FINAL REPORT

SENATE SPECIAL COMMITTEE ON AUTOMOBILE INSURANCE REFORM

September 16, 1986

LETTER OF TRANSMITTAL

September, 1986

HONORABLE JOHN RUSSO, PRESIDENT OF THE SENATE

THE HONORABLE MEMBERS OF THE SENATE

The Senate Special Committee on Automobile Insurance Reform herewith submits its report on private passenger automobile insurance in New Jersey.

/s/ Daniel J. Dalton
Hon. Daniel J. Dalton

/s/
Hon. John A. Lynch

/s/
Hon. Leonard T. Connors

/s/
Hon. Carmen A. Orechio

/s/
Hon. Christopher J. Jackman

/s/
Hon. Raymond J. Zane

/s/
Hon. Lee B. Laskin

4071

New Jersey Senate

TRENTON

LETTER FROM THE CHAIRMAN

As chairman of the Senate Special Committee on Automobile Insurance Reform, I would like to thank all of the committee members for the many hours of work they contributed towards the development of the recommendations contained in this report.

The Senate Special Committe on Automobile Insurance Reform created in January, 1986 by Senate President John F. Russo, was charged with undertaking a complete study of all aspects of the automobile insurance system in the State of New Jersey and reporting to the Senate its recommendations for changes in the system.

Accordingly, this committee has conducted numerous meetings and hearings during the past six months at which time a comprehensive examination was undertaken of the rate making process, competition in the automobile insurance market, the no-fault system, the residual market, regulation of the insurance industry, and insurance systems in use in other states.

As a result of this careful, deliberative study of what is an extremely complex issue, significant modifications to the present automobile system are recommended. The goal of this committee is to simplify the system as much as possible and to permit consumers to purchase a basic insurance package which will meet their needs but which will also be less expensive than the present package of mandated benefits.

The complexity of automobile insurance and the problems that exist in our system do not allow for quick easy solutions. This committee strongly believes that the difficulties in the automobile market must be dealt with in an orderly manner, over a period of time. An attempt to completely change the system all at once may create more problems than it would solve.

Therefore, while the recommendations oulined in this report are deemed to have a significant impact on the system, the committee members recognize these recommendations are only a first step in what must be an ongoing process. A commitment has been made by all the committee members to continue their work towards the development of the most efficient and cost effective automobile system for the consumers of the State of New Jersey.

Sincerely,

Daniel J. Dalton

Daniel J. Dalton, Senator
Chairman, Senate Committee on
Automobile Insurance Reform

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September, 1986

I. NO-FAULT

publication of a book by Professors Robert E. Keeton and Jeffrey O'Connell, Basic Protection for the Accident Victim, which proposed the introduction of an automobile accident victim compensation system on a no-fault basis.

Under the no-fault concept, persons were to be compensated for damages by their own insurance companies regardless of fault. Under the initial no-fault proposals, the compensation was to be limited to benefits which were analagous to the special damages under the tort system - payment for medical expenses, economic loss, and replacement services during periods of convalescence. These benefits, commonly called personal injury protection coverage, or P.I.P., are at the heart of the no-fault system.

The first true no-fault law in the United States was adopted in Massachusetts and took effect in January 1971. Subsequently, some twenty-four states adopted some type of no-fault system. By the mid-1970's, however, the nationwide trend toward no-fault showed some signs of reversing as two states repealed their no-fault laws. New Jersey's no-fault law took effect in January, 1973. The New Jersey and Michigan no-fault laws provide the most comprehensive first party benefits of all the no-fault states; the laws of both states provide for unlimited medical benefits, wage replacement benefits, essential services benefits, and death benefits. In many other no-fault states, the first party benefits are considerably less; South Carolina, for example, limits first party medical benefits to $1000.00.

While the no-fault benefits in the other no-fault states vary widely, all states have retained the traditional tort liability system as a part of their automobile insurance systems; in no state are all benefits, including damages

for pain and suffering, paid on a no-fault basis. There are two basic kinds of no-fault systems - the so-called "add-on" systems and the systems which place a limitation on the right to sue for general damages, or pain and suffering.

States with "add-on" systems simply provide that injured parties are entitled to a first party benefit for the payment of medical expenses, but there is no restriction on the right to sue an individual whose negligence caused the injury. Many add-on states have an offset provision which requires the reduction of a court award in the amount of the medical benefits collected under the first party coverage. Most states which have add-on programs have relatively modest first party benefits. Because the benefits are nominal, the premium cost associated with these systems is relatively low. In many add-on states, the first party coverage is not compulsory.

In all of the sixteen states which provide for a compulsory first party benefit, there is some limitation on the right to sue for pain and suffering. The device which is used to restrict the right to sue is commonly referred to as a "threshold" - this is a measurable point at which a lawsuit may be instituted. In general, there are three types of thresholds: (1) a monetary, or "dollar" threshold, (2) a verbal, or descriptive, threshold, and (3) a combination threshold, which has both a dollar and verbal threshold.

The concept of the threshold is related to the concept of "balance" in no-fault laws. Behind the idea of a "balanced" no-fault system is the

RECOMMENDATIONS

NO-FAULT: THE NO-FAULT SYSTEM WILL BE RETAINED, BUT INSUREDS SHOULD BE ABLE TO SAVE MONEY BY TAILORING THE SYSTEM TO THEIR INDIVIDUAL NEEDS

Recommendations:

1. The mandatory personal injury protection benefit should be reduced to $10,000.00, and the insured should be given the option of obtaining unlimited medical benefits as an alternative.

2. The mandatory basic threshold amount should be raised to $500.00, and insureds should be given the option of a verbal threshold, which should permit suits for personal injury which results in death, serious impairment of body function, or permanent serious disfigurement. The present alternative $1700.00 threshold should be eliminated.

3. Basic personal injury protection benefits should consist of medical benefits only; additional benefits, such as essential services benefits, wage loss benefits, and death benefits, should be offered as options to the insured.

4. The present personal injury protection deductibles for medical benefits should be retained, but the 20% personal injury protection offset should be eliminated.

5. A medical fee schedule should be established on a regional basis to assist in holding down the cost of personal injury protection coverage.

1. Medical Expense Benefits:

The core of the no-fault system is the first party medical benefit which is provided under personal injury protection coverage. While it represents an increase in the cost of insurance as opposed to the benefits payable under the tort system, it should be recognized that an estimated 35% of injured parties presently being paid benefits under personal injury protection coverage would not have been able to collect any benefits at all under the tort system; these are persons who were at fault in accidents as well as those who were injured in one-car accidents.

Moreover, the existence of a first-party benefit provides assurance to persons whose injuries are caused by persons who have relatively low policy limits that their medical expenses will be paid. In addition, it is worth noting that the first party coverages represent the most efficient use of the premium dollar, because a much greater portion of that dollar is returned to the insured in the form of benefits than is the case with respect to benefits recovered in a tort action.

As already noted, the present basic personal injury protection medical benefit in New Jersey provides unlimited coverage. While the committee recognizes that the unlimited medical benefit is a valuable benefit, particularly for those who are catastrophically injured, it also recognizes that there are those who cannot afford such extensive coverage as well as those who do not need such coverage because it is duplicative of health insurance coverage which they already have.

Insurance company statistics show that well over 90% of all medical payments for injuries sustained in automobile insurance accidents are under $10,000.00. Thus, for most people, this is a sufficient amount of coverage to carry to protect themselves. The committee recommends, therefore, that $10,000.00 become the basic mandatory medical expense benefit, and that insurers be required to offer unlimited medical benefits to all insureds for an additional premium. The $10,000.00 medical benefit will save insureds about 30% of the present personal injury protection premium, exclusive of the policy constant. Insureds who choose unlimited medical coverage will pay about the same as at present.

2. Threshold Recommendations:

Critics of New Jersey's no-fault system have often centered their criticism on New Jersey's threshold, which, as has been noted, is the point at which an insured may sue for pain and suffering. The federal Department of Transportation report was critical of New Jersey's no-fault threshold because it was not "balanced" - that is, that the $200.00 threshold was too low to offset the relatively rich first-party benefit package; this has been cited as one of the factors in New Jersey's having the highest premiums of any no-fault state.

In 1983, in recognition of the relatively high cost of residual bodily injury insurance coverage (that portion of the premium which represents the cost of litigation in the system for pain and suffering), the Legislature created

an optional higher dollar threshold amount for those individuals who were willing to give up the right to sue in return for a premium reduction. The committee supports the idea of providing threshold options for insureds. It must be recognized that, just as there are people who are willing to pay for a higher level of medical benefits, there are people who are willing to pay to maintain the right to sue. There is a mechanism in place, the New Jersey Risk Exchange, to facilitate the operation of a dual threshold.

At the same time, however, to assure that the lower threshold amount is provided at a reasonable cost and that the higher threshold amount provides optimum savings, the committee recommends that the present $200.00 threshold be replaced by a $500.00 threshold, and that the present $1700.00 threshold be replaced by a strong verbal threshold.

It is clear that inflation has reduced the effectiveness of the $200.00 threshold to the extent that individuals with minor injuries may initiate a tort action. Therefore, it would seem that $500.00 would be a more effective threshold. On the other hand, the verbal threshold, by limiting the right to sue for pain and suffering only for serious injury, will give insureds optimum savings on this coverage. Insureds who presently have a $200.00 threshold would reduce their residual bodily injury premium by 45% by selecting the verbal threshold, and insureds who presently have the $1700.00 threshold will reduce their residual bodily injury premium by an additional 10%.

The committee does not recommend the retention of the $1700.00 as a third alternative, because the complexity of a three-tiered system would significantly increase the costs of administering the system and would thus undercut the savings which would result from the options which the committee recommends.

3. Additional Personal Injury Protection Benefits

The committee recommends that the basic personal injury protection package consist only of medical expense benefits in the amount elected by the insured, and that the additional PIP benefits - wage loss benefits, essential services benefits, death benefits, and the like - be made available to insureds as an option. The 1983 reforms permit insureds to elect not to take the additional benefits, but the committee believes that the election option should be reversed; many individuals have benefits which duplicate these benefits and are unaware that they may elect not to carry them. These benefits should be continued to be made available as a mandatory offer from insurers in both the basic amounts and additional amounts provided for in section 10 of the no-fault law, P. L. 1972, c. 67 (C.39:6A-10). The elimination of these benefits as part of the basic PIP coverage will result in a savings to all insureds of about $6.00 from their personal injury protection premium.

4. Deductibles and PIP Offset

The committee recommends that the personal injury protection deductible options which were enacted in 1983 be retained. These deductibles enable persons to save on their personal injury protection premiums if they have other health insurance coverage.

The committee recommends, however, that the 1983 amendment to the law which permits insureds to elect to repay up to 20% of any award to their own insurer as partial reimbursement for personal injury protection benefits paid on their behalf be repealed. The committee believes that the option is not understood by policyholders, and that the savings which may be realized are not significant enough to mandate that it be offered as an option.

5. Medical Fee Schedule

The committee believes that it is essential that some steps be taken to ensure that there is cost containment with respect to the paying of medical expense benefits under personal injury protection coverage. Reimbursement schedules for health care providers are common in connection with health insurance policies, and the committee believes that the same principal should

be applied with respect to reimbursement of providers under automobile insurance policies.

Accordingly, the committee recommends that legislation be enacted which requires the Commissioner of Insurance to promulgate reimbursement schedules for health care providers on a regional basis. The fee schedule should incorporate the reasonable and prevailing fees of 90% of the practitioners within the defined region. If the number of specialists within a region is less than 50, a statewide standard should apply. The fee schedule would be revised on a biannual basis.

EFFECT OF RECOMMENDATIONS

The committee believes that these recommendations will give insureds greater opportunity to reduce the cost of their insurance by tailoring their policies to their own needs. Many individuals are willing to trade their right to sue for pain and suffering for relatively minor injuries for a reduction in their insurance premiums. The savings for the election of a verbal threshold can be significant for certain high-rated classes and territories (see Appendix); individuals who have multi-car policies will also enjoy substantial savings.

A few examples may serve to illustrate the savings which may be brought about by the election of various options under the committee's recommendations. For a two-car family in Camden, for example, election of a verbal threshold can result in savings of $133 from the present policy

premium of $835. For the same policy, election of a verbal threshold, a $10,000.00 medical benefit, and a $2500.00 deductible will result in estimated savings of $199.

For a four-car family in Newark, with one youthful driver, the election of a verbal threshold, a $10,000.00 medical benefit, and a $2500.00 deductible will result in a savings of $306.

A single adult male, living in Atlantic County, who now has a $200.00 threshold would save $56 on his present premium of $362 by electing the verbal threshold. For the same driver, election of the verbal threshold, a medical benefit of $10,000.00, and a deductible of $2500.00 would result in a savings of $94.

These are significant savings, and the committee strongly recommends that the necessary modifications be made to the law so that consumers can take advantage of these options.

II. RATE REGULATION AND COMPETITION

RATE REGULATION AND COMPETITION IN THE MARKETPLACE

An important area of concern to the committee was the rate regulatory process for automobile insurance in New Jersey, the operation of the automobile insurance market in the state, and the degree of competition in the marketplace.

Accordingly, the committee looked at insurance ratemaking, rate regulation in general and New Jersey's rate regulatory system in particular, and assessed the impact of this upon the operation of the market.

Rate Regulation by the States

Ratemaking, the formulation of rates which will be charged to insureds, is regulated by the laws of each state. State laws establish a statutory standard for insurance rates and provide for the administration of the rate regulation process. There are three major types of state insurance rate regulation systems - open rating, file and use, and prior approval. In an open rating system, insurers are permitted to charge any rates which they choose. In some states with this system, insurers are not required to make any rate filing with the state whatsoever, while in other open rating states a rate filing is required. Some states use a "file and use" system, which means that insurers may file rates with the state regulatory authorities and then put them into effect without the specific permission of the regulators.

The third major statutory system is the prior approval system, in which insurers are required to obtain the approval of the state regulatory authority before the rates may take effect. New Jersey is a prior approval state for the so-called "personal lines" of insurance - automobile insurance and homeowners' insurance, but it uses a "use and file" system for commercial insurance.

Nearly all of the state regulatory systems have one thing in common, which is that the statutory standard for insurance rates is virtually the same, and may be enforced by the regulatory authorities. This standard is that rates may not be "excessive, inadequate, or unfairly discriminatory." Regulators in all states may, after examination, order insurers to cease using rates which do not meet these standards. While much emphasis has been placed upon rates which are excessive, rates which are inadequate (that is, rates which are lower than the actual cost of insuring the risk) are just as worrisome to regulators because they may threaten an insurer's solvency.

In the states which require rate filings, insurers and rating bureaus are required to file their rating plans with the Commissioner of Insurance, together with such supporting data as the commissioner may require. Rate filings may be made at the request of the commissioner, for the purpose of testing them against the statutory standard, or filings may be made voluntarily by the insurer or rating bureau; in the latter case, insurer-originated rate filings nearly always occur when the insurer wishes to raise rates or change its rating plan. Rate filings generally include a manual of rate classifications being used by the insurer, the insurer's rules for applying the rates, and the rates themselves.

Rating Bureaus: Their Evolution and Function

Rate filings are either formulated by individual insurers, utilizing their own actuaries and loss experience, or by rating bureaus, which file rates on behalf of a number of insurers. In New Jersey, the Insurance Services Office (I.S.O.) collects loss experience information and other data from its member companies, pools the collective data, and formulates rates which are based on the combined information. The bureau files the rates with the commissioner, and if they are approved, they may be used by any of the bureau's member companies. Some insurers which are members of the I.S.O. use bureau rates on an advisory basis, and deviate from them on the basis of their own loss experience. For many companies writing relatively little insurance in any given state, the use of bureau rates is essential because their own data is too minimal to be statistically credible.

Insurance rating bureaus have had a long and controversial history. In the nineteenth century, cutthroat competition among insurers resulted in the inadequate pricing of coverage and subsequent insolvencies. By the late nineteenth century, however, some insurers had begun to pool their loss experience and to develop rates on the basis of the combined data; they also agreed to charge rates which were formulated on the pooled data as a means of ending the destructive competition. For the most part, this was welcomed by the states, because it promised to ameliorate the effects of competition

upon insurers' solvency. The possible anti-trust implications of such combinations were negated by a series of court decisions, most notably Paul vs. Commonwealth of Virginia (8 Wall. 168) 1868), which established that insurance contracts were not in interstate commerce and thus not within the purview of federal anti-trust law. Toward the end of the century, many states enacted their own anti-trust laws, and the pooled insurance ratemaking was eliminated as a result. Subsequently, however, as a result of a new wave of price competition and resulting insurer insolvencies, many states exempted rating bureaus from the purview of their own laws and bureau-made rates became the norm until the middle of the next century.

The rate regulatory system in use between the turn of the century and the mid-1940's, with its reliance on rates formulated by rating bureaus, was designed primarily to protect the insurance industry from destructive competition; little attention was given to the need to protect the public from excessive, non-competitive price levels. Regulators were aware of the anti-competitive implications of this method of formulating rates as a means of protecting the public interest; Virginia, for example, required that all insurers be members of rating bureaus, and placed the bureaus under the direct control of the state.

The modern era of insurance rate regulation began in 1944, when the United States Supreme Court reversed the Paul vs. Virginia case in United States vs. Southeastern Underwriters Association (322 U.S. 533 (1944)), which determined that insurance was a part of interstate commerce and therefore subject to the federal anti-trust laws. This case would have meant the elimination of the bureau system of ratemaking unless Congress acted.

In 1945, Congress passed the McCarran-Ferguson Act, which exempted insurance from the provisions of the federal anti-trust laws to the extent that it was regulated by the several states.

The Development of the All-Industry Laws

All state regulatory schemes must be seen within the framework of the anti-trust exemption which was provided by the McCarran-Ferguson Act of 1945. The so-called "All-Industry Laws" were developed as a response to the McCarran-Ferguson Act by the National Association of Insurance Commissioners (NAIC), in concert with the insurance industry. They were intended to establish a state regulatory scheme which met the standards imposed by the act so that the industry would continue to be exempt from the anti-trust laws while still using the services of rating bureaus to pool data and to formulate rates. By 1955, the model rating laws had been adopted by nearly all of the states.

The rate regulatory system which was established by the All-Industry laws became known as the "prior approval" system. Technically, the prior approval of the regulator was not necessary under the provisions of these laws, because there was generally a so-called "deemer" provision - insurers were required to file rates with the state regulatory authorities and if, after a specified waiting period, the regulator had not acted, the rates

would be "deemed" to be approved. In practice, however, the system as it came to be used required the prior approval of the regulator before rates were permitted to be used.

Under the model laws, membership in rating bureaus was voluntary, and deviations from the bureau rates were permitted as long as regulatory approval was obtained. Downward rate deviations, however, were permitted only under very limited circumstances. It has been said that the laws were tailored to hinder competition; in some state versions of the model laws, the rating bureau itself could be an "aggrieved party" with respect to deviations or filings by independent companies.

The state systems which resulted from the All-Industry Model laws varied, although some states, such as Virginia, continued their prior system of state regulation through the rating bureau by requiring all insurers to be members of bureaus and to use bureau rates as a condition of doing business in the state. Other state versions of the model laws permitted insurers and bureaus to enter into agreements requiring all parties to the agreement to adhere to bureau rates and rules. A few states, such as California, adopted a form of open competition, but prohibited any agreements among insurers to adhere to any set of rates. All state systems met the requirements of the McCarran-Ferguson Act in terms of serving to continue to exempt insurers from the anti-trust laws.

New Jersey's Rate Regulatory System

New Jersey's rating law dates from the mid-1940's, and it falls within the All-Industry model as a prior approval state. The law establishes as a basic statutory standard that rates must not be:

> "unreasonably high or inadequate for the safety and soundness of the insurer, and which do not unfairly discriminate between the risks in this State involving essentially the same hazards and expense elements..."

The New Jersey law provides that every insurer or rating bureau must file a copy of its rating system with the commissioner; if the commissioner finds that the rates meet the statutory standards, the commissioner approves the rate filing. If the rates do not meet the statutory standards, the commissioner may direct that the rating system be altered to produce rates which do meet the standards. The New Jersey law provides that if the commissioner does not act on the rate filing within 90 days, the rates are deemed to be approved. In practice, however, inaction on the part of the commissioner for the 90-day period does not result in insurers' putting the filed rates into effect; all insurers wait for the approval of the commissioner before they use the rates which are filed.

New Jersey law provides for the licensing of rating bureaus. Members of rating bureaus may make a written application to the

commissioner for permission to file a uniform percentage decrease or increase to be applied to the rating system which is on file. The commissioner may approve or disapprove the request for a deviation, depending upon whether or not he believes that the request meets the statutory standard.

Under New Jersey law, rating systems may be altered, supplemented, or amended at any time by insurers or rating bureaus. The commissioner reviews the applications for amendments in the same manner as for original filings, and the same statutory standards apply. When applications are made, the commissioner may certify the matter for a hearing; the commissioner must certify the matter for a hearing if this is requested by the Public Advocate. The law requires that the rates on file and approved must be used, and prohibits any rebate or discount to be given by either the insurer or the agent or broker. The prior approval law does not apply to commercial lines of insurance or to reinsurance.

By the late 1940's some insurers, for competitive reasons, moved away from the bureau rating system to become independent filers. Because they were apart from the bureau, they often developed different types of products and marketing methods; among the marketing innovations utilized by some of the independents was the abandonment of the traditional agency system in favor of selling policies directly to insureds. This marketing method

delivered the insurance product more cheaply than the older methods employed by the bureau companies. In addition, some of the independent insurers developed more sophisticated underwriting techniques than were used by the bureau companies; these techniques helped the independent insurers target certain segments of the market which were considered to be preferred risks.

The emergence of the independent companies brought more competition to the marketplace, and the All-Industry system, with its emphasis on collective ratemaking, began to be modified by some states to accommodate the changes which were taking place in the industry. The movement in many states away from prior approval was based not only on philosophical considerations regarding the role of regulation, but also upon the deficiencies of the existing system. Many states acted to modify the All-Industry laws; some states adopted a file-and-use system and other states adopted an open competition system. Other states attempted to limit the role of the rating bureaus by requiring that they serve in an advisory capacity only, rather than filing rates on behalf of insurers.

New Jersey has retained its prior approval system, and the rating bureau remains strong in the state: well over half of the New Jersey insurance market files through the Insurance Services Office.

COMMITTEE RECOMMENDATIONS

Throughout its deliberations, the committee heard a great deal of testimony regarding the state of the insurance market in New Jersey. There is ample evidence to suggest that the New Jersey market is considerably less competitive than that of other states. The reasons for this are extremely complex, involving virtually all aspects of the system, including the present no-fault law, the regulatory delays which exist under the present system, and the structure of the joint underwriting association, as well as a number of other factors.

The committee heard testimony from regulators of other states, including Indiana, Illinois, and Michigan, all of which have a significant degree of competition among automobile insurers in terms of both the price and product which is offered to insureds in their respective states. The committee believes very strongly that this issue needs to be addressed promptly by the Legislature.

As has been noted, New Jersey is one of the relatively few states which has not moved away from the All-Industry prior approval regulatory system which was developed in the 1940's. In this state, both rates and classifications are subject to prior approval. Individual insurers may obtain approval from the state authorities to deviate from the bureau rates by a fixed percentage for all classes of risks or they may adopt an independent

schedule. Because of long regulatory delays in approving rate changes, exacerbated in part by the intervention in the regulatory process by the Public Advocate, a substantial portion of insurers in the state file rates through the bureau to avoid the expenses of a long rate approval proceeding. Moreover, the residual market mechanism, the joint underwriting association, writes its business at voluntary market levels, which is established by law at the bureau rate. All of this has resulted in an homogenization of the rate structure.

In 1977, a study by the United States Department of Justice concluded that rigid state regulation in insurance, such as the system used in New Jersey, has fostered a greater adherence to bureau-made rates, discouraged rate reductions, contributed to instability in insurance company operations, and aggravated availability problems. A less highly regulated system, such as file and use, the study suggests, fosters independent pricing, operating stability, and greater flexibility in the insurance pricing structure.

The Justice Department study concluded that essentially unrestricted price competition can provide an effective substitute for rate regulation as a means of achieving reasonable prices and maximum efficiency in the sale and distribution of insurance.

The committee notes that its discussions with regulators in other states seem to bear out these conclusions. In Michigan, for example, there is a significant variation in the price of policies among insurance companies writing automobile business in the state.

Accordingly, the committee has made a series of recommendations which deal with the question of competition. Some of the recommendations can be implemented now without too much disruption in the insurance market, while others need to be studied further and phased in over a longer period.

RATEMAKING AND COMPETITION: ATTENTION SHOULD BE GIVEN TO MAKING THE AUTOMOBILE INSURANCE MARKET MORE COMPETITIVE IN NEW JERSEY.

Recommendations:

1. The Public Advocate should be prohibited from intervening in any rate filing which results in an overall rate decrease or from intervening in any rate filing which results in rates being restored to a level which had been previously approved within an 18-month period of the filing.

2. To expedite the rate approval process, insurers should be required to use a uniform format for rate filings.

3. The present nonrenewal law should be eliminated in favor of a system wherein insurers are permitted to non-renew a limited number of policies each year, but mid-term cancellation should continue to be prohibited.

4. Prior approval should be retained for the present time, but the committee recommends that the Legislature study the question of competition in the marketplace further, including limiting the number of insurers who are permitted to file bureau rates, the admission of non-standard insurers, and the adoption of an alternative regulatory scheme, such as file and use.

1. The Role of the Public Advocate

It seems clear that the role of the Public Advocate as an intervenor in the rate approval process has resulted in a substantial increase in the "regulatory lag" - that is, the time period between which a request for a rate change is filed with the Department of Insurance by an insurer or a rating bureau and the request is finally approved.

It also seems clear that the regulatory lag has worked against real price competition in the marketplace because it distorts the pricing process - insurers must calculate the time needed for regulatory approval in their estimates of their rate needs. Delays of a year or more are not unusual in the rate approval process. Hence, rates which are filed probably do not really reflect market conditions. Insurers have complained that the role of the Public Advocate has exacerbated this problem in New Jersey. The committee believes that this question needs to be looked at in much greater detail by the Legislature, and that the role of the Public Advocate in this process needs to be assessed, and perhaps modified.

However, the committee has been made aware that at least one insurer's request for a rate decrease was held up for an unconscionably long period of time due to the intervention of the Public Advocate. This meant that during this period New Jersey insureds were paying much higher rates

than they needed to. For this reason, the committee recommends that the law governing the Public Advocate's role in the ratemaking process be modified immediately to prohibit intervention in the rate approval process in the case of a rate decrease. Moreoever, a "deemer" provision should be added to the rating law which permits a rate reduction to take effect within 60 days if the commissioner has not previously acted to approve it or disapprove it.

In addition, the committee recommends that insurers which have taken advantage of the rate decrease provision should be permitted to readjust their rates upward to the previously approved level, providing that the adjustment takes place within 18 months of the time that the rate filing was initially approved.

2. Modification of Present Non-Cancellation Law

In New Jersey, insurers may cancel or non-renew an existing policy of automobile insurance only for nonpayment of premium, or if the driver's license of the insured or any other operator under the policy has been revoked or suspended. This provision of law, enacted in 1968, appears to have served as a deterrent for insurers to write new risks or to take risks out of the joint underwriting association because if the risk proves to be a substandard risk (i.e., has a number of accidents or violations), the insurer is unable to get rid of them. Moreover, it serves to inhibit insurers from writing new policies because it deprives them of flexibility to change their books of business

through changes in their underwriting practices or in the demographic or geographical distribution of their business. It is likely that this is one of the major factors which has contributed to the growth of the residual market in this state since the mid 1970's.

As the willingness of insurers to write new business is a sine qua non of a more competitive market in the state, the committee believes that the law regarding non-renewals is urgently in need of modification. When the law was initially enacted to protect insureds, the market-rate-level residual market mechanism which the state now has in the joint underwriting association did not exist; with this mechanism in place, it does not seem that the protection against loss of insurance coverage which was afforded by the non-cancellation law is necessary. Adequate and equal coverage can readily be secured through the association if the insured cannot find alternative coverage in the voluntary market.

While recognizing that the non-cancellation law cannot be eliminated completely because of the enormous disruption which would occur in the automobile insurance market generally, the committee recommends that the law be modified to permit selective non-renewals. Mid-term cancellations of policies would continue to be prohibited.

The committee suggests that the Legislature follow the same procedure adopted by New York, in which insurers are permitted to non-renew up to 2% of their voluntary market risks each year. In addition, insurers could

non-renew risks over and above that amount if they write two new risks for each risk cancelled. This, the committee believes, would provide an incentive for insurers to write new policies. It would also help to depopulate the association, as insurers would have a greater incentive to take "clean" risks out of the association if they knew that they would not have to keep them on their book of business forever, as is the case at present.

3. Uniform Format For Rate Filings

The committee suggests that legislation be passed to require the use of uniform formats for rate filings for automobile insurance. Because the regulatory lag is partly the result of delays caused by requests by the department for further information to be submitted with rate filings and by disputes between the department and insurers over the availability, or lack thereof, of certain types of information, it would seem essential to develop a format which would contain all of the material desired by the department so that insurers would know what statistics they are expected to maintain and to submit with filings.

The committee hopes that the adoption of such a program by the department would serve to cut down the time necessary for department action upon rate filings.

4. Prior Approval Should be Retained for the Present, but Alternative Approaches to Rate Regulation Should be Considered

The committee, as has been noted previously, is very concerned about the effect of the lack of price competition in the state. In a state in which the combination of a rich automobile insurance benefits package and a relatively high population density has caused insurance rates to be among the highest in the nation, it is essential that everything be done that needs to be done to ensure that the marketplace operates in such a way that the product is delivered to the New Jersey consumer at the optimum price.

As optimum price efficiency is achieved only through a highly competitive market, it seems clear that some adjustments need to be made in this state to create that kind of environment. Under the present system, where there is enormous reliance on bureau-made rates, the loss and expense experience of both the most efficient and least efficient insurers is put together to formulate these rates; while this is true in every state in which bureau rates are used, the number of insurers which are members of the bureau in New Jersey is unusually large in terms of the percentage of the market which is represented. Moreover, the non-competitive nature of the rates in New Jersey is exacerbated by the use of the bureau rate for the drivers in the joint underwriting association.

The committee recommends that the Legislature act expeditiously to explore alternative systems of rate regulation, such as a file and use system, which would create an environment in which more competitive pricing would exist in the New Jersey automobile insurance market. Ideally, there should be a number of different rate structures and class plans in use in the state, and insurers should be able to adjust their rates easily when market conditions so warrant. It should be the goal of a rate regulatory system to ensure that rates accurately reflect the cost of insuring drivers and that competition is sufficient so that rates reach, and maintain, an optimum level of pricing efficiency.

It should be noted that the committee does not recommend the immediate institution of a file and use system because it believes that, in keeping with its belief that reforms need to be phased in rather than effected all at once, the institution of a new regulatory system along with other reforms would result in inordinate disruptions in the marketplace. Therefore, while the committee believes that rate regulatory reform is of immediate concern, it suggests that the matter be studied further by the Legislature and that a program be developed to bring about this reform in an orderly manner with minimum disruption to the market.

5. The Role of the Rating Bureau Should be More Closely Examined

The committee considered, but is not recommending at this time, the enactment of legislation which would restrict the use of bureau-made rates to insurers with less than 2% of the market. This approach has been recommended, most notably by the Public Advocate. The committee feels however, that trying to bring this about would cause market disruption and would also require a number of insurers, some of whom do not have their own actuaries, to expend considerable sums of money; this cost, of course, would ultimately be borne by New Jersey insureds. It would be hoped that certain of the committee's other recommendations, such as a reform of the rate approval process, would provide an incentive for insurers to make their own rate filings.

SUMMARY OF RECOMMENDATIONS

In summary, the committee believes that the lack of competition in automobile insurance in New Jersey is singularly detrimental to New Jersey drivers. It also recognizes, however, that because the regulatory climate in New Jersey has deteriorated somewhat over the past fifteen years, the creation of a competitive market in the state will not happen overnight. Insurers were promised some pricing flexibility in connection with the enactment of the law creating the joint underwriting association, but that provision was deleted from the law before it took effect.

The committee believes that the enactment of such things as a modification of the non-renewal provisions of law, the use of a uniform format to speed the rate approval process, and the modification of the role of the Public Advocate in one aspect of the rate regulatory process are important first steps in the direction of regulatory reform. Real reform, however, involves the development of a well constructed plan which eliminates the problems in the New Jersey automobile insurance market which work against reform and which lays the groundwork for a well-functioning, truly competitive marketplace.

III. THE RESIDUAL MARKET

THE RESIDUAL MARKET: THE ASSIGNED RISK PLAN AND THE JOINT UNDERWRITING ASSOCIATION.

In every automobile insurance market in the United States, there is some differentiation between individuals who are considered to be good risks and those who are considered to be poor risks. The insurers' determination of who is considered to be a good or bad risk might be based on the driver's risk classification, the territory in which the automobile is garaged, or whether or not the insurer considers rate levels to be adequate for particular classes of drivers. Those individuals who cannot be insured in the voluntary market form what is known as the "residual market."

The size of the residual market varies from state to state, depending upon such factors as the regulatory scheme in use in the state, the rate structure, the capacity of insurers to write new business, and the degree of selectivity used by individual insurers in establishing their underwriting standards. At times, the size of the residual market can be a function of the mechanism used to handle residual market business, including the degree of subsidy between the residual and voluntary markets, as well as the presence or absence of incentives built into the residual market mechanism to discourage placements there.

Important to an understanding of the residual market is the concept of "subsidy." Subsidy deals with the partial payment of one group's insurance

by other insurance consumers. In its broadest sense, all insurance can be considered subsidization by some insurance consumers of other insurance consumers, the latter being those in the system who suffer loss. The issue of subsidy becomes particularly important in automobile insurance, where personal characteristics and driving records are used by insurers to identify those individuals who have a high probability of loss.

The Assigned Risk Plan

New Jersey's first compulsory insurance law was enacted in 1972 as part of the no-fault package enacted that year. This law, which required that insureds carry certain coverages, replaced the former financial responsibility law. When insurance became compulsory in the state, it was essential to provide a mechanism to ensure that coverage would be available to all drivers who insurers refused to write as part of their voluntary market book of business. Accordingly, New Jersey, like many other states, used the residual market mechanism known as the Assigned Risk Plan.

Under the Plan, which was not statutory, high risk drivers were assigned to insurers in proportion to the insurers' share of the voluntary market. Hence, an insurer which wrote 20% of the state's total voluntary market business was assigned 20% of the risks who applied to the Assigned Risk Plan for coverage. Agents and brokers took applications for insurance,

forwarded the applications to the Plan, which assigned them to insurers. The agent or broker would continue to service the policy, whether or not he had a contractual relationship with the insurer. If there was a loss on the policy, the assigned insurer took the loss on its own books.

The Plan had its own rating system; clean risks who were placed in the assigned risk category were initially insured at rates which approximated those in the voluntary market, but if an assigned risk driver had an accident, he was charged significantly higher rates than drivers in the voluntary market. In general, assigned risk business received poorer service than voluntary market business, even though in many cases the insureds were paying higher rates, and the Plan offered a more limited range of policy limits.

Included in the Assigned Risk Plan were two levels of base rates; drivers with clean records paid lower base rates, and drivers with accidents or chargeable violations paid higher base rates, plus a surcharge. The second tier of rates for the drivers with accidents or violations had the effect of limiting the subsidization of the Assigned Risk Plan by the voluntary market.

1974-1976: Developing Instability in the Market

After the passage of the no-fault law in 1972, the insurance market in New Jersey was characterized by increasing instability. Beginning in 1974,

insurers began to complain that insurance rates were inadequate because of increasing claims frequency and inflation. They also complained that the Department of Insurance was slow in acting on rate filings. As a result, insurers limited the number of new policies which they were willing to write in the voluntary market and the population of the Assigned Risk Plan began to grow.

Insurers' voluntary market writings were further circumscribed by the "capacity" problem which emerged in 1974. The recession of that year and the concommitant decline in the stock market resulted in a sharp decline in insurers' investment income. Investment income affects the amount of an insurer's surplus, which in turn affects the amount of business it can safely write. Regulators usually insist upon a 3-to-1 premium-to-surplus ratio for reasons of safety and soundness: it is this ratio that gives the insurer "capacity" to write new business.

The shrinking of the voluntary market in New Jersey because of insurers' unwillingness or inability to write new business in the state was exacerbated by the insolvency of the Gateway Insurance Company and the subsequent departure from the state of the Government Employees Insurance Company (GEICO), which had a substantial market share. While some of the risks formerly insured by these insurers were picked up by others in their voluntary market business, a number of risks were forced into the Assigned Risk Plan. In 1972, the Plan insured 362,588 drivers; by 1976, the number had grown to 490,000.

As the residual market grew rapidly, there was increasing criticism of the Assigned Risk Plan because there were a large number of drivers assigned to the plan who, under normal market conditions, should have been written in the voluntary market. These individuals, it was argued, suffered a severe disability in being in the Plan; if they had an accident, they were not only surcharged, as were most of their counterparts in the voluntary market, but they were also charged higher base rates. In addition it was suggested that those in the Plan were "stigmatized," having poor service and limited choices in terms of coverage and policy limits. Despite their presence in the Plan, most of these drivers were considered to be standard risks in terms of an actuarial estimate of their probability of loss.

As the Plan grew steadily in size, insurers grew even more reluctant to write business in the voluntary market because the expansion of an insurer's voluntary market share meant increasing its liability to write assigned risks. By 1977, there were 735,332 risks in the Plan, which was a 102% increase over the 362,588 risks in the Plan in 1972. Critics of the system, including Commissioner of Insurance James Sheeran, began to talk in terms of creating a residual market mechanism which was identical in all respects to the voluntary market, including rate level. Others, including some insurers, recommended the scrapping of the Assigned Risk Plan and the creation of an alternative residual market mechanism which, unlike the Plan, would operate independently of the insurers.

The Byrne administration took the position that because the residual market was so large and because it was no longer being used for its original purpose - to insure bad drivers - the Assigned Risk Plan should be replaced with a residual market mechanism which would result in the elimination of virtually all distinctions between the voluntary and residual markets. It proposed the establishment of a reinsurance facility to replace the Plan.

Under this proposal, there would be no distinction, or stigma, between voluntary and residual market risks; in fact, the insured would not be aware of the fact that he was a ceded risk. The philosophy behind this approach was that every driver was entitled, on a nondiscriminatory basis, to purchase automobile insurance at standard market rates. A similar approach had been adopted in Massachusetts.

The major automobile insurance companies in the state were bitterly opposed to the concept of a reinsurance facility. They upheld the principle that a visible distinction should be maintained between the residual and voluntary market, although they acknowledged that the residual market in New Jersey was too large. They disliked the notion, which was implicit in the reinsurance facility concept, of the "homogenization" of risks.

The insurance companies favored either retaining the Assigned Risk Plan with modifications or establishing a joint underwriting association. A joint underwriting association is virtually an independent insurer, composed of

all of the insurers writing business in the state; the association itself writes the policies. In a traditional joint underwriting association, which the insurers were proposing be adopted, the rates paid by drivers in the association are made from the loss experience of the association. A joint underwriting association can take two forms; a separate syndicate pool can be established which functions as a separate company, with its own marketing outlets, or a pooling arrangement may be established which uses "servicing carriers" which service policies on behalf of the association. At the time that the insurers proposed the joint underwriting association for New Jersey, another no-fault state, Florida, had recently established the servicing-carrier type of joint underwriting association.

Under the servicing-carrier approach, several member companies are designated to issue and service policies on behalf of the association, in return for a servicing fee. As a separate company, the joint underwriting association mechanism has the advantages of separating the losses of the residual market from the insurer's own business, unlike the Assigned Risk Plan, but it is more "visible" than a reinsurance facility, because the insured is aware that he is in the residual market.

In June, 1978, an Ad Hoc Committee on Automobile Insurance Reform was created by the Chairman of the Assembly Banking and Insurance Committee, Assemblyman James W. Bornheimer. The Ad Hoc Committee was chaired by Assemblyman Michael F. Adubato. The Ad Hoc Committee recommended the establishment of what it termed a "hybrid" residual market

mechanism: a market-rate level joint underwriting association. In January, 1979, Assemblyman Adubato introduced Assembly Bill 3050, which embodied the recommendations of the Ad Hoc Committee. The bill provided for the establishment of a servicing-carrier type of joint underwriting association. In May, 1979, the Byrne administration put forward Assembly Bill 3386, which embodied the Ad Hoc Committee concept of a market-rate level joint underwriting association, but which differed from Assembly Bill 3050 in the rates which would be used by the association, and which gave the commissioner somewhat greater authority over the operation of the association.

Assembly Bills 3050 and 3386 differed in terms of the means of funding the deficit which would be produced by charging drivers written by the association the same rates which were charged in the voluntary market. Assembly Bill 3050 provided that the losses of the JUA would be certified to the commissioner, and permitted insurers to charge the losses back to drivers in whatever manner they chose. On the other hand, Assembly Bill 3386 introduced the concept of the Residual Market Equalization Charge (RMEC), which was to be a flat, per-car charge to be levied back to all insureds in both the residual and voluntary markets.

In June, 1979, the Byrne administration version and the Adubato bill were combined, provisions were added from several companion bills, and Assembly Bill 3455 was the result. For the most part, the joint underwriting association provisions of the bill encompassed the administration version from Assembly Bill 3386.

The major modification to the administration bill was a provision requiring the commissioner to promulgate a merit rating schedule of surcharges which would at least produce an amount equal to the differential between the two former Assigned Risk Plan base rates; the surcharges collected would be paid over to the association.

Present Structure of the Joint Underwriting Association

The New Jersey Full Insurance Underwriting Association, as established by P. L. 1983, c. 65, is required to write coverage for all New Jersey drivers who have a valid driver's license. The association only writes private passenger insurance. The income of the association is derived from the premium income which it collects, surcharges levied on all drivers in the state for certain motor vehicle violations, the residual market equalization charge, and a flat charge, or policy constant, which was levied on all policies in the state in the last years of the Assigned Risk Plan in anticipation of the establishment of the joint underwriting association, and which still continues to be collected. The policy constant was an early version of the residual market equalization charge, as it was applied to all policies to make up the deficit in the residual market. After the passage of the legislation creating the joint underwriting association, separate legislation was passed to transfer this money to the association. The merit rating surcharges are collected by

the Division of Motor Vehicles, which retains 20% of the amount which they collect for their own use.

Under the provisions of the law, the board of the association in required to make a rate filing with the commissioner which projects income, expenses, losses and reserve requirements of the association for the ensuing year. The filing is required to include a computation of the residual market equalization charge to be collected by each insurer from its voluntary insureds; this would not apply to senior citizens, who do not have to pay the RMEC. The commissioner is required to act on the filing within 60 days. To date, the commissioner has not approved the imposition of a RMEC.

The association is operated through the use of servicing carriers. At present, there are 15 carriers which service the association's business. They are compensated by means of a servicing carrier fee paid by the association. Agents and brokers are assigned to carriers for the purpose of forwarding business to the association. Agents who are exclusive representatives of a company which is a servicing carrier are assigned to that carrier for the servicing of association policies. Agents and brokers who are not exclusive representatives of a servicing carrier may contract with a servicing carried if there is agreement between both parties. Other agents and brokers are assigned to servicing carriers by the association. The rate of commission paid by the association approximates voluntary market rate levels. The rates used by the association are I.S.O. voluntary market rates.

COMMITTEE RECOMMENDATIONS

There are few aspects of the New Jersey automobile insurance system which are as controversial as the joint underwriting association. As has been noted, the JUA was structured deliberately in such a manner as to permit little or no distinction between the voluntary and residual markets. The cost of doing this, including the cost of writing residual market risks at voluntary market rates, was to be spread among all insureds through the imposition of a flat charge, known as the residual market equalization charge (RMEC). This was to make up any shortfall between the normal income of the JUA, which consists primarily of premium income, surcharge income, investment income, and income from the "policy constant."

There have been two significant developments after the creation of the joint underwriting association which have had a material effect upon the association's financial condition. The first of these has been that the association has not been able to collect all of the revenue which it was intended to collect, most particularly the income from surcharges for accidents and violations, and the second is that the population of the residual

market has continued to grow significantly in size. The latter has had a crucial impact upon the financial structure of the association because the association's rates are based upon an ever-shrinking number of voluntary market risks; the loss experience of over 50% of the market is not calculated in striking what was intended to be a "market level" rate.

It seems clear that this anomaly was not foreseen by the architects of the association, but this, along with insufficient surcharge income, has resulted in an ever-increasing JUA deficit. To date, no RMEC has been imposed in addition to the policy constant. As has been noted, the constant, while similar to the RMEC, really represents the deficit in the former Assigned Risk Plan, and bears no real relationship to the financial structure of the association. It has been estimated by some that the JUA has a deficit which would require a RMEC of some $200.00 per policy, although others, including the Department of Insurance, have insisted that this figure is excessive. The committee feels that it should be noted, however, that despite the statutory requirement that they do so, the Department has never certified the amount of the losses of the association.

The committee heard a considerable amount of testimony on the subject of the joint underwriting association. The members of the committee believe that a series of initiatives need to be undertaken now to enhance association revenues, but it also seems clear that the Legislature needs to take another look at the structure of the association to determine whether or

not it has efficacy or should be modified to be more traditional in form.

The committee believes that revenue-enhancing measures combined with the cost containment proposals which the committee is making in other areas, such as no-fault, will help the financial situation in the short-term. Over the long term, however, it may be that more significant changes in the system need to be made. To make more significant changes at this time, concurrent with the other changes which the committee has recommended, would be severely disruptive.

RECOMMENDATIONS

JOINT UNDERWRITING ASSOCIATION: REVENUES SHOULD BE AUGMENTED AND A SECOND RATE TIER SHOULD BE ESTABLISHED FOR DRIVERS WITH BAD RECORDS

Recommendations:

1. The revenue of the joint underwriting association should be augmented by a more efficient collection of the surcharges by the Division of Motor Vehicles, and the amount that the Division receives should be reduced to 10% of the amount collected or the actual cost, whichever is less.

2. A second rate tier should be established for drivers with an excess number of points for accidents and violations.

3. JUA revenues should be increased by increasing the statutory fines for failure to maintain insurance and remitting a portion of the fines to the association; enforcement of the mandatory insurance law should be made more stringent.

4. JUA revenues should be enhanced by requiring fully earned producers' commissions on JUA business.

5. Relaxation of the non-renewal law should serve to assist in depopulating the joint underwriting association.

6. The Legislature should undertake a study of the structure of the JUA to determine if it is an appropriate mechanism for the New Jersey residual market as it is presently constituted.

1. Augmentation of Revenue

Because of the problems which have been experienced by the Division of Motor Vehicles in terms of their computerization, the collection of surcharge income from motor vehicle accidents and violations has been slow, and the joint underwriting association has received less than half of the income which it anticipated from this source. In addition, the statute which created the association, P. L. 1983, c. 65, provided that the Division of Motor Vehicles would retain 20% of the amount which it collected.

It would appear that the problem of collection is easing somewhat and that the association is receiving more revenue from this source. While the committee believes that the situation will improve markedly in the next few months because of the correction of the computer problems in the Division of Motor Vehicles, the committee also believes that the Division's share of the collections should be reduced. It is equitable for the Division to be reimbursed for its actual costs in collecting the surcharges, but at the same time it should be encouraged to keep those costs as low as possible. While there may have been some justification for an initially high percentage of the surcharges being retained by the Division in recognition of its start-up costs, the committee believes that the present 20% is no longer justified.

Therefore, the committee recommends that the Division's share of the revenues from the collection of the surcharges be reduced to its actual cost or 10% of the revenues, whichever is less.

2. Creation of a Second Rate Tier in the JUA

The philosophy behind the creation of the joint underwriting association was to create a residual market which was virtually a mirror image of the voluntary market. Thus, persons who found themselves in the residual market would no longer have the "stigma" of being there; they would have the same coverage, enjoy the same service, and pay the same rates as those individuals in the voluntary market.

If the Assigned Risk Plan had been composed only of drivers who were genuinely poor risks, these issues may never have arisen, but, as has been noted earlier, by the late 1970's the New Jersey residual market was growing rapidly. Good risks found themselves in the plan merely because insurers were generally refusing to write new business and if they had accidents or certain violations they paid much higher rates than their counterparts in the voluntary market.

As has been previously suggested, the chief cause of the higher rates of the drivers in the Assigned Risk Plan was that accidents and certain violations caused the base rates of those drivers to rise, and they were surcharged on the higher base rate. In the voluntary market, on the other hand, drivers with accidents and violations were merely surcharged (although some insurers surcharged for accidents only and some did not surcharge at all for their voluntary market risks).

Thus, because of the perceived "unfairness" of the Assigned Risk Plan, particularly as it affected drivers who probably didn't belong in the Plan

at all, it was determined to create a residual market in which this unfairness did not exist. While the committee believes that the reasoning was, and still is, sound, it also believes that the genuinely bad, and irresponsible, drivers need to be identified and should make a greater contribution to the revenue of the association. The committee notes that the original architects of the association recognized such a possibility by giving the commissioner the authority to create a second "tier" of rates for persons with bad records.

Thus, the committee recommends that a statutory second tier be created for drivers within the association. Base rates for drivers should be increased if they have, within a three-year period, three chargeable accidents, or two chargeable accidents and moving violations for which they have received 9 points, or one chargeable accident and moving violations for which they have received 12 points. The committee believes that the creation of a second tier of base rates using these standards will not create any situation as existed in the Assigned Risk Plan, where drivers are charged the higher rates unfairly. By any objective standard, drivers with this type of driving record should be paying more than other drivers because their risk of loss is much greater.

3. Fines For Failing To Maintain Insurance Should Be Increased And A Portion Should Be Remitted To The Association

Ever since the inception of compulsory insurance in 1972, there has been a problem in enforcing the law. In part, the growing numbers of uninsureds are a function of the skyrocketing costs of insurance, and the committee hopes that its recommendations relative to cost containment will result in fewer drivers being uninsured.

The committee recommends, however, that a new system be established to enforce the compulsory insurance law. Insurers should be required to send the FS-2 form with supplemental data, including the license plate and registration number, to the Division of Motor Vehicles when an insurance policy is cancelled. The Division should then be required to notify the person whose policy was cancelled that they will be subject to a fine and a suspension of their license if proof of insurance is not supplied within 30 days. If proof of insurance is not provided within this time period, a notice of suspension and fine would be required to be sent. Of those fines collected by the Division, the Division would retain 20% and forward 80% to the joint underwriting association.

In addition, the committee recommends that the penalties for driving without insurance be increased. For the first offense, a person driving without insurance should be fined $300.00 and be required to perform community service for a period to be ordered by the court. In addition, there

should be a mandatory suspension of license for one year. For the second offense, a person driving without insurance should be fined $500.00 and should be required to serve a mandatory term of imprisonment, as well as having his license suspended for a period of not less than two years.

4. Only Fully Earned Commissions Should Be Paid To Agents And Brokers On JUA Business

When the joint underwriting association was established, insurance agents and brokers were permitted to keep the full commission on all policies which they submitted to the association, whether or not the policy was subsequently cancelled before the end of the policy period.

The experience of the association to date suggests that more association policies are cancelled before the end of the policy period than is the case with policies which are written in the voluntary market. It has been alleged that many individuals contract for an association policy, pay one installment in order to get the insurance card, and then cancel the policy. The agent or broker, however, is permitted to keep the entire amount of the commission on the policy.

The committee believes that agents and brokers should not be permitted to keep the full commission on a cancelled policy, particularly in view of the high expenses and the present deficit of the association. Savings to the association would result from a modification of this policy, and the committee strongly recommends that such a statutory change be made.

5. Modification of the Nonrenewal Law

The committee's recommendations for changes in the noncancellation-nonrenewal law have been discussed elsewhere. It is worth noting, however, that the committee anticipates that the proposed modifications in this law should result in depopulation of the association, as insurers will be given an incentive to take risks out of the association.

6. Further Study Of The Structure of the Association Should Be Undertaken Immediately By The Legislature

As has been suggested frequently in this report, the joint underwriting association was established on the basis of a series of assumptions about the nature of the automobile insurance market in the state and the nature of the residual market. The size of the residual market has grown significantly; while the causes of this are part of a complex problem

which needs to be sorted out piece by piece by both the regulators and the Legislature, it seems clear that the significant increase in the size of the residual market is caused partly by the capping of rates which was carried out by the Legislature as part of the 1982 reform package and by the unwillingness of insurers to write new business because of uncertainty over the disposition of the association's deficit.

It is possible, and even likely, that the architects of the original residual market proposal, the reinsurance facility, and its successor, the market-rate-level joint underwriting association, would not have been concerned about the size of the residual market, as long as it met the basic standard that the system was fair to all insureds. However, if that is to be the prevailing philosophy, some decision must be made with respect to the funding of the system; absent the utilization of the existing statutory mechanism, the RMEC, some disposition may have to be made for finding an alternative means of striking a market rate level for the association which includes its own loss experience. The "market rate" presently being used, it would seem, is really the market rate for less than 50% of the drivers in the state.

These are public policy matters which deserve a fresh look by the Legislature and which will likely take more time than was allotted to this committee to accomplish its work. The committee urges, however, that the study be undertaken expeditiously.

SUMMARY OF RECOMMENDATIONS

In summary, the committee believes that the joint underwriting association's present situation needs immediate relief in the form of enhanced revenue, and needs long-term relief in that a comprehensive policy analysis needs to be undertaken to assess the association's rightful position within the automobile insurance system. The situation is critical in that some definitive action should probably be taken within the next twelve months to provide the association with a more stable funding base.

One of the things which the committee hopes will happen is that increased competition in the automobile insurance market generally will result in the gradual depopulation of the association. The committee recognizes that one of the problems seems to be that many agents and brokers have no affiliation with any insurer in terms of placing voluntary market business; this means that the association is their only market. There is no easy solution to this problem, but enhanced competition may result in some of these producers' being able to affiliate with insurers writing in the voluntary market, even if only on a brokerage basis.

In connection with its discussion with regulators in other states, the committee became aware that nearly every state admits carriers which are termed "non-standard" carriers. For whatever reason, these carriers have not been allowed to operate in New Jersey. Normally, the non-standard carriers,

which write voluntary market business, accept risks which are not categorized as "preferred" risks. This may be because of their age, inexperience, certain other demographic characteristics, or their driving records. The non-standard insurers write at rates which are somewhat higher than the regular voluntary market. Frequently, insureds who have established a good record while being insured with these carriers are able to buy policies subsequently with regular carriers. In New Jersey, of course, risks who might be written by these non-standard carriers are in the joint underwriting association. The committee believes that consideration should be given to admitting these non-standard insurers into the New Jersey market. This would both enhance competition and provide some relief for the joint underwriting association.

The committee was also impressed with the operation of the Michigan Essential Insurance Act, which requires carriers to write risks unless the risks have certain specific types of accidents or violations on their driving record. The Michigan system, however, is part of a comprehensive system which includes a file and use rate regulatory system and which has certain other features which permit it to work well - less than 1% of Michigan drivers are in the residual market. In more concrete terms, it might be noted that Michigan's residual market is composed of fewer than 100,000 cars, while New Jersey's is composed of well over a million cars. While the committee recognizes that the problems of the New Jersey system are such that a system similar to Michigan's could not be introduced here, it believes that the Michigan automobile insurance system deserves a closer look and further study by the Legislature.

IV. ADDITIONAL RECOMMENDATIONS

ADDITIONAL RECOMMENDATIONS

1. The New Jersey Legislature should reassess the efficacy of mandatory liability insurance. A special study commission should be constituted to consider the question of mandatory liability insurance and should report its findings to the Legislature within one year.

2. The present law requiring mandatory arbitration for all cases of $15,000 or less should be amended to require arbitration for all cases of $20,000 or less as a further cost containment device.

3. Insurers should be required to provide discounts of from 5% to 20% of the comprehensive premium for anti-theft devices.

4. Insurers should be given statutory authority to give discounts for insureds who take defensive driving courses.

1. Mandatory Liability Insurance Should be Reassessed

In 1972, the Legislature established a statutory requirement for mandatory insurance as a part of the adoption of the no-fault system for automobile insurance. As a consequence, New Jersey drivers are required to maintain personal injury protection coverage, mandatory liability insurance for residual bodily injury and property damage in a minimum amount of $15,000/$30,000/$5000, and uninsured motorist coverage. On a nationwide basis, mandatory insurance was generally accepted as being an essential part of a no-fault system.

In the years since the adoption of mandatory insurance, however, as insurance costs rise and fewer individuals are able to afford the required coverage, more and more drivers are driving while completely uninsured. While the exact number of uninsured drivers in the state is unknown, estimates range from 500,000 to 750,000, and the number appears to be growing every year.

The committee believes that a thoughtful study needs to be made of the mandatory insurance system, particularly with respect to liability insurance. At least one no-fault state, Florida, has abandoned the requirement that liability insurance be carried, and instead requires that individuals carry only personal injury protection insurance to pay for their own injuries.

The effect of this is to shift the system more toward first party coverage - everyone purchases insurance to take care of his own needs rather than the needs of others. Hence, each individual purchases personal injury protection coverage to take care of his own medical expenses. Beyond that, if an individual has assets which need to be protected against suit, he purchases liability coverage to protect himself if he is at fault. In addition, each person may purchase uninsured motorist coverage and underinsured motorist coverage in whatever amount he desires so that he may collect for pain and suffering and economic damages in the event that he is injured by someone who does not have liability insurance coverage.

Critics of mandatory liability insurance note that inequities result when individuals are forced to buy liability coverage to protect assets which they do not even possess. Ironically, the persons who, because of the structure of the risk classification system, pay the most for liability insurance are those persons who often have the fewest assets to protect. An 18-year old driver in Newark, for example, would pay the most for this coverage, yet would most likely own little property which would require protection from suit.

For these reasons, and because of the great difficulty in enforcing the mandatory insurance laws, the committee believes that the issue should be studied further by the Legislature and that consideration be given to eliminating the requirement.

2. Arbitration Should Be Required For All Cases of $20,000 Or Less

In 1983, as part of the no-fault reform which passed the Legislature, arbitration was mandated for all automobile insurance cases in excess of $15,000. This system has been very successful, and, as its authors had hoped, has resulted in savings to the system as a whole. To increase the effectiveness of the law, the committee recommends that the law be amended to require that all cases of $20,000 or more be submitted to arbitration.

3. Discount For Anti-Theft Devices

While the committee has dealt primarily with the no-fault portion of the insurance premium in its recommendations to reduce insurance rates, it should be noted that one of the most substantial factors in the cost of insurance coverage is the cost of physical damage insurance, including both collision and comprehensive.

Automobile theft is an increasing problem nationwide, and it is a particular problem in the northeast, where organized rings operate to steal vehicles, break them down, and sell the parts. During the past several years, automobile manufacturers have designed sophisticated anti-theft systems which are effective in thwarting car theft. While some insurers provide a

discount on comprehensive coverage for these devices, the committee believes that such a discount should be mandatory, to encourage the purchase of these devices.

4. Discounts for Defensive Driving Courses

The committee believes that insurers should be given the statutory authority to grant discounts for insureds who take defensive driving courses, in recognition that those courses assist in cutting down losses.

Courses which are given by the Division of Motor Vehicles to persons with accidents or violations should be excluded.

APPENDIX

TERRITORY 12 - CAMDEN SUBURBAN

Adult Male
Drives to Work (short)
Basic Limits $15/$30/$5
Mandatory Coverages Only

$200 Threshold, Unlimited Medical

P.I.P.	$123
R.B.I.	$198
P.D.	89
U.M.	12
	$422

$1700 Threshold, Unlimited Medical

P.I.P.	$123
R.B.I.	$145
P.D.	89
U.M.	9
	$366

$500 Threshold, $10,000 Medical

P.I.P.	$ 98
R.B.I.	187
P.D.	89
U.M.	12
	$386

$500 Threshold, $10,000, $2500 Ded.

P.I.P.	$ 93
R.B.I.	187
P.D.	89
U.M.	12
	$381

Verbal Threshold, Unlimited Medical

P.I.P.	$123
R.B.I.	129
P.D.	89
U.M.	9
	$350

Verbal Threshold, $10,000 Medical

P.I.P.	$ 98
R.B.I.	129
P.D.	89
U.M.	9
	$325

Verbal Threshold, $10,000 Medical, $2500 Ded.

P.I.P.	$ 93
R.B.I.	129
P.D.	89
U.M.	9
	$320

Savings, Highest to Lowest: $102

TERRITORY 02 - NEWARK

2 Adults, 2 Cars:
1 Drives to Work (short)
1 Drives to Work (Long)
Basic Limits ($15/$30/$5)
Mandatory Coverages Only

$200 Threshold, Unlimited Medical

#1	
P.I.P.	$172
R.B.I.	195
P.D.	100
U.M.	12
#2	
P.I.P.	$172
R.B.I.	232
P.D.	121
U.M.	12
	$1016

$1700 Threshold, Unlimited Medical

#1	
P.I.P.	$172
R.B.I.	143
P.D.	100
U.M.	9
#2	
P.I.P.	172
R.B.I.	167
P.D.	121
U.M.	9
	$893

$500 Threshold, $10,000 Medical

#1	
P.I.P.	$132
R.B.I.	185
P.D.	100
U.M.	12
#2	
P.I.P.	$132
R.B.I.	220
P.D.	121
U.M.	12
	$914

$500 Threshold, $10,000, $2500 Ded.

#1	
P.I.P.	$126
R.B.I.	185
P.D.	100
U.M.	12
#2	
P.I.P.	$126
R.B.I.	220
P.D.	121
U.M.	12
	$902

Verbal Threshold, Unlimited Medical

#1	
P.I.P.	$172
R.B.I.	128
P.D.	100
U.M.	9
#2	
P.I.P.	$172
R.B.I.	149
P.D.	121
U.M.	9
	$860

Verbal Threshold, $10,000 Medical

#1	
P.I.P.	$132
R.B.I.	128
P.D.	100
U.M.	9
#2	
P.I.P.	$132
R.B.I.	149
P.D.	121
U.M.	9
	$780

2 Adults - Territory 2 (Cont'd.)

Verbal Threshold, $10,000 Medical, $2500 Ded.

#1	
P.I.P.	$126
R.B.I.	128
P.D.	100
U.M.	9

#2	
P.I.P.	$127
R.B.I.	149
P.D.	121
U.M.	9
	$769

Savings, Highest to Lowest: $247

TERRITORY 12 - CAMDEN SUBURBAN

2 Adults, 2 Cars:
1 Drives to Work (short)
1 Drives to Work (long)
Basic Limits (15/30/5)
Mandatory Coverages

$200 Threshold, Unlimited Medical

#1	
P.I.P.	$123
R.B.I.	178
P.D.	80
U.M.	12
#2	
P.I.P.	$123
R.B.I.	211
P.D.	96
U.M.	12
	$835

$1700 Threshold, Unlimited Medical

#1	
P.I.P.	$123
R.B.I.	132
P.D.	80
U.M.	9
#2	
P.I.P.	$123
R.B.I.	154
P.D.	96
U.M.	9
	$726

$500 Threshold, $10,000 Medical

#1	
P.I.P.	$ 98
R.B.I.	169
P.D.	80
U.M.	12
#2	
P.I.P.	$ 98
R.B.I.	198
P.D.	96
U.M.	12
	$763

$500 Threshold, $10,000, $2500 Ded.

#1	
P.I.P.	$ 93
R.B.I.	169
P.D.	80
U.M.	12
#2	
P.I.P.	$ 93
R.B.I.	199
P.D.	96
U.M.	12
	$754

Verbal Threshold, Unlimited Medical

#1	
P.I.P.	$123
R.B.I.	119
P.D.	80
U.M.	9
#2	
P.I.P.	$123
R.B.I.	137
P.D.	96
U.M.	9
	$696

Verbal Threshold, $10,000 Medical

#1	
P.I.P.	$ 98
R.B.I.	119
P.D.	80
U.M.	9
#2	
P.I.P.	$ 98
R.B.I.	137
P.D.	96
U.M.	9
	$646

2 Adults - Territory 27 (Cont'd.)

Verbal Threshold, $10,000 Medical, $2500 Ded.

#1	
P.I.P.	$107
R.B.I.	102
P.D.	80
U.M.	9

#2	
P.I.P.	$107
R.B.I.	116
P.D.	96
U.M.	9
	$626

Savings, Highest to Lowest: $ 173

TERRITORY 02 - NEWARK

Family, 2 Cars
1 Pleasure Use
1 Drives to Work
1 Youthful Driver
Basic Limits (15/30/5)
Mandatory Coverages (Multi-car discount applied)

$200 Threshold, Unlimited Medical

#1	
P.I.P.	$172
R.B.I.	173
P.D.	88
U.M.	12
#2	
P.I.P.	$172
R.B.I.	396
P.D.	212
U.M.	12
	$1237

$1700 Threshold, Unlimited Medical

#1	
P.I.P.	$172
R.B.I.	128
P.D.	88
U.M.	9
#2	
P.I.P.	$172
R.B.I.	274
P.D.	212
U.M.	9
	$1064

$500 Threshold, $10,000 Medical

#1	
P.I.P.	$132
R.B.I.	164
P.D.	88
U.M.	12
#2	
P.I.P.	$132
R.B.I.	373
P.D.	212
U.M.	12
	$1125

$500 Threshold, $10,000, $2500 Ded.

#1	
P.I.P.	$127
R.B.I.	164
P.D.	88
U.M.	12
#2	
P.I.P.	$127
R.B.I.	373
P.D.	212
U.M.	12
	$1115

Verbal Threshold, Unlimited Medical

#1	
P.I.P.	$172
R.B.I.	116
P.D.	88
U.M.	9
#2	
P.I.P.	$172
R.B.I.	239
P.D.	212
U.M.	9
	$1017

Verbal Threshold, $10,000 Medical

#1	
P.I.P.	$132
R.B.I.	120
P.D.	88
U.M.	9
#2	
P.I.P.	$132
R.B.I.	239
P.D.	212
U.M.	9
	$941

Family of 4, Territory 12 (Cont'd.)

Verbal Threshold, $10,000 Medical, $2500 Ded.

#1	
P.I.P.	$ 93
R.B.I.	108
P.D.	71
U.M.	9

#2	
P.I.P.	$ 93
R.B.I.	218
P.D.	165
U.M.	9
	$766

$500 Threshold, Unlimited Medical

#1	
P.I.P.	$123
R.B.I.	151
P.D.	71
U.M.	12

#2	
P.I.P.	$123
R.B.I.	335
P.D.	165
U.M.	12
	$992

Savings, Highest to Lowest $254

TERRITORY 25 - DOVER, MORRISTOWN, SOMERVILLE

Family, 2 Cars
1 Pleasure Use
1 Drives to Work
1 Youthful Driver
Basic Limits (15/30/5)
Mandatory Coverages (Multi-car discount applied)

$200 Threshold, Unlimited Medical

#1	
P.I.P.	$132
R.B.I.	115
P.D.	63
U.M.	12
#2	
P.I.P.	$132
R.B.I.	236
P.D.	144
U.M.	12
	$846

$1700 Threshold, Unlimited Medical

#1	
P.I.P.	$132
R.B.I.	91
P.D.	63
U.M.	9
#2	
P.I.P.	$132
R.B.I.	171
P.D.	144
U.M.	9
	$751

$500 Threshold, $10,000 Medical

#1	
P.I.P.	$104
R.B.I.	110
P.D.	63
U.M.	12
#2	
P.I.P.	$104
R.B.I.	222
P.D.	144
U.M.	12
	$771

$500 Threshold, $10,000 Med., $2500 Ded.

#1	
P.I.P.	$ 99
R.B.I.	110
P.D.	63
U.M.	12
#2	
P.I.P.	$ 99
R.B.I.	222
P.D.	144
U.M.	12
	$761

Verbal Threshold, Unlimited Medical

#1	
P.I.P.	$132
R.B.I.	84
P.D.	63
U.M.	9
#2	
P.I.P.	132
R.B.I.	152
P.D.	144
U.M.	9
	$725

Verbal Threshold, $10,000 Medical

#1	
P.I.P.	$104
R.B.I.	84
P.D.	63
U.M.	9
#2	
P.I.P.	104
R.B.I.	152
P.D.	144
U.M.	9
	$669

Family of 4, Territory 27

Verbal Threshold, $10,000 Medical, $2500 Ded.

#1	
P.I.P.	$105
R.B.I.	95
P.D.	71
U.M.	9

#2	
P.I.P.	$105
R.B.I.	178
P.D.	165
U.M.	9
	$738

$500 Threshold, Unlimited Medical

#1	
P.I.P	$143
R.B.I.	127
P.D.	71
U.M.	12

#2	
P.I.P.	$143
R.B.I.	269
P.D.	165
U.M.	12
	$942

Savings: Highest to Lowest: $230