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May 5, 2014

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

Re: Department of Banking and Insurance Budget Hearing Response

Dear Chairman Schaer,

Please accept the following in response to your April 11, 2014 letter requesting follow-up information with respect to the questions raised by you, Assemblyman Singleton, Assemblyman Brown and Assemblyman Cryan at the Department of Banking and Insurance (Department) budget hearing on April 9, 2014.

- 1. Please provide the most recent occasion on which rates for health insurance premiums were submitted to the department for review with a request for a decrease in health insurance premiums the following year.**

The Department has most recently received a submission effective November 1, 2013 to review rates that included a decrease in health insurance premiums of eight percent on a Horizon Blue Cross Blue Shield of New Jersey Indemnity Plan.

It is important to note that carriers are required to file their rates with the Department once a year, even if those rates remain unchanged. Thus, the Department does not review rate increases or decreases per se. Instead, the Department simply reviews rate filings for compliance with statute and regulation. This review is primarily based on the statutory requirement that a carrier meets the minimum loss ratio requirement of 80 percent. If a carrier can actuarially demonstrate that expected claims will exceed 80 percent of expected premiums, the proposed rate level is legally acceptable, regardless of the range. This statutory standard ensures that premiums are neither excessive relative to the claims paid to providers on behalf of consumers, nor inadequate to maintain the solvency of the company. This standard is further enforced by the requirement that if a company does not subsequently meet the 80 percent minimum loss ratio, it must refund the difference to insureds. Given this direct connection between the cost of claims received and the rates charged, one expects insurance premiums to generally track increases in medical costs, currently in the 8-12 percent range annually.

- 2. On page D-24 of the Budget Recommendation, data indicates that the department estimates that it will receive 7,400 complaints through the Insurance Consumer Assistance unit and will resolve 7,500 complaints in FY 2014 and FY 2015. The discrepancy between the number resolved and the number received was due to a carryover from the previous year. Please provide to the committee the number of complaints that were not resolved in FY 2013 and estimated not to be resolved for FY2014.**

At the end of FY 2013, there were 2,294 open complaints. At that time, many of these complaints were related to Super Storm Sandy and have been addressed in the interim. At the end of FY 2014, the Department anticipates that there will be approximately 1,000 open complaints.

- 3. On page D-24 of the Budget Recommendation, data indicates that there was a reduction of 5,856 in the number of complaint/inquiries received by the Office of Managed Care between FY 2013 and FY 2014. Please provide information on the reasons behind this reduction.**

Early on during FY 2014, the Department began tracking consumer inquiries/complaints using the National Association of Insurance Commissioners' State Based Systems (SBS). Prior to this transition, each consumer call was logged as an individual inquiry/complaint. Thus if a department representative spoke with a consumer four times, each discussion was logged as a separate inquiry, resulting in an inflated inquiry/complaint count.

Following the implementation of SBS, the system allowed each consumer call to be paired with the original inquiry/complaint, thus, the Department is now able to provide a more accurate representation of individuals making inquiries or complaints to the Office of Managed Care. This is reflected in the reduction in inquiries/complaints.

- 4. Please provide to the committee the number of New Jersey residents who have purchased a health insurance policy through the federal Marketplace. Please provide the number of these policyholders who have paid and who have not paid their first month's premium for this health insurance coverage.**

As the federal Department of Health and Human Services (HHS) administers the federal Marketplace that currently operates in New Jersey, any inquiries related to enrollment data and premium payments should be directed to the Centers for Medicare and Medicaid Services (CMS). The most recent publically available data previously released by HHS indicates that 161,775 individuals in New Jersey selected a plan on the marketplace. This can be found at: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014apr_enrollment.pdf.

- 5. Please provide to the committee the number of New Jersey employers who have purchased a health insurance policy through the federal Small Business Health Options Program (SHOP) Marketplace.**

Please see the above answer.

6. Please detail the metrics used by the department when determining network adequacy as it relates to health care providers under health benefits plans regulated by the department. Please specify the metrics used for each of the different types of providers, if they differ.

The Department requires health maintenance organizations (HMOs) and insurers offering managed care plans to maintain an adequate network of primary care providers, specialists, institutional services and ancillary providers to serve the enrolled population at all times. The Department has established geographic access and availability standards for each of these categories of providers based on where 90 percent of members within each county or approved sub-county service area reside. The Department may grant relief from the time and mileage standards in limited circumstances when the HMO or carrier is able to document that appropriate access to alternative sites is available.

The provider network standards, codified at N.J.A.C. 11:24-6 for HMOs and at N.J.A.C. 24A-4.10 for insurers, require the following:

Provider Type	Maximum Travel Time/Distance
Primary Care Providers	At least two within 10 minutes or 30 miles average driving time or public transit, whichever is less.
Specialists	A sufficient number within 45 miles or one hour driving time, whichever is less.
Acute Care Hospital with medical/ surgical, pediatric, obstetrical and critical care services	At least one in any county or service area no greater than 20 miles or 30 minutes driving time, whichever is less.
Surgical facilities including acute care hospitals, licensed ambulatory surgical facilities and/or Medicare certified physicians and surgical practices	A sufficient number in each county or service area no greater than 20 miles or 30 minutes driving time, whichever is less.
Tertiary/specialized services including: <ul style="list-style-type: none"> • A hospital providing: <ul style="list-style-type: none"> Regional perinatal services; Tertiary pediatric services; Cardiac catheterization. • In-patient psychiatric care for adults, adolescents, & children • Residential substance abuse treatment center • Specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio facial and congenital anomalies • Comprehensive rehab services 	At least one available within 45 miles or 60 minutes average driving time, whichever is less.
Tertiary/specialized services including: <ul style="list-style-type: none"> • A licensed long term care facility with 	At least one available within 20 miles or 30 minutes average driving time, whichever is less.

<ul style="list-style-type: none"> • Medicare-certified skilled nursing beds • Therapeutic radiation provider • MRI • Diagnostic radiology, including x-ray, ultrasound, and CAT scan • Emergency mental health services, including a short term care facility for involuntary psychiatric admissions • Out-patient therapy providers for mental health and substance abuse conditions • Licensed renal dialysis providers 	
Home Health Agency	At least one to serve each county where 1,000 or more members reside.
Hospice program certified by Medicare	At least one in any county where 1,000 or more members reside.

In addition, the Department expects carriers to grant access to an out of network provider in cases where a network provider is not available, at the same level of member cost sharing as if the out of network provider was in network.

7. Of the total number of New Jersey residents who have purchased a health insurance policy through the Federal Marketplace, how many were previously insured through a differen[t] health insurance policy?

Please see the answer to Question 4. Additionally, the Department is unaware of any meaningful way to track how many individuals were previously insured through a different health insurance policy, as the reasons for enrollment in different plans is extremely fact specific.

8. As detailed in the department’s response to the OLS Discussion Point No. 10, please provide a graphic listing the filed rate increase or decrease requests in the Individual Health Care and Small Employer Health Care markets for FY 2011, FY 2012 and FY 2013.

FY 2011

Carrier	Total Filings	Individual (Percent)	Small Emp. (Percent)
Horizon	23	0 – 19.8	7.8 – 23.0
Aetna	8	0	8.3 – 27.9
AmeriHealth	11	0 – 12.0	9.4 – 23.3
CIGNA	2	N/A	11.4 – 17.2
Oxford	5	8.9 – 19.7	14 – 14.4

FY 2012

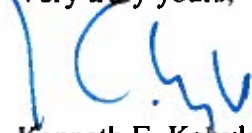
Carrier	Total Filings	Individual (Percent)	Small Emp. (Percent)
Horizon	20	-3.2 – 19.8	0 – 17.7
Aetna	5	0 – 15.0	5 – 16.5
AmeriHealth	11	8.8 – 9.8	2.6 – 10.1
CIGNA	2	N/A	11.4 – 16.1
Oxford	7	19.3	14 – 16.1

FY 2013

Carrier	Total Filings	Individual (Percent)	Small Emp. (Percent)
Horizon	23	4.2 – 19.5	9.3 – 17.7
Aetna	10	0 – 9.0	13.8 – 18.8
AmeriHealth	8	3.1 – 9.8	1.9 – 13.26
CIGNA	2	N/A	11.1 – 12.1
Oxford	5	5.5 – 8.3	7.9 – 13.7

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

Very truly yours,



Kenneth E. Kobylowski
Commissioner