This report was prepared by the Commerce, Labor and Industry Section of the Office of Legislative Services under the direction of the Legislative Budget and Finance Officer. The primary author was Robin C. Ford with additional contributions by David Lorette, Richard Corbett and Jennifer Budd.

Questions or comments may be directed to the OLS Commerce, Labor and Industry Section (Tel. 609-984-0445) or the Legislative Budget and Finance Office (Tel. 609-292-8030).
DEPARTMENT OF BANKING AND INSURANCE

Budget Pages....... C-4, C-11, C-28, C-29, D-23 to D-28, F-9, H-12 to H-15, H-39, H-56

Fiscal Summary ($000)

<table>
<thead>
<tr>
<th></th>
<th>Expended FY 2009</th>
<th>Adjusted Appropriation FY 2010</th>
<th>Recommended FY 2011</th>
<th>Percent Change 2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Budgeted</td>
<td>$65,059</td>
<td>$67,668</td>
<td>$59,739</td>
<td>(11.7%)</td>
</tr>
<tr>
<td>Federal Funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Other</td>
<td>$1,343</td>
<td>$496</td>
<td>$531</td>
<td>7.1%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>$66,402</td>
<td>$68,164</td>
<td>$60,270</td>
<td>(11.6%)</td>
</tr>
</tbody>
</table>

TO THE READER

The Office of Legislative Services presents its analysis of the New Jersey Budget for Fiscal Year 2010-2011 in truncated form due to extraordinary time constraints. Unlike those of previous years, this year’s analysis is confined to a review of significant changes in appropriations and language provisions, respectively, recommended by the Governor. It also presents one or more background papers on selected topics pertinent to this agency’s mission. Discussion points, long a feature of annual OLS budget analyses, will be made available under separate cover and on the Internet, together with agency responses, from time to time as they are received.

Link to Website: [http://www.njleg.state.nj.us/legislativepub/finance.asp](http://www.njleg.state.nj.us/legislativepub/finance.asp)

Office of Legislative Services
Legislative Budget and Finance Office
April 2010
## Significant Changes/New Programs ($000)

<table>
<thead>
<tr>
<th>Budget Item</th>
<th>Adj. Approp. FY 2010</th>
<th>Recomm. FY 2011</th>
<th>Dollar Change</th>
<th>Percent Change</th>
<th>Budget Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECONOMIC REGULATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ANTICIPATED REVENUE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Anticipated Revenue</td>
<td>$125,547</td>
<td>$140,564</td>
<td>$15,017</td>
<td>12.0%</td>
<td>C-4</td>
</tr>
</tbody>
</table>

The FY2011 Budget Recommendation anticipates $140,564 million in revenue for the department, a $15 million (12%), increase from FY2010. The anticipated increase reflects the following significant changes:

**Insurance – Special Purpose Assessment**

|                      | $10,513             | $33,179        | $22,666       | 215.6%         | C-4         |

The FY2011 Budget Recommendation anticipates a $22.7 million (215%) increase in revenue from the Insurance Special Purpose Assessment in FY2011, from $10.5 million in FY2010 to $33.2 million estimated in FY2011.

This increase is largely due to the administration’s proposal to no longer dedicate the revenue from the “FAIR Act Administration” taxes, imposed pursuant to Section 2 of P.L.1945, c.132 (C.54:18A-2) and described in more detail below, to the department’s administrative costs. The Insurance Special Purpose Assessment would instead be the source of funding for the administrative costs of the department.

This proposed change will increase the assessments charged to insurers pursuant to the Insurance Special Purpose Assessment by approximately the amount collected pursuant to the FAIR Act Administration taxes (the most recent actual collection equaled $21.776 million in FY2009).

Additionally, the increase is due to the department’s need for additional personnel. The department has reportedly hired twelve new staff in FY2010 and plans to hire an additional seven staff in FY2011.

The Insurance Special Purpose Assessment was established as the “special purpose apportionment” by P.L.1995, c.156 (C.17:1C-19 et seq.), to fund administrative and regulatory expenses incurred by the division in the department. Although established in statute as an “apportionment,” it is more commonly referred to as the Special Purpose Assessment.

The Special Purpose Assessment is charged to all insurers writing most classes of insurance in the State (including, but not limited to: property; fire; flood; vehicle; life and health; accident; title; death; credit; personal liability; malpractice; homeowners; and any other specified kind of insurance) and those health maintenance organizations (HMOs) granted a certificate of authority to operate in New Jersey pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.). This Special Purpose Assessment is used for funding the activities of the division in regulating, monitoring and supervising these carriers. The annual amount assessed each carrier is based on the proportion that its net written premiums for the preceding calendar year bears to the combined
net written premiums of all carriers in the preceding year, except that no carrier is required to pay an assessment that exceeds 0.20 percent of its net written premium in any one year.

The “FAIR Act Administration” taxes were established pursuant to Section 2 of P.L.1945, c.132 (C.54:18A-2). They consist of two taxes dedicated to department administrative costs: a tax of 0.1%, upon taxable premiums of insurance carriers, (except those carriers that are life insurance companies, marine insurance companies, health maintenance organizations (HMOs), group accident and health insurance policies, and legal insurance policies); and, a tax of 0.05%, upon taxable premiums of group accident and health insurance policies and legal insurance carriers.

The “FAIR Act Administration” taxes are collected by the Department of the Treasury from the insurers and then transferred to the department for administrative expenses. Currently, the amounts collected offset the total special purpose assessment established pursuant to P.L.1995, c.156 (C.17:1C-19 et seq.) leading to a decrease in the total special purpose assessment charged to all insurers.

<table>
<thead>
<tr>
<th>Budget Item</th>
<th>Adj. Approp. FY 2010</th>
<th>Recomm. FY 2011</th>
<th>Dollar Change</th>
<th>Percent Change</th>
<th>Budget Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Fraud Prevention</td>
<td>$32,454</td>
<td>$22,500</td>
<td>($9,954)</td>
<td>(30.7%)</td>
<td>C-4</td>
</tr>
</tbody>
</table>

The FY2011 Budget Recommendation anticipates a $10 million reduction in revenue from Insurance Fraud Prevention, a 31% decrease from FY2010. This revenue reduction is matched by an expenditure decrease of $10 million dedicated to Insurance Fraud Prosecution Services (page D-27).

Currently, the department receives revenue from an assessment, reported in the budget as Insurance Fraud Prevention revenue, from certain insurers for all services related to the Division of Insurance Fraud Prevention’s expenditures pursuant to P.L. 1983, c.320 (C.17:33A-1 et seq.). The Division of Insurance Fraud Prevention (DIFP) was established under the Department of Banking and Insurance, but its functions were transferred to the Department of Law and Public Safety pursuant to Reorganization Plan No. 007-1998. The costs of the DIFP are certified by the Department of Law and Public Safety, approved by the Treasurer and then the revenue is transferred from the Department of Banking and Insurance to the Department of Law and Public Safety.

The Office of Insurance Fraud Prosecutor (OIFP) is located within the DIFP. The OIFP was established in the Department of Law and Public Safety, pursuant to the Automobile Insurance Cost Reduction Act (AICRA), section 32 of P.L.1998, c.21 (C.17:33A-16). The funding for the OIFP is provided through the Insurance Fraud Prevention assessment collected for the operation of the DIFP.

A note in the FY2011 Budget Recommendation (page D-27) indicates that the OIFP is proposed to be transferred from the Department of Law and Public Safety to the Department of Banking and Insurance in FY2011. Additionally, the FY2011 Recommended Budget also states that there will be a shift of 183 non-State funded positions from the Department of Law and Public Safety to the Department of Banking and Insurance due to the transfer of the OIFP (page H-12).
Significant Changes/New Programs ($000) (Cont’d)

<table>
<thead>
<tr>
<th>Budget Item</th>
<th>Adj. Approp. FY 2010</th>
<th>Recomm. FY 2011</th>
<th>Dollar Change</th>
<th>Percent Change</th>
<th>Budget Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real Estate Commission</td>
<td>$7,500</td>
<td>$10,000</td>
<td>$ 2,500</td>
<td>33.3%</td>
<td>C-4</td>
</tr>
<tr>
<td>Banking – Licenses and Other Fees</td>
<td>$2,500</td>
<td>$2,300</td>
<td>($ 200)</td>
<td>( 8.0%)</td>
<td>C-4</td>
</tr>
<tr>
<td>Salaries and Wages</td>
<td>$31,179</td>
<td>$33,280</td>
<td>$ 2,101</td>
<td>6.7%</td>
<td>D-27</td>
</tr>
</tbody>
</table>

Overall position data available in the FY2011 Recommended Budget (page D-26) indicates 201 positions funded for Insurance Fraud Prosecution and Prevention in FY2011. The discrepancy in numbers of staff positions transferred (183 vs. 201) is not explained in the FY2011 Budget Recommendation.

According to the Office of Management and Budget (OMB), the transfer of the OIFP will result in savings of $5 million by ensuring that OIFP designated funds be expended solely on OIFP matters. However, a review of the FY2009 budget in the OIFP FY2009 annual report does not indicate any expenditures on non-OIFP matters.

OMB also asserts that an additional $5 million in savings will be realized by eliminating grants currently made to counties for fraud prevention that go beyond the purpose of OIFP. It is unclear to the Office of Legislative Services (OLS), what fraud prevention activities are being conducted by the counties that are unrelated to the purpose of OIFP. The FY2009 Annual Report for the OIFP indicates that $3.391 million was the total grant for county prosecutors in FY2009.

The FY2011 Budget Recommendation anticipates $10 million in revenue from the Real Estate Commission, a $2.5 million (33%), increase from FY2010. The increase can be attributed to FY2011 being a renewal year of a two-year licensing schedule.

The FY2011 Budget Recommendation anticipates $2.3 million in revenue from Banking-Licenses and Other Fees, a $200,000 (8%), decrease from FY2010. The decrease can be attributed to the changes in licensing of financial entities due to the passage of the “New Jersey Residential Mortgage Lending Act,” (NJRMMLA), sections 1 through 49 of P.L.2009, c.53 (C.17:11C-51 et seq.) and the decision in Watters v. Wachovia Bank, N.A., in which the United States Supreme Court held that states are preempted from using their inspection and regulatory powers with respect to national banks and their operating subsidiaries. Both of these events effectively reduced the number of financial entities that must be licensed in the State and will likely have a long standing impact on the revenue collected from licensing and other fees.

DIRECT STATE SERVICES

Salaries and Wages | $31,179 | $33,280 | $ 2,101 | 6.7% | D-27 |

The FY2011 Budget Recommendation includes a $2.1 million (6.7%) increase in funding for salaries and wages. According to the department, the increase reflects the amount needed to
Significant Changes/New Programs ($000) (Cont’d)

<table>
<thead>
<tr>
<th>Budget Item</th>
<th>Adj. Approp. FY 2010</th>
<th>Recomm. FY 2011</th>
<th>Dollar Change</th>
<th>Percent Change</th>
<th>Budget Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund the hiring of an additional 19 staff as compared to the estimated appropriation for staff in FY2009. The department has already hired twelve staff in FY2010 and plans to hire seven more in FY2011. Additionally, personnel have been redeployed among programs to better meet the needs of the department. Funding has been increased for additional personnel in the following program classes:</td>
<td></td>
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</tr>
<tr>
<td>Consumer Protection Services and Solvency Regulation</td>
<td>$18,122</td>
<td>$19,373</td>
<td>$1,251</td>
<td>6.9%</td>
<td>D-27</td>
</tr>
<tr>
<td>The FY2011 Budget recommendation indicates 219 funded positions in FY2011, as compared to 210 in FY2009 and 218 in FY2010.</td>
<td></td>
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</tr>
<tr>
<td>Actuarial Services</td>
<td>$5,862</td>
<td>$5,887</td>
<td>$25</td>
<td>0.4%</td>
<td>D-27</td>
</tr>
<tr>
<td>The FY2011 Budget recommendation indicates 57 funded positions in FY2011, as compared to 56 in FY2009 and 54 in FY2010.</td>
<td></td>
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</tr>
<tr>
<td>Supervision and Examination of Financial Institutions</td>
<td>$3,115</td>
<td>$4,018</td>
<td>$903</td>
<td>29.0%</td>
<td>D-27</td>
</tr>
<tr>
<td>The FY2011 Budget recommendation indicates 39 funded positions in FY2011, as compared to 28 in FY2009 and 33 in FY2010.</td>
<td></td>
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</tr>
<tr>
<td>Funding dedicated for salaries and wages has been decreased for the New Jersey Real Estate Commission as follows:</td>
<td></td>
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</tr>
<tr>
<td>New Jersey Real Estate Commission</td>
<td>$3,134</td>
<td>$3,056</td>
<td>($78)</td>
<td>(2.5%)</td>
<td>D-27</td>
</tr>
<tr>
<td>The proposed decrease of $78,000 (2.5%) dedicated to salaries and wages in the New Jersey Real Estate Commission reflects the Governor’s proposal, as stated in the language provision on page F-9 of the FY2011 Budget Recommendation, to limit compensation for the seven public members of the Real Estate Commission to $100 per month.</td>
<td></td>
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</tr>
<tr>
<td>Currently, the salaries of the members of the Real Estate Commission are established pursuant to R.S.45:15-6 as follows: the president receives a salary of $15,000 per year, and each of the other six members of the public receive $10,500 each year. The department representative serves without compensation.</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Insurance Fraud Prosecution Services $29,771 $19,771 ($10,000) (33.6%) D-27

The FY2011 Budget Recommendation anticipates a $10 million reduction in funding for Insurance Fraud Prosecution Services (page D-27) from Insurance Fraud Prevention, a 34%, decrease from FY2010. The funding reduction is matched by a revenue decrease of $10 million (page C-4) dedicated to Insurance Fraud Prosecution Services. This reduction of support for insurance fraud prosecution services is accompanied by a transfer of the Office of Insurance Fraud Prosecutor from the Department of Law and Public Safety to the Department of Banking and Insurance during FY2011, as noted in a budget footnote on page D-27.

Currently, the Office of Insurance Fraud Prosecutor (OIFP) is located within the Division of Insurance Fraud Prevention (DIFP) in the Department of Law and Public Safety pursuant to the Automobile Insurance Cost Reduction Act (AICRA), section 32 of P.L.1998, c.21 (C.17:33A-16). Funding for the OIFP is provided through the Insurance Fraud Prevention assessment on certain insurers for all services related to the DIFP’s expenditures pursuant to P.L. 1983, c.320 (C.17:33A-1 et seq.). The DIFP was established under the Department of Banking and Insurance, but its functions were transferred to the Department of Law and Public Safety pursuant to Reorganization Plan No. 007-1998.

According to the Office of Management and Budget (OMB), the transfer of the OIFP will result in savings of $5 million by ensuring that OIFP designated funds be expended solely on OIFP matters. However, a review of the printed budget in the OIFP annual report does not indicate any expenditures on non-OIFP matters.

OMB also asserts that an additional $5 million in savings will be realized by eliminating grants currently made to counties for fraud prevention that go beyond the purpose of OIFP. It is unclear to the Office of Legislative Services (OLS), what fraud prevention activities are being conducted by the counties that are unrelated to the purpose of OIFP which amount to $5 million. The FY2009 Annual Report for the OIFP indicates that $3.391 million was the entire grant for county prosecutors.

Affirmative Action and Equal Employment Opportunity $30 $0 ($30) (100.0%) D-27

The FY2011 Budget Recommendation eliminates the $30,000 appropriation for Affirmative Action and Equal Employment Opportunity. The department asserts that this funding is used to support a portion of the affirmative action officer’s salary and states that alternative sources of non-State funding will be secured and the position will not be eliminated.
### Significant Changes/New Programs ($000) (Cont’d)

<table>
<thead>
<tr>
<th>Budget Item</th>
<th>Adj. Approp. FY 2010</th>
<th>Recomm. FY 2011</th>
<th>Dollar Change</th>
<th>Percent Change</th>
<th>Budget Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL OTHER FUNDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer Protection Services and Solvency Regulation</td>
<td>$496</td>
<td>$531</td>
<td>$ 35</td>
<td>7.1%</td>
<td>D-27</td>
</tr>
</tbody>
</table>

The FY2011 Budget Recommendation anticipates an increase of $35,000 (7.1%) in revenue collected from licensing fees charged to public adjusters. This increase matches the revenue actually collected from these licensing fees in FY2009 (total collected $87,000).
Modifying compensation for certain boards and commissions

|----------|-------------------------------------|

Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated to the County Boards of Taxation, Real Estate Commission, Civil Service Commission, State Commission on Investigation, Pilot Commissioners, Athletic Control Board, Public Employment Relations Commission and Appeal Board, Board of Mediation, Council on Affordable Housing, New Jersey Racing Commission, Council on Local Mandates, Garden State Preservation Trust, the various State professional boards, the Certified Psychoanalysts Advisory Committee and the Audiology and Speech-Language Pathology Advisory Committee in the Department of Law and Public Safety, shall be subject to the following conditions: 1) the base salary, per diem salary, or any other form of compensation, including that for expenses, for the board members or commissioners paid for out of State funds shall not exceed $100 per month; and 2) no State monies shall be used to pay for participation in the State Health Benefits Program by board members or commissioners. No other compensation shall be paid.

Explanation

The proposed language is intended to limit the compensation provided for members of certain boards and commissions to an amount not to exceed $100 per month, and requires that no State monies be used to pay for State Health Benefits Program participation for members of these boards or commissions. One of these boards, the New Jersey Real Estate Commission, is statutorily established in the Department of Banking and Insurance (N.J.S.A.45:15-5).

There are 8 members of the New Jersey Real Estate Commission. Of the 8 members, 7 members are appointed directly by the Governor. The eighth member is an employee of any State department which is closely affiliated with the real estate industry.

Currently, the salaries of the members of the Real Estate Commission are established pursuant to R.S.45:15-6 as follows: the president receives a salary of $15,000 per year, and each of the other six members of the public receive $10,500 each year. The department representative serves without compensation.

Under current compensation levels, the commission members are eligible to participate in the State Health Benefits Program. The proposed language would end this participation for these members. It should also be noted that eligibility for membership in the Public Employees Retirement System may also be affected by this language.

The commission is scheduled to meet 25 times during calendar year 2010. According to the department, the commission “frequently acts as a quasi-judicial body rendering decisions on contested license applications and disciplinary actions. It also promulgates rules interpreting

Significant Language Changes (Cont’d)

and implementing the provisions of the license law and establishing standards of practice for the real estate brokerage profession.”

Transfer of funds from the Medical Malpractice Liability Insurance Premium Assistance Fund to the General Fund in FY2010


Notwithstanding the provisions of any law or regulation to the contrary, there is appropriated from the Medical Malpractice Insurance Liability Premium Assistance Fund $1,800,000 for transfer to the General Fund as State revenue.

Explanation

The language provision authorized the transfer of $1.8 million from the Medical Malpractice Liability Insurance Premium Assistance Fund (MMLIPA) to the General Fund as State revenue in FY2010.

The FY2011 Recommended Budget includes a statement for the fund (page H-39) that indicates a $1.834 million transfer to other funds in FY2010 and a zero balance by year end FY2010.

Pursuant to P.L.2004, c. 17 the MMLIPA was authorized for a three year period, 2004 – 2007, to provide medical malpractice liability insurance premium relief for certain specialized health care providers in the State who experienced a liability insurance premium increase. Eligibility for relief is determined by class of practitioner, whose average medical malpractice premiums as a class are in excess of a particular amount per year, as established by the Commissioner of Banking and Insurance by regulation.

The MMLIPA was comprised of revenue collected from a $3 annual surcharge paid on or by employees subject to the "unemployment compensation law" and a $75 annual surcharge paid on the professional licenses of physicians, podiatrists, dentists, chiropractors, and attorneys, unless exempted under the law. The surcharges statutorily authorized to be deposited in the fund were discontinued on June 30, 2007.
Transfer of funds from the Workers’ Compensation Security Fund to the General Fund

<table>
<thead>
<tr>
<th>Deleted</th>
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</thead>
<tbody>
<tr>
<td><strong>There is appropriated $20,000,000 from the Workers’ Compensation Security Fund for transfer to the General Fund as State revenue.</strong></td>
</tr>
</tbody>
</table>

**Explanation**

The language provision authorized the transfer of $20 million from the Workers Compensation Security Fund (WCSF) to the General Fund as State revenue in FY2010. Language is no longer needed because there is no planned transfer of funds from the WCSF to the General Fund in FY2011.

Additionally, legislation was enacted in FY2010, transferring the responsibility for the management, administration and claims activities of the WCSF from the Department of Banking and Insurance to the New Jersey Property-Liability Insurance Guaranty Association (PLIGA) (P.L.2009, c. 327 (C.34:15-105.1 et al.)).

PLIGA is a “private, nonprofit, unincorporated, legal entity” given certain statutory obligations to act as a safety net for policyholders and claimants in the property and casualty insurance marketplace pursuant to N.J.S.A.30A-1 et seq.

The WCSF (R.S.34:15-105) is a depository for monies received from assessments levied against mutual and stock insurance carriers writing workers’ compensation insurance in the State. The revenue in the fund is disbursed to persons entitled to receive workers’ compensation from a carrier when that mutual or stock carrier is determined to be insolvent.

Budget data indicates that the WCSF (page H-56) had an estimated available fund balance of $54 million at the start of FY2010. However, as is referenced above, effective FY2011, the WCSF balance is no longer reported in the budget as it is now part of the independent PLIGA.
Background Paper: Historical Analysis of Revenues and Expenditures of the Department of Banking and Insurance

The mission of the Department of Banking and Insurance is to regulate the banking, insurance, and real estate industries in a professional and timely manner that protects and educates consumers and promotes the growth, financial stability and efficiency of those industries. The department is divided into two main regulatory divisions: the Division of Banking and the Division of Insurance. The department also contains the New Jersey Real Estate Commission, which regulates the real estate industry in the State.

The funding used to support the department is generated primarily through the collection of assessments and taxes on the industries that it regulates. The Division of Banking collects revenue from the following three sources: assessments; examination fees; and fees associated with the issuing of licenses. The Division of Insurance receives revenue from the following nine sources: special purpose apportionments; FAIR Act Administration taxes; actuarial services; “HMO Covered Lives” fees; Small Employers Health Benefits (SEH) assessments; Individual Health Coverage Program (IHC) assessments; insurance licenses and other fees; public adjusters licensing; and examination billings.1 The department also receives a small amount of revenue from miscellaneous sources.2 The New Jersey Real Estate Commission receives revenue from fees and licenses associated with the regulation of the real estate industry.

Revenues vs. Expenditures (thousands)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues</td>
<td>$111,024</td>
<td>$114,176</td>
<td>$113,576</td>
<td>$159,232</td>
<td>$137,945</td>
<td>$126,043</td>
<td>$141,008</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenditures</td>
<td>$68,749</td>
<td>$64,818</td>
<td>$69,999</td>
<td>$93,460</td>
<td>$73,399</td>
<td>$65,059</td>
<td>$67,668</td>
<td>$59,739</td>
</tr>
<tr>
<td>Surplus</td>
<td>$42,275</td>
<td>$49,358</td>
<td>$43,577</td>
<td>$65,772</td>
<td>$64,546</td>
<td>$86,126</td>
<td>$58,375</td>
<td>$81,269</td>
</tr>
</tbody>
</table>

*Actual **Estimated

1 The Division of Insurance also collects an assessment which is not included in this revenue background paper because the funds collected are transferred to a different department. The department collects a motor vehicle assessment for the Motor Vehicle Security Responsibility Fund pursuant to section 1 of P.L.1952, c. 176(C. 39:6-58). This assessment is billed and collected by the Department of Banking and Insurance and used to reimburse the New Jersey Motor Vehicle Commission.
2 Miscellaneous revenue is collected each year by the department. This revenue varies each year and is generally below $100,000 a year.
3 Not included in this figure is a one time revenue occurring in FY2008, in the amount of $22,000, given to the department from an outside source for the purpose of enhancing examiner training. This revenue is listed in the budget as the Bryce Curry Memorial Scholarship fund. Funding under the Health Insurance Security and Privacy Collaboration is also not included in the revenue breakdown. In FY2008, the department collected $153,000 for this purpose, which was collected for one time funding used to conduct research on electronic medical records as part of the electronic health information technology partnership between the department and the Department of Health and Senior Services.
4 The FY2011 revenue includes $21 million in FAIR Act Administration revenue that the proposed budget would transfer directly to the General Fund as State revenue as discussed in more detail on page 5 of this backgrounder. Therefore, the surplus revenue will more likely equal approximately $61 million.
The table above details total revenues collected by the department compared to the total dollar amount expended by the department from FY2004 to FY2011. The table includes both Schedule 1 “on-budget” (anticipated) revenues and Schedule 2 “off-budget” (appropriated) revenues as well as Schedule 3 “on-budget” (anticipated) expenditures as well as Schedule 4 “off-budget” (expenditures not budgeted) appropriations.

As the table suggests, the department has historically generated revenues in excess of the amount necessary to support its annual operations. This surplus revenue, which reached a high of $86.1 million in FY 2009 due to one-time revenue sources, accrues annually to the State General Fund.

Notably, while the department is self-funded, it has still been required to participate in Statewide layoffs or furlough programs which resulted in reductions to personnel costs. Since the personnel costs are passed on to the industry through assessments, the cuts to personnel have resulted in an overall decrease in the assessment received by the State. For example, in FY2009 expenditures decreased by $8.3 million, primarily due to reductions in personnel costs. This led to a $2.1 million decrease in the assessment for that year.

Following is a breakdown of the revenue received by the department, sorted by each of the divisions and the New Jersey Real Estate Commission. The reader will note that there are differences in the collection of revenue for each section of the department.

The Division of Banking has experienced a gradual decline in total revenue collected from the industries it regulates over the past eight years. The decline can be attributed to several factors, including: a change to the assessment process in the Division of Banking implemented in FY2007; the overall downturn in the economy; and the sharp decline in the number of businesses and individuals licensed as participants in the financial services industry.

The Division of Insurance has experienced a gradual increase in total revenue collected. The increase can be attributed to an increase in the revenue generated by insurance licenses and other fees. This revenue includes settlements collected from the industry for certain violations of regulations and fee increases charged to the industry.

The New Jersey Real Estate Commission has maintained steady revenue since FY2004 with biennial fluctuations related to a biennial licensing system.

Each of the revenue streams from the two divisions and the commission will now be discussed in greater detail.

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5 The surplus in FY2009 is due to excess revenue collected from two settlements totaling $15.5 million from two insurers who had been found to have violated certain regulatory requirements.
Division of Banking

Revenues Collected by the Division of Banking

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<td>Assessments</td>
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<td>$13,552</td>
<td>$11,988</td>
<td>$12,000</td>
<td>$11,800</td>
</tr>
</tbody>
</table>

*Actual  **Estimated

Assessments

P.L.2005, c.199 (C.17:1C-33 et seq.), established a new assessment on all financial entities the department charters, licenses and registers for all services related to the department’s financial regulation, supervision and monitoring of these entities. The division began charging this assessment in 2007 and charges it to the financial entities in two parts on, or around, October 1 of each year: a Licensing Banking Assessment and a Depositor Banking Assessment.

The reader will note in the above chart that the revenue collected from the assessment increased as of 2007, which corresponded with a decrease in the revenue collected due to examination fees and licenses. The assessment, as it has been implemented since 2007, eliminated examination fees, certain licenses and other fees charged by the department, resulting in an overall loss in revenue to the department. Additionally, a 2007 Supreme Court decision, Watters v. Wachovia Bank N.A., and the enactment of the New Jersey Residential Mortgage Lending Act (sections 1 through 49 of P.L.2009, c.53; C.17:11C-51 et seq.) (required as part of the federal legislation, the “Housing and Economic Recovery Act of 2008” (Pub.L.110-289) enacted in 2008) have affected the ability of the department to regulate certain financial industries. Due to these changes, financial entities may choose to eliminate their State charter and be solely federally chartered. Many financial entities have chosen to be solely federally chartered. The decrease in State chartered financial entities has resulted in less work for the department and thus a lower assessment.

Licenses

The division issues many different licenses; including, but not limited to, consumer lending licenses, licenses related to the mortgage industry, check cashing licenses, debt adjusting licensing, and high cost home loan credit counseling licenses. The fees for each license vary.

The revenue raised by fees from licenses has gradually decreased since FY2006. The largest effect was the new assessment implemented in 2007, which eliminated many licenses required to be obtained by financial institutions. Additionally, the overall number of licensees who are required to be licensed by the State was adversely affected by both the decision of Watters v. Wachovia Bank N.A. and the enactment of the “New Jersey Residential Mortgage Lending Act” (sections 1 through 49 of P.L.2009, c.53; C.17:11C-51 et seq.). Both of these changes significantly decreased the number of mortgage lending entities and individuals who are required to be licensed by the State. Furthermore, the downturn in the economy led to a decrease in the number of individuals who were employed in the mortgage lending industry. For example, in response to OLS questions during the review of the FY2010 budget, the
department indicated that it had collected $1.192 million in licensing fees from various mortgage lending entities and individuals in 2009, a decrease of $9.71 million, as compared to the $10.9 million collected in 2005, the highest revenue collecting year.

Examination Fees

The division conducts examinations related to the industry it regulates. Fees were previously charged for these examinations.

The revenue raised from examination fees has been eliminated due to the changes enacted with the new assessment, provided for in P.L.2005, c.199, which altered the division’s method of collecting revenue from the industry, and eliminated examination fees.

### Division of Insurance

**Revenues Collected by the Division of Insurance**

*(thousands)*

<table>
<thead>
<tr>
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<td>HMO Covered Lives</td>
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<td>n/a</td>
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<td>Public Adjusters Licensing</td>
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<td>$36</td>
<td>$118</td>
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<td><strong>Total Revenues</strong></td>
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<td><strong>$127,291</strong></td>
<td><strong>$106,543</strong></td>
<td><strong>$119,208</strong></td>
</tr>
</tbody>
</table>

*Actual **Estimated

Special Purpose Apportionment

P.L.1995, c.156 (C.17:1C-19 et seq.), established a special purpose apportionment for funding expenses incurred by the division in the department. Although established in statute as an apportionment, it is more commonly referred to as the Division of Insurance assessment. The assessment is charged to all insurers writing most classes of insurance in the State (including, but not limited to: property; fire; flood; vehicle; life and health; accident; title; death; credit; personal liability; malpractice; homeowners; and any other specified kind of insurance)
Background Paper: Historical Analysis of Revenues and Expenditures of the Department of Banking and Insurance (Cont'd)

and those health maintenance organizations (HMOs) granted a certificate of authority to operate in New Jersey pursuant to P.L.1973, c.337 (C.26:2j-1 et seq.). This assessment is used for funding the activities of the division in regulating, monitoring and supervising these carriers. The assessment of each carrier is based on the proportion that its net written premiums for the preceding calendar year bears to the combined net written premiums of all carriers in the preceding year, except that no carrier is required to pay an assessment that exceeds 0.20 percent of its net written premium.

The reader will note that the revenue generated from the special purpose assessment has gradually decreased from FY2008 to FY2010. This reflects the decrease in the numbers of staff employed by the department and other cost containment measures undertaken by the department during this time period. Conversely, the amounts estimated to be collected in FY2011 increase by approximately $22 million. This increase is due to changes proposed by Governor Christie to the use of the “FAIR Act Administration” taxes.

Currently, the amounts charged to the insurers as the special purpose assessment is offset by the revenue collected pursuant to the “FAIR Act Administration” taxes (see below for more explanation of these taxes). However, Governor Christie has proposed, subject to enabling legislation, that the revenue from the “Fair Act Administration” would no longer be dedicated to the department’s administrative costs and the special purpose assessment would instead be the source of funding for the administrative costs of the department. This change would necessitate an increase in the assessment of an amount equal to the revenue raised by the “FAIR Act Administration” taxes, approximately $22 million in FY2009.

Actuarial Services

Actuarial services are those fees collected by the department from application fees paid by companies that are newly entering the New Jersey market. The application fee is used to process the new company’s application and conduct an actuarial review and solvency review before the company is reviewed by an admittance committee.6

The revenue collected is dependent on the number of companies choosing to enter the market and has been influenced both by the downturn in the economy and the department’s staffing level and thus, its ability to conduct reviews.

FAIR Act Administration Taxes

Section 2 of P.L.1945, c.132 (C.54:18A-2), establishes two taxes dedicated to department administrative costs: a tax of 0.1%, upon taxable premiums of insurance carriers, (except those carriers that are life insurance companies, marine insurance companies, health maintenance organizations (HMOs), group accident and health insurance policies, and legal insurance policies); and, a tax of 0.05%, upon taxable premiums of group accident and health insurance policies and legal insurance carriers.

The revenue from these taxes is collected by the Department of Treasury from the insurers and then transferred to the department for administrative expenses. The amounts collected offset the total special purpose assessment established pursuant to P.L.1995, c.156 (C.17:1C-19 et seq.).

Governor Christie has proposed that, as of FY2011, the revenue from the “FAIR Act Administration” taxes would no longer be dedicated to the department’s administrative costs

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6 Currently, according to the department, the application fee is $250.
and the special purpose assessment instead would be the source of funding for the administration costs of the department.

_Fraud Fines_

The department collects the payment of fines that were levied in association with the commission of fraud. The monies collected from these fines are transferred to the General Fund.

The revenue collected due to the fraud fines has steadily declined since FY2008. This decline can be attributed to a decline in the staff dedicated to the investigation of fraud and collection of fines.

_HMO Covered Lives fees_

Section 18 of P.L.2002, c.34 (C.26:2J-23) established a fee charged to HMOs, in the amount of $1.50 per covered life per year, collected by the department. The revenue from this fee is used both for the administrative costs of the Department of Health and Senior Services (approximately $100,000 a year) and as an offset to the special purpose assessment charged insurers pursuant to P.L.1995, c.156 (C.17:1C-19 et seq.) and discussed in more detail above.

The division monitors the compliance of HMOs with New Jersey rules through in-depth reviews and targeted examinations. The division investigates consumer complaints concerning HMOs and other carriers offering managed care health benefits plans.

The revenue collected from “HMO Covered Lives” should remain stable each year; however, according to the department, the timing of the collection schedule may lead to certain inconsistencies in collections for fiscal years. For example, the assessment for FY2009 was sent out to the insurers in June 2009. Certain insurers returned the fee within the time period needed to account for the funding in FY2009. Others returned it later and the funds will be reflected in the actual funding for FY2010. The department asserts that this is the reason for the increased revenue for FY2009.

_Small Employer Health Insurance Assessment (SEH assessment)_

Pursuant to section 16 of P.L.1992, c.162 (C.17B:27A-32), the department charges an assessment on all Small Employer Health Insurance carriers for the reasonable and necessary organizational and operating expenses of the SEH board of directors. The revenue generated is typically constant.

_Individual Health Care Program Assessment (IHC assessment)_

This assessment is charged to all Individual Health Care carriers for the reasonable and necessary organizational and operating expenses of the IHC Program board of directors pursuant to section 10 of P.L.1992, c.162 (C.17B:27A-11).

The IHC assessment also reflects the loss assessment reconciliation that the IHC performs every two years for the carriers. In FY2007, litigation affecting several loss calculation periods was concluded which resulted in greatly increasing the revenue collected by the department in that fiscal year. However, these funds were then expended by the department to the carriers. According to the IHC program, each two-year calculation period addresses events that are unique to that period and a comparison cannot be made between the years.
Insurance Licenses and Other Fees

The division issues various licenses to resident and non-resident insurance producers. The department collects fees for the licenses that it issues. Additionally, settlements negotiated with insurance carriers for certain violations of insurance regulations are reflected as revenue collected under this category.

In FY2006 and FY2007, the implementation of additional fees generated additional revenue in the amount of $19 million. Furthermore, in FY2007, there were changes to the renewal cycle of certain licenses that resulted in increased revenue. In FY2009, two insurers were required to pay settlements, equaling $15.5 million, to the department. In the future, revenue may also fluctuate due to orders on the industry, but these amounts cannot be anticipated.

Public Adjuster Licensing

The division issues public adjuster licenses to resident and non-resident individuals and organizations. The department collects fees for the licenses that it issues. The revenue generated is typically constant.

Examination Billings

The division conducts financial examinations on all domestic insurers and an examination fee is charged to the insurance company for this service. The revenue generated is typically constant.

Insurance Fraud Prevention

The division collects an assessment from certain insurers for all services related to the Division of Insurance Fraud Prevention’s expenditures pursuant to P.L. 1983, c.320 (C.17:33a-1 et seq.). The Division of Insurance Fraud Prevention (DIFP) was established under the Department of Banking and Insurance, but its functions were transferred to the Department of Law and Public Safety pursuant to Reorganization Plan No. 007-1998. The costs of the DIFP are certified by the Department of Law and Public Safety, approved by the Treasurer and then the revenue is transferred from the Department of Banking and Insurance to the Department of Law and Public Safety.

The revenue generated through this assessment has been consistent since FY2004. However, Governor Christie, in the Budget in Brief (page 86), has proposed a reduction of $10 million dedicated for the Office of Insurance Fraud Prevention (OIFP). The OIFP is located in the DIFP in the Department of Law and Public Safety and is funded through the insurance fraud prevention assessment. Consequently, the Budget in Brief (page 118), also reflects a $10 million reduction in revenue anticipated to be generated from the Insurance Fraud Prevention assessment.

New Jersey Real Estate Commission

Revenues Collected by the New Jersey Real Estate Commission

7 The fees range from $20 - $270 per license, http://www.state.nj.us/dobi/licfees.htm.
8 The fees range from $150 - $320 per license, http://www.state.nj.us/dobi/licfees.htm.
9 According to the department, the fee for each examination is not a set fee, but rather the insurers are charged an hourly rate by the department.
The New Jersey Real Estate Commission collects revenue from fees associated with the licensing of real estate salespersons and brokers, and from the collection of fines. The licensing of certain real estate professionals is conducted on a biennial basis and the revenue fluctuates accordingly.
INTRODUCTION AND BACKGROUND

Generally, individual health insurance is available in the private market for purchase by individuals and families who do not have access to employer-provided insurance or to public programs such as Medicare and Medicaid. Although employer-provided insurance has a much larger market share, individual health insurance nonetheless plays an important role as a source of coverage for persons who are self-employed, unemployed, or do not have the option of obtaining group insurance. Nationwide, state legislatures have struggled with structuring the individual market so as to provide coverage that is both affordable and widely available.

For several reasons, individual health benefits plans are more expensive than comparable plans offered in the small employer market (generally covering 2-50 employees), and the large employer market (generally covering over 50 employees). People with serious medical conditions are more likely to seek coverage, and more likely to be unemployed, and therefore, to select coverage under an individual health plan. Since these individuals tend to need extensive medical services, premium rates in the individual market reflect this higher level of “adverse selection.” Younger, healthier individuals tend not to see the value of health insurance coverage and they tend to be put off by high rates that are due, in part, to adverse selection. Lower premium rates in the employer group market reflect the greater pool of covered individuals and less of an impact from adverse selection in that market.

In addition, the individual market does not benefit from the administrative efficiencies inherent in the employer-provided market. It is much less expensive for a health insurance carrier to enroll employees of a large business than to enroll persons individually. Further, individuals purchasing in the individual market face another economic challenge - while employers often pay a significant share of group health plan premiums using pre-tax dollars, individuals generally buy their own coverage with after-tax dollars.

NEW JERSEY LEGISLATIVE REFORMS

In New Jersey, the individual health insurance market has experienced the same challenges and market forces as experienced nationally, thus leading to serious issues of availability and affordability that reached a crisis level in 1992. At the time, Blue Cross and Blue Shield of New Jersey (“BCBS”), as the State’s insurer of last resort, was required to issue an individual health insurance policy to anyone willing to pay the premium. As a result of heavy participation in the individual market, BCBS bore a disproportionate share of losses because other carriers were reluctant to participate in this higher risk market. These losses tended to drive up premiums, which in turn caused many individuals to drop coverage.

By 1992, the individual market, which had been largely unregulated, was in crisis. As premiums continued to rise, the number of uninsured New Jersey residents also rose. BCBS was in dire financial condition, due in part to its individual market participation, and the Legislature faced the prospect of the State’s insurer of last resort raising premiums even higher or
undergoing a financial collapse, which would have left many more residents without any health insurance coverage.

The “Health Care Reform Act of 1992”

To address the factors that contributed to the individual market’s crisis situation and other health care cost-related issues, the Legislature enacted a package of bills commonly known as the “Health Care Reform Act of 1992.” Included in this package was P.L.1992, c.161 (C.17B:27A-2 et seq.), which provided for a major restructuring of the individual health insurance market by establishing the Individual Health Coverage Program (the “IHCP”). The IHCP was designed to stabilize a financially precarious individual health insurance market by: creating incentives for carriers to participate in the market in order to spread the cost of providing individual coverage among New Jersey’s entire health insurance industry; allowing consumers to comparison shop based on premiums by standardizing all available plans; and creating the Individual Health Coverage Program board to govern how carriers provide individual policies to New Jersey residents.

The “Health Care Reform Act of 2008”

In 2008, after assessing the experiences in the individual health insurance market between 1992 and 2008, and as part of a broader plan to expand health insurance coverage generally in the State, the Legislature enacted P.L.2008, c.38 (hereinafter referred to as the “Health Care Reform Act of 2008”). In that act, the Legislature made changes effective in 2009 to certain aspects of the IHCP in order to make plans more affordable to individuals. These reforms included: moving from a pure community rating system to a modified community rating system for standard plans; requiring that a carrier make a good faith effort to market individual policies as a condition of participation in the small employer market; increasing minimum loss ratio requirements to 80%; and shifting certain oversight responsibilities from the IHCP to the Department of Banking and Insurance.

KEY FEATURES – STANDARD PLANS AND THE BASIC AND ESSENTIAL PLAN

As a result of these two major legislative enactments and other various revisions, the IHCP is currently structured so that New Jersey residents, regardless of their health status, claims history, or any other risk factor, are guaranteed the right to purchase renewable health benefits coverage under standard plans and a basic plan offered by a variety of private health insurance carriers. The key features of the standard plans, the basic plan, and the IHCP, are described below. Some changes made by the enactment of the Health Care Reform Act of 2008 are explained in further detail in footnotes, to draw certain distinctions between the operations of the IHCP between 1992 and 2008 under the Health Care Reform Act of 1992, and the current operations of the IHCP, with the revisions made by the Health Care Reform Act of 2008.
Background Paper: New Jersey’s Individual Health Coverage Program
(Cont’d)

Standard plans

- Carriers can only offer New Jersey residents coverage under five standard plans (and a basic plan as described below). Carriers must offer at least three of the five standard plans, which are known as A/50, B, C, D, and an HMO. The standard plans were designed to facilitate consumer access to coverage. Limiting the number and range of plans that a carrier can offer enables consumers to comparison shop for benefits based on premiums, without being overwhelmed by a multitude of plan options.

- The standard plans all contain a common, comprehensive set of covered services including: office visits, hospital care, prenatal and maternity care, well-child care, certain preventive care screenings, x-ray and lab services, certain mental health services, and prescription drugs. The plans vary in terms of the policyholder’s responsibility for coinsurance and deductibility options and, accordingly, vary as to premiums charged. Carriers may offer riders to increase the benefits under one or more of the standard plans.

- Standard plans are subject to a modified community rating, which means that all persons enrolled in a particular plan are charged the same rate, except that a carrier can use age as a criteria for setting premiums, but by no more than a 3.5 to 1 ratio between the highest and lowest rated plans. This means that the highest premium rate cannot be more than three and one-half times the rate for the least expensive policy. Carriers cannot vary rates based on health status, claims history, gender, geographic location, or any other risk factor.10

Basic and essential health care services plan – the “B&E plan”

- By a separate legislative enactment in 2001, carriers are required to offer a basic health care services plan through the IHCP.11 The Basic and Essential Health Care Services plan (the “B&E plan”) is intended to be more affordable than the standard plans, although it is not as generous in coverage. The B&E plan provides “bare bones” coverage for hospital stays and some limited preventive services. Carriers may offer riders to enhance the coverage.

- For the B&E plan, carriers may use community rating modified by using age, gender, and geographic location as criteria for setting premiums, but by no more than a 3.5 to 1 ratio between the highest and lowest rated plans.

Individual Health Coverage Program

10 From 1992 to 2008, the standard plans were held to a pure community rating standard, meaning that premiums could not be adjusted by any risk factors. The Health Care Reform Act of 2008 revised the community rating for standard plans to allow for a premium differential based on age.

Background Paper: New Jersey's Individual Health Coverage Program
(Cont'd)

- The Individual Health Coverage Program board proposes and adopts regulations that govern the operations of the IHCP. The board, which is "in but not of" the Department of Banking and Insurance, is composed of nine members, and includes both carrier and consumer representatives as board members. The board adopted an extensive set of regulations to implement the act, which are set forth at N.J.A.C. 11:20-1.1 et seq. The board's functions are carried out by an executive director.12

- A New Jersey resident who is not eligible for coverage under an employer-provided plan, a government plan, or certain other plans, may purchase a standard plan or a B&E plan through the IHCP for a single person, two adults, a family, or an adult and children.

- Carriers must offer and make a good faith effort to market individual policies through the IHCP as a condition of participation in the small employer market, in order to ensure greater participation by carriers in the individual market.

- To provide coverage to higher-risk persons, and to prevent carriers from selecting only persons with low probabilities of using expensive medical care, carriers that sell policies must accept all applicants who lack access to group insurance (guaranteed issue) and cannot refuse to renew policies (guaranteed renewal). Thus, an eligible New Jersey resident who can afford policy premiums can never be denied coverage due to a medical condition or high incidence of claims. Carriers can limit coverage by excluding pre-existing conditions, but only for the first 12 months of coverage.

- A carrier may change its premium rates for a particular plan as of a specified date, provided the carrier makes an informational filing with the Department of Banking and Insurance before the rates are used. However, carriers must price the plans to comply with an 80% minimum loss ratio requirement, which means that 80 cents of every premium dollar must be expended on the payment of claims, while the remaining 20 cents can be used for administrative expenses and profits.13

ENROLLMENT, CARRIER PARTICIPATION AND COSTS OF COVERAGE

Enrollment

In New Jersey, about 112,000 persons obtain insurance in the IHCP – about 1% of New Jersey's population. By comparison, 11% of the State’s residents obtain insurance in the small employer market and 46% obtain insurance in the large employer market. In terms of overall enrollment and carrier participation, the IHCP continues to experience significant challenges, despite a steady increase in enrollment in the B&E plan.

12 The Health Care Reform Act of 2008 transferred regulatory oversight regarding approval of policy and contract forms, and review of premium rate filings and similar matters, from the Individual Health Coverage Program board to the Commissioner of Banking and Insurance.

13 From their inception in 1992, the standard plans were subject to a 75% minimum loss ratio. B&E plans from their inception in 2001 were subject to a 75% minimum loss ratio. The Health Care Reform Act of 2008 increased the minimum loss ratio for standard and B&E plans from 75% to 80%.
Background Paper: New Jersey’s Individual Health Coverage Program (Cont’d)

Overall enrollment in the IHCP has declined from the program’s early years, when it was most successful. Enrollment was at a high point of 200,000 in 1996, declined steadily to a low of 77,000 in the fourth quarter of 2005, and then increased steadily to the current enrollment of 112,000 as of the 4th quarter of 2009.

The overall decline in enrollment from the program’s beginnings is usually attributed to several factors:

- Initially, the Health Care Reform Act of 1992 included a State subsidy program – the ACCESS program – to facilitate the purchase of individual health insurance through the IHCP for low-income persons. However, the ACCESS program proved to be costly to the State and was eventually phased out, causing a drop in enrollment.

- In the late 1990’s, the State’s growing economy allowed more residents to obtain employment and move from the individual market to employer-provided insurance.

- Due to adverse selection, subscribers to IHCP plans are currently, on average, older and less healthy than New Jersey residents who have employer-provided insurance. These market characteristics contribute to a cycle of rising premiums to meet high claims experience, which results in declining enrollment in the program, especially by young, healthy subscribers who are generally less willing to pay for coverage that they do not anticipate using.

The overall increase in enrollment in the IHCP plans between 2005 and 2009 can be attributed to growth in B&E plan enrollment. Enrollment in the standard plans decreased steadily during that period from 77,500 in the fourth quarter of 2005 to a low of 52,000 in the 4th quarter of 2009, while B&E plan enrollment increased steadily from 7,800 in the fourth quarter of 2005 to 59,800 in the 4th quarter of 2009. The Department of Banking and Insurance has indicated that the success of the B&E plan is largely due to the use of modified community rating which provides carriers more flexibility in setting their premiums in relation to their claims experience, and the availability of riders to increase the coverage above basic coverage.

Carrier participation

There has also been a decline in the number of carriers participating in the IHCP, from a high of 28 initially to 10 carriers currently. Although this decline can to some extent be attributed to several mergers among carriers participating in this market, it is nevertheless significant in terms of providing less competition and the corollary effect of less downward pressure on prices.

Costs of Coverage

Standard plan and B&E plan coverage rates vary widely. Rates are available in detail at the department’s website at www.state.nj.us/dobi, under “Division of Insurance, Health Insurance Programs IHC and SEH.” The following are some sample illustrations of costs of
coverage under the standard plans and the B&E plan, using data from the department’s website, as of February, 2010.

Standard plan costs are dependent upon the selection of both the amount of co-insurance to be paid by the insured and the rate structure of the particular carrier. Carriers can also vary premiums based on age, although not all carriers choose to do so.

- For single coverage, an insured under age 25 could pay from $361 to $1,228 per month for an HMO with a $30 copay, with an average cost of $833 per month.

- For family coverage, with an insured aged 45 to 49, the average monthly cost of an HMO with a $30 copay is $2,561. If that family were to choose one of the four other standard plans, for a plan with a $2,500 deductible, they could pay from $2,528 to $12,375 per month, with an average cost of $4,715 per month for a policy with no rider for additional coverage.

The B&E plan coverage also comes in a wide range of rates, depending on the choice of a carrier and the carrier’s use of community rating factors. Carriers may vary premiums by age, gender, and geographic location.

- For single coverage, a male under age 25 and residing in Essex, Hudson or Union Counties could pay from $138 to $854 per month, with an average cost of $368 per month, for a policy with no rider for additional coverage. For the same coverage, a female under 25 could pay from $155 to $939 per month, with an average cost of $451 per month.

- For family coverage, an insured aged 45 to 49, residing in Essex, Hudson or Union counties, could pay from $654 to $4,499 per month, with an average cost of $2,058 per month, for a policy with no rider for additional coverage.

ANALYSIS

Given the increasing IHCP premiums, declining enrollment in the standard plans, and decreased carrier participation, some health care analysts have questioned the effectiveness and sustainability of the IHCP. However, in assessing how well the IHCP met the goals that it was originally intended to meet, due consideration should also be accorded to the dire situation that prevailed in 1992, prior to the enactment of the Health Care Reform Act of 1992. Given the problems at the time - the potential collapse of the State’s insurer of last resort and the high number of uninsureds - the Legislature’s policy objective to enact legislation to avert the collapse of the individual market, provide some market stability, and bring more carriers into meaningful participation in the market so as to create more competition, would appear to have been realized.

In addition, the Legislature, by including the community rating, guaranteed issue, and guaranteed renewal features of the IHCP, ensured coverage for many New Jersey residents who most needed it – the very sick and the disabled. Other states have taken different policy approaches that utilize medical underwriting – basing premiums on the health experience of
the individual - and do not require policies to be guaranteed issue and guaranteed renewable. Such a regulatory structure results in lower premiums for healthier residents who can obtain individual health insurance, but it also excludes some residents who desperately need insurance, from being eligible to purchase it from any insurer, thus increasing the uninsured or “charity care” population.

Further, the enactment of Health Care Reform Act of 2008 represents another attempt to address ongoing affordability and enrollment issues by adjusting certain characteristics of New Jersey’s individual health insurance market, while retaining much of the structure of the IHCP as originally provided by the Health Care Reform Act of 1992. Most notably, these reforms have applied to the standard plans some of the features that appear to have contributed to increasing enrollment in the B&E plan – allowance of modified community rating and the use of riders to increase coverage benefits.

As the changes from the Health Care Reform Act of 2008 only took effect in January, 2009, their impact on affordability and accessibility can not yet be determined with any degree of certainty; legislative reforms in the health insurance market typically need a longer period of operation in order to conduct a meaningful assessment. As time passes, and the Department of Banking and Insurance continues to compile data on carrier participation, individual enrollment, and premium levels, the impact of the Health Care Reform Act of 2008 may become the subject of further review and analysis by State policymakers and health care analysts.

Finally, it is unclear at this time what affect the federal “Patient Protection and Affordable Care Act “(Pub. L.111-148) and “Health Care and Education Reconciliation Act of 2010” (Pub. L. 111-152) will have on the IHCP. Enacted in March, 2010, these laws will, among other things: establish a mandate for most residents of the United States to obtain health insurance; set up insurance exchanges through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare’s payment rates for most services (relative to the growth rates projected under current law); impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the federal tax code, Medicare, Medicaid, and other programs. Many of these provisions are phased in over the next several years, including the 40 percent excise tax that will be implemented in 2018 and imposed on health insurance premiums exceeding $10,200 for single coverage and $27,500 for family coverage.

It is certainly possible that federal mandates on individuals to obtain insurance and the establishment of insurance exchanges may, in particular, have a large impact both on the population served by IHCP and the method through which individuals can access health insurance in the future.
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