STATE HEALTH BENEFITS PROGRAM (SHBP)
PLAN DESIGN COMMITTEE
August 11, 2022 at 3 pm
AGENDA

Microsoft Teams meeting

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Sunshine Act Statement

Adequate notice of this meeting has been provided through the annual notice of the schedule of regular meetings of the Commission filed with and prominently posted in the offices of the Secretary of State. The 2022 annual meeting schedule was mailed to the Secretary of State on December 10, 2021, Star Ledger and the Trenton Times on December 15, 2021. Updates regarding this special TEAMS meeting were sent to the Star Ledger, the Trenton Times, The Secretary of State and posted to the Divisions Website on August 6, 2022.

RESOLUTION TO GO INTO EXECUTIVE SESSION TO REQUEST/RECEIVE ATTORNEY-CLIENT ADVICE FROM THE DEPUTY ATTORNEY GENERAL

"In accordance with the provisions of the Open Public Meetings Act, N.J.S.A. 10:4-13, be it resolved that the SHBP Plan Design Committee go into closed (executive) session to discuss matters falling within the attorney client privilege, and/or matters in which litigation is pending or anticipated, pursuant to N.J.S.A. 10:4-12(7).

The minutes of such meeting shall remain confidential until after such time as the Committee determines that the need of confidentiality no longer exists and the matters discussed can be disclosed and the Committee waives the attorney-client privilege."

1. PLEDGE OF ALLEGIANCE

2. ROLL CALL

3. MEETING MINUTES

4. DISCUSSION ONLY: CONTINUING RESOLUTIONS
    - RESOLUTION 2022-1 Formulary Management and Out of Network Physical Therapy
    - RESOLUTION 2022-2 Mail Order Incentive and $0 Copay for Generic Mail Order Prescription Drugs
    - RESOLUTION 2022-3 Generic Substitution Preference
    - RESOLUTION 2022-4 Copay Reduction for Retiree Mail Order Preferred Brand Prescription Drugs
    - RESOLUTION 2022-5 Tiered Network Plan Financial Incentive Pilot Program

5. RATE RENEWAL DISCUSSION

6. ADJOURNMENT

Reform #	Plan Design Change	Explanation	Members Impacted	Comments	State Actives		State Pre-65 Retirees		Local Actives		Local Pre-65 Retirees		Total
					$ in millions Plan Year	% Impact	$ in millions Plan Year	% Impact	$ in millions Plan Year	% Impact	$ in millions Plan Year	% Impact	% Impact
Health Benefits (savings for presented reforms may not be additive and will have to be re-evaluated once decisions are made)													
Range of Potential Savings:													
$ = $10 million													
Short Term Savings													
Cost-share changes													
1S	Increase Active Rx Copays to Retiree Levels	An increase in Active Rx Copays to Retiree levels could impact generic and brand drug utilization, which may result in a positive impact to total health care costs. The increase of copays could impact utilization by encouraging change in member behavior with more Actives seeking generic medication rather than brand where available.	State and local government actives and pre-65 retirees. No impact to high-deductible plans or the 2035 PPO plans.	Current active copay levels of $3 to $15 have remained unchanged since the NJ Direct 10/15 plans were created in 2007.	$5.3	0.30%			$3.7	0.30%			**$9.0**
2S	Increase Specialist/primary care physician (PCP) Copay Differential $20	Copays for primary care physicians (PCP) and specialists are both set at $15. It is anticipated that an increase in the Specialist copay would impact Specialist utilization long-term, while encouraging members to engage with their existing primary care physician (PCP) to manage chronic conditions, which may be better suited for medical management in the primary care setting. It is common to see a copay differential between PCP and Specialist services for both public and private health plans. No change is assumed to the current PCP copay of $15. Based on utilization statistics provided by Horizon, 2021 State Actives specialist visits have increased 8.0% compared to 2019 and 20.9% compared to 2020. 2021 Local Government Active specialist visits have increased 5.7% compared to 2019 and 16.3% compared to 2020. National benchmarking data gathered suggests average 2022 PCP copays are $27 while average 2022 Specialist copays are $45.	State and local government actives and pre-65 retirees	Current active copay levels of $10 (NJD10) and $15 (NJD15) have remained unchanged since the NJ Direct 10/15 plans were created in 2007. Copays for the NJDirect/Unity plans were also kept at $15.	$19.4	1.0%	$4.2	1.0%	$9.0	0.7%	$2.4	0.5%	**$35.0**
3S	Increase Urgent Care copays $50 higher than Primary Care copays	An increase in Urgent Care copay could directly impact Urgent Care utilization long-term, while encouraging members to engage with their existing PCP. It is common to see a copay differential between PCP and Urgent Care services.	State and local government actives and pre-65 retirees	Current urgent care copays for most members range between $10-$15	$6.2	0.30%	$1.4	0.30%	$4.2	0.30%	$1.4	0.30%	**$13.2**
4S	Increase in-network (INN)/out-of-network (OON) deductibles for each plan $200 (applicable for all services)	Increasing deductibles may encourage employees to better manage how and where they receive medical care. A majority of public employers require deductibles on all plan options. Currently, a majority of Members do not have a significant in-network (INN) or out-of-pocket (OON) deductible level. The current deductibles may encourage members to over utilize the healthcare system ($100 in-network deductible only applies to hires after 2019); a higher deductible for members could encourage member behavior when deciding site of care for certain non-emergent services.	State and local government actives and pre-65 retirees	No in-network deductibles are in place for most employees hired prior to 2019; Most State actives: out-of-network deductibles $400 single/ $1,000 for family coverage; local gov most pay $100 single/$250 family	$25.2	1.30%	$3.7	0.90%	$16.7	1.20%	$3.6	0.80%	**$49.2**
Out-of-Network Changes													
5a	Update Out-of-Network (OON) reimbursement to 175% of CMS (195% Mental Health/Substance Use) for NJ Direct 10/15 (non-negotiated plans)	If SHBP based out-of-network reimbursements at a percentage of CMS reimbursements instead of using the Fair Health Index, there is an expectation this would yield savings both through limiting the allowed amount the State is willing to pay for these procedures and having a long-term effect by steering participants towards In-network (INN) providers which could reduce costs further due to competitive negotiated rates. A change to the out-of-network reimbursement is at its core meant to improve provider accountability, pricing transparency, and more tightly manage plan cost over a longer period-of-time. This change would not impact network access for members as the change in strategy is tied to the financial reimbursement the State is willing to pay for certain services. Reducing the out-of-network (OON) reimbursement may result in a higher percentage of members receiving bills from providers for the additional cost of services, also known as balance billing if they choose to visit an OON provider.	State and local government actives and pre-65 retirees	Impacts NJDirect 10/15 plans. NJ Direct/CWA Unity plans already cap reimbursements at the proposed levels. Most local government members are enrolled in the NJD 10/15 plans.	$13.4	0.70%	$5.5	1.30%	$40.0	3.00%	$11.7	2.50%	**$70.6**

Reform #	Plan Design Change	Explanation	Members Impacted	Comments	State Actives		State Pre-65 Retirees		Local Actives		Local Pre-65 Retirees		Total
					$ in millions Plan Year	% Impact	$ in millions Plan Year	% Impact	$ in millions Plan Year	% Impact	$ in millions Plan Year	% Impact	% Impact
5b	Update Out-of-Network (OON) reimbursement to 200% of CMS for NJ Direct 10/15 (non-negotiated plans)	If SHBP based out-of-network reimbursements at a percentage of CMS reimbursements instead of using the Fair Health Index, there is an expectation this would yield savings both through limiting the allowed amount the State is willing to pay for these procedures and having a long-term effect by steering participants towards In-network (INN) providers which could reduce costs further due to competitive negotiated rates. A change to the out-of-network reimbursement is at its core meant to improve provider accountability, pricing transparency, and more tightly manage plan cost over a longer period-of-time. This change would not impact network access for members as the change in strategy is tied to the financial reimbursement the State is willing to pay for certain services. Reducing the out-of-network (OON) reimbursement may result in a higher percentage of members receiving bills from providers for the additional cost of services, also known as balance billing if they choose to visit an OON provider.	State and local government actives and pre-65 retirees	Impacts NJDirect 10/15 plans. NJ Direct/CWA Unity plans cap OON at 175% of CMS (195% for mental health/substance use). Most local government members are enrolled in the NJD 10/15 plans.	$11.3	0.60%	$4.7	1.10%	$34.6	2.60%	$9.9	2.10%	**$60.5**
Long Term Changes													
1L	Referenced Based Pricing and bundling of services	Set pricing for specific procedures and services can be pursued with providers and facilities with high-quality performance standards (e.g. centers of excellence). Preliminary discussions from a joint SHBP/SEHBP PDC sub-committee identified colonoscopies, gastric sleeve/bypass, and muscular/skeletal services as potential areas of focus. The DPB and the PDC will need to develop performance criteria to ensure member care is not compromised. Direct contracting with providers and facilities that meet specified criteria (e.g. low readmission rates or complications) may need to be pursued.	State and local government actives and pre-65 retirees		$		$		$		$		**TBD**
2L	Spousal Surcharge $50 per month	Add a spousal premium surcharge (for these purposes, $50 per month), which is a monthly charge in addition to regular medical coverage contribution/premium for a spouse. The spousal premium surcharge encourages those participants who are eligible for other group coverage to take advantage of their employer sponsored plan, and it also allows the SHBP to share healthcare costs with other employers. Since SHBP medical plans are self-insured and pay a portion of the cost of the member's medical coverage and actual claims, if the spouse moves to her/his employer's plan and utilizes that benefit instead it saves the SHBP on future plan costs. If the spouse decides to elect the SHBP plan coverage rather than her/his employer plan, plan costs will remain the same, but the employer subsidy will be lower.	Active and Early Retirees	No surcharge is currently in place. Savings assume 5% of spouses drop coverage. Remaining spouses would pay surcharge that could be used to reduce premium rates.	$9.6	0.50%	$1.9	0.50%	$6.7	0.50%	$2.4	0.50%	**$20.6**
Health Benefits Total					**$79.10**		**$16.70**		**$80.30**		**$21.50**		**$197.60**
	Savings assume an effective date of January 2023. Savings would have to be adjusted depending on the required implementation timeframe.												

State of New Jersey

Plan Year 2023 Renewals

State Active, Early, and Medicare Retiree PDC Impacts

	Medical Increase	Rx Increase	Total Increase	% Change From Baseline
Premium Increase as of July 13, 2022				
Actives	22.5%	7.0%	20.0%	
Early Retiree	15.9%	(2.8%)	12.7%	
Medicare Retiree	(11.1%)	1.7%	(2.9%)	
Scenario 1: Remove SHBP OON Reforms				
Actives	25.4%	7.0%	22.5%	2.5%
Early Retiree	19.2%	(2.8%)	15.4%	2.7%
Medicare Retiree	(11.1%)	1.7%	(2.9%)	0.0%
Scenario 2: Remove Generic Substitution and Closed Formulary				
Actives	22.5%	19.4%	22.0%	2.0%
Early Retiree	15.9%	9.3%	14.8%	2.1%
Medicare Retiree	(11.1%)	1.7%	(2.9%)	0.0%
Scenario 3: Revert Active Generic Copay from $0				
Actives	22.5%	6.3%	19.9%	(0.1%)
Early Retiree	15.9%	(2.8%)	12.7%	(0.0%)
Medicare Retiree	(11.1%)	1.7%	(2.9%)	0.0%
Scenario 4: Revert Rx Retiree Copays				
Actives	22.5%	7.0%	20.0%	0.0%
Early Retiree	15.9%	(2.8%)	12.7%	(0.0%)
Medicare Retiree	(11.1%)	1.7%	(2.9%)	(0.0%)
Combined Impact of All Scenarios				
Actives	25.4%	18.6%	24.3%	4.3%
Early Retiree	19.2%	9.3%	17.5%	4.8%
Medicare Retiree	(11.1%)	1.7%	(2.9%)	(0.0%)

Notes:

- Baseline results are consistent with the PY2023 Rate Setting Increases Presented to the Commissions as of July 13, 2022
- Individual Scenarios only show the impacts of individual changes and are not cumulative
- Scenario 1 reflects the reversal of SHBP OON Chiropractic, Acupuncture, and Physcial Therapy reforms; estimated impacts provided by Horizon
- Scenario 2 reflects the removal of the Generic Substituation Requirement and Closed Formulary; estimated impacts provided by Optum
- Scenario 3 reflects the reversal of the $0 Active Generic Copay to pre-resolution levels; estimated impacts are based on Aon's Actuarial Value Model
- Scenario 4 reflects the reversal of the Retiree Rx Copays to pre-resolution levels; estimated impacts are based on Aon's Actuarial Value Model

State of New Jersey

Plan Year 2023 Renewals

Local Government Active, Early, and Medicare Retiree PDC Impacts

	Medical Increase	Rx Increase	Total Increase	% Change From Baseline
Premium Increase as of July 13, 2022				
Actives	24.0%	3.7%	21.6%	
Early Retiree	16.6%	(5.7%)	13.0%	
Medicare Retiree	(7.9%)	7.8%	0.7%	
Scenario 1: Remove SHBP OON Reforms				
Actives	28.8%	3.7%	25.7%	4.1%
Early Retiree	20.9%	(5.7%)	16.6%	3.6%
Medicare Retiree	(7.9%)	7.8%	0.7%	0.0%
Scenario 2: Remove Generic Substitution and Closed Formulary				
Actives	24.0%	15.9%	23.1%	1.5%
Early Retiree	16.6%	5.5%	14.8%	1.8%
Medicare Retiree	(7.9%)	7.8%	0.7%	0.0%
Scenario 3: Revert Active Generic Copay from $0				
Actives	24.0%	3.5%	21.5%	(0.0%)
Early Retiree	16.6%	(5.7%)	13.0%	0.0%
Medicare Retiree	(7.9%)	7.8%	0.7%	0.0%
Scenario 4: Revert Rx Retiree Copays				
Actives	24.0%	3.7%	21.6%	0.0%
Early Retiree	16.6%	(5.7%)	12.9%	(0.0%)
Medicare Retiree	(7.9%)	7.8%	0.7%	(0.0%)
Combined Impact of All Scenarios				
Actives	28.8%	15.7%	27.2%	5.6%
Early Retiree	20.9%	5.5%	18.4%	5.4%
Medicare Retiree	(7.9%)	7.8%	0.7%	(0.0%)

Notes:

- Baseline results are consistent with the PY2023 Rate Setting Increases Presented to the Commissions as of July 13, 2022
- Individual Scenarios only show the impacts of individual changes and are not cumulative
- Scenario 1 reflects the reversal of SHBP OON Chiropractic, Acupuncture, and Physcial Therapy reforms; estimated impacts provided by Horizon
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- Scenario 3 reflects the reversal of the $0 Active Generic Copay to pre-resolution levels; estimated impacts are based on Aon's Actuarial Value Model
- Scenario 4 reflects the reversal of the Retiree Rx Copays to pre-resolution levels; estimated impacts are based on Aon's Actuarial Value Model
- Local Government Results include 2.0% premium margin

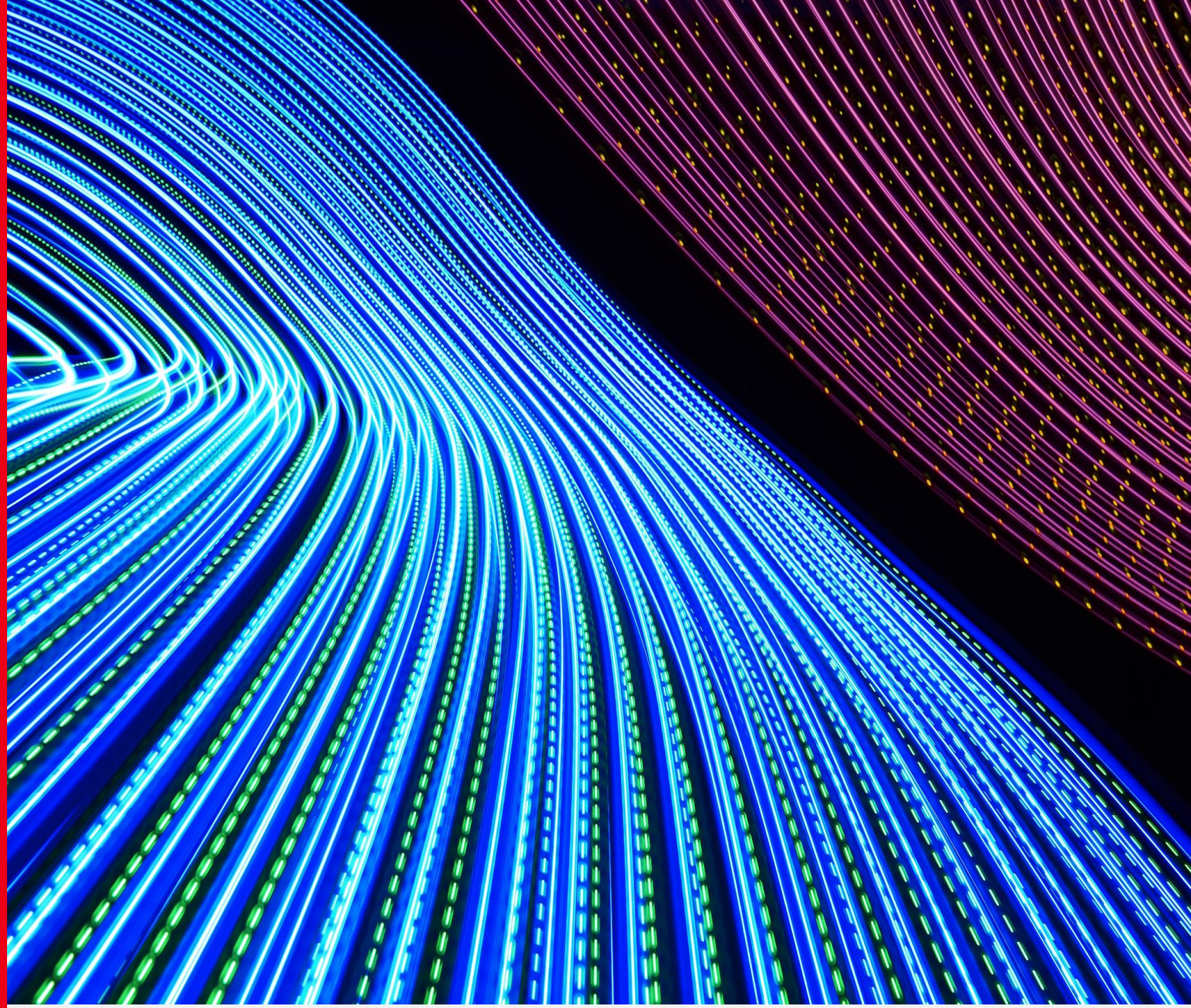
AON

2023 SHBP Rate Setting Analysis

State of New Jersey

Rates as presented to the Commission on July 13, 2022

August 11, 2022



Overview of Rate Setting Environment

Utilization/Covid-19

- There was significant deferral of care during 2020
- 2021 Projection assumed an 8-10% claims increase to account for bounce back
- Actual bounce back may have been higher – 2021 utilization of some services up 20%-30% over 2020

Inflation

- Current inflationary environment suggests an increase in trend assumptions for 2023 claims as cost increases make their way into medical billing schedules

Anticipated Program Savings

- Both 2021 and 2022 projections assumed savings from navigation and other point solution programs
- Available savings from these programs is now assumed to be in 2021 claims experience and future savings assumptions have been mostly removed due to lack of support in current experience

Overview of SHBP Recommended Premium Rate Impact

Plan Year 2023 Rate Impact Recommendations

Plan Year 2023 Premium Rate Changes	Actives			Early Retirees			Medicare Retirees		
	Medical	Rx	Total	Medical	Rx	Total	Medical	Rx	Total
Local Government									
PPO / NJDIRECT / HDHP	24.0%	3.8%	21.6%	16.6%	(5.7%)	13.0%	N/A	N/A	N/A
HMO	24.1%	1.9%	21.0%	16.6%	(5.7%)	12.6%	N/A	N/A	N/A
Tiered Network	24.2%	3.4%	20.9%	16.6%	(5.7%)	12.6%	N/A	N/A	N/A
Total	**24.0%**	**3.7%**	**21.6%**	**16.6%**	**(5.7%)**	**13.0%**	**(7.9%)**	**7.8%**	**0.7%**
State									
PPO / HDHP	21.4%	4.6%	18.7%	15.9%	(2.8%)	12.7%	N/A	N/A	N/A
HMO	21.4%	4.6%	18.6%	15.9%	(2.8%)	12.4%	N/A	N/A	N/A
Tiered Network	22.3%	2.0%	18.6%	15.9%	(2.8%)	12.4%	N/A	N/A	N/A
CWA Unity / NJDIRECT	22.9%	8.4%	20.7%	15.9%	(2.8%)	12.7%	N/A	N/A	N/A
Total	**22.5%**	**7.0%**	**20.0%**	**15.9%**	**(2.8%)**	**12.7%**	**(11.1%)**	**1.7%**	**(2.9%)**

- 2023 Active, Early Retiree, and Medicare Retiree pricing is projected with Medical and Prescription Drug claims incurred from January 1, 2021 through December 31, 2021 with runout through March 31, 2022 (adjusted for impact of COVID-19)
- Medicare Retiree Medicare Advantage Rate increase reflects fully insured rates from Aetna provided on June 17, 2022
- Active and Retiree premiums include a 2.0% margin, since the projected total Claim Stabilization Reserve for the Local Government Group is expected to be below the recommended level of 2.0 months at the end of Plan Year 2023

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Local Government Active Premium Increase Drivers

Local Government Active premiums are projected to increase **21.6%** in total for 2023. This is primarily a result of the following:

- **8.1%** - Actual 2021 claims experience was higher compared to expected 2021 claims:
  - While significant increases to member utilization in 2021 were anticipated because of COVID-19's impact on 2020, actual utilization appears to be even higher, with utilization trends of 26.5% for Outpatient visits, 18.2% for Professional visits, 16.4% for Specialist visits, 17.0% for Emergency Room and 38.0% for Urgent Care
  - The 2022 rate setting analysis included estimated vendor reported savings in 2021 for Horizon's Navigation Advocacy program as well as third-party vendor point solutions; savings for these programs are now assumed to be in the underlying 2021 claims experience
  - Actual 2021 prescription drug claims experience trend was 3.7%, lower than expected
- **3.5%** - The 2022 rate setting analysis included an additional 3.0% medical claims savings in Plan Year 2022 as well as additional projected savings for the third-party vendor point solutions; The savings attributable to these programs have been mostly removed in the updated projections
- **7.6%** - Annual medical and Rx trend projection assumptions have increased from the prior renewal analysis as a result of economic wide inflationary pressures on medical trends, expected increases in specialty drug trend costs and utilization, and an additional year of trend to 2023
- **-1.5%** - Impact of increases in projected rebates
- **0.5%** - Impact of other changes including changes in plan migration assumptions, and changes in administrative fees
- **2.0%** - Additional 2023 premium margin

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*Impacts are multiplicative, not additive

State Active Premium Increase Drivers

State Active premiums are projected to increase **20.0%** in total for 2023. This is primarily a result of the following:

- **8.7%** - Actual 2021 claims experience was higher compared to expected 2021 claims:
  - While significant increases to member utilization in 2021 were anticipated because of COVID-19's impact on 2020, actual utilization appears to be even higher, with utilization trends of 36.2% for Outpatient visits, 22.5% for Professional visits, 21.4% for Specialist visits, 13.0% for Emergency Room and 44.0% for Urgent Care
  - The 2022 rate setting analysis included estimated vendor reported savings in 2021 for Horizon's Navigation Advocacy program as well as third-party vendor point solutions; savings for these programs are now assumed to be in the underlying 2021 claims experience
  - Actual 2021 prescription drug claims experience trend was 6.4%, higher than expected, driven by high utilization surrounding inflammatory conditions (17.6% trend), diabetes (9.8% trend), and oncology (12.3% trend)
- **3.6%** - The 2022 rate setting analysis included an additional 3.0% medical claims savings in Plan Year 2022 as well as additional projected savings for the third-party vendor point solutions; The savings attributable to these programs have been mostly removed in the updated projections
- **7.7%** - Annual medical and Rx trend projection assumptions have increased from the prior renewal analysis as a result of economic wide inflationary pressures on medical trends, expected increases in specialty drug trend costs and utilization, and an additional year of trend to 2023
- **-2.1%** - Impact of increases in projected rebates
- **1.1%** - Impact of other changes in plan migration assumptions, and changes in administrative fees

*Impacts are multiplicative, not additive

SHBP Cost & Utilization Trends by Service Category

COMBINED NJ DIRECT, HMO, OMNIA PMPM TRENDS BY SEGMENT

Hospital Inpatient

	2020 PLACE OF SERVICE TRENDS			2021 PLACE OF SERVICE TRENDS		
	Cost	Utilization	Trend	Cost	Utilization	Trend
State Actives	11.2%	-6.9%	3.5%	9.1%	-5.2%	3.5%
State Early Retirees	8.5%	-6.5%	1.4%	14.7%	-7.3%	6.4%
Local Government Actives	8.5%	-4.0%	4.2%	13.9%	-5.1%	8.1%
Local Government Early Retirees	12.0%	-10.7%	0.0%	14.4%	-7.4%	6.0%

Hospital Outpatient

	Cost	Utilization	Trend	Cost	Utilization	Trend
State Actives	3.9%	-15.7%	-12.5%	-5.1%	22.9%	16.6%
State Early Retirees	1.2%	-11.7%	-10.7%	-3.6%	16.9%	12.7%
Local Government Actives	0.1%	-13.7%	-13.7%	0.8%	21.1%	22.1%
Local Government Early Retirees	3.0%	-12.9%	-10.2%	-2.6%	18.6%	15.5%
ASO/Insured Book of Business	5.8%	-11.4%	-6.3%	-6.4%	30.6%	22.2%

Professional

	Cost	Utilization	Trend	Cost	Utilization	Trend
State Actives	-0.5%	-11.0%	-11.4%	-6.8%	24.4%	15.9%
State Early Retirees	3.0%	-12.6%	-10.0%	-1.6%	16.1%	14.3%
Local Government Actives	-2.6%	-9.4%	-11.8%	-5.2%	19.6%	13.3%
Local Government Early Retirees	-1.2%	-11.4%	-12.4%	-3.0%	14.8%	11.4%

Total

	Cost	Utilization	Trend	Cost	Utilization	Trend
State Actives	3.8%	-11.5%	-8.2%	-2.6%	17.2%	14.1%
State Early Retirees	3.7%	-10.8%	-7.6%	1.4%	11.1%	12.6%
Local Government Actives	0.9%	-9.4%	-8.7%	1.0%	14.5%	15.7%
Local Government Early Retirees	3.2%	-11.7%	-8.9%	0.9%	11.4%	12.4%

*Data provided by Horizon

SHBP Utilization Trends by Place of Service

Emergency Room Visits / 1,000 members

Group	2019	2020	2021	2020 vs 2019	2021 vs 2020
State Active	252.8	190.5	214.7	-25%	13%
State Early Retiree	256.0	214.5	242.8	-16%	13%
Govt Active	288.3	219.9	256.8	-24%	17%
Govt Early Retiree	273.6	216.7	249.0	-21%	15%

Urgent Care Visits / 1,000 members

Group	2019	2020	2021	2020 vs 2019	2021 vs 2020
State Active	429.9	492.3	709.4	15%	44%
State Early Retiree	343.1	408.9	552.6	19%	35%
Govt Active	487.7	609.0	840.7	25%	38%
Govt Early Retiree	413.5	517.0	699.3	25%	35%

*Data provided by Horizon

SHBP Utilization Trends by Place of Service (cont)

PCP Visits / 1,000 members

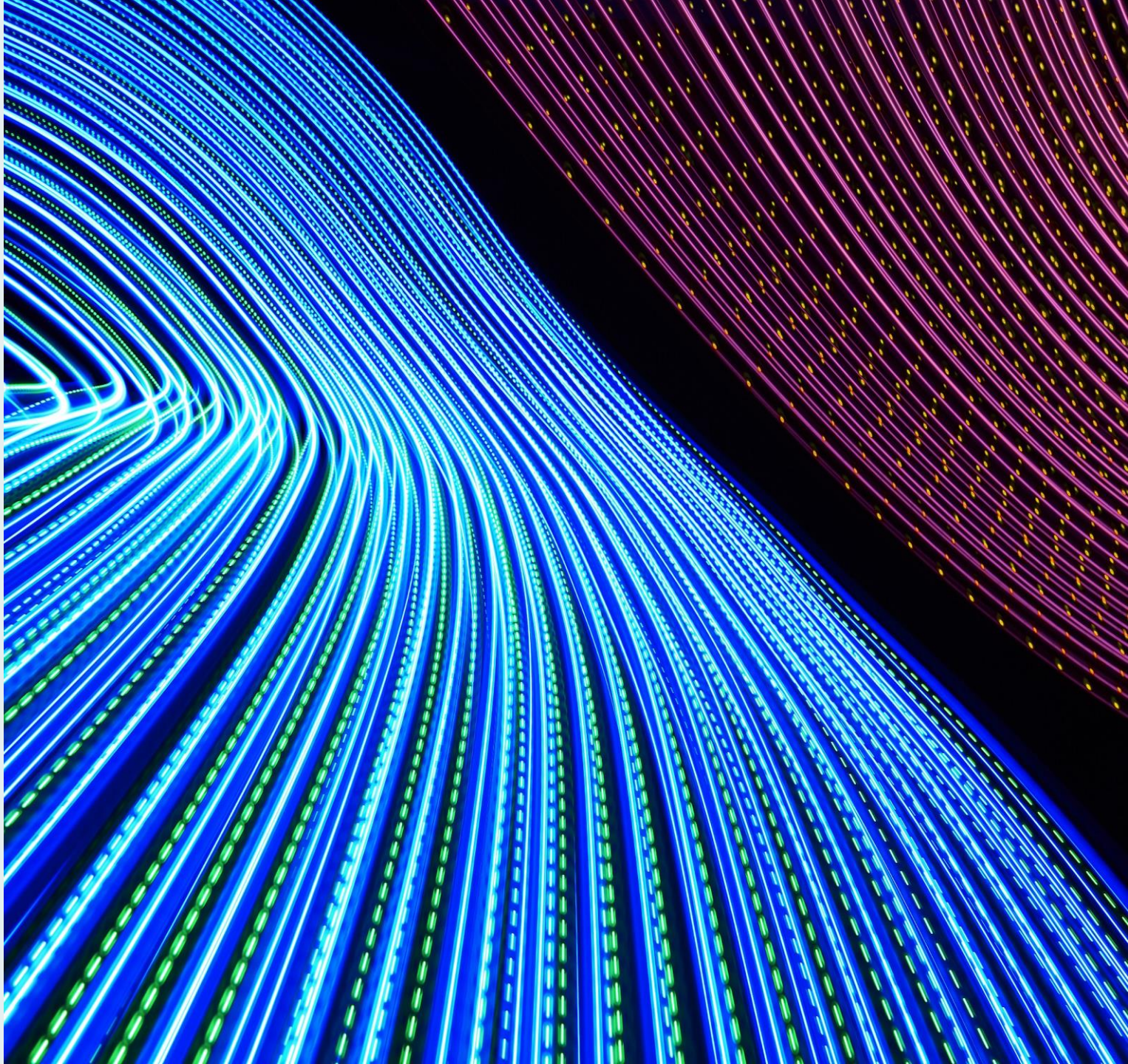
Group	2019	2020	2021	2020 vs 2019	2021 vs 2020
State Active	2,524.5	2,421.8	2,765.7	-4%	14%
State Early Retiree	2,499.1	2,478.0	2,725.0	-1%	10%
Govt Active	2,632.7	2,434.5	2,813.3	-8%	16%
Govt Early Retiree	2,474.4	2,306.1	2,680.4	-7%	16%

Specialist Visits / 1,000 members

Group	2019	2020	2021	2020 vs 2019	2021 vs 2020
State Active	8,055.0	7,193.0	8,697.3	-11%	21%
State Early Retiree	9,795.5	8,220.4	9,643.7	-16%	17%
Govt Active	8,535.5	7,759.0	9,022.2	-9%	16%
Govt Early Retiree	10,426.2	9,225.3	10,420.6	-12%	13%

*Data provided by Horizon

Appendix



Local Government Claim Stabilization Reserve

Claim Stabilization Reserve Balance (in $ millions)	Total	Active	Retiree	Months of Plan Cost as of Dec 31
12/31/2021	$294	$298	($4)	2.0
12/31/2022	$105	$155	($50)	0.7
12/31/2023	$145	$182	($37)	0.9

- The projected reserves as of December 31, 2021, 2022, and 2023 are based on the reserve balance as of June 30, 2021 provided by the State
- Projections do not reflect CSR withdrawals to reduce 2022 and 2023 premiums
- Local Government Active and Retiree premium rate changes reflect a 2.0% margin since the projected total Claim Stabilization Reserve for the Local Government Group is expected to be below the recommended level of 2.0 months at the end of Plan Year 2023

Disclaimers

The projections in this analysis are measured on an incurred basis and are consistent with the assumptions and methodology disclosed herein. Future projections may differ significantly from the current projections presented in this analysis due to (but not limited to) such factors as the following:

- Plan experience differing from what is anticipated by the economic or demographic assumptions;
- Changes in actuarial methods or in economic or demographic assumptions;
- Changes in plan provisions or applicable law.

Plan Year 2022 Rate Setting analyses included vendor reported savings for each program. Savings for these programs in the Plan Year 2023 rate setting analyses are assumed to be included in the claims and do not include any additional savings in 2022 and 2023 other than what is noted in this document.

This analysis contains the primary actuarial assumptions and methods used to develop the cost projections but may not include a comprehensive list of these methodologies and assumptions. Aon provided guidance with respect to these assumptions, and it is our belief that the assumptions represent reasonable expectations of anticipated plan experience.

Preparation of this Actuarial Analysis

This report has been prepared to present our analysis of the Plan Year 2023 Rate Setting for the State Health Benefits Program (SHBP). The purpose of this analysis is to recommend premium levels for the SHBP for January 1, 2023 through December 31, 2023. The use of this report for purposes other than those expressed herein may not be appropriate.

It should be noted that Aon's conclusions are based on certain assumptions that appear reasonable at this time. Actual experience can vary from projected experience, and this difference may be material.

Source of Information

In conducting this analysis, we relied on census data provided by the State and claims data provided by carriers. We reviewed the data for reasonableness and consistency with prior data but have not audited it; as such, we are not certifying, herein, as to its accuracy.

SHBP PDC RESOLUTION #2022-1

RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE TO CONTINUE RESOLUTIONS 2016-3, 2016-5; 2019-8, AND 2021-3 RELATED TO FORMULARY REIMBURSEMENT AND OUT OF NETWORK REIMBURSEMENT RATES FOR PHYSICAL THERAPY

WHEREAS, pursuant to N.J.S.A. 52:14-17.25 to -17.46a, the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State of New Jersey (State) and participating local employers; and

WHEREAS, the SHBP was created in 1961 to provide affordable health care coverage for public employees on a cost-effective basis; and

WHEREAS, all SHBP plans, with the exception of Medicare Advantage plans, are self-funded, which means the money paid out for benefits comes directly from a SHBP fund supplied by the State, participating local employers, and member premiums; and

WHEREAS, the costs for health and prescription drug benefits continue to increase exponentially, which has strained the budgets of the State and local employers and caused increased costs to members; and

WHEREAS, on August 29, 2016, after reviewing multiple recommendations and reports of AON Consulting, Inc., Horizon and Aetna, the SHBP Plan Design Committee adopted Resolution #3 on formulary management (attached) and Resolution #5 on out of network physical therapy reimbursements (attached), finding these changes to be in the best interest of the State, local employers, and employees; and

WHEREAS, on July 27, 2017, the SHBP Plan Design Committee, adopted Resolution 2017-01 (attached), which extended Resolutions #3 and #5 for one year; and

WHEREAS, on June 22, 2018, the SHBP Plan Design Committee, adopted Resolution 2018-1 (attached), which extended Resolutions #3 and #5 for one year; and

WHEREAS, on September 26, 2019, the SHBP Plan Design Committee, adopted Resolution 2019-08 (attached), which extended Resolutions #3 and #5 for one year; and

WHEREAS, on August 31, 2020, the SHBP Plan Design Committee adopted Resolution 2020-1 (attached), which extended Resolutions #3 and #5 for one year; and

WHEREAS, on August 13, 2021, the SHBP Plan Design Committee adopted Resolution 2021-3 (attached), which extended Resolutions #3 and #5 for one year; and

WHEREAS, pursuant to N.J.S.A. 52:14-17.29(D), the SHBP Plan Design Committee finds it in the best interest of the State, local employers, and employees, to continue the formulary management and structured out of network physical therapy reimbursements because they provide a substantial savings to the SHBP and its members.

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

1. The formulary management approved by the SHBP Plan Design Committee on August 29, 2016, in Resolution #3 is continued until further action by the SHBP Plan Design Committee.
2. The structured out of network reimbursement rates for physical therapy approved by the SHBP Plan Design Committee on August 29, 2016, in Resolution #5 is continued until further action by the SHBP Plan Design Committee.
3. These provisions shall continue for one plan year and will continue thereafter only by an affirmative majority vote of the Committee.

DATED: July 27, 2022


2016-3 SHBP PDC Res - Formulary Mar


2017-1 SHBP PDC RES to continue 201


2018-1SHBP PDC RES- continue 2016


2019-8 SHBP PDC Res Formulary Renev


2020-1 SHBP PDC Res - Re-Renewal Fc


2021-3 SHBP PDC Res - Re-Renewal Fc

SHBP PDC RESOLUTION # 2022-2

RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE TO INCENTIVIZE MAIL ORDER PRESCRIPTIONS AND ADOPT $0 COPAYS FOR GENERIC MAIL ORDER PRESCRIPTION DRUGS

WHEREAS, pursuant to N.J.S.A. 52:14-17.25 to -17.46a, the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State of New Jersey (State) and participating local employers; and

WHEREAS, the SHBP was created in 1961 to provide affordable health care coverage for public employees on a cost-effective basis; and

WHEREAS, all SHBP plans, with the exception of Medicare Advantage plans, are self-funded, which means the money paid out for benefits comes directly from a SHBP fund supplied by the State, participating local employers, and member premiums; and

WHEREAS, the costs for health and prescription drug benefits continue to increase exponentially, which has strained the budgets of the State and local employers and caused increased costs to members; and

WHEREAS, the SHBP Plan Design Committee recognizes pharmaceuticals are an integral part of medical treatment, keep patients healthier, and extend or save lives and in many situations, proper pharmaceutical use saves money by avoiding costly hospitalizations, emergency room use, moving to a nursing home, or repeat visits to specialists; and

WHEREAS, the SHBP Plan Design Committee recognizes the federal Food and Drug Administration (FDA), which approves all drug products sold legally in the United States, certifies the "safety and suitability of generic drugs and encourages their use"; and

WHEREAS, all generic drugs must meet the same strict quality guidelines and have exactly the same active ingredient as brand-name drug equivalents; and

WHEREAS, the Division of Pensions and Benefits implemented a program to encourages non-Medicare eligible members in the SHBP prescription plan on maintenance medications to use mail order service through OptumRx, the Pharmacy Benefit Manager for the SHBP, by requiring members to make an affirmative election of whether to continue purchasing prescription drugs through retail or through the mail order service program by contacting OptumRx via telephone or on the OptumRx online portal; and

WHEREAS, the SHBP Plan Design Committee, therefore, seeks to encourage active members to use "generic drug products," N.J.S.A. 52:14-17.46.6(f)(1)(d), over "brand name" drug products, N.J.S.A. 52:14-17.46.6(f)(1)(a); and

WHEREAS, to incentivize members to use mail order service for generic drugs, the SHBP Plan Design Committee seeks to reduce the member copay for generic prescriptions filled through the mail service program; and

WHEREAS, on September 6, 2019, the SHBP Plan Design Committee, adopted Resolution 2019-10 (attached), which set a $0 copay for prescriptions for generic drugs filled through OptumRx's Mail Order Pharmacy by active members; and

WHEREAS, on August 31, 2020, the SHBP Plan Design Committee, adopted Resolution 2020-3 (attached), which continued the $0 copay for prescriptions for generic drugs filled through OptumRx's Mail Order Pharmacy by active members for one year; and

WHEREAS, on August 13, 2021, the SHBP Plan Design Committee, adopted Resolution 2021-4 (attached), which continued the $0 copay for prescriptions for generic drugs filled through OptumRx's Mail Order Pharmacy by active members for one year; and

WHEREAS, pursuant to N.J.S.A. 52:14-17.29(D), the SHBP Plan Design Committee finds it in the best interest of the State, local employers, and employees to continue to incentivize use of cost-effective generic drug products.

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

1. The SHBP Plan Design Committee approves the requirement for a $0 copay for prescriptions for generic drugs filled through OptumRx's Mail Order Pharmacy by active members.
2. The foregoing mail order generic provision shall not apply to retirees, including Medicare eligible retirees.
3. The Committee requests the State Health Benefits Commission and/or Division of Pensions and Benefits take appropriate action to effectuate a modification of the existing contract, if required, and require OptumRx provide adequate notice to the plan participants of the changes, including notice to Medicare eligible retirees that such changes shall not apply to them.
4. The Mail Order Generic $0 copay shall continue for one plan year and will continue thereafter only by an affirmative majority vote of the Committee.

DATED: August 13 2021


2019-10 SHBP PDC Res Generic CoPay.p


2020-3 SHBP PDC Res Generic 0 CoPay

SHB PDC RESOLUTION # 2022-3

RESOLUTION OF THE STATE HEALTH BENEFITS PLAN DESIGN COMMITTEE TO ADOPT GENERIC SUBSTITUTION PREFERENCE OFFERED BY STATE PHARMACY BENEFIT MANAGER

WHEREAS, pursuant to N.J.S.A. 52:14-17.25 to -17.46a, the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State of New Jersey (State) and participating local employers; and

WHEREAS, the SHBP was created in 1961 to provide affordable health care coverage for public employees on a cost-effective basis; and

WHEREAS, all SHBP plans, with the exception of Medicare Advantage plans, are self-funded, which means the money paid out for benefits comes directly from a SHBP fund supplied by the State, participating local employers, and member premiums; and

WHEREAS, the costs for health and prescription drug benefits continue to increase exponentially, which has strained the budgets of the State and local employers and caused increased costs to members; and

WHEREAS, the SHBP Plan Design Committee recognizes pharmaceuticals, are an integral part of medical treatment, keep patients healthier, and extend or save lives and in many situations, proper pharmaceutical use saves money by avoiding costly hospitalizations, emergency room use, moving to a nursing home, or repeat visits to specialists; and

WHEREAS, the SHBP Plan Design Committee recognizes the federal Food and Drug Administration (FDA), which approves all drug products sold legally in the United States, certifies the "safety and suitability of generic drugs and encourages their use"; and

WHEREAS, all generic drugs must meet the same strict quality guidelines and have exactly the same active ingredient as brand-name drug equivalents; and

WHEREAS, the SHBP Plan Design Committee, therefore, seeks to encourage members to use "generic drug products," N.J.S.A. 52:14-17.46.6(f)(1)(d), over "brand name" drug products, N.J.S.A. 52:14-17.46.6(f)(1)(a); and

WHEREAS, to incentivize use of generic drug products the SHBP Plan Design Committee seeks to impose the cost for the use of unnecessary brand name drug products on the members using brand name medications; and

WHEREAS, on October 30, 2019, the SHBP Plan Design Committee adopted Resolution 2019-12 (attached), which required members to bear the full difference in cost between the brand name and generic drug products; and

WHEREAS, on August 31, 2020, the SHBP Plan Design Committee adopted Resolution 2020-5 (attached), which extended Resolution 2019-12 for one year; and

WHEREAS, on August 13, 2021, the SHBP Plan Design Committee adopted Resolution 2021-5 (attached), which extended Resolution 2010-5 for one year; and

WHEREAS, pursuant to N.J.S.A. 52:14-17.29(D), the SHBP Plan Design Committee finds it in the best interest of the State, local employers, and employees to continue to incentivize use of cost-effective generic drug products (Generic Substitution Preference).

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

Prescription drug plans provided to State and local participants in the SHBP shall include a generic substitution requirement for all FDA authorized generic drug products where the member will pay the difference in cost between the brand name and the generic medication if the member chooses to take the brand name instead of the generic. The total cost paid by the member shall never exceed the full price of the brand name medication. If the member's health care provider demonstrates the brand name medication is medically necessary and appropriate as determined by the laws governing the SHBP and the Plan handbook, then OptumRx, the Pharmacy Benefit Manager for the SHBP, shall not apply the cost difference to the member.

1. This Resolution shall not apply to Medicare eligible retirees.
2. The Committee requests the State Health Benefits Commission and/or Division of Pensions and Benefits take appropriate action with OptumRx to implement this Resolution.
3. The Generic Substitution Preference shall continue for one plan year and will continue thereafter only by an affirmative majority vote of the Committee.

DATED: July 25, 2022


2019-12 SHBP PDC Res- Generic Sub_FI


2020-5 SHBP PDC Res- Generic Sub_FI


2021-5 SHBP PDC Res- Generic Sub 8-

SHBP PDC RESOLUTION #2022-4

RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE TO REDUCE THE RETIREE PRESCIPTION DRUG COPAYMENT FOR MAIL ORDER PREFERRED BRAND COPAYS

WHEREAS, pursuant to N.J.S.A. 52:14-17.25 to -17.46a, the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State of New Jersey (State) and participating local employers; and

WHEREAS, the SHBP was created in 1961 to provide affordable health care coverage for public employees on a cost-effective basis; and

WHEREAS, all SHBP plans, with the exception of Medicare Advantage plans, are self-funded, which means the money paid out for benefits comes directly from a SHBP fund supplied by the State, participating local employers, and member premiums; and

WHEREAS, the costs for health and prescription drug benefits continue to increase exponentially, which has strained the budgets of the State and local employers and caused increased costs to members; and

WHEREAS, the SHBP Plan Design Committee recognizes pharmaceuticals, are an integral part of medical treatment, keep patients healthier, and extend or save lives and in many situations, proper pharmaceutical use saves money by avoiding costly hospitalizations, emergency room use, moving to a nursing home, or repeat visits to specialists; and

WHEREAS, the Division of Pensions and Benefits implemented a program to encourages non-Medicare eligible members in the SHBP prescription plan on maintenance medications to use mail order service through OptumRx, the Pharmacy Benefit Manager for the SHBP, by requiring members to make an affirmative election of whether to continue purchasing prescription drugs through retail or through the mail order service program by contacting OptumRx via telephone or on the OptumRx online portal; and

WHEREAS, to incentivize members to use mail order service for preferred medications, the SHBP Plan Design Committee seeks to reduce the member copay for prescriptions for preferred medications filled through the mail service program; and

WHEREAS, on July 27, 2017, the SHBP Plan Design Committee, adopted Resolution 2017-03 (attached), which reduced the prescription drug copays in the Retiree Prescription Drug Plan associated with the PPO 10 and 15 medical plans from $33 per 90-day prescription to $28 per 90-day prescription for prescriptions for preferred medications filled through the mail service for Plan Year 2018; and

WHEREAS, on September 26, 2019, the SHBP Plan Design Committee adopted Resolution # 2019-9 (attached), which extended Resolution 2017-03 for Plan Year 2019; and

WHEREAS, on August 31, 2020, the SHBP Plan Design Committee adopted Resolution 2020-3 (attached), which extended Resolution 2017-03 for Plan Years 2020 and 2021; and

WHEREAS, on August 13, 2021, the SHBP Plan Design Committee adopted Resolution 2021-6 (attached), which extended Resolution 2017-03 for Plan Year 2022; and

WHEREAS, pursuant to N.J.S.A. 52:14-17.29(D), the SHBP Plan Design Committee finds it in the best interest of the State, local employers, and retirees to incentivize retirees to use cost-effective preferred medications through the mail service by reducing the copayment for retiree prescription drug copayments for mail order preferred brand copayments in the PPO 10 and 15 plans.

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

1. The retiree copayments in the Retiree Prescription Drug Plan associated with the PPO 10 and 15 medical plans shall continue to be set at $28 per 90-day prescription for prescriptions for preferred medications filled through the mail service for Plan Year 2023.
2. This provision shall continue for one plan year and will continue thereafter only by an affirmative majority vote of the Committee.

DATED: July 25, 2022


2019-9 SHBP PDC Res Retiree Copays.


2020-3 SHBP PDC Res Generic 0 CoPay


2021-6 SHBP PDC Res Retiree Copays.

SHBP PDC RESOLUTION #2022-5
RESOLUTION OF THE STATE HEALTH BENEFITS PROGRAM PLAN DESIGN COMMITTEE RELATED TO PILOT PROGRAM GRANTING FINANCIAL INCENTIVES FOR SELECTING A TIERED NETWORK MEDICAL PLAN

WHEREAS, pursuant to N.J.S.A. 52:14-17.25 to -17.46a, the State Health Benefits Program (SHBP) provides health coverage to qualified employees and retirees of the State of New Jersey (State) and participating local employers; and

WHEREAS, the SHBP was created in 1961 to provide affordable health care coverage for public employees on a cost-effective basis; and

WHEREAS, all SHBP plans, with the exception of Medicare Advantage plans, are self-funded, which means the money paid out for benefits comes directly from a SHBP fund supplied by the State, participating local employers, and member premiums; and

WHEREAS, on August 29, 2016, after reviewing multiple recommendations and reports of AON Consulting, Inc., Horizon, and Aetna, the SHBP Plan Design Committee adopted Resolution #7 to create a one-year pilot program to incentivize members to select a tiered network medical plan (attached) finding this change to be in the best interest of the State, local employers, and employees; and

WHEREAS, on July 27, 2017, the SHBP Plan Design Committee, adopted Resolution 2017-02 (attached), which extended Resolution #7 for a period of one year; and

WHEREAS, on June 22, 2018, the SHBP Plan Design Committee, adopted Resolution 2018-02 (attached), which extended Resolution #7 for a period of one year; and

WHEREAS, on September 26, 2019, the SHBP Plan Design Committee adopted Resolution 2019-11 (attached), which extended Resolution #7 for a period of one year; and

WHEREAS, on August 31, 2020, the SHBP Plan Design Committee adopted Resolution 2020-4 (attached), which extended Resolution #7 for a period of one year with certain modifications to the original incentive structure; and

WHEREAS, Resolution 2020-4 changed the financial incentive for new Tiered Network Plan enrollees to $1000 for single, member and spouse, parent and child, or family coverage, and required the SHBP subscriber be enrolled in the Tiered Network Plan for one full Plan Year; and

WHEREAS, on August 13, 2021, the SHBP Plan Design Committee adopted Resolution 2021-7 (attached), which extended Resolution #7 for a period of one year with the modifications to the original incentive structure established by Resolution 2020-4; and

WHEREAS, pursuant to N.J.S.A. 52:14-17.29(D), the SHBP Plan Design Committee finds it in the best interest of the State, local employers, and employees to continue the financial incentive for new Tiered Network Plan enrollees.

NOW THEREFORE, BE IT RESOLVED AS FOLLOWS:

1. The financial incentive program for selecting a tiered network medical plan approved by the SHBP Plan Design Committee on August 29, 2016 in Resolution #7 is continued with the modifications to the original incentive structure established by Resolution 2020-4; and

2. New subscribers shall be defined to include all new employees eligible for the SHBP whose benefits were effective on or after August 29, 2016, or any existing employees who experienced a life event prior to January 1, 2017, and applied to alter coverage and who otherwise meet the requirements of Resolution #7 adopted on August 29, 2016, and who has not received an incentive in the past related to Tiered Network; and
3. Those eligible subscribers described in #2 above shall be paid an incentive as set forth above no later than the end of the current tax year; and
4. This provision shall continue for one plan year and will continue thereafter only by an affirmative majority vote of the Committee.

DATED: July 27, 2022


2017-2 SHBP PDC
RES to continue tier


2018-2 SHBP PDC
RES- Tiered Network


2019-11 SHBP PDC
Res Tiered Network_


2020-4 SHBP PDC
Res Tiered Network_


2021-7 SHBP PDC
Res Tiered Network