CHAPTER 21

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

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

C.39:6A-1.1 Short title; findings, declarations.

1. a. This act shall be known and may be cited as the "Automobile Insurance Cost Reduction Act."

b. The Legislature finds and declares:

WHEREAS, While New Jersey's automobile insurance no-fault law, enacted twenty-six years ago, has provided valuable benefits in the form of medical benefits and wage replacement benefits, without regard to fault, to New Jersey residents who have been injured in an automobile accident; and

WHEREAS, Medical benefits paid by no-fault policies over those years amount to billions of dollars, which would otherwise have been paid by health insurance, thus raising the cost of health insurance for everyone; and

WHEREAS, While medical benefits under no-fault insurance were unlimited under the law enacted in 1972, the rapidly escalating cost of those benefits made it necessary for the Legislature to reduce those benefits to a limit of $250,000 in 1990; and

WHEREAS, Since the enactment of the verbal threshold in 1988, the substantial increase in the cost of medical expense benefits indicates that the benefits are being overutilized for the purpose of gaining standing to sue for pain and suffering, thus undermining the limitations imposed by the threshold and necessitating the imposition of further controls on the use of those benefits, including the establishment of a basis for determining whether treatments or diagnostic tests are medically necessary; and

WHEREAS, The present arbitration system has not sufficiently addressed the Legislature's goal of eliminating payment for treatments and diagnostic tests which are not medically necessary, leading to the belief that a revised dispute resolution mechanism needs to be established which will accomplish this goal; and

WHEREAS, The principle underlying the philosophical basis of the no-fault system is that of a trade-off of one benefit for another; in this case, providing medical benefits in return for a limitation on the right to sue for non-serious injuries; and

WHEREAS, While the Legislature believes that it is good public policy to provide medical benefits on a first party basis, without regard to fault, to persons injured in automobile accidents, it recognizes that in order to keep premium costs down, the cost of the benefit must be offset by a reduction in the cost of other coverages, most notably a restriction on the right of persons who have non-permanent or non-serious injuries to sue for pain and suffering; and

WHEREAS, The high cost of automobile insurance in New Jersey has presented a significant problem for many-lower income residents of the state, many of whom have been forced to drop or lapse their coverage in violation of the State's mandatory motor vehicle insurance laws, making it necessary to provide a lower-cost option to protect people by providing coverage to pay their medical expenses if they are injured; and

WHEREAS, To meet these goals, this legislation provides for the creation of two insurance coverage options, a basic policy and a standard policy, provides for cost containment of medical expense benefits through a revised dispute resolution proceeding, provides for a revised lawsuit threshold for suits for pain and suffering which will eliminate suits for injuries which are not serious or permanent, including those for soft tissue injuries, would more precisely define the benefits available under the medical expense benefits coverage, and establishes standard treatment and diagnostic procedures against which the medical necessity of treatments reimbursable under medical expense benefits coverage would be judged; and

WHEREAS, It is generally recognized that fraud, whether in the form of inappropriate medical treatments, inflated claims, staged accidents, falsification of records, or in any other form, has increased premiums, and must be uncovered and vigorously prosecuted, and while the pursuit of those who defraud the automobile insurance system has heretofore been addressed by the State through various agencies, it has been without sufficient coordination to aggressively combat fraud, leading to the conclusion that greater

consolidation of agencies which were created to combat fraud is necessary to accomplish this purpose; and

WHEREAS, With these many objectives, the Legislature nevertheless recognizes that to provide a healthy and competitive automobile insurance market, insurers are entitled to earn an adequate rate of return through the ratemaking process, which shall reflect the impact of the cost-saving provisions of this act and other recent legislative insurance reforms; and

WHEREAS, The Legislature has thus addressed these and other issues in this comprehensive legislation designed to preserve the no-fault system, while at the same time reducing unnecessary costs which drive premiums higher.

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

C.39:6A-2 Definitions.

2. As used in this act:

a. "Automobile" means a private passenger automobile of a private passenger or station wagon type that is owned or hired and is neither used as a public or livery conveyance for passengers nor rented to others with a driver; and a motor vehicle with a pickup body, a delivery sedan, a van, or a panel truck or a camper type vehicle used for recreational purposes owned by an individual or by husband and wife who are residents of the same household, not customarily used in the occupation, profession or business of the insured other than farming or ranching. An automobile owned by a farm family copartnership or corporation, which is principally garaged on a farm or ranch and otherwise meets the definitions contained in this section, shall be considered a private passenger automobile owned by two or more relatives resident in the same household.

b. "Essential services" means those services performed not for income which are ordinarily performed by an individual for the care and maintenance of such individual's family or family household.

c. "Income" means salary, wages, tips, commissions, fees and other earnings derived from work or employment.

d. "Income producer" means a person who, at the time of the accident causing personal injury or death, was in an occupational status, earning or producing income.

e. "Medical expenses" means reasonable and necessary expenses for treatment or services as provided by the policy, including medical, surgical, rehabilitative and diagnostic services and hospital expenses, provided by a health care provider licensed or certified by the State or by another state or nation, and reasonable and necessary expenses for ambulance services or other transportation, medication and other services as may be provided for, and subject to such limitations as provided for, in the policy, as approved by the commissioner. "Medical expenses" shall also include any nonmedical remedial treatment rendered in accordance with a recognized religious method of healing.

f. "Hospital expenses" means the cost of treatment and services, as provided in the policy approved by the commissioner, by a licensed and accredited acute care facility which engages primarily in providing diagnosis, treatment and care of sick and injured persons on an inpatient or outpatient basis; the cost of covered treatment and services provided by an extended care facility which provides room and board and skilled nursing care 24 hours a day and which is recognized by the administrators of the federal Medicare program as an extended care facility; and the cost of covered services at an ambulatory surgical facility supervised by a physician licensed in this State or in another jurisdiction and recognized by the Commissioner of Health and Senior Services, or any other facility licensed, certified or recognized by the Commissioner of Health and Senior Services or the Commissioner of Human Services or a nationally recognized system such as the Commission on Accreditation of Rehabilitation Facilities, or by another jurisdiction in which it is located.

g. "Named insured" means the person or persons identified as the insured in the policy and, if an individual, his or her spouse, if the spouse is named as a resident of the same household, except that if the spouse ceases to be a resident of the household of the named insured, coverage

shall be extended to the spouse for the full term of any policy period in effect at the time of the cessation of residency.

h. "Pedestrian" means any person who is not occupying, entering into, or alighting from a vehicle propelled by other than muscular power and designed primarily for use on highways, rails and tracks.

i. "Noneconomic loss" means pain, suffering and inconvenience.

j. "Motor vehicle" means a motor vehicle as defined in R.S. 39:1-1, exclusive of an automobile as defined in subsection a. of this section.

k. “Economic loss” means uncompensated loss of income or property, or other uncompensated expenses, including, but not limited to, medical expenses.

l. “Health care provider” or “provider” means those persons licensed or certified to perform health care treatment or services compensable as medical expenses and shall include, but not be limited to, (1) a hospital or health care facility which is maintained by a state or any of its political subdivisions, (2) a hospital or health care facility licensed by the Department of Health and Senior Services, (3) other hospitals or health care facilities designated by the Department of Health and Senior Services to provide health care services, or other facilities, including facilities for radiology and diagnostic testing, freestanding emergency clinics or offices, and private treatment centers, (4) a nonprofit voluntary visiting nurse organization providing health care services other than in a hospital, (5) hospitals or other health care facilities or treatment centers located in other states or nations, (6) physicians licensed to practice medicine and surgery, (7) licensed chiropractors, (8) licensed dentists, (9) licensed optometrists, (10) licensed pharmacists, (11) licensed chiropodists, (12) registered bio-analytical laboratories, (13) licensed psychologists, (14) licensed physical therapists, (16) certified nurse-midwives, (17) certified nurse-practitioners/clinical nurse-specialists, (18) licensed health maintenance organizations, (19) licensed orthotists and prosthetists, (20) licensed professional nurses, and(21)providers of other health care services or supplies, including durable medical goods.

m. “Medically necessary” means that the treatment is consistent with the symptoms or diagnosis, and treatment of the injury (1) is not primarily for the convenience of the injured person or provider, (2) is the most appropriate standard or level of service which is in accordance with standards of good practice and standard professional treatment protocols, as such protocols may be recognized or designated by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health and Senior Services or with a professional licensing or certifying board in the Division of Consumer Affairs in the Department of Law and Public Safety, or by a nationally recognized professional organization, and (3) does not involve unnecessary diagnostic testing.

n. "Standard automobile insurance policy" means an automobile insurance policy with at least the coverage required pursuant to sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4).

o. "Basic automobile insurance policy" means an automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1).

3. Section 3 of P.L.1972, c.70 (C.39:6A-3) is amended to read as follows:

C.39:6A-3 Compulsory automobile insurance coverage; limits.

3. Compulsory automobile insurance coverage; limits. Except as provided by section 4 of P.L.1998, c.21 (C.39:6A-3.1), every owner or registered owner of an automobile registered or principally garaged in this State shall maintain automobile liability insurance coverage, under provisions approved by the Commissioner of Banking and Insurance, insuring against loss resulting from liability imposed by law for bodily injury, death and property damage sustained by any person arising out of the ownership, maintenance, operation or use of an automobile wherein such coverage shall be at least in:

a. an amount or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident; and

b. an amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to or death of, more than one

person, in any one accident; and

c. an amount or limit of $5,000.00, exclusive of interest and costs, for damage to property in any one accident.

No licensed insurance carrier shall refuse to renew the required coverage stipulated by this act of an eligible person as defined in section 25 of P.L.1990, c.8 (C.17:33B-13) except in accordance with the provisions of section 26 of P.L.1988, c.119 (C.17:29C-7.1) or with the consent of the Commissioner of Banking and Insurance.

C.39:6A-3.1 Election of basic automobile insurance policy; coverage provided.

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

a. Personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household, who sustained bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured, and to pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an object propelled by or from such automobile. "Personal injury protection coverage" issued pursuant to this section means and includes payment of medical expense benefits, as provided in the policy and approved by the commissioner, for the reasonable and necessary treatment of bodily injury in an amount not to exceed $15,000 per person per accident; except that, medical expense benefits shall be paid in an amount not to exceed $250,000 for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of personal injury to any one person in any one accident, such excess shall be paid by the insurer in consultation with the Unsatisfied Claim and Judgment Fund Board and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1). Benefits provided under basic coverage shall be in accordance with a benefit plan provided in the policy and approved by the commissioner. The policy form, which shall be subject to the approval of the commissioner, shall set forth the benefits provided under the policy, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the policy may provide. The commissioner shall set forth by regulation a statement of the basic benefits which shall be included in the policy. Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude

variance from the standard when warranted by reason of medical necessity. The policy form may provide for the precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods, as approved by the commissioner, provided that the requirement for precertification shall not be unreasonable, and no precertification requirement shall apply within ten days of the insured event. The policy may provide that certain benefits provided by the policy which are in excess of the basic benefits required by the commissioner to be included in the policy may be subject to reasonable copayments in addition to the copayments provided for herein, provided that the copayments shall not be unreasonable and shall be established in such a manner as not to serve to encourage underutilization of benefits subject to the copayments, nor encourage overutilization of benefits. The policy form shall clearly set forth any limitations on benefits or exclusions, which may include, but need not be limited to, benefits which are otherwise compensable under workers' compensation, or benefits for treatments deemed to be experimental or investigational, or benefits deducted pursuant to section 6 of P.L.1972, c.70 (C.39:6A-6). The commissioner may enlist the services of a benefit consultant in establishing the basic benefits level provided in this subsection, which shall be set forth by regulation no later than 120 days following the enactment date of this amendatory and supplementary act. The commissioner shall not advertise for the consultant as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

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

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

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

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

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

No licensed insurance carrier shall refuse to renew the coverage stipulated by this section of an eligible person as defined in section 25 of P.L.1990, c.8 (C.17:33B-13) except in accordance with the provisions of section 26 of P.L.1988, c.119 (C.17:29C-7.1) or with the consent of the Commissioner of Banking and Insurance.

C.39:6A-3.2 Issuance, renewal of automobile insurance policies; required coverage; exception for basic policy.

5. a. All automobile insurance policies issued or renewed on or after the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.) shall be issued or renewed including at least the coverages required pursuant to sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), unless the named insured elects a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1). Election of a basic automobile insurance policy shall be in writing and signed by the named insured on the coverage selection form required by section 17 of P.L.1983, c.362

(C.39:6A-23). The coverage election form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that election of a basic automobile insurance policy will result in less coverage than the $250,000 medical expense benefits coverage mandated prior to the effective date of this act. Furthermore, the coverage election form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that election of a basic automobile insurance policy without the optional $10,000 liability coverage provided for in section 4 of P.L.1998, c.21 (C.39:6A-3.1) may subject the named insured to a claim or judgment for noneconomic loss which is not covered by the basic automobile insurance policy, and which may place his assets at risk, and in the event the named insured is sued, the insurer shall not provide legal counsel.

b. The insurance coverages provided for in section 4 of P.L.1998, c.21 (C.39:6A-3.1) shall be offered by every insurer which writes insurance coverages pursuant to sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4) for a period of five years after the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.). The commissioner shall require every company writing such insurance coverage to report to him annually during that five-year period as to the number of policies written pursuant to this subsection in the previous year, the number of policies with the coverage offered pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) which have been converted to policies with the coverage offered pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) and any other information the commissioner may require such as, but not limited to, the age of the policyholders and the territories in which the policyholders reside. The commissioner shall then report to the Governor and the Legislature regarding the acceptance of the basic automobile insurance policy by the automobile insurance consumers of this State annually for the first four years the basic policy is sold. On or before January 1, 2003, the commissioner shall make a final, cumulative report which shall include recommendations as to the continuation of the basic policy to the Governor and the Legislature.

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

C.39:6A-4 Personal injury protection coverage, regardless of fault.

4. Personal injury protection coverage, regardless of fault.

Except as provided by section 4 of P.L.1998, c.21 (C.39:6A-3.1), every standard automobile liability insurance policy issued or renewed on or after the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.) shall contain personal injury protection benefits for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household who sustain bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with permission of the named insured, and to pedestrians sustaining bodily injury caused by the named insured's automobile or struck by an automobile or struck by an object propelled by or from that automobile.

"Personal injury protection coverage" means and includes:

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

commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity. The policy form may provide for the precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods, as approved by the commissioner, provided that the requirement for precertification shall not be unreasonable, and no precertification requirement shall apply within ten days of the insured event. The policy may provide that certain benefits provided by the policy which are in excess of the basic benefits required by the commissioner to be included in the policy may be subject to reasonable copayments in addition to the copayments provided for pursuant to subsection e. of this section, provided that the copayments shall not be unreasonable and shall be established in such a manner as not to serve to encourage underutilization of benefits subject to the copayments, nor encourage overutilization of benefits. The policy form shall clearly set forth any limitations on benefits or exclusions, which may include, but need not be limited to, benefits which are otherwise compensable under workers' compensation, or benefits for treatments deemed to be experimental or investigational, or benefits deducted pursuant to section 6 of P.L.1972, c.70 (C.39:6A-6). The commissioner may enlist the services of a benefit consultant in establishing the basic benefits level provided in this subsection, which shall be set forth by regulation no later than 120 days following the enactment date of P.L.1998, c.21 (C.39:6A-1.1 et al.). The commissioner shall not advertise for bids for the consultant as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

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

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

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

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

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

Benefits payable under this section shall:

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

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

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

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

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

C.39:6A-4.3 Personal injury protection coverage options.

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

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

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

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

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

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

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

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

Any named insured who chooses the option provided by subsection d. of this section shall

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

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

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

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

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

8. Section 14 of P.L.1985, c.520 (C.39:6A-4.5) is amended to read as follows:

C.39:6A-4.5 Loss of right to sue for failure to insure, for DWI, for intentional acts.

14. a. Any person who, at the time of an automobile accident resulting in injuries to that person, is required but fails to maintain medical expense benefits coverage mandated by section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L.1998, c.21 (C.39:6A-3.1) shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of an accident while operating an uninsured automobile.

b. Any person who is convicted of, or pleads guilty to, operating a motor vehicle in violation of R.S.39:4-50, section 2 of P.L.1981, c.512 (C.39:4-50.4a), or a similar statute from any other jurisdiction, in connection with an accident, shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of the accident.

c. Any person acting with specific intent of causing injury to himself or others in the operation or use of an automobile shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of an accident arising from such conduct.

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

C.39:6A-6 Collateral source.

6. Collateral Source. The benefits provided in sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) and the medical expense benefits provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1) shall be payable as loss accrues, upon written notice of such loss and without regard to collateral sources, except that benefits, collectible under workers' compensation insurance, employees' temporary disability benefit statutes, medicare provided under federal law, and benefits, in fact collected, that are provided under federal law to active and retired military personnel shall be deducted from the benefits collectible under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) and the medical expense benefits provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1).

If an insurer has paid those benefits and the insured is entitled to, but has failed to apply for, workers' compensation benefits or employees' temporary disability benefits, the insurer may

immediately apply to the provider of workers' compensation benefits or of employees' temporary disability benefits for a reimbursement of any benefits pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) or medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) it has paid.

10. Section 7 of P.L.1972, c.70 (C.39:6A-7) is amended to read as follows:

c.39:6A-7 Exclusion from certain insurance benefits.

7. Exclusions. a. Insurers may exclude a person from benefits under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) and medical expense benefits provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1) if that person's conduct contributed to his personal injuries or death occurred in any of the following ways:

(1) while committing a high misdemeanor or felony or seeking to avoid lawful apprehension or arrest by a police officer; or

(2) while acting with specific intent of causing injury or damage to himself or others.

b. An insurer may also exclude from the benefits provided in sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) and the medical expense benefits provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1) any person having incurred injuries or death, who, at the time of the accident:

(1) was the owner or registrant of an automobile registered or principally garaged in this State that was being operated without personal injury protection coverage;

(2) was occupying or operating an automobile without the permission of the owner or other named insured;

(3) was a person other than the named insured or a member of the named insured's family residing in his household, if that person is entitled to coverage under section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10), or both, or section 4 of P.L.1998, c.21 (C.39:6A-3.1), as a named insured or member of the named insured's family residing in his household under the terms of another policy: or

(4) was a member of the named insured's family residing in the named insured's household, if that person is entitled to coverage under section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10), or both, or section 4 of P.L.1998, c.21 (C.39:6A-3.1) as a named insured under the terms of another policy.

11. Section 8 of P.L.1972, c.70 (C.39:6A-8) is amended to read as follows:

C.39:6A-8 Tort exemption, limitation on the right to noneconomic loss.

8. Tort exemption; limitation on the right to noneconomic loss.

One of the following two tort options shall be elected, in accordance with section 14.1 of P.L.1983, c.362 (C.39:6A-8.1), by any named insured required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4):

a. Limitation on lawsuit option. Every owner, registrant, operator or occupant of an automobile to which section 4 of P.L.1972, c.70 (C.39:6A-4), personal injury protection coverage, or section 4 of P.L.1998, c.21 (C.39:6A-3.1), medical expense benefits coverage, regardless of fault, applies, and every person or organization legally responsible for his acts or omissions, is hereby exempted from tort liability for noneconomic loss to a person who is subject to this subsection and who is either a person who is required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1), or is a person who has a right to receive benefits under section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L.1998, c.21 (C.39:6A-3.1), as a result of bodily injury, arising out of the ownership, operation, maintenance or use of such automobile in this State, unless that person has sustained a bodily injury which results in death; dismemberment; significant disfigurement or significant scarring; displaced fractures; loss of a fetus; or a permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement. An injury shall be considered permanent when the body part or organ, or both, has not healed to function normally and will not heal to function normally

with further medical treatment. For the purposes of this subsection, "physician" means a physician as defined in section 5 of P.L.1939,c.115 (C.45:9-5.1).

In order to satisfy the tort option provisions of this subsection, the plaintiff shall, within 60 days following the date of the answer to the complaint by the defendant, provide the defendant with a certification from the licensed treating physician or a board-certified licensed physician to whom the plaintiff was referred by the treating physician. The certification shall state, under penalty of perjury, that the plaintiff has sustained an injury described above. The certification shall be based on and refer to objective clinical evidence, which may include medical testing, except that any such testing shall be performed in accordance with medical protocols pursuant to subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4) and the use of valid diagnostic tests administered in accordance with section 12 of P.L.1998, c.21 (C.39:6A-4.7). Such testing may not be experimental in nature or dependent entirely upon subjective patient response. The court may grant no more than one additional period not to exceed 60 days to file the certification pursuant to this subsection upon a finding of good cause.

A person is guilty of a crime of the fourth degree if that person purposefully or knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omits a material fact from, or causes a material fact to be omitted from, any certification filed pursuant to this subsection. Notwithstanding the provisions of subsection e. of N.J.S. 2C:44-1, the court shall deal with a person who has been convicted of a violation of this subsection by imposing a sentence of imprisonment unless, having regard to the character and condition of the person, the court is of the opinion that imprisonment would be a serious injustice which overrides the need to deter such conduct by others. If the court imposes a noncustodial or probationary sentence, such sentence shall not become final for 10 days in order to permit the appeal of such sentence by the prosecution. Nothing in this subsection a. shall preclude an indictment and conviction for any other offense defined by the laws of this State. In addition, any professional license held by the person shall be forfeited according to the procedures established by section 4 of P.L.1997, c.353 (C.2C:51-5); or

b. No limitation on lawsuit option. As an alternative to the basic tort option specified in subsection a. of this section, every owner, registrant, operator, or occupant of an automobile to which section 4 of P.L.1972, c.70 (C.39:6A-4), personal injury protection coverage, or section 4 of P.L.1998, c.21 (C.39:6A-3.1), medical expense benefits coverage, regardless of fault, applies, and every person or organization legally responsible for his acts or omissions, shall be liable for noneconomic loss to a person who is subject to this subsection and who is either a person who is required to maintain the coverage mandated by P.L.1972, c.70 (C.39:6A-1 et seq.) or is a person who has a right to receive benefits under section 4 of that act (C.39:6A-4), as a result of bodily injury, arising out of the ownership, operation, maintenance or use of such automobile in this State.

The tort option provisions of subsection b. of this section shall also apply to the right to recover for noneconomic loss of any person eligible for benefits pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L.1998, c.21 (C.39:6A-3.1) but who is not required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or medical expense benefits coverage pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) and is not an immediate family member, as defined in section 14.1 of P.L.1983, c.362 (C.39:6A-8.1), under a standard automobile insurance policy or basic automobile insurance policy.

The tort option provisions of subsection a. of this section shall also apply to any person subject to section 14 of P.L.1985, c.520 (C.39:6A-4.5) and to every named insured and any other person to whom the medical expense benefits of the basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) apply whether or not the person has elected the optional $10,000 liability coverage insuring against loss resulting from liability imposed by law for bodily injury or death provided for in subsection c. of section 4 of P.L.1998, c.21 (C.39:6A-3.1).

The tort option provisions of subsections a. and b. of this section as provided in this 1998 amendatory and supplementary act shall apply to automobile insurance policies issued or renewed on or after the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.) and as otherwise

provided by law.

C.39:6A-4.7 Compilation of list of valid diagnostic tests used in treatment of persons sustaining bodily injury.

12. The professional licensing boards governing health care providers in the Division of Consumer Affairs shall promulgate, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), a list of valid diagnostic tests to be used in conjunction with the appropriate health care protocols in the treatment of persons sustaining bodily injury and subject to subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8). Inclusion of a test on the list of valid diagnostic tests shall be based on demonstrated medical value, and a level of general acceptance by the relevant provider community and shall not be dependent for results entirely upon subjective patient response. The initial lists shall be promulgated within 180 days of the effective date of this section and shall be revised from time to time as determined by the respective boards to reflect new testing procedures and emerging technologies enjoying a level of general acceptance within the appropriate provider community. In updating its list, a board may take action at a regularly scheduled meeting, notwithstanding the provisions of P.L.1968, c.410 (C.52:14B-1 et seq.) to the contrary, after notice as provided herein. The professional boards, individually or collectively, may enlist the services of a consulting firm to assist in compiling and updating the list. The Commissioner of Banking and Insurance may reimburse the boards for the cost of the services of the consultant. The list of valid diagnostic tests, once approved by the commissioner shall apply only to benefits under section 4 of P.L.1972, c.70 (C.39:6A-4) and section 4 of P.L.1998, c.21 (C.39:6A-3.1). The board or boards hiring a consultant shall not advertise for bids, as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9). Notwithstanding any of the provisions of this section to the contrary, a diagnostic test performed in an acute care facility, or extended care facility recognized by Medicare, shall not be excluded from a list of valid diagnostic tests promulgated pursuant to this section.

a. For the purposes of this section, "action" includes, but is not limited to:

(1) the addition or deletion of a test to the list; or

(2) procedures and standards for the performance of a test.

"Action" shall not include the hearing and resolution of contested cases, licensing matters, personnel matters or any other duties of a professional licensing board.

b. Prior to the adoption of an action by the board, the board shall forward the notice of intended action and a detailed description of the intended action to the Office of Administrative Law for publication in the New Jersey Register.

A copy of the text of the intended action shall be available in the Division of Consumer Affairs in accordance with the provisions of P.L.1963, c.73 (C.47:1A-1 et seq.).

c. The board may hold a public hearing on any intended action.

d. Whether or not a public hearing is held, the board shall afford all interested persons an opportunity to comment in writing on the intended action. Written comments shall be submitted to the board within the time established by the board in the notice of intended action, which time shall not be less than 10 calendar days from the date of notice. The board shall give due consideration to all comments received. A copy of the submissions shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

e. The board may adopt the intended action immediately following the expiration of the public comment period provided in subsection d. of this section, or the hearing provided for in subsection c. of this section, whichever date is later. The final action adopted by the board shall be submitted for publication in the New Jersey Register to the Office of Administrative Law, and shall be effective on the date of the submission or such later date as the board may establish.

f. Actions filed with the Office of Administrative Law pursuant to this section shall be filed subject to the provisions of subsections (a), (c), (d) and (e) of section 5 of P.L.1968, c.410 (C.52:14B-5).

g. Nothing in this section shall be construed to prohibit the board from adopting any action pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

h. Nothing in this section shall be construed to prohibit the Director of the Division of Consumer Affairs from adopting any rule or regulation pursuant to the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

13. Section 20 of P.L.1983, c.362 (C.39:6A-9.1) is amended to read as follows:

C.39:6A-9.1 Recovery from tortfeasor.

20. An insurer, health maintenance organization or governmental agency paying benefits pursuant to subsection a., b. or d. of section 13 of P.L.1983, c.362 (C.39:6A-4.3) or personal injury protection benefits in accordance with section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10) or medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1), as a result of an accident occurring within this State, shall, within two years of the filing of the claim, have the right to recover the amount of payments from any tortfeasor who was not, at the time of the accident, required to maintain personal injury protection or medical expense benefits coverage, other than for pedestrians, under the laws of this State, including personal injury protection coverage required to be provided in accordance with section 18 of P.L.1985, c.520 (C.17:28-1.4), or although required did not maintain personal injury protection or medical expense benefits coverage at the time of the accident. In the case of an accident occurring in this State involving an insured tortfeasor, the determination as to whether an insurer, health maintenance organization or governmental agency is legally entitled to recover the amount of payments and the amount of recovery, including the costs of processing benefit claims and enforcing rights granted under this section, shall be made against the insurer of the tortfeasor, and shall be by agreement of the involved parties or, upon failing to agree, by arbitration.

14. Section 10 of P.L.1972, c.70 (C.39:6A-10) is amended to read as follows:

C.39:6A-10 Additional personal injury protection coverage.

10. Additional personal injury protection coverage. Insurers shall make available to the named insured electing the standard automobile insurance policy and covered under section 4 of P.L.1972, c.70 (C.39:6A-4), and, at his option, to resident relatives in the household of the named insured, suitable additional first party coverage for income continuation benefits, essential services benefits, death benefits and funeral expense benefits, but the income continuation and essential services benefits shall cease upon the death of the claimant, and shall not operate to increase the amount of any death benefits payable under section 4 of P.L.1972, c.70 (C.39:6A-4) and such additional first party coverage shall be payable only to the extent that the claimant establishes that the amount of loss sustained exceeds the coverage specified in section 4 of P.L.1972, c.70 (C.39:6A-4). Insurers may also make available to named insureds electing a standard automobile insurance policy and covered under section 4 of P.L.1972, c.70 (C.39:6A-4), and, at their option, to resident relatives in the household of the named insured or to other persons provided medical expense benefits coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), or both, additional first party medical expense benefits coverage. The additional coverage shall be offered by the insurer at least annually as part of the coverage selection form applicable to the standard automobile insurance policy and required by section 17 of P.L.1983, c.362 (C.39:6A-23). Income continuation in excess of that provided for in section 4 of P.L.1972, c.70 (C.39:6A-4) shall be provided as an option by insurers for disabilities, as long as the disability persists, up to an income level of $35,000.00 per year, provided that a. the excess between $5,200.00 and the amount of coverage contracted for shall be written on the basis of 75% of said difference, and b. regardless of the duration of the disability, the benefits payable shall not exceed the total maximum amount of income continuation benefits contracted for. Death benefits provided pursuant to this section shall be payable without regard to the period of time elapsing between the date of the accident and the date of death, if death occurs within two years of the accident and results from bodily injury from that accident to which coverage under this section applies. The Commissioner of Banking and Insurance is hereby authorized and empowered to establish, by rule or regulation, the amounts

and terms of income continuation insurance to be provided pursuant to this section.

15. Section 11 of P.L.1972, c.70 (C.39:6A-11) is amended to read as follows:

C.39:6A-11 Contribution among insurers.

11. Contribution among insurers. If two or more insurers are liable to pay benefits under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) under a standard automobile insurance policy for the same bodily injury, or death, of any one person, the maximum amount payable shall be as specified in those sections 4 and 10 of P.L.1972, C.70 (C.39:6A-4 and 39:6A-10) and section 4 of P.L.1998, c.21 (C.39:6A-3.1), respectively, if additional first party coverage applies and any insurer paying the benefits shall be entitled to recover from each of the other insurers, only by inter-company arbitration or inter-company agreement, an equitable pro-rata share of the benefits paid.

16. Section 12 of P.L.1972, c.70 (C.39:6A-12) is amended to read as follows:

C.39:6A-12 Inadmissibility of evidence of losses collectible under personal injury protection coverage.

12. Inadmissibility of evidence of losses collectible under personal injury protection coverage. Except as may be required in an action brought pursuant to section 20 of P.L.1983, c.362 (C.39:6A-9.1), evidence of the amounts collectible or paid under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) and amounts collectible or paid for medical expense benefits under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1), to an injured person, including the amounts of any deductibles, copayments or exclusions, including exclusions pursuant to subsection d. of section 13 of P.L.1983, c.362 (C.39:6A-4.3), otherwise compensated is inadmissible in a civil action for recovery of damages for bodily injury by such injured person.

The court shall instruct the jury that, in arriving at a verdict as to the amount of the damages for noneconomic loss to be recovered by the injured person, the jury shall not speculate as to the amount of the medical expense benefits paid or payable by an automobile insurer under personal injury protection coverage payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) or medical expense benefits under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) to the injured person, nor shall they speculate as to the amount of benefits paid or payable by a health insurer, health maintenance organization or governmental agency under subsection d. of section 13 of P.L.1983, c.362 (C.39:6A-4.3).

Nothing in this section shall be construed to limit the right of recovery, against the tortfeasor, of uncompensated economic loss sustained by the injured party.

17. Section 13 of P.L.1972, c.70 (C.39:6A-13) is amended to read as follows:

C.39:6A-13 Discovery of facts as to personal injury protection coverage.

13. Discovery of facts as to personal injury protection coverage. The following apply to personal injury protection coverage benefits payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) and medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1):

a. Every employer shall, if a request is made by an insurer or the Unsatisfied Claim and Judgment Fund providing personal injury protection benefits under a standard automobile insurance policy or medical expense benefits payable under a basic automobile insurance policy against whom a claim has been made, furnish forthwith, in a form approved by the Commissioner of Banking and Insurance, a signed statement of the lost earnings since the date of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

b. Every physician, hospital, or other health care provider providing, before and after the

bodily injury upon which a claim for personal injury protection benefits or medical expense benefits is based, any products, services or accommodations in relation to such bodily injury or any other injury, or in relation to a condition claimed to be connected with such bodily injury or any other injury, shall, if requested to do so by the insurer or the Unsatisfied Claim and Judgment Fund against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates and costs of such treatment of the injured person, and produce forthwith and permit the inspection and copying of his or its records regarding such history, condition, treatment dates and costs of treatment. The person requesting such records shall pay all reasonable costs connected therewith.

c. The injured person shall be furnished upon demand a copy of all information obtained by the insurer or the Unsatisfied Claim and Judgment Fund under the provisions of this section, and shall pay a reasonable charge, if required by the insurer and the Unsatisfied Claim and Judgment Fund.

d. Whenever the mental or physical condition of an injured person covered by personal injury protection under a standard automobile insurance policy or medical expense benefits under a basic automobile insurance policy is material to any claim that has been or may be made for such past or future personal injury protection benefits or medical expense benefits, such person shall, upon request of an insurer or the Unsatisfied Claim and Judgment Fund submit to mental or physical examination conducted by a health care provider licensed in this State in the same profession or specialty as the health care provider whose services are subject to review under this section and who is located within a reasonable proximity to the injured person's residence. The injured person shall provide or make available to the provider any pertinent medical records or medical history that the provider deems necessary to the examination. The costs of any examinations requested by an insurer or the Unsatisfied Claim and Judgment Fund shall be borne entirely by whomever makes such request. Such examination shall be conducted within the municipality of residence of the injured person. If there is no qualified health care provider to conduct the examination within the municipality of residence of the injured person, then such examination shall be conducted in an area of the closest proximity to the injured person's residence. Insurers providing personal injury protection coverage under a standard automobile insurance policy or medical expense benefits under a basic automobile insurance policy are authorized to include reasonable provisions requiring those claiming personal injury protection coverage benefits or medical expense benefits to submit to mental or physical examination as requested by an insurer or the Unsatisfied Claim and Judgment Fund pursuant to the provisions of this section. Failure to submit to a mental or physical examination requested by an insurer or the Unsatisfied Claim and Judgment Fund pursuant to the provisions of this section shall subject the injured person to certain limitations in coverage as specified in regulations promulgated by the commissioner.

e. If requested by the person examined, a party causing an examination to be made, shall deliver to him a copy of every written report concerning the examination rendered by an examining health care provider, at least one of which reports must set out his findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled upon request to receive from the person examined every written report available to him, or his representative, concerning any examination, previously or thereafter made of the same mental or physical condition.

f. The injured person, upon reasonable request by the insurer or the Unsatisfied Claim and Judgment Fund, shall sign all forms, authorizations or releases for information, approved by the Commissioner of Banking and Insurance, which may be necessary to the discovery of the above facts, in order to reasonably prove the injured person's losses.

g. In the event of any dispute regarding an insurer's or the Unsatisfied Claim and Judgment Fund's or an injured person's right as to the discovery of facts about the injured person's earnings or about his history, condition, treatment, dates and costs of such treatment, or the submission of such injured person to a mental or physical examination subject to the provisions of this section, the insurer, Unsatisfied Claim and Judgment Fund or the injured person may petition a court of competent jurisdiction for an order resolving the dispute and protecting the rights of all parties. The order may be entered on motion for good cause shown giving notice to all persons

having an interest therein. Such court may protect against annoyance, embarrassment or oppression and may as justice requires, enter an order compelling or refusing discovery, or specifying conditions of such discovery; the court may further order the payment of costs and expenses of the proceeding, as justice requires.

18. Section 11 of P.L.1972, c.203 (C.39:6A-13.1) is amended to read as follows:

C.39:6A-13.1 Two-year limitation on action for payment of benefits.

11. a. Every action for the payment of benefits payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) or medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1), except an action by a decedent's estate, shall be commenced not later than two years after the injured person or survivor suffers a loss or incurs an expense and either knows or in the exercise of reasonable diligence should know that the loss or expense was caused by the accident, or not later than four years after the accident whichever is earlier, provided, however, that if benefits have been paid before then an action for further benefits may be commenced not later than two years after the last payment of benefits.

b. Every action by a decedent's estate for the payment of benefits provided under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) or medical expense benefits provided under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) shall be commenced not later than two years after death or four years after the accident from which death results, whichever is earlier, provided, however, that if benefits had been paid to the decedent prior to his death then an action may be commenced not later than two years after his death or four years after the last payment of benefits, whichever is earlier, provided, further, that if the decedent's estate has received benefits before then an action for further benefits shall be commenced not later than two years from the last payment of benefits.

19. Section 15 of P.L.1972, c.70 (C.39:6A-15) is amended to read as follows:

C.39:6A-15 Penalties for false and fraudulent representation.

15. n any claim or action arising for benefits payable under a standard automobile insurance policy under section 4 of P.L.1972, c.70 (C.39:6A-4) or any claim or action arising for medical expense benefits payable under a basic automobile insurance policy under section 4 of P.L.1998, c.21 (C.39:6A-3.1) wherein any person obtains or attempts to obtain from any other person, insurance company or Unsatisfied Claim and Judgment Fund any money or other thing of value by (1) falsely or fraudulently representing that such person is entitled to such benefits; (2) falsely and fraudulently making statements or presenting documentation in order to obtain or attempt to obtain such benefits; or (3) cooperates, conspires or otherwise acts in concert with any person seeking to falsely or fraudulently obtain, or attempt to obtain, such benefits may upon conviction be fined not more than $5,000.00, or imprisoned for not more than three years or both, or in the event the sum so obtained or attempted to be obtained is not more than $500.00, may upon conviction, be fined not more than $500.00, or imprisoned for not more than six months or both, as a disorderly person.

In addition to any penalties imposed by law, any person who is either found by a court of competent jurisdiction to have violated any provision of P.L.1983 c.320 (C.17:33A-1 et seq.) pertaining to automobile insurance or been convicted of any violation of Title 2C of the New Jersey Statutes arising out of automobile insurance fraud shall not operate a motor vehicle over the highways of this State for a period of one year from the date of judgment or conviction.

20. Section 1 of P.L.1972, c.197 (C.39:6B-1) is amended to read as follows:

C.39:6B-1 Maintenance of motor vehicle liability insurance coverage.

1. a. Every owner or registered owner of a motor vehicle registered or principally garaged in this State shall maintain motor vehicle liability insurance coverage, under provisions approved by the Commissioner of Banking and Insurance, insuring against loss resulting from liability

imposed by law for bodily injury, death and property damage sustained by any person arising out of the ownership, maintenance, operation or use of a motor vehicle wherein such coverage shall be at least in: (1) an amount or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident; and (2) an amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to or death of, more than one person, in any one accident; and (3) an amount or limit of $5,000.00, exclusive of interest and costs, for damage to property in any one accident.

b. Notwithstanding the provisions of subsection a. of this section, an owner or registered owner of an automobile, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), registered or primarily garaged in the State may satisfy the requirements of subsection a. of this section by maintaining a basic automobile insurance policy containing coverages provided pursuant to subsections a. and b. of section 4 of P.L.1998, c.21 (C.39:6A-3.1).

21. Section 2 of P.L.1952, c.174 (C.39:6-62) is amended to read as follows:

C.39:6-62 Definitions relative to the Unsatisfied Claim and Judgment Fund.

2. Definitions. As used in this act:

"Executive director" means the official designated by and serving at the pleasure of the commissioner to administer to and be in charge of the Unsatisfied Claim and Judgment Fund and who shall be responsible to the Unsatisfied Claim and Judgment Fund Board.

"Treasurer" means the State Treasurer of New Jersey acting as the custodian of the Unsatisfied Claim and Judgment Fund.

"Commissioner" means the Commissioner of Banking and Insurance.

"Unsatisfied Claim and Judgment Fund" or "Fund" means the fund derived from the sources specified in this act.

"Unsatisfied Claim and Judgment Fund Board" or "Board" means the board created in section 4 of this act.

"Qualified person" means a resident of this State or the owner of a motor vehicle registered in this State or a resident of another state, territory, or federal district of the United States or province of Canada or of a foreign country, in which recourse is afforded, to residents of this State, of substantially similar character to that provided for by this act; provided, however, that no person shall be a qualified person where such person is an insured under a policy provision providing coverage for damages sustained by the insured as a result of the operation of an uninsured motor vehicle in a form authorized to be included in automobile liability policies of insurance delivered or issued for delivery in this State, pursuant to the provisions of, or any supplement to, chapter 28 of Title 17 of the Revised Statutes or in a form substantially similar thereto.

"Uninsured motor vehicle" means a motor vehicle as to which there is not in force a liability policy meeting the requirements of section 3 or 26 of the "Motor Vehicle Security-Responsibility Law," P.L.1952, c.173 (C.39:6-25 or C.39:6-48), and which is not owned by a holder of a certificate of self-insurance under said law, but shall not include a motor vehicle with a policy in force which is insured pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1).

"Person" includes natural persons, firms, copartnerships, associations and corporations.

"Insurer" means any insurer authorized in this State to write the kinds of insurance specified in paragraphs d. and e. of R.S.17:17-1.

"Net direct written premiums" means direct gross premiums written on policies, insuring against legal liability for bodily injury or death and for damage to property arising out of the ownership, operation or maintenance of motor vehicles, which are principally garaged in this State, less return premiums thereon and dividends paid to policyholders on such direct business.

"Registration license year" means the period beginning June 1, 1956, and ending May 31, 1957, and each subsequent 12 month period, beginning June 1 and ending the following May 31.

22. Section 14 of P.L.1988, c.156 (C.17:29A-15.2) is amended to read as follows:

C.17:29A-15.2 Commission of producer unaffected by tort option.

14. Notwithstanding any other provision of law to the contrary, the dollar amount of the commission paid to a producer for residual bodily injury coverage provided pursuant to section 8 of P.L.1972, c.70 (C.39:6A-8) shall be the same whether the named insured elects the tort option provided for in subsection a. of that section or the tort option provided for in subsection b. of that section. This section shall not apply to commissions on a basic automobile insurance policy issued pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1).

23. Section 5 of P.L.1972, c.70 (C.39:6A-5) is amended to read as follows:

C.39:6A-5 Payment of personal injury protection coverage benefits.

5. Payment of personal injury protection coverage benefits.

a. An insurer may require written notice to be given as soon as practicable after an accident involving an automobile with respect to which the policy affords personal injury protection coverage benefits payable under a standard automobile insurance policy pursuant to section 4 of P.L.1972, c.70 (C.34:6A-4) or medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1). In the case of claims for medical expense benefits under either policy, written notice shall be provided to the insurer by the treating health care provider no later than 21 days following the commencement of treatment. Notification required under this section shall be made in accordance with regulations adopted by the Commissioner of Banking and Insurance and on a form prescribed by the Commissioner of Banking and Insurance. Within a reasonable time after receiving notification required pursuant to this act, the insurer shall confirm to the treating health care provider that its policy affords the claimant personal injury protection coverage benefits as required by section 4 of P.L.1972, c.70(C.39:6A-4) or medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1).

b. For the purposes of this section, notification shall be deemed to be met if a treating health care provider submits a bill or invoice to the insurer for reimbursement of services within 21 days of the commencement of treatment.

c. In the event that notification is not made by the treating health care provider within 21 days following the commencement of treatment, the insurer shall reserve the right to deny, in accordance with regulations established by the Commissioner of Banking and Insurance, payment of the claim and the treating health care provider shall be prohibited from seeking any payment directly from the insured. In establishing the standards for denial of payment, the Commissioner of Banking and Insurance shall consider the length of delay in notification, the severity of the treating health care provider's failure to comply with the notification provisions of this act based upon the potential adverse impact to the public and whether or not the provider has engaged in a pattern of noncompliance with the notification provisions of this act. In establishing the regulations necessary to effectuate the purposes of this subsection, the Commissioner of Banking and Insurance shall define specific instances where the sanctions permitted pursuant to this subsection shall not apply. Such instances may include, but not be limited to, a treating medical provider's failure to provide notification to the insurer as required by this act due to the insured's medical condition during the time period within which notification is required.

d. A health care provider who fails to notify the insurer within 21 days and whose claim for payment has been denied by the insurer pursuant to the standards established by the Commissioner of Banking and Insurance may, in the discretion of a judge of the Superior Court, be permitted to refile such claim provided that the insurer has not been substantially prejudiced thereby. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to notify the insurer within the period of time prescribed by this act.

e. (Deleted by amendment, P.L.1998, c.21.)

f. In instances when multiple treating health care providers render services in connection with emergency care, the Commissioner of Banking and Insurance shall designate, through regulation, a process whereby notification by one treating health care provider to the insurer

shall be deemed to meet the notification requirements of all the treating health care providers who render services in connection with emergency care.

g. Personal injury protection coverage benefits pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) and medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) shall be overdue if not paid within 60 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 60 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 60 days after such written notice is furnished to the insurer; provided, however, that any payment shall not be deemed overdue where, within 60 days of receipt of notice of the claim, the insurer notifies the claimant or his representative in writing of the denial of the claim or the need for additional time, not to exceed 45 days, to investigate the claim, and states the reasons therefor. The written notice stating the need for additional time to investigate the claim shall set forth the number of the insurance policy against which the claim is made, the claim number, the address of the office handling the claim and a telephone number, which is toll free or can be called collect, or is within the claimant's area code. Written notice to the organization administering dispute resolution pursuant to sections 24 and 25 of P.L.1998, c.21 (C.39:6A-5.1 and C.39:6A-5.2) shall satisfy the notice request for additional time to investigate a claim pursuant to this subsection. For the purpose of determining interest charges in the event the injured party prevails in a subsequent proceeding where an insurer has elected a 45-day extension pursuant to this subsection, payment shall be considered overdue at the expiration of the 45-day period or, if the injured person was required to provide additional information to the insurer, within 10 business days following receipt by the insurer of all the information requested by it, whichever is later.

For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

h. All overdue payments shall bear interest at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.

i. All automobile insurers and the Unsatisfied Claim and Judgment Fund shall provide any claimant with the option of submitting a dispute under this section to dispute resolution pursuant to sections 24 and 25 of P.L.1998, c.21 (C.39:6A-5.1 and C.39:6A-5.2).

C.39:6A-5.1 Dispute resolution provided regarding recovery of personal injury protection benefits.

24. a. Any dispute regarding the recovery of medical expense benefits or other benefits provided under personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), or section 4 of P.L.1998, c.21 (C.39:6A-3.1) arising out of the operation, ownership, maintenance or use of an automobile may be submitted to dispute resolution on the initiative of any party to the dispute, as hereinafter provided.

b. The Commissioner of Banking and Insurance shall designate an organization, and for that purpose may, at his discretion, advertise for proposals, for the purpose of administering dispute resolution proceedings regarding medical expense benefits and other benefits provided under personal injury protection pursuant to section 4 of P.L. 1972, c.70 (C.39:6A-4) or medical expense benefits coverage pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1). The commissioner shall promulgate rules and regulations with respect to the conduct of the dispute resolution proceedings. The organization administering dispute resolution shall utilize qualified professionals who serve on a full-time basis and who meet standards of competency established by the commissioner. The commissioner shall establish standards of performance for the organization to ensure the independence and fairness of the review process, including, but not limited to, standards relative to the professional qualifications of the professionals presiding over the dispute resolution process, and standards to ensure that no conflict of interest exists which

would prevent the professional from performing his duties in an impartial manner. The standards of performance shall include a requirement that the organization establish an advisory council composed of parties who are users of the dispute resolution mechanism established herein. The commissioner may contract with a consulting firm for the formulation of the standards of performance of the organization and establishment of qualifications for the persons who are to conduct the dispute resolution proceedings. The commissioner shall not advertise for bids for the consulting firm, as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9). Compensation to the dispute resolution professionals shall be established by the commissioner and adjusted from time to time as appropriate, with the approval of the commissioner. In no case shall compensation be paid on a contingency basis. The organization shall establish a dispute resolution plan, which shall include procedures and rules governing the dispute resolution process and provisions for monitoring the dispute resolution process to ensure adherence to the standards of performance established by the commissioner. The plan, and any amendments thereto, shall be subject to the approval of the commissioner.

c. Dispute resolution proceedings under this section 24 and section 25 of this amendatory and supplementary act shall include disputes arising regarding medical expense benefits provided under subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L.1998, c.21 (C.39:6A-3.1), benefits provided pursuant to subsection b., c., d. or e. of section 4 of P.L.1972, c.70 (C.39:6A-4), subsection b., c., d. or e. of section 7 of P.L.1972, c.198 (C.39:6-86.1), and disputes as to additional first party coverage benefits required to be offered pursuant to section 10 of P.L.1972, c.70 (C.39:6A-10). Disputes involving medical expense benefits may include, but not necessarily be limited to, matters concerning: (1) interpretation of the insurance contract; (2) whether the treatment or health care service which is the subject of the dispute resolution proceeding is in accordance with the provisions of section 4 of P.L.1972, c.70 (C.39:6A-4)or section 4 of P.L.1998, c.21 (C.39:6A-3.1) or the terms of the policy; (3) the eligibility of the treatment or service for compensation; (4) the eligibility of the provider performing the treatment or service to be compensated under the terms of the policy or under regulations promulgated by the commissioner, including whether the person is licensed or certified to perform such treatment; (5) whether the disputed medical treatment was actually performed; (6) whether diagnostic tests performed in connection with the treatment are those recognized by the commissioner; (7) the necessity or appropriateness of consultations by other health care providers; (8) disputes involving application of and adherence to fee schedules promulgated by the commissioner; and (9) whether the treatment performed is reasonable, necessary, and compatible with the protocols provided for pursuant to P.L.1998, c.21 (C.39:6A-1.1 et al.). The dispute resolution professionals may review the entire claims file of the insurer, subject to any confidentiality requirement established pursuant to State or federal law. All decisions of the dispute resolution professional shall be in writing, in a form prescribed by the commissioner, shall state the issues in dispute, the findings and conclusions on which the decision is based, and shall be signed by the dispute resolution professional. All decisions of a dispute resolution professional shall be binding. The dispute resolution organization shall provide for the retention of all documents used in dispute resolution proceedings under this section and section 25 of this amendatory and supplementary act, including the written decision, for a period of at least five years, in a form approved by the commissioner, or for such additional time as may be established by the commissioner. The written decisions of the dispute resolution professional shall be forwarded to the commissioner, who shall establish a record of the proceedings conducted under the dispute resolution procedure, which shall be accessible to the public and may be used as guidance in subsequent dispute resolution proceedings.

d. With respect to disputes as to the diagnosis, the medical necessity of the treatment or diagnostic test administered to the injured person, whether the injury is causally related to the insured event or is the product of a preexisting condition, or disputes as to the appropriateness of the protocols utilized by the provider, the dispute resolution professional shall, either at his option or at the request of any party to the dispute, refer the matter to a medical review organization for a determination. The determination of the medical review organization on the dispute referred shall be binding upon the dispute resolution professional.

e. Any person submitting a matter to the dispute resolution process established herein may

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

C.39:6A-5.2 Establishment of standards for certification of medical review organizations.

25. a. The commissioner shall establish standards for the certification of medical review organizations, which shall include standards of performance formulated by the commissioner in consultation with the Commissioner of Health and Senior Services. The standards of performance shall set forth procedures to ensure a timely and impartial review of the medical records of the injured person by a medical review organization, including, but not limited to, a review of the necessity or appropriateness of treatments for injuries, including diagnostic tests, sustained in an automobile accident. The commissioner shall establish standards for persons conducting the medical review, including standards with respect to credentials, experience, licensure, fees, and confidentiality. The standards shall include a requirement that all persons performing reviews are New Jersey licensed or certified health care providers, and a requirement that any medical review panel contain a health care provider licensed or certified in the same profession as the treating health care provider and that it contain a sufficient representation of reviewers to judge the appropriateness of treatment or treatments in dispute, including, but not limited to, the medical necessity of such treatments, appropriateness of the protocols used by the treating provider, issues regarding causality and preexisting conditions, the appropriateness and efficacy of diagnostic tests performed in connection with the diagnosis, and whether the diagnostic tests meet the requirements established by the commissioner. The commissioner may contract with a consultant for the formulation of the standards governing the certification of the persons conducting the medical reviews. The commissioner shall not advertise for bids for the consultant, as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

b. Before certifying a medical review organization to receive referrals from dispute resolution proceedings, the commissioner shall determine that the organization has a sufficient number of qualified health care providers, by specialty, to perform the reviews, has a satisfactory procedure for maintaining the confidentiality of medical records, is not owned or controlled by an insurer, and has met any other requirements established by the commissioner.

c. The medical review organization shall establish and utilize written review procedures, which shall be filed with the commissioner. Every determination made by a medical review organization shall be in writing and shall be retained by the organization for a period of no less than five years.

d. The medical review organization may review the medical treatment or treatments in dispute to determine whether: (1) the treatment or diagnostic test being given for the injury or the services provided in connection with the injury is medically necessary; (2) the treatment is in accordance with or compatible with medically recognized standard protocols, professional standards, and commonly accepted medical practice in the same health care discipline as the treating provider; (3) the treatment is consistent with the symptoms or diagnosis of the injury; (4) the treatment or health care service is related to the injury sustained in the insured event, or is required for the diagnosis, evaluation or confirmation of the injury; (5) the treatment is of a palliative, rather than restorative, nature; and (6) medical procedures, treatment, or testing which have been repeated are medically necessary and consistent with standard practice.

e. Cases referred by a dispute resolution professional for medical review shall be referred to appropriate certified medical reviewers affiliated with the certified medical review organization by a dispute resolution organization. The dispute resolution organization shall forward the referrals to certified medical reviewers on a random basis, so that there is a relatively equal apportionment among all medical reviewers. Referrals shall be made in such a manner so as not to disclose to the medical reviewers the identity of the insurer, nor shall the identity of the

reviewer be disclosed to the insurer.

f. When appropriate in the context of its review of services or treatments under dispute, a medical reviewer may request and shall receive a written report or copy of the provider's records regarding the case history, treatment dates, or the dates diagnostic tests or other services were performed, and the provider's projected treatment plan. The injured person or provider, as applicable, shall provide or make available to the medical reviewer any pertinent medical records or medical history which the medical reviewer may request. The medical reviewer shall complete its review and make a determination within 20 business days of receipt of all of the requested information from the dispute resolution professional or provider, as the case may be. The medical reviewer shall submit its determination in writing to the referring dispute resolution organization, which shall forward it to the dispute resolution professional.

g. The cost of the proceedings shall be apportioned by the dispute resolution professional. Fees shall be determined to be reasonable if they are consonant with the amount of the award, in accordance with a schedule established by the New Jersey Supreme Court. If the treatment, diagnostic test, or service performed is not determined to be medically necessary or appropriate, the injured person shall not be liable to pay the provider the disputed amount.

C.17:29A-48 Establishment of new territorial rating plans.

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

a. Territories shall be defined in such a manner as to recognize throughout the territorial rating plan both qualitative similarities and qualitative differences in driving environments or mix of driving environments, which may include, but not be limited to, traffic density, population density, comparative severity of loss, and the degree of homogeneity within a territory in terms of driving environments, population, and driver classification, and the territory shall be comprised of towns or cities which are contiguous;

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

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

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

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

f. Factors to be considered in establishing territorial rate relativities shall include taking into account similarities or differences in driving environments or mix of driving environments, including traffic density, population density, mix of driver classifications within a territory, including classifications capped pursuant to the provisions of section 7 of P.L.1983, c.65

(C.17:29A-36), comparative degree of severity of loss, and the relative number of intraterritory and inter-territory trips;

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

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

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

C.17:29A-49 Filing of territorial rating plan.

27. a. An insurer or rate filer shall file its territorial rating plan with the commissioner for the commissioner's approval. The commissioner shall approve the plan if he finds that the plan complies with the provisions of section 26 of this amendatory and supplementary act and the regulations promulgated thereto. If the commissioner does not believe that the territorial rating plan meets the standards established by this act or by regulation, or that the territorial rating plan would serve to work against competition among insurers in this State, he shall order that the plan be modified.

b. A filer may file for its use:

(1) an individual territorial rating plan which it has developed; or

(2) the common territorial rating plan established and approved pursuant to section 28 of this act.

c. Approved individual territorial rating plans shall be on file with the commissioner and available for review by filers subject to this section.

d. Every filer shall periodically review, at least once in every five-year period, the continued validity of the territorial rating plan which it is using and shall report its findings to the commissioner, along with such data as the commissioner deems necessary. If the commissioner finds that it is not in accordance with the standards established pursuant to section 26 of this act, he may order that the filer amend its plan or, if the filer fails to do so, require the filer to adopt the common territorial rating plan established pursuant to section 28 of this act.

e. Any filer or filers may object to the territorial rating plan used by another filer on the grounds that it (1) is anticompetitive; (2) does not meet the standards established by the commissioner pursuant to section 26 of this act; or (3) results in the insurer or filer not meeting its obligations pursuant to the provisions of section 27 of P.L.1990, c.8 (C.17:33B-15).

f. No territorial rating plan of any insurer or any rating organization filed with and approved by the commissioner pursuant to section 27 of this act shall be implemented by any insurer until the 180th day following the approval of the common territorial rating plan established by the commission created pursuant to section 28 of this act, but in no event no later than January 1, 2000.

C.17:29A-50 Automobile Insurance Territorial Rating Plan Advisory Commission.

28. a. There is established the Automobile Insurance Territorial Rating Plan Advisory Commission to review insurer data and establish a common territorial rating plan for use by insurers not filing a territorial rating plan pursuant to section 27 of this amendatory and supplementary act. The territorial rating plan established by the commission shall be established according to the criteria and standards provided in section 26 of this amendatory and supplementary act and in accordance with regulations established by the commissioner. The common territorial rating plan shall be subject to the prior approval of the Commissioner of

Banking and Insurance, and shall be reviewed by the commissioner from time to time but not less than once every five years.

b. The commission shall consist of fifteen members: nine representatives of insurers writing private passenger automobile insurance in this State and one representative of a rating bureau filing rates on behalf of its members in this State, who shall be appointed by the Governor with the advice and consent of the Senate; four public members, of whom one shall be appointed by the President of the Senate, one by the Speaker of the General Assembly, one by the Minority Leader of the Senate and one by the Minority Leader of the General Assembly; and the Commissioner of Banking and Insurance, who shall serve ex-officio. Of the insurer members appointed by the Governor, at least two members shall be selected from member companies of the Alliance of American Insurers, and two members selected from member companies of the National Association of Independent Insurers or their successor organizations. The remaining insurer members shall be selected from insurers writing automobile insurance in this State, but no insurer or group of insurers under common control shall have more than one representative appointed to serve on the commission.

c. The members of the commission shall serve for two-year terms and until their successors are appointed and qualified.

d. The commission shall elect a chairman and a vice chairman from among the insurer members.

e. After its initial territorial rating plan has been approved, the commissioner may convene the commission at any time to review the plan and to gather data from insurers. The commissioner may, if he finds that the common territorial rating plan does not meet the standards established pursuant to section 26 of this act, order that the plan be revised.

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

C.17:29A-36 Contents of filing for automobile insurance rate making.

7. a. Any filing made for the purpose of automobile insurance rate making shall indicate the actual rate needs of the filer; provided, however, that (a) each filer's rate classification definitions, as used by that filer, shall be uniform Statewide; and (b) the automobile insurance rate charged an insured shall not exceed two and one-half times the filer's territorial base rate for each coverage, exclusive of driving record surcharges and discounts; and (c) the automobile insurance rate of the base class in any territory for any filer shall not exceed 1.35 times the filer's Statewide average base rate for each coverage, exclusive of driving record surcharges and discounts for any standard policy issued or renewed before January 1, 2000 or the 180th day following approval of the common territorial rating plan pursuant to section 28 of P.L.1998, c.21 (C.17:29A-50), whichever first occurs.

b. No rating plan or rate filing applicable to any policy issued or renewed on or after January 1, 2000 or the 180th day following the approval of the common rating territory provided for in sections 27 and 28 of P.L.1998, c.21 (C.17:29A-49 and C.17:29A-50), whichever first occurs, shall be approved by the commissioner which creates territorial relativities which are significantly disproportionate to those in effect as of the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.).

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

d. As a result of the filings made pursuant to sections 26 and 27 of P.L.1998, c.21 (C.17:29A-48 and C.17:29A-49) and sections b. and c. of this section, the filer's aggregate premium for all territories shall not exceed the filer's aggregate premium in effect prior to the date established in subsection b. of this section.

As used in this section, base rate means the automobile insurance rate charged for an automobile that is not used in business and not used in going to and from work, except for the going to and from work distance included in the pleasure use classification of the filer, and where

there is no youthful operator, as defined in the filer's classification system. The base rate class shall not include automobiles to which discounts apply under the filer's classification system, including, but not limited to, farmers' and senior citizens' automobiles or any discount from a standard rate provided for in the filer's tier rating system.

The provisions of this section shall be implemented after the implementation of the provisions of subsection a. of section 8 of this act.

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

C.17:33B-41 Cancellation for nonpayment of premium; suspension of registration.

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

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

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

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

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

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

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

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

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

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

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

i. Within 180 days of the effective date of this act the Division of Motor Vehicles shall develop a format for electronic reporting by insurers writing private passenger automobile insurance to the division, on a real-time basis, information regarding the cancellation of policies of motor vehicle insurance, the issuance of new policies of motor vehicle insurance, and changes of vehicle on policies of motor vehicle insurance in force in order to verify compliance with the motor vehicle liability insurance requirements of section 1 of P.L1972, c.197 (C.39:6B-1), and the mandatory automobile insurance requirements of section 4 of P.L.1998, c.21 (C.39:6A-3.1). Information shall be maintained by driver's license number of the named insured. Other information to be provided by insurers shall be established by the director by regulation.

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

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

31. Section 1 of P.L.1970, c.215 (C.17:29D-1) is amended to read as follows:

C.17:29D-1 Rules, regulations for insurance plans; administration; requirements for automobile plan.

1. The Commissioner of Banking and Insurance may adopt, issue and promulgate rules and regulations establishing a plan for the providing and apportionment of insurance coverage for applicants therefor who are in good faith entitled to, but are unable to procure the same, through ordinary methods. Every insurer admitted to transact and transacting any line, or lines, of insurance in the State of New Jersey shall participate in such plan and provide insurance coverage to the extent required in such rules and regulations.

The governing board of any plan established pursuant to the commissioner's rules and regulations shall continue to exercise such administrative authority, subject to the commissioner's oversight and as provided in any rules and regulations promulgated pursuant to this section, as is necessary to ensure the plan's efficient operation, including, but not limited to, the authority to investigate complaints and hear appeals from applicants, insureds, producers, servicing carriers or participants about any matter pertaining to the plan's proper administration, as well as the authority to appoint subcommittees to hear such appeals. Any determination of an appeal by a plan's governing board shall be subject to review by the commissioner on the record below, and shall not be considered a contested case under the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The commissioner's determination shall be a final order and shall be subject to review by the Superior Court.

Any plan established pursuant to this section to provide insurance for automobiles, as defined

in section 2 of P.L.1972, c.70 (C.39:6A-2), shall provide:

a. For a rating system which shall produce rates for each coverage which are adequate for the safeness and soundness of the plan, and are not excessive nor unfairly discriminatory with regard to risks in the plan involving essentially the same hazards and expense elements, which rates may be changed from time to time by a filing with the commissioner in a manner and form approved by the commissioner;

b. For rates charged to plan insureds which shall be sufficient to meet the plan's expenses and the plan's losses on an incurred basis, including the establishment and maintenance of actuarially sound loss reserves to cover all future costs associated with the exposure;

c. For a limited assignment distribution system permitting insurers to enter into agreements with other mutually agreeable insurers or other qualified entities to transfer their applicants and insureds under such plan to such insurers or other entities;

d. That it shall not provide insurance coverage for more than 10 percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State. The plan shall provide for the cessation of the acceptance of applications or the issuance of new policies at any time it reaches 10 percent of marketshare, as certified by the commissioner, until such time that the commissioner certifies that the plan is insuring less than 10 percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State;

e. Except for risks written in automobile insurance urban enterprise zones pursuant to subsection i. of this section, that it shall not provide coverage to an eligible person as defined pursuant to section 25 of P.L.1990, c.8 (C.17:33B-13);

f. (Deleted by amendment, P.L.1997, c.151.)

g. That the plan shall not be subsidized by any source external to the plan;

h. That a qualified insurer who writes automobile insurance risks in those automobile insurance urban enterprise zones designated by the commissioner pursuant to section 20 of P.L.1997, c.151 (C.17:33C-2) shall receive assigned risk credits for voluntary risks written in those designated automobile insurance urban enterprise zones as a direct writer or through a UEZ agent or agents or through any agent with whom the insurer has an in-force contract as of the effective date of P.L.1997, c.151(C.17:33B-64 et al.). The commissioner shall establish by regulation the manner in which any qualified automobile insurer may utilize the provisions of this subsection. In no event shall that credit apply to reduce an insurer's obligations under subsection i. of this section; and

i. (1) For a voluntary rating tier to accommodate eligible persons, as defined in section 25 of P.L.1990, c.8 (C.17:33B-13), residing in automobile insurance urban enterprise zones, designated by the commissioner pursuant to section 20 of P.L.1997, c.151 (C.17:33C-2), to provide increased availability and encourage the voluntary writing of eligible persons residing in those zones;

(2) The rates utilized in this voluntary rating tier shall be the voluntary market rates in use by the insurer to whom the risk is assigned in that territory;

(3) The voluntary rating tier shall not provide insurance coverage for more than five percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State, and the number of exposures written in the voluntary rating tier shall be included for computing the maximum number of exposures permitted to be written in the plan;

(4) The plan shall distribute risks submitted by qualified producers to insurers authorized to write automobile insurance in this State pursuant to a fair and nondiscriminatory formula established by the commissioner. The formula shall provide that insurers which have, and maintain, an aggregate voluntary automobile insurance marketshare in automobile insurance urban enterprise zones, which is reasonably equal to the insurer's voluntary Statewide marketshare excluding risks written in automobile insurance urban enterprise zones, shall be exempt from these distributions;

(5) Qualified producers may submit eligible person risks from automobile insurance urban enterprise zones to the plan for coverage in the voluntary rating tier. As used in this subsection

i.: a "qualified producer" means a UEZ agent, as defined in section 19 of P.L.1997, c.151 (C.17:33C-1), who has met any limit on exposures that may be written in accordance with the UEZ agent's agreement with the appointing insurer pursuant to section 22 of P.L.1997, c.151 (C.17:33C-4); and a producer who: is duly licensed with property/casualty authority for the three years immediately preceding the effective date of P.L.1997, c.151 (C.17:33B-64 et al.); has no affiliation with a voluntary market insurer for the placement of automobile insurance; had an affiliation with a voluntary market insurer for the placement of automobile insurance that was terminated by the insurer in the last three years; demonstrates to the plan his competency, efficiency and effectiveness in the solicitation, negotiation and effectuation of automobile insurance as evidenced by any history of disciplinary actions or complaints against the producer, and other relevant factors; and conducts his business in an office in an automobile insurance urban enterprise zone. For purposes of this subsection i., 'insurer" means an insurer or group of affiliated insurers admitted or authorized to transact the business of automobile insurance in this State;

(6) This subsection shall expire on the first day of the 61st month after the first policy using the voluntary rating tier required by this subsection was issued to a risk, as certified by the commissioner.

Prior to the adoption or amendment of such rules and regulations, the commissioner shall consult with such members of the insurance industry as he deems appropriate. Such consultation shall be in addition to any otherwise required public hearing or notice with regard to the adoption or amendment of rules and regulations.

The governing body administering the plan shall report annually to the Legislature and the Governor on the activities of the plan. The report shall contain an actuarial analysis regarding the adequacy of the rates for each coverage for the safeness and soundness of the plan.

C.17:33A-16 Office of the Insurance Fraud Prosecutor.

32. There is established in the Division of Criminal Justice in the Department of Law and Public Safety the Office of the Insurance Fraud Prosecutor. The Insurance Fraud Prosecutor shall be appointed by, and serve at the pleasure of, the Governor with the advice and consent of the Senate and be under the direction and supervision of the Attorney General. Any person appointed as Insurance Fraud Prosecutor shall have had prosecutorial experience, including experience in the litigation of civil and criminal cases. The Attorney General shall establish standards of performance for the Office of Insurance Fraud Prosecutor, which shall include standards of accountability.

C.17:33A-17 Appointment; transfer of personnel.

33. The Attorney General may appoint such personnel, including attorneys and clerical personnel, as necessary to carry out the duties of the office. The personnel charged with investigatory work in the Division of Insurance Fraud Prevention in the Department of Banking and Insurance shall be transferred to the Office of the Insurance Fraud Prosecutor as determined by the Commissioner of Banking and Insurance and the Attorney General, in accordance with a plan of reorganization, and shall become the Fraud Investigatory Section of the Office of the Insurance Fraud Prosecutor. Personnel transferred from the Division of Insurance Fraud Prevention in the Department of Banking and Insurance to the Office of the Insurance Fraud Prosecutor pursuant to this section and any such reorganization plan shall be transferred with all tenure rights and any rights or protections provided by Title 11A of the New Jersey Statutes or other applicable statutes, as provided in section 8 of P.L.1983, c.320 (C.17:33A-8), and any pension law or retirement system.

C.17:33A-18 Establishment of liaison between office, other departments; responsibilities.

34. a. A section of the Office of Insurance Fraud Prosecutor shall be designated to be responsible for establishing a liaison and continuing communication between the office and the Department of Health and Senior Services, the Department of Human Services, any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police, every county prosecutor’s

office, such local government units as may be necessary or practicable and insurers.

b. The section of the office responsible for such liaison shall establish procedures: (1) for receiving notice from all entities enumerated in subsection a. of this section of any case in which fraud is suspected or has been substantiated; (2) for receiving referrals for the investigation of alleged fraud; (3) for receiving referrals for the prosecution of fraud by the office; (4) for receiving and referring information regarding cases, administrative or otherwise, under investigation by any department or other entity to the appropriate authority; and (5) for providing information to and coordinating information among any referring entities on pending cases of insurance fraud which are under investigation or being litigated or prosecuted. The liaison section of the office shall maintain a record of every referral or investigation.

C.17:33A-19 Duties of Insurance Fraud Prosecutor.

35. The Insurance Fraud Prosecutor shall investigate and, if warranted, prosecute, cases referred to it by insurers, State agencies, or county and municipal governments. The Insurance Fraud Prosecutor may assist county prosecutors in the investigation and prosecution of fraud, and shall give county prosecutors access to the data base maintained pursuant to section 38 of this amendatory and supplementary act.

C.17:33A-20 Establishment of Statewide fraud enforcement policy.

36. The Attorney General shall, in consultation with county prosecutors, establish a Statewide fraud enforcement policy for all State and local agencies, including guidelines for the investigation and prosecution of fraud, which shall include standards for detecting fraud, for the investigation of alleged fraud and standards for the submission of cases for prosecution. Priorities shall be established among the cases referred to the office for prosecution or other litigation and the office shall assist referring entities in establishing priorities among investigations or cases to be disposed of by the entities themselves. The Insurance Fraud Prosecutor shall prosecute criminal cases, litigate civil cases as appropriate, or assist county prosecutors in prosecuting criminal cases in accordance with the guidelines and priorities so established.

C.37:33A-21 Standards of performance for Fraud Investigatory Section.

37. Standards of performance shall be established for the Fraud Investigatory Section, which shall include, but not be limited to, recording the cases referred by insurers, local government agencies and others which are assigned to the Fraud Investigatory Section, investigating cases of alleged fraud in accordance with the priorities established by the Insurance Fraud Prosecutor, recording the disposition of the cases referred to the section, and making recommendations to the Insurance Fraud Prosecutor as to any procedural, regulatory, or statutory changes which may be necessary to carry out the provisions of this amendatory and supplementary act.

C.17:33A-22 Maintenance of data base; reporting of claims information.

38. a. The Insurance Fraud Prosecutor shall maintain a data base which includes referrals, reports of fraud investigations, prosecution, or litigation, and the results of such proceedings, which shall include: (1) identification of the referring entity; (2) type of fraud; (3) disposition of case; and (4) such other data as may be necessary to the work of the office and the referring entities.

b. The Insurance Fraud Prosecutor shall provide for the reporting of claims information by insurers writing at least $2,000,000 in direct insurance premiums in any calendar year, in a standard reporting form, which shall include, but shall not be limited to, information on stolen vehicles, including the owners of such vehicles, information on automobile accidents, including date and location of accidents, persons involved in accidents, the kinds of injuries sustained in accidents and treating health care providers, for the purpose of identifying patterns of possible fraudulent activity, which information shall be shared with county prosecutors, local law enforcement officials, and the New Jersey State Police. Every insurer shall submit the data required by the Insurance Fraud Prosecutor for all claims closing with payment during a period established by the Insurance Fraud Prosecutor.

C.17:33A-23 Access to information provided to Insurance Fraud Prosecutor.

39. The Insurance Fraud Prosecutor shall have access to all necessary information in the possession of the State or local public entities, including agency inspection reports, motor vehicle records and license information, individual case files, and intelligence information compiled and maintained by the Division of State Police in the Department of Law and Public Safety. Upon the request of the Insurance Fraud Prosecutor, any insurer which has referred a case to the Insurance Fraud Prosecutor or to any county or local government agency shall make available to the Office of the Insurance Fraud Prosecutor all information on the case in the insurer's possession.

C.17:33A-24 Additional duties of office; annual report.

40. The Attorney General shall direct the Office of the Insurance Fraud Prosecutor to:

a. Confer from time to time with departments or other units of State government which have units which investigate fraud, in order to coordinate activities, share information, and provide any assistance necessary to any State agency in overseeing administrative enforcement activities;

b. Formulate and evaluate proposals for legislative, administrative and judicial initiatives to strengthen insurance fraud enforcement;

c. In connection with insurance fraud enforcement activities, act as the liaison for the Executive Branch of government with agencies involved in insurance fraud enforcement outside the Executive Branch, including federal agencies and the Judiciary;

d. Provide an annual report to the Governor and the Legislature, no later than March 1 of each year, as to the activities of the Insurance Fraud Prosecutor for the preceding twelve months, including, but not limited to, the number of cases referred, the number of cases investigated, the number of cases in which professional licenses were suspended or revoked, by type of license, the number of cases prosecuted, the number of convictions procured, and the aggregate amount of money collected in fines and returned in restitution to insurers or others.

C.17:33A-25 Recommendation for suspension, revocation of professional license.

41. In the case of a professional licensed or certified by a professional licensing board in the Division of Consumer Affairs in the Department of Law and Public Safety who is guilty of fraud, the Insurance Fraud Prosecutor may recommend to the appropriate board a suspension or revocation of the professional license.

C.17:33A-26 Restitution; seizure of assets.

42. The Insurance Fraud Prosecutor shall consider the restitution of moneys to insurers and others who are defrauded as a major priority, in order that policyholders may benefit from the prosecution of those persons guilty of insurance fraud, and to that end, any assets of any person guilty of fraud shall be subject to seizure.

C.17:33A-27 Specific goals, strategies.

43. The Insurance Fraud Prosecutor shall have access to all information concerning insurance fraud enforcement activities in the possession of all State departments and agencies. The office shall meet on a regular basis with representatives of State departments and agencies and county prosecutors to set specific goals and strategies for the most effective resolution of insurance fraud cases, whether by criminal, civil, or administrative enforcement action, or a combination thereof.

C.17:33A-28 Application for reimbursement.

44. Any county prosecutor may apply to the Office of the Insurance Fraud Prosecutor for reimbursement for activities undertaken in connection with investigating and prosecuting insurance fraud. The Attorney General shall allocate such funds as he deems necessary from such moneys as may be appropriated for the operation of the Office of the Insurance Fraud Prosecutor to a fund dedicated for the purpose of reimbursing county prosecutors or sharing in fines levied by the Attorney General, which reimbursement or sharing may be made by the Attorney General at his discretion.

C.17:33A-29 Provision of information from accident report.

45. Every state and local law enforcement agency, including the New Jersey State Police, shall make available to investigators employed by insurers, upon presentation of appropriate identification, information from any accident report, as set forth in this section, no later than 24 hours following the time of occurrence. The information may include, but need not be limited to, the names and addresses of the owners of the vehicles, insurance information recorded on the accident report, and the names and addresses of passengers in the vehicles at the time of the occurrence and, if applicable, the name of any pedestrian injured in an accident. Every accident report form shall contain the names and addresses of any person occupying a vehicle involved in an accident, and any pedestrian injured in an accident.

C.17:33A-30 Certification of amount allocable to office expenses.

46. The Attorney General shall annually, on or before October 1, certify to the State Treasurer an amount allocable to the expenses of the Office of the Insurance Fraud Prosecutor for the preceding fiscal year, which amount shall be transferred to the Department of Law and Public Safety by the State Treasurer from the amounts assessed and collected for the operation of the Division of Insurance Fraud Prevention in the Department of Banking and Insurance pursuant to section 8 of P.L.1983, c.320 (C.17:33A-8).

C.17:29E-1 Definitions relevant tot he Insurance Claims Ombudsman.

47. For the purposes of sections 48 through 61 of this amendatory and supplementary act:

"Commissioner" means the Commissioner of Banking and Insurance;

"Claim" means any claim filed under a policy of insurance issued pursuant to R.S.17:17-1, P.L.1972, c.70 (C.39:6A-1 et seq.) or any policy of life or health insurance issued pursuant to Title 17 of the Revised Statutes or Title 17B of the New Jersey Statutes;

"Insurance" means any contract of direct insurance written pursuant to R.S.17:17-1, P.L.1972, c.70 (C.39:6A-1 et seq.) or any policy of life or health insurance issued pursuant to Title 17 of the Revised Statutes or Title 17B of the New Jersey Statutes;

"Ombudsman" means the Insurance Claims Ombudsman appointed pursuant to section 48 of this amendatory and supplementary act.

C.17:29E-2 Office of the Insurance Claims Ombudsman.

48. There is created within the Department of Banking and Insurance the Office of the Insurance Claims Ombudsman. The ombudsman shall be appointed by the Governor with the advice and consent of the Senate and shall serve at the pleasure of the Governor during the Governor's term of office. The ombudsman shall devote his entire time to the duties of his office. Any vacancy occurring in the position of ombudsman shall be filled in the same manner as the original appointment. If the ombudsman shall be unable for any reason to serve his full term of office, the Governor may designate an acting ombudsman until a successor is appointed and qualified. The ombudsman shall have at least a baccalaureate degree and at least seven years' experience in property and casualty or life and health insurance, which may include experience as a broker or an agent.

C.17:29E-3 Duties of ombudsman.

49. The ombudsman shall:

a. Administer and organize the work of the office and hire such persons as shall be deemed necessary to effectuate his duties, subject to Title 11A (Civil Service) of the New Jersey Statutes, and within the limits of funds made available by the Department of Banking and Insurance;

b. Appoint and employ attorneys, in accordance with any applicable law, regulation or executive order, and any consultants, independent adjusters, claims specialists or others for the purpose of providing professional advice as the ombudsman may from time to time require, within the limits of the funds provided therefor;

c. Investigate consumer complaints regarding policies of insurance, including the payment of claims on policies of insurance;

d. Establish procedures to monitor the implementation of P.L.1985, c.179 (C.17:23A-1 et seq.), P.L.1947, c.379 (C.17:29B-1 et seq.), P.L.1982, c.95 (C.17:35C-1 et seq.) and chapter 30 of Title 17B of the New Jersey Statutes and investigate violations of section 8 of P.L.1992, c.144 (C.17:35C-11).

e. Respond to inquiries from consumers, including, but not limited to, those regarding policy provisions and the availability of coverage;

f. Publish and disseminate buyers' guides and, where provided by law, comparative rates; provided, however, that this shall not apply to any policy of health insurance issued pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or P.L.1992, c.162 (C.17B:27A-17 et seq.);

g. Review conduct of arbitrators appointed under the terms of the policy to arbitrate disputes, except policies issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.);

h. Promulgate such rules and regulations as shall be necessary to effectuate the purposes of sections 48 through 61 of this amendatory and supplementary act; and

i. Perform such other functions as may be prescribed by this or by any other law or regulation.

C.17:29E-4 Application for review of claims settlement; exemptions.

50. Any person who: a. has reasonable cause to believe that an insurer has failed or refuses to settle a claim in accordance with the provisions of the insurance contract or engaged in any practice in violation of the provisions of P.L.1985, c.179 (C.17:23A-1 et seq.), P.L.1947, c.379 (C.17:29B-1 et seq.), P.L.1982, c.95 (C.17:35C-1 et seq.), chapter 30 of Title 17B of the New Jersey Statutes or section 8 of P.L.1992, c.144 (C.17:35C-11); and, in the case of disputed claims, b. has previously filed an appeal with the insurer's internal appeals procedure established pursuant to section 55 of this amendatory and supplementary act, which has been adjudicated, or other dispute resolution procedure established pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), P.L.1997, c.192 (C.26:2S-1 et seq.), or sections 1 through 12 of P.L.1983, c.358 (C.39:6A-24 through 39:6A-35, inclusive) may file an application with the ombudsman for a review of the claims settlement. Any disputes which may be or have been filed or adjudicated pursuant to sections 24 and 25 of P.L.1998, c.21 (C.39:6A-5.1 and C.39:6A-5.2) shall not be subject to the ombudsman's review.

C.17:29E-5 Powers of ombudsman involving disputed claim.

51. In any investigation involving a disputed claim, the ombudsman may:

a. Investigate whether the claims settlement was appropriate and in accordance with the contract;

b. Make the necessary inquiries and obtain such information as he deems necessary;

c. Hold a hearing on the disputed claim;

d. Inspect any books or records which are relevant to the claim;

e. Compel any person to produce at a specific time and place, by subpoena, any documents, books, records, papers, objects or other evidence which he believes may relate to a claim under investigation.

C.17:29E-6 Refusal of ombudsman to investigate complaint; grounds.

52. The ombudsman need not investigate any complaint if he determines that:

a. The complaint is trivial, frivolous, vexatious or not made in good faith;

b. The complaint has been too long delayed to justify present investigation;

c. The resources available, considering the established priorities, are insufficient for an adequate investigation; or

d. The matter complained of is not within the investigatory authority of the office.

C.17:29E-7 Maintenance of central registry of claims investigations; reports.

53. The ombudsman shall maintain a central registry of all claims investigations which have been disposed of and closed, the nature of the investigation, findings, and recommended actions. No information so compiled shall be construed to be a public record. In addition, the ombudsman shall:

a. Report to the commissioner any evidence that an insurer has established a pattern of settlement practices which would constitute an unfair claims settlement practice within the meaning of P.L.1947, c.379 (C.17:29B-1 et seq.) or any violations of P.L.1985, c.179 (C.17:23A-1 et seq.), P.L.1947, c.379 (C.17:29B-1 et seq.), P.L.1982, c.95 (C.17:35C-1 et seq.) chapter 30 of Title 17B of the New Jersey Statutes or section 8 of P.L.1992, c.144 (C.17:35C-11);

b. Report to the commissioner any contract provision, including any endorsements, which are unfairly discriminatory, confusing, misleading or contrary to public policy, along with a recommendation as to whether the policy form should be modified or withdrawn.

C.17:29E-8 Powers relative to trade, marketing practices.

54. With respect to trade or marketing practices, the ombudsman may:

a. Conduct an investigation regarding an insurer's trade practices, including claims settlement practices and marketing practices;

b. Make the necessary inquiries and obtain such information as he deems necessary;

c. Hold a hearing;

d. Inspect any books or records which may be necessary for the investigation;

e. Compel any person to produce at a specific time and place, by subpoena, any documents, books, records, papers, objects or other evidence which he believes may relate to the investigation.

The ombudsman shall report his findings to the commissioner with respect to the trade practices or marketing practices under investigation.

C.17:29E-9 Insurer to establish internal appeals procedure.

55. Every insurer writing property and casualty insurance or life insurance in this State shall establish an internal appeals procedure for the review of disputed claims, in accordance with terms set forth by the commissioner by rule and regulation or as otherwise provided by law or regulation. The review shall be conducted by a panel of the insurer's employees, who shall be personnel other than those responsible for claims payment on a day-to-day basis and shall be conducted within 10 business days of the receipt of the complaint.

C.17:29E-10 Form for filing complaints; recommendation of ombudsman.

56. Complaints shall be filed on a form set forth by the ombudsman. The office of the ombudsman shall acknowledge the receipt of complaints, and advise the applicants of any action taken or opinions and recommendations which may have been made by it to the insurer. The ombudsman shall make recommendations to the commissioner as he deems necessary, including, but not limited to:

a. A recommendation that a policy form or endorsement thereon which he finds unfairly discriminatory, misleading or contrary to public policy be modified;

b. A recommendation that specific rules and regulations promulgated by the commissioner, including rules concerning trade practices and claims settlement practices, be modified or repealed;

c. A recommendation that the claims settlement practices of a specific insurer or insurers be further investigated by the commissioner;

d. A recommendation that the commissioner impose penalties or other sanctions against an insurer or insurers as a result of the insurer's claims settlement practices.

C.17:29E-11 Publicizing of information pertaining to ombudsman.

57. Every buyer's guide which is required to be provided to insureds for any line of insurance shall contain a notice describing the functions of the ombudsman, the mailing address of the ombudsman, and a toll-free information telephone number. The ombudsman may publicize his existence, function and activities to the public at large.

C.17:29E-12 Confidentiality of information; privilege.

58. a. Any correspondence or written communication from any complainant and any written

material submitted by an insurer shall remain confidential and shall not be part of any public record, unless the parties authorize, in writing, the release of the information, or except for such disclosures as may be necessary to enable the ombudsman to perform his duties and to support any opinions or recommendations or as may be necessary to enable the commissioner to perform any function authorized by law.

b. Any person conducting or participating in any investigation of a complaint who discloses to any person, other than the office of the ombudsman or the Department of Banking and Insurance, or those authorized by the ombudsman or the commissioner to receive it, any information collected during the investigation, is guilty of a disorderly person's offense.

c. Any statement or communication made by the office of the ombudsman relevant to a complaint received by the ombudsman, to proceedings conducted either by the ombudsman or by or on behalf of the commissioner, or relating to an investigation conducted by the ombudsman, which is provided to the office in good faith, shall be absolutely privileged.

d. The ombudsman shall not be required to testify in court with respect to matters held to be confidential except as the court may deem necessary to enforce the provisions of sections 48 through 61 of this amendatory and supplementary act or as the commissioner may deem necessary in conjunction with the execution of any power of the commissioner authorized by law.

e. Nothing in this section shall be deemed to limit the disclosure of information to law enforcement and regulatory agencies.

C.17:29E-13 Notification of disposition of claim; admissibility.

59. Upon making his determination as to the appropriate disposition of a claim, the ombudsman shall notify the insurer and the claimant of his decision. The decision shall be admissible in any court action or any other proceeding which is instituted to determine final disposition of the claim. The ombudsman may file a brief with the court in connection with an action relating to the disposition of a claim.

C.17:29E-14 Violations, penalties.

60. Any person who willfully hinders the lawful actions of the ombudsman or willfully refuses to comply with his lawful demands, including the demand for the inspection of records, shall be subject to a penalty of not more than $5,000. The penalty shall be collected and enforced by summary proceedings pursuant to "the penalty enforcement law," N.J.S.2A:58-1 et seq. Each violation of sections 48 through 61 of this amendatory and supplementary act shall constitute a separate offense. Notwithstanding any other provision of law to the contrary, no investigation or determination made by the ombudsman shall be dispositive of a violation of P.L.1960, c.39 (C.56:8-1 et seq.) but may be considered relevant in determining whether a violation of such act has occurred.

C.17:29E-15 Annual report to Governor, Legislature.

61. The ombudsman shall report to the Governor and the Legislature on or before September 30 of each year, summarizing his activities for the preceding year, documenting any significant insurance industry problems with regard to claims settlement practices in any line of insurance, and setting forth any recommendations for statutory or regulatory change which will further the State's capacity to resolve claims disputes.

62. Section 4 of P.L.1968, c.158 (C.17:29C-9) is amended to read as follows:

C.17:29C-9 Intention not to renew, notice required.

4. No insurer shall fail to renew a policy unless it shall mail or deliver to the named insured, at the address shown in the policy, at least 60 days' advance notice of its intention not to renew. This section shall not apply:

(a) If the insurer has manifested its willingness to renew; nor

(b) In case of nonpayment of premium;

provided that, notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile

designated in both policies.

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

C.17:28-8 Filing of endorsement to automobile liability insurance policy; "named excluded driver"; rules, regulations.

63. a. An insurer authorized to transact or transacting automobile insurance business in this State shall file with the commissioner, for the commissioner's approval, an endorsement to its automobile liability insurance policy which contains a "named excluded driver" provision that would exclude physical damage coverage on an automobile covered by an automobile liability insurance policy if it is operated by the "named excluded driver." For purposes of this section, "named excluded driver" means a driver in the household of the named insured who is specifically identified in the endorsement as a person whose operation of an automobile covered under the automobile liability insurance policy at the time of an accident would result in the denial of a physical damage claim for that automobile.

b. The premium charged for the physical damage coverage on a policy containing a "named excluded driver" endorsement shall not reflect the claim experience or driving record of the "named excluded driver" or drivers.

c. Election of a "named excluded driver" endorsement shall be in writing and signed by the named insured on a form prescribed by the commissioner. The "named excluded driver" endorsement shall continue in force as to subsequent renewal or replacement policies until the insurer or its authorized representative receives a properly executed form electing to discontinue the endorsement.

d. Notwithstanding any other provision of the law to the contrary, no person, including, but not limited to, an insurer or an insurance producer, shall be liable in an action for damages on account of the election of a "named excluded driver" endorsement.

e. The commissioner may promulgate rules and regulations necessary to implement the provisions of this section.

C.17:33B-36.1 Selection of auto body repair shop; notification form.

64. If an insurer has a financial arrangement with one or more auto body repair shops or other repair facilities or a network of facilities for the purpose of repairing vehicles covered under physical damage, collision, or comprehensive coverages, the insurer shall not deny a person the right to select an auto body repair shop or other repair facility of his choice for repair of a covered vehicle, provided that such auto body repair shop or other repair facility elected by the person accepts the same terms and conditions from the insurer, including, but not limited to, price, as the shop, facility, or network with which the insurer has the most generous arrangement. Prior to undertaking any repair, the auto body repair shop or other repair facility of the insured's choice shall provide the insured with written notification, in a form to be established by the Commissioner of the Department of Banking and Insurance by regulation, that, by agreeing to have the auto body shop or other repair facility of the insured's choice accept the same terms and conditions from the insurer as the shop, facility or network with which the insurer has the most generous arrangement, the insured may jeopardize any manufacturer or dealer warranty or lease agreement. Such notification form shall be signed by the insured prior to the undertaking of any repair.

C.17:29A-5.17 Review of filing; "qualified independent actuary" defined.

65. a. The Commissioner of Banking and Insurance may, in connection with any profits report made under P.L.1988, c.118 (C.17:29A-5.6 et seq.), require a review of all or part of the filing by a qualified independent actuary, including, but not limited to, the filer’s assumptions with respect to the development of losses or loss adjustment expenses developed to an ultimate basis, allowance for profit and contingencies and anticipated investment income.

b. For the purposes of this section, “qualified independent actuary” means a person or firm with annual billings of at least $5,000,000, who has not worked for the insurer or filer whose filing is under review during the previous three-year period.

C.17:29A-46.8 Definitions; standards for interventions in rate filings; offenses.

66. a. For the purposes of this section:

"Qualified person" means a person qualified by the Commissioner of Banking and Insurance to intervene in public hearings pursuant to this section, who shall be deemed a "public servant" within the meaning of N.J.S.2C:30-2;

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

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

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

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

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

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

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

h. A person commits a crime of the third degree if he solicits, accepts or agrees to accept any benefits as consideration for knowingly violating or agreeing to violate a duty of fidelity to which he is subject pursuant to this section. In addition to any disposition authorized by law, the Commissioner of Banking and Insurance shall forever bar from registration as an intervenor any person convicted under this subsection.

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

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

C.17:29A-51 Filing of rates by insurer writing private passenger automobile insurance; rate reductions.

67. a. Except for the plan established pursuant to section 1 of P.L.1970, c.215 (C.17:29D-1), every insurer writing private passenger automobile insurance in this State pursuant to P.L.1972,

c.70 (C.39:6A-1 et seq.) shall file rates with the Commissioner of Banking and Insurance which result in:

(1) a reduction of at least 25% from the personal injury protection territorial base rate applicable to medical expense benefits, at least 10% of which shall reflect a reduction in the actuarial value of the medical expense benefits provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), within the policy limits provided for in that section;

(2) a reduction of at least 22% in the territorial base rate for bodily injury liability coverage applicable to named insureds to whom the Limitation on Lawsuit Option provided for in subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8) applies;

(3) a reduction of at least 6% in the territorial base rate for collision coverage which shall reflect the provisions of section 64 of this amendatory and supplementary act; and

(4) after the reductions required pursuant to paragraphs (1), (2) and (3) of this subsection have been applied, an additional aggregate reduction of at least 3% in the territorial base rates for personal injury protection, bodily injury, property damage, comprehensive and collision coverages, as apportioned by the insurer and approved by the commissioner, which reduction is attributable to the effect of the enhanced insurance fraud provisions of this amendatory and supplementary act and of other such laws including, but not limited to P.L.1997, c.353 (C.2C:21-4.2 et seq.) and P.L.1997, c.151 (C.17:33B-64 et al.).

b. The rate filings reflecting these reductions shall apply to policies issued or renewed on or after 90 days following:

(1) the establishment by the commissioner of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4); or

(2) the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of P.L.1998, c.21 (C.39:6A-4.7);

whichever is later.

68. Section 3 of P.L.1991, c.154 (C.17:28-1.7) is amended to read as follows:

C.17:28-1.7 Exemption from tort liability for owner, registrant, operator of motor bus.

3. Every owner, registrant or operator of a motor bus registered or principally garaged in this State and every person or organization legally responsible for his acts or omissions, is hereby exempted from tort liability for noneconomic loss to a passenger who has a right to receive benefits under section 2 of this act as a result of bodily injury arising out of the ownership, operation, maintenance or use of a motor bus in this State, unless that person has sustained a personal injury which results in death; dismemberment; significant disfigurement or significant scarring; displaced fractures; loss of a fetus; or a permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement. An injury shall be considered permanent when the body part or organ, or both, has not healed to function normally and will not heal to function normally with further medical treatment. For the purposes of this subsection, "physician" means a physician as defined in section 5 of P.L.1939, c.115 (C.45:9-5.1).

In order to satisfy the provisions of this section, the plaintiff shall, within 60 days following the date of the answer to the complaint by the defendant, provide the defendant with a certification from the licensed treating physician or a board-certified licensed physician to whom the plaintiff was referred by the treating physician. The certification shall state, under penalty of perjury, that the plaintiff has sustained an injury described above. The certification shall be based on and refer to objective clinical evidence, which may include medical testing, except that any such testing shall be performed in accordance with medical protocols pursuant to subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4) and the use of valid diagnostic tests administered in accordance with section 12 of P.L.1998, c.21 (C.39:6A-4.7). Such testing may not be experimental in nature or dependent entirely upon subjective patient response. The court may grant no more than one additional period not to exceed 60 days to file the certification pursuant to this section upon a finding of good cause.

A person is guilty of a crime of the fourth degree if that person purposefully or knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material

fact in, or omits a material fact from, or causes a material fact to be omitted from, any certification filed pursuant to this section. Notwithstanding the provisions of subsection e. of N.J.S. 2C:44-1, the court shall deal with a person who has been convicted of a violation of this section by imposing a sentence of imprisonment unless, having regard to the character and condition of the person, the court is of the opinion that imprisonment would be a serious injustice which overrides the need to deter such conduct by others. If the court imposes a noncustodial or probationary sentence, such sentence shall not become final for 10 days in order to permit the appeal of such sentence by the prosecution. Nothing in this section shall preclude an indictment and conviction for any other offense defined by the laws of this State. In addition, any professional license held by the person shall be forfeited according to the procedures established by section 4 of P.L.1997, c.353 (C.2C:51-5).

69. Section 2 of P.L.1977, c.310 (C.39:6-73.1) is amended to read as follows:

C.39:6-73.1 Assumption of excess payment by fund; exceptions.

2. In the event medical expense benefits paid by an insurer, in accordance with subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L.1998, c.21 (C.39:6A-3.1), are in excess of $75,000.00 on account of personal injury to any one person in any one accident, the Unsatisfied Claim and Judgment Fund shall assume such excess up to $250,000 and reimburse the insurer therefor in accordance with rules and regulations promulgated by the commissioner; provided, however, that this provision is not intended to broaden the coverage available to accidents involving uninsured or hit-and-run automobiles, to provide extraterritorial coverage, or to pay excess medical expenses.

70. Section 13 of P.L.1995, c.156 (C.17:1C-31) is amended to read as follows:

C.17:1C-31 Permitted increase in amount assessable.

13. The total amount assessable to companies in any fiscal year for all special purpose assessments made pursuant to applicable law as of the effective date of this act, including the special purpose apportionment established by this act, shall not increase, as a percentage, more than the percentage increase in the combined net written premiums received, as defined in subsection b. of section 2 of this act, by all companies for the previous year, except that, with respect to fiscal year 1998 and each fiscal year thereafter, the total amount of all direct and indirect expenditures incurred by the Division of Insurance Fraud Prevention, the Office of the Insurance Fraud Prosecutor and the Office of the Insurance Claims Ombudsman shall be included in the special purpose apportionment, notwithstanding any limitation on the total amount assessable to companies under this section. With respect to each fiscal year after 1999, the total amount assessable to companies in any fiscal year for all special purpose assessments individually allocable to the direct and indirect expenditures incurred by the Division of Insurance Fraud Prevention, the Office of the Insurance Fraud Prosecutor and the Office of the Insurance Claims Ombudsman, respectively, shall not increase, as a percentage, more than the percentage increase in the combined net written premiums received, as defined in subsection b. of section 2 of this act, by all companies for the previous year.

71. Section 2 of P.L.1968, c.385 (C.17:28-1.1) is amended to read as follows:

C.17:28-1.1 Required coverage; exceptions.

2. a. Except for a basic automobile insurance policy, no motor vehicle liability policy or renewal of such policy of insurance, including a standard liability policy for an automobile as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), insuring against loss resulting from liability imposed by law for bodily injury or death, sustained by any person arising out of the ownership, maintenance or use of a motor vehicle, shall be issued in this State with respect to any motor vehicle registered or principally garaged in this State unless it includes coverage in limits for bodily injury or death as follows:

(1) an amount or limit of $15,000.00, exclusive of interest and costs, on account of injury

to, or death of, one person, in any one accident, and

(2) an amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to or death of more than one person, in any one accident, under provisions approved by the Commissioner of Banking and Insurance, for payment of all or part of the sums which the insured or his legal representative shall be legally entitled to recover as damages from the operator or owner of an uninsured motor vehicle, or hit and run motor vehicle, as defined in section 18 of P.L.1952, c.174 (C.39:6-78), because of bodily injury, sickness or disease, including death resulting therefrom, sustained by the insured, caused by accident and arising out of the ownership, maintenance, operation or use of such uninsured or hit and run motor vehicle anywhere within the United States or Canada; except that uninsured motorist coverage shall provide that in order to recover for non-economic loss, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), for accidents to which the benefits of section 4 (C.39:6A-4) of that act apply, the tort option elected pursuant to section 8 (C.39:6A-8) of that act shall apply to that injured person.

All motor vehicle liability policies, except basic automobile insurance policies, shall also include coverage for the payment of all or part of the sums which persons insured thereunder shall be legally entitled to recover as damages from owners or operators of uninsured motor vehicles, other than hit and run motor vehicles, because of injury to or destruction to the personal property of such insured, with a limit in the aggregate for all insureds involved in any one accident of $5,000.00, and subject, for each insured, to an exclusion of the first $500.00 of such damages.

b. Uninsured and underinsured motorist coverage shall be provided as an option by an insurer to the named insured electing a standard automobile insurance policy up to at least the following limits: $250,000.00 each person and $500,000.00 each accident for bodily injury; $100,000.00 each accident for property damage or $500,000.00 single limit, subject to an exclusion of the first $500.00 of such damage to property for each accident, except that the limits for uninsured and underinsured motorist coverage shall not exceed the insured's motor vehicle liability policy limits for bodily injury and property damage, respectively.

Rates for uninsured and underinsured motorist coverage for the same limits shall, for each filer, be uniform on a Statewide basis without regard to classification or territory.

c. Uninsured and underinsured motorist coverage provided for in this section shall not be increased by stacking the limits of coverage of multiple motor vehicles covered under the same policy of insurance nor shall these coverages be increased by stacking the limits of coverage of multiple policies available to the insured. If the insured had uninsured motorist coverage available under more than one policy, any recovery shall not exceed the higher of the applicable limits of the respective coverages and the recovery shall be prorated between the applicable coverages as the limits of each coverage bear to the total of the limits.

d. Uninsured and underinsured motorist coverage shall be subject to the policy terms, conditions and exclusions approved by the Commissioner of Banking and Insurance, including, but not limited to, unauthorized settlements, nonduplication of coverage, subrogation and arbitration.

e. For the purpose of this section, (1) "underinsured motorist coverage" means insurance for damages because of bodily injury and property damage resulting from an accident arising out of the ownership, maintenance, operation or use of an underinsured motor vehicle. Underinsured motorist coverage shall not apply to an uninsured motor vehicle. A motor vehicle is underinsured when the sum of the limits of liability under all bodily injury and property damage liability bonds and insurance policies available to a person against whom recovery is sought for bodily injury or property damage is, at the time of the accident, less than the applicable limits for underinsured motorist coverage afforded under the motor vehicle insurance policy held by the person seeking that recovery. A motor vehicle shall not be considered an underinsured motor vehicle under this section unless the limits of all bodily injury liability insurance or bonds applicable at the time of the accident have been exhausted by payment of settlements or judgments. The limits of underinsured motorist coverage available to an injured person shall be reduced by the amount he has recovered under all bodily injury liability insurance or bonds;

(2) "uninsured motor vehicle" means:

(a) a motor vehicle with respect to the ownership, operation, maintenance, or use of which there is no bodily injury liability insurance or bond applicable at the time of the accident;

(b) a motor vehicle with respect to the ownership, operation, maintenance, or use of which there is bodily injury liability insurance in existence but the liability insurer denies coverage or is unable to make payment with respect to the legal liability of its insured because the insurer has become insolvent or bankrupt, or the Commissioner of Banking and Insurance has undertaken control of the insurer for the purpose of liquidation; or

(c) a hit and run motor vehicle as described in section 18 of P.L.1952, c.174 (C.39:6-78).

"Uninsured motor vehicle" shall not include an automobile covered by a basic automobile insurance policy; an underinsured motor vehicle; a motor vehicle owned by or furnished for the regular use of the named insured or any resident of the same household; a self-insurer within the meaning of any financial responsibility or similar law of the state in which the motor vehicle is registered or principally garaged; a motor vehicle which is owned by the United States or Canada, or a state, political subdivision or agency of those governments or any of the foregoing; a land motor vehicle or trailer operated on rails or crawler treads; a motor vehicle used as a residence or stationary structure and not as a vehicle; or equipment or vehicles designed for use principally off public roads, except while actually upon public roads.

72. Section 18 of P.L.1985, c.520 (C.17:28-1.4) is amended to read as follows:

C.17:28-1.4 Mandatory coverage.

18. Any insurer authorized to transact or transacting automobile or motor vehicle insurance business in this State, or controlling or controlled by, or under common control by, or with, an insurer authorized to transact or transacting insurance business in this State, which sells a policy providing automobile or motor vehicle liability insurance coverage, or any similar coverage, in any other state or in any province of Canada, shall include in each policy coverage to satisfy at least the personal injury protection benefits coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or section 19 of P.L.1983, c.362 (C.17:28-1.3) for any New Jersey resident who is not required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L.1998, c.21 (C.39:6A-3.1) and who is not otherwise eligible for such benefits, whenever the automobile or motor vehicle insured under the policy is used or operated in this State. In addition, any insurer authorized to transact or transacting automobile or motor vehicle insurance business in this State, or controlling or controlled by, or under common control by, or with, an insurer authorized to transact or transacting automobile or motor vehicle insurance business in this State, which sells a policy providing automobile or motor vehicle liability insurance coverage, or any similar coverage, in any other state or in any province of Canada, shall include in each policy coverage to satisfy at least the liability insurance requirements of subsection a. of section 1 of P.L.1972, c.197 (C.39:6B-1) or section 3 of P.L.1972, c.70 (C.39:6A-3), the uninsured motorist insurance requirements of subsection a. of section 2 of P.L.1968, c.385 (C.17:28-1.1), and personal injury protection benefits coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or of section 19 of P.L.1983, c.362 (C.17:28-1.3), whenever the automobile or motor vehicle insured under the policy is used or operated in this State.

Any liability insurance policy subject to this section shall be construed as providing the coverage required herein, and any named insured, and any immediate family member as defined in section 14.1 of P.L.1983, c.362 (C.39:6A-8.1), under that policy, shall be subject to the tort option specified in subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8).

Each insurer authorized to transact or transacting automobile or motor vehicle insurance business in this State and subject to the provisions of this section shall file and maintain with the Department of Banking and Insurance written certification of compliance with the provisions of this section.

"Automobile" means an automobile as defined in section 2 of P.L.1972, c.70 (C.39:6A-2).

C.39:6A-1.2 Rules, regulations.

73. The commissioner may promulgate any rules and regulations pursuant to P.L.1968, c.410

(C.52:14B-1 et seq.) deemed necessary in order to effectuate the provisions of this amendatory and supplementary act.

74. a. This act shall take effect 90 days following the establishment by the Commissioner of Banking and Insurance of basic benefits required to be provided pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) or the adoption by rule of the professional boards of the designation of valid diagnostic tests pursuant to the provisions of section 12 of this act, whichever is later, except that: (1)sections 47 through 61 shall take effect on the 90th day after the date of enactment; (2) sections 1, 12, 26 through 46, 62 through 65 and 67 shall take effect immediately.

b. Prior to the effective date of any section of this act, the Commissioner of Banking and Insurance may take those actions and promulgate those regulations necessary to implement the provisions of this act.

Approved May 19, 1998.