Discussion Points

1a. The federal "Affordable Care Act" (ACA) was enacted in March 2010 to facilitate the availability and affordability of health insurance nationally. The law has been contested since enactment and several actions by the federal government since January 2017 either have or will affect the national health insurance market.

In October 2017, the federal government ceased to make cost-sharing reduction subsidy payments to health insurance carriers. These payments effectively lowered the cost of qualified insureds for health insurance policies purchased through the health insurance marketplace. In Executive Order 13813 of October 12, 2017, the President of the United States also instructed the Departments of Labor, Health and Human Services, and Treasury to consider expanding the types of plans individuals and small businesses may purchase that do not meet the general requirements of the ACA.

In December 2017, the federal "Tax Cuts and Jobs Act" repealed the individual mandate penalty (also known as the shared responsibility payment) under the ACA as of tax year 2019. The ACA required taxpayers who did not have minimum essential health insurance coverage or qualify for an exemption to pay a penalty on their tax returns.

- ***Questions:*** **What has been the impact of the federal actions on the individual health insurance market in New Jersey and individuals who purchase individual health insurance coverage? How did the federal actions affect 2019 individual health insurance plan designs and rates? If applicable, please detail the impact of the federal actions on each carrier's 2019 plans and rates.**

- ***Question:*** **Please project the impacts of the federal actions on individual health insurance plans and rates in 2020.**

RESPONSE:

It is reasonable to expect significant continued upward pressure on health insurance premiums from these developments at the federal level. While it is difficult to put specific dollar impacts on rates due to a particular federal action, the Department's rate review process and discussions with carriers has revealed significant upward pressure on rates as a result of federal actions for 2019. Additionally, since the State has taken significant steps to mitigate the impact of these federal actions on rates, the full impact on rates and enrollment was not experienced in New Jersey. With regard to 2020 rates, similar dynamics are at play in the market, but it is too early to calculate specific impacts because the carriers have yet to file proposed rates for the 2020 plan year.

Impact of Repeal of Federal Individual Mandate:

The repeal of the individual mandate at the federal level led to requested rate increases in states across the country, however, the federal action was mitigated by action taken in New Jersey with the enactment of P.L. 2008, c. 31. The coverage mandate required under New Jersey law continued the individual mandate in New Jersey.

The Department asks carriers to estimate the impact the elimination of the penalty would have had if it had not been replaced. If New Jersey had taken no action to stabilize its market, carriers indicated to the Department that residents would have seen premium rates in the individual market rise by 12.6 percent over last year. Instead, as a result of the continuation of an individual mandate in New Jersey, carriers requested a 5.8 percent average increase in premium rates. In addition, Federal approval of the 1332 State Innovation Waiver in August, designed to lower anticipated premium rate increases by 15 percent, ultimately resulted in a combined or total average decrease of 9.3 percent in the 2019 rates compared to 2018.

Discussion Points (Cont'd)

Impact of Federal Elimination of Cost-Sharing Reduction Payments to Carriers: Although Federal funding of the cost sharing reduction payments was eliminated for 2019, carriers were nevertheless required to issue silver plans (70% actuarial value) to consumers eligible for cost sharing reduction with reduced deductible, copays and/or coinsurance to the richer actuarial value level of 73%, 87% or 94%. In consideration of the ongoing requirement to provide these plans, carriers upwardly adjusted the rates for all silver plans that are offered on the marketplace and directly to consumers. This was required under Federal law's single risk pool requirement.

Actuarial Memorandum from each carrier in support of the rate filings included the impact of the Federal government's elimination of the Cost Sharing Reduction payments on the rates in plan year 2019 rate filing as increases between 4% and 11%.

Under the ACA, the advanced premium tax credit, often referred to as a subsidy, is determined based on the premium for the second lowest cost silver plan. The rate adjustment to all silver plans thus increased the rates for the second lowest cost silver plan. Because the cost of the second lowest-cost silver plan was higher, consumers who are eligible for a subsidy (income below 400% Federal Poverty Level (FPL)) were eligible for larger subsidies as compared to 2017. Although the ACA assumes a consumer will use the subsidy to buy a silver plan, only consumers eligible for and wishing to receive cost sharing reduction are required to buy a silver plan. Other consumers may apply the subsidy toward the premium for a richer plan such as a gold plan, or may choose to buy a less rich bronze plan. Some consumers found the higher subsidy amount was enough to pay almost the full premium for a bronze plan, and thus enjoyed comprehensive coverage at minimal monthly cost. Consumers eligible for a subsidy enjoyed a lower net cost and were insulated from the premium increase to silver plans.

The elimination of cost sharing reduction payment did not necessitate plan changes.

For plan year 2019 the Department encouraged carriers to develop and offer an off-marketplace only silver plan. Since the plan would not also be offered on the marketplace, the rates for such silver plans did not require upward adjustment for the absence of cost sharing reduction funding. Two carriers offered the off marketplace only silver plan. As compared to a comparable plan that is offered on the marketplace, the rates for these off marketplaces only plans are about 10% lower.

Overall Rate Impacts of Federal Actions Mitigated by NJ Actions:

The above steps taken by New Jersey regarding the State-based individual mandate and silver loading of CSRs, when combined with the effects of our reinsurance program under the Federally-approved 1332 State Innovation Waiver (discussed in more detail below), lowered anticipated premium rate increases, ultimately resulted in a combined or total average decrease of 9.3 percent in the 2019 rates compared to 2018.

	Average Rate Change without NJ Individual Mandate	Average Rate Change with NJ Individual Mandate in effect	Rate Reduction % with NJ Reinsurance Program	Average Rate Change after NJ Reinsurance Program applied to Offset Federal Actions
Average Changes	**12.6%**	**5.8%**	**-15.1%**	**-9.3%**

Discussion Points (Cont'd)

2019 Base Rate comparison between on- and off-marketplace plans, and off-marketplace only plans:

Carrier / Entity	Plan Name	On- and Off-Marketplace	Off-Marketplace	Difference
AmeriHealth	IHC (Select) Silver EPO H.S.A. AmeriHealth Advantage $25/$50*	$267.25	$239.64	$27.61
AmeriHealth	IHC (Select) Silver EPO H.S.A. AmeriHealth Hospital Advantage $50/$75*	$271.81	$243.50	$28.31
AmeriHealth HMO	IHC (Select) Silver HMO Local Value $50/$75	$282.85	$253.81	$29.04
Oscar	Oscar Classic Silver	$318.61	$272.28	$46.33

***** The plan names with "Select" are off-marketplace plans
****** Horizon did not offer any off-exchange only plans
******* Oxford sells plans only at off-exchange

1b. In response to the federal actions affecting the ACA, New Jersey enacted the "New Jersey Health Insurance Market Preservation Act," P.L.2018, c.31, to ensure stability in the New Jersey health insurance market by requiring individuals to maintain minimum essential health insurance coverage beginning in 2019 and imposing a tax penalty for the failure to maintain coverage. Penalty payments are to be deposited into the New Jersey Health Insurance Premium Security Fund to support the establishment and operation of a health insurance reinsurance plan. Penalties will first be charged in calendar year 2020 for the lack of required coverage in calendar year 2019. In a September 2018 press release, the Governor reported that the two pieces of legislation combined lowered the average individual market health insurance rates by 9.3 percent in calendar year 2019 over calendar year 2018.

The health insurance reinsurance plan was enacted through a separate piece of legislation, the "New Jersey Health Insurance Premium Security Act," P.L.2018, c.24. The law directed the Department of Banking and Insurance (DOBI) to apply to the U.S. Department of Health and Human Services for a state innovation waiver to allow a health insurance reinsurance plan in the State. The plan, known as the Health Insurance Premium Security Plan, allows health insurance carriers that experience a sudden increase of high-cost claimants and high-cost claims to be reimbursed from the reinsurance fund. The act requires the Board of Directors of New Jersey's Individual Health Coverage Program to design the payment parameters for the plan to ensure that they will stabilize or reduce premium rates in the individual market by achieving between a 10 percent and 20 percent reduction in what premium rates would be for the applicable benefit year without the plan.

On August 16, 2018, DOBI received federal waiver approval for the reinsurance plan for the period from January 1, 2019 through December 31, 2023. The waiver letter stated that the State would receive pass-through funding from the federal government based on the amount of premium tax credits that would have been provided to individuals in the State absent the waiver. DOBI reported that the State has received $218 million in federal pass-through funds to support the Health Insurance Premium Security Plan for 2019. It also reported that the reinsurance program is projected to achieve a 15 percent reduction in what premium rates would otherwise be without the program.

Discussion Points (Cont'd)

Section 1332 of the ACA allows states to implement unique, state-specific health care reform solutions, subject to the approval of the U.S. Department of Health and Human Services. In order to be approved, a state's 1332 waiver proposal must ensure that:

- Residents will have access to coverage that is at least as comprehensive as it would be without the waiver;
- Premiums and cost-sharing must be at least as affordable as they would be without the waiver;
- At least as many people must be covered under the state's new approach as would be covered without the waiver; and
- The state's approach cannot result in increased federal spending.

- ***Questions:*** **What was the cost to the department to prepare the waiver application? Did DOBI employ additional personnel or contract for actuarial, accounting, legal, and other professional services?**

RESPONSE:

The Department contracted for actuarial services to assist with the preparation of the 1332 waiver application. The application was prepared by the Department's staff as a part of their regular duties, with the assistance of an actuarial consultant. The total amount paid to the consultant was $180,595.

- ***Questions:*** **Please project the separate and combined impacts of P.L.2018, c.24 and P.L.2018, c.31 on individual health insurance plans and premiums in 2020.**

RESPONSE:

Because of P.L.2018 c. 31 (individual mandate) and c. 24 (reinsurance program), rates for individual plans available in 2019 were, on average, 9.3% lower than rates for comparable plans in 2018. The filed rates for 2019 were 15% lower than they would have been without a reinsurance program.

If New Jersey had taken no action to stabilize its market, carriers indicated to the Department of Banking and Insurance that residents would have seen premium rates in the individual market rise by 12.6 percent over last year. Instead, as a result of the continuation of an individual mandate in New Jersey, carriers requested a 5.8 percent average increase in premium rates. Federal approval of the 1332 State Innovation Waiver in August, designed to lower anticipated premium rate increases by approximately 15%, ultimately resulted in a combined or total average decrease of 9.3 percent in the 2019 rates compared to 2018.

	Average Rate Change without NJ Individual Mandate	Average Rate Change with NJ Individual Mandate in effect	Rate Reduction % with NJ Reinsurance Program	Average Rate Change after NJ Reinsurance Program applied
Average Changes	**12.6%**	**5.8%**	**-15.1%**	**-9.3%**

Discussion Points (Cont'd)

The Department is directing carriers to file individual plan rates for 2020 assuming the same reinsurance plan parameters as in 2019 and thus the same 15% reduction as compared to what rates would be in the absence of the reinsurance program.

As explained above, the enactment of P.L. 2018, c. 31, by maintaining a requirement to have coverage and a penalty for not having coverage in certain circumstances, mitigated upward pressure on premiums in 2019. As estimated by New Jersey carriers, if this law had not been enacted, rates in 2019 would have increased by 12.6% instead of 5.8% with the law. A similar impact may be experienced in subsequent years, but it is too early to quantify since rates for plan year 2020 have not been filed yet.

- ***Question:*** **Please provide an accounting of the Health Insurance Premium Security Plan for calendar years 2019 and 2020. Please delineate program revenues and expenditures. What is the annual cost to the department of administering the program? What is the number of positions required to administer the program?**

RESPONSE:

The Health Insurance Premium Security Plan is currently in the beginning of its first year of operation. Therefore, it is too early to delineate program revenues and expenditures. As part of the Department's 1332 waiver application to the federal government, an actuarial analysis was performed to provide estimates of program costs and revenues, which was approved in August 2018. However, these estimates are not the actual revenues and expenditures of the program, which will not be known until all of the reinsurance eligible claims are reported for the entirety of plan year 2019.

Further, expenditures for the program are based on carrier claims that meet the payment parameters as established for the 2019 plan year, which are: an attachment point of $40,000; reinsurance cap of $215,000; and 60% coinsurance. While carriers will make quarterly reinsurance requests pursuant to the law, these are only partial-year estimates. The full cost of the program will not be available until after the 2019 plan year has ended and all claims can be analyzed to calculate the amounts that fall with the payment parameters. For plan year 2019, the reinsurance payments to carriers must be made no later than November 1, 2020.

On April 26, 2019, the federal government provided the Department with its administrative determination that New Jersey's pass-through funding for plan year 2019 would be over $180 million. The pass-through funding payment is not expected to be made until 2020.

The administration of the program has been added to the responsibilities of existing Department and IHC Board staff. There will be audit costs associated with the audits of the reinsurance requests submitted by the carriers. Those costs will be funded as part of the IHC program assessment on member carriers.

- ***Questions:*** **Is the new State individual health insurance mandate sufficiently advertised to avoid the imposition of the penalty in 2020 on a large number of individuals who may have been unaware that they had to have health insurance coverage for all of 2019? What are the department's efforts, if any, to inform concerned individuals to get health insurance coverage or pay a fine? Please provide an**

Discussion Points (Cont'd)

estimate for health insurance year 2019 of the tax penalties the department expects will be collected due to the failure of individuals to maintain coverage.

RESPONSE:

While the Department is not the primary agency charged with implementing P.L.2018, c.31, the Department has made information regarding P.L.2018, c.31 available as part of a multi-Departmental health coverage public awareness campaign, Get Covered New Jersey, the first statewide coordinated effort to promote the Open Enrollment Period. Information on the public awareness campaign website points out that failure to have health coverage or qualify for an exemption will result in a penalty and refers individuals to an informational website on the coverage requirement operated by Treasury. Additionally, the mandate was featured in the campaign's advertisements, which included billboards, web based and social media advertising.

The Department is not in a position to estimate the tax penalties that will be collected under P.L.2018, c.31. That law provides that the tax imposed by the act is to be assessed and collected in the same manner as under the "New Jersey Gross Income Tax Act." The reporting of minimum essential health coverage will take place as part of the Gross Income Tax collection in 2020 for coverage during the 2019 plan year.

2a. In New Jersey, the individual health insurance market is administered through the Individual Health Coverage (IHC) Program. Established pursuant to P.L.1992, c.161 (N.J.S.A.17B:27A-2 et seq.), the program seeks to ensure that people without access to employer- or government-sponsored health care programs can purchase health care coverage for themselves and their families from a variety of private carriers. Among other provisions, this law established incentives for carriers to participate in the individual market and allowed consumers to comparison shop based on premiums.

The Small Employer Health Benefits Program (SEH), enacted pursuant to P.L.1992, c.162 (N.J.S.A.17B:27A-17 et seq.), in turn, was established to provide small employers (those with 2 to 50 employees) with the option to purchase standardized health benefits plans. The plans can be modified based on the age, gender and family status of the employees and location of the business.

- ***Questions:*** **Please provide sample policy costs for individuals purchasing policies through the IHC program, as well as the number of carriers and number of plans available in the IHC market, for the three most recent years available. Please explain the difference in the cost of policies over the previous years.**

RESPONSE:

The most popular Silver and Bronze Plans are selected below:

Plan Name	Base Rate*		
	2017	2018	2019
Horizon OMNIA Silver	$310.65	$371.96	$343.59
Horizon OMNIA Bronze	$240.23	$298.26	$278.57

Discussion Points (Cont'd)

* *The base rate above is based on 21-year old individual. The actual individual premium will be determined by (Base Rate)*(Age Rating Factor).*

***There is a total of 4 carriers that sell plans in the IHC market**, they sold a total of 32 plans.*

Number of Carriers and Number of Plans Available in the IHC Market for Plan Year 2019:

Metal Level	Number of Carriers	Number of Plans
Gold	3	6
Silver	4	17
Bronze	4	6
Catastrophic	3	3
Total	**4**	**32**

- ***Questions:*** **In the IHC program, how many individuals are covered through plans purchased directly from the carrier and how many are covered through plans purchased on the Affordable Care Act marketplace? Please provide these data for the three most recent years available.**

RESPONSE:

The following table shows year end enrollment data:

	2016			2017			2018		
	Total	**MktPlc**	**Off**	**Total**	**MktPlc**	**Off**	**Total**	**MktPlc**	**Off**
Plans	198,625	143,144	55,481	197,782	143,721	54,061	186,120	138,208	47,912
Lives	308,821	214,566	94,255	309,521	214,900	94,621	287,103	204,871	82,232

- ***Questions:*** **What percentage of individuals covered through the Affordable Care Act marketplace receives a federal subsidy? What is the average federal subsidy?**

RESPONSE:

The IHC Board collects quarterly enrollment from all carriers but does not capture information regarding the subsidy. According to the information available from CMS, 87% of the consumers that enrolled using healthcare.gov during the 2019 open enrollment period received a subsidy. The average premium paid by consumers, after application of the subsidy Is $87.

- ***Questions:*** **Please provide sample policy costs for businesses purchasing insurance through the SEH, as well as the number of carriers and number of plans available in the SEH market, for the three most recent years available. Please explain the difference in the cost of policies over the previous years.**

RESPONSE:

Discussion Points (Cont'd)

The most popular Silver and Bronze Plans are selected below. SEH Rates are updated every quarter while each plan's rate purchased/renewed during any quarter will be valid for the whole year.

Plan Name	2017				2018				2019	
	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q
Horizon OMNIA Silver	$286	$297	$305	$314	$291	$297	$303	$303	$326	$314
Horizon OMNIA Bronze	$225	$234	$240	$247	$252	$258	$263	$263	$269	$263

The rates on the table are base rates prior to the application of Territory & Age Rating Factors. The actual individual premium rate is determined by (Quarterly Base Rate) x (Territory Rating Factor) x (Age Rating Factor). The individual rates are different by his/her age and the county (territory factor).

Number of Carriers and Number of Plans per year:

Year	Number of Carriers	Number of Plans
2017	5*	205
2018	5*	129
2019	4	113

* *Aetna exited from NJ SEH market at the end of 2017 and Cigna did at the end of 2018. Oscar re-entered New Jersey SEH market in 2018.*

- ***Question:*** **How many small businesses and covered individuals participated in the SHE in each of the three most recent years?**

RESPONSE:

The following table shows year end enrollment data:

	2016	2017	2018
Employer Plans	**59,672**	**53,508**	**47,613**
Covered lives (ee + dep)	**431,544**	**370,330**	**326,851**

Discussion Points (Cont'd)

2b. The department is responsible for reviewing all health insurance rate increases in the individual and small employer markets pursuant to the federal Affordable Care Act. Furthermore, under the federal law, individuals are supposed to be able to access information on federal, State, or insurer websites regarding rate increase requests that meet the threshold of 10 percent or more. In response to FY 2018 OLS Discussion Points, the department stated that its rate review process determined whether a proposed rate increase was reasonable. The department considers a requested rate increase unreasonable if, for example, the rate increase: a) is based on faulty assumptions or unsubstantiated medical trends; b) includes the charging of different prices to people who pose similar risks; c) does not meet Minimum Loss Ratio standards; and d) does not comply with permissible rating factors. The department added that the federal government had determined that New Jersey had an effective rate review program.

Under State law, pursuant to P.L.2008, c.38, the department also has the authority to disapprove rates in the individual or small group markets when the filing is incomplete, contrary to law, or the rates are inadequate or unfairly discriminatory.

- ***Questions:*** **Please describe any instance in calendar year 2017, 2018, and thus far in 2019 in which the department has found noncompliance with applicable laws. Please indicate the reason for the noncompliance and any resolution, if applicable, that was achieved.**

RESPONSE:

The Department reviews rate filings to ensure the reasonableness of each carrier's assumptions and projections in meeting MLR and compliance with all single risk pool and rating requirements of the ACA. By law, rate filings in the individual and small employer markets are informational and not subject to prior approval; however, the Department may disapprove any informational filing if the Department finds that the filing is incomplete and not in compliance with relevant laws or that the rates are inadequate or unfairly discriminatory. The Department uses its review process to ensure compliance with all applicable laws.

- ***Question:*** **Please provide the filed rate increase or decrease requests for health care plans available in the IHCP and SEH in calendar year 2018 and thus far in 2019.**

RESPONSE:

Below is a table showing the range in the IHCP rate change for 2018 and 2019 by carrier.

Carrier	% change in 2018 rates	% change in 2019 rates
AmeriHealth HMO, Inc.	9.3% to 53.6%	-14.3% to -15.5%
AmeriHealth Insurance Company of New Jersey	9.3% to 75.1%	-15.2% to -13.4%
Cigna HealthCare of New Jersey, Inc.	7.2% to 196.2%	NA

Discussion Points (Cont'd)

Horizon Healthcare of New Jersey, Inc.	5.20%	-14.7%
Horizon Healthcare Services, Inc.	13.7% to 25.6%	-8.4% to -6.6%
Oscar Garden State Insurance Corporation	NA - new	-14.6% to -9.1%
Oxford Health Insurance, Inc.	46.0% to 46.9%	-16.0% to -15.2%

*****Oscar Garden State Insurance Corporation entered in New Jersey IHC market in 2018.

2018 Changes in Rates – SEH

Below is a table showing the range in the SEH rate change for 2018 and 2019 by carrier.

Carrier	% change in 2018 rates	% change in 2019 rates
AmeriHealth HMO, Inc.	2.0% to 17.6%	6.9% to 14.4%
AmeriHealth Insurance Company of New Jersey	-8.3% to 14.7%	5.3% to 16.0%
Cigna HealthCare of New Jersey, Inc.	-38.7% to -4.6%	NA
Horizon Healthcare of New Jersey, Inc.	8.10%	4.40%
Horizon Healthcare Services, Inc.	1.2% to 34.8%	-3.3% to 12.1%
Oscar Garden State Insurance Corporation	NA - new	NA
Oxford Health Insurance, Inc.	-2.1% to 32.0%	-3.6% to 17.7%

3. The federal Affordable Care Act (ACA) established a minimum level of health care benefits, referred to as the Essential Health Benefits (EHB) package, that all qualified health plans (QHPs) offered nationwide must include. The ACA authorizes states to require QHPs to cover additional benefits, provided that states defray the costs of the mandated benefits. In 2017, New Jersey enacted several laws which mandate certain health care benefits: P.L.2017, c.28; P.L.2017, c.48; P.L.2017, c.176; P.L.2017, c.241; P.L.2017, c.305; and P.L.2017, c.309.

The ACA requires state governments to defray the costs associated with benefit mandates enacted after December 31, 2011. In reply to a FY 2019 OLS Discussion Point, the department clarified that the cost defrayal obligation would only be triggered by a mandate to cover a service or supply that was not previously required. Defrayal was not triggered by newly enacted utilization management requirements.

With regard to P.L.2017, c.28, which requires health insurance carriers to adhere to certain coverage requirements for treatment of substance use disorders, the department expected that the law would likely result in significant costs to carriers, putting upward pressure on premiums. However, there would also be some offsetting savings because substance use treatment should reduce the development of more serious and costly health conditions.

- ***Questions:*** **What is the department's estimate for the costs for QHP to provide benefits pursuant to P.L.2017, c.28; P.L.2017, c.48; P.L.2017, c.176; P.L.2017, c.241; P.L.2017, c.305; and P.L.2017, c.309? Please explain whether each of these laws triggered the cost defrayal obligation the ACA places on state**

Discussion Points (Cont'd)

governments? For any law that triggered the cost defrayal obligation, please indicate the expenditures the State is projected to incur in FY 2019 and FY 2020 and the budget line(s) in which the added expenditures are included.

RESPONSE:

While the ACA requires state governments to defray the costs associated with mandates enacted after December 31, 2011, defrayal is triggered only by a mandate to cover a service or supply that was not previously required.

Defrayal is not triggered by newly enacted utilization management requirements, such as in P.L. 2017, c. 28. That law does not mandate coverage for the treatment of substance use disorder, as coverage for services or supplies to treat substance use disorder were already covered before this law. Rather, P.L. 2017, c. 28 addresses how carriers can perform utilization management on those benefits by imposing restrictions with respect to the determination of medical necessity and the frequency and nature of required treatment authorizations, and thus does not implicate defrayal.

P.L. 2017, c. 48 addresses coverage for the treatment of infertility. The law does not apply to individual or small employer plans. No benefits were required to be added to the standard plans. Defrayal is not required.

P.L. 2017, c.176 addresses certain discrimination in provision of health benefits coverage, commonly referred to as gender identity. No benefits were required to be added to the standard plans. Defrayal is not required.

P.L. 2017, c. 241 requires insurance coverage for prescribed contraceptives. This law amended an existing mandate for coverage of contraceptives and is therefore not a new mandate. Defrayal is not required.

P.L. 2017, c. 305 requires health insurance coverage for digital tomosynthesis of the breast. This law amended an existing mandate for coverage of mammograms and is therefore not a new mandate. Defrayal is not required.

P.L. 2017, c. 309 requires coverage for donated human breast milk. The law provides that this coverage requirement does not take effect until there is a supply of human breast milk that meets certain requirements in the law. The requirements of the law have not been met and the benefit is not yet available.

4. On March 22, 2019, the Governor announced that the State would move to a state-based health exchange for calendar year 2021. The State currently uses the federally-facilitated exchange. According to the press release, operating a State-Based Exchange (SBE) would: give the State more control over the open enrollment period; provide access to data that can be used to better regulate the market, conduct targeted outreach and inform policy decisions; and allow user fees to fund exchange operations, consumer assistance, outreach and advertising.

The press release explained that legislation would be required to implement the intended SBE funding plan. The Administration proposes using the annual amount the State currently pays as a federal exchange user fee - which is presently set at 3.5 percent of premiums and raises over $50 million per year - to fund the SBE and Affordable Care Act-related health insurance outreach and enrollment efforts.

- ***Questions:*** **What are the anticipated capital costs of establishing an SBE, delineated by component? What are projected user fee collections in calendar years 2020, 2021, and 2022? Would anticipated**

Discussion Points (Cont'd)

calendar year 2020 user fee collections be sufficient to cover the full cost of establishing the SBE? If the capital costs are to be financed over several years, please provide a plan of finance.

RESPONSE:

The Department is in the early planning stages of establishing an SBE and creating an Exchange Blueprint Application, which must be approved by the Centers for Medicare & Medicaid Services (CMS). There are a range of possible approaches available to establish the SBE, but they generally include, at a minimum, creating an integrated online health insurance exchange technology platform, funding for navigators, and associated consumer assistance center to support the SBE. These functions can be performed by the Department or be done by a properly procured vendor, or by a combination of the two. To fund the operation of the SBE, legislation will be required to transfer the current federal exchange user fee, which is presently set at 3.5% of premiums, to a 3.5% State-Based Exchange user fee for plan year 2021 –a rate that raises over $50 million a year. Maintaining the existing user fee in the individual market at 3.5% of premium in New Jersey will allow the state to dedicate funding towards outreach and enrollment efforts, which have been reduced at the federal level, as it transitions to an SBE for 2021. It is anticipated that redirecting to the State the current exchange user fee revenue that goes to the federal government will be adequate to fund the costs of establishing and operating the SBE.

CMS recently released the payment parameters for plan year 2020 in which it modified the exchange user fee from 3.5% of all premiums sold on the exchange to 3%. The administration's proposal to transfer the user fee would come in two steps: 1) It would require a state assessment in the amount of 0.5% on the monthly premiums of health insurance issuers offering a plan on the individual market for plan year 2020 (this is in place of the 0.5% modification in the federal assessment). The State would use the revenue to support enrollment outreach, reinsurance and possibly additional market stabilization efforts. 2) If the State-Based-Exchange is created for plan year 2021, as proposed, this assessment for 2020 would be coupled with a 3% assessment for 2021 to maintain the current level of assessment on premiums. This action would keep in place at the state level the current 3.5% assessment paid to the federal government.

Since the calculation of revenue generated by exchange user fees is based primarily on enrollment and premiums, both of which are difficult to predict, it is difficult to predict the amount that the user fee will generate in future years. The Department cannot predict the user fee revenue for years 2020, 2021, and 2022.

- ***Questions:*** **What is the projected annual cost of operating the SBE, once it is fully established? Please detail for calendar years 2020, 2021, and 2022, the amount that is projected to be available for outreach and enrollment efforts after defraying the cost of establishing and operating the SBE.**

RESPONSE:

While the costs of operating an SBE will vary depending on the final Exchange Blueprint, the costs to operate an SBE in New Jersey is not expected to exceed the current exchange user fee revenue of $50 million that goes to the federal government each year.

5. The "New Jersey Insurance Trade Practices Act," (N.J.S.A.17:29B-1 et seq.), provides a comprehensive framework to regulate trade practices in the business of insurance. Among other things, the act defines and prohibits certain "unfair methods of competition and unfair and deceptive acts or practices" and provides DOBI with the authority to examine and investigate whether any person has engaged in such practices.

Discussion Points (Cont'd)

Specifically with respect to unfair settlement claim practices, the act prohibits "committing or performing with such frequency as to indicate a general practice" certain specific actions, including: (1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies; (3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; and (4) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

The act also requires insurers to maintain complaint handling procedures, including a complete record of all complaints received. This record must indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint.

Further, the act allows DOBI to issue a notice of hearing whenever the department has reason to believe that any insurer has engaged in an unfair or deceptive act or practice. Upon such a hearing, DOBI may impose a penalty not to exceed $1,000 for each violation, unless the insurer knew or reasonably should have known of the violation, in which case the penalty is not to exceed $5,000.

- ***Question:*** **With respect to the application of the act to health insurers, automobile insurers, and homeowners insurers; please provide for each category of insurance for calendar years 2016, 2017, and 2018: (a) the number of times that insurers objected to a notice of hearing, including the identity of each objecting insurer; (b) the number of times insurers were found to be in violation of the act, including the identity of each concerned insurer and the amount of the fine imposed; and (c) the three most common practices that resulted in the assessment of a fine, out of the specific unfair claim settlement practices set forth by the act.**

RESPONSE:

Information with respect to items (a), (b) and (c) is set forth in chart below. Note that no orders to show cause (i.e. notices of hearing) were issued in 2016-2018 because the parties agreed to resolve the issues regarding unfair trade practices through consent orders (COs).

Calendar Year	2016	2017	2018
# of times that insurers objected to notice of hearing, including identity of each objecting carrier	0	0	0
# of times insurers were found to be in violation of the act, including the identity of each concerned insurer and the amount of the fine imposed	4 COs (1) Fidelity Security Life Ins. Co., $95,000 (2) Oxford Health Ins. Co., Oxford Health Plans (NJ) Inc. and United HealthCare Ins. Co.,	2 COs (1) Horizon Healthcare of NJ, Inc., $150,000 (2) Horizon Healthcare Services, Inc. and	3 COs (1) Americhoice of NJ, Inc., Oxford Health Ins, Inc., Oxford Health Plans (NJ) Inc., United HealthCare Ins Co., $2,500,000 (2) Indiana

Discussion Points (Cont'd)

	$300,000 (3) Horizon Healthcare Services, Inc. and Horizon Healthcare Of NJ, Inc., $400,000 (4) CareCentrix of NJ, Inc. and CareCentrix, Inc., $400,000	Horizon Healthcare of NJ, Inc., $1,500,000	Lumbermens Mutual Ins. Co., $2,500 (3) Oscar Garden State Ins. Co., $500,000
Three most common practices that resulted in assessment of fine	NJSA 17B:30-13.1c NJSA 17B:30-13.1d NJSA 17B:30-13.1f	NJSA 17B:30-13.1c NJSA 17B:30-13.1d NJSA 17B:30-13.1f	NJSA 17B:30-4 NJSA 17:29B-4(a)(f) NJSA 17B:30-13.1a

6. The Governor proposes newly including in the FY 2020 Appropriations Act General Provision #101 that would transfer $33.0 million from the amounts deposited with the New Jersey State Firemen's Association (NJSFA) to the General Fund as State revenue. The amount is included in estimated FY 2020 Insurance Premiums Tax collections of $513.9 million.

On December 19, 2018, the New Jersey Office of the State Comptroller (OSC) released an investigative report entitled, "Administration of Benefit Funds by the New Jersey State Firemen's Association." The OSC's investigation revealed an accumulation of about $245.0 million in combined assets by the NJSFA and local relief associations (LRAs). The report attributed this buildup of assets to statutes that date back to the 1880s, which have limited the use of funds to burial benefits and financial assistance for "needy" firefighters and their families. (N.J.S.A.43:17-1, et seq.)

Out-of-State insurance companies pay two percent tax on premiums for fire insurance written on New Jersey properties. The NJSFA receives foreign fire tax collections and distributes this money to the 538 LRAs based upon the amount of revenue derived from the insurance policies written in that municipality. The NJSFA retains 52 percent of the annual tax revenue which can be used towards burial benefits, the special relief fund, administrative costs, and other expenses. The LRAs receive the remaining 48 percent of the tax funds. The LRAs' use of the funds is also dictated by statute and limited to paying relieve benefits, convention expenses, and administrative expenses, such as salaries of the LRA officers and trustees.

In 2016, the NJSFA received approximately $32.0 million in tax revenue and distributed about $16.0 million of those funds to the LRAs. As stated by the OSC, all 538 LRAs collectively spent 15.3 percent of their annual tax revenue on relief payments. As a result, each year the unspent assets held collectively by the LRAs grow by between $5.2 million and $7.3 million. The report also noted several instances of questionable expenditures by the LRAs, which the OSC attributed to a lack of oversight and training by the NJSFA.

Discussion Points (Cont'd)

- ***Questions:*** **Please provide detailed information on the recommended transfer. Is the transfer intended to be annually recurring? To what extent was the transfer recommendation driven by the OSC's investigative report?**

RESPONSE:

The above question does not fall within the Department's purview.

- ***Questions:*** **To what extent does the department agree with the OSC's findings and recommendations? Has there been any action from the department to address the issues outlined in the investigative report? Does the department recommend any legislative action regarding the rate of the tax imposed on fire insurance premiums written by out-of-State insurers or the permissible uses of tax collections?**

RESPONSE:

The Department's statutory authority regarding the activities of the NJ State Fireman's Association is very limited and does not allow the Department to act on the issues outlined in the report.

7. On February 28, 2018, Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) announced that it expected to receive $550 million in federal tax refunds over the next five years as a result of the federal tax reforms enacted in December 2017. Horizon BCBSNJ would work with DOBI to identify the most appropriate mechanisms to use half of the tax refunds as follows: distribute $150 million to its policyholders in calendar year 2018 and invest an additional $125 million in "significant initiatives that will drive improvements in health care for Horizon BCBSNJ members."

Section 4 of P.L.2017, c.100 (N.J.S.A.17:48E-17.3) requires DOBI to examine the annual regulatory filings of health service corporations, a legal status that applies to Horizon BCBSNJ, to determine whether a health service corporation's risk-based capital ratio is within 550 percent to 725 percent. If a health service corporation's surplus results in a ratio that exceeds 725 percent, DOBI must notify the health service corporation and the health service corporation shall, within 30 days, file a report with DOBI to reduce the surplus to be within the range. The report is to include a plan to benefit subscribers, which may include but not be limited to proposals to lessen potential rate increases in the future.

In response to an FY 2019 OLS Discussion Point, DOBI indicated that Horizon's proposed plan was under review by the department and that Horizon's risk-based capital ratio was confidential. As a result, it is not clear whether Horizon's plan to disburse the $275 million for the benefit of its policyholders is causally related to P.L.2017, c.100.

- ***Questions:*** **Please provide an update on the department's work with Horizon BCBSNJ to develop the parameters for the use of the $275 million the company intends to disburse for the benefit of its policyholders. Is the plan to disburse the $275 million related to P.L.2017, c.100? What does Horizon BCBSNJ intend to do with the other $275 million it expects to realize from the federal tax reforms?**

Discussion Points (Cont'd)

RESPONSE:

On December 17, 2018 Horizon distributed $131.9 million directly to its policy holders. Under order number 19-41 the Department took enforcement action.

8. The "Health Care Quality Act (HCQA)," (N.J.S.A.26:2S-1 et seq.), authorizes health insurance carriers to make decisions to deny, reduce, or terminate coverage of a health care service proposed to be delivered to a covered person based on the carrier's physician's clinical judgment as to whether the service is medically necessary. The HCQA also provides certain protections to covered persons in the event that there are no providers in the carrier's network that can provide medically necessary care, allowing a covered person to request what is commonly known as an "in-plan exception."

Under the HCQA, medical necessity is determined through Utilization Management (UM) review, a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines. The purpose of UM review is to determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan.

A carrier's UM program is required to be administered under the direction of a physician licensed to practice in this State under the clinical direction of the carrier's medical director. UM decisions must be based on written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers within the carrier's network and must be based on generally accepted medical standards. Any decision to deny payment for a requested service must be made according to these statutory guidelines.

Further, a carrier with an UM program is required to provide notice and allow insureds and their health care providers to appeal the carrier's decisions through the Independent Health Care Appeals Program (IHCAP) established under N.J.S.A.26:2S-11 and administered by the department. The department contracts through the State procurement process with multiple Independent Utilization Review Organizations to perform both the preliminary and full reviews of the cases presented to the IHCAP. Carriers bear the costs of the preliminary and full review.

- ***Question:*** **Please provide the number and type of appeals the department has received through the IHCAP in FY 2017, FY 2018, and thus far in FY 2019, and indicate how those appeals were resolved.**

RESPONSE:

IHCAP Appeal Information – Note the Department uses an Independent Utilization Review Organization (IURO) to conduct these appeals.

Number of Appeals by Fiscal Year

FY 2017	
Received by DOBI	1518

Types of Appeals

Allergy Immunology	16
Anesthesiology	13

Discussion Points (Cont'd)

Forwarded to IURO	1096
Ineligible for IURO	328
IURO Upheld	487
IURO Overturned	662

FY 2018

Received by DOBI	2733
Forwarded to IURO	2213
Ineligible for IURO	538
IURO Upheld	832
IURO Overturned	939

FY 2019 - Through 3/31/19

Received by DOBI	2445
Forwarded to IURO	1956
Ineligible for IURO	597
IURO Upheld	965
IURO Overturned	864

Cardiology	357
Dental	300
Dermatology	83
Endocrinology	90
ENT (Eye, Nose, Throat)	14
Gastroenterology	724
General Surgery	166
Geriatrics	36
Hematology Oncology	84
Infectious Disease	516
Internal Medicine	997
Neonatology	79
Nephrology	53
Neurology	259
Neurosurgery	17
OB/GYN	124
Oncology	53
Ophthalmology	14
Oral Maxillofacial	109
Orthopedics	82
Pain Management	34
Pediatric Endocrinology	57
Pediatric Otolaryngology	21
Pediatric Pulmonary	38
Pediatrics	447
Plastic Surgery	46
Psychiatry	364
Pulmonary	211
Radiation Oncology	64
Rehabilitation	273
Urology	68

- ***Question:*** **Please indicate the number of appeals the department has received through the IHCAP in FY 2017, FY 2018, and thus far in FY 2019 that involve a covered person's request for an in-plan exception, and how those appeals were resolved.**

RESPONSE:

FY-2017

In-Network Exception - 0

FY-2018

Discussion Points (Cont'd)

In-Network Exception - 11
Reversed – 6

Total # Per Carrier
Horizon - 6
UHCP -2
AmeriHealth - 2
WellCare - 1

FY-2019

In-Network Exception - 14
Reversed -7

Total # per Carrier
Horizon - 8
AmeriHealth - 2
Amerigroup- 1
Americhoice- 2
WellCare - 1

- ***Questions:*** **How many appeals through the IHCAP from FY 2017 to present have concerned the coverage of inpatient and outpatient treatment of substance use disorder? Please indicate the carrier associated with each appeal, and how those appeals were resolved.**

RESPONSE:

FY-2017

Substance Abuse
Total: 21
Reversed-6

Total # per carrier
Horizon - 11
United - 7
Cigna - 2
Amerihealth -1

FY-2018

Substance Abuse
Total: 17
Reversed - 5

Total # per Carriers:

Discussion Points (Cont'd)

Horizon - 16
United/oxford/UHCP - 1

FY- 2019

Substance Abuse
Total: 72
Reversed - 22

Total # per carrier
Horizon – 57
WellCare - 5
United/UHCP - 7
Amerigroup - 3

9. Surplus lines insurance is insurance coverage that is not available from insurers licensed in the State and which must be purchased from a non-admitted carrier. Surplus lines insurers provide the marketplace with coverage for catastrophic-prone risks and risks that are declined by the standard underwriting and rating process of admitted insurance carriers. DOBI collected $78.6 million from the surplus lines premium tax in 2017.

The federal "Non-admitted and Reinsurance Reform Act of 2010" (NRRA) authorizes states to enter into multi-state compacts or agreements with respect to the collection of surplus lines premium taxes. If a state does not join such an agreement, it may collect 100 percent of the taxes on surplus lines premiums in which the insured is located in its jurisdiction, otherwise known as a "home-state" insured. This includes the ability to collect all premium taxes associated with "home-state" insureds for their risks located in other states. However, a state that does not participate in a compact or agreement is precluded from collecting surplus lines premium taxes attributable to risks situated in its jurisdiction that belong to the home-state insureds of other jurisdictions.

P.L.2011, c.119 authorized DOBI to enter into compacts or agreements with other states with respect to the collection of surplus lines premium taxes in order to maximize State tax revenue. In response to FY 2019 OLS Discussion Points, the department stated that it was not in negotiations with any other states regarding participation in such an agreement or compact and that the department had determined it was not advantageous for the State to participate in such an agreement or compact. In the absence of an interstate compact, all surplus lines premiums for "home-state" insureds are assessed the five percent surplus lines premium tax, even if the premiums are on risks located out of the State.

- *Questions:* **Please provide the total surplus lines premium tax amount charged and collected for FY 2018 and estimated to be charged and collected for FY 2019 and FY 2020. How much of the revenue in FY 2018 is derived from policies that include out-of-State exposures?**

- *Questions:* **Please indicate the amount of tax charged, but yet to be collected for FY 2018 and thus far for FY 2019. In each year, please identify the amount of tax yet to be collected that is attributable to policies that include out-of-State exposures.**

Discussion Points (Cont'd)

- ***Question:*** **Please provide the surplus lines tax rate assessed in the states that are in the vicinity of New Jersey, including: Pennsylvania, Maryland, Delaware, New York, and Connecticut, if it has changed in the last four years.**

RESPONSE:

*2018: $82.7M **
2019: $86.8M est.
2020: $91.2M est.

Ten percent (10%) of the surplus lines tax is attributable to policies that include out-of-State exposures. Since the revenues are relatively stable, the Department anticipates that a similar number of tax payers and revenue will be generated going forward. The surplus lines premium tax is deposited in the state's general fund. Surplus Lines taxes are self-reported and paid by the producers. To our knowledge all taxes reported have been collected.

The surplus lines tax for neighboring states is:

Pennsylvania	*3 percent, plus a $20 stamping fee*
Maryland	*3 percent*
Delaware	*3 percent (changed from 2 percent)*
Connecticut	*4 percent*
New York	*3.6 percent, plus a 0.17 percent stamping fee (decreased stamping fee from .2 percent).*

New Jersey's present surplus lines tax rate is 5 percent.

10. The Office of Consumer Protection exercises the function and duties statutory law assigns to the Office of the Insurance Claims Ombudsman. N.J.S.A.17:29E-2 et seq. charges the ombudsman with investigating insurance consumer complaints regarding policies of life, health, auto, and other property and casualty insurance, except for claims for personal injury protection (PIP) coverage under automobile insurance. PIP claims are handled separately under an arbitration system.
Regulations (N.J.A.C.11:25-1.1 et seq.) provide that the ombudsman may conduct a review of any disputed insurance claim settlements, if certain circumstances are met, and that all complaints must be entered into a data tracking system. The ombudsman may hold hearings for disputes between all insurers and consumers. Life, property and casualty insurers are required by law (N.J.S.A.17:29E-9) to establish an internal appeals system for consumers, which must include notification to claimants that they may contact the ombudsman if they are dissatisfied by the internal appeals process.

The ombudsman is required to report to the Governor and the Legislature annually, summarizing the office's activities for the preceding year, documenting any significant industry-wide problems regarding claims settlement practices in any line of insurance, and setting forth any recommendations for statutory or regulatory change which would further the State's capacity to resolve claims disputes. However, the last report received by the Legislature was the 1999-2000 annual report.

Discussion Points (Cont'd)

- ***Questions:*** **How many complaints were filed with the Office of Consumer Protection in 2018 and thus far 2019? Please categorize by line of insurance. For those years, has the department identified any significant industry-wide problems regarding claims settlement practices in any line of insurance that require statutory or regulatory attention to further the State's capacity to resolve claims disputes?**

RESPONSE:

	2018	***2019****
Accident & Health	*2400*	*502*
Auto	*1683*	*318*
Fire, Allied Lines & CMP	*157*	*40*
Homeowners	*838*	*193*
Liability	*65*	*22*
Life & Annuity	*391*	*95*
Miscellaneous	*291*	*59*
*Unknown***	*2*	*445*
Total	*5827*	*1674*
****Confirmed Complaints of Total***	***1301***	***322***

**2019 is for 1/1/19 to 4/2/19*

*** Some are unknown because the file is still open and closing codes have not been entered to identify the line of insurance or closed prior to identifying the line of Insurance*

****A confirmed complaint is one in which the insurer, producer or other licensee committed a violation of (1) applicable state insurance law, (2) a federal requirement that the Department has the authority to enforce, or (3) a term or condition of an insurance policy or certificate. A confirmed complaint also includes those matters in which the complaint and the licensee's response, considered together, indicate that the licensee was in error. For confirmed complaints, the Department requires the offending licensee to remediate the issue to make the consumer whole and may take enforcement action to seek the imposition of license penalties (suspension/revocation) or monetary penalties in addition to restitution, when warranted by the conduct*

The Department actively engages in consumer assistance and protection. The Office of Consumer Protection acts as the primary point of contact for consumers. The Office contains a Consumer Inquiry and Response Unit, an Enforcement Unit, the Office of Managed Care and the Market Conduct Unit. Through these units, consumer inquiries and complaints are addressed and resolved. In addition, all consumer inquiries and complaints are monitored for concerning patterns and/or practices, either through the receipt of a chain of similar complaints or as demonstrated through statistical analysis. Finally, action is taken to obtain restitution for consumers and impose penalties on violating insurers. The Department's enforcement actions and market conduct exams are made public and are available on our website. Overall, neither consumer complaints nor the various Department-initiated investigations have indicated the presence of any significant industry-wide claim settlement problems.

Discussion Points (Cont'd)

11. P.L.2019, c.32 established several multiyear schedules for gradually raising the State minimum wage from currently $8.85 per hour to not less than $15.00 per hour. The increase may affect department staff, third parties that provide services to or on behalf of the department, and programs with means-tested eligibility criteria.

In FY 2020, the general State minimum wage will rise as follows: 1) on July 1, 2019 to $10 per hour; and 2) on January 1, 2020, to not less than $11 per hour. The general minimum wage schedule will increase to at least $12 per hour on January 1, 2021; $13 per hour on January 1, 2022; $14 per hour on January 1, 2023; and $15 per hour on January 1, 2024.

- *Questions:* **Please quantify the fiscal impact to the department in FY 2020 of the increases in the minimum wage of department employees from $8.85 to $10 per hour on July 1, 2019 and from $10 to $11 per hour on January 1, 2020, and the number of employees who will be impacted by each increase. Relative to current compensation levels, please provide the same information assuming an hourly minimum wage of $12, $13, $14, and $15.**

RESPONSE:

The Department does not have any employees who make below the minimum wage at either scale.

- *Questions:* **Please quantify the fiscal impact to the department in FY 2020 of the increases in the minimum wage of employees of third parties that provide services either to the department, including temporary employment services, or on behalf of the department according to contractual agreements. Relative to current compensation levels, please provide the same information assuming an hourly minimum wage of $12, $13, $14, and $15.**

- *Questions:* **If applicable, please quantify the fiscal impact to the department in FY 2020 of the increases in the minimum wage of enrollees in programs run by the department that have means-tested eligibility criteria. Relative to current compensation levels, please provide the same information assuming an hourly minimum wage of $12, $13, $14, and $15. Please list the programs with income-based eligibility criteria that will be affected by P.L.2019, c.32 and for each such program specify the law's projected effects on enrollment, the benefits provided to enrollees, and the projected cost savings to the department.**

RESPONSE:

The Department does not run any programs where benefits are provided to enrollees.

12a. The department imposes a special purpose apportionment for funding expenses incurred by the Division of Insurance (N.J.S.A.17:1C-19 et seq.). The apportionment is charged to all insurers writing most classes of insurance in the State and those health maintenance organizations granted a certificate of authority to operate in New Jersey pursuant to P.L.1973, c.337 (N.J.S.A.26:2J-1 et seq.). Collections fund the activities of the division in regulating, monitoring and supervising these carriers. The apportionment of each carrier is based on the proportion that its net written premiums for the preceding calendar year bear to the combined net written premiums of all carriers in the preceding year, except that no carrier pays an apportionment that exceeds 0.10 percent of its net written premiums. Each year, the Office of Management and Budget in the Department of the Treasury certifies to DOBI, by category, the total amount of expenses incurred by or on behalf of the division (N.J.S.A.17:1C-20).

Discussion Points (Cont'd)

- **Questions: Please provide the amount of the total special purpose apportionment charged and collected for FY 2018 and estimated to be charged and collected for FY 2019 and FY 2020. Please provide the number of payers of the apportionment in FY 2018 and the estimated number of payers in FY 2019 and FY 2020.**

RESPONSE:

Special Purpose Apportionment	*FY 2018*	*FY 2019 Estimated*	*FY 2020 Estimated*
Charged	*$36,312,435.63*	*$37,300,000*	*$38,000,000*
Collected	*$36,206,704.29*	*$37,300,000*	*$38,000,000*
Number of Payers	*1009*	*1009*	*1009*

- **Questions: How many companies paid the individual maximum apportionment of 0.10 percent of their net written premiums in FY 2017 and FY 2018? For each of these companies, please identify the assessed amount and the company's net written premiums.**

RESPONSE:

No company paid the maximum apportionment in FY 2017 and FY 2018.

- ***Question:*** **Please provide the expenses of the division detailed in N.J.S.A.17:1C-20 and approved by the Office of Management and Budget in the Department of the Treasury and provide the number of employees dedicated to the division for FY 2017 and FY 2018.**

RESPONSE:

OMB Certified Expenses

FY 2017	*$35,419,780.14*
FY 2018	*$36,312,435.63*

Insurance Division Employees

FY 2017	*264*
FY 2018	*261*

12b. In addition to the special purpose apportionment, insurance carriers are subject to the following assessments billed and collected by DOBI:

1. An insurance fraud prevention assessment on certain insurers for reimbursement of costs related to the activities of the Office of the Insurance Fraud Prosecutor within the Department of Law and Public Safety and the Bureau of Fraud Deterrence within DOBI (N.J.S.A.17:33A-1 et seq.);
2. An assessment on Small Employer Health Benefits Plan (SEH) carriers to cover the operating expenses of the SEH board of directors, pursuant to N.J.S.A.17B:27A-32;
3. A biennial assessment on Individual Health Coverage Program (IHCP) carriers to cover the operating expenses of the IHCP board of directors, pursuant to N.J.S.A.17B:27A-11;

Discussion Points (Cont'd)

4. An assessment on companies writing motor vehicle liability insurance or motor vehicle liability bonds for the Motor Vehicle Security Responsibility Fund, pursuant to N.J.S.A.39:6-58; and
5. An assessment on lines of insurance subject to the jurisdiction of the Division of Rate Counsel, an in-but-not-of agency in the Department of Treasury, to reimburse the division for expenses in connection with the administration of insurance rate cases, pursuant to N.J.S.A.52:27EE-48.

- ***Questions:*** **Please provide an accounting of all assessments charged and collected by the department for FY 2017 and FY 2018 and estimated to be charged and collected for FY 2019 and FY 2020. Please provide the number of payers of each assessment in FY 2017 and FY 2018 and the estimated number of payers in FY 2019 and FY 2020. Please detail this information by source, as numbered above**

RESPONSE:

	FY 2017	FY 2018	FY 2019	FY 2020
			Estimated	Estimated
Fraud				
Charged	$27,989,822.20	$27,152,390.23	$27,000,000.00	$27,500,000.00
Collected	$27,960,762.00	$27,150,866.77	$27,000,000.00	$27,500,000.00
Number of Payers	1014	999	999	999
SEH				
Charged	$341,923.00	$340,900.00	$291,316.00	$270,000.00
Collected	$340,478.00	$340,900.00	$291,316.00	$27,000.00
Number of Payers	11	10	10	10
IHC				
Charged	$772,389.00	$663,183.00	$1,616.00	$300,000.00
Collected	$772,389.00	662820	$1,979.00	$300,000.00
Number of Payers	10	32	5	20
Motor Vehicle Assessment				
Charged	$19,080,470.56	$21,416,575.31	$20,390,000.00	$20,590,000.00
Collected	$19,081,058.36	$21,412,656.69	$20,390,000.00	$20,590,000.00
Number of Payers	308	314	314	314
Rate Counsel				
Charged	$47,932.01	$33,456.73	$36,200.00	$3,700.00
Collected	$47,932.01	$33,386.83	$36,200.00	$3,700.00
Number of Payers	96	83	83	83

Discussion Points (Cont'd)

- ***Questions:*** **Please provide the FY 2017, FY 2018, and FY 2019 organizational and operating expenses of the SEH board of directors and the IHCP board of directors. Please provide the number of employees dedicated to administering each program.**

RESPONSE:

	IHC	***SEH***
FY2017	*$262,348*	*$251,752*
FY2018	*$260,665*	*$245,026*
FY2019 (Budget)	*$330,950*	*$340,600*
Number of Employees	*5 employees – shared by the two programs*	

12c. P.L.2016, c.38 limits the premium volume for any single contract of life insurance at $100 million per year for the purpose of calculating the annual special purpose apportionment and the insurance fraud prevention assessment in the case of foreign life insurers. Foreign life insurers mean those insurers not domiciled in New Jersey. While this law changes the allocation of the annual special purpose apportionment and insurance fraud prevention assessment, it does not affect the total amount collected under either revenue stream as any apportionment or assessment amount on foreign life insurers premiums excluded as being above the cap will be distributed on a pro rata basis among the life insurance companies domiciled in New Jersey, known as domestic life insurance companies.

- ***Questions:*** **How many foreign life insurers reached the maximum premium volume in regard to the annual special purpose apportionment and insurance fraud assessment in FY 2018, and how many does the department estimate will reach the maximum in FY 2019 and FY 2020? What is the total apportionment and assessment amount that the department estimates will be re-allocated to domestic life insurance companies as a result of P.L.2016, c.38? By what amount will the average apportionment and assessment amounts charged to domestic life insurance companies increase?**

RESPONSE:

Only one foreign life insurer reached the Maximum volume in FY 2018. The Department estimates that that will remain the same in FY 2019 and FY 2020.

FY 2018 Premium Volume Reallocated	*$ 72,521,511*
FY 2018 Fraud Assessment Amount Reallocated	*$ 48,147.10*
FY 2018 Special Purpose Assessment Amount Reallocated	*$ 48,744.15*

The reallocation effected only three companies in FY 2018. In one case the reallocation was so small that it did not generate an increased assessment. The average apportionment reallocated was $24,372.08. The average assessment amount reallocated was $24,073.55.

Discussion Points (Cont'd)

12d. N.J.S.A.17:1C-31 caps the combined amount of all DOBI insurance industry assessments in a given fiscal year at 0.25 percent of the combined net written premiums received by all companies for the previous calendar year (CY). In response to FY 2018 OLS Discussion Points, the department estimated that the combined net written premiums would total $52.5 billion in CY 2016, with companies being assessed a total of $89.1 million in FY 2017. As a reference, the maximum amount the State was permitted to assess insurance companies in FY 2017 based on the CY 2016 net written premiums total was $131.3 million.

- ***Question:*** **Please provide the CY 2016, CY 2017, and CY 2018 and the estimated CY 2019 combined net written premiums for all insurers, breaking down these data by line of insurance.**

RESPONSE:

Calendar Year	**2017**	**2016**
DSC - Dental Service Corp	$242,110,738.00	$241,995,609.00
DENTAL PLAN ORGANIZATION	$77,504,864.00	$74,794,806.00
FRATERNAL	$149,131,682.00	$159,096,658.00
HOSP/MED/DENT CORPORATION	$5,672,042,868.00	$5,358,550,987.00
LIFE/HEALTH	$17,259,563,032.21	$17,139,672,352.00
MORTGAGE	$118,290,744.00	$128,281,934.00
HMO	$9,846,291,495.00	$9,822,444,324.00
PROPERTY/CASUALTY	$19,609,360,679.00	$19,246,123,850.00
TITLE	$414,098,959.00	$405,787,398.00
SURPLUS LINES	$1,015,158,913.00	$1,096,900,761.00
	$54,403,553,974.21	$53,673,648,679.00

Estimated Net Written Premiums for Calendar Year 2018 and 2019 are below:
CY 2018 $55,500,000,000
CY 2019 $56,500,000,000

- ***Question:*** **Please provide the total amount assessed to, and collected from, companies in FY 2017 and FY 2018 and the amount estimated to be collected and charged in FY 2019.**

RESPONSE:

Total	**FY 2017**	**FY 2018**	**FY 2019 Estimated**
Assessed	$63,396,971.81	$63,040,966.19	$64,380,000.00
Collected	$63,396,971.81	$63,005,998.31	$64,380,000.00

Discussion Points (Cont'd)

13. The Workers Compensation Security Fund (WCSF) (N.J.S.A.34:15-105) is a depository for moneys 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 that became insolvent. The New Jersey Property-Liability Insurance Guaranty Association (PLIGA) administers the WCSF. As an independent entity, PLIGA's budget is not included in the State budget.

According to DOBI's FY 2018 OLS Discussion Point responses, as of March 30, 2017, the outstanding loss reserves for the fund were approximately $268.8 million.

- ***Questions:*** **Please provide an accounting of all resources and expenditures for the WCSF for 2017 and 2018 and estimates thereof for 2019 and 2020, including, with respect to revenues: assessments, liquidation dividends, investment earnings, and any other type of revenue; and with respect to expenditures: claim disbursements, administrative expenses, any other type of expenses, and transfers to other funds (both State and PLIGA held). Please include the balance of the fund, both at the beginning of each year and projected for the end of each year.**

RESPONSE:

New Jersey Workers' Compensation Security Fund
Schedule of Balances, Receipts and Disbursements
For Fiscal Years 2017, 2018 and 2019 estimated

	FY2017	*FY2018*	*FY2019 (est)*
Beginning Balance	***$164,226,847***	***$174,603,911***	***$188,036,927***
Receipts:			
Assessments	***23,869,626***	***24,210,926***	***23,685,853***
Liquidation Dividend	***6,703,698***	***15,905,748***	***10,905,070***
Interest/Other Income	***1,806,146***	***2,588,735***	***3,075,608***
Claims Disbursement	***18,603,770***	***24,797,877***	***29,521,701***
Administrative Expenses	***3,398,636***	***4,474,516***	***5,385,834***
Ending Balance	***$174,603,911***	***$188,036,927***	***190,795,923***

- **Question: Please provide details for the dividend in 2018 and 2019.**

Discussion Points (Cont'd)

RESPONSE:

Please see attachment Liquidation Dividends January 2017 – March 2019 pdf (Printed Version will be added to the end)

OLS Question 13
Dividends Attachment

- **Question: Please provide the outstanding loss reserves for the most recent year available, and for the previous year.**

RESPONSE:

Outstanding Loss Reserves as of March 29, 2019 - $291,378,791
Outstanding Loss Reserves as of March 28, 2018 - $291,558,985
Outstanding Loss Reserves as of March 30, 2017 - $268,843,796

	FY2020(Est)
Beginning Balance	*$190,795,923*
Receipts:	
Assessments	*23,735,371*
Liquidation Dividend	*0*
Interest/Other Income	*3,000,000*
Claims Disbursements	*32,000,000*
Administrative Expenses	*5,500,000*
Ending Balance	*$180,031,294*

WCSF

SUMMARY OF LIQUIDATION DIVIDENDS REC'D IN 2017

FUND	CO #	COMPANY MA,E	Deposit Date	Check Date	GROSS AMOUNT	EE AMOUNT	CHECK AMOUNT	% Distribution	LIQ DIV/ LG DED	Type of Distribution
WCSF	69	Warwick (Allstate)	01/11/17	12/28/2016	619.66		619.66		LIQ DIV/	Administrative
WCSF	69	Warwick (Allstate)	02/06/17	1/28/2017	619.66		619.66		LIQ DIV/	Administrative
WCSF	117	Atlantic Mutual	02/14/17		0.00		142,255.51			
WCSF	69	Warwick (Allstate)	03/03/17	2/25/2017	619.66		619.66		LIQ DIV/	Aadministrative
WCSF	81	Casualty Reciprocal	PLIGA		(6,827.70)		(6,827.70)		LIQ DIV/	
WCSF	69	Warwick (Allstate)	04/04/17	3/28/2017	619.66		619.66		LIQ DIV/	Administrative
WCSF	69	Warwick (Allstate)	05/03/17	4/27/2017	619.66		619.66		LIQ DIV/	Administrative
WCSF	69	Warwick (Allstate)	06/07/17	5/28/2017	619.66		619.66		LIQ DIV/	Administrative
WCSF	94	Cosmotolitan Mutual Ins	06/07/17	6/2/2017	20,236.44		20,236.44	1.7800	LIQ DIV/	Final Dividend Distribution
WCSF	81	Casualty Reciprocal	06/20/17	6/8/2017	4,180,409.89		4,180,409.89	0.7000	LIQ DIV/	Partial
WCSF	69	Warwick (Allstate)	07/10/17	7/7/2017	619.66		619.66		LIQ DIV/	Administrative
WCSF	26	Reliance	07/31/17	7/27/2017	179,494.89		179,494.89		LIQ DIV/	Administrative
WCSF	69	Warwick (Allstate)	08/07/17	7/28/2017	619.66		619.66		LIQ DIV/	Administrative
WCSF	121	Lumberman Mutual Casualty	08/14/17	8/3/2017	91,130.07		91,130.07		LIQ/DIV	Administrative
WCSF	10	Ideal Mutual Insurance	08/28/17	8/23/2017	18,765.23		18,765.23	42.5000	LIQ/DIV	Catch-up Distribution
WCSF	69	Warwick (Allstate)	09/05/17	9/7/2017	619.66		619.66		LIQ/DIV	Administrative
WCSF	121	Lumberman Mutual Casualty	09/26/17	9/21/2017	713,380.11		713,380.11		LIQ/DIV	Administrative
WCSF	69	Warwick (Allstate)	10/04/17	9/27/2017	619.66		619.66		LIQ/DIV	Administrative
WCSF	69	Warwick (Allstate)	11/09/17	10/28/2017	619.66		619.66		LIQ DIV/	Administrative
WCSF	87	Califiornia Ins Comm (Mission National)	11/09/17	Wire	13,515.58		13,515.58		LIQ DIV/	Interest
WCSF	61	The Home Insurance	11/20/17	11/9/2017	251,948.10		251,948.10		LIQ DIV/	Defense Expenses
WCSF	61	The Home Insurance	11/20/17	11/9/2017	11,051.21		11,051.21		LIQ DIV/	Administrative
WCSF	69	Warwick (Allstate)	12/06/17	11/27/2017	619.66		619.66		LIQ/DIV	Administrative
WCSF	69	Warwick (John Hancock)-George Wojc	12/26/17	12/15/2017	4,336.80		4,336.80		LIQ/DIV	Administrative
			YTD TOTAL		5,484,876.54	-	5,627,132.05			

WCSF

SUMMARY OF LIQUIDATION DIVIDENDS REC'D IN 2018

FUND	CO #	COMPANY MA,E	Deposit Date	Check Date	GROSS AMOUNT	EE AMOUNT	CHECK AMOUNT	% Distribution	LIQ DIV/ LG DED	Type of Distribution
WCSF	69	Warwick (Allstate)	01/04/18	12/28/2017	619.66		619.66		LIQ/DIV	
WCSF	46	PHICO	02/07/18	1/26/2018	616.17		616.17		LIQ/DIV	final distribution
WCSF	69	Warwick (Allstate)	02/07/18	1/28/2018	619.66		619.66		LIQ/DIV	
WCSF	121	Lumbermens Mutual Casualty	02/21/18	2/7/2018	748,354.86		748,354.86		LIQ/DIV	LAE
WCSF	69	Warwick (Allstate)	03/14/18	2/25/2018	619.66		619.66		LIQ/DIV	
WCSF	83	Casualty Reciprocal Exchange	03/27/18	3/9/2018	144,527.71		144,527.71		LIQ/DIV	6TH Gen Dist
WCSF	81	Casualty Reciprocal Exchange	03/27/18	3/9/2018	1,704,487.15		1,704,487.15		LIQ/DIV	6TH Gen Dist
WCSF	69	Warwick (Allstate)	04/04/18	3/28/2018	619.66		619.66		LIQ/DIV	
WCSF	69	Warwick (Allstate)	05/08/18	4/27/2018	619.66		619.66			
WCSF	69	Warwick (Allstate)	06/05/18	5/28/2018	619.66		619.66		LIQ/DIV	
WCSF	26	Reliance Insurance Co	06/26/18	6/21/2018	8,754,979.65		8,754,979.65	80% of Total AA Class B	LIQ/DIV	
WCSF	69	Warwick (Allstate)	07/06/18	6/27/2018	619.66		619.66		LIQ/DIV	
WCSF	69	Warwick (Allstate)	08/10/18	7/28/2018	619.66		619.66		LIQ/DIV	
WCSF	69	Warwick (Allstate)	09/07/18	8/28/2018	619.66		619.66		LIQ/DIV	
WCSF	121	Lumbermens Mutual Casualty	09/12/18	9/7/2018	625,827.16		625,827.16		LIQ/DIV	Administrative
WCSF	61	The Home	09/25/18	9/20/2018	34,562.61		34,562.61		LIQ/DIV	Administrative
WCSF	69	Warwick (Allstate)	10/05/18	9/27/2018	619.66		619.66		LIQ/DIV	
WCSF	26	Reliance Insurance Co	10/05/18	9/27/2018	465,300.00		465,300.00		LIQ/DIV	Administrative
WCSF	69	Warwick (Allstate)	11/06/18	10/28/2018	619.66		619.66		LIQ/DIV	
WCSF	121	Lumbermens Mutual Casualty	11/15/18	11/8/2018	261,986.25		261,986.25		LIQ/DIV	
WCSF	69	Warwick (Allstate)	12/05/18	11/27/2018	619.66		619.66		LIQ/DIV	
WCSF	69	Warwick (John Hancock)-George Wojc	12/17/18	12/17/2018	4,336.80		4,336.80		LIQ/DIV	
WCSF	26	Reliance Insurance Co	12/18/18	12/13/118	8,148,499.76		8,148,499.76		LIQ/DIV	
		YTD TOTAL			20,900,914.04	-	20,900,914.04			

WCSF

SUMMARY OF LIQUIDATION DIVIDENDS REC'D IN 2019

FUND	CO #	COMPANY MA,E	Deposit Date	Check Date	GROSS AMOUNT	EE AMOUNT	CHECK AMOUNT	% Distribution	LIQ DIV/ LG DED	Type of Distribution
WCSF	69	Warwick (Allstate)	01/10/19	1/10/2019	619.66		619.66		LIQ/DIV	
WCSF	69	Warwick (Allstate)	02/06/19	2/6/2019	619.66		619.66		LIQ/DIV	
WCSF	121	LUMBERMENS MUTUAL CASUALT	03/19/19	3/14/2019	226,423.67		226,423.67		LIQ/DIV	
		YTD TOTAL			227,662.99	-	227,662.99			

WCSF

SUMMARY OF EARLY ACCESS REC'D IN 2017

FUND	CO #	COMPANY NAME	Deposit Date	Check Date	GROSS AMOUNT	FEE AMOUNT	CHECK AMOUNT	% Distribution	LIQ DIV/ LG DED	Type of Distribution
WCSF	117	Atlantic Mutual Ins Co	02/14/17	2/8/2017	142,255.51		142,255.51	17.5000	LIQ DIV/	Early Access
WCSF	125	Lumberman's Underwriting Allian	09/29/17	9/22/2017	365,841.45		365,841.45		LIQ DIV/	Early Access
WCSF	184	Commercial Comp (Superior Na'tl)	10/24/17	Wire	141,600.00		141,600.00		LIQ DIV/	Early Access
WCSF	125	Lumberman's Underwriting Allian	11/16/17		85,606.58		85,606.58		LIQ DIV/	Early Access
WCSF	125	Lumberman's Underwriting Allian	11/21/17	11/15/2017	10,676.09		10,676.09		LIQ DIV/	Early Access
WCSF	122	Ullico Casualty Company	12/27/17	12/15/2017	373,235.00		373,235.00		LIQ DIV/	Administrative
		YTD TOTAL			1,119,214.63	-	1,119,214.63			

WCSF

SUMMARY OF EARLY ACCESS REC'D IN 2018

FUND	CO #	COMPANY NAME	Deposit Date	Check Date	GROSS AMOUNT	FEE AMOUNT	CHECK AMOUNT	% Distribution	LIQ DIV/ LG DED	Type of Distribution
WCSF	125	Lumberman's Underwriting Allian	02/21/18	2/15/2018	21,796.90		21,796.90		LIQ/DIV	Early Access
WCSF	211	Reinsurance Company of America	02/27/18	2/16/2018	60,566.00		60,566.00		LIQ/DIV	Early Access
WCSF	121	Lumbermens mutual Casulaty	04/04/18	3/29/2018	2,032,889.28		2,032,889.28		LIQ/DIV	Early Access
WCSF	125	Lumberman's Underwriting Allian	05/23/18	5/15/2018	19,343.84		19,343.84		LIQ/DIV	Early Access
WCSF	86	Shelby Casualty Insurance Co.	06/01/18	5/23/2018	1,386.57		1,386.57	100% Class 1 & 12% Class 2	LIQ/DIV	Early Access
WCSF	125	Lumberman's Underwriting Alliance		8/15/2018	1,503.65		1,503.65		LIQ/DIV	Early Access
WCSF	125	Lumberman's Underwriting Allian	09/25/18	9/21/2018	610,612.19		610,612.19		LIQ/DIV	Early Access
WCSF	125	Lumberman's Underwriting Alliance		11/15/2018	11,822.82		11,822.82		LIQ DIV/	Early Access
WCSF	117	The Atlantic Mutual Ins Co	12/12/18	12/4/2018	188,269.14		188,269.14		LIQ DIV/	Early Access
		YTD TOTAL			2,948,190.39	-	2,948,190.39			

WCSF

SUMMARY OF EARLY ACCESS REC'D IN 2019

FUND	CO #	COMPANY NAME	Deposit Date	Check Date	GROSS AMOUNT	FEE AMOUNT	CHECK AMOUNT	% Distribution	LIQ DIV/ LG DED	Type of Distribution
WCSF	122	ULLICO CASUALTY COMPANY	01/29/19	1/25/2019	426,425.00	0.00	426,425.00		LIQ DIV/	EARLY ACCESS
WCSF	125	LUA	02/25/19	2/15/2019	3,356.85		3,356.85		LIQ DIV/	EARLY ACCESS
		YTD TOTAL			429,781.85	-	429,781.85			