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State of New Jersey

State Health Benefits Program and Consultant Review

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Contents

1: Overview

1

Overview

The State of New Jersey retained Mercer Human Resource Consulting (Mercer) to conduct a comprehensive strategic review of the design and financing of the State Health Benefits Program (SHBP) as defined in *Request for Qualifications for State Health Benefits Program and Consultant Review Reference Number H.B. 2140-002.*

The following report is a summary of findings with a particular focus on the following five key areas:

- Current ***benefit program review,*** including the adequacy of the coverage provided and competitiveness of the SHBP programs relative to the marketplace.
- ***Program financial review,*** including adequacy of reserve levels and liability exposure.
- ***Current rate structure and methodology,*** including appropriateness of current actuarial assumptions and principles; adequacy of current SHBP contingency margins; and review of current rate structures and subsidies.
- Review of ***local employer needs****,* with respect to plan design, employee cost sharing and program operations.
- ***Cost containment***, including a review of the current mechanisms in place as well as recommendations for change if appropriate.

2: Executive Summary

2

Executive Summary

Introduction

- This report has been prepared for the State of New Jersey by Mercer Human Resource Consulting (Mercer). It provides an analysis of the State Health Benefits Program (SHBP) as requested in the "State Health Benefits Program and Consultant Review – Reference Number: H.B. 2140-002".
- The SHBP provides health insurance coverage to State and local public employers through contracts or riders for an indemnity health plan, a point of service plan, five HMOs, two prescription drug plans, one indemnity dental plan and eleven dental plan organizations.
- Participation in the SHBP was originally limited to employees of the State, until the SHBP Act, N.J.S.A. 52:14-17.26 et seq. was amended in 1964 to permit participation by local public employers. Today, in addition to the State and its colleges and universities, approximately 940 public employers participate in the SHBP for medical plan coverage including counties, municipalities and school boards. The total cost of the program is $2.3 billion for all medical, prescription drug, and dental plans. The total number of members and their dependents enrolled in the seven SHBP medical plans is approximately 775,000. Most employees are covered by collective bargaining agreements.
- In the early 1990's, health care cost increases were reduced primarily as a result of the introduction of managed care. However, beginning in 1998, the rate of increase in the cost of health care began to once again exceed the rate of increase in the medical CPI. Over the past few years, as health care cost increases have returned to double digits, employers have taken a variety of actions to control the increase in costs.
- The SHBP currently employs actuaries to assist in setting reserve estimates and premium rates but does not retain strategy or design consultants.
- With that as the backdrop, this report analyzes various aspects of the design, cost and competitiveness of the current program.

Project Approach

- In preparing this report, Mercer reviewed a variety of program descriptions, financial reports, analyses prepared by the SHBP's current and previous actuary, and vendor reports. We compared the SHBP to a group of state and private peers. The "state peers" included the states of Connecticut, Maryland, Massachusetts, New York, North Carolina, Pennsylvania, Vermont, and Virginia as well as the City of New York. The "private peers" included 14 large employers all of whom have employees working in the State of New Jersey. Included in this group were several employers headquartered in New Jersey such as American Standard, ADP, Merck, Prudential, and Verizon Wireless.
- For general survey data, we drew heavily from the 2002 Mercer National Survey of Employer Sponsored Health Plans. Other available survey data and reports were also used.
- Interviews were conducted with Horizon BlueCross BlueShield, Aetna, and CIGNA. Information on the local employer perspective was obtained, in part, through interviews with the New Jersey Education Association, New Jersey School Board Association, New Jersey Council of County Colleges, New Jersey State League of Municipalities, and the Communication Workers of America.
- Finally, we drew on Mercer's broad experience consulting on health care and insurance issues with many employers in both the public and private sectors.

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Summary of Findings and Recommendations

Plan Design

- Almost every SHBP medical plan has "first dollar" coverage with minimal to no deductibles and low out of pocket maximums. While in general, state programs have been less aggressive than private employers in changing plan design, these cost-sharing features in the SHBP have basically remained unchanged since 1996.
- As a result, the SHBP program has a plan design that is, on average, about 10% more generous than those of the state peers.
- The SHBP may want to evaluate the potential financial impact of changes in cost sharing features that will bring the SHBP more in line with other state and private employer plans.

Coverage

- Over the past several years, there has been a dramatic decrease in enrollment in traditional indemnity plans, nationwide. At the same time, PPO (preferred provider organizations) enrollment has shown a steady increase. HMO (health maintenance organization) enrollment has started to decline while POS (point of service) enrollment has been declining. The inability of managed care plans to control utilization in recent years, along with the backlash against restricted networks and "gatekeepers" have led to this shift to more flexible PPOs.
- The SHBP does not offer a PPO. Their active employee enrollment compares to that of the state peers and all states as shown in the table below.

	SHBP	State Peers	All States
▪ HMO	26%	35%	34%
▪ PPO	0%	49%	37%
▪ POS	47%	12%	14%
▪ Indemnity	27%	4%	15%
▪ Total	100%	100%	100%

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Summary of Findings and Recommendations *(continued)*

Coverage *(continued)*

- Over the three years 2000 to 2002, there has been a decrease in SHBP's enrollment in the indemnity plan (32% to 27%) and in the HMOs (34% to 26%). This has been offset by an increase in the POS plan (i.e., NJ PLUS) from 34% to 47%.
- As part of any evaluation of plan design features, the SHBP may want to consider evaluating its mix of plan offerings. Any such evaluation would have to consider such factors as cost, access to providers, and employee choice.

Cost

- Comparing the SHBP to their peer groups, the annual per active employee medical and dental costs in 2002 were the highest among all peers. Similarly, the SHBP had the highest average total health benefit cost when expressed as a % of payroll as shown in the table below.

	Annual Cost	Cost as % of Payroll
▪ SHBP	$6,797	14.6%
▪ State Peers	$5,412	13.2%
▪ Private Peers	$5,106	11.1%

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Summary of Findings and Recommendations *(continued)*

Employee Contributions

- State employees in the SHBP do not have to pay for coverage in the POS (NJ PLUS) plan while they do contribute towards the HMO and indemnity plans as shown in the table below.

SHBP Active Employee Contributions as a % of Total Cost, By Plan Type

	Employee Only	Family
▪ POS	0%	0%
▪ HMO	5%	5%
▪ Indemnity	25%	25%

- By contrast, employees who work for local employers who participate in the SHBP do not contribute towards the cost of employee only coverage. Contributions for family coverage vary by local employer.
- Among the state peers, 27% do not require contributions for employee only coverage while 11% do not for family coverage. For private employers, over 85% require contributions for either employee or family coverage.
- Among the state peers and the private peers that do require contributions, contributions as a percent of total cost vary by plan. These are shown in the table below.

Active Employee Contributions as a % of Total Cost

	Employee Only	Family
▪ State Peers	14% to 20%	22% to 31%
▪ Private Peers	23% to 25%	28%

Summary of Findings and Recommendations *(continued)*

Employee Contributions *(continued)*

- Employee contributions have an impact on a medical program in several ways:
  - They are a direct offset to cost,
  - They influence which plan an employee elects, and
  - They influence whether or not an employee who has a working spouse will elect coverage through their own employer.
- Accordingly, any review of plan design or plan offerings should also include a review of employee contributions. Furthermore, a review of employee cost sharing including employee contributions is best evaluated in the context of overall compensation.

Retiree Medical

- Over 86% of state/local governments offer retiree medical coverage. This is in contrast to the private sector where most employers have been reducing or eliminating coverage for retiree medical. Retiree medical coverage is much more prevalent among large employers.
- For the most part, retiree medical coverage under the SHBP is free to retirees. In certain situations, surviving spouses have to pay the full cost of coverage. In other state plans, about 25% also offer free coverage, almost half share the cost with retirees, and the remaining 27% require the retiree to pay the full cost of coverage. For private employers, the percentage of employers sharing the cost is similar to the state plans. The difference is that a lower percentage pay the full cost – 12% pre-Medicare and 19% post-Medicare. The average retiree contribution percentage where the state and the retirees share the cost of coverage is 40%.

Summary of Findings and Recommendations *(continued)*

Retiree Medical *(continued)*

- Large private-sector employers offering retiree medical benefits have made an effort to control rising costs. Changes of this nature are expected to continue in the future.
- Prescription drugs are a major component of the cost of retiree medical coverage. This is particularly true for retirees eligible for Medicare because Medicare does not cover prescription drugs. However, legislation is imminent that would introduce prescription drug coverage into Medicare. While the details of any final legislation are being worked out, it is clear that there will be an impact on the cost of employer provided retiree medical coverage.
- The Government Accounting Standards Board (GASB) is considering adoption of accounting standards for various governmental entities within the United States. These entities would include state and municipal governments. Any such standards - which would not be effective for accounting periods beginning after June 15, 2006 - if enacted will likely raise the visibility of the cost of retiree medical programs for state employers.
- Any review of the active medical coverage and plans under the SHBP must also take into account the affect on retiree coverage because currently the choice of active benefit plan levels continue into retirement. Any changes in the retiree contribution structure should be evaluated in the context of the overall retirement benefits provided to State employees. Finally, the expected changes in Medicare for prescription drug coverage plus the anticipated GASB accounting standards provide additional reasons for a careful review of retiree medical benefits.

Summary of Findings and Recommendations *(continued)*

Advantages of Benchmarking and Monitoring the Marketplace

- As costs continue to rise, all employers in both the public and private sector can be expected to make changes in their medical programs. Cost shifting to employees will continue. Insurance carriers will work with employers to implement programs to control utilization. Innovative designs such as consumer directed health plans which to date have not been adopted by any state plans will gain in popularity as employers continue to look for ways to control cost and to improve quality. An active ongoing review of benefit trends and changes in the marketplace is well-advised for the SHBP.

Program Financial Review

- The financial soundness of the SHBP's self-insured program was evaluated by reviewing the adequacy of:
  - Reserves for incurred but not paid claims and
  - Rates and resulting surplus/deficit position.
- Reserve levels are adequate to cover the liability for incurred but not paid claims.
  - The reserve established by the SHBP was 117% of the actual needed as of December 31, 2001 and 114% as of December 31, 2002.
  - Included in the SHBP reserve is a liability for extension of benefits for disabled individuals that is not reflected in the determination of the actual incurred but not paid liability. Generally accepted accounting principles would have these two components calculated separately and reported separately. No information was available on the actual measurement of that liability though it is estimated to be 1% of the incurred but not paid reserve.
  - The SHBP may want to consider an independent actuarial calculation of the SHBP's liabilities as opposed to reviewing the reserve estimates provided by Horizon BlueCross BlueShield and basing their estimates on the Horizon calculations.
  - Furthermore, the SHBP may want to consider a retrospective true-up of the actual liability to better understand any differences between actual and expected reserves.

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Summary of Findings and Recommendations *(continued)*

Program Financial Review *(continued)*

- The following chart presents a four year history of surpluses and deficits generated under the State and local employer self-insured plans with Horizon.

Policy Year Ending	Surplus/(Deficit)			
	State Plan		Local Plan	
	Current Year	Cumulative	Current Year	Cumulative
6/30/98	–	$5.3M	–	$156.0M
6/30/99	($22.2M)	($16.9M)	($23.7M)	$132.3M
6/30/00	($10.4M)	($27.3M)	($103.4M)	$28.9M
12/31/01*	($70.3M)	($97.6M)	($139.8M)	($110.9M)
12/31/02*	($36.2M)	($133.7M)	($81.4M)	($192.3M)

**Results for the last two years were estimated by Mercer using Mercer's incurred claim estimates.*

- Based on the chart above, premium rates were inadequate to cover claims and expenses for four consecutive policy years. Each individual year's rate inadequacy also prevented any recovery of existing deficits.

Summary of Findings and Recommendations *(continued)*

Program Financial Review *(continued)*

- While the rates appear to have been set using techniques that are in the range of generally accepted actuarial practice, the pattern of continued deficits suggests considering alternate techniques or alternate assumptions.
  - Mercer recommends using incurred claims, not paid claims, as the basis for rate setting. Such an approach appropriately adjusts for payment lags and changes in enrollment.
  - It appears that the trend rates used for the indemnity and POS plans for active employees and pre-65 retirees were too low. The actual trends used as compared to Mercer's estimates are shown in the table below.

Year	Indemnity		POS	
	Actual	Mercer	Actual	Mercer
1999	5.7%	11%	4%	10%
2000	6.3%	12%	5%	11%
2001	8.0%	13%	8%	12%

  - It does not appear that any provision for the effect of anticipated changes in cost by plan due to "selection" was reflected. Such a provision is typical when there is large migration among plans. This was the case from 2000 to 2002 as a result of the introduction of employee contributions for the indemnity and HMO plans for the State program and easing of re-entry rules on the local plans.
  - It does not appear that there was any recognition of changes in demographic mix (e.g. age, sex, location) or contract mix (e.g. plan, coverage level – employee/dependents) in the rates.
  - It does not appear that any margins or explicit deficit recovery provisions were included in the rates.

Summary of Findings and Recommendations *(continued)*

Program Financial Review *(continued)*

- The SHBP may want to consider an alternate approach in setting retiree rates that does not balance the use of actuarial judgment in the retiree rating with a rate action on the active plan. Such an aggregated approach introduces explicit subsidization across the two groups. Credibility adjusted rating for the retiree group may be appropriate in light of upcoming GASB rules for valuing retiree medical liabilities. The NJ code sections requiring certain "rate relationships" between actives and retirees should be reviewed in light of the rules for appropriately valuing retiree medical liabilities as well.
- Based on our review, it is appropriate that the State plan be administered on a self-insured basis.

Local Employer Needs

- From the local employer perspective, the SHBP appears to offer adequate choice of plans, acceptable designs, and solid vendors. Feedback included:
  - consideration of a PPO option,
  - more flexibility in the design of the benefit plans, and
  - frustration with the inability to negotiate plan design.
- Employee contributions for the locals are governed by Administrative Code Section 17:9-5.4 which mandates that the employer pay the full cost of an employee's coverage. While local employers may negotiate contributions for dependent coverage, they must pay the same proportion of the cost of dependent coverage for all employees covered in the program. The effect of this is that employers are essentially constrained from implementing contributions for dependent coverage.
- The local plans are prospectively rated at the beginning of each year. Because there is no experience adjustment at the end of each year and no deficit recovery built into rates in the years after a loss, the local employers have essentially a "fully-insured" plan. Furthermore, if a local employer withdraws from the SHBP, there is no requirement to pay any portion of allocated deficits.

Summary of Findings and Recommendations *(continued)*

Local Employer Needs *(continued)*

- Given the recent deficits in the plan, the SHBP should give strong consideration to a review of the rating methodology and should develop a plan to run the program on a self-supporting basis and recover the existing deficit.
- Reserve levels of the local plans are adequate at 119% and 116% of actual needed as of December 31, 2001 and December 31, 2002. However, the same observations that were made for the State plan apply to the locals.
- The SHBP may want to give consideration to geographic rating which would allow for variation of rates based on a selected geographic framework. Such an approach has actuarial support and could address the perception that the SHBP's current rating structure may be uncompetitive in the lowest cost areas of the State.

Cost Containment

- The cost management programs that are currently in place with Horizon, Aetna and CIGNA are comparable to those in place at other state and large employers.
- Fees paid to the carriers for these programs are generally in line with the marketplace; however, there are some outliers for which the SHBP might benefit from further review.
- Return on investment (ROI) was difficult for the vendors to provide on a "client-specific" basis. This is still common in the general marketplace though there is increasing pressure to provide specific ROI statistics.
- The SHBP may benefit from stronger due diligence (e.g. program evaluations or clinical audits) to measure current performance.
- A detailed analysis of utilization patterns could highlight areas of opportunity for fine-tuning current programs or adding additional programs.

3: Benefit Program Review

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3

Benefit Program Review

Overview

- Mercer completed a comprehensive review of the SHBP Program, including adequacy of coverage and competitiveness of the program relative to the marketplace. The marketplace includes general market prevalence and a detailed comparison of the SHBP to specific state (state peers) and large local employers (private peers). Detailed comparisons can be found in the appendices.
- Nine public sector employers (8 states plus one city) and 14 large employers headquartered in the Northeast were included in our analysis. These organizations were reviewed and approved by the State prior to the analysis and are listed below:

State Peers	Private Peers	
▪ State of Connecticut	▪ American Express	▪ Merck & Company*
▪ State of Maryland	▪ American Standard Companies*	▪ Merrill Lynch & Co.
▪ State of Massachusetts	▪ Automatic Data Processing (ADP)*	▪ Prudential Insurance Company of America*
▪ State of New York	▪ Comcast Corporation	▪ Siemens Corporation
▪ State of North Carolina	▪ PSE&G	▪ Verizon Wireless*
▪ State of Pennsylvania	▪ Lockheed Martin Corporation	
▪ State of Vermont	▪ Lucent Technologies, Inc.*	
▪ State of Virginia	▪ Marriott International	
▪ City of New York	▪ Marsh & McLennan Companies, Inc.	**Headquartered in New Jersey.*

- Where information provided by the benchmark organization was incomplete, Mercer incorporated survey results from the 2002 Mercer National Survey of Employer Sponsored Plans for similar benchmark organizations. See appendix for a list of participating organizations in the survey.

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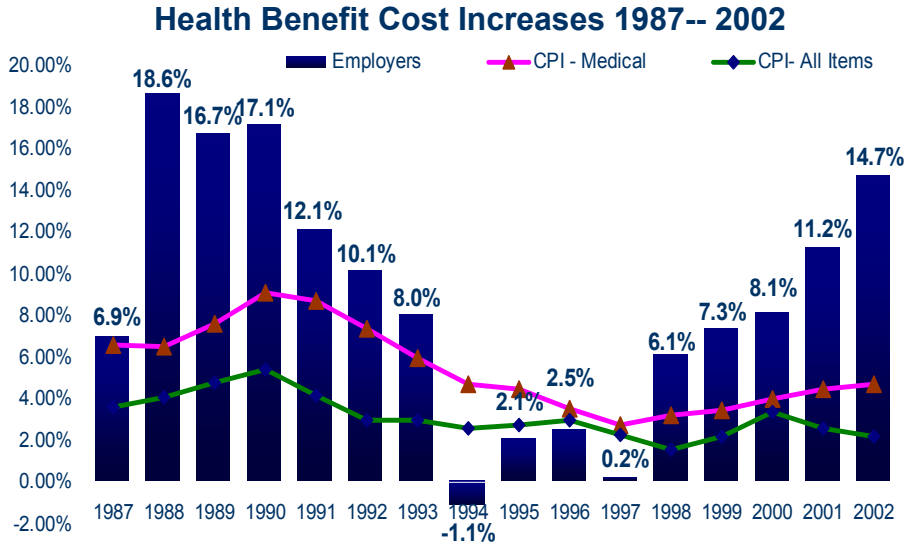
Review of The Marketplace -- Benefits

- "Change" has been about the only constant thing in the health care environment in the past decade. The reduction in cost escalation achieved in the mid 90's, primarily as a result of managed care, was short lived. The rate of health benefit cost increases began to rise higher than the medical CPI in 1998, returning employers to the high cost quandary they faced from 1987 – 1993 (see chart below).
- Both private and state employers were impacted by these cost increases, but their reaction over the past ten years has varied - from re-evaluating vendors and plan designs offered to shifting costs to employees by way of increased copays and premium share requirements and more recently to disease management and consumer directed health plans.
- While all employers shared the common goal of controlling the rate at which their health care cost increases, the rate at which the state employers implemented these strategies lagged their private employer counterparts. The following section examines these strategies and highlights major differences between private and state employers, in general, as well as the SHBP relative to specific state and private peers.



Source: 2002 Mercer National Survey of Employer Sponsored Health Plans.
Included medical, dental and prescription.

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Review of The Marketplace -- Benefits *(continued)*

- Plan design changes, while the easiest to implement, are among the most visible to employees. Historically, state peers have been less aggressive than private employers in increasing plan design elements such as copays, deductibles or out of pocket maximums. The following chart highlights major changes to the SHBP over the past six years:

Summary of SHBP Accomplishments Since 1996

Year	Initiative(s)	Potential Cost Impact (+/–)
1996	– Standardized office visit copayment of $5 in 1996 to the HMO and NJ PLUS programs	+
	– Eased eligibility timing for retiree dependents	–
	– Implemented prescription drug card (improved financial terms) in NJ PLUS and Traditional Plan	+
	– Established subrogation recovery application in NJ PLUS and Traditional Plan	+
	– Established performance guarantees for the NJ PLUS and Traditional Plan	+
1997	– Introduced rate differentials between education and municipality groups	=
	– Implemented eligibility process to drop ineligible dependents without consent	+
	– Introduced RFP process for HMO and dental renewal process	+
	– Implemented Medicare Risk/Medicare Plus Choice Plans (since removed)	+
	– Increased COB coverage (allowing up to full charges)	–
	– Expanded vision coverage; at same time eliminated hardware coverage	+
	– Introduced Lyme disease treatment policy	+
	– Implemented “silent” pre-cert/concurrent review process for Horizon network of hospitals	+

+ = Potential Cost Reduction
– = Potential Cost Increase
= = No Cost/Impact

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Review of The Marketplace -- Benefits *(continued)*

Summary of SHBP Accomplishments Since 1996

Year	Initiative(s)	Potential Cost Impact (+/–)
1998	– Standardized HMO benefits/operating procedures	=
	– Established Employee Assistance Service (EAS) consortium	=
	– Established dental benefit coverages	+
	– Increased DPO copays	+
	– Implemented passive DPO network	+
	– Developed new policy on prescription drug carve out for local employees	+
	– Developed new program on retiree prescription drug coverage	+
	– Introduced new communication tools/materials	=
	– Transitioned three largest HMOs from fully insured to self-insured basis	+
1999	– Implemented new performance standards for HMOs	=
	– Increased coverage for congenital birth defects (as a result of mandate)	–
	– Implemented utilization review process for chiropractic services	+
	– Increased performance standards for Horizon programs	+
	– Increased selected DPO copayments, clarified several benefits	+
	– Implemented utilization evaluation tool for DPOs	+
	– Eliminated several DPOs	=
	– Reinstated mail order copays	+
	– Expanded Aetna HMO/CIGNA HMO service areas	+
	– Developed Lyme Disease/In Vitro Fertilization medical policy	+
	– Revised benefit design for dental expense plan	=
	– Adopted composite rate for DPO's	=

+ = Potential Cost Reduction
– = Potential Cost Increase
= = No Cost/Impact

Review of The Marketplace – Benefits *(continued)*

Summary of SHBP Accomplishments Since 1996

Year	Initiative(s)	Potential Cost Impact (+/–)
2000	– Implemented open access HMO	=
	– Capped chiropractic services (30 visits) on Horizon Plans	+
	– Implemented 90-day Rx supply at retail pharmacy	–
	– Adopted clinical trials agreement for self-insured plans (as a result of mandate)	–
	– Increased retiree eligibility coverage (as a result of Chapter 330)	–
2001	– Implemented three-tiered prescription drug program in HMOs	+
	– Implemented select pharmacy network	+
2002	– Redesigned Dental Expense Plan	=
	– Offered Long Term Care Plan	=
	– Expanded NJ PLUS Network Area	+

+ = Potential Cost Reduction
– = Potential Cost Increase
= = No Cost/Impact

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Review of The Marketplace -- Benefits *(continued)*

- With the exception of the dental and the HMO programs, the SHBP has implemented few changes to plan design elements such as increased copays or out of pocket maximums over the past six years.
  - Almost every SHBP medical plan has “first dollar” coverage with minimal to no deductibles and copayment requirements.
  - Low out of pocket maximums ensure that employees who experience a catastrophic illness are not financially impacted.
  - Over the past few years, SHBP has implemented some changes to the dental and prescription programs, but the out of pocket expenses on the medical programs have remained unchanged since 1996. As a result, the program lags those of the state peers and private peers with:
    - Average 2002 office copays of $5 for the SHBP programs compared to $10/$15 copays for peer programs (see chart on following page),
    - Average 2002 deductibles of $100 per individual for non network coverage which is below both state and private norms at $250 or $300 per individual, and
    - Average 2002 out of pocket maximum per individual of $400 versus $1,000 for peer organizations.
    - The coinsurance for the POS plan (30% non network coverage) is within 2002 competitive norms.

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Review of The Marketplace -- Benefits *(continued)*

- Some state and many private employers have introduced copay differentials between lower cost primary care providers and their higher cost specialist counterparts (see chart below).

Average 2002 Office Visit Copays (for active employee program)

	SHBP	State Peers	Private Peers	
HMO Office Visit				
▪ PCP	$5	$5	$15	
▪ Specialist	$5	$10	$15	
PPO/POS Office Visit			**PPO**	**POS**
▪ PCP	$5	$15	$15	$10
▪ Specialist	$5	$15	$15	$20

Source: Combination of Mercer proprietary database and 2002 Mercer National Survey of Employer Sponsored Health Plans.

- Overall, when compared to the state peers, the SHBP program is about 10% more generous.

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Review of The Marketplace -- Benefits *(continued)*

- Over the past five years, most state and private employers have introduced "two-tiered" drug programs to differentiate between generic and more costly brand prescriptions. More than half of employers nationally have a "three-tiered" (i.e., generic, brand formulary, brand non-formulary) prescription drug program in 2002 (see chart below). SHBP implemented a three-tiered copay program in their HMOs in 2001. However, the other SHBP active plans remain two-tiered.

National Distribution of Rx Drug Program Cost Sharing (for active employee program)

	2000	2001	2002
1 copay for all drugs	9%	7%	5%
2 copays for generic, brand drugs	52%	39%	31%
3 copays for generic, formulary brand, non-formulary brand	26%	40%	51%
Other form of copay	4%	3%	3%
Coinsurance	10%	10%	10%
No cost-sharing required	1%	1%	0%

Source: 2002 Mercer National Survey of Employer Sponsored Health Plans.

- While the SHBP's has made changes to their prescription drug program, out of pocket expenses continue to lag the marketplace as well.
  - The SHBP's two-tiered program with 2002 copays of $1 for generic drugs and $5 for brand drugs is well below the national benchmark of $8 and $18 (see chart below).
  - Additionally, most organizations have implemented a separate mail order copay to encourage mail order utilization. Typically, this copay is set at two times the retail program.

Average Amount of 2002 Copayment, When Required (for active employee program)

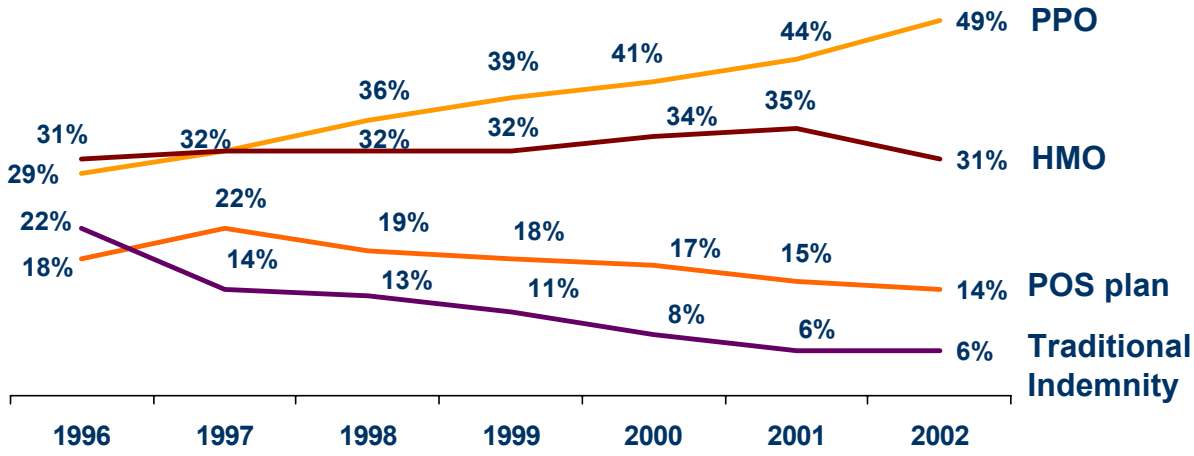
	SHBP	National Employers
TWO-TIER COPAYMENTS		
Generic	$1	$8
Brand-name	$5	$18
THREE-TIER COPAYMENTS	**HMO Only**	
Generic	$5	$10
Formulary brand	$10	$19
Non-formulary brand	$20	$35

Source: 2002 Mercer National Survey of Employer Sponsored Health Plans.

Review of The Marketplace -- Coverage

- **Introduction/Migration to Managed Care Programs** - Realizing that indemnity plans were the most costly and did little in the way of managing utilization, private employers began to introduce managed care plans. At the same time, enrollment in indemnity plans was discouraged through increased employee contributions and in some cases, the traditional indemnity program was eliminated as an option completely.
  - Recent data shows a trend away from heavily managed health plans. The percentage of employers offering Preferred Provider Organization (PPO's) has increased steadily since 1998. Employee enrollment in PPOs has gradually risen as well from 29% in 1996 to 49% in 2002 (see below).

Percentage of Active Employees Enrolled, By Type of Health Plan



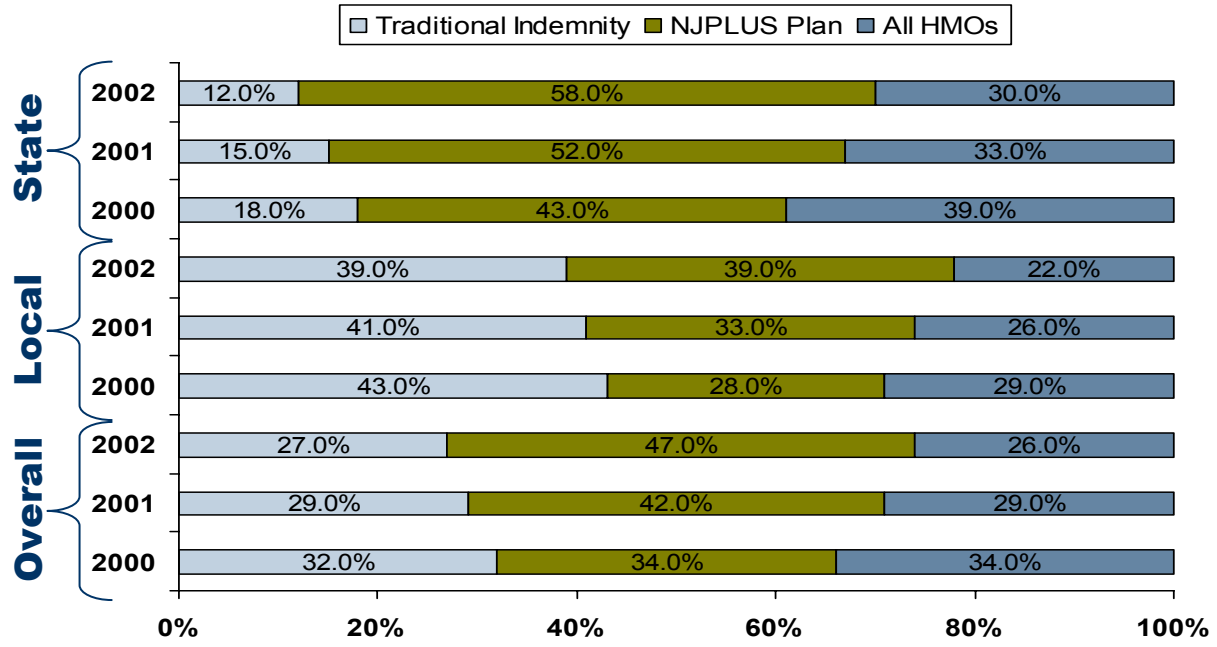
Source: *Mercer Human Resource Consulting, 2002 National Survey of Employer Sponsored Health Plans.*

  - The inability of managed care plans to control utilization in recent years, along with the backlash against restricted networks and "gatekeepers" models, have led to this shift into more flexible PPO models.

Review of The Marketplace -- Coverage *(continued)*

- As shown in the chart below, the State portion of the SHBP has seen some migration to the NJ PLUS POS plan from the Indemnity and HMO plans. Some of this migration is a result of changes to the indemnity plan employee contributions. The local segment has seen similar migration to the NJ PLUS Plan. However, the indemnity plan maintains an unusually high percentage of enrollees compared to national norms.

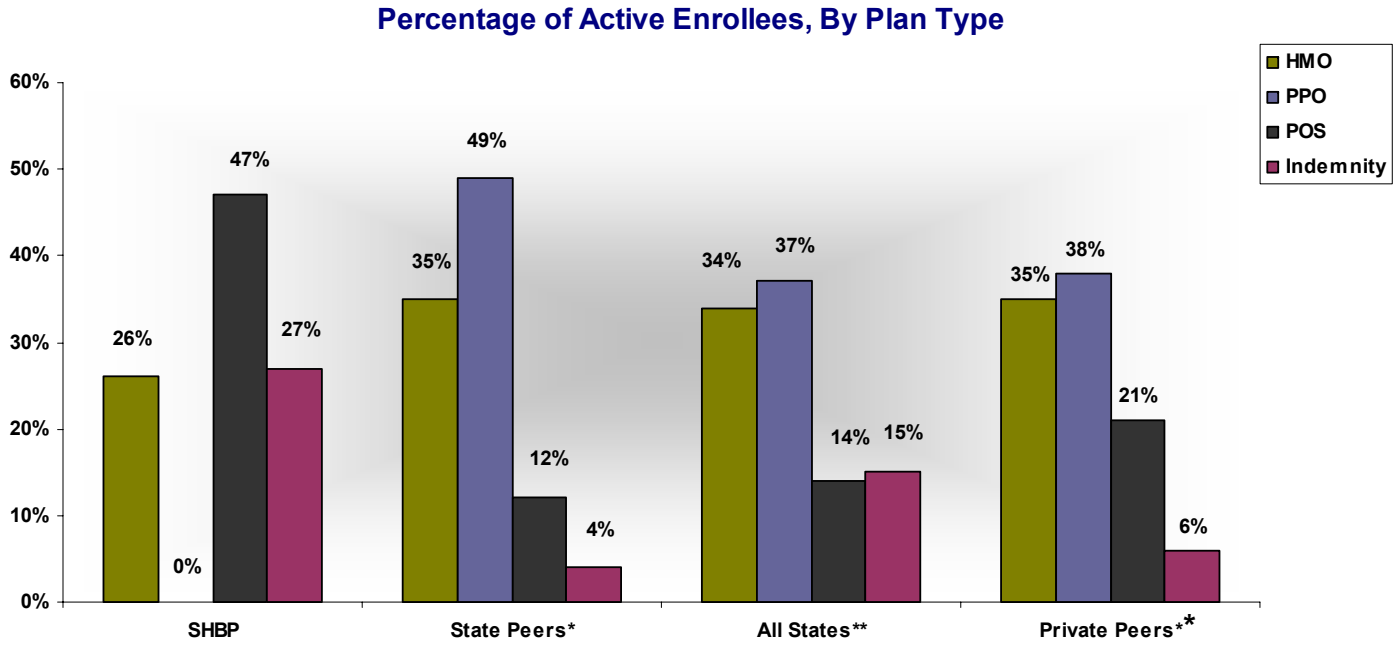
Percentage of SHBP Active Employees Enrolled, By Type of Health Plan



Source: *Headcounts provided by State of New Jersey.*

Review of The Marketplace – Coverage *(continued)*

- Unlike the SHBP, many of the state and private peers limit the indemnity offering to out of area employees only.
- PPO remains the most prevalent plan for both state and private peers, yet it is the only plan type not offered by SHBP. While SHBP enrollment in managed care programs, such as the HMO and POS programs, is very strong; the traditional indemnity enrollment is disproportionately large (see chart below).



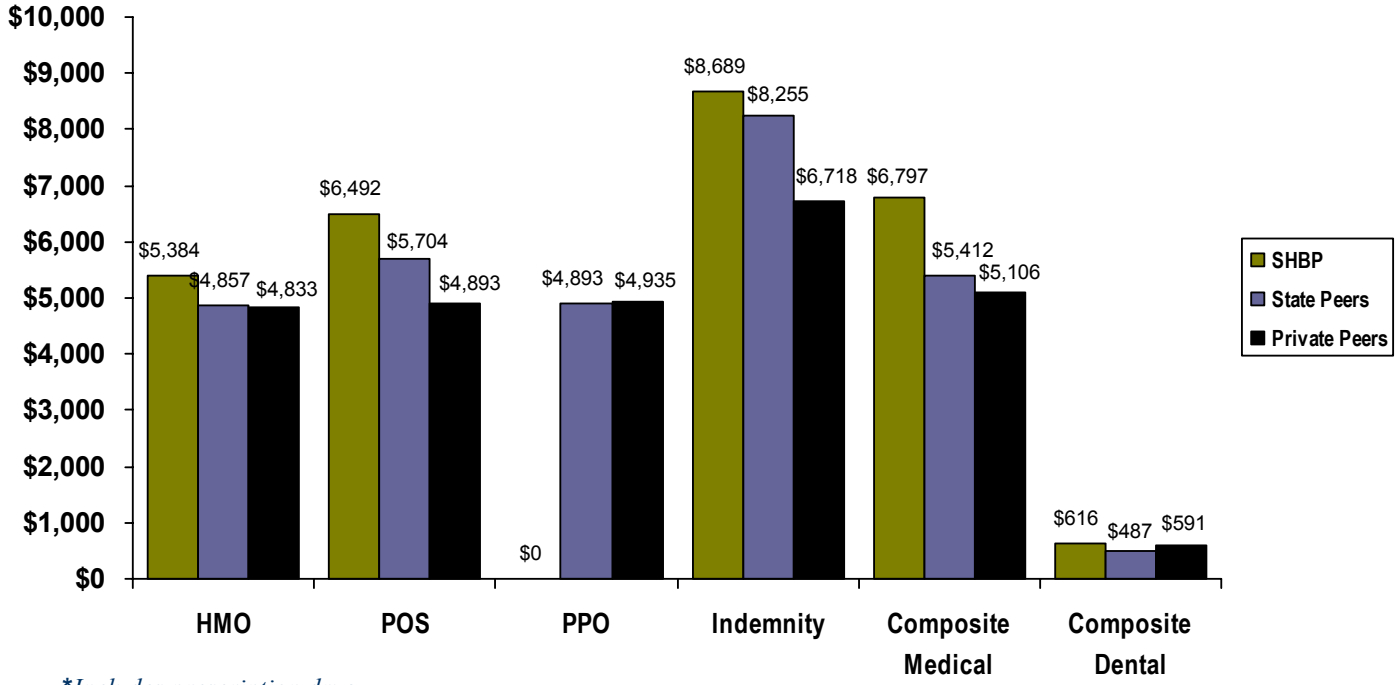
Sources: **Mercer Human Resource Consulting, 2002 National Survey of Employer Sponsored Health Plans.*

***Health Care Purchasing among State Employers, National Health Care Purchasing Institute, February 2003.*

Review of The Marketplace -- Cost *(continued)*

- **Overall Per Employee Costs**
  - Comparing the SHBP to their peer groups, the SHBP's annual per employee medical and dental costs were the highest among all peers, regardless of plan type (e.g,. POS, HMO, etc). Richer benefit design via lower deductibles, copayments and out of pocket maximums are primarily responsible.

Average Annual Per Active Employee Medical and Dental Costs (2002)*



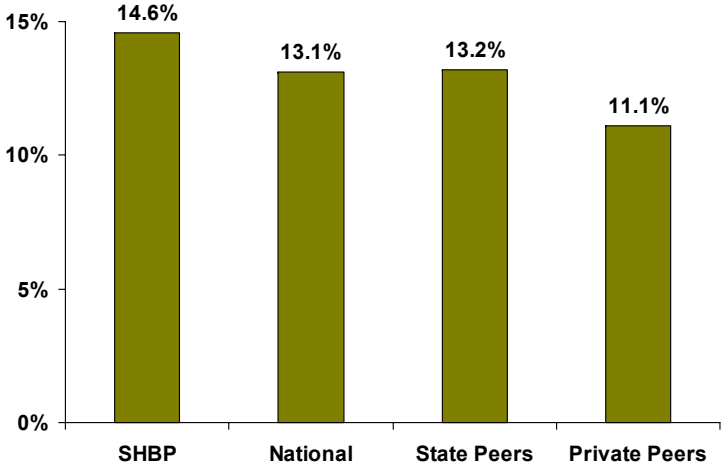
**Includes prescription drug.*

Source: *2002 Mercer Survey of Employer Sponsored Health Plans. SHBP Data based on 2002 actual incurred claims and administrative fees.*

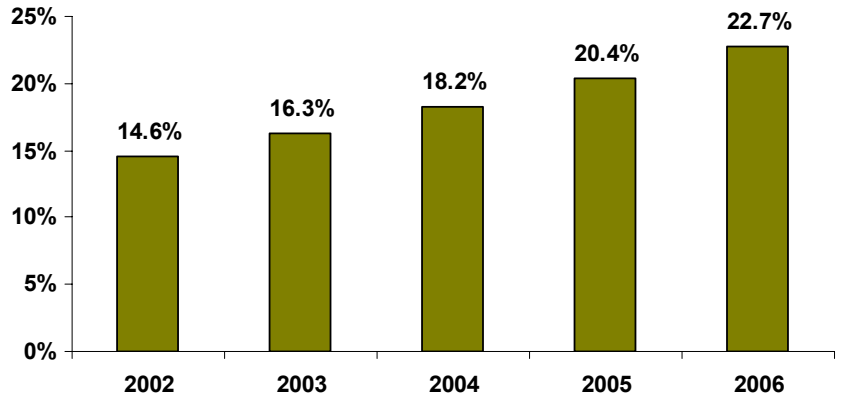
Review of The Marketplace -- Cost *(continued)*

- **Average Total Health care as a Percentage of Pay**
  - Typically, benefit packages comprised of medical, dental and prescription drug represent 8.8% of overall payroll expenses [1]. The SHBP program represents over 14.6% of overall payroll[2] which could be a combination of higher overall costs and/or lower salaries compared to other peers.
  - Among peer organizations, benefits comprise approximately 13.2% of state peers payroll and 11.1% of private peers payroll.
  - Assuming the SHBP made no changes to the program over the next five years and salaries increased at the current market norm of 3% of pay, total health benefit cost as a percentage of pay would increase to over 22% of pay by 2006 (see below). [3]

2002 Average Total Health Benefit Cost (as a % of Payroll)



SHBP Average Total Health Benefit Cost, 2002 -- 2006 (As a % of Payroll)



Source: *Mercer Human Resource Consulting, 2002 National Survey on Employer Sponsored Health Plans.*

[1] *US Chamber of Commerce, 2002 Employee Benefits Study.*

[2] *Assuming average salary of $50,673 – which was provided to Mercer from the State, average Medical, Dental and Rx Cost of $7,413 for SHBP.*

[3] *Assuming 2002 salary of $50,673 increasing 3% and per capita health care cost of $7,413 increasing 15% over the next five years.*

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Review of The Marketplace -- Financing

- **Funding** – Funding strategy is influenced by such factors as business performance, risk tolerance, budgetary practices and constraints, and employer size. A large majority of large employers "self fund" (i.e., self-insure) their medical and dental programs allowing these employers to more effectively manage risk charges.
  - Majority of both state and private peer employers offer their medical options through a self-insured arrangement.
  - The SHBP POS and Indemnity programs are self-insured. In 1998, SHBP moved the three largest HMO programs to a self-insured basis, saving the SHBP over $30 million to date.[1] The SHBP has a minimum threshold of 5,000 enrollees before they will consider self-insuring.
- **Premium Share Requirements** – By 2002, employees at large private organizations were contributing on average 23% to 28% towards the cost of health care coverage and over 85% require contributions for employee or family coverage.
  - By comparison, in 2003, over a third of all state peers still do not require a contribution towards the cost of employee only medical coverage (see chart).[2]
  - Almost 50% of state peers do not require a contribution towards the cost of employee only dental coverage.

Percentage of Employers Who Do Not Require Contributions for Active Medical or Dental Coverage

	SHBP		State Peers	Private Peers
MEDICAL	**State**	**Local**		
▪ Employee Only:	POS only	No contribution required	27%	15%
▪ Family:	POS only	Varies by local	11%	13%
DENTAL				
▪ Employee Only:	Require Contribution	Not Offered to locals	48%	23%
▪ Family:	Require Contribution		15%	14%

Source: 2002 Mercer National Survey of Employer Sponsored Health Plans

[1] *"State accomplishments Summary" provided by the SHBP.*

[2] *"Health Care Purchasing Among State Employers", National Health Care Purchasing Institute, February, 2003.*

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Review of The Marketplace --- Financing *(continued)*

- Similar to the SHBP, state and private peers do vary premium sharing by plan type and tier of coverage.
  - » For those state peers who do require employee contributions, they require an average of 14% to 20% of the total cost of coverage for employee only coverage and 22% to 31% for family coverage.
  - » Private peers require a larger percentage – 23% to 25% of total cost for employee only and 28% for family coverage.

Average Employee Contribution
(As a Percent of Total Cost)

	SHBP		State Peers	Private Peers
	State	Local		
EMPLOYEE ONLY				
– Indemnity:	25%	0%	14%	25%
– POS:	0%	0%	20%	23%
– HMO:	5%	0%	16%	24%
– PPO:	N/A	N/A	16%	24%
FAMILY				
– Indemnity:	25%	Varies	22%	28%
– POS:	0%	by	31%	28%
– HMO:	5%	local	25%	28%
– PPO:	N/A		31%	28%

Source: Mercer 2002 National Survey of Employer Sponsored Health Plans.

Average Employee Contribution, All States
(as a Percent of Total Costs for Most Prevalent Plan)

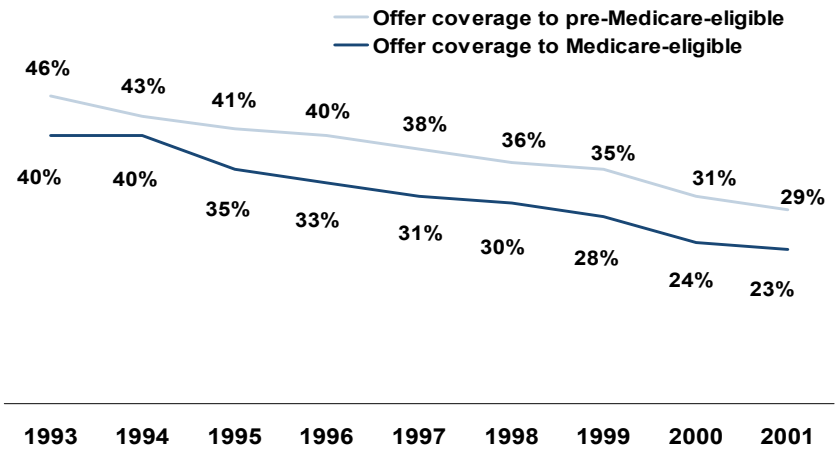
Percentage of Total Costs	Percentage of States	
	Employee Only Coverage	Family Coverage
No Contribution	32%	14%
> 0% -- 10%	20%	12%
11% -- 20%	20%	26%
21% -- 30%	10%	12%
31% -- 40%	0%	12%
41%+	4%	16%
Varies	14%	0%

Source: 2003 State Employee Benefit Survey, Work Place Economics. Inc.

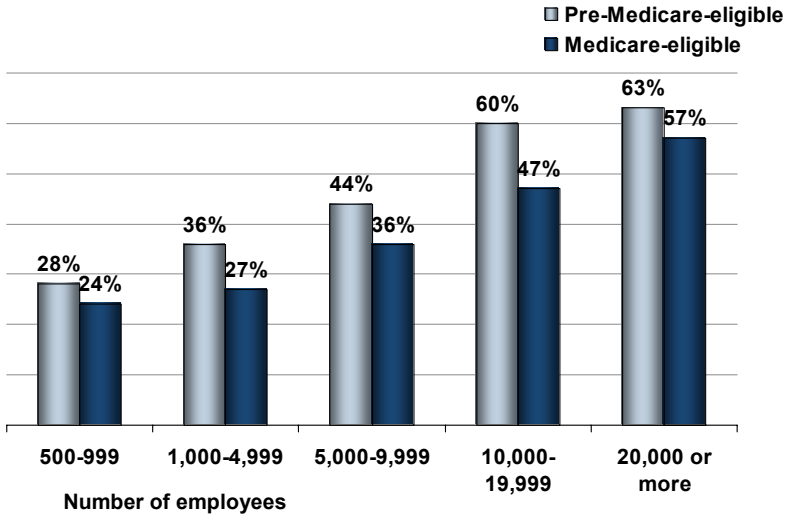
Review of The Marketplace – Retiree Medical

- While most employers in the private sector were reducing or in many cases eliminating retiree medical coverage over the past eight years (see chart below), over 86% of state/local governments offer retiree health benefits. [1]
- Not surprisingly, large employers are almost twice as likely as small employers to offer retiree medical coverage as shown below.

Employers Offering Retiree Medical Programs, 2001



Percentage of Employers Offering Retiree Medical in 2002, By Size



Source: *Mercer Human Resource Consulting, 2002 National Survey of Employer Sponsored Health Plans.*

[1] *"Health Care Purchasing Among State Employers", National Health Care Purchasing Institute, February, 2003.*

Review of The Marketplace – Retiree Medical *(continued)*

- State plans appear to subsidize the cost of coverage more than large private employers. Average contribution as a percentage of total costs for state plans is about 40%.[1]

Distribution of Cost Sharing Approaches for Retiree Coverage

	All Retirees	Pre-Medicare		Post-Medicare	
	SHBP	All States*	Large Employers**	All States	Large Employers
State/Employer Pays All	82%	25%	12%	25%	19%
Cost Shared	<1%	48%	51%	48%	46%
Retiree Pays All	18%	27%	37%	27%	35%

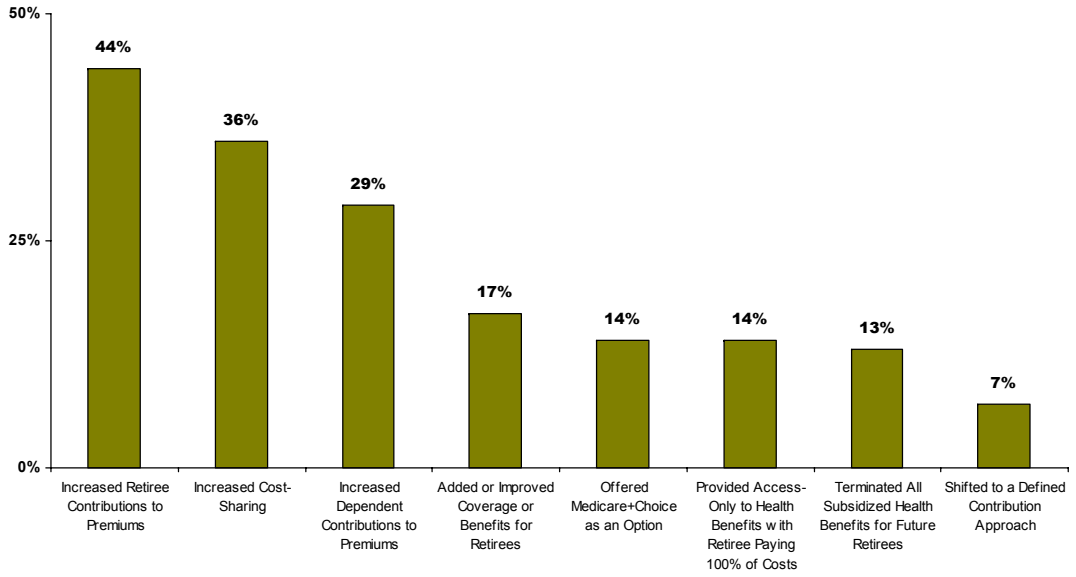
Sources: **2003 State Employee Benefits Survey, Workplace Economics, Inc.*
***Mercer 2002 Survey of Employer Sponsored Health Plans*

[1] *Kaiser/Hewitt 2002 Retiree Health Survey, December 2002.*

Review of The Marketplace – Retiree Medical *(continued)*

- Large private-sector employers offering retiree health benefits have made substantial changes in recent years in an effort to control rising costs, and are expected to sustain these efforts in the future.
  - In the past two years, 44% of large private-sector firms increased retiree contributions to premiums and 36% increased cost-sharing requirements for retirees.
  - Thirteen percent of surveyed employers terminated health benefits for future retirees.
  - Seven percent shifted to a defined contribution approach.

Summary of Employer Changes to Retiree Medical Programs



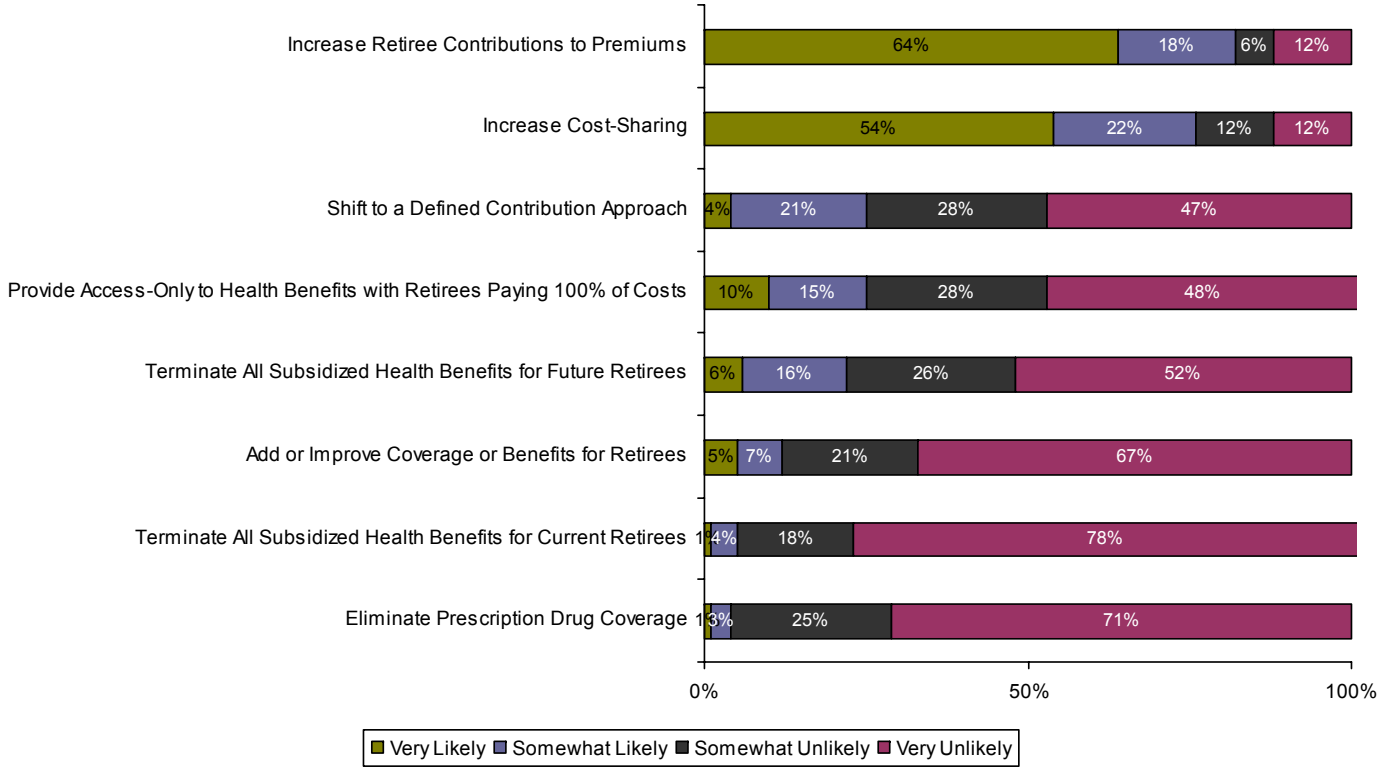
Note: Based on responses from private-sector firms with 1,000 or more employees that offer retiree health benefits

Source: *Kaiser/Hewitt 2002 Retiree Health Survey, December 2002.*

Review of The Marketplace – Retiree Medical *(continued)*

- Looking to the future, it appears that private employers are giving serious consideration to a number of changes related to retiree contributions and cost-sharing requirements. The vast majority of employers are somewhat likely to make the following changes in the next three years:

Summary of Employer Future Considerations for Retiree Health



Note: Based on responses from private-sector firms with 1,000 or more employees that offer retiree health benefits. Due to rounding, numbers may not sum to 100%.

Source: *Kaiser/Hewitt 2002 Retiree Health Survey, December 2002.*

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Review of The Marketplace – Retiree Medical *(continued)*

- While only a small share say they are very or somewhat likely to terminate subsidized coverage for *current* retirees (5%), more than one in five employers say they are very or somewhat likely to terminate coverage for future retirees (22%).[1]
- Prescription drug costs for retirees are a major concern for employers. To help rein in costs in the last two years, employers have used higher cost-sharing requirements and new strategies to manage utilization of drugs.
  - Nearly half of surveyed employers (49%) have increased drug copayments or coinsurance and close to two-thirds (63%) have imposed tiered copayments for pharmaceuticals.[1]
  - Despite the implementation of more aggressive cost-management tools in the past two years, most employers say they are very or somewhat likely to increase drug copayments or coinsurance for pharmaceuticals in the next three years (85%) and many expect to impose more stringent controls on utilization in the future. However, less than 4% say that they are very or somewhat likely to eliminate drug coverage.[1]
- Many major legislative proposals for Medicare drug coverage would offer incentives for employers to maintain some level of retiree health drug coverage, including direct and indirect subsidies and/or reinsurance payments.
  - When asked about the ongoing national debate to provide a Medicare drug benefit, the majority of employers surveyed (6%) say they think their firm would save money if a Medicare prescription drug benefit were enacted and 16% do not think their firm would save money. The remaining 23% say they do not know.[1]

[1] *Kaiser/Hewitt 2002 Retiree Health Survey, December 2002.*

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Review of The Marketplace – Other Considerations

- **HMO Consolidation –** In the late eighties and early nineties, employers provided employees with a large array of plan design choices and HMO vendors. "Choice" became a driving factor for program offerings. Many private employers have consolidated the number of HMOs offered in order to leverage larger volume; reduce administration complexities and mitigate adverse selection.
  - Overall, most state employers have not moved as rapidly towards this approach and on average continue to offer employees a choice of three or more HMO carriers.
  - The SHBP consolidated their active HMO offerings from 11 in 1998 to five in 2003 and standardized many of the benefit and operating procedures of the HMOs.
- **Vendor Contracts -** Many employers believed that securing a long term contract with their vendor was financially advantageous. Rate guarantees of two or three years were not uncommon. By comparison, most state employer contracts lasted three to five years[1]. The SHBP awarded a three year contract to Horizon in 2002 but review ASO fees annually. HMO offerings are evaluated annually, as well. Many private employers have moved towards annual contracts. Contract renewals on a yearly basis allow private organizations to negotiate cost savings and improved performance guarantees.

[1] *Health Affairs, 2003 "Role of Public Employers in a Changing Health Care Market."*

Review of Program Alternative Delivery Systems or Arrangements

- In the face of double digit health care cost increases, public and private plan sponsors continue to offer comprehensive benefits to employees. Employers are pursuing specific strategies to reduce costs and to preserve benefit value. These strategies include:
  - Health and Productivity Management
  - Specialty Carve-out Vendors, Efficient Provider Networks or Collective Purchasing Efforts
  - Consumer (employee and family) Decision-making and Accountability
  - Consumer Directed Health Plans (CDHPs)

Health and Productivity Management

- Health Management Programs are designed to avoid problems before they occur. A health and productivity management strategy combines the best benefit design and coverage, with health promotion, disease prevention, self-care management, and disease management to avoid or minimize the effects of poor health.
- Proactive management acknowledges that employee health is a necessary asset for a highly productive work environment and community. By managing health, companies, health plans and providers believe they can achieve better performance and avoid costs.
- Disease management is a multi-faceted approach to health care delivery that proactively identifies plan participants who are at risk for or have established chronic medical conditions. The goal is to ensure that physicians and all health care providers involved in the care of these individuals follow established clinical guidelines. Additionally, the affected individual is provided the resources, knowledge and support to manage their disease appropriately.

Review of Program Alternative Delivery Systems or Arrangements *(continued)*

Specialty Carve-outs Vendors

- To reduce costs and increase flexibility, many employers are using carve-out programs or direct contracting. Common benefit programs that can be carved out include prescription drugs, mental health, chronic care and disease management. In a recent study by the Health Care Purchasing Institute, state governments report that 50% have a separate prescription drug benefit administrator and 44% have a separate mental health administrator.[1]

Efficient Provider Networks

- There is growing evidence that efficient medical care is consistent with quality medical care. Some employers have started to measure this connection directly, and are incorporating physician quality assessment into the development of "efficient" provider networks.
- An "efficient network" uses data to identify and qualify the most efficient providers. By shifting medical care to more efficient physicians, employers may yield significant savings.
  - An inefficient specialist can use over 40% more resources than necessary to treat a particular illness or injury.
  - Variances of over 200% are not unusual.
- This concept works best when an organization has a concentration of plan members – at least 5,000 – in one or more markets.
- Typical savings can be as much as 10% of costs.

[1] *"Health Care Purchasing Among State Employers", National Health Care Purchasing Institute, February, 2003.*

Review of Program Alternative Delivery Systems or Arrangements *(continued)*

Collective Purchasing Efforts

- Rising health care costs and growing dissatisfaction with health plan management are pressuring employers to consider sweeping changes to their health plans. But many employers, acting alone, lack the business clout to negotiate better prices with vendors or providers or have them make plan changes to accommodate their unique interests.
- In the health care arena, employers are joining together to get better results. And while negotiating savings in annual premium rate can be a good, short term win, getting health plans to make the kind of significant changes that align with business objectives and employee needs require strong commitment and industry influence.
- Collective purchasing allows employers to leverage size or geographic concentration to improve financial arrangements, vendor performance and clinical program reviews. Typical savings from a coalition can be as much as 6%-10% of costs.

Consumer Decision-making and Accountability

- Following the pattern of consumer involvement in retirement benefits, health care has become the latest area where consumer involvement is expanding. Many firms, large and small, have already adopted consumer focused approaches that give employees better access to health information, and improved resources for making health care decisions, and more control over their health care dollars.
- Several carriers have taken a lead role in developing websites for greater employee access to information.
- Recently, the State of NJ released its 7th Annual HMO Performance Rating Report which provides ratings of HMOs offered in NJ.

[1] *"Health Care Purchasing Among State Employers", National Health Care Purchasing Institute, February, 2003.*

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Review of Program Alternative Delivery Systems or Arrangements *(continued)*

Consumer Directed Health Plans (CDHPs)

- Most employers nationwide have been slow to introduce consumer-driven health plans (CDHPs), typically a plan that may include an employer funded health care savings account (that accumulates over the employee's term of employment); catastrophic coverage (i.e., high deductible plan); proactive care management support systems; and a provider network that provides consumers an incentive to use cost-efficient providers (who follow evidence-based guidelines). The key goal of a CDHP is reduced plan costs over time by changing consumer behavior and empowering plan participants to be more accountable for their health care decisions and spending.
- CDHPs give employees greater personal involvement through choice and control over their health care decisions. These plans have not gained wide acceptance among workers or support from the public sector unions, in particular since the majority of state workforces are typically comprised of low – to moderate wage workers, who could be adversely affected by the high deductibles in such plans.[1]
- However, beginning in 2004, the Federal Employee Health Benefits Program will be offering three CDHP plans in a variety of markets.
- A recent study by Forrester Research Inc. (2003) predicts that there will be growth in the CDHP share of the market to 2% in 2005 and 7% by 2007.

[1] *"Health Care Purchasing Among State Employers", National Health Care Purchasing Institute, February, 2003.*

4: Program Financial Review

4

Program Financial Review

Introduction

- The SHBP is composed of two separate and distinct programs:
  - The program for State employees (actual employees of the State and its affiliates) and
  - The program for local employees (actual employees of other education and governmental entities).
- Mercer used the same methodology to review the finances of the State program and the local program. However, the implications of the findings are different. The framework in which the situation should be reviewed and actions which should be taken are significantly different.
- The local program issues are addressed separately in the "Local Employer Needs" section of the document, but the financial review of the local portion of the program is included in this section as well.

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Overview

- Mercer's review of the financial soundness of the SHBP program included:
  - Incurred but not paid (IBNP) estimates for the Horizon programs,
  - Adequacy of the rates for the Horizon medical and prescription drug programs, and a
  - Framework for understanding the potential risk of self-insurance, and whether the exposure is reasonable for the SHBP to assume.
- Mercer's findings are presented in four distinct sections:
  - Reserve Level Adequacy
  - Rate Level Adequacy
  - Current Rate Structure and Methodology
  - Appropriateness of Being Self-Insured
- The SHBP engages an actuarial consulting firm to assist in setting IBNP reserve estimates and premium rates for the self-insured programs. Over the course of Mercer's study period (i.e., June 1999 – January 2003), the SHBP had two separate actuarial firms. Below is a summary of the actuary and their particular renewal assignment.

Report Date	Renewal Calculation at	Actuary	Reserve Calculation at	Actuary
1/19/1999	7/1/1999	Buck	-	-
1/21/2000	7/1/2000	Buck	-	-
6/18/2001	1/1/2002	Milliman	6/30/2000	Milliman
8/19/2002	1/1/2003	Milliman	6/30/2001	Milliman

- In the following section, Mercer refers to these actuaries collectively as "actuary".

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Reserve Level Adequacy

- Mercer's review of the SHBP Horizon-based IBNP reserves included the fiscal years 2001 and 2002. Data was provided by the vendors, the State and their actuary. Information for 2000 and prior was not available.
- While the reserve levels are adequate to cover incurred but not paid claims, Mercer has some concerns with the actuary's methodology:
  - From the actuary's perspective, the recommended reserve is comprised of two components that are posted to the IBNP section of the financial statements:
    - Liability for claims incurred but not paid and
    - Liability for extension of benefits for disabled individuals.
  - GAAP accounting rules for private employers would have these two components *calculated separately and segmented*, as they would be subject to disclosure in different segments of the financial statement:
    - Incurred but not paid liability is for plan participants, active and retired, but is an incurred liability (i.e., for expenses incurred in the past).
    - Extension of benefits for disabled individuals is an actuarial liability for benefits that are expected to be paid in the future (i.e., benefits provided upon termination for disabled individuals).
    - Due to the different nature of these liabilities, Mercer believes that extension of benefits should not have been aggregated into the SHBP's reserve calculations, but disclosed separately.
- Mercer's review includes an independent calculation of the IBNP liability estimate, with data which would have been available at the time of the actuary's calculation.
  - Mercer's calculation does not include extension of benefits.
  - "Actual Needed" (true liability calculation) does not include extension of benefits.
  - Mercer's estimate includes the addition of 10% margin to increase the probability that the reserve is adequate.
    - The "best estimate" is calculated to have an equal chance of being too high or too low.
    - Margin is added to increase the probability of being too high, i.e., fiscally conservative.

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Reserve Level Adequacy *(continued)*

- The following financial exhibit shows the Horizon program's IBNP information for fiscal years 2001 and 2002:
  - The "Actual Needed" column is Mercer's best estimate, today, of the liability which existed as of June 30, 2001 and June 30, 2002. The "SHBP" column represents the "booked" reserves, found in the SHBP's annual report. The "Mercer" column represents our calculation of the SHBP's reserve requirements based on our methodology and the data which would have been available at the time.
- Overall, the SHBP reserve levels for 2001 and 2002 were 117% and 113% of "Actual Needed". The reserve levels were adequate for actual incurred but not paid claims.
- Mercer's methodology, which is explicitly conservative due to the inclusion of "margin," would have produced liability estimates 4% to 8% higher than the current best estimate of the "Actual" liability. Note the SHBP includes a provision for a liability, extension of benefits, not measured in the "Mercer" or "Actual" columns. We understand the extension of benefits reserve is 1% of the IBNP reserve.

Review of SHBP IBNP Estimates for Fiscal Year 2001 and Fiscal Year 2002

Coverage	State/Local	IBNP for 2001 Fiscal Year			IBNP for 2002 Fiscal year		
		SHBP[1]	Mercer[2]	Actual Needed	SHBP[1]	Mercer[2]	Actual Needed
Traditional	State	29,000,000	26,200,000	26,800,000	28,300,000	28,800,000	25,500,000
	Local	89,700,000	74,500,000	73,100,000	96,800,000	88,400,000	82,700,000
	Total	118,800,000	100,700,000	99,900,000	125,100,000	117,200,000	108,200,000
NJ PLUS	State	40,100,000	35,100,000	32,300,000	47,500,000	44,200,000	42,500,000
	Local	35,800,000	32,700,000	31,300,000	45,300,000	42,800,000	39,000,000
	Total	75,800,000	67,700,000	63,600,000	92,700,000	87,000,000	81,500,000
Active Rx	State	9,300,000	10,900,000	9,700,000	12,000,000	12,600,000	11,800,000
	Local	2,100,000	2,200,000	2,000,000	3,300,000	3,400,000	3,100,000
	Total	11,400,000	13,100,000	11,600,000	15,200,000	16,000,000	14,900,000
Retiree Rx	State	3,200,000	3,300,000	3,100,000	4,000,000	4,400,000	3,800,000
	Local	8,400,000	8,900,000	8,100,000	10,700,000	11,400,000	10,200,000
	Total	11,500,000	12,200,000	11,200,000	14,600,000	15,800,000	14,000,000
Total	*State*	*81,600,000*	*75,400,000*	*71,900,000*	*91,800,000*	*90,000,000*	*83,700,000*
	Local	*135,900,000*	*118,300,000*	*114,500,000*	*156,000,000*	*145,900,000*	*135,000,000*
	Total	*217,500,000*	*193,700,000*	*186,300,000*	*247,700,000*	*235,900,000*	*218,700,000*
% vs. Actual Needed	State	113%	105%	-	110%	108%	-
	Local	119%	103%	-	116%	108%	-
	Total	117%	104%	-	113%	108%	-

Notes: *1 Includes unspecified reserve for extension of benefits for disabled employees*
2 Includes explicit margin of 10%
Note all $ figures rounded to nearest $100K.

Reserve Level Adequacy *(continued)*

- While the reserve levels are adequate for IBNP Claims, the following observations regarding methodology are important to note:
  - Based on the documents Mercer reviewed, the SHBP actuary's methodology apparently builds on Horizon's methodology, which is undisclosed.
  - Mercer would expect the actuary to independently estimate SHBP's liabilities using data and best practice methods for:
    - IBNP liability (or separately, the incurred but not reported liability, and the reported but not paid liability) and
    - Extension of benefits liability.
  - Mercer would expect that margin would be added to increase the probability that the reserve posted to the financial statement was adequate for the actuarial liability in existence at the time.
  - Mercer would expect documentation that required monitoring whether the previously posted liability was adequate or not, and if not, what influences, issues, or method flaws generated the inadequacy. Mercer saw no documentation regarding required monitoring and we found no evidence of any inadequacy.

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Rate Levels Adequacy

- When reviewing the adequacy of the SHBP's current rates, Mercer examined the following:
  - Overall surplus/deficit history and implications, and
  - Current rate structure and methodology.
- Information was provided by the SHBP (the actuary's rate recommendation reports), SHBP financial statements, and claim data provided for the reserve level adequacy review.
- The SHBP and the actuary prepared formal estimates of projected costs of the programs, and resulting rate actions for the upcoming rating year.
  - Note: The rating year was changed from a fiscal year to a calendar year in 2001, necessitating an 18-month "year."
- During Mercer's review period (7/1/98 forward), both the State Horizon program and the local Horizon program experienced a loss (premium rates were inadequate when compared to claims and expenses) during each and every projection year (see chart below).
- The following financial exhibit shows the Surplus/Deficit History of the State and local Horizon programs from 6/30/98 through 12/31/02. Deficits from 7/1/00 to 12/31/02 were estimated by Mercer using incurred claims from the reserve level adequacy review.

Surplus/Deficit History of State and Local Horizon Program, 1998 -- 2002

State Plan – Deficit History

Surplus/(Deficit)		
End Date	**Year**	**Cumulative**
6/30/98	—	$5.3M
6/30/99	($22.2M)	($16.9M)
6/30/00	($10.4M)	($27.3M)
12/31/01	($70.3M)	($97.6M)
12/31/02	($36.2M)	($133.7M)

* *Does not reflect the action taken by the SHBP to release the funded IBNP reserve to pay claims. The cash balance in SHBP's records should be $91M greater than this, i.e., deficit of approximately $42M.*

Source: Actuary's Deficit History through 6/30/00.

Local Plan – Deficit History

Surplus/(Deficit)		
End Date	**Year**	**Cumulative**
6/30/98	—	$156.0M
6/30/99	($23.7M)*	$132.3M
6/30/00	($103.4M)**	$28.9M
12/31/01	($139.8M)	($110.9M)
12/31/02	($81.4M)	($192.3M)

* *Some surplus used to reduce FY99 rate action*
** *Includes 10/99 premium holiday of $45M*

Rate Levels Adequacy *(continued)*

Impact of Declining Surplus Levels

- Before examining possible drivers of this deficit, it is important to highlight the implications of a declining surplus.
- Surplus levels have declined from a positive at the beginning of the study period to a negative (deficit position) at the end of the study period.
  - This has significantly different implications for the State segment as compared to the local segment. The detailed implications for the local segment are addressed in the "Local Employers Needs" section of our review.
- If the SHBP were an insurance company, the SHBP would be subject to a surplus review including a Risk-Based Capital (RBC) calculation (see chart on next page).
  - The RBC calculation attempts to quantify the amount of capital a plan sponsor should have access to in order to accept "insurance" of benefit programs.
    - » Health RBC emerged in the mid-1990's as an actuarially formulated measure of the appropriate level of capital or surplus necessary for any health risk-taker (e.g., employer or a commercial carrier) to utilize.
    - » The National Association of Insurance Commissioners (NAIC) implemented the tool for evaluating health insurers and managed care organizations in the late 1990's.
  - The Department of Banking and Insurance (DOBI) monitors the risk capital relative to an organization's total adjusted capital to ensure program solvency.
    - » This process results in a comparison of the total adjusted capital (surplus) of the risk-taker to its Authorized Control Level (ACL) need, resulting in one of five recommendations to the DOBI.
    - » The authorized control level is the level at which the DOBI may require action or in extreme cases overtake the program if adjusted capital falls below it.

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Rate Levels Adequacy *(continued)*

– As of December 31, 2002, both the State and local programs were in a significant deficit position. Adjusted capital was well below the ACL. If the SHBP were an insurance company the DOBI Commissioner would be looking to rehabilitate or liquidate the insurer (e.g., mandatory control level due to lack of solvency). While, this does not happen on self-insured employer groups such as the SHBP, it does apply on MEWAs. More discussion regarding the potential impact on the local portion is discussed later in this report.

Risk Based Capital Calculation

Program	*Period*	*Total Adjusted Capital*	*Authorized Control Level Risk-Based Capital*	*SHBP Current % (Adjusted Capital to Risk-Based Capital)*	*Level of Action by DOBI, if Any*
State	Fiscal Year 1998	$5,300,000	$17,800,000	30%	Mandatory Control Level
	Fiscal Year 1999	-$16,900,000	$18,000,000	-94%	Mandatory Control Level
	Fiscal Year 2000	-$27,300,000	$18,500,000	-148%	Mandatory Control Level
	Calendar Year 2001	-$97,600,000	$25,100,000	-389%	Mandatory Control Level
	Calendar Year 2002	-$133,700,000	$33,400,000	-400%	Mandatory Control Level
Local	Fiscal Year 1998	$156,000,000	$23,400,000	667%	NONE
	Fiscal Year 1999	$132,300,000	$24,400,000	542%	NONE
	Fiscal Year 2000	$28,900,000	$26,100,000	111%	Regulatory Action Level
	Calendar Year 2001	-$110,900,000	$35,800,000	-309%	Mandatory Control Level
	Calendar Year 2002	-$192,300,000	$49,600,000	-388%	Mandatory Control Level

Legend:

- No action = greater than 200% of Authorized Control Level
- Company Action Level=200% of Authorized Control Level, but not less than 150%.
- Regulatory Action Level=150% of Authorized Control Level, but not less than 100%.
- Authorized Control Level=100% of Authorized Control Level, but not less than 70%.
- Mandatory Control Level=70% of Authorized Control Level

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Current Rate Structure and Methodology

- The deficit described in the previous pages is due in part to rating deficiencies. The following highlights the current Horizon rate development methods and comments on appropriateness of current actuarial assumptions.
- In general, the actuary used rating techniques which are in the range of generally accepted actuarial practice. However, it appears that the projections from 7/1/99 forward may have a technical flaw in their formulation of premium rates.
- Mercer believes there were instances in which best-practice techniques were appropriate but were not used, and would have resulted in a more accurate prediction of projected costs. These are detailed in the following pages.
- Actuaries and consultants developing projected costs for self-insured programs typically use the following basic formula to develop those projected costs:
  - Capture claims experience in some prior period;
  - Project that forward in time (the concept of “trend”) to the projection year;
  - Add in the non-claim cost requirements for the projection year (e.g., administration costs);
  - Make provision for any differences in the projection year from the experience year; and
  - Take this projection and formulate premium rates.
- On the following pages, Mercer details each of these steps and comments on the actuary’s techniques.

Current Rate Structure and Methodology *(continued)*

- Capturing of experience period claims
  - The process begins with capturing experience period paid claims, typically for a period two years prior to the projection period (e.g. calendar year 2000 for projection year 2002). This two year projection period is longer than most large private employers, due to SHBP timing requirements.
  - In an attempt to match plan participants appropriately with paid claims, "set-back" enrollment is used to develop a per-employee cost.
  - This per employee cost is used as the projection basis in the formula.
  - Mercer believes best practice would be to utilize estimated incurred claims, not paid claims, as the basis for the projection formula. Estimated incurred claims are a direct by-product of an appropriate incurred but not paid liability estimation process. This eliminates several possible drivers of potential variance, including:
    - » Any payment process variations which would be addressed in the incurred claim estimation process; and
    - » The need to approximate per employee costs with set-back enrollment as actual enrollment can be matched to incurred claims.

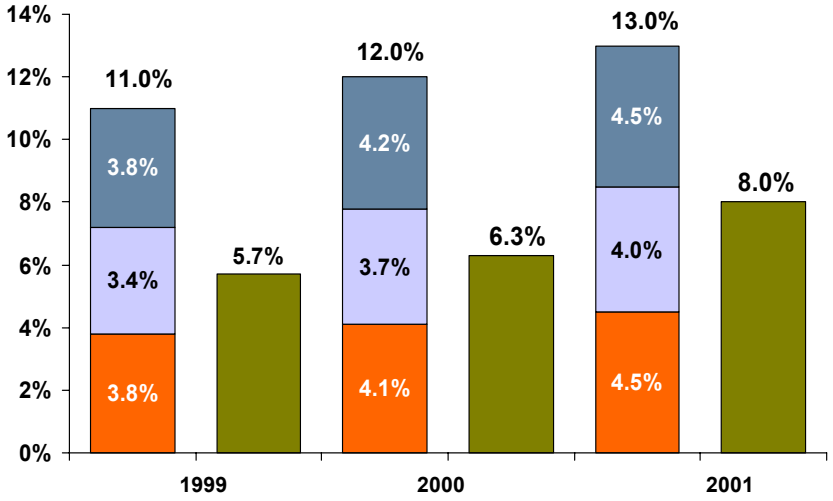
Current Rate Structure and Methodology *(continued)*

- Projection trend
  - The actuary begins the trend estimation process by reviewing Horizon's assumption, then contrasting that with their own choice of trend rates. In general, the actuary performed their own analysis but gave substantial weight to the Horizon analysis.
  - Projection trend is typically viewed as having three major components:
    - » Cost per service,
    - » Utilization of services, and
    - » Mix of services purchased.
      - Mix is typically difficult to capture, and is therefore part of both Cost and Utilization if only those two dimensions are captured.
    - » Other secondary influences are often cited, including aging, cost-shifting and technology, and benefit leveraging.
  - In setting projection trend assumptions, the actuary should review not only the past experience (which, as previously mentioned, is close to two years old when being reviewed) but also current and possibly future conditions appropriate for the medical program.
  - The Horizon analysis, upon which the actuary relied heavily, seemed focused solely on the Cost per service component, and made little provision for the Mix component or the Utilization component.
  - The result is that for medical, the actuary's rating trends were insufficient.
  - The following exhibits, provide detail on the medical and prescription drug trends Mercer was generally recommending during 1999, 2000, and 2001. These trends were consistent with the marketplace and are substantially greater than those used by the SHBP Plan's actuary.

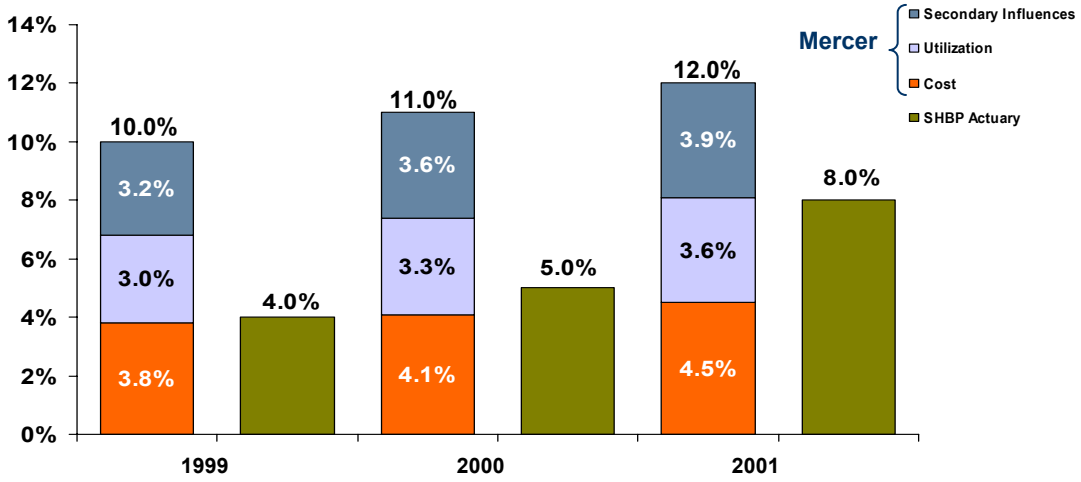
Current Rate Structure and Methodology *(continued)*

Medical Trend Comparison, Rating Years 1999-2001 (For Both State and Local Plans)

Active and Pre-65 Plans: Traditional Medical Plans



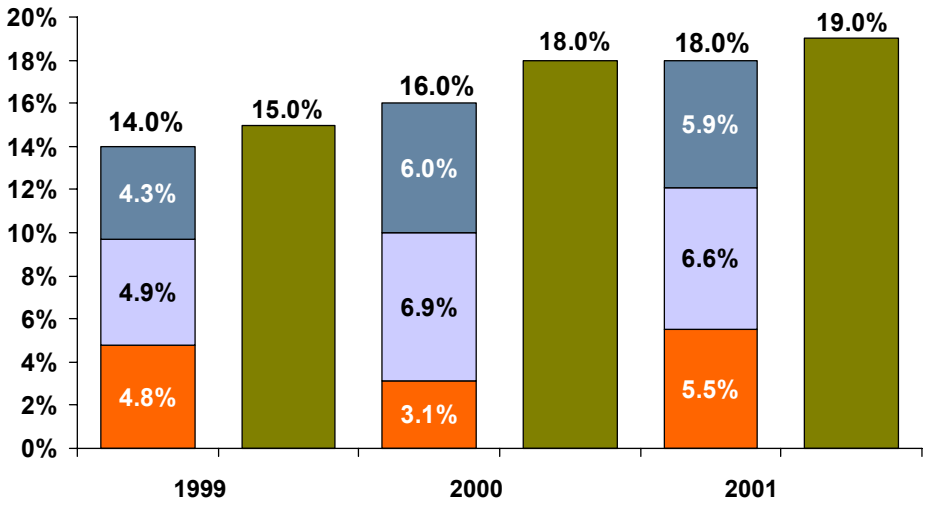
Active and Pre-65 Plans: POS Medical Plans



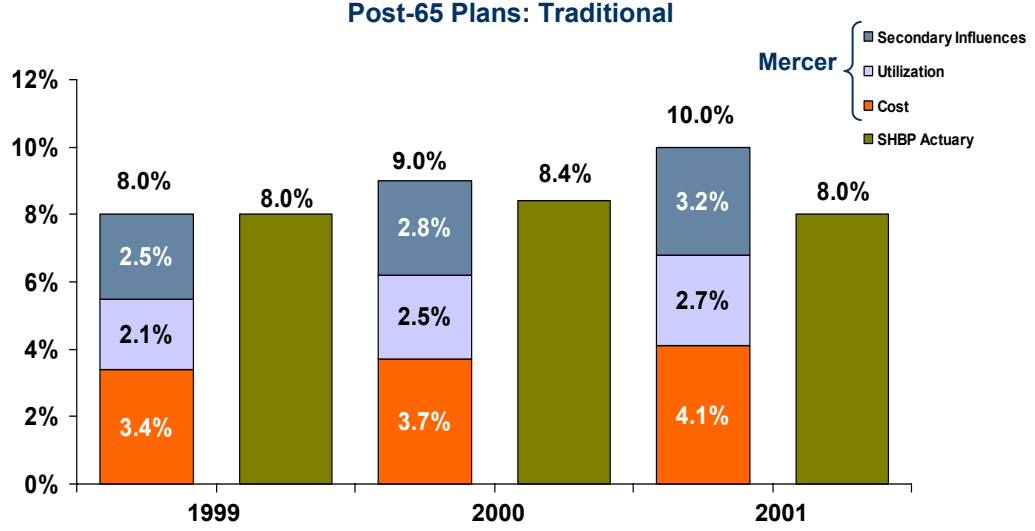
Current Rate Structure and Methodology *(continued)*

Medical/Prescription Trend Comparison, Rating Years 1999-2001 (For Both State and Local Plans)

Prescription Drug Trend



Medical Trend Comparison, Post-65 Plans: Traditional



Current Rate Structure and Methodology *(continued)*

- Addition of non-claim expense for the projection year
  - This includes Horizon's expenses, the SHBP's administrative expenses, and investment income on the Incurred but not Paid claim reserve. It also includes a revenue projection for non-participating local agencies to support the movement of retirees into the SHBP program.
  - Inclusion of Horizon's administrative requirements (which are charged on a per employee basis) and the SHBP additional administrative load are relatively straightforward.
  - Provision of investment income from a funded Incurred but not Reported reserve is unusual in the State program, but is appropriate for the local program.
    - » However, no provision is made in either the State or local projection formula for interest income (either positive or negative) due to the surplus position of the overall program. This asymmetry is inappropriate, particularly on the local segment.
      - The State program appears to be an unfunded program working from current cash flow and general assets. An unfunded liability should prompt the actuary to make no provision for investment returns. Additionally, the SHBP "moved" the liability, giving the appearance of cashing out the funded reserve and decreasing the deficit on the State program. Thereafter, the 2003 renewal rates make no provision for IBNP investment income.
      - Conversely, the local program operates similar to a MEWA. Actual premiums are received from participating employers, and the cash inclusion for the IBNP liability should form a reserve which earns interest. This interest can be used in the projection formula for the locals.

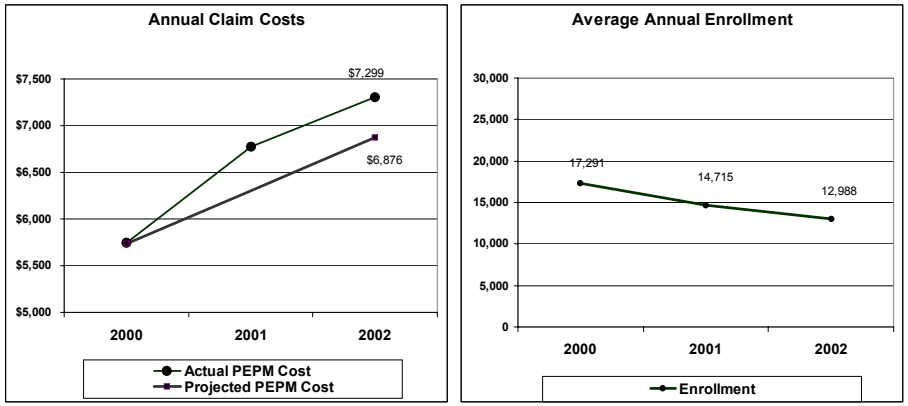
Current Rate Structure and Methodology *(continued)*

- Provision for differences in the rating year, compared to the experience year
  - This step can take into account any structural or demographic change between the experience year and the rating year which the actuary can or should know about, or be monitoring.
  - Best practice calls for monitoring the changes in demographics over time, and more specifically contract mix. If the contract mix changes over time, this will have an impact on the projection of costs, particularly when they are done on a per-employee basis. The actuary provided no provision for demographic changes and it is unclear to what extent they account for contract mix changes.
  - Further, the actuary must be on the lookout for the effect of selection. Often referred to as adverse selection or anti-selection, this effect manifests itself when plan participants select from multiple plan options.
    - » It is typical to assume an immaterial effect of selection if nothing changes (plan types, cost-sharing, or premium sharing requirements) from the experience period to the rating year.
    - » It is essential to assume a selection effect if material changes are made to the plan types, cost-sharing, or premium-sharing requirements of the plan.
  - The actuary does not appear to make any explicit provision in the SHBP program for the effect of selection when employee cost-sharing was implemented. This is outside the range of generally accepted actuarial practice.
- There was retrospective commentary in the plan year actuary's report that states "it appears the cost sharing provisions may have had an impact on enrollment." However, to the best of Mercer's knowledge, there were never any studies undertaken to understand the cost difference between the plan participants moving into the NJ PLUS plan from the HMOs or the Traditional Plan, or any hypothesizing about the impact either retrospectively or prospectively, of the impact of the significant migration which took place.

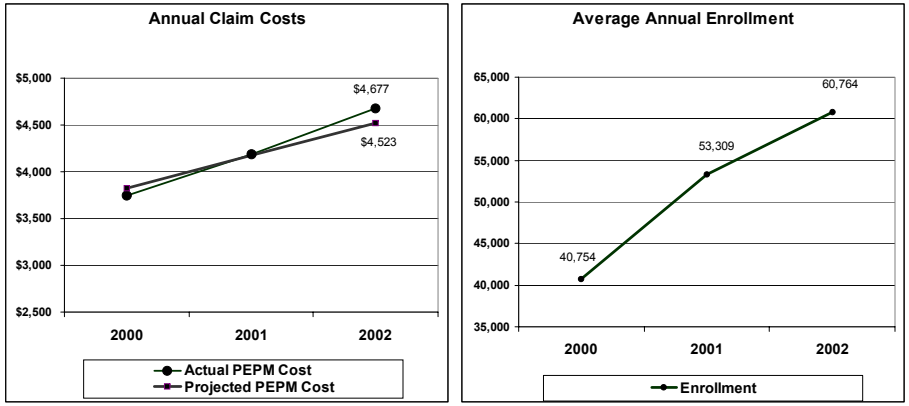
Current Rate Structure and Methodology *(continued)*

- The following exhibits illustrate the effect of migration on the program costs. Enrollment in the State portion of the NJ PLUS program nearly doubled from 2000 to 2002, possibly spurred by the increase in employee contributions to the Traditional Plan (i.e., 25% of premium) and HMOs (i.e., 5% of premium).
  - Selection from the Traditional Plan to the NJ PLUS (whose contribution remained at 0%) does not appear to be anticipated in the rates.
  - This, coupled with low trend assumptions previously mentioned, could have resulted in a combined shortage of $14.8M in 2002.

State Actives – Traditional Plan



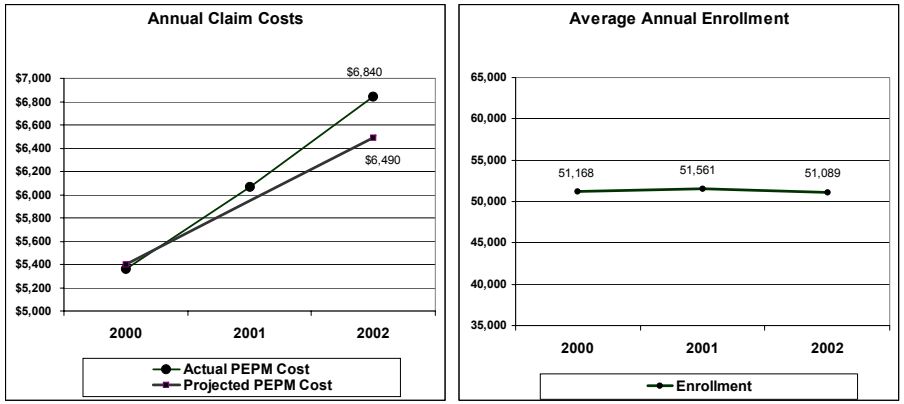
State Actives – NJ PLUS Plan



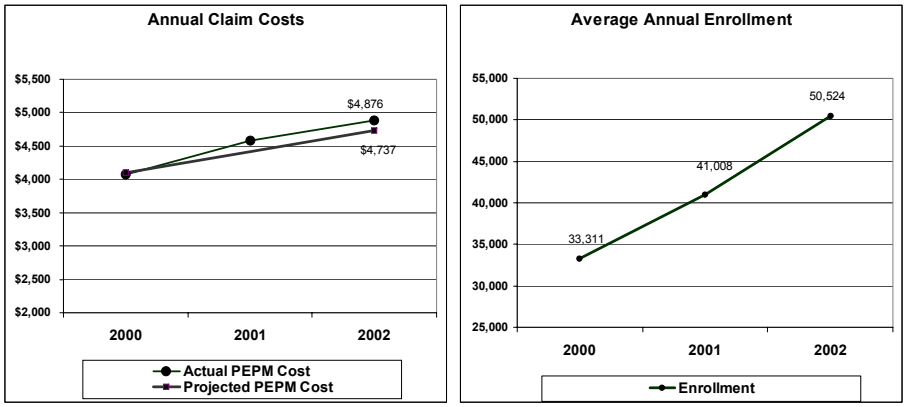
Current Rate Structure and Methodology *(continued)*

- The local program also experienced significant enrollment growth. While the Traditional Plan remained static, the NJ PLUS enrollment doubled from 2000 to 2002, presumably as a result of actions taken by the SHBP to encourage locals to join the SHBP plan such as easing re-entry rules; revamping rate structures; and low trend assumptions.
  - Many local employers who had left the SHBP, and experienced large increases, returned to the SHBP.
  - Enrollment jumping 23% in the NJ PLUS plan in one year (2001) should have caused a red flag. It is unclear whether 2002 rates consider this implication.
  - Enrollment in the Traditional Plan remained relatively constant, but a low trend assumption may have contributed to a $17M deficit.

Local Actives – Traditional Plan



Local Actives – NJ PLUS Plan



Current Rate Structure and Methodology *(continued)*

- Formulation of Premium Rates
  - Premium rates can be formulated in several ways. The actuary utilizes a "rate increase" method, where current rates are tested against the revenue requirements of the program, then increased by a percentage if they are inadequate.
  - The actuary appears to have a technical flaw in their methodology.
    - » Mercer has identified that the actuary's methodology produced rates levels that – when adjusted for enrollment -- do not reproduce the actual premium collected in the period. Mercer refers to this as "loss of realized premium".
    - » In the table below, Mercer shows the derivation of our estimated deficit as of 12/31/02. The majority of the deficit, for both the State and local programs, is due to a loss of realized premium.
    - » The loss of realized premium is estimated by making a headcount adjustment to the projected premium in the actuary's projections and comparing it to the actual "audited" premium, with the same headcount. The differences should be negligible, but generate losses of $67.7 million for the State and $111.9 million for the local program over a 30 month period.

Projected Deficit Summary (in $Millions)

State Plans		
6/3/00 Audited Balance		**$(27.3)**
7/00 – 12/01 Projected Premium	$867.0	
7/00 – 12/01 Actual Premium	$827.2	
Loss of Realized Premium		$(39.8)
7/00 – 12/01 Premium – Claims – Fees		$(30.4)
Estimated Balance at 12/31/01		**$(97.6)**
1/02 – 12/02 Projected Premium	$735.9	
1/02 – 12/02 Actual Premium	$708.0	
Loss of Realized Premium		$(27.9)
1/02 – 12/02 Premium – Claims – Fees		$(8.2)
Estimated Balance at 12/31/02		**$(133.7)**

Local Plans		
6/3/00 Audited Balance		**$28.9**
7/00 – 12/01 Projected Premium	$1,247.3	
7/00 – 12/01 Actual Premium	$1,187.6	
Loss of Realized Premium		$(59.7)
7/00 – 12/01 Premium – Claims – Fees		$(80.1)
Estimated Balance at 12/31/01		**$(110.9)**
1/02 – 12/02 Projected Premium	$1,093.8	
1/02 – 12/02 Actual Premium	$1,041.7	
Loss of Realized Premium		$(52.2)
1/02 – 12/02 Premium – Claims – Fees		$(29.3)
Estimated Balance at 12/31/02		**$(192.3)**

Current Rate Structure and Methodology *(continued)*

- This loss of realized premium may be the result of other factors, including:
  - Appropriation changes on the State program, and
  - Premium "drag" issues on the local program, if the premium drag is not included in the actual premium.
  - Mercer recommends further analysis to document what is causing the loss of realized premium.
- As noted above (and by the actuary in several of their reports), actuaries would typically add a margin to increase the probability that rates are adequate. This was not done in any circumstance.
  - Emerging losses should prompt the actuary to review their methods, assumptions, or other reasons for losses. Margin provides for a contingency against unforeseen events, including overly aggressive assumptions.
  - Margins or explicit deficit recovery provisions are typically added by insurers or MEWA sponsors to replenish surplus. This is typically not done for self-insured employers. The local program deficit position should be reviewed and explicit margins should be added to rating process, which is discussed in more detail in the local section. Adding margin in the State program would increase the probability that the rates are adequate.

- In summary, low medical trend assumption, lack of margins, and inadequate anticipation of selection due to the implementation of cost sharing provisions, were the main drivers behind the SHBP's rating inadequacy. In addition, the issue of loss of realized premium adds significantly to the deficit position.

Current Rate Structure and Methodology *(continued)*

- Retiree Rates
  - The retiree population is substantially smaller than the active group, increasing the need for credibility adjustments.
  - In general, the claims experience and the population the experience applies to must be credible. In this situation, credible means that the experience captured is a reasonable predictor of claims cost in the future, and that the group's random fluctuation of claims -- inherent in medical and related plans of benefits -- is of an acceptable tolerance.
  - If a group is not credible, utilization of information, such as that of a larger group, with adjustments, is appropriate to gain a valid projection of costs.
  - The current actuary makes credibility adjustments by way of actuarial judgment. Rather than solely adjusting the retiree group premium rates, the active group premium rates are adjusted to counterbalance the action on the retirees in some years.
  - The State should consider explicit credibility adjustments and expected variance on the retiree groups, rather than this subsidy counterbalance. The retiree groups will continue to have random fluctuation, while the active group has had variance injected into its rating process by this subdivision.
- The actuary makes reference to the need to suppress the retiree rates and rebalance the rates as a result of legislative code NJSA 52:14-17.32 that stipulates the maximum allowable differences a retiree can be charged for medical coverage versus an active. In general, Mercer would prefer to apply the credibility adjustment prior to this suppression.
  - Benchmark groups may not have this legislative constraint.
  - The majority of employer groups with retirees segment them along a variety of dimensions such as years of service or date of retirement.
  - Typically, employers do not vary rating by region.

Appropriateness of the State Program for Being Self-Insured

- The Horizon plan and the three largest HMOs which cover over 96% of the covered population are self-insured. That means the SHBP is at risk for all claims experience. The majority of the SHBP's peer organizations, self-insure their programs as well.
  - The SHBP currently has a threshold of 5,000 enrollees before they consider self-insurance; accordingly, only two HMOs plans – Oxford and AmeriHealth - remain insured.
- When considering the option of self-insurance, an organization must evaluate risk tolerance and potential for adverse claims experience. Given the large number of employees covered by the SHBP, the risk of adverse experience should be manageable.
  - Risk tolerance can be managed in several ways:
    - » Purchase of reinsurance,
    - » Accumulation of surplus, and
    - » Access to general liquid assets of the employer.
  - For the SHBP, the appropriate frame of reference is different for the State program as compared to the local program, which is discussed in detail in the "Local Employer Needs" section.
- The role of contingency reserves and contingency margin in self-insured programs varies for employers and commercial insurance carriers.
  - Similar to the SHBP, most self-insured employers do not explicitly accumulate a contingency reserve, i.e. surplus, for a variety of reasons, but mainly because:
    - » In general it is not tax deductible as a business expense, and
    - » Cash management officers believe it is better used for other business purposes.
- Margin is the vehicle to fund the surplus accumulation/contingency reserve. Many employers utilize rating margin – a form of contingency margin – to increase the probability of having adequate rates. However, they do not fund this margin unless claims experience develops.
  - The SHBP does not explicitly utilize rating margin – the appropriate use of margin was previously discussed in the rate adequacy analysis.
- In conclusion, the State portion should be self-insured like any other employer group.

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Appropriateness of the State Program for Being Self-Insured *(continued)*

- Mercer reviewed the SHBP's risk aversion using the Risk-Based Capital calculator described in the previous section.
  - The Authorized Control Level (ACL) is the minimum amount of capital a program should have access to in order to provide protection against "random" fluctuation.
    - » Typically, an organization's access to capital should be at least 100% of the RBC calculation, with 200% preferred.
    - » For example in 2002, the SHBP program's required capital (as shown in the chart below) is approximately $66.8M (200% of $33.4M). The surplus requirements, or access to capital, of $66.8M is equivalent to approximately one month of claims.
    - » It is reasonable to assume the State portion has access to this capital requirement and thus appropriate for the State portion to be self-insured.

Risk Based Capital Calculation

Program	*Period*	*Total Adjusted Capital*	*Authorized Control Level Risk-Based Capital*	*SHBP Current % (Adjusted Capital to Risk-Based Capital)*
State	Fiscal Year 1998	$5,300,000	$17,800,000	30%
	Fiscal Year 1999	-$16,900,000	$18,000,000	-94%
	Fiscal Year 2000	-$27,300,000	$18,500,000	-148%
	Calendar Year 2001	-$97,600,000	$25,100,000	-389%
	Calendar Year 2002	-$133,700,000	$33,400,000	-400%
Local	Fiscal Year 1998	$156,000,000	$23,400,000	667%
	Fiscal Year 1999	$132,300,000	$24,400,000	542%
	Fiscal Year 2000	$28,900,000	$26,100,000	111%
	Calendar Year 2001	-$110,900,000	$35,800,000	-309%
	Calendar Year 2002	-$192,300,000	$49,600,000	-388%

5: Local Employer Needs

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5

Local Employer Needs

Introduction

- As stated before, the SHBP is composed of two separate and distinct programs:
  - The program for State employees (actual employees of the State and its affiliates), and
  - The program for local employees (actual employees of other governmental entities).
- The locals are comprised of local governmental and educational institutions, including county colleges, counties, municipalities and school boards.
- Mercer's review of the program reflects an analysis of the program finances, benchmarking and input gathered from interviews Mercer conducted with various local employers and special constituents, including [1]:
  - New Jersey Education Association
  - New Jersey School Board Association
  - New Jersey Council of County Colleges
  - New Jersey State League of Municipalities
  - Communication Workers of America
- The review encompasses:
  - Benefit Delivery, including current level of benefits, administration of benefits and plan design modifications;
  - Benefit Subsidy, including employee contributions;
  - Financial Review, including adequacy of reserves and rates and appropriateness of the SHBP offering a self-insured plan to the locals; and
  - Geographic Rating, including the level of subsidy across geographic regions within the State and considerations in establishing geographic rates.

[1] *New Jersey Association of Counties was also invited to participate.*

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Program Overview

- Subsidy of Benefits/Employee contributions is governed by Administrative code section 17:9-5.4; the highlights are that the local employer:
  - must pay the full cost of employee's coverage,
  - may pay any portion of the cost for the dependent coverage, and
  - must pay the same proportion of the cost of dependent coverage for ***all*** employees covered in the program.
- All medical plans must be offered by each employer.
  - Local employers may participate in the SHBP medical or purchase their own coverage.
  - Local employers must offer a plan of equal benefits to the SHBP for one year, if they purchase their own coverage.
  - Prescription drug coverage must be offered but it does not have to be purchased from the SHBP.
  - Dental is not available through the SHBP.
- The local employers are prospectively rated, acting like a "fully-insured" product.
  - Premium rates are established for a rating year.
    - » Rates vary by medical plan type and by educational/governmental entity.
  - Local employers fully discharge risk of insurance when participating in the SHBP.
    - » There is no deficit recovery or other financial provision regarding (e.g., refund) the experience of the group in the program.
    - » One exception was the premium holiday granted several years ago (1999) to release substantial accumulated surplus.

Benefit Delivery

- Many state governments offer benefit programs to some subset of their local employer groups - mostly to municipal/county employees, or affiliated or community colleges.
  - Most states offer a choice of medical options (e.g., Indemnity/PPO/POS/HMOs) to their local employers. However, typically, smaller private employers similar in size to the locals, offer fewer options to their employees.
- From the local employer's perspective, the SHBP appears to offer adequate choice of offerings, acceptable plan design and solid vendors. Some feedback from the locals to note include:
  - Consider offering a PPO alongside or in lieu of the current medical options and
  - Consider allowing more flexibility in designing the benefit plan offered to locals.
- The high level of benefits results in high costs for the local employers.
  - As a result of legislative mandates and union lobbying, uniform level of benefits is required, even if a local is not participating in the SHBP. There is a view that the benefits must match on a line-item basis for the first year after existing the SHBP.
  - The locals expressed frustration with the inability to negotiate or reduce overall costs through plan design modifications.
- Currently, employee contributions for the locals are governed by Administrative code section 17:9-5.4 which mandates the level of subsidy.
  - Local employers must pay the full cost of employee's coverage.
  - Local employer may negotiate any portion of the cost for the dependent coverage ***but*** they must maintain the same proportion of the cost of dependent coverage for ***all*** employees covered in the program.
    - The consequence of this is that the employer cannot begin to charge one group a different amount than other groups.
    - Thus, many local employers are constrained from implementing cost sharing other than 100% subsidy for dependent coverage

Benefit Subsidy

- As discussed in Section 3 “Benefits Review”, one third of state peers require no employee contribution towards the cost of coverage. Local government peers vary employee contributions by type of plan.

Percentage of Employers Who Do Not Require Contributions For Active Medical or Dental Coverage

	SHBP *(Locals)*	Government Peers *(< 500 employees)*	Private Peers *(< 500 employees)*
Medical			
▪ Employee Only	No Contribution	POS: 77% Indemnity: 63%	POS: 53% Indemnity 43%
▪ Family	Varies by local	POS: 48% Indemnity: 33%	POS: 18% Indemnity: 32%
Dental			
▪ Employee Only	Not offered to locals	61%	50%
▪ Family		31%	24%

Monthly Average Employee Contribution for Active Medical
(as a Percent of Total Cost)

	SHBP *(Locals)*	Government Peers *(< 500 employees)*	Private Peers *(< 500 employees)*
Employee Only			
▪ Indemnity	0%	25%	28%
▪ POS	0%	15%	24%
▪ HMO	0%	13%	21%
▪ PPO	N/A	19%	23%
Family			
▪ Indemnity	Varies by local	41%	34%
▪ POS		36%	33%
▪ HMO		26%	31%
▪ PPO		44%	32%

Source: 2002 Mercer National Survey of Employer Sponsored Health Plans.

Benefit Subsidy *(continued)*

- In general, this generous subsidy is putting significant pressure on the local employer budget. Local income to fund premium cost includes tax and tuition which is difficult to raise without negative public reaction.
- The ability to offer waiver credits is perceived as a vehicle to relieve some of these cost pressures.
- While both sides (management & union) recognize this as a collectively-bargained issue, management feels unable to bargain on these issues due to legislative/code requirements.
- Additionally, local employers feel as though they are not involved in the decision making process regarding the SHBP program and have little authority to change the local plans.

Financial Review of Local Programs

- Mercer used the same methodology to review the finances of the State program and the local program, however the implications of the findings are different. The framework in which the situation should be reviewed, and the actions which should be taken are significantly different for the two groups.
- Mercer's findings are highlighted in the following sections:
  - Reserve Level Adequacy
  - Rate Level Adequacy, including a brief review of current structure and subsidies
  - Appropriateness of Being Self-Insured
  - Geographic Rating
- During the period of Mercer's review, the SHBP had two different actuarial firms. The following chart summarizes the actuary and their particular assignment.

Report Date	Renewal Calculation at	Actuary	Reserve Calculation at	Actuary
1/19/1999	7/1/1999	Buck	-	-
1/21/2000	7/1/2000	Buck	-	-
6/18/2001	1/1/2002	Milliman	6/30/2000	Milliman
8/19/2002	1/1/2003	Milliman	6/30/2001	Milliman

- In the following section, Mercer refers to these actuaries collectively as "actuary".

Reserve Level Adequacy

- Mercer's review of the SHBP Horizon-based IBNP reserves included the fiscal years 2001 and 2002. Data was provided by the vendors, the State and the actuary.
- Overall, the reserve levels for 2001 and 2002 local programs were 119% and 116% of "Actual needed". The reserve levels were adequate for actual IBNP. (See Section 4 for complete reserve exhibit).
- While the reserve levels are adequate, Mercer did observe some concerns with the actuary's methodology which have been stated in Section 4 of this report.
- The State, and its actuary, prepared formal estimates of projected costs of the programs, and resulting rate actions for the upcoming rating year
  - Note: The rating year was changed from a fiscal year to a calendar year in 2001, necessitating an 18-month "year."
- During Mercer's review period (7/1/98 forward), the local Horizon program experienced a loss (premium rates were inadequate when compared to claims and expenses) during each and every projection year. (See chart below)
- The following financial exhibit shows the Surplus/Deficit History of the local Horizon programs from 6/30/98 through 12/31/02. Deficits from 7/1/00 to 12/31/02 were estimated by Mercer.

Surplus/Deficit History of Local Horizon Program, 1998 -- 2002

Surplus/(Deficit)		
End Date	**Year**	**Cumulative**
6/30/98	—	$156.0M
6/30/99	($23.7M)*	$132.3M
6/30/00	($103.4M)**	$28.9M
12/31/01	($139.8M)	($110.9M)
12/31/02	($81.4M)	($192.3M)

* *Some surplus used to reduce FY99 rate action*
** *Includes 10/99 premium holiday of $45M*

Source: Actuary's Deficit History thru 6/30/00.

Rate Level Adequacy

- Section 4 of this report highlights additional drivers of this deficit, including underestimation of trend and other factors which resulted in continued underestimation of premium requirements for the upcoming rating year.
- The actuary mentions the need for rating margin to protect against claim volatility and mention the need for the local program to be self-supporting but:
  - There is no evidence that contingency margin or explicit loads to rebuild surplus were included in any of the local program renewals;
  - No explicit action was undertaken to correct this pattern, including addition of margin; and
  - Expected increases in enrollment were not explicitly recognized for in the rating process.

Impact of Declining Surplus Levels

- Surplus levels have declined from a positive at the beginning of the study period to a negative (deficit position) at the end of the study period.
- For local employers, the SHBP acts similar to an “insurance carrier” offering prospectively-rated “insurance.”
  - Local employers do not bear the risk of gains or losses.
  - Local employers do not incur any potential “withdrawal liability” when they exit the plan.
  - Neither a local’s own losses, or an allocation of overall losses, are assessed if a local withdraws to obtain insurance elsewhere.
- Given MEWA surplus/capital requirements in the State of New Jersey, and the fact that the local employers as a group act similar to a MEWA, Mercer felt it important to outline the implications of a deficit to the local plan.
- The Commissioner of the Department of Banking and Insurance (DOBI) participates in the oversight of this program but has no jurisdiction.
- The SHBP management have expressed an opinion that the program should be run on a self-supporting, risk-appropriate basis.

Rate Levels Adequacy *(continued)*

- The local program was in a significant deficit position and adjusted capital was well below authorized levels in both 2001 and 2002. If the State were an insurance company, the DOBI Commissioner would be looking to rehabilitate or liquidate the insurer (e.g., mandatory control level due to lower solvency). While, this does not happen on self-insured employer groups such as the State, it does occur on MEWAs.

Risk Based Capital Calculation

Program	*Period*	*Total Adjusted Capital*	*Authorized Control Level Risk-Based Capital*	*SHBP Current % (Adjusted Capital to Risk-Based Capital)*	*Level of Action by DOBI, if Any*
Local	Fiscal Year 1998	$156,000,000	$23,400,000	667%	NONE
	Fiscal Year 1999	$132,300,000	$24,400,000	542%	NONE
	Fiscal Year 2000	$28,900,000	$26,100,000	111%	Regulatory Control Level
	Calendar Year 2001	-$110,900,000	$35,800,000	-309%	Mandatory Control Level
	Calendar Year 2002	-$192,300,000	$49,600,000	-388%	Mandatory Control Level

Legend:

- No Action = Greater than 200% of Authorized Control Level
- Company Action Level=200% of Authorized Control Level, but not less than 150%.
- Regulatory Action Level=150% of Authorized Control Level , but not less than 100%.
- Authorized Control Level=100% of Authorized Control Level , but not less than 70%.
- Mandatory Control Level=70% of Authorized Control Level

Rate Levels Adequacy *(continued)*

- At the time of planning and implementation of the premium holiday (10/99), significant surplus existed. Granting a holiday of $35M to $40M can still be viewed as appropriate at that time.
  - However, continuing significant losses in 2000, 2001 and 2002 have put the program in a deficit position, which is well into the Mandatory Control Level in New Jersey.
  - In retrospect, as surplus shrank to less than $30M at the end of fiscal year 2000, a provision should have been made to rebuild the surplus.
  - Additional capital is often required when undertaking risk such as
    - » Splitting of the rating pools into two (e.g., government and education), or
    - » Growing overall membership; both of which the SHBP experienced during these years.
- The need to rebuild surplus is dramatically increased as the program deficit grows. In the latest (CY 2003) renewals, the actuary recommends a margin of at least 3% to attempt to rebuild surplus – with a projected deficit of at least $180M (The Mercer estimate is $192M). A deficit of this order of magnitude requires significant study to avoid continued losses and develop a realistic long-term recovery plan. To recover and build the actuary's recommendation of 2 months of claims as a surplus target, the program must abate losses and generate $350M in gains over the long term.
- The State, as the financial backer of the program, is ultimately responsible for sustained losses of the program and should prepare a firm position on managing this risk down to an acceptable level.
  - Utilization of RBC measures for the local employer program would be best practice for management of surplus.
  - The actuary has stated that 2 months of emerging claims should be an appropriate level of surplus. This is conservative from an RBC perspective for a program of this size. Mercer suggests that the State consider a target of 200% of the Authorized Control Level Risk Based Capital Requirement. At 12/31/2002, this equates to $100M, or about one month of claims.

Appropriateness of the State to Offer Self-Insured Program and Take on Local Employer Risk

Mercer reviewed the State's risk aversion using the Risk-Based Capital calculator described in the previous section.

- The Authorized Control Level (ACL) is the minimum amount of capital a program should have access to in order to provide protection against "random" fluctuation.
  - Typically, an organization's access to capital should be at least 100% of the RBC calculation, with 200% preferred.
  - For example in 2002, the locals required capital (as shown in the chart below) is approximately $100 million (200% of $49.6M)
  - The State is offering a benefit to its local employer constituents by offering this program. Many states offer such programs, making the offering itself reasonable. However, the State should make every effort to rebuild the surplus of the plan, and should not be in a long-term position of offering under-priced insurance products to local employers, creating $190M debt and counting.

Risk Based Capital Calculation

Program	*Period*	*Total Adjusted Capital*	*Authorized Control Level Risk-Based Capital*	*SHBP Current % (Adjusted Capital to Risk-Based Capital)*
State	Fiscal Year 1998	$5,300,000	$17,800,000	30%
	Fiscal Year 1999	-$16,900,000	$18,000,000	-94%
	Fiscal Year 2000	-$27,300,000	$18,500,000	-148%
	Calendar Year 2001	-$97,600,000	$25,100,000	-389%
	Calendar Year 2002	-$133,700,000	$33,400,000	-400%
Local	Fiscal Year 1998	$156,000,000	$23,400,000	667%
	Fiscal Year 1999	$132,300,000	$24,400,000	542%
	Fiscal Year 2000	$28,900,000	$26,100,000	111%
	Calendar Year 2001	-$110,900,000	$35,800,000	-309%
	Calendar Year 2002	-$192,300,000	$49,600,000	-388%

Geographic Rating

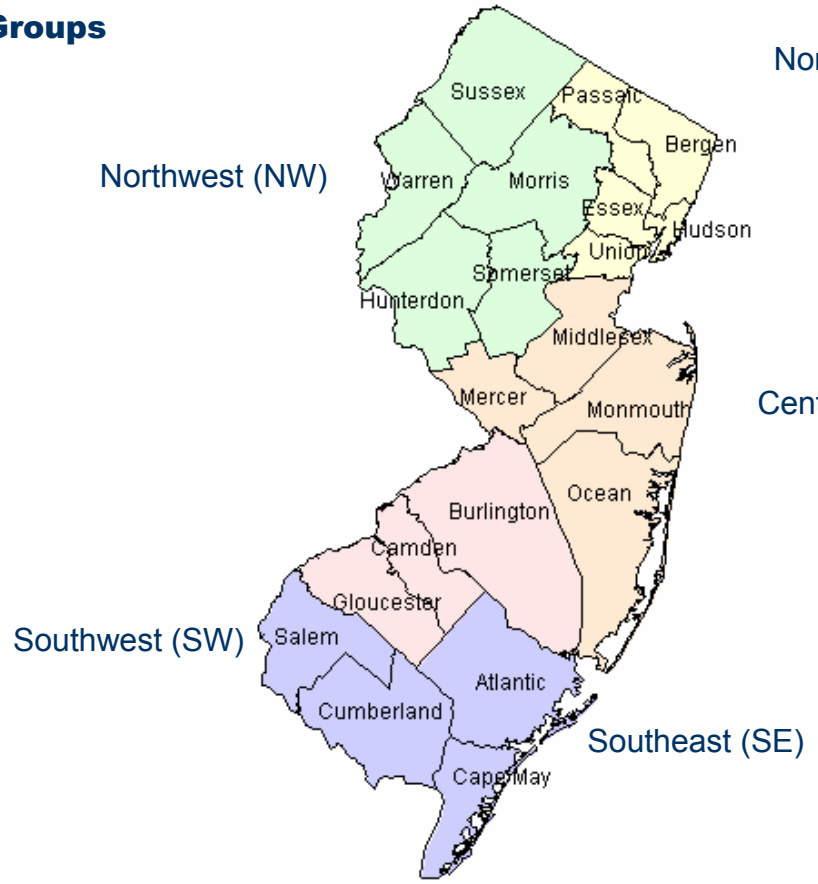
- Recognizing that health care costs vary significantly within the State, Mercer reviewed the possibility of different rates by geography.
  - Currently, Educational vs Governmental is the only demographic differentiator in the SHBP rating process.
  - The rating process and resulting rate levels are viewed favorably by local employers.
- In general, rates have been stable and increasing less than or equal to underlying trend rates - causing losses (which is addressed elsewhere in this report), and making rates even more favorable for the local participants.
  - The SHBP's non-claim expenses have been less than small and medium market insurance products.
  - SHBP underwriting has been significantly less volatile than small and medium market insurance products
  - "Insured" rate stability with the SHBP is significantly greater than being self-insured on their own, or in small or medium market insurance products.
- Geographic rating does have actuarial support and is consistent with the perception that the SHBP's current rating structure may be uncompetitive in the lowest cost areas of the State. Moving from a statewide rate to a county-specific or "regional" rate structure more appropriately matches premium levels to cost.
  - Aligning rates and cost on an area basis has the advantage of attracting more favorable groups in lower cost areas. It is likely that retention in high cost areas, such as Northeast NJ, will not be impacted since rates would be in alignment with the market.
  - Due to limited credibility of any one county and administrative ease, Mercer believes rate setting is more appropriate at the regional, not county level.

Geographic Rating *(continued)*

- SHBP Horizon experience and enrollment as well as other cost indices are consistent in supporting cost differentials. Specifically, the heavily populated Northeast region of the State is more expensive versus all other regions.
- Mercer's analysis supports geographic rating and reviewed a number of alternatives, including 'two area" and "three area" rating setting. These alternatives were considered for the State of NJ's Medicaid population and Horizon populations, respectively. However, Mercer recommends a "five area" alternative for the establishment of local rating differentials as presented on the following page.
- Determining the specific rate factors by region requires additional review of current SHBP medical plan claims experience. Mercer's supplied suggestions are based on Horizon's analysis.

5 Area Rate Setting for Local Groups

Mercer Recommended Regions



Potential Area Rate Setting for Local Groups

Variance from State Average Loss Ratio	NE Region	NW Region	Central Region	SE Region	SW Region (near Philadelphia)
Horizon Enrollment with Horizon Cost Index (Claims Experience)	+4.2%	-14.5%	-3.3%	-11.1%	-12.4%
Counties:	Bergen Essex Hudson Passaic Union	Hunterdon Morris Somerset Sussex Warren	Mercer Middlesex Monmouth Ocean	Atlantic Cape-May Cumberland Salem	Burlington Camden Gloucester

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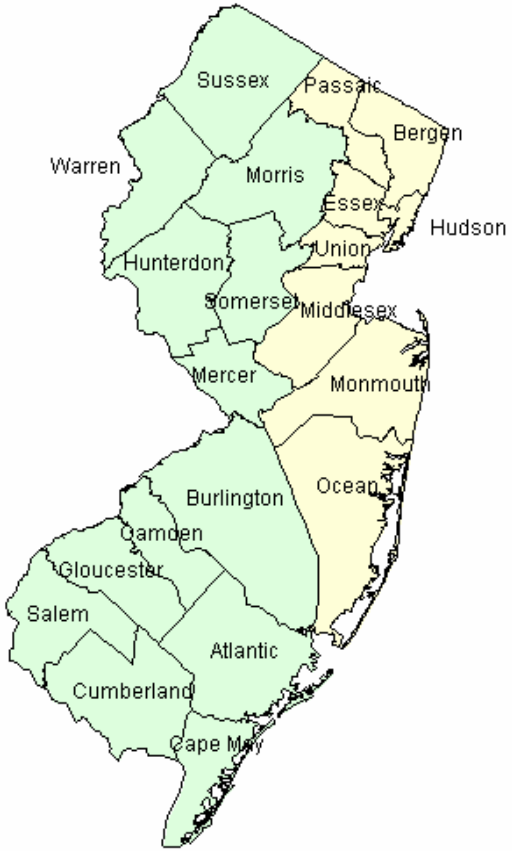
Geographic Rating – Area Rate Setting Alternatives

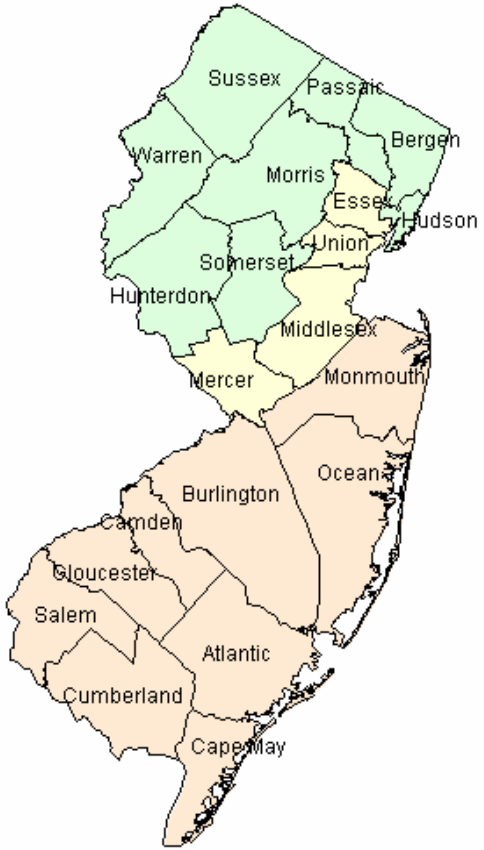
2 Area Rate Setting for Local Groups

Mercer Reviewed for Medicaid Population



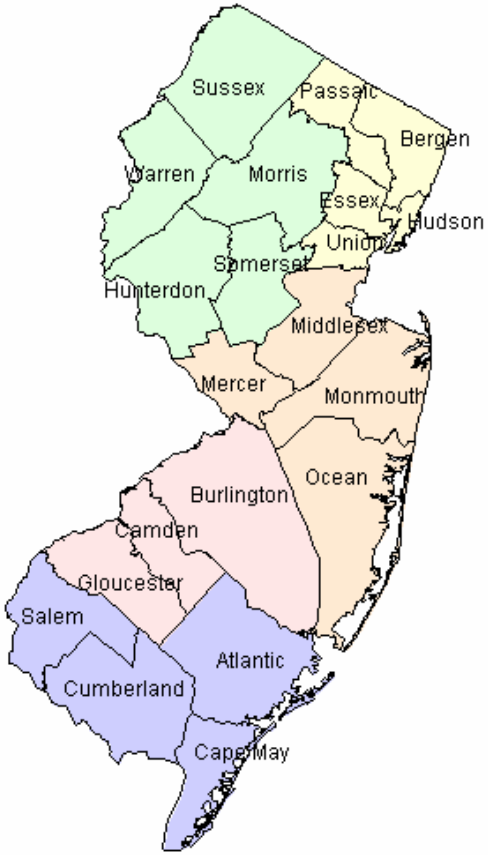
3 Area Rate Setting for Local Groups

Horizon Recommended Regions



5 Area Rate Setting for Local Groups

Mercer Recommended Regions



6: Cost Containment

6

Cost Containment

Overview of Analysis

Mercer reviewed the current cost management arrangements in place with the Horizon, Aetna and CIGNA programs which cover the majority of SHBP enrollees. This review included an analysis of the program descriptions as well as phone discussions with representatives from the vendors. This section presents a summary of findings.

Overall Findings

- The cost management programs currently in place with the SHBP vendors are comparable to those programs provided to other states and large employers. However, stronger due diligence, such as health plan program evaluations are recommended in order for the SHBP to identify specific needs and implement relevant targeted programs, such as stronger disease management.
- The fees paid to the carriers for these services are comparable. There are some outliers that Mercer believes may require closer review. Return on Investment (ROI) for these programs was difficult for the vendors to supply on a client specific basis.

Utilization Review

Overview

- Within the health care continuum, the primary functions of utilization management (UM) are to provide ***evaluation of medical necessity*** and ***appropriateness***, and the ***efficient utilization of health care services***, ***procedures and facilities*** under the auspices of the applicable health benefit plan. All vendors use scientific, evidence – based medical guidelines to manage the UM program.

Overview of Analysis *(continued)*

- Best in class programs have identified the critical UM components and applied them to targeted diagnoses, conditions, procedures, and medical technologies. These critical components include prior authorization, concurrent stay review and discharge planning.
  - Key clinical information and utilization patterns assist with the identification of actual or potential gaps in or barriers to the delivery and coordination of health care services across the health care continuum.
- UM is an excellent mechanism to identify potential candidates for case management, disease management, or other health management programs.
- The development of a comprehensive acute care plan is a primary intervention that includes discharge planning as well as pre-admission and post-discharge outreach.
- Clear and concise protocols need to be in place to facilitate the seamless coordination and management of cases, among all available internal and external programs.

SHBP Experience

- Overall, the ***UM services provided by the State are comparable to those provided to other states and large private employers***. Horizon, Aetna and CIGNA have all recently redesigned their UM and Case Management programs. All are investing significantly and redesigning these programs to provide maximum value to clients. Specific onsite clinical program reviews would provide greater insight into the effectiveness of the program redesign. A review of the mental health and out of state UR programs is advisable for the SHBP.
- Horizon fees for UM and Case Management (CM) are broken out by each component. CIGNA and Aetna fees for UM and CM are included in the general administration fee for each vendor. Further information needs to be provided before a valid analysis of fees can be provided.
- Only Horizon currently reports on UM ROI using a formula that was independently validated by Cap Gemini-Ernst and Young. Their reported ROI is 3.6:1. It is based on their total membership and not SHBP specific. Aetna is currently developing a projection of savings related to their medical management programs. CIGNA only reports on savings for CM and does not currently use a substantiated ROI methodology.
- Based on our limited telephone evaluation, the ***SHBP appears to have the appropriate UM program components in place***.

Overview of Analysis *(continued)*

Large Case Management

- A best in class case management (CM) program uses a formal, multidisciplinary, dynamic approach through which accountability for member care outcomes is maintained using assessment, planning, coordination, referral, and the effective use of resources across a continuum of care. It includes the ongoing confirmation, management and evaluation of health care service delivery and coordination, with the ultimate goals of improving functional status, clinical outcomes, and cost savings by avoided inpatient admissions and emergency room visits. This approach incorporates all team members including the member, family, providers, employer, and community. Empowering patients to play active roles in their care has been demonstrated to significantly improve health care outcomes.
- Best in class CM is dependent on timely identification and interventions tailored to a specific patient's needs.
- Overall, ***the CM services provided by the SHBP are comparable*** to those provided to other states and large employers. However, some employers who are experiencing an increase in costly high cost claimants have added specialized case management services from a national CM vendor that excels at managing complex, catastrophic and end-of-life cases.
- Horizon fees for CM are broken out by components. CIGNA and Aetna fees for CM are included in the general administration fee for each vendor. **Further information needs to be provided in order to give a valid analysis of the fee components. At this time, it is not available.**
- To date, Aetna has developed a methodology for savings but has not reported any results. Aetna is currently developing a projection of savings related to all of their medical management programs. CIGNA reports on savings for CM but does not currently use a ROI formula. Horizon does not report on ROI for CM.

Overview of Analysis *(continued)*

Disease Management

- Each of the plans offers different disease management (DM) programs. Some have been internally developed DM programs while others are outsourced to DM vendors. The programs typically vary by disease category, maturity, scope and effectiveness, ROI and cost. Only Horizon reported a DM ROI of 1.3 to 1 for its total managed population. This is below the industry average of 2:1.
  - It is not clear that the DM programs offered by the plans are the appropriate programs to meet the State's disease burden. Matching the appropriate set of programs to the disease burden of a population is a best practice. ROI will vary by disease state.

Hospital Billing Audits

- Hospital bill audits are used to validate large hospital bills ($5,000+) that have a high likelihood of error. They have become less frequent with managed care due to the predominance of per diem hospital contract arrangements.
- The ***hospital audits performed by the SHBP vendors are standard among large employers and commercial carriers***.
- Typically these audits are:
  - performed at least annually at network facilities;
  - focused on *"number of days",* at network facilities, since most facilities have a per diem arrangements;
  - more in depth for non-network facilities (or in absence of per diems for network facilities) if pre-screening criteria indicate potential for recovery;
  - often limited to network facilities;
  - typically not client or account specific;
  - performed by an internal department (although Aetna and Horizon will subcontract to outside vendor if necessary);
  - included in the overall ASO fee (e.g., no additional charge for SHBP); and
  - are supplemented with "backend programs" to identify any potential billing irregularities and fraud.

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Overview of Analysis *(continued)*

Hospital Billing Audits

- While most carrier audits are limited to network facilities, Horizon includes five non network facilities in New Jersey. Additionally, all other participating Blues plans conduct their own hospital bill audits under similar contractual arrangements with Horizon so consistency is evident.
- Horizon, Aetna and CIGNA internally audit all claims over $5,000, whichever is common practice.
- Determining ROI for these services is difficult since there are not explicit fees for these standard services.
- ***Mercer would recommend that the SHBP conduct a standard independent claims audit to verify the accuracy of these billing audits.***

Performance Review

- Continuous quality monitoring (internal quality audits) is essential to maintaining and ensuring high quality claims and customer levels.
- Overall, the ***SHBP performance reviews are comparable*** to marketplace norms.
- CIGNA, Aetna and Horizon conduct regular reviews of their internal operations, including: claims audits, claims accuracy, and claims turnaround time. All three audit programs are consistent with industry norms.
  - Horizon (NJ PLUS) is the only vendor with claim accuracy performance guarantees - quarterly audits conducted on "claims paid" basis and self reported to SHBP.
  - All three vendors conduct monthly audits of individual staff (e.g., claims, customer service, data entry, etc.).
- Current performance reviews and electronic audit results are self reported by the vendors. Independent audits typically produce poorer vendor performance results than vendor self reported results.
- A periodic independent audit which supplements the current electronic audit is recommended to validate vendor results. Additionally, this audit may identify "problem areas," if any; which can be used as a guide for future electronic audits.

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Overview of Analysis *(continued)*

Online Information

- In order to choose the most appropriate health care option based on price, quality and service, employees must have appropriate health care information and decision-making tools. Employers are leveraging their overall business technology investment to support their benefits strategy but many are relying on the vendors to support them in providing this information in an efficient manner.
- According to a recent Mercer study, more than 80% of large employers (20,000 or more employees) use internet/intranet applications in administering health benefit programs.
  - The most common uses include providing forms and accessing health and welfare benefit information. Over half of these large employers are conducting open enrollment for 2003 via internet/intranet, although most of them will also give employees the option of paper enrollment as well.
  - A recent study of state employers found that 56% of states have implemented web-based information on general health, such as exercise and nutrition, and 40% of states offer web-based information on specific disease conditions.[1]
- ***Overall, most of the SHBP vendors provide the basic online capabilities***, such as provider directories, eligibility and claims status. However, some vendors have made significant investments in their technology and self service tools, such as Aetna and HealthNet. In the recent past, Horizon has made substantial improvements to their website development structure as well.
- Almost as important as member services are on-line services to employers and plan sponsors, such as access to eligibility reconciliation, billing and utilization reports. Some vendors have better capabilities in regard to these tools than others. Aetna has one of the strongest plan sponsor support tools.
- All the SHBP vendors provide online access to
  - Eligibility information;
  - Plan coverage details;
  - Provider listings and search tools;
  - Request ID cards; and
  - Review claims status
- A detailed listing of each vendor's online capabilities is attached in the Appendix.

[1] *"Health Care Purchasing Among State Employers", National Health Care Purchasing Institute, February, 2003.*

Overview of Analysis *(continued)*

Usual, Customary and Reasonable Limits for Non Network Claims

- Usual, Customary and Reasonable (UCR) rates are a cost control method that third parties utilize to control fees paid to medical care providers for medical goods and services. UCR fees are limited to the lowest cost of the actual charge of the physician, the customary charge for that service or the prevailing charge in the local area.
- Horizon reimburses UCR fees at the HIAA 90th percentile, as defined by the SHBP in their contract with each vendor. Typically***, large employers and commercial carriers set UCR at the HIAA 80th and 70th percentile as a means to encourage in-network utilization***.
  - UCR fees are updated every 6 months.
  - UCR is applied to surgery, anesthesia, chiropractic and assistant surgeon services only for the Traditional Plan.
  - UCR is applied to all services for the NJ PLUS plan.
- The use of UCR fees, in both the Aetna and CIGNA HMO, is infrequent since virtually all claims are in-network and are based on negotiated rates, with the exception of emergencies.

Coordination of Benefits

- Coordination of benefits (COB) provisions are designed to eliminate duplicate payments and provide the sequence for which coverage will apply (primary and secondary) when a person has coverage under two contracts (e.g., coverage through employer and through spouse's employer).
- The ***COB procedures*** in place for Horizon, CIGNA and Aetna ***were similar*** and ***consistent with those procedures at other large employers and commercial carriers***:
  - ***Traditional COB*** provision where the employee is entitled to the balance of the normal benefit (e.g., the benefit they would receive under the SHBP) minus other payer benefits.
  - Over the past ten years, BlueCross BlueShield organizations have moved away from the *pay and pursue* practice which involved reimbursing providers and claimants for services prior to confirming other coverage and adopted the ***"pursue and pay"*** approach long used by commercial carriers which produces higher rates of COB savings.
  - **"Birthday" rule** – the plan of the parent whose birthday falls earliest in the year pays first**.**
  - All vendors update their COB information on a yearly basis.

Overview of Analysis *(continued)*

Coordination of Benefits (continued)

- All three vendors include COB service in the current general administration (ASO) fee. Bundling these fees within the larger ASO fee is common for commercial insurance carriers.
- Book of business savings reported for Horizon and CIGNA are in line with industry standards; 4% to 8% of claims payments that would otherwise had been paid. Aetna self reported savings exceeded industry expectations; however, they are reviewing their overall calculation methodology:
  - **Horizon (2002): 4.5% to 5%**
  - **CIGNA (2002): 4.5% to 5%**
  - **Aetna (2003): 9% to 10%**

Other Cost Containment Mechanisms

- Subcontracting with best in class vendors:
  - Currently more proactive vendors (carriers/health plans) have begun to redesign/improve their current UM and CM programs as well as addressing population health through adding (external) or developing (internal) programs that manage and support the delivery of health care across the care continuum**.** This involves segmenting the population into different risk groups and ensuring appropriate interventions are implemented for each group. The groups include members who are: healthy; well, but at risk; chronically ill; acutely ill; and those with complex/catastrophic conditions. In addition, these vendors are typically investing significantly in technology and employee training.
  - The key attributes of best practice vendors include
    - » Effective participant identification, stratification, recruitment and enrollment;
    - » Multi-disciplinary program interventions for both provider and member-guidelines and self-management;
    - » Strong technology to drive program operations;
    - » Employer-specific program tracking and reporting;
    - » Effective contracting to provide return on investment; and
    - » Successful implementation and employer-focused integration strategy.

Overview of Analysis *(continued)*

Other Cost Containment Mechanisms (continued)

- Best in class vendors offer programs and tools that address population needs across the entire health care continuum. These programs include:
  - **Health promotion/ wellness:** Providing information in a targeted manner has been demonstrated to achieve the highest returns on wellness programs. Information can be hard copy (e.g., Healthwise handbook) or via the website (e.g., Aetna's Intelihealth site which provides information from University of Penn and Harvard on a variety of conditions.) Empowering consumers with information at a time when they are ready to change unhealthy behaviors generates the highest yield. For this reason, access must be easy, constant and timely. Newsletters, payroll stuffers, and health fairs are additional approaches to health promotion.
  - **Total Behavioral Modification:** Total behavioral modification programs focus on lifestyle management. They identify individuals with potential risks and behavior change opportunities. Critical components of a best in class program include risk identification, an integrated patient management system, educational distribution vehicles and coordination of care, with disease management and case management as necessary. Web interface for targeted messaging and interactive training along with education tools are important features. Appropriate stratification of members into the right intervention, at the right time, with the right level of intensity is critical to achieve effective outcomes. Program reporting should include participation rates, eligibility rates, stratification delineation, predictive risk modeling and interventions based on stratification level (e.g., calls, mailings, web tracking, etc.).
  - **Nurse Advise Line (NAL):** NALs focus on acute care delivery. They assist with those individuals that are trying to make a decision on which care option to select. Intervention options need to be well communicated, thoroughly explained and provided within the context of the employer's benefit plan. NALs are more effective when integrated with a self care book. Members need appropriate training to best use self care books. NAL evaluation needs to focus on ROI, redirection of care and appropriate use of the health care system. NAL reporting should be monthly in order to provide proper communication and educational programs, and foster the most optimal utilization of the NAL and self care books.

Overview of Analysis *(continued)*

Other Cost Containment Mechanisms (continued)

- **Predictive Modeling**: Best in class predictive modeling is a tool that uses medical claims, pharmacy, and available lab data to identify members likely to incur significant costs in the coming year. It is used along with information from inpatient case management, HRAs (health risk appraisals), physician referrals, self-referrals, nurse advice line referrals and referrals from other care management programs to identify candidates for disease and case management. Predicting the relative risk of a patient can assist in prioritizing patient outreach and implementing the most appropriate intervention. The best predictive tools use gaps in care as important input into the identification process.
- **Disease Management**: Best in class disease management programs are population-based programs that focus on the person and not on the disease. These programs are guided by scientific, evidence-based guidelines and serve as a tool for members and the physician community. Highly effective programs are driven by strong technology that works in tandem with the overall medical management strategy to identify, stratify, enroll and engage members. Best in class systems used for disease management utilize a combination of tools including well-defined algorithms, predictive modeling, and interdependent integration points that connect processes and information throughout the care management system.

- **Employer Strategy:** The most proactive employers have begun the development and implementation of a multi-year health care strategy to improve work force health and productivity. Strategies are focused on keeping healthy people healthy, identifying and reducing health risks to avoid or delay illness and disease and managing chronic conditions. The goals are to avoid costly complications and to coordinate care for highly complex patients to optimize outcomes and improve quality of life. The SHBP has an excellent opportunity with tenured employees to improve their health care over the long term and positively impact cost savings. Some of the strategy initiatives include:
  - **Health Plan Data Review:** Conducting an analysis of employer-specific health plan data to identify opportunities to improve case management and to identify impactable conditions that are driving costs due to prevalence and condition cost.

Overview of Analysis *(continued)*

Other Cost Containment Mechanisms (continued)

- **Data Management Vendor**: Some employers have implemented an independent data management vendor who manages the employers health plan data regularly to assess the needs of the population and to evaluate health plan performance, on quarterly and/or annual basis.
- **Benefits Program Integration**: Integrating all benefit programs and resources to more successfully support the Human Resources' health and care management strategy. Programs and resources include but are not limited to: Corporate health, onsite clinics, health plans, DM programs, wellness/preventive programs, safety, and disability.
- **Performance Guarantees**: Develop and implement care management performance guarantees.
- **Clinical Program Reviews**: Conducting clinical program reviews to determine program effectiveness, facilitate best practice development, identify opportunities for improvement and to develop and monitor performance improvement plans or to eliminate or add vendors/programs.
- **Disease Management (DM)**: Implementing best in class DM programs that address the specific burden of illness needs of an employer's population.

APPENDICES

Comparison of Current SHBP Programs to Specific Market Place (State and Private Employers)

Participants

Nine states (and one city) employers and 14 large employers headquartered in the Northeast were included in our analysis. These organizations were reviewed and approved by the State prior to the analysis and are listed below.

State Peers	Private Peers	
▪ State of Connecticut	▪ American Express	▪ Merck & Company*
▪ State of Maryland	▪ American Standard Companies*	▪ Merrill Lynch & Co.
▪ State of Massachusetts	▪ Automatic Data Processing (ADP)*	▪ Prudential Insurance Company of America*
▪ State of New York	▪ Comcast Corporation	▪ Siemens Corporation
▪ State of North Carolina	▪ PSE&G	▪ Verizon Wireless*
▪ State of Pennsylvania	▪ Lockheed Martin Corporation	
▪ State of Vermont	▪ Lucent Technologies, Inc.*	
▪ State of Virginia	▪ Marriott International	
▪ City of New York	▪ Marsh & McLennan Companies, Inc.	

Where information provided by the benchmark organization was incomplete, Mercer incorporated survey results from the 2002 Mercer National Survey of Employer Sponsored Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.

**Companies headquartered in New Jersey.*

Appendix 1

Comparison of Current SHBP Programs to Specific Market Place (State and Private Employers) *(continued)*

Medical – Overall

	SHBP		State Peers* *(N=10)*	Private Employer* Peers *(N=14)*
▸ Type of Plan Offered	– Indemnity – POS – HMO		– 7 offer PPO – 7 offer POS – 8 offer HMO – 4 offer Indemnity	– 10 offer PPO – 6 offer POS – 9 offer HMO – 6 offer Indemnity
	State	**Local**		
▸ Most Prevalent Plan * (Highest Enrollment)	– POS	POS/Indemnity	– PPO	– PPO
▸ Percent of Employers Who Require No Employee Contribution				
– Employee Only	POS only	Yes	27%	15%
– Family:	POS only	Varies by local	11%	13%
▸ Employee Contribution (as a % of cost or premium)				
– Employee Only				
» Indemnity:	25%	0%	14%	25%
» POS:	0%	0%	20%	23%
» HMO:	5%	0%	16%	24%
» PPO:	N/A	N/A	16%	24%
– Family				
» Indemnity:	25%	Varies	22%	28%
» POS:	0%	by	31%	28%
» HMO:	5%	local	25%	28%
» PPO:	N/A		31%	28%

Appendix 1

Comparison of Current SHBP Programs to Specific Market Place (State and Private Employers) *(continued)*

Medical – Detailed Plan Design

HMO	SHBP	State Peers*	Private Employer Peers*
▸ Number Offered	6 HMOs (currently 5 HMOs)	– 8 states; most offer more than one HMO – Only NY/NYC offer as many as SHBP	– 9 employers, most offer only one HMO – Only 1 employer has as many as SHBP
▸ Active Enrollment (% of total)	26% (Aetna most prevalent)	35%	35%
▸ Funding	3 self-insured comprising 85% Active HMO employees	12% self-fund 51% experience-rate	Predominantly self-insured
▸ 2002 Annual Per Capita Total Cost (Includes Rx and employee contribution)	$5,384	$4,893	$4,833
▸ Lifetime Maximum	None	None	None
▸ Deductible	None	None	None
▸ out of pocket Limit	None	None	None
▸ Copayment:		Reflects Median Response	Reflects Median Response
– Office visit			
» PCP	$5	$5	$15
» Specialist	$5	$10	$15
– Inpatient Hospital	None	None	None
– Outpatient Surgery	None	None	None
– Mental Health			
» Inpatient	None	None	None
» Outpatient	$5	$10 to $20	$15 to $25

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

Comparison of Current SHBP Programs to Specific Market Place (Other State and Private Employers) *(continued)*

Medical – Detailed Plan Design

HMO	SHBP		State Peers*	Private Employer Peers*
– Substance Abuse				
» Inpatient	None		None	None
» Outpatient	None		$10 to $15	$15 to $20
– Prescription Drug				
» Retail	**Carve-out**	**HMO**		
▪ Generic	$1	$5	$5 - $10; Median $5	$5-$10; Median $10
▪ Brand	$5	$10	$5-$20; Median $20	$5-$20; Median $20
▪ Brand Non-Formulary	$5	$20	$5-$40;Median $30	$40+
» Mail Order				
▪ Generic	$1	$5	$10	$10
▪ Brand	$5	$15	$40	$20-$40
▪ Brand Non-Formulary	$5	$25	$60-$120	$20-$80+

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

Comparison of Current SHBP Programs to Specific Market Place (Other State and Private Employers) *(continued)*

Medical – Detailed Plan Design

POS	SHBP		State Peers*		Private Employer Peers*	
Number Offered	One Plan		7 states; most states offer only one POS		6 employers; most offer only one plan POS	
Funding	100% self-insured		59% self-fund		80% self-fund	
Active Employee Enrollment (as percent of total)	47%		12%		21%	
2002 Annual Per Capita Cost (includes Rx and employee contributions)	$6,492		$5,704		$5,198	
	In Network	**Non Network**	**In Network**	**Non Network**	**In Network**	**Non Network**
Lifetime maximum	None	$1,000,000	None	None	None	$2,000,000
Deductible						
– Individual	None	$100	None	$250	None	$300
– Family	None	$250	None	$500	None	$900
Out of Pocket Limit						
– Individual	$400	$2,000	$1,000	$2,500	$1,000	$3,000
– Family	$1,000	$5,000	$3,000	$7,500	$2,000	$6,000
Coinsurance	None	30% after deductible	None	20% after deductible	None	30% after deductible
Copayments:						
– Office visit						
» PCP	$5	30% after deductible	$15	20% after deductible	$10	30% after deductible
» Specialist	$5	30% after deductible	$15	20% after deductible	$20	30% after deductible
– Inpatient Hospital	None	30% after $200/per admit	$100 copay/admit	20% after deductible	None	30% after deductible
– Outpatient Surgery	None	30% after deductible	None	20% after deductible	None	30% after deductible

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

Appendix 1

Comparison of Current SHBP Programs to Specific Market Place (Other State and Private Employers) *(continued)*

Medical – Detailed Plan Design

POS	SHBP			State Peers*		Private Employer Peer*	
	In Network		Non Network	In Network	Non Network	In Network	Non Network
– Mental Health							
» Inpatient	None		50% after deductible	None	20% after deductible	None	30% after deductible
» Outpatient	10%		30% after deductible	$15 copay	20% after deductible	$20 copay	50% after deductible
– Substance Abuse							
» Inpatient	None		30% after $200 per admit	None	20% after deductible	None	30% after deductible
» Outpatient	None		30% after deductible	$15 copay	20% after deductible	$20 copay	50% after deductible
– Prescription Drug							
» Retail	Carve-out	POS	POS				
▪ Generic	$1	10%	30% after deductible	$10	20% after deductible	$5	30% after deductible
▪ Brand	$5	10%	30% after deductible	$20	20% after deductible	$15	30% after deductible
▪ Brand Non-Formulary	$5	10%	30% after deductible	$30	20% after deductible	$35	30% after deductible
» Mail Order							
▪ Generic	$1	10%	30% after deductible	$10	20% after deductible	$5	30% after deductible
▪ Brand	$5	10%	30% after deductible	$40	20% after deductible	$15	30% after deductible
▪ Brand Non-Formulary	$5	10%	30% after deductible	$60	20% after deductible	$35	30% after deductible

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

Comparison of Current SHBP Programs to Specific Market Place (Other State and Private Employers) *(continued)*

Medical – Detailed Plan Design

Indemnity	SHBP	State Peers*	Private Employer Peer*
▸ Number Offered	One Plan	4 states, most states offer one plan	6 employers; most employers two plans
▸ Active Enrollment (as percent of total)	27%	4%	6%
▸ 2002 Annual Per Capita Cost (includes Rx and employee contributions)	$8,689	$8,255	$6,718
▸ Lifetime maximum	$1,000,000	None	$2,000,000
▸ Deductible			
– Individual	$100	$275	$250
– Family	$200	$550	$500
▸ Out of Pocket Limit (excludes deductible)			
– Individual	$400	$1,500	$1,750
– Family	None	$3,000	$3,500
▸ Coinsurance/Copayments:	0% for Basic, 20% for Major Medical	20% after deductible	20% after deductible
– Office visit			
» PCP	20% after deductible	20% after deductible	20% after deductible
» Specialist	20% after deductible	20% after deductible	20% after deductible
– Inpatient Hospital	0%	20% after deductible	20% after deductible
– Outpatient Surgery	20% after deductible	20% after deductible	20% after deductible
– Mental Health			
» Inpatient	0%, no deductible (up to 20 days), then 80% after deductible**	20% after deductible	10% after deductible
» Outpatient	20% after deductible**	20% after deductible	$20 copay

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

***Mental Health substance abuse maximum of $10,000 annual and $20,000 lifetime.*

Comparison of Current SHBP Programs to Specific Market Place (Other State and Private Employers) *(continued)*

Medical – Detailed Plan Design

Indemnity	SHBP		State Peers*	Private Employer Peer*
– Substance Abuse				
» Inpatient	0%, no deductible		0% or 20% after deductible	10% after deductible
» Outpatient	20% after deductible		0% or 20% after deductible	$20 copay
– Prescription Drug				
» Retail	**Carve-out**	**Indemnity**		
▪ Generic	$1	20% after deductible	20% after deductible	20% after deductible
▪ Brand	$5	20% after deductible	20% after deductible	20% after deductible
▪ Brand Non-Formulary	$5	20% after deductible	20% after deductible	20% after deductible
» Mail Order				
▪ Generic	$1	20% after deductible	20% after deductible	20% after deductible
▪ Brand	$5	20% after deductible	20% after deductible	20% after deductible
▪ Brand Non-Formulary	$5	20% after deductible	20% after deductible	20% after deductible

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

Comparison of Current SHBP Programs to Specific Market Place (Other State and Private Employers) *(continued)*

Medical – Detailed Plan Design

PPO	SHBP		State Peers*		Private Employer Peers*	
▸ Number Offered	Not offered		7 states; most states offer one PPO		10 employers; most offer one plan PPO	
▸ Funding	N/A		47% self-insured 32% self-insured with stop loss		57% self-insured 34% self-insured with stop loss	
▸ Enrollment (as percent of total)	N/A		49%		38%	
▸ 2002 Annual Per Capita Cost (includes Rx and employee contributions)	N/A		$4,857		$4,935	
	In Network	**Non Network**	**In Network**	**Non Network**	**In Network**	**Non Network**
▸ Lifetime maximum	N/A		None	None	None	None
▸ Deductible						
– Individual	N/A		None	$325	$250	$400
– Family	N/A		None	$725	$600	$1,000
▸ Out of Pocket Limit						
– Individual	N/A		$1,450	$2,500	$1,500	$3,000
– Family	N/A		$2,900	$5,000	$3,000	$6,000
▸ Coinsurance	N/A		None	20% after deductible	10%	30% after deductible
▸ Copayments:						
– Office visit						
» PCP	N/A		$15	20% after deductible	$15	30% after deductible
» Specialist	N/A		$15	20% after deductible	$15	30% after deductible
– Inpatient Hospital	N/A		None	20%	10% after deductible	30% after deductible
– Outpatient Surgery	N/A		None	20%	10% after deductible	30% after deductible

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

Comparison of Current SHBP Programs to Specific Market Place (Other State and Private Employers) *(continued)*

Medical – Detailed Plan Design

PPO	SHBP		State Peers*		Private Employer Peers*	
– Mental Health						
» Inpatient	N/A		None	20% after deductible	10% after deductible	30% after deductible
» Outpatient	N/A		$15 copay	20% after deductible	$15 copay	30% after deductible
– Substance Abuse						
» Inpatient	N/A	N/A	None	20% after deductible	10% after deductible	30% after deductible
» Outpatient	N/A	N/A	$15 copay	20% after deductible	$15 copay	30% after deductible
– Prescription Drug						
» Retail						
▪ Generic	N/A	N/A	$7	20% after deductible	$10	30% after deductible
▪ Brand	N/A	N/A	$15	20% after deductible	$20	30% after deductible
▪ Brand Non-Formulary	N/A	N/A	$40	20% after deductible	$40	30% after deductible
» Mail Order						
▪ Generic	N/A	N/A	$10	20% after deductible	$10	30% after deductible
▪ Brand	N/A	N/A	$30	20% after deductible	$30	30% after deductible
▪ Brand Non-Formulary	N/A	N/A	$70	20% after deductible	$80	30% after deductible

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

Comparison of Current SHBP Programs to Specific Market Place (Other State and Private Employers) *(continued)*

Dental – Overall and Detailed Plan Design

	SHBP		State Peers*		Private Employer Peers*	
Plan Type	Indemnity DPOs (11)		Indemnity DPO DMO		Indemnity DPO DMO	
Most Prevalent Plan	Indemnity (54%)		DPO (68%)		DPO (71%)	
Employee Contribution Percentage (expressed as a % of costs or premium)	– Employee Only: 50% – Family: 50%		– Employee Only: » No Contribution: 48% » Average Contribution: 71%; – Family: » No Contribution: 15% » Average Contribution: 67%		– Employee Only: » No Contribution: 23% » Average Contribution: 45%; – Family: » No Contribution: 14% » Average Contribution: 48%	
2002 Annual Per Capita Cost (includes Rx employee contributions)	**Indemnity:** $807	**DPO:** $391	$487		$591	
Deductible	**Indemnity**	**DPO**	**Non DMOs**	**DMO**	**Non DMOs**	**DMO**
– Individual	$50	None	$25	None	$25-$100	
– Family	$150	None	$75	None	$75-$225	
– Orthodontia	None	None	None	None	None	None
Annual Maximum	$3,000	None	$1,000	None	$1,500	None
Orthodontia Lifetime Maximum	$1,000	None	None	None	$1,000-$1,500	None
Coinsurance:						
– Preventive	100%	Scheduled	100%	100%	100%	100%
– Basic	80%	Scheduled	80%	Scheduled	80%	100%
– Major	50% -- 65%**	Scheduled	50%	Scheduled	50%-80%	60%-80%
– Orthodontia	50%	Scheduled	50%	Scheduled	50%	50%-75%

***Note:** *Represents "**median**" response. Where data provided by the peer organizations was incomplete, we have incorporated survey results from 2002 Mercer National Survey of Employer Sponsored Health Plans for similar benchmark organizations. See appendix 2 for list of participating organizations.*

*** Coinsurance varies by service.*

Appendix 2

2002 Mercer National Survey of Employer Sponsored Plans
State Participant List

- Calpers
- Commonwealth of Kentucky
- Commonwealth of Virginia
- Employees Retirement System of Texas
- Georgia Department of Community Health
- Kansas Department of Administration
- New York State Health Insurance Program
- Office of the State Employer
- Oklahoma State and Education (OSEEGIB)
- SC Budget & Control Board-EIP
- State of Alabama
- State of Alaska
- State of Arkansas
- State of Colorado
- State of Florida
- State of Iowa
- State of Maine
- State of Minnesota
- State of Missouri
- State of Montana
- State of MS., DFA, Office of Insurance
- State of Nebraska
- State of New Jersey
- State of New Mexico
- State of North Carolina Health Plan
- State of North Dakota
- State of Ohio
- State of Tennessee
- State of Wisconsin Employee Trust Funds
- State of Wyoming Group Health Plan
- Washington State Health Care Authority
- West Virginia Public Employees Insurance Agency

Appendix 2

2002 Mercer National Survey of Employer Sponsored Plans
Large Employer Participant List

- Abbott Laboratories
- ABM Industries Incorporated
- ACCOR North America, inc.
- Advocate Healthcare
- Affiliated Computer Services, inc.
- ALCOA
- Allstate Insurance Company
- Alltel
- American Airlines
- American Express
- American Standard Companies, Inc.
- Ashland, Inc.
- Automatic Data Processing, inc.
- Bally Total Fitness Holding Corp.
- Bank of America Corporation
- Barnes & Noble Inc.
- Bellsouth Corporation
- Big Lots, Inc.
- Board of Education Baltimore County
- Bob Evans Farms Inc.
- Boeing Company
- Bon Secours Health System, Inc.
- Branch Banking & Trust Co.
- Brinker International
- Brunswick Corporation
- CVS Corporation
- Calpers
- Cargill Inc.
- Carlson Companies Inc.
- Christus Health
- CIGNA
- CINTAS Corporation
- Circuit City
- Citigroup Inc.
- City of Detroit Board of Education
- City of Houston
- Clark County School District NEV
- Coca Cola Company
- Commonwealth of Virginia
- County of Los Angeles
- Cox Enterprises, inc.
- Cracker Barrel Old Country Store, Inc.
- Daimler Chrysler Corporation
- Delta Air Lines, Inc.
- Disneyland
- Dollar Tree Stores Inc.
- E I DuPont De Nemours
- Eastman Kodak Company
- Edward Jones
- Electronic Data Systems, inc.
- Employees Retirement System of Texas
- Ernst & Young LLP
- Fairfax County Public Schools
- Federal Express Corporation
- Fedex Ground
- Fidelity Investments
- Fleet Boston Financial Corporation
- Foot Locker Inc.
- GAP, Inc.
- General Electric Co.
- General Motors Corporation
- Georgia Department of Community Health
- Hallmark Cards Inc.
- Hannaford Bros. Co.
- Harrah's Entertainment Inc.
- Hartford Insurance Co.
- HCA Inc.
- HMS Host Corporation
- JC Penney Company, Inc.
- Kansas Department of Administration
- Keycorp
- Kindred Health Care
- K-Mart Corporation
- Kohls Corporation
- Laidlaw Education Services
- Limited Brands Inc.
- Lockheed Martin Corporation
- Loxothica Retail
- LSU System
- Lutheran Church Missouri Synod
- Marsh & McLennan Companies, Inc.
- Mayo Found. for Medical Ed. & Research
- Meijer, Inc.
- Metromedia Restaurant Group
- Mount Sinai NYU Health
- National City Corp
- Nationwide

Appendix 2

2002 Mercer National Survey of Employer Sponsored Plans
Large Employer Participant List *(continued)*

- New York State Health Insurance Program
- Norfolk Southern Corporation
- Office Max Inc.
- Office of the State Employer
- Ohio State University
- Oklahoma State & Education (OSEEGIB)
- Oregon University System
- Penn State University
- Pep Boys – Manny Moe & Jack
- Pepsico, Inc.
- PNC Financial Services Group Inc.
- Presbyterian Church USA
- Publix Super Markets, Inc.
- Quest Diagnostics Incorporated
- Reed Elsevier Inc.
- Ruby Tuesday Inc.
- Safeway, Inc.
- Saint-Gobain Corporation
- Saks Incorporated
- Sara Lee Cororation
- SC Budget & Control Board-EIP
- Schlumberger
- School Board of Broward County
- School District of Hillsborough County
- Sear Roebuck & Co.
- Shaw Group Inc.
- Sherwin-Williams Company
- Southwest Airlines Company
- Sprint
- Staples Inc.
- Starwood Hotels & Resorts Worldwide Inc.
- State of Alabama
- State of Arkansas
- State of Colorado
- State of Florida
- State of Iowa
- State of Minnesota
- State of Missouri
- State of MS., DFA, Office of Insurance
- State of New Jersey
- State of New Mexico
- State of North Carolina Health Plan
- State of North Dakota
- State of Ohio
- State of Tennessee
- State of Wisconsin Employee Trust Funds
- Sun Trust Bank
- Supervalu
- Sysco Corporation
- Tahoe Joes Management
- Texas A&M University System
- Toys R Us, Inc.
- Triad Hospitals, Inc.
- Tribune Company
- United Technologies Corporation
- Universal Health Services Inc.
- University of Iowa
- University of Missouri System
- University of Virginia
- University System of Maryland
- University Wisconsin System
- UPMC Health System
- USAA
- Valley Health Systems LLC
- Viacom Inc.
- Wachovia Corporation
- Wake County Board Education
- Washington State Health Care Authority
- Wegmans Foods Markets Inc.
- Wendy's International Inc.
- WV Public Employees Insurance Agency
- Wyndham International
- Xerox Corporation

Appendix 3

Projected Financial Results

Deficit Summary (in $ Millions)

State Plans		
6/3/00 Audited Balance		**$(27.3)**
7/00 – 12/01 Projected Premium	$867.0	
7/00 – 12/01 Actual Premium	$827.2	
Loss of Realized Premium		$(39.8)
7/00 – 12/01 Premium – Claims – Fees		$(30.4)
Estimated Balance at 12/31/01		**$(97.6)**
1/02 – 12/02 Projected Premium	$735.9	
1/02 – 12/02 Actual Premium	$708.0	
Loss of Realized Premium		$(27.9)
1/02 – 12/02 Premium – Claims – Fees		$(8.2)
Estimated Balance at 12/31/02		**$(133.7)**

Local Plans		
6/3/00 Audited Balance		**$28.9**
7/00 – 12/01 Projected Premium	$1,247.3	
7/00 – 12/01 Actual Premium	$1,187.6	
Loss of Realized Premium		$(59.7)
7/00 – 12/01 Premium – Claims – Fees		$(80.1)
Estimated Balance at 12/31/01		**$(110.9)**
1/02 – 12/02 Projected Premium	$1,093.8	
1/02 – 12/02 Actual Premium	$1,041.7	
Loss of Realized Premium		$(52.2)
1/02 – 12/02 Premium – Claims – Fees		$(29.3)
Estimated Balance at 12/31/02		**$(192.3)**

Projected Financial Results

State Plans - Fiscal Year 2002

	Actives			Early Retirees		Medicare Retirees		Total
	Traditional Plan	NJ Plus Plan	Rx Plan	Traditional Plan w/Rx	NJ Plus Plan w/Rx	Traditional Plan w/Rx	NJ Plus Plan w/Rx	
Enrollment								
2002 Average	12,988	60,764	105,044	4,364	3,191	14,577	3,148	
January 2001	15,198	51,223	103,413	4,172	1,582	14,504	1,755	
Difference	-14.5%	18.6%	1.6%	4.6%	101.7%	0.5%	79.4%	
Projected Financial Results ($M)								
Projected Premium Level[1]	$ 96.7	$ 291.3	$ 188.0	$ 46.9	$ 32.4	$ 65.1	$ 15.4	$ 735.9
Incurred Claims	94.8	284.2	176.7	46.4	29.4	61.4	15.2	708.0
Administrative Charges[2]	4.2	21.5	(2.7)	1.7	1.9	5.5	1.7	33.8
State Administrative Charges[3]	0.2	1.4	-	0.1	0.1	0.3	0.1	2.3
Investment Income/BOE	-	-	-	-	-	-	-	-
(Gain/Loss)	**$ (2.5)**	**$ (15.8)**	**$ 14.0**	**$ (1.3)**	**$ 1.0**	**$ (2.0)**	**$ (1.5)**	**$ (8.2)**
Projected Premium Level	$ 113,205,516	$ 245,571,551	$ 185,087,847	$ 44,843,197	$ 16,077,705	$ 64,807,784	$ 8,584,267	$ 678,177,867
Incurred Claims[4]	$ 94,803,386	$ 284,181,204	$ 176,701,060	$ 46,447,220	$ 29,394,111	$ 61,355,519	$ 15,152,418	$ 708,034,917
Reported Administrative Charges	$ 4,171,325	$ 21,483,833	$ (2,666,667)	$ 1,715,760	$ 1,918,475	$ 5,506,133	$ 1,683,336	$ 33,812,195
State Administrative Charges	$ 231,740	$ 1,432,256	$ -	$ 95,320	$ 127,898	$ 305,896	$ 112,222	$ 2,305,333
Investment Income/BOE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Notes

1 Projected Premium Level adjusted for enrollment change from January 2001 to 2002 average
2 Administrative Charges based on Milliman report as of August 2002, converted for 12 months and subdivided by enrollment
3 State Administrative Charges based on Milliman report as of August 2002, converted for 12 months and subdivided by enrollment
4 Incurred Claims based on actual data

Appendix 3

Projected Financial Results

Local Plans - Fiscal Year 2002

	Actives			Early Retirees		Medicare Retirees		Total
	Traditional Plan	NJ Plus Plan	Rx Plan	Traditional Plan w/Rx	NJ Plus Plan w/Rx	Traditional Plan w/Rx	NJ Plus Plan w/Rx	
Enrollment								
2002 Average	51,089	50,524	29,583	17,526	5,005	43,124	4,567	
January 2001	51,466	38,617	18,605	16,244	3,800	41,200	3,140	
Difference	-0.7%	30.8%	59.0%	7.9%	31.7%	4.7%	45.5%	
Projected Financial Results ($M)								
Projected Premium Level[1]	$ 352.2	$ 250.5	$ 55.0	$ 189.9	$ 43.8	$ 180.4	$ 22.0	$ 1,093.8
Incurred Claims	349.4	246.4	52.5	182.7	42.6	174.0	20.3	1,068.0
Administrative Charges[2]	18.2	19.1	(0.7)	6.8	1.9	16.2	1.9	63.3
State Administrative Charges[3]	0.9	1.5	-	0.3	0.1	0.8	0.1	3.8
Investment Income/BOE[4]	4.9	1.1	0.7	2.6	0.2	2.5	0.1	12.0
(Gain/Loss)	**$ (11.4)**	**$ (15.3)**	**$ 3.8**	**$ 2.7**	**$ (0.7)**	**$ (8.1)**	**$ (0.3)**	**$ (29.3)**
Projected Premium Level	$ 354,779,951	$ 191,454,518	$ 34,599,826	$ 176,023,366	$ 33,257,365	$ 172,366,498	$ 15,124,522	$ 977,606,046
Incurred Claims[5]	$ 349,427,149	$ 246,356,406	$ 52,518,362	$ 182,708,337	$ 42,615,035	$ 173,998,412	$ 20,346,008	$ 1,067,969,709
Reported Administrative Charges	$ 18,154,954	$ 19,065,495	$ (666,667)	$ 6,768,943	$ 1,901,290	$ 16,158,051	$ 1,916,100	$ 63,298,167
State Administrative Charges	$ 907,748	$ 1,466,577	$ -	$ 338,447	$ 146,253	$ 807,903	$ 147,392	$ 3,814,319
Investment Income/BOE	$ 4,874,432	$ 1,055,940	$ 666,667	$ 2,628,523	$ 184,654	$ 2,497,045	$ 92,739	$ 12,000,000

Notes

1 Projected Premium Level adjusted for enrollment change from January 2001 to 2002 average
2 Administrative Charges based on Milliman report as of August 2002, converted for 12 months and subdivided by enrollment
3 State Administrative Charges based on Milliman report as of August 2002, converted for 12 months and subdivided by enrollment
4 Investment Income based on Milliman report as of August 2002, converted for 12 months and subdivided as a percentage of Premium
5 Incurred Claims based on actual data

Projected Financial Results

State Plans - 18-month Period Ending 12/31/01

	Actives			Early Retirees		Medicare Retirees		Total
	Traditional Plan	NJ Plus Plan	Rx Plan	Traditional Plan w/Rx	NJ Plus Plan w/Rx	Traditional Plan w/Rx	NJ Plus Plan w/Rx	
Enrollment								
18-month Average ending 12/01	15,120	51,418	103,850	4,146	1,629	14,530	1,782	
Projected 7/00 - 6/01	19,291	32,131	99,873	4,220	1,186	14,260	1,319	
Difference	-21.6%	60.0%	4.0%	-1.8%	37.3%	1.9%	35.1%	
Projected Financial Results ($M)								
Projected Premium Level[1]	$ 142.1	$ 312.9	$ 240.4	$ 51.4	$ 24.7	$ 82.3	$ 13.2	$ 867.0
Incurred Claims	147.6	315.2	224.1	58.1	22.7	80.1	11.6	859.3
Administrative Charges[2]	7.5	24.1	(1.9)	1.6	0.9	5.5	1.0	38.7
State Administrative Charges[3]	0.6	1.6	-	0.1	0.1	0.4	0.1	2.8
Investment Income/BOE[4]	0.6	1.5	0.5	0.2	0.1	0.4	0.1	3.4
(Gain/Loss)	**$ (12.9)**	**$ (26.5)**	**$ 18.7**	**$ (8.2)**	**$ 1.1**	**$ (3.3)**	**$ 0.7**	**$ (30.4)**
Premium Level 7/99 - 6/00	$ 104,917,806	$ 124,397,346	$ 113,315,165	$ 31,898,870	$ 5,834,170	$ 45,039,070	$ 2,652,168	$ 428,054,595
18-month Self Supporting Rate %	12.0%	3.8%	27.9%	7.4%	77.9%	15.4%	105.6%	15.3%
Projected Premium Level (18 months)	$ 181,327,213	$ 195,501,037	$ 231,189,164	$ 52,314,480	$ 17,980,024	$ 80,804,944	$ 9,794,250	$ 768,911,113
Incurred Claims[5]	$ 147,604,040	$ 315,192,284	$ 224,057,804	$ 58,066,626	$ 22,738,064	$ 80,088,887	$ 11,589,296	$ 859,337,002
Reported Administrative Charges	$ 7,456,742	$ 24,119,587	$ (1,871,684)	$ 1,631,199	$ 890,288	$ 5,512,060	$ 990,126	$ 38,728,316
State Administrative Charges	$ 561,809	$ 1,577,050	$ -	$ 122,899	$ 58,211	$ 415,292	$ 64,739	$ 2,800,000
Investment Income/BOE	$ 618,252	$ 1,516,195	$ 500,000	$ 223,573	$ 119,666	$ 358,175	$ 64,139	$ 3,400,000

Notes

1 Projected Premium Level adjusted for enrollment change from Buck's projected average for the previous period to 18-month average ending 12/01
2 Administrative Charges based on Milliman report as of June 2001, subdivided by enrollment
3 State Administrative Charges based on Milliman report as of June 2001, subdivided by enrollment
4 Investment Income based on Milliman report as of June 2001, subdivided as a percentage of Premium
5 Incurred Claims based on actual data

Projected Financial Results

Local Plans - 18-month Period Ending 12/31/01

	Actives			Early Retirees		Medicare Retirees		Total
	Traditional Plan	NJ Plus Plan	Rx Plan	Traditional Plan w/Rx	NJ Plus Plan w/Rx	Traditional Plan w/Rx	NJ Plus Plan w/Rx	
Enrollment								
18-month Average ending 12/01	51,436	39,154	20,175	16,588	3,952	41,391	3,198	
Projected 7/00 - 6/01	51,482	29,435	16,087	15,673	2,958	38,098	2,223	
Difference	-0.1%	33.0%	25.4%	5.8%	33.6%	8.6%	43.9%	
Projected Financial Results ($M)								
Projected Premium Level[1]	$ 438.0	$ 262.7	$ 51.2	$ 205.2	$ 46.1	$ 222.1	$ 21.9	$ 1,247.3
Incurred Claims	456.3	262.8	46.5	228.2	47.3	215.8	20.4	1,277.3
Administrative Charges[2]	23.2	18.4	(0.3)	7.1	1.8	17.2	1.4	68.8
State Administrative Charges[3]	1.6	1.2	-	0.5	0.1	1.2	0.1	4.7
Investment Income/BOE[4]	9.6	3.4	0.2	4.5	0.6	4.9	0.3	23.4
(Gain/Loss)	**$ (33.5)**	**$ (16.3)**	**$ 5.2**	**$ (26.1)**	**$ (2.5)**	**$ (7.3)**	**$ 0.4**	**$ (80.1)**
Premium Level 7/99 - 6/00	$ 281,637,661	$ 118,077,966	$ 20,032,335	$ 98,811,015	$ 13,153,750	$ 98,598,982	$ 4,576,841	$ 634,888,550
18-month Self Supporting Rate %	3.0%	9.1%	27.7%	23.9%	56.5%	29.6%	89.4%	14.3%
Projected Premium Level (18 months)	$ 438,444,942	$ 197,488,159	$ 40,790,728	$ 193,841,639	$ 34,536,933	$ 204,430,369	$ 15,253,941	$ 1,124,786,710
Incurred Claims[5]	$ 456,270,514	$ 262,838,472	$ 46,455,483	$ 228,203,368	$ 47,285,491	$ 215,838,319	$ 20,395,095	$ 1,277,286,742
Reported Administrative Charges	$ 23,233,495	$ 18,367,113	$ (300,000)	$ 7,073,124	$ 1,845,759	$ 17,193,382	$ 1,387,127	$ 68,800,000
State Administrative Charges	$ 1,614,116	$ 1,190,461	$ -	$ 491,396	$ 119,633	$ 1,194,488	$ 89,906	$ 4,700,000
Investment Income/BOE	$ 9,567,877	$ 3,414,863	$ 200,000	$ 4,481,027	$ 599,869	$ 4,851,095	$ 285,268	$ 23,400,000

Notes

1 Projected Premium Level adjusted for enrollment change from Buck's projected average for the previous period to 18-month average ending 12/01
2 Administrative Charges based on Milliman report as of June 2001, subdivided by enrollment
3 State Administrative Charges based on Milliman report as of June 2001, subdivided by enrollment
4 Investment Income based on Milliman report as of June 2001, subdivided as a percentage of Premium
5 Incurred Claims based on actual data

Projected Financial Results

State Plans - 6-month Period Ending 12/31/01

	Actives			Early Retirees		Medicare Retirees		Total
	Traditional Plan	NJ Plus Plan	Rx Plan	Traditional Plan w/Rx	NJ Plus Plan w/Rx	Traditional Plan w/Rx	NJ Plus Plan w/Rx	
Enrollment								
6-month Average ending 12/01	14,467	54,489	105,499	4,099	1,797	14,605	1,896	
Projected 7/00 - 6/01	19,291	32,131	99,873	4,220	1,186	14,260	1,319	
Difference	-25.0%	69.6%	5.6%	-2.9%	51.5%	2.4%	43.7%	
Projected Financial Results ($M)								
Projected Premium Level[1]	$ 48.0	$ 112.6	$ 92.1	$ 17.6	$ 12.1	$ 29.6	$ 6.7	$ 318.7
Incurred Claims	49.8	114.2	78.9	20.1	9.1	28.9	4.7	305.9
Administrative Charges[2]	2.5	8.0	(0.6)	0.5	0.3	1.8	0.3	12.9
State Administrative Charges[3]	0.2	0.5	-	0.0	0.0	0.1	0.0	0.9
Investment Income/BOE[4]	0.2	0.5	0.2	0.1	0.1	0.1	0.0	1.1
(Gain/Loss)	**$ (4.3)**	**$ (9.7)**	**$ 13.9**	**$ (3.0)**	**$ 2.7**	**$ (1.2)**	**$ 1.7**	**$ 0.1**
Premium Level 7/99 - 6/00	$ 104,917,806	$ 124,397,346	$ 113,315,165	$ 31,898,870	$ 5,834,170	$ 45,039,070	$ 2,652,168	$ 428,054,595
Projected Premium Level (12 months)	$ 115,725,945	$ 127,561,775	$ 139,108,191	$ 33,739,473	$ 10,253,539	$ 50,952,822	$ 5,387,404	$ 482,729,149
18-month Self Supporting Rate %	12.0%	3.8%	27.9%	7.4%	77.9%	15.4%	105.6%	15.3%
Projected Premium Level (6 months)	$ 63,966,228	$ 66,393,641	$ 87,152,830	$ 18,071,858	$ 7,993,868	$ 28,934,740	$ 4,681,246	$ 277,194,412
Incurred Claims[5]	$ 49,830,179	$ 114,249,454	$ 78,930,487	$ 20,088,643	$ 9,104,595	$ 28,944,743	$ 4,717,025	$ 305,865,126
Reported Administrative Charges	$ 7,456,742	$ 24,119,587	$ (1,901,397)	$ 1,631,199	$ 890,288	$ 5,512,060	$ 990,126	$ 38,698,603
State Administrative Charges	$ 561,809	$ 1,577,050	$ -	$ 122,899	$ 58,211	$ 415,292	$ 64,739	$ 2,800,000
Investment Income/BOE	$ 604,927	$ 1,456,299	$ 500,000	$ 221,358	$ 156,689	$ 373,715	$ 87,012	$ 3,400,000

Notes

1 Projected Premium Level adjusted for enrollment change from Buck's projected average for the previous period to 6-month average ending 12/01
2 Administrative Charges based on Milliman report as of June 2001, converted for 6 months and subdivided by enrollment
3 State Administrative Charges based on Milliman report as of June 2001, converted for 6 months and subdivided by enrollment
4 Investment Income based on Milliman report as of June 2001, converted for 6 months and subdivided as a percentage of Premium
5 Incurred Claims based on actual data

Projected Financial Results

Local Plans - 6-month Period Ending 12/31/01

	Actives			Early Retirees		Medicare Retirees		Total
	Traditional Plan	NJ Plus Plan	Rx Plan	Traditional Plan w/Rx	NJ Plus Plan w/Rx	Traditional Plan w/Rx	NJ Plus Plan w/Rx	
Enrollment								
6-month Average ending 12/01	51,900	42,754	23,465	17,063	4,253	42,291	3,421	
Projected 7/00 - 6/01	51,482	29,435	16,087	15,673	2,958	38,098	2,223	
Difference	0.8%	45.2%	45.9%	8.9%	43.8%	11.0%	53.9%	
Projected Financial Results ($M)								
Projected Premium Level[1]	$ 149.5	$ 99.9	$ 22.4	$ 78.3	$ 20.7	$ 86.1	$ 10.8	$ 467.7
Incurred Claims	163.9	99.1	18.8	83.6	18.1	79.8	8.3	471.6
Administrative Charges[2]	7.7	6.1	(0.1)	2.4	0.6	5.7	0.5	22.9
State Administrative Charges[3]	0.5	0.4	-	0.2	0.0	0.4	0.0	1.6
Investment Income/BOE[4]	3.0	1.1	0.1	1.6	0.2	1.7	0.1	7.8
(Gain/Loss)	**$ (19.7)**	**$ (4.7)**	**$ 3.8**	**$ (6.2)**	**$ 2.2**	**$ 1.9**	**$ 2.1**	**$ (20.6)**
Premium Level 7/99 - 6/00	$ 281,637,661	$ 118,077,966	$ 20,032,335	$ 98,811,015	$ 13,153,750	$ 98,598,982	$ 4,576,841	$ 634,888,550
Projected Premium Level (12 months)	$ 285,614,180	$ 127,272,132	$ 24,536,800	$ 122,169,667	$ 20,334,559	$ 125,203,953	$ 8,562,954	$ 713,694,245
18-month Self Supporting Rate %	3.0%	9.1%	27.7%	23.9%	56.5%	29.6%	89.4%	14.3%
Projected Premium Level (6 months)	$ 148,336,163	$ 68,759,416	$ 15,365,109	$ 71,935,953	$ 14,401,897	$ 77,563,401	$ 6,997,627	$ 403,359,566
Incurred Claims[5]	$ 163,937,274	$ 99,115,100	$ 18,796,889	$ 83,562,229	$ 18,128,247	$ 79,754,127	$ 8,321,121	$ 471,614,986
Reported Administrative Charges	$ 23,233,495	$ 18,367,113	$ (300,000)	$ 7,073,124	$ 1,845,759	$ 17,193,382	$ 1,387,127	$ 68,800,000
State Administrative Charges	$ 1,614,116	$ 1,190,461	$ -	$ 491,396	$ 119,633	$ 1,194,488	$ 89,906	$ 4,700,000
Investment Income/BOE	$ 9,002,283	$ 3,269,536	$ 200,000	$ 4,714,549	$ 677,923	$ 5,183,167	$ 352,542	$ 23,400,000

Notes

1 Projected Premium Level adjusted for enrollment change from Buck's projected average for the previous period to 6-month average ending 12/01
2 Administrative Charges based on Milliman report as of June 2001, converted for 6 months and subdivided by enrollment
3 State Administrative Charges based on Milliman report as of June 2001, converted for 6 months and subdivided by enrollment
4 Investment Income based on Milliman report as of June 2001, converted for 6 months and subdivided as a percentage of Premium
5 Incurred Claims based on actual data

Summary of Annual Costs vs. Enrollment, 2000-2002

- The SHBP actuary performs rate developments for the various plans offered by Horizon, for State and local populations, separately. Mercer's summary of annual costs are broken out by these populations and detailed in the table below.

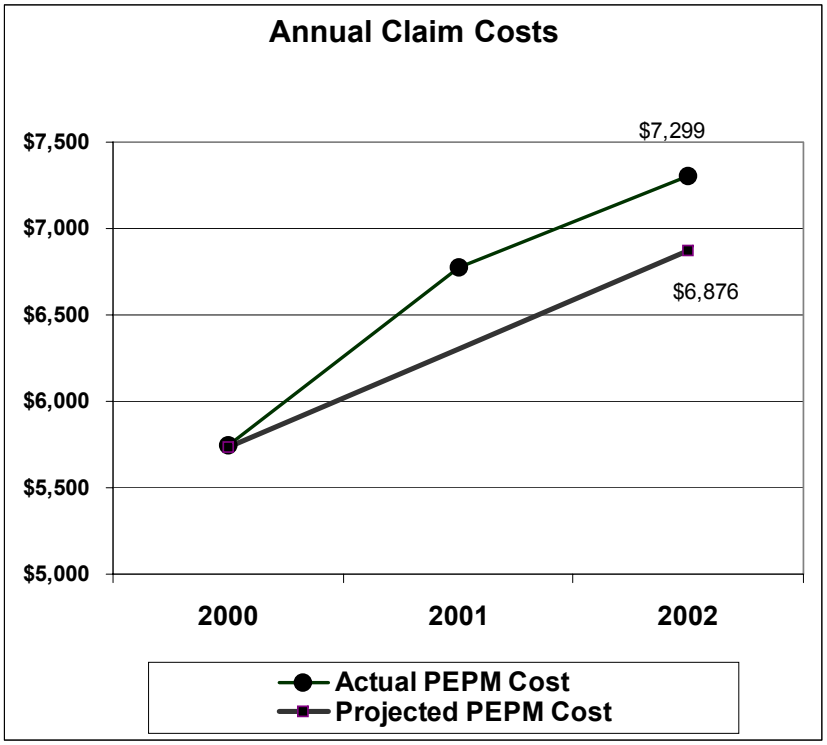
Summary of Population "Groups" Used for Renewal Rating

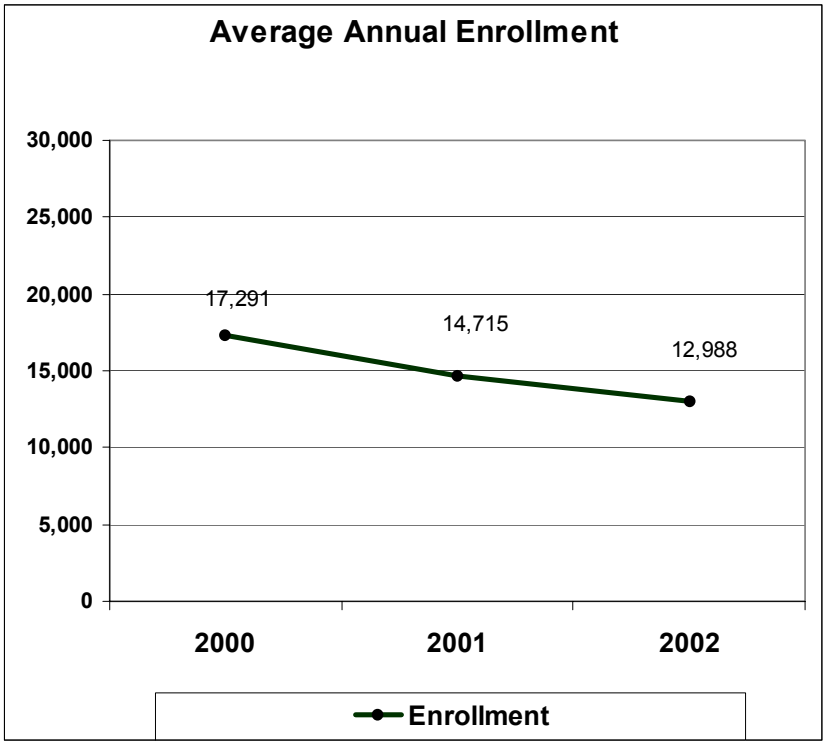
SHBP Plan	Population Subgroup
Traditional	Active Retiree less than 65 Retiree 65 or older
NJ PLUS	Active Retiree less than 65 Retiree 65 or older
Prescription Drug	Active Retiree less than 65 Retiree 65 or older

- In the following charts, the experience period claims are captured in 2000. These are increased by two years with trend to develop the projected by claims for 2002.

Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-1
State Actives - Traditional Plan

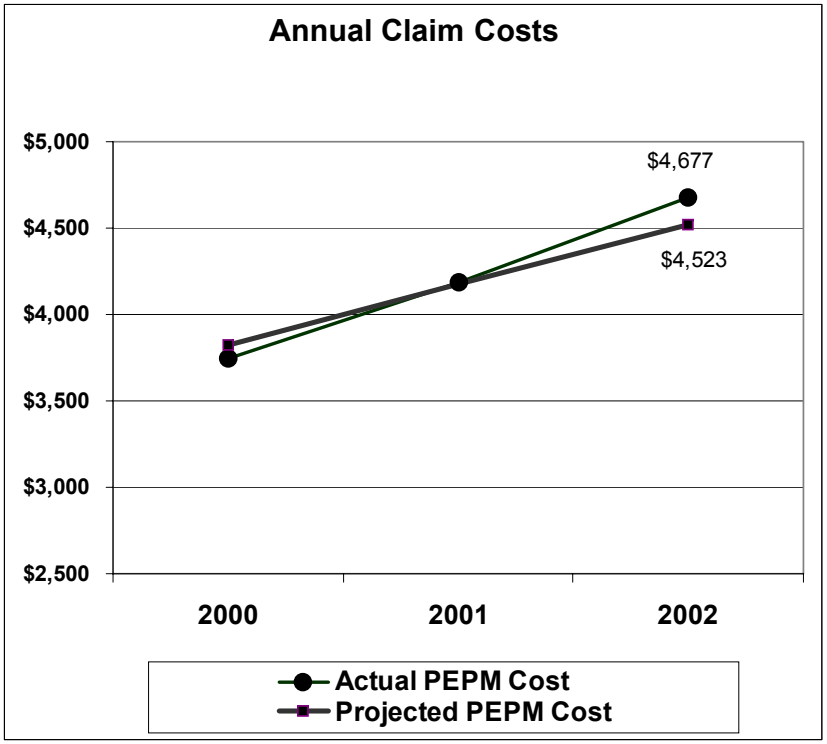


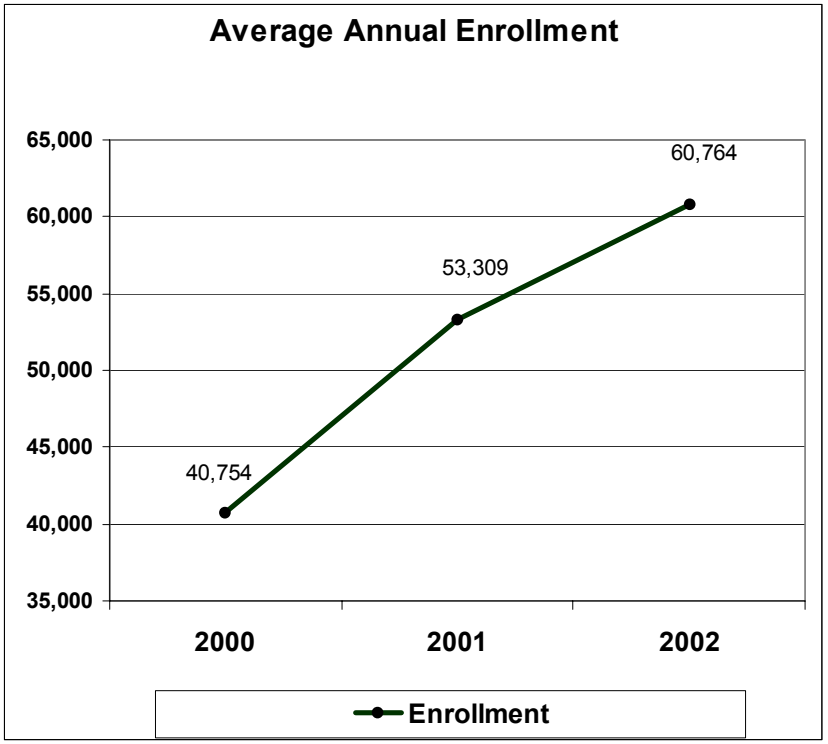


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-2

State Actives - NJ PLUS Plan

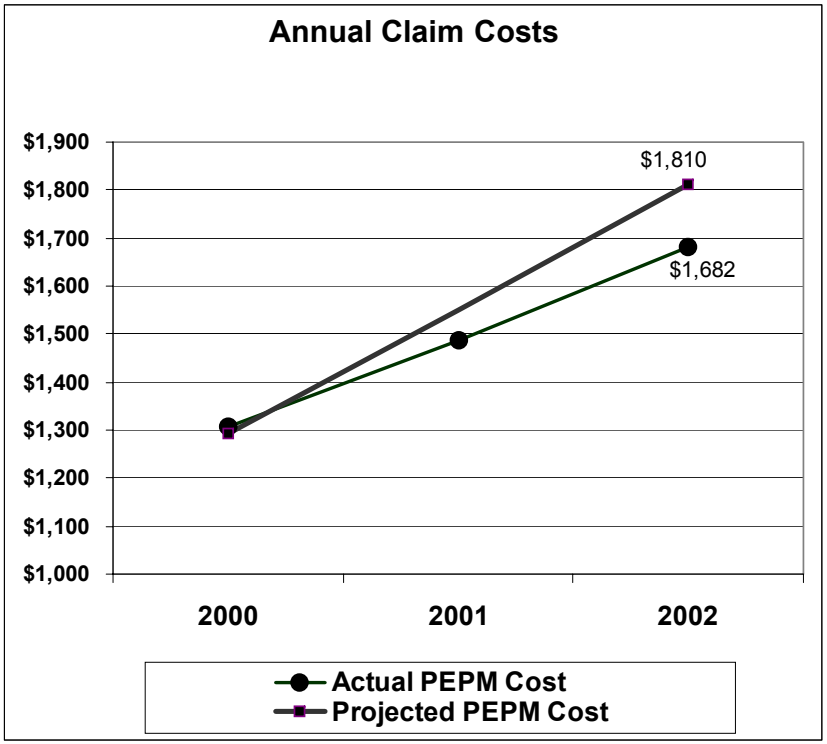


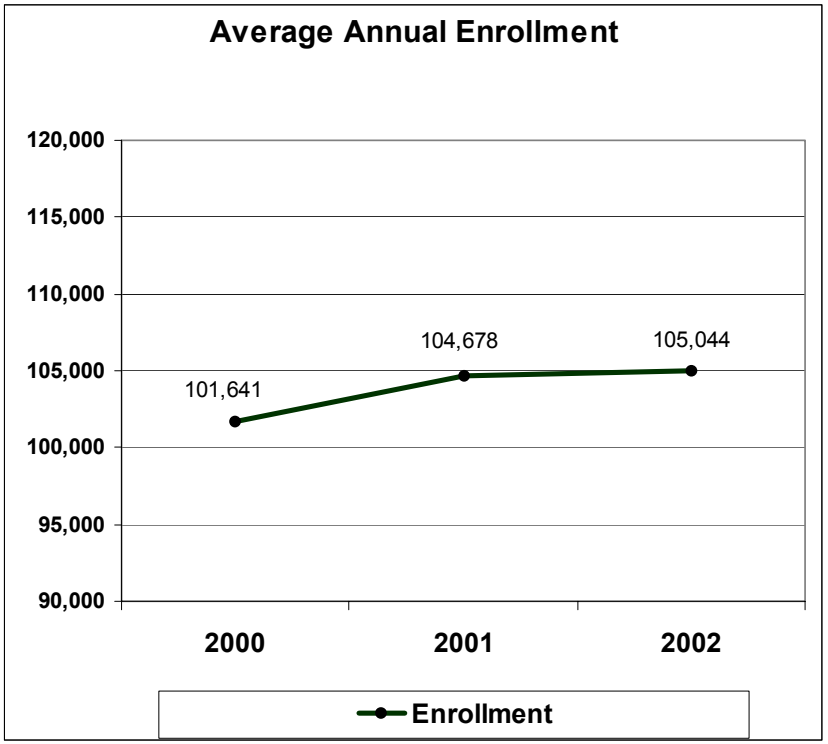


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-3

State Actives - Rx Plan

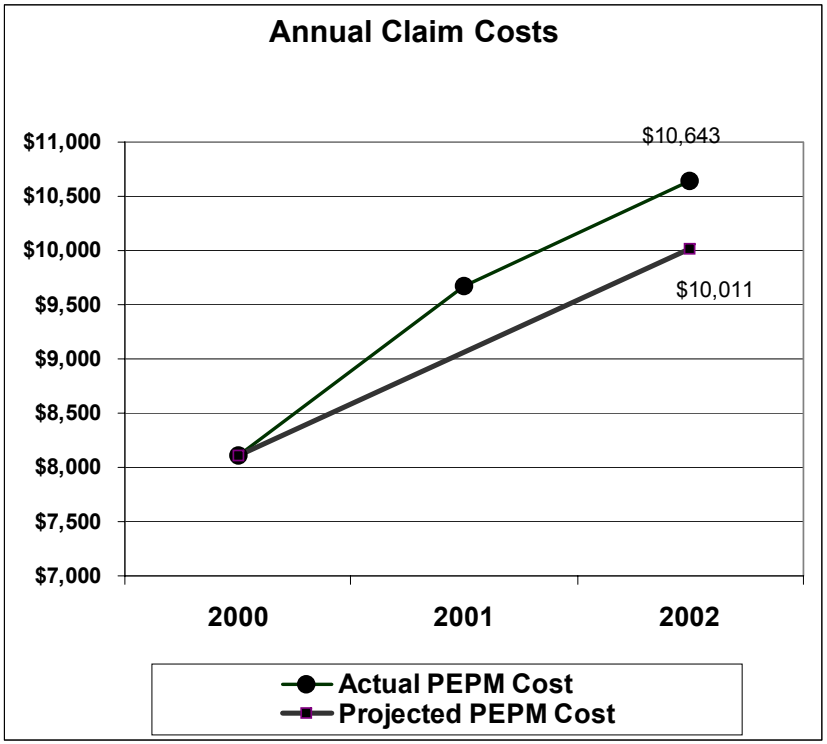


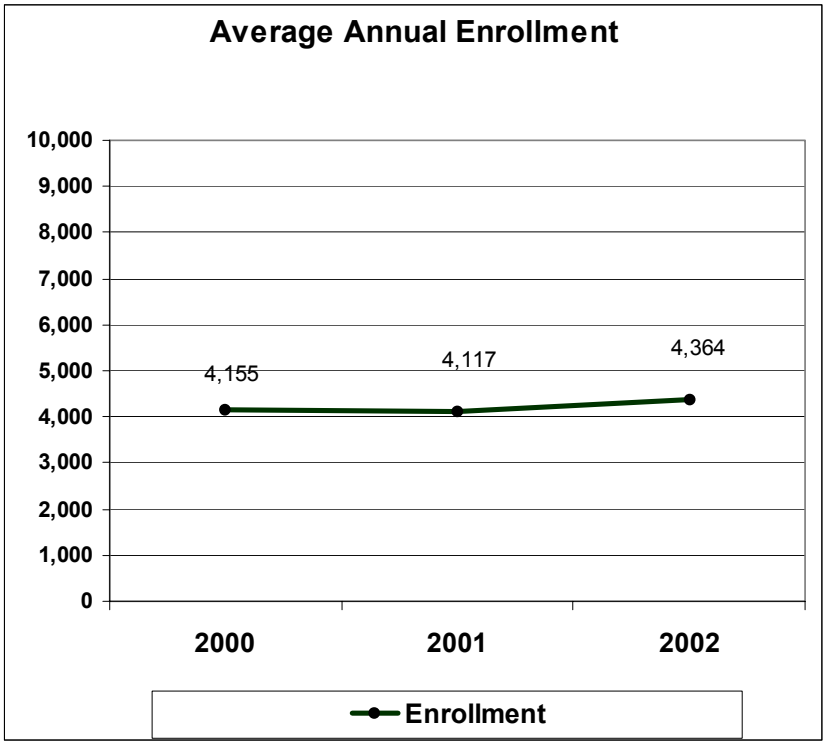


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-4

State Early Retirees - Traditional Plan with Rx

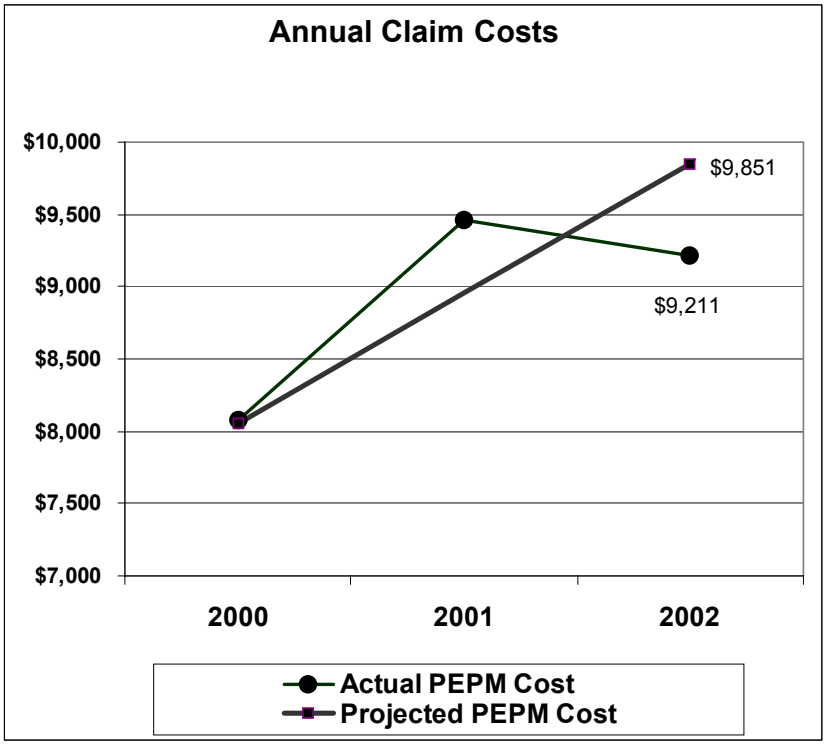


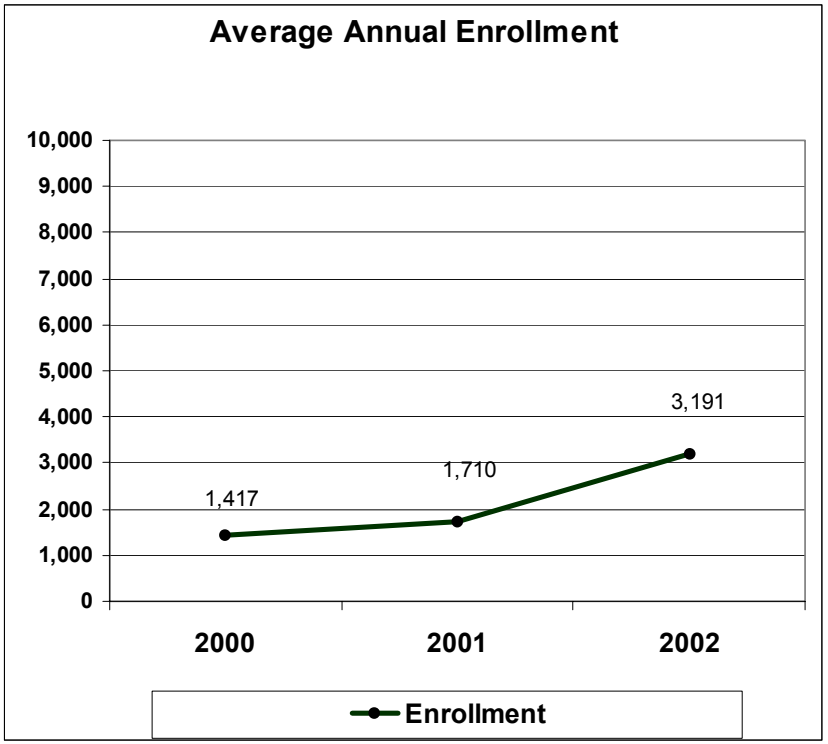


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-5

State Early Retirees - NJ PLUS Plan with Rx

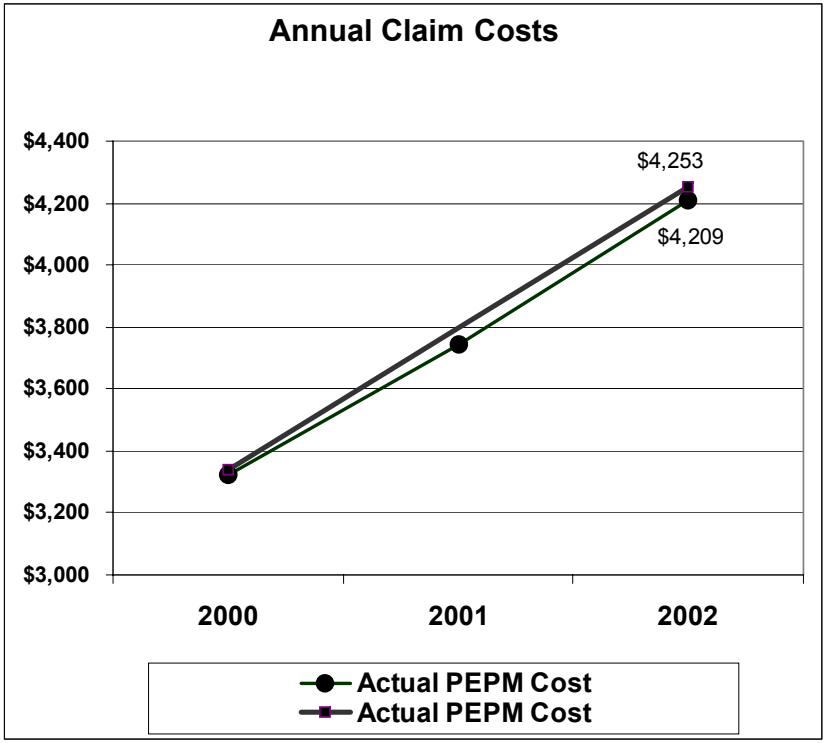


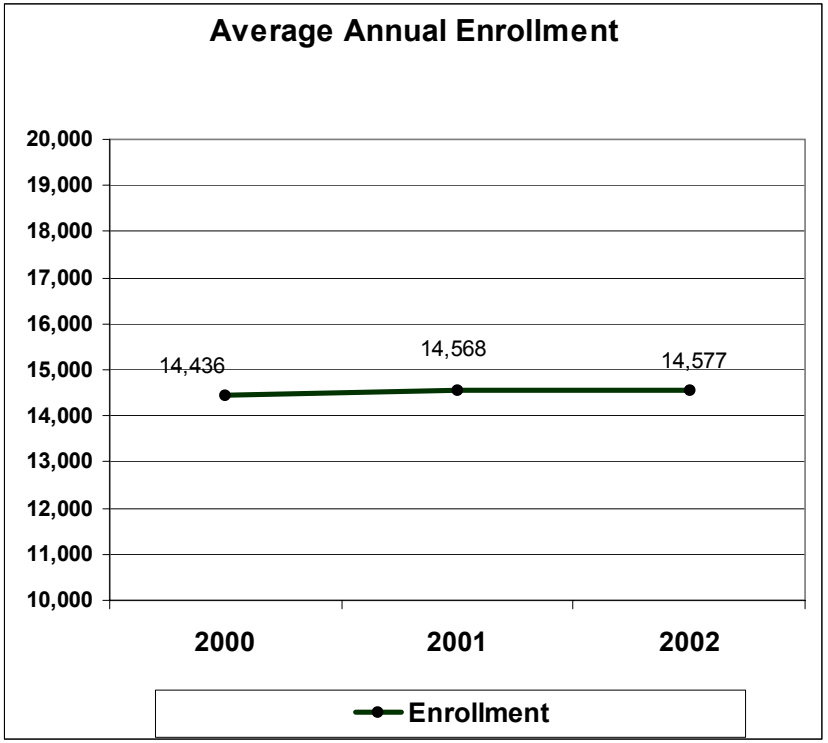


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-6

State Medicare Retirees - Traditional Plan with Rx

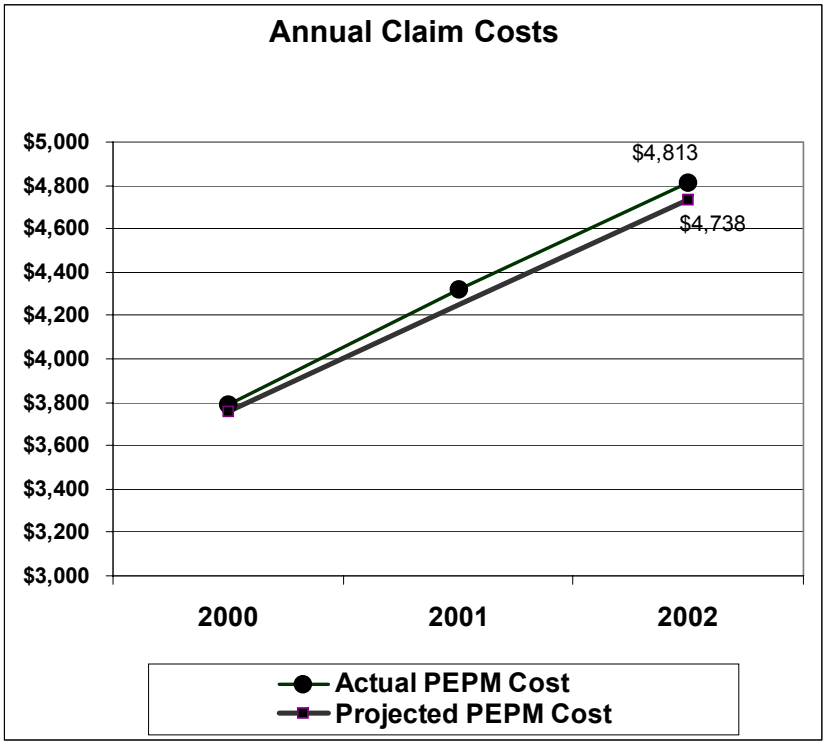


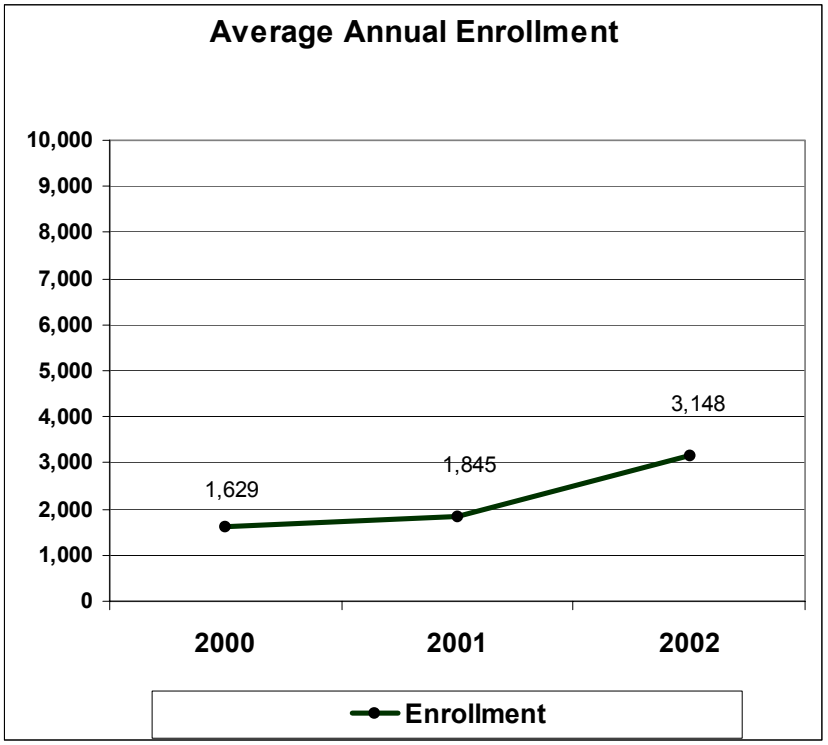


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-7

State Medicare Retirees - NJ PLUS Plan with Rx

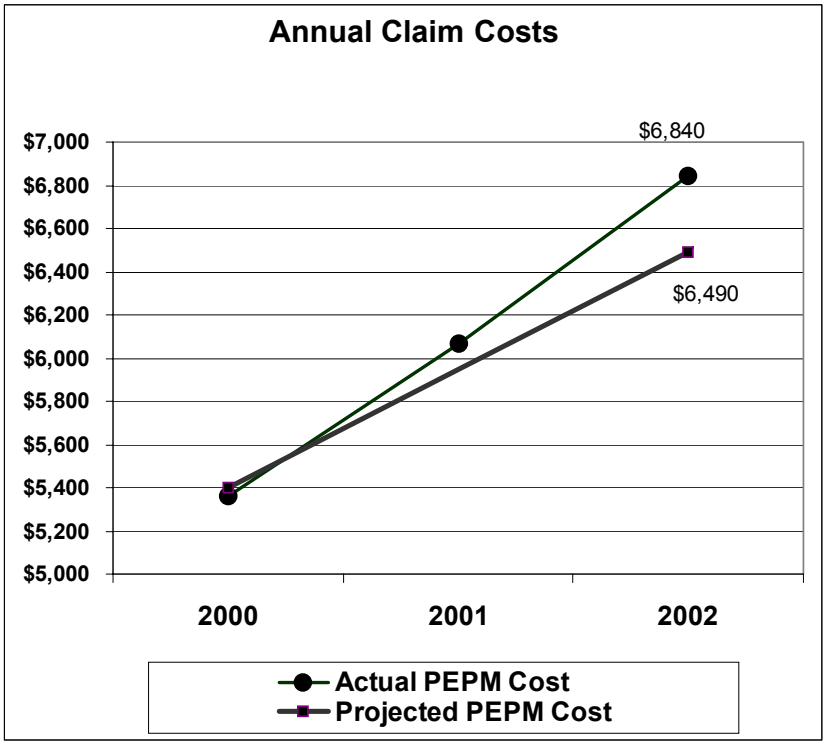


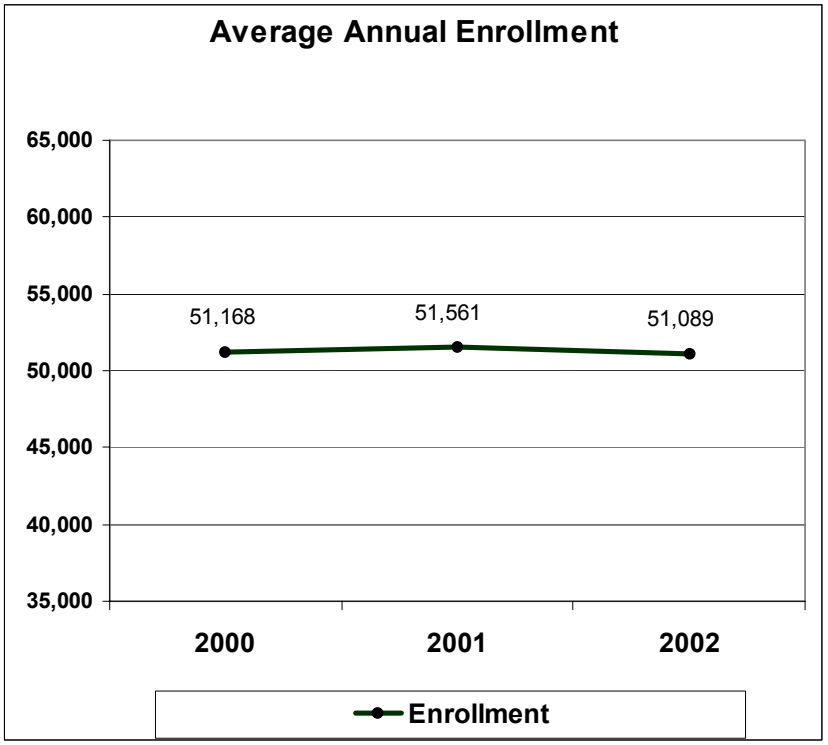


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-8

Local Actives - Traditional Plan

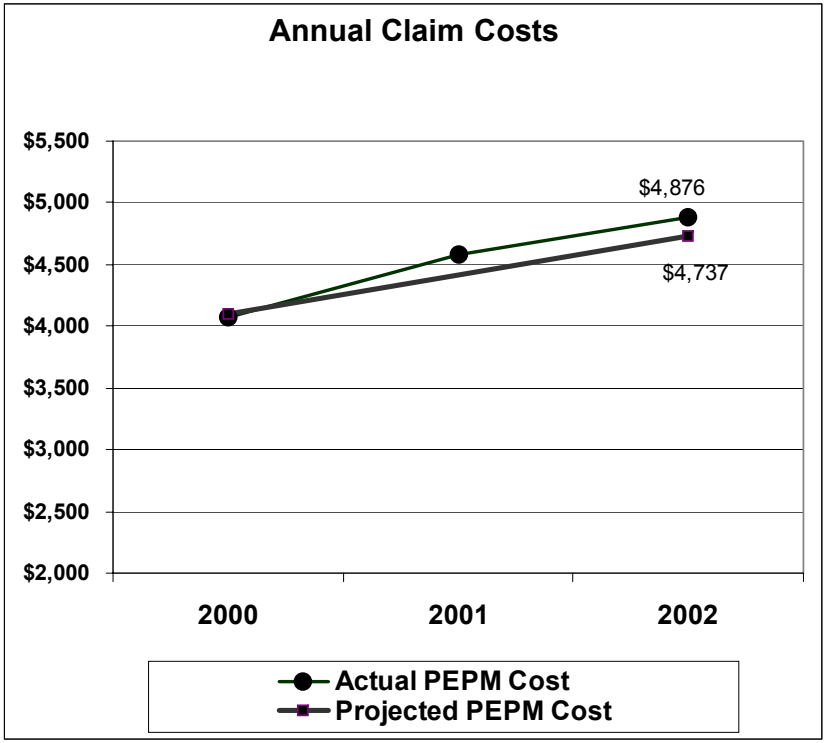


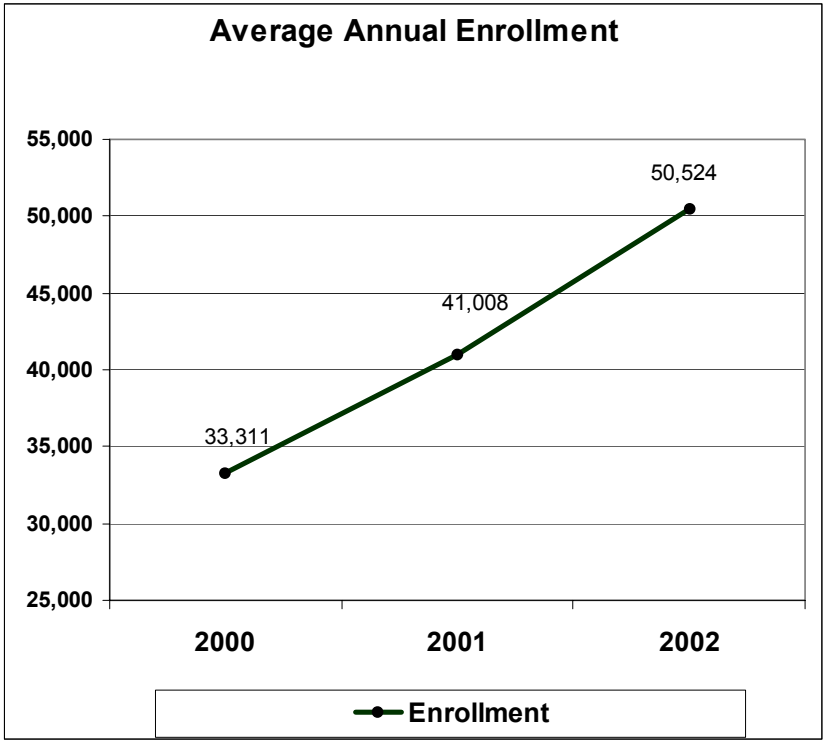


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-9

Local Actives - NJ PLUS Plan

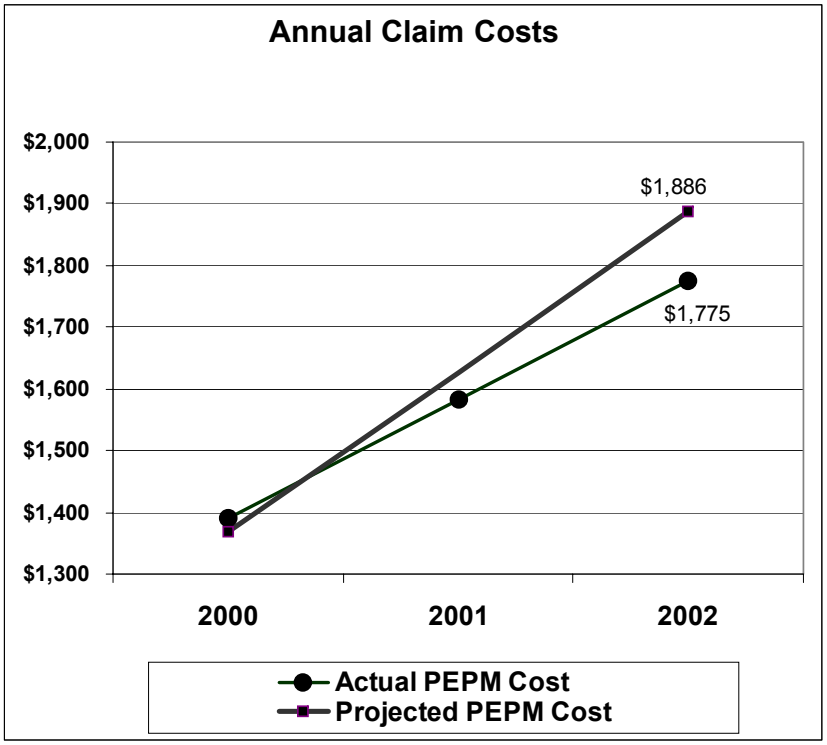


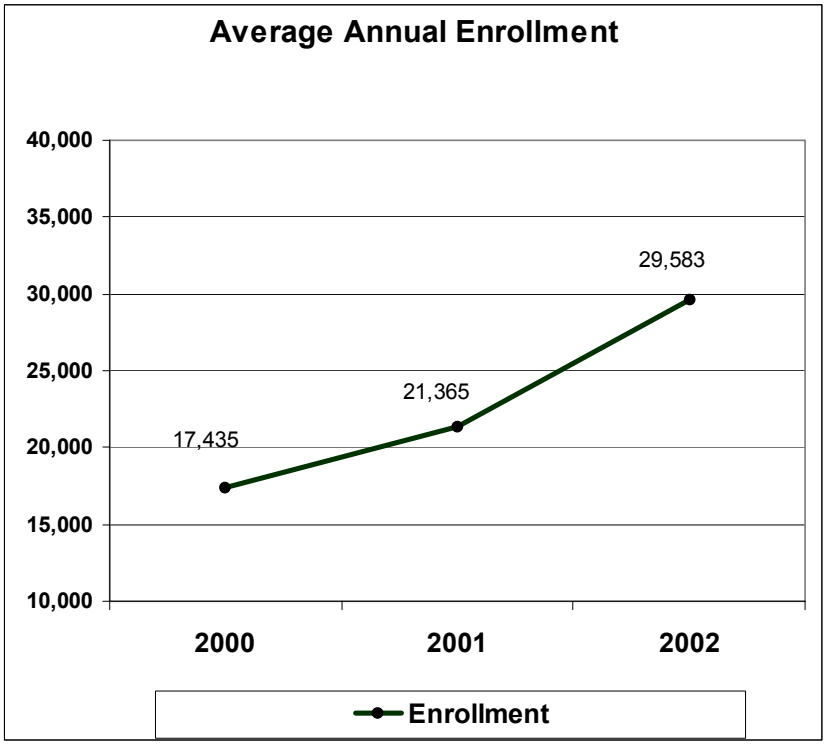


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-10

Local Actives - Rx Plan

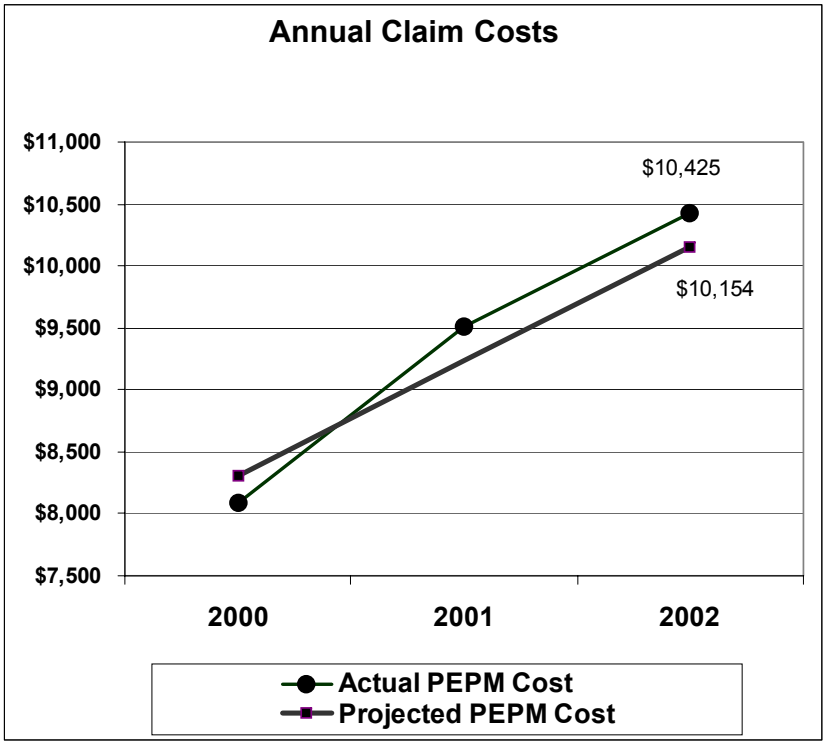


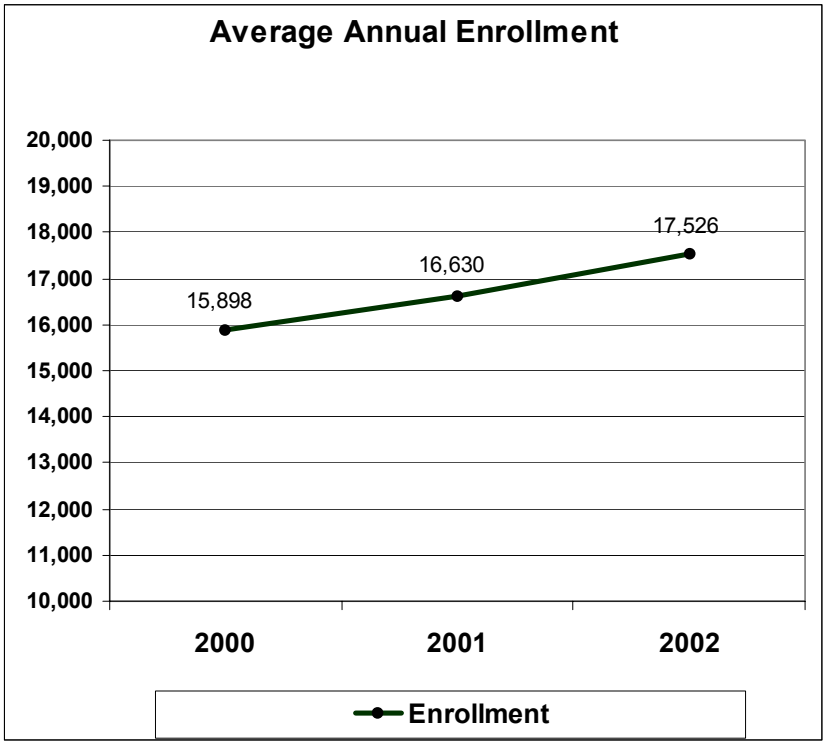


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-11

Local Early Retirees - Traditional Plan with Rx

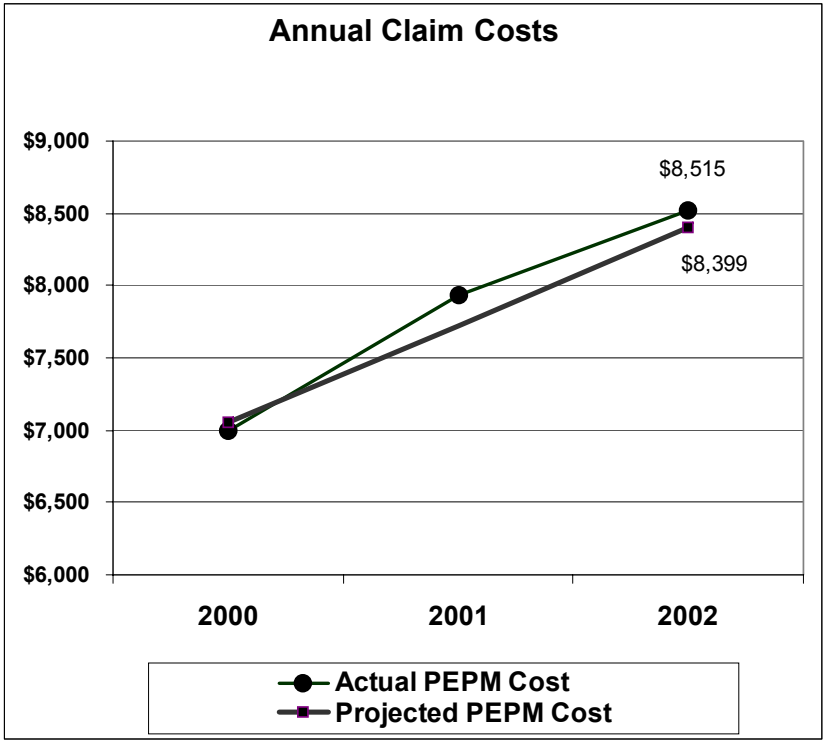


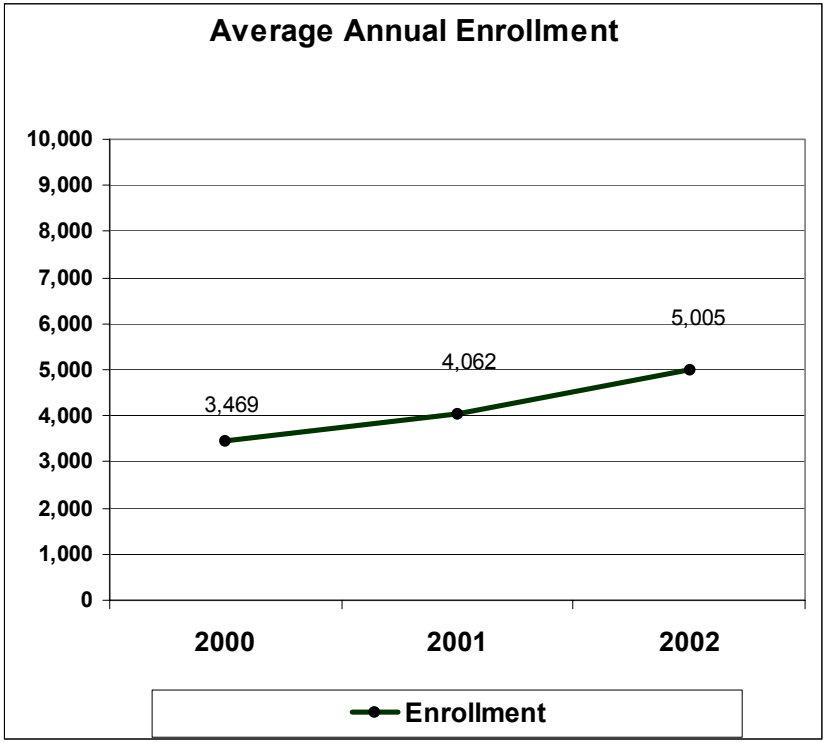


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-12

Local Early Retirees - NJ PLUS Plan with Rx

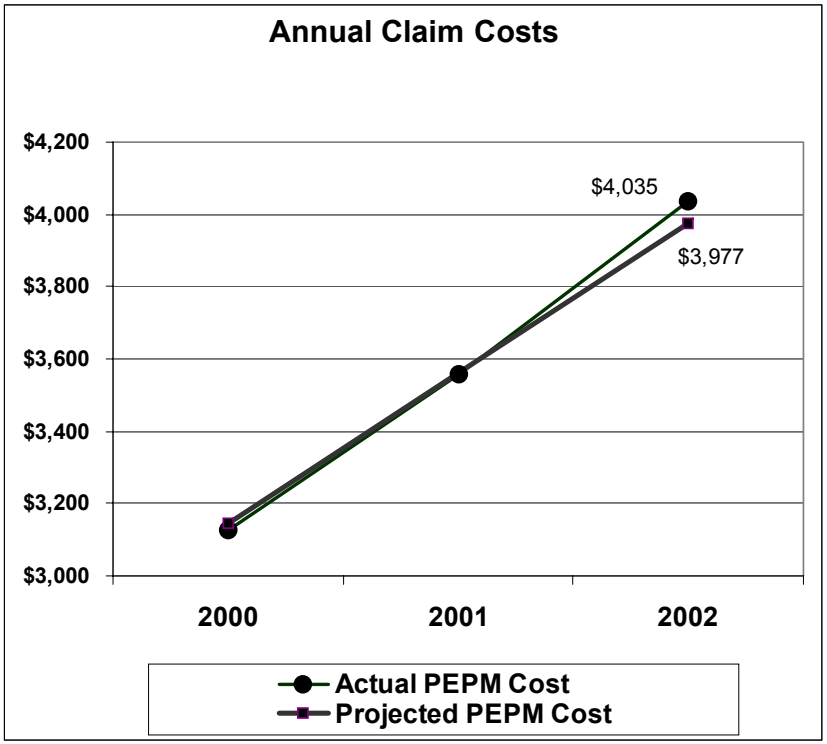


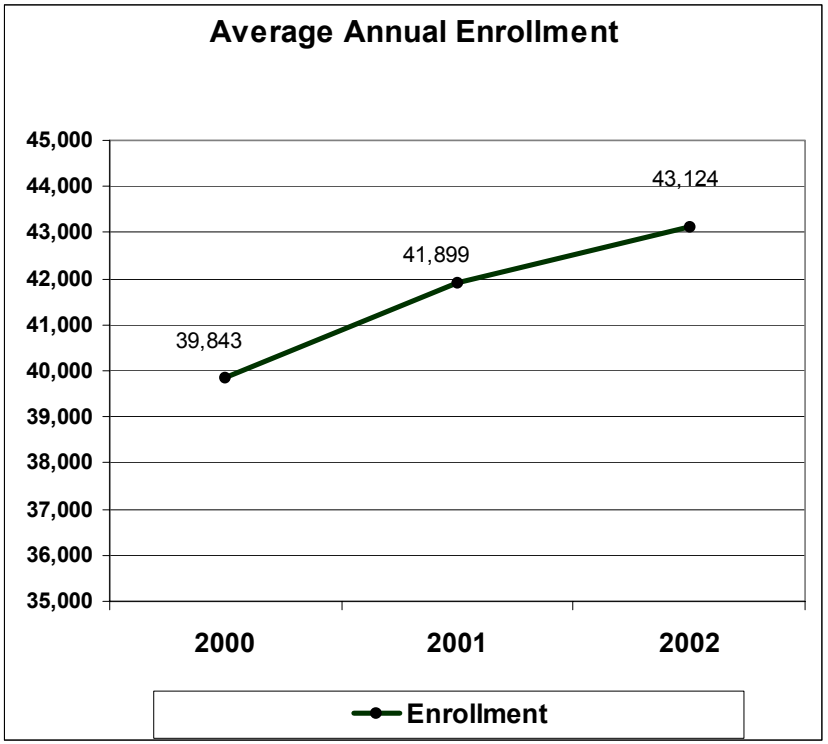


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-13

Local Medicare Retirees - Traditional Plan with Rx

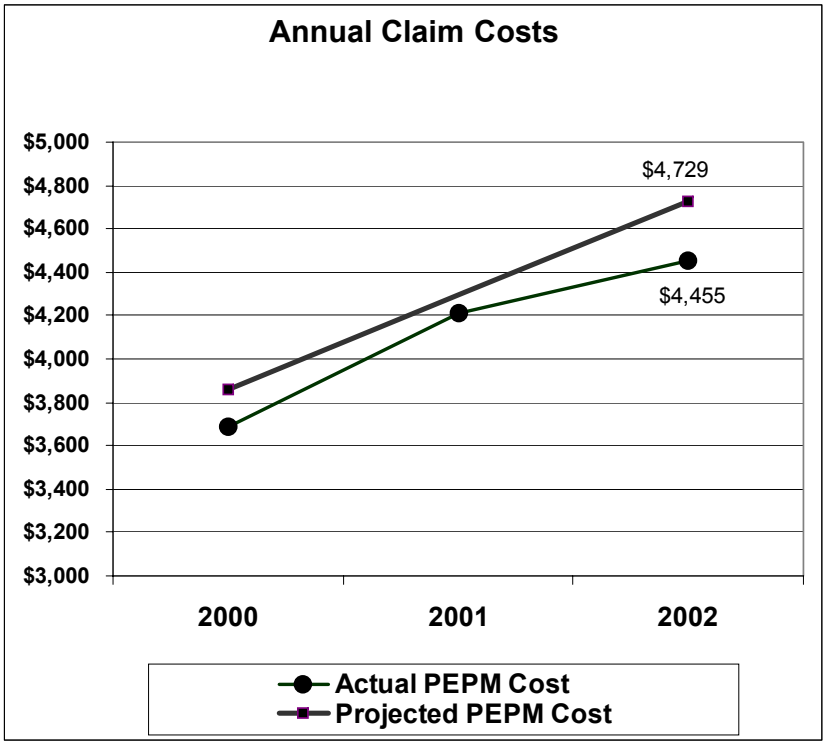


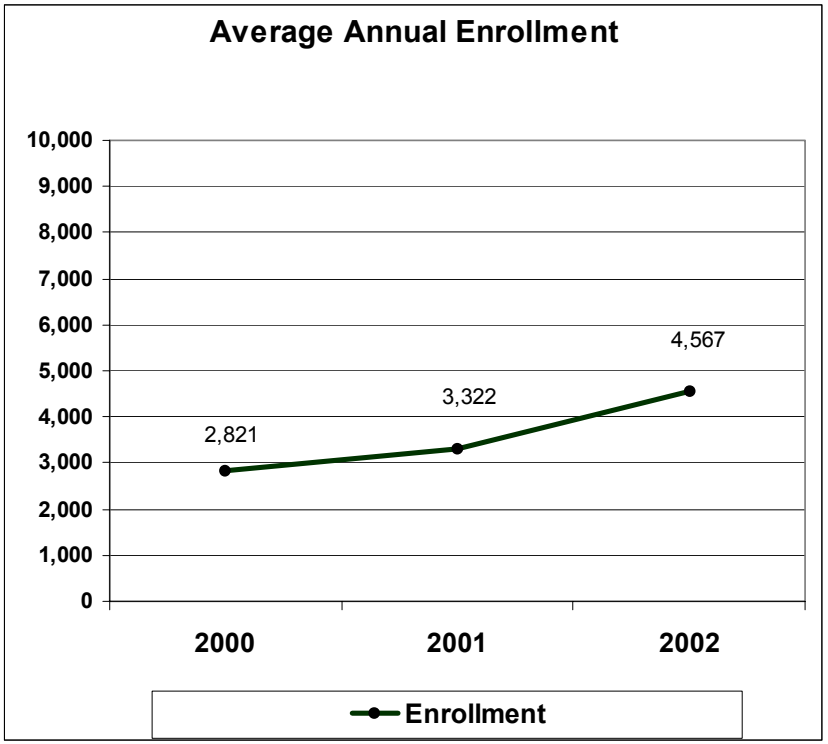


Summary of Annual Costs vs. Enrollment, 2000-2002

Financial Exhibit 4-14

Local Medicare Retirees - NJ PLUS Plan with Rx





Summary of Online Services, by Vendor

AETNA

- **Aetna NavigatorTM** - A web-based tool designed to help members access and navigate a wide range of health information and programs. Navigator provides a single source for online benefits and health-related information. Navigator allows members to request member ID cards, review plan coverage details and claim status, change primary physician, research health topics and conditions, review EOBs (explanation of benefits) and more.

  Aetna Navigator is a self-service website which allows members to
  - View/print current eligibility information;
  - Locate a doctor or dentist (including phone number);
  - Check claim status;
  - Request ID cards; and
  - Contact Member Services.

- **DocFind®** - Members can choose a Primary Care Physician (PCP), search for participating physicians, hospitals and other health care providers from our extensive network via the Internet. Members can select a provider based on geographic location, medical specialty, hospital affiliation, and/or languages spoken. Members can also obtain maps, driving directions, and physician performance summaries. DocFind is updated three times a week.

CIGNA

- CIGNA's online tool allows members to
  - Change their PCP.
  - Download a personalized provider directory.
  - Find out if a doctor is accepting new patients.
  - Order refills through the mail-order pharmacy.

- Site also provides plan design, claims data and forms, a Hospital Quality tool, CIGNA's Drug List, and access to information about health, wellness, and pharmaceuticals.

Summary of Online Services, by Vendor *(continued)*

Overview of Analysis *(continued)*

Horizon BlueCross BlueShield

- The Member Portal is Horizon BlueCross BlueShield of New Jersey's online information tool.
- Members can view information about
  - Eligibility (A list of products, covered persons (subscribers can view all covered persons, dependents can view only their own information), coverage effective dates, coverage termination dates, and selected PCP information (the PCP's name and ID, and the PCP Selection Date);
  - Claims (can display all your claims processed within the last 18 months). Information includes claim #, first and last dates of service, patient name and birth date, total claim charge amount, claim status, date received;
  - Authorizations and referrals;
  - Premium billing and payment;
  - Request for identification cards;
  - Other insurance coverage information;
  - Health and wellness information;
  - Pharmacy services including a formulary listing;
  - Case management;
  - Discount programs; and
  - Doctor and hospital finder.
- Members can obtain downloadable forms.

Summary of Online Services, by Vendor *(continued)*

Overview of Analysis *(continued)*

HealthNet

HealthNet's online tool provides

- DocSearch: a database of medical professionals.
- Hospital Comparison Report: a personalized report that compares hospitals for a particular procedure, in seconds.
- Also available: The Leapfrog Group, a source for online survey results on hospital safety standards.
- Pharmacy Info
  - Participating pharmacies
  - Download pharmacy forms
  - View recommended drug list
- Web Health Resources
  - EBM Solutions- Evidence Based Medicine
  - Living with chronic disease
  - Asthma
  - Diabetes
  - Chronic heart failure
- Wellsite
  - Women matter
  - Teen health
  - Healthy extras
  - Preventive healthcare guidelines
- Member Eligibility
  - View/change member information
  - Change PIN
  - Member forms
  - ID cards
  - E-Mail member services
  - Frequently asked questions

Summary of Online Services, by Vendor *(continued)*

Overview of Analysis *(continued)*

Oxford Health Plans

- Self service available via Website - Members can search for providers, check benefits, order ID cards, request materials and access wellness resources.
- Transactions available on the site include:
  - Review claims
  - Check referrals
  - Change mailing or e-mail address
  - Change a PCP or OB/GYN
- Resources available on the site include
  - Doctor search
  - Oxfordhealth Center
  - Self-Help Library/SM
  - Preventive care schedules
- Information available on the site include
  - Covered benefits
  - Complementary and alternative medicine information
  - Oxford policies and procedures
  - Healthy Bonus® discounts on wellness-related products

Appendix 6

Bibliography of Financial and Program Sources

Name/Description	Source
Original RFP & Response *RFQ for State Health Benefits Program and Consultant Review*	State of New Jersey
Calendar Year 2002 Financial Projections ▪ State Plan ▪ Local Plan ▪ HMO Plans ▪ Dental Program	State of New Jersey
18-Month Financial Projections (7/1/2000 – 12/31/2001) ▪ State Plan ▪ Local Plan ▪ HMO Plans ▪ Dental Program ▪ Medicare HMO	State of New Jersey
Fiscal Year 2000 (7/1/1999 – 6/30/2000) Financial Projections ▪ State Plan ▪ Local Plan ▪ HMO Plans ▪ Dental Program	State of New Jersey
HMO Renewal Questionnaires ▪ 1/1/03 – 12/31/03 ▪ 1/1/04 – 12/31/04	State of New Jersey
Request for Proposal ▪ Traditional Plan ▪ NJ PLUS Plan	State of New Jersey
Calendar Year 2003 Financial Projections ▪ Dental ▪ Local ▪ State ▪ HMO	State of New Jersey

Bibliography of Financial and Program Sources

Name/Description	Source
Comprehensive Annual Financial Report – Fiscal Year 6/30/02	
Alpha History of Local Employers	State of New Jersey
Rate Sheets ▪ 1999 ▪ 18-Month ▪ 1/1/02 – 12/31/02 ▪ 12/28/02 – 12/26/03	State of New Jersey
SPD	State of New Jersey
Summary ASO Rates 1998-2003	State of New Jersey
Summary of HMOs Offered 1998-2002	State of New Jersey
Health Benefits Financial Overview	State of New Jersey
Headcounts ▪ Overall summary of plan enrollment as of 6/30/02 ▪ Dental Program as of 00/01/02 ▪ Medical Program as of 00/01/02	State of New Jersey
History of Accomplishments since 1996	State of New Jersey
Summary of Plan Changes since 1992	State of New Jersey
Summary of Disease Management Programs	State of New Jersey
Fact Sheets ▪ Publications to Employees	State of New Jersey
Public Performance Reports ▪ 2000/2001/2002	State of New Jersey
Generic HMO Performance Standards	State of New Jersey
Actual HMO Performance Rating Reports ▪ Internal	State of New Jersey
Performance Guarantee Information ▪ Traditional Plan ▪ NJ Plans	Health Plan Vendor Interviews (Horizon BCBS, Aetna, CIGNA)

Bibliography of Financial and Program Sources

Name/Description	Source
HMO Employee Handbooks ▪ Aetna ▪ CIGNA ▪ AmeriHealth	State of New Jersey
Regulations ▪ Proposed ▪ Actual	State of New Jersey
Mandates	State of New Jersey
DPO Renewal Questionnaires ▪ Effective 2002 ▪ Effective 2003 ▪ Effective 2004	State of New Jersey
10-Year Health Benefits Costs (1994-2003)	State of New Jersey
Local Employer Membership Info ▪ Resolution to join ▪ Resolution after joining	State of New Jersey
HMO Benefits & Operating Standards *for materials sent to Members*	State of New Jersey
NJ PLUS Employee Handbook	State of New Jersey
Traditional Plan Member Handbook	State of New Jersey
NJ PLUS Member Handbook	State of New Jersey
Rx Employee Handbook	State of New Jersey
Program Comparison Charts	State of New Jersey
Employee Handbook – 1996	State of New Jersey

Appendix 6

Bibliography of Financial Sources

Name/Description	Source
Aetna HMO enrollment and claims data (1/2000 – 3/2003	Aetna
IBNR Reports (6/1999 – 3/2003)	Milliman
Employee Enrollment Data (1/2000-6/2003)	Milliman
Current Cost Management Program Descriptions, Including:	Health Plan Vendor Interviews (Horizon BCBS, Aetna, CIGNA)
▪ 2002 Calculated ROI numbers or information	
▪ Member Headcounts	
– Case management	
– In total, per plan	