INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Automobile Insurance

Readoption with Amendments: N.J.A.C. 11:3

Adopted Repeals: N.J.A.C. 11:3-17, 28.15 and 28.17

Proposed: November 7, 2005 at 37 N.J.R. 4162(a)

Adopted: June 6, 2006 by Steven M. Goldman, Commissioner, Department of Banking and Insurance

Filed: June 7, 2006 as R. 2006 d.243, **with substantive change and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1 and 17:1-15e

Effective Date: June 7, 2006., Readoption;
July 3, 2006, Amendments and Repeals

Operative Date: July 16, 2006 as to Repeal of N.J.A.C. 11:3-17

Expiration Date: June 7, 2011

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance received timely written comments from: New Jersey Manufacturers Insurance Group, the Insurance Council of New Jersey, the Property Casualty Insurers Association of America and the National Motorist Association.

COMMENT: Two commenters expressed their opposition to the Department's proposed amendment to N.J.A.C. 11:3-33.6(d) and requested that it be deleted from the proposal. The Department's amendment requires insurers to reimburse an applicant if he or she obtains comparable coverage from another company at a higher cost when the Department has determined that the denial was improper.

One commenter stated that they failed to see the necessity of including language that requires an insurer to pay the premium difference in coverage offered by another insurance carrier. The commenter stated that, if a consumer successfully appeals a declination of coverage from an insurer, then subsequently refuses to accept the insurer's offer of coverage and opts to obtain coverage from another carrier, the insurer should not be required to pay any difference in the premium cost.

The commenter noted that in many cases applicants for insurance are declined coverage by an insurer for not providing complete information. The commenter stated that the necessary information is frequently provided to the insurer during the appeal process.

A commenter stated that the Department offers no explanation for requiring an insurer to reimburse an applicant if he or she obtains comparable coverage from another company at a higher cost. The commenter believes that it is fair, when an insurer who has been found to have erred, agrees to reinstate or write the policy. The commenter stated that if a denied applicant refuses an insurer's offer of coverage, the insurer should not be required to pay the premium difference for a policy from another company selected by the consumer, particularly given the availability of auto insurance and the wide range of premiums being offered in today's market.

RESPONSE: N.J.A.C. 11:3-33.6(d) requires that, in the event the insured obtains comparable replacement coverage at a higher cost than the denied coverage, the Department may require the insurer to reimburse the insured the difference. In cases where an insurer is required to reimburse an insured, the cost is based on comparable replacement coverage. Comparable replacement coverage would not mean that in all cases an insurer would be responsible to reimburse an insured for the total difference between the cost of the wrongfully denied coverage and the cost of the replacement coverage. For example, a prior insurer would not be required to

pay the total difference in premium where, after an improper denial, its former insured obtained replacement coverage that included an additional person, additional coverage, and/or increased limits.

With regard to the commenter's concern regarding cases when an applicant is declined coverage for not providing complete information, the Department notes that the first part of N.J.A.C. 11:3-33.6(d) states that, upon a determination by the Department that a denial was improper, the insurer shall be required to offer the applicant the requested coverage effective as of the date of the declination. The Department would not consider instances where an insurer denied coverage because an insured did not provide complete information to be improper declinations.

Finally, the Department does not believe that an insurer should be relieved of its obligation to pay the additional premium cost incurred by an insured for a comparable policy when the insurer had improperly denied coverage, regardless of whether it subsequently offers to reinstate or write the denied policy. An insured who had already expended additional funds for comparable coverage at a higher premium should not be required to accept coverage from the company that improperly denied their application in lieu of being made whole for the financial loss they incurred as a result of that company's improper action.

COMMENT: Two commenters expressed concern with the proposed deletions found in N.J.A.C. 11:3-12, Automobile Rate Filers: Flattening of Premium Taxes and Assessments Made for the Unsatisfied Claim and Judgment Fund to remove references to Fund (UCJF), assessments. One commenter stated that it does not object to the amendments, as long as the

UCJF assessments as defined in the rules can be submitted as a variable expense in a rate filing. A second commenter wanted clarification from the Department of that position.

RESPONSE: The New Jersey Property-Liability Insurance Guaranty Association (PLIGA) is now the statutory administrator for the Unsatisfied Claims and Judgment Fund (UCJF). The assessments for UCJF costs are divided into two parts. One part is included in the NJPLIGA assessment against all lines of business assessable as provided in the PLIGA statute, N.J.S.A. 17:30A-6 et seq., which is a "pass through" charge to consumers. The second UCJF part is assessed on each insurer's automobile liability net direct written premium, which may be considered to be a variable expense.

COMMENT: One commenter expressed concern with the proposed amendment to N.J.A.C. 11:3-28.7, which relates to the reimbursement of excess medical benefits paid by insurers. This amendment requires insurers to submit to the UCJF requests for reimbursement of claim payments of $20,000 or more on a quarterly basis, and those less than $20,000 at the close of the calendar year in which such expenses are incurred. The commenter stated that it is their understanding that PLIGA was seeking to lessen the burden on insurers filing for reimbursement amounts less than $20,000 by giving them the option to file either quarterly or annually. The commenter believes that the Department's proposal requires insurers seeking such reimbursement to wait until the end of the year to make such filings. The commenter recommended that the Department amend N.J.A.C. 11:3-28.7, by adding the words in bold as follows: "For claim payments of less than $20,000, insurers [shall] **may** submit to the Fund itemized accounts with supporting documentation of excess medical expense benefits **either quarterly or** at the close of the calendar year in which such expenses are incurred."

RESPONSE: The Department agrees with the commenter and has amended this provision accordingly; however, the language "shall submit" is retained to make clear that submission in one of the two timeframes is mandatory.

COMMENT: One commenter requested that the Department amend N.J.A.C. 11:3-34.5 pertaining to frequency in underwriting and rating. The commenter stated that the current language fails to permit insurers the flexibility to consider frequency in underwriting and rating for accidents less than $1,000. The commenter stated that the Department's rules currently would not permit an insurer to consider two or more accidents where the damage totaled less than $1,000 per accident.

RESPONSE: The Department disagrees with the commenter. N.J.S.A. 17:33B-14 specifically requires that "at fault accidents" must each be $1,000 or over. At fault accidents under $1,000 may not be accumulated, so as to total more than $1,000 for rating purposes. Accidents under $1,000 may be used as "incidents," where an insurer's approved rating/tiering procedures recognize incidents.

COMMENT: One commenter stated that on page 18, the amendment to correct the Department's website address created a new error. The commenter stated that the two backslashes on either side of "state" should have remained periods.

RESPONSE: The commenter is correct. The Department has amended this provision accordingly to correct the Department's website address.

Summary of Agency-Initiated Changes

The Department is repealing N.J.A.C. 11:3-17 on adoption (operative July 16, 2006) because the Public Advocate Restoration Act of 2005, P.L. 2005, c. 155, which was effective January 17, 2006, restored the Department of the Public Advocate as a principal department in the Executive Branch of State government, and provides for the Division of Rate Counsel. Pursuant to the Public Advocate Act, the Division of Rate Counsel has limited jurisdiction with respect to insurance. The Division of Rate Counsel has no jurisdiction or authority to participate or intervene in: 1) expedited prior approval rate filings made by an insurer or affiliated group of insurers; 2) prior approval rate filings of seven percent or less, and 3) rule or form filings for any other form of insurance. The Division of Rate Counsel may represent and protect the public interest in significant proceedings that pertain solely to prior approval rate increases for Personal Lines Property Casualty Coverage or Medicare Supplemental Coverages. As a result, the Public Advocate Restoration Act of 2005 amends N.J.S.A. 17:29A-46.8 by adding paragraph k which notes that the section shall expire 180 days (July 16, 2006) after the effective date of the Public Advocate Restoration Act. Consequently, N.J.A.C. 11:3-17, which implemented N.J.S.A. 17:29A-46.8, is being repealed upon the readoption of Chapter 3, with the repeal operative on July 16, 2006.

Federal Standards Statement

A Federal standards analysis is not required because the rules set forth in this subchapter regulate and relate to the business of insurance and are not subject to any Federal requirements or standards.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 11:3.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks ***[thus]***):

11:3-3A.3 Report requirements

(a) - (g) (No change.)

(h) Reports shall be submitted using the Excel templates, available on the Department's website at ***[**http://www/state/nj.us/dobi**]*** ***http://www.state.nj.us/dobi*** on one of the following media:

1. - 3. (No change.)

(i) - (j) (No change.)

11:3-28.7 Reimbursement of excess medical expense benefits paid by insurer

(a) Insurers shall submit to the Fund itemized accounts with supporting documentation of excess medical expense benefit claim payments as soon as practicable after the close of the quarter for which reimbursement is sought for claim payments of $20,000 or more. For claim payments of less than $20,000, insurers shall submit to the Fund itemized accounts with supporting documentation of excess medical expense benefits ***either quarterly or*** at the close of the calendar year in which such expenses are incurred. Insurers shall not be reimbursed for interest, attorney fees or punitive damages.

1. - 2. (No change.)

(b) - (d) (No change.)

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