

Discussion Points

1. In the mid-1990's, following the devastating effects of Hurricanes Andrew in Florida and Iniki in Hawaii, insurance companies began to decline to write new policies in coastal areas, and began to apply stricter standards to the type and condition of homes they would insure. To address the availability and affordability of homeowners insurance in coastal areas of New Jersey, the department established the Windstorm Market Assistance Program (WindMAP) by regulation. Through the WindMAP program, homeowners in 92 coastal zip codes, primarily located in Ocean, Cape May, Atlantic, and Monmouth Counties could apply for coverage with admitted companies that voluntarily entered into the WindMAP program. If the consumer could not obtain coverage in the voluntary market, the consumer is referred to the FAIR (Fair Access to Insurance Requirements) Plan, a statutorily-created residual market insurer, to obtain coverage. The goal of the WindMAP program was to reduce the number of homeowners covered by the FAIR Plan, since the FAIR Plan offers homeowners only basic coverage for property damage.

In the aftermath of Hurricane Katrina, which caused widespread property damage along the Gulf Coast in 2005, insurers are again examining their exposure in coastal areas. Further, using catastrophic modeling, industry experts have indicated that the Northeast part of the country is vulnerable to a hurricane or other catastrophic weather event that is statistically likely to occur in the relatively near future.

Citing the potential for increased storm damage, Allstate New Jersey Insurance Company, the second largest insurance company offering homeowners insurance in the State, stopped writing new homeowners insurance policies throughout the State in February of this year. Generally, it is reported to be increasingly difficult for homeowners in coastal areas of the State to find coverage in the voluntary market as insurers are reexamining their exposure, and more homeowners are turning to more expensive coverage available in the surplus lines market or less comprehensive coverage offered through the NJ Fair Plan.

- **Question:** a. Please indicate how many insurers are currently offering homeowner insurance policies: (1) in the State; and (2) in coastal areas of the State.

Response: At the end of 2006, we have 98 companies offering homeowners insurance in New Jersey. This compares to 97 companies in 2005 and 112 companies in 2004. Based on our latest coastal report, 89 companies have policies on the coast.

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b. Please indicate whether the department anticipates: (1) any decline in the number of companies offering policies in the State; (2) any decline in the number of companies offering policies in coastal areas of the State; or (3) any increase in the percentage of homeowners in coastal areas who obtain insurance through the FAIR Plan.

Response: We believe some companies will cut back on their writing in the coastal area. We are not aware of any company, except Allstate, that has stopped writing new homeowners business. Based on our current numbers, we continue to see the coastal exposures drop from the FAIR Plan. As of 12/31/05 the FAIR Plan reported 10,836 policies, as of 12/31/06 they reported 9,709 policies and as of 3/30/07 they report 8,963 policies. The surplus lines market continues to offer policies for coastal risks that cannot obtain coverage in the admitted market.

c. Please describe the current status of the WindMAP program and any plans the department has for using this program or other programs or methods to counteract reported problems of affordability and availability of homeowners insurance in New Jersey coastal areas.

Response: The WindMap program receives very few applications on a yearly basis. When they receive them, they forward them to the carriers that are participating. Most agents have either the admitted market or surplus lines to write the policies. The department continues to work with the companies to make coastal insurance available. Many companies are getting mandatory hurricane deductibles up to 5% approved. In addition, we continue to monitor consumer phone calls and continue to receive very few calls about this issue. With regard to affordability, we believe rates are in line with the actuarial support for increases in this area.

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2. Pursuant to the "New Jersey Home Ownership Security Act of 2002," P.L.2003, c.64 (C.46:10B-22 et seq.) the department is directed to enforce the act's prohibitions against certain predatory lending practices in the residential mortgage market. The act categorizes residential mortgage loans as "home loans" or "high-cost home loans," depending on the loan terms, and applies certain restrictions on lending practices to each category of loans. Generally, these restrictions are designed to prevent loan terms that present an unreasonable risk of the homeowner's ultimate default and resulting loss of equity in the home through foreclosure. In addition, the department is directed to implement, in consultation with the Divisions of Consumer Affairs and Civil Rights in the Department of Law and Public Safety, a program of consumer protection to protect vulnerable consumers against predatory lending practices. The act became effective in November, 2003.

- **Question:** a. Please indicate the number of complaints regarding predatory lending filed with the department for each year, from 2004 to 2006, and whether the annual rate of complaints has decreased from the three years prior to the act's effective date. Please also indicate the amount the department has collected in fines or penalties for violations of the act, for each year, from 2004 to 2006.

Response: The complaint figures that have been maintained by the Department were categorized to capture a variety of types of violations but did not, until 2004, categorize complaints under "predatory" and "deceptive". We have since been doing so. We also maintain a specific category for violations of HOSA. Unfortunately, the figures requested for 2001 and 2002 are not available from the Department's database.

The "predatory" and "deceptive" complaint figures for 2003 (the last year before the effective date) and for the period 2004 to 2006 (after the act) are given below:

2003 - 616
2004 - 326
2005 - 326
2006 - 265

On the basis of these numbers, there is an apparent decline in "predatory" and "deceptive" consumer complaints from the last of the three years preceding the effective date of HOSA (i.e., 2003) and the years following enactment. This probably reflects the reality, however, one should also temper the conclusions given that 2003 was a heavy mortgage volume year due to very low interest rates. Some lock-in agreements were not honored within the lock-in period therefore automatically including the loan in the above numbers although the failure was more a consequence of high loan volume rather than bad

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faith on the part of lenders). Heavier volume will, in itself, almost always produce more complaints.

As a result of the Department's assistance with these complaints, consumers received refunds in the following amounts:

2004	\$608,247
2005	\$901,329
2006	\$1,466,280

Since the enactment of the bill, there has been sharp decline in the numbers of loans that exceed the interest threshold or the points and fees threshold of HOSA. Partially as a consequence of this decline in volume, the Department has opened only eight files for violations of the act. We have imposed penalties in two of these: \$10,000 in 2005 and \$20,000 in 2007. Pursuant to HOSA and the dedicated funding law, 60% of the penalty amount goes to the General Fund and 40% is reserved for consumer education purposes. See N.J.S.A. 46:10B-28d(1). The other six open files are being pursued.

b. Please outline the status of the consumer education program required to be established by the department, including: (1) a general description of the activities conducted through the program; (2) the number of staff positions involved in implementing the program; and (3) the average number of public outreach efforts conducted annually as part of the program. Are any modifications necessary to the "New Jersey Home Ownership Security Act of 2002" to further restrict predatory lending practices in the State?

Response: The Department remains concerned regarding abusive lending practices by the entities that it regulates, as well as by those making loans in this state under federal authority and therefore not subject to state law.

The Department has continued to contract with community organizations to provide presentations on predatory lending issues. The Department guides the content and locations of these presentations. We feel that this is a highly useful way to make sure that our efforts are targeted in the most effective way to maximize our use of resources.

The Department has an ongoing program of making presentations in the community in a variety of settings. Five staff are involved in making the presentations. Additional staff are assigned as needed. The topics are on the types of financial services offered by our regulated entities: banking, licensed lending, insurance, and real estate. Some of these presentations have to do with predatory lending practices and caution consumers about abusive loan terms.

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In addition, in cooperation with the banking industry, the Department conducts financial awareness presentations at schools across the State. Last fall, the program reached 6,000 students in 100 schools. We have another event planned for April of this year and intend on conducting them on an ongoing basis. These presentations focus on budget, savings and credit and heighten the awareness of students to the potential financial impact of contractual terms.

The Department maintains highly useful information on its web site on predatory lending. In addition, links are provided to other sites that can assist consumers.

The Department publishes written materials on financial services in pamphlet form that are written for use by consumers. They provide basic guidance on what to look for when getting a mortgage loan.

The Department licenses one credit counselor who provides information and services to consumers who are experiencing difficulties with their repayment obligations. These counselors operate on a non-profit basis and their fees are limited.

In light of the recent problems in the sub-prime lending market, the Department is currently reviewing whether statutory changes to NJ HOSA are necessary.

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3. P.L.1992, c.161 established the New Jersey Individual Health Coverage Program (IHC) to provide access to a broad choice of private health insurance products to any New Jersey resident who does not have access to employer-based or other group health coverage. The act, which was part of a major health insurance reform effort, requires all carriers, as a condition of issuing health insurance in the State, to offer individual health benefits plans through the IHC or pay a share of losses incurred by other carriers in that market. Pursuant to the act, the IHC board created five standardized health benefits plans, which are guaranteed-issue and guaranteed-renewable. The act requires all plans to be community rated, meaning that carriers cannot vary rates based on health status, age, claims history, geographic location, or any other risk factor. Since the mid-1990's, the IHC market has experienced a steady increase in premiums and a change in composition toward older and potentially more expensive enrollees. In addition, the department's website reports a decline in enrollment from 186,130 covered lives in the fourth quarter of 1995 to 66,934 in the third quarter of 2006.

- **Question:** Please explain the department's efforts to date in addressing the issues of affordability and decline in enrollment associated with the IHC. Does the department see a need for modification to any aspect of the IHC at this time?

Response: Implementation of the IHC Act is the responsibility of the Board of the program. Although the Commissioner is a member of the Board, he has only one vote on the nine member Board. Thus the Department does not implement the Act but participates on the Board.

As shown by the attached chart, IHC enrollment peaked at 220,000 at the end of 1995, steadily decreased to 78,000 as of the end of 2005, and is currently at 83,000 (including enrollment in the Basic & Essential plans). The Department believes the decline in enrollment since 1995 is attributable to several factors - the virtual elimination of the loss reimbursement mechanism, pure community rating and the elimination of the Health Access program. Elimination of the loss reimbursement mechanism and pure community rating have created a market that attracts only the most expensive risks, leading to a spiral of higher costs and lower enrollment.

As originally enacted in 1992, carriers offering standard IHC plans were reimbursed for claims plus administrative expenses (up to 25% of premium) in the individual market in excess of individual premium and investment income. The reimbursement formula was changed in 1997 to eliminate reimbursement of administrative expenses and to permit reimbursement only of claims in excess of 115% of individual premium

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plus investment income. In mathematical terms, the original loss reimbursement formula was:

$$(\text{Premiums} + \text{Investment Income}) - (\text{Claims} + \text{Administrative Expenses (up to 25\% of Premium)})$$

Under this formula, carriers had an incentive to underprice. Carriers who underpriced individual plans did not need to worry about excess claims because the reimbursement formula ensured that they would not pay any more than the premiums and the investment thereon and could retain a cushion of 25% of premium for administrative expenses. In other words, the original formula guaranteed that a carrier could not lose money on individual plans. Due to the generosity of this formula, the number of carriers in the individual market grew from 2 prior to reform to 28 after reform and carriers reported individual losses of approximately \$220 million from 1993 - 1996, with the bulk going to Horizon (\$142 million). The revised formula is:

$$(115\% (\text{Premiums} + \text{Investment Income})) - \text{Claims}$$

Under the revised formula, carriers have no incentive to underprice. A carrier who underprices could lose money as reimbursement only activates when claims exceed 115% of the sum of premium and investment income. After enactment of the revised formula, several carriers exited the individual market and the number participating fell to 15. Reduction of the subsidy implicit in the assessment mechanism meant that the IHC rates had to be self-supporting. When the formula changed, rates increased and only those most in need of coverage (i.e. those with high claims) remained.

The IHC law requires that carriers offering health benefit plans in New Jersey pay an assessment to fund the losses of carriers issuing coverage in the individual market. A carrier's assessment liability may be reduced or eliminated if the carrier offers standard plans in the IHC market.

The second factor leading to a decline in IHC enrollment relates to the rating rules in this market. The law requires that the rate charged by a carrier for a particular plan in the IHC market be the same for all applicants, regardless of age, gender, health status, geography or any other factor (pure community rating). The Basic & Essential plan, however, may be modified community rated, based on age, gender and location only, subject to a 3.5:1 rate band, which means that the carrier's highest rate for an individual covered by a Basic & Essential plan can not be more than 3.5 times the lowest rate for an individual covered by a Basic & Essential plan based on age, gender and location.

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Pure community rating requires the younger, healthier participants in the IHC market to subsidize the premiums paid by older, or less healthy participants. The average age in the IHC market has been increasing over time and is substantially higher than the average age in the group market. It appears that pure community rating is discouraging younger persons from purchasing IHC coverage. Under a modified community rating system, such as in the Small Employer Health market, the youngest insureds subsidize the system and an influx of younger lives reduces rates for all.

The decline in IHC enrollment is also attributable to the phasing out of the Health Access program. Enacted at the same time as the IHC law, Health Access provided subsidies to individuals, married couples and families that did not have access to employer sponsored coverage and had income under 250% of the Federal Poverty Level. The subsidy was provided on a sliding scale based on income and was to be used to purchase certain IHC products. Five carriers participated in the Health Access program and were required to maintain a minimum 85% loss ratio for this program, but could submit any losses in excess of the 85% loss ratio attributable to Health Access New Jersey business to the IHC loss reimbursement mechanism. At its peak in 1996, Health Access covered 23,000 people. New enrollment in Health Access was halted on December 31, 1995, and enrollment for all participants terminated on October 31, 2002.

DOBI, in conjunction with other officials within the Administration, is working on strategies to address current problems in the commercial health insurance markets. Pending the legislature's consideration of more significant reforms, DOBI has attempted to improve the IHC market through promotion of ridered Basic and Essential plans that offer lower cost options to younger citizens. Moreover, we have worked informally with Horizon to moderate IHC rate increases for some of the most expensive individual policies.

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4. P.L.2001, c.368 requires health insurance carriers to offer a limited health care services plan through the IHC. The Legislature's intent in establishing this plan, known as the Basic and Essential Health Care Services Plan (the "B&E Plan") was to create a plan that was more affordable, even though it was not as generous in coverage as the five standard plans. The act permits carriers to rate the B&E Plan by using factors for age, gender, and geographic location, but by no more than a 3.5 to 1 ratio between the highest and lowest rated plans. The department's website reports an increase in the number of covered lives under the B&E Plan from 814 in the fourth quarter of 2003 to 18,763 in the third quarter of 2006.

- **Question:** Please comment on the effectiveness of the Basic and Essential Health Care Services Plan in providing affordable health insurance coverage and reducing the number of uninsured New Jersey residents. As the B&E Plan does not provide some benefits that consumers may have come to expect from health insurance coverage generally, please indicate how many complaints the department has received annually about the B&E plan. To what market or plan design factor does the department attribute the increase in consumer use of the B&E plan?

Response: Three carriers actively sell the B & E plan, all with riders increasing the benefits of the plan. Amerihealth has two riders to the B & E plan. Its so-called "Preferred" rider is the richest rider offered by the carriers. It removes the 90 day limit for hospitalization, removes the dollar cap for PCP and specialist visits, covers wellness and outpatient diagnostic tests at 100%, covers home health and durable medical equipment, and covers outpatient drugs up to \$1,500 per year. Amerihealth has another rider, the basic rider, that removes the \$600 limitation on wellness and the \$500 limit on outpatient diagnostic services, and allows unlimited specialist care. Amerihealth's basic rider costs between \$1 and \$2 and therefore, as a practical matter, Amerihealth does not sell the B & E plan unridered. Horizon's B & E rider adds the fewest benefits. It removes the cost sharing on wellness but retains the \$600 annual cap, covers diabetic supplies and durable medical equipment up to \$2,500, covers infusion therapy and outpatient diagnostic testing, and covers prescription drugs up to \$500. The Oxford rider removes the 90 day limit on hospitalization, lowers the cost sharing and increases the maximum benefit for wellness and physician visits to \$1,000 per year, and covers prescription drugs up to \$1,000.

A. Premiums Charged

The premiums charged by Amerihealth, Horizon and Oxford for the B & E plan as compared to their rates for the lowest priced standard IHC

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plan is shown below. Note the effective date for these rates is 3/1/2007.

Basic and Essential Rates as of 3/1/07

Carrier	Plan	Region	Male 25	Female 25	Male 35	Female 35	Male 45	Female 45
AmeriHealth	B & E	State	\$142	\$297	\$176	\$258	\$233	\$281
AmeriHealth	w/basic rider	State	\$143	\$298	\$177	\$259	\$234	\$282
AmeriHealth	w/preferred rider	State	\$199	\$414	\$246	\$360	\$325	\$392
AmeriHealth	\$30 HMO	State	\$559	\$559	\$559	\$559	\$559	\$559
Horizon	B & E	North	\$155	\$228	\$217	\$277	\$267	\$271
Horizon	B & E	South	\$147	\$217	\$206	\$263	\$253	\$257
Horizon	w/rider	North	\$195	\$287	\$272	\$349	\$336	\$341
Horizon	w/rider	South	\$185	\$272	\$259	\$331	\$319	\$324
Horizon	\$30 HMO	State	\$465	\$465	\$465	\$465	\$465	\$465
Oxford	B & E	North	\$155	\$170	\$182	\$214	\$240	\$235
Oxford	B & E	South	\$147	\$161	\$172	\$203	\$228	\$222
Oxford	w/rider	North	\$195	\$213	\$228	\$268	\$301	\$294
Oxford	w/rider	South	\$184	\$202	\$216	\$254	\$285	\$278
Oxford	PPO, \$2,500 deductible	State	\$391	\$391	\$391	\$391	\$391	\$391
Oxford	\$30 HMO	State	\$430	\$430	\$430	\$430	\$430	\$430

B. Enrollment

The three carriers shown above had B & E enrollment as of 12/31/06 of about 19,000 out of the total IHC enrollment of approximately 83,000. The B & E plans became available at the end of 2003 and enrollment has increased each quarter. The enrollment is divided among carriers as follows:

Amerihealth
 B & E 0
 B & E w/ Basic Rider 1,594
 B & E w/Preferred Rider 1,007

Horizon
 B & E 2,264
 B & E w/rider 10,128

Oxford
 B & E 3,721
 B & E w/rider 143

This enrollment and pricing data suggests that the success of the B & E plans in making coverage more affordable for younger residents is

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largely due to the fact that these plans are modified community rated and are therefore not competing fairly with the standard plans which are required to be pure community rated. For younger persons, particularly males, a B & E ridered plan is significantly less expensive than the lowest priced standard IHC plan. Another factor contributing to the success of the B & E plans involves self-selection. Health persons buy plans with limited benefits. So the lower rates associated with the B & E plans are not caused by the lower benefits provided by these plans as compared to the standard IHC plans, but rather from the purchasing behavior that is induced by a system that offers low benefit and high benefit plans side by side.

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5. The "New Jersey Medical Care Access and Responsibility and Patients First Act," P.L. 2004, c.17 (the Act), provides a comprehensive set of reforms affecting the State's tort liability system, health care system, and medical malpractice liability insurance carriers. The goal of these reforms is to ensure that health care services continue to be available and accessible to residents of the State.

The act established the Medical Malpractice Liability Insurance Premium Assistance Fund (MMLIPA), the purpose of which is to provide medical malpractice liability insurance premium relief for certain specialized health care providers in the State who have experienced or are experiencing a liability insurance premium increase. Eligibility for the relief is determined by class of practitioner, whose average medical malpractice premiums as a class, is in excess of a particular amount per year, as established by the Commissioner of Banking and Insurance by regulation.

The MMLIPA fund is comprised of revenue from \$3 annual surcharges paid on or by employees who are subject to the "unemployment compensation law" and \$75 annual surcharges paid on the professional licenses of physicians, podiatrists, dentists, chiropractors, and attorneys, unless exempt under the law.

The act further provides that the fund, which will expire in July, 2007, shall be administered by the Department of Banking and Insurance. The act provides that in each of the three years of its operation, the MMLIPA fund shall distribute a total of \$26.1 million annually, allocated as follows: \$17 million for premium relief to eligible health care providers who have experienced or are experiencing a premium increase; \$6.9 million for the Health Care Subsidy Fund; \$1 million for a student loan expense reimbursement program for obstetricians/gynecologists who agree to practice in medically underserved areas of the State for a minimum of four years; and \$1.2 million for the NJ FamilyCare program to enroll new mothers with income up to 100% of the federal poverty level whose postpartum eligibility for Medicaid has expired.

Pursuant to the department's Public Notice issued on March 14, 2007, eligible specialties for 2006 premium relief subsidies included obstetrics/gynecology and neurosurgery; however, diagnostic radiology, covered previously, was not continued for 2006. According to the Governor's Budget, the department distributed over \$16 million to over 1,200 physicians in high-risk specialties. The revenue to the MMLIPA fund totaled \$24.1 million in FY 2006.

- **Question:** Please indicate if the Act has successfully effected the retention of key medical specialties in the State and if the implementation of the Act has stabilized the market. How has the medical malpractice insurance market place changed since 2004? Given that the MMLIPA fund will expire in July, 2007, does the

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department see a need for extending the MMLIPA fund past July, 2007 in order to aid certain practitioners and providers?

Response: In 2004 the MMLIPA Fund reimbursed 1,202 obstetricians, neurosurgeons and diagnostic radiologists a portion of their medical malpractice insurance premium. In 2005, 1,282 physicians in these same specialties received reimbursement. For 2006, the Department has proposed including obstetricians and neurosurgeons, but not including diagnostic radiologists, whose numbers have risen slightly since 2004. Over the same period the number of practicing neurosurgeons has declined slightly from 64 to 60 and obstetricians from 740 to 683. These numbers are based upon insurer counts of individual practitioners that pay premiums for these specialties, which the Department believes is a better indication of the number of individuals actually practicing than the generally larger number of practitioners licensed to practice these specialties. Establishing a "cause and effect" relationship to the funds distributed by MMLIPA is problematic because of the number of factors involved in individuals' decisions to cease practicing their specialty. Medical trade associations and practitioners report that the current problem in maintaining sufficient practitioners in these specialties is attracting new specialists to replace those who retire.

Since 2004, the price of medical malpractice insurance generally has begun to stabilize, albeit at a relatively high level. The weighted average increase in medical malpractice insurance premiums in 2005 was 13.12%; in 2006 it was 5.89%; and in 2007 to date is 0.28%. Since medical malpractice insurance rates are often filed to be effective January 1 of the year, it appears that prices in 2007 may likely remain relatively stable; the cost of coverage for neurosurgeons and obstetricians, however, continued to increase in 2006 faster than the average.

Whether to extend operations of the MMLIPA Fund beyond its expiration this year is a policy judgment, balancing the impact of the cost to employers, physicians and lawyers with the expected beneficial impact of the use of the funds; such determination exceeds the jurisdiction of this Department.

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6. Pursuant to P.L.2005, c.375, certain health insurers are required to extend health insurance coverage to certain dependents up to 30 years of age. In response to one of last year's OLS discussion points, the department indicated that a problem exists with the interaction of the law and COBRA, the federally required continuation of coverage for dependents who age out. Specifically, a dependent must choose between electing COBRA continuation coverage and State law continuation coverage at the time they age out under the terms of the underlying insurance policy, typically at age 18 or upon graduation from an institution of higher education as a fulltime student at 21 or 23. A dependent who subsequently loses eligibility under the State law coverage at age 30 for further dependent coverage would not then be able to elect COBRA.

- **Question:** Please indicate if any other problems have occurred with the implementation of the under 30 law. If so, does the department recommend any legislative initiatives to alleviate these particular issues? Please provide any available data concerning the number of individuals who are impacted by having to choose between COBRA and coverage pursuant to the State's under 30 coverage law?

Response: We estimate that there are 7,000 persons covered by commercial carriers under the Dependent Under 30 law and another 200 covered through the State Health Benefits Plan (SHBP). Horizon has a high number of persons covered under the Dependent Under 30 law because it has elected to waive the age-out requirement. The SHBP number is low because it did not implement the law until January 1, 2007 and the SHBP set the rate for Dependent Under 30 coverage at 110% of the single rate. Since coverage may be continued under COBRA at 102% of the single rate for three years after aging out of the SHBP, Dependent Under 30 is not an attractive option until aged-out dependents have exhausted their COBRA continuation rights. In the commercial market, Dependent Under 30 rates are 65 to 80% of the single premium as compared to the COBRA rate of 102% of the single premium. Thus in the commercial market, Dependent Under 30 is more attractive than COBRA with respect to rates. However, a dependent's right to coverage under Dependent Under 30 continuation is lost if he marries, has a child, finishes school or moves out of state and he cannot, at that time, elect COBRA. A person who elects to continue coverage under COBRA does not lose eligibility upon a change in life events. We do not have any information on the number of persons who are electing between Dependent Under 30 continuation and COBRA continuation.

Due to the extensive news coverage about the Dependent Under 30 law, we received many inquiries, many from persons whose coverage was not subject to the law. The law highlighted the fact that New Jersey insurance law does not apply to all New Jersey residents.

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7. Pursuant to the "Automobile Insurance Cost Reduction Act," P.L.1998, c.21, the commissioner was directed to establish standards, through regulation, for redrawing the 50-year-old territorial rating plan used in determining automobile insurance premiums throughout the State, no later than January 1, 2000. On April 18, 2005, the department adopted N.J.A.C. 11:3-16A, setting forth standards for the creation of new territory maps and establishing a process for their filing and approval. According to proposed new regulations, Proposal Number 2007-10, the department is offering the Territorial Rating Equalization Exchange plan (TREE). The TREE plan will operate in a manner similar to the New Jersey Automobile Insurance Risk Exchange mechanism, which redistributes the additional premium collected by insurers from insureds who choose the no-limitation-on-lawsuit threshold to the insurers that incur the costs for the additional lawsuits permitted by no limitation threshold policies.

According to the proposal, TREE will be an unincorporated association operating on a no-profit, no-loss basis and establish a governing committee with the purpose to promote sustainable competition in all areas. The proposal further states that the TREE governing committee will determine the zip codes where member companies will be eligible to receive an equalization reimbursement, calculate the territorial equalization charge that will be levied by TREE against each member company, and calculate the territorial equalization reimbursement for those companies that write business in the designated zip codes. Under the TREE plan, premiums received by an insurer that writes a policy in one of the zip codes designated by the exchange governing committee will be supplemented by an equalization payment on a direct one-to-one basis, thus establishing no financial justification for an insurer to limit its writing in certain geographic areas.

- **Question:** Please indicate the goals of the TREE plan. Assuming that the proposed rules are adopted, please detail the timeline for the implementation of the TREE plan. What, if any, additional funds or staff will be needed to implement the TREE plan?

Response: GOALS:

TREE seeks to extend the benefits of auto insurance competition to more urban drivers and to preserve competition in urban areas under a variety of challenges such as cyclical downturns in the market and the expiration in 2009 of the "Take All Comers" requirement and auto UEZ assignment program. The ultimate goal of this effort is a stable and sustainable competitive market for auto insurance statewide.

A specific goal of TREE is the implementation of AICRA's mandate to eliminate rate caps in urban areas while preventing premiums that are substantially disproportionate to prior premium levels. TREE's equalization mechanism is designed to accomplish this by redirecting

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existing premium dollars on an industry-wide basis to moderate territorial rating differentials and thereby minimize financial disincentives to insure urban drivers.

TIMELINE:

The TREE timeline runs parallel to the timeline for the territorial re-mapping process, as both are necessary to implement the AICRA mandate to eliminate rate caps in urban areas while preventing premiums that are substantially disproportionate to prior premium levels.

DOBI anticipates that the work of the Commission will be completed this summer and that the TREE mechanism will be organized at about the same time. This would permit new maps and rating systems to be submitted for approval late this year and implemented in 2008.

FUNDING AND STAFF:

Auto insurers will fund the TREE operation. The TREE Board will administer the mechanism with the assistance of a central processor hired and compensated by the Board, and other consultants as needed. At this time the Department is not aware of a need for additional Department funding or staff for TREE implementation.

April 19, 2007