

## Discussion Points

1. Under State law, insurance carriers regulated by the Department of Banking and Insurance (DOBI) must file with the department by March 1<sup>st</sup> of each year annual financial statements in accordance with the format adopted by the National Association of Insurance Commissioners. DOBI is to post the financial statements on its website within 30 days of their receipt in accordance with section 5 of P.L.2017, c.100 (N.J.S.A.26:25-18.1), with the posting requirement first applicable to financial statements received in 2018. A company neglecting to file its annual financial statement in the required form by March 1<sup>st</sup> must pay \$100 for each day's neglect, to be recovered in a civil action; and upon notice by DOBI to that effect, its authority to do new business must cease while the default continues. The term insurance carrier refers to insurers, health maintenance organizations, hospital service corporations, medical service corporations, and health services corporations.

In Bulletin No. 18-03 released on March 16, 2018, entitled, "Annual Financial Statements – Supplemental Compensation Exhibit," DOBI advised all domestic insurance carriers on how the department will handle requests under the Open Public Records Act (OPRA), N.J.S.A.47:1A-1 et seq., for production of the Supplemental Compensation Exhibits (SCEs), which constitute a part of the annual financial statements that carriers must file with the department.

According to the bulletin, for years, upon the receipt of OPRA requests for annual statements or SCEs, the department released the annual statement, including the SCE, without redaction. The only items withheld from the annual statement release were the Management Discussion and Analysis and any submitted Actuarial Memoranda as proprietary commercial or financial information, because they discussed the reporting entity's financial condition and results of operations from the perspective of management and proprietary actuarial analyses, and the Risk-Based Capital report pursuant to N.J.A.C.11:2-39.10(a).

According to the bulletin, the department had recently received a request from a carrier to redact certain compensation information from the SCE in response to an OPRA request on the basis that the compensation of certain individuals should be withheld as proprietary because it would place the carrier at a competitive disadvantage for retaining and attracting talent. At that time, the department allowed the redaction based upon OPRA exemption asserted by the carrier; however, after allowing other carriers to make objections to the release of SCEs, the department found abundant discrepancies in the carriers' requests.

The department reevaluated the issue and determined that it was within the public's interest that there should be uniformity in the filing of SCEs, including among others, compensation data for carriers' boards, directors, and senior management.

- **Questions:** Have all carriers filed their 2017 financial statements in the form required by March 1 of this year? By what date does the department anticipate posting the statements on its website? Has the department encountered any difficulties or delays in posting the requirement documents? What parts of the annual filings, if any, will DOBI not post on its webpage and for what reasons? Will DOBI post the SCEs? What information from the annual filings will DOBI redact before publication and for what reasons? Please indicate any category of information from the financial statements that DOBI will not post on its webpage but that the public could obtain through OPRA requests.

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### RESPONSE:

All domestic insurers are in compliance with the annual financial statement filing requirements under State law. The Department has reviewed those filings for completeness and they were accepted as filed. To comply with newly enacted N.J.S.A. 26:2S-18.1, the Department will post the annual statements of the domestic health carriers within 30 days. The financial statements will be posted in full, with all public and non-confidential information and exhibits.

- **Questions:** Please provide the following information on the carrier whose request for redaction of certain compensation information in copies of its SCEs that were to be released to the public in response to OPRA requests prompted the issuance of Bulletin No. 18-03: (1) the name of the carrier; (2) the number of employees whose compensation information was requested to be withheld; (3) elements of the compensation information that were requested to be withheld; and (4) any additional information requested to be withheld by the carrier. Since then, how many carriers, by type of insurance, objected to the department's release of SCEs? What were the most common reasons presented for the objections?

### RESPONSE:

As stated in the Bulletin, in response to a 2017 OPRA request for multiple carriers' supplemental compensation exhibits, the Department provided an opportunity for redaction to those carriers. Therefore, there is no one carrier to identify. Despite being in the same market, the nature of the redactions by the carriers for this one OPRA request ran the gamut from complete redaction of all data and withholding of the exhibit to full unredacted release, and various levels of redaction in between. Despite assertions of proprietary commercial and/or financial information, the Department could not discern a rational basis for such distinctions. Moreover, the Department believes that the public has an interest in the information provided in this exhibit that is a part of the public annual financial statement. The carriers subject to the OPRA requests for supplemental compensation exhibits that were pending at the time of issuance of Bulletin No. 18-03 were provided an opportunity to file for a court injunction prohibiting release; no carriers sought such an injunction. Thus, we have returned to the practice of producing the supplemental compensation exhibits in full and without an opportunity for redaction.

- **Question:** To what extent have DOBI's deliberations on the implementation of the website posting requirements of section 5 of P.L.2017, c.100 (N.J.S.A.26:2S-18.1) informed the general policy announced in Bulletin No. 18-03?

### RESPONSE:

Without waiving applicable deliberative process privileges, the Bulletin would have been issued even in the absence of enactment of P.L. 2017, c.100. Thus, the implementation of that law did not inform the policy announced in the Bulletin.

- **Questions:** By carrier, please provide the amount of penalty payments, if any, that the department imposed and received pursuant to N.J.S.A.17:23-2 for failure to file the annual

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**statement in the manner and timeframe prescribed for the last three calendar years and indicate how many of these penalties have been recovered through civil action. In the three last calendar years, did DOBI direct a carrier that was in violation of the filing requirement to cease to do new business for the duration of the violation?**

### **RESPONSE:**

*The Department has not issued any violations, fines or cease and desist orders regarding domestic insurers' filing of annual financial statements in the past three years.*

2a. 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" (ACA), were comprehensive pieces of federal legislation enacted in March 2010 to facilitate the availability and affordability of health insurance nationally. The ACA has been contested since enactment and several actions by the federal government since January 2017 either have or will affect the national health insurance market.

In Executive Order 13765 of January 20, 2017, the President of the United States announced that it was "the policy of [his] Administration to seek the prompt repeal of the Patient Protection and Affordable Care Act" and that in preparation for the repeal all federal implementing departments and agencies were to scale back the ACA's enforcement.

In October 2017, the federal government then ceased to make cost-sharing reduction subsidy payments to health insurance carriers. These payments effectively lowered the cost of qualified insureds for health insurance policies purchased through the health insurance marketplace. In Executive Order 13813 of October 12, 2017, the President of the United States also instructed the departments of Labor, Health and Human Services, and Treasury within 60 days to consider proposing regulations or revising guidance on several different options for expanding the types of plans individuals and small businesses could purchase that do not meet the general requirements of the ACA.

In December 2017, the "Tax Cuts and Jobs Act," Pub.L.115-97, repealed the individual mandate penalty under the ACA as of tax year 2019. The ACA currently requires taxpayers who do not have minimum essential health insurance coverage or qualify for an exemption to pay a penalty on their tax returns.

Assembly Bill No. 3380 and Senate Bill No. 1877, entitled the "New Jersey Health Insurance Market Preservation Act," would restore the individual mandate in New Jersey. The bills are intended to ensure that health insurance markets in the State remain robust and affordable by providing an incentive for individuals who can afford to purchase insurance to participate in the market. If a taxpayer does not obtain coverage, the bill imposes a State shared responsibility tax equal to the taxpayer's federal penalty under the ACA prior to the repeal of the mandate.

In New Jersey, the individual market is administered through the Individual Health Coverage Program (IHCP).

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- **Questions:** Absent intervention by the State of New Jersey, what will be the impact of these federal actions on the IHCP and individuals who purchase health insurance coverage through the IHCP? Will the federal actions have an impact on the IHCP's 2019 individual health benefits plans and rates? If so, please provide a table with information, by carrier, and the impact on each carrier's plans and rates. What would be the impact of A-3380 on the New Jersey health insurance market? Is the Administration supportive of the initiative?

### **RESPONSE:**

*It is reasonable to expect significant continued upward pressure on health insurance premiums from these developments at the federal level. However, it is too early to calculate specific dollar impacts because the carriers have yet to file proposed rates for the 2019 plan year. The Department remains open to reviewing all options to stabilize the market and lower premiums for consumers.*

2b. Section 1332 of the "Affordable Care Act" (ACA) allows states to be innovative in their approach to health care reform by obtaining 1332 waivers from the federal government. States can propose unique, state-specific solutions, which can include substantial changes in how the ACA is implemented in the state. In order to be approved, a state's 1332 waiver proposal, however, must ensure that:

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

To apply for a 1332 waiver, a state must submit its proposal to the Centers for Medicare and Medicaid Services (CMS) in the United States Department of Health and Human Services, with detailed explanations of which ACA provisions it wishes to waive, how the state-specific program will be implemented, the proposed budget, and how the program will meet the four basic guidelines described above. As of March 2018, waivers have been approved for Alaska, Hawaii, Minnesota, and Oregon.

In New Jersey, Senate Bill No. 1878, as introduced, and Assembly Bill No. 3379, as introduced, would direct DOBI to apply to the CMS for a waiver of certain provisions of the ACA to support a reinsurance program to help stabilize premiums in the New Jersey individual health insurance market for plan years beginning on or after January 1, 2019. The bill is similar to a program in Minnesota, which received approval by the CMS in September of 2017 and authorizes reinsurance payments of up to \$271 million per year in 2018 and 2019. Program funds will be used to reduce premiums for consumers by partially reimbursing insurers for high-cost claims. Specifically, reinsurance will cover 80 percent of an individual's annual claims costs between \$50,000 and \$250,000.

If the waiver is granted and DOBI accepts the waiver, the bills will create a reinsurance plan to be known as the Health Insurance Premium Security Plan. DOBI is to administer the reinsurance

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plan, a responsibility that includes the setting of specific payment calculation parameters and the exercise of certain auditing and review functions to ensure the plan operates pursuant to the bill's provisions.

The New Jersey bills set the following parameters, among others: (1) the attachment point for the plan is the threshold amount for claims costs incurred by an eligible carrier for an enrolled individual's covered benefits in a benefit year beyond which the claims costs for benefits are eligible for reinsurance payments, set at \$50,000 or more, but not exceeding the reinsurance cap; (2) the reinsurance cap is the threshold amount for claims costs incurred by an eligible carrier for an enrolled individual's covered benefits above which the claims costs for benefits are no longer eligible for reinsurance payments, set at \$250,000 or less; and (3) the coinsurance rate for the plan is the rate at which the eligible carrier will be reimbursed for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap, set at a rate between 50 and 70 percent.

- **Question:** In addition to the 1332 waiver proposal requirements above, what benefits may result if the State obtained a waiver for the implementation of a Minnesota-style reinsurance program?

### **RESPONSE:**

*An important element of a successful 1332 waiver proposal would be an infusion of federal dollars into a state's health insurance marketplace. In principle, the receipt of federal dollars should place downward pressure on rates. The creation of a reinsurance program under the 1332 waiver backed by significant federal funds could have a stabilizing effect on rates in the individual health insurance market. This would result in an improved quality of health among the population and increase the number of persons whose medical treatments are reimbursed by the insurance industry and feasibly reducing the amount of uncompensated care. In addition to the reinsurance program, the Department is open to other possible mechanisms to stabilize the marketplace and reduce premiums.*

- **Questions:** If Senate Bill No. 1878, as introduced, is enacted, what will be the cost to the department to prepare the waiver application? Would DOBI need to employ additional personnel or contract for actuarial, accounting, legal, and other professional services? What would be the annual cost to the department of administering the envisioned reinsurance program?

### **RESPONSE:**

*The Department is currently seeking bids for professional actuarial services to assist with the potential 1332 waiver application. Bids have yet to be received, so the cost is unknown at this time. The annual costs to the Department will depend on the final design of any legislation as enacted; however, the current bill proposes that the costs of administering the program will be borne by the reinsurance fund.*

- **Question:** What would be the cost of a reinsurance program as outlined in Senate Bill No. 1878 under reinsurance payment calculation parameters that the department would

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**be most likely to consider? What amount would have to be raised annually from insurance carriers?**

**RESPONSE:**

*As currently proposed in S-1878, the costs of administering the program will be borne by the reinsurance fund. According to the legislation, the reinsurance program would need to achieve between a 10% and 20% reduction in what the rates would be without a reinsurance plan. The Department will require actuarial analysis to determine the total costs for a reinsurance plan. The current version of S-1878 does not include any carrier assessments in the funding.*

- **Questions:** By what amount and percentage did New Jersey’s individual health insurance premiums increase from calendar year 2017 to calendar year 2018? Assuming an attachment point of \$50,000, a reinsurance cap of \$250,000, and a coinsurance rate of 50 percent, 60 percent, and 70 percent, how much money would need to be directed to a reinsurance fund in calendar year 2018 in order to reduce individual premiums by 10 percent and 15 percent, as compared to premiums if the plan were not adopted? Does the analysis differ when making projections for calendar year 2019?

**RESPONSE:**

*Below is a table showing the range in the IHCP rate increases for 2018 when compared to the 2017 IHCP rates by carrier.*

<b>Carrier</b>	<b>% change in 2018 rates</b>
AmeriHealth HMO, Inc.	9.1% to 53.3%
AmeriHealth Insurance Company of New Jersey	9.3% to 75.1%
Cigna HealthCare of New Jersey, Inc.	7.2% to 196.2%
Horizon Healthcare of New Jersey, Inc.	7.2% to 7.2%
Horizon Healthcare Services, Inc.	15.9% to 28.0%
Oscar Garden State Insurance Corporation	NA - new
Oxford Health Insurance, Inc.	49.2% to 51.5%

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

*The Department is currently seeking bids for the actuarial analyses necessary to determine the attachment point, reinsurance cap, coinsurance rate and overall fund size necessary to achieve various rate reduction levels.*

2c. The “Affordable Care Act” (ACA) established a minimum level of health care benefits, referred to as the Essential Health Benefits (EHB) package, that all qualified health plans (QHPs) offered nationwide must include. States are required to select a “benchmark plan” that offers all of

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these benefits as the standard for plans offered in the state. New Jersey's benchmark plan is the Horizon HMO Access HAS Compatible.

Furthermore, the ACA authorizes states to require a QHP to cover additional mandated benefits beyond those in the EHB, provided that the state defrays the costs of such mandated benefits. However, the regulations (45 CFR Parts 147, 155 and 156) provide that states may include, as part of their "benchmark plan," state benefit mandates that were enacted before December 31, 2011 without triggering cost defrayment obligations. In the last year, New Jersey enacted one law which mandates certain health care benefits: P.L.2017, c.28, which requires health insurance carriers to adhere to certain coverage requirements for treatment of substance use disorders. In reply to a FY 2018 OLS Discussion Point, the department responded that it was too early to gauge the cost impact of the law. A year earlier, the department had indicated in FY 2017 OLS Discussion Point responses that the other State laws which mandate certain health care benefits enacted since December 31, 2011 did not require the State to defray any costs as each law contained certain provisions that precluded the ACA requirement.

- **Question: What is the department's estimate for the costs for QHP to provide substance use disorder services pursuant to P.L.2017, c.28?**

### **RESPONSE:**

*The carriers have not yet submitted rates for policy year 2019 and those rates will - for the first time - incorporate the costs of P.L. 2017, c.28. The Department's preliminary expectation is that while the new law will likely result in significant costs to carriers (resulting in upward pressure on premiums), there will also be some offsetting savings because substance use treatment should reduce the development of more serious and costly health conditions.*

*While the ACA requires state governments to defray the costs associated with mandates enacted after December 31, 2011, defrayal is triggered only by a mandate to cover a service or supply that was not previously required. Defrayal is not triggered by newly enacted utilization management requirements, such as in P.L. 2017, c. 28. That law does not mandate coverage for the treatment of substance use disorder, as the coverage for services or supplies to treat substance use disorder were already covered before this law. Rather, P.L. 2017, c. 28 addresses how carriers can perform utilization management on those benefits by imposing restrictions with respect to the determination of medical necessity and the frequency and nature of required treatment authorizations, and thus does not implicate defrayal.*

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

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

In New Jersey, the individual market is administered through the Individual Health Care Program (IHCP), while the small group market is administered through the Small Employer Health Benefits Program (SEH).

- **Questions:** Please describe any changes to the rate review process that the department has made since its response to the FY 2018 OLS Discussion Points. Does the department expect to alter aspects of the rate review process before the end of calendar year 2018?

### **RESPONSE:**

*The Department does not foresee any changes to the rate review process. The rate review process is conducted by the Department's actuaries and actuarial consultants. This process involves reviewing the rates proposed by carriers, as well as the assumptions used to justify the carriers' change in rates. The primary focus of the Department in the rate review process is to verify that each filing is reasonable to enable projected compliance with applicable State and Federal medical loss ratio (MLR) requirements and that it complies with the ACA's single risk pool requirement.*

- **Questions:** Please describe any instance in calendar year 2017 or thus far in 2018 in which the department has disapproved of a rate. Please indicate the reason for the disapproval and any resolution, if applicable, that was achieved.

### **RESPONSE:**

*The Department works with the carriers to ensure the reasonableness of their assumptions and projections in meeting MLR and compliance with all single risk pool and rating requirements of the ACA. By law, rate filings in the individual and small employer markets are informational and not subject to prior approval; however, the Department uses its review process to ensure compliance with all applicable laws.*

- **Question:** Please provide the filed rate increase or decrease requests for health care plans available in the IHCP and SEH in calendar year 2017 and thus far in 2018.

### **RESPONSE:**

#### **2018 Changes in Rates -- IHC**

*Below is a table showing the range in the IHCP rate increases for 2018 when compared to the 2017 IHCP rates by carrier.*

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<b>Carrier</b>	<b>% change in 2018 rates</b>
AmeriHealth HMO, Inc.	9.1% to 53.3%
AmeriHealth Insurance Company of New Jersey	9.3% to 75.1%
Cigna HealthCare of New Jersey, Inc.	7.2% to 196.2%
Horizon Healthcare of New Jersey, Inc.	7.2% to 7.2%
Horizon Healthcare Services, Inc.	15.9% to 28.0%
Oscar Garden State Insurance Corporation	NA - new
Oxford Health Insurance, Inc.	49.2% to 51.5%

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

**– 2018 Changes in Rates – SEH**

Below is a table showing the range in the SEH rate increases for 2018 when compared to the 2017 SEH rates by carrier.

<b>Carrier</b>	<b>% change in 2018 rates</b>
AmeriHealth HMO, Inc.	9.1% to 53.3%
AmeriHealth Insurance Company of New Jersey	9.3% to 75.1%
Cigna HealthCare of New Jersey, Inc.	7.2% to 196.2%
Horizon Healthcare of New Jersey, Inc.	7.2% to 7.2%
Horizon Healthcare Services, Inc.	15.9% to 28.0%
Oscar Garden State Insurance Corporation	NA - new
Oxford Health Insurance, Inc.	49.2% to 51.5%

3. According to Department of Human Services Medicaid Communication No. 16-04, several insurance companies in the State are selling supplemental dental insurance policies to individuals receiving Medicaid Long Term Services and Supports in nursing homes and assisted living facilities. DOBI has granted the authority for these limited benefit dental policies.

When the supplemental dental insurance policy information is submitted to the Medicaid eligibility determining agency (EDA) directly from the insurance company, the EDA must verify with the Medicaid recipient, or the recipient’s authorized representative, that this policy has been purchased. The purchase of these policies by a Medicaid recipient is considered a “change in circumstances” and must be followed by a complete Medicaid eligibility redetermination before the change can occur to the individual’s Medicaid cost share.

When an EDA is completing a redetermination, it may realize that there may not be enough income to cover the cost of this new insurance premium. If there is not enough income to cover the cost of the supplemental policy, then the EDA will notify the Medicaid recipient, or the recipient’s authorized representative, that the Medicaid recipient may not be able to purchase the policy due to insufficient income. Under federal regulations, an individual’s income must first cover all personal, maintenance needs, and community spouse maintenance needs allowances before any additional health insurance premiums can be paid.

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- **Questions:** Under what authority and pursuant to what rationale and analysis has DOBI authorized these plans? How do the supplemental dental insurance policies differ from the dental benefits provided under Medicaid? How does DOBI monitor companies offering supplemental dental insurance policies to make sure the companies are not selling largely duplicative policies to individuals receiving Medicaid Long Term Services and Supports in nursing homes and assisted living facilities?

### **RESPONSE:**

*Currently, there are no carriers selling individual dental insurance policies to Medicaid recipients residing in nursing homes and assisted living facilities. The Department has approved a variety of individual dental policies filed pursuant to N.J.S.A. 17B:26-2. Those policies are compliant with State law. Of concern in the Medicaid Communication is not the existence of these policies, which can be of value to many New Jerseyans, but rather the sale of such policies to Medicaid recipients residing in nursing homes and assisted living facilities. That is of concern to both Medicaid and the Department because DMAHS has advised that the coverage is duplicative of the coverage already provided by Medicaid. The following will provide additional context to the issuance of the Medicaid Communication and the Department's efforts in this regard.*

*In 2016, the Division of Medical Assistance and Health Services in the Department of Human Services (DMAHS) advised the Department of Banking and Insurance (DOBI) of its concern that individual dental insurance was unnecessary when sold to Medicaid members residing in nursing homes and assisted living facilities because it duplicated benefits already provided by Medicaid. DOBI commenced an investigation, reviewed DMAHS assertions, and identified one carrier that had sold 7 individual policies to Medicaid recipients. As a result of the investigation, the carrier agreed to immediately cease sales and to withdraw the dental insurance policy and it is no longer available for sale in New Jersey. The producer also agreed to cease sales of individual dental insurance to Medicaid members resident in nursing homes and assisted living facilities.*

*The Department has responded to numerous requests from a particular dental provider network regarding this issue. The Department advised the dental provider network that the benefits provided in New Jersey Medicaid/NJ Family Care program are fulsome and thus individual dental insurance is likely duplicative coverage for persons covered by the program. The Department has not permitted a carrier to engage in a business plan to sell individual dental insurance to Medicaid recipients since advised by DMAHS of the duplicative nature of such coverage. The Department could take enforcement action – if necessary – against any carrier or producer that engages in such conduct.*

- **Questions:** Delineated by Medicaid recipients and individuals with commercial insurance, how many supplemental dental insurance policies were sold in New Jersey in FY 2016 and FY 2017, and what are the projected sales for FY 2018 and FY 2019? Do the data suggest that the companies have targeted individuals receiving Medicaid, especially those receiving Medicaid Long Term Services and Supports in nursing homes and assisted living facilities?

### **RESPONSE:**

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Based on information uncovered by DOBI during its investigation, seven individual dental policies were sold by the carrier to Medicaid recipients. To the Department's knowledge, no other carriers have sold individual dental insurance to Medicaid recipients resident located in nursing homes and assisted living facilities.

- **Question:** Please list the companies that were authorized to sell these policies in the State in FY 2016 and FY 2017, are authorized to do so in FY 2018, and are projected to do so in FY 2019.

### **RESPONSE:**

The carriers that have approved individual dental insurance forms and rates are listed below. As stated above, no carriers are currently permitted to limit sales of individual dental policies to only Medicaid recipients. The Department does not require reporting of the number of individual dental policies sold in New Jersey; however, carriers' report their premium volume in New Jersey in their annual financial statements.

Aetna Life Insurance Company  
American Family Life Assurance Company of Columbus  
American Progressive Life and Health Insurance Company of New York  
AmeriHealth Insurance Company of New Jersey  
Ameritas Life Insurance Corporation  
Cigna Health and Life Insurance Company  
Colonial Life & Accident Insurance Company  
Corvesta Life Insurance Company  
Delta Dental of New Jersey, Inc.  
Dental Services Organization, LLC  
Dentegra Insurance Company  
Dentsured Inc  
Dominion National Insurance Company  
Family Life Insurance Company  
Fidelity Security Life Insurance Company  
Golden Rule Insurance Company  
Horizon Healthcare Services, Inc.  
International Healthcare Services, Inc.  
Madison National Life Insurance Company  
Managed Dental Guard, Inc. (NJ)  
Metropolitan Life Insurance Company  
Mutual of Omaha Insurance Company  
Pennsylvania Life Insurance Company  
Renaissance Life & Health Insurance Company  
Security Life Insurance Company of America  
Standard Security Life Insurance Company of America  
The Guardian Life Insurance Company of America  
Time Insurance Company  
United Concordia Life and Health Insurance Company

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4. Executive Order No. 4 of 2018 directs all State entities that regularly interact with the public to undertake reasonable measures, to the extent permitted by law and budgetary constraints, to provide information to the public regarding the Affordable Care Act marketplace and ways to enroll.

- **Questions: What has been the department's response to Executive Order No. 4 of 2018? What related initiatives has the department already implemented and what related initiatives does it intend to implement in FY 2018 and FY 2019? What, if any, related expenditures has the department incurred to date? Will there be any additional expenses the department expects to incur to comply with the executive order in FY 2018 or FY 2019?**

### **Response:**

*A primary goal of the Murphy Administration is to ensure that every New Jerseyan has access to affordable health insurance. The Department is committed to working to achieve that goal by substantially increasing education and outreach efforts regarding enrollment in health coverage under the Affordable Care Act.*

*On February 8, 2018, the Department issued Bulletin No. 18-02 announcing a special enrollment period under the Affordable Care Act for individual health benefits plans for individuals who relocated to New Jersey after they were affected by the recent hurricanes in Puerto Rico and the U.S. Virgin Islands. The bulletin provided guidance to health carriers and other interested parties regarding this additional special enrollment period available to individuals impacted by the hurricanes who relocated to New Jersey. The Department also provided this information to the media, and to the public through the Governor's Commission on Puerto Rico Relief.*

*Under the leadership of Governor Murphy, and in accordance with Executive Order No. 4, the Department is currently developing a multi-faceted plan to provide education and access to affordable and quality health coverage for our residents. As a department that interacts with the public on a daily basis, on health insurance and various other issues that affect the lives of New Jersey families, the Department of Banking and Insurance has the ability and, in the interest of the health, safety and wellbeing of New Jersey residents, an obligation to serve a vital role in providing information, education and outreach to the public regarding enrollment in health coverage. The department expects to submit its report to the Governor by the May 31, 2018 deadline detailing the actions it has undertaken in furtherance of the executive order and to facilitate enrollment in the Affordable Care Act marketplace.*

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

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

- **Questions:** Is Horizon BCBSNJ required to obtain DOBI's approval to use the \$275 million in the manner the company intends to benefit policyholders? If so, DOBI approval is required under what statutory and regulatory provisions?

### RESPONSE:

*Horizon's proposed plan is subject to the Department's review regarding regulatory issues including, but not limited to: Horizon's ability as a health service corporation to dividend; the impact of the plan on Horizon's financial condition; and, analysis of the permissibility of the proposed return of funds to policyholders under applicable rebating and anti-inducement laws. See N.J.S.A. 17:48E-1 et seq., N.J.S.A. 17:23-24 and N.J.S.A. 17:27A-1 et seq., and N.J.S.A. 17B:30-13.*

- **Questions:** Has the department begun working with Horizon BCBSNJ to develop the parameters for the use of the \$275 million the company intends to disburse for the benefit of its policyholders? If so, what are they? What does Horizon BCBSNJ intend to do with the additional \$275 million it expects to realize from the federal tax reforms?

### RESPONSE:

*As stated above, this plan is currently under review at the Department.*

- **Questions:** Please identify other health insurance carriers with which DOBI has collaborated to distribute to policyholders tax refunds the carriers are projected to realize as a result of the federal tax law changes. Would the other health insurance carriers be required to consult with, or seek the approval of, DOBI to implement such initiatives?

### RESPONSE:

*Any discussions with other domestic carrier that have not made a public announcement would be confidential. The nature of any approvals would depend on the intended use of the refunds and the type of carrier. All reviews and approvals would be based on the same types of regulatory analyses being applied to the Horizon proposal.*

- **Question:** Has the department analyzed the impact of these federal refunds on the Medical Loss Ratios of all carriers' health insurance products?

### RESPONSE:

## Discussion Points (Cont'd)

*Medical Loss Ratios (MLRs) are state and federal laws that require carriers to spend a certain percentage of the premiums they collect in various markets (individual and small employer under State law) on the cost of providing care. The federal tax refunds do not increase the premiums collected or the health care spend in any given policy year.*

- **Questions:** Please comment on the impact of Horizon BCBSNJ's expected \$550 million federal tax refunds on its risk-based capital ratio. What is Horizon BCBSNJ's current risk-based capital ratio? Would the full \$550 million federal tax refund increase the ratio above 725 percent and trigger section 4 of P.L.2017, c.100 if Horizon BCBSNJ did not implement a plan to use \$275 million to benefit policyholders? What would be its projected risk-based capital ratio at the end of 2018 and 2019 if Horizon BCBSNJ did not implement a plan to use \$275 million of the anticipated federal tax refunds to benefit policyholders? What would be the carrier's projected risk-based capital ratio at the end of 2018 and 2019 if Horizon BCBSNJ did implement a plan to use the \$275 million to benefit policyholders?

### **RESPONSE:**

*A carrier's risk-based capital (RBC) ratio is confidential pursuant to N.J.A.C. 11:2-39.10(a). Therefore, the Department cannot discuss the impact of the tax wind-fall on Horizon's RBC ratio. The Department will perform the required analysis under the provisions of P.L. 2017, c. 100, specifically N.J.S.A. 17:48E-17.3, but it is noted that nothing contained therein makes such analysis of Horizon's RBC ratio public.*

6. The New Jersey Program for Independent Claims Payment Arbitration (PICPA) was established by the "Health Claims Authorization, Processing and Payment Act" (HCAPPA), P.L. 2005, c.352. PICPA is designed to provide an independent body to arbitrate health care claims disputes between a health insurance carrier and health care provider. DOBI contracts with an independent vendor, currently MAXIMUS, Inc., to perform the arbitration and related administrative functions.

PICPA arbitration covers disputed health insurance claim amounts in any situation in which there is a difference of at least \$1,000 between the amount that the carrier paid to the health care provider and the amount the provider contends the carrier should have paid. To qualify for PICPA arbitration, the carrier's internal claims payment appeal process must already have been exhausted.

- **Questions:** What is the percentage of instances in which health care providers prevail during PICPA arbitration by obtaining additional claim reimbursement amounts from the health insurance carrier? What are the most common treatments that result in PICPA arbitration? For the last three fiscal years, please provide: (1) the number of PICPA arbitration cases filed with MAXIMUS, Inc.; and (2) the average amount awarded as additional reimbursement to health care providers.

### **RESPONSE:**

*The number and percentage of cases in which providers prevailed in PICPA cases in FY15, FY16 and FY17 is shown below as well as the average award.*

Discussion Points (Cont'd)

	Fiscal Year 2015	Fiscal Year 2016	Fiscal Year 2017
# PICPA Filings Received	576	296	305
# PICPA Filings where Providers Prevailed	160	100	92
% PICPA Filings where Providers Prevailed	28%	34%	30%
Average PICPA Award	\$11,390	\$18,328	\$12,498

To determine the most common procedures involved in PICPA awards, all procedures for each case decided in the last three fiscal years were identified and CPT codes grouped. Where a main procedure was identified, the case was associated with procedure. The results are shown in the chart below. The most common categories addressed in PICPA decisions are spinal surgery and emergency room visits.

NJ DOBI Decisions, by Fiscal Year and Common Procedures	Fiscal Year									All
	2015			2016			2017			
	Disposition			Disposition			Disposition			
	Full/ Part Award	No Award	Withdraw/ Dismiss	Full/ Part Award	No Award	Withdraw/ Dismiss	Full/ Part Award	No Award	Withdraw/ Dismiss	
<i>Procedure</i>										
<b>Not Grouped</b>	51	15	186	34	15	100	39	11	151	602
<b>Anesthesia</b>	0	6	9	0	0	0	0	0	0	15
<b>Arthroscopic Surgery</b>	2	1	4	0	0	3	0	0	2	12
<b>Bone Graft</b>	0	0	0	0	0	0	2	0	0	2
<b>C-section</b>	2	0	3	2	0	1	2	1	0	11
<b>Cholecystectomy</b>	2	0	4	3	0	1	8	0	2	20
<b>Colonoscopy</b>	1	6	13	0	0	0	0	0	0	20
<b>Coronary bypass</b>	0	0	1	2	0	2	0	0	3	8
<b>Coronary stent</b>	3	2	3	0	0	0	5	0	5	18
<b>ER Visit</b>	15	1	7	12	0	3	5	1	7	51
<b>Facet Joint Injection</b>	2	1	2	1	3	2	0	0	2	13
<b>Fluoroscopy</b>	5	2	8	3	3	4	3	1	1	30
<b>Laminotomy</b>	0	0	5	4	1	1	0	0	1	12
<b>Nasal Surgery</b>	9	0	4	0	0	1	0	0	0	14
<b>Nursing Services</b>	0	0	0	0	8	0	0	0	0	8
<b>Pain Management</b>	11	18	18	1	10	7	1	1	1	68
<b>Peripheral vascular bypass</b>	1	0	4	1	1	3	2	0	1	13
<b>Spinal Device Insertion</b>	8	0	3	1	0	0	0	0	0	12
<b>Spinal Surgery</b>	30	4	53	26	9	11	24	4	16	177
<b>Stereotactic Computer Cranial proc</b>	4	4	6	0	0	0	0	0	0	14
<b>Thoracoscopy</b>	6	0	4	10	4	3	0	0	0	27
<b>Tympanostomy</b>	2	1	1	0	0	0	0	0	1	5

## Discussion Points (Cont'd)

NJ DOBI Decisions, by Fiscal Year and Common Procedures	Fiscal Year									All
	2015 Disposition			2016 Disposition			2017 Disposition			
	Full/ Part Award	No Award	Withdraw/ Dismiss	Full/ Part Award	No Award	Withdraw/ Dismiss	Full/ Part Award	No Award	Withdraw/ Dismiss	
Upper GI Endoscopy	5	3	10	0	0	0	0	0	1	19
Vaginal Delivery	1	1	3	0	0	0	1	0	0	6
All	160	65	351	100	54	142	92	19	194	1,177

7. In its January 1, 2018 report to Governor-elect Phil Murphy and Lieutenant Governor-elect Sheila Oliver, the Stronger and Fairer Economy Transition Advisory Committee recommended that a feasibility study be conducted on a proposed public bank in New Jersey “that could potentially offer loans to small businesses, local infrastructure projects, and college students. The bank would use state deposits to finance local investments and emphasize the importance of making New Jersey’s [sic] money work for its residents. The potential costs and benefits should be assessed in detail and compared to other strategies for improving local lending and streamlining our state’s incentive programs.”

Senate Bill No. 885 would create the State Bank of New Jersey. The bill would authorize the creation of a 13-member board of directors to oversee the bank. DOBI would perform a regulatory function vis-à-vis the State bank in that the department would have to examine the State bank in the same manner as a State-chartered financial institution and may conduct any additional investigation of the bank which may be necessary to ensure its proper operation.

- **Questions:** Please describe the activities the department has undertaken with regard to the possible creation of a State bank, if any. Has the department been asked to contribute, or has it already contributed, its expertise to a feasibility study of a State bank? If so, what entity leads the feasibility study, what other entities are involved, and what is the deadline for the completion of the study? If the department has not yet performed any work with regard to the creation of a State bank, does the department anticipate that a feasibility study will be conducted in FY 2018 and FY 2019, and that the department will have to assign department resources to the effort?

*As Acting Commissioner, I have directed my staff to begin to research the North Dakota state bank, as well as other previous and currently proposed state banks across the country. The Department has not been asked to participate in a feasibility study, however, it will be prepared to fulfill and implement any statutorily authorized role, should the legislature create a state bank.*

8. Surplus lines insurance is insurance coverage that is not available from insurers licensed in the State and which must be purchased from a non-admitted carrier. Surplus lines insurers provide the marketplace with coverage for catastrophic-prone risks and risks that are declined by the standard underwriting and rating process of admitted insurance carriers.

## Discussion Points (Cont'd)

The methods for the regulation and collection of surplus lines insurance premium taxes were revised by P.L.2011, c.119 to comply with the federal “Nonadmitted and Reinsurance Reform Act of 2010” (NRRRA), which was passed by Congress as part of the “Dodd-Frank Wall Street Reform and Consumer Protection Act.” Prior to the enactment of NRRRA, states shared surplus lines premium tax revenue based on the location of the insured’s various risks.

Currently, NRRRA provides that states may enter into multi-state compacts or agreements with one or more other states. If a state does not join such an agreement, it may collect 100 percent of the taxes on surplus lines premiums when the insured is located in its state, otherwise known as a “home-state” insured. This includes the continued ability to collect all premium taxes associated with “home-state” insureds for their risks located in other states. Conversely, a state that does not participate in a compact or agreement is precluded from collecting surplus lines premium taxes attributable to risks situated in its state that belong to the home-state insureds of other jurisdictions.

The Commissioner of Banking and Insurance was authorized pursuant to P.L.2011, c.119 to enter into compacts or agreements with other states with respect to the collection of surplus lines premium taxes to maximize State tax revenue. In response to FY 2016, 2017, and 2018 OLS Discussion Points, the department stated that it was not in negotiations with any other states regarding participation in an agreement or compact to collect surplus lines premium taxes and that the department had determined it was not advantageous for both consumer protection reasons, and the State, to contemplate negotiations to participate in such an agreement or compact. In the absence of an interstate compact regarding future surplus lines tax collections, all surplus premiums for “home-state” insureds are assessed the five percent surplus lines premium tax, even if the premiums are on risks located out of the State.

According to DOBI, the State collected \$74.4 million in revenue from the surplus lines premium tax in 2016, of which approximately 10 percent was attributable to policies that include out-of-State exposures.

- **Questions: Please provide the total surplus lines premium tax amount charged and collected for FY 2017 and estimated to be charged and collected for FY 2018 and FY 2019. Please provide the number of payers of the tax in FY 2017 and the estimated number of payers in FY 2018 and FY 2019. How is this revenue utilized?**

### **RESPONSE:**

2016: \$74.4M (750 s/l producer and 16 IPC filers)

2017: \$78.6M (750 s/l producer and 13 IPC filers)

2018: \$80.0M est.

2019: \$82.0M est.

*Since the revenues are relatively stable, the Department anticipates that a similar number of tax payers and revenue will be generated going forward. The surplus lines premium tax is deposited in the state’s general fund.*

## Discussion Points (Cont'd)

- **Questions:** How much of the revenue in FY 2017 is derived from policies that include out-of-State exposures? Please indicate the number of payers of the tax in FY 2017 that have policies that include out-of-State exposures.

### **RESPONSE:**

Ten percent of the surplus lines tax is attributable to policies that include out-of-State exposures. However, the current reporting system cannot determine the number of payers nor the location of the exposures insured thereunder.

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

### **RESPONSE:**

The surplus lines tax for neighboring states is:

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

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

- **Questions:** Does the department continue to consider it not to be advantageous for the State to participate in a multi-State compact? If so, please explain the basis for that determination.

### **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. The Department determined it is advantageous for New Jersey to adopt the "home state" approach with respect to the revenue it would generate for the State. Further, the Department is not aware of any successfully implemented multi-state compacts.

## Discussion Points (Cont'd)

9. On March 1, 2017, the Commonwealth Court of Pennsylvania placed Penn Treaty Network America Insurance Company and its subsidiary, American Network Insurance Company (ANIC), in liquidation. The companies provided long-term care insurance to policyholders in all 50 states and the District of Columbia.

As of March 1, 2017, the life and health insurance guaranty associations in the states where Penn Treaty and American Network were licensed to do business have assumed responsibility for their policies. This includes continuing coverage and paying eligible claims, subject to guaranty association coverage limits and the terms and conditions of coverage.

Under the “New Jersey Life and Health Insurance Guaranty Association Act,” P.L.1991, c.208 (N.J.S.A.17B:32A-1 et seq.), the New Jersey Life and Health Insurance Guaranty Association acts as an insurance backstop, up to established statutory limits, whenever an insurer issuing certain life and health insurance policies or annuities becomes insolvent. There is no limit of protection provided by the guaranty association for health insurance claims. The guaranty association assesses member insurers to carry out its administrative functions and its duties to pay out on claims of insolvent member insurers. The guaranty association is a private entity; however, it may work in cooperation with the department in fulfilling its role of protecting New Jersey policyholders of insolvent life and health insurance companies.

The department replied to an FY 2018 OLS Discussion Point that the guaranty association was seeking a rate increase in excess of 100 percent for the majority of ANIC policyholders and that the department was currently reviewing the official rate increase filing.

The long-term-care insurance industry in general has faced significant financial challenges in recent years that are primarily attributable to the underpricing of legacy long-term-care insurance policies. Interest rates have been lower than assumed at the time of policy issuance while increases in longevity and health care cost have exceeded projections at the time of policy issuance. As a result, a number of long-term-care insurers have had to strengthen their balance sheets and have ceased to write new policies.

- **Questions: Please provide the department’s analysis of the New Jersey Life and Health Insurance Guaranty Association’s proposed rate increase for ANIC policyholders. Has the department approved the proposed rate increase?**

### **RESPONSE:**

*The March 1, 2017 Order of Liquidation issued by the Commonwealth Court of Pennsylvania declared ANIC and its affiliated company Penn Treaty insolvent. The Pennsylvania court’s decision made NJLHIGA responsible for paying the claims of New Jersey residents with ANIC LTC policies. Like many carriers in the LTC business, ANIC/Penn Treaty charged premiums that were far too low to cover all the claims of their policyholders – but ANIC/Penn Treaty had no other prominent lines of insurance to offset this mispricing that was caused by mistaken assumptions regarding things like policyholder life spans, market circumstances like low interest rates, policyholder lapse rates, and policyholder morbidity – including an increase in the number of assisted living facilities to provide care less intensive than nursing homes. The LTC claims of ANIC and Penn Treaty combined are expected to total approximately \$4.5 billion nationwide, and New Jersey is just one of over forty states affected.*

## Discussion Points (Cont'd)

The NJLHIGA has estimated that the costs in New Jersey alone to cover ANIC's claims will be approximately \$211 million.

The claims assumed by NJLHIGA are funded by insurers writing the same lines of business as the liquidating company – in the case of ANIC/Penn Treaty, it is all other NJ health insurers and LTC writers. Those health and LTC insurers in return receive a state tax credit for a portion of the payments to NJLHIGA, and can pass the remaining costs of insolvencies through to their policyholders in increased rates.

With this backdrop, NJLHIGA (and all guaranty associations nationwide as coordinated by the National Organization of Life and Health Guaranty Associations) filed for a package of rate increases with the Department with various policyholder options.

In order to balance the impact of the ANIC insolvency between the ANIC policyholders that were undercharged and the State's taxpayers and other insurance consumers and after substantial analysis and discussions with NJLHIGA, the Department approved a modified package of rate increases for New Jersey's ANIC policies. The approved rate increases did not recoup past losses and did not attempt to cover all of the costs to be borne by NJLHIGA for the ANIC insolvency. The increases were only sufficient to achieve premium prices commensurate with those that would be charged for this coverage today. The rate increases ranged from a low of 0% to a high of 410%, and they varied on the age of the policyholder at issuance of the LTC policy and whether the policy contained annual inflation increases of 5% in the amount of benefits. The Department's approval of the ANIC rate increases was contingent upon the simultaneous offer to affected policyholders of options that could decrease or negate the impact of any approved rate increase. Specifically, all policyholders received a written notice of the rate increase and new premium for their specific ANIC policy that included an offer to choose reduced benefits in exchange for a lesser or no premium increase, or to surrender their long term care insurance in exchange for a cash payment that was specified in the offer.

The Department also worked with ANIC and the NJLHIGA to ensure clear policyholder communications regarding the options presented. In addition, the Department also engaged in direct consumer outreach

- **Questions:** Please assess the stability of companies that have provided long-term-care insurance to policyholders in New Jersey. Is the department concerned that additional long-term-care insurance providers will become insolvent in the next five years? Are the finances of the New Jersey Life and Health Insurance Guaranty Association adequately robust to assume the long-term-care insurance policies of additional providers in the event of provider insolvency? For each of the last ten years, please provide the number of insurance companies that were authorized to sell long-term-care insurance policies in New Jersey and the number of long-term-care insurance policies issued.

### **RESPONSE:**

As widely discussed in the press, as well as in the insurance industry, and by insurance regulators nationwide, LTC insurance has since its inception suffered from mispricing due to a perfect storm of mistaken assumptions – such as policyholder longevity, sustained low interest rates in the capital

## Discussion Points (Cont'd)

*markets, policyholder lapse rates, and policyholder morbidity. Many larger insurers no longer sell traditional LTC insurance because the original policies would be unaffordable to consumers if properly priced by the insurers.*

*Also, many state insurance commissioners are reluctant to, and/or constrained from, granting large rate increases for older LTC books of business. For example, under New Jersey law (N.J.S.A. 17B:27E-11), LTC rates must demonstrate that the benefits are reasonable in relation to the premium charged in addition to not being excessive, inadequate or unfairly discriminatory. Thus, many insurers who sold LTC will likely incur reduced profits - and even some losses - on their LTC blocks of business. For larger insurers with diversified business lines, these losses are likely absorbable; for smaller or mono-line LTC insurers, the impact can have solvency impacts similar to ANIC/Penn Treaty. The Department is active and participates on work streams at the National Association of Insurance Commissioners (NAIC) to monitor all troubled companies – regardless of the type of insurance policy - that transact business in this State.*

*The Department does not publicly discuss the financial condition of specific insurers, absent when it institutes formal insolvency proceedings. To do so could move markets and create an unlevel regulatory environment.*

*There are 54 insurers that have submitted and received approval or acknowledgement of form, rate, or advertising for long-term care policies from 2007 through 2017. However, this does not mean that 54 insurers are currently writing LTC business because it is likely that the carriers have discontinued many of these approved products or the products have been discontinued for new sales. The Department does not require reporting of the number of individual LTC policies sold in New Jersey; however, carriers report their premium volume in New Jersey in their annual financial statements.*

10a. The National Association of Insurance Commissioners recently reported that New Jersey drivers paid on average \$1,266 for automobile insurance in 2015, the last year for which figures are available, marking the sixth straight year that New Jersey has topped the list of all 50 states and the District of Columbia. Various efforts have been made to increase the availability and affordability of automobile insurance, including the “Fair Automobile Insurance Reform Act of 1990,” P.L.1990, c.8 (N.J.S.A.17:33B-1 et al.); the “Automobile Insurance Cost Reduction Act,” P.L.1998, c.21 (N.J.S.A.39:6A-1.1 et al.); P.L.2003, c.89 (N.J.S.A.17:30A-2.1 et al); and, according to the department’s answer to an OLS FY 2017 Discussion Point, regulations adopted by the department that were designed to control the rising cost of Personal Injury Protection (PIP).

These efforts have been successful to varying degrees in containing costs. However, some requirements established pursuant to these reforms, such as “take-all-comers,” which required all private-passenger auto insurers to provide coverage to all eligible persons, have expired, while others have been amended since enactment, such as medical fee schedules for the reimbursement of health care providers under the medical expense benefit portion of the PIP coverage.

The department reported in its response to an OLS FY 2017 Discussion Point that regulations adopted on November 15, 2012 would continue to have at least a moderate impact on controlling PIP costs through calendar years 2016 and 2017.

**Discussion Points (Cont'd)**

- Questions:** Please provide the number of insurers offering automobile insurance in the State in 2016, 2017, and thus far in 2018. Please provide the rate increases filed by these companies in 2016, 2017, and thus far in 2018. Please comment on the reasons stated for these rates increases and provide an estimate for automobile insurance rates for 2019 in New Jersey. Since their adoption in 2012, what has been the impact of the regulations on controlling the cost of PIP?

**RESPONSE:**

Year	Number of Insurers
2018	78
2017	78
2016	80

Please see Attachment A for the rate increases filed by individual companies from 2016 through 2018. The overall average PPA rate increases for CY 2015, 2016, and 2017 were +3.7%, +4.7%, and +3.7%, respectively. We expect the average increases for CY 2018 and 2019 to again be in the range of 3%-5% annually. Factors that have most recently exerted upward pressure on the cost of auto insurance include lower gasoline prices – when more people drive there are statistically more accidents, distracted driving and increased accidents, and the costs of modern technology found in many newer vehicles – which is costly to replace/repair and is driving up the average vehicle cost overall.

The size of the residual market continues to decline. As of December 31, 2017, there were 12,746 PAIP exposures, which is 0.2% of the market. This is down from 48,684 PAIP exposures in 2011, which was 0.9% of the market.

Effective November 15, 2012, the Department adopted regulations designed to contain the rising cost of PIP. We believe these regulations worked as intended. Data suggests we achieved downward pressure on PIP costs for a number of years and the indicated rate need after adoption of the new fee schedules and rules. However, billing practices and medical utilization change over time in response to adjustments to the schedules, and the Department’s statutory obligation to make inflation adjustments to the PIP fee schedules. The Department has recently embarked on this process. Thus, future conditions may vary. The Department continues to monitor PIP rate indications and company experience to assist in evaluating the impact of the schedules.

10b. Over time, the Legislature has expanded the options available for automobile insurance coverage by establishing the “standard,” “basic,” and “special” coverage options:

- Standard coverage – The New Jersey no-fault law that required drivers to maintain certain levels of insurance coverage was the basis for the standard automobile policy, which provides certain benefits and gives insureds the option to purchase additional coverages. It is the most popular type of policy in New Jersey: according to data provided by the department to the OLS in response to an FY 2017 Discussion Point, vehicles insured by standard policies represented approximately 98 percent of vehicles insured in the State in 2015.
- Basic coverage – This coverage provides more limited benefits than the standard policy, and is typically a more affordable option. The basic policy was introduced as part of the “Automobile Insurance Cost Reduction Act” of 1998, as a way to get more drivers, who might

**Discussion Points (Cont'd)**

otherwise drive without insurance, to maintain automobile insurance. According to data provided by the department, vehicles insured by basic policies represented just over 1 percent of insured vehicles in the State in 2015.

- Special coverage – This coverage, as explained in more detail below, offers very limited benefits, is less costly than standard or basic coverage, and is only available to certain low-income drivers eligible and enrolled in the federal Medicaid program. According to DOBI, there were 45,462 vehicles in New Jersey insured by a special policy in 2015, which represented less than 1 percent of insured vehicles in the State.

The least-expensive special policy option was introduced to encourage more drivers to maintain insurance coverage and thereby address an ongoing situation in the State in which many drivers violate the automobile insurance mandate and drive without coverage, presumably due to the high cost of insurance coverage. In other words, the special policy provided a more affordable opportunity to become “street legal.” One of the policy goals was to help provide low-income individuals with transportation to employment, with the hope that if these individuals became employed, they would improve their economic situation generally and also possibly purchase better automobile insurance coverage going forward.

Motorists driving under a special policy do not have liability insurance coverage to compensate third parties suffering property damage as a result of an accident with a special policy motorist. These motorists are nevertheless considered to be insured for the purposes of the mandatory insurance requirement for automobiles registered in the State. However, they are considered uninsured motorists for purposes of determining whether an insured motorist with whom they are involved in an accident may recover damages via uninsured motorist (UM) coverage. Accordingly, motorists who are insured under a standard automobile policy and who are involved in an accident with a special policy driver who is at-fault may recover from the UM part of their own policy, if they purchased UM coverage. Only standard coverage includes UM coverage.

- **Questions:** What was the total number of vehicles insured with a standard automobile insurance policy, a basic automobile insurance policy, and a special automobile insurance policy in 2016, 2017, and thus far in 2018? How many complaints did the department receive regarding special automobile insurance policies in 2016, 2017, and thus far in 2018? Please specify, to the extent possible the reasons behind these complaints.

**RESPONSE:**

See below. The amount is for year end.

<b>Policy Type</b>	<b>Standard Exposures</b>	<b>Basic Exposures</b>	<b>SAIP Exposures</b>
<b>03/31/18</b>			53,332
<b>12/31/17</b>	5,617,501	56,485	53,319
<b>12/31/16</b>	5,559,002	53,338	51,191

## Discussion Points (Cont'd)

*The Department received 12 complaints regarding the Special Automobile Insurance Policy (SAIP) during 2016, 7 complaints in 2017, and no complaints so far in 2018. Of the 19 total complaints, eleven related to claim handling; 4 related to underwriting; 2 related to customer service; and 2 related to marketing and sales. Of these 19, only 2 complaints were substantiated.*

10c. Pursuant to section 10 of P.L.1988, c.119 (N.J.S.A.39:6a-4.6), the Commissioner of Banking and Insurance 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 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 January 4, 2013, the department revised the regulatory framework for the provision and payment of PIP benefits. The changes, among other things, amended the alternate dispute resolution process and expanded the PIP medical fee schedules. These changes were 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 schedule is intended to standardize the cost of procedures for both providers and insurers. Standardization leads to certainty in the marketplace and less administration and lower costs incurred by both parties in establishing payment for a service. In response to FY 2017 OLS Discussion Points, the department commented that it would continue to monitor PIP rate indications and company experience to assist in evaluating the impact of the 2013 fee schedules.

- **Questions:** What has been the impact of the 2013 PIP fee schedules on the cost of private passenger automobile insurance to consumers in New Jersey since their implementation in 2013? Please provide specific information on the continuing effects of the 2013 changes to the alternate dispute resolution process. Have the changes 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:**

*Data suggests that the 2013 PIP fee schedule achieved the indicated rate need, along with downward pressure on PIP costs, which, absent other developments, should generally put downward pressure on auto rates. However, billing practices and medical utilization change over time in response to adjustments to the schedules, and the Department’s statutory obligation to make inflation adjustments to the PIP fee schedules. The Department has recently embarked on this process. Thus, future conditions may vary. The Department continues to monitor PIP rate indications and company experience to assist in evaluating the impact of the schedules. As to the changes to the alternative dispute process, the ability to have on-the-papers arbitrations for fee disputes of \$1,000 or less has increased efficiency and exerted downward pressure on the costs of arbitration.*

- **Questions:** 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

## Discussion Points (Cont'd)

**the UCR fees due to the inclusion of more procedures on the fee schedule? Does the department anticipate changing any aspect of its process in the next year?**

### **RESPONSE:**

*The addition of new current procedural terminology (CPT) codes on the fee schedule tends to constrain PIP costs. CPT codes are updated annually, however, as medical procedures are reevaluated, combined, and new procedures gain acceptance, the fee schedule may lag a bit behind. Moreover, billing at times has been seen to migrate from CPT codes on the fee schedules to unlisted CPT codes, which may be done to maximize reimbursement through payment of UCR. Because of this, there will be a continual need to update the fee schedules and the CPT codes contained therein.*

11. The Office of the Insurance Claims Ombudsman (N.J.S.A.17:29E-2 et seq.) in the department is charged with investigating insurance consumer complaints regarding policies of life, health, auto, and other property and casualty insurance, except for claims for personal injury protection (PIP) coverage under automobile insurance. PIP claims are handled separately under an arbitration system (N.J.S.A.39:6A-5.1 and N.J.S.A.39:6A-5.2).

Regulations (N.J.A.C.11:25-1.1 et seq.) provide that the ombudsman may conduct a review of any disputed insurance claim settlements, if certain circumstances are met, and that all complaints must be entered into a data tracking system. The ombudsman may hold hearings for disputes between all insurers and consumers. Life, property and casualty insurers are required by law (N.J.S.A.17:29E-9) to establish an internal appeals system for consumers, which must include notification to claimants that they may contact the ombudsman if they are dissatisfied by the internal appeals process.

The ombudsman is required to report to the Governor and the Legislature on or before September 30 of each year, summarizing the office's activities for the preceding year, documenting any significant industry-wide problems regarding claims settlement practices in any line of insurance, and setting forth any recommendations for statutory or regulatory change which will further the State's capacity to resolve claims disputes (N.J.S.A.17:29E-15). However, the last report received by the Legislature was the 1999-2000 annual report. Furthermore, in response to an FY 2015 OLS Discussion Point, the department indicated that the function and duties of the ombudsman were absorbed by the Consumer Protection Services and Solvency Regulation program.

- **Question: How many complaints were filed with the Consumer Protection Services and Solvency Regulation Program in 2016, 2017, and thus far in 2018? Please categorize by line of insurance.**

**Discussion Points (Cont'd)**

**RESPONSE:**

	2015	2016	2017	2018*
Total	6651	7094	6740	1481
Accident & Health	3210	3257	2945	441
Auto	1524	1715	1817	305
Fire, Allied Lines & CMP	169	155	138	25
Homeowners	966	869	833	143
Liability	51	51	73	10
Life & Annuity	433	549	501	87
Miscellaneous	295	493	413	58
Unknown**	3	5	20	412

\*2018 is for 1/1/18 to 4/2/18

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

- **Question: Has the department identified any significant industry-wide problems regarding claims settlement practices in any line of insurance that require statutory or regulatory attention to further the State's capacity to resolve claims disputes?**

**RESPONSE:**

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