Honorable Vincent Prieto c/o
David J. Rosen
Legislative Budget and Finance Officer
Office of Legislative Services
State House Annex
PO Box 068
Trenton, NJ 08625-0068

Re: Department of Banking and Insurance Budget Hearing Response

Dear Chairman Prieto,

Please accept the following in response to your April 17, 2012 letter requesting follow-up information with respect to the questions raised by Assemblyman Singleton at the Department of Banking and Insurance (Department) budget hearing on April 16, 2012.

1. **Please provide to the committee the number of small employer and individual health insurance carriers which have filed increases in 2011 and thus far in 2012.**

   **Individual Health Coverage Program**

   There are six carriers that participate in the New Jersey Individual Health Coverage (IHC) Market: AmeriHealth; Aetna; Celtic; CIGNA; Horizon; and United/Oxford. All carriers except Celtic filed for rate increases in 2011 (Celtic has only one contract and is not changing its rates). Additionally, four carriers have thus far filed rate increases in 2012: AmeriHealth; CIGNA; Horizon; and Oxford.

   **Small Employer Health Program**

   There are five carriers that participate in the New Jersey Small Employer Health (SEH) Market: AmeriHealth; Aetna; CIGNA; Horizon; and United/Oxford. All five carriers filed for rate increases in 2011 and 2012.
2. Please provide to the committee the number of such health insurance carriers which were denied rate increases in 2011 and thus far in 2012.

Rate filings that are found defective by the Department may fall into several dispositions: the change may be disallowed entirely; the change may be reduced to a lesser increase; or the filing may initially be disapproved (or found incomplete) for insufficient information but the rates or rate increase subsequently permitted when sufficient information is provided.

There are therefore four types of "disapprovals:"
1. Rate change not permitted;
2. Initial rate change reduced;
3. Filing initially disapproved for lack of information, but a rate change is eventually permitted; and
4. Filing initially found incomplete for lack of information, but a rate change is eventually permitted (The difference between 3 and 4 is that the term "disapproved" is not used when additional information is requested).

Carriers are required to file rates with the Department at least annually, whether their rates change or not. The date of the filing is not mandatory. Carriers may also make different filings for different products (i.e. HMO or PPO). For example, a carrier offering four different products and filing quarterly would make 16 filings per year with the Department, not one.

The Department's actuarial bureau reviews the rate filings to ensure that: the filing is complete; the data, assumptions and methods used are appropriate from an actuarial perspective; the projected medical loss ratio meets the State's Minimum Loss Ratio (MLR) standards; only the permissible factors are used in determining rates; and any other applicable regulatory requirements, such as caps on increases, are observed. The Department can disapprove rates, but the Department is not required to approve rates. This is generally described as a "File and Use" process. However, be assured that the Department does review all rate filings.

Since carriers must file rates whether or not they are changing, the number of filings disapproved in relation to the number of filings is not as significant if only increases (or increases above a certain amount) are filed and reviewed. Under the federal process, only rate increases greater than 10 percent are reported to the US Department of Health and Human Services (HHS). As New Jersey's rate review process has been found to be effective by HHS, this is only an informational requirement – HHS does not perform a review of New Jersey rate filings.

It is noteworthy that since September 1, 2011 (the effective date of federal reporting) no IHC rate filing and only one SEH rate filing has exceeded the 10 percent increase threshold and been reported to HHS.
Summary of Rate Actions for 2011

Individual Health Coverage Program

Carriers filed 22 rate filings with the Department, 14 of which were for increases, while the remaining 8 were for no change. The Department disapproved three filings which resulted in decreased rates for some policyholders. The Department also “disapproved” eight that required more information. This includes disapprovals of filings of 0 percent if the filing is not in order or if the Department believes that a decrease might be required because of the loss ratio rules.

Small Employer Health Program

Carriers filed 29 rate filings with the Department, all for rate increases. The Department disapproved 15 due to additional information being required.

Summary of Rate Actions for 2012

Individual Health Coverage Program

Carriers filed nine rate filings with the Department, six of which were for rate increases. The Department disapproved six of these filings due to being incomplete. One filing is currently pending review.

Small Employer Health Insurance

Carriers filed 12 rate filings with the Department, all for rate increases. The Department disapproved two of the filings resulting in reduced rates. The Department disapproved two other filings due to additional information being required.

The Department can provide additional information on each of these filings if requested.

The Department would also like to take this opportunity to respond to the separate questions that Assemblyman Singleton sent to the Department through the Chair on April 16, 2012.

1. In 2003, the Legislature adopted a comprehensive reform of auto insurance in New Jersey. Furthermore in 2009 your department crafted a new medical fee structure to reduce the cost of medical care. How have these changes affected auto insurance rates?

Regarding the 2003 reforms, the Department believes that the auto market has been competitive, with average premiums decreasing from $1,193 in 2003 to $1,101 in 2009, as reported by the National Association of Insurance Commissioners (NAIC). Regarding PIP, the average paid claim (per industry Fast Track data reports) did decrease from $17,261 at the end of 2009 to $16,468 at the end of 2010; however, the average amount increased in 2011 to $17,766. The Department attributes this increase in large
part to providers changing their billings practices from billing treatment codes on the current schedule to other codes not currently on the schedule in order to benefit from the higher rates usually generated by reimbursement at usual, customary, and reasonable fees pursuant to N.J.A.C. 11:3-29.4(e) and resulting PIP arbitrations. As a result, the medical fee schedules that the Department proposed in 2011 seek to expand the treatment codes subject to the fee schedules to contain these growing costs.

2. The proposed PIP rules drastically reduces the amount of time that providers have to file for arbitration from two years to 5 days. What is the rationale behind such a massive reduction and does this change violate the No Fault Act, which provides for the two year period?

The proposed rules do not reduce the amount of time that providers have to file for arbitration in violation of the No Fault Act, N.J.S.A. 39:6A-13.1. Rather, the proposed rules establish a uniform internal appeal process for PIP that providers must complete before going to arbitration. The proposal provides for two types of appeals: treatment and administrative. Treatment appeals are limited to denials of medical treatment that had not yet been performed. The Department believes that it is in the best interests of insureds receiving medical treatment to appeal treatment denials as soon as possible, and that therefore providers would want to submit these appeals right away since the patient would be waiting for treatment the provider believed was necessary, thus the reason for the 5-day deadline in the proposed rule. The proposal requires insurers to respond to treatment appeals within 10 days. The proposed rule further provides that if a provider misses the 5-day deadline, he or she can resubmit the treatment request, which if denied by the insurer, would initiate another opportunity for an appeal. Therefore, the proposed 5-day deadline does not operate as a statute of limitations or conflict with the two year limitation on filing a PIP action set forth in N.J.S.A. 39:6A-13.1. The Department received many comments from providers objecting to the proposed deadline for filing treatment appeals, and the Department is currently reexamining the proposed rules for the internal appeal process.

3. How did the department arrive at the $1,000 ceiling for "on the papers" dispute resolution? Furthermore, how does this new process ensure that due process will continue to be carried out?

Forthright, the PIP arbitration administrator, conducted an analysis of arbitration claims and concluded that a $1,000 ceiling for “on-the-papers” disputes would apply to approximately 25 percent of the claims it handles. The Department required that bidders for the PIP alternate dispute resolution administrator contract include a proposal for the reduction of costs, which are paid by users of the system. Forthright included the $1,000 threshold on-the-papers process as a cost-reduction proposal in its successful bid for the contract. On-the-papers proceedings are very common in judicial and quasi-judicial forums including summary judgment motions and most commercial arbitration proceedings. In addition, the New Jersey Program for Independent Claims Payment Arbitration (PICPA), established in 2005 for certain kinds of health care disputes, is conducted only on-the-papers. The Financial Industry Regulation Authority (FINRA), which regulates securities dealers, requires on-the-papers arbitration for claims under $25,000. Additionally, other state statutory arbitration schemes permit summary
disposition on-the-papers (N.J.S.A. 2A:23B-15) without limiting such to where no facts are in dispute.

Moreover, N.J.S.A. 39:6A-5.1, the PIP arbitration provision at issue here, does not require in-person hearings, but speaks in terms of "dispute resolution" and gives the Commissioner the power to promulgate rules as to conduct of the PIP dispute resolution proceedings. Although such proceedings have been traditionally in-person hearings, under the proposed rule it is only cases where no further treatment is at issue and the claim is less than $1,000 that will be conducted on-the-papers. Additionally, Forthright's rules for on-the-paper proceedings provide that if coverage under the policy is at issue, fraud is suspected, or causation is an issue, then the respondent can remove the matter for an in-person hearing. Thus, the only cases where on-the-papers hearings will be mandatory are payment disputes between the insurer and usually medical providers seeking reimbursement for medical services that have already been provided.

Due process requires that the parties have an opportunity to be heard at a meaningful time and in a meaningful manner, and such requirements can be satisfied by on-the-papers proceedings. Additionally, even in the current PIP arbitration process, it is very uncommon for a claimant, a doctor or an insured to appear at an in-person PIP arbitration hearing. Generally, only the counsel for the parties attend and their comments are limited to the documents that were submitted to the arbitrator and, in most instances, no in-person testimony is provided by any of the parties. In both on-the-papers and in-person proceedings, the arbitrator's decision is primarily based on the documents supporting each party's position. Thus, the Department believes that the on-the-papers proceedings satisfy the requirements of due process.

4. **Has the department conducted any research as to what the cost premiums to the consumer and the cost of medical care would be if New Jersey's No Fault Insurance Law were repealed?**

In 2002, the Department commissioned the Insurance Services Office (ISO) to begin a study that estimated the overall costs that would be saved or incurred by changing from the current New Jersey choice no-fault system to a tort system with specified limits of coverage. However, a final report was never commissioned. The draft report examined a number of scenarios and factors, with some resulting in decreased costs, while others resulted in increased costs at that time.

5. **How many states have repealed no-fault insurance in the past 10 years? What has been the effect on insurance rates in those states?**

Colorado repealed its no-fault system in 2003. Colorado previously provided $50,000 in PIP medical expense benefits (compared to New Jersey's $250,000 limit), but with other ancillary coverages (wages, rehabilitation, etc.) the potential coverage limit was actually $130,000. According to the Rocky Mountain Insurance Information Association, PIP rates increased as much as 80 percent in the 18 months prior to the repeal. This is supported by the National Association of Insurance Commissioner's (NAIC) Auto Database Report, which showed average premiums of $808 in 2001, but $921 in 2002 and $923 in 2003, the last year of no-fault. The 2009 average expenditure in
Colorado was $741, an 8 percent decrease from 2001 levels, and a 20 percent decrease from 2003 levels. Usually, whenever any law is changed, some drop is to be expected; however, the Department believes that one would need to examine a longer time period to understand the impact of any substantive changes. At this time, the Department has not done any research into Colorado’s law to make any meaningful comparison.

Additionally, Florida’s no-fault system sunset on October 1, 2007, but was reinstated to be effective only three months later, January 1, 2008. To the Department’s knowledge, no other states have repealed no-fault since 2003.

6. What are the department’s plans to further the establishment of a NJ Health Insurance Exchange?

A threshold issue for the State, if the law survives the Supreme Court challenge, is whether the State will run a State-based exchange or default to a federally-facilitated exchange. Planning has focused on determining what the state’s best alternative to a federally-facilitated exchange would look like, to keep the State’s options open.

Using a planning grant from the federal government, the Department commissioned Rutgers Center for State Health Policy (CSHP) to perform the following tasks:

1. Estimate the number and the demographic and health characteristics of New Jersey residents who will be eligible and who are likely to enroll in Medicaid/FamilyCare and subsidized Exchange products (through individual and small-group Exchanges) in New Jersey, by category.
2. Conduct forums and on-line surveys to obtain stakeholder input into the design of Exchange(s) in New Jersey. CSHP engaged in a two-fold process to gather comprehensive input from a broad array of stakeholder groups in New Jersey. These activities included a series of stakeholder forum discussions and an online stakeholder survey.
3. Complete an in-depth review and analysis of policy issues of importance to the design of the Exchange in New Jersey. The topics include the following:
   o Whether “defined contribution” plans should be permitted for small groups & whether the Exchange should assume billing functions;
   o Adopting federal methodologies for medical loss ratios and rate banding, and structuring reinsurance and risk adjustment methodologies;
   o The effect of merging the non-group and small-group markets in New Jersey;
   o Alternative methods for dealing with biased risk selection across plans and/or between Exchange and non-Exchange plans;
   o Alternatives for incorporating quality, cost effectiveness and care management measures in plan rankings, including mental health and substance abuse;
   o Options to mitigate “churning” or the movement of low-income populations among public programs and private coverage due to changes in circumstances;
   o Requirements and entities responsible for redeterminations and tax credits;
○ How to coordinate and transition from Medicaid/CHIP to and from the Exchange products, while promoting continuity of coverage (including recommendations concerning consistency of network access standards for Medicaid and Commercial plans); and
○ Pros and cons of offering a Basic Health Plan.

The results of the CSHP research finalized to date can be found here: http://www.cshp.rutgers.edu/home.htm.

The Department also engaged KPMG to perform an IT Gap Analysis and a Business Operations Gap Analysis.

The IT Gap Analysis included tasks associated with an overall plan for the development, design, and creation of an Information Technology (IT) implementation plan for an Exchange. This includes performing a review and inventory of current operational procedures and supporting technology capabilities used by the State to perform eligibility screening and verification and enrollment of participants in various subsidized programs, primarily Medicaid. It also includes creating a strategic IT plan identifying potential Exchange IT goals, IT technical decisions, and project timelines for decision making, and issues and analysis required for each decision. Options will address all required Exchange functionality including a public web portal interface, eligibility screening and verification, enrollment activity, premium tax credit administration, cost-sharing assistance administration, health plan management to support Qualified Health Plan certification, and all required interfaces with health plans and government agencies.

The Business Operations Gap Analysis included required customer service capabilities, other staffing needs, projected expenses and revenue options, considering various projected Exchange utilization scenarios and proposed information technology solutions for the purpose of developing a business and operational plan.

The Department expects these reports to be finalized this spring.

The $7.674 million awarded in federal FY 2012 is intended to further refine the identified IT gaps, gather stakeholder input on specific decision points, detail a financial management plan, establish audit and fraud detection procedures, develop reinsurance and risk adjustment plans, research Medicaid network issues, analyze projected plan costs and utilization, and further develop plans and standards for plan management, including options for defining Essential Health Benefits, and associated administrative costs.

7. **Does the department intend to apply for additional federal Exchange Planning Grants? Is there a fear that the resources for setting up the exchange will be gone by delaying?**

The Department has obtained sufficient funds to move the planning process forward and is committed to only spending the minimum necessary to maintain the State’s options in the best interests of New Jersey’s residents. The Department does not anticipate any grant submissions prior to a United States Supreme Court decision on the constitutionality of the Affordable Care Act. The potential for discontinuance of federal
resources exists under any scenario; however, the federal government has announced several opportunities for grant requests with deadline dates after the expected Supreme Court ruling.

8. **What mechanisms does the Department have to ensure that NJ state chartered banks are freeing up capital for NJ businesses? If none, is there a model from another state that the department would recommend to statutorily provide those mechanisms?**

As regulators of New Jersey State chartered banks it would be a conflict of interest for the Department to promote/mandate the “freeing up of capital” for the purposes of investment, including lending to New Jersey businesses, because the Department oversees the safety and soundness of the banks, including asset quality. In addition, New Jersey, as well as our partner regulators the Federal Deposit Insurance Corporation (FDIC), Federal Reserve Bank and the Office of Comptroller, of the Currency require minimum capital levels that banks must maintain. This is true for state chartered banks as well as national banks (who have a much larger New Jersey market share).

Additionally, Community Reinvestment Act loans that are statutorily required are, for many banks, a source of problem assets. This mandatory lending requirement is an example of a mechanism that many banks would argue decreases overall lending capacity.

Finally, I would like to clarify an issue raised by Assemblyman Singleton at the hearing regarding the Wind Market Assistance Program (WindMAP). At the time, information in Question 16a of the OLS Discussion Points indicated that the difference in the way companies define coastal was a contributing factor to an affordability issue in the homeowners insurance marketplace and that additionally, companies were limited to only deeming policies in those zip codes as coastal.

Based on the 2009 NAIC Homeowners Report, New Jersey is ranked 21st nationally in average premium at $865, compared to the countrywide average of $875. New Jersey also has higher valued homes than most states, which makes our average premium that much more affordable in comparison to them. Previously, in order to keep companies writing homeowners insurance in New Jersey, the Department instituted a voluntary program to allow companies to submit mandatory hurricane deductibles in accordance with the WindMAP Regulations. Originally, the regulation allowed mandatory hurricane deductibles in 92 zip codes. Over the years, based on new catastrophe models, many companies believed the original zip codes were not adequate for the risk. The Department then increased the number of zip codes to 112 in the WindMAP Program. Still, companies believed that was not adequate. In addition, no companies participated in the WindMAP Program as it was voluntary. As a result of this situation, the Department repealed the WindMAP Program in February 2011.

However, many companies and agents still refer to the WindMAP zip codes. Based on current regulations, the WindMAP zip codes are no longer applicable except for the reporting of data. As such, the Department continues to use the 112 zip
codes from the WindMAP program to track each company's writings. Our regulation now allows companies to file to use additional deductibles beyond the 112 zip codes that were contained in the WindMAP regulations. By doing this, many companies continue to write business in New Jersey. In addition, the Department has been successful and fortunate in attracting new coastal writers in New Jersey, such as Narragansett Bay, Rutgers Enhanced, Privilege Underwriters Reciprocal Exchange, American Commerce and Pacific Specialty. Accordingly, the Department is not seeing any increase in consumer inquiries about the availability of coastal insurance. Further, enrollment in the FAIR Plan residual market continues to decrease, including in coastal areas. That is a strong indicator of a competitive market with ample availability of coverage in coastal areas. Based on the above, the Department believes that the homeowners market is healthy and companies continue to compete for business throughout the State.

I trust that the foregoing is responsive to your inquiries. Please advise if you require any additional information.

Very truly yours,

Kenneth E. Kobylowski
Acting Commissioner