

Discussion Points

1. In June, 2004, the "New Jersey Medical Care Access and Responsibility and Patients First Act" P.L. 2004, c.17, was enacted. That act provides for 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 health care providers in the State who have experienced or are experiencing a liability insurance premium increase. Eligibility for the relief is determined by the amount of the premium, which is 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 exempted under the law.

The act further provides that the fund, which will expire in July, 2007, 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 Order #A05-122, issued on June 29, 2005, eligible specialties for 2004 premium relief subsidies included obstetrics/gynecology, neurosurgery, and diagnostic radiology. According to the Governor's Budget, the department distributed over \$13 million to over 1,200 physicians in high-risk specialties. The revenue to the MMLIPA fund totaled \$21.3 million in FY 2005. The Governor's Budget Recommendation estimates that the fund's resources will total \$37.7 million in FY 2006 and \$22.3 million in FY 2007.

- **Question:** Please indicate the amount of projected revenue generated from the respective surcharges, by category, for FY 2006.

What is the average amount of premium relief subsidy per physician and the number of covered physicians by physician specialty? Does the department have any plans to study: (1) the effect of the premium relief subsidy on the retention of key medical specialties in the State; (2) whether additional specialties should be eligible for the subsidy; or (3) the state of the medical malpractice insurance market?

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Response: Please see attached chart regarding amounts collected this year to date. The distribution per physician for this year's program has not yet been established; the attached chart shows last year's amounts. Note that proposed rules would adjust those amounts per physician based on actual premium for each specialty. Over the three year period, in conducting its annual analysis, the Department focuses on data specifically addressing the numbers of physicians engaged in designated specialties or subspecialties in recent years and information indicating the extent to which practitioners in those specialties have curtailed the providing of, or declined to offer certain services in recent years. The last annual analysis, required by this Act, will be conducted in early 2007.

In view of the limited amount of funds available for distribution, the Department recognized that the greater the number of classes deemed eligible to receive subsidies from the Fund, the lower any premium subsidy available to be distributed to individual practitioners and providers would be. Therefore, upon consulting with the Department of Health and Senior Services, the Department conferred eligibility upon only those classes of practitioners in specialties where access to care is most seriously threatened. To extend eligibility to additional specialties or subspecialties would minimize or eliminate the ameliorative effect of the subsidy, undermining the intent of the Act.

The Department regularly studies and continually collects data from all regulated markets and has paid special attention to the medical malpractice market since the emergence of hard market conditions in 2001. Department analyses of the market contributed to the development of Legislative measures to address market problems, specifically the New Jersey Medical Care Access and Patients First Act of 2004. These analyses were used directly in the formation of Department regulations and Decisions and Orders regarding the selection of and distribution to physicians in 2005 of more than \$13 million in premium assistance subsidy payments under the Medical Malpractice Liability Insurance Premium Assistance Fund. Such distributions, and studies necessary for that purpose, will continue in calendar years 2006 and 2007, when the Fund expires.

The Department also administers and participates in the Medical Care Availability Task Force established by the Act, which is designed to study barriers to care resulting from problems in the medical malpractice market.

The Department also continues to study various other aspects of medical malpractice market conditions, including premium levels and trends, and insurer solvency.

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Medical Malpractice Insurance Fund

Revenue	Anticipated	FY 2005 Actual	FY 2006 to Date
Employers		\$16,575,608	\$15,949,080
Health Care Professionals		\$2,430,398	\$2,718,230
Attorneys		\$1,734,294	\$2,024,371
Interest		\$292,403	
Total	\$26,100,000	21,032,703	\$20,691,681

Disbursements

Premium Subsidy	\$17,000,000	\$13,699,462	
Charity Care	\$6,900,000	\$5,560,370	
Student Loan Reimbursement	\$1,000,000	\$805,851	
Medical Assistance	\$1,200,000	\$967,021	
	\$26,100,000	\$21,032,704	
Subsidy per Physician		\$10,872	
Subsidies Issued		1203	
OB GYN		709	
Neurosurgeon		61	
Diagnostic Radiologist		433	

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2. On June 30, 2005, Governor Richard Codey filed Reorganization Plan No. 005-2005 transferring the Office of Managed Care from the Department of Health and Senior Services to the Department of Banking and Insurance. According to the Governor's FY 2007 Budget, 21 managed care staff were transferred as a result of the reorganization resulting in an increase of \$1.8 million in staffing costs.

- **Question:** Please indicate if administrative efficiencies and cost savings have been achieved by the transfer of Office of Managed Care to the department. Will the department seek any further changes to streamline the regulation of health insurance?

Response: The Health Department had 26 positions. Based on our analysis of the work, we took 21. For FY 2007 we are only planning to fill 18. Three funded vacancies are being removed from the budget. Savings associated with the Office of Managed Care from Health and Senior Services to the Department of Banking and Insurance are also realized through the office space provided for the transferring of employees since the employees would not be housed in another building. In addition, the Division of Insurance recoups its costs from insurance company assessments for the unit's salaries, fringe benefits, building and indirect costs. Existing administrative staff in the Department of Banking and Insurance has absorbed the functions for processing revenue and personnel inquiries.

With the reorganization, the Department is looking for ways to streamline the review of applications from start-up HMOs seeking authority to do Medicare business in New Jersey. Areas of review that duplicate CMS review related to delivery of care will be eliminated. CMS preempts state review for Medicare plans, with the exception of determination of financial solvency. CMS defers to states on whether an entity meets State licensure requirements with respect to financial solvency.

The department also anticipates changes will be made to regulations to standardize and streamline managed care requirements for all entity types. For example, requirements for provider agreements currently set forth in regulations by entity type will be consolidated into one regulation setting forth consistent standards for HMOs, health insurers using network providers, DPO's and organized delivery systems. A similar approach is being considered for one regulation to establish subcontracting requirements for all entity types.

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3. The Workers' Compensation Security Fund (WCSF), established pursuant to P.L. 2004, c.179, provides payment for individuals entitled to receive workers' compensation benefits when a stock or mutual workers' compensation insurer is determined insolvent. The WCSF is funded through assessments levied against stock insurance carriers writing workers' compensation business in the State. The WCSF year end FY 2006 balance is estimated to be \$3.7 million, reflecting expenditures of \$40 million. The FY 2007 budget (p.H-37) estimates the WCSF balance to be depleted by the end of FY 2007.

- **Question:** Please provide an explanation for the level of spending anticipated for FY 2006 and an analysis of expected WCSF revenue and expenditures for FY 2007. Please include the amount estimated to be paid from the WCSF for claims in FY 2006 and FY 2007, the number of insolvent companies with outstanding claims, and the value of these claims. Given the \$0 estimated fund balance for year end FY 2007, are current assessment levels sufficient to cover future possible insolvencies and resultant claims?

Response: The Worker's Compensation Security Fund (NJSA 34:15-105) pays claims to injured workers for medical expenses and temporary and permanent disability on behalf of insolvent insurance companies.

The Fund balance as of June 30, 2006 should be about \$10,276,000 based on current payouts and assuming no revenues received between now and then.

There currently are 22 insolvent insurance companies with open claims. As of September 30, 2005, there were over 2300 open claims. Anticipated payments on these claims exceed \$94 million.

As noted on the attached chart, current assessment levels are at the statutory maximum of 1% of premiums. This is not sufficient to pay claims at their current level. In order to increase the assessment, legislative action is necessary.

See attached analysis for the Security Fund through June 2007.

Discussion Points (Cont'd)**N.J. Workers Compensation Security Fund
Revenue and Expenditure Analysis**

As of April 10, 2006 current Fund balance is \$19,131,463.

Expenses

FY 2006 Claims and expenses (through April 10, 2006)	\$25,206,945
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ANALYSIS OF REVENUE and EXPENDITURES for FY2007

Assessment to be collected August 2006	\$15,600,000
Estimate of distributions to be received from estates	4,200,000
Interest for year	145,000
Estimate of ending balance FY2006	10,276,258
Total FY 2007 revenue	30,221,258
Estimate FY 2007 claims & administrative expenses	36,000,000
Total cash available at end of FY2007	-\$ 5,778,742

Current expenses of \$3,000,000 per month the Fund will be depleted before May 1, 2007.

Next assessment is not collectable until August 2007.

NOTES:

1. This assumes no additional insolvencies.
2. The Fund has no control over the receipt of distributions from estates due to the complexity of liquidating an estate. Each state and court varies in finalizing the conversion and disbursement of assets of the insolvent insurance company to cash.

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4. Pursuant to P.L.2005, c.375, enacted on January 12, 2006, and effective May 12, 2006, certain health insurers are required to extend health insurance coverage to certain dependents up to 30 years of age. According to the department's bulletin No.06-06 the department is in the process of developing rules for implementing this new law. Carriers must develop rates for coverage for qualified eligible dependents prior to the effective date of May 12, 2006.

- **Question:** Has the department experienced any problems in implementing the act? If so, how does the department plan to remedy the problems?

Response: We have encountered some issues of interpretation (effective date, who precisely is eligible, rate determination) that require promulgation of administrative rules in order to provide certainty and uniformity in implementation.

A key concern is that dependents who aged out prior to the law's effective date (May 12, 2006) can elect continuation as of May 12, 2006 while dependents who age out after May 12, 2006 must wait until the plan's renewal date to elect continuation. However, this disparate result is required by the clear language of the law. The Department has addressed these issues temporarily by issuing these Bulletins, and will address permanently by adoption of rules.

Another problem we encountered is the interaction of this law with COBRA, the federally required continuation of coverage for dependents who age out. It appears that a dependent will be allowed to, and must, choose between electing continuation COBRA and continuation pursuant to Under 30 coverage at the time they age out. A dependent who subsequently loses Under 30 eligibility would not then be able to elect COBRA. We are powerless to address this problem because COBRA is a federal law.

One insurance industry trade organization suggested that the rates permitted by the law will be inadequate. The Department will approve initial rates that appear adequate.

Practical implementation has gone more smoothly than expected. We expect carriers to file rate methods and have administrative systems in place by May 12.

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5. The "Automobile Insurance Cost Reduction Act" (AICRA), P.L.1998, c.21 established the Office of Insurance Claims Ombudsman, which is charged with the responsibility to: investigate consumer complaints regarding automobile insurance policies and the payment of claims; monitor the implementation of various insurance regulations; respond to consumer inquiries about policy provisions and coverage availability; and publish and distribute buyers' guides and comparative rates. In FY 2004, the Office of the Insurance Ombudsman was re-organized by the department. The Governor's Budget shifts the \$711,000 appropriation to the department's Consumer Protection Services and Solvency Regulation.

- **Question:** Please detail how the \$711,000 appropriation for the Ombudsman was allocated during FY 2006 and how the department anticipates the Ombudsman reallocation to the Consumer Protection Services and Solvency to be spent in FY 2007, including the number of staff. Please detail the Office's accomplishments to date. Please provide the number of complaints and inquiries the Ombudsman's office has handled, including the disposition of those complaints.

Response: The \$711,000 appropriated for the Ombudsman Unit was utilized for the following expenditures in FY2006.

Salaries	\$491,796
Operating Costs	\$9,982
Supplies	\$350
Travel	\$1539
Telephone	\$2507
Software	\$65
Training	\$395
Subscriptions, memberships, other	\$2,567
Rental faxes and copiers	\$2,559

The Department has not filled the Ombudsman since 2002. The functions are being executed by the Manager of Insurance Enforcement.

The unit has 10 full time employees. Since the functions of investigations are similar the Department has proposed to merge the \$711,000 for FY2007 into the Licensing and Enforcement Appropriation (for Consumer Protection Services).

With the merger of the Ombudsman Unit into the Office of Consumer Protection Services (CPS), the unit is still providing claims assistance services to New Jersey consumers consistent with the original responsibilities of the Ombudsman.

Some of the responsibilities have been delegated to other areas within the Department and within CPS to create greater efficiencies and avoid

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duplication. For example, the Ombudsman Unit identifies potential market trends or matters that may result in consumer harm when handling consumer inquiries, appeals and complaints. Such findings are now being handled by the Market Analysis Unit for more detailed review and to determine the appropriate action from among the continuum of regulatory responses that can be initiated in response to compliance and consumer protection issues. Additionally, in 2005, staff members from the Ombudsman Unit who handle consumer outreach were reassigned to Public Affairs to consolidate Department consumer education and efforts within a single unit.

With the reorganization of the unit, during the first 9 months of Fiscal Year 2006 (7/1/2005 - 3/31/2006) five investigators in the Trenton Office and one supervisor opened 494 complex and time sensitive investigations and closed 495 investigations.

These investigations are handled by the Ombudsman Unit because they require more detailed review and technical knowledge than routine complaints.

The 495 investigations that were finalized to date in FY 2006 resulted in \$1,607,668 in additional payments or premium adjustments for New Jersey consumers. Thirty policy non-renewals were rescinded and coverage continued for personal and commercial lines policyholders. Claim delays or denials were corrected in 108 situations and in 8 cases a compromise settlement was offered to resolve matters where the company did not violate any insurance laws but we advocated for the consumer.

In addition to investigations into written complaints, the staff handled over 3,000 phone inquiries, responded to 480 email inquiries regarding insurance matters, and made 110 "public presentations."

All coverage selection forms and buyers guides for private passenger auto insurance carriers are also reviewed and approved by the Ombudsman.

The Department foresees the Ombudsman Unit continuing on its present course, which course appears to be achieving goals consistent with those originally proposed for the Ombudsman.

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6. P.L. 2005, c.195, enacted in August 2005, strengthens the enforcement powers of the Division of Banking over State-chartered banks, savings banks, and savings and loan associations. The new law provides the department with expanded regulatory authority which corresponds more closely to its federal counterparts.

- **Question:** Please detail the department's progress in supervising financial institutions and protecting consumers as a result of the broader enforcement authority provided by P.L. 2005, c.195.

Response: To date, circumstances in New Jersey chartered banks, and savings and loan associations have not warranted use of the Enforcement Act that was passed by the Legislature and signed by the Governor on August 18, 2005. It took effect 60 days following enactment. Conditions in our institutions are generally good with only a few supervisory problems. With the current State economy almost all are doing well. Any enforcement matters are confidential.

When the Department was seeking passage of the act, we indicated that we did not anticipate frequent use of it but that the provisions were needed for effective supervision in the small minority of cases where that kind of action was needed. The Conference of State Bank Supervisors, our national association of state regulators, commended the Legislature and the Department for this new statutory tool during its reaccreditation of the Department in October, 2005.

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7. Under P.L.1999, c.154, an advisory board comprised of representatives from the department and the Department of Health and Senior Services, health insurance carriers, health care providers, higher education, business, organized labor, and health care consumers, was established to ensure that the State was compliant with federal privacy laws concerning medical information and its electronic transmission. The advisory board, which is now based in the department and referred to as the HINT/HIPAA Task Force, has received nation-wide acclaim for effectively ensuring that the State was compliant with federal law. Under the authority of P.L.1999, c.154 and P.L.2005, c.352, the task force launched the "Electronic Health Records Health Policy Initiative" to develop policies and the infrastructure to implement the use of electronic health records in the private and public sectors of the State.

With the ultimate goal of having a fully digitized or "paperless" health care system, electronic health records hold the promise of reducing the rate of medical errors, eliminating unnecessary testing, and streamlining administration, all of which could lower the cost of health care.

- **Question:** What is the progress to date of the task force? How many staff members are assigned to the task force? What kind of financial investment is needed from the State in order to support a paperless infrastructure? Assuming the goal of a paperless health care system is met, please estimate the cost savings to the State of a paperless system. Specifically, where would these cost savings be achieved?

Response: In 2005, The DOBI HINT/HIPAA Task Force organized and presented two successful conferences on electronic health records. Payers, providers, vendors, clearinghouses, trade groups, government entities and many interested parties participated. The Task Force issued a newsletter on EHR in September 2005 and has established a list serve at DOBI for the exchange of useful EHR information.

DOBI and the Task Force have joined with the NJ Medical Society and the Institute of Medicine and Public Health of New Jersey by physicians in the management of chronic diseases. This project is funded by a grant from the Physicians Foundation for Health Systems Excellence and is focused at introducing certain EHR's into small provider offices to reduce costs and increase the quality of care for chronically ill persons.

Recently, DOBI and the Task Force with the approval of Governor Corzine responded to a request for proposal issued by the National Governors Association and RTI International to participate in a US HHS project to identify best practices and barriers to protected health information privacy and security in electronic health records systems. If

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awarded, the DOBI Task Force, in consort with the other successful states and territories, would be part of the group that will help to design the architecture for the national EHR network. The DOBI Task Force will seek other forthcoming federal and private grants on various EHR projects and intends to submit proposals when appropriate.

It is not yet clear what amount might be needed to fully implement EHR systems. In terms of the NJ State Health Plan, very little state money would be required. The state would merely contract with its' health care vendor and require that the vendor employ national paperless record systems. Initially, the costs would be reflected in the premiums but within a short time, the anticipated savings should act to restrict or reduce the constant increase in expenditures.

In some instances the State would have to incur developmental costs for the creation and deployment of its own IT systems. For instance in the many programs and facilities operated by or under the NJ State Disability Fund, Vocational Rehabilitation, Military and Veterans Affairs, DHSS, Corrections and The Department of Human Services major savings would be generated by these EHR systems. While exact costs are not predictable, the costs sharing are. About seven years ago, DHSS spent \$500,000 on developing an electronic system for acute care hospital inpatient/outpatient reporting. In that time frame, there has been a demonstrated savings of \$10,000,000 not to mention the more timely availability of critical information.

In 1994, the New Jersey HINT Study reported possible savings of \$760,000,000 in New Jersey if electronic systems were deployed. Within the last year, the US Government Accounting Office estimated a national projected net yearly savings of 78 billion dollars. The Office of the National Coordinator for Health Information Technology (ONC) anticipates that savings of 20% per year will be realized in time saved and reduced waste and duplication. Also, The Institute of Medicine estimated that as many as 98,000 Americans die in hospitals each year from medical errors that might easily be prevented by the use of EHR systems.

ONC also notes that there are fraudulent health care claims filed in an amount of \$56.7 billion to \$170 billion annually. One of the major elements of these electronic systems is the ability to conduct real time scans for fraud indicators.

The development and deployment of these systems is and should be a public/private undertaking. The Task Force has already determined that there is a high level of increase by payers, providers, business, labor, industry, auto, PIP and Workers Compensation carriers,

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institutions and many other entities that would benefit from the use of EHR's. Thus, any and all costs should be shared by and with these many other stakeholders.

At the appropriate time, all interested parties should join together to consider these issues, benefits and savings; and the development of a public/private Regional Health Information Organization (RHIO) to move this initiative forward.

To date, DOBI has only staffed the Task Force on a part time basis with one manager. DHSS has provided assistance with the part time help of one Regulatory Officer. Thomas Edison State College continues to provide consultative, management and economic support as needed if available. This manpower commitment will need to be increased as these projects move forward.

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8. The FY 2007 Budget anticipates about \$122 million in revenue from departmental assessments, fees, billings and other charges, an increase of approximately \$22 million over revised FY 2006 estimates. The Budget recommends approximately \$68 million for the department's operations, or about 56 percent of department revenues.

- **Question:** Please explain why the department's revenues exceed appropriations by this extent. How frequently does the department examine its assessments and schedules for other fees and charges? What factors, other than the costs of executing departmental regulatory and oversight duties, are considered in establishing assessments, fees and other charges?

Response: The Department's revenues exceed appropriations because certain fees imposed by the Department are credited to the General Fund. In the FY 2007 Budget the Department has proposed a fee for appointment and termination of insurance producers. This fee is common in most states. It is estimated that the fee will raise \$20,200,000. In addition it is proposed that fees for original applications for consumer finance licenses in Banking be raised to produce an additional \$1,800,000 in revenue.

Traditionally fees for insurance producer licenses, examinations, and fees for Banking and Real Estate regulation above their expenditures have always gone to the General Fund. All fines and penalties collected by the Department are credited to the General Fund

In FY 2007 the Banking Division will begin an assessment process similar to the Insurance Division. Fees for the initial license, fines and penalties will go to the General Fund.

Assessments are reviewed annually and are based on actual expenditures, including costs such as fringe benefits, rent and utilities that are the responsibility of the Banking and Insurance Department, but found in the Treasury Department's Interdepartmental Budget.

Fees and other charges are examined annually as a part of the budget process. Factors such as the amount charged by surrounding states, and the length of time the amount of the fee has been in place, are considered. The Department's Insurance Unit and the Office of the Fraud Prosecutor are funded through insurance company assessments.