1. Needle electromyography (needle EMG) when used in the evaluation and diagnosis of neuropathies and radicular syndrome where clinically supported findings reveal a loss of sensation, numbness or tingling. A needle EMG is not indicated in the evaluation of TMJ/D and is contraindicated in the presence of infection on the skin or cellulitis. This test should not normally be performed within 14 days of the traumatic event and should not be repeated where initial results are negative. Only one follow up exam is appropriate.

2. Somasensory evoked potential (SSEP), visual evoked potential (VEP), brain audio evoked potential (BAEP), or brain evoked potential (BEP), nerve conduction velocity (NCV) and H-reflex Study are reimbursable when used to evaluate neuropathies and/or signs of atrophy, but not within 21 days following the traumatic injury.

3. Electroencephalogram (EEG) when used to evaluate head injuries, where there are clinically supported findings of an altered level of sensorium and/or a suspicion of seizure disorder. This test, if indicated by clinically supported findings, can be administered immediately following the insured event. When medically necessary, repeat testing is not normally conducted more than four times per year.

4. Videofluroscopy only when used in the evaluation of hypomobility syndrome and wrist/carpal hypomobility, where there are clinically supported findings of no range or aberrant range of motion or dysmmetry of facets exist. This test should not be performed within three months following the insured event and follow up tests are not normally appropriate.

5. Magnetic resonance imaging (MRI) when used in accordance with the guidelines contained in the American College of Radiology, Appropriateness Criteria to evaluate injuries in numerous parts of the body, particularly the assessment of nerve root compression and/or motor loss. MRI is not normally performed within five days of the insured event. However, clinically supported indication of neurological gross motor deficits, incontinence or acute nerve root compression with neurologic symptoms may justify MRI testing during the acute phase immediately post injury. In the case of TMJ/D where there are clinical signs of internal derangement such as nonself-induced clicking, deviation, limited opening, and pain with a history of trauma to the lower jaw, an MRI is allowable to show displacement of the condylar disc, such procedure following a panographic or transcranial x-ray and six or eight weeks of conservative treatment. This TMJ/D diagnostic test may be repeated post surgery and/or post appliance therapy.

6. Computer assisted tomographic studies (CT, CAT Scan) when used to evaluate injuries in numerous aspects of the body. With the exception of suspected brain injuries, CAT Scan is not normally administered immediately post injury, but may become appropriate within five days of the insured event. Repeat CAT Scans should not be undertaken unless there is clinically supported indication of an adverse change in the patient's condition. In the case of TMJ/D where there are clinical signs of degenerative joint disease as a result of traumatic injury of the temporomandibular joint, tomograms may not be performed sooner than 12 months following traumatic injury.

7. Dynatron/cyber station/cybex when used to evaluate muscle deterioration or atrophy. These tests should not be performed within 21 days of the insured event and should not be repeated if results are negative. Repeat tests are not appropriate at less than six months intervals.

8. Sonograms/ultrasound when used in the acute phase to evaluate the abdomen and pelvis for intra-abdominal bleeding. These tests are not normally used to assess joints (knee and elbow) because other tests are more appropriate. Where MRI is performed, sonograms/ultrasound are not necessary. However, echocardiogram is appropriate in the evaluation of possible cardiac injuries when clinically supported.

9. Thermography/thermograms only when used to evaluate pain associated with reflex sympathetic dystrophy ("RSD"), in a controlled setting by a physician experienced in such use and properly trained.

10. Brain mapping, when done in conjunction with appropriate neurodiagnostic testing.

(c) The terms "normal," "normally," "appropriate" and "indicated" as used in (b) above, are intended to recognize that no single rule can replace the good faith educated judgment of a health care provider. Thus, "normal," "normally," "appropriate" and "indicated" pertain to the usual, routine, customary or common experience and conclusion, which may in unusual circumstances differ from the actual judgment of course of treatment. The unusual circumstances shall be based on clinically supported findings of a health care provider. The use of these terms is intended to indicate some flexibility and avoid rigidity in the application of these rules in the decision point review required in (d) below.

(d) Except as provided in (e) below, a determination to administer any of the tests in (b) above shall be subject to decision point review pursuant to N.J.A.C. 11:3–4.7.

(e) The requirements of (b) and (d) above shall not apply to diagnostic tests administered during emergency care.

(f) Pursuant to N.J.A.C. 13:30–8.22(b), the personal injury protection medical expense coverage shall not provide reimbursement for the following diagnostic tests which have been identified by the New Jersey State Board of Dentistry as failing to yield data of sufficient volume to alter or influence the diagnosis or treatment plan employed to treat TMJ/D:

1. Mandibular tracking;

2. Surface EMG;

3. Sonography;

4. Doppler ultrasound;

5. Needle EMG;

6. Electroencephalogram (EEG);

7. Thermograms/thermographs;

8. Video fluoroscopy; and

9. Reflexology.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
In (a), deleted a former 6. and recodified former 7 through 9 as 6 through 8; in (b), substituted a reference to infections for a reference to staph infections in 1, added fourth and fifth sentences in 5, rewrote 6. deleted a former fourth sentence in 8, and added 9 and 10; in (c), substituted references to health care providers for references to trained medical professionals throughout; and added new (f).

11:3–4.6 Medical protocols

(a) Pursuant to N.J.S.A. 39:6A–3.1 and 39:6A–4, the Commissioner designates the care paths, set forth in the subchapter Appendix incorporated herein by reference, as the standard course of medically necessary treatment, including diagnostic tests, for the identified injuries.

(b) Where the care path indicates a decision point either by a hexagon in the care path itself or by reference in the text to a second opinion, referral for a second independent consultative medical opinion, development of a treatment plan or mandatory case management, the policy shall provide for a decision point review in accordance with N.J.A.C. 11:3–4.7.

(c) Treatments that vary from the care paths shall be reimbursable only when warranted by reason of medical necessity.

(d) The care paths do not apply to treatment administered during emergency care.

Law Review and Journal Commentaries

What's Next for No Fault? Gerald H. Baker, 159 N.J.L.J. 267 (2000).

11:3–4.7 Decision point review plans

(a) No insurer shall impose the co-payments permitted in N.J.A.C. 11:3–4.4(d), (e) and (f) unless it has an approved decision point review plan.

1. Initial decision point review plan filings and amendments to approved plans shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Office of Property Casualty–DPR
PO Box 325
Trenton, New Jersey 08625–0325

(b) No decision point or precertification requirements shall apply within 10 days of the insured event or to emergency care. This provision should not be construed so as to require reimbursement of tests and treatment that are not medically necessary.

(c) A decision point review plan filing shall include the following information:

1. Identification of any PIP vendor with which the insurer has contracted. PIP vendors shall designate a New Jersey licensed physician to serve as medical director for services provided to covered persons in New Jersey. The medical director shall ensure that decision point review and precertification requests are based upon medical necessity in accordance with the requirements of this subchapter;

2. Identification of any specific medical procedures, treatments, diagnoses, diagnostic tests, other services or durable medical equipment that are subject to precertification. The inclusion of precertification requirements in a decision point review plan is optional. The medical procedures, treatments, diagnoses, diagnostic tests or durable medical equipment required to be precertified shall be those that the insurer has determined may be subject to overutilization and that are not already subject to decision point review;

3. Copies of the informational materials described in (d) below and an explanation of how the insurer will distribute information to policyholders, injured persons and providers at policy issuance, renewal and upon notification of claim. An insurer shall make its informational materials available on the World Wide Web and provide the URL and any changes thereto to the Department's webmaster at: webmaster@dobi.state.nj.us;

4. Procedures for the prompt review, not to exceed three business days, of decision point review and precertification requests by insureds or providers. All determinations on treatments or tests shall be based on medical necessity and shall not encourage over or underutilization of benefits. Denials of decision point review and precertification requests on the basis of medical necessity shall be the determination of a physician. In the case of treatment prescribed by a dentist, the denial shall be by a dentist;

5. Procedures for the scheduling of physical examinations pursuant to (e) below;

6. An internal appeals procedure that permits the provider to provide additional information and have a rapid review of a decision to modify or deny reimbursement for a treatment or the administration of a test;

7. Reasonable restrictions on the assignment of benefits pursuant to N.J.A.C. 11:3–4.9(a); and

8. The information required in order to use a network pursuant to N.J.A.C. 11:3–4.8(d), if applicable.

(d) The informational materials for policyholders, injured persons and providers shall be on forms approved by the Commissioner and shall include at a minimum the information in (d)1 through 9 below. In order to make the requirements of this subchapter easier for insureds and providers to use, the Commissioner may by Order require the use of uniform forms, layouts and language of information materials.

1. How to contact the insurer or vendor to submit decision point review/precertification requests including the telephone, facsimile numbers or email addresses. The insurer or its vendor shall be available, at a minimum, during normal working hours to respond to decision point review/precertification requests;

2. An explanation of the decision point review process including a list of the identified injuries and the diagnostic tests in N.J.A.C. 11:3-4.5(b). The materials shall include copies of the Care Paths or indicate how copies may be obtained;

3. A list of the medical procedures, treatments, diagnoses, diagnostic tests, durable medical equipment or other services that require precertification, if any;

4. An explanation of how the insurer will respond to decision point review/precertification requests, including time frames. The materials should indicate that:

i. Telephonic responses will be followed up with a written authorization, denial or request for more information within three business days;

5. An explanation of the insurer's option to require a physical examination pursuant to (e) below;

6. An explanation of the penalty co-payments imposed for the failure to submit decision point review/precertification requests where required in accordance with N.J.A.C. 11:3-4.4(d);

7. An explanation of the insurer's voluntary network or networks for certain types of testing, durable medical equipment or prescription drugs authorized by N.J.A.C. 11:3-4.8, if any;

8. An explanation of the alternatives available to the provider if reimbursement for a proposed treatment, diagnostic test or durable medical equipment is denied or modified, including insurer's internal appeal process and how to use it; and

9. An explanation of the insurer's restrictions on assignment of benefits, if any.

(e) A physical examination of the injured party shall be conducted as follows:

1. The insurer shall notify the injured person or his or her designee that a physical examination is required to determine the medical necessity of further treatment, diagnostic tests or durable medical equipment. An insurer shall include reasonable procedures for the notification of the injured person and the treating medical provider where reimbursement of further treatment, diagnostic testing or durable medical equipment will be denied for failure to appear at scheduled medical examinations.

2. The appointment for the physical examination shall be scheduled within seven calendar days of receipt of the notice in (e)1 above unless the injured person agrees to extend the time period.

3. The medical examination shall be conducted by a provider in the same discipline as the treating provider.

4. The medical examination shall be conducted at a location reasonably convenient to the injured person.

5. The injured person, upon the request of the insurer, shall provide medical records and other pertinent information to the provider conducting the medical examination. The requested records shall be provided at the time of the examination or before.

6. The insurer shall notify the injured person or his or her designee and the treating medical provider whether it will reimburse for further treatment, diagnostic tests or durable medical equipment as promptly as possible but in no case later than three business days after the examination. If the examining provider prepares a written report concerning the examination, the injured person or his or her designee shall be entitled to a copy upon request.

7. Insurers may include in their decision point review plan a procedure for the denial or reimbursement for treatment, diagnostic testing or durable medical equipment after repeated unexcused failure to attend a scheduled physical examination. The procedure shall provide for adequate notification of the insured and the treating provider of the consequences of failure to attend the examination.

(f) In administering decision point review and precertification, insurers shall avoid undue interruptions in a course of treatment. As part of their decision point review plans, insurers may include provisions that encourage providers to establish an agreed upon voluntary comprehensive treatment plan for all of a covered person's injuries to minimize the need for piecemeal review. An agreed comprehensive treatment plan may replace the requirements for notification to the insurer at decision points and for treatment, diagnostic testing or durable medical equipment requiring precertification. In addition, the insurer may provide that reimbursement for treatment, diagnostic tests or durable medical equipment consistent with the agreed plan will be made without review or audit.

(g) An insurer shall not retrospectively deny payment for treatment, diagnostic testing or durable medical equipment on the basis of medical necessity where a decision point review or precertification request for that treatment or testing was properly submitted to the insurer unless the request involved

fraud or misrepresentation, as defined in N.J.A.C. 11:16-6.2, by the provider or the person receiving the treatment, diagnostic testing or durable medical equipment.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Deleted a former (c); and recodified former (d) and (e) as (c) and (d).
Repeal and New Rule, R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).
See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).
Section was "Decision point review".
Amended by R.2006 d.243, effective July 3, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).
In (e)7, substituted "decision" for "description"; and in (g), substituted "N.J.A.C. 11:16-6.2" for "N.J.A.C. 11:16-16.2".

11:3-4.8 Voluntary networks

(a) No insurer shall file a decision point review plan utilizing a voluntary network or networks unless the network is a health maintenance organization licensed pursuant to N.J.S.A. 26:2J-1 et seq.; or approved by the Department as part of a selective contracting arrangement with a health benefits plan pursuant to N.J.A.C. 11:4-37 and 8:38A-4.10; or approved as part of a workers' compensation managed care organization pursuant to N.J.A.C. 11:6, or is licensed or certified as an organized delivery system pursuant to N.J.A.C. 11:22-4 and 8:38B.

(b) Voluntary networks may be offered for the provision of the following types of non-emergency benefits only:

1. Magnetic Resonance Imagery;

2. Computer Assisted Tomography;

3. The electrodiagnostic tests listed in N.J.A.C. 11:3-4.5(b)1 through 3 except for needle EMGs performed by the treating physician;

4. Durable medical equipment with a cost or monthly rental in excess of $50.00; or

5. Prescription drugs.

(c) Insurers that offer voluntary networks either directly or through a PIP vendor shall meet the following requirements:

1. The insurer shall notify all insureds upon application for and issuance of the policy and upon renewal of the types of benefits for which it has voluntary networks. Use of the network by the insured is voluntary but bills for out-of-network services or equipment are subject to the penalty deductibles set forth in N.J.A.C. 11:3-4.4(f).

2. Upon receipt of a request for PIP benefits under the policy, the insurer or its PIP vendor shall make available to the insured and the treating medical provider information about approved networks and providers in the network, including addresses and telephone numbers. Insureds shall be able to choose to go to any provider in the network.

(d) An insurer offering a voluntary network or networks directly or through a PIP vendor shall submit the following information to the Department with its Decision Point Review Plan:

1. A narrative description of the benefits to be offered through the network or networks;

2. The identity and a description of the network and the specific services or supplies to be provided by the network or networks;

3. A description of the procedures by which benefits may be obtained by persons using the network; and

4. A statement of how the network meets the requirement of (a) above.

(e) Any voluntary network used by an insurer pursuant to this subchapter shall agree to disclose to a participating provider, upon written request, a list of all the clients or other payers that are entitled to a specific rate under the network's contract with the participating provider.

Amended by R.2000 d.454, effective November 6, 2000.
See: 31 N.J.R. 4210(a), 32 N.J.R. 4005(c).
Rewrote the section.
Repeal and New Rule, R.2004 d.218, effective June 7, 2004 (operative October 27, 2004).
See: 35 N.J.R. 3072(a), 36 N.J.R. 2890(a), 36 N.J.R. 4319(a).
Section was "Precertification".

11:3-4.9 Assignment of benefits; public information

(a) Insurers may file for approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage. Insurers may not prohibit the assignment of benefits to providers. Reasonable restrictions may include, but are not limited to:

1. A requirement that as a condition of assignment, the provider agrees to follow the requirements of the insurer's decision point review plan for making decision point review and precertification requests;

2. A requirement that as a condition of assignment, the provider shall hold the insured harmless for penalty co-payments imposed by the insurer based on the provider's failure to follow the requirements of the insurer's Decision Point Review Plan; and/or

3. A requirement that as a condition of assignment, the provider agrees to submit disputes to alternate dispute resolution pursuant to N.J.A.C. 11:3-5.

past, or has not collected it in a form so as to facilitate reporting, it is not required to compile it retrospectively.

(b) Separate insurance companies that are affiliated by a parent-subsidiary or any group relationship and that choose to submit a single filing for the group shall provide the minimum data requirements set forth in N.J.A.C. 11:3-16.8, 16.9, and 16.10, either:

1. Separately for each company with a different rate level or different acceptance criteria; or

2. Combined for those companies of the group, which use a common rating system, including both base rates and acceptance criteria, or when the difference is based only on expense differences.

(c) All filings shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Office of Property and Casualty
PO Box 325
Trenton, New Jersey 08625-0325

(d) All filings shall be accompanied by a NAIC Uniform Property and Casualty Transmittal Document and accessible, with instructions, at N.J.A.C. 11:1-2.2(b).

(e) All filings shall be accompanied by the following certification signed by an officer of the filer: "I _____ certify that the attached filing complies with all statutory and regulatory requirements and that all the information it contains is true and accurate. I further certify that I am authorized to execute this certification on behalf of the filer."

(f) All data shall be reported on a direct basis exclusive of business ceded to reinsurers or reinsurance assumed from other companies.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Provisions added to confirm that rate filings should contain only voluntary market data and not include data from risks that may be insured through the assigned risk plan to be instituted pursuant to section 34 of the Act.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.
Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Deleted requirement to send filings to the Public Advocate.
Amended by R.1998 d.128, effective March 2, 1998.
See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).
In (a), deleted the former fourth and fifth sentences; in (d), changed the mailing address; deleted former (i); recodified former (j) as (i); recodified former (k) as (j), and substituted "prior approval rate or lost cost" for "rate" in the first sentence; and added new (k) and (*l*).
Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
Amended by R.2002 d.101, effective April 1, 2002.
See: 33 N.J.R. 1875(a), 34 N.J.R. 1431(b).
Rewrote (e).
Amended by R.2003 d.173, effective May 5, 2003.
See: 34 N.J.R. 3475(a), 35 N.J.R. 1907(a).
In (g), added "A total of three copies shall be submitted." at the end of the paragraph.
Amended by R.2003 d.499, effective December 15, 2003.
See: 35 N.J.R. 3084(a), 35 N.J.R. 5604(a).
In (i), deleted reference to the transactions with UCJF.
Amended by R.2005 d.176, effective June 6, 2005.
See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
Rewrote the section.
Amended by R.2007 d.91, effective April 2, 2007.
See: 38 N.J.R. 4976(b), 39 N.J.R. 1313(a).
Rewrote (d).
Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).
See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).
In (b)1 and (b)2, substituted "acceptance criteria" for "underwriting guidelines"; and in (b)2, inserted a comma after "group".

11:3-16.4 Insurer informational filings due July 1 of each year

(a) Informational filings shall be made by all insurers transacting private passenger automobile insurance in the voluntary market, including all individual members and subscribers of rating organizations, pursuant to N.J.S.A. 17:29A-36.2b.

(b) The information filing shall consist of the following documents:

1. The insurer's Excess Profits Report for each company filed pursuant to N.J.A.C. 11:3-20. In lieu of providing copies, the filer may submit a certification of an officer that the report has been filed and is incorporated by reference.

2. Such other specific information on a particular subject at a particular time as the Commissioner may require by Order.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Deleted (b)2. through 8.; added new 2.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.
Amended by R.1995 d.171, effective March 20, 1995.
See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).

11:3-16.5 (Reserved)

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Amended to implement provisions of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted without change.
Amended by R.1992 d.189, effective April 20, 1992.
See: 23 N.J.R. 3199(a), 24 N.J.R. 1504(a).
Rate calculation to be included in memo.
Amended by R.1995 d.171, effective March 20, 1995.
See: 27 N.J.R. 41(a), 27 N.J.R. 1190(b).
Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).

Repealed by R.1998 d.128, effective March 2, 1998.
See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).
Section was "Insurer flex rate filings".

11:3-16.6 Filings for rates requiring prior approval

(a) Any filer that desires to modify its rates or rating systems in a manner other than that provided by N.J.S.A. 17:29A-46.6 shall provide the following standard information in support of its application:

1. A cover letter notifying the Department of its intention to modify its rating system in a manner that requires prior approval, pursuant to N.J.S.A. 17:29A-14; a statement describing the proposed changes, which shall include the proposed effective date of the change, and the name, telephone number and mailing address of the company officer familiar with the filing, to whom inquires about the filing may be directed. Filers may choose to eliminate the submission of a cover letter provided that the "Filing Description" of the NAIC Uniform Property and Casualty Transmittal Document referenced in N.J.A.C. 11:3-16.3(d) is fully completed with a clear and precise description of the filing;

2. A checklist that sets forth the information in Exhibit A in the Appendix incorporated herein by reference;

3. Exhibit B in the Appendix incorporated herein by reference;

4. A narrative overview that sets forth the contents of the filing, and explains the reasons and procedures used to derive the rate change requested;

5. Premiums, losses and loss adjustment expenses data, as set forth in N.J.A.C. 11:3-16.8;

6. Expense data, as set forth in N.J.A.C. 11:3-16.9. Rating organizations are exempt from this requirement;

7. Profit and contingency provision, as set forth in N.J.A.C. 11:3-16.10. Rating organizations are exempt from this requirement;

8. Proposed rates or loss costs for each territory and coverage together with their derivation;

9. Calculations showing that the proposed rates are in compliance with N.J.S.A. 17:29A-36; and

10. Data described in N.J.A.C. 11:3-16.8, 16.9 and 16.10 shall be submitted in written copy and, except for purely textual information, on an MS-DOS formatted 3.5 inch 1.44 MB disk or a CD-ROM. The information shall be provided in a Microsoft Excel 97 or compatible spreadsheet. All calculated values shall be given as a formula in the spreadsheet.

(b) All rate filers shall submit data in support of their application for approval of their proposed rating system based on their own loss experience to the extent it is credible (N.J.A.C. 11:3-16.8), their own expense and profit provisions (N.J.A.C. 11:3-16.9) except rating organizations, and their own profit and contingency provision (N.J.A.C. 11:3-16.10). If the application is not supported by the required data, filers shall submit other appropriate documentation as necessary in addition to the required data. Those filers who refer, without deviation, to the loss experience data of a rating organization shall not be required to file their own loss experience data.

(c) Upon approval, insurers shall file manual rating pages on or before the effective date of the rates. In the case of rating organizations, the manual rating page shall reflect the loss cost information.

(d) In those cases where, due to their small size and/or lack of historical experience, filers are unable to completely fulfill all of the data submission requirements set forth in N.J.A.C. 11:3-16.8, 16.9 and 16.10, such filers shall be required to submit as much required information as they are able to supply, and each filing shall be reviewed accordingly.

(e) Filers shall provide any additional rate filing information specifically requested by the Department that may be necessary to constitute a proper rate filing.

Emergency Amendment, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Provisions to implement the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted without change.
Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Amended (a)1 and 5, and added (a)6.
In (a)1 eliminated the exclusion of the policy constant and RMEC from the grand total.
Amended by R.1998 d.128, effective March 2, 1998.
See: 29 N.J.R. 5240(a), 30 N.J.R. 828(a).
In (a), inserted a reference to loss costs in 4, added an exception at the beginning of 5, inserted a reference to loss cost calculations in 6, and changed N.J.A.C. references and deleted a reference to 5.25 inch 360 KB disks in 7; in (b), inserted an exception relating to rating organizations and inserted a reference to loss cost calculations in the first sentence, and added a second sentence; and rewrote (c).
Amended by R.2003 d.173, effective May 5, 2003.
See: 34 N.J.R. 3475(a), 35 N.J.R. 1907(a).
Rewrote the section.
Amended by R.2005 d.176, effective June 6, 2005.
See: 36 N.J.R. 5640(a), 37 N.J.R. 2026(a).
Rewrote the section.
Amended by R.2007 d.91, effective April 2, 2007.
See: 38 N.J.R. 4976(b), 39 N.J.R. 1313(a).
In (a)1, inserted the last sentence.

11:3-16.7 (Reserved)

Emergency Repeal and New Rule, R.1990 d.621, effective November 26, 1990 (expired January 25, 1991).
See: 22 N.J.R. 3790(a).
Formerly entitled Rating Organization Filings; new rule to implement section 69 of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8.
Adopted Concurrent Proposal, R.1991 d.91, effective January 25, 1991.
See: 22 N.J.R. 3790(a), 23 N.J.R. 514(a).
Provision of emergency amendment, R.1990 d.621, readopted with changes effective February 19, 1991.

(i) Pursuant to N.J.S.A. 17:29A-36, the initial territorial relativity for any territory shall not be significantly disproportionate to the current relativity for that territory. For the purposes of this subchapter, the current relativity means the relativity that is in effect on the date of the initial filing pursuant to this subchapter. The current relativity shall be calculated for each zip code and compared with the indicated or selected relativity in accordance with (h) above for the territory in which the zip code is now located. The territorial relativity for a zip code shall be based on a Statewide average relativity of 1.000.

(j) Insurers shall not be required to make separate filings of basic policy data. However, filings made in accordance with this subsection shall comply with the provisions of N.J.S.A. 17:29A-36a concerning the basic policy.

11:3-16A.6 Review of filings

(a) All filings and other items submitted to the Commissioner pursuant to this subchapter shall be sent to the Department at the following address:

New Jersey Department of Banking and Insurance
Office of Property and Casualty
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

(b) The time periods for the Department's review of territorial rating plan filings made pursuant to this subchapter are as set forth below:

1. Sixty days for insurers that use the common territory map, the territory map approved for a rating organization or a map that modifies either the common territory or rating organization map, as provided in N.J.A.C. 11:3-16A.3(b)3. For good cause, the Department may extend the review period for 30 days.

2. Ninety days for filers that are filing their own territory map. For good cause, the Department may extend the review period for a reasonable time, not to exceed 45 days.

(c) If the filing is incomplete, the Department shall so advise the filer not later than 20 business days after the receipt of the filing. If the Department does not advise the filer that the filing is incomplete, it shall be deemed to be complete on the 20th business day after receipt.

1. Notice to the filer that the filing is incomplete shall specify the missing item(s) or information. The notice shall advise the filer that a new 20-day time period for the Department's completeness review of the filing starts again upon receipt by the Department of the information intended to cure the deficiency.

2. If the Department requests further information from the filer pursuant to N.J.A.C. 11:3-16A.5(c), the time frame for the Department's review of the filing is tolled until the information is received.

3. A determination by the Department that a filing is complete relates solely to the inclusion in the filing of the items requested by N.J.A.C. 11:3-16A.5 and shall not be considered a finding regarding the accuracy or reasonableness of the information or calculations.

(d) The Department shall not approve any filing that does not comply with N.J.S.A. 17:29A-48 et seq. and 17:29A-36 and this subchapter.

11:3-16A.7 Territorial rating plan review

(a) Each filer shall periodically review, no less frequently than once every five years, the continued validity of its territorial rating plan and report its findings in a format to be established by the Commissioner by Order.

(b) The Commissioner shall convene the Commission to review the continued validity of the common territory map at least once every five years.

11:3-16A.8 Objection to filings

(a) Any filer may object to an approved filing made in accordance with this subchapter on the grounds that it:

1. Is anti-competitive;

2. Does not meet the standards established in N.J.S.A. 17:29A-48 and this subchapter; or

3. Results in the filer not meeting its obligations pursuant to N.J.S.A. 17:33B-15.

(b) The filer shall have the burden of proof in making an objection to an approved filing.

(c) Any objection to an approved filing shall be in writing with all supporting materials. Two copies shall be sent to the Department at the address for filings set forth at N.J.A.C. 11:3-16A.6(a).

(d) The Department will review the objection and may ask for additional information from the filer making the objection. The Department may also ask for a response to the objection from the filer against whom the objection was made.

(e) The Department shall respond to the objection within 90 days of receipt of all information from the filer.

11:3-16A.9 Transition requirements

(a) The Commission shall file a territory map in accordance with N.J.A.C. 11:3-16A.4 and territorial relativities in accordance with N.J.A.C. 11:3-16A.5 for the Commissioner's approval.

1. The Commissioner shall approve or disapprove the filing within 30 days. If the Commissioner disapproves all or any part of the Commission's filing, it shall be returned with recommendations. The Commission may accept the recommendations of the Commissioner or may propose a

new territory map within 30 days after the return of a disapproved map. If the Commission does not file a map acceptable to the Commissioner within 30 days of the disapproval of the original map, the Commissioner shall certify his or her own map.

(b) If a rating organization intends to file a territory map and relativities, the filing shall be made no later than 60 days after the Commissioner's approval or certification of the common territory map. For good cause shown, the rating organization may request an extension of the filing deadline.

(c) No later than 180 days after the Commissioner's approval or certification of the common territory map, every insurer, including the PAIP, shall file a territory map, territorial relativities and amendments to its rating plan that meet the requirements of this subchapter. For good cause shown, an insurer or the PAIP may request an extension of the filing deadline.

1. If an insurer that intends to use its own territorial map fails to make an acceptable filing, the Commissioner may by Order require it to use the common territory map.

2. The insurer shall demonstrate that the initial filing is revenue neutral by coverage in accordance with N.J.S.A. 17:29A-36d.

3. The PAIP shall use the common territory map and the relativities developed by the Commission.

11:3-16A.10 Territorial Rating Equalization Exchange (TREE)

(a) There is hereby created in the State of New Jersey an unincorporated association that operates on a non-profit, non-loss basis to be known as the Territorial Rating Equalization Exchange (TREE).

(b) The purpose of the TREE is to promote sustainable competition in the private passenger automobile insurance market in all areas of the State.

(c) All insurers writing personal lines private passenger automobile insurance business in New Jersey shall be members of the exchange.

(d) The TREE shall be administered by a governing committee appointed pursuant to this subchapter and a Plan of Operation approved by the Commissioner.

(e) The administrative offices of the TREE shall be located within the State of New Jersey.

New Rule, R.2008 d.31, effective February 4, 2008.
See: 39 N.J.R. 13(a), 40 N.J.R. 786(a).
Former N.J.A.C. 11:3-16A.10, Penalties, recodified to N.J.A.C. 11:3-16A.13.

11:3-16A.11 TREE governing committee

(a) The TREE shall be administered by a governing committee comprised of 11 voting members appointed by the Commissioner.

1. Eight members shall be salaried employees of insurers that write private passenger automobile insurance in this State.

2. Two members shall be licensed producers of private passenger automobile insurance in this State.

3. One member shall be a public representative appointed by the Commissioner who is knowledgeable about automobile insurance matters but is not employed by, or otherwise affiliated with, private passenger automobile insurers.

4. The Commissioner or his or her representative shall be an ex officio, non-voting member of the governing committee.

(b) The following insurer trade organizations shall each nominate two members to represent insurers:

1. The American Insurance Association, or its successor; and

2. The Property Casualty Insurers Association of America, or its successor.

(c) The Commissioner shall appoint:

1. Two members from insurers that are not members of the organizations identified in (b) above;

2. Two members from New Jersey domestic insurers which may be members of the trade associations in (b) above;

3. The licensed producer representatives as referenced in (a) above; and

4. The public representative as referenced in (a) above.

(d) The initial governing committee appointed pursuant to this subchapter shall serve for staggered terms of two or three years or until successors are appointed. Thereafter, all members of the governing committee shall serve for two years until a successor is appointed. Each member may designate an alternate.

(e) All meetings of the governing committee shall be conducted in accordance with this subchapter and the Plan of Operation.

(f) The governing committee shall have the power and the duty to:

1. Develop and submit to the Commissioner for approval a Plan of Operation;

1. All insurers, affiliated groups of insurers and rating organizations writing or transacting private passenger automobile insurance in the voluntary market in this State; and

2. The New Jersey Personal Automobile Insurance Plan.

(c) These rules shall apply to base rate changes by coverage and territory, including expense fees, as well as to increased limit and deductible relativity factor changes. Classification factor changes will also be permitted to the extent necessary for filers to maintain compliance with N.J.S.A. 17:29A-36(c).

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).
In (a), deleted "expedited" preceding "process" and inserted "limited rate" preceding "changes"; in (b)1, inserted ", affiliated groups of insurers" following "All insurers".
Amended by R.2007 d.179, effective June 4, 2007.
See: 38 N.J.R. 4161(a), 39 N.J.R. 2260(b).
Rewrote (c).

11:3-16B.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Accident year" means the 12-month period covering the occurrences during that period.

"Affiliate" means an insurer that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the insurer making a filing.

"AIRE" means the Automobile Insurance Risk Exchange, established pursuant to N.J.S.A. 39:6A-21.

"Base rate" means the manual rate that results from all rating factors (limits, class, tiers, etc.) being at unity (1.000 factor).

"Claim" means a request for payment for a loss which comes under the terms of an insurance contract.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Coverage" means:

1. Split limit bodily injury ("BI");

2. Split limit property damage ("PD");

3. Combined single limit BI and PD ("CSL");

4. Personal injury protection including medical payments ("PIP");

5. BI, PD and PIP combined ("PACK");

6. Uninsured and underinsured motorists, bodily injury and property damage ("UM");

i. For developing the indications by coverage, UM data may be combined with liability data in 1, 2, 3 or 5 above;

7. Comprehensive ("COMP"); and

8. Collision ("COLL").

"Department" means the New Jersey Department of Banking and Insurance.

"Expenses" means that portion of a rate that is attributable to commissions and brokerage, other acquisition expenses, general expenses, and taxes, licenses and fees in addition to other miscellaneous expenses. Other miscellaneous expenses include the Automobile Insurance Risk Exchange (AIRE) assessments, AIRE allocations, AIRE investment income, Limited Assignment Distribution (LAD) carrier fees, if applicable, the expected gain (deficit) resulting from assigned risk business, and assessments for losses and costs relating to uninsured motorist coverage and pedestrian personal injury protection.

"Exposure" means one car insured for one year, or two cars insured for six months, each, etc.

"Filer" means any insurer or rating organization who makes an annual informational filing or rate filing requiring prior approval pursuant to these rules.

"Group of coverages" means liability coverages (to include bodily injury liability, property damage liability, personal injury protection and uninsured/underinsured motorists) and physical damage coverages (to include collision and comprehensive).

"Informational filing" means a filing made annually on July 1, in accordance with N.J.S.A. 17:29A-36.2b.

"Loss cost multiplier" means the adjustment reflecting expenses, profit and contingency loading and any modifications that the insurer used on the loss costs to produce final rates.

"Personal Automobile Insurance Plan" or "PAIP" means the New Jersey Personal Automobile Insurance Plan established by N.J.S.A. 17:29D-1 et seq.

"Prior approval filing" means a filing made pursuant to N.J.S.A. 17:29A-14 and N.J.A.C. 11:3-16.6 to alter, supplement or amend a rating system or any part thereof.

"Prospective loss cost" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

"Rate" means the unit charge by which the measure of exposure or the amount of insurance specified in a policy of insurance or covered thereunder is multiplied to determine the premium. The unit charge may be expressed as a single number or as a prospective loss cost and an adjustment to account

for the treatment of expenses, profit and variations in loss experience.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of ratemaking for two or more insurers.

"Rating system" means every schedule, class, classification, rule, guide, standard, manual, table or rating plan by whatever name described containing the rates and rules used by any insurer in determining or ascertaining a rate.

"Reasonable total rate of return" means that rate of return appropriate for an enterprise given the risk involved.

"Small filer" means a filer with less than 0.5 percent of the total New Jersey written premiums in the voluntary market for private passenger automobile insurance for the most recently available prior calendar year.

"Tier" and "tier rating system" refer to one or more tier placement criteria, filed and approved pursuant to N.J.S.A. 17:29A-46.1 et seq. and N.J.A.C. 11:3-19A, which defines and characterizes one or more mutually exclusive group of insureds.

"Total rate of return" means underwriting return and investment return on both reserves plus capital and surplus, related as a percentage to capital and surplus.

"Written premium" ("WP") means direct, written premium net of dividends paid or incurred.

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).
Rewrote "Rate change" and "Written premium".
Amended by R.2007 d.179, effective June 4, 2007.
See: 38 N.J.R. 4161(a), 39 N.J.R. 2260(b).
Added definitions "Accident year", "Affiliate", "AIRE", "Base rate", "Claim", "Department", "Expenses", "Exposure", "Filer", "Group of coverages", "Informational filing", "Loss cost multiplier", "Prior approval filing", "Prospective loss cost", "Rate", "Rating organization", "Rating system", "Reasonable total rate of return", "Small filer", "Tier" and "Total rate of return"; in definition "Commissioner", inserted "New Jersey" preceding "Department" and deleted "in the State of New Jersey" following "Insurance"; in paragraph 3 of definition "Coverage", inserted "BI and PD"; in paragraph 6i of definition "Coverage", substituted "may" for "shall" and inserted "2,"; in definition "Personal Automobile Insurance Plan", substituted "N.J.S.A. 17:29D-1 et seq." for "N.J.A.C. 11:3-2"; and deleted definitions "Earned premium" and "Rate change".
Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).
See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).
In definition "Tier" and "tier rating system", substituted "tier placement criteria" for "underwriting rules".

11:3-16B.3 Rate process for limited rate changes; insurers and rating organizations

(a) An insurer and/or rating organization, pursuant to N.J.S.A. 17:33B-31, may file for a rate change in accordance with this subchapter. The insurer shall provide the following information in support of its filing:

1. A cover letter notifying the Department of its intention to make a rate change according to the provisions of this subchapter; a statement containing the effective date of the change for new and renewal policyholders; and the name, telephone number and mailing address of the company officer familiar with the filing to whom further inquiries regarding the filing may be directed;

2. The information in N.J.A.C. 11:3-16 Appendix Exhibit B incorporated herein by reference;

3. A checklist that sets forth the information in Exhibit A in the subchapter Appendix incorporated herein by reference;

4. Exhibits that illustrate that the new rates are within the ranges permitted by N.J.S.A. 17:29A-36 and 29A-46.6(e). The exhibits shall include Statewide average rates, rating factors, and any underlying premium and exposure distributions necessary to the calculations;

5. The manual rating pages containing the territorial base rates by coverage to be implemented, accompanied by an explanatory memorandum showing the calculation of the new rates by coverage, using the existing rates by coverage as the starting point in the calculation;

6. Completed rating examples using the examples set forth in N.J.A.C. 11:3-45.3, which shows the proposed premium amounts;

7. The distribution of exposure – level rate impacts by five percent intervals, including descriptions of the characteristics of risks receiving the minimum and maximum impact; and

8. A CD-ROM or MS-DOS formatted 3.5 inch 1.44 MB disk, as described at N.J.A.C. 11:3-16B.4(e).

(b) The filer may supplement a complete filing in response to questions from the Department about matters that require clarification or additional explanation, provided that the prompt review of the filing within the time frames set forth in this subchapter is not adversely affected.

(c) Separate insurance companies that are affiliated by a parent-subsidiary or any group relationship and that choose to submit a single filing for the group shall provide the data, either:

1. Separately for each company with a different rate level or different acceptance criteria; or

2. Combined for those companies of the group, which use a common rating system, including both base rates and acceptance criteria, or when the difference is based only on expense differences.

(d) All filings shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
Office of Property and Casualty
P.O. Box 325
Trenton, NJ 08625-0325

(e) All filings shall be accompanied by the following certification signed by an officer of the filer: "I _____certify that the attached filing complies with all statutory and regulatory requirements and that all the information contained in it is true and accurate. I further certify that I am authorized to execute this certification on behalf of the filer."

(f) All data shall be reported on a direct basis exclusive of business ceded to reinsurers or business assumed from other companies.

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).
In (a), inserted "the company's file number," following "the provisions of this subchapter;" and "for new and renewal policyholders" following "of the change" in 1 and deleted the last sentence of 4.
Amended by R.2006 d.243, effective July 3, 2006.
See: 37 N.J.R. 4162(a), 38 N.J.R. 2828(c).
In (a)5, substituted "N.J.A.C. 11:3-45" for "N.J.A.C. 11:3-19A.3" and "show" for "shows".
Amended by R.2007 d.179, effective June 4, 2007.
See: 38 N.J.R. 4161(a), 39 N.J.R. 2260(b).
Rewrote (a)1; added new (a)2; recodified former (a)2 through (a)5 as (a)3 through (a)6; rewrote (a)4; in (a)5, deleted "and" from the end; in (a)6, updated the N.J.A.C. reference and substituted a semicolon for a period at the end; and added (a)7, (a)8, (c), (d), (e), and (f).
Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).
See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).
In (c)1 and (c)2, substituted "acceptance criteria" for "underwriting guidelines"; and in (c)2, inserted a comma after "group".

11:3-16B.4 Rate process for limited rate changes; calculation for private passenger automobile insurance

(a) General requirements for limited rate change filings are as follows:

1. Filers shall provide coverage indications based on three accident years of data. For coverages that are fully credible based on less than three years of data, filers may use two accident years of data to calculate indications for those coverages;

2. Indications may be based on either total limit or basic limit data for the liability coverages;

3. Coverage indications shall be calculated as follows:

i. Filers that only sell split limits policies shall submit separate BI and PD indications;

ii. Filers that only sell CSL policies shall submit one CSL indication. However, the BI and PD portion of losses shall be developed and trended using separate loss development triangles and trend factors;

iii. Filers that sell both split limits and CSL policies can either submit separate BI, PD and CSL indications or allocate the CSL data between BI and PD;

iv. Filers that sell PACK policies can submit one indication for the policy but the BI, PD and PIP portion of the losses shall be developed and trended using separate loss development triangles and trend factors; and

v. UM data shall be combined with liability data in (a)3i, ii, iii or iv above. Filers do not have to calculate a separate indication for UM; and

4. All supporting exhibits must include documentation of formulas and data sources.

(b) Filers shall provide the following information regarding projected earned premium:

1. New Jersey (NJ) earned premium by coverage, by accident year;

2. On-level factors by coverage, based on company specific historical NJ rate changes; and

3. The premium trend factors, based on either annual selections from the latest approved Insurance Services Office (ISO) filing in NJ, or internal company data.

i. If supplying premium trend factors developed from internal company data, the filer shall provide all data and methods used.

(c) Ultimate loss and loss adjustment expense ("LAE") shall be determined by:

1. NJ incurred loss and defense/cost containment expense ("DCC"), by coverage, by accident year either combined (loss and DCC) or developed separately;

i. For COMP and COLL coverages, filers may use paid loss instead of incurred loss.

2. New Jersey loss development factors (LDFs) by coverage, either combined (loss and DCC) or separately;

i. The selected age-to-age factors shall be based on the latest five-year X HI/LO average, that is, using a straight average of the latest five age-to-age factors, excluding the highest and lowest.

ii. BI and PIP LDFs shall be developed to 87 months, with a five percent tail factor from 87 months to ultimate.

iii. PD, COMP and COLL LDFs shall be developed out to 51 months, with no subsequent tail factor;

iv. LDFs for COLL and COMP shall be consistent with the method used in (c)1 above.

3. Loss trend factors shall be based on either annual selections from the latest approved ISO filing in NJ, or the latest available NJ Fast Track data, computed separately for severity and frequency by coverage (BI, PIP, PD, COMP, COLL). All data must be based on paid, not incurred/arising, claims.

i. If supplying Fast Track trend factors, the filer shall use the 12 quarter-rolling average and provide all data and calculations.

ii. For COMP, filers may use country-wide Fast Track data to smooth out the effect of catastrophes;

4. Adjusting and other claims related expenses ("AO") shall be determined as a ratio of incurred AO to incurred loss plus incurred DCC from the latest three-year average of Countrywide Insurance Expense Exhibit (IEE) in the insurer's annual statement filed with the Department;

5. Filers shall account for impacts of significant changes to legislative, regulatory, social, economic, or operational factors that have an impact on loss frequency or severity, or on loss adjustment expenses. These impacts shall be accounted for as supplemental to the standard data and procedures described elsewhere in this regulation, and must be justified. If the addition of such impacts results in an alternative method of calculating the indications, then the Department's review of and decision on the method will be governed by the time frames as set forth in N.J.A.C. 11:3-16B.4(k); and

6. Filers may exclude catastrophe losses from the COMP data and include a load based either on the selected factor from ISO's last approved private passenger automobile filing in New Jersey or derive a factor from at least 10 years of the filer's internal New Jersey catastrophe COMP data.

(d) Expenses shall be determined by group of coverages (liability versus physical damage) from the total of:

1. Three year average of commissions and brokerage expense ratios based on the NJ page 14 of the insurer's latest annual statement filed with the Department and calculated as ratios to NJ WP;

2. Three-year average of general and other acquisition expense ratios, based on the countrywide IEE of the insurer's latest annual statement filed with the Department and calculated as ratios to EP;

3. The sum of (d)1 and 2 above are subject to the expense limitations found in N.J.A.C. 11:3-16.9(c) and shall not include any of the expenses listed in N.J.A.C. 11:3-16.9(d). Current expense limitations by type of insurer will be posted annually on the Department's website www.njdobi.org, by group of coverages (liability versus physical damage).

4. Three-year average of taxes, licenses and fee ratios, based on the NJ page 14 of the insurer's latest annual statement filed with the Department and calculated as ratios to NJ WP; plus

5. The profit and contingency provision shall be the last provision approved for the filer pursuant to either N.J.A.C. 11:3-16.10 or this subchapter. If the filer is proposing a revision to the profit and contingency provision, the filer shall provide all information related to the derivation of the profit and contingency loading contained in the filing by group of coverages. Filers shall specifically include all data used and judgments made, as well as a description of the method used to arrive at the selected loading. Filers shall demonstrate that the profit and contingency loading does not result in rates that are excessive, inadequate, or unfairly discriminatory. The Department's review of, and decision on any filing that includes a change to the profit and contingency provision is not governed by the time frames in N.J.A.C. 11:3-16B.6(d), but instead will be subject to the time frames set forth in (k) below.

6. Total expenses shall be determined from the sum of (d)1, 2, 4 and 5 above.

(e) Permissible loss and LAE ratios by group of coverages (liability versus physical damage) shall be determined by subtracting total expenses, determined in (d)6 above from 1.00.

(f) Credibility shall be determined by:

1. If the filer submits indications on a total limit basis, the full credibility standard shall be based on 4,000 claims for BI, PD, CSL and PACK. If the filer submits indications on a basic limits basis, the full credibility standard shall be based on 3,000 claims for BI, PD, CSL and PACK. The full credibility standard for PIP, COMP and COLL shall be based on 3,000 claims.

2. Alternatively, the filer may support different full credibility standards than those in (f)1 above by calculating the mean, variance and coefficient of variation from the company's internal size-of-loss distributions by coverage and then adjust the 1,082 claims frequency standard by the appropriate factors by coverage to reflect variation in severity. The severity adjustment shall be made and the filer shall provide all data together with the method used.

3. The filer shall apply the classical credibility procedure using the square-root rule to the full credibility standards obtained in either (f)1 or 2 above to determine the credibility of each coverage. The minimum credibility assigned to any coverage or combination of coverages (CSL or PACK) shall be 50 percent.

(g) The complement of credibility shall be assigned to the loss ratio trends by coverage, trended from the average date of earning during the experience period to the average date of earning for the proposed effective period using premium and loss trends by coverage determined in (b)3 and (c)3 above, respectively.

(h) The indicated rate changes by coverage and overall shall be calculated as follows:

1. The all year projected ultimate loss and LAE by coverage determined in (c) above divided by the all year projected premium by coverage determined in (b) above.

2. The raw indications by coverage shall be calculated by the all year loss and LAE ratios determined in (h)1

above divided by the permissible loss and LAE ratios determined in (e) above.

3. The credibility-weighted indications by coverage shall be determined by:

i. Paragraph (h)2 above (raw indication);

ii. Multiplied by (f)3 above (credibility);

iii. Plus (1 + (g) above) (loss ratio trend);

iv. Multiplied by (1 - (f)3 above) (complement of credibility).

4. The overall indication results from the credibility-weighted indications by coverage, determined in (h)3 above, weighted by the latest year's on-level projected earned premium by coverage determined in (b) above.

(i) If only uniform Statewide base rate changes by coverage are proposed, the information in (a) through (h) above is sufficient. If proposed base rate changes vary by territory, the filer shall provide credibility-weighted territorial indications by coverage, in addition to (a) through (h) above.

1. Territorial indications by coverage shall be based on at least three years of data and shall be indexed to the indications by coverage, derived in (h)3 above.

2. Territorial indications by coverage shall be based on a full-credibility standard of 3,000 claims per territory, with the complement of credibility applied to the Statewide indications by coverage determined in (h)3 above or to the current territorial rate/relativity.

(j) Filers that include changes to expense fees shall provide the standard, fixed expense fee calculation. For changes to deductible factors and increased limit factors, filers shall provide three-year relative loss ratios to justify the proposed changes. Filers shall also provide the overall percentage impact resulting from these changes independent of any proposed base rate impacts.

(k) All filers shall use the Department's method set forth in (a) through (j) above. The filer may submit an alternate method or use different data in support of specific elements of its filing provided that it is clearly labeled as such and is submitted in addition to the method in (a) through (j) above. The filer may also submit a completely alternate method, not using the rules set forth in (a) through (j) above, provided it is clearly labeled as such and the identical alternate method has been submitted to the Department for review by the filer prior to its use in a filing under this subchapter. The Department's review of, and decision on, any alternate method or data submission as referenced above are not governed by the time frames in N.J.A.C. 11:3-16B.6(d), but instead will be subject to the time frames set forth in N.J.A.C. 11:3-18.4.

(*l*) Data described above in this section shall be submitted in written copy and, except for purely textual information, on an MS-DOS formatted 3.5 inch 1.44 MB disk or a CD-ROM. The information shall be provided in a Microsoft Excel or compatible worksheet. All calculated values shall be given as a formula in the spreadsheet.

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).
Rewrote the section.
Amended by R.2007 d.179, effective June 4, 2007.
See: 38 N.J.R. 4161(a), 39 N.J.R. 2260(b).
Rewrote the section.

11:3-16B.5 Limitation on filer's rate request

(a) If the overall indicated change as determined in N.J.A.C. 11:3-16B.4 is an increase of seven percent or more, the filer shall request an overall increase of no more than seven percent.

(b) If the overall indicated change as determined by N.J.A.C. 11:3-16B.4 is less than seven percent, the filer shall request no more than the overall rate change that is indicated.

(c) Filers shall be permitted to seek base rate increases of up to 15 percent provided:

1. The increases are indicated by territory and coverage;

2. The overall increase for any single coverage does not exceed 10 percent;

3. The overall increase for all coverages for all policyholders combined does not exceed seven percent; and

4. In the event that (f) below applies, the percentage limits in this section shall be doubled.

(d) No individual policy shall experience a rate increase in excess of 15 percent within a 12-month period as a result of any filings made pursuant to this subchapter, inclusive of all filed changes to rates and rating factors. In the event that (f) below applies, the percentage limit of 15 percent shall be doubled.

(e) A filer may not have more than one rate-change request pursuant to this subchapter approved in any 12-month period; however, this limitation shall not apply to a filing for an overall reduction in rates, or to a filing reflecting a statutory change in coverage.

(f) An insurer not using this limited rate change process in a 12-month period may elect to file a proposed alteration to its rating system that will result in a rate change of not more than double the increase permitted pursuant to (a) above, if the filing complies with the requirements of N.J.S.A. 17:29A-46.6 and this subchapter, and a prior filing for a proposed alteration as referenced in this subsection has not been approved and effective more than once within a 24-month period.

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).

Raised the percentages from there to seven throughout; in (c), raised the single coverage percent from five to ten percent; rewrote (d) and added (e).
Amended by R.2007 d.179, effective June 4, 2007.
See: 38 N.J.R. 4161(a), 39 N.J.R. 2260(b).
Rewrote (c); inserted new (d); and recodified former (d) through (e) as (e) through (f).

11:3-16B.6 Review; general principles; action

(a) If the Commissioner determines that the filing includes all the information and calculations required to support the rate change, then the Commissioner shall approve the filing.

(b) A filing will be deemed submitted when it is received by the Department's Property and Casualty Office and is accompanied by:

1. All the documents, exhibits and calculations required by this subchapter.

2. In those cases where, due to their small size and/or lack of historical experience, filers are unable to fulfill completely all of the data submission requirements set forth in this subchapter, such filers shall be required to submit as much required information as they are able to supply, and each filing shall be reviewed accordingly. The Department's review of, and decision, on any such filing are not governed by the time frames in (d) below, but instead will be subject to the time frames set forth in N.J.A.C. 11:3-18.4.

(c) After a filing has been submitted in accordance with (b) above, the Department, within 20 days of receipt, shall conduct a preliminary review to determine if it is in compliance with N.J.S.A. 17:29A-46.6 and this subchapter. If the filing is in compliance, it shall be deemed complete by the Department. If a filing is not in compliance, the filer will be notified of deficiencies in the filing within 20 days of receipt. If the filer is not notified of deficiencies within 20 days of receipt, it shall be deemed complete and is under review.

(d) Unless extended as provided in N.J.S.A. 17:29A-46.6d, the Commissioner shall render a decision on a filing requesting an increase of up to three percent within 30 days after receipt of the filing and shall render a decision on a filing requesting an increase of more than three percent, but no more than seven percent overall, within 45 days after receipt of the filing. These time frames are subject to the exceptions found in N.J.A.C. 11:3-16B.4(c)5, (d)5, (k) or (b)2 above.

(e) The Commissioner, pursuant to (a) above and N.J.S.A. 17:29A-46.6d, shall render one of the following determinations on the filing:

1. Approve the rate change filing as filed;

2. Disapprove the rate change filing; or

3. Approve a modified rate change filing.

(f) In the event additional time is needed to act on a complete rate change filing, the Commissioner may extend the time periods for review specified in (d) above by no more than 15 days.

(g) A disapproval or modification of the filing by the Commissioner shall be considered a final agency decision in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(h) If a filer has a pending application for prior approval rate change submitted in accordance with N.J.A.C. 11:3-16.6, the filer shall promptly amend such pending filing to reflect any rate change approved in accordance with this subchapter.

(i) If a filer has a pending application for a limited rate change pursuant to this subchapter, the filer shall promptly amend such pending filing to reflect any rate change approved in accordance with N.J.A.C. 11:3-16.6.

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).
Rewrote the section.
Amended by R.2007 d.179, effective June 4, 2007.
See: 38 N.J.R. 4161(a), 39 N.J.R. 2260(b).
In (b)1, substituted a period for "; and" at the end; and rewrote (b)2 and (d).

APPENDIX

Exhibit A

Section	Description	Page Number
16B.3(a)1	• Cover letter including proposed revision, effective date, and company contact information.	
16B.3(a)2	N.J.A.C. 11:3-16 Appendix Exhibit B.	
16B.3(a)3	This checklist	
16B.3(a)4	• Compliance with N.J.S.A. 17:29A-36 • No 65+ charged >1.25 x 65+average • Compliance with N.J.S.A. 17:29A-46.6(e)	
16B.3(a)5	• Revised Manual Pages • Includes calculation of new rates	
16B.3(a)6	Rating Examples	
16B.3(a)7	Rating Impacts	
16B.3(a)8	Data Disk	
16B.3(e)	Officer Certification	
16B.4(a)1	Indications by coverage based on three years of data (or two years if fully credible with that data)	
16B.4(a)2	Liability data can be either at basic or total limits	
16B.4(a)3	Required Indications by Types Sold: • Only split limit: separate BI and PD (with UM) • Only CSL: CSL (with UM) with losses developed separately • Both split & CSL: separate BI & PD (with UM), with CSL either allocated or done separately • Only Package: PACK (with UM) with losses developed separately	
16B.4(b)1	Earned Premium by coverage by accident year	
16B.4(b)2	On-Level factors based on company NJ rate changes	

Section	Description	Page Number
16B.4(b)3	Premium Trend Factors from ISO or internal data (with data and methods used for internal)	
16B.4(c)1	NJ incurred loss and incurred DCC (may be combined) by accident year by coverage (paid loss OK for COMP and COLL)	
16B.4(c)2	Loss Development Factors based on average of last five years excluding high and low (that is, middle three of five years' factors) • BI/PIP developed to 87 months, tail factor of 1.05 PD/Comp/Coll developed to 51 months, tail factor of 1.00	
16B.4(c)3	Loss Trend Factors based on latest approved ISO filing or latest available NJ Fast Track, separately for frequency and severity by coverage. For Fast Track, 12 quarter rolling average used. For COMP, countrywide Fast Track data permitted. Must use paid claims (not incurred claims).	
16B.4(c)4	AO Factor is ratio of incurred AO to incurred Loss + DCC, and comes from latest three available IEES.	
16B.4(c)5	Changes that impact frequency and/or severity accounted for.	
16B.4(c)6	Catastrophe Factor permitted for Comp from either ISO or internal data (minimum 10 years)	
16B.4(d)1	Commission and Brokerage Expenses based on NJ WP From Page 14 (three-year average)	
16B.4(d)2	General Expense and Other Acquisition Expense based on CW EP from IEE (three-year average)	
16B.4(d)3	Expenses (1 and 2 above) capped by N.J.A.C. 11:3-16 Appendix E Calculation (see www.nj.gov/dobi for current expense caps)	
16B.4(d)4	Tax, License, and Fee Expense based on NJ WP from Page 14 (three-year average)	
16B.4(d)5	Profit and Contingency provision based on filer's latest approved filing under N.J.A.C. 11:3-16.10	
16B.4(d)6	Total Capped Expenses is sum of 3 through 5 above	
16B.4(e)	Permissible Loss Ratio is 1 minus (d)6	
16B.4(f)1	DOBI Credibility Standards BI/PD/CSL/PACK at total limits: 4,000 claims BI/PD/CSL/PACK at basic limits: 3,000 claims PIP/COMP/COLL: 3,000 claims	
16B.4(f)2	Company Calculated Credibility Standards (optional)	
16B.4(f)3	Credibility determined using square root rule, minimum 50 percent.	
16B.4(g)	Complement of credibility assigned to Loss Ratio Trend (Loss Trend divided by Premium Trend), trend period is average date of earning during experience period to average date of earning during proposed period.	
16B.4(h)1	Projected Ultimate Loss + LAE Ratio is (c)/(b)	
16B.4(h)2	Raw indication is (h)1/(e)	
16B.4(h)3	Credibility-weighted indication is as described	
16B.4(h)4	Overall indication is weighted average by latest year's earned premium	
16B.4(i)	If proposing territorial changes, territorial indication based on three years of data with credibility standard of 3,000 claims per territory (complement is Statewide indication above or current relativity)	
16B.4(j)	If expense fees changing, standard expense fee calculation. For other items changing, changes based on three-year relative loss ratios.	
16B.4(k)	Alternate Method permitted (optional, see regulation)	
16B.5(a)-(b)	Request overall limited to smaller of seven percent increase or indicated change	
16B.5(c)	Request by coverage limited to smaller of 10 percent or indicated change by coverage, provided the overall increase does not exceed seven percent.	
16B.5(d)	Individual policy impact limited to 15 percent.	
16B.5(e)	Last limited rate change filing approved at least 12 months ago	Yes/No

Amended by R.2003 d.500, effective December 15, 2003.
See: 35 N.J.R. 3093(a), 35 N.J.R. 5611(a).
Rewrote the section.
Amended by R.2007 d.179, effective June 4, 2007.
See: 38 N.J.R. 4161(a), 39 N.J.R. 2260(b).
Rewrote Exhibit A.
Administrative correction.
See: 39 N.J.R. 2539(a).

SUBCHAPTER 17. (RESERVED)

SUBCHAPTER 18. PRIVATE PASSENGER AUTOMOBILE INSURANCE: RATE FILING REVIEW PROCEDURES

11:3-18.1 Purpose and scope

(a) This subchapter sets forth the procedures used by the Department to review voluntary market private passenger automobile insurance rate filings and implements N.J.S.A. 17:29A-1 et seq. and N.J.S.A. 52:27EE-46 et seq. It is intended to provide for the expeditious review and disposition of automobile insurance rate filings consistent with applicable statutes regarding insurance and administrative procedures.

(b) This subchapter applies to private passenger automobile rate filings that require prior approval of the Commissioner made pursuant to N.J.S.A. 17:29A-14.

(c) This subchapter shall be construed so as to be compatible with the rules that set forth requirements for rate filings, N.J.A.C. 11:3-16; the provisions of the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.; and the administrative procedure rules, N.J.A.C. 1:1 and 1:11 concerning the disposition of matters after they have been determined to be a contested case.

(d) The Public Advocate Division of Rate Counsel shall have no jurisdiction or authority to participate or intervene in:

1. Expedited prior approval rate filings made by an insurer or affiliated group of insurers pursuant to N.J.S.A. 17:29A-46.6 or 17:36-5.35;

2. Prior approval rate filings having an overall impact of seven percent or less; or

3. Rule or form filings for any other form of insurance.

Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
Rewrote (b).
Amended by R.2007 d.371, effective December 3, 2007.
See: 39 N.J.R. 344(a), 39 N.J.R. 5084(a).
In (a), inserted "and N.J.S.A. 52:27EE-46 et seq."; in (b), inserted "private passenger automobile" and updated the N.J.S.A. reference; and added (d).

11:3-18.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Annual informational filing" means a filing made in accordance with the provisions of N.J.S.A. 17:29A-36.2b and N.J.A.C. 11:3-16.4.

"Contested case" means any proceeding so defined in N.J.S.A. 52:14B-2(b), specifically including a prior approval filing when request for a hearing has been made by any party or when the Commissioner determines that a hearing on the filing is necessary.

"Day" means a calendar day.

"Department" means the New Jersey Department of Banking and Insurance.

"Filer" means a rating organization or any insurer making its own rates or a portion thereof, establishing or proposing to establish a new rate or rate change.

"Parties" includes the filer and any other person with a legal right to participate in the proceedings who has served notice on the Commissioner of its intention to participate.

"Prior approval filing" means a filing made pursuant to N.J.S.A. 17:29A-14 and N.J.A.C. 11:3-16.6 to alter, supplement, or amend rating systems or any part thereof, except limited rate change filings pursuant to N.J.A.C. 11:3-16B.

"Public Advocate" means the Division of Rate Counsel in the Department of the Public Advocate of New Jersey.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of making rates or a portion thereof for two or more insurers and licensed in accordance with N.J.S.A. 17:29A-2.

Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Deleted definition of "Public Advocate".
Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
Deleted "Flex rate filing"; and in "Parties", deleted "the Public Advocate" following "the filer".
Amended by R.2007 d.371, effective December 3, 2007.
See: 39 N.J.R. 344(a), 39 N.J.R. 5084(a).
In definition "Annual informational filing", deleted "or 16.7(a)" from the end; in definition "Filer", deleted ", or making an annual informational filing" from the end; in definition "Prior approval filing", deleted "or 16.7(d)" following "11:3-16.6" and substituted "limited rate change filings pursuant to N.J.A.C. 11:3-16B" for "flex rate filings"; added definition "Public Advocate"; and deleted definition "Qualified member".

11:3-18.3 General provisions applicable to all filings

(a) Filings may be submitted by insurers or licensed rating organizations which are authorized to file rates for insurers which are members or subscribers of the rating organization.

1. Insurers that make their own rates shall submit filings themselves.

2. Filings submitted by rating organizations shall be submitted only for and on behalf of their member companies.

(b) In computing any period of time fixed by this subchapter, the day of the act or event from which the designated period begins to run is not to be included. The last day of the period so computed is to be included, unless it is on a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday nor legal holiday.

(c) All documents filed with the Commissioner, except initial filings, shall contain a statement certifying that the item is being submitted within the time provided by this subchapter.

(d) Provisions of this subchapter that establish time limits may be relaxed or modified by the Commissioner for good cause shown.

(e) A determination by the Department that a filing is complete relates solely to the presence in the filing of the items required by N.J.A.C. 11:3-16 and shall not be considered a finding regarding the accuracy or reasonableness of the information or calculations.

(f) All filings and other items submitted to the Commissioner shall be sent to the Department at the following address:

New Jersey Department of Banking and Insurance
Property/Casualty Division
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

(g) Any filing or other item which is required to be provided to the Public Advocate shall be sent to the Public Advocate at the following address:

Division of Rate Counsel
Department of the Public Advocate
31 Clinton Street, 11th Floor
PO Box 46005
Newark, NJ 07101

Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Deleted provision for sending filings to the Public Advocate.
Amended by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
Amended by R.2007 d.371, effective December 3, 2007.
See: 39 N.J.R. 344(a), 39 N.J.R. 5084(a).
Rewrote (a)1; in (a)2, deleted "qualified" preceding "member"; and added (g).

Case Notes

Insurers' filings for rate increases were ruled complete due to commissioner's failure to timely respond. Allstate Ins. Co. v. Fortunato, 248 N.J.Super. 153, 590 A.2d 690 (A.D.1991).

11:3-18.4 Procedures for review of prior approval filings

(a) The time period for the Department's review of a prior approval filing shall commence the day after the filing is received. The filer shall concurrently provide a copy of the filing to the Public Advocate.

(b) The Public Advocate shall notify the Department and the filer if it intends to intervene no later than 10 days after receipt of the filing.

(c) The Department shall advise the filer if the filing is incomplete not later than 25 days after receipt of the filing.

1. The filing shall be deemed to be complete if the filer is not notified that the filing is incomplete.

2. Notice to the filer that the filing has been found to be incomplete shall specify the missing item(s) or information. The Department shall send a copy of the notice that the filing is incomplete to the Public Advocate, if notice of the intent of the Public Advocate to intervene on the filing has been received.

3. The Department may disapprove an incomplete filing as a nonconforming filing. Any resubmission of the filing after the deficiency has been cured shall be considered initial receipt.

(d) If the Department requests further information from the filer, which information must be provided to the Department upon request pursuant to N.J.A.C. 11:3-16.8, 16.9 or 16.10, the filer shall submit the information to the Department and simultaneously to the Public Advocate within 10 days of the receipt of the request.

(e) The Department deems the filing requirements set forth in N.J.A.C. 11:3-16 to be sufficient information to review and evaluate any rate change requested. Therefore, no supplemental information, other than limited clarifying or explanatory information as referenced in (e)1 and 2 below, shall be required. If necessary, the following procedures may be used to obtain clarifying or explanatory information.

1. Not later than 20 days after its receipt of a filing, the Public Advocate may request in writing that the filer provide information to clarify or explain information contained in the filing. Not later than 10 days after receipt of any such request, the filer shall provide the clarifying or explanatory information to the Public Advocate.

2. Copies of any correspondence between the parties, and any additional information or documents supplied by the filer in response to a request from the Public Advocate shall also be simultaneously provided to the Department.

(f) No later than 60 days after receipt of a filing, the Public Advocate shall file with the Department its report and recommendations, and simultaneously submit a copy to the filer.

(g) Not later than 60 days after receipt of a filing by the Department either the filer or the Public Advocate pursuant to N.J.S.A. 17:29A-46.8 may request in writing a hearing on the filing. A request for hearing shall include a statement of facts and issues in sufficient detail so as to notify the Department and any other party of the matters in dispute.

(h) Upon receipt of a request for a hearing, or not later than 75 days after receipt of a filing by the Department, the Commissioner shall determine whether the matter is a contested case and notify all parties in writing.

1. If no hearing is requested the Commissioner shall enter an appropriate final order disposing of all issues raised by the filing. The final order shall be issued not later than 90 days from receipt of the filing, except for good cause the Commissioner may extend the time to issue a final Order by not more than 30 days.

2. If a hearing is requested the Commissioner may hear the matter; direct that the matter be transmitted to the Office of Administrative Law; or may appoint a salaried employee of the Department to hear the matter pursuant to N.J.S.A. 17:29A-14c.

(i) The hearing shall be conducted pursuant to the provisions of N.J.S.A. 17:29A-14c and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and applicable administrative rules, N.J.A.C. 1:1 and 1:11.

Amended by R.1996 d.58, effective February 5, 1996.
See: 27 N.J.R. 3682(a), 28 N.J.R. 855(a).
Deleted provisions relating to the Public Advocate.

Recodified from N.J.A.C. 11:3-18.6 by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
Former N.J.A.C. 11:3-18.4, Procedures for review of annual informational filings, and 11:3-18.5, Procedures for review of rate flex filings, repealed.
Amended by R.2001 d.270, effective August 6, 2001.
See: 33 N.J.R. 1305(a), 33 N.J.R. 2694(a).
In first sentence of (d), inserted "either" following "Department" and inserted "or a registered intervenor pursuant to N.J.S.A. 17:29A-46.8" following "filer".
Amended by R.2007 d.371, effective December 3, 2007.
See: 39 N.J.R. 344(a), 39 N.J.R. 5084(a).
In (a), inserted "after" and the second sentence; added new (b); recodified former (b) and (c) as (c) and (d); in (c)2, added the second sentence; in (d), inserted a comma following "16.10" and substituted "and simultaneously to the Public Advocate within 10 days" for "within 15 days"; added new (e) and (f); recodified former (d) through (f) as (g) through (i); and in (g), substituted "the Public Advocate" for "a registered intervenor".

Case Notes

Insurers' filings for rate increases were ruled complete due to commissioner's failure to timely respond. Allstate Ins. Co. v. Fortunato, 248 N.J.Super. 153, 590 A.2d 690 (A.D.1991).

11:3-18.5 (Reserved)

Repealed by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).
Section was "Procedures for review of rate flex filings".

11:3-18.6 (Reserved)

Recodified to N.J.A.C. 11:3-18.4 by R.2001 d.44, effective February 5, 2001.
See: 32 N.J.R. 3891(a), 33 N.J.R. 573(a).

11:3-18.7 Other remedies preserved

Nothing in this subchapter shall prevent the Commissioner from at any time initiating an action pursuant to N.J.S.A. 17:29A-1 et seq. to direct that rating systems be altered or revised if found to provide for, result in, or produce rates which are unreasonable, inadequate, or which discriminate unfairly between risks in this State involving essentially the same hazards and expense elements.

SUBCHAPTER 19. (RESERVED)

SUBCHAPTER 19A. TIER RATING PLANS AND TIER PLACEMENT CRITERIA

11:3-19A.1 Purpose and scope

(a) This subchapter implements N.J.S.A. 17:29A-46.1 et seq., which requires that personal private passenger automobile insurers file for approval their tier placement criteria used to assign risks to a tier rating plan. Approval of tier placement criteria shall serve to confirm that each insurer's business practices are consistent with law regarding the assignment of a risk to an insurer's tier rating plan.

(b) This subchapter applies to all insurers that are licensed and authorized to transact personal private passenger automobile insurance in the voluntary market. It applies to groups of affiliated companies which insure risks through separate individual insurance companies.

(c) This subchapter does not apply to the New Jersey Personal Automobile Insurance Plan or to private passenger automobile insurance written in a commercial lines rating system filed pursuant to N.J.S.A. 17:29AA-1 et seq. except to those risks that are assigned to an insurer pursuant to N.J.S.A. 17:29D-1i.

(d) Pursuant to N.J.S.A. 17:33B-31, insurers may use information provided by a rating organization or advisory organization, including, but not limited to, rules used to assign risks to a tier rating plan, classifications, rating rules and relativities. An insurer duly participating with a rating organization may make a reference filing to utilize rating and advisory organization rules used to assign risks to a tier rating plan, classifications, rating rules and relativities.

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).
See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).
Rewrote (a); and in (c), deleted "eligible person" following "those".

11:3-19A.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Affiliated companies" means two or more individual insurance companies that are authorized to transact private passenger automobile insurance business in New Jersey where one insurer controls, is controlled by, or is under common control with the other insurer.

"Applicant" means a person applying to an insurer for a policy of automobile insurance who is not currently a named insured under an existing policy of automobile insurance issued by that insurer.

"Commissioner" means the Commissioner of the Department of Banking and Insurance of the State of New Jersey.

"Department" means the New Jersey Department of Banking and Insurance.

"Insurance score" means a number or rating, including that which is derived from an algorithm, computer application, model or other process, that is based in whole or part on credit information.

"Insured" when used as a noun means a named insured or other person insured under a policy of automobile insurance and not a named insured under another automobile insurance policy.

CDT-3	Description	Region 1	Region 2	Region 3
D9221	GEN ANES-EA ADD 15 MINUTES	132	130	154
D9230	ANALGESIA-ANXIOLYSIS-INHAL NITROUS OXIDE	43	42	50
D9310	CONS (DIAG SERV BY NON TREATING PRACTIONER)	166	162	193
D9430	OFFIC VISIT FOR OBSRV (REG HRS-NO OTH SERV)	56	55	65
D9610	THERAP DRUG INJECTION	65	72	84
D9940	OCCLU GUARD	423	485	484
D9950	OCCLU ANALY-MOUNTED CASE	220	215	256
D9951	OCCLU ADJUSTMENT-LTD	100	98	116
D9952	OCCLU ADJUSTMENT-COMPLT	561	550	655

Exhibit 3

Fee Schedule—Home Care Services

Service	Fee
PRIVATE NURSING CARE (PER HOUR)	
Registered nurse	55.00
Licensed practical nurse	50.00
Home health aide	16.50
Medical Social Worker	55.00
Live-in attendant (per 24-hour shift)	140.00
HOME HEALTH VISITS (PER VISIT)	
Registered nurse	85.00
Licensed practical nurse	70.00
Physical therapist	90.00
Speech therapist	90.00
Occupational therapist	90.00

Exhibit 4

Ambulance Services

Ambulance Services

HCPCS	Description	North	South
A0425	GROUND MILEAGE, PER STATUTE MILE	6.05	6.05
A0426	AMBULANCE SERVICE, ALS, NON-EMERGENCY TRANSPORT, LEVEL 1	266.89	250.54
A0427	AMBULANCE SERVICE, ALS, EMERGENCY TRANSPORT, LEVEL 1	422.57	396.69
A0428	AMBULANCE SERVICE BLS, NON-EMERGENCY TRANSPORT	222.41	208.78
A0429	AMBULANCE SERVICE, BLS, EMERGENCY TRANSPORT	355.85	334.05
A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT ONE WAY (ROTARY WING)	3,264.60	3,116.07
A0433	ADVANCED LIFE SUPPORT, LEVEL 2 (ALS 2)	611.62	574.15
A0434	SPECIALTY CARE TRANSPORT (SCT)	722.83	678.54
A0436	ROTARY WING AIR MILEAGE, PER STATUTE MILE	19.14	19.14

Exhibit 5

Fee Schedule for Durable Medical Equipment, Prosthetics, Orthotics & Supplies

HCPCS	Mod	Description	Fee
A4216		Sterile water/saline, 10 ml	$0.45
A4217		Sterile water/saline, 500 ml	$3.13
A4221		Maint drug infus cath per wk	$22.64
A4222		Infusion supplies with pump	$46.73
A4253	NU	Blood glucose/reagent strips	$36.94
A4254	NU	Battery for glucose monitor	$6.58
A4254	RR	Battery for glucose monitor	$0.67
A4254	UE	Battery for glucose monitor	$4.94
A4255		Glucose monitor platforms	$3.91
A4256		Calibrator solution/chips	$9.72
A4257		Replace Lensshield Cartridge	$12.75
A4258		Lancet device each	$18.05
A4259		Lancets per box	$12.06
A4265		Paraffin	$3.39
A4280		Brst prsths adhsv attchmnt	$4.94
A4310		Insert tray w/o bag/cath	$7.14
A4311		Catheter w/o bag 2-way latex	$12.61
A4312		Cath w/o bag 2-way silicone	$15.33
A4313		Catheter w/bag 3-way	$18.15
A4314		Cath w/drainage 2-way latex	$24.01
A4315		Cath w/drainage 2-way silcne	$25.80
A4316		Cath w/drainage 3-way	$26.95
A4320		Irrigation tray	$5.04
A4321		Cath therapeutic irrig agent	$0.00
A4322		Irrigation syringe	$2.94
A4326		Male external catheter	$10.79
A4327		Fem urinary collect dev cup	$42.27
A4328		Fem urinary collect pouch	$10.45
A4330		Stool collection pouch	$7.15
A4331		Extension drainage tubing	$3.18
A4332		Lube sterile packet	$0.12
A4333		Urinary cath anchor device	$2.20
A4334		Urinary cath leg strap	$4.93
A4338		Indwelling catheter latex	$10.56
A4340		Indwelling catheter special	$31.75
A4344		Cath indw foley 2 way silicn	$13.62
A4346		Cath indw foley 3 way	$17.05

HCPCS	Mod	Description	Fee
A4348		Male ext cath extended wear	$27.83
A4349		Disposable male external cat	$2.02
A4351		Straight tip urine catheter	$1.74
A4352		Coude tip urinary catheter	$6.42
A4353		Intermittent urinary cath	$6.99
A4354		Cath insertion tray w/bag	$11.70
A4355		Bladder irrigation tubing	$8.91
A4356		Ext ureth clmp or compr dvc	$45.63
A4357		Bedside drainage bag	$9.19
A4358		Urinary leg or abdomen bag	$6.63
A4359		Urinary suspensory w/o leg b	$30.63
A4361		Ostomy face plate	$18.26
A4362		Solid skin barrier	$3.46
A4364		Adhesive, liquid or equal	$2.93
A4365		Adhesive remover wipes	$11.32
A4366		Ostomy vent	$1.30
A4367		Ostomy belt	$7.35
A4368		Ostomy filter	$0.26
A4369		Skin barrier liquid per oz	$2.42
A4371		Skin barrier powder per oz	$3.65
A4372		Skin barrier solid 4x4 equiv	$4.18
A4373		Skin barrier with flange	$6.28
A4375		Drainable plastic pch w fcpl	$17.18
A4376		Drainable rubber pch w fcplt	$47.58
A4377		Drainable plstic pch w/o fp	$4.29
A4378		Drainable rubber pch w/o fp	$30.75
A4379		Urinary plastic pouch w fcpl	$15.02
A4380		Urinary rubber pouch w fcplt	$37.33
A4381		Urinary plastic pouch w/o fp	$4.61
A4382		Urinary hvy plstc pch w/o fp	$24.62
A4383		Urinary rubber pouch w/o fp	$28.19
A4384		Ostomy faceplt/silicone ring	$9.62
A4385		Ost skn barrier sld ext wear	$5.10
A4387		Ost clsd pouch w att st barr	$0.00
A4388		Drainable pch w ex wear barr	$4.36
A4389		Drainable pch w st wear barr	$6.22
A4390		Drainable pch ex wear convex	$9.61
A4391		Urinary pouch w ex wear barr	$7.07
A4392		Urinary pouch w st wear barr	$8.18
A4393		Urine pch w ex wear bar conv	$9.04
A4394		Ostomy pouch liq deodorant	$2.58
A4395		Ostomy pouch solid deodorant	$0.05
A4396		Peristomal hernia supprt blt	$40.48
A4397		Irrigation supply sleeve	$4.79
A4398		Ostomy irrigation bag	$13.81
A4399		Ostomy irrig cone/cath w brs	$12.26
A4400		Ostomy irrigation set	$48.87
A4402		Lubricant per ounce	$1.39
A4404		Ostomy ring each	$1.54
A4405		Nonpectin based ostomy paste	$3.40
A4406		Pectin based ostomy paste	$5.74
A4407		Ext wear ost skn barr <=4sqö	$8.76
A4408		Ext wear ost skn barr >4sqö	$9.87
A4409		Ost skn barr w flng <=4 sqö	$6.22
A4410		Ost skn barr w flng >4sqö	$9.04
A4413		2 pc drainable ost pouch	$5.50
A4414		Ostomy sknbarr w flng <=4sqö	$4.93
A4415		Ostomy skn barr w flng >4sqö	$6.00
A4416		Ost pch clsd w barrier/filtr	$2.75
A4417		Ost pch w bar/bltinconv/fltr	$3.72
A4418		Ost pch clsd w/o bar w filtr	$1.81
A4419		Ost pch for bar w flange/flt	$1.74
A4420		Ost pch clsd for bar w lk fl	$0.00
A4422		Ost pouch absorbent material	$0.12
A4423		Ost pch for bar w lk fl/fltr	$1.86
A4424		Ost pch drain w bar & filter	$4.75
A4425		Ost pch drain for barrier fl	$3.58
A4426		Ost pch drain 2 piece system	$2.73
A4427		Ost pch drain/barr lk flng/f	$2.78
A4428		Urine ost pouch w faucet/tap	$6.51
A4429		Urine ost pouch w bltinconv	$8.25
A4430		Ost urine pch w b/bltin conv	$8.52
A4431		Ost pch urine w barrier/tapv	$6.22
A4432		Os pch urine w bar/fange/tap	$3.59
A4433		Urine ost pch bar w lock fln	$3.34
A4434		Ost pch urine w lock flng/ft	$3.76
A4450	AU	Non-waterproof tape	$0.09
A4450	AV	Non-waterproof tape	$0.09
A4450	AW	Non-waterproof tape	$0.11
A4452	AU	Waterproof tape	$0.36
A4452	AV	Waterproof tape	$0.36
A4452	AW	Waterproof tape	$0.40
A4455		Adhesive remover per ounce	$1.40
A4462		Abdmnl drssng holder/binder	$3.29
A4481		Tracheostoma filter	$0.37
A4483		Moisture exchanger	$0.00
A4556		Electrodes, pair	$12.14
A4557		Lead wires, pair	$17.94
A4558		Conductive paste or gel	$5.45
A4561		Pessary rubber, any type	$18.63
A4562		Pessary, non rubber,any type	$46.38
A4595		TENS suppl 2 lead per month	$28.81
A4605	NU	Trach suction cath close sys	$16.40
A4608		Transtracheal oxygen cath	$58.15
A4611	NU	Heavy duty battery	$196.45
A4611	RR	Heavy duty battery	$20.37
A4611	UE	Heavy duty battery	$147.34
A4612	NU	Battery cables	$67.94
A4612	RR	Battery cables	$6.92
A4612	UE	Battery cables	$51.81
A4613	NU	Battery charger	$144.21
A4613	RR	Battery charger	$14.43
A4613	UE	Battery charger	$104.29
A4614		Hand-held PEFR meter	$23.78
A4618	NU	Breathing circuits	$8.89
A4618	RR	Breathing circuits	$1.02
A4618	UE	Breathing circuits	$6.67
A4619		Face tent	$1.21
A4623		Tracheostomy inner cannula	$6.55
A4624	NU	Tracheal suction tube	$2.35
A4625		Trach care kit for new trach	$6.93
A4626		Tracheostomy cleaning brush	$3.19
A4628	NU	Oropharyngeal suction cath	$3.67
A4629		Tracheostomy care kit	$4.63
A4630	NU	Repl bat t.e.n.s. own by pt	$5.69
A4632	NU	Infus pump rplcemnt battery	$0.00
A4632	RR	Infus pump rplcemnt battery	$0.00
A4632	UE	Infus pump rplcemnt battery	$0.00
A4633	NU	Uvl replacement bulb	$41.04
A4635	NU	Underarm crutch pad	$5.12
A4635	RR	Underarm crutch pad	$0.69
A4635	UE	Underarm crutch pad	$3.39
A4636	NU	Handgrip for cane etc	$3.58
A4636	RR	Handgrip for cane etc	$0.43

CPT*	Description		
97020	APPLIC MODAL 1/> AREAS; MICROWAVE	SUPERVISED MODALITY	
97022	APPLIC MODAL 1/> AREAS; WHIRLPOOL	SUPERVISED MODALITY	
97024	APPLIC MODAL 1/> AREAS; DIATHERMY	SUPERVISED MODALITY	
97026	APPLIC MODAL 1/> AREAS; INFRARED	SUPERVISED MODALITY	includes cold laser or low-power laser treatment
97028	APPLIC MODAL 1/> AREAS; ULTRAVIOLET	SUPERVISED MODALITY	
97032	APPLIC MODAL 1/> AREAS; ELEC STIM EA 15 MIN	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97033	APPLIC MODAL 1/> AREAS; IONTOPHORESIS EA 15 MIN	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97034	APPLIC MODAL 1/> AREAS; CONTRAST BATHS EA 15 MIN	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97035	APPLIC MODAL 1/> AREAS; ULTRASOUND EA 15 MIN	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97036	APPLIC MODAL 1/> AREAS; HUBBARD TANK EA 15 MIN	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97110	THERAP PROC 1/> AREAS EA 15 MIN; EXERCISES	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97112	NEUROMUSCULAR REEDUCATION	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97124	THERAP PROC 1/> AREAS EA 15 MIN; MASSAGE	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97140	MANUAL THERAP TECH-1/> REGIONS-EA 15 MIN	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
97150	THERAP PROC GROUP	CONSTANT ATTENDANCE OF PROVIDER REQUIRED	
97530	THERAPEUTIC ACTIVITIES	DIRECT ONE-ON-ONE PATIENT CONTACT REQUIRED	
98925	OSTEOPATHIC MANIP TX; 1-2 BODY REGIONS INVOLVED		
98926	OSTEOPATHIC MANIP TX; 3-4 BODY REGIONS INVOLVED		
98927	OSTEOPATHIC MANIP TX; 5-6 BODY REGIONS INVOLVED		
98928	OSTEOPATHIC MANIP TX; 7-8 BODY REGIONS INVOLVED		
98929	OSTEOPATHIC MANIP TX; 9-10 BODY REGIONS INVOLVED		
98940	CHIROPRACTIC MANIP TX; SPINAL 1-2 REGIONS		
98941	CHIROPRACTIC MANIP TX; SPINAL 3-4 REGIONS		
98942	CHIROPRACTIC MANIP TX; SPINAL 5 REGIONS		
98943	CHIROPRACTIC MANIP TX; EXTRA SPINAL 1 OR MORE REGIONS		

NOTE: FOR CHIROPRACTIC MANIPULATIVE TREATMENT, THE 5 SPINAL REGIONS REFERRED TO ARE: CERVICAL REGION (INCLUDES ATLANTO-OCCIPITAL JOINT); THORACIC REGION (INCLUDES COSTOVERTEBRAL AND COSTOTRANSVERSE JOINTS); LUMBAR REGION; SACRAL REGION; AND PELVIC (SACRO-ILIAC JOINT) REGION. THE FIVE EXTRA-SPINAL REGIONS REFERRED TO ARE: HEAD (INCLUDING TEMPOROMANDIBULAR JOINT, EXCLUDING ATLANTO-OCCIPITAL) (EXCLUDING COSTOTRANSVERSE AND COSTOVERTEBRAL JOINTS AND ABDOMEN)

NOTE: FOR OSTEOMANIPULATIVE TREATMENT, THE BODY REGIONS REFERRED TO ARE: HEAD REGION; CERVICAL REGION; THORACIC REGION; LUMBAR REGION; SACRAL REGION; PELVIC REGION; LOWER EXTREMITIES; UPPER EXTREMITIES; RIB CAGE REGION; ABDOMEN AND VISCERA REGION

Exhibit 7

Ambulatory Surgical Center Facility Fee Schedule

ASC Group	Facility Fee North	Facility Fee South
Group 1	1,265.10	1,171.93
Group 2	1,694.39	1,569.61
Group 3	1,937.53	1,794.84
Group 4	2,393.42	2,217.16
Group 5	2,723.94	2,523.34
Group 6	3,138.04	2,906.94
Group 7	3,780.09	3,501.70
Group 8	3,696.51	3,424.28
Group 9	5,086.97	4,712.34

New Rule, R.2001 d.253, effective July 16, 2001.
See: 32 N.J.R. 4332(a), 33 N.J.R. 226(a), 33 N.J.R. 2507(a).
Amended by R.2002 d.59, effective March 4, 2002.
See: 33 N.J.R. 3617(a), 34 N.J.R. 1032(a).
Inserted Exhibit 2, Dental Fee Schedule.
Amended by R.2003 d.143, effective April 7, 2003.
See: 34 N.J.R. 1237(a), 35 N.J.R. 1547(b).
Amended Exhibit 3 and inserted Exhibit 6.
Amended by R.2004 d.481, effective December 20, 2004.
See: 36 N.J.R. 2579(a), 36 N.J.R. 5912(a).
Repealed former Exhibit 2 and inserted a new Exhibit 2.
Petition for Rulemaking: Department of Banking and Insurance; Division of Insurance; Property and Casualty Division; Notice of receipt of petition for rulemaking: review of the medical fee schedule.
See: 38 N.J.R. 1880(a), 2745(c).
Petition for Rulemaking: Department of Banking and Insurance; Division of Insurance; Property and Casualty Division; Notice of action on petition for rulemaking: review of the medical fee schedule.
See: 38 N.J.R. 3681(a).
Amended by R.2007 d.305, effective October 1, 2007.
See: 38 N.J.R. 3437(a), 39 N.J.R. 4126(c).
Former Exhibits 1, 4, 5 and 6 repealed; added new Exhibits 1, 4, 5 and 6; and added Exhibit 7.
Notice of Stay of Implementation: See: 39 N.J.R. 4849(a).
By Order of the Appellate Division of the Superior Court of New Jersey entered on September 28, 2007, the implementation of amendments to this rule published in the October 1, 2007 New Jersey Register at 39 N.J.R. 4126(c) was stayed pending a decision in the matter of *Alliance for Quality Care, Inc., et al. v. New Jersey Department of Banking and Insurance*, Docket No. A33-07 T3, now pending before the Appellate Division.

SUBCHAPTER 30. MOTOR VEHICLE SELF-INSURANCE

11:3-30.1 Purpose

This subchapter sets forth the filing requirements for motor vehicle self-insurers pursuant to N.J.S.A. 39:6-50.1, and 39:6-52 to 39:6-54.

11:3-30.2 Scope

The provisions of this subchapter apply to any person seeking to qualify as a motor vehicle self-insurer in New Jersey, except public entities pursuant to N.J.S.A. 39:6-54.

11:3-30.3 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Applicant" means a person applying for a certificate of self-insurance who does not currently possess a valid certificate.

"Association" means the New Jersey Automobile Full Insurance Underwriting Association created pursuant to N.J.S.A. 17:30E-1 et seq.