questions of the Department of Insurance, Gerry?

ASSEMBLYMAN ZECKER: No.

ASSEMBLYMAN GILL: Thank you very much, men.

MR. KING: Thank you.

ASSEMBLYMAN GILL: Okay. I think we have-- In fact, I do see Mr. Gerry Baker is here from ATLA. Gerry, would you please come forth?

Mr. Baker, at the last hearing you outlined several key issues that this Committee could consider in its deliberations of the medical claims process under the FAIR Act. I would like you, if possible, to focus on those issues of deductibles and copays, offering unlimited PIP and medical expense benefits, the PIP switch, and the Catastrophic Loss Fund. I'd also like if you would discuss with this Committee some specific changes that you recommend. You recommended an awful lot of them last time, and I'm hoping-- And that was with very brief notice. I trust that you have done some further exploration and review of those topics, and we would appreciate your sharing your wealth of information with this Committee.

G E R A L D H. B A K E R, ESQ.: I thank you, Assemblyman Gill, Assemblyman Zecker. How much time are you going to give me?

ASSEMBLYMAN GILL: Well--

MR. BAKER: I'll be brief.

ASSEMBLYMAN GILL: I think-- You're not charging us by the hour today, so--

MR. BAKER: No. I understand. At this point, this is my second appearance, and you're interested in asking some questions and working on some issues, as opposed to just having a statement which is typically what happens before committees, and I have an idea of what it is you want to explore with me.

I think the first question we talked about the last time, and you mentioned in your question to me, was the issue of the amount of PIP coverage that is available. And you know that historically, since 1972, when New Jersey adopted its No-Fault Act, we provided unlimited PIP coverage, unlimited medical expense coverage; unlimited as to time and unlimited as to amount. That made New Jersey's No-Fault Act the best coverage of any state in the United States. No consumer could get a better deal under their No-Fault -- their automobile policy -- than in New Jersey.

Oddly enough, I kept telling people that if you had a choice and you could insure your cars in New Jersey-- I have been advising people for many years to insure their cars in New Jersey, even though the headlines talk about the cost. You have to recognize that some of the cost is because of the quality of the coverage we were giving our consumers. And the cost of, say, roughly $150 for a basic PIP premium, was better than you could possibly get from any policy that you went out to purchase on your own for health insurance coverage. It would cost you far more than that.

So, we actually gave our consumers a bargain, in my opinion. I know this is contrary to the newspaper headlines, but I believe the consumers in New Jersey got a fair deal and got quality for the cost of their insurance, recognizing that automobile insurance is traditionally liability insurance.

It's intended to protect you if someone sues you. There is nothing that says an automobile policy has to be a health insurance policy.

What we did in 1972 was, we engrafted a health insurance policy onto our automobile insurance. We also provided uninsured/underinsured motorists coverage. We provided, of course, property damage coverages. We provided a whole package of benefits that were far more advanced than any state in the United States, but cost more money.

So, if you broke down your premiums and looked at the basic cost of liability coverage in New Jersey, I don't believe it was out of line with any other state. And if you want to have cheaper insurance, I used to tell people, move to another state: You can get cheaper coverage.

ASSEMBLYMAN GILL: Mr. Baker, what you are saying is that we had the Cadillac of the industry, and if you want to own a Cadillac, you have to pay the premium?

MR. BAKER: You've got to pay the price. And in my opinion, it was a reasonable price for the quality of the coverage, forgetting the simplicity of the system. You have doctors here who want to testify, who are up in arms because they can't get their bills paid. You have constituents who have complaints because they can't get their bills paid. You have people having to make confusing decisions about which coverages are better for them: their automobile insurance, their health care, are there proper coverages, does it cover their family, do they exhaust their benefits? None of these were issues before, because you simply-- If you had an accident in New Jersey, you paid for PIP, you submitted the bill to the PIP carrier, they paid your bills, and everyone went home. It was the most simplified system.

Now you have a huge administrative cost built into the insurance industry. They have Medical Fee Schedules. Every doctor's bill has to be broken down by type of service,

multiple procedures, how many body parts were involved. And then you have to look at a schedule, three different regions, 1200-some-odd different procedures in the schedule, and they have to calculate. The carriers don't make money when they have adjusters sitting out there calculating benefits. The administrative cost of running today's system has not yet been accounted for by the insurance industry. If there are some savings, perhaps they are being eaten up by the fact that the companies have to go out--

A lot of companies can't even run their PIP departments today. They are hiring independent auditing outfits that are coming in and auditing every single medical bill, because they don't have the staff for it. And they are paying these auditing companies, which undoubtedly is going to be part of their rating application, showing what their expenses are.

ASSEMBLYMAN GILL: Mr. Baker, you do believe that unlimited PIP medical benefits would significantly increase premiums?

MR. BAKER: Significantly increase? No, quite the opposite. We have never had one representative from the insurance industry come in and give us hard facts about how much money the consumers of the State of New Jersey would save when unlimited PIP was reduced with a $250,000 cap.

I was at all the hearings. I never heard anyone come in and say, "This is how much money the consumer is going to save if you put on a $250,000 cap." So if you're asking me how much more will it cost if we eliminate the cap, as an attorney I can't give you stuff the insurance industry itself won't give you. I listen to all the very nice gentlemen that the industry produces. Some of them have never offended a legislator in their entire careers, because they pick the nicest people to come down to Trenton to testify before you, but they don't give you facts. So how am I supposed to tell you how much more it

would cost people if you give them unlimited PIP, if the industry itself never told you how much the consumer has saved?

The Department of Insurance -- and it's nice seeing these two gentlemen come in-- I miss Ms. Mason not being here, but they have two fine representatives here. Can they tell us-- Can they tell you, since we've changed the law, how much money has the consumer saved because there is a $250,000 cap on medical expenses? They can't.

I can bring you people. I can bring you a nice lady from Fort Lee whose son was just transferred, with my help and the help of her insurance people and her carrier -- who was cooperative -- from Englewood Hospital out to a head injury trauma center. He's been in a coma for the last two months. His $250,000 cap is going to be gone within months, if not sooner. How am I going to justify to her that the insurance industry put a cap on her medical coverage so that somebody is going to save some unidentified amount of money?

Maybe I should bring her in at the next hearing, so that you can actually have some member of the community. You have the Head Injury Institute, who I have had communications with in the past. They have Barbara Gallagher -- I believe is the name of the Director. They have some very capable people who understand what it is like to be catastrophically injured in New Jersey.

Until someone can tell me how much the public is saving by putting a cap on, I have to come before you and say, in the most absolute terms, we should have unlimited PIP in New Jersey. Consumers have had that for 20 years in New Jersey, and they're entitled to it.

ASSEMBLYMAN GILL: Are you saying that should be mandatory, or should that be by choice?

MR. BAKER: Well, my first argument is, it should be unlimited PIP. We should go back to the old system.

Okay, now, as an attorney we learn to say, "My horse didn't cause the damage, and I don't even own a horse." So, my other argument, shifting to the other foot, would be that if you're not going to eliminate a cap and make it mandatory for unlimited coverage, at a minimum the people of the State should be entitled to have the option available to them to purchase unlimited PIP, at a cost -- at a cost.

I have no problem with the Commissioner of Insurance -- and their people down there -- going through the rate applications and setting the proper fee. And then, if you and I want to purchase unlimited PIP, we can do that.

I'm a little surprised. We now know that four companies offer PIP, but I can't believe that the Department of Insurance doesn't know how much it costs. I do, and you can find out just by calling any one of the four companies, or the four agents. I think that Mr. Zecker probably could communicate with someone at State Farm and find out exactly how much they are charging for it. I think you will find out that the charges are quite reasonable. They run between $50 and $100.

Again, it should be a mandatory option, and that would require just a simple change in the language. This is one of the specific things you asked me to produce -- N.J.S.A. 39:6A-10 -- where it says, "Insurers may also make available to the named insureds, at their option, additional first-party medical expense benefit coverage." The word "may" should simply be changed to "shall." And I, quite frankly, from my conversations with some of the legislators, think that some people in Trenton thought that the language was a mandatory option. They thought it said "shall," and there are a few people who are a little bit surprised today, when I talk about this, to realize that it says "may," rather than "shall."

The reason why I say that there is precedent for it, as you know, under the uninsured motorist provisions -- which

is 17:28-1.3, I think it is; 1.1 or 1.3 -- we do already have mandatory options in New Jersey. And that is that the insurance companies are required to give you $15,000 per person, $30,000 per accident of mandatory uninsured motorist. But they must offer you higher UM limits, up to your liability limits. You don't have to buy it; if you buy it you pay premium for it. But it is a mandatory offer, and I think the same thing should apply here. I don't see how the industry should really want to object to that, because you are going to pay a premium for it.

The question is frequently asked: "Well, what about the small companies, the companies that can't afford to pay for a catastrophic loss?" But we know the answer to that, as does the industry, and that is: Under our current law, any medical claims over $75,000 are paid out jointly through the fund, where it is an assessment that is an industry-wide assessment. So, how could any individual carrier object to providing what, in a sense, is $75,000 of coverage to their policyholders on a first-party basis for a fair premium? And how can you, as legislators, truly go back to your constituents and say you are not going to provide this benefit for them?

It really is a shame, and, again, if-- You're in Bergen County (addressing Assemblyman Zecker) and my lady is from Fort Lee, so she's not in your district, but she's close enough. And Assemblyman Zecker knows that I have a couple of people in his district -- because I send him letters from time to time about their particular problems -- who have had catastrophic injuries. One gentleman, in particular, who I have written to you about before, is just about to exhaust his $250,000, and then what are we going to do for him? Not much under the current system, but at least give him the option.

So, that would be my second choice, the mandatory option. And my third choice would be to go back to some sort of a catastrophic loss proposal. I remember very clearly that

when the Legislature spoke in terms of eliminating unlimited PIP in New Jersey, there was mapped with that legislation other bills to provide a CAT Fund. I believe the representation was made -- at least tacitly through the Governor's Office -- that any limitation on PIP coverage would be matched by some form of Catastrophic Loss Fund to provide for our really sad cases in our society, of people who have these terrible injuries. And suddenly, in the political climate of the time, the PIP cap was put on and the CAT Fund was lost. I mean, there was no further discussion nor any explanation as to why it was never pursued.

I think it should be pursued-- Frankly, again, I would argue that it should be pursued on some sort of a mandatory basis, with State funding through motor vehicle registration fees, or whatever. But, if you can't do that, then at a minimum it should be available as an option. Some program should be established that people can go out and purchase, so that if you want to pay the bills for it, it's available to you to pay for.

ASSEMBLYMAN GILL: Do you have any specific suggestions as to how this fund would operate?

MR. BAKER: Well, there were many proposals, Assemblyman, and until we have some things on the table, I can't really-- I can go back into my files from the last couple of years of arguments and look at the different bills. My preference is that it should be funded through some sort of a regular State-funding mechanism. Again, whether it's some sort of an assessment on motor vehicle registration, or whatever, I think that's as much of an obligation of the Legislature to provide as anything else.

There were a variety of proposals. Of course, everyone says that's just another way of putting a tax on the consumer, but here you are getting a huge benefit, because, you know, if you're the unfortunate one who has the catastrophic injury, who are you going to turn to? And we've sat here at

meetings-- I think Assemblyman Zecker was at the meeting in Bergen County with Assemblyman Adubato when we had a whole bunch of people from the various head injury institutes in wheelchairs.

ASSEMBLYMAN ZECKER: It was with Senator Ambrosio, the one that was held in Hackensack--

MR. BAKER: Maybe.

ASSEMBLYMAN ZECKER: --during the hearings on the FAIR Plan we had.

MR. BAKER: Yeah. And I remember people who were yelling and stomping in the back of the room, when people were talking about, how can you take away and not provide protection for people who have-- I mean, it could be you or I who has the next accident. We can't tell who is going to be the next person.

The thing about insurance is, consumers want to save money because they are not the ones who are injured. As soon as they become injured, they become a different type of consumer. They become a victim. And now, all of a sudden, they want recovery. And it's hard to explain to people after they have had accidents why their insurance doesn't provide coverage. They say, "Well, why weren't you here before?" But see, we can't identify for you-- I can't bring in-- We don't have a lobbying group for people who are well. We only have victims. You don't know that you have been harmed by the system until you have been victimized in an accident. And then you find out you've been victimized not just by the careless driver, but also victimized by the system that has taken away your coverage.

ASSEMBLYMAN GILL: I think many people are unaware that they don't have the coverage, or they think they have coverage which they do not, in all honestly. I think part of the problem is the complicated form, or just not being able to understand exactly what they are buying and what they are paying for and what coverage they do have.

MR. BAKER: Which is why our prior system, whatever the cost of it may have been, was the simplest one to monitor, because you were able to provide to the public unlimited medical coverage. Now, if you want to tie that in with a Medical Fee Schedule, or some other things that will provide some caps within the unlimited coverage, that's another approach to it. But once you start putting caps on the top and deductibles on the bottom, you create problems. You provide gaps, and you require people to have to understand the policies, and none of us can do that.

Now, I've been doing this for 20 years myself, and I don't understand my Blue Cross/Blue Shield policy, and I don't mean to. I won't select health care primary because I'm just not going to take a chance. I know somehow or other there are going to be bills that Blue Cross is not going to pick up, and I'm going to end up paying for it.

If you want me to move on?

ASSEMBLYMAN GILL: Please.

MR. BAKER: Before I get to the PIP switch, closely related to the cap on PIP is the bottom end, the deductibles and the copay. You know our statute provides a $250 statutory deductible per accident, not per person. If there is more than one person in the car, that is supposed to be divided. So, big deal. So it's $125 rather $250, and 20% copay, up to $5000, which is interpreted to be per person -- each person involved in the accident.

So, how do you explain? What it means is, if you have $5000 worth of medical bills, and you pay a $250 deductible, plus 20% of the next $4750, you have to pay $1200 out of your own pocket. Now, you are stopped at a red light, and you're struck in the rear by a careless driver who is going 60 miles an hour while drunk through a traffic light; you get hit in the rear. How do I explain to my client that you have to pay the $1200 to the doctor out of your pocket?

Now, if the other driver is careless, then you can sue the other driver to get your $1200 back. Well, that's okay if you have a major injury case and your lawyer is proceeding through court anyway. But if you don't have a big case, how are you going to get a lawyer to take on a $1200 claim? Are you going to file with Small Claims? Then the Small Claims judge is going to be deciding issues of negligence: Which driver was careless for the accident? You're not saving litigation; you're not saving time. You're just creating more of a hassle for your constituent, who is now stuck with a $1200 unpaid bill.

What happens if, you know, your driver happens to be at fault? You caused the accident; not because you are a bad person -- people have accidents -- and you can't sue the other driver. Now you have to eat the $1200. You don't feel as concerned because you're the bad person; you caused the accident. But the concept of the system is to provide coverage routinely for everyone, even if you are the cause of the accident, and those people have no remedy to recover those deductibles.

What happens if you have the verbal threshold, Assemblyman -- you and I have argued this many times -- and you go to your fancy lawyer and your lawyer says, "I can't represent you because your injury doesn't meet the threshold"? Now, you were stopped at a red light; you were hit in the rear by a careless driver. You have to pay $1200 of medical bills out of your own pocket for an accident that wasn't your fault, and your lawyer says he's not going to represent you because you can't make a claim against the other driver because you didn't meet the verbal threshold. And I have to explain to that person that really it's because of the operation of the New Jersey insurance system: We're trying to bring down costs of insurance, and this was the cost to society. As a result of the system, now you have to pay your own medical bills.

Do you know what they are going to say? They are going to say, "My lawyer screwed me." And when I'm finished with them, I'm going to make sure to send a letter to their legislators. I make sure to let them know who their State Senator is and who their State Assemblymen are, and let them find out how their people voted when it came to verbal threshold, and why it is that they have lost their right to sue, and now have to pay $1200 out of their pocket.

But we're not here today to talk about the verbal threshold. I brought it-- I wanted to bring it to you because this is what I do, and I know what happens to people who have accidents. And you bring it into contact, you combine it with the verbal threshold, and you have constituents who end up having to pay a whole lot of money out of their pocket.

Now, let's say they could save $50 on their auto insurance, and yet they have to pay $1200 out of their pocket. Well, that's 24 years of savings. They would have to save the $50 for 24 years before they made a good deal on this deductible and copay. People are supposed to have accidents every 12 years on the average, so what ends up happening is, you never catch up. You can never save money because you are eventually going to have an accident that is going to cost you more than you save by having these deductibles and copays.

So, that leads me, again, to what the obvious point would be: I think that deductibles and copays should be eliminated. But, if they are not eliminated, at least give people the option to purchase insurance coverage with no deductibles or copay. The same thing is my argument on the maximum. This would be on the minimum side. Give people the choice of purchasing the insurance that we used to have before 1988, which was unlimited medical.

ASSEMBLYMAN GILL: And you believe that the increase in premiums would be minimal?

MR. BAKER: Not minimal, but if you ask my opinion I would say it's $100 a car.

If you want to buy it, you buy it. If you don't want to buy it, you don't buy it. And if it's more than that--

ASSEMBLYMAN GILL: But the choice should be available?

MR. BAKER: If it's more than that, it's more than that. The Commissioner of Insurance-- I have confidence in the quality of the people down there. They are going to review the ratings and make sure they are reasonable. Whatever the ratings are, you buy it or you don't buy it, but at least you have the choice of it. Today you have no choice. Anybody who is involved--

I can tell you, absolutely, as a practicing attorney, anyone who is involved in an automobile accident in the State of New Jersey today is going to have unpaid medical bills -- period. Between Medical Fee Schedules, deductibles, maximums, and everything else, there is going to be unpaid medical bills, unless somewhere down the line, years later, in his tort suit, in his third-party action against a culpable driver -- if there is a careless driver -- you can recover it as part of that action. But along the way, there are going to be unpaid medical bills. You're going to have doctors who are looking to be paid, hospitals who are looking to be paid. What happens now--

We're starting to see this wonderful Homestead Rebate Plan, where they are now withholding your Homestead Rebates if you have unpaid hospital bills. What do I do if my PIP carrier doesn't pay a hospital bill, or there are some deductions under the copays or the deductibles? Let's say they take a $250 deductible out of the hospital bill, and the hospital, since there is an unpaid bill, notifies the State of New Jersey, and they now withhold my Homestead Rebate.

What do you think your constituent is going to say to you when they say-- "What do you mean, they withheld--?" I have two people who have already had their Homestead Rebates withheld because of allegedly unpaid bills resulting from this

automobile insurance mess, because there were deductibles and copays. How do you deal with those constituents? They have another problem.

So, those would really be the first two points which are that closely related. You have to do something with the maximums, and you have to do something with deductibles. At a minimum, offer people the option to buy them; then they can't complain. If they choose not to buy it-- I have much less sympathy for someone who comes into my office and says, "This is what I chose to buy." And I say, "Well, that's the way it goes. You haven't purchased the coverage." It's really hard to explain something to a young housewife in -- oh, pick any city in this State; Paterson, Passaic-- What's your district?

ASSEMBLYMAN GILL: Clifton.

MR. BAKER: Clifton, Clifton. How do I explain to them about why they have to pay $1200 worth of medical bills?

Let's go on to health insurance primary, which is the PIP switch, which I guess is closely related to the first two. I don't know where PIP switch came from. It's called the Health Insurance Option. I call it Health Care Primary, or Health Insurance-- I like Health Insurance Primary. That is what I call it, because that's H-I-P, HIP. We're used to talking about Personal Injury Protection, PIP, for the last 20 years. So, to me, when I talk about it, I put down H-C-P, Health Care Primary, or HIP, in my mind, to distinguish the Health Insurance Option.

Now, I told you the last time I was here, and you asked me to bring a little more information-- On the first issue: What kind of health care plans are available in the State of New Jersey, and are they quality plans, as this gentleman asked in his question? What do people really have? The Governor, during the debate, talked about 85% of the people in the State of New Jersey had health care plans, and why should they be paid through their automobile insurance if they have all this other coverage?

Well, we have now found, and it's only been six months -- or really eight months, moving into our ninth month-- We have now found that most of the health care plans that are set forth in the very nice statute that I think both of you gentlemen voted for--

ASSEMBLYMAN ZECKER: No.

MR. BAKER: Oh, some of you gentlemen voted for.

ASSEMBLYMAN ZECKER: It's a matter of record.

MR. BAKER: Okay. --you can't make primary. The statute talks about Medicare and Medicaid. You can't make Medicare and Medicaid primary to New Jersey PIP. Out-of-state plans-- Of course, we recognize that many New Jersey residents work out of the State, and you can't tell New York, or Pennsylvania, or Delaware that their health insurance programs can be made primary to New Jersey automobile insurance law. You can't do that.

But the major gap is in self-funded employer plans, which qualify under Federal law -- under ERISA -- as part of a retirement benefit. New Jersey still doesn't have the right to dictate to the Federal government how plans qualified under ERISA -- the Employment Retirement Income Security Act, whatever it is -- are to be paid. And realistically what is happening is-- I'm just going to give you a wild guess, and I would hope that the Department of Insurance can give us the answer to that some day. I'm going to guess that 50% of the people in New Jersey who think they are covered cannot make their plan primary.

Now, how do they know that? They say, "I want to save some money." We'll talk about the savings in a moment. The statute says you have to provide proof to your agent that you have a health insurance plan. So, you check off the box, and you say, "I have health insurance." And you put down Blue Cross, or private plan, or whatever. And I'm sure the agents aren't asking you to bring in the policies so they can make copies of it and document it and verify it.

So you put down, "Yes, I have a health insurance plan." Now you find out that maybe there is a 50% chance that your plan doesn't provide primary coverage. What happens to you? Do you remember? There's a $750 penalty. You haven't had one of those. When I get one from someone from Clifton who has a $750 penalty thrown on top, I'm going to know who to ask them to go see, because how do you justify-- Not only do they have a $250 statutory deductible, now they have a $750 deductible added on. So now they have to pay the first $1000 out of their pocket, plus they have to pay the 20% copay of the next $4000 -- which is another $800 -- so they are out-of-pocket $1800. Why? Because they made the wrong choice; they didn't know. So we're putting the burden on the consumer, your constituents. And I would suspect that in Bergen County you have a whole lot of constituents who think they are covered under their employer's plans.

That's a symbol of-- What happens if it's your spouse that's injured, and you find out that your spouse is not covered under your plan? What's more typical is that you have a 21-year-old child living at home. Let's take Blue Cross/Blue Shield. After -- what is it? -- 18 or 19, your kids lose their coverage. So you have a 21-year-old kid at home. You've checked off health care primary. Your kid is the one who is hurt in the accident, and you submit a claim to your automobile carrier. Or, you submit a claim to your health insurance carrier and Blue Cross says, "Sorry, we don't cover your children."

Now what? Well, the statute says PIP then has to take over. So you submit the claim to your automobile carrier who says, "Fine, we'll pay your bills." But they hit you with a $750 penalty.

Why? What did you do wrong to justify the $750 penalty? Because you didn't know that your health care plan did not provide coverage for your children, so you get hit with a penalty. Coverage is one problem--

ASSEMBLYMAN GILL: That's a very important point you're making. I think most consumers are absolutely unaware of what you just brought out, Gerry. You've got me thinking as to what kind of coverage I have for my family. I've got four kids, and I think I fall into the category you are bringing out. I don't know if I've got coverage for them in an accident such as that.

MR. BAKER: And you really won't know until, probably, after the accident, because who are you going to go ask? Are you going to start writing letters to Blue Shield?

ASSEMBLYMAN GILL: That's when you look for it, and that's when it becomes important to you -- after the accident, when you become a victim, as you pointed out before.

MR. BAKER: Now, what are you balancing this against? What kind of savings? Twenty-five percent of the PIP premium for one year-- It's only bound for one year under the statute. And some nice gentleman testified-- I happened to pull out an article from The New York Times. The fellow's name doesn't matter, but he testified that he has an insurance agency out in western New Jersey, and he said the 25% reduction was guaranteed only for the first year. After that, they have to go to a claims experience basis, and he has projected that the actual savings will be, and I'm quoting, "will be in the area of $20 per car per year."

Are you going to take that chance for $20? First of all, I wouldn't take that chance for $40, of selecting a health care plan that's not going to provide me coverage. But I'm sure as hell not going to do it for $20.

So, what kind of savings are we talking about? Are we really doing a service to the consumers of New Jersey when we're providing them cost savings' options that take away their benefits and their potential for coverage in the future? Aren't we better off on some occasions simply telling the public, "Look, we're going to give you the best coverage in the

United States. You're a New Jersey resident. We're going to take care of you properly. You're going to pay the price for it, but I don't know that the price is so outrageous, given the fact that you're getting unlimited, or major health coverages"?

The flip of this, of course-- I think, Assemblyman Gill, you asked the question, "What effect will this have on health care insurance?" I mean, we'd have to be way out of the 20th century to think that the health insurance industry is not going to raise their premiums to cover the potential that they may have to pick up automobile insurance accidents on a primary basis.

The same article from The New York Times, which I quoted the last time I was here -- or referred to, but not quote -- the testimony from the spokesman from Blue Cross/Blue Shield at the time that they put in their last rate application, was they estimated that the health care primary option would account for 6.9% of its requested 47% rate increase for its 270,000 customers who do not belong to group plans. So, they are only talking about one limited portion of their population -- individual plans.

And how much is that, 6.9% of their 47% increase? Well, they were asking for an individual policy costing $2500 a year. The increase would be $172, and for a family policy costing $4500 a year, the increase would be $310. I can't make those numbers go away by saying them in a monotone. By saving $40, your Blue Cross policy is going to go up by $172. Now that was just an application. Blue Cross never gets what it asks for, fortunately, but the bottom line is that it is obvious that your Blue Cross premiums are going to go up more than the $20 to $40 savings that we are going to get from health care primary.

Again, I'm not the one who is supposed to be bringing you this data. I'm not in the insurance industry. I am waiting for our nice friends from the industry to come in with

some of the statistics to wow you with the savings that the public is making as a result of these options.

Remember-- Assemblyman Zecker, you and I go back far enough to remember who it was who wanted the automobile insurance carriers to be primary for PIP. Remember, there was an argument back then between the automobile carriers, led primarily, my recollection is, by Allstate and Prudential, as opposed to the health care carriers. Each one of them wanted to be primary. Why did they want to pay the bills? Because the more bills they pay, the higher premiums they can charge.

And auto insurance won. Maybe they're not so happy that they won, but auto insurance became primary. So now what does the industry want? I mean, the bottom line of it is we are stuck with a system where we are making people -- consumers -- make choices that are totally beyond their capacity to understand, for savings that have not been documented by the industry that wanted to have PIP primary, and now wants to have health insurance primary so they don't have to pay the claims. Let's make them tell us what it is the consumers are going to save, and let's make it something that is worthwhile, and not penalize the consumer who makes the wrong choice.

I don't know what the answers are. To me the answer is to eliminate health care primary, or the PIP switch. I just don't see where we have gained anything.

Again, look at the administrative costs. First of all, look at the--

ASSEMBLYMAN GILL: You do believe that if we did eliminate the PIP switch, the consumer would be greatly served by that?

MR. BAKER: Absolutely. And why do only 3% of the public-- Why have only 3% selected it? Because they are probably the only 3% whose agents checked off the boxes on the forms and gave it to them without them knowing it because it was a little cheaper; not much, but a little cheaper.

ASSEMBLYMAN ZECKER: Mr. Chairman?

ASSEMBLYMAN GILL: Yes, Mr. Zecker?

ASSEMBLYMAN ZECKER: Back in the '70s, when who was going to be primary was an argument, the argument that was provided by the health care carriers was their administration costs per dollar were about 4% to 5%, whereas the insurance companies ranged from a 14% to 18% administration fee.

Lou, what that means is, in theory, 96 cents on the dollar could be returned to the public by Blue Cross/Blue Shield, and 83 cents to 87 cents would be returned by auto carriers. The auto carriers argued that their administration costs were higher because they investigated every accident, whereas Blue Cross/Blue Shield took a pile of bills-- You know, they would have an in-office OCR, and that person would just pay 100 to 200 claims a day, and the administration cost was low. The insurance companies won out because they said, "You will have better scrutiny because our administration cost is higher because we investigate every claim, and only pay what we owe." Okay?

So that's why the argument was won then. I was not in Trenton. I was shocked -- because I worked for an insurance company then -- that the administration costs were so high -- you know, 16%, 17%, 18%.

One other thing: You know, you have Assemblyman Gill who voted for the bill, and myself who voted against the bill, for different reasons. Now, Assemblyman Gill-- I never went up to Lou and said, "Lou" -- you know -- "I could punch you in the mouth," because Lou was doing what he thought was right. And I was doing what I thought was right.

When it came to an option -- you may be surprised over this -- I opted to take the right to sue. I also opted to make my automobile insurance carrier the primary pay for all of the reasons that you have come up with, and some that you haven't.

Many health plans have lifetime benefit payments. They will only pay out so much. With my luck, I'm going to get into an automobile accident, use my health carrier as primary, run up a half-a-million dollars in bills -- or three-quarters of a million -- be made healthy, and then all of a sudden develop cancer, where I'm going to have another three-quarters of a million in bills.

I said I didn't want that to happen to me. I have a wife and three children, Lou, and I was doing this to protect not only me, but my family. Maybe if I was single I might have looked upon this differently.

So, Counselor, you know, I have told you many times, I agree with 90% of what you say, but at the time commitments were made by both parties to reduce insurance, and this was perceived to be a way to reduce insurance premiums. I never felt that it was a reduction of premiums. I always felt it was just a cost transference.

But the one thing you haven't addressed, and I think -- Republicans and Democrats, this is not partisan -- we need-- We have not a Cadillac policy, or we didn't have a Cadillac policy. We had a Mercedes-Benz or a Rolls Royce policy, probably the best insurance policy in the United States. I think I can say that safely. But it was going to cost you money.

What we do need, though, it got to be so high priced, we almost need a Yugo plan for people. I was born and raised on Fourth Street in Passaic, and I still make visits back to my old neighborhood. You have urban people who want to comply with the law. They want to insure their cars. They need to insure their cars, because they need to go to work. They want to get out. They want to make life better for themselves. But when their automobile insurance approaches $900, $1000, $1200, they almost can't go to work because they can't afford the insurance on their car, you know, for as much as even buying a car.

So in some instances we are going to have to address a bottom-line plan. And one of the things that has been introduced is that a person who has no assets-- What are they worrying about being insured for their assets, you know, being sued? They have nothing that they even own. They rent an apartment. Their furniture is worth $2000 to $3000, but they have to be insured for health coverage.

I mean there's a policy-- If anything, health insurance is the most important thing to have. The liability portion isn't even that important. We must address-- The Legislature must address a truly affordable plan for the people on the bottom of the heap, who want to have the proper insurance. And as you said, the one major thing that we all want is to be protected in case we get into an accident and our wives or our children or ourselves are hurt.

Now, the other thing is, you didn't mention HMOs, and many of the HMOs do not provide for primary. So there are a lot of instances, but the thing that concerned me the most was that health coverage. Lots of times there are lifetime benefits that are replenished on a percentage basis each year. Let's say the top end limits are a half-a-million or a million dollars. They will replace it at 10% or 5% a year. The other thing is, and one of the things that I was concerned with, I probably could take a $25,000 to $50,000 medical hit. I don't know how I would pay my daughter's college tuition, but I could stretch that out. But God forbid I ever got into an accident where, you know, the limits went over $250,000, to $300,000 to $400,000. I would truly be in trouble. That's one of the arguments that I came up with.

I was willing to raise the deductible portion. You know, in other words, let a health carrier come in for the first $10,000, $20,000, or $30,000, but it's the PIP coverage that becomes important -- most important -- when you have the serious injuries.

One thing I'm a little bit upset about: I know that insurance companies keep tracking -- since the mid-1970s -- as to cases that exceeded $250,000. And I think the Insurance Department could readily get that information, not necessarily for the last five years, but for the last 16 or 17 years when PIP first came in -- exactly how many cases in the State of New Jersey where medical bills exceeded $250,000. I think that's very readily available, and I think this Committee should have it; not for five years, but since the inception of the PIP coverage.

And we hear, you know, from various groups -- I think ATLA was one of them -- that last year, or two years ago, there were 27 cases that exceeded $250,000. You know, those are the kinds of things that don't fall in the cracks. Believe me, the insurance companies know when they have the big hits, because they have been paying on a lot of those for two, three, four, and five years.

MR. BAKER: The Fund would know, because any claim over $75,000 gets submitted to the Fund, and it's paid out on an industry-wide basis, jointly. The Fund has got to know exactly how many files they opened up every single year--

ASSEMBLYMAN ZECKER: Readily available information.

MR. BAKER: --and exactly how much money they are raising and how much money they are paying out. That data has got to be available.

And I remember -- maybe it was this guy Churi, C-H-U-R-I, or whoever it was-- I remember someone from the insurance industry being asked, "How much will the premium savings be if we put a $250,000 cap on PIP?" And the response was, "Minimal."

ASSEMBLYMAN ZECKER: I asked that in the hearings, you know, on the insurance plan, from every insurance company that came, and nobody could give me the answer. To me, it's an actuarial thing that could be easily arrived at. If, in the

course of 16 years, there were 100 of them -- or whatever the number is -- you take that and divide it by the number of policyholders in the State of New Jersey-- I mean, that's probably not the way you do it, but from an actuarial standpoint, I truly believe that there is sufficient data already existing; 17 years of loss runs in this particular area, and we should know how much it saves.

ASSEMBLYMAN GILL: Gerry, I agree with you. I think that data can be made available to this Committee, and I think we should have that data.

ASSEMBLYMAN ZECKER: I look at the response here -- and I'm glad that Verice didn't come today, because we don't like to reprimand her-- The response is, "While the impact of the $250,000 medical cap is not yet quantifiable, it should be reflected in the claims experience of an insurer. It should be noted that auto insurers were given the option--" etc., etc. But believe me, this is readily available information that should come to this Committee.

I agree with you that many legislators-- You know, this thing was hastily prepared, and it was hastily prepared because the public was crying out for lower cost insurance. But I think the majority of the legislators, and possibly even the Governor, thought that, you know, it was a matter of "shall" provide. It was a point that I kept bringing up, rather than, "may." It's definitely the kind of thing that the majority of the people who are making-- Say a family making $40,000 to $50,000 a year and owning a home, they would be fools not to carry that excess coverage, because all you need is one hit like that, Lou, and you lose your house; you lose everything. It's gone.

MR. BAKER: Well, you can invite-- You have ways of inviting people to come and visit you, voluntarily or otherwise. And my guess is that you could probably get that data from the Unsatisfied Claim and Judgment Fund with a request.

ASSEMBLYMAN ZECKER: You have to understand one thing: I've made requests like this for many, many years. I've made requests of carriers. I make a lot of requests. Some of the companies honor my requests. Some of the agencies in Trenton honor my requests, and other companies and some of the agencies are very, very slow in responding: some as long as eight years before they give their response.

I like committees like this. I particularly like committees with subpoena power, because if we don't get cooperation--

ASSEMBLYMAN GILL: We will get cooperation.

ASSEMBLYMAN ZECKER: We will get cooperation.

And what you do is-- You have personnel changes, you have commissioner changes, and all of a sudden things get put aside. And we, as legislators -- you know, everybody is well-intended -- don't get the right information to make decisions. That's why I'm particularly happy that subcommittees like this are being created. They are really the answer -- it's more information gathering.

But, Counselor, there's not one thing you said today that I haven't agreed with, even to the point on the verbal threshold. You know, I had always felt that it was an option that should be made to the public, and I believe that's already been done. And I think you've agreed with me now, that if you want to, you can pick the right to sue. You're going to pay more money for it. If you don't want that right, you don't pay for it. I picked the right to sue, and I've never sued anyone in my life, except the City of Clifton, when they created an MUA in 1970. I sued the City Manager, the whole City Council. I lost, but I won a couple of weeks ago when the State disbanded it.

MR. BAKER: We've come to terms, basically. The compromise is really the response to the difference between the Cadillac policy and the Mercedes-Benz policy.

ASSEMBLYMAN ZECKER: It's really a Mercedes compared to a Yugo. You almost need a Yugo plan, but even that Yugo plan has to provide one thing -- medical benefits. A car damage of $5000 to $7000, property damage--

ASSEMBLYMAN GILL: Gerry, there's no question that we need a bare-bones type of a policy to provide protection.

ASSEMBLYMAN ZECKER: Right. We need that. We really need that.

MR. BAKER: Which is what we have. And the rest of it is the matter of providing appropriate options. I think that's really-- While I've taken positions so far today on most issues about things that should be mandatory or eliminated, truly the compromise positions have been on providing the appropriate options. Now, the maximum PIP coverage can be handled with an option. Deductibles can be handled with an option. There are several things that I still argue, like health care primary, that should not be made available as an option, for the simple reason that it is just so confusing and the money savings aren't enough. It was on my list, and I haven't heard many people understand it.

But Assemblyman Zecker's comment about exhausting-- Your health care coverage is really there to provide for the potential of major illnesses in your family. If you exhaust your health care benefits-- And most policies -- I don't know if most-- Many policies have limits. They have limits as to amounts. They have limits as to time. They even have their fee schedules -- surgical schedules. They have all kinds of limitations on them. If you exhaust your health care insurance on an automobile accident to save yourself $40, you're crazy -- just crazy.

You're dealing with people who are trying to learn to make a living, to support their family, to make rational choices to protect themselves and their family units. And to even give them an option whereby they could lose the long-term

protection for their family-- I'm not-- Assemblyman Zecker's comments are far thinking, not the immediate problem of an accident tomorrow. It's just not sound financial planning. It's just something that should never even be opened up to people as a choice.

ASSEMBLYMAN GILL: Again, I think this is due to a lack of information on the consuming public. That's the bottom line of it.

And, Gerry, to answer what you said before in a brief statement: You know the PIP switch is just one item in an 80-page document. We're here because the document is not perfect, and we're here because we want to address those problems that that particular provision is creating for the consuming public in New Jersey.

MR. BAKER: And also for others. We have doctors here today. Health care primary is an administrative nightmare for the medical profession. They have hard enough problems today with Medical Fee Schedules and all of the other obligations that we put on them. Now, they don't even know-- It used to be that they had unlimited coverage from one source. All they had to get was the name of the PIP carrier and their bills were paid. Now they have to fight with-- First they have to figure out who is primary--

ASSEMBLYMAN GILL: Yeah.

MR. BAKER: --and they're not supposed to be in the business of having to sit their patients down-- You know we all have that image of, you know, you're lying on the stretcher in the emergency room and the first question they ask is, you know, "Who is your health insurance carrier?" Not, "What's wrong with you?" We're requiring physicians to figure out how they are going to get their bills paid, which is a perfectly legitimate business decision that they have to make.

ASSEMBLYMAN ZECKER: You have your carrier tattooed on your underwear. My mother sewed it in on all the labels.

MR. BAKER: And if you change, or if it gets lost in the laundry and you end up with the wrong pair, you blow the whole thing. But the bottom line is, you put a tremendous burden on the health care industry itself, on the medical providers who have to make the decisions first as to who is primary. Then they have to go and they have to submit the bills to, say, the health care carrier, who has their own schedules and their own provisions for what they are going to pay and their maximums and their deductibles. And when that's finished, then they have to take the same bills and submit them to the PIP carrier.

The PIP carrier starts all over again. They take the same bills and compare them against the Medical Fee Schedule, make the deductions, and they are supposed to pay the balance.

How are health care providers supposed to exist under that type of a system? It's impossible for them to deal with the PIP carriers today on the Medical Fee Schedules, but now to find out that they have to deal first with the health care insurance providers -- health care insurance -- and then PIP, is a massive administrative problem.

I guess the last thing-- We probably spent much more time on PIP switch than we should. The last thing is, think of the administrative burden on the automobile carriers, who are supposed to be saving the money by not being primary. They have to train their entire staff to figure out-- They, too, have to find out whether or not there is health insurance; to find out whether, and verify if the person has selected health care primary, that there is, in fact, health care coverage that is going to act as primary, because if there is no health care primary, then PIP has to pick it up anyway. So they have to do an additional type of analysis they never had to do before. And then we know health care isn't going to pay 100% of the bills, so the bills are going to be submitted to the PIP carrier anyway, who then has to recreate the PIP schedule, and then make the deductions from what was paid by health care.

There is no administrative savings to the automobile industry from this. It's just a crazy thing that just really doesn't work, and, fortunately, no substantial number of the population have picked it.

Just briefly: I know we've gone longer than you probably intended. The two other things you wanted me to talk about are Medical Fee Schedules and the "Buyer's Guide" coverage selection form and whatever.

Basically, the Medical Fee Schedule, as I have said before, works, in my opinion, in concept, as long as the amounts that the doctors are allowed to charge are truly set at a level that the doctors can afford to provide medical care. Most doctors, to my knowledge -- and I haven't talked to any of the physicians who are in the room today-- Most doctors can live with the specific amounts of money that are in the Fee Schedule. The problem is, on the office visits for new and established patients when you deal with doctors who are specialized. There is no provision in the scale to provide a different schedule of compensation for a specialist, who charges differently for office visits than a general practitioner.

So, by putting all of your physicians together into one group, the scale is skewed too low. And the risk, the real risk to the consumer -- and I believe it is one that is in the process of being realized -- is that competent specialists like your orthopedic surgeons, or your neurosurgeons, or your psychiatrists, would be really your three major areas, but even people who are-- We now have board certifications in physiatry and whatever. The bottom line of it is, specialists may look at a Fee Schedule and say, "Hey, $107. I charge $250 for an initial exam. I'm willing to cut down my fees, but you're paying me less than half of what I used to charge."

The general practitioner, who might have charged $50 or $60 can now increase his fees up to the Medical Fee

Schedule. For the general practitioner, that's a boon. But specialists, who are the people that we would want someone who is injured in an accident to go to, are going to find that they may start withholding medical care to people.

The issue is not how much the doctor gets paid, because, quite frankly, I don't care how much the doctors get paid. We have to have good relations between our professions, but that's not my problem, how much money they make. What my problem is, is the consumer issue; that is, is competent medical care available to people who are injured in accidents? And if the nice gentlemen who are in the medical profession don't offer their services because the State is not allowing them to be compensated at fair rates, or feel that their office visit time is no more valuable than the time of the general practitioner, you're going to have constituents who are going to come to you and say, "My doctor won't treat me. Now what do I do?"

So that's something that I think has to be addressed by the Department of Insurance, and perhaps by this Committee. There is absolutely nothing that says that you can't pass legislation that mandates how the Medical Fee Schedule is to be drafted. So far you've simply said, "Let the Department of Insurance do it." And if you find certain things, like this bulletin which we are going to get dealing with multiple procedures which hopefully will resolve that problem-- If you find a particular problem which has not -- the regulations don't satisfy, I think there is absolutely no reason why you can't come in and legislate.

I think the two major problems on the Medical Fee Schedule are: One which is apparently going to be addressed about multiple procedures, and the second one is the charges for doctors who are specialists in their fields. These are the things that I think you have to look at. I'd like you to ask

whatever doctors testify about whether or not they feel that the charges that they are getting are sufficient for them to be able to treat victims of accidents.

Remember the doctor who testified the last time, who kind of said -- he implied, he didn't say it flat out-- He implied that he may not be able to afford to continue to render care for people if he doesn't have a proper system for compensating him for his time.

ASSEMBLYMAN GILL: It is a major problem with the medical industry. I have met with the medical industry, aside from committees, and they have shown great concern in that area, Gerry.

MR. BAKER: I mean, I think I'm supportive on that. I really think I'm on the side of the medical profession on these issues, and I have written three letters -- one a year -- to the Department of Insurance, in which I have gone through the Medical Fee Schedules and made suggestions about things that should be added and individual fees that should be raised. So I don't think there is any argument between our professions in this area. I basically support the arguments from the Medical Society dealing with the appropriate amounts of money under the Fee Schedule. I think the concept is acceptable, but there are a few areas that you have to continue to explore.

The payment of bills today is a disaster. My guess is that virtually any doctor you talk to today who has any type of a personal injury practice has more than $100,000 in unpaid bills. And I think you will find physicians who have a half-a-million dollars in unpaid bills, and they are getting-- The system was designed, in my opinion, to make the medical profession pay a huge portion of the reduction in the cost of automobile insurance, by putting on the profession a limit on what they can charge.

The Medical Fee Schedule is a direct threat, or challenge to the medical profession. Nonetheless, I think

doctors can live with it; but not if they don't get paid. And I don't think the Legislature, or certainly not the industry is doing its part to see that the system works. It's one thing to tell a doctor how much he can charge. It's another thing not to pay him.

These phony audits-- They are supposed to pay within 60 days. At the end of 60 days, they start notifying doctors that they want to audit their bills. There is nothing in the statute that says they are entitled to an additional 45 days simply for the purpose of auditing a doctor's bill. Why can't they do their audits within 60 days?

They're not paying the interest. They're not giving the explanation of benefits forms. They're not explaining to the doctors what they are paying for. Doctors are getting checks without covering letters. The doctors don't know whether to deposit them, and if they deposit them and they charge it off against their total bill, they keep billing the patients for the balance without any understanding about what it is the carriers have actually paid for.

A lot of the stuff is not legislative. I think most of it is actually in the legislation and in the regulations today to make the system work. You do have a 60-day time provision. You do have a provision for interest. The problem is, it is not working as the legislation has set it up. I've heard a lot of doctors testify; I've listened to them testify and I say they are in the wrong place in some cases, because a lot of the stuff they are complaining about is already provided for in the statute.

But what you are asking the medical profession to do is start wholesale litigation against the insurance industry. I'm talking wholesale. I'm talking about hundreds of cases. And some doctors with hundreds of unpaid bills, because the industry--

In many cases it's the servicing carriers who are now going out of business. But it's not always the servicing carriers. We have much better performance from the major insurance companies -- you know, the Allstates, and the NJMs, and the State Farms -- but they can't hide behind servicing carriers. The fact of the matter is, the actual administration of this part of the system requires a lot more study, and I think it's the responsibility of the Department of Insurance. I don't know how much legislation you can do beyond what we already have, to see that the system functions.

The last thing, I guess, would be education -- the educated choice. I've argued to you before, and I still do, that the "Buyer's Guide" -- the new "Buyer's Guide" -- the 1990 version of the "Buyer's Guide," which came out in, I guess, as of January 1, 1991 -- is much more understandable. The language is much simpler, but if you read through the sections on the choice of threshold--

My two major problems with the "Buyer's Guide" are, how you select the threshold. You have a choice. The coverage selection form says-- I pulled one out, because it's so clear and understandable. It says, "You have a choice as follows." It says, "Yes, I want the lawsuit threshold," or, "No, I want no threshold."

What's that mean? First of all, you would assume that the lawsuit threshold means that you can sue, but we know that's not the truth. The lawsuit threshold is the one that limits your right to sue, but what does the double negative mean: "Yes, I want the lawsuit threshold," or, "No, I want no threshold."

Well, certainly there is a psychological effect to the positive and the negative. Why doesn't it say, "Yes, I want no threshold," and, "No, I want the lawsuit threshold"? Or, was someone trying to tell us something? Are they trying to direct the consumer to choosing what it is that the Department of

Insurance -- probably the prior Commissioner, not necessarily this Commissioner -- wanted the public to choose? I mean, is this a fair-- First of all, beside the fact that it is unintelligible, is it a fair choice?

So this whole coverage selection form has to be looked at. The "Buyer's Guide" language is not particularly clear.

ASSEMBLYMAN GILL: I agree with you totally. It should be simplified so that the average consumer can understand what he is buying. I don't think the average guy out there, or the average woman, knows what they are buying when they are buying insurance. They have absolutely no idea that they have purchased what, in their opinion, is the wrong policy, or the wrong option.

MR. BAKER: And after they bought it, they then get a form from the insurance company -- A declarations page it's called. Does the declarations page tell you what it is you have? Try reading a declarations page. There are a couple of companies that have clear ones. We had meetings when Hazel Gluck was the Commissioner. We had a committee and we had meetings to draft a standard declarations form.

You try figuring out whether you have selected the verbal threshold or no threshold. Some policies-- Allstate's form specifically says in English what your threshold is, but most of the forms have a number identification. Try figuring out what your PIP coverages are; what your deductibles are; what your income continuation benefits are. Most policies, you cannot figure that information out from reading your declarations page.

Now, I don't want to-- You're talking about medical coverages, but how about rating information? How about the key thing about your premium coverages? Do you have any prior accidents which are being charged? And, do you have any moving violations that are being charged to you?

ASSEMBLYMAN GILL: These are not listed anywhere?

MR. BAKER: They've made some changes in the regulations now with respect to those two items, so I can't testify with the same degree of assurance as I have on some of the other things that I have talked about. I have to review the current regulations. Some companies give you that information. It is my belief that today it's not mandatory, and if you can get a declarations page, you may be charged a $300 surcharge, and they don't tell you. It doesn't say it on the form.

Now, I mentioned earlier, outside of the hearing, that two years ago when I was testifying, one of the legislators who was roundly razzing me during the course of the questioning was complaining about how much his policy premiums went up, and I asked him to send me his policy.

He said, "Nothing has changed in my life except for the fact that my insurance goes up." Well, of course, the fact that he had sold his $24,000 car and bought a $35,000 car, which substantially increased his property damage, collision, and comprehensive; that escaped him. Also, the fact that he had two moving violations and an accident that were charged to him during the course of the prior 12 months; he forgot about that, too. All of which increased his premiums probably about $750, without any basic changes in the insurance premiums.

But, how do you know that as a consumer?

ASSEMBLYMAN ZECKER: For the record: It wasn't the two legislators who are sitting here.

MR. BAKER: It wasn't the two of you.

ASSEMBLYMAN GILL: I think you make a very valid point in that there may be errors on these forms and so forth that the consumer may want to address. He may want to investigate the accuracy of what's being presented -- what he is being charged with. I think you make a very, very valid suggestion; a very valid suggestion.

MR. BAKER: How do you implement it from a legislative standpoint? I'll give you some suggestions as my final comments.

First of all, it has to be included on the forms that are given to people. But another way of doing it is simply-- Companies can't say, "Well, this is expensive for us to give to the public." The answer is, they are using it for rating. If they are using it for rating, it is in their computers. If it's in their computers, they can get it out to you. A way of doing it would be to require verification.

So, let's look at the threshold as just an example. I argue that we should flip the thresholds; that the basic threshold in New Jersey should be no threshold because that gives people the unlimited right to make a claim, and that if you choose to save some money, then you can choose the verbal threshold. Well, that's been my argument. It will always be my argument, okay?

But beyond that, the statute today says that if you don't make a choice, you are deemed to have elected the lawsuit threshold, which limits your rights to sue. Well, what does "deemed" mean? How do people know that they have been deemed? I mean, the insurance company sends you a package of information with a "Buyer's Guide," which they can't understand, coverage selection forms which are unintelligible, and a lot of rating information and advertisements, and included in all this information, somewhere in the back probably, is the coverage selection form, and then maybe they get a declarations page showing them how much their premium is.

All people are interested in is, they want to know how much they have to pay. They pull out the bottom part, write a check, and that's the end of it.

ASSEMBLYMAN GILL: And where to sign. That's it. You're right.

MR. BAKER: Now, the Legislature in their wisdom, says that our policy in New Jersey is that basic coverage should be the lawsuit threshold, and if you don't make the election, you have been deemed to have elected the lawsuit threshold. Why not do a simple thing? Why not make the carriers send you a letter if they are automatically assigning you something which you have not positively selected?

You have to start from someplace. People have to fill out a form and sign it. You can't refuse to give them insurance if you haven't signed the form, because people would keep driving around. They would never complete their policies. So you have all elected-- I give this the broad "you," because you have associated yourselves with the other legislators. You've elected to make basic coverage in New Jersey the verbal threshold.

Well, if somebody hasn't signed the coverage selection form to indicate that's their choice, at a minimum, why not require the carriers to send a follow-up letter saying, "We are renewing or issuing your policy. We are advising you that since you have not filed a signed coverage selection form, you have been deemed to have elected the lawsuit threshold" -- or verbal threshold, whatever you want to call it today -- "and please be advised that if you wish to purchase no threshold you simply have to advise your agent or your insurance company." That's clear enough. But people don't know what they have.

Why don't they know what they have? Because the format in which they are given this stuff is unintelligible, and I think it's intentionally set up so that people are persuaded, or don't pay attention to it.

So, at least notify-- The statistics are that 85% -- now gone down to, I think, 78% -- of the people in the State have elected -- not have elected, have the verbal threshold. But that doesn't mean 78% of the people have elected it.

ASSEMBLYMAN GILL: They are deemed to have it.

MR. BAKER: They have been deemed.

Now, we have yet to get numbers from the Department of Insurance as to how many people have actually said-- I don't think they will ever get it, because the insurance companies will never give it to them. How many people have actually signed coverage selection forms in which they have elected the verbal threshold, and how many people have been automatically assigned the verbal threshold? That's the one I'd like to see.

Because when I talk to people, I can tell you that 80% of the people select no threshold. The other 20%, I lock the door; I don't let them out of my office.

But the bottom line is that it depends on how you ask, and if you want to make fair and educated choices, explain it to them better. But then if you assign somebody something, at least require the companies to send a follow-up. If you know that everyone has got that letter, then, you know, it's a little extra something.

So, that's something-- You asked me to come give you things that can be done to revise the legislation, and so that's one of the things I would offer to you. I don't think that's ever been suggested before, as a way of providing some more consumer education.

So, the coverage selection form, the declarations page, and the "Buyer's Guide," are the three key things that we use to communicate with the public, and I think those three things have to be worked on, somewhat.

ASSEMBLYMAN GILL: Thank you very much, Mr. Baker.

Mr. Zecker, any questions?

ASSEMBLYMAN ZECKER: Thank you. You know, for starters, if the information mailed to the insured as to what his options were, were clearly defined, I think you would probably solve at least 60% to 70% of the problems. You know, in instances where agents get heavily involved with their clientele, that is really the agent's job. But you have your

New Jersey Manufacturers that doesn't have agents. You have other companies, that the majority of them are direct billers now, you know. So after the agent puts the business on, most of the relationship is directly between the carrier and the insured.

I would agree with you that it would almost appear that with all of the information that you get on your renewal notice, it's almost intentional that they want to confuse you as much as possible. You know, we have heard years ago about the easy insurance policy; the readable insurance policy. I would love to see a reasonable billing.

I agree with you 100% that the declarations page is more of a technical tool for the insurance company, rather than as a source of information for the insured.

I have spent a lot of time in the industry, and I have to really read, and many times pick up the phone and call up the company -- and they are annoyed that I'm calling up -- or call up my agent. And many times the agent doesn't even understand. He says, "That's a good question. You're the first one to call me up. I'll call up the company." And three days later he calls me back.

So, I think the information that is mailed out with the billing -- with the initial billing -- has to be made more clear. And, you know, if we have to do it legislatively-- I think if legislators can understand it, anybody can understand it, we would hope. (laughter)

I thank you for, you know, as always-- You know, your input is always beneficial, and I think you hit the mark. We may not agree with everything you say -- or at least some of us may not agree with everything -- but this is one day when everything you say I 100% agree with.

MR. BAKER: Thank you. I'm going to work on the other 10% that you don't agree with me.

ASSEMBLYMAN ZECKER: Well, no. We already settled it today. You agreed that the verbal threshold is good. That it's an option--

MR. BAKER: As long as it's optional.

ASSEMBLYMAN GILL: Mr. Baker, I want to thank you for your testimony. You have been enlightening, and we certainly will be taking many of your suggestions into consideration. Hopefully, we will come out with something better for everyone on this. Thank you very much.

MR. BAKER: Thank you for the invitation.

ASSEMBLYMAN GILL: I see Mr. Lucianin is in the audience. Mr. Lucianin, who has testified before us once before, and I think he has further testimony to add. Mr. Lucianin?

K E N N E T H L U C I A N I N: Mr. Gill, Mr. Zecker, at the last meeting I did testify that there were numerous bills in my office, where I'm the Office Manager for a provider, that were quite delinquent. Well, I asked my computer to print them out. (witness shows Committee computer printout) These are over 100 days. There's 18 pages, 12 names to a page.

Now, as Mr. Baker stated, this could result in massive litigation. By law, every one of these bills is delinquent. Every one of these bills is subject to, what is commly known as a PIP suit -- a suit for payment of a delinquent bill.

ASSEMBLYMAN GILL: That's over 2000 in those you have?

MR. LUCIANIN: Pardon me?

ASSEMBLYMAN GILL: Over 2000 bills?

MR. LUCIANIN: Well, it's 18 pages, 12 names to a page.

ASSEMBLYMAN GILL: I'm sorry, over 200 bills?

MR. LUCIANIN: Yes. This could easily result in an additional expenditure, besides the payment of these bills, of a quarter-million dollars, because the PIP suits and PIP arbitration have been averaging between $750 to $1000 in legal fees. That's only for the patient's attorney. Of course, the

insurance company also has to be represented. So they have their fees, whatever they are paid, whether it's a retainer per case-- Then of course, you can hold firm that you will not settle this PIP without the interest being paid. That can be a provision which will, then again, just inflate the cost of a bill not being paid.

ASSEMBLYMAN GILL: Mr. Lucianin, you mentioned that they're all over 100 days old?

MR. LUCIANIN: Yes.

ASSEMBLYMAN GILL: Do you have some which go much further than that, in time?

MR. LUCIANIN: Oh, yes. Since your last meeting, I've received a check in the office from one of the servicing agencies for July 1990. Two-hundred-and-two days, 175 days, 292 days, 190 days, 175 days, 167 days, 188 days, 106 days, 107, 202, 252, 163, 167, 169, 195, 365--

ASSEMBLYMAN GILL: Although they're supposed to be making payment within the 60 days, it's not happening with your company?

MR. LUCIANIN: It's not happening. As I brought out earlier, you know, it's not only the fact that theses bills aren't paid. As Mr. Baker brought out, about the Homestead Rebate, I know two people who had their Homestead Rebates attached due to medical bills from a hospital. Hospitals, they don't hesitate to -- after notifying the patient a couple of times -- just send it in for collection, and that's their right.

One other thing that I think we're missing, or that was missed, is that the specialist -- and he was right again, I brought that up earlier-- There are some specialists who will not accept a case or referral unless their bill is paid up front, and they give the patient a paid bill which he can then submit to his insurance carrier, whether it be private or whether it be PIP or a secondary insurance carrier.

There are medical providers out there who after 30 days -- 60 days, 90 days -- put an interest penalty in their bill, and that's not provided for anywhere in PIP care. I don't care about the Fee Schedule. The doctor could be applying the Fee Schedule right to the limit. If he's not paid after 60 days, he's entitled to put an interest penalty on that bill which has to be handled by the consumer. There's only one place that money is going to come from, and that's from the consumer.

The insurance company has no qualm -- no cause to worry about that interest penalty unless there's a PIP suit, and it's held firm that the client will not settle unless their interest is paid. So, once again, the consumer is hit with the bill. So, not only is their credit in jeopardy, but they have to pay for something that they shouldn't have to pay for.

Assemblyman Zecker said he never made a claim. I think that's great. But, if he ever does have to make a claim, after paying insurance for over 25 years, having his check in the mail prior to -- never being cited for being late, and he now calls upon his insurance carrier to pay his bills, he will then find out that he has to pay an interest penalty because the physician of his choice was not paid for 365 days; or, he gets a letter from TRW that his credit is impugned and he has to pay that interest on top of that again. That just doesn't make any sense.

The consumer is the person who is at the bottom of the totem pole in this whole thing. The poor patient who is involved in the accident, who had the pain and suffering, has to put up with all of this other aggravation. If they didn't need a psychiatrist because of the accident, they may need one after all of the things they're put through: having their credit rating put to a test, paying interest where there shouldn't be any, all because companies out there just can't manage what they're paid to do.

You're right, Assemblyman Zecker, it's over 95% of servicing agencies that are not paying the bills, not the established insurance companies. So, I think this Committee has to address themselves, as Mr. Baker said, to the existing laws that are already on the books. And somebody has to start seeing that the bills are paid on time, not only for the medical provider, who, again, is nice if he does get his money and he can keep his practice going, but more for the consumer, so that they don't get these letters from hospitals, specialists, radiologists, MRIs, and CAT scans.

These people expect their money. They're providing a service, and they expect their money. They don't want to wait. The old-time medical provider, he may wait. He may say, "All right, I don't get paid for 60 days -- 90 days. Eventually I'll get paid." These people, they're a business. They're all computerized. That bill gets generated. Every 30 days you get a bill. After you get that third bill, it's going to the collection agency. After four months, it's going to an attorney. There's no reason that people have to put up with that. They paid their insurance.

If you don't pay your car insurance, you're dropped. They give you that 30 days, and you're gone. Unfortunately, the consumer doesn't have the right to say, "Well, you didn't pay my medical bill. Well, what am I going to do now? What can I do? Who do I go to see?"

ASSEMBLYMAN GILL: He's kind of stuck, isn't he?

MR. LUCIANIN: You're darned right he's stuck. And now, since the last meeting, in an attempt to get these bills paid, I have been calling companies. They're not taking any calls. The adjusters and several of the computer companies are not accepting phone calls. Someone gets on the phone and says, "They're working on claims. They do not have time to talk to you."

ASSEMBLYMAN GILL: This has occurred since when?

MR. LUCIANIN: Since your last meeting.

You can't even get through to check on the status of a claim. I'll give you telephone numbers to call. You can call yourself. Tell them you want to check on a claim. Tell them it's your claim, and you want to check on it. They'll tell you, "The adjusters are not accepting calls. They're working on claims. Leave your name, number, and claim number, and someone will attempt to get back to you." I have yet to get a callback.

ASSEMBLYMAN GILL: Have you-- They've yet to call you back, you say?

MR. LUCIANIN: I've yet to get a callback.

ASSEMBLYMAN GILL: And how long have you been calling them -- three weeks?

MR. LUCIANIN: Since the last meeting.

That's basically my testimony, Mr. Gill. I just wanted to update you since--

ASSEMBLYMAN GILL: Mr. Zecker?

ASSEMBLYMAN ZECKER: Mr. Lucianin, have you had to place many of your billing into litigation?

MR. LUCIANIN: I try not to.

ASSEMBLYMAN ZECKER: Have you ever had to?

MR. LUCIANIN: Yes.

ASSEMBLYMAN ZECKER: What's been your success rate in litigations?

MR. LUCIANIN: A hundred. I've never lost a PIP suit.

ASSEMBLYMAN ZECKER: Never lost. So, ultimately, it's going to be paid?

MR. LUCIANIN: As I stated the last time, 99% of the time it's just a telephone call between the insurance company's attorney and the patient's attorney. What do we have to do to make this go away? Why would there be two legal fees that have to go out, plus the filing of the suit, before a bill gets paid?

ASSEMBLYMAN GILL: I think that was testified to last time. I think Mr. Baker -- if I'm not mistaken -- testified that he hasn't lost a case in 17 years.

ASSEMBLYMAN ZECKER: It was one of the other attorneys.

ASSEMBLYMAN GILL: Or one of the other attorneys.

ASSEMBLYMAN ZECKER: Yeah, one of the other attorneys testified that he never--

ASSEMBLYMAN GILL: Levinson.

MR. LUCIANIN: We have never been denied payment, ever.

ASSEMBLYMAN ZECKER: No, he said he lost one case.

ASSEMBLYMAN GILL: One case.

MR. BAKER: (speaking from audience) Maybe you need some sort of a intermediate arbitration system where the physicians can file directly, themselves, with some form of an arbitrator, without having to go through the patients, the patients' attorneys, and their own counsel. Maybe even the Medical Society, in the relationship-- There has got to be some intermediate proceeding, whereby the physician--

I listen to all of this and I simply say, "Sue them." That's not really the answer. The answer is to figure out some way to provide a system whereby physicians who are not being paid within 60 days can find some kind of recovery. We have PIP arbitration where you don't have to hire a lawyer, but if you hire a lawyer, you have to file a form to the American Arbitration Association which cost you $150, or something.

Maybe even the AAA-- If you can communicate with Richard Naimark and the people with AAA, maybe they can set up some sort of a more generalized system whereby the physicians can file a form with the AAA, funded through some other type of program, or whatever, and have some sort of direct resolution of their claims. There's something missing.

ASSEMBLYMAN GILL: There's something missing.

MR. LUCIANIN: That's an important point that Mr. Baker just brought up. These suits that are filed, they have

to be filed in the patient's name. In other words, I have to notify Mr. Louis Gill that his bill in my office is still outstanding. It's in excess of 100 days. All attempts to collect from his insurance company were fruitless. Therefore, we have no recourse but to ask him for his money.

Now, you will run to your attorney, who will call our office and say, "Wait a minute. Please extend him the courtesy. We will file the suit on your behalf." But you have to file the suit. The doctor cannot do anything to collect his unpaid bill except go back to the patient.

ASSEMBLYMAN GILL: So, again, more problems for the victim, or the patient.

MR. LUCIANIN: Again.

ASSEMBLYMAN GILL: He's got to take a day off from work to get a lawyer and--

MR. LUCIANIN: It's another point, one more time.

MR. BAKER: I don't agree with that 100%, but I think we're still on a key point. I'm not so sure a doctor could not take an assignment--

MR. LUCIANIN: Oh, you can take an assignment--

MR. BAKER: --and sue in the patient's name.

MR. LUCIANIN: --but the patient still has to sue.

MR. BAKER: But suing in the patient's name.

MR. LUCIANIN: Yeah, the patient still has to sue.

MR. BAKER: There is no reason, I don't think, why a doctor couldn't sue for 100 patients against the same insurance company, in one lawsuit. But nonetheless, you're still requiring the physicians to hire attorneys.

ASSEMBLYMAN GILL: Right.

MR. BAKER: And I'm not speaking against lawyers. They're not interested in this kind of litigation.

ASSEMBLYMAN GILL: No, we're trying to get down to the bottom line on this.

MR. BAKER: A personal injury law practice doesn't litigate medical claims. This is a waste of my time, as well as anyone else's. But if you can find some way to create a system through the Department of Insurance, or whatever it is -- the Arbitration Association, or a voluntary board provided by the Medical Society, the insurance industry -- without lawyers; don't put any lawyers on the committee -- and let them hassle out these bills without the payment of fees, without the assessment of charges, so that these bills can be resolved on a fast basis-- I don't know how to do it. It's the first time it's come out. Someone has to create a system.

ASSEMBLYMAN GILL: It's something we will be looking at. I can assure you of that. Gerry?

ASSEMBLYMAN ZECKER: Mr. Lucianin, on the one that you had for a year, did you get interest on that or did you settle it?

MR. LUCIANIN: It's still pending.

ASSEMBLYMAN ZECKER: You said you got a check. I believe you said a check.

MR. LUCIANIN: Oh, with no interest.

ASSEMBLYMAN ZECKER: Oh, you didn't get it?

MR. LUCIANIN: No.

ASSEMBLYMAN ZECKER: No interest?

MR. LUCIANIN: No interest.

ASSEMBLYMAN ZECKER: And you said you would prefer not to go into the route of litigation. So, you tend to negotiate in-house?

MR. LUCIANIN: Right.

ASSEMBLYMAN ZECKER: And you're just waiving interest? So you're losing the interest on a bill that's outstanding 100, 120, 150, 200, 250 days, right?

MR. LUCIANIN: That's because we don't charge any interest.

ASSEMBLYMAN ZECKER: You don't charge interest?

MR. LUCIANIN: We don't charge any interest.

ASSEMBLYMAN ZECKER: Did you ever get the opinion that the companies are using cash flow?

MR. LUCIANIN: Yes.

ASSEMBLYMAN ZECKER: Because if they're doing this on enough cases--

MR. LUCIANIN: See, when I sued on my case, I did get the interest. I demanded the interest, and I did get the interest in my case.

ASSEMBLYMAN ZECKER: But it's almost-- It's to the point when you can settle this in-house without having to go the route of litigation-- The concession you make is to waive interest for three to six months?

MR. LUCIANIN: Right. Just send us the check.

MR. BAKER: The statute does provide--

ASSEMBLYMAN ZECKER: Are these under investigation? In other words, the insurance companies have what they call "red flag" cases; you know, cases that they feel look a little suspicious. Are many of these "red flag" cases, or are they clear-cut injuries?

MR. LUCIANIN: I have received-- I do not have one letter in our files stating why these bills are not paid. There's not even a request for an extension of the 60 days; not one on any one of these cases.

ASSEMBLYMAN ZECKER: I realize, and I don't mean to question or sound wrong-- Are many of those repeater cases, or are many of them first time?

MR. LUCIANIN: First.

ASSEMBLYMAN ZECKER: First-time injuries.

MR. LUCIANIN: Ninety percent are first-time injuries.

ASSEMBLYMAN ZECKER: A red flag would be a two-, three-, four-time injured person; prior injuries, maybe a preexisting injury.

MR. LUCIANIN: No, no. No, no. As I said, Mr. Zecker, every one of these cases is the Fee Schedule, and every one is the reduction in the multiple modalities, the 100%/50%/25%.

ASSEMBLYMAN ZECKER: And generally clean cases?

MR. LUCIANIN: All clean cases.

ASSEMBLYMAN ZECKER: Not the kind that would normally arouse suspicion?

MR. LUCIANIN: If they're arousing suspicion we don't have any knowledge of it, because we haven't got a letter saying that it's under investigation.

ASSEMBLYMAN ZECKER: You're not put on notice by the carrier for the reason?

MR. LUCIANIN: Not one letter from the carrier on any one of these cases. Not one.

ASSEMBLYMAN ZECKER: Thank you.

ASSEMBLYMAN GILL: Thank you, Mr. Lucianin.

MR. LUCIANIN: Thank you, gentlemen.

ASSEMBLYMAN GILL: I know Mr. Megariotis has been waiting here for quite a while this morning.

DR. MEGARIOTIS: Dr. Megariotis.

ASSEMBLYMAN GILL: I'm sorry?

DR. MEGARIOTIS: Dr. Megariotis.

ASSEMBLYMAN GILL: I'm sorry. Dr. Megariotis, from the Board of Certified Orthopedic Surgeons. Thank you for being so patient.

DR. MEGARIOTIS: It's okay. Today's Wednesday; I play golf. (laughter) I don't play golf.

Thank you for having me. I'm Dr. Evanbelos Megariotis. I am an M.D. I am a Board Certified Orthopedic Surgeon. I am the Director of the Clifton Trauma Rehabilitation Center. A good portion of my practice involves patients who are injured in automobile accidents, or at work, or at other places. I've been in pratice for eight years. I

was born in Passaic, and raised in Paterson, so this is home. I have now moved to the suburbs in Clifton. I still live in Clifton, Assemblyman Zecker. So, I think I know a little bit about the area, and a little bit about the problem.

As an operating orthopedic surgeon, and one who does surgery, I handle the big cases -- the disasters -- and I also handle all of the little cases -- the soft tissue injuries, the headache cases -- because they need care also. I see people the day they get swept off of the street and brought in by an ambulance. And I see people five years later when they're still trying to figure out what's wrong with them, why they still have problems, or when something like orthopedic metal has to be removed. I literally operate on the patients of dead orthopedic surgeons.

Out of neccesity, because the fees in orthopedics are high, nobody walks into an orthopedic surgeon's office anymore and pays his bill cash. I have had to become some sort of an expert, and knowledgeable in insurance matters. We have learned to work with the carriers, and learned to work with the legal profession, and learned to work with the patient. I literally sit in the middle.

I have to care for the patient and all of his problems, order the things that have to be done to figure out what's wrong with him, get him better, and get him back to work; talk to, argue with, and document to the nth degree everything I do. I have to talk to them about their insurance, their hospitals, their bosses, their spouses, their lawyers, their suit, all of their supplies, and everything that's going to happen to them; otherwise it's not good care. It's comprehensive care that I do.

The problem is, that it's changing again. The question here was, what has this new law done for the patient? It's been nine months, so the baby's been born, and it's a disaster. We're talking about accounts receivable 100 days.

That's a joke. Standard procedure for me is six months. I can tell you that I dictate the letter the day I see the patient. It gets typed within 24 hours. It's put in an envelope and mailed to the carrier. If I get paid in less than six months, it's a joke. That's standard procedure. That's not even why I'm here.

You've talked about cash flow. I charge interest. I never get it, but I charge it. It's standard procedure. They just roll and roll and roll things. I sit here as a provider and talk to you, but I'm also a consumer. I did the PIP switch. I have excellent health care, and I take care of it, and I'm attending to it. I'm a doctor. I have three children, one on the way, and a wife. I want them taken care of. The PIP switch saved me $40, and I was blessed with a 34% increase in my premium by the same carrier.

I won't name names, but the same insurance company that insures my vehicles, my facilities, and my health care, as well as 10 employees, raised my premiums 34% three months ago, and that's not even including what Blue Shield is going to do to me -- Blue Cross is going to do to me -- the first chance they get. Last year they raised me 25%. So, now my premiums are $9500 for a family.

I can no longer offer health insurance to some of my employees, because how do I tell a girl who works 2000 hours a year that I have to deduct $3 an hour from her pay to give her insurance? Now, I could get cheaper insurance; there's a lot of junk out there. I see it because they come into my office and they want to be cared for by me, and I tell them, "You don't have any coverage."

You talked about Medicare and Medicaid: 10 cents on the dollar, 20 cents on the dollar, 30 cents on the dollar. PIP has now become, by law, 75 cents on the dollar, but that's before you start factoring in penalties and deductibles. Deductibles and copays will result in a patient or doctor being

paid at half price. I started eight years ago. I'm a specialist. In order to see me it was $150. That fee went up. Today I am paid $118. It's CPT. It's cold and clean. It's there. They get a letter and they still won't pay me for six months. They won't even consider it so I can send it, or mail it to the next insurance company.

We have this down to a science. We're trying to do what's right. I'm a young man. I'm going to be around, God willing, for another 20 years. I have to do it right. I'm not semiretired. I don't have one girl. We have 25 employees. Unfortunately, half of them are busy chasing insurance companies. That's what it takes to support two doctors, three therapists, and aides. Otherwise we can't work, because there would be no money. It's worked for eight years, but it's become an absolute disaster.

ASSEMBLYMAN GILL: How do you keep your cash flow, if they're six months behind?

DR. MEGARIOTIS: I'm getting paid for cases that I did three years ago. I have put in the dues at 100 hours a week for eight years. If it wasn't for old money, I'd be in big trouble the last nine months, because the money is just not coming in. I also have private patients. They pay. I can tell you that there has been cost shifting, okay?

What has happened is, Medicare and Medicaid have been taken out of the office. I can't afford them anymore. Private patients, you can charge more. They'll pay. But still, how long are they going to pay? There will come a time, and I've considered it, when I may have to stop doing certain things. One has to remember that I can render medical services, but I can't really do it alone.

I may want to do a big fancy operation. If I can't get the right equipment, or if after I've done the operation nobody wants to give the patient a brace, or no nurse wants to show up and take care of them, guess: Who gets in trouble when

things don't work out? Me. Though it hasn't happened yet for real, there's going to come a case when I'm going to go there and I'm going to see the patient and I'm going to say, "Do you know what, in order for me to take care of this patient--" This is going to be a mess. This is going to be an infected leg. I'm going to need all kinds of other people to help me. I think I'm going to put him in a cast, and I'm going to send him someplace else.

What you have to remember is, there's not just the services rendered here; there's massive risk. So, what has happened with this new law is that doctors -- the specialists -- are doing more work at higher risk for less money. That makes sense. I want to do that. I'm doing it still, because I've done it for a while, and there's a need. I felt that the thing could be corrected. Believe me, I've made phone calls and I'm in the process of educating my own insurance carriers, and my own patients.

I've spoken to Mr. Pott. I've written him letters. I've talked to the Medical Society. I'm a Trustee for the Passaic County Medical Society. I sit on a Legislative Committee for the State of New Jersey. We're going to meet in a couple of weeks. We're trying to figure out the right answer. We know there are problems, but the problems have been dumped on the physician.

The statistics that we talk about are-- Of the health care dollars-- Of the motor vehicle dollars, do you know that 50% of it is not for human bodies. It's for auto bodies. No one's talked about that 50% that goes for metal. When you pay your dollar for car insurance, 50 cents is for metal, 20 cents is for lawyers, and 20 cents is for health care, of which doctors are 4%. So, I'm 4 cents of the dollar, and yet, guess who's carrying the load right now? Ten percent is for administration, so 50% is for metal. Twenty percent is for lawyers, 10 on either side. Twenty percent is for health

care: hospitals, nurses, chiropractors, orthopedic surgeons, generalists, everybody, and 10 cents for the insurance company to do their work.

ASSEMBLYMAN GILL: Now, Doctor, just to interrupt you-- You are the head of the Passaic Medical Society?

DR. MEGARIOTIS: No, no. I'm a Trustee for one of my hospitals.

ASSEMBLYMAN GILL: A Trustee. Have you been meeting with the Society as to streamlining this process in any way? Have you come up with--

DR. MEGARIOTIS: This was rammed down our throat. You have to realize what Governor Florio did with the stroke of his pen was created, what is considered mandatory trauma assignments, something that we fought with the Federal government for about 10 years. I have no choice. I have to take what they give me, and I do, without explanations of benefits. I'm literally at hazard of committing a crime. When you talk about a specialist saying that he's going to give his bill to the patient and wants to be paid up-front, he's hoping that the patient doesn't send the bill to PIP, because if the patient sends the bill to PIP, he's a criminal. He overcharged.

ASSEMBLYMAN GILL: Have you met with the Bergen County medical people, or are you people splintered?

DR. MEGARIOTIS: Well, the Medical Society of New Jersey does most of the work. The local societies are trying to put out the local fires. Honestly, you have to realize that the vast majority of M.D.s do not see trauma patients, and they refer them to specialists. The specialists then care for them, or refer back. Again, the time scale is just too short.

ASSEMBLYMAN GILL: I asked you because I have met with the Bergen County Medical Society. Now, you're here with the Passaic County--

DR. MEGARIOTIS: I'm here privately. I'm not here as part of the--

ASSEMBLYMAN GILL: Privately, okay, or whatever it may be. I think one of the things that we have to do is have a line of communication set up between the Medical Society, or among the Medical Society, the legal profession, and all other responsible parties, so that we can arrive at a more just solution.

What you're saying, I'm certain, is absolutely true, and I'm certain that what Mr. Lucianin said is absolutely true, and I certainly believe Mr. Baker's testimony today. What we need to do is find a way to forge all of these problems that we've been exposed to into a simple-- I don't know if there is a simple way to attack this, and approach this, but I'm sure there's got to be a better way to do it then we're doing it now.

DR. MEGARIOTIS: I agree.

ASSEMBLYMAN GILL: That's the bottom line of it.

DR. MEGARIOTIS: Well, you had two systems--

ASSEMBLYMAN GILL: What we're here today for is to get all of this input so that we can make that decision, and forge that element.

DR. MEGARIOTIS: But the system is crumbling right now. The system is crumbling. If I were to send the patients that haven't paid their bills, right now, to collection, there would be 300 PIP suits. I do charge interest to the carriers. Some of them, once in a while, will say, "Yeah, you're right. We did do all this. We did do all of that, and we'll pay you something." Most of the time they just throw it in the garbage. It's a joke.

Now, I'm also a stockholder. I own stocks in some of these insurance companies, and I read it from their side. They love what's going on. It has confused things. It has allowed them to hold money for quite a long period of time, and I'm not talking about $500 bills. I'm talking about a patient that had $10,000 bills because of surgery and rehab.

ASSEMBLYMAN GILL: Doctor, so, if it wasn't profitable for them, they wouldn't be doing it?

DR. MEGARIOTIS: Well, no. They have problems. The only people who have benefited-- You asked, "Who has benefited from this?" The patient hasn't benefited. They have lost access. Doctors are either not seeing them at all-- I was told, two or three months ago -- I don't have it officially -- that if you had PIP insurance you couldn't be seen by orthopedic surgeons in Wayne. If you came in with private insurance they might see you, because if you have private insurance I can balance bill you.

If my fee is $150 and that's what they want to pay me, under PIP law you can't even pay me that. What's going to ultimately happen if that is kept the way it is, you're going to have a reduction to mediocrity. Why should I get up at 4:00 in the morning? Why should I go to courses? Why should I bust my butt to take care of you if the other guy who does it average gets the same fee? Why should I try harder to be at the edge of knowledge? Why should I even come here and testify and worry about all of this stuff getting done, and done right? You're going to pay me the same as the guy who barely gets by.

There's no way-- You can't even tip me. I asked the Medical Society, "Can I work for tips?" Doesn't that sound disgusting? Can I work for tips? Can I leave a cup there and say, you know, "If you think I'm a good doctor, put some money in the cup"? -- as a joke. I can't. It's against the law. It would become a tariff. If I said to my patient -- Mr. Gill, the patient -- "Would you please-- My fee is $150. The carrier only pays $118." It's really $250, and they're paying $118. I write off $132 the first visit, in the garbage. "I'll tell you what, if you think I'm good and you like what I did, why don't you pay me by giving me a tip?" It's a tariff, so I can't do that.

Ultimately, you're going to cut down services. If you want to see what's happened with Fee Schedules, think about two great medical wonders: Medicare and Medicaid. They're both disasters. You have just done that with PIP. If you want an example, look across the river to New York State. PIP in New York is like Medicaid; nobody wants to see those patients. They all get shipped to universities where there are lots of people who can take care of them. Nobody wants to see them in a private practice. They wind up in large practices where the economies of scale help them to cover the costs. That's not what used to happen in New Jersey.

When I went to conventions and would discuss with other orthopedics in the whole world, we not only had the best health care in the United States; we had the best health care in the world. If you had to get sick, get sick in your car and you were fine. Now we have something that is unrecognizable, and who knows where it's going to wind up? If you want to look at history, New York's system, which we are trying to mimic, basically created higher costs; less cost to the physician and therefore less access, and more litigation.

Every single one of my patients is angry when we tell them what's going on, and the example is the classic one: You're sitting in your car minding your own business and you get hit. You're going to incur expenses. I guess if they told you before you had the accident that you were self-insuring, you could say, "That was my choice." Okay, I want less insurance so I'm going to have to put $1000 in the bank, because when I walk into Dr. Megariotis' office, I'm going to have to pay him some money.

If you want to have headaches, watch what happens to a patient who comes back as a repeater; the patient who was injured four or five years ago, when everything was taken care of. They came in. It was sent to the insurance company, and it was done. Now they want to know why they have to pay? Why

do I care about their private health insurance? Why do I have to know whether they were the driver or the passenger? I'm an orthopedic surgeon, but the laws are different, whether it's a liability case or a personal injury case.

If you're at risk-- If you were driving in my car, you'd get paid differently than if you were riding in my car. Where are we in the case? Did the guy go to the hospital? Did he not go to the hospital? Did he see other people? Has he just seen me? Does he have health care that's primary or secondary? If he has an HMO, in spite of the laws saying that everyone is supposed to have coverage, in my office if you have an HMO you have no private insurance, because I have never had an HMO take a patient back when I said to them, "Look, this patient belongs to you. I saw him as an emergency. In my opinion as an expert, he's going to need all of this care: therapy, x-rays, evaluation." He gets patted on the head and shipped out. If he decides to come back to me, his HMO hasn't authorized me, so he has no insurance.

Now, how much and how long can I be benevolent? Orthopedic surgeons do well. We'll always do well. We work hard. We're skilled. But how long can I subsidize my private patients? How long can I say, "Mrs. Jones, don't worry about the fact that you have a $10,000 bill with me. I operated on you. You got therapy for four months. I gave you braces."

I gave up giving prescriptions for braces many, many years ago, because we couldn't get the quality. We couldn't get the fitting, and I never knew what I had. So, I was asking you to get a brace and couldn't fit it, and if you screwed up I got blamed. So, I have my own braces I give people. I'm not getting paid for them anymore. It's a losing affair.

The Medicare Fee Schedule is a joke. Everyone knew it was 30 cents on the dollar, and yet that's what was chosen. I don't know where the input came from for this? It did not come

from the Medical Society. We paid attention and we were kind of put to the side. This was shoved down our throats, but you've got to take care of people.

I doubt very much that established organizations like mine are going to suddenly close their doors. We're not selling widgets, where if the price isn't right you just put them in the warehouse and wait until the price goes up. You have us in that sense, but you're going to lose us.

The way you're going to lose us is very simple: The old ones are going to quit, and they're doing it. They're starting to send them to other people. The ones that are almost old, if such a case exists, are going to stop seeing them by limiting the ones they see: "I'm not going to see messy cases. I'm not going to see people who don't have private insurance. I'm not going to see people who don't come for their visits, who don't cooperate. I'm not going to see people who don't have lawyers."

I'm afraid of the patient who comes in without an attorney, because, frankly, I know that they're going to be so muddled up by all of this, that the result is going to be a long outstanding bill. Perhaps Mr. Lucianin can send people to collection. One of the most-- If you want to provoke a malpractice suit, sue them for a bill. So, you're almost at the mercy at the patient, and the carrier--

ASSEMBLYMAN GILL: What do you mean, "If you want to provoke a malpractice suit"?

DR. MEGARIOTIS: The patient-- Many of the things that orthopedics treat inherently do not result in a good result. When your leg is in 27 pieces, it shall always hurt, no matter what I do. If I send you a big bill for the $10,000 to put the pieces back together and you can't pay those bills, the first thing you're going to do is rattle your sword and say, "Well, you know, it's not straight and it doesn't work."

An orthopedic surgeon cannot act like a businessman. Yes, we charge interest. Yes, I'm very businesslike. I have computers. But when it really comes down to the patient, you have no idea what we write off -- you have no idea -- and it's because:

1) the patients can't afford it;
2) you're going to set up trouble; and
3) what else can I do?

You can't get blood out of a stone. We know our patients. We don't see them once: At least I don't. I don't see them once, and they're gone. They're with me for one, two, three years sometimes.

Continued care is a dead issue. I don't even know what to tell people anymore. I have people who are coming to me who I've been seeing every year for complications or problems of their leg, or their back, or their spine. I'm actually treating people of other orthopedists who have passed away. There were never any problems. Now, when they come to me, first of all, they can't get access. Second of all, they had a contract that was supposed to pay 100%; now it's a Fee Schedule. So, money just disappears and they have to pay money. They're saying, "Wait a minute. When I settled my case 10 years ago, because I had a broken leg and a broken back, they told me they'd take care of me forever, provided it was reasonable, customary, and legitimate, etc. Now you're telling me that I have to give you a 20% copay." I'm saying, either that or I have to write it off.

And when I write to the company and say, "But the contract was five years ago. You took the money and said you were going to pay all of the bills," they send me a nice little letter that says, "The Insurance Commissioner has interpreted that all fees will be paid under the present schedule." I just move on. I say, "Okay, goodbye. I'll see you next year."

There is, literally, in my computer right now, a category called, "Written off because of Fee Schedule." I'm hoping that some sort of legal remedy will ultimately come and we'll have access to that. The doctor has become the banker for the insurance company and all of its ills in our recession. He has become the carrier for the attorneys who don't understand it. You understand it well. (witness motions to Mr. Baker) Most attorneys have no idea what's going on.

When I tell them I'm sorry they're not going to get an MRI-- An MRI costs $850. If you don't have $150, you don't get in. Then if I decide to talk to an MRI unit, and say, "Hey guys, I'm going to send you 10 patients legitimately. Would you be so kind as to see the 11th patient and not ask them for the $150, because they don't have it?" Then it's collusion. I'm referring. But when I ask them to go see a specialist, the specialist wants money up-front, or they just won't see trauma patients. So, I'm supposed to do my work and I can't get help from other people, but if they get in trouble, or if something messes up, who's resposible? I am.

I'm also seeing the patients later. When they call my office and we talk about these things, they go away and most of them don't get better. They come back worse. They go back to-- They substitute. They try to find less expensive care, and then when that doesn't work, they're already gone. I'm taking out more and more menisci that are old. I'm doing more laminectomies that should have been done a long time ago, and I'm doing more and more diagnostic tests to clear up what other people haven't been able to diagnose because they couldn't force the issue. They didn't know how to get an MRI.

I have to get on the phone and say, "You will do the MRI, please," and beg, and they'll do it, but why should we do that? You wanted to make it cheaper. You haven't made it cheaper. You heard the costs of PIP suits. I can tell you

that I've had to hire two more girls just to call people up. You cannot get through to these companies. You cannot get through to the main companies either.

The computer companies are bad, but the major carriers are not better. We do everything they want us to do. They just don't care. They say they want an audit. You send them the records, they don't have enough information. You ask them to come to the office. "Please come to the office and audit my records right there, and I will answer all of your questions." They answer all of my questions. They smile. They say, "Everything is in order, Dr. Megariotis. Thank you." Fine.

They negotiate my bill. I say, "No thank you. There's a Fee Schedule." I get a letter a week or two later, "We've decided to send it to peer review. Send it to peer review. When we call back two months later and say, "What happened?" "Oh, everything's okay. You're calendared for payment in 60 days." In other words, they have 60 days to pay the bill after they've done all of their work, but the result of that is nine months. I'm not even talking about 1990.

In 1991, I can tell you that the vast majority of bills have not been paid, or have been paid at nominal rates. I do physical therapy in my office. I do rehabilitation. They are totally inconsistant. I was paid on thousands of occasions for eight years of work, using Medicare codes. They refused to even consider office visits, because the physical therapy and rehabilitation codes were not changed. I resisted for one or two months because it was ridiculous. I said, "Come on, you've been paying me-- The same patient had 30 visits. You paid them, and there's one visit in 1991 and you don't want to pay it?" "No."

Okay, I went back in time three months and reprogrammed all of the computers and put everything in CPT, which is the little code that itemizes. I itemized my therapy. The result of that was that they went to this

percentile discounting. So there's still no way of figuring out what you're going to get. If you don't know what you're going to get, you don't know what to send to the other carrier. So it's become a mishmash, and the only advantage is there's all of this money in limbo. But we're having trouble functioning.

ASSEMBLYMAN GILL: Doctor, you have, apparently, obviously, spent a lot of time not only researching this. I think you know what you're speaking of. Have you any recommendations to this Committee as to--

DR. MEGARIOTIS: Yes, I do.

ASSEMBLYMAN GILL: I'd like to hear those.

DR. MEGARIOTIS: All right. There are a few suggestions, and they're complex. The first one involves patient counseling or patient information. The patient should know exactly what is going to happen to him if he gets into an accident -- not after, before. If you get into an accident: 1) You can, or you cannot sue; and 2) We'll pay all of your bills; we'll pay none of your bills; we'll pay some of your bills. Your carrier will be primary -- meaning Blue Cross/Blue Shield Major Medical -- or we'll be primary. If you get into an accident, you should see a lawyer or you shouldn't see a lawyer. You can see a lawyer or you don't have to see a lawyer. How do you report an accident?

People walk into our office with their collars on, in their slings and their casts, and they have no idea what to do. You wonder why they go to an attorney? That's why they go to an attorney. I'm expert at this, and we're still scratching our heads half of the time. Many times we will tell a patient one thing and things change. We will be billing someone for six months and then be told another company's primary. There's no way of actually finding out. You can't make a phone call and say to Travelers or Allstate, "John Smith was injured in a car accident, and he says you'll cover it. Are you primary or secondary?" That's a simple question.

They don't know. The patient doesn't know either. They have to bring in two policies. There are 8000 insurance companies out there. Can I be expert in 8000 insurance companies? So, you're always at risk. The patient's at risk. That's the first suggestion. They should get counseling after an accident, too. They should have someone, somewhere, that can advise them.

Should the insurance company be advising them? Well, they have their point of view. Should the doctor be advising them? He has his point of view. Should an attorney be advising them? He's the paid advisor. But if you think about that, that could be skewed. A lot of our problems here are based on litigation. Do you want the counselor to be the person who has a vested interest in litigation? I don't know about that. Think about it.

The second suggestion I would make has to do with what I would call the "gatekeeper concept." Right now, you're using money to limit access and prevent more money from being spent. That's not a good idea, because your ultimate goal is to take care of injured people. You need to have a gatekeeper, a doctor, an expert, someone who will see the patient and care for him.

I act as a gatekeeper for my patients in terms of who they're going to see, what they're going to get done, where they're going to go, etc. Some physicians don't. They just take care of their little problem: "I'm a neurologist. They take care of nerves." "I'm an orthopedist. I take care of fractures." "I'm a physiatrist. I take care of physical therapy." And that's what they do. I've chosen to practice this way. Other people practice other ways.

A gatekeeper is already being used, by the way, in private health policies, which is called "managed health care." I have some problems with that, but the way you have structured the reimbursement of PIP right now, you are shooting

yourself in the foot. The most expert people are being driven away, and the least expert people are actually being well compensated. I hired a private duty nurse for my wife when she delivered. That was only a few years ago. I can tell you the PIP schedule pays private duty nurses double that fee, right now. It's a wonder they didn't complain.

When I told my nurses what a nurse gets for private duty nursing, I said, "Gee, girls, why work for me? Go see one patient and you can make in eight hours--" There's only one other profession, I know, that makes that kind of money in that short of time, and it's not legal. The gatekeeper should be considered.

Right now it's a nurse who is a rehabilitation specialist. She gets $100 an hour. She sits in my office. The first question I've learned to now ask them is, "Who are you, and what is your expertise?" because I'm talking to them in doctor and they have no idea what I'm saying. Yet, this is the person who is going to decide when my patient needs treating, whether they can have a special test, or what's going to happen. So, that's a concept -- gatekeeper.

The third thing I would suggest to you is that the Fee Schedules that you've created always existed anyway. PIP was 17 years old when it was changed -- right? -- two years ago when they had deductibles and copays. It was 100% pay for 17 years. I'm sure that the carriers had Fee Schedules. They generated them all the time. We were allowed to buy them through all sorts of organizations to make sure that our fees were right, because we didn't want to overcharge and we didn't want to undercharge. Yet, they say that there's no Fee Schedules. They exist. The point is, making them fixed creates problems.

If somebody wants to charge less, let him. You know, what's right, within range. Fine. He may charge less because it was easy work and he has low costs. If somebody wants to

charge more, what's reasonable? Does every single product in the marketplace have one price? No. Yet, medical services now have one price, or lower. We'll pay our price or lower, and it's already set at half price. If someone is exceptionally good, wouldn't you like to pay him to continue to be exceptionally good? You don't do this with this schedule.

Leave things as a range. If someone is exorbitant, carriers know; they already had mechanisms for that-- There's peer review. There's medical societies. One of the major committees on a local society is adjudicating these overcharges. Frankly, if you think something is overpriced, don't pay it. But when you know it's within the range, get on with it. Let us do our work.

The forth suggestion I would make has to do with tort reform. There is no question in my mind that a lot of what goes on here represents the problems of tort, and the long period of time it takes. Much of the pain and suffering in medical care would probably not be necessary if cases didn't go two-and-a-half to three years.

Passaic County is blessed. It only takes two-and-a-half years to go to court after you file suit. So, technically speaking, we can settle things in five-and-a-half years. So, for five-and-a-half years you have no idea what's going on. You'd better have your case well documented. You better not leave any stones unturned, and you better not take any chances, because if anything happens, you're stuck.

When insurance companies don't pay their bills, more litigation ensues. When patients -- innocent patients -- have bills to pay, their first response is going to be, "I didn't do anything. Why am I paying these bills?" You didn't tell them they had to pay bills. So, they're going to sue. I believe that they're not supposed to bring up the cost of medical expenses in a suit, but it's still done.

The last thing is, you talked about caps and why you want to get rid of them. Nobody's talked about the fact that, unfortunately, our present tort system often bases the awards on the medical expenses that were paid. So the hidden agenda, if you will, in my opinion as an orthopedist is, the caps were made, not so much to help those few people that have more than a quarter-of-a-million dollars worth of damages--

If you want to know what happens to those people in other states, I have people like that -- middle-class people with jobs who have catastrophic events -- and after $250,000, you wind up on Medicaid. That's what happens to you. Or, you come to my office and we take care of you. We do that, but how many of those can I do? I can't.

The real reason for caps is that a $250,000 medical expense cap will limit the big litigation expenses, and until you address the method in which torts are settled and not tie them to how much money is spent in medicine, you're not going to put this fire out.

People do get sicker when they have the threat of a case above them. They actually do get better when everything is settled, or they learn to accept things and get on with their lives. But, as long as there's an open case, 500 people are asking them how they feel; 200 people are asking them if they want more medicine and more treatment; and seven different people want information about exactly what's going on with them. It's no wonder they go to psychiatrists. If a typical case -- typical fender bender -- takes two or three years to be settled, what does a disaster take?

Those are my suggestions.

ASSEMBLYMAN GILL: Assemblyman Zecker?

ASSEMBLYMAN ZECKER: You've testified that 12 of your employees are there, almost specifically, to collect money. Is that generally correct, or was that on the high end?

DR. MEGARIOTIS: I have three girls who do nothing but call PIP carriers; one girl who does nothing but call attorneys; and about every single person in my practice, including myself-- I would estimate that one-third of what I do is to document the data base for third-party carriers. The last time someone testified, "Do you have different fees for different patients?" Sure I do.

If you walk into my office and say, "I hurt my back when I bent over," I'm going to write a one-minute note: "Back pain, tenderness." I made my diagnosis and what I was going to do, and I was done. That will not be adequate documentation for a private insurance carrier, a motor vehicle carrier, a Workers' Comp carrier, or some legal case that's going to take five years to settle. They're going to say I was a bad doctor. I have to give a real long history. I have to give a perfect physical, so that anyone can read that data five years from now and know exactly why I said, "You have a back sprain."

That's what I do. That documentation requires a full-time transcriptionist, a part-time transcriptionist, the three or four girls that do nothing but call and, an in-house bookkeeper who spends half of his time calling up people and never getting on the phone. Now, we're not a mom and pop operation. We're not the Kessler Institute.

I am a private rehabilation firm. I see people in my office. But that's what it takes to continue to function. It didn't happen overnight. We kept growing and growing. We started out with two people, but otherwise I wouldn't be able to see these people. How can I not see one-half of the people that are injured in orthopedics? The common code of orthopedics is a car accident. That's what people get hurt in.

ASSEMBLYMAN ZECKER: Years ago, insurance companies used to give their clients -- not all companies, but many companies -- checkbooks. They went out and they dealt with the

public, and many of the providers were paid. I'm going back into the '60s. I was a product of that. The theory was, if you paid quickly and promptly on the claims that you owed, you'd minimize the abuses, and in my mind it worked very, very well.

I knew the company I worked for-- I had a great rapport with a lot of the providers because they knew that at least from one company they'd be paid quickly. They would tend to abuse the companies that they knew were slow payers. Do you think if we went to a voucher system-- We had vouchers back in those days too, where the medical forms were sent out and the check was on the bottom of the medical form, so the doctor-- At least for the intitial consultation, the agent would give him a form that had a voucher on the bottom, where the doctor could write out his own fee, and deposit it after submitting the report.

Do you think if we went into a quicker pay, which would reduce your overhead, that it would ultimately result in better medical providers, or would there be more abuses? I know there would be some abuses, but would it be a respected type of thing -- quicker paying, insuring the providers quicker payment? I know that you're going to be around for 20 years. If we catch you abusing, you've got a lot to lose.

DR. MEGARIOTIS: That's exactly why I don't want to abuse it. Yet, I'm treated like the lowest dirt. How many times are you going to come--

ASSEMBLYMAN ZECKER: But the question is, is a quicker pay system -- a voucher system -- the answer?

DR. MEGARIOTIS: No.

ASSEMBLYMAN ZECKER: Well, it's going to save you 12 employees. It's going to reduce your overhead.

DR. MEGARIOTIS: But it won't happen because of the superstructure that's been created. Theoretically, it sounds like a good idea.

ASSEMBLYMAN ZECKER: But, again, we punish the 90% of good--

DR. MEGARIOTIS: I realize that.

ASSEMBLYMAN ZECKER: --for the 10% who are crooks. Should we not go after the 10% crooks and pay the 90% promptly?

DR. MEGARIOTIS: Yes. Your assumption here is that the increased costs here are a function of bad medicine.

ASSEMBLYMAN ZECKER: Oh, no, no. I'm just saying--

DR. MEGARIOTIS: I will suggest to you that that's not the case.

ASSEMBLYMAN ZECKER: --a good portion of the medical dollar is because-- I mean, I go to my dentist-- I go to my doctor for general checkups, and I look--

DR. MEGARIOTIS: And you better have a check, or he won't talk to you.

ASSEMBLYMAN ZECKER: No. I look at the amount of people that are working just in a dentist's office, and his problem is collecting fees. A single practitioner dentist with a good group of clients has to have two people doing exactly what you're doing, and that's just in a dentist's office. It's always collections, collections, collections, that are keeping a lot of people busy. If collections were speeded up, if we went more towards a voucher system, would it be a fairer way to provide quality health care? Or, would the abuses outweigh any of the advantages?

DR. MEGARIOTIS: More rapid payment would cut costs, but the complexity of this kind of care, where you've got two different insurance companies, two different attorneys, and if you have a multivehicle accident you have seven different people, will never be simple.

ASSEMBLYMAN ZECKER: Can I tell you how simply that can be satisfied? An insurance card can be bar coded -- okay? -- and every provider could have that insurance card and put it right in and find out what the person's coverage is.

DR. MEGARIOTIS: The gatekeeper phenomena would do that. If you had a gatekeeper--

ASSEMBLYMAN ZECKER: Yeah, but it could be easily done. The provider would just put in the person's insurance card and find out if the auto is primary or the health carrier is primary. As a matter of fact, they ask you for that information now on your insurance card, and then you can even find out from the auto insurance card who the health care provider is. It isn't the way it was 25 years ago.

DR. MEGARIOTIS: Having less employees will cut your costs.

ASSEMBLYMAN ZECKER: The technology is there very cheaply to provide you with a lot of the information you need as a provider.

ASSEMBLYMAN GILL: I have nothing else. I'd like to thank you for your testimony. It was enlightening.

We also have Mr. Anthony La Duca, who is here representing the Passaic Medical Group. Mr. La Duca will be our last person to testify this morning.

A N T H O N Y R. L A D U C A: Mr. Chairman, my name is Anthony La Duca. I am the Director of several medical clinics which are owned by a Dr. Gaston. One is in Passaic; one is in Paterson; and one is in East Orange.

We have a further problem. We have a problem of economics. We employ -- or had employed, as recently as two weeks ago -- over 85 people in these three clinics, 15 of which were doing strictly collection work. We have since had to let 12 people go because our sources of cash are drying up. We have in excess of $1.5 million out there, and the insurance companies just said, "Don't pay," for a variety of reasons, all of which don't make much sense.

I get explanations of bills that come in, and they say-- Within the same bill it will say-- A physical modality, let's say, would be a hot pack. It is paid at $34 per hot

pack. Within the same bill, for no apparent reason -- on a different day, the same procedure -- they pay $21. You call them and they say, "Well, the computer is set up that way. We can't change it." That's a great excuse. I mean, it doesn't help us any.

ASSEMBLYMAN GILL: Do I understand you correctly, Mr. La Duca, the same modality--

MR. La DUCA: Same modality.

ASSEMBLYMAN GILL: --one day $34, and the next day $21?

MR. La DUCA: Right.

ASSEMBLYMAN GILL: Same carrier?

MR. La DUCA: Same carrier.

ASSEMBLYMAN GILL: Same everything?

MR. La DUCA: Same bill.

ASSEMBLYMAN GILL: Same bill.

MR. La DUCA: On their same explanation sheet. If you ask them why, they say, "Well, the computer is set up that way." I don't know what that means. It simply means that they are trying to do everything in their power to harass you; to stall you, not paying bills.

We used to get-- I guess about January, or February, we got a lot of calls for audits and for progress notes and for complete files, and we used to send them out. But then we started realizing that that was a way of delaying paying for any of these things. So when they called from then on, we said: "We would be happy to provide you with the files at a cost of $75 per file. If you come into the office, we will charge you $75 per file; plus, if you take any of our help's time, an additional $75 for the help." That stopped. They didn't ask us for any more of those things. The files that they did ask for -- asked for charts on -- all of a sudden got paid. Why? I don't know why, but we have very few audits, at least coming to our office. I'm sure they audit most of our files, because I guess it is standard now in the industry that

anything that is over $2000 in medical bills is going to be audited. All our bills are over $2000, so we expect to be audited on everything.

It is just a shame that-- Related to what the Doctor said about eating part of the medical bill-- Well, we started doing that, too, except then they started threatening us with it. They said, "Look, if you are willing to forgo that deductible, or that copay, that means you charged too much to begin with," forgetting the fact that these are people-- We are in minority areas. We're in Paterson, Passaic, and it is obvious these are minority areas. We try to render a service to everyone. We'll treat them. We will give them all the services they need, but we have to bother them for the copay. In most cases, they don't have it. It is a useless exercise.

What we do is, we send out letters, a little threat and the whole thing, but it never gets paid anyway. We would rather just say in the beginning, "Look, we understand these are minority groups. They don't have the money." We would rather just eat it, because then the insurance company will come back to us and say, "Well, if you are willing to do that, you shouldn't have charged it to begin with." Now we're stuck. We're stuck with trying to be good and trying to help the community by actually cutting down our own bills.

We used to charge $70 for a procedure. The Fee Schedule says you should only pay at the rate of $34. So, we want to be good citizens. We lowered everything to $34, and they paid us $21. So we said, "Hey, what happened here? You said that the Fee Schedule would allow $34." They say, "Yes, that's 'up to' $34. We choose to give you $21." We lowered ours from $70, because we wanted to be good citizens and try to help the situation. So we lowered our fees to meet the Fee Schedule. It hasn't helped us; it's hurt us.

Now what is going to happen is, if any of those fees go up, we are not going to be able to raise them, because they

are going to say, "Just because the Fee Schedule has gone up, you can't raise your medical bills." That's what they said in this one. They said, "If the Medical Fee Schedule is higher than what you are charging now, you can raise it because it is higher." So the fact that we lowered it or not to meet that criteria, now if it happened to go back up, we would be stuck, because we couldn't raise it any more. And we're not even going to be getting that, because they're saying, "That is only up to what we can pay. We don't choose to pay you that."

I don't know what the answer is. I guess the first place you have to look is in that prompt payment bill -- the prompt payment 60 days -- because you will find that you can't get to an insurance company on the phone for about 30 days, because you have to sit a girl down and just let that phone ring and ring and ring. When you finally get them you are put on hold, and it is two hours before you can talk to anybody. When you finally talk to somebody, they say, "Well, we don't have that information. Could you call back?" So, that is a useless day. It might take four days to get one claim number.

But, in any event, you'll notice-- We notice that somehow, right around the 50th day, we get a notice that they want to have an audit. It never happens before. It always happens on the 50th day, and there is nothing you can do about it. If they want to have an audit, you have to give them an audit. We will provide all the things they need, but then, as the Doctor says, the stall tactics come in. You know, "Yes, we didn't receive this," or, "We sent it to you by certified mail, and one of your employees signed for it." "Well, we can't find it. Send it out again," and it takes another two weeks. By the time they have an audit, it takes another month-and-a-half. Then by the time the auditor gets to it, their nurse-- She is an expert, better than any doctor, because she can tell you that this patient, whom she has never seen, has never diagnosed, has never come across, has made a

decision that 22 treatments should have cured that patient. How she does it, I don't know, but I wish our doctors could do that. They can't do it.

So now she has made a determination and you are stuck with it. You either accept it, or you PIPs with it. We see over 1200 patients. We can't PIPs with everybody. It would become incredibly burdensome to do that.

On the verification of insurance, that is another horror -- primary, secondary; who has insurance, who doesn't have insurance. You'll find in the minority areas that they will come in with a temporary insurance card, and you will take the information down from that insurance card. By the time you have given them about two or three weeks of treatment, you'll find out that that card was only gotten so they could buy a car. Then they never pay the balance; they really don't have insurance. They were treated three weeks for nothing, because they don't have any money. These are poor people.

You have to factor in all the treatment that is given that you don't collect for -- a $250 deductible, a 20% copay. A dollar of billing really means, like, 28 cents, and then we don't get the money. Now you have to factor in our (indiscernible) bill and pay the additional 10% to get cash to operate on. It just can't go on. I mean, we employ a lot of people. We want to render a service, but you can't do it without money. You just can't; it is impossible.

These people need the treatment; we give them the treatment. We want to forget about what they owe us if we can, but we can't even do that. We want to collect promptly so we can have a cash flow to keep 75 people employed on a constant basis. Most of them are nonprofessional people. They are receptionists, they are clerks, they are secretaries, bill collectors -- people we can employ, all from the inner city. None of them-- In the first place, it is difficult to get anybody to come--

ASSEMBLYMAN GILL: How many physicians do you have on board?

MR. La DUCA: We have five, six physicians on board. We have all the specialists -- physiatrists, orthopods, neurologists. We have a full staff. We provide all the services necessary. We give thermographies. We send out for MRIs and CAT scans, because we don't have that type of equipment. But, we give full service -- full service. But it will be difficult to continue the service. It is going to be even more difficult to continue to keep people employed, if we can't get our money.

ASSEMBLYMAN GILL: Well, Mr. La Duca, that is one of the reasons this Committee was formed. We will certainly try to find an amenable way to address your problems and to forge some type of legislation which will help, not only your profession, but the people of New Jersey.

ASSEMBLYMAN ZECKER: And it may not be one piece of legislation. There may be multiple pieces of legislation that only address small segments, because sometimes when we put too many thoughts in one piece of legislation--

ASSEMBLYMAN GILL: It doesn't work out.

ASSEMBLYMAN ZECKER: --it doesn't work.

MR. La DUCA: Just let me say one more thing: It seems that we have a great language called English, and it is pretty easy to understand if you use it properly. Verbal threshold-- I can walk outside these doors and come to the first 40 people and ask what "verbal threshold" means, and they will look at me as if I am talking Chinese. It doesn't mean a thing to them.

Lawsuit threshold-- They have no idea what that means. Right to sue-- We don't have the right to sue -- period. That's it; it's over with. They understand that. But yet if we use "verbal threshold," the public just doesn't

understand that. It's simple English. Even the Legislature should use simple English.

In Bill No. 546, it says that a physician cannot use unlicensed -- not unlicensed-- "A physician cannot use an employee who is not a licensed health provider to apply modalities." Great, so we hire nurses -- licensed health providers. I learned the other day, "We can't pay you." "Why?" "The nurses can't give that therapy." "Why can't they?" "Well, because we have a deal with a physical therapy outfit that says that nurses cannot give physical therapy." I don't understand what that means.

I mean, the law says we need a licensed health provider, so we got a nurse. They say, "No, that's no good." What are they talking about? What was the Legislature talking about -- a "licensed health provider"? Certainly an optometrist is not going to give physical therapy. Certainly a licensed speech therapist is not going to do therapy. You would assume that they meant "nurse."

I think the language should be more explicit in the bill. It should say, "These people can work for a doctor." Then we would know. There would be no question. If the insurance company can masturbate a word, they will, and they will use it against you. Now we will have a $6000 bill that is in limbo because therapies are not supposed to be given by nurses. Now what will I do? If that tack is taken by every insurance company we're out of business, because nurses give all the therapy under our physicians' orders. I mean, that is just the tip of the iceberg. If they stop, every physician who does that type of work is going to be out of business, and all the employees they hire, and all the people they service.

It is just plain English. They go on to say what people are health providers. Nurses are under that category, except the word "licensed" is not in that category. So the insurance company says, "Well, you notice it doesn't say

licensed health provider as the law says." They are mixing and matching the language just to stall and prevent the payment of bills.

I said we have in excess of $1.5 million that is owed more than nine months, and if something doesn't happen soon we are going to be out of business.

ASSEMBLYMAN GILL: Mr. Zecker?

ASSEMBLYMAN ZECKER: Nothing, thank you.

ASSEMBLYMAN GILL: I would like to thank all of those of you who have come here today to provide this Committee with your invaluable insight, your ideas, and your information. I also want to take this opportunity to publicly thank the members of this Committee, Assemblyman Zecker in particular, and Assemblyman Kenny, who heard the testimony in the first session, but who couldn't be here today, and particularly Assemblyman Adubato for allowing me to chair this special Subcommittee.

We have now conducted two full public hearings on the issue of private auto insurance and the medical claims process, and I think we all have a better understanding of how the system operates and where improvements can, and must be made.

Of equal importance, we also understand that many of those changes in the FAIR Act have proven successful, and yet there are still many areas to address to forge a better way of providing that service to consumers. The legislative process is one of continual editing and refinement. The day we are perfect is the day we should all retire. Still, as part of our continual oversight responsibilities, hearings of this nature are crucial to the legislative process.

I, myself, have a better understanding of PIP, the Medical Fee Schedule caps, and of the confusion that is involved in the automobile insurance process. I also believe it is critical that the Department of Insurance continue to be present at these hearings, and I am confident that the

Department will undertake those changes necessary to improve and update the Medical Fee Schedules.

Having had two full hearings and almost a month to study the medical claims process/auto insurance issue, I think this Committee has a better understanding of those ideas and of ways that we probably will propose to improve the system. I want to work with those professionals testifying before this Committee, in particular the legal profession, the medical profession, chiropractors, and so forth, and the Department of Insurance, and fellow members and staff in order to fashion bipartisan legislation that will improve auto insurance for the people of this State.

I think we want to begin to do this immediately, Mr. Zecker. Specifically, I think we are interested in drafting a bill that will provide the motorists of this State with a greater choice, more simplicity, and effective changes that work to keep our insurance premiums as low as possible. I intend to have this legislation introduced, I hope, at the next legislative session. However, after hearing all of the problems we have today, I don't know if we can get it done that quickly, and I don't know if we can do it in one bill, as Assemblyman Zecker has pointed out. But I do expect it to include language for prompt payment incentives, improving the timeliness of medical payments, PIP benefits and provisions, and simplifying items such as insurance questionnaires and identification cards.

I will also work to incorporate those other ideas and suggestions presented here today, and will ask the Insurance Committee to promptly consider such legislation.

Once again, I would like to thank all of you for taking the time to appear before this Subcommittee today. The members of this Committee look forward to working with you

toward our mutual goal of improving New Jersey's auto insurance system. I would like to thank you once again for being here and spending a good part of the day with us. Thank you.

(HEARING CONCLUDED)

APPENDIX

DEPARTMENT OF INSURANCE
LEGISLATIVE AND REGULATORY AFFAIRS

MEMORANDUM

TO: Carolyn Mealing

FROM: Verice M. Mason
Assistant Commissioner

DATE: September 3, 1991

RE: Request for Information Dated 8/27/91

Due to time constraints, I am unable to provide complete responses to all the questions contained in your memo of 8/27/91. Nevertheless, I am providing responses to those questions where information is readily available. The following responses follow the sequence of questions contained in your 8/27/91 memo.

1. Attached is a print out of the 25 largest private passenger automobile insurers showing how many insureds have selected their health insurance as primary PIP coverage. It should be noted that 3 of these 25 carriers have not completed the survey. Furthermore, this survey only covers the period from 1/1/91 through 6/30/91. Therefore, some insureds whose policies do not renew until after 6/30/91 have not yet had the opportunity to select the "PIP switch" option.

Auto insurers were ordered to reduce the PIP premium by 25% for those insureds who select their health insurer as primary. The average PIP premium in New Jersey is $165, making the reduction worth slightly more than $40. Note, however, that this is an average figure. The actual PIP premium varies from insurer to insurer as well as by territory so that an individual's savings could be greater or less than the $40 average.

Blue Cross/Blue Shield would only be aware that an insured has selected it to be primary if the insured were injured in an auto accident and submitted a claim. Since this option only became available on 1/1/91, there is insufficient data available.

2. The Department is unable to supply this information at this time. However, the Unsatisfied Claim and Judgement Fund (UCJF) reimburses insurers when medical expense benefits on an individual exceed $75,000. We are attempting to develop a computer program that will show when an individual excess claim reaches or exceeds $250,000.

While the impact of the $250,000 medical expense cap is not yet quantifiable, it should be reflected in the claims experience of an insurer. It should be noted that auto insurers were given the option under the FAIR Act to offer medical expense benefits in excess of $250,000 and that 4 insurers (N.J. Manufacturers, State Farm, Amica Mutual and Horne) are currently offering such excess benefits.

3. The Department does not yet have sufficient data to respond to this request. The Fraud Prevention Division is altering its computer system to better monitor this for future reports.

4. Although it is impossible to quantify, savings to insureds have undoubtedly resulted from the balance billing prohibition which is set forth both in the FAIR Act and the medical fee schedule rules. Additional savings to insureds should result in reduced insurance premiums due to the anticipated decreases in medical expense payments by insurers. Such decreases will be reflected in the overall annual claims paying experience of insurers.

The dollar amounts shown on the fee schedule are upper limits beyond which providers are prohibited from charging. It is true that providers, in many instances, will be tempted to automatically increase their fees to these upper limits. This practice specifically discouraged by the rules which provide that nothing shall compel a PIP insurer "to pay more for any service or equipment than the provider's usual, customary and reasonable fee, even if such fee is well below the automobile insurer's limit of liability as set forth in the fee schedules." N.J.A.C. 11:3-29.4(a) It is incumbent on insurers and claim review organizations to recognize abuses and avoid making payments that are in excess of usual, customary and reasonable amounts.

The Department has endeavored to be as responsive as possible within the time allowed and hopes that the information provided proves useful to the subcommittee.

VMM/BK/dc
BK169/GCS
Attachment

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PRIVATE PASSENGER AUTOMOBILE
COVERAGE OPTION SURVEY

INSURER	Health Primary	Auto Primary
AETNA CAS & SURETY	253	48,942
ALLSTATE	40,765	445,422
AMERICAN RELIANCE	65	12,872
AMICA MUTUAL	379	23,548
ATLANTIC EMPLOYERS	70	31,918
COLONIAL PENN	44	14,233
CONTINENTAL INS COS		
GENERAL ACCIDENT	181	41,104
HANOVER	290	39,433
HARLEYSVILLE	354	36,944
HARTFORD	199	42,235
IFA INSURANCE CO	91	11,470
KEYSTONE	227	56,579
LIBERTY MUTUAL FIRE	255	128,484
MCA(MOTOR CLUB)	212	43,788
NJ MANUFACTURERS	28,745	303,104
OHIO CASUALTY		
PRUDENTIAL PROP & CAS	4981	340,744
RUTGERS CASUALTY	400	33,347
SELECTIVE INS CO	787	129,784
STATE FARM	3,187	388,531
TRAVELERS		
UNITED SERVICES AUTO	742	63,115
USAA CASUALTY	530	22,734
USF&G	92	24,518
TOTALS	82,849	2,282,849

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