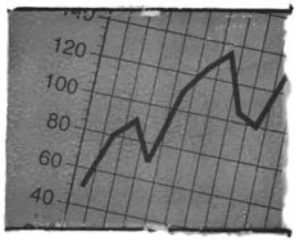

ANALYSIS OF THE NEW JERSEY BUDGET

DEPARTMENT OF BANKING AND INSURANCE

FISCAL YEAR 2011 - 2012

PREPARED BY OFFICE OF LEGISLATIVE SERVICES
NEW JERSEY LEGISLATURE • APRIL 2011

NEW JERSEY STATE LEGISLATURE

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DEPARTMENT OF BANKING AND INSURANCE

Budget Pages..... C-4, C-10, C-17, C-26, C-28, D-21 to D-26 and F-8

Fiscal Summary ($000)

	Expended FY 2010	Adjusted Appropriation FY 2011	Recommended FY 2012	Percent Change 2011-12
State Budgeted	$60,666	$61,320	$62,970	2.6%
Federal Funds	0	$746	$9,236	1,138%
Other	$2,087	$531	$535	0.7%
Grand Total	$62,753	$62,597	$72,741	16.2%

Personnel Summary - Positions By Funding Source

	Actual FY 2010	Revised FY 2011	Funded FY 2012	Percent Change 2011-12
State	0	0	0	0
Federal	0	0	0	0
Other	424	502	527	5%
Total Positions	424	502	527	5%

FY 2010 (as of December) and revised FY 2011 (as of January) personnel data reflect actual payroll counts. FY 2012 data reflect the number of positions funded.

Link to Website: http://www.njleg.state.nj.us/legislativepub/finance.asp

Highlights

- The proposed budget recommends a $72.74 million appropriation for the Department of Banking and Insurance, an increase of $10.14 million (16.2%) from the FY 2011 adjusted appropriation. The increase is primarily due to a $8.49 million increase in anticipated federal funds and a $1.65 million increase in State budgeted funds.

- The department's activities are entirely funded through revenue collected from fees and assessments on the industries it regulates and federal funding.

- The proposed budget anticipates $118.9 million in State revenue (page C-4) for the department, a $689,000 overall decrease (0.5%) from FY 2011. The changes are anticipated as follows: increases: $350,000 (13.5%) from Banking - Licenses and Other Fees; $500,000 (25%) from Fraud Fines; $1.65 million (7.3%) from Insurance Fraud Prevention; $3.834 million (10.6%) from Insurance – Licenses and other fees; and a $5.645 million decrease for the Real Estate Commission.

- The proposed budget anticipates $9.23 million in federal funding (page C-17) for the department, an $8.49 million increase (1,138%) from FY 2011. The increase in federal funding includes three grants related to the "Protection and Affordability Care Act," Pub. L.111-148, and the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, more commonly known as the "Affordable Care Act."

- The FY 2012 Budget Recommendation includes a $1.65 million increase in authorized State appropriations for the Bureau of Fraud Deterrence (page D-25). The increase is due to the restoration of funding for the County Prosecutors Reimbursement program. This increase in expenditures is matched by an equal increase in anticipated revenue from the Insurance Fraud Assessment (page C-4).

- The FY 2012 Budget Recommendation supports a five percent increase in the number of positions in the department. Position growth affects all organizational components, but particularly affects areas concentrated on consumer protection services (+12), oversight of financial institutions (+4) and central administration (+5). At least two new funded positions are due to federal grant funding.

Background Papers:

Fiscal and Personnel Summary

AGENCY FUNDING BY SOURCE OF FUNDS ($000)

	Expended FY 2010	Adj. Approp. FY 2011	Recom. FY 2012	Percent Change 2010-12	Percent Change 2011-12
General Fund					
Direct State Services	$60,666	$61,320	$62,970	3.8%	2.7%
Grants-In-Aid	0	0	0	0.0%	0.0%
State Aid	0	0	0	0.0%	0.0%
Capital Construction	0	0	0	0.0%	0.0%
Debt Service	0	0	0	0.0%	0.0%
Sub-Total	**$60,666**	**$61,320**	**$62,970**	**3.8%**	**2.7%**
Property Tax Relief Fund					
Direct State Services	$0	$0	$0	0.0%	0.0%
Grants-In-Aid	0	0	0	0.0%	0.0%
State Aid	0	0	0	0.0%	0.0%
Sub-Total	**$0**	**$0**	**$0**	**0.0%**	**0.0%**
Casino Revenue Fund	$0	$0	$0	0.0%	0.0%
Casino Control Fund	$0	$0	$0	0.0%	0.0%
State Total	**$60,666**	**$61,320**	**$62,970**	**3.8%**	**2.7%**
Federal Funds	$0	$746	$9236	0.0%	1138.1%
Other Funds	$2,087	$531	$535	(74.4%)	0.8%
Grand Total	**$62,753**	**$62,597**	**$72,741**	**15.9%**	**16.2%**

PERSONNEL SUMMARY - POSITIONS BY FUNDING SOURCE

	Actual FY 2010	Revised FY 2011	Funded FY 2012	Percent Change 2010-12	Percent Change 2011-12
State	0	0	0	0.0%	0.0%
Federal	0	0	0	0.0%	0.0%
All Other	424	502	527	24.3%	5.0%
Total Positions	**424**	**502**	**527**	**24.3%**	**5.0%**

FY 2010 (as of December) and revised FY 2011 (as of January) personnel data reflect actual payroll counts. FY 2012 data reflect the number of positions funded.

AFFIRMATIVE ACTION DATA

Total Minority Percent	32.3%	28.3%	26.6%	----	----

Significant Changes/New Programs ($000)

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page
		ECONOMIC REGULATION			
SPECIAL PURPOSE					
Insurance Fraud Prosecution Services	**$11,246**	**$12,896**	**$ 1,650**	**14.7%**	**D-26**

The FY 2012 Budget Recommendation includes a $1.65 million (14.7%) increase in funding for Insurance Fraud Prosecution Services within the Bureau of Fraud Deterrence (p. D-25) and reflects all of the changes to that program class. The increase can be attributed to a restoration of funding for the County Prosecutors Reimbursement program. The increase in expenditures is matched by an equivalent increase in anticipated revenue from the Insurance Fraud Prevention assessment (page C-4).

During the FY 2011 budget process, changes were proposed to the administration of insurance fraud prosecution services, including a decrease in spending for the County Prosecutors Reimbursement Program. The $1.65 million expenditure increase and matching revenue increase reflect a continuation of funding for the County Prosecutors Reimbursement Program at FY 2010 levels for FY 2012. At this time, it cannot be determined whether the FY 2010 funding level for the program was maintained in FY 2011 as well, regardless of the increase.

The County Prosecutors Reimbursement Program is administered by the Office of the Insurance Fraud Prosecutor (OIFP) in the Department of Law and Public Safety, but funded through the Insurance Fraud Prevention assessment collected by the Department of Banking and Insurance and transferred to the Department of Law and Public Safety pursuant to section 46 of P.L.1998, c.21 (17:33A-30). The program was established pursuant to section 44 of P.L.1998, c.21 (C.17:33A-28) to provide reimbursement to the County Prosecutor's offices for their activities undertaken in connection with investigating and prosecuting insurance fraud.

The Insurance Fraud Prevention assessment (page C-4) is an assessment on certain insurers for reimbursement of all costs related to the activities and responsibilities of the OIFP and the Bureau. Pursuant to section 8 of P.L.1983 c. 320 (C.17:33A-8), as amended by P.L.2010, c.32, the assessment is paid by the insurance companies to the Department of Banking and Insurance prior to December 31 of each calendar year for expenses accrued in the previous fiscal year. The funds are then paid into the State Treasury in reimbursement to the State for these expenses.

Pursuant to P.L.2010, c.21 the former division of Insurance Fraud Prevention (DIFP), was renamed and reconstituted as the Bureau of Fraud Deterrence. The former division was originally 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 new Bureau is located in DOBI and consists of all civil investigators formerly assigned to the OIFP, other than those assigned to the Case Screening, Litigation and Analytical Support Unit, and those additional administrative and clerical support personnel transferred from the OIFP to the Bureau.

Significant Changes/New Programs ($000) (Cont'd)

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

The Office of Insurance Fraud Prosecutor (OIFP) was established in the Department of Law and Public Safety, pursuant to section 32 of the "Automobile Insurance Cost Reduction Act" (AICRA), P.L.1998, c.21 (C.17:33A-16). P.L.2010, c.32 provided that the OIFP retain responsibility for all criminal prosecutions and investigations of fraud, including the County Prosecutor's Reimbursement Program.

FEDERAL					
Consumer Protection Services and Solvency Regulation	**$246**	**$1,736**	**$ 1,490**	**605.7%**	**D-26**

The FY 2012 Budget Recommendation includes a $1.49 million increase in anticipated federal funding for consumer protection services and solvency regulation.

The $1.736 million anticipated in FY 2012 includes the $736,000 balance of a $982,000 grant approved for federal FY 2011 and an additional $1 million grant for federal FY 2012 for the Consumer Assistance Program established pursuant to the "Protection and Affordability Care Act," Pub. L.111-148.

The Consumer Assistance Program is a federally funded program that enhances and expands many of the currently provided services of the department's Consumer Assistance Unit. The Consumer Assistance Unit, currently employing 9 investigators, two supervisors and a manager, is responsible for responding to escalated consumer calls of a technical or emergent nature. The staff also investigates inquiries and complaints involving all lines of insurance. The enhancements include: increased staffing with two newly created positions exclusively devoted to health insurance consumer assistance; enhanced activities of existing staff; additional communication fees; new consumer education programs and materials; additional training for staff; enhanced computer database systems and needed office supplies and materials.

Actuarial Services	**$500**	**$7,500**	**$ 7,000**	**1400.0%**	**D-26**

The FY 2012 Budget Recommendation includes a $7 million increase in anticipated federal funding for actuarial services.

The anticipated increase reflects two program areas related to the "Protection and Affordability Care Act," Pub. L.111-148, and the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, more commonly known as the "Affordable Care Act."

The Affordable Care Act made expansive changes to the way that consumers and businesses will obtain health insurance. One such change was the opportunity for states to establish state-based "American Health Benefit Exchanges" for individuals, and "Small Business Health Options Program Exchanges" for small businesses.

Significant Changes/New Programs ($000) (Cont'd)

Budget Item	Adj. Approp. FY 2011	Recomm. FY 2012	Dollar Change	Percent Change	Budget Page

The State received an initial $1 million planning and exploration grant related to establishing a State Exchange in federal FY 2011. Additionally, the State may apply for a grant of up to $5 million in federal FY 2012 for the next step in exploring the establishment of an exchange in New Jersey. (Please see the Office of Legislative Services' background paper *"State Health Insurance Exchanges - Federal Health Care Reform Law Requirements" on page 9 of this report* for more information on the Exchanges).

$5.75 million of the $7.5 million in anticipated revenue in the FY 2012 Budget Recommendation includes the $750,000 balance of the federal FY11 $1 million exchange planning grant currently being implemented, and an anticipated $5 million grant for federal FY 2012 to continue the planning and possible implementation of an exchange.

The remaining $1.75 million of the $7.5 million in anticipated revenue in the FY 2012 Budget Recommendation includes $750,000 of a $1 million grant awarded to the State in federal FY 2011 to enhance the department's ability to review insurance companies' rate proposals. The grant is continued for an additional $1 million in federal FY 2012 for the same purpose.

Significant Language Changes

Deleted

2011 Handbook: p. B-12
2012 Budget: p.

~~Receipts derived from extraordinary financial condition examinations or actuarial certifications of loss reserves are appropriated for the conduct of such examinations or certifications, subject to the approval of the Director of the Division of Budget and Accounting~~.

Explanation

According to the department, this language provision is recommended to be deleted because no receipts are generated from the referenced activities, and if there should be any such receipts in the future, other provisions of the budget would apply with identical results; therefore, the provision is not necessary.

Deleted

2011 Handbook: p. B-13
2012 Budget: p.

~~The amount hereinabove appropriated for FAIR Act Administration shall be funded from the additional taxes on the taxable premiums of insurers for the payment of Department of Banking and Insurance administrative costs related to its statutory duties, pursuant to P.L.1990, c.8 (C.17:33B-1 et al.).~~

Explanation

This language provision is recommended to be deleted because, pursuant to P.L.2010, c.21 (C.54:18A-2), revenue from the "Fair Act Administration" is no longer dedicated to the department's administrative costs and is instead retained by the General Fund pursuant to P.L.2010, c.21 (C.54:18A-2).

Deleted

2011 Handbook: p. B-13
2012 Budget: p.

~~There is appropriated such sums as are necessary to fund the administrative costs of the Hospital Care Payment Commission pursuant to P.L.2003, c.112 (C.17B:30-41 et seq.), subject to the approval of the Director of the Division of Budget and Accounting.~~

EXPLANATION: FY 2011 language not recommended for FY 2012 denoted by strikethrough.
Recommended FY 2012 language that did not appear in FY 2011 denoted by underlining.

Significant Language Changes (Cont'd)

Explanation

The language provision is recommended to be deleted because the statute establishing the Hospital Care Payment Commission was repealed pursuant to P.L.2010, c.87 which eliminated multiple boards, commissions, committees, councils and task forces that were found to be inactive by the Red Tape Review Group.

The Health Care Payment Commission was established pursuant to P.L. 2003, c.112 (C.17B:30-41 et seq.); yet, it appears that the Commission did not meet. The Red Tape Review Group in its findings report issued April 19, 2010, recommended that the Hospital Care Payment Commission statute be repealed.

EXPLANATION: FY 2011 language not recommended for FY 2012 denoted by strikethrough.
Recommended FY 2012 language that did not appear in FY 2011 denoted by underlining.

Background Paper: State Health Insurance Exchanges - Federal Health Care Reform Law Requirements

Budget Pages.... C-17, D-26

INTRODUCTION

The federal health care reform legislation enacted in 2010 makes expansive changes to the way that individuals and businesses will obtain health insurance. The legislation, enacted as the "Patient Protection and Affordable Care Act," Pub.L.111-148, and the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, (collectively referred to hereinafter as the "reform law") relies, in substantial part, on the development of state health insurance exchanges to make health insurance coverage more available to individuals and small businesses.

To a large extent, the reform law is designed to become effective in stages. The details as to various components of the reform law will be handled through federal regulations that will be adopted as each stage of the law unfolds.

The reform law requires states to establish, by January 1, 2014, a state-based "American Health Benefit Exchange" for individuals and a "Small Business Health Options Program Exchange" ("SHOP") for small employers.[1] Exchanges are essentially health insurance marketplaces that administer the offering of health insurance plans by private insurers to individuals and employers, consistent with the new market rules and health benefit plan formats within the reform law. For ease of reference, the individual exchange and small employer exchanges mandated by the reform law will be referred to hereinafter as an "exchange."

An exchange must be administered by a governmental agency or a non-profit organization. A state can create a statewide or regional exchange, or join a multi-state exchange. If a state fails to establish an exchange by January 1, 2014, the U.S. Department of Health and Human Services (DHHS) will establish and operate an exchange in that state.

The reform law has several other major components that are designed to work in conjunction with the exchange. Most significantly, the law mandates that nearly all individuals be covered by health insurance and, under certain circumstances, penalizes employers with more than 50 employees if they do not provide coverage to their employees. An exchange facilitates compliance with these individual and employer mandates by providing an additional marketplace in which to seek health insurance coverage.

The Congressional Budget Office estimates that, nationally, 29 million people will purchase coverage through an exchange by 2019.[2] The reform law also allows individuals and

[1] Small businesses with up to 100 employees will be able to purchase coverage through the SHOP exchange beginning in 2014. In 2017, states will have the option to allow businesses with more than 100 employees to purchase coverage through a SHOP exchange.

[2] See *A Profile of Health Insurance Exchange Enrollees*, March, 2011, publication #8147 available on the Kaiser Family Foundation's website at www.kff.org.

Background Paper: State Health Insurance Exchanges - Federal Health Care Reform Law Requirements (Cont'd)

employees to continue to purchase health insurance in the markets currently available outside an exchange.

DESIGN OPTIONS FOR A STATE EXCHANGE

Although the reform law requires an exchange to adhere to certain responsibilities and to offer health benefits plans with certain defined benefit levels, as described in more detail below, states have a considerable degree of autonomy in how an exchange could be structured. For example, states will decide whether:

- The exchange will be run by a state agency or a nonprofit organization; and if it is a state agency, whether it resides in an existing agency, a new agency, or has an independent status.

- Separate exchanges will be created for individuals and small employers, or whether the two markets will be combined into one exchange.

- The exchange will be a statewide, regional, or a multistate exchange.

- The exchange will serve as a market organizer that simply acts as a clearinghouse for qualified health plans while letting the marketplace set rates, or whether it will act as an active negotiator on behalf of the public that limits which plans qualify for exchange status.

EXCHANGE PLANS

The reform law requires each health benefits plan purchased through the exchange to offer the following essential benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services; laboratory services; preventive and wellness services, including chronic disease management; and pediatric services, including oral and vision care.

While each plan will contain the essential benefits, an exchange must offer plans in four tiers with varying levels of benefits for individuals and businesses to choose from:

- The Bronze Tier offers the essential benefits and cost-sharing protections that require the insurance plan to cover 60 percent of the full value of the benefits provided in the plan.

- The Silver Tier offers the essential benefits and cost-sharing protections that require the insurance plan to cover 70 percent of the full value of the benefits provided in the plan.

Background Paper: State Health Insurance Exchanges - Federal Health Care Reform Law Requirements (Cont'd)

- The Gold Tier offers the essential benefits and cost-sharing protections that require the insurance plan to cover 80 percent of the full value of the benefits provided in the plan.

- The Platinum Tier offers the essential benefits and cost-sharing protections that require the insurance plan to cover 90 percent of the full value of the benefits provided in the plan.

As to each of the plans, the consumer would pay the remaining percentage of health care benefits expense that is not paid by the insurer, in the form of deductibles, co-payments and other charges. By standardizing the plans offered through the exchanges by tier levels, individuals and small businesses can easily compare the relative costs and benefits of plans offered by different insurers. In addition, an exchange must provide a catastrophic plan which could be offered with less coverage, but at a lower premium, to individuals up to age 30.

MARKET RULES

Generally, the reform law applies market rules regarding plan design and administration to exchange plans and to other individual and group health benefits plans offered by private insurers. Plans offered both within the exchange and outside the exchange will be required to adhere to the following market rules:

- Plans are subject to a minimum loss ratio of 80 percent in the individual and small employer markets. (This means that insurers must price plans so that at least 80 cents of every premium dollar is expended on the payment of claims, while the remaining 20 cents can be used for profits and administrative expenses.) Plans in the large group market are subject to a minimum loss ratio of 85 percent.

- Modified community rating will be applied to ensure all persons enrolled in a plan are charged the same rate regardless of their medical history, except that rates can vary based on geography, plan design, age, and tobacco use, within certain limits. For example, insurers can charge older people three times more than younger ones and can charge smokers one and one-half times more than nonsmokers.

- Annual limits or lifetime limits on the dollar value of coverage are prohibited.

- Plans that offer dependent coverage must extend this coverage to adult children up to age 26.

- Plans cannot contain a pre-existing condition exclusion as to children under the age of 19. This prohibition on exclusion will apply to all persons in 2014.[3]

[3] The required market rules listed vary in terms of: effective dates, whether they have an accompanying "grandfathering" rule that allows existing plans to be exempt under certain circumstances, and whether they apply to self-funded plans in addition to insured plans.

Background Paper: State Health Insurance Exchanges - Federal Health Care Reform Law Requirements (Cont'd)

EXCHANGE RESPONSIBILITIES

In addition to ensuring that the four tiers of plans are offered, the reform law assigns other responsibilities to an exchange, including:

- Certifying whether plans qualify to participate in the exchange, based upon several factors, including the adequacy of health care provider networks and the quality of health benefits design.

- Coordinating with the Secretary of DHHS to verify the eligibility of individuals to receive subsidies to purchase coverage, as described in more detail below.

- Assessing which plan offerings show a pattern of excessive or unjustified premium increases by insurers, for purposes of excluding such plans from exchange participation.

- Coordinating with federal agencies to determine whether an individual is granted an exemption from the mandate that individuals maintain health insurance coverage.

- Establishing a "Navigator" program and awarding grants to outside Navigator entities that will conduct public education efforts and facilitate enrollment in an exchange.

SUBSIDIES FOR PURCHASING COVERAGE THROUGH AN EXCHANGE

To encourage low and moderate income individuals to purchase coverage through an exchange, the reform law provides for subsidies from the federal government to assist with premium payments for plans purchased through an exchange. Subsidies will be available on a sliding scale for individuals and families who earn between 133 and 400 percent of the federal poverty level.

An exchange has a key role in coordinating the subsidies. To apply for a subsidy, a consumer applies to an exchange to obtain coverage and provides income information. The exchange sends the applicant's information to the DHHS. If the department determines that the applicant is eligible, the U.S. Department of the Treasury sends monthly payments to the insurer to subsidize premiums.[4]

FUNDING FOR EXCHANGE DEVELOPMENT AND OPERATIONS

To assist states in planning exchanges, in September, 2010, the DHHS awarded $1 million Exchange Planning and Establishment Grants to 48 states, including New Jersey. The

[4] The reform law also makes tax credits available to small employers, starting with tax year 2010. In tax year 2014, the tax credit increases up to 50 percent of the employer's contribution toward the employees' premiums for small employers purchasing coverage through an exchange. The tax credit for purchasing through the exchange will only be available to the employer for two years, from 2014 to 2016.

Background Paper: State Health Insurance Exchanges - Federal Health Care Reform Law Requirements (Cont'd)

New Jersey Department of Banking and Insurance will use New Jersey's grant of $1 million to engage experts in benefit design, build health care providers' capacity to handle anticipated enrollment, and obtain stakeholder input in determining exchange design. To date, the department used part of the grant, $250,000, to contract with the Rutgers Center for State Health Policy (RCSHP) to determine the appropriate design for an exchange in New Jersey. The RCSHP report is expected to be released in April, 2011.

The DHHS will make additional federal grants available for the purpose of establishing exchanges. States will have to meet certain milestones in order to be awarded further grants and the size of the grant may be related to the progress made toward establishing an exchange. The New Jersey Department of Banking and Insurance will apply for additional grants in FY2012 and has included information in the FY2012 Budget Recommendation (page D-26) anticipating a grant of up to $5 million in FY2012. Grants will be provided by the DHHS until 2015. After January 1, 2015, exchanges must be self-funded; the reform law permits exchanges to charge assessments or user fees to participating insurers in order to pay for exchange operations.[5] The department has not determined the funding mechanism to be used to fund the exchanges, if they are established.

The reform law also requires an exchange to establish a "Navigator" program and award grants to Navigator entities to conduct public awareness programs about qualified health plans and to facilitate enrollment in exchange plans. The law specifies that these grants must come from non-federal, general exchange operating funds. Thus, it appears funds for these grants would need to come from whatever mechanism is used to fund ongoing exchange operations after grants from the DHHS end in 2015.

[5] See the DHHS' "Initial Guidance to States on Exchanges," at the department's website: www.hss.gov.

Background Paper: Historical Analysis of Revenues and Expenditures of the Department of Banking and Insurance

Budget Pages..... C-4, C-10, C-17, C-26, C-28, D-21 to D-26

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; actuarial services; "HMO Covered Lives" fees; Small Employer Health Benefits (SEH) assessments; Individual Health Coverage Program (IHC) assessments; insurance licenses and other fees; public adjusters licensing; examination billings; and federal funding.[6] The department also receives a small amount of revenue from miscellaneous sources.[7] 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)

	2004*	2005*	2006*	2007*	2008* [8]	2009*	2010*	2011**	2012**
Total Revenues	$111,024	$114,176	$113,576	$159,232	$137,945	$151,135	$123,256	$119,512	$128,695
Total Expend-itures	$68,749	$64,818	$69,999	$93,460	$73,399	$65,059	$62,753	$62,597	$72,741
Surplus Revenue	**$42,275**	**$49,358**	**$43,577**	**$65,772**	**$64,546**	**$86,076**	**$60,503**	**$56,915**	**$55,954**

*Actual **Estimated

The table above details total revenues collected by the department compared to the total dollar amount expended by the department from FY 2004 to FY 2012. The table includes both Schedule 1 "on-budget" (anticipated) revenues and Schedule 2 "off-budget" (appropriated)

[6] 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.
[7] Miscellaneous revenue is collected each year by the department. This revenue varies each year and is generally below $100,000 a year.
[8] 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 ($153,000 in FY 2008 and $48,000 in FY 2010) under the Health Insurance Security and Privacy Collaboration (HISPC) is also not included in the revenue breakdown. HISPC is a partnership between the department and the Department of Health and Senior Services to conduct research on electronic medical records as part of the electronic health information technology commission.

Background Paper: Historical Analysis of Revenues and Expenditures of the Department of Banking and Insurance (Cont'd)

revenues as well as Schedule 3 "on-budget" (anticipated) expenditures and Schedule 4 "off-budget" (expenditures not budgeted) appropriations.

As the table suggests, the department has historically generated annual revenues in excess of the amount necessary to support its operations. This surplus revenue, which reached a high of $86.1 million in FY2009 due to one-time revenue sources,[9] 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 FY 2009, 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 experienced a gradual decline in total revenue collected from the industries it regulates from FY 2004 through FY 2008. Revenue generated has fluctuated slightly from FY 2009 to FY 2012 but has generally stabilized between $12 and $13 million. Corresponding with this stabilization was the implementation of a change to the assessment process in the Division of Banking, discussed in more detail on the following page.

The Division of Insurance has experienced a gradual increase in total revenue collected. The increase can be attributed to growth 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 FY 2004 with year-to-year 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.

[9] 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.

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Division of Banking

Revenues Collected by the Division of Banking

(thousands)

	2004*	2005*	2006*	2007*	2008*	2009*	2010*	2011**	2012**
Assessments	$3,685	$3,153	$2,974	$9,860	$10,369	$9,790	$10,248	$10,000	$10,000
Licenses and Other Fees	$12,265	$12,608	$12,002	$4,889	$3,181	$2,198	$3,136	$2,600	$2,950
Examination Fees	$2,300	$2,221	$2,182	$856	$2	n/a	n/a	n/a	n/a
Total Revenues	**$18,250**	**$17,982**	**$17,158**	**$15,605**	**$13,552**	**$11,988**	**$13,384**	**$12,600**	**$12,950**

*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 to 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 U.S. 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 lower assessment revenues.

Licenses

The division issues many different licenses; including, but not limited to: consumer lending license;, 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 FY 2006. 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 Watters decision 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 factors significantly decreased the number of mortgage lending entities and individuals 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 FY 2010 budget, the department indicated that it had

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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)

	2004*	2005*	2006*	2007*	2008*	2009*	2010*	2011**	2012**
Special Purpose Apportionment	$14,969	$13,696	$13,787	$13,563	$12,091	$9,944	$9,473	$31,000	$31,000
Actuarial Services	$46	$45	$126	$80	$120	$64	$72	$55	$55
FAIR Act Administration	$16,863	$19,778	$20,985	$22,131	$23,348	$21,776	$22,590	n/a	n/a
Fraud Fines	$1,955	$1,954	$1,579	$1,547	$1,495	$1,092	$1,410	$2,000	$2,500
HMO Covered Lives	n/a	n/a	n/a	$1,819	$1,571	$2,675	$702	$1,600	$1,600
SEH *** Assessment	$242	$336	$371	$626	$530	$850	$505	$444	$445
IHC**** Assessment	$1,258	$0	$3,936	$24,542	$4,073	$433	$1,099	n/a	n/a
Insurance Licenses and Other Fees	$12,087	$14,768	$15,193	$33,345	$40,210	$56,301	$38,977	$35,980	$39,814
Public Adjuster Licensing	$46	$31	$36	$118	$72	$87	$97	$87	$90
Examination Billings	$1,750	$2,035	$2,494	$2,093	$2,076	$2,886	$2,639	$2,500	$2,500
Insurance Fraud Prevention	$33,240	$31,807	$30,578	$33,384	$30,958	$31,133	$28,112	$22,500	$24,150
Federal Revenue								$746	$9,236
Total Revenues	**$82,456**	**$84,450**	**$89,085**	**$133,248**	**$116,544**	**$127,291**	**$105,676**	**$96,912**	**$111,390**

*Actual **Estimated *** Small Employer Health ****Individual Health Care Program

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;

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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 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 FY 2008 to FY 2010. This reflects the decrease in the number 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 FY 2011 increase by approximately $22 million. This increase is due to changes to the use of the "FAIR Act Administration" taxes authorized by the adoption of P.L.2010, c.21 (C.54:18A-2).

Prior to the enactment of this statute, the amounts charged to the insurers as the special purpose assessment were offset by the revenue collected pursuant to the "FAIR Act Administration" taxes (see below for more explanation of these taxes). However, P.L.2010, c.21 (C. 54:18A-2) provided 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 necessitated an increase in the assessment charged by the department in FY 2011 in an amount approximately equal to the revenue raised by the "FAIR Act Administration" taxes, estimated at $22.6 million in FY 2010.

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.[10]

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

Prior to the enactment of P.L.2010, c.21 (C.54:18A-2), Sections 2 and 3 of P.L.1945, c.132 (C.54:18A-2, and C.54:18A-3), established two taxes dedicated to department administrative costs: a tax of 0.1%, upon taxable premiums of insurance carriers, (except those carriers that are 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 was collected by the Department of Treasury from 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.).

However, as noted above, P.L.2010, c.21 (C.54:18A-2) provided that the revenue from "Fair Act Administration" would no longer be dedicated to the department's administrative

[10] Currently, according to the department, the application fee is $250.

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costs and the special purpose assessment would instead be the source of funding for the administrative costs of the department.

Fraud Fines

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

Revenue collected due to these fines steadily declined from FY 2004 to FY 2009 and then increased in FY 2010 and is projected to continue to grow in FY 2011 and FY 2012. The changes in revenue collections may be attributed to the fluctuation in the number of 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 certain fiscal years. For example, the assessment for FY 2009 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 FY 2009. Others returned it later and the funds were reflected in the actual funding for FY 2010. The department asserts that this is the reason for the increased revenue for FY 2009 and the decreased revenue in FY 2010.

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, resulting in greatly increased revenue collections 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.

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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.[11] Additionally, settlements negotiated with insurance carriers for certain violations of insurance regulations are reflected as revenue collected under this category.

In FY 2006 and FY 2007, the implementation of additional fees generated a $19 million increase in revenue. Furthermore, in FY 2007, there were changes to the renewal cycle of certain licenses that resulted in increased revenue. In FY 2009, 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.[12] 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.[13] The revenue generated is typically constant.

Insurance Fraud Prevention

The department collects an assessment from certain insurers for all activities related to insurance fraud prevention services pursuant to P.L. 1983, c.320 (C.17:33A-1 et seq.). The administration of these insurance fraud prevention services are divided between the newly established Bureau of Fraud Deterrence in the department with the Office of Insurance Fraud Prosecutor (OIFP) in the Department of Law and Public Safety (DLP). P.L.2010 c. 32 (C.17:33A-8) transferred all civil investigators and those additional administrative and clerical support personnel formerly assigned to OIFP to DOBI. The criminal component of the OIFP remains in the DLP.

The revenue generated through the Insurance Fraud Prevention assessment was roughly consistent from FY 2004 to FY 2009. Then in FYs 2010 and 2011, actual anticipated revenue decreased by $3 million and $5.6 million respectively.

The decrease in FY 2010 appears to be related to a reduction in costs for the County Prosecutors' Reimbursement Program, a shift in charging for the costs of building rent and maintenance and a decrease in salaries and fringe benefits. The reasons for the decrease estimated for FY 2011 are not entirely clear at this time and may not be accurate when the actual costs are calculated for the FY 2011 assessment.

The estimate for revenue generated through this assessment are not always accurate in the Budget Recommendation because the assessment is made after the expenditures. Since the assessment is processed as a reimbursement, there is uncertainty in estimating the anticipated revenue during the budget process. For example, P.L.2010, c.32 established the new Bureau of

[11] The fees range from $20 - $270 per license, http://www.state.nj.us/dobi/licfees.htm.

[12] The fees range from $150 - $320 per license, http://www.state.nj.us/dobi/licfees.htm.

[13] 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.

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Fraud Deterrence and shifted duties from the DLP to the DOBI. The costs for these changes were not entirely understood during the budget process in FY 2011. The costs of administering the insurance fraud prevention services appear to have increased for FY 2012 but this may possibly be an adjustment to represent the actual costs incurred in FY 2011 and is reflected in increased FY 2012 anticipated revenues.

Federal Revenue

The "Protection and Affordability Care Act," Pub. L.111-148, and the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, together often referred to as the "Affordable Health Care Act," made expansive changes to the way that consumers and businesses will obtain health insurance. The federal revenue reported in the FY 2011 and FY 2012 budgets is due to three federal grants to the State issued pursuant to the Affordable Health Care Act.

The State received an initial $1 million planning and exploration grant related to establishing a State Health Care Exchange in federal FY 2011. Additionally, the State may apply for a grant of up to $5 million in federal FY 2012 for the next step in exploring the establishment of a State Health Care Exchange in New Jersey. (Please see the Office of Legislative Services' background paper *"State Health Insurance Exchanges; Federal Health Care Reform Law Requirements"* for more information on the Exchanges).

The State also received a $1 million grant in federal FY 2011 to enhance the department's ability to review insurance companies' rate proposals. The grant is continued for the same purpose for an additional $1 million in federal FY 2012.

Lastly, the State was awarded a $982,000 federal grant for federal FY 2011 and anticipates an additional $1 million grant for federal FY 2012 to enhance and expand many of the currently provided services of the Consumer Assistance Unit. The Consumer Assistance Unit, currently employing 9 investigators, two supervisors and a manager, is responsible for responding to escalated consumer calls of a technical or emergent nature. The staff also investigates inquiries and complaints involving all lines of insurance.

New Jersey Real Estate Commission

Revenues Collected by the New Jersey Real Estate Commission

(thousands)

	2004*	2005*	2006*	2007*	2008*	2009*	2010*	2011**	2012**
Real Estate Commission	$10,318	$11,744	$7,333	$10,379	$7,849	$11,906	$4,196	$10,000	$4,355

*Actual **Estimated

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. Additionally, as the number of real estate professionals has decreased due to the decline in the housing market, so has the revenue from licensing those professionals. During the peak months of the real estate market, the department estimates that it issued approximately 900 new licenses a month. That number has decreased to approximately 300 new licenses a month.

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Individuals wishing information and committee schedules on the FY 2012 budget are encouraged to contact:

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