State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
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Commissioner

July 10, 2017

The Honorable Gary S. Schaer
c/o Frank Haines
Legislative Budget and Finance Officer
Office of Legislative Services
State House Annex
P.O. Box 068
Trenton, New Jersey 08625-0068

Dear Chairman Schaer:

Please accept the following response to your letter of May 26, 2017, which contained questions raised during the Department of Banking and Insurance's budget hearing on May 10, 2017, and additional questions not raised at the hearing.

Assemblyman Schaer:

- In his budget address on February 28, 2017, the Governor urged the Legislature to partner with him and the insurance industry to support the "underserved … our most vulnerable population who access Charity Care and Medicaid," referencing Horizon Blue Cross Blue Shield of New Jersey and their "abundant surplus" and proposing a permanent fund that Horizon would fund every year through its surplus to "help this population gain even greater access to in-patient and out-patient drug rehabilitation treatment."

In response to FY 2018 OLS Discussion Point Questions, the department provided the following financial data with regard to Horizon's surplus position and statutory minimum requirements:

CY	Net Premium Income	Surplus	Statutory Min. Req.
2016	$6,722,127,972	$2,385,936,594	$624,261,018
2015	$6,172,302,659	$2,305,909,361	$625,426,676
2014	$5,816,204,026	$2,230,234,344	$590,676,381
2013	$5,228,439,361	$2,212,037,895	$564,983,913
2012	$4,941,623,873	$2,106,940,035	$565,117,498
2011	$4,831,136,532	$1,973,204,361	$483,861,048
2010	$5,006,640,647	$1,771,102,162	$484,896,661

Please provide a copy of the formula the department utilizes to calculate such a statutory minimum requirement and the legal basis for that formula. Furthermore, please share

the name of the staff person within the Governor's office to whom the committee can inquire about the Governor's proposal to establish a permanent fund utilizing Horizon's surplus.

RESPONSE: There is a well-established legal basis for the Department to require a health service corporation to meet a minimum capital and surplus requirement. N.J.S.A. 17:48E-17.2, provides that a health service corporation must meet the financial requirements of N.J.S.A. 17B-18-68 through 70. Those are the sections for minimum capital and surplus for health insurers. Additionally, in 2014, the Solvency Modernization Act (P.L. 2014, c. 81) permitted the Commissioner to increase the minimum capital and surplus requirements for health service corporations by rule. See N.J.S.A. 17:48E-37.2 and 17:48E-37.3. As is the case for all other insurers in this State, the Commissioner has promulgated rules N.J.A.C. 11:2-39A.1 et. seq. to require increases in minimum capital and surplus levels through calculation and compliance with the NAIC's Risk-Based Capital ("RBC") requirements. The Department has provided an attachment from the NAIC instructions to insurers on how to complete the RBC Report. These instructions detail the formulas and procedures for determining RBC. The resulting RBC Report is filed with the annual Financial Statement, but as noted previously RBC Reports and RBC Plans are confidential and privileged pursuant to N.J.A.C. 11:2-39A.10.

All legislative inquiries should be directed to the Office of Counsel to the Governor.

- Under State law, the department has the authority to review and disapprove health insurance carrier rate filings that are found to be incomplete or not in compliance with the law. The department's rate review process determines if the rate increase is unreasonable if, for example:
a) It is based on faulty assumptions or unsubstantiated medical trends; b) It charges different prices to people who pose similar risks; c) It does not meet Minimum Loss Ratio standards; or d) It does not comply with permissible rating factors.

  Please explain how a health insurance carrier's surplus amount relates to the department's rate review process. Under the rate review process, if all other factors were deemed reasonable according to statute and regulation, would the department determine that a health insurance carrier's rate increase is reasonable if filed on the basis to augment an insufficient or declining surplus?

  RESPONSE: The Department has the authority to disapprove rates that are contrary to law, inadequate or unfairly discriminatory. New Jersey law also includes a minimum loss ratio (MLR) requirement for insurers in the individual and small employer markets. The MLR requires that companies pay at least 80% of premium dollars on health care claims in a given policy year. Premium rates that are determined by our Department to likely result in a violation of this MLR requirement can be disapproved by requiring adjustments. In addition, if a carrier does not meet the MLR requirement based upon approved and charged premium rates for a given policy year, the carrier is required to provide a refund (or credit) to policyholders to achieve the MLR for the policy year. In addition, as an Effective Rate Review State under provisions of the Affordable Care Act, federal regulations require the Department to examine the carrier's financial condition before making a final determination on rates.

  Assuming there are no capital or solvency concerns and all other requirements are satisfied, the Department would not disapprove premium increases that meet or exceed the MLR requirement, namely rates which in our Department's expertise will likely result in carriers

paying at least 80% of all premium on policyholder claims.

However, in a situation where solvency concerns exist, the Department would request the following additional information:

- *A forecast of the carrier's capital and RBC to the end of the following year based on the assumption that the filed rates are approved exactly as priced, and*

- *An explanation and quantification of how increases in the assumed pricing margins would impact MLR, capital and RBC levels.*

This additional information would be used by the Department in making its final rate determination. However, by law the overall MLR constraint always applies, meaning that carriers must always meet the MLR standard despite any strains on its financial condition.

Assemblyman Wimberly:

- Zombie properties are homes that residents abandon-- often after they have received a foreclosure notice -- which then languish until the foreclosure process is complete. New Jersey had the highest foreclosure rate in the nation in 2015 and studies have found that the State has the most vacant zombie foreclosures in the nation. Please provide research produced by the new Jersey Bankers Association regarding zombie properties in the state.

  RESPONSE: The Department contacted the New Jersey Banker's Association to request the information sought by the committee. Unfortunately, the Association does not have any research regarding zombie properties to share.

Additional questions:

- On February 7, 2017, the Department of Banking and Insurance announced it intended to propose amendments to the current Personal Injury Protection (PIP) regulations and in accordance with Governor Christie's Executive Order 2, and sought comment from various stakeholders. The Department stated that the $1,000 current limit for on-the-papers arbitration proceedings has reduced the duration and expense of arbitrations. Please elaborate on this statement. To what extent do built-in timelines affect the length of time to complete arbitration proceedings on-the-papers? Please provide statistics comparing the length of time that traditional arbitration proceedings take to reach a conclusion to the length of time to conclude on-the-papers proceedings.

  RESPONSE: For on-the-papers cases, initial submissions of the parties are due 120 days from initiation of the claim and final submissions are due 150 days from the initiation of the case. The deadline for the arbitrator to issue an award is 45 days from the final submissions of the parties, resulting in a fixed period of approximately 10 months. For in-person cases, the hearing date is assigned based on the availability of the arbitrator and the counsel for the petitioner and respondent. This makes the in-person process longer, especially when combined with hearing postponements requested by either the petitioner or respondent, which are not unusual.

  Specifically, an analysis of the number of days from initiation to disposition of arbitrations in 2016 provided by the Arbitration administrator, Forthright, indicates that the average time from initiation to disposition for on-the-papers cases is 190 days or approximately 6 months, and

about 60% percent of the dispositions are settlements within 45 days of initiation, in which case the respondent gets a refund of the arbitration fee.

For in-person cases, in contrast, the average time from initiation to disposition is 379 days or approximately 12 months and only 40% are settled within 45 days of initiation.

- What data support the department's claim that raising the limit for on-the-papers arbitration proceedings to $2,000 would make the process more efficient?

  RESPONSE: An increase in the threshold for on-the-papers arbitrations means that more cases would be subject to the faster process described above, which would result in greater efficiency in the handling of disputes about PIP.

- What data show that increasing the limit for on-the-papers arbitration proceedings would "continue to exert downward pressure on premiums?" What studies have been done that conclude on the papers cases cause reductions in premiums?

  RESPONSE: The cost of defending PIP arbitrations is part of the expenses an insurer has for handling an auto insurance claim. If the costs of arbitration are lowered, then that savings is eventually reflected in the rate-making process. Thus, lower claim-handling costs exert a downward pressure on rates.

- Bills that have been introduced in each house of the Legislature to increase the minimum required levels of automobile insurance coverage (A-4730, S-2163). When were minimum levels of auto insurance coverage last adjusted? Are the current levels adequate?

  RESPONSE: The minimum levels of coverage have not been adjusted since auto insurance became mandatory in New Jersey.

  As a general matter, the Department does not comment on pending legislation and has not taken a formal position on these matters. It is worth noting, however, that if NJ's minimum levels of coverage were changed, as proposed in A-4730 and S-2163, it would move NJ from tied for second (with PA and CA) with the lowest minimum limit requirement to the third highest among all states. In addition, such a change would likely result in premium increases between 13– 15% on average. Raising the minimum limits as proposed may also increase the number of drivers in our residual market mechanism (NJPAIP) or that choose to drive without insurance, causing further upward pressure on rates as insurers would likely have increased uninsured and underinsured motorist claims.

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

Very truly yours,

Richard J. Badolato
Commissioner