Discussion Points

1a. Hurricane Sandy made landfall in New Jersey as a Tropical Storm on October 29 and wreaked havoc throughout the State, causing in excess of $37 billion in damage. The damage resulted in a lack of services severely disrupting people's lives and ability to conduct business throughout the State for several days, and for weeks and months in certain areas of the State. In the aftermath of the storm it was difficult for individuals to contact their banks and insurance providers to begin the process of recovering and rebuilding. The Department of Banking and Insurance (department) responded by conducting outreach to State licensed financial institutions and insurance providers to coordinate a response to the emergency. The department also set up mobile offices in the counties of Middlesex, Monmouth and Ocean. Staff from the department worked overtime coordinating the State's response, and to address the numerous questions raised regarding the response of the financial and insurance industries concerning hurricane deductibles, flood insurance, homeowners insurance, and public adjusters.

Question: a. Please provide to the Legislature details on the department's response to Hurricane Sandy, including the outreach that has been conducted in the community and the number of consumers assisted. What is the department's current level of activity related to Hurricane Sandy?

Response: Since Super Storm Sandy struck, the Christie Administration, including the Department of Banking and Insurance, has worked ceaselessly with New Jersey residents as they recover and rebuild in the aftermath of unprecedented damage. Immediately following the storm, Governor Christie ordered this Department's regulated firms to forbear deadlines on items such as mortgage and insurance premium payments delayed by Sandy. The Governor also ordered insurance carriers to refrain from charging hurricane deductibles since the regulatory threshold for applying them was not met. These actions saved thousands of residents significant expenses which could be applied to the recovery effort.

In the weeks and months since Sandy, this Department has worked with the Governor's Office in overseeing the insurance industry's response to its customers impacted by the storm. As of March 1, New Jersey consumers filed 445,200 Sandy-related claims. To date, 93 percent of Sandy-related, homeowner's insurance cases in New Jersey have been closed.

At the same time, rebuilding continues for many. In some instances, mortgage lenders who are co-recipients of insurance proceeds are managing disbursements of funds. This Department has intervened on behalf of hundreds of consumers when mortgage servicers have unfairly delayed disbursements. This Department was gratified to learn recently that the four major mortgage servicers would release 50 to 75 percent of remaining insurance proceeds so that homeowners can begin to rebuild.

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Other claims remain open because the claimant is not satisfied with the insurer's offer. A top concern of consumers calling the Department is unsatisfactory settlement offers. To address that issue, the Department is establishing a mediation program designed to settle unresolved claims. Mediation will prevent costly and time consuming litigation for many open Sandy cases. Faster case resolution will permit New Jerseyans to rebuild and recover from Sandy in a more timely manner. Those with unresolved claims will be notified of their eligibility for participation in the program. The State's insurance companies have been supportive of the new program.

In February, at the request of the Governor, the Department ordered State regulated insurance companies to respond to the Department within five business days when a consumer files a request for assistance regarding claims related to Super Storm Sandy. Insurance companies previously had 15 days to respond. Further, the Department issued an order limiting insurance companies to one extension of five business days instead of the unlimited number of extensions they could previously request.

In the meantime, since Sandy struck, Governor Christie has asked investigators from the Department, as well as others, to bring Trenton to New Jersey communities. To date, the Department has hosted twenty (20) Mobile Offices throughout New Jersey, including offices in Newport, Seaside Heights, Stafford, Brick Township and Bayville. Additional Mobile Offices were also located throughout the State in Manasquan, Highlands, Atlantic Highlands, North Wildwood, Union Beach, Sea Bright, Neptune, Little Ferry, Sayreville and Oakhurst. The Department also sent more than 40 staff members to assist consumers in the field at Disaster Recovery Centers. Staff has assisted people in Atlantic City, Springfield, Bayhead, Belmar, Burlington, Hackensack, Harvey Cedars, Jersey City, Leonardo, Long Branch and Somerville among other locations. The Department continues to hold Mobile Offices to assist New Jerseyans who have suffered property loss as a result of Sandy. Staff from the Department and other State agencies, the Governor's Office and the National Flood Insurance Program (NFIP) handle consumers' questions and assist them in filing storm-related insurance claims.

The Department has also seen an influx of calls regarding delays in handling flood insurance claims. That area is administrated and financed by the federal NFIP. In February,

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hearing complaints from New Jersey residents, the Governor called for changes in NFIP's performance. Since then, the NFIP has begun to work more closely with the Department and has established a call center at (800) 427-4661. At the same time the closure of flood claims has increased dramatically.

Every day, staff members at the Department's Office of Consumer Protection assist consumers by answering banking and/or insurance related questions regarding their case, including nearly 5,000 Sandy-related insurance inquiries. Department investigators contact the policyholder's insurance company or bank to try and resolve any outstanding issues in order to settle the claim.

If a consumer files a formal request for assistance, staff from the Office of Consumer Protection will investigate to determine if any State laws or statutes relating to banking and insurance have been violated. Violations are referred to the Department's Enforcement Unit for possible administrative action.

The recovery and rebuilding process will continue. The Christie administration and this Department will continue to work tirelessly to resolve consumers' insurance claims and help them rebuild their homes and restore their communities.

b. Please detail any additional expenditures incurred by the department as a result of Hurricane Sandy and indicate whether those expenditures will be recouped through federal or State funding.

Response: The only additional expenditures incurred by the Department were for overtime. Customer Service staff worked nights, weekends, Election Day, and Veteran's Day to field consumer inquiries regarding Super Storm Sandy.

The Department incurred minimal expenditures as a result of Super Storm Sandy. Any costs not covered by Federal reimbursement will be paid through our annual assessments. None of our costs will be charged to the State's General Fund.

1b. Prior to the onset of Hurricane Sandy, financial institutions throughout the State had to prepare by having enough cash available for customers to withdraw in the days preceding the storm. Then, after the storm, many financial institutions had to deal with the impact of the storm

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on their infrastructure, including flooded branches and power outages, while maintaining communication with their customers and staff as well as the department.

According to the department, all banks are required to have a Disaster Recovery Plan on file with the department that outlines the steps the institution will take in a disaster to ensure public confidence in the industry.

Subsequent to the storm, Executive Order No. 107 of 2012 directed banks to take into consideration the difficulties related to Hurricane Sandy and exercise appropriate forbearance on collection, cancellation, documentation, and other regulatory requirements, such as due dates and late fees. It has been reported that homeowners and businesses requested and received temporary deferral of their mortgage payments due to the delay in processing insurance claims and the inability of owners to conduct business due to the storm.

Question: a. What guidance did the department provide to State licensed banks in preparation for the storm?

Response: On October 25, 2012, the Department issued Bulletin 12-11 which recommended that State licensed banks review and activate their disaster preparation plans, which include provisions for providing services to consumers in the event of an emergency. The bulletin also addressed these matters for State-chartered credit unions. Institutions also had access to the Office of Homeland Security communications and calls leading up to the storm.

b. How did the department communicate with banks during the immediate aftermath of the storm? How did the department ensure that consumers would be able to access their financial accounts during the immediate aftermath of the storm?

Response: The Department reached out to bank CEOs the day after the storm to inquire if:

1. The bank was open?
2. How many branches are closed?
3. Are they closed due to lack of power and/or damage?
4. When will they reopen?
5. Do they need assistance of any kind?
6. How are they notifying customers?

Banks communicated with the Department daily via email and phone. The Department also participated in conference calls daily with the Federal Deposit Insurance Corporation and the Federal Reserve Banks of New York and Philadelphia. The Conference of State Bank

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Supervisors facilitated the calls and included Treasury as needed. Topics discussed on the calls included number of banks closed and customer impact issues. There were no access to cash issues as federal deliveries were made as necessary.

These calls also provided factual information "boots on the ground" to reassure Federal agencies that New Jersey banks were operational and customers had access to cash.

c. How many mortgages and loans held by State licensed financial institutions were affected by Hurricane Sandy? What percentage of these mortgages and loans have deferred payments due to Hurricane Sandy? Has the department provided the banks with any guidance on deferrals of payments by business and residential owners who have been severely impacted by Hurricane Sandy? Does the department have any plans to provide these owners with financial assistance?

Response: The Department does not track the mortgage and loans held by State licensed financial institutions that were affected by Sandy. Banks are currently assessing the number and size of loans, damage, collateral and capital impact. Results will be known in the coming months. This data will be part of the bank's risk management but is not required to be submitted to the Department separate from the bank examination.

The Department has been in communication with banks and anticipates that they adhere to existing regulatory guidelines on any payment deferrals. Banks are working with customers on an individual basis. Some are adding the forbearance amount to the end of the loan term which reduces the financial hardship of a balloon payment of the deferred amount.

Federal guidance may be issued pertaining to the treatment of loans impacted by Super Storm Sandy which the State would follow.

As a financial regulator, the Department is not in a position to directly provide or require regulated institutions to provide financial assistance. The Small Business Administration, New Jersey Economic Development Authority, United States Economic Development Authority and banks will provide financial assistance.

d. How many financial institutions are still not operating due to damage from Hurricane Sandy? How many banks had to move operational headquarters after Hurricane Sandy?

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Response: Statewide three branches were closed. Of those, two remain closed while undergoing repairs and one is closed permanently.

Two headquarters were relocated to back-up locations. One was due to flooding and power issues while the other was due to power issues only. Both banks were fully operational and experienced no adverse customer impact.

e. How many consumers have contacted DOBI with complaints about their financial institutions related to Hurricane Sandy? Please provide some details of these complaints and the department's related actions.

Response: The Department received approximately 275 complaints pertaining to the release of insurance proceeds: two were New Jersey state chartered institutions and the remaining 273 were national banks or mortgage servicer companies.

The Department has been managing bank complaints regarding insurance proceed checks. These matters require extensive follow-up and outreach to the banks. The complaints originate as referrals from the Governor's Office, Mobile Offices, legislative offices or through the Department's call center. As described above, most of the complaints relate to mortgages held by national banks or mortgage servicers. The Department works as a liaison to assist the resolution by escalating the complaints to top management. We have escalated approximately 100 consumer matters; 83 of which are resolved to date.

f. Does the department foresee any changes to the Disaster Recovery Plans currently required of the financial institutions? Were there any lessons learned from the response to Hurricane Sandy that the department will be using to implement changes in the future?

Response: Banks are required to have Disaster Recovery Plans pursuant to the inter-agency statement of policy required by the Department. They were open and able to serve their customers. They will do their own assessments of how they can improve their response for future events. Additionally, the Department is a participant on the Financial Sector Working Group, which is tasked by the Office of Homeland Security with reviewing and recommending an after action plan. Industry representatives are also participating on this working group. Final recommendations will be forthcoming.

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These ongoing working group meetings include identifying issues and solutions to problems that emerged.

1c. Hurricane Sandy resulted in significant damage to property throughout the State. After the storm, individuals immediately began filing claims with their homeowner's insurance carriers to restore damaged homes and repair or replace personal property. The claims process uncovered numerous problems and questions regarding homeowners insurance coverage, flood insurance coverage, hurricane deductibles and public adjusters.

Insurance carriers throughout the State were mobilized immediately after Hurricane Sandy to respond to customer requests for assistance on filing claims and for questions regarding their levels of coverage. At first, there was confusion among carriers and the general public as to whether the hurricane deductible permitted to be part of homeowners insurance policies pursuant to N.J.S.A.17:36-5.34 would be applied or if, as was the case after Hurricane Irene in 2011, the Commissioner of Banking and Insurance would issue a Bulletin prohibiting companies from applying hurricane deductibles (Bulletin No. 11-16). (For more information on the hurricane deductible, please see the OLS backgrounder beginning on page x of this report.) On November 2, 2012, Governor Christie issued Executive Order No. 107, clarifying that due to the National Weather Service's categorization of Hurricane Sandy as a post-tropical storm at the time it made landfall in New Jersey, insurers could not apply a hurricane deductible to the payment of claims for property damage attributable to the storm.

Question: a. What guidance did the department provide to insurance providers in preparation for the storm?

Response: On October 25, 2012 the Commissioner issued Bulletin 12-12 advising both insurance companies and insurance producers to activate their disaster plans, marshaling all appropriate resources to secure their ability to provide timely assistance to insureds. The Bulletin also reminded insurance companies of their obligations as set forth in Order Nos. A07-126 and A09-103, issued in 2007 and 2009, respectively. These Orders detailed several expectations of the Department regarding matters such as the expedited payment of claims and the suspension of cancellation and nonrenewal of policies for reasons related to the occurrence of the disaster. The Bulletin also advised insurance companies that, if conditions warrant, any so-called "deemer" timeframes specified in various authorities within which the Department is required to act on a filing from an insurance company may be suspended for the duration of the disaster or catastrophic event.

As indicated by the above referenced Orders, Department guidance and direction to insurance companies and producers regarding disaster preparedness is an ongoing effort not limited to periods when a disaster appears imminent. Such guidance and direction has

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included the submission for review by the Department of insurance company Continuity of Operations and Disaster Recovery Plans, the demonstration of redundancy of key systems and resources, the participation of insurance companies and producers in hurricane preparedness exercises coordinated by State emergency management and homeland security officials, and the participation of insurance companies and producers in the State's private-sector essential employee credentialing system.

During the days preceding the storm the Department also verbally reinforced to insurance companies and insurer trade associations the Department's expectations, and engaged in dialogue aimed at anticipating issues that might arise from this specific storm, such as the potential imposition of hurricane deductibles.

Additionally, the Department would disagree with the assertion that there was confusion among carriers and the public as to whether the hurricane deductible applied. The Department alerted companies that the regulatory threshold for applying the hurricane deductible was not met on the evening of October 30, 2012 and that as a result the hurricane deductible should not be applicable. The Governor subsequently formally issued Executive Order 107 on November 2, 2012 confirming this, less than four days after Sandy struck.

b. What percentage of homeowners insurance policies written in New Jersey include a mandatory hurricane deductible? An optional hurricane deductible? Approximately what percentage of premium do policyholders save due to the current hurricane deductible?

Response: The Department does not collect the data on the percentages of policies with mandatory or optional hurricane deductibles. Most policyholders save approximately 5 percent-10 percent due to having a hurricane deductible, with the amount dependent on the size of the deductible, the value and location of the home, and other policy characteristics.

c. Does the department anticipate that insurers will eliminate the availability of the hurricane deductible to insureds, as a result of declarations such as Executive Order 107?

Response: The Department is aware of interest inside the insurance industry in exploring potential alternatives to hurricane deductibles. Industry representatives in a number of states have expressed concern that government actions to stay the application of the

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deductibles is preventing those deductibles from achieving their purpose of expanding the availability of coverage in coastal areas by containing and increasing the predictability of losses. Whether these industry deliberations will result in significant changes to the practice is unclear at this time. The Department notes that Executive Order 107 did not invalidate the hurricane deductible provision, if any, or other contractual provisions of homeowner insurance policies in New Jersey. Instead, the Executive Order notified insurance companies that the storm failed to meet the State's long-standing regulatory test for the use of hurricane deductibles. While a number of significant insurance companies reached this conclusion independently, the Executive Order made it clear that the State would act to enforce its regulation on hurricane deductibles should any insurance company violate that regulation by attempting to impose the deductible.

d. Does the department anticipate recommending any changes to the administrative code regulating the hurricane deductible?

Response: No specific recommendation is anticipated at this time. However, the Department is open to discussions with stakeholders on the wisdom of potential changes to the administrative code regarding hurricane deductibles.

1d. Since many of the property claims from Hurricane Sandy were due to flooding from overflow of inland or tidal waters, people looked to their flood insurance, rather than their homeowners insurance, for coverage of their losses. In many instances, this was the first time individuals and businesses had incurred a flood loss and many were unaware that regular homeowners or commercial insurance does not cover this type of flood damage. Additionally, newspaper reports reflect concern that individuals were not adequately informed of their need to purchase flood insurance coverage by their insurance carriers.

Flood damage from inland or tidal water is covered through the National Flood Insurance Program (NFIP), which is run by the federal government through the Federal Emergency Management Agency (FEMA) and is purchased separately from private homeowners insurance coverage. If a property is in a designated flood zone pursuant to the Flood Insurance Rate Maps (FIRMs) and the community participates in the NFIP, individuals and businesses can purchase federal flood insurance, but are not required to do so unless mandated by their financing agency. (Please see the OLS backgrounder on Flood insurance beginning on page x of this report for more information.)

Unfortunately, Hurricane Sandy not only resulted in widespread flooding in designated flood zones, but also in certain areas that were not designated as flood zones, and thus not covered by the NFIP. Additionally, since there are no federal or State mandates requiring property owners to maintain flood insurance, some homeowners and businesses did not carry flood insurance.

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Subsequent to the storm, FEMA issued Advisory Base Flood Elevations (ABFEs) in November, 2012. Prior to the storm, FEMA had been studying the New Jersey coastline to update the FIRMs, something that had not been done in 25 years, but FEMA had not yet completed updating the maps. The ABFEs are not final, but indicate a more current higher flood elevation in certain areas and were released to assist communities and homeowners in their reconstruction efforts. Additionally, Public Law No. 112-141, including the federal "Biggert-Waters Flood Insurance Reform Act of 2012" enacted on July 6, 2012, contained several reforms that could assist the State and local governments in implementing policies to adapt to sea-level rise and other flood impacts from climate change, including minimal requirements for building in the FIRM's.

Question: a. How many consumer inquiries did the department receive related to flood insurance? Please classify these inquiries by type.

Response: The Department did not track phones calls by line of insurance. For written requests for assistance, 646 of the 1,746 requests received to date were recorded as related to flood claims. The reasons for complaint are not input into our system until the file is closed. Closed flood files include the following reasons for complaint:

Adjuster Handling/Claim Handling	69
Cancellation	2
Coverage Questions	8
Delay	161
Denials	32
Misrepresentation	3
Post Claim Underwriting	1
Premium/Rating	5
Unsatisfactory Settlement Offer	69
Total	**350**

At the end of February, the NFIP instructed the Department to send all calls and complaints related to the flood program to them for handling. Since that time, 110 flood related inquiries (a subset of the 646 flood complaints) were referred to NFIP. The reasons and dispositions of these matters are not recorded by the Department.

b. How many complaints have been filed by individuals regarding the misrepresentation of insurance coverage? What steps is the department taking to ensure that individuals are aware of their coverage levels after Hurricane Sandy?

Response: There have been three complaints filed specifically alleging misrepresentation. All three were related to policies written through the NFIP.

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The Department is pursuing its mission to educate consumers on coverage issues on a number of fronts. These include the revision, just prior to Sandy, of the consumer publication "Insuring Your Home," located at http://www.state.nj.us/dobi/division_consumers/pdf/insuringyourhome.pdf.

Also on the Department's website are FAQs, located at http://www.state.nj.us/dobi/ins_ombudsman/om_hofaq.htm, that provide information on key coverage matters such as deductibles, Replacement Cost and Actual Cash Value. The Department has also been discussing coverage levels and related issues directly with consumers in response to inquiries by phone and in person at disaster response centers since Sandy.

The Department's website also links to the National Association of Insurance Commissioner's (NAIC) Insure U, a web based educational program for consumers to learn about various insurance productions and make appropriate coverage selections based upon their particular life circumstances. Insure U provides a mobile application for creating a home inventory, consumer brochures on homeowner products and cost saving tips. http://www.insureuonline.org/home_inventory_page.htm.

The Department has also undertaken public speaking to businesses with regard to insurance needs of a business, which included topics as business interruption, ordinance of law coverage, replacement cost versus actual cash value, and hurricane versus wind deductibles, excess flood coverage and terrorism.

c. Is the department recommending any changes to the notifications currently included in homeowners insurance policies to better promote individuals' awareness of the exclusion of flood insurance in traditional homeowners insurance policies?

Response: Notification to consumers of the exclusion of flood coverage from traditional homeowner's insurance policies is required by N.J.S.A. 17:36-5.31. This law and subsequent regulation (N.J.A.C. 11:1-5.5) requires notice of the exclusion at: the time of issuance of the policy; at each renewal and in no event less frequently than annually.

d. Has the department conducted any analysis, or is it aware of any analysis, of the impact of the new Advisory Base Flood Elevations on flood insurance policy costs in

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the applicable regions? Please share any cost estimates that the department may have with the Legislature.

Response: As FEMA and the NFIP are federally regulated programs, the Department has no input of the revisions to the ABFEs. Additionally, due to the federal regulatory authority of FEMA and NFIP, the Department has not conducted any analysis of the impact on flood insurance premiums, of which it has no regulatory jurisdiction. The Department's jurisdiction pertaining to flood insurance extends only to the sales of flood policies by New Jersey licensed insurance companies and agents. Finally, each property is subject to specific variables that need to be considered that prevents a general estimate from being calculated.

e. Does the department have a position on requiring local communities to amend zoning laws to allow individuals to rebuild to the specifications required by FEMA for lower flood insurance rates?

Response: As noted previously, FEMA and the NFIP are federally regulated programs, and the Department has no input on or regulatory jurisdiction over either the specifications promulgated by FEMA for rebuilding in designated flood zones or on flood insurance premium rates. The Department's jurisdiction pertaining to flood insurance does not extend beyond oversight of the sale of flood insurance policies by insurance companies and agents licensed in this State. The Department plays no role in local zoning.

1e. It has been widely reported that FEMA is slow in responding to claims, with a little over 50 percent of claims (37,000 of the 73,000 total) having been closed as of February 5, 2013. Conversely, as of February 15, 2013, approximately 87 percent of all insurance claims related to Hurricane Sandy had been closed. In response to the remaining open claims, the department, on February 25, 2013, announced plans to begin a new Mediation Program to give consumers the option to settle disputed cases without resorting to lawsuits. The Mediation Program will not include flood insurance claims because those claims are handled by the National Flood Insurance Program pursuant to federal regulations.

Additionally, on February 5, 2013 the department issued Order No. A13-104 requiring all insurers to respond with a complete and accurate written response to an inquiry by the department on any claim related to Hurricane Sandy within 5 working days of receipt of such claim. This is 1/3 of the 15 days normally given to insurers to respond to such a query. Reports indicate that insurers have varied widely in their response and ability to settle claims quickly after Hurricane Sandy.

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Question: a. Please provide more details on the Mediation Program. Who will be operating the program? What are the costs of the program? For how long will it operate? How many cases have been handled by the program thus far?

Response: The Mediation program was awarded to The American Arbitration Association on March 25, 2013. The cost for mediation is $750 and this cost will be borne by the insurance company. The Department is in the process of starting up the program and has issued Order A13-106 and Bulletin 13-07. The program will be in operation as long as it is required.

b. How many inquiries has the department submitted to insurers on behalf of consumers? Has Order No. A13-104 had the desired effect of shortening response time for the department as well as individuals?

Response: The Department has submitted 1,636 inquiries to insurance companies on behalf of consumers and beginning in March, referred 110 flood related matters to the NFIP for handling.

To date we have found that licensed insurance companies have been responding in a timely manner as required by Order No. A13-104. Flood insurance and non-admitted insurance companies are not subject to these timeframes.

c. In addition to the Mediation Program and the shortened response time, what other steps has the department taken to ensure a quicker settlement of claims, both flood insurance and homeowners insurance, so individuals can begin to rebuild?

Response: The Department observes that the large majority of significant claims arising from Sandy are flood claims, and that Federal law preempts the Department's authority, preventing staff from intervening in insurance company practices regarding the settlement of such claims. Information provided to the Department indicates that most delays in the processing of flood claims result from federal rules and procedures regarding the adjustment of these claims, and from the relative lack of adjusters certified and thus permitted by the NFIP to adjust the claims.

Insurance company performance on claims subject to the Department's purview, such as those arising from homeowner and auto policies, has generally been strong, particularly considering the volume of claims received (more than 445,000 such claims as of March). Nonetheless, the Department has been in frequent and regular contact with insurance

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companies and insurer trade associations to communicate the Department's expectation of prompt and fair claim settlement. We have also communicated this expectation through the complaint handling process in our Consumer Protection Services unit as we make formal contact with insurance companies where insureds are dissatisfied.

1f. Insurance providers employ adjusters to survey the damage to property after an incident and decide on the value of a claim. Individuals may also employ public adjusters to evaluate the damage and assure that a settlement is consistent with the terms of the individual's coverage. In New Jersey, public adjusters must be licensed pursuant to P.L.1993, c. 66 (C.17:22B-1 et seq.). Anticipating the need for additional public adjusters after the storm, the department established Temporary Public Adjuster Sublicenses, valid for up to 90 days from the date of the declaration of the catastrophic loss occurrence. State regulations require that the public adjuster contract specify a list of services to be rendered and that the maximum fee charged must be "reasonably related to services rendered." (N.J.A.C. 11:1-37.7) However, based on department communication, press reports and testimony before Legislative committees, it appears that there are public adjusters who are taking advantage of the unprecedented need for their services and charging extremely high rates. The department issued Bulletin No. 12-16 to "remind all public adjusters... that any fees for adjusting services charged to consumers must be reasonably related to the services rendered" and that the department "will closely monitor all fees charged by public adjusters, and in particular any fees that appear excessive." Additionally, Senate Bill No. 2472, approved by the Senate Commerce Committee on February 2, 2013, provides that no licensed adjuster may accept compensation in excess of 12.5 percent of the claim payment made by the insurer, except in limited circumstances.

Adjusters are licensed every two years and pay a fee ranging from approximately $150 to $320 per license. The State historically has collected approximately $90,000 every other year in revenue from these fees. The temporary public adjuster fee is also $150.

Question: a. How many Temporary Public Adjuster Sublicenses were issued since the State of Emergency was declared by Governor Christie on October 27, 2012? How many different sponsors were associated with these sublicensees?

Response: The Department issued two (2) temporary public adjuster sublicenses with one ninety day extension for each license. There were two different sponsors associated with these sublicenses. Each extension is $150.

b. What is the total amount of revenue collected thus far in license fees from temporary licenses?

Response: The total amount of revenue to date from temporary licenses is $600.

c. How many complaints regarding public adjusters has the department received in the aftermath of the storm?

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Response: The Department has received 77 phone calls inquiring about public adjusters including: whether an individual is licensed; whether it is necessary to hire a public adjuster; fee related questions; and public adjuster conduct. The Department has received 20 written complaints or inquiries involving public adjusters.

d. Has the department hired additional staff to audit public adjusters' records in the aftermath of the storm? Has the department taken any administrative action against any public adjusters, temporary or otherwise, due to misconduct in the aftermath of the storm?

Response: The Department has not hired additional staff to audit public adjusters' records. At this point, the Department has not taken any administrative action since complaint files are still under investigation.

e. What has been the average compensation collected by adjusters on Hurricane Sandy related claims? How does this compare to adjusters' normal range of fees?

Response: Statutes licensing public adjusters do not include requirements for the Department to review or track public adjuster fees, so the Department does not have information on average compensation prior to or after Sandy.

f. Does the department intend to increase the licensing fee charged to public adjusters to compensate for any additional staffing or auditing needed in the aftermath of the storm?

Response: The Department has no plan to increase fees.

2. Hurricane Sandy is one in a long list of extreme weather events in the United States over the past 20 years. Industry experts, most recently in the National Climate Assessment and Development Advisory Committee's Report (draft released in January 2013), predict that the Northeast is statistically likely to endure more catastrophic weather events in the future. The combination of these weather events and the experts' warnings have led insurance companies to exercise increased caution in writing new policies in coastal areas and to apply stricter standards to the type and condition of homes they would insure. In response to FY 2013 OLS Discussion Points, the department stated that there are approximately 100 companies writing homeowners insurance throughout the State. However, 22 of these companies, which represent 27 percent of the market share, are only writing renewal business. Additionally, some of these companies do not write coastal policies and some consider the entire state to be coastal. The department can not be certain as to which companies continue to write new policies because there is no "take all comers" requirement in the line of homeowners insurance. Thus, there is

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no way for the department to be certain these companies are offering coverage in all areas of New Jersey.

> **Question: Please provide the 2012 New Jersey Market Share for Homeowners Insurance report and indicate: which companies are writing new business in the State and where; which companies are not writing in coastal areas; which companies only write in the surplus market; and, which companies are only writing renewal policies, and are not accepting new homeowners policies.**

Response: Please refer to Attachments 1 and 2 for market share information for both admitted companies and also surplus lines companies. The attachments note those companies that do not write new policies (i.e. renewal only). As described in prior years, companies are not required to submit their acceptance criteria (i.e. underwriting guidelines) so therefore we do not know which companies are writing new policies in various areas of the State.

3 a. The FY 2012 Appropriations Act included an $8.49 million increase in federal funding for the department. The increase in federal funding included three grants related to the "Patient Protection and Affordable Care Act," Pub. L.111-148, and the "Health Care and Education Reconciliation Act of 2010," Pub.L.111-152, collectively more commonly known as the "Affordable Care Act." As described in more detail below, all of these anticipated funds were not realized by the State, due to the Executive's decision not to go forward with implementing a State Health Insurance Exchange.

The first grant anticipated $982,000 from Federal FY 2011 and $1 million from Federal FY 2012 for the Consumer Assistance Program (CAP), which is a federally funded program that enhances and expands many of the services currently provided by the department's Consumer Assistance Unit. The Consumer Assistance Unit, currently employing 9 investigators, two supervisors and a manager, is responsible for responding to consumer calls about health insurance issues of a technical or emergent nature. The staff also investigates inquiries and complaints involving all lines of insurance. According to the department's response to the OLS Discussion Points during the FY 2013 budget process, the department expended $265,019 to temporarily hire two new consumer assistance staff members, who developed resource lists for members of the public, trained department employees and assisted in setting up the data reporting system required of CAP grant recipients. The two employees were subsequently reallocated to the Rate Review grant (see Discussion Point #3b.) as of October 2011. The enhancements to the system implemented by these temporary employees were needed due to the changes required as a result of the Affordable Care Act. For example, the State may now accept complaints from, and advocate on behalf of, persons covered by self funded health benefits plans, an area in which the State was precluded from interceding prior to enactment of the Affordable Care Act.

> **Question: a. Please provide the number of customer inquiries, by subject area, handled by the CAP program in FY 2011, FY 2012 and thus far in FY 2013.**

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Response: The federal government awarded only one grant to the Department to fund a Consumer Assistance Program (CAP) as part of the Affordable Care Act (ACA). That grant was for the period from October 1, 2010 to September 30, 2011 and was for $928,000. The Department spent $265,019 of the grant funds primarily to fund staff salaries and fringe benefits for two new employees of the Consumer Protection Services area of the Department as well as to partially fund salaries of staff handling health insurance inquiries related to the ACA.

The Department handled 2,185 health related inquiries during the grant period of October 1, 2010 to September 30, 2011, which are broken down by category as shown below. For the purposes of the chart, this is a description of the nature of the calls.

- Uninsured – A consumer with no health insurance.
- Insured in Transition – The consumer is insured at the time of initial contact with the program, but faces an imminent (within the next 12 months) loss of coverage.
- Insured Other Problems – An insured consumer who intends to keep current coverage but is having difficulty affording the premium or is experiencing adequacy problems.
- Information Only – Typically an insured consumer seeking general information, definitions, contact information, but not seeking assistance related to a specific health insurance problem.
- Other Assistance Referred – A consumer whose needs are outside of the scope of the program. Scenarios where this would apply include, but are not limited to:
  - a Medicaid recipient with questions about coverage;
  - a Medicare recipient with Part D having difficulty paying for prescriptions; or
  - a VA beneficiary seeking an expedited appointment with a doctor.
- Appeals – Consumers who have appeals due to denials of claims, termination of coverage when there was a claim represented and who seek information on options for appeal of carrier claim determinations.

Discussion Points (Cont'd)

Nature of Call	Number of Calls
Uninsured	379
Insured in Transition	332
Insured Other Problems	558
Information Only	290
Other Assistance Referred	33
Appeals	593
Total	2,185

As discussed earlier, the grant ended September 30, 2011, thus there is no other data to provide related to the CAP program.

b. Please detail the current CAP staffing levels and any planned future hires and the associated budget for CAP.

Response: The CAP Grant ended September 30, 2011. There are no plans for future hires and associated budget for the CAP Program. Health inquiries and consumer complaints are being handled with existing staff in the Office of Consumer Protection Services.

3b. The second grant included approximately $7.4 million for Federal FYs 2011 through 2014 to enhance the department's ability to review insurance companies' rate proposals. Pursuant to the Affordable Care Act, the federal Department of Health and Human Services must work with state insurance departments to review unreasonable rate increases for health insurance plans. The FY 2014 Governor's Budget Recommendation indicates that $1.586 million in funds were appropriated for this purpose in FY 2012 and $5.82 million is anticipated to be appropriated in FY 2013 (page D-28).

According to the department's response to the OLS Discussion Points during the FY 2013 budget process, the department engaged the Hay Group in 2011 to study the actuarial information that should be included in the rate filings, and to develop an automated process for receiving and analyzing the numerical information in rate filings published on the federal website, www.HealthCare.gov. The funding was also used, in cooperation with other states' funding, to assist the National Association of Insurance Commissioners (NAIC) in modifying the State Electronic Rate and Form Filing (SERFF) system to allow direct capture of information on rate increases. The State has also held annual rate forums, providing training and outreach efforts to stakeholders, and is preparing a report on the effectiveness of its rate review process.

(Please see the OLS background paper, "Health Insurance Rate Review; Federal Health Care Reform Law Requirements" in the FY 2013 budget analysis book for more information.)

Question: a. Please update the Legislature on the work of the Hay Group, hired to develop an automated process for receiving and analyzing the numerical information in rate filings, as well as on the use of the enhanced SERFF system. Please detail any

Discussion Points (Cont'd)

remaining work to be completed by the Hay Group and provide an accounting of all monies provided to the Hay Group for their services in FY 2012, FY 2013 and anticipated in FY 2014.

Response: Hay Group's work for the Department on Rate Review involves two different engagements. From January 2011 to September 2012 (covering parts of FY2011, 2012, and 2013) Hay Group worked primarily on an automated information gathering system, including a data base. This work was funded by Rate Review Grant – Cycle I and was completed by September 30, 2012. As part of this project, Hay Group also provided reports analyzing our rate review system.

Hay Group was separately engaged as consultant in June 2012 to a series of tasks related to rate review, including standardization of non-numerical information, impact on rates of ACA risk mitigation programs, and comparison of federal and state rate requirements, for example. This was funded by Rate Review Grant – Cycle II. (For a period of four months, June 2012 through September 2012, Hay Group was working under two separate engagements.) This work by Hay Group is ongoing and has a targeted completion date of Sept. 30, 2014. We anticipate the greatest work effort to be during the summer of 2013 as carriers file rates in preparation for major ACA changes on January 1, 2014.

Cycle I Spending for Hay Group by Fiscal Year

FY 2011	FY 2012	FY 2013
$239,557	$185,718	$26,588

Cycle II Spending for Hay Group by Fiscal Year

	Estimated	Estimated
FY 2011	FY 2012	FY 2013
$75,576	$180,000	150,000

b. Please detail any new staff hired in FY 2013, or anticipated to be hired in FY 2014, for the Rate Review program and the anticipated duration of their employment.

Response: Current fulltime staff of the Rate Review Program is four (4) professional employees. One of these employees was hired in FY 2013; the other three (3) were hired previously. It is hoped to add a clerical/administrative employee by the end of FY 2013 and another professional employee during FY 2014. All employees funded by the Rate Review grant are employed for the duration of that grant, which is until September 30, 2014. It is

Discussion Points (Cont'd)

possible that the grant could be extended through September 30, 2016 if funds from the grant are available.

c. Please detail how the department anticipates using the remaining $5.82 million, referenced in the FY 2014 Budget Recommendation? What is the timeline for the use of these funds?

Response: The Department anticipates that approximately $1.3 million will be spent in FY 2014 for rate review. This includes salary and benefits for Rate Review Program staff, payments to Hay Group, payments to Rutgers Center for State Health Policy (CSHP) in connection with the annual rate review forum and research on claims data bases, and additional actuarial consulting in connection with advising the exchange on rates of carriers. The Department has been in discussions with the Centers for Medicare & Medicaid Service (CMS) about the potential to use the balance in connection with potential system enhancements.

d. Does the department anticipate applying for federal grants to fund continued Rate Review activities into the future? What is the timeline for these grants?

Response: The Department has no plans at present for applying for additional funds.

3c. The third grant, $1 million from Federal FY 2011 and $7.67 million from Federal FY 2012, was to be used to plan and explore the possibility of establishing a State Health Insurance Exchange to be operational in 2014. However, due to the decision by Governor Christie not to go forward with establishing a State based Exchange, all activity exploring the establishment of an Exchange has been halted.

The Affordable Care Act provided the states with the opportunity to establish state-based "American Health Benefit Exchanges" for individuals, and "Small Business Health Options Program Exchanges" for small businesses. A portion of the $1 million Exchange planning grant was awarded to the Center for State Health Care Policy at Rutgers, the State University, for a report outlining the State's options to establish an Exchange and to facilitate stakeholder forums. The report was issued in September 2011 and provided information on implementation options, including the possible design of a Health Insurance Exchange. The forums, held throughout the State until October 2011, obtained input from stakeholders with an interest in the healthcare delivery and financing systems on how the State should establish an Exchange.

The $7.674 million awarded in Federal FY 2012 was intended to "close the identified Informational Technology gaps, gather stakeholder input on specific decision points, detail a financial management plan, establish audit and fraud detection procedures, develop reinsurance and risk adjustment plants, research Medicaid network issues, analyze projected

Discussion Points (Cont'd)

plan costs and utilization, and further develop plans and standards for plan management, including options for defining Essential Health Benefits."

Both of the awards were intended to fund the exploration of the steps needed to establish an Exchange. The FY 2011 grant was expended and the FY 2012 grant, as of January 2013, was not being used due to the Executive's decision not to go forward with a State based Exchange at this time. Governor Christie, in his veto of Senate Bill No. 2135 in December 2012, indicated that he did not want to "ask New Jerseyans to commit today to a State-based Exchange" but, that the veto should not be "interpreted as foreclosing future consideration on this matter." Indeed, the Governor indicated that he did not feel that the federal government had presented "a structured blueprint for the design and operation of a Federally Facilitated Exchange and the technical details for its linkage to each state. This uncertainty regarding the potential operation of Partnership Exchanges and Federally Facilitated Exchanges necessarily clouds the analysis of whether a State-based Exchange would be the best option of the three for New Jersey."

Question: a. Please detail any activities undertaken by the department to continue to remain aware of and involved in the establishment of other State Exchanges, Partnership Exchanges and a Federally Facilitated Exchange.

Response: The Department has been monitoring Exchange developments through several outlets. First, the Department actively participates with the NAIC and the National Governors Association (NGA). Second, the Department monitors Federal activity directly, through calls scheduled weekly with the Federal Center for Consumer Information and Insurance Oversight (CCIIO), and through updates that alert us as new regulations and guidance are released. The Department participates in webinars and other educational and information-sharing activities of organizations such as the National Academy for State Health Policy and the NGA. Finally, stakeholders also bring information and perspective to the Department.

b. Is any portion of the $7.674 million awarded in Federal FY 2012 committed for work completed before the Governor's decision to forgo a State Exchange? Please elaborate, detailing the amounts committed and to whom they are committed.

Response: Only approximately $3,400 of the $7.6 million has been spent, and that amount was for participation in an information session hosted by CCIIO that the Department was required to attend.

c. Please discuss any information learned during the Exchange planning process that will benefit the department overall, even if a State Exchange is not operated in New Jersey.

Discussion Points (Cont'd)

Response: Most of the studies undertaken by Rutgers Center for State Health Policy (RCSHP) were designed to be useful without regard to the exchange model ultimately adopted by the state. These include a study of the health insurance status of individuals in New Jersey after the ACA, an examination of the impact of merging the individual and small group markets, helping New Jersey families coordinate transitions and maintain coverage when changing health plans, federal and state medical loss ratio methodologies, federal and state regulation of rating factors and rate bands, preventing adverse risk selection, and provider networks after the ACA. All of these studies are available on RCSHP's website.

4. Pursuant to the Affordable Care Act, individuals can now access information regarding health insurance carrier requests for rate increases on the federal website devoted to the Affordable Care Act, www.healthcare.gov. Rate review information for every state can be accessed at http://companyprofiles.healthcare.gov/ and those rate increase requests that meet the threshold of 10 percent or more are required to be on the website. A review of this website in January 2013, revealed 51 requests for rate increases meeting this threshold in New Jersey in 2011 and 2012. The 51 requests were for plans offered by three companies and ranged from 11 percent for an Oxford Health Plans (NJ) Inc. plan to 28 percent for an Aetna Life Insurance Company plan. It appears that the majority of requests were generally "approved" by the department, even though the department does not have the statutory or regulatory power to technically approve or disapprove rates, and the website and the rate review are purely for consumer information. (Please see the OLS background paper, "Health Insurance Rate Review; Federal Health Care Reform Law Requirements" in the FY 2013 OLS budget analysis of the department for more information.)

Question: a. Please describe the rate review process the department employs. Please describe any instance where a rate has been deemed excessive and the insurance carrier has been instructed to re-evaluate the proposal.

Response: A distinction should be drawn between the information required to be posted on the Federal web site, and the actual process used by New Jersey to review individual and small employer rates as set by New Jersey statute. Because the Federal government determined that New Jersey has an effective rate review process, the postings on the Federal web site are informational only. However, the state actions reflected on the Federal web site are not purely informational.

The Department does not agree with the assertion that "the Department does not have the statutory or regulatory power to technically approve or disapprove rates." P.L. 2008, c. 38, which became effective in 2009, empowers the commissioner to disapprove rates in the IHC and SEH markets when the filing is incomplete, contrary to law, or the rates are inadequate

Discussion Points (Cont'd)

or unfairly discriminatory. When the Department allows rates to go into effect by not disapproving them that is sometimes characterized as an approval. The public for whom informational web sites are intended would find it difficult to distinguish between "non-disapproval" and an "approval."

The Department's rate review process, based on statute and regulation, evaluates the Individual Health Care (IHC) and Small Employer Health (SEH) filings for completeness, legal compliance, adequacy and unfair discrimination. Some of the information is submitted in standardized templates and stored in a data base to enhance cross-carrier and historical review. An important part of the Department review is verifying that the 80 percent minimum loss ratio requirement is satisfied.

The Department posts information about all rate filings on its web site, not just those calculated to be over 10 percent
http://www.state.nj.us/dobi/lifehealthactuarial/rateinfo/index.html

Whenever possible, the Department works with the submitting carrier if an initial rate filing appears not to be supported by the record, reserving formal disapproval as a final resort. The following are recent actions in which carriers were asked to reevaluate rates:

Individual

1. The Department suggested that Horizon Blue and Cross Blue Shield lower the August 1, 2012 rate increase for Basic & Essential (B&E) EPO from 3.7 percent to 0 percent. Even though the increase was modest, the B&E plans have very good experience, so the increase did appear excessive. Horizon BCBS did make the suggested modification. This affected approximately 80,000 people.

2. There are three rate filings which the Department has not yet finalized and which may have excessive rates: Oxford Health Insurance Standard PPO effective February 1, 2013, Oxford Health Plan (NJ) Standard HMO effective February 1, 2013, and AmeriHealth Standard HMO effective March 1, 2013. The Department has suggested that carriers reevaluate these rates.

Discussion Points (Cont'd)

Small Group

1. The February 2012 Horizon BCBS rate filing was not considered excessive. However, the Department did examine it closely to gain some insight into why the Horizon BCBS increase was so much higher than the Horizon HC (HMO) increase.

2. The Department questioned the rate increase for Oxford Health Insurance and Oxford Health Plan (New Jersey) effective February 1, 2012. The carriers reevaluated their assumptions and reduced rates.

b. Please provide the filed rate increase requests for FY 2012 and thus far in FY 2013 which did not meet the 10 percent threshold by each company.

Response: In the individual market, there was only one rate action in FY 2012 or so far in FY 2013 that exceeded the 10 percent threshold. This was the Horizon Direct Access PPO product rates effective February 1, 2013.

There were many increases in the small employer market that exceeded 10 percent annually. Note that some carriers file quarterly so the annual increase is only for groups renewing in that quarter.

Aetna

Company	Effective Date	Percent Increase
Aetna Health	11/1/2011	16.5 QPOS
Aetna Health	8/1/2012	13.8
Aetna Health	1/1/2013	18.8
Aetna Health	5/1/2013	15.9
Aetna Life	1/1/2013	15.8
Aetna Life	5/1/2013	16.1
AmeriHealth Ins Co. of NJ	4/1/2013	13.3
AmeriHealth Ins Co of NJ	7/1/2013	19.1
AmeriHealth HMO	7/1/2013	13.3
Horizon BCBS	8/1/2011	14 - 17
Horizon BCBS	11/1/2011	14 - 18
Horizon BCBS	2/1/2012	14 - 16
Horizon BCBS	8/1/2012	14.9

Discussion Points (Cont'd)

Horizon BCBS	11/1/2012	14.9
Horizon BCBS	2/1/2013	14.9
Horizon BCBS	5/1/2013	17.7
Oxford Health Ins	2/1/2012	13.3
Oxford Health Ins	8/1/2012	13.3
Oxford Health Ins	2/1/2013	13.7
Oxford Health Plans	8/1/2011	16.1
Oxford Health Plans	11/1/2011	16.1

c. Although the Affordable Care Act establishes a 10 percent threshold, states have the option of establishing a different threshold. Is the State contemplating a different threshold for rate review?

Response: It is important to emphasize that the 10 percent threshold is a threshold for reporting to the Federal Agency CCIIO, not for a rate being considered excessive. Pursuant to New Jersey law, all rates are reviewed for compliance, even those that involve decreases. Effective January 1, 2014, the Federal reporting threshold will apply to all rate increases. Thus, the question of the State contemplating a different threshold becomes unnecessary.

5. In 1992, New Jersey enacted two laws establishing two programs, the New Jersey Individual Health Coverage Program and the Small Employer Health Program that gave individuals and small employers in the State guaranteed access to health insurance coverage, regardless of health status, age, claims history, or any other risk factor.

The New Jersey Individual Health Coverage Program (IHCP), P.L.1992, c.161 (C.17B:27A-2 et seq.), was established to provide access to a broad choice of private health insurance products to any New Jersey resident who does not have access to employer-based or other group health coverage. At first, the IHCP market was robust, but starting in the mid 1990's there was a steady increase in the premium and a change in participation toward older and potentially higher risk insureds. In 1993, its first year of reporting, the IHCP detailed 156,565 covered lives. This increased to a maximum of 220,384 lives covered in 1995, gradually decreasing to 100,853 in the third quarter of 2012.

Since 2001, the Legislature has made two changes to the original IHCP intended to make more affordable policies available to a wider population. P.L.2001, c.368 (C.17B:27A-4.4 et seq.) requires health insurance carriers to offer a limited health care services plan, known as the Basic and Essential Health Care Services Plan (the "B&E Plan") that is more affordable than the standard IHCP plans, although not as generous in coverage. The act permits carriers to rate the B&E Plan by using factors for age, gender, and geographic location, but by no more than a 3.5 to 1 ratio between the highest and lowest rated plans. The B&E Plan was successful for those individuals who could choose a plan with limited coverage. It covered 814 lives in the first year of implementation (2003), increasing to 100,853 in the third quarter of 2012.

Discussion Points (Cont'd)

In 2008, the Legislature recognized a need for more affordable policies with full coverage. P.L.2008, c.38 (C.26:15-1 et al) modified the requirements on policies available under IHCP to make them more affordable and therefore attractive to younger uninsured persons. These modifications, including modified community rating; reduction in the number of plans required to be offered; and the addition of optional riders on the policies, were intended to control policy costs for the insureds. However, the changes do not appear to have increased the number of people choosing standard IHCP coverage, which has continued to decline each year from a maximum of 220,384 covered lives in 1995 to 44,294 covered lives in the third quarter of 2012.

Also in 1992, the Small Employer Health (SEH) Program, P.L. 1992, c.162 (C. 17B:27A - 17 et seq.) was established to provide small employers (those with 2 – 50 employees) with the option to purchase standardized health benefits plans. The plan can be modified based on the age, gender and family status of the employees and location of the business. However, the ratio for the highest rates for a SEH plan to the lowest rates may not exceed 2:1. In 1994, its first year of reporting, the SEH program reported 694,312 covered lives. This increased to a maximum of 919,953 covered lives in 2005 and has gradually decreased to 678,508 covered lives reported in the third quarter of 2012.

Question: a. Please provide sample policy costs for individuals purchasing policies through the IHCP, for the most recent year available and for as many previous years as possible. Please explain the difference in the cost of policies over the previous years. Please comment and provide analysis on the decline in the number of covered lives through the IHCP. What factors does the department believe contributed to the decline in the number of lives covered through the IHCP?

Response: The table below shows monthly rates for Horizon's two most common standard plans. Horizon is by far the largest carrier in New Jersey. The HMO plans were the most popular standard plans in 2009 and the age rated Direct Access plans were the most popular standard plans in 2013.

	Horizon			
February	$30 HMO	DA 80/70 (age 50)	HMO Enrolled	DA Enrolled
2009	$670	$438	30,058	New
2010	$711	$490	21,235	9,921
2011	$821	$549	16,072	13,882
2012	$872	$598	12,287	16,519
2013	$980	$664	10,068	17,718

Discussion Points (Cont'd)

Decline in Number of Lives in the Standard Individual Market

The Department believes that the comparison of 220,834 lives in 1995 to 44,924 lives in 2012 does not present a complete picture. In 1995, there was no B&E plan – if there had been, at least some of the lives would have been in B&E. A truer comparison would be 220,834 lives in 1995 to 145,147 in 2012, which includes B&E enrollment. Furthermore, approximately 20,000 people in the 1995 population were receiving subsidies to purchase their coverage. No such direct subsidy existed in the 2012 figure.

Finally, enrollment in 1995 was inflated by artificially low premiums due to a loss reimbursement mechanism that gave an incentive to carriers to offer coverage at less than self-supporting rates but still make money through reimbursement from other carriers. This system was abandoned around 1998.

The fundamental reason for increasing prices and declining enrollment in the standard IHC market is that the market bears the cost of claims for individuals who in other states would be considered uninsurable due to health. New Jersey's individual market offers comprehensive coverage to anyone regardless of medical condition. (A pre-existing condition exclusion does deter people from waiting until the last minute to gain coverage.) The individual policyholders, healthy or sick, collectively bear the cost of all claims and most administrative expenses. (The average loss ratio for standard plans is about 90 percent. This means that B&E plans and other lines of business of the carrier do contribute slightly to the cost of standard coverage).

In most other states, sicker people are excluded from the standard individual market through medical underwriting or pricing. They are covered in a high risk pool or other mechanism that is subsidized in part by sources outside the individual market (general revenue or taxes or assessments on other insurance business, for example). Average premiums are lower because the people covered are generally healthier. Access to coverage for those who are less healthy may be rationed by limited enrollment in the high risk pool or limited benefits.

b. Please provide sample policy costs for individuals purchasing policies through the B & E program for the three most recent years available. Please explain the difference in the cost of policies over the previous years.

Discussion Points (Cont'd)

Response: These rates are for February effective dates and for Middlesex County

Horizon BCBS B&E with Rider

	2010	2011	2012	2013
Male 25	$165	$191	$200	$208
Female 25	$243	$280	$294	$306
Male 55	$419	$484	$507	$528
Female 55	$341	$395	$413	$430

The Horizon EPO B&E ridered plan is by far the most popular plan in the New Jersey individual market. Almost 70,000 people, about 50 percent of the entire individual plan enrollment and 70 percent of the B&E plan enrollment, have this plan. Another 15,000 or so people have the less expensive Horizon unridered B&E plan.

With the exception of 2011, the year by year increases have been very small (less than 5 percent). This is because B&E experience has been consistently better than expected. For 2011, an unfavorable trend in claims was predicted which did not emerge. (Horizon individual policyholders received refunds for 2011 as a consequence.) Subsequently, rate increases have been in the 5 percent range.

Since 2004, when carriers began actively marketing B&E plans and using the option to enrich these plans through riders, B&E plans have been an affordable form of coverage for New Jersey policyholders. The uninsured rate in New Jersey would be about 1 percent higher if this option were not available.

Effective in 2014, B&E plans are not expected to be available as they reach their renewal dates, because the plans do not meet the minimum benefit standards of the ACA. (In fact, a waiver is currently required from ACA requirements to allow these plans to continue to be available prior to 2014.) More significantly, the ACA eliminates this affordable and popular health insurance option for New Jersey residents.

c. Please provide sample policy costs for businesses purchasing insurance through the SEH program for the three most recent years available. Please explain the difference in the cost of policies over the previous years. Please comment and provide analysis on the decline in the number of covered lives under the SEH program.

Discussion Points (Cont'd)

Response: The table below gives typical monthly rates for the largest carrier, Horizon. The PPO plan provides both in and out of network benefits and has deductible and coinsurance. The HMO plan provides in-network only with copayments. Asterisks indicate where the reference plan was changed, usually to reflect that the typical employer plan has more cost sharing. Bold face indicates the dramatic increase that happened around 2010 for all plans due to the impact of the great recession.

It is obvious that the rate of increase for the PPO plan is higher overall than for the HMO plan. One way that small employers have responded to increased costs is to shift their coverage from more expensive PPO plans to less expensive HMO plans.

At the end of 2006, about 215,000 people had small group coverage through Horizon POS, PPO, and Indemnity plans with out-of-network benefits; only 101,000 had Horizon HMO (in-network only) coverage. Six years later, at the end of 2012, Horizon covered 146,000 people in POS, PPO and Indemnity and 244,000 people in HMO.

Horizon effective Feb. Typical Group and Plan

	PPO Plan	HMO Plan
2004	$453	$433
2005	$510	$482
2006	511*	$491*
2007	$551	$528
2008	$617	$587
2009	$708	$666
2010	**$919**	**$831**
2011	$659*	$573*
2012	$757	$631
2013	$863	$694

There are many reasons for the decline in enrollment (and increase in premiums) in the SEH program as detailed below:

Small Employer coverage is employment based. Employment was reduced during the recent recession.

Discussion Points (Cont'd)

Enrollment decreases when premiums increase because of cost/affordability issues. Premiums increased for a number of reasons:

- Younger people may have been laid off leaving an older workforce. This would cause premiums to go up even if medical costs were stable;
- New IHC options, such as B&E, may have caused employers or employees to shift to individual coverage. In past years, there were fewer situations where this was clearly advantageous;
- Some insurance companies developed and marketed "self-insurance" or "self-funding" options to small employers. These programs tend to take the youngest and healthiest groups out of the SEH program, reducing enrollment and increasing premiums; and
- Rules of the SEH program require carriers to compensate out-of-network providers at a higher level than is required for plans in, for example, the large employer market.

d. Please comment on the anticipated effect of the Affordable Care Act's requirement for individuals to maintain insurance coverage and for employers to provide insurance coverage, in certain circumstances, on the IHCP, SEH and B&E programs.

Response: The ACA is a "marketplace" for individual consumers and a Small Business Health Insurance Options Program (SHOP) for small employer purchasers. The IHC Program and the SEH Program require the development of standard plans which are the only plans that can be sold in the individual and small employer markets. Thus the plans developed by the IHC and SEH Boards will be the plans available on the Marketplace for individual purchasers and through the SHOP for small employer purchasers. The IHC and SEH Boards established regulations governing guaranteed issue, guaranteed renewability and various consumer protections consistent with requirements of the 1992 New Jersey law. The requirements of the ACA are very similar to existing New Jersey requirements but require some modifications to the regulations governing the IHC and SEH markets.

The requirement for individuals to maintain insurance coverage and the advance payment tax credits available to individual purchasers with incomes between 133 percent and 400 percent of the Federal Poverty Level is projected by RCSHP to add approximately 300,000 lives to the individual market. As of December 31, 2012 enrollment in the individual market was 143,944 lives which means the availability of the advance payment tax credits is

Discussion Points (Cont'd)

expected to result in a significant increase in the number of persons covered under individual plans.

At the same time, the Department recognizes that persons for whom an advance payment tax credit is not available may find the policies available in 2014 to be more expensive than they can afford. The inclusion of essential health benefits and elimination of dollar limits will result in rich benefit plans that will be priced consistent with the benefits provided.

For the initial year of operation it appears there will be little incentive for a small employer to secure coverage through the SHOP as opposed to securing coverage in the non-SHOP small employer market. As of December 31, 2012 enrollment in the small employer market was 670,594 lives. Enrollment in the small employer market has been declining. We think the decline is due, in part, to the cost of coverage. The inclusion of essential health benefits and elimination of dollar limits will result in richer benefit plans which will be priced accordingly. Additionally, some small employers may elect to discontinue offering coverage due to the availability of subsidized Exchange coverage. RCSHP anticipates approximately a 90,000 life decrease in the small employer market. This number is of course highly sensitive to the premiums that will ultimately be charged. The mandate for employers to provide coverage (or "shared responsibility fee") exempts all firms that have fewer than 50 employees and therefore is not expected to have an impact on the SEH market.

The B&E policy was created by law to be a reasonably affordable plan. As discussed earlier, the plan features limited benefits and dollar limitations on specified services. Annual dollar limitations are expressly prohibited by the ACA. In order to maintain the plan with dollar limits since 2010, New Jersey requested and received a waiver of the annual limits requirements. That waiver expires on December 31, 2013. Accordingly, residents covered by a B&E plan will not be permitted to renew the B&E plan as of the first anniversary date on or after January 1, 2014. Thus, a resident whose policy renews on August 1, 2014 will be able to keep the policy until such date. A resident may elect to terminate the B&E policy prior to the anniversary date in order to enroll in a new plan through the Marketplace during the October through December 2013 open enrollment period for a policy that will be effective January 1, 2014.

Discussion Points (Cont'd)

Since the B&E policy defined in law does not feature benefits consistent with the essential health benefits required by the ACA and features impermissible dollar limits on benefits, the B&E policy will not be available for new sales after December 31, 2013.

As of December 31, 2013, 100,917 of the 143,944 lives covered in the individual market are covered by a B&E policy.

To the extent the people covered by a B&E policy qualify for advanced payment tax credit, they will be able to afford the premiums for a policy offered in the marketplace. The policy will provide much richer coverage than the B&E policy. Persons who have the B&E policy whose incomes exceed 400 percent of the federal poverty level will have the opportunity to purchase a comprehensive individual policy. The rates for such policy will be greater than the rates for the B&E policy largely because of the difference in coverage. Catastrophic plans are also expected to be available for individuals who are either under age 30 or exempt from the individual mandate.

6. In 2010, NJ Protect was launched as a new health insurance option for uninsured New Jerseyans with pre-existing medical conditions pursuant to Section 1101 of the Affordable Care Act, which established a temporary national high-risk health insurance pool to provide coverage to individuals with pre-existing medical conditions. The new pools could be administered directly by the state, or states may defer to the federal government to administer the new programs. These pools were originally meant to accept clients until 2013 and conclude in 2014 with the implementation of the Health Insurance Exchanges, which are intended to provide alternatives for individuals with pre-existing conditions to access health benefits coverage. However, a directive from the federal government required that all states cease accepting new applications for enrollment after the close of business hours on Friday, March 1, 2013. The federal Department of Health and Human Services issued this directive due to concern that the program was going to surpass its $5 billion national appropriation. Subsequently, in response to the federal directive, the department requested it be permitted to continue enrolling individuals through the end of 2013, emphasizing the State's prudent management of NJ Protect, however, the State is no longer accepting new enrollees.

The department, in its response to the OLS Discussion Points during the FY 2013 budget process, indicated that as of February 2012, New Jersey had drawn down $18.19 million from the federal government and had collected $4.15 million in premiums for NJ Protect costs. Furthermore, the department estimated that NJ Protect costs would equal $53.23 million by year end 2012 and $100.27 million by year end 2013.

To be eligible for NJ Protect, an individual must be: a U.S. citizen, or lawfully present in the United States; a New Jersey resident; without creditable coverage for at least six months; and have a pre-existing condition. The State offers NJ Protect through two private carriers,

Discussion Points (Cont'd)

AmeriHealth of New Jersey and Horizon Blue Cross Blue Shield of New Jersey. The carriers began accepting applications in August 2010.

Question: a. Please provide the number of enrollees (by age group) for NJ Protect in Calendar Years 2011 and 2012 and estimated for Calendar Year 2013.

Response:

	2011	2012	2013
0+19	*	26	30
20-34	*	648	735
35-44	*	382	434
45-54	*	590	670
55-64	*	672	762
65+	*	61	69
all ages	*	2,379	2,700

* not reported at this time

All figures are estimates based on actual age group distribution at year-end 2012 and are cumulative from the beginning of the program.

b. Please provide a report detailing the specific number of plans chosen by enrollees in Calendar Years 2011 and 2012 and estimated for Calendar Year 2013.

Response:

	2011	2012	2013
100/70	*	1,615	1,832
80/70	*	537	610
30/50/90	*	227	258
all plans	*	2,379	2,700

* not available

Figures are estimates based on the distribution by plan at year-end 2012 and are cumulative from the beginning of the program.

c. Please provide an accounting of federal funds and premiums received by the State for NJ Protect in FY 2011 and FY 2012 and estimates for FY 2013 and FY 2014. Please detail the uses of funding received.

Discussion Points (Cont'd)

Response:

	FY 2011	FY 2012	FY 2013	FY 2014
Draw Downs	$5,685,277	$19,878,128	$46,511,211	$38,395,885
Premiums	$1,146,620	$4,608,510	$9,028,101	$4,941,654
Claims	$6,440,331	$24,003,607	$53,897,779	$41,273,847
Administration	$391,567	$453,031	$1,641,533	$2,063,692

These projections assume enrollment suspension remains in place for the balance of the year, and current enrollees are allowed to continue NJ Protect coverage through the end of calendar year 2013.

d. What is the date that all current enrollees of NJ Protect will no longer receive coverage through NJ Protect? How does the department anticipate that these individuals will access health care services at that time?

Response: The IHC Program Board entered into a contract with HHS to run the Pre-Existing Conditions Insurance Program (PCIP) that New Jersey called NJ Protect. The initial contract entered in July 2010 expired as of December 31, 2010. Annual contracts were offered and accepted for 2011 and 2012. Beginning in 2013 HHS offered and New Jersey accepted a contract for first quarter 2013. New Jersey was directed to suspend new enrollments in NJ Protect no later than March 2, 2013 which New Jersey complied with. HHS offered and New Jersey accepted a one month contract for April 2013. Each contract contains cost data which obligates funds to New Jersey to fund claims incurred through the contract period. HHS has stated that the next contract will be for May and June and then quarterly contracts will be offered for the balance of 2013.

The Department anticipates that the persons currently enrolled in NJ Protect will have the opportunity to remain covered until December 31, 2013.

As part of the contract with HHS, New Jersey agreed to assist NJ Protect consumers to transition to new policies to be effective January 1, 2014. New Jersey will provide written materials to these consumers and will be ready to assist them as needed.

Policies sold in 2014 will not include a pre-existing conditions exclusion. NJ Protect consumers enjoyed a subsidized premium. Consumers may qualify for advanced payment tax credits at that time. The Department does not have income information for NJ Protect

Discussion Points (Cont'd)

consumers to be able to offer any information regarding how many might be eligible for tax credits.

As of March 15, 2013 there are 1,613 lives covered through NJ Protect.

e. Has the department received an exception from the federal government to continue to enroll individuals in NJ Protect? If so, for how long may the State continue to enroll individuals in NJ Protect?

Response: Commissioner Kobylowski wrote to Secretary Sebelius of HHS on February 22, 2013 to appeal her directive that NJ Protect cease new enrollments as of March 2, 2013. The Commissioner pointed out that New Jersey prudently designed and managed the program to stay within its original allotment of $141 million through 2013, after which pre-existing condition exclusions could no longer apply.

The Commissioner received a declination from Marilyn Tavenner, Acting Administrator of CMS to that appeal on March 1, 2013. Applications received on or before March 1, 2013 have been processed, but subsequent enrollment has been discontinued per the federal government's direction.

7. The "Interstate Insurance Product Regulation Compact," P.L.2010, c.120 (C.17B:37-1 et seq.), made New Jersey a member of the Interstate Insurance Product Regulation Commission ("Commission"). The Commission is a joint public agency that administers the Interstate Insurance Product Regulation Compact ("Compact") on behalf of compacting states and develops uniform standards for certain insurance products, including annuities, life insurance, and disability income insurance.

By entering into the Compact, a state facilitates prompt review of these insurance product filings by providing insurers a single office to which a filing of an eligible insurance product may be submitted for approval. If the insurance product is approved by the Commission in accordance with its standards, the product will be accepted by the regulatory agencies in all the states that have joined the Compact. Information from the Commission indicates that 41 states and Puerto Rico are members of the Compact as of January 2013. Business in these states represents approximately 70 percent of the premium volume nationwide.

There are over 62 uniform standards in disability income, individual life, group life, annuity and long-term care product lines already adopted and available. Additional standards are in development for term life insurance and group and individual life annuities. Under the compact, insurers and third party filers seeking to have a product approved by the commission are required to file the product with, and pay applicable filing fees to, the commission.

Discussion Points (Cont'd)

Question: a. How has entering into the Compact affected the department's work load? Has there been an increase in the overall time spent by department staff analyzing products approved by the commission? Has this increased the department assessment on insurance carriers?

Response: As of March 15, 2013 on a cumulative basis, approximately 700 individual life insurance and individual annuity filings (as of March 15, 2013) have been approved for sale in New Jersey as a result of New Jersey's membership in the Compact. We do not know how many of these filings are actually made available for sale to New Jersey consumers, nor do we know how many of these filings would have been submitted to the Department in the absence of the Compact.

The Department does not analyze Compact filings but it periodically reviews Compact-approved filings primarily for employee development purposes. The Department's assessment of insurance carriers has been largely unaffected by the Compact. Any workload reduction has allowed the Department to redeploy those resources to work on other filings, and to improve overall speed-to-market.

b. What are the applicable filing fees paid to the commission by insurance providers? Please provide a comparison of fees paid to the commission relative to fees previously paid to the State? Is there any cost to the State for being a member of the Compact?

Response: Insurance companies that file products through the Compact pay an annual registration fee and a filing fee per product. Both fees vary based on company size and complexity of the filing. The Compact's filing fees in 2013 range from $250 to $1,000 per filing, regardless of the number of states in which the product is approved for use. The details are provided in the attached schedule (also available at: http://www.insurancecompact.org/documents/industry_resources_fees.pdf).

We estimate that the cost to the State of being in the Compact is about $50,000. This figure reflects the fact that New Jersey has a seat of the Management Committee and that we have representatives of the Department actively participating in Compact meetings. It also recognizes that we are active on the Products Standard Committee. These are new functions and come with an incremental cost. Offsetting this cost, however, the Compact's product standards development process has helped strengthen product expertise among regulators across the nation, including New Jersey. In addition, consumers have benefited because of improvements in speed-to-market and uniformity in products.

Discussion Points (Cont'd)

8. P.L.2011, c.25 (C.17:47B-1 et seq.), more commonly known as the "Captive Insurers Act" took effect in May 2011 and permits a captive insurance company to be licensed by the department to do business in the State in any of the lines of insurance in subtitle 3 of Title 17 of the Revised Statutes (R.S.17:17-1 et seq.) or Title 17B of the New Jersey Statutes (N.J.S.17B:17-1 et seq.), generally including contracts or policies of life insurance, health insurance, annuities, indemnity, property and casualty, fidelity, guaranty and title insurance, and reinsurance, provided the captive meets certain requirements. "Captive insurance companies are insurance companies established with the specific objective of financing risk emanating from their parent group or groups." (DOBI PRN 2011-192) The act regulates captive insurance companies, which include pure captive insurance companies, association captive insurance companies, sponsored captive insurance companies, and industrial insured captive insurance companies. Prior to enactment of P.L.2011, c.25, captive insurance companies were not permitted to be domiciled in New Jersey.

The department asserted in Bulletin No.11-08 that the Captive Insurers Act "provides significant new opportunities for New Jersey business to better manage their own risk by insuring themselves through a New Jersey-based captive, instead of a captive domiciled in another state or by purchasing insurance in the commercial market." The addition of captive insurance companies to New Jersey is also intended to increase the number of professionals dedicated to the captive insurance market, such as accountants, actuaries, and managers who may all become registered service providers with the department.

Pursuant to the act, a premiums tax is collected from captive insurance companies, but the companies are excluded from the requirement to pay the special purpose apportionment (discussed in more detail in Discussion Point #11b). The tax is collected at the following rate on direct premiums for all lines of insurance, except reinsurance premiums: 0.0038 on the first $20,000,000; 0.00285 on the next $20,000,000; 0.0019 on the next $20,000,000; and 0.00072 on each dollar thereafter. Companies are required to pay the following tax rate on *reinsurance* premiums: 0.00214 on the first $20,000,000; 0.00143 on the next $20,000,000; 0.00048 on the next $20,000,000; and 0.00024 of each dollar thereafter. The tax is due on March 1 each year on the premiums the company earned in the previous calendar year. The minimum aggregate premiums tax to be paid by a company is established at $7,500 and the maximum tax is $200,000 per company.

Section 13 of P.L.2011 c.25 (C.17:47B-13) establishes the "Captive Insurance Regulation and Supervision Fund" to provide the department with a funding source to administer the Captive Insurers Act. Pursuant to statute, the commissioner is responsible for establishing the fees and assessments necessary for the administration of the act and all fees and assessments established in the act must be deposited into the fund.

The department promulgated regulations implementing the act (N.J.A.C. 11:28-1.1 to 1.23) in 2012. The regulations provide for a maximum $4,000 fee for the initial application review required for licensing a captive insurance company, and a $300 license renewal fee.

Question: a. Please provide the number of captive insurers, by type, that have submitted applications to be licensed in New Jersey in 2011, 2012 and thus far in 2013. How many of these have completed the application process and are licensed in New Jersey?

Discussion Points (Cont'd)

Response:

	License Applications	Pure Captives	Industrial Captive	Cell Captive	Attach to Sponsored Cell	Withdrawn
2011	3	2	1			
2012	7	6		1	1	2
2013	2	1		1	1	

In 2013, one cell applied to attach to the sponsored cell company approved in 2012.

New Jersey currently has 10 captive insurance companies licensed in New Jersey.

b. Please provide the number of other professionals--i.e., accountants, auditors and managers--that have registered to be service providers for the captive market in 2011, 2012, and thus far in 2013.

Response:

2011	2012	2013 as of 3/25/2013
30	20	9

A total of 59 professionals have registered to date.

c. Please provide an estimate of premiums tax and registration fees the department anticipates from captive insurers in FY 2012 and FY 2013.

Response:

	FY 2012	FY 2013
Premium Taxes	$300,000	$643,150
Fees	$10,500	$28,000

d. Please detail the expenditures made by the department for the administration of the Captive Insurers Act.

Response: The cost to administer the Captive Insurance Companies Act since enactment is approximately $239,000 and consists primarily of salaries, fringe benefits and overhead.

e. Please provide an accounting of the Captive Insurance Regulation and Supervision Fund, including opening and closing balances, revenues and disbursements, since inception.

Discussion Points (Cont'd)

Response: Since its inception all admission and licensing fees have been deposited into the Captive Insurance Regulation and Supervision Fund. The balance as of March 27, 2013 is $44,607. There have been no disbursements to date.

f. Please indicate how many captive insurance conferences the department has held since the enactment of P.L.2011, c.25 and how often the department plans to hold such conference in the future?

Response: To date the Department has held one formal captive insurance conference: the 2012 New Jersey Captive Insurance Summit where the theme was "Growing Your Captive in the Garden State." An information session on captive insurance was part of the larger 2011 Commissioner's Insurance Symposium.

In addition to this, the Department was also present when invited to groups with an interest in captive insurance in New Jersey.

g. Please indicate how many captive insurance companies have re-domesticated to New Jersey, pursuant to N.J.A.C.11:28-1.4?

Response: Two of the captives insurance companies licensed have re-domesticated from other states, one from New York and one from Vermont. The Department has had conversations with at least two (2) others that are expected to re-domesticate before year end 2013.

9. Historically, New Jersey has struggled to contain the costs of motor vehicle insurance. Several reforms by the Legislature have attempted to resolve this problem. In the past, P.L.2003, c.89 (C.17:30A-2.1 et al) was enacted, following the "Automobile Insurance Cost Reduction Act," (AICRA) P.L.1998, c.21 (C.39:6A-1.1 et al), both of which established reforms to increase the availability of motor vehicle insurance and contain costs of that insurance. Prior to AICRA, the "Fair Automobile Insurance Reform Act of 1990," P.L.1990, c.8 (C. 17:33B-1 et al), (FAIR Act) was enacted to provide comprehensive reform of the automobile insurance system in the State. The legislation has been successful to varying degrees in containing costs. However, some requirements established pursuant to these reforms, such as "take-all-comers" and the establishment of medical fee schedules, have expired or have been amended since enactment and there have been reports that the cost of automobile insurance has again begun to increase in the State.

Discussion Points (Cont'd)

Question: a. Please provide the total number of automobile insurers offering automobile insurance in the State in 2011 and 2012 and thus far in 2013?

Response: The total number of insurance companies offering automobile insurance in the State is as follows:

2011	2012	2013
68	71	71

b. Please provide the rate increases filed by these companies in 2010, 2011, 2012 and 2013. Please comment on the reasons stated for these rate increases and provide an estimate for automobile insurance rates for 2014 and 2015 in New Jersey. Does the department believe any statutory changes aimed at ensuring the availability of auto insurance and containing costs for consumers are warranted at this time?

Response: Please see Attachment 3 for the rate increases filed by these companies from 2010 thru 2013.

The average rate change was a 6.4 percent increase in 2010 and a 6.3 percent increase in 2011, but decreased to 3.8 percent in 2012. Insurance companies have been implementing rate increases over the last several years due to increasing PIP costs. However, the Department has adopted regulations expected to contain the rising cost of PIP, and we expect moderate changes to insurance rates for 2014 and 2015, similar to 2012 levels. The Department does not believe any statutory changes are warranted at this time.

10. Section 10 of P.L.1988, c.119 (C.39:6a-4.6) provides that the commissioner is responsible for the promulgation of medical fee schedules to be used in the reimbursement of health care providers for medical expense benefits under the personal injury protection (PIP) coverage of automobile insurance policies. Additionally, "the commissioner may contract with a proprietary purveyor of fee schedules for the maintenance of the fee schedule, which shall be adjusted biennially for inflation and for the addition of new medical procedures."

On November 5, 2012, the department adopted new rules, repealed certain rules, and made other amendments to revise the regulatory framework for the provision and payment of PIP benefits. The changes, among other things: add new procedures to the PIP medical fee schedules; require PIP vendors to be licensed in the State; implement standardized forms to be used by insurers; exclude emergency rooms from the imposition of medical fee schedules; amend the internal appeals process; and amend the alternate dispute resolution process.

The expansion of the PIP medical fee schedules was intended to lessen the reliance of providers and insurers on determining reimbursement for procedures on the "usual, customary and reasonable fee" (UCR) in those instances in which a procedure is not included in the PIP medical fee schedule. The expansion to include many more procedures on the PIP medical fee

Discussion Points (Cont'd)

schedules is intended to standardize the cost of procedures for both providers and insurers. Standardization leads to certainty in the marketplace and less administration and cost incurred by both parties in establishing payment for a service.

Question: a. Please update the Legislature on the impact of the new PIP fee schedules on the cost of private passenger automobile insurance to consumers in New Jersey.

Response: The regulations only became operative on January 4, 2013. There has not been sufficient time to assess any impact on the cost of private passenger automobile insurance. The Department anticipates the new PIP fee schedules will put downward pressure on the cost of private passenger automobile insurance in New Jersey.

b. Please provide specific information on the effect of changes to the alternate dispute resolution process. Have the changes implemented to the process resulted in a shorter time frame, and thus lower cost, associated with dispute resolution? Has this had a measurable impact on PIP costs overall?

Response: The regulations became operative on January 4, 2013 and the on-the-papers cases for low value disputes only began to be filed on March 1, 2013. There has not been sufficient time to assess any impact on time frames or the costs of the alternate dispute resolution process. The Department anticipates that the changes to the alternate dispute resolution process will shorten times frames and lower costs, which will put downward pressure on the cost of private passenger automobile insurance in New Jersey.

c. Please provide information on the use of UCR fees for services not included in the PIP medical fee schedule. Has there been a significant decrease in the reliance on the UCR fees due to the inclusion of more procedures on the fee schedule? Which database, or databases, are most commonly used by insurers to determine the UCR fee? Does the department anticipate changing any aspect of this process in the next year?

Response: The regulations became operative on January 4, 2013. There has not been sufficient time to determine if there has been any decrease in the reliance on UCR fees due to the inclusion of new fees in the fee schedules. However, the Department expects that the changes to the fee schedules will reduce the use of UCR fees. The Department does not collect any information on what national databases of fees insurance companies use. However, the fee schedule rule specifically permits the use of Fair Health and Wasserman fee databases. The Department does not anticipate changing this process during the next year.

Discussion Points (Cont'd)

d. Has the department conducted any analysis of the codes billed by providers to determine any patterns in the provision of services due to modified funding structures as provided for in the regulations? If not, will the department be conducting any sort of analysis in the future?

Response: The regulations only became operative on January 4, 2013. There has not been sufficient time for enough data to be generated to merit conducting a study. The Department will begin collecting data to study the effect of the new rules when the new rules have been in effect for at least six months.

11a. The mission of the Department of Banking and Insurance is to regulate the banking, insurance and real estate industries in a professional and timely manner that protects and educates consumers and promotes the growth, financial stability and efficiency of those industries. The funding used to support the department is generated primarily through the collection of assessments and premiums taxes on the industries that it regulates.

P.L.2005, c.199 (C.17:1C-33 et seq.) established an assessment on all banks and other financial entities the department charters, licenses and registers for all services related to the department's financial regulation, supervision and monitoring of these entities. The Division of Banking imposes two assessments on financial entities on or around October 1 of each year: a Banking Licensing Assessment and a Banking Depositor Assessment. The assessment is based on calendar year business for the companies and fiscal year expenditures for the Division of Banking. Each year, the Director of the Division of Budget and Accounting in the Department of the Treasury certifies to the Commissioner of Banking and Insurance by category the total amount of expenses incurred by the division. These expenses include, in addition to the direct cost of personal service, the cost of maintenance and operation, the cost of employee benefits and workers' compensation, rentals for space occupied in State-owned or State-leased buildings and all other direct and indirect costs of the administration of those functions of the department, as well as any amounts remaining uncollected from the assessment of the previous fiscal year (N.J.S.A.17:1C-35).

Question: a. Please provide the total Banking Licensing Assessment charged and revenue collected for FY 2011, FY 2012, and estimated for FY 2013. Please provide the total Banking Depositor Assessment charged and revenue collected for FY 2011, FY 2012, and estimated for FY 2013. Please provide the number of payers of each of these assessments.

Response: Banking Licensing Assessment

	FY 2011	FY 2012	Estimated FY 2013
Charged	$6,879,716	$6,599,057	$6,709,112
Collected	$6,750,556	$6,363,477	N/A
Payers	3,077	2,815	2,825

Discussion Points (Cont'd)

Banking Depositor Assessment

	FY 2011	FY 2012	Estimated FY 2013
Charged	$4,581,539	$4,217,518	$4,289,000
Collected	$4,600,235	$4,268,342	N/A
Payers	107	108	103

b. Please provide the expenses of the division detailed in N.J.S.A.17:1C-35 and approved by the Director of the Division of Budget and Accounting in the Department of the Treasury, as well as the number of employees dedicated to the division for FY 2011, FY2012 and estimated for FY 2013.

Response:

Depositories

	FY 2011	FY 2012
Salaries and Wages	$2,954,772.39	$2,821,826.11
Materials and Supplies	$11,220.99	$11,446.21
Services other than Personnel	$423,348.18	$249,575.65
Maintenance and Fixed Charges	$19,449.00	$82,887.80
Equipment	$29,265.09	$413.47
Subtotal	$3,438,005.65	$3,166,149.24
Other Expenses		
Administration Adjustments – Salaries/Fringe	($105,773.00)	($42,254.00)
Fringe Benefits	$963,533.14	$961,104.70
Indirect costs	$16,238.32	$14,442.12
Building Operations and Maintenance	$178,144.06	$28,836.64
Debt Service – Roebling Building	$72,771.90	$79,839.03
Warren Street Parking Costs	$3,000.00	$1,500.00
Bank Street Parking Costs	$8,238.77	$7,120.08
Rent Calculation	$7,380.46	$780.39
Subtotal	$1,143,533.66	$1,051,368.96
Banking (Depository)		
Total Expenses 2012	**$4,581,539.31**	**$4,217,518.20**

The total estimated assessment for FY 2013 is $$4,289,000. The Department does not have a specific breakdown for FY 2013 at this time.

Discussion Points (Cont'd)

Licensing

	FY 2011	FY 2012
Salaries and Wages	$4,363,826.73	$4,339,349.95
Materials and Supplies	$9,181.78	$8,262.61
Services other than Personnel	$555,497.63	$370,720.14
Maintenance and Fixed Charges	$2,000.00	$940.67
Subtotal	$4,939,506.14	$4,719,273.37
Other Expenses		
Administration Adjustments – Salaries/Fringe	$141,887.00	$58,579.00
Fringe Benefits	$1,430,318.76	$1,539,379.10
Indirect costs	$16,238.32	$14,442.12
Building Operations and Maintenance	$178,144.06	$28,836.64
Debt Service – Roebling Building	$23,837.83	$22,040.87
Warren Street Parking Costs	$7,500.00	$7,500.00
Bank Street Parking Costs	$15,104.41	$16,829.29
Rent Calculation	$50,187.14	$59,309.32
Write-Offs	$85,992.51	$32,867.00
Subtotal	$1,949,210.04	$1,879,783.34
Banking-Licensing Expenses 2012	**$6,879,716.18**	**$6,599,056.71**

The total estimated assessment for FY 2013 is $6,711,000. The Department does not have a specific breakdown for FY 2013 at this time.

The total number of Division of Banking staff:

FY 2011	FY 2012	FY 2013 (as of February 28, 2013)
90	88	88

11b. P.L.1995, c.156 (C.17:1C-19 et seq.) established a special purpose apportionment for funding expenses incurred by the Division of Insurance. The apportionment is charged to all insurers writing most classes of insurance in the State (including, but not limited to: property; fire; flood; motor vehicle; life and health; accident; title; credit; personal liability; malpractice; homeowners; and any other specified kinds of insurance) and those health maintenance organizations (HMOs) granted a certificate of authority to operate in New Jersey pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.). This assessment is used for funding the activities of the division in regulating, monitoring and supervising these carriers. The apportionment of each

Discussion Points (Cont'd)

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 is required to pay an apportionment that exceeds 0.10 percent of its net written premiums. Each year, the Director of the Division of Budget and Accounting in the Department of the Treasury certifies to the Commissioner of Banking and Insurance, by category, the total amount of expenses incurred by the division. These expenses include, in addition to the direct cost of personal service, the cost of maintenance and operation, the cost of employee benefits and workers' compensation, rentals for space occupied in State-owned or State-leased buildings and all other direct and indirect costs of the administration of those functions of the department, as well as any amounts remaining uncollected from the special purpose apportionment of the previous fiscal year (N.J.S.A. 17:1C-20).

Question: a. Please provide the amount of the total insurance special purpose apportionment for FY 2010, FY 2011, FY 2012, and estimated for FY 2013.

Response: Special Purpose Assessment

FY 2010	FY 2011	FY 2012	Estimated FY 2013
$9,572,834	$33,921,374	$35,325,271	$34,425,000

b. How many companies reached the individual maximum apportionment in FY 2010, FY 2011 and FY2012?

Response: No companies reached the individual maximum apportionment in FY 2010, 2011 or 2012.

b. Please provide the expenses of the division detailed in N.J.S.A.17:1C-20 and approved by the Director of the Division of Budget and Accounting in the Department of the Treasury and provide the number of employees dedicated to the division in FY 2012.

Response: As of 12/31/2011 the number of employees dedicated to the Division of Insurance was 286.

	FY 2012
Salaries and Wages	$22,144,970.95
Materials and Supplies	$125,475.28
Services other than Personnel	$3,974,855.93
Maintenance and Fixed Charges	$33,733.06
Equipment	$334,310.21
Subtotal	$26,613,345.43
Other Expenses	
Administration Adjustments – Salaries/Fringe	$253.00
Fringe Benefits	$8,587,527.13

Discussion Points (Cont'd)

Indirect costs	$94,468.48
Building Operations and Maintenance	
Roebling Building	$188,625.55
Debt Service – Roebling Building	$992,217.49
Warren Street Parking Costs	$55,500.00
Cancelled Obligations FY 2010-2011	($21,197.26)
Lockbox	$2,554.02
Parking Costs – Bank Street	$126,866.94
Rent Calculation for Leased Office Space	$17,948.87
Subtotal	$10,044,764.22
Total Expenses	$36,658,109.65
Revenue	$1,332,838.00
Write-offs	0
Net Revenue	($1,332,838.00)
Total Insurance Expenses 2012	**$35,325,271.65**

11c. In addition to the special purpose apportionment, several different statutes subject insurance carriers to additional assessments to reimburse the department for operating expenses, including the following:

1) An assessment on insurers for all services related to the department's fraud prevention expenditures, pursuant to P.L.1983, c.320 (C.17:33A-1 et seq.). This assessment is billed and collected by the department, but is used to reimburse the Department of Law and Public Safety for the operations of its Office of the Insurance Fraud Prosecutor (OIFP).

2) An assessment on all Small Employer Health Insurance Benefits (SEH) carriers for the reasonable and necessary organizational and operating expenses of the SEH board of directors pursuant to section 16 of P.L.1992, c.162 (C.17B:27A-32).

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

4) An assessment for the Motor Vehicle Security Responsibility Fund pursuant to section 1 of P.L.1952, c.176 (C.39:6-58). The assessment is billed and collected by the department but used to reimburse the New Jersey Motor Vehicle Commission.

Question: a. Please provide an accounting of all assessments collected by the department for FY 2011, FY 2012, FY 2013 and estimated for FY 2014. Please detail this information by source, as numbered above.

Discussion Points (Cont'd)

Response:

1) Fraud Assessment

	FY 2010	FY 2011	FY 2012	Estimated FY 2013	Estimated FY 2014
Charged	$28,135,680	$25,055,381	$25,540,987	$25,541,000	$25,541,000

2) Small Employer Health Insurance

FY 2010	FY 2011	FY 2012	Estimated FY 2013	Estimated FY 2014
$262,900	$259,400	$287,283	$257,000	$255,000

3) Individual Health Insurance Coverage

FY 2010	FY 2011	FY 2012	Estimated FY 2013	Estimated FY 2014
$329,300	$1,061,000	$675,416	$685,000	$0

Note: The IHC program assessments occur on a 2-year cycle.

4) Motor Vehicle Assessment

	FY 2010	FY 2011	FY 2012	Estimated FY 2013	Estimated FY 2014
Charged	$17,800,000	$16,772,703	$17,500,000	$19,320,000	$18,527,000
Collected	$17,800,000	$16,772,673	$17,500,000	N/A	N/A

5) Premium Tax

FY 2010	FY 2011	FY 2012	Estimated FY 2013	Estimated FY 2014
$481,214,000	$458,234,000	$528,327,000	$560,000,000	$598,000,000

11d. The New Jersey Real Estate Commission (REC), in the Department of Banking and Insurance was created to administer and enforce New Jersey's real estate licensing law, N.J.S.A. 45:15-1 et seq. The REC issues licenses to real estate brokers and salespersons, real estate schools, and course instructors, as well as establishes standards of practice for the real estate brokerage profession. The REC collects revenue from the issuance of licenses on a biennial basis as well as various other fees.

Question: Please provide the amount of revenue collected by the REC for FY 2010, FY 2011, FY 2012, FY 2013 and estimated for FY 2014. Please detail the source of this revenue by type of transaction; for example, license renewal or other regulatory fees.

Response:

	FY 2010	FY 2011	FY 2012	Estimated FY 2013	Estimated FY 2014
Fees	$3,837,738	$11,327,213	$3,700,000	$11,175,000	$3,700,000
Fines	$ 367,499	$ 165,285	$ 168,908	$ 170,000	$ 170,000

Discussion Points (Cont'd)

12. Section 13 of P.L.1995, c.156 (C.17:1C-31) provides that each insurer is liable for a maximum total assessment as follows: "the total amount assessable to companies in any fiscal year for all special purpose assessments made pursuant to applicable law as of the effective date of this act, including the special purpose apportionment established by this act, shall not exceed 0.25 percent of the combined net written premiums received, as defined in subsection b. of section 2 of this act, by all companies for the previous year." P.L.2010, c.21 increased the allowable percentage from 0.20 percent to 0.25 percent. In response to OLS Discussion Points during the FY 2013 budget process, the department indicated that total net written premiums for FY 2011 were $41.5 billion.

Question: a. What are the combined net written premiums for all insurers for FY 2012 and estimated for FY 2013?

Response: The latest available net written premiums are approximately $43 billion from year end 2011, which were used for the 2012 Special Purpose Apportionment Assessment Premiums appear to have increased slightly from the past year, therefore the Department expects the 2012 net written premiums will be more than $43 billion.

b. What was the total amount assessed to, and total amount collected from, companies in FY 2012 and FY 2013? Is there any concern by the department that this number might exceed the "cap" in the near future?

Response: The total amount assessed to companies in FY 2012 and estimated for FY 2013 is $60.8 million. This includes the Fraud Assessment ($25 million) and the Special Purpose Assessment ($35.8 million.) There is no concern that this number might exceed the cap in the near future.

13. The FY 2014 Budget Recommendation anticipates that DOBI will collect a total of $123 million in revenue (pages, C-3, C-10 and C-18) for the department. Additionally, the department anticipates collecting $18.527 million in FY 2014 for the Motor Vehicle Commission. This revenue is reported under the Department of Transportation's anticipated revenue (page C-15).

$63.45 million is recommended to be appropriated for the department's operations as represented on pages D-23 to D-29 of the FY 2014 Budget Recommendation, which is unchanged from the current year.

Question: a. Is there any other revenue collected for the department that is not referenced in the FY 2014 Budget Recommendation as the department's revenue?

Response: In addition to the Motor Vehicle Assessment, the Department also collects the HMO Assessment which is transferred to the Charity Care Fund.

Discussion Points (Cont'd)

b. Please provide the overall revenue collected through the department and the total amount that is dedicated to the department, the total amount transferred to other departments for their operations and the total remaining in the General Fund for other State purposes unrelated to the department's scope of activities.

Response: Below is a summary of the revenue for FY 2012, the last year with complete information.

Revenue Category	FY 2012
Dedicated	$ 75,101,528
General Fund	$ 49,762,006
Transferred to other Departments	$150,339,660
Total	$275,203,194

14. The department is responsible for investigating in both the Banking and Insurance divisions fraud committed by licensees. In certain insurance fraud, the department investigates in coordination with the Office of the Insurance Fraud Prosecutor (OIFP) in the Department of Law and Public Safety. These investigations may result in consumer recoveries and fines imposed on the industries the department regulates. In response to FY 2013 OLS Discussion Points, the department replied that it had made the following recoveries on behalf of consumers: $29.4 million in FY 2012(as of 2/29/12); $17.5 million in FY 2011; $11.35 million in FY 2010; and, approximately $52.4 million in FY 2009.

In its response, the department also provided a broad summary of the types of fines it collects from the different industries. Insurance companies are typically fined for improper claim denials or underpayments, use of unapproved policy forms and/or rates, transacting business without a license and failing to file required reports. Insurance producers are generally fined for misappropriation of premiums, failure to secure coverage, and forgery. Licensed financial entities and State chartered credit unions are usually fined as a result of examinations, consumer complaint handling and enforcement actions. The department stated that it had collected the following fines from the banking, insurance and real estate industries: $1.45 million in FY 2012 (as of 2/29/12); $3.85 million in FY 2011; $1.1 million in FY 2010; and $17.8 million in FY 2009.

Question: a. Please provide an inventory of all recoveries for consumers collected by the department for FY 2012 and thus far in FY 2013. Please detail this information by division.

Response: Consumer Recoveries

	FY 2012	FY 2013 (as of 2/28/13
Banking	$ 821,729	$ 948,003
Insurance	$33,041,812	$17,052,250
Real Estate	$ 0	$ 0
Total	$33,863,541	$18,000,253

Discussion Points (Cont'd)

b. Please provide a detailed inventory of the fines *levied* and fines *collected* by the department for FY 2012 and thus far in FY 2013. Please detail this information by division and by cause by industry. Please provide the collection rate for fines levied. Based on this information, does the department conclude that there are any significant increases in industry behavior punishable by fines that warrant attention by the Legislature?

Response: The Department typically fines insurance companies for improper claim denials or underpayments, use of unapproved policy forms and/or rates, transacting business without a license and failing to file required reports. The Department generally fines insurance producers for misappropriation of premium, failure to secure coverage and forgery. The Department fines state licensed financial entities and state chartered credit unions as a result of examinations, consumer complaint handling and enforcement actions.

Fines Levied

	FY 2012	FY 2013
Banking	$ 580,682	$ 619,350
Insurance	$ 2,033,138	$2,003,116
Real Estate	$ 158,059	$ 147,750
Bureau of Fraud Deterrence	$ 8,926,750	$1,717,500
Total	$11,698,629	$4,487,716

Fines Collected

	FY 2012	FY 2013 (as of 2/28/13)
Banking	$ 29,627	$ 319,400
Insurance	$4,358,366	$2,364,947
Real Estate	$ 168,858	$ 59,090
Bureau of Fraud Deterrence	$ 954,253	$ 513,456
Total	$5,511,104	$3,256,893

Total Fines FY 2012 to FY 2013 (as of 2/28/13)

	Total Fines Levied	Total Fines Collected	Percent Collected
Banking	$ 619,350	$ 319,400	51
Insurance	$2,003,116	$2,364,947	118
Real Estate	$ 147,750	$ 59,090	40
Bureau of Fraud Deterrence	$1,717,500	$ 513,456	30

c. Please detail the amount of revenue collected through fines which is retained in the Department of Banking and Insurance.

Response: All fines collected by the Department are designated to the General Fund.

15. The New Jersey Surplus Lines Insurance Guaranty Fund, P.L.1984, c.101(C.17:22-6.70 et seq.) (the fund), administers the claims of insolvent surplus lines insurers that provided

Discussion Points (Cont'd)

medical malpractice and homeowners coverage as eligible non-admitted insurers in New Jersey. All surplus lines companies in New Jersey are required to be members of the fund and to contribute funds for its operation.

Each member insurer must make an initial one time payment of $25,000 into the fund. Additionally, a surcharge, in an amount determined by the commissioner, is collected on any surplus lines coverage policy issued in New Jersey. The surcharge is collected by the surplus lines agent and forwarded to the fund on a quarterly basis. The amount may be adjusted annually to meet projected expenses of the fund, but it may not exceed 4 percent of the policy premium pursuant to section 6 of P.L.1984, c.101(C.17:22-6.75). However, according to the department, this surcharge has not been collected since 1993.

Question: a. Please provide an update on the status of the New Jersey Surplus Lines Insurance Guaranty Fund, including: balances and disbursements made from the fund in the past 10 years; and estimates for FY 2013 and FY 2014.

Response:

New Jersey Surplus Lines Insurance Guaranty Fund
Schedule of Balances and Disbursements
For Calendar Years Ended **2003** thru **2014**

Year	Total Disbursements	Year End Fund Balance
2003	$ 4,298,165.00	$35,614,234.00
2004	$ 3,117,750.00	$37,783,977.00
2005	$ 916,429.00	$40,514,728.00
2006	$ 768,630.00	$42,673,743.00
2007	$ 125,549.00	$45,630,566.00
2008	$ 113,852.00	$48,849,080.00
2009*	$60,094,052.00	$13,317,585.00
2010	$ 5,588,444.00	$10,484,881.00
2011	$ 496,275.00	$10,107,767.00
2012	$ 74,900.00	$10,087,500.00
2013 (est.)	$ 142,000.00	$10,087,500.00
2014 (est.)	$ 140,000.00	$ 9,935,500.00

*$60 million of the disbursements in 2009 was the result of the enactment of P.L.2009, c.75, which Governor Corzine transferred from the surplus lines insurance guaranty fund to balance the FY 2010 Budget.

b. Please comment on the history of the surcharge and provide the reasons why the surcharge is not collected.

Response: Effective August 1, 1998, the collection of a surcharge of four percent of the gross premium was suspended subject to reinstatement by the Commissioner if necessary.

Discussion Points (Cont'd)

16. P.L.2011, c. 119 revised the method for the regulation and collection of surplus lines insurance premium taxes. These revisions brought "the surplus lines law," P.L.1960, c.32 (C.17:22-6.40 et seq.), into compliance with the federal "Nonadmitted and Reinsurance Reform Act of 2010" (NRRA), which was passed by Congress as part of the "Dodd-Frank Wall Street Reform and Consumer Protection Act." Prior to the enactment of NRRA, states shared surplus lines premium tax revenue based on the location of the insured's various risks. Under NRRA, this ability to share surplus lines premium tax revenue was suspended in July 2011 until such time as New Jersey enters into a multi-state compact or agreement with one or more other states.

NRRA provides that if a state does not join such an agreement, it may collect 100 percent of the taxes due from insureds located in its state, otherwise known as "home-state" insureds. This includes the continued ability to collect all premium taxes owed by "home-state" insureds for their risks located in other states. However, as established under NRRA, a state that does not participate in a compact or agreement is precluded from collecting surplus lines premium taxes it currently receives attributable to risks situated in its state that belong to the home-state insureds of other jurisdictions.

P.L. 2011, c. 119 authorized the Commissioner of Banking and Insurance to enter into compacts or agreements with other states with respect to the collection of surplus lines premium taxes in order to maximize the tax revenue rightfully due and owing the State. As of July 2011, in the absence of an interstate compact regarding future surplus lines tax collections, all insurers for whom New Jersey qualifies as their "home state" are assessed the 5 percent surplus lines premium tax on all surplus lines insurance premiums, even if the premiums are on risks located out of the State.

At the time of enactment, it was unclear as to what affect this law would have on revenue collected by the State from surplus lines insurance premiums. According to the Department of Banking and Insurance, the State collected $42 million in revenue from the surplus lines premium tax in 2010 and approximately 80 percent of this revenue was from "home state" insureds. The remaining 20 percent of revenue was collected from insureds for whom there was uncertainty as to their "home state." The department estimated that there may be increased revenue due to capturing current out of State risks from "home state" insureds and due to increased clarity of the standardized procedures for the market participants.

Question: a. What is the current status of the State's participation in an agreement or compact with other states to collect surplus lines insurance premium taxes? Which states are part of any negotiations with the department? What is the anticipated timeline for the State's future participation in an agreement or compact with other states to collect the surplus lines tax?

Response: The Department is not currently in negotiations with any other states regarding participation in an agreement or compact to collect surplus lines premium taxes. No plans are contemplated to open negotiations for this purpose.

Discussion Points (Cont'd)

b. Please provide the surplus lines tax rate assessed in the states immediately surrounding New Jersey, including: Pennsylvania, Maryland, Delaware, New York and Connecticut.

Response: The surplus lines tax for neighboring states is:

Pennsylvania	3 percent, plus a $25 stamping fee
Maryland	3 percent
Delaware	2 percent
Connecticut	4 percent
New York	3.6 percent, plus a .2 percent stamping fee

New Jersey's present surplus lines tax rates is 5 percent, up from 3 percent pursuant to P.L.2009, c.75.

c. Please report the revenue collected from the surplus lines tax in 2012. What percentage of that revenue was from policies located in State and what percentage was from policies located out of state but whose parent company identifies New Jersey as its "home state"?

Response: The surplus lines tax collected in 2011 was $50.1 million. We are not able to identify what percent is in state or out of state. The amount of 2012 surplus lines tax collected will not be available until later in the year.

17a. In addition to its responsibility to regulate and provide oversight to the insurance and banking industries, the department is also responsible for the oversight of the mortgage lending system and various other regulated professions discussed in more detail below.

a. The federal "Housing and Economic Recovery Act of 2008" (Pub.L.110-289) was signed into law in July, 2008. Among other initiatives, this act included the "Secure and Fair Enforcement for Mortgage Licensing Act of 2008" (S.A.F.E. Act). The S.A.F.E. Act defines a loan originator as an individual who takes a residential mortgage loan application and offers or negotiates terms of a residential mortgage loan for compensation or gain. The act requires the states to participate in the Nationwide Mortgage Licensing System (NMLS), established by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators. Each state's system must include, at a minimum, requirements that meet the established national standards for licensing loan originators. These requirements include, among other things, minimum education requirements, ethics training, background checks, proof of financial responsibility, bonding requirements and the successful completion of a written exam. The State complied with these new federal standards by enacting the "New Jersey Residential Mortgage Lending Act," (NJRMLA), sections 1 through 39 of P.L.2009, c.53 (C.17:11C-51 et seq.), which updated the current regulatory scheme to conform to the

Discussion Points (Cont'd)

requirements of the federal S.A.F.E. Act, and replaced the "New Jersey Licensed Lenders Act" (NJLLA) (N.J.S.A.17:11C-1 et seq.) as the statutory framework for mortgage lenders.

The department, in its response to OLS Discussion Points during the review of the FY 2013 budget, revealed that there were 1,430 licenses issued to financial institutions participating in the mortgage lending business in the State in FY 2012 (as of March, 2012), pursuant to the NJRMLA. Furthermore, there were 7,178 licenses issued to individuals participating in the mortgage lending business in the State in FY 2012 (as of March, 2012). The department reported $25,900 in total revenue collected from licensees under the NJRMLA. This revenue was dedicated to the State. Additionally, $638,985 in revenue was collected by the NMLS. This is a decrease in total revenue collected and dedicated by the State under the NJLLA ($2.6 million in FY 2010, its last year of solo operation)

Question: a. Please provide the number of individuals who have been regulated, registered, and licensed by the State for FY 2011, FY 2012 and thus far in FY 2013 as participating in the mortgage lending business pursuant to the "New Jersey Residential Mortgage Lending Act."

Response:

	FY 2011	FY 2012	FY 2013 as of 3/21/2013
Individual Residential Mortgage Lenders	317	320	346
Individual Correspondent Residential Mortgage Lenders	168	155	149
Individual Residential Mortgage Brokers	201	210	222
Mortgage Loan Originators	6,085	6,848	7,934

b. Please detail the number of financial institutions, participating in the mortgage lending business, that are licensed by the State for FY 2010, FY 2011, FY 2012 and thus far in FY 2013 pursuant to the "New Jersey Residential Mortgage Lending Act."

Response: During FY 2010, a transition in licensure occurred from the "New Jersey Licensed Lenders Act" to the "New Jersey Residential Mortgage Lending Act." Statistics are therefore separated as set forth below:

As of 12/31/2009 of FY 2010 under the "New Jersey Licensed Lenders Act" Companies (includes Corps, LLCs, Part, & Sole Props)	
Secondary Mortgage Lender	384
Mortgage Banker	308
Correspondent Mortgage Banker	214
Mortgage Broker	274

Discussion Points (Cont'd)

Branches	
Secondary Mortgage Lender	956
Mortgage Banker	788
Correspondent Mortgage Banker	221
Mortgage Broker	233

	FY 2010	FY 2011	FY 2012	FY 2013 as of 3/21/13
Companies				
Residential Mortgage Lenders	30	252	298	311
Correspondent Mortgage Lenders	22	125	145	144
Residential Mortgage Brokers	18	158	196	209
Branches				
Residential Mortgage Lenders	14	599	642	749
Correspondent Mortgage Lenders	0	120	108	135
Residential Mortgage Brokers	23	93	92	65

c. Please indicate how much revenue the department has collected from each type of fee authorized under the "New Jersey Residential Mortgage Lending Act" in FY 2010, FY 2011, FY 2012 and anticipates collecting in FY 2013.

Response:

	FY 2010	FY 2011	FY 2012	FY 2013
Licensed Lender Add Authority	$33,900	$ 600	$ 3,000	$ 300
Licensed Lender Branch	$87,500	$27,200	$16,100	$5,600
Licensed Lender Company	$45,500	$ 7,700	$ 5,600	$2,800
Licensed Individual	$60,200	$ 9,100	$12,600	$9,800
Mortgage Solicitors	$70,000	$ 0	$ 0	$ 0
Electronic Debits(All License types)	$133,900	$ 0	$ 0	$ 0

d. Please indicate how much revenue has been collected from New Jersey licensees by the Nationwide Mortgage Licensing System (NMLS) in FY 2010, FY 2011, FY 2012 and how much is anticipated in FY 2013.

Response:

National Mortgage Licensing System

FY 2010	FY 2011	FY 2012	Estimated FY 2013
$1,839,950	$1,400,000	$939,035	$1,000,000

e. Has the shift toward licensure and regulation occurring through the NMLS resulted in less department staff dedicated to reviewing mortgage licensees? What has the impact of these changes been on the department's budget for this division?

Discussion Points (Cont'd)

Response: The shift to licensure through the NMLS has resulted in the need to add staff to be dedicated to reviewing mortgage licensees. The increased complexity of the license approval process for individual Mortgage Loan Originators and Qualified Individual licensees includes review of testing and pre-licensure education information, FBI and New Jersey State Police criminal background check results as well as individual credit reports for compliance with the requirements of the Federal Secure and Fair Enforcement (SAFE) for Mortgage Licensing Act of 2008 and the New Jersey Residential Mortgage Lending Act. Determinations are required to be made as to the character and fitness and financial responsibility of individual license candidates. Determinations are also required to be made concerning felony convictions in accordance with the restrictions of the federal and state laws. Felony convictions within seven years of the date of application are disqualifications from licensure, and financially-related felony convictions, irrespective of when they occurred, are forever disqualifications from licensure. These matters require a formal license denial process which includes an applicant's rights under the New Jersey Administrative Procedures Act.

17b. In addition to licensing and regulating individuals employed in the mortgage industry, the department also licenses and regulates several other professional groups, including: debt adjusters (P.L.1979, c.16 (C.17:16G-1 et seq.)); home repair contractors (P.L.1968, c.224 (C.17:16C-95 et seq.)); insurance producers (P.L.2001, c. 210 (C.17:22A-26 et seq.)); pawnbrokers (R.S.45:22-1 et seq.); and public adjusters (P.L.1993, c.66 (C.17:22B-1 et seq.). Each of these individuals pays a fee to be licensed, and in some cases, to renew that license. These fees are intended to fund the administrative costs of providing oversight of these professions.

Question: a. Please provide the current initial fee and the renewal fee for each of these professions.

Response:

License Type	Initial Application Fee	Renewal Fee
Motor Vehicle Installment Seller	$300	$0
Home Repair Contractor	$300	$0
Home Financing Agency	$400	$0
Pawnbroker	$500	$0
Check Casher	$700	$0
Insurance Premium Finance Company	$500	$0
Debt Adjuster	$300	$0
Foreign Money Transmitter	$700	$0
Money Transmitter	$700	$0

Discussion Points (Cont'd)

Sales Finance Company	$700	$0
Consumer Lender	$700	$0
Home Repair Salesperson (Individuals)	$60	$0
High Cost Home Loan Credit Counseling Agency (Registration not license)	$100	$0
Residential Mortgage Lender	$1,200	$0
Correspondent Residential Mortgage Lender	$1,200	$0
Residential Mortgage Broker	$1,200	$0
Branches of each mortgage type	$1,000	$0
Qualified Individual of each mortgage type	$500	$0
Mortgage Loan Originator (Individuals)	$150	$0
Insurance Producer	$150*	$150
Limited Lines Insurance Producer	$ 75*	$ 75
Public Adjuster	$ 75**	$ 75

*additional $20 for electronic filing or $40 for paper filing
**additional $40 filing (paper only)

b. Please provide the annual revenue collected from each of these fees for the previous five fiscal years.

Response:

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Debt Adjusters	$3,300	$3,300	$1,800	$1,500	$1,200
Home Repair Contractors	$8,100	$11,400	$10,800	$9,600	$11,100
Insurance Producers	$37,877,338	$37,656,645	$38,512,649	$38,903,095	$16,135,920
Pawnbrokers	$2,500	$4,500	$1,500	$7,500	$4,500
Public Adjusters	$88,560	$96,860	$152,340	$45,600	$57,760

c. Please provide the annual cost to administer these programs for the previous five fiscal years and the number of full time equivalent staff assigned to licensing and regulatory activities per year, per profession.

Response:

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Insurance Licensing	$598,319	$629,810	$718,247	$640,459	$647,663
Full time Staff	10	10	11	9	9

All Insurance Licensing staff handle a variety of activities involved in the review and processing of initial and renewal paper and electronic filings for licensure, the maintenance of licensing records, and the handling of telephone calls, e-mail inquiries, and written correspondence that relate to the licensure of insurance producers and public adjusters.

Discussion Points (Cont'd)

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

In January 2010, P.L.2009, c. 327 (C.34:15-105.1 et al.) was enacted, transferring responsibility for the management, administration and claims activities of the WCSF from the Department of Banking and Insurance to the New Jersey Property-Liability Insurance Guaranty Association (PLIGA).

PLIGA is a "private, nonprofit, unincorporated, legal entity" given certain statutory obligations to act as a safety net for policyholders and claimants in the property and casualty insurance marketplace pursuant to N.J.S.A.17:30A-1 et seq. As an independent entity, PLIGA is not included in the State budget, and the WCSF is no longer a State-administered fund.

In response to FY 2013 OLS Discussion Points, the department estimated that the WCSF would receive $15.3 million in assessments and would have total expenditures of $17.34 million in FY 2012, with an ending balance in the WCSF of $82.2 million.

Question: Please provide an accounting of all resources and expenditures for the WCSF for FY 2011, FY 2012 and estimated for FY 2013, including, with respect to revenues: services and assessments and investment earnings; and with respect to expenditures: economic planning, development and security expenses and transfers to other funds (both State and PLIGA held). Please include the balance of the fund, both at the beginning of each fiscal year and projected for the end of each fiscal year. Please provide details for the dividend in FY 2011, FY 2012 and FY 2013.

Response:

New Jersey Workers' Compensation Security Fund
Schedule of Balances, Receipts and Disbursements

	FY2012	FY2013 (estimated)	FY2014 (estimated)
Beginning Balance	$70,864,000	$82,620,700	$97,522,800
Receipts			
Assessments	$15,343,700	$16,577,500	$16,607,000
Liquidation Dividend	$12,927,420	$13,585,758	N/A
Interest/Other Income	$ 710,380	$ 654,242	$ 613,400
Claim Disbursements	$17,224,800	$15,915,400	$20,968,000
Ending Balance	$82,620,700	$97,522,800	$93,775,200

Discussion Points (Cont'd)

Outstanding Loss Reserves as of 3/26/12 = $129,697,406
Outstanding Loss Reserves as of 3/25/13 = $150,708,669
Projected Outstanding Loss Reserves as of 3/31/14 = $218,000,000*
*- Lumbermens Group (part of Kemper) insolvency is scheduled to happen in 2013 - preliminary numbers show $70M in unpaid losses with the estimate for disbursements increasing for FY2014

19. Pursuant to P.L.2010, c.32 the former Division of Insurance Fraud Prevention (DIFP), was renamed and reconstituted as the Bureau of Fraud Deterrence. The former division was originally established under the Department of Banking and Insurance, but its functions were transferred to the Department of Law and Public Safety pursuant to Reorganization Plan No. 007-1998. The Bureau is now located in DOBI and consists of all civil investigators formerly assigned to the Office of the Insurance Fraud Prosecutor (OIFP) in the Department of Law and Public Safety, (other than those assigned to the Case Screening, Litigation and Analytical Support Unit), and those additional administrative and clerical support personnel transferred from the OIFP to the Bureau within DOBI. The OIFP was established in the Department of Law and Public Safety, pursuant to section 32 of the "Automobile Insurance Cost Reduction Act" (AICRA), P.L.1998, c.21 (C.17:33A-16). P.L.2010, c.32 provided that the OIFP retain responsibility for all criminal prosecutions and investigations of fraud, including the County Prosecutors' Reimbursement Program.

The functions of the Bureau and the OIFP are funded through the Insurance Fraud Prevention assessment (page C-4, FY 2013 Budget Recommendation). The Insurance Fraud Prevention assessment is an assessment on certain insurers for reimbursement of all costs related to the activities and responsibilities of the OIFP and the Bureau. Pursuant to section 8 of P.L.1983 c. 320 (C.17:33A-8), as amended by P.L.2010, c.32, the Director of the Division of Budget and Accounting in the Department of the Treasury shall, on or before September 1 in each year, certify the total amount of expenses incurred by the State in connection with the administration of insurance fraud prevention in the previous fiscal year. This amount is then apportioned among the insurance companies by the department and an assessment is paid by the insurance companies prior to December 31 of each calendar year for expenses accrued in the previous fiscal year.

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

Question: a. Please update the Legislature on the activities of the Bureau of Fraud Deterrence, including the number of cases being investigated and the types of fraud discovered.

Response: On June 30, 2010, pursuant to P.L.2010, c.32 the former Division of Insurance Fraud Prevention (DIFP) was renamed and reconstituted as the Bureau of Fraud Deterrence within the Department of Insurance.

Discussion Points (Cont'd)

The law transferred the civil component back to the Department of Banking and Insurance, naming it the Bureau of Fraud Deterrence (the Bureau). The criminal component remained with the Office of the Insurance Fraud Prosecutor. The law mandated the collaboration of the criminal and civil components in the Department of Law and Public Safety, citing specific requirements such as regular formal meetings, dual insurance industry fraud referrals, and coordination, related to administrative subpoenas, etc.

As of October 23, 2010, the transfer of the Bureau to the Department was complete.

Two and one half years since the transfer, the Bureau's operational independence, both the Bureau and OIFP have optimized their independent authority, while collaborating, communicating and jointly discerning when to work independently or in concert.

The Bureau and OIFP formally meet monthly. Our respective leadership has 24-7 access to one another. Our agencies have also benefited from longstanding professional/personal relationships that are both deep and broad amongst and between their respective cadres. Civil Investigators have been "sworn-in" as Special State Investigators, with New Jersey Office of the Attorney General authority for access to grand jury and other privileged information on particularly significant/sensitive joint investigations.

The Bureau and OIFP have successfully prosecuted several significant cases, through negotiated settlements. Stakeholder interests, such as insurance carrier restitution and medical board actions, are also collaboratively addressed. Litigation is the alternative to settlement. In such instances, criminal and civil components proceed independently, yet communicate, as appropriate.

Section 7D of the Act provides insurance carriers with the legal authority to independently litigate matters, involving their interests against entities they view as being liable for a violation of the Act. In instances in which the State joins the action, the New Jersey Office of the Attorney General, Division of Law, serves as counsel. While the Bureau assumes primary investigative responsibility, Bureau-OIFP communication and collaboration continue throughout the 7D process.

In calendar years 2011 and 2012, the Bureau opened 3,246 and 4,299 investigative cases, respectively. In August 2011 the Bureau established a dedicated investigator PIP unit. PIP

Discussion Points (Cont'd)

cases comprised 803 of the 4,299 calendar year 2012 Bureau cases opened, representing 18.8 percent of that total.

Bureau civil prosecutions total monetary values were $6,243,000 and $6,956,250 in 2011 and 2012, respectively. Complex, multi-transaction/event cases accounted for $4,725,000 and $4,775,500 of these totals for calendar years 2011 and 2012, respectively. Such results reflect the increased emphasis the Bureau has placed on complex, multi-transaction/event fraud schemes.

b. Please provide expenses as they were certified by the Department of the Treasury pursuant to N.J.S.A.17:33A-8 for FY2012. Please break the expenses down to include, at a minimum, the direct cost of personal service, the cost of maintenance and operation, the cost of retirement contributions made, workers' compensation paid for and on account of personnel, rentals for space and all other indirect or direct costs of the administration.

Response:

Salaries and Wages	$ 7,208,095.42
Materials and Supplies	$ 75,419.88
Services other than Personnel	$ 1,190,916.44
Maintenance and Fixed Charges	$ 281,477.15
Equipment	$ 319,869.00
Special Purpose	
Insurance Fraud Prosecutor	$11,348,602.72
Subtotal	$20,424,380.61
Other Expenses	
Fringe Benefits	$ 4,640,337.31
Indirect costs	$ 31,262.95
Building Operations and Maintenance	
Roebling Building	$ 62,422.84
Debt Service – Roebling Building	$ 152,952.28
Warren Street Parking Costs	$ 3,000.00
Cancelled Obligations FY 2010-2011	$ (744.19)
Lockbox	$ 2,229.53
Parking Costs – Bank Street	$ 1 8,123.85
Rent Calculation for	
Leased Office Space	$ 207,022.03
Subtotal	$ 5,116,606.60
Total Fraud Expenses 2012	**$25,540,987.21**

Discussion Points (Cont'd)

c. Please provide the annual awards for the County Prosecutors' Reimbursement Program for each award year since its inception and its estimated cost for FY 2014.

Response: A budget summary from the inception of the program, funding cycle 1 (June 16, 1999-June 15, 2001) through funding cycle 13 (January 1, 2013-December 31, 2013) is provided in Attachment 4. The estimated cost for FY 2014 is anticipated to be at the same level as 2013 for a total of $3,572,249.

Since 2004, the program has operated on a calendar year basis instead of a fiscal year basis to better match county budgets.

20. The Department of Banking and Insurance appears to be increasing the use of electronic registration for many of the services it provides both licensees and consumers. For example, insurance carriers and real estate licensees can renew and apply for licenses on the department's website and consumers can submit consumer complaints electronically. However, there also appear to be numerous licensees who must download forms from the website and mail them back to the department. For example, pawn brokers, debt adjusters, home repair contractors and check cashers must all submit through a regular mail service and there is no live chat option for consumers to access real time contact with a staff person from the Consumer Assistance Program.

Question: Does the department anticipate increasing the number of licensees who can submit license applications electronically? Does the department foresee adding any real time electronic customer service to its Consumer Assistance Program? What are the barriers to increasing electronic communication with the public and licensees?

Response: During the past few years the Department has migrated all of the high volume license transactions for all of the industries we regulate to online platforms. We are constantly evaluating other opportunities for online transactions.

An additional project is planned for the summer to review the statutory and administrative requirements for the Consumer Finance original license filings to look for opportunities for automation.

We are in the process of updating our information Technology Strategic Plan which directs our IT work. We anticipate based on the development of the plan to date to begin evaluating placing the original licensing of real estate salespersons online, allowing the salesperson license to be displayed on a smart phone, and improving the Department's web site.

Discussion Points (Cont'd)

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