P.L. 1998, CHAPTER 22, ***approved May 19, 1998***
Senate, No. 1051

AN ACT concerning automobile insurance and amending various parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 4 of P.L. , c. (C.) (now before the Legislature as Senate Bill No. 3 (2R) of 1998) is amended to read as follows:

4. As an alternative to the mandatory coverages provided in sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), any owner or registered owner of an automobile registered or principally garaged in this State may elect a basic automobile insurance policy providing the following coverage:

a. Personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household, who sustained bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured, and to pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an object propelled by or from such automobile. "Personal injury protection coverage" issued pursuant to this section means and includes payment of medical expense benefits, as provided in the policy and approved by the commissioner, for the reasonable and necessary treatment of bodily injury in an amount not to exceed $15,000 per person per accident; except that, medical expense benefits shall be paid in an amount not to exceed $250,000 for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgement of the attending physician. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of personal injury to any one person in any one accident, such excess shall be paid by the insurer in consultation with the Unsatisfied Claim

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.

and Judgment Fund Board and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1). Benefits provided under basic coverage shall be in accordance with a benefit plan provided in the policy and approved by the commissioner. The policy form, which shall be subject to the approval of the commissioner, shall set forth the benefits provided under the policy, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the policy may provide. The commissioner shall set forth by regulation a statement of the basic benefits which shall be included in the policy. Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity. The policy form may provide for the precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods, as approved by the commissioner, provided that the requirement for precertification shall not be unreasonable, and no precertification requirement shall apply within ten days of the insured event. The policy may provide that certain benefits provided by the policy which are in excess of the basic benefits required by the commissioner to be included in the policy may be subject to reasonable copayments in addition to the copayments provided for herein, provided that the copayments shall not be unreasonable and shall be established in such [as] a manner as not to serve to encourage underutilization of benefits subject to the copayments, nor encourage overutilization of benefits. The policy form shall clearly set forth any limitations on benefits or

exclusions, which may include, but need not be limited to, benefits which are otherwise compensable under workers' compensation, or benefits for treatments deemed to be experimental or investigational, or benefits deducted pursuant to section 6 of P.L.1972, c.70 (C.39:6A-6). The commissioner may enlist the services of a benefit consultant in establishing the basic benefits level provided in this subsection, which shall be set forth by regulation no later than 120 days following the enactment date of this amendatory and supplementary act. The commissioner shall not advertise for the consultant as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

Medical expense benefits payable under this subsection shall not be assignable, except to a provider of service benefits, in accordance with policy terms approved by the commissioner, nor shall they be subject to levy, execution, attachment or other process for satisfaction of debts. Medical expense benefits payable in accordance with this subsection may be subject to a deductible and copayments as provided for in the policy, if any. No insurer or provider providing service benefits to an insured shall have a right of subrogation for the amount of benefits paid pursuant to any deductible or copayment under this section.

b. Liability insurance coverage insuring against loss resulting from liability imposed by law for property damage sustained by any person arising out of the ownership, maintenance, operation or use of an automobile in an amount or limit of $5,000, exclusive of interest and costs, for damage to property in any one accident.

c. In addition to the aforesaid coverages required to be provided in a basic automobile insurance policy, optional liability insurance coverage insuring against loss resulting from liability imposed by law for bodily injury or death in an amount or limit of $10,000, exclusive of interests and costs, on account of injury to, or death of, one or more persons in any one accident.

If a named insured has elected the basic automobile insurance policy option and an immediate family member or members or relatives resident in his household have one or more policies with the coverages provided for in sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), the provisions of section 12 of P.L.1983, c.362 (C.39:6A-4.2) shall apply.

Every named insured and any other person to whom the basic automobile insurance policy, with or without the optional $10,000 liability coverage insuring against loss resulting from liability imposed by law for bodily injury or death provided for in subsection c. of this section, applies shall be subject to the tort option provided in subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8).

No licensed insurance carrier shall refuse to renew the coverage stipulated by this section of an eligible person as defined in section 25

of P.L.1990, c.8 (C.17:33B-13) except in accordance with the provisions of section 26 of P.L.1988, c.119 (C.17:29C-7.1) or with the consent of the Commissioner of Banking and Insurance.
(cf: P.L. , c. , s.4 (now before the Legislature as Senate Bill No. 3 (2R) of 1998))

2. Section 4 of P.L.1972, c.70 (C.39:6A-4) is amended to read as follows:

4. Personal injury protection coverage, regardless of fault.

Except as provided by section 4 of P.L. , c. (C.)(as amended by section 1 of this bill), every standard automobile liability insurance policy issued or renewed on or after the effective date of P.L. , c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998) shall contain personal injury protection benefits for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household who sustain bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with permission of the named insured, and to pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an automobile or struck by an object propelled by or from that automobile.

"Personal injury protection coverage" means and includes:

a. Payment of medical expense benefits in accordance with a benefit plan provided in the policy and approved by the commissioner, for reasonable, necessary, and appropriate treatment and provision of services to persons sustaining bodily injury, in an amount not to exceed $250,000 per person per accident. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of bodily injury to any one person in any one accident, that excess shall be paid by the insurer in consultation with the Unsatisfied Claim and Judgment Fund Board and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1). The policy form, which shall be subject to the approval of the commissioner, shall set forth the benefits provided under the policy, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the policy may provide. The commissioner shall set forth by regulation a statement of the basic benefits which shall be included in the policy. Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the

covered injury. Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity. The policy form may provide for the precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods, as approved by the commissioner, provided that the requirement for precertification shall not be unreasonable, and no precertification requirement shall apply within ten days of the insured event. The policy may provide that certain benefits provided by the policy which are in excess of the basic benefits required by the commissioner to be included in the policy may be subject to reasonable copayments in addition to the copayments provided for pursuant to subsection e. of this section, provided that the copayments shall not be unreasonable and shall be established in such [as] a manner as not to serve to encourage underutilization of benefits subject to the copayments, nor encourage overutilization of benefits. The policy form shall clearly set forth any limitations on benefits or exclusions, which may include, but need not be limited to, benefits which are otherwise compensable under workers' compensation, or benefits for treatments deemed to be experimental or investigational, or benefits deducted pursuant to section 6 of P.L.1972, c.70 (C.39:6A-6). The commissioner may enlist the services of a benefit consultant in establishing the basic benefits level provided in this subsection, which shall be set forth by regulation no later than 120 days following the enactment date of P.L. , c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998). The commissioner shall not advertise for bids for the consultant as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

b. Income continuation benefits. The payment of the loss of income of an income producer as a result of bodily injury disability,

subject to a maximum weekly payment of $100. Such sum shall be payable during the life of the injured person and shall be subject to an amount or limit of $5,200, on account of injury to any one person in any one accident, except that in no case shall income continuation benefits exceed the net income normally earned during the period in which the benefits are payable.

c. Essential services benefits. Payment of essential services benefits to an injured person shall be made in reimbursement of necessary and reasonable expenses incurred for such substitute essential services ordinarily performed by the injured person for himself, his family and members of the family residing in the household, subject to an amount or limit of $12 per day. Such benefits shall be payable during the life of the injured person and shall be subject to an amount or limit of $4,380, on account of injury to any one person in any one accident.

d. Death benefits. In the event of the death of an income producer as a result of injuries sustained in an accident entitling such person to benefits under this section, the maximum amount of benefits which could have been paid to the income producer, but for his death, under subsection b. of this section shall be paid to the surviving spouse, or in the event there is no surviving spouse, then to the surviving children, and in the event there are no surviving spouse or surviving children, then to the estate of the income producer.

In the event of the death of one performing essential services as a result of injuries sustained in an accident entitling such person to benefits under subsection c. of this section, the maximum amount of benefits which could have been paid to such person, under subsection c., shall be paid to the person incurring the expense of providing such essential services.

e. Funeral expenses benefits. All reasonable funeral, burial and cremation expenses, subject to a maximum benefit of $1,000, on account of the death of any one person in any one accident shall be payable to the decedent's estate.

Benefits payable under this section shall:

(1) Be subject to any option elected by the policyholder pursuant to section 13 of P.L.1983, c.362 (C.39:6A-4.3);

(2) Not be assignable, except to a provider of service benefits under this section in accordance with policy terms approved by the commissioner, nor subject to levy, execution, attachment or other process for satisfaction of debts.

Medical expense benefit payments shall be subject to**[**a**]** any deductible and any copayment which may be established as provided in the policy **[**, of any**]**. Upon the request of the commissioner or any party to a claim for benefits or payment for services rendered, a provider shall present adequate proof that any deductible or copayment related to that claim has not been waived or discharged by

the provider.

No insurer or health provider providing benefits to an insured shall have a right of subrogation for the amount of benefits paid pursuant to any deductible or copayment under this section.

(cf: P.L. , c. , s.6 (now before the Legislature as Senate Bill No. 3 (2R) of 1998))

3. Section 13 of P.L.1983, c.362 (C.39:6A-4.3) is amended to read as follows:

13. Personal injury protection coverage options. With respect to personal injury protection coverage provided on an automobile in accordance with section 4 of P.L.1972, c.70 (C.39:6A-4), the automobile insurer shall provide the following coverage options:

a. Medical expense benefit deductibles in amounts of $500.00, $1,000.00, $2,000.00 and $2,500.00 for any one accident;

b. The option to exclude all benefits offered under [subsection] subsections b., c., d., and e. of section 4;

c. (Deleted by amendment, P.L.1988, c.119.)

d. For policies issued or renewed on or after January 1, 1991, the option that other health insurance coverage or benefits of the insured, including health care services provided by a health maintenance organization and any coverage or benefits provided under any federal or State program, are the primary coverage in regard to medical expense benefits pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4). If health insurance coverage or benefits are primary, an automobile insurer providing medical expense benefits under personal injury protection coverage shall be liable for reasonable medical expenses not covered by the health insurance coverage or benefits up to the limit of the medical expense [benefit] benefits coverage. The principles of coordination of benefits shall apply to personal injury protection medical expense benefits coverage pursuant to this subsection.

e. Medical expense benefits in amounts of $150,000, $75,000, $50,000 or $15,000 per person per accident; except that, medical expense benefits shall be paid in an amount not to exceed $250,000 for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician. The coverage election form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that election of any of the aforesaid medical expense benefits options results in less coverage than the $250,000 medical expense benefits coverage mandated prior to the effective date of [this act]P.L. , c. (now before the

Legislature as Senate Bill No. 3 (2R) of 1998) .

If none of the aforesaid medical [expenses] expense benefits options is affirmatively chosen in writing, the policy shall provide $250,000 medical expense benefits coverage.

f. The insurer shall provide an appropriate reduction from the territorial base rate for personal injury protection coverage for those electing any of the options in subsections a., b., d. and e. of this section.

Any named insured who chooses the option provided by subsection d. of this section shall provide proof that he and members of his family residing in his household are covered by health insurance coverage or benefits in a manner and to an extent approved by the commissioner. Nothing in this section shall be construed to require a health insurer, health maintenance organization or governmental agency to cover individuals or treatment which is not normally covered under the applicable benefit contract or plan. If it is determined that an insured who selected or is otherwise covered by the option provided in subsection d. of this section did not have such health coverage in effect at the time of an accident, medical expense benefits shall be payable by the person's automobile insurer and shall be subject to any deductible required by law or otherwise selected as an option pursuant to subsection a. of this section, any copayment required by law and an additional deductible in the amount of $750.

An option elected by the named insured in accordance with this section shall apply only to the named insured and any resident relative in the named insured's household who is not a named insured under another automobile insurance policy, and not to any other person eligible for personal injury protection benefits required to be provided in accordance with section 4 of P.L.1972, c.70 (C.39:6A-4).

Medical expense benefits payable in any amount between the deductible selected pursuant to subsection a. of this section and $5,000.00 shall be subject to the copayment provided in the policy, if any.

No insurer or health provider providing benefits to an insured who has elected a deductible pursuant to subsection a. of this section shall have a right of subrogation for the amount of benefits paid pursuant to a deductible elected thereunder or any applicable copayment.

The Commissioner of Banking and Insurance shall adopt rules and regulations to effectuate the purposes of this section and may promulgate standards applicable to the coordination of personal injury protection medical expense benefits coverage.

(cf: P.L. , c. , s.7 (now before the Legislature as Senate Bill No. 3 (2R) of 1998))

4. Section 24 of P.L. , c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998) is amended to read as follows:

24. a. Any dispute regarding the recovery of medical expense benefits or other benefits provided under personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), or section 4 of P.L. , c. (C.) (as amended by section 1 of this bill) arising out of the operation, ownership, maintenance or use of an automobile may be submitted to dispute resolution on the initiative of any party to the dispute, as hereinafter provided.

b. The Commissioner of Banking and Insurance shall designate an organization, and for that purpose may, at his discretion, advertise for proposals, for the purpose of administering dispute resolution proceedings regarding medical expense benefits and other benefits provided under personal injury protection pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or medical expense benefits coverage pursuant to section 4 of P.L. , c. (C.)(as amended by section 1 of this bill). The commissioner shall promulgate rules and regulations with respect to the conduct of the dispute resolution proceedings. The organization administering dispute resolution shall utilize qualified professionals who serve on a full-time basis and who meet standards of competency established by the commissioner. The commissioner shall establish standards of performance for the organization to ensure the independence and fairness of the review process, including, but not limited to, standards relative to the professional qualifications of the professionals presiding over the dispute resolution process, and standards to ensure that no conflict of interest exists which would prevent the professional from performing his duties in an impartial manner. The standards of performance shall include a requirement that the organization establish an advisory council composed of parties who are users of the dispute resolution mechanism established herein. The commissioner may contract with a consulting firm for the formulation of the standards of performance of the organization and establishment of qualifications for the persons who are to conduct the dispute resolution proceedings. The commissioner shall not advertise for bids for the consulting firm, as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9). Compensation to the dispute resolution professionals shall be established by the commissioner and adjusted from time to time as appropriate, with the approval of the commissioner. In no case shall compensation be paid on a contingency basis. The organization shall establish a dispute resolution plan, which shall include procedures and rules governing the dispute resolution process and provisions for monitoring the dispute resolution process to ensure adherence to the standards of performance established by the commissioner. The plan, and any amendments thereto, shall be subject to the approval of the commissioner.

c. Dispute resolution proceedings under this section 24 and section 25 of this amendatory and supplementary act shall include disputes arising regarding medical expense benefits provided under subsection

a. of section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L. , c. (C.) (as amended by section 1 of this bill), benefits provided pursuant to subsection b., c., d. or e. of section 4 of P.L.1972, c.70 (C.39:6A-4), subsection b., c., d. or e. of section 7 of P.L.1972, c.198 (C.39:6-86.1), and disputes as to additional first party coverage benefits required to be offered pursuant to section 10 of P.L.1972, c.70 (C.39:6A-10). Disputes involving medical expense benefits may include, but not necessarily be limited to, matters concerning: (1) interpretation of the insurance contract; (2) whether the treatment or health care service which is the subject of the dispute resolution proceeding is in accordance with the provisions of section 4 of P.L.1972, c.70 (C.39:6A-4)or section 4 of P.L. , c. (C.) (as amended by section 1 of this bill) or the terms of the policy; (3) the eligibility of the treatment or service for compensation; (4) the eligibility of the provider performing the treatment or service to be compensated under the terms of the policy or under regulations promulgated by the commissioner, including whether the person is licensed or certified to perform such treatment; (5) whether the disputed medical treatment was actually performed; (6) whether diagnostic tests performed in connection with the treatment are those recognized by the commissioner; (7) the necessity or appropriateness of consultations by other health care providers; (8) disputes involving application of and adherence to fee schedules promulgated by the commissioner; and (9) whether the treatment performed is reasonable, necessary, and compatible with the protocols provided for pursuant to P.L. , c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998). The dispute resolution professionals may review the entire claims file of the insurer, subject to any confidentiality requirement established pursuant to State or federal law. All decisions of the dispute resolution professional shall be in writing, in a form prescribed by the commissioner, shall state the issues in dispute, the findings and conclusions on which the decision is based, and shall be signed by the dispute resolution professional. All decisions of a dispute resolution professional shall be binding. The dispute resolution organization shall provide for the retention of all documents used in dispute resolution proceedings under this section and section 25 of this amendatory and supplementary act, including the written decision, for a period of at least five years, in a form approved by the commissioner, or for such additional time as may be established by the commissioner. The written decisions of the dispute resolution professional shall be forwarded to the commissioner, who shall establish a record of the proceedings conducted under the dispute resolution procedure, which shall be accessible to the public and may be used as guidance in subsequent dispute resolution proceedings.

d. With respect to disputes as to the diagnosis, the medical necessity of the treatment or diagnostic test administered to the injured

person, whether the injury is causally related to the insured event or is the product of a preexisting condition, or disputes as to the appropriateness of the protocols utilized by the provider, the dispute resolution professional shall, either at his option or at the request of any party to the dispute, refer the matter to a medical review organization for a determination. The determination of the medical review organization on the dispute referred shall be [binding upon] presumed to be correct by the dispute resolution professional , which presumption may be rebutted by a preponderance of the evidence. Should the dispute resolution professional find that the decision of the medical review organization is not correct, the reasons supporting that finding shall be set forth in the dispute resolution professional's written decision.

e. Any person submitting a matter to the dispute resolution process established herein may submit for review all or a portion of a disputed treatment or treatments or a dispute regarding a diagnostic test or tests or a dispute regarding the providing of services or durable medical goods. Any portion of a treatment or diagnostic test or service which is not under review shall be reimbursed in accordance with the provisions of section 5 of P.L.1972, c.70 (C.39:6A-5). If the dispute resolution proceeding results in a determination that all or part of a treatment or treatments, diagnostic test or tests or service performed, or durable medical goods provided are medically necessary and appropriate, reimbursement shall be made with interest payable in accordance with the provisions of section 5 of P.L.1972, c.70 (C.39:6A-5).

(cf: P.L. , c. , s. 24 (now before the Legislature as Senate Bill No. 3 (2R) of 1998))

5. Section 26 of P.L. , c. (C.) (now before the Legislature as Senate Bill No. 3 (2R) of 1998) is amended to read as follows:

26. Every insurer writing private passenger automobile insurance in this State and every rating organization establishing territorial rating plans on behalf of its member companies shall establish new territorial rating plans in place of the [insurer] insurer's or filer's territorial rating plan in effect on June 1, 1998, which shall include territorial definitions, territorial relativity factors and territorial base rates, and which are in accordance with the provisions of sections 26 through 29 of this amendatory and supplementary act. The Commissioner of Banking and Insurance shall promulgate regulations establishing standards governing the establishment of new rating territories, which standards shall include, but not be limited to:

a. Territories shall be defined in such a manner as to recognize throughout the territorial rating plan both qualitative similarities and qualitative differences in driving environments or mix of driving environments, which may include, but not be limited to, traffic density,

population density, comparative severity of loss, and the degree of homogeneity within a territory in terms of driving environments, population, and driver classification, and the territory shall be comprised of towns or cities which are contiguous;

b. Territories shall contain a sufficient number of exposures to result in statistically credible experience, in accordance with regulations established by the commissioner, and shall be defined in a manner which minimizes the effect of variability of loss in a territory on a year-to-year basis;

c. Territory definitions shall take into account the impact of the overlapping of traffic patterns on exposure to loss, including the relative number of intraterritory trips and inter-territory trips applicable to each proposed territory, for which the commissioner shall make available to the insurer, filer, or the commission established pursuant to section 28 of this amendatory and supplementary act, appropriate information collected pursuant to the provisions of section 1 of P.L.1987, c.450 (C.43:21-14a) by the Department of Labor;

d. Territories shall be created in a manner which results in an equable distribution of exposures among territories throughout the State and no territorial rating plan shall result in territories which are arbitrary, unfairly discriminatory, significantly disproportionate in terms of the number of exposures per territory, or created in a manner which is primarily for marketing purposes rather than measuring relativity of exposure to probable loss, or created in a manner which can be used to avoid the **[**insurer**]** insurer's or filer's obligations under section 27 of P.L.1990, c.8 (C.17:33B-15);

e. Territories shall be created in a manner which does not result in disproportionate differences in territorial relativity factors or territorial base rates between contiguous territories with similar driving environments or similar mix of driving environments;

f. Factors to be considered in establishing territorial rate relativities shall include taking into account similarities or differences in driving environments or mix of driving environments, including traffic density, population density, mix of driver classifications within a territory, including classifications capped pursuant to the provisions of section 7 of P.L.1983, c.65 (C.17:29A-36), comparative degree of severity of loss, and the relative number of intraterritory and inter-territory trips;

g. Territories shall be defined in a manner which does not result in unfair inter-territorial subsidization among territories with significant differences in driving environments or mix of driving environments, population density, traffic density, mix of driver classifications, including classifications capped pursuant to the provisions of section 7 of P.L.1983, c.65 (C.17:29A-36) and comparative degree of severity of loss.

h. For the purpose of defining territories and establishing territorial

relativity factors, loss experience allocated to any territory by an insurer or filer (1) shall take into account any recovery applicable to exposures in the territory which are attributable to subrogation or any other kind of recovery by the insurer reporting the losses and (2) shall not include any loss attributable to capping of driver classifications pursuant to section 7 of P.L.1983, c.65 (C.17:29A-36).

The commissioner shall establish by regulation the minimum number of exposures which shall be deemed to meet the standard of being statistically credible for the purpose of defining territories.

(cf: P.L. , c. , s. 26 (now before the Legislature as Senate Bill No. 3 (2R) of 1998))

6. Section 7 of P.L.1983, c.65 (C.17:29A-36) is amended to read as follows:

7. a. Any filing made for the purpose of automobile insurance rate making shall indicate the actual rate needs of the filer; provided, however, that (a) each filer's rate classification definitions, as used by that filer, shall be uniform Statewide; **[**and**]** (b) the automobile insurance rate charged an insured shall not exceed two and one-half times the filer's territorial base rate for each coverage, exclusive of driving record surcharges and discounts; and (c) the automobile insurance rate of the base class in any territory for any filer shall not exceed 1.35 times the filer's Statewide average base rate for each coverage, exclusive of driving record surcharges and discounts for <u>any basic policy issued or renewed at any time and for</u> any standard policy issued or renewed before January 1, 2000 or the 180th day following approval of the common territorial rating plan pursuant to section 28 of P.L.1998, c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998), whichever first occurs.

b. No rating plan or rate filing applicable to any policy issued or renewed on or after January 1, 2000 or the 180th day following the approval of the common <u>territorial</u> rating **[**territory**]** <u>plan</u> provided for in sections 27 **[**through**]** <u>and</u> 28 of P.L.1998, c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998), whichever first occurs, shall be approved by the commissioner which creates territorial relativities which are significantly disproportionate to those in effect as of the effective date of P.L. , c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998).

[d.**]** <u>c.</u> The automobile insurance rate of an automobile whose principal operator is 65 years of age or older shall not exceed one and one-quarter times the Statewide average rate for principal operators 65 years of age or older for each coverage, exclusive of driving record surcharges and discounts; provided, however, that no filer shall increase rates for principal operators 65 years of age or older as a result of the implementation of this section unless more than 50% of its insureds are principal operators 65 years of age or older.

[e.] d. As a result of the filings made pursuant to sections 26 and 27 of P.L.1998, c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998) and [subparagraphs] subsections a., b. and c. of this section, the filer's aggregate premium for all territories shall not exceed the filer's aggregate premium in effect prior to the date established in [subparagraph (a) of] subsection b. of this section.

As used in this section, base rate means the automobile insurance rate charged for an automobile that is not used in business and not used in going to and from work, except for the going to and from work distance included in the pleasure use classification of the filer, and where there is no youthful operator, as defined in the filer's classification system. The base rate class shall not include automobiles to which discounts apply under the filer's classification system, including, but not limited to, farmers' and senior citizens' automobiles or any discount from a standard rate provided for in the filer's tier rating system.

The provisions of this section shall be implemented after the implementation of the provisions of subsection a. of section 8 of [this act] P.L.1983, c.65 (C. 17:29A-37).

(cf: P.L. , c. , s.29 (now before the Legislature as Senate Bill No. 3 (2R) of 1998))

7. Section 50 of P.L.1990, c.8 (C.17:33B-41) is amended to read as follows:

50. a. Upon the termination of a policy of motor vehicle liability insurance by cancellation for nonpayment of premium pursuant to section 2 of P.L.1968, c.158 (C.17:29C-7), notice of that cancellation shall be filed by the insurer with the Division of Motor Vehicles not later than 30 days following the effective date of that cancellation.

b. The division shall notify the person whose policy was canceled that, unless proof of motor vehicle liability insurance is filed with the division within 30 days of the notification or some other allowable circumstance exists and the division is notified of that circumstance within 30 days of the notification, the sanctions and penalties of this section shall apply.

c. If the Director of the Division of Motor Vehicles has not received proof of motor vehicle liability insurance or other allowable circumstances within 30 days pursuant to subsection b. of this section, he shall suspend the registration of such vehicle, except that:

(1) Suspension shall not be made under this subsection upon the basis of a cancellation of motor vehicle liability insurance if the registration certificate and registration plates of the motor vehicle are surrendered prior to the time at which the cancellation of insurance becomes effective. Such surrender shall be made to such officers of the division as the director shall direct. For the purposes of this paragraph, the expiration of a registration without renewal of that

registration shall be deemed to be a surrender of registration as of the date of expiration;

(2) Suspension shall not be made under this subsection upon a cancellation of motor vehicle liability insurance if the vehicle has been, or will be, prior to the date of that cancellation, removed from the United States in North America and the Dominion of Canada for the purpose of international traffic, provided that the owner of the vehicle, prior to the date of that cancellation, has filed with the director a statement, in a form prescribed by him, indicating that the vehicle has been, or will be, so removed, and agreeing to notify the director immediately upon return of the vehicle to the United States in North America or the Dominion of Canada. Upon receipt of the statement the director shall restrict the use of the registration to such international traffic until new proof that motor vehicle liability insurance has been secured for the vehicle;

(3) Suspension need not be made under this subsection upon the basis of a cancellation of motor vehicle liability insurance if the period of time during which the motor vehicle remained both registered and uninsured was not greater than 15 days. The director shall promulgate regulations governing the conditions under which suspension action may be withheld pursuant to this paragraph.

d. Notwithstanding the provisions of subsection c. of this section, an order of suspension may be rescinded if the registrant pays to the commissioner a civil penalty in the amount of $4 for each day up to 90 days for which motor vehicle liability insurance was not in effect. The provisions of this subsection shall apply only once during any 36-month period and only if the registrant surrenders the certificate of registration and registration plates to the director not more than 90 days from the date of cancellation of motor vehicle liability insurance coverage or submits to the director proof of motor vehicle liability insurance which took effect not more than 90 days from the cancellation of his previous motor vehicle liability insurance.

e. Any motor vehicle, the registration for which has been suspended pursuant to this section, shall not be registered or reregistered in the name of the same registrant, or in any other name where the director has reasonable grounds to believe that such registration or reregistration will have the effect of defeating the purposes of this section, and no other motor vehicle shall be registered in the name of such person during the period of suspension.

f. No registration plates shall be returned to the registrant until proof of motor vehicle liability insurance is submitted to the director.

g. If a registrant has not surrendered his certificate of registration and registration plates or obtained motor vehicle liability insurance within 90 days from the date of cancellation of motor vehicle liability insurance, the director shall suspend the driver's license of any such registrant. The suspension shall take effect on the date specified in the

order and shall remain in effect until termination of the suspension of the registrant's registration.

h. The Director of the Division of Motor Vehicles shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to implement the provisions of this section. The director may, by regulation, require that the provisions of this section shall be applicable to the termination of policies of motor vehicle liability insurance for reasons other than cancellation for nonpayment of premium, including nonrenewals.

i. Within 180 days of the effective date of this act the Division of Motor Vehicles shall develop a format for electronic reporting by insurers writing private passenger automobile insurance, to the division, on a real-time basis, information regarding the cancellation of policies of motor vehicle insurance, the issuance of new policies of motor vehicle insurance, and changes of vehicle on policies of motor vehicle insurance in force in order to verify compliance with the motor vehicle liability insurance requirements of section 1 of P.L.1972, c.197 (C.39:6B-1), and the mandatory automobile insurance requirements of section 4 of P.L.1998, c. (C.)(as amended by section 1 of this bill). Information shall be maintained by driver's license number of the named insured. Other information to be provided by insurers shall be established by the director by regulation.

j. The director shall establish an electronic data base containing the information provided for in subsection [a.] i. of this section, which shall be made available to all law enforcement officers for the purpose of enforcing the mandatory motor vehicle insurance requirements of section 1 of P.L.1972, c.197 (C.39:6B-1). The data base shall not be made available until every insurer writing private passenger insurance has complied with regulations of the director and the information required by subsection [a.] i. of this section is reported on a real-time basis. The Division of Motor Vehicles shall establish security procedures to protect the confidentiality of the information on the data base, which shall preclude access to the information to any person not otherwise entitled to it under this or any other law.

k. The data base shall be funded from the Uninsured Motorist Prevention Fund established pursuant to section 2 of P.L.1983, c.141 (C.39:6B-3).

(cf: P.L. , c. , s.30 (now before the Legislature as Senate Bill No. 3 (2R) of 1998))

8. Section 66 of P.L. , c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998) is amended to read as follows:

66. a. For the purposes of this section:

"Qualified person" means a person qualified by the Commissioner of Banking and Insurance to intervene in public hearings pursuant to this section, who shall be deemed a "public servant" within the

meaning of N.J.S.2C:30-2;

"Rate filing" means a filing for a rate increase by an automobile insurer writing private passenger automobile insurance in this State, other than an expedited prior approval rate filing made pursuant to section 34 of P.L.1997, c.151 (C.17:29A-46.6) and other than a rate filing made pursuant to any statutory change in coverage provided under a policy of private passenger automobile insurance.

b. The Commissioner of Banking and Insurance shall establish standards for qualifying persons to intervene in rate filings pursuant to this section. The standards shall include, but shall not necessarily be limited to, requiring that any person intervening in a rate filing demonstrate: (1) expertise in the insurance laws of this State; (2) an understanding of the actuarial principles employed in establishing rates and rating systems; (3) sufficient access to a qualified actuary and sufficient expertise to conduct a technical examination of a rate filing; (4) sufficient resources to intervene in the rate filing process as provided herein; and (5) that the person represents the interest of consumers and accepts a duty of fidelity to do so.

c. The commissioner shall require such documentation as he determines is necessary to qualify a person to intervene in a rate filing, and may charge a fee for registration with the department as an intervenor, which fee shall be payable annually.

d. The commissioner may remove the registration of an intervenor if he determines that (1) the intervenor no longer meets the qualifications, or (2) if the intervenor is convicted of a crime or loses a professional license for misconduct.

e. If an insurer or rating organization files for a rate increase for private passenger automobile insurance, the commissioner shall notify the public of the proposed rate change in a newspaper or newspapers of general circulation throughout the State. A qualified person may request, and shall receive, a copy of the rate filing and any amendments and supplements thereto and shall pay the expenses in connection therewith. The qualified person may request that the commissioner certify the rate filing for a hearing pursuant to section 14 of P.L.1944, c.27 (C.17:29A-14).

f. The commissioner shall establish by regulation the terms and conditions under which the proceedings under this section shall be conducted, including, but not limited to the supporting material which shall accompany the intervention.

g. Upon determining that the intervenor has demonstrated that the qualified person has made a substantial contribution to the adoption of any order or decision by the commissioner or a court in connection with a rate filing made pursuant to this section, the commissioner shall award reasonable advocacy and witness fees and expenses.

h. A person commits a crime of the third degree if he solicits, accepts or agrees to accept any benefits as consideration for

knowingly violating or agreeing to violate a duty of fidelity to which he is subject pursuant to this section. In addition[,] to any disposition authorized by law, the Commissioner of Banking and Insurance shall forever bar from registration as an intervenor any person convicted under this subsection.

i. A person commits a crime of the third degree if he confers, or offers or agrees to confer, any benefit the acceptance of which would be criminal under this section. In addition to any disposition authorized by law, the Commissioner of Banking and Insurance shall deny the rate filing of any person convicted under this subsection and the person shall be barred from filing for any rate increase for a period of one year.

j. Nothing herein shall be construed to preclude a prosecution or conviction for a violation of any other law.

(cf: P.L. , c. , s. 66 (now before the Legislature as Senate Bill No. 3 (2R) of 1998))

9. This act shall take effect immediately upon the enactment of P.L. , c. (now before the Legislature as Senate Bill No. 3 (2R) of 1998), except that sections 1 through 4 and section 8 of this act shall remain inoperative until the 90th day following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L. 1972, c. 70 (C. 39:6-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of P.L. , c. (C.)(now before the Legislature as Senate Bill No. 3 (2R) of 1998), whichever is later.

STATEMENT

This bill amends certain provisions of the "Automobile Insurance Cost Reduction Act," P.L. , c. , now pending before the Legislature as Senate Bill No. 3 (2R) of 1998. In some cases, the amendments are technical in nature, to correct or clarify the provisions of the bill as amended by the Governor's conditional veto; in other cases, the amendments make substantive changes or clarifications to the bill's provisions, namely:

1. The bill amends the current version of the dispute resolution procedure to modify the weight which should be given to a determination of a medical review organization. Instead of the medical review organization's determination being binding upon the dispute resolution professional, it will be presumed to be correct, which presumption may be rebutted by a preponderance of the evidence. Further, should the dispute resolution professional find that the determination of the medical review organization is not correct,

the reasons supporting that finding shall be set forth in the dispute resolution professional's written decision.

2. Amendments made to the statute concerning rate "caps" by the Governor's conditional veto message are modified to clarify that the existing 1.35 cap on an insurer's rate for the base class in any territory will remain in effect for the new basic policy authorized by Senate Bill No. 3 (2R). Other internal technical amendments are made to this section as well.

Revises certain provisions of the "Automobile Insurance Cost Reduction Act."