Committee Meeting

before

ASSEMBLY SELECT COMMITTEE ON CIVIL SERVICE AND EMPLOYEE BENEFITS

LOCATION: Committee Room 10
Legislative Office Building
Trenton, New Jersey

DATE: April 21, 1992
2:35 p.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblyman David C. Russo, Chairman
Assemblywoman Harriet Derman
Assemblyman George F. Geist
Assemblywoman Stephanie R. Bush
Assemblyman Louis A. Romano

ALSO PRESENT:

Wayne L. Bockelman
Office of Legislative Services
Section Chief
State Government Section

Hearing Recorded and Transcribed by
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New Jersey State Legislature
ASSEMBLY SELECT COMMITTEE ON CIVIL SERVICE
AND EMPLOYEE BENEFITS
Legislative Office Building, Cn 068
TRENTON, NEW JERSEY 08625-0068
(609) 292-9106

COMMITTEE NOTICE

TO: MEMBERS OF THE ASSEMBLY SELECT COMMITTEE ON CIVIL SERVICE AND EMPLOYEE BENEFITS

FROM: ASSEMBLYMAN DAVID C. RUSSO, CHAIRMAN

SUBJECT: **COMMITTEE MEETINGS - APRIL 21, 1992 and April 23, 1992**

The public may address comments and questions to Pamela H. Espenshade, Committee Aide, or make scheduling inquiries to Kathleen Lieblang, Secretary, at (609) 292-9106.

The Assembly Select Committee on Civil Service and Employee Benefits will meet on **Tuesday, April 21, 1992 at 2:00 P.M. and on Thursday, April 23, 1992 at 2:00 P.M. in Committee Room 10 of the Legislative Office Building, Trenton, New Jersey.**

Issued April 15, 1992

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ASSEMBLYMAN GEORGE GEIST (Acting Chairman): Good afternoon ladies and gentlemen. In the absence of Chairman Russo, we will begin the meeting. We'd like to call upon the representatives from the New Jersey School Boards Association for their testimony at this time. Thank you for your patience.

K A T H E R I N E M c M I C H A E L: Members of the Committee, thank you very much. Again, I'm Kathy McMichael, New Jersey School Boards Association.

We have developed our formal testimony, and this is presented to you today. It basically conforms to what I said a couple of weeks ago. As you can see, the areas that we're most concerned about are the State health benefit area, the State Health Benefit Plan, and we listed four areas that we would like to have some changes made. And now I'll turn the meeting over to Esther Strassman, our labor relations expert, who will be going into more detail on this area for us. Esther?

E S T H E R S T R A S S M A N: Thank you. And, again, I'd like to thank you for giving us the opportunity to offer our comments on the testimonies that we heard presented last week. I must say that I was-- As I was listening to the Division of Pensions and to the NJEA comments, it occurred to me that our perspectives appeared quite different. It appeared to us that we were hearing the Division and NJEA support doing business as usual. It seemed to us that they were saying, the way we are providing health benefits under the State Health Benefit Plan for our public employees is working just fine.

Well, the perspective of boards of education -- and I suspect of other public employers, as well as the taxpayers -- is that things are not working well; that there are problems in the old procedures that are based on outdated assumptions and that create a very nonproductive, counterproductive environment, where the costs of providing the State Health Benefit Plan simply cannot be ignored. Those costs are being borne by the taxpayers, and those costs are threatening the

allocation of necessary funds to support our educational programs.

I would like to distribute for you a chart of premium costs under the State Health Benefit Plan in the last decade. I think you will see that since 1981-'82 the tremendous increase that has occurred in the State Health Benefit premiums. They range from an increase of 470 percent to an increase of 512 percent. As we mentioned in our last testimony, those increases are fully borne by local taxpayers. Another way of looking at the increase in the premiums of the State Health Benefit Plan is to compare the premiums as a percentage of teachers' salaries.

The document you are receiving now compares B.A. minimum and maximum salaries in 1981-'82 and 1990-'91. The rates of the State Health Benefit Plan for both years are listed for single and family. You will see that in 1981-'82, the B.A. minimum average -- that is the entry-level starting salary -- throughout the State averaged $12,219. At that time the single premium of $373.44 represented 3.1 percent of the starting salary.

In 1990-'91 the single premium now represents 7.1 percent of the starting salary. Even a greater significant increase can be seen when you judge the percentage of the family premium against the starting salary. In 1981-'82 boards of education were paying 7.6 percent of starting salaries to fund family coverage under the State Health Benefit Plan. In 1990-'91 boards are now paying -- were paying 18.3 percent of the starting salary to provide family coverage. The percentages are less as the salaries increase, and you have before you the percentage of the B.A. maximum salary, on the guide. But you still see the tremendous increase.

In 1981-'82 family coverage represented 4.3 percent of that average salary, on the B.A. column of the guide. Currently, it is almost 11 percent of that salary. These costs

are impressive, and they continue to increase dramatically. Now, we are not suggesting that the plan is responsible for these increases in the costs of insurance premiums. We all know that the crisis of providing health insurance is a national crisis, and it requires national attention and a national solution. However, it is not enough to wait for the Federal government to come up with a new system of providing health insurance.

We must deal with the issue now, and we must see what is happening around us to contribute to the increase of those costs, and what could possibly be done to help achieve cost containment for local boards of education, other public employers, and ultimately, the taxpayer.

As we indicated in our testimony two weeks ago, there are several structures of the plan that prevent cost containment, that preclude participating employers from pursuing options that are available with prior carriers, that are available to employers in the private sector. For the 72 percent of the boards of education who participate in the State Health Benefit Plan those options are available.

I have to tell you that boards of education are vigorously looking for ways of controlling the increases in providing their employees with health insurance. Boards of education are not interested in eliminating coverage, reducing level of benefits, or denying coverage to groups of employees. Their interest is primarily in finding a way of sharing those costs, of containing those costs, so those same level of benefits can be provided at an affordable cost.

Boards of education have tried very creatively, with a great deal of responsibility and accountability to the public, to examine ways in which these cost containment and cost saving approaches can occur.

The first attempt that boards of education have made has been through negotiations. As we indicated, the first we

spoke to you, boards of education must negotiate changes in any level of health coverage that is provided by contract. The State Health Benefit Plan requires, by code and by regulations, that the employer pay the full cost of the employee premium. So, that is not an issue for the 470-odd boards who are participating in the State Health Benefit Plan. What is a matter of negotiations is the cost of providing for dependent coverage.

As we indicated last time, 96 percent of the boards participating in the State Health Benefit Plan provide full coverage to dependents. That means that all increases -- the 512 percent that you have seen in the last decade, has been carried fully by boards of education. The only way boards of education can achieve a change in that area in obtaining cost sharing in reaching agreement where increases in dependent coverage is shared equally between the employee receiving the benefit and the employer, is for a change in negotiations. And in advising boards throughout the State, I can tell you the number of proposals that have come across the tables seeking participation, in an agreement, to have employees share the cost has probably occured in practically every single district.

To the best of my knowledge, only one district has been able to achieve a modest employee contribution towards the costs of dependent coverage -- the increase in cost of dependent coverage. So, the options of negotiating cost containment by reducing boards' obligation to full coverage is not a practical option. So, what do boards do then? Boards then start looking for options of different insurance carriers, and this was spoken to you last week by the NJEA. The NJEA indicated that many of the State school districts that have negotiated a private carrier or who have changed to a private carrier have indeed gotten premiums that were higher than those of the State Health Benefits Plan, and that is truth that has occurred.

However, similarly, there are many districts -- and I have just chosen a few -- generally in the same counties selected by the NJEA, that have achieved coverage through a private carrier at lower premiums than available under the State Health Benefit Plan, which immediately suggest that perhaps the State Health Benefit Plan is not the competitive entity we would wish it to be.

The NJEA also focused on the costs of the premiums. We would like to circulate one page from the NJEA research, which is excellent, and which we use a lot to understand what is happening throughout the State. I would focus you first to the major heading at the top of the page. You will see, I guess it's the fourth column over called "Annual Premium." In parenthesis appears this statement, "Regardless of amount paid by board." This means that the premiums that are listed in the NJEA research may not be the totality of what a board pays.

For example: If under the County of Morris, which is at the top of the page, you go to the next to the last district -- West Morris Regional -- which was a district cited by the NJEA as having far higher premiums with its Blue Cross/Blue Shield private carrier than available under the State Health Plan, and you keep on reading to the column that has -- that is numbered number two and has listed 55 percent employee and dependent -- E & D -- that notation by the NJEA indicates that West Morris Regional only pays 55 percent of the premium and the remainder of the premium is paid by employee. Therefore, the actual cost to that board is not the full premium. That board, with a private carrier, is able to achieve cost containment through the coverage and through the rules and regulations of a private carrier.

That board is not the only board. Having taken the list of districts submitted to you by the NJEA last week, I checked some of their contracts, and found, for example -- and those selected articles are duplicated for you -- that the

district of Pennsauken in Camden County has an article in its insurance protection coverage, insurance purchased from a private carrier, that prohibits duplication of coverage.

West Morris Regional, that we just saw on the detailed sheet from the NJEA publication, has employee contribution for employee premiums as well as dependent premiums. That district, with a private carrier, has been able to negotiate cost sharing of the benefit, which leads to cost containment.

And finally, Woodbridge Township, in Middlesex, has negotiated an insurance waiver with an incentive that saves the board money. So, once again, while the premiums may be higher, the total cost to the district because of what it is able to negotiate under the rules of a private carrier are less than they could be under the State Health Benefit Plan, and this is exactly what boards of education are saying. Boards of education are saying, in today's world there are ways of containing insurance cost, of approaching the providing of health insurance by shared contribution of employer and employee that do not diminish coverage, but do diminish taxpayers' obligations, and do allow for additional moneys to be allocated towards educational programs and student programs.

Currently, under the rules of the Plan, none of the options that you see listed before you are available to the 72 percent of local boards of education, to the municipal government, or to the State government that participates in the State Health Benefit Plan. Those options are not available because outdated regulations and outdated statutes prevent those options.

ASSEMBLYMAN GEIST: Who are they not available to?

MS. STRASSMAN: They are not available to any of the participating employers in the State Health Benefit Plan: the State of New Jersey, and in the local employer group, municipalities, counties, boards of education--

ASSEMBLYMAN GEIST: Thank you.

MS. STRASSMAN: --and any other employer that I have left out.

One of the issues that has been negotiated by many boards is that of incentives for nonenrollment for unnecessary coverage. This issue has been one that has been given much attention by this Committee, and I'd like to resurrect the issue once again. The Pension Division claimed last week that permitting incentives for nonenrollment would immediately create a pool of high utilizers that would result in significant increases in the premiums that would ultimately increase the employers' costs. That may very well be so, but that kind of statement, ladies and gentlemen, I believe requires some statistical documentation, some assessment with actuaries.

Clearly it can be done: to run an estimation of what permitting incentives or what prohibition against duplicate coverage would do on the premiums of the State Health Benefit Plan. We believe that access to this documentation is particularly important, when just a number of years ago the Division of Pensions, that was supporting the influx of a large number of retirees into the State Health Benefit Plan-- The Division's position at that time was that the influx of high utilizers into the State Health Benefit Plan would not have a negative effect on the premiums, because of the size of the Plan.

We would like to know if that logic carries through to prohibitions or limits on duplicate coverage? We believe that the Division should, therefore, provide that kind of data before any changes or lack of change is considered in this area. Premiums may go up, but will the cost to local boards, local government entities, and to the State also go up if one adopts a policy limiting duplicate coverage?

If the number of dollars that you put forth through each employee ends up being diminished, or the number of

employees covered is reduced, what is the net effect on the cost to the taxpayer? Again, this is something that requires study, an assessment, and estimates -- statistical and not just statements.

Dual coverage, we have been told, is prohibited by other states. Incentives are permitted by other states. Refunds of premiums paid for duplicate coverage is another way in which the costs of duplicate coverage which as we all know does not yield the same benefit as one coverage per employee or per family-- There is a rule in the State Health Benefit Plan, N.J.A.C. 17:9-5.7 which is entitled "Multiple Coverage Refund." There is a rule on the books that provides for the refund of a premium, that provides multiple coverage if that premium is paid by an employee. There is no refund available if the premium is paid by an employer. We ask why?

We know that there are other limitations in other states that balance the utilization of a group that does not have duplicate coverage and the costs of providing those benefits. Perhaps we should look at them. The pattern of enrollment in the State Plan as we heard testified to last week is completely left up to the individual. We know by experience -- and it's very human nature, and it's probably very legitimate -- that any employee that is given coverage, the availability of coverage, will opt for the highest coverage available. Boards of education who had negotiated incentives prior to the adoption of the rule prohibiting incentives, reported that all of their employees who had taken the option of the incentive -- when that option was not legally available -- all of those employees enrolled immediately for the full family coverage at a great increase to the boards' costs and to the taxpayers' costs.

We must keep in mind that duplicate enrollment in the State Health Benefit Plan is not an isolated occurrence. For some reason public employees tend to be married to public

employees, and people are both enrolled in the State Health Benefit Plan. One district reported to me that 30 percent of their employees have duplicate coverage. It's something like 27 percent duplicate coverage through the State Health Benefit Plan. Their small administrators' unit of five members, of those, three members have duplicate coverage with the State Health Benefit Plan. So, we are paying for benefits possibly not received.

There are many legislative options available to close this loophole. First: Mandate a refund for duplicate coverage. Second: Authorize incentives for nonenrollments for unnecessary coverage. Or three: Legislate a prohibition against employer paid premiums for unnecessary coverage. This approach could, for example, prohibit an employer from paying the premium for more than single coverage for any employee who was covered by a spouse's coverage elsewhere.

The employee could, at the employee's option, purchase -- at his or her costs -- additional coverage through the State Health Benefit Plan. We are not advocating the unavailability of insurance coverage. We are identifying areas which cost the taxpayers money and which force the allocation of limited funds towards employees' benefits rather than towards educational programs.

We are not advocating a reduction in employees' insurance coverage, but we are asserting that it is time to reexamine the taxpayers' bills for providing these benefits, and we are advocating that public employees should begin to share the costs of health insurance, either through direct payment, partial payment of premiums, or higher deductibles, and higher copays.

When the State Health Benefit Plan was extended to school employees in 1964, that bill's statement of intent was as follows, and I quote, "To provide the greatest benefits to public employees in New Jersey, at the lowest cost to both

employers and employees." Since that time the level of benefits in the plan have increased continuously with concurrent increases in the employer's cost. It is time to reexamine the plan, to achieve its purpose, and to bring it in line with the economic realities of the 1990s.

Thank you very much.

ASSEMBLYMAN DAVID C. RUSSO (Chairman): Thank you. George?

ASSEMBLYMAN GEIST: Are your comments of today incorporated within your prepared text?

MS. STRASSMAN: No, they are not.

ASSEMBLYMAN GEIST: Could you provide a copy of your testimony?

MS. STRASSMAN: Yes, I could. Certainly.

ASSEMBLYMAN GEIST: Question, Mr. Chairman, if I may--

ASSEMBLYMAN RUSSO: Sure.

ASSEMBLYMAN GEIST: --on the revolving door. I believe that question was presented in your presence. The revolving door restriction which precludes returning to the State Health Benefit Program for a period of five years-- You raised a question about what I call low balls, where the private enterprise quotes low premiums as an inducement to attract a new customer away from the State Health Benefit Program, but, obviously, with awareness that there's no possibility of a return for a period of five years. And in that fourth or fifth year, that private plan premium suddenly skyrockets, and ultimately, what was a plan to protect the best interest of the taxpayer turns into a catastrophe. What's the position of the School Boards Association on the five-year bar?

MS. STRASSMAN: I'm glad you raised that question, because that is an issue that I forget to address. We believe that the five-year bar leads to a great deal of inflexibility. We do not believe that we have been persuaded that the existence of the bar provides cost containment or any

additional benefits to employees. Therefore, we really do not see the purpose of the bar. Boards of education are very, very aware of that bar. They are very aware of the risk they take, and boards of education have approached the decision making with a great deal of responsibility and accountability.

Boards of education engage insurance consultants. They do not simply rely on insurance brokers who may receive a commission. They also consult with us and with all of their other resources. They are very aware of the five-year bar, and they do put that factor in the equations, and, on balance, some boards -- particularly the larger boards who are not going to be devastated by one very medically serious illness that will cost a lot of money and increase the utilization -- those larger boards are willing to take the risk. Why? Because they are guaranteed lower premiums in the first three years, and there is an understanding on the board's part that they can then attempt to negotiate further cost containments that are not available under the State Health Benefit Plan, and that is what they are working towards.

Let me give you some example of those cost containments that have been successfully negotiated just this last two years:

A commitment to maintain the board's current obligation under contract to current employees -- that is full dependent coverage -- but new employees will only receive, at board's expense, employee only. Those employees are permitted to purchase on their own, dependent coverage. For a number of years, the board's obligation is limited. That option is not available under the State Health Benefit Plan.

Another board is planning -- the board with the 30 percent of its teaching bargaining unit with duplicative coverage -- is planning to offer an incentive for nonenrollment in nonnecessary coverage, which is something that they used to have under the -- before the State Health Benefit Plan passed the rule.

So, boards are looking forward to being able to negotiate the cost containment with a private carrier, which is not available now. Will it work? Only time will tell. Is it a risk? Yes, it is a risk, but we will submit to you that that risk is created not by boards of education but by a difficult-to-understand rule of the State Health Benefit Plan.

ASSEMBLYMAN GEIST: Have you studied the experience of any other states which do not have such a five-year bar, where competitive forces within the private sector are allowed to really develop into presentation of viable alternatives to State plans?

MS. STRASSMAN: No, we have not.

ASSEMBLYMAN GEIST: I've heard testimony suggesting as though the State Health Benefits Program is the best program, i.e., in terms of benefits for the employee, but also, in the fact that the administrative costs are rather small. Does the idea of elimination of the five-year rule, allowing then protection for the employee by more readily available access back into the State Health Plan-- Would you advocate elimination of the five-year bar?

MS. STRASSMAN: At this point I could not speak for the Association to support advocating the elimination. I would, however, believe that the Association would study it very carefully, and unless we're presented with evidence that this would damage the Plan, we would support it because we do believe that it is responsible for difficulties for boards, possibly employees, and we do not see the purpose. I'm not saying that there is no purpose. Perhaps it can be demonstrated to us.

ASSEMBLYMAN GEIST: Mr. Chairman, one other question. Do you know of any records of the refund program established by the Administrative Code being implemented?

MS. STRASSMAN: No, I do not. I also do not know whether at this point there is any employer -- public employer

that does not pay at least partial employee coverage, which may be why that rule is not being implemented. But you should ask the Division of Pensions for that, because that rule is still on the books.

ASSEMBLYMAN GEIST: How do you interpret this being applied?

MS. STRASSMAN: The way I see it being applied--

ASSEMBLYMAN GEIST: I appreciate the questions, Mr. Chairman.

MS. STRASSMAN: Excuse me?

ASSEMBLYMAN GEIST: Go ahead, I'm sorry.

MS. STRASSMAN: I did some inquiries a number of years ago to see how this worked. My understanding was that-- If you turn to 9-5.9, on the other side it tells you what refunds are not available. This refund -- the way I see it -- appears to provide an employee whose spouse is also enrolled in the State Health Benefit Plan, and an employee who opts for that spouse to be covered under a second plan as a dependent, for reimbursement -- a refund of a certain amount of money. The amount of money that was explained to me, three or four years ago by the Division of Pensions, was that it was a cost to the employer of providing single coverage. But that doesn't make a whole lot of sense to me, and I, again, would refer that to the Division of Pensions.

ASSEMBLYMAN GEIST: Thank you. Thank you, Chairman.

ASSEMBLYMAN ROMANO: Since there are no other questions, I have two. First of all, when we talk about the private carriers, on balance with the State Health Benefits Program, these plans are comparable to the State Health Benefits Program, with the deductible and what the coverage is for the State health benefits?

MS. STRASSMAN: Some of them are. Some of them may not be. I do not know that.

ASSEMBLYMAN ROMANO: Well, I think that's an important point, because to my understanding the State Health Benefits Plan, with the $100 deductible and $200 for family, is outstanding, but I do also know that Blue Cross/Blue Shield has what they call the PACE or Medallion, whatever the cases they have, which is supposed to be top of the line.

MS. STRASSMAN: Medallion.

ASSEMBLYMAN ROMANO: But in comparison of these numbers here, with private insurance carriers, unless one can absolutely say, on balance, that the two plans are identical you can't make this sort of a statement. That's number one.

Number two: The points that you raised are excellent. And let me be the first to say, you're an expert in the field, and in negotiations there's none better. On behalf of the employer, let me put it that way. However, during these times -- these unsettled times-- You know, my mind is charged with people who came to represent the NJEA. You know, we're talking about paying money on one hand and/or on the other hand. All of this extra money that a board might be paying for dual coverage goes into the overall self-regulated program that doesn't have broker's fees and everything else that keeps the rates at what they are.

It would be interesting if we all started to take away the dual coverage and to try to minimize the cost to an individual employer, what the eventual charge for the premium would be in subsequent years. During these times here, I believe health care coverage, first of all, becomes paramount. One has to understand this; that the health care coverage -- local employers might be paying what is called their own way of uncompensated care, by putting it into the fund. I think that the State Health Benefits Plan becomes the closest thing in the State of New Jersey today, to a single-payer system. There's nothing else like it.

The points that you raised about dependent coverage being paid by the employee-- I think it's incumbent upon you to equally explain that when one enters the negotiations process, everything is on the table. Okay? And as everything is on the table-- When one talks-- I know that certain employee groups like to talk in terms of new money. Let's talk in terms of money; that if there was an increase in health benefits that the particular employee would receive credit in the bargaining process to say well, this package that we are now giving is 8 percent of the entire salary package if one includes the differences in the health benefits, because understandably when one starts to charge employees -- coming out of a payroll deduction or what have you here -- that is an administrative cost. Plus the fact that what are we achieving by this, is just having them pay part of the charges, whereas, this could also be realized if, in a total package as given, there was a reduction, if you will, in the salary package which represented the concomitant increase in the State health benefits.

Do you agree with me, with this? I only mention this for my colleagues, because in the negotiation the health benefits is part of it, and it doesn't have to be where, cover the employer -- the employee rather -- and the dependent separately, could be taken care of under the uniform contract with the understanding that it's part of the contract as negotiated.

MS. STRASSMAN: I think, Assemblyman Romano, that's an excellent point. But the key of what you have just said is: "assuming it is negotiated." We clearly have advised boards of education, for at least five years, to negotiate only in terms of the total economic package. We have advised boards, and boards are doing it increasingly: negotiating in terms of the total settlement, and if you get--

If we're going to continue the insurance coverage, your salary increase must be lower. That is absolutely true. I will, however, differ with you on one point; that everything is up for grabs in negotiations. My experience, and the experience of my colleagues, when one sits at the table -- unless the contract specifically states that the board will pay for the dependents' coverage for the '90-'91/-'92 school year period-- And it simply says, "The board will pay the full premium for the dependents," that there is an assumption out there, that is reality with a capital "R," that the board will always pay for the dependent coverage -- the full dependent coverage -- until the union, the local union agrees otherwise. And as I've indicated before, in my experience throughout the State in the last five years, one board -- a little board in Hunterdon County -- was able to get that kind of a commitment from its work force, that was primarily under 20 women who had coverage elsewhere.

It is an extremely difficult, which is not to say impossible, but it is an extremely difficult concession to get at the bargaining table, understandably so.

ASSEMBLYMAN ROMANO: I'm assuming that all of the employers use negotiators as good as you are.

MS. STRASSMAN: They're probably better. (laughter)

ASSEMBLYMAN ROMANO: That's all I have, Mr. Chairman.

ASSEMBLYMAN RUSSO: Anyone else? (no response) Thank you very much.

MS. McMICHAEL: Thank you, Mr. Chairman.

MS. STRASSMAN: Thank you very much. We really appreciate the opportunity and your interest in this area.

MS. McMICHAEL: Definitely.

ASSEMBLYMAN RUSSO: Commissioner Cimino.

C O M M I S S I O N E R A N T H O N Y J. C I M I N O: Mr. Chairman, do you have something you need to clear there?

ASSEMBLYMAN RUSSO: No, I just think they want a copy of something, Commissioner.

COMMISSIONER CIMINO: Thank you very much, Mr. Chairman.

Mr. Chairman, thank you very much for inviting the Department of Personnel back today. I'm pleased to appear before the Select Committee on Civil Service and Employee Benefits again, today, while you examine the policies and the procedures with respect to the bumping process utilized in a layoff procedure. With me today -- I'm sure most of you are becoming familiar with these individuals, but let me just reiterate -- is Deputy Commissioner Linda Kassekert, as well with us is the head of our Office of Personnel Management, Mr. William Parikas, and, additionally the Director of our Appellate Practices Unit, Janet Zatz.

The rules associated with layoffs are found in the New Jersey Administrative Code. They exist to protect employees from arbitrary and capricious actions on the part of employers. They exist to provide due process to affected employees. They exist because, frankly, layoffs are tragic events that should only be undertaken if all other options are exhausted.

I might indicate to you that the framework within which the Civil Service Reform Act went forward and the rules are written, the title of those are alternatives to layoffs, because Governor Kean as well as the Legislature and the Merit System Board at that time, recognized the depravation that, in point of fact, layoffs can cause.

They are devastating at any time, but are especially devastating in times such as these. Rules such as these exist in the private sector. In fact, Federal law requires that in the event of plant closings, a 60-day notice must be provided to employees. Juxtaposed that with the 45-day notice that we give here in the State of New Jersey to our employees as a

requirement under State statute, for each and every State employee, and I might add you're talking about, effectively, two weeks less time than we even provide at the Federal level for plant closings.

I should also point out that we are operating under new rules that are dramatically different from the rules utilized in the past, with regard to layoff. The new rules became effective in January in 1990. They are indeed the rules that were utilized last year in implementation of layoffs. Last year was the first opportunity to utilize those rules since the Civil Service Reform Act of 1986.

These rules have cut down, dramatically, on the number of bumps. Under the old rules, for example, the average layoff resulted in a bumping ratio of a minimum of eight to one; that is, eight displacements or bumps for every person laid off. Under the new rules, the bumping ratio has been reduced significantly to a maximum of 2.71 moves to one layoff.

We have also streamlined rights. We've done this through the Merit System Board. Under the old rules the affected employee had a right to bump into similar titles -- a fairly broad standard. This has been tightened considerably, and the standard under the new rules is, substantially similar titles, ensuring that employees now bump into titles and position that they possess the required skills and expertise to fulfill the responsibilities of the new position that they're moving to.

We have required appointing authorities to investigate and explore alternatives to layoffs and prelayoff actions. Indeed, appointing authorities must submit, to the Department of Personnel -- whether it be at the State level, or indeed within your own municipalities -- pre-layoff packages that need to be approved before they move forward. These options range from voluntary demotions and furloughs, to releasing nonpermanent, noncareer employees. These would be the

unclassified service that we talk about, when we talk about nonpermanent type employees.

In addition, we have also given management additional flexibility by giving the Commissioner of each department the ability to extend the layoff if necessary, and flexibility in the determination of job locations. These changes have increased management prerogative, while at the same time providing safeguards as required by law.

Thank you for the opportunity to appear before the Committee, to provide this additional input into your important process. We hope to help you in your deliberations, and we have provided additional information on the bumping rights, as well as information regarding the Merit System. We'd be happy to answer any additional questions that, in fact, you may have, and, indeed, Mr. Parikas' single biggest responsibility last year, during the period time, was to run the Layoff Task Force, and he can get into specific numbers with you, as well as I.

ASSEMBLYMAN RUSSO: Thank you. Questions?

ASSEMBLYMAN ROMANO: It's not a question. It's a comment. Mr. Cimino, if you keep coming back here I think that you should be made ex officio part of this Committee. (laughter) Now, how many times have you been here, testifying?

COMMISSIONER CIMINO: Assemblyman, I think, with this, it's probably our third opportunity to be here.

ASSEMBLYMAN ROMANO: Okay.

COMMISSIONER CIMINO: We welcome the opportunity to have this repartee, if you will, with the Committee.

ASSEMBLYMAN ROMANO: Of course that's the type of a guy you are.

COMMISSIONER CIMINO: Yeah. Thank you very much.

ASSEMBLYMAN RUSSO: Questions?

ASSEMBLYWOMAN DERMAN: I have a question. Could you give us an example of bumping into a substantially similar title; just an example.

COMMISSIONER CIMINO: Sure. Bill--

W I L L I A M P A R I K A S: Yes?

COMMISSIONER CIMINO: --you want to outline that for Assemblywoman Derman?

MR. PARIKAS: For example, in the State and local government services there are, what we call, series titles -- in series titles. For example, if someone is employed in the personnel office, the series may go from personnel officer, or personnel assistant I, II, III, or IV, and obviously each additional title would warrant additional salary. The highest title being a personnel assistant I.

Our normal procedure would be that that individual would then bump in that series. In other words they could bump the personnel titles only. In the past, when the -- before the streamlining of the layoff title rights -- people were bumping from similar positions. For example, a personnel employee might bump into a training function. We did determine that through the requirements that training functions, although they might sound similar, are-- A person that handles a training function could not necessarily do personnel work or vice versa.

ASSEMBLYWOMAN DERMAN: So, a personnel officer at level I, could bump somebody at level II--

MR. PARIKAS: That's correct.

ASSEMBLYWOMAN DERMAN: --III, or IV?

COMMISSIONER CIMINO: That's correct.

ASSEMBLYWOMAN DERMAN: Is it always confined to the department?

COMMISSIONER CIMINO: Yes. Bumping--

MR. PARIKAS: The bumping?

ASSEMBLYWOMAN DERMAN: Yes.

COMMISSIONER CIMINO: It's confined within the department, today, under the Civil Service Reform Act. Previously, Assemblywoman, you could bump anywhere, anywhere in the government, based on seniority. That has been dramatically

changed today. To give you a for instance: There were 531 employees laid off in the classified service last year. The result of that was, effectively, there were 625 employees, as well, displaced, for a total of 1200 to effectuate the number of layoffs that we had to create. Previously you would have talked about some substantially greater number. You would have had almost 4000 moves to do that based on the old scenario.

ASSEMBLYWOMAN DERMAN: In the example you gave, I could bump II, and II - III, and III - IV. To what do you attribute the fact that you've decreased the number of displacements? What happens to IV? What does that individual do?

MR. PARIKAS: If the lowest title in the series is a IV, then that person would not have any bumping rights. That person would be the one that gets laid off.

ASSEMBLYWOMAN DERMAN: That's it?

MR. PARIKAS: That's correct. In other words, once you complete the series--

ASSEMBLYWOMAN DERMAN: And how high, or how low can the series go?

MR. PARIKAS: Well, in that particular case, the example, the personnel assistant IV, would probably have to be the individual displaced.

ASSEMBLYWOMAN DERMAN: Does it go, the higher the number, which is lower in seniority?

MR. PARIKAS: No.

ASSEMBLYWOMAN DERMAN: No. Or is the--

MR. PARIKAS: In that particular series, yes.

ASSEMBLYWOMAN DERMAN: And then, here's a really basic question.

MR. PARIKAS: That's all right.

ASSEMBLYWOMAN DERMAN: How does one get attributed the series title? How do you get to be a I, a II, a III, or a IV?

COMMISSIONER CIMINO: Through testing and promotion.

ASSEMBLYWOMAN DERMAN: Testing and promotion?

COMMISSIONER CIMINO: Yeah. The Merit System requires -- the Constitution requires that we do this through-- There are three provisos within the article in the Constitution. You must be moved based on merit. To create the merit you must test, and the third piece is that veterans have an absolute preference.

MR. PARIKAS: If I could just interject for a moment: I may be reading into your question. The fact that you are a particular title at the present time, in the personnel series for example, this does not prohibit you from competing, if you have qualifications, to move into other areas. In other words, if you -- the example I gave -- if you have experience that would qualify you to be a training officer, there's nothing to prohibit you from taking examinations to move from the personnel series into the training series. I didn't want you to think that you're restricted.

You are restricted as far as the bumping process goes, but not as far as opportunities to compete.

COMMISSIONER CIMINO: Not in terms of promotional opportunities.

MR. PARIKAS: Yeah.

COMMISSIONER CIMINO: Not in terms of promotional opportunities.

ASSEMBLYMAN RUSSO: Is the 45-day notice the only notice? Is that the only notice? I heard one time that there was something about a 70-day notice.

COMMISSIONER CIMINO: Actually, there is a 30-day-- Effectively, there is a 30-day prelayoff package. That package does not necessarily connote to announcement to the employee, but they are to be effected. What it simply does is, it is a layoff or prelayoff plan that says that the Department has exhausted a number of alternatives before we actually approved that. Once the 30-day layoff package is approved by the

Department of Personnel, then the clock starts on the 45-day notification process.

One of the things, I think, that we've learned out of the past experience of the past year is that-- One of the unfortunate things that happened that created a great deal of unnecessary turmoil, was that everybody got noticed. We don't really have to, and we think that, you know, if we, unfortunately, have to go through this again -- I hope not -- if that becomes a necessity, we don't think you have to notice everybody in every department and get everybody in a turmoil as to whether, in fact, they're going to have a job or not have a job, particularly in these times.

I have to tell you that by and large, each and every Commissioner that talks to me -- there is a very, very big problem with morale, particularly right now. With the level of uncertainty that exist in the work force, as to whether, in fact, people are going to have jobs on July 1, it's a very real problem. It's a very serious problem. It's having an effect on productivity, because people are concerned.

We're having an increase in the number of people using our Employee Assistance Service, a system that is already strained because of budgetary cuts. It's taken us sometimes two weeks to get to these individuals, and it's having a very, very serious effect.

ASSEMBLYMAN RUSSO: Questions?

ASSEMBLYWOMAN BUSH: One question.

ASSEMBLYMAN RUSSO: Sure.

ASSEMBLYWOMAN BUSH: What is the Employee Assistance Service?

COMMISSIONER CIMINO: Assemblywoman, that is where we have-- I mean, we are not unlike a town. When we employ 74,000 people, it's sort of like being the eighth or ninth largest town in the State of New Jersey -- if you could picture it that way -- or we are the corresponding equal to a Fortune

500 company. We have a lot of people who end up with substance abuse problems, alcohol abuse problems, and marital problems, and they all come to work and we will provide counseling.

One of the tragedies of the budget cutting process has been that we have, in large measure, had people who have been adversely affected in terms of the cuts, and we can no longer provide, as quickly, the level of assistance. I might also add, Assemblywoman, this does not have anything to do with job category. We have professionals making substantive amounts of money, as well as lower ranking employees, who are all feeling the weight because of the fact that they are increasingly concerned. They are not unlike you and I. They have families. They have wants and needs. They have mortgages to pay, car insurance to pay, and it is having a very, very serious effect.

I talked with each and every Commissioner about this, and the level of morale, in this government, is, quite frankly, very, very poor. We're trying to keep a handle on sick leave, and one of the reasons for the increase in sick leave is because of the level of morale being as poor as it is. So, it's having that kind of an effect. Because of the number of the increase in incidents that we are witnessing and the diminution of staff, we're getting a wider span. I had a woman call me the other day from the Department of State crying for help. We can't get to them fast enough, in some instances. So, I mean, it is the dramatic side; it's the emotional side. And I don't want to embellish upon it any more than what the facts are, but they're there.

ASSEMBLYWOMAN BUSH: Thank you.

ASSEMBLYMAN RUSSO: When the notices are sent out, you mentioned for example 2.71 being the ratio, in a real life example, be it whether this year or last year or whatever, you first have this 30-day prenotice, which would be a total of 75 days, backwards. So, you're dealing, I would assume, with a

July 1 date; you count back 75 days. What would that notice look like to the person who gets it? Is it a letter or some kind of short note? Obviously, it's some kind of form letter. What is it?

MR. PARIKAS: Yes. There are two notices; one which is a general notice that can go out to everybody--

ASSEMBLYMAN RUSSO: Right.

MR. PARIKAS: --then there's a notice if your specific position has been targeted for displacement--

ASSEMBLYMAN RUSSO: Right.

MR. PARIKAS: --you are told specifically that your position is targeted, and you will be informed of your rights, according to the Department of Civil Service rules and regulations. So, basically, a layoff notice indicates the reason for the layoff and the effective date. That's the only thing that actually has to be a part of the notice, but we have tried to take the humanistic side and indicated that if and when you are affected there are certain programs that we have instituted. And in answer to the young lady's question over here--

ASSEMBLYWOMAN BUSH: Assemblywoman.

MR. PARIKAS: Assemblywoman, excuse me.

ASSEMBLYMAN RUSSO: She came in with Lou. (laughter)

MR. PARIKAS: Part of the Task Force, for those individuals that were affected, we had workshops whereby resumés were prepared. We had companies come in from the outside to help people secure position. We had the Labor Department there to help sign up for unemployment benefits, prior to the actual individuals being displaced, so that they wouldn't have to do all of this work on their own. So, there were those types of unfortunate types of benefits that we did provide, considering the severity of the layoff process.

ASSEMBLYMAN RUSSO: When you're giving out that first 30--

MR. PARIKAS: Forty-five?

ASSEMBLYMAN RUSSO: Yeah. No. You're not even up to the 45 yet. The 30-day, would that be the one, for sure, that would go to the 2.7 people, if you know what I mean, or not? That would just go to--

COMMISSIONER CIMINO: No. That's a prelayoff package.

ASSEMBLYMAN RUSSO: This is a prelayoff package.

COMMISSIONER CIMINO: I want to get this clear.

ASSEMBLYMAN RUSSO: Okay. Let me hear.

COMMISSIONER CIMINO: The notice doesn't go until the Department says, "You've exhausted all remedies here in terms of alternatives to layoffs." We've done hiring freezes. We've eliminated vacant positions. We've done-- And from a budgetary standpoint--

ASSEMBLYMAN RUSSO: Okay.

COMMISSIONER CIMINO: Now, in large measure, this government has done that. There are no holes left here. I mean, I've gone through the litany of what it is that we've cleaned up, in a systematic way. At the end of that, when we sign off, that begins the 45-day clock. At that point, people get noticed that the layoff is due to commence.

Under the Federal statute, we give 60 days here for a plant closing. For instance, if General Motors, which is always considered for closing here in Mercer County, if that were to move ahead they'd have to give a 60-day -- a two month notice. We give a 45-day notice for people.

ASSEMBLYMAN RUSSO: The 30-day was by rule or just by custom?

COMMISSIONER CIMINO: The 30-day is articulated within the rule under the Merit System Board, which, let me just reiterate for you again, and I'm not-- Please don't misunderstand me. This is relatively complicated stuff. It's not easy stuff to always get through. The Merit System Board is a bipartisan Board. It is a Board comprised of both

Republicans and Democrats, and those rules govern that Board. Janet is effectively the Executive Director, if you will, of the Merit System Board.

When and if we do a layoff, you can anticipate that 50 percent of what you lay off will appeal. So, if there were to be a massive layoff in this government, let's say, in the neighborhood of -- let's pick a number-- Let's say if there were to be 6000 layoffs, more than likely there would be 3000 appeals go before the Merit System Board to ensure due process, and most of those appeals would be based on whether, in fact, the layoff was done in good faith, because there is a period of time where it is ripe for abuse.

MR. PARIKAS: If I can just piggyback on one of your particular questions, to give you a better understanding. If I went back to my office today, and a department called me up and indicated they were contemplating a layoff, I would arrange to meet with them and my staff. At that time we would discuss what their plans were, what concerns they had, and what prelayoff actions they had planned on taking, or alternatives to layoffs they had planned on taking. We would emphasize to them that there are certain requirements that have to be entailed in the layoff package that is actually delivered to us for review. We would ensure that they meet with the union representatives for any employees that they have to ensure that all bases are covered. During that--

After that package is submitted, and if we find holes in the package, if you will, or if something doesn't comply with our rules, we would send the package back and tell them what the problems were. They may have designed a 45-day notice that does not meet the qualifications. Assuming that all of the rules are met and the package is in order, we would then send it back to them and tell them they now have permission to issue the 45-day notice; in other words, that they're ready to go with the layoff.

We've ensured that everything's proper. We would train their staffs, because this is part of the Task Force assignment, and familiarize them with the rules which, again, was done last time. We have training manuals that they have. We observe the layoffs. We're on-site to ensure that everything is done within the rules. The unions are invited to sit and observe the layoff process, to ensure that their clients, if you will, are -- everything is in order; there's no shenanigans going on. So, we work the entire process with them and ensure that all of the rules are met, and if there are appeals and anything is done improperly, we obviously rectify those things. So, I think, hopefully that gives you a better idea of the process.

ASSEMBLYMAN RUSSO: Thanks. George?

ASSEMBLYMAN GEIST: Three different type questions: First of all, you said, "Bumping can occur within a department." Can bumping occur from one division to another division or from one division to another office within that department?

MR. PARIKAS: Yes.

COMMISSIONER CIMINO: Yes.

ASSEMBLYMAN GEIST: Question about veterans' preference: Do we have veterans' preference recognition for those who served in Desert Storm?

COMMISSIONER CIMINO: Yes. As a matter of fact, Assemblyman, there is a new level of combat. It is the female combat, that did not occur prior to this conflict, and the level of activity that is going on in terms of that now, is rather substantial with regard to Desert Storm in terms of everyone, but we now have a female veteran who has served at the frontline in a combat role.

ASSEMBLYMAN GEIST: Thank you. And last, but not least, since your first appearance here have you changed your sentiments in any way related to the merits of the Governor's proposed Pension Reevaluation?

COMMISSIONER CIMINO: I haven't changed my sentiments with regard to the pension proposal, in large measure. I understand that there's a contemplation within the Legislature, perhaps, -- if I read the papers like you do -- that you all may push the assumption rate up from 8-1/2 -- 8-3/4 to 9. I think that the proposal the Governor has put forward is a reasonable proposal.

ASSEMBLYMAN GEIST: Okay. Thank you. Thank you, Chairman.

ASSEMBLYMAN RUSSO: Sure.

ASSEMBLYMAN ROMANO: Likewise, Commissioner, you haven't changed my assumption of you. (laughter) It's surprising. I shouldn't say that. You've only been there a short time, but you speak as a person who's been 20 years on the job.

COMMISSIONER CIMINO: Thank you.

ASSEMBLYMAN ROMANO: In fact, whenever your staff comes here they're all very knowledgeable. I'm impressed.

COMMISSIONER CIMINO: Thank you very much, Assemblyman.

ASSEMBLYMAN ROMANO: And gratified.

COMMISSIONER CIMINO: Thank you.

ASSEMBLYMAN RUSSO: I thought you were going to say 8-3/4 years. (laughter) Well, I didn't-- I didn't think you'd do that, Lou.

Last month, or the month before, there was a lot of press on the Furlough Program, I believe. Could either of you or both of you address that and where that stands now?

COMMISSIONER CIMINO: That's a good question, and it's something that the Legislature as well as the executive branch ought to take pride in and credit in. Indeed, we all ought to compliment the work force of the State of New Jersey. As of yesterday morning we have passed the $4.3 million mark in voluntary furlough. We have had in excess of 3500 State employees participate in the Voluntary Furlough Program.

Now, there are several things you ought to be aware of. Not every employee can participate, because some employees are paid by Federal funds. So, there is no advantage in having the federally funded people participate. Secondly, not every employee can participate if they're in an absolutely critical job function. That is something that we cannot have, for lack of coverage, but we are-- I suspect, Assemblyman Russo, that we will probably come close to our goal, which was $6 million. We will probably come close to that goal, even though the program actually got off the ground two months late. And the reason that I think that the two months are critical to attainment of the goal is because they were the months of July and August.

In all candor there would have been, I think, substantially more people, particularly the women who work in the government, who may well have taken voluntary time because of the needs to raise children during the summer and not have that opportunity. I'm so confident of this program that I have indicated that I would like this program to move forward at the county and the municipal level, if we can get the concurrence and the commitment of the State Health Benefits Plan to ensure, as we did at the State level, the continuance of the payment of health benefits, and secondarily that there be no implications for seniority rights as there are no implications for seniority rights at the State level. That's a very, very good program, and we should continue to support that.

ASSEMBLYMAN RUSSO: That's good to hear. What critical jobs aren't covered by that, for example, and who defines that?

COMMISSIONER CIMINO: Well, it's really at the discretion of a Commissioner, but let's say you were to get into one of our facilities. Perhaps, maybe it's a critical job function in Marlboro or Greystone, something along those lines. Probably, it's not a person that we could do without, or shift coverage.

ASSEMBLYMAN RUSSO: In essence, what in private industry, as you are well aware, are a key person maybe or -- key man or woman insurance?

COMMISSIONER CIMINO: Yeah, exactly. Exactly.

ASSEMBLYMAN RUSSO: Okay.

COMMISSIONER CIMINO: But we've had-- We've had a very, very good response to that program, and I'm very, very pleased, and I've told it to the Governor as well; that this thing is working and it's working to our advantage

ASSEMBLYMAN RUSSO: Do you think the State Health Benefits Plan will go along with this at the local level as it did the State, in your opinion?

COMMISSIONER CIMINO: I'm confident that they will look in that direction. There are two advantages that we are experiencing in noticing a lot of layoff -- contemplation layoff activity -- at the county and the municipal level. At this point two things will give counties the sway and municipalities the sway not to have to go through layoffs and keep people working, one of which is a Voluntary Furlough Program. Indeed, I've been told by one county if that were to be the case they would probably not experience layoffs. They would be able to close the gap.

The second thing is, as Assemblyman Geist has spoken to, is the pension proposal. I have had lots of governments tell me, because of the reduction in cost in having to pay up pension dollars, that reduction will actually allow for them to continue to employ people. So, that was a benefit. I have to tell you, no one ever anticipated that benefit. That was a benefit that just comes by virtue of the proposal itself.

ASSEMBLYMAN RUSSO: Anyone else? (no response) Gentlemen, thank you.

MR. PARIKAS: Thanks very much.

COMMISSIONER CIMINO: Thanks very much. Have a good day.

ASSEMBLYMAN RUSSO: Can we have the representatives of the GMRC?

M I C H A E L J. S C H E I R I N G: Good afternoon

ASSEMBLYMAN RUSSO: Good afternoon.

MR. SCHEIRING: Mr. Chairman, what we're handing out are copies of remarks and copies of the studies--

ASSEMBLYMAN RUSSO: Thank you.

MR. SCHEIRING: --related to the audits review, in this area.

ASSEMBLYMAN RUSSO: Before we start, is anybody here from the Chamber of Commerce? Is anybody in the audience from the Chamber? (no response) Okay, because if that's the case, most likely we're going to be here Thursday. So, probably Mr. Morford, maybe -- I'm trying to think of who else we have scheduled -- that would be good. We can devote the rest of the time to this important testimony. Okay, Mr. Scheiring.

MR. SCHEIRING: Good afternoon, Chairman Russo, and members of the Assembly Select Committee on Civil Service and Employee Benefits.

Thank you for inviting the Governor's Management Review Commission to appear here today to discuss the results of the audit.

Stanley Van Ness, the Chairman of the Commission, regrets that he could not be here today. It was not because he won the Lottery. (laughter) It was because he had an important employee benefit to use. He's on vacation. Otherwise, he would have been here today. He did ask that I, as Executive Director, come here today to discuss the audit findings with you, and I'm joined by Charles Ardman, on my right, who is the Director of Health Care Management with Prudential Insurance Company, and by Steve Clark, on my left, who is the Associate Executive Director of the Commission.

I'd like to make some brief remarks outlining the efforts the Commission has made to improve services and reduce the cost of government operations.

The audit, as you know, has come a long way since April of 1990 when Governor Florio convened the first meeting of this Commission. Thanks to the generous assistance of the many fine corporations and accounting firms in New Jersey, significant opportunities have been identified to improve our State government.

As we are meeting here to discuss matters that are important to State employees, it is important to recognize the dedicated work of the hundreds of State employees who participated in the GMRC audits. Without the assistance of these hard-working professionals, the audit could not have been as successful as it has been.

To make our time before you as productive as possible, I want to, briefly, describe the audit, highlight the audit reports which we believe are most relevant to this Committee's mission, and focus on the State's Health Benefits Plan and the audit's recommendations to control the spiraling costs of employee health care, which are being experienced nationwide.

The Chairman, and members of the Commission, appreciate your interest in the State audit. The Commission believes that this unique partnership, which joined experts from the private and public sectors, has reaped significant results. It has established a strategic direction to improve and economize State government operations.

As you know, the first phase of our audit identified over 400 recommendations to more effectively manage State government. These recommendations offer significant opportunities to improve government operations and to reduce costs.

In his remarks before the Assembly Appropriations Committee two weeks ago, Chairman Van Ness noted that the Commission is delighted that the Governor and the Legislature have already been able to use many of the audit recommendations, achieving almost a quarter billion dollars in

savings to date. Stan stressed that while opportunities to improve operations and reduce costs remain, that these will require legislation, negotiation, investment, time, and in many instances, changes in policy to achieve the investments -- I'm sorry -- in improvements and savings that were identified.

Recently, we completed the second phase of the audit. These 10 reviews have yielded an additional 299 recommendations and $96 million in savings opportunities.

But, frankly, the nature of these recommendations is quite different in the first round, in the sense that these have continued to reflect the fiscal strains that the State is experiencing, and the downsizing that has been occurring in the past few years. Many of the savings opportunities that have been identified are longer term in nature. Many require investments, and do not yield immediate budgetary relief. A significant proportion of the savings benefit local school districts, the Federal government, and the Unemployment Trust Funds, and not the State directly.

With the completion of phase II of the audit, I am pleased to note that every department in State government has now been reviewed. In total, the Commission has produced 41 separate audits of governmental operations containing over 700 recommendations to make government work better. The audit has identified over $1 billion in productivity, cost avoidance, revenue, and direct cost savings opportunities. This is an outstanding testament to the power of public-private partnerships in identifying solutions to complex policy and operational issues facing State government.

Now I would like to give you an overview of the Commission's efforts in the area of human resource management.

Over the past two years, the Commission has been fortunate to have the skills and expertise of some of New Jersey's top human resource and health benefits professionals. Experts from Public Service Electric and Gas, WANG

Laboratories, Digital Equipment Corporation, Laventhol and Horwath, Blue Cross and Blue Shield, Prudential, AT&T, Deloitte & Touche, have joined their own Division of Pensions and have been loaned to the Commission. They have performed a number of detailed analyses of the State's current human resource management practices and its benefit plan structures.

These reviews, I believe, represent one of the most comprehensive series of studies performed in decades, dealing with a spectrum of elements that now presently consist of how the State handles its work force. The reviews include:

* employee training and development;
* the Senior Executive Service;
* work force reduction;
* the State's Health Benefits and Pension Plan;
* the State's compensation program;
* contingency staffing;
* sick leave usage;
* sick leave injury; and
* organizational strategies for managing human resources.

Together, these reports stress the importance of linking these elements into a thoughtful, comprehensive human resource strategy, with a total compensation program.

This set of intense reviews provides a holistic view of the State's human resource program. It provides a revealing comparison to private sector and other public sector employers. In each review, serious questions were raised in terms of the level of benefits provided, how such programs are administered, the relationship of one program to another, marketplace considerations, and, ultimately, the effectiveness and affordability of employee benefit programs at their current levels.

As the individual reviews were completed, one thing became abundantly clear to the Commission. The State has not

established a long-term strategy and vision for where it wants to be relative to the marketplace, with regards to the employee benefits or levels of compensation for its 70,000-plus employees. In fact, years have passed since compensation levels have been analyzed or health benefit plan structures updated.

Absent a long-term strategy, circumstances have evolved through a mix of negotiated enhancement, statutory thresholds, and reactions to new health care alternatives such as HMOs. Changes have been handled in a reactive and piecemeal fashion. There has been little integration of the various human resource elements.

While many companies in the private sector have established managed care programs in order to aggressively address escalating health care cost trends, a proactive approach to managing employee benefits was found to be lacking in the State. Nor were there sufficient incentives for controlling costs and usage.

The audit's most fundamental recommendation is the need for a long-term human resource strategy encompassing all elements of employee compensation and benefits into a total compensation program. Once a strategy has been developed, it must be implemented. Unfortunately, what most employers consider the fundamental elements of labor negotiations have been excluded from the State's negotiations process.

Indeed, the Commission observed that labor negotiations at the State level have been defined so narrowly that salaries have become the primary focus. With over 85 percent of all State employees represented by unions, it is critical that negotiations encompass a broader complement of compensation and benefit elements.

Now, let me turn to health benefits, per se. You requested the Commission come here today to discuss the State's Health Benefit Plan. I now want to spend a few minutes

describing that present Health Benefit Plan and the Commission's recommendations contained in our Operational Review of Fringe Benefits.

This review was performed by the leadership of human resource and health benefit experts from Prudential Insurance Company and WANG Laboratories, again, in context, and in joint and partnership with the Division of Pensions. In addition, Blue Cross and Blue Shield of New Jersey provided us with tremendous help in producing records on State usage experience.

The State of New Jersey's budget is over $1 billion on employee benefits for Fiscal Year 1991, which over $400 million was for State employee health benefits. The level of employee benefits, for the most part, is prescribed in statute and has not been the subject of labor negotiations.

The State offers a number of health plan options. State employees may select the traditional Blue Cross/Blue Shield Plan, and the Major Medical Health Plan, the Preferred Provider Plan, or one of 17 different HMO plans. The State is self-insured for the traditional and the PPO Plan, and pays premiums for the HMOs. In addition, the State provides employees with a prescription drug plan and offers dental and vision care plans.

The review found that the State's medical plan costs have increased at an annual rate of approximately 16 percent between 1987 and 1989, and that is continuing today. In 1989 the cost per employee for medical coverage averaged $2550 per employee. Today, these costs have spiraled to almost $3000. Given the continuing health care inflationary trends, the study projects that the cost of maintaining the present health benefits plan will grow to as high as $6345 by Fiscal Year 1994.

State government is by no means unique in experiencing these cost growth trends, and it is recognized that action of a much broader scope is needed on medical costs generally. Nonetheless, options are available to lessen the expenses borne by the State for its employees.

Our review found that New Jersey's health care benefit program design has remained virtually unchanged for two decades. The operational review found that the plan's design is incompatible with reasonable expectations of cost containment. The State's traditional plan is not a managed care program. There are few precertification or concurrent review requirements, and there are no financial penalties for noncompliance with the program.

Some of the specific findings contained in the fringe benefit review included the following:

1) As I mentioned, medical plan costs have risen between 1987 and 1989 at a rate of over 16 percent, and that cost is now totaling $2550.

2) The current plan design contains a minimal financial incentive for the use of generic drugs. The State prescription drug plan ligibility includes employees enrolled in HMOs, which may offer separate prescription drug plans.

3) The State's Health Benefit Program does not require contributions from active State employees or their dependents, while 45 percent of the public and private employers require employees to contribute for their own coverage and 75 percent require contributions for dependent coverage.

4) Managed care programs provide the greatest opportunity to control overutilization and to cap costs. The State's traditional plan is not a managed care program, as I mentioned. There are no precertification or concurrent review requirements and no noncompliance financial penalties associated with that.

5) Overutilization is a major concern of all health benefit programs. Employees want to have the best possible care and health care professionals are asked to provide that care at a level that maximizes their fees. Our review analyzed over 500,000 medical claims. Our findings included:

Of the 18,506 claims that were identified as physician consultations in a hospital, over 13,700 were billed as comprehensive, which is defined as a written in-depth patient evaluation, complete with a plan for the management of that patient.

Of those 511,000 diagnostic tests and procedures paid for by the State's Health Benefit Plan in 1989, eight of the nine most frequent tests that are on the HCFA list as questionably needed were present. These accounted for almost 33 percent of all the tests in nonsurgical procedures performed on behalf of our employees.

In the area of alcohol and drug dependence, the diagnoses account for almost 57 percent of all psychological and substance abuse hospitalization costs spent in the past three years and represented almost 62.8 percent of the hospital days. On a per diem basis, the cost to treat alcoholism in a hospital increased by 56 percent during these past three years, while drug dependence treatment has increased by 40 percent.

As I mentioned, there are 17 HMOs available to the State and local employees. One has only seven employees enrolled; another had 159 members. There is a minimum of four HMOs available in every county. Twelve of the 21 counties offer a choice of at least 10 HMOs. This proliferation drives up the State's administrative costs. The State has not established a comprehensive plan of benefit standards to qualify for acceptance as an authorized HMO.

In the area of employee benefits, this review identified significant opportunities to address overutilization of services resulting in inappropriate and ineffective procedures, which contribute directly to the rising medical expenses. The results of this review, and implementation of the associated recommendations identified, could realize potential savings of over $162 million. The total savings are generated by three distinct types of changes that are being suggested:

1) Limit the eligibility for prescription drug benefits to employees who are not members of an HMO.

2) Institute contributions for employees and dependent medical coverage at levels of 10 percent and 30 percent respectively.

3) Implement various plan design changes to both share costs and to insure that appropriate health care measures are utilized. An example of sharing costs would be to increase the employee deductible from the current $100 to $200, and increase the family deductible to $400. An example of insuring appropriate health care would be, again, the implementation of the mandatory precertification program or establishing a catastrophic case management system.

Other managed care options that the audit recommended include:

* implementation of a minimum level of benefits that an HMO must provide to be offered to State and local employees;

* revision of the current HMO contribution methodology;

* establishing a flexible benefit program to allow employees to contribute toward their medical coverage on a pretax basis, and to recognize what we heard from our two previous witnesses -- the fact that we do have two income earners, not only will participate in the States program, but of course providing in the participating plans throughout the marketplace;

* negotiate discounts with hospitals that receive the most revenue from the State's Health Benefit Program.

In our review of 500,000 cases, we found that almost 25 to 30 percent of those cases were being, basically, directed towards 10 hospitals in this State, and there ought to be opportunities to gain some discounts through that area.

And lastly, we reviewed under the current PPO plan in the context of using it to replace existing traditional medical benefits as the primary benefit plan, in a sense to be able to provide for that managed care option that we recommended.

By enacting a managed care program, employees can be directed to the appropriate health care provider. Employees will receive high quality health care, while inappropriate or excessive treatments will be minimized.

The Commission report calls for systemic changes in the manner in which this key benefit is managed. To be effective, health care management needs to be a cooperative effort of the provider -- the State -- and the consumer -- the insured. Traditionally, the insured were unaware of the escalating costs associated with health. In that environment there is no incentive to become a wise consumer. This needs to be changed.

The objective of the audit was not to reduce employee benefits. Our focus was to identify opportunities that would maximize appropriate benefit use through better communication, through education of employees to be wise consumers, and through stronger incentives that will provide flexible benefits that meet the employees' health care needs while controlling the costs. This cannot be accomplished unless fundamental changes are made in both the benefits plan design and its funding.

I also want to reiterate the Commission's most basic recommendation: that a holistic approach is needed to manage the State's human resources. Absent a thoughtful, comprehensive, total compensation strategy, the State will continue to move in a piecemeal reactive fashion which, in our judgment, will do little to enhance the quality or to control the costs of employee health care. This strategy must encompass all elements of human resources, compensation, fringe benefits, and it must reflect market conditions.

This does not mean cutting specific benefits which are more generous than market norms while preserving elements which the State terms as more favorable. It means defining a balance for the whole range of benefits, both direct and indirect,

which insures that the State is able to compete for quality employees.

The Commission is careful to note that the journey to a total compensation strategy is a long one. However, it is a journey we must embark on soon if the State is to achieve a cogent, cost-effective work force strategy.

The Commission is pleased that the Governor and the Legislature are examining its recommendations. On behalf of the Governor's Management Review Commission, I thank you for the opportunity to make this presentation. My colleagues and I are prepared to respond to any questions that you may have.

ASSEMBLYMAN RUSSO: Thank you. Questions? George.

ASSEMBLYMAN GEIST: You can always count on me, Chairman, for questions. (laughter)

ASSEMBLYMAN RUSSO: In multiples.

ASSEMBLYMAN GEIST: This is true.

Limit the eligibility for prescription drug benefits to employees who are not members of an HMO: Can you clarify that?

MR. SCHEIRING: Well, what we're responding to there is that a number of the HMOs, and I'm sure you're familiar with them, have a prescription drug program as a component. Currently, as the State has involved those programs, they have not participated in the HMO program. In a sense there are questions of whether or not in terms of the total package there could be cost savings by having that participation take place.

ASSEMBLYMAN GEIST: On the recommendation, the State has not established a comprehensive plan of minimum benefit standards to qualify for acceptances as an authorized HMO. Each county has their own criteria?

MR. SCHEIRING: No. That's not the case. Again, as I mentioned, there currently is, or at the time of the study, there were 17 HMOs. I've been notified, in recent days, we reduced to 15, but what the State had not established was a set

of standards of what would be the types of programs and provisions provided as minimum level for all of those 15 HMOs. My understanding now is that, currently, the Director of Pensions is, in fact, moving towards that, and our (indiscernible) had recently been released in that area, but up to date that has not been the practice. So, it's not a situation of county-by-county difference. It's a standard program of benefits for all 17 of those.

ASSEMBLYMAN GEIST: And on page seven, the last sentence, it says: "The State's traditional plan is not a managed care program. There are no precertification or concurrent review requirements and no noncompliance financial penalties." Could you explain that?

MR. SCHEIRING: I'm going to let Charles take a stab at that, since we have an expert here who I think would be very good at it.

ASSEMBLYMAN GEIST: Thank you.

C H A R L E S B. A R D M A N: It means that-- One of the recommendations that Michael mentioned was a proposed precertification concurrent review program for hospitalization, that the necessity of a hospitalization be confirmed, that in fact the procedure desired to be performed needs to be performed in a hospital, that the best outcome will occur in a hospital setting. That type of program does not exist on a mandatory basis in the program, and typically in order to incent an individual to pursue the requirements of such a program, there is a 10 or 20 percent difference in the amount of payment based on whether they comply with calling and notifying the precertification company or not. That's what this means.

ASSEMBLYMAN GEIST: Concurrent review means, while they're hospitalized, review--

MR. ARDMAN: The ongoing necessity of staying in the hospital as opposed to having -- moving the person to a less intensive site for receiving the same types of services.

ASSEMBLYMAN GEIST: Okay.

MR. SCHEIRING: Might I add, Assemblyman?

ASSEMBLYMAN GEIST: Sure.

MR. SCHEIRING: For example, the review that we looked at talked about the fact that we had a large proportion of the folks being treated in a hospital setting for psychological and drug abuse. In fact, the treatment practice there was approximately seven days. In the private sector, the normal norm is to have that person, perhaps in a hospital base setting for three to four days, and then move them to a more community-based type program. Obviously those costs are driven up extensively and through having the kind of program that Mr. Ardman's speaking about, you can ensure that that kind of practice did not take place.

ASSEMBLYMAN GEIST: Thank you.

ASSEMBLYMAN RUSSO: Okay.

ASSEMBLYMAN ROMANO: You did such a good job, you limited Assemblyman Geist to only a few questions. (laughter) And he knows that these are ongoing jibes that we take at one another.

MR. SCHEIRING: I think I must have just achieved something here.

ASSEMBLYMAN ROMANO: I just have a basic question. This is the Commission's report. Has this been presented to the Governor?

MR. SCHEIRING: Yes, it has.

ASSEMBLYMAN ROMANO: Has the Governor said anything about this plan?

MR. SCHEIRING: Again, the Commission report was completed last October and provided to the Governor. I'm sure, as you're aware, as part of last year's budget actions, the Governor had proposed that there be a certain amount of consideration given with regards to potential reductions or givebacks with the unions, and as part of the discussions that

were being held with the labor unions some of the elements that were contained in this report were part of that discussion. I think, as you all are aware, unfortunately, there was a decision made by the union that the contract would not be reopened, so those did not become a part of the current budget that we're dealing with at this time.

ASSEMBLYMAN ROMANO: So, what are you telling me about your report then?

MR. SCHEIRING: Forgetting that the report has been obviously intensively reviewed by the Governor, has been accepted by the Governor, served as, in part, a basis for some of the discussions that the Governor had last year as part of the discussions with the unions reopening the contracts, I would suspect it will be again in part of the discussion and basis of some discussion that will be going on as we speak, in terms of the negotiations we have currently underway.

ASSEMBLYMAN ROMANO: Thank you.

ASSEMBLYMAN RUSSO: What I'd like to do, and we can take questions as we go through here -- we have a little time-- I think everybody on the Committee has the recommendations portion of the GMRC report, and what I'm going to do-- Do we all have copies of that? Yeah. You have the blue copy here. I wanted to go through some of these things starting with the recommendations really on the second page, or really page five--

S T E V E N A. C L A R K: The savings from them?

ASSEMBLYMAN RUSSO: The bottom of page five.

What you initially did was talk about-- The basic idea that I got from reading it was that you set forth what is existing and then you gave some recommendations, and sometimes some alternate recommendations. On the bottom of page five you talked about medical recommendations and prescription drugs with regard to the State Health Benefit Plan, so I want to first go through the medical, and make sure that we understand

on the Committee what you're recommending and why you're recommending it. I know at the end of this, you've made a chart up -- you've formulated a chart and also another chart on page 27 with preferred and alternate dollar savings, so they would all tie in from what I can understand.

On medical it says, "Terminate the first dollar surgical-medical benefit and consider all such expenses eligible under the major medical, subject to a deductible and coinsurance." Who'd like to talk about that?

MR. ARDMAN: I will. Current plan design includes benefits that are paid immediately, not subject to a deductible or coinsurance for certain medical procedures -- surgical procedures that are performed. For example, the bill for a surgical procedure that might be $2000 could generate $500 immediate payment and then the balance would be subject to the $100 deductible and the 80 percent benefit. This is proposing that 100 percent first dollar benefit be taken out of the plan and the entire surgical or the medical benefit would be subject to the deductible and coinsurance.

It was recommended in the context of trying to make a comparison between the current State plan -- State Health Benefit Plan design -- and what we're seeing in the rest of the benefit world.

ASSEMBLYMAN RUSSO: You mean the private sector or the public sector?

MR. ARDMAN: Both.

ASSEMBLYMAN RUSSO: Both. Because your background is Prudential, right?

MR. ARDMAN: Correct.

ASSEMBLYMAN RUSSO: Okay. Have you ever done government studies before, or worked, in essence, with government this way, or for government?

MR. ARDMAN: In this specific role, no, I have not.

ASSEMBLYMAN RUSSO: Good. Very good. Okay, so the rationale for that was you felt, collectively, that this would bring it more into line with private sector -- with what's being done out in the real world -- as far as you were concerned, and we won't get into dollar amounts at this point.

The next thing you said was, "Increase the deductible to $200 per person," and again I'm skipping -- as opposed to what it is now. So maybe you should not take for granted everybody read the entire report. "Change the family deductible exposure to two times the individual deductible." Charles or whomever?

MR. SCHEIRING: Well, again, as I indicated here, whereas the current deductible is $100 for an individual and $200 for a family, we're suggesting, again, because of the continuing driving rising costs, that that has completely not kept pace with what the current market is out there, and that the rates should be raised from $200 for an individual and twice that amount for a family to $400, which is more reasonable in line with what current, both private and public sector plans are.

ASSEMBLYMAN RUSSO: This is for A and B. We're doing both parts at this point. Those thresholds, when were they set -- and how long has it been since they weren't changed?

MR. ARDMAN: Good point. I believe they were set in, no later than the early '70s.

ASSEMBLYMAN RUSSO: Early '70s.

MR. ARDMAN: And relative to an average bill at that time it was a significant amount. It's eroded over time. It might be worth $35 today, relative to today's average costs.

ASSEMBLYMAN RUSSO: Because one of the problems we know in auto insurance was that we had set a $200 threshold back in 1973 or something which got eroded, and I know Assemblywoman Bush and I dealt with the Casino Revenue Fund last year and the Senior Citizens Committee, and one of the

problems there was the copay with regards to seniors, which I think originally was $1, and then it was $3, and it just never changed, which is not their fault. But on the other hand, it gets eroded and then you've got a big hole in the fund.

Okay, so you're talking about increasing the deductible and doing those two items. Would those numbers-- Next thing: Pretending that if there are changes, they won't be done again for 20 years -- taking the positive view here -- (laughter) should they maybe be indexed for inflation? Would that be something that's being done -- I'm directing this to all of you -- in the private sector or other public sector employee plans, meaning in the other 49 states?

MR. SCHEIRING: I would suggest, Mr. Chairman, that the problem is that we lag what everyone else has already done.

ASSEMBLYMAN RUSSO: We, being New Jersey, or we, being public sector?

MR. SCHEIRING: We, being New Jersey.

ASSEMBLYMAN RUSSO: New Jersey. Is that something that's being done is other places, indexing it for inflation?

MR. SCHEIRING: In terms of indexing, no. I'm suggesting that in terms of the thresholds that we're talking about now, those are basically what the current practices are. In terms of whether we would want to index that to inflation, I would suggest, because of the very nature of what you've described and some of the other reviews that we've been involved with, we would highly support that.

ASSEMBLYMAN RUSSO: You would?

MR. SCHEIRING: Very much so.

ASSEMBLYMAN RUSSO: And you recommended that, and that's not in here.

MR. SCHEIRING: No it's not in here. We didn't recommend it, but again--

ASSEMBLYMAN RUSSO: Because?

MR. SCHEIRING: It didn't come up.

ASSEMBLYMAN RUSSO: It wasn't discussed? The reason I asked that, you know-- It wasn't discussed or it was rejected? It's a difference.

MR. SCHEIRING: It really wasn't discussed.

ASSEMBLYMAN RUSSO: Okay. I used to prosecute and a lot of times when you ask witnesses later well, what happened, why didn't you say that, the answer was many times, "Nobody asked me."

MR. SCHEIRING: Again, one thing -- I'd like Mr. Ardman to stop and join in on this -- I think you should be aware of is Mr. Ardman is Director of National Health Benefit Accounts, primarily deals with the Fortune 500 companies on behalf of Prudential, and does a managed program, and it has to examine a wealth of experience, both in term of what's happening nationally both in the private and in the public sector. Again, from your experiences, are either private or public sector firms seeing indexing?

MR. ARDMAN: Many private sector firms are creating a deductible schedule that is geared to salary levels, so that as a person's income increases, it's bringing the deductible amount higher without changing it for everybody every year. People earning under $25,000, $200; $25,000 -- $50,000, $300. So there is an effect of indexing there, but it keeps the plan design fairly simple, straightforward, and easy to understand.

ASSEMBLYMAN RUSSO: So, that's really an indirect way to index?

MR. ARDMAN: It is, and it's becoming more prevalent.

ASSEMBLYMAN RUSSO: Was that recommended in the report?

MR. ARDMAN: No, it was not.

ASSEMBLYMAN RUSSO: No. George?

ASSEMBLYMAN GEIST: Mr. Chairman, I like that idea because of fundamental fairness. In a sense, increasing the deductible is a regressive type of tax almost, and therefore I think there should be some consideration for income if we're

going to consider increasing the deductible. Thank you for the suggestion.

ASSEMBLYMAN ROMANO: How are you going to incorporate that in the Plan? When you say, "Increasing the deductible--"

ASSEMBLYMAN GEIST: Instead of a simple mathematical doubling of the deductible, take into consideration income of the individual so that there's not a disproportion in effect upon the lower income State employees. Perhaps I have been listening to Assemblywoman Bush and her expression of some concerns, but I believe in this particular instance there should be some--

ASSEMBLYMAN ROMANO: I agree with what you're saying in principle -- in the breach -- but in the practice now, who's going to design all of these programs to come up with the varying deductibles, etc., etc.? You know, you've got to be realistic as to what the health benefit system is going to provide when you start with these nuances, if you will, you know.

See, I happen to believe, what you caught before, that all of the things we're talking about, saving three, saving four, saving five, should be made plain in the negotiation process, and that the employee say, "No, we don't want to give this up. We'd like to keep that." Fine. That becomes, you know, what you have here, and that should give us a certain amount of credit in this negotiation package.

I've gone through the same when we talk about the $1 copay. People say, in my own board of education, I have one of the most unusual programs. I still have a $1 copay, and that's on name drugs. In that particular situation, if that's dated, they allowed $35,000 which would have been the difference in the premium, and took less money in their salary. So be it. Let it be the case. What I'm always concerned about when I look at all of these recommendations, I'm not looking to kick into health care other people who are going to be going into uncompensated care, and/or charity cases.

As you start to say that there's going to be copays from the employee, sometimes the employees don't have the money in this particular situation, and that perhaps we should give them the finest health care possible, but with the understanding this program is worth "X" dollars and the new rates are "X" dollars, and one gets credit for this exquisite program as against dollars in the pocket.

ASSEMBLYMAN GEIST: Mr. Chairman, perhaps I was misconstrued. My only basic suggestion was to incorporate the private sector practice of taking into consideration income. I believe that perhaps a scaled increase in the deductible to reflect fairness would be appropriate. An individual earning a $100,000 salary should not have the same deductible as an individual earning a mere $15,000. I believe what's fair is fair. If we're going to consider recommendations of increases of deductibles, we should take into consideration principles of fundamental fairness.

ASSEMBLYMAN RUSSO: I would also say to both points that, some of these things -- and I understand exactly what Assemblyman Romano is saying -- are purely statutory, and whether we do anything -- whether this Legislature does anything or doesn't do anything, it's at least incumbent for us to look at them which is what we're doing now. Because the system, as Mr. Van Ness has been quoted as saying before -- some of these things are not just rural they're in the statute, and they're not really negotiable, and what we're locked into are low copays. That's reality.

I think the best way to do it in a perfect world would be the way that Assemblyman Romano just stated, but the system is not exactly everything on the table fairly. That's the problem. It is a piecemeal system, where some of this is purely legislative, and that's why this Commission, I believe, has even stated that. They can only recommend. But even if the recommendations were all done, they have to be implemented

by the Legislature. We may not agree with everything, but I just throw that open to you.

The other thing I would throw open to you -- and I don't have the profile -- a question of fairness. George, you're right, where you have a system where the person making $75,000 or $65,000 probably can afford a higher copay, than the individual making $15,000. One thing may be the profile. Maybe you may have a lot more people making under $50,000 than above $50,000 as a practical matter, and the second thing is the implementation of it. It gets very difficult putting those brackets to an extent, whereas we're looking at a system that, I think probably all seven of us would agree, hasn't changed in 20 years. So there seems to be, maybe, some modification needed, but I don't know. Your way isn't totally wrong either. It's just not easy to do.

ASSEMBLYMAN GEIST: Mr. Chairman, I thought we had a mandate from the Speaker to become pioneers for innovative solutions to the problems.

ASSEMBLYMAN RUSSO: Well, as long as they have 41 votes. (laughter) Now, the next one, "Increase the amount at which the plan begins to reimburse at 100 percent, from $2000 of eligible charges to $10,000."

MR. SCHEIRING: Again, as I think you'll recall, under the current Plan you pay your initial deductible, then you're paying on a shared basis of 80/20, up to currently $2000, and then it kicks into the major medical at 100 percent. Again, that's another figure that has been set some time ago. It does not represent what current market conditions are in the private/public sector. We're suggesting that it should go to a higher threshold, the threshold being $10,000. Again, there are ranges of options to be considered in that area. It could be five. It could be seven. It could be 10. We chose that as an example, in terms of what the opportunity would be.

ASSEMBLYMAN ROMANO: Mr. Scheiring, each comment that you make points up the fact that the State Health Benefit system, in many ways, is a better system than the private system; that when we talk about rates of what they're paying where many of the things that you have in the State Health Benefits, the private plans have already taken out, and this is why the State Health Benefit system, in most part, is an excellent health benefit system, and I think this gets pointed up by all the recommendations you see about saving money, because it is a fine system. There are glitches; don't get me wrong. There are things about the program I don't like, being part of the program.

MR. SCHEIRING: Assemblyman, we quite concur and agree with you, and again I think that with the spirit of our recommendations--

ASSEMBLYMAN ROMANO: I know the spirit in which you did this. This was your task, but from the prior witnesses that we had, the point has come up about private plans. These are the nuances that make the difference between the State Health Benefit system and the so-called private plans when you match the private plan provision to provision of the State Health Benefits plan.

ASSEMBLYMAN RUSSO: "Include a separate $50 dr g deductible," in essence, for medical prescriptions, "per person in the major medical plan."

MR. ARDMAN: When this Plan was originally designed, the $100 deductible was intended to encompass both the medical-surgical expenses and prescription expenses, which was in the early 1960s, not the '70s, that this Plan design was implemented. Where a minimum part of overall medical expenses currently with the recent escalation, the last five-year escalation, and the costs of prescription drugs combined with the relative low absolute amount contained in keeping that $100 as a deductible, it was felt that it made sense to segregate

the types of charges that are being used to meet that deductible and apply a separate deductible for it. Fifty dollars doesn't get you very much these days in a pharmacy, but still it would have a significant impact, both immediate and long-term, in terms of the cost.

ASSEMBLYMAN GEIST: So, you're saying, eliminate the copay and come up with the $50 deductible?

MR. ARDMAN: No, no. I'm not saying eliminate the drug plan -- the card plan. We're saying, right now drugs are eligible under both the major medical plan and the card plan, so the $3.50 times 16 prescriptions a year would get you into benefits here, but it also, currently, goes to the $100 benefit -- the $100 deductible.

ASSEMBLYWOMAN BUSH: I'm lost. You're saying, don't have the $3.50?

MR. ARDMAN: Keep the $3.50.

ASSEMBLYWOMAN BUSH: Keep that?

MR. ARDMAN: Keep the card plan.

ASSEMBLYWOMAN BUSH: Okay.

MR. ARDMAN: But currently, the $3.50 copay can go towards satisfying your $100 deductible under the major medical.

ASSEMBLYWOMAN BUSH: Oh, okay.

MR. ARDMAN: I mean, what this recommendation means is not towards the $100, but toward a separate deductible only for the drugs. Separate the $50 for drugs only. Keep the balance of the deductible. Keep the other deductible for medical-surgical expenses.

ASSEMBLYWOMAN BUSH: Okay. Thank you.

ASSEMBLYMAN RUSSO: I'm on page six now.

ASSEMBLYWOMAN DERMAN: Excuse me.

ASSEMBLYMAN RUSSO: Yeah. Go ahead.

ASSEMBLYWOMAN DERMAN: I didn't understand number one. Perhaps you can give an example of number one?

ASSEMBLYMAN RUSSO: You mean, terminate the first dollar?

ASSEMBLYWOMAN DERMAN: Yes.

ASSEMBLYMAN RUSSO: "Terminate the first dollar of surgical-medical benefit and consider all such expenses eligible under major medical subject to a deductible and coinsurance." An example?

MR. ARDMAN: For example, there is a schedule of benefits currently that may pay $500 for an appendectomy before any deductible or coinsurance bill for the appendectomy. The surgeon's bill is $2000. You submit the bill. Your payment would be $500, then $100 deductible. The remaining $1400 is paid at 80 percent. Number one is recommending that the formula be changed, that the entire $2000 be subject to the $100 deductible and then the remaining $1900 be paid at 80 percent. No more first dollar $500 benefit. It's changing the emphasis of where the dollars are being spent in benefit plan -- a little closer toward the back end.

ASSEMBLYWOMAN DERMAN: Well, it's 80 percent of $1400 versus 80 percent of $1900? Is that what you said?

MR. ARDMAN: It's $500 plus 80 percent of $1400, yes, compared to 80 percent of $1900.

ASSEMBLYMAN ROMANO: In your explanation, didn't we lose something on the UCR? I mean, if someone puts in a bill for $2000, and they don't consider that bill viable, they're not going to pay 80 percent of the remainder of the $2000 if they don't believe that that's the price of that operation.

MR. ARDMAN: That's possible, but the way the schedule is constructed is, that is far lower than any measure of UCR. It, historically, was established in the 1960s.

ASSEMBLYMAN ROMANO: No, what I'm getting at-- I know the schedule you're talking about first.

MR. ARDMAN: Oh, okay.

ASSEMBLYMAN ROMANO: When we talk about the 80 percent--

MR. ARDMAN: Should it be $2000, or is it $1800, or--

ASSEMBLYMAN ROMANO: If that operation according to them is only worth $1500, they're only going to pay 80 percent of that amount up to $1500. They're not going to pay up to the $2000.

MR. ARDMAN: That's correct, but it would have the same effect when you took the $500 off the front end, regardless.

ASSEMBLYWOMAN DERMAN: It's a small difference. I did the math. It's not a big number. It is a difference.

ASSEMBLYMAN RUSSO: This one saves money theoretically under the present system? The theory being-- I just want to make sure I understand this, too. By doing it that way, the advantages are going to be what, in plain English, besides you're going to save some dollars?

MR. ARDMAN: You're going to save some claim dollars.

ASSEMBLYMAN RUSSO: Right.

MR. ARDMAN: And you're going to save some administrative expense, because you don't have the-- There's not a check required for every $5, $10, $15 lab test, etc.

ASSEMBLYMAN RUSSO: Okay.

ASSEMBLYWOMAN DERMAN: And it would also, excuse me, work more effectively if the bill was under $500 as well. Is that not correct?

ASSEMBLYMAN ROMANO: For the Plan, not for the employee.

ASSEMBLYWOMAN DERMAN: Right.

ASSEMBLYMAN ROMANO: Because, if now you had an employee who could have that operation for that $500, and then that employee could have it for $500 without any cost coming out of pocket.

MR. ARDMAN: Theoretically yes, but the level of the benefits in the schedule is such that I wouldn't want the surgeon who would perform it for $500.

ASSEMBLYMAN ROMANO: There are some who take the time to call to find out what the basic amount would be paid, and try to go to doctors who meet that amount. There are some people who live life, that close.

MR. ARDMAN: I absolutely agree. There are people who do just that, but in this case for this schedule benefit it was established in the 1960s, and it really doesn't cover any expenses in full anymore. It was a reasonable approximation then, but it's been frozen for 30 years.

MR. SCHEIRING: I mean, in a sense, Mr. Chairman, this is almost like the DRG process back in 1960. What they set was a schedule saying, "Here's what we will pay," and in those days it would have paid. But the problem is that schedule has not been revised since 1960. So, it frankly has created a series of administrative burdens as Assemblywoman Derman was talking about. We're basically saying, let's cut it out. Let's not recognize it. Let's go back to the situation of just saying -- let's go on a straight kind of program that says, "Yes, you do your deductible; do your 80/20; go in the max. It's not covering the cost anyway. Yes, there will be some loss of income or more cost sharing by the employee, but it's not a significant amount and given the fact of what that schedule means today.

ASSEMBLYMAN RUSSO: Anyone else, on those points? (no response) Okay.

On page six, on prescription drugs, recommendation: "Increase the prescription drug copay to at least $5, excluding mail order prescriptions and generics." Talk about what it is now, and how it got there.

MR. SCHEIRING: Again, as I indicated, you're all aware that in the current State program it's $3.50. We're

suggesting it just be moved to, or raised to $5. We're suggesting though, at the same time, we should not in any sense of the word provide any disincentives for utilizing the mail order prescriptions, which are again saving costs relative to the administrative costs, or to the use of generics. That remains at levels that would in fact give incentives to people to utilize both of those aspects.

ASSEMBLYMAN RUSSO: How did you arrive at $5?

MR. SCHEIRING: Again--

MR. ARDMAN: The $5 was basically a recommendation. It was a combination of a recommendation that historically has been made by the prescription drug administrator, and it's also at the low end of what I am seeing -- we have seen in the current market.

ASSEMBLYMAN RUSSO: In the current market, if that's the low end, whether government or private sector, do they index that for inflation, even if you leave it at let's say $5, because the $3.50 has been in effect for how long, probably 20 years, again? Ten?

MR. SCHEIRING: The program is fairly, relatively new -- the Prescription Drug Program -- which I think you're aware. I think it's probably been maybe-- Marge, I know, is here. There's only been a couple of changes.

MR. ARDMAN: Since 1974.

M A R G A R E T M. M c M A H O N: It went to $3.50 in the early '80s.

ASSEMBLYMAN RUSSO: It was originally $1 -- right? -- then it went to $3.50?

MR. ARDMAN: Right.

ASSEMBLYMAN RUSSO: Every 10 years or something.

MR. SCHEIRING: Again, generally -- and Charlie, please correct me if I'm wrong in this -- I think primarily in the private sector and also in other public concerns, both State and local, these are fairly new programs. Most of them

have not seen a need to have a escalator clause in them. They've made changes on a regularized basis on their own.

I think the other thing, as we talked about earlier, is the fact that New Jersey is unique; unique in the sense that we're one of very few states that don't have this as part of the -- again as Assemblyman Romano was talking about -- as a full negotiation process. So, this comes up from time to time.

I think the escalator you're looking for is really found in a combination of this and the next suggestion, and that is, it used to be a flat $5, regardless. The escalator really now encompasses a differential -- a mandatory differential based on whether it's a brand or generic drug. That precludes the need for moving the $5 to $6.50, or $7, or whatever. Five is not the only copay. There's still a majority of copays out there that are $5, but there are a number of $10 copay plans too. It's pretty much a function of what the particular employer wants to spend on this benefit.

ASSEMBLYMAN RUSSO: The $3.50, is that by statute, is that by reg, or is that by negotiation? It's never changed, so I'm just wondering does anybody know?

MR. SCHEIRING: It's by statute.

ASSEMBLYMAN RUSSO: It's by statute. No. I see a hand go up in the back.

MS. McMAHON: It's negotiated.

ASSEMBLYMAN RUSSO: It's negotiated. And then it's put in the appropriations I guess? Is that-- Ms. McMahon?

MS. McMAHON: Yeah. I believe so.

ASSEMBLYMAN RUSSO: So, that was through negotiation. As long as we get the information. That's why I don't exactly care where it comes-- Then you've got your limit plan eligibility to non-HMO members.

MR. ARDMAN: This ties into what was mentioned earlier in the overview in that one of the recommendations was that there be a standard, a minimal plan of benefits that a HMO must

offer to participate in the offering to State employees. Most HMOs have the facility to provide a prescription drug plan, and therefore it made sense to limit the card plan only to those who weren't members of HMOs. It's kind of a disincentive for the HMO not to do all that it can in the context of managing all of the care of its members, and it might not let certain HMOs qualify, or it might incent HMOs to incorporate a drug plan where they currently don't have one, to give them a full complement of benefits.

ASSEMBLYMAN RUSSO: Questions? Harriet?

ASSEMBLYWOMAN DERMAN: Yes. Mr. Ardman, given the fact that we're all concerned about protecting our State employees and making health benefits available to them and their families, could you give some examples of what other states are doing faced with the same costs problems that the State of New Jersey is facing?

MR. ARDMAN: I can give you one example and unfortunately, it's more financial than plan design. In the research that we did for this study, we noticed that there were a significant number of states that required contributions of their employees and of their employees for family coverage as well. I interpreted that the same as I interpreted the private sector, and that is to try and to allow a state to continue to provide as rich a benefit plan as it can, it needs to be competitive in the marketplace, which is competing for employees with the private sector; yet help to educate the employees and their dependents that they are medical consumers. Here's the cost associated with services they're seeking from the system, and that as they go forward there's going to be cost sharing, because typically these contributions are indexed. They're set at a percent of the state's cost, and as the State's costs go up, so do the contributions, by the same percentage. So, everyone is sharing in the future cost. Everybody has an incentive to become a wiser consumer.

ASSEMBLYWOMAN DERMAN: But this is also a recent change by other states?

MR. ARDMAN: I honestly don't know how recent. I know it's-- I've seen it for at least the last three to four years. I suspect it's occurred much longer than that in certain states.

ASSEMBLYWOMAN DERMAN: You don't have any breakdown by states or anything? I saw you pointing to something. Have you made that available?

MR. CLARK: Well, there's a couple of points on it. There's a survey that we have, which is the Segal Survey, and we can provide the Committee with a copy of this, and it provides a description for each state of what their benefit plans are. And it notes that, I believe-- Michael, was it 11 states including New Jersey provided totally free health care for their employees? (no response) Other states required some level of contribution for either dependents or for the employees themselves, and it runs the gamut in terms of doing that.

In the small study that we've provided you with today on the total compensation there's a chart in there, and I believe it's somewhere around page five, perhaps. Oh, we had two different printed versions, so it may vary. But it just notes that in the course of this study we discovered that New York State employees paid 10 percent of their health care costs, and the state pays the other 90 percent. However, for dependents in New York State, the study indicates that 82 percent of dependent costs are paid by the state, and 18 percent are by the employee.

You'll also note Maryland is another one that we used in this example here, and in this instance the data that we received states that the State pays 66 percent, or two-thirds of the cost. I'm sure we have much more data back there, too, (laughter) but at the same time another neighboring state, Pennsylvania, pays 100 percent. So, you can find--

MR. SCHEIRING: The whole gamut.

MR. CLARK: --the example to fit your comparison.

ASSEMBLYMAN RUSSO: I don't know if you know the answer to this, but my understanding originally was it was contemplated that the employee would take care of the dependents with regard to these issues, and then somewhere along the line it changed, I assumed either negotiations or statutorily. Was that ever discussed on your Committee?

MR. CLARK: (negative response)

ASSEMBLYMAN RUSSO: No. Anybody heard that or not? That's what my understanding was. Commissioner, would you know-- Director, would you know that? My understanding originally was that the employee was suppose to be covered, but the dependents it was going to be the employees obligation. Did that change over the years? Was it being negotiated, or was it statutorily? Do you know?

MS. McMAHON: When you say, "originally," do you mean back to 1953?

ASSEMBLYMAN RUSSO: Yeah.

MS. McMAHON: My understanding was that prior to the formation of the State Health Benefits Program, a number of local employers -- and I'm more familiar with them -- did have a variety of plans, and usually employees contributed. But if you go back to 1963 and the 1970s, even in the private sector most employees contributed towards insurance. Then there was a movement away from that, and now the movement, certainly in the private sector, has come back.

ASSEMBLYMAN RUSSO: Thanks. I'd like to deal with one more piece if we could. I'm looking at page eight, "Results of Review": "Over 175,000 New Jersey State and local active employees have free coverage. Over 120,000 of these employees receive free dependent coverage. Over 4600 New Jersey State and local active employees contribute 25 percent or less to the cost of dependent coverage. The 25 percent level equates to

monthly contributions between $14 and $46 per month. When contributions are" -- these are just findings obviously -- "required of State and local employees for dependent coverage they are typically increased each year to the same extent the total plan costs increased.

"When the suggestion to require contributions for dependent coverage is initially proposed, a typical concern is whether or not the financial ability will be so great as to prevent an individual from covering his or her family. The enrollment data you have reviewed, indicates that virtually all local employees who must contribute for dependent coverage choose to do so. This group is comprised of far fewer bodies than the number of State and local employees who qualify for free dependent coverage, even with the disparity in population size, we believe" -- the Commission believes -- "the results are indicative of the fact that all who have a single source of group medical coverage, for example the State Health Benefits Plan, find a way to budget for the cost and they will not be left without protection.

"There was a distinct movement by employers during the '80s to require contributions for both employee and dependent coverage. In '85, over 60 percent of employers paid the cost of employee coverage in full, but in 1989, only 50 percent did so. So, in '85 over 60 percent paid. By 1989 only 50 percent. Likewise, 65 percent of employers required contribution for dependent coverage in '85. In 1989, 75 percent required some contributions." So, taking those results -- those are the results from your data -- you recommend: One, implement a contribution requirement of 10 percent for employee coverage and 30 percent for dependent coverage. Again, in line with those concerns and your data, you picked those figures based upon private sector and contribution of--

MR. ARDMAN: Looking at surveys, private sector-- The survey didn't encompass both private and public sector.

ASSEMBLYMAN RUSSO: Right.

MR. ARDMAN: Where we saw the majority fall, that it was not putting New Jersey out on the leading edge of standing alone, requiring more than either other states or those with whom New Jersey competes in the private sector for employees. Again, updating that since then, the recent Segal Survey that was mentioned indicates that as of 1988 the number of states that pay 100 percent of their health care decreased from 31 to 26, and that same survey also indicated that 11 of the 50 states now only pay the full costs of health benefits. So, the continuum, or the trend that was discussed -- that you just talked about has continued in that vain, and more and more folks are asking their employees to be a participant in the cost-sharing aspect.

ASSEMBLYMAN RUSSO: Your data doesn't indicate that using 10 and 30 percent figures would drive people, as Lou was talking about-- We don't want to drive them, obviously, off the Plan, number one, and into the Uncompensated Care Fund. I mean, that's one thing. From your data, you don't feel that, and, in fact, if I read correctly, you feel and believe that there would be enough budgeted money left over that they would still stay in the Plan and work that out. That's what your data indicates?

MR. SCHEIRING: We think so, yes.

MR. ARDMAN: Yes.

ASSEMBLYMAN RUSSO: Two: "Reevaluate the methodology currently used to determine HMO contributions. Incorporating an approach that reflects the impact of risk segmentation by the HMOs on the risk characteristics of the remaining group should produce a more equitable determination of contributions for all participants." Explain that.

MR. ARDMAN: This was a recommendation based on the fact that we saw a distinct -- we saw the State population in the HMOs being distinctly comprised of the younger people,

under age 40, which is not surprising. HMOs tend to attract younger people; people who don't have an established relationship with a physician, because they have not been a long time member of the community; people who don't have an established relationship by virtue of not needing or having cause to deal with a specialist for a particular problem for years; people who are looking for value in care, because historically, HMOs have been offered at little or no contribution.

However, one of the long-term potential problems is that you experience what we call the risk segmentation that an older, more mature, and more expensive population ends up in, the traditional indemnity plan, and a younger, healthier, less expensive population ends up with the HMOs. It tends to accelerate the increase of the cost for the traditional plan, and this is part and parcel of another recommendation, which is basically: We wanted to see a better defined State policy -- what we want to do relative to offering health care, and funding it, and making it available, and communicated it to our employees, and we felt this was a natural complement to that.

If you didn't look at HMOs on a stand-alone basis, and maybe charge little or no contribution, because they're charging less than what the State Plan is costing for an active employee, but rather you look at them in concert with what the State Plan is costing, you recognize that HMOs provide comprehensive benefits and provide benefits that are both preventive as well as dealing with illnesses and injuries, and there's a value to that.

On a stand-alone basis, absent the healthier population, HMOs, by virtue that they're able to negotiate discounts by their ability to manage utilization, and by their ability to incorporate preventive care, which ultimately is going to reduce the cost of medical care for the HMO population, are able to deliver a more comprehensive product,

usually at a very competitive cost relative to a traditional indemnity plan.

We don't want to see the cost get too out of sync that the entire population -- that a significant portion of the population migrates to HMOs, and leaves the SHBP sitting there increasing 20 percent to 25 percent, 30 percent to 35 percent a year for the population that remains in that and is unable or unwilling to move from it. We want to see a rational, all encompassing strategy that deals with contributions for all components of the health care delivery system.

ASSEMBLYMAN RUSSO: I don't know if you know this, but when there are layoffs -- actual layoffs -- of State employees, their health coverage terminates with the actual layoff, or continues for how long?

Lou?

ASSEMBLYMAN ROMANO: Allow me--

ASSEMBLYMAN RUSSO: Sure.

ASSEMBLYMAN ROMANO: --because this goes back to when we were in the Assembly together. If the State is like the local employer -- you'll have to correct me -- you're carried, for your State Health Benefits Program for one additional month for which pay has been received. What happens with drug, dental, and optical?

MS. McMICHAEL: Boards make it--

ASSEMBLYMAN ROMANO: No. I'm talking about the State.

MS. McMAHON: The State-- The drug, I think, is the next pay period. It terminates very quickly.

ASSEMBLYMAN ROMANO: They terminate quickly. Beyond that one month, Mr. Chairman, then it becomes 18 months that they pay at the group rates, either through Medix or through the State; however they operate it. For 18 months they're assured of the group rate, and then after the 18 months, should they want to continue -- should they have wanted to continue -- then they apply to the company on an individual basis.

Obviously, the group rate is always much less. If you go back to when I told that story about when they said they were going to lay off that many employees, I said, when a person is not working, perhaps, the HMO is the best. Some people took advantage of it, because the HMO range from $100 a month cheaper than the State Health Benefits rate -- which I believe, saying this off of the top of my head -- and then you have the Cadillac of all HMOs, which costs the employee money if they want that HMO over and above the State health benefits, because it provides medical examinations, what you might call preventive maintenance, and also the drugs are equally involved with the generics. So, they're allowed more under that HMO. Did I say it correctly?

MR. ARDMAN: Yes. Absolutely.

ASSEMBLYMAN RUSSO: "Introduce a flexible benefit program structured according to Section 125 of the Internal Revenue Code. Limit the scope of the program to allow employees to use pretax income to fund required contributions. Make participation mandatory. Assuming an average salary of $35,000 and a marginal tax rate of 25 percent, the benefit of using this approach is that each $1 of revenue generated from employee contributions is the equivalent of a 75-cent reduction to the employees' take-home. Absent this approach, each $1 of contribution revenue costs the employee $1 of after tax income." Expand.

MR. ARDMAN: There is a provision of the Internal Revenue Code that does allow designation of pretaxed dollars -- gross salary dollars -- to pay for certain benefits including contributions for certain types of plans, medical care being one. There may have been some progress in reviewing the appropriateness of this for State employees since this report was written. I'm not sure of that, but basically what this is saying is that if you require a person to contribute $1 of take-home pay, it costs the person $1 out of his pocket, but

that same dollar which is moving as contribution from the employee to the State to offset costs can be taken pretax and would have the net effect of 75 cents take-home.

In other words, to get $1 you can take it pretaxed, and it impacts the employee by 75 cents, or you can do it post tax and it impacts the employee by $1. The code allows for it. There are a number of private sector employers who have incorporated this provision in their plan as mandatory. An employee doesn't have a choice. Any contribution for that employer's medical plan is automatically taken through a flexible spending account, or flexible benefit account as it's known, and it minimizes the impact on the take-home of the employee.

MR. SCHEIRING: Mr. Chairman, I might add, again, I think the other factor that we were talking about, and we were not trying to be very specific as to what that flexible benefit would include, because there are a range of options as Mr. Ardman just talked about, but it is to recognize in fact that we do have two-income families, and we have two-income families that not only work for the State, but also work for other employers. Given the fact that each of us as we move through that system, depending upon our age, depending upon the conditions that our families are experiencing, we may want to make different choices.

Currently, the State's Health Benefit Program doesn't allow you to make very many choices. You basically are provided with a menu of benefits, that with the exception of the vision care and the dental care are in a sense mandatory to accept, and do not reflect what your conditions may be, relative to the needs of your family or the circumstances that you and your spouse find yourselves in. And if there are situations that do exist where there is dual coverage occurring, where there may be opportunities for that family to make some wise decisions as to how that could best benefit

them, we shall allow that to happen, and they should have a flexible benefit program that meets their needs, that would not only save them dollars but also the State dollars.

A more important matter of course, is the fact that the State, yes, is paying itself through a self-insurance type program, and on a dollar-to-dollar basis. No, we're not paying double premiums, but it's experienced type rating, and there is an impact, of course, relative to the cointegration that's going on that affects that experience rate. So, there should be savings to be had, in a sense, for both the employer and employee by doing those kinds of options.

ASSEMBLYMAN ROMANO: Mr. Chairman?

ASSEMBLYMAN RUSSO: Yes.

ASSEMBLYMAN ROMANO: Mr. Scheiring, you know, I want to correct any misgivings that you might have, you know, in my questioning, because first of all I think you did an excellent job. Your job was to do what you did here, to present all of these things in terms of how one can save money on health benefits, but obviously it impacts on terms and conditions of employment. Now, what you have in your final recommendation there, I think, points up the fact that it is better for the employee to get whatever he possibly can -- or she can -- as a health benefit because it's outside of the income tax; because the moment that one starts to have a copay this is out of their net they're paying this. They are not paying this before, unless they can fulfill this particular justification. That's a specter that just hangs out there in mid space, whether when they talk about a universal health care system, if it's ever going to get to a point where they say, if anybody is getting health benefits to the tune of more than $10,000 a year the employer is going to give them a 1099, that remains way out there, because all health benefits, all fringes, are not subject to income tax at this point in time.

So, anyone who says, copay from the employees themselves has to understand that they're taking out of their net and paying into it, unless they can fulfill this right here. And the State Health Plan, I don't think, fulfills this situation.

ASSEMBLYWOMAN DERMAN: I was going to ask the same question. Just to confirm, if we decide to go to an employee coverage we should see the implementation of some sort of cafeteria style plan?

MR. ARDMAN: Flexible benefit plan, and flexible spending account is really kind of a generic term that encompasses either a single, very narrow in scope approach, such as the example that's used here, that you mandate any contributions be done pretaxed to minimize the impact on the employee's take-home, or it could be as broad as having a list of different plan options that an individual can design a plan for themselves from picking and choosing among the various options that suit their own personal situation best.

ASSEMBLYWOMAN DERMAN: But it certainly would be foolish not to implement and plan a employee coverage payment that did not qualify for deduction by the employee.

MR. ARDMAN: When we looked at this we said, we know contributions in this culture are going to be -- are unpliable (sic) and that's bottom line. So how can we-- What can we do? What can we implement to try to offset that a little bit? So this saves -- it saves a person $1 out of $4.

ASSEMBLYWOMAN DERMAN: I have another question.

ASSEMBLYMAN RUSSO: Sure.

ASSEMBLYWOMAN DERMAN: You raised, before, the possibility of having a deductible system based on income, which Mr. Geist liked. Has it ever been considered of having a system based on salary or income level for the cost of dependent coverage?

MR. ARDMAN: Contributions based--

ASSEMBLYWOMAN DERMAN: The higher the income of the family, the higher the cost for dependent coverage.

MR. ARDMAN: I'm not familiar with that exact type of arrangement, but--

ASSEMBLYWOMAN DERMAN: I just made it up. (laughter)

ASSEMBLYMAN ROMANO: Harriet, everything is possible. You can made all kinds of (indiscernible) codes with these things here. As the person's salary goes up, the percentage given to them goes down. You know, down.

MR. ARDMAN: There's an item of interest, I'd say, to something that's relatively new and being discussed by a few large, private sector corporations, and in fact just implemented by General Electric this year, is a higher contribution for spouse coverage when the spouse is employed and has the opportunity to get coverage from his or her employer. But if the coverage comes from GE, then the GE employee is going to pay a premium to cover his or her spouse.

ASSEMBLYWOMAN DERMAN: Because, in addition to the people in our Plan that live on the edge, I'm aware of people in the Plan that don't live on the edge, whether they're teachers, or deputy attorney generals, or whatever, and have spouses in the Plan and families who could well afford coverage, and the effect that I've seen is not only are we paying for the spouses and the children in these affluent families, but the result is that the spouses are not maintaining coverage for their employees if they run small business, which I happen to be aware of in a few cases.

So you have a rippling effect, because in these cases the wives' Plans are so great -- their State Health Plan -- that everybody's jumping on board. So, I think it could cut both ways. It may be very difficult to implement. One caveat is that this whole area is difficult to implement administratively. So, I think we could handle another one or two wrinkles.

MR. SCHEIRING: Mr. Chairman, I'd like to add to that statement, I think it's very important, as Assemblywoman Derman mentioned, that any review that this Committee takes a look at, it has to do it in very close consideration in terms of the administrative capability. Again, we're talking a very large system here. It impacts a number of providers, a number of people, in the ease of the administration, and the understandability.

I think the one thing that struck the Commission, and I think also struck the members of the study team was the -- and it's not something that New Jersey stands out on -- is that frankly, most people don't understand their Health Benefits Program, and we don't do a very good job of educating our folks in terms of what those benefits are and what the value of them is. If there's more we can do in that area, we strongly, strongly urge it.

The other factor is just the issue that you also raised, is that relatively-- It's, again, a total compensation package. The direct compensation of (indiscernible) in our benefit structure. The example that you made, for example, in terms of DAGs, where we found in our compensation review that frankly these folks are willfully underpaid, in terms of what you see in the marketplace. So, perhaps that benefit structure in some ways has helped to bring them up to a par, and any tweaking that's done relative to these areas, needs to be looked at from a holistic point of view, and again, from a total compensation point of view.

I think some of the suggestions that were raised here today-- I know Assemblyman Geist thought that the recommendation in terms of structuring, perhaps, some sort of schedule based on salaries is a wide one, and perhaps it is, but again I think we need to look at it from a total perspective, and I don't want that to be lost sight of, because I think that's something the Commission feels very, very strongly about.

The problems that we see in this State are not related towards the fact that we don't have good, well-meaning programs. It's the fact that we have tweaked with them at the fringes, and haven't looked at them from a broad, visionary perspective of what do we want to do for our employees; how do we want to treat them relative to the marketplace; how are we going to ensure that those folks are equitably treated both in a direct compensation way and in a employee benefit kind of way; and how can we do that in a way that doesn't have overutilization as some understanding to what those benefits are and well use of them?

ASSEMBLYMAN ROMANO: Is that your epilogue, or are you going to add that sheet on? (laughter)

ASSEMBLYMAN RUSSO: And with that--

MR. SCHEIRING: That's what 5:00 will do for you, I guess. (laughter)

ASSEMBLYMAN ROMANO: No, no. It was very good. I didn't mean that as if I was cutting you off. It should have been another page at the end; the epilogue, because it represents as a-- I know my colleagues and I feel-- We're concerned about quality, affordable health care for everyone, and this is part of my concern with the programs. I want them to have everything at their fingertips, paying out the least amount of money so that we're all assured of getting the same sort of health care.

ASSEMBLYMAN RUSSO: Can you come back, Thursday, to finish this? Is that possible?

MR. SCHEIRING: What time would you like us?

ASSEMBLYMAN RUSSO: Two o'clock.

MR. SCHEIRING: Yeah, we could. Yes, Mr. Chairman.

ASSEMBLYMAN RUSSO: You would be the first witnesses. What we'd like to do, I was going to start with utilization of services. I wanted to do it today, but I didn't. I want as many questions as possible. I think it's good, the give and

take. I'd like to start with utilization on page nine, work through your recommendations, the alternates. We'll hav enough time, I think, to do that. I'd also like to talk about your recommendation with regard to the pension program.

And, Director McMahon, would you be able to be here Thursday, again? Part of what we're going to get into would be the pension recommendation, and that might--

MS. McMAHON: Okay.

ASSEMBLYMAN RUSSO: If you could that would be-- Probably, we will not get there right away. I'd like to thank you very much. We'll be here at 2:00 on Thursday. We'll start where we are now, complete that. We have possibly a representative from the State Chamber?

MR. KINGSTON (Majority Staff Aide): Possibly.

ASSEMBLYMAN RUSSO: Possibly. And?

MR. KINGSTON: And an employee benefits consultant from the private sector.

ASSEMBLYMAN RUSSO: And an employee benefits consultant from the private sector. That may well be the final testimony that we're going to take on this Committee. Yeah, George?

ASSEMBLYMAN GEIST: Mr. Chairman, I just want to present a concept: It's called digestion -- digestion of all of the information. Today, on my request, OLS provided me with some wonderful listing materials and copies of transcripts. Some of our colleagues, because of their other Committee assignments have been unable to attend. Because of the nature of the mandate from the Speaker, I trust that we're going to fulfill our responsibilities diligently and carefully.

Perhaps -- food for thought, Mr. Chairman -- instead of having a comprehensive session next Tuesday with the notion of perhaps voting formal action, perhaps more time will be needed. I don't know what your personal timetable is for this Committee. I'm just sharing with you that there's a great deal

of information that needs to be evaluated, and I see our staffers being bombarded with paper in every session. Perhaps they need additional time. I know personally, I think it would be beneficial. I just wanted to share that with you, because you are hoping to have next Tuesday as a comprehensive session through which we could tie all the loose ends together.

ASSEMBLYMAN RUSSO: That's going to depend on what we do Thursday. It may or may not be. That's what we've got that geared for, but I don't know. Anybody else feel that way?

ASSEMBLYWOMAN BUSH: I concur. Actually, I'm still waiting for the transcript from the first meeting, which we weren't assigned to the Committee.

ASSEMBLYMAN ROMANO: Oh, that's right, we didn't hear those two.

ASSEMBLYWOMAN BUSH: Right.

ASSEMBLYMAN ROMANO: We were not here for the first two meetings.

ASSEMBLYWOMAN BUSH: And we were told we would get--

ASSEMBLYMAN RUSSO: I think the first one should be ready, I'm told, the end of this week, or early next week -- the transcripts for all meetings up until today.

ASSEMBLYWOMAN BUSH: Okay. Well then, that would still create a problem, because if it's the end of this week or the beginning of next week, and we're talking about doing, as you said, on Tuesday, it's no way to-- If it was three or four hours as these have been that I've attended, I'd have to put it on and go to sleep.

ASSEMBLYMAN RUSSO: Did you miss the first one or two?

ASSEMBLYMAN ROMANO: Two. We missed the two. There were two other people here. I don't even know who they were. You had two other Committee members the first two meetings. Who were they?

ASSEMBLYMAN RUSSO: No, no. Maybe staff. You were here--

UNIDENTIFIED AIDE: Right. The first meeting we had nobody. It was just me.

ASSEMBLYMAN ROMANO: The first meeting no one was here.

UNIDENTIFIED AIDE: Right. It was just me.

ASSEMBLYMAN ROMANO: And the second meeting?

UNIDENTIFIED AIDE: I don't know, I wasn't here. I was out.

ASSEMBLYMAN ROMANO: I thought we came on the third meeting.

ASSEMBLYMAN RUSSO: I think it was only the second. Was it third or second?

ASSEMBLYWOMAN BUSH: How many meetings did you have in your first week, two?

ASSEMBLYMAN ROMANO: Two.

ASSEMBLYWOMAN BUSH: We missed the first week. I know that.

ASSEMBLYMAN ROMANO: There was no one here.

MR. SCHEIRING: See you Thursday, Mr. Chairman.

ASSEMBLYMAN RUSSO: See ya. Thank you.

(MEETING CONCLUDED)

APPENDIX

New Jersey
School Boards Association

Headquarters: 413 West State Street, P.O. Box 909, Trenton, New Jersey 08605
Telephone (609) 695-7600 Fax 609-695-0413

NJSBA'S POSITION ON SCHOOL EMPLOYEES' MANDATED BENEFITS

Presented to the Assembly Select Committee on Civil Service and Employee Benefits

April 21, 1992

The New Jersey School Boards Association welcomes the committee's interest in school employee benefits and appreciates the opportunity to express boards' perspective on the issue. Boards of education are not opposed to providing their employees with benefits. In fact, local negotiations have resulted in a wide array of contractual benefits which include: medical, surgical, dental and prescription insurances, generous extended and temporary leaves of absences; payment for unused sick leave; and tuition reimbursement plans. Boards do not object to the negotiated grant of benefits--they do have deep concerns about aspects of the process of negotiations that prevent boards from responding to changing economic circumstances and that memorialize agreements reached many years ago. Unlike private sector contracts, the provisions of an agreement negotiated in New Jersey's public sector do not end with a contract's expiration. The PERC bargaining law requires boards to continue to honor all agreements reached through prior negotiations unless a change can be negotiated. Thus, once given in negotiations, a benefit is seen to belong to the employees and is extremely difficult to reduce or to eliminate through successor negotiations. The requirement to maintain the negotiated status quo, which includes the obligation to pay increment on an expired guide before a new agreement is reached, creates an uneven playing field in negotiations that guarantees the continuation of expensive benefits and outdated approaches to employee compensation.

Boards are also concerned that employee benefits that cannot be obtained through negotiations are achievable through legislation. Statutory provisions grant a variety of benefits to school employees, but the burden of providing the benefit is imposed on local school districts and taxpayers. Statutory tenure, mandated binding arbitration of school employees' grievances over discipline--including the nonrenewal of a fixed term employment contract--complicate and increase the costs of schools' personnel administration. Statutory benefits, such as individual employees' right to be absent without loss of pay on legal holidays,

supersede or preempt locally negotiated agreements. Boards have no control over benefits established by law, but are required to comply with their mandate and to cover their costs even if the benefits interfere with their ability to manage their schools as efficiently as possible.

For years, boards of education have been attempting to deliver their mandated services in a most cost effective manner. This search to control the costs of providing thorough and efficient local public schools has been intensified by shrinking economic resources. However, under current laws and regulations governing school operations, boards cannot unilaterally contain the costs of maintaining their local educational programs. Rather, decisions involving the largest item in any school district's budget--employee compensation--require the joint decision-making of collective negotiations. Decisions involving employee salaries and benefits must receive the approval of both the board and the union. In 1991, boards have been successful in persuading their local unions to agree to the lowest teacher increases in ten years. The 1991-92 settlements reflect the current economic downturn, with salary increases dropping steadily in relation to the date of the settlement (see Attachment B). Unencumbered by interest arbitration, school negotiations have been, and will continue to be, responsive to their communities' desire to contain increases in teachers' and other employees' salaries.

But salaries are only one aspect of employee compensation; boards are having far more difficulties in containing the skyrocketing increases in the cost of maintaining their employees' negotiated health insurance benefits. The difficulties in containing these costs (which have been increasing at an annual rate nearly nine times the cost of living) are due to many factors, including the national crisis in providing health insurance, the need to negotiate changes in insurance coverage, and the complex requirements of the State Health Benefits Plan.

According to the latest enrollment data available, 427 boards of education--or 72% of all school districts--were covered by the State Plan in 1990-91. Therefore, the Plan's structure, and its effect on the local cost of health insurance, has a pervasive but locally uncontrollable influence on school districts' budget. Yet, the State Plan's requirements preclude its participating public employers, including the State, municipalities and local boards of education from pursuing cost containment in health insurance coverage. Indeed, for boards of education, many requirements of the Plan result in inflated insurance costs for the local employer. These include the Plan's rule concerning: part-time employees; uniformity of coverage; its prohibition against incentives to avoid duplicate coverage; and designated level of benefits which preclude containment of employer costs.

Part-Time Employees. The State Health Benefits Plan requires that participating employers provide full coverage to all employees who work on the average of 20 hours per week. Boards of education employ far more part-time staff than other public employers. According to the New Jersey

Department of Education 1990 statistics, school districts employed almost 4,000 part-time teaching staff members and almost 12,000 part-time noncertificated staff. In other words, almost 10% of the state's school employees work on a part-time basis.

Under the Plan's rules, boards must offer all their part-timers who work 20 or more hours per week, the same insurance coverage as full-time employees. This means that boards must pay for the full premium for the part-time employee and for the employee's dependents. This leads to the expensive anomaly where districts' cost of providing health insurance can exceed a part-time employee's salary. For example, in 1990-91, a cafeteria worker who received a salary of $3,100 for working four hours on each school day would also have received mandated family health insurance coverage at a cost to the board of $4,486.56 for the year. In 1991-92, the insurance premium for that employee would have cost the district $5,675.64--or a 26.5% increase which would have far exceeded any negotiated increase in salary.

While part-time salaries are frequently higher than the cost of providing fully paid medical insurance, the requirement that the Board offer the same level of insurance coverage to all eligible part-time employees increases the cost of operating school districts. Under the SHBP, boards cannot negotiate prorated payment of insurance premiums nor provide employee only coverage for their part-time staff. These cost-saving options are available in private insurance plans.

It must also be noted that the Plan's part-time policy does not serve employees' interests. Boards that participate in the Plan, but cannot afford to pay the costs of part-timers' insurance, are very reluctant to employ part-time staff for 20 hours per week. This understandable cost saving effort can result in reduced employment opportunities and/or the total denial of insurance coverage--the Plan absolutely prohibits the enrollment of any individual who works less than 20 hours per week.

Uniformity of Coverage. The SHBP requires all participating employers to provide all their eligible employees with access to equal, identical and uniform coverage. This means that boards must pay the full premium for all eligible employees and must extend their obligation towards dependent coverage to all employees who qualify for that type of enrollment.

Ninety-six percent of the boards participating in the SHBP have agreed, through negotiations, to fully pay the dependents' cost of coverage. Most of these negotiated agreements date back to boards' entry into the State Plan, which permitted, at that time, excellent employee benefits at an affordable price. In the 1981-82 school year (for example), the annual cost of employee only coverage was $373.44 and family coverage was less than $1,000 per year ($927.12). In 1991-92, individual rates have increased to $2,214.72 (or a 493% increase) and family rates have risen to $5,675.64, a 512% increase. These increases have been paid by boards of education: the Plan requires the employer to fully pay the employee's

premiums, regardless of the increase in costs; and boards have generally been unable to obtain union agreement to charge their members' a portion of the cost of providing dependent coverage.

Boards that purchase their health insurance from a private carrier have had a higher degree of success in curtailing their obligation to the dependents of future employees. These negotiated provisions reflect a responsiveness to changing circumstance and result in a potentially significant cost sharing of insurance coverage. However, this option is unavailable to boards participating in the Plan as establishing various levels of board-paid coverage violates the Plan's uniformity rule.

The uniformity rule also requires that boards offer all their current employees access to equal coverage. Thus, the selection of the type of coverage available is left to the employee - but the full cost of the selection must be borne by the board, even if the employee's enrollment results in duplicate insurance coverage. Duplicate coverage means that the board is paying a full family premium for individuals who are already covered by another policy either in the same group plan or in another plan. Under insurance plans' "coordination of benefits," duplicate payment or reimbursement of medical expenses do not occur. Thus, individual employees with duplicate coverage receive identical benefits available to individually covered group members - but the employer pays twice as much for their coverage. The best illustration of this situation is found when a married couple, with children, is employed by the same district. Typically, both employees opt for family coverage and the Board pays two family plan premiums. [$5,675.64 in 1991-92 or $3,460.92 more than individual coverage.] However, the children's coverage is paid through the primary policy coverage, in the same way that would have been reimbursed if the Board only paid the family premium for one employee. As in 1992-93, family coverage will cost in excess of $4,000 more than individual coverage - these costs continue to increase. Thus, this rule increases local costs without providing a concurrent benefit to employees.

The same rule applies to married employees whose spouse is also enrolled in the SHBP by virtue of employment with another public employer. It also applies to employees who have duplicate coverage under their spouse's insurance group with a private carrier. Under this rule, a local board paid full duplicate family premiums for approximately 30% of their employees enrolled in the SHBP. In this district, 60% of the administrators' bargaining unit received duplicate coverage at full cost to the Board when the district participated in the State Plan.

Cost adjustments for providing dual coverage is available in the State Plan. The Plan's rule (N.J.A.C. 17:9-5.7) authorize reimbursement of employees' costs of dependent coverage when the employee must pay for dependent coverage when both husband and wife are enrolled in the State Plan. However, no reimbursement is authorized when the employer pays for dependent coverage under the same conditions. Thus, the costs of duplicate coverage increase boards' insurance obligations.

Prohibition Against Incentives. In March 1989, the State Plan adopted a rule that prohibits boards of education, and other participating employers, from offering a cash incentive to employees who chose not to enroll in the State Plan. This rule has been interpreted to also prevent boards from offering incentives to employees to select individual coverage rather than duplicative family or dependent coverage.

Before the adoption of that rule, a number of boards of education had negotiated incentives for nonenrollment for unnecessary coverage. Employees not enrolling, or enrolling for minimal individual coverage, would receive another desired benefit or a cash stipend. This mutual arrangement worked to both parties' advantage: the employee would receive a desired benefit and the board reduced its insurance costs. The implementation of the rule invalidated these local agreements, denying employees their choice of benefits and increasing district costs. One district reported that the rule increased its insurance costs by 5% in the 1989-90 school year. Another district reported that its ability to offer incentives for nonenrollment with a private carrier led to a 30% savings in its costs of premiums paid to the State Plan.

Defined Levels of Benefits. The State Plan provides all its participating employers with an established level of benefits that cannot be adjusted to meet local needs. The Plan's major medical deductible is set at $100 per person, with a maximum of $200 per family. Its reimbursement is based on 80% of the first $2,000 and on 100% thereafter. This level of benefit is the result of continuous legislative improvements which increased major medical benefits, upgraded the surgical payment schedule, and involved a general improvement in the Plan's insurance coverage. (In the early 1980's, the State's negotiations with its employees led to the purchase of the 14/20 Fee Program; this benefit improvement and its 30% increase in cost was automatically imposed on all local boards.)

It is important to note that none of the amendments to the Plan have ever involved increased employee contributions or higher deductibles. The unchanging level of employee contributions to their medical costs in years marked by escalating costs of medical services is an unquestionable factor in the increasing costs of the State Plan's premiums. Private insurance plans' options of increasing deductibles and copays have resulted in employers' ability to contain and to reduce their cost of providing health insurance for their employees. One board reports a savings of $70,000 or 10% of its SHBP premium by increasing deductibles with a private insurance carrier.

If boards can save money by purchasing health insurance through private carriers, why do so many boards continue to participate in the State Plan? Board participation in the Plan is voluntary and thus Boards would appear to be free to drop out of the Plan to achieve cost savings. However, once again, this decision may require negotiations and the agreement of the union. Decisions by the Public Employment Relations Commission hold that an employer cannot unilaterally change insurance

carriers if the change reduces, in any way, the level of existing benefits. Thus, reductions in part-time eligibility, tiered coverage, incentives for nonenrollment for duplicate coverage and increased deductibles and copays must receive union approval. Maintenance of existing levels of benefits is, understandably, a high priority of unions in negotiations. However, boards' desires to achieve cost containment in an environment that offers employer options is also understandable--and boards have been successful in negotiating changes to private carriers.

Yet, many boards do not have the option to change carriers. Boards with 50 or less employees have traditionally had great difficulties in obtaining coverage from private carriers. It has been estimated that approximately 200 boards employ less than 50 people; thus one-third of New Jersey's local boards are likely to have great difficulty obtaining an alternate carrier. Somewhat larger districts who could obtain coverage run into difficulty because they are unable to obtain their employee's utilization rate from the State Plan.

Therefore, the option to switch to private carriers had been realistically open to larger districts that could insure a group of more than 100 employees. For smaller districts, the long term risks of leaving the Plan in search of an immediate reduction in costs is high--as the rules of the Plan prohibit an employer from returning to participation in the State group for five years. So many boards have little or no choice and continue, with great frustration, to accept the Plan's inflexible rules and its concurrent inflated local costs.

School boards are therefore searching for assistance in controlling their insurance costs. The rules of the State Plan are established by statutes and regulations and can only be changed by legislative action. We believe that the time is ripe for the legislature to reconsider the outmoded and expensive structure of the Plan that affects the cost of all employment in public schools and in all other aspects of public employment in New Jersey.

While the emphasis is currently on the health care costs, the continuous increases related to increasing public employee pension benefits cannot be ignored as the ultimate obligation falls on the taxpayer. NJSBA's December 1991 Delegate Assembly authorized the establishment of an Ad Hoc Pension Committee made up of board members and staff who have been meeting all winter and who will release their report at the June 1992 Delegate Assembly. The committee was given the following charge:

- To study and publicize the procedures of school employees' pension systems, and their actual and projected costs;
- To identify effective management controls and means for containing the costs of pension systems; and
- To examine, and if indicated, to recommend new approaches to provide fiscally-sound pension systems for school employees.

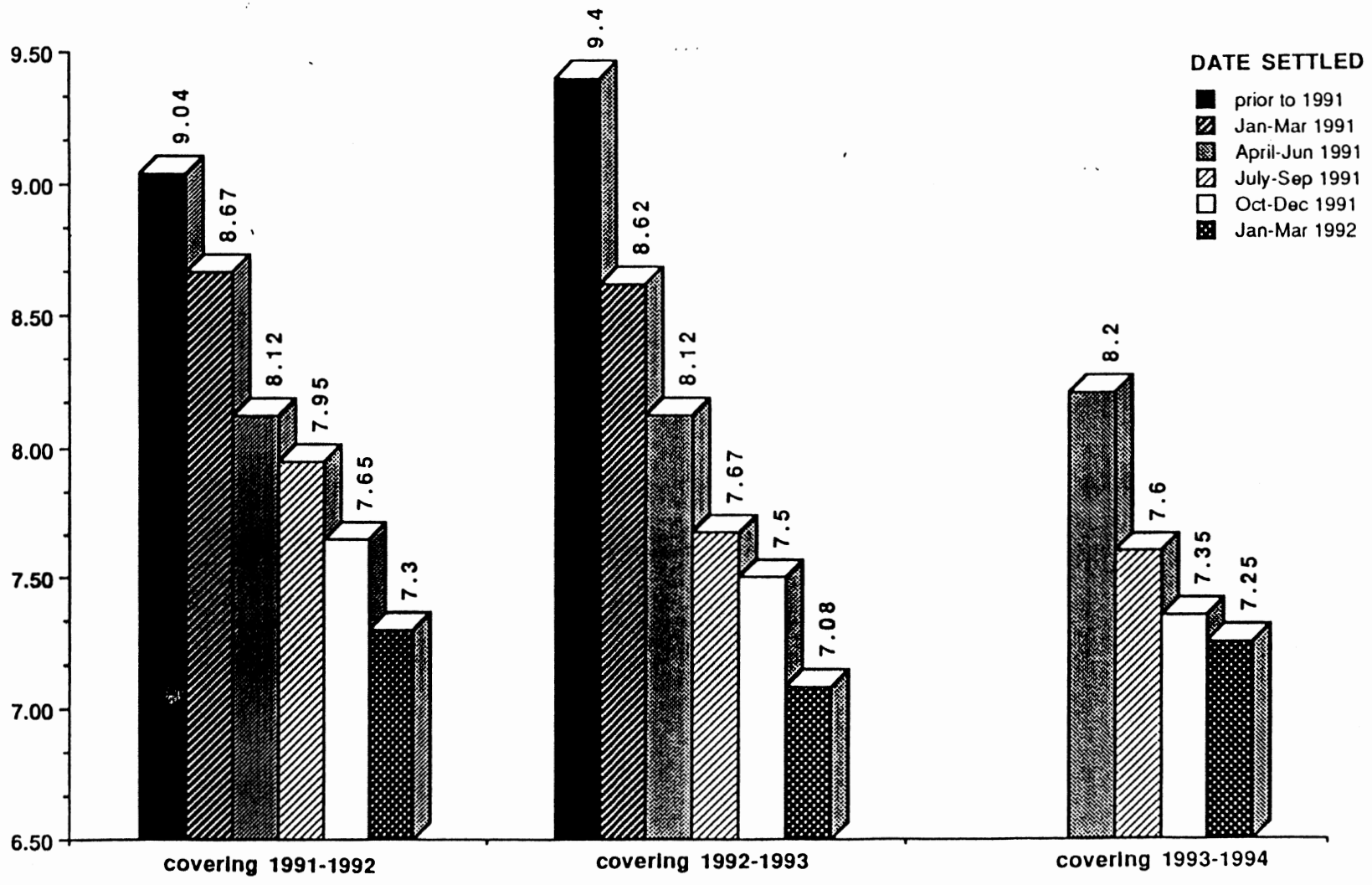
NJSBA will share this completed report with the New Jersey Legislature and hopes that the research which we have conducted will be helpful in the ongoing discussion about employee benefits. Moreover, NJSBA has been continuously testifying in opposition to various pension enhancement bills for public employees and attached is a position statement on a current pension and health benefit bill which NJSBA strongly opposes (see Attachment B).

NJSBA urges this committee and the legislature to seriously consider the long-term, as well as short-term implications of these type of bills and oppose them. Our concerns with these increasing employer costs of maintaining and providing employees' defined retirement benefits are real, and we feel that this is diverting state money for the support of public schools to teachers' pensions rather than to the education of our students.

ATTACHMENT A

X8

Quarterly Settlement Rate Trends 1991-1992



DATE PRINTED 04/02/92

DISTRICTS WHOSE CONTRACTS WERE SETTLED IN 1991 OR 1992
ALL NEW JERSEY
BY SETTLEMENT DATE

Settlement Rate Data
1991-92/ 1992-93/ 1993-94

		WHEN SETTLED QTR	MO/YR	YRS COV FR-TO	PERCENT INCREASE 1991-92	DOLLAR INCREASE 1991-92	PERCENT INCREASE 1992-93	DOLLAR INCREASE 1992-93	PERCENT INCREASE 1993-94	DOLLAR INCREASE 1993-94
1991 QUARTER 1										
ATLANTIC	HAMMONTON	1	1-91	91-93	8.90	$3,184	8.90	$3,467		
BERGEN	BOGOTA	1	1-91	90-93	8.90	$3,129	8.90	$3,408		
MIDDLESE	HIGHLAND PARK	1	1-91	90-92	7.88	$3,358				
MIDDLESE	SOUTH AMBOY	1	1-91	90-93	8.70		8.70			
BERGEN	FAIRVIEW	1	2-91	89-92	8.50					
BERGEN	TEANECK	1	2-91	90-93	8.00		7.90			
BURLINGT	NORTH HANOVER	1	2-91	90-93	9.80		9.00			
CUMBERLA	BRIDGETON	1	2-91	90-93	10.00	$3,135	10.00	$3,450		
HUNTERDO	HOLLAND TWP	1	2-91	90-92	8.00					
MONMOUTH	MANASQUAN	1	2-91	90-93	8.50	$2,500	8.25	$2,500		
MONMOUTH	RED BANK REG	1	2-91	90-93	8.50	$3,258	8.00	$3,327		
MONMOUTH	KEYPORT	1	3-91	90-93	8.50	$3,076	8.00	$3,141		
MONMOUTH	MARLBORO TWP	1	3-91	90-92	8.60					
SUSSEX	KITTATINNY REG	1	3-91	90-92	8.30	$3,323				
UNION	GARWOOD	1	3-91	90-93	9.00	$2,858	8.50	$2,943		
1991 QUARTER 1 AVERAGE					**8.67**	**$3,091**	**8.62**	**$3,177**		
NUMBER COUNTED					15	9	10	7		
1991 QUARTER 2										
CAMDEN	BERLIN TWP	2	4-91	91-92	8.00					
MONMOUTH	WEST LONG BRANC	2	4-91	91-94	8.35	$3,262	8.30	$3,442	7.40	$3,326
MORRIS	BUTLER	2	4-91	90-93	7.25	$2,924	7.25	$3,136		
SALEM	LOWER ALLOWAYS	2	4-91	90-92	8.00					
SALEM	UPPER PITTSGROV	2	4-91	90-93	8.25		8.00			
SUSSEX	NEWTON	2	4-91	91-92	6.30	$2,484				
UNION	BERKELEY HEIGHT	2	4-91	91-94	7.99	$3,435	7.99	$3,709	7.99	$4,006
UNION	ELIZABETH	2	4-91	90-93	8.00		8.00			
UNION	SPRINGFIELD	2	4-91	91-93	7.75	$3,457	7.75	$3,725		
UNION	SUMMIT	2	4-91	91-93	8.20	$3,571	8.20	$3,866		
ATLANTIC	ESTELL MANOR	2	5-91	90-94	8.75		8.75		8.75	
ATLANTIC	WEYMOUTH TWP	2	5-91	91-95	9.00		9.00		9.00	
BERGEN	HILLSDALE	2	5-91	91-94	8.00	$3,947	6.95	$3,677	5.50	$3,133
BERGEN	HO-HO-KUS	2	5-91	91-93	7.30	$3,101	7.80	$3,651		
BERGEN	MONTVALE	2	5-91	91-93	8.10	$3,743	7.95	$3,971		
CAMDEN	BLACK HORSE PIK	2	5-91	91-93	8.73	$3,122	8.74	$3,398		
CUMBERLA	SHILOH	2	5-91	91-92	8.30	$2,073				
GLOUCEST	FRANKLIN TWP	2	5-91	91-94	8.90		8.50		8.50	
GLOUCEST	WASHINGTON TWP	2	5-91	91-94	9.00		9.00		8.50	
MIDDLESE	NO BRUNSWICK	2	5-91	91-94	8.50	$3,078	8.50	$3,349	8.50	$3,621
MONMOUTH	RUMSON F-HAVEN	2	5-91	90-92	7.70	$3,200				
MORRIS	HARDING TWP	2	5-91	90-93	8.30		7.85			

		WHEN SETTLED QTR	MO/YR	YRS COV FR-TO	PERCENT INCREASE 1991-92	DOLLAR INCREASE 1991-92	PERCENT INCREASE 1992-93	DOLLAR INCREASE 1992-93	PERCENT INCREASE 1993-94	DOLLAR INCREASE 1993-94
EAN	OCEAN GATE	2	5-91	90-92						
EAN	SEASIDE HEIGHTS	2	5-91	90-92	8.00	$2,312				
EAN	TOMS RIVER SCHO	2	5-91	91-94	8.50		8.50		8.50	
SSEX	HAMPTON	2	5-91	91-93	8.00		8.00			
SSEX	STANHOPE	2	5-91	90-93	8.70		8.10			
ION	KENILWORTH	2	5-91	90-93	8.25		8.00			
ION	UNION VOC	2	5-91	90-93	9.00		9.00			
RGEN	BERGEN SP SRV	2	6-91	91-92						
RGEN	RIDGEFIELD	2	6-91	91-93	8.00		7.00			
RLINGT	BURLINGTON VOC	2	6-91	91-93	8.00	$2,832	8.00	$3,050		
RLINGT	PEMBERTON TWP	2	6-91	91-94	8.50	$2,822	8.25	$2,973	8.50	$3,315
RLINGT	SPRINGFIELD	2	6-91	91-93	8.50		8.00			
SEX	BLOOMFIELD	2	6-91	90-92	7.50	$3,110				
SEX	NUTLEY	2	6-91	91-94	8.50	$3,403	8.47	$3,525	8.43	$3,716
OUCEST	GLOUCESTER VOC	2	6-91	91-94	10.00		12.00		10.00	
OUCEST	HARRISON TWP	2	6-91	91-93	9.50		8.50			
RCER	W.WINDSOR PBORO	2	6-91	91-93	8.00		7.90			
DDLESE	JAMESBURG	2	6-91	90-93	7.50		6.50			
MOUTH	COLTS NECK TWP	2	6-91	91-93	8.00	$3,175	8.00	$3,445		
MOUTH	HIGHLANDS BOROU	2	6-91	91-93	8.20		8.00			
MOUTH	SPRING LAKE HTS	2	6-91	91-94	8.30		8.40		8.50	
RRIS	EAST HANOVER	2	6-91	90-92	8.20					
RRIS	RIVERDALE	2	6-91	91-93	7.50	$2,070	7.50	$2,234		
EM	MANNINGTON	2	6-91	90-93	8.25		8.25			
SSEX	LENAPE VALLEY R	2	6-91	91-93	9.20		9.00			
SSEX	SUSSEX-WANTAGE	2	6-91	91-93	6.50		7.00		7.50	
ON	UNION CO REG	2	6-91	91-93	8.20	$3,186	8.00	$3,317		
RREN	BLAIRSTOWN	2	6-91	91-93	6.50		7.00			
RREN	NORTH WARREN RE	2	6-91	91-94	4.91		6.50		7.50	
91 QUARTER 2 AVERAGE					8.10	$3,062	8.11	$3,404	8.20	$3,520
MBER COUNTED					49	21	41	16	15	6
91 QUARTER 3										
PE MAY	WILDWOOD CREST	3	7-91	91-94	9.80		9.50		9.30	
RRIS	MOUNT ARLINGTON	3	7-91	91-94	7.50		7.90		7.95	
RREN	FRELINGHUYSEN	3	7-91	91-93	7.90		7.30	$2,481		
RGEN	ALPINE	3	8-91	91-93	8.00	$3,172	8.00	$3,425		
DEN	HADDONFIELD	3	8-91	91-93	9.50	$3,209	9.50	$3,569		
PE MAY	CAPE MAY SP SRV	3	8-91	90-93	8.85		8.50			
SEX	NORTH CALDWELL	3	8-91	91-94	8.50	$3,387	7.25	$3,127	7.00	$3,239
RCER	EAST WINDSOR RE	3	8-91	91-94	8.20	$2,886	7.80	$2,971	7.80	$3,202
EM	SALEM VOC	3	8-91	91-94	7.49	$2,000	7.49	$2,150	7.20	$2,250
RREN	BELVIDERE	3	8-91	91-92	7.93	$2,800				
RREN	WASHINGTON TWP	3	8-91	90-93						
ANTIC	MAINLAND REGION	3	9-91	91-93	8.90		6.50			
RGEN	CARLSTDT E.RUTH	3	9-91	91-93	8.50	$3,688	8.00	$3,834		
RGEN	GLEN ROCK	3	9-91	91-92	7.97	$3,854				
RGEN	HACKENSACK	3	9-91	91-94	7.90		7.50		7.20	
RGEN	OLD TAPPAN	3	9-91	91-93	7.50					
RGEN	PARK RIDGE	3	9-91	90-93	7.65	$3,692	6.85	$3,572		
RLINGT	CINNAMINSON	3	9-91	91-93	7.00	$2,808	7.00	$2,986		
RLINGT	DELANCO	3	9-91	91-94	9.00		8.50		8.50	
RLINGT	DELRAN	3	9-91	91-93	7.00		7.00			

		WHEN SETTLED QTR	MO/YR	YRS COV FR-TO	PERCENT INCREASE 1991-92	DOLLAR INCREASE 1991-92	PERCENT INCREASE 1992-93	DOLLAR INCREASE 1992-93	PERCENT INCREASE 1993-94	DOLLAR INCREASE 1993-94
BURLINGT	WILLINGBORO	3	9-91	90-93	6.00		6.00			
CAMDEN	CAMDEN VOC	3	9-91	91-92	8.50					
CAMDEN	EASTRN CAM CO R	3	9-91	91-93	8.25	$3,128	7.60	$3,128		
CAMDEN	GLOUCESTER TWP	3	9-91	91-93	8.50		8.50			
CAMDEN	HADDON TWP	3	9-91	91-94	8.40	$2,979	8.00	$3,082	7.80	$3,253
CAPE MAY	LOWER CAPE MAY	3	9-91	91-93	8.00	$3,006	6.70	$2,722		
CUMBERLA	MILLVILLE	3	9-91	91-94	6.10		6.90		8.30	
ESSEX	FAIRFIELD	3	9-91	91-94	6.90		6.50		6.40	
ESSEX	LIVINGSTON	3	9-91	91-93	7.30		7.00			
ESSEX	MONTCLAIR	3	9-91	91-93	7.80		8.00			
ESSEX	NEWARK	3	9-91	91-94	8.05					
GLOUCEST	SO GLOUC CO REG	3	9-91	91-94	9.00		8.20		8.00	
HUDSON	BAYONNE	3	9-91	91-94	9.10		9.00		8.30	
HUNTERDO	LEBANON BORO	3	9-91	91-94	7.20	$2,465	7.80	$2,858	6.30	$2,484
MERCER	EWING	3	9-91	91-94	7.50	$2,953	7.50	$3,174	7.50	$3,418
MONMOUTH	FAIR HAVEN	3	9-91	91-94	8.00	$3,019	7.50	$3,057	7.50	$3,286
MONMOUTH	KEANSBURG	3	9-91	90-93	7.75		8.25			
MONMOUTH	MATAWAN ABERD R	3	9-91	91-94	7.60		7.50		7.00	
MORRIS	MORRIS PLAINS	3	9-91	90-93	7.75		7.25			
MORRIS	PARSIP-TROY HIL	3	9-91	91-93	7.50	$3,375	7.50	$3,605		
OCEAN	BRICK TWP	3	9-91	91-94	8.00		8.00		8.00	
OCEAN	PLUMSTED	3	9-91	91-94	8.10		7.90		7.00	
SALEM	WOODSTOWN PILSG	3	9-91	91-94	7.90		7.60		7.30	
UNION	WESTFIELD	3	9-91	91-93	7.70	$3,362	7.50	$3,527		
WARREN	HOPE	3	9-91	91-92	8.44	$2,850				
WARREN	INDEPENDENCE	3	9-91	91-92	8.40	$2,921				
WARREN	KNOWLTON	3	9-91	91-92	6.70					
1991 QUARTER 3 AVERAGE					7.95	$3,078	7.67	$3,133	7.60	$3,019
NUMBER COUNTED					46	20	38	17	19	7
1991 QUARTER 4										
ATLANTIC	LINWOOD	4	10-91	91-94	9.00	$3,239	8.50	$3,335	8.00	$3,405
BERGEN	NORTH ARLINGTON	4	10-91	91-94			7.00	$2,990	6.80	$3,108
BERGEN	NORTHVALE	4	10-91	91-93	7.50		7.00			
BERGEN	RIVER EDGE	4	10-91	91-93	7.90	$2,966	7.70	$3,050		
BURLINGT	BURLINGTON TWP	4	10-91	91-94	7.40		7.40		5.80	
BURLINGT	LENAPE REG	4	10-91	91-93	8.42	$3,100	8.38	$3,346		
BURLINGT	MANSFIELD	4	10-91	91-93	7.60	$2,600	7.36	$2,700		
CAMDEN	BARRINGTON	4	10-91	91-93	7.80		7.50			
CAMDEN	LAWNSIDE	4	10-91	91-93	8.00	$2,464	8.00	$2,661		
CAPE MAY	WOODBINE	4	10-91	91-94	8.50		8.00		8.50	
ESSEX	CALDWELL- W.CDW	4	10-91	91-94	7.50		7.10		7.00	
ESSEX	EAST ORANGE	4	10-91	91-94	7.91		7.91		7.91	
GLOUCEST	LOGAN TWP	4	10-91	91-93	10.00	$2,800	8.80			
HUNTERDO	CLINTON TOWN	4	10-91	91-93	8.50	$2,942	8.50	$3,189		
MERCER	HAMILTON TWP	4	10-91	91-94	7.50		7.50		7.50	
MERCER	WASHINGTON TWP	4	10-91	91-93	7.95	$2,572	7.95	$2,776		
MIDDLESE	SOUTH RIVER	4	10-91	91-94	7.00		7.00		7.00	
MONMOUTH	HENRY HUDSON RE	4	10-91	91-93	7.50		7.50			
MONMOUTH	LITTLE SILVER	4	10-91	91-94	7.71	$2,628	7.80	$2,816	7.70	$2,993
MONMOUTH	NEPTUNE TWP	4	10-91	91-94						
MONMOUTH	SHREWSBURY BORO	4	10-91	90-92	8.00					
MORRIS	MONTVILLE	4	10-91	91-93	7.00	$2,744	7.00	$2,844		

		WHEN SETTLED QTR	MO/YR	YRS COV FR-TO	PERCENT INCREASE 1991-92	DOLLAR INCREASE 1991-92	PERCENT INCREASE 1992-93	DOLLAR INCREASE 1992-93	PERCENT INCREASE 1993-94	DOLLAR INCREASE 1993-94
N	SEASIDE PARK	4	10-91	91-93						
AIC	WEST MILFORD	4	10-91	91-94	8.60	$3,575	8.20	$3,685	7.60	$3,695
RSET	BOUND BROOK	4	10-91	91-93	7.99	$3,210	7.47	$3,240		
EX	ANDOVER REG	4	10-91	91-93	7.00		7.00			
EN	LIBERTY	4	10-91	91-94	8.00					
NTIC	EGG HARBOR CITY	4	11-91	91-93	7.50		7.50			
EN	DUMONT	4	11-91	91-93	7.30	$3,292	6.90	$3,338		
EN	RIVER DELL REG	4	11-91	91-94	7.00	$3,089	7.00		6.50	
EN	ROCHELLE PARK	4	11-91	91-93	7.50		7.50			
EN	RUTHERFORD	4	11-91	91-94	6.70	$2,087	7.20	$3,387	7.70	$3,343
INGT	BASS RIVER	4	11-91	91-93	8.40	$2,029				
EN	COLLINGSWOOD	4	11-91	91-93	7.00	$2,423	7.00	$2,593		
EN	MAGNOLIA	4	11-91	91-94	8.00		7.00		7.00	
EN	WOODLYNNE	4	11-91	91-93	8.00		7.50			
MAY	AVALON	4	11-91	91-94	8.03	$3,000	7.69	$3,100	7.02	$3,050
X	WEST ESSEX REG	4	11-91	91-94	8.00	$3,200	7.50	$3,240	7.25	$3,364
ON	HARRISON	4	11-91	91-94	8.10		8.10		8.10	
ERDO	FLEMGTN RARITAN	4	11-91	91-93	7.99	$3,024	7.50	$3,060		
ER	TRENTON	4	11-91	91-94	6.00		7.20		7.20	
OUTH	FREEHOLD REG	4	11-91	91-94	8.25		8.25		8.00	
OUTH	HAZLET TWP	4	11-91	91-94	7.80		7.50		7.10	
IS	WEST MORRIS REG	4	11-91	91-94	7.50		6.20		5.80	
N	LAKEWOOD	4	11-91	91-93	6.50		7.50			
M	QUINTON	4	11-91	91-92	8.00					
EX	HIGH POINT REG	4	11-91	91-94	7.00		7.25		7.50	
EN	HACKETTSTOWN	4	11-91	91-93	6.50		7.90			
EN	WARREN HILLS RE	4	11-91	91-93	6.80		6.30			
EN	HASBROUCK HEIGH	4	12-91	91-94	7.50		7.25		7.00	
EN	HAWORTH	4	12-91	91-93	8.96		8.56			
EN	RAMSEY	4	12-91	91-93	7.00	$3,398	6.90	$3,584		
EN	RIDGEFIELD PARK	4	12-91	91-93	7.50		7.00			
EN	OAKLYN	4	12-91	91-93	8.00		8.25			
LESE	OLD BRIDGE	4	12-91	91-94	7.50		7.50		7.50	
OUTH	MANALAPAN ENG T	4	12-91	91-94	7.10		7.90		7.70	
IS	CHATHAMS, S.D.	4	12-91	91-93	6.95		6.90			
N	LONG BEACH ISLA	4	12-91	91-94	7.90		7.60		7.30	
AIC	PASSAIC CITY	4	12-91	91-94	6.19	$2,692	7.30	$3,240	8.50	$4,045
M	PNS GRV CRNY PT	4	12-91	91-94	7.00					
N	HILLSIDE	4	12-91	91-93	7.00		7.00			
N	WINFIELD	4	12-91	91-93	7.77	$2,453	7.00	$2,382		
QUARTER 4 AVERAGE					**7.64**	**$2,849**	**7.49**	**$3,074**	**7.35**	**$3,375**
ER COUNTED					59	23	55	21	26	8
QUARTER 1										
EN	LEONIA	1	1-92	91-93	5.48		5.40			
EN	TENAFLY	1	1-92	91-93	7.25		6.90			
EN	WALLINGTON	1	1-92	91-93	8.50		8.50			
X	ROSELAND	4	1-92	91-94	7.90	$3,184	7.50	$3,166	7.25	$3,162
LESE	SPOTSWOOD	1	1-92	91-93	7.50	$2,557	6.00	$2,199		
OUTH	RUMSON	1	1-92	91-93	7.00	$3,000	7.30	$3,100		
IS	HANOVER PARK RE	1	1-92	91-93	7.25	$3,225	7.00	$3,339		
IS	MOUNT OLIVE	1	1-92	90-92						
EX	STILLWATER TWP	1	1-92	91-94	7.70		7.60		7.50	

		WHEN SETTLED QTR	MO/YR	YRS COV FR-TO	PERCENT INCREASE 1991-92	DOLLAR INCREASE 1991-92	PERCENT INCREASE 1992-93	DOLLAR INCREASE 1992-93	PERCENT INCREASE 1993-94	DOLLAR INCREASE 1993-94
WARREN	HARMONY	1	1-92	91-93	8.00		8.00			
SALEM	SALEM CITY	1	3-92	91-94	7.00		7.00		7.00	
1992 QUARTER 1 AVERAGE					**7.36**	**$2,992**	**7.12**	**$2,951**	7.25	$3,162
NUMBER COUNTED					10	4	10	4	3	1
RECENT STATE AVERAGE					**7.91**	**$3,002**	**7.75**	**$3,174**	7.62	$3,292
NUMBER COUNTED					179	77	154	65	63	22

New Jersey
School Boards Association

Headquarters: 413 West State Street, P.O. Box 909, Trenton, New Jersey 08605
Telephone (609) 695-7600 Fax 609-695-0413

POSITION STATEMENT

A-1136 (Heck)/S-455 (Palaia)

STATE PAID HEALTH BENEFITS FOR RETIRED SUPPORT STAFF PERSONNEL EMPLOYED BY LOCAL BOARDS OF EDUCATION

The New Jersey School Boards Association strongly opposes A-1136/S-455, which would provide state paid health benefits to all eligible PERS retirees who were employed by local boards of education and county colleges.

This bill is a state mandate that asks the public to write a blank check. This is completely inappropriate at a time when the state is in a fiscal crisis. Recent changes in QEA require our local boards to meet contractual obligations for salaries and related benefits by reducing programs, laying off staff, or seeking waivers which pass on the increasing costs to the local property taxpayers.

There are many significant problems with this legislation which must be given serious consideration and cannot be ignored. These include:

- additional mandated costs of public employment: Last year, it was estimated that this mandate would cost approximately $6 million and there are no updated figures for these costs, at a time when the state budget is in a major deficit. In establishing a fiscal note on this bill, it is essential to obtain the following information: How many school employees would become eligible for this benefit? How many would become eligible for this benefit in 1993? 1994? In the next ten years? The total number of affected employees will increase every year as will the costs to the state and ultimately--the New Jersey taxpayer.

- future costs to the state: While this bill would be limited to school and county college employees, it can be expected that municipal and county employees will seek similar benefits. For many years, retired state employees have received state paid insurance coverage after 25 years of service. This fact became a persuasive argument used by the NJEA to extend coverage teaching retirees. Can it be expected that the Legislature will then turn its back on the "me too" demands of other public employees? This predictable expansion will place a severe drain on the state treasury that will eventually affect all public services and the level of taxation.

-over-

- impact on the ratio of retirees and active employees on SHBP premiums: An influx of new participants in the SHBP program would result in an across-the-board increase in all premiums. Health insurance costs are already skyrocketing. This increase does not represent increased or improved benefits, but simply reflects greater usage, higher costs of medical care, and extended coverage to retirees. Is it coincidental that SHBP premiums in the four years after TPAF extension increased by 66 percent whereas in the four years prior they increased by 19 percent? This huge increase in health insurance costs further taxes our ability to provide a quality education system and presents a perpetual increase in the cost of public employment.

- the money could be better spent on direct programs for children: If there is additional money to spend, it should be spent on direct instructional programs that help children such as more classroom teachers, guidance counselors, and AIDS education, not on fringe benefits for employees. These fringe benefits for employees will continually divert public funds from needed educational services.

In light of the huge fiscal deficit, the state is attempting to reexamine all its existing costs. It has particularly focused on means to reduce the costs of employment in all portions of the public sector. This bill flies in the face of the state's attempts to reduce and control costs.

Resisting new mandated costs of employment is particularly critical at a time when the State of New Jersey is seeking solutions to address the current budget deficit and to avoid future drains on public resources.

Therefore, NJSBA strongly urges opposition to A-1136/S-455.

This is the wrong bill at the wrong time.

STATE HEALTH BENEFIT PLAN PREMIUMS
(Traditional Plan)

	1981-82	1982-83	1983-84	1984-85	1985-86	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	Inc.
Single	$ 373.44	$ 487.56	$ 641.76	$ 703.44	$ 703.44	$ 764.88	$ 845.00	$1092.36	$1381.56	$1732.44	$2214.48	= 493%
Parent/Child	568.08	740.04	970.68	1061.64	1061.64	1152.48	1266.24	1639.32	2040.48	2558.40	3243.60	= 470%
Husband/Wife	849.84	1103.04	1450.32	1587.48	1587.48	1723.08	1890.96	2449.92	3072.84	3856.08	4863.72	= 472%
Family	927.12	1211.40	1598.28	1749.36	1749.36	1900.32	2095.08	2709.12	3576.96	4486.56	5675.64	= 512%

SHBP PREMIUMS AS PERCENT
OF AVERAGE TEACHERS' SALARIES
ON BA COLUMN OF SALARY GUIDES

	1981-82	1990-91
SHBP Rates		
Single:	$373.44	$1,732.44
Family:	$927.12	$4,486.56
BA Minimum	$12,219	$24,572
Single Premium:	3.1% of salary	7.1% of salary
Family Premium:	7.6% of salary	18.3% of salary
BA Maximum	$21,750	$41,826
Single Premium:	1.7% of salary	4.1% of salary
Family Coverage:	4.3% of salary	10.7% of salary

6585H

SELECTED DISTRICTS' PREMIUMS WITH PRIVATE
INSURANCE CARRIERS

1990-91 SHBP rates: Single: $1,732.44
Family: 4,486.56

County	District	Carrier	Single*	Family*
Burlington	Evesham	BC/BS of PA	$1,251.84	$3,384.48
Camden	Voorhees	BC/BS of PA	$1,220.00	$3,365.00
Hudson	Harrison	Conn. General	$1,357.66	$3,883.08
Mercer	East Windsor	Conn. General	$1,614.72	$3,913.68
Middlesex	No. Brunswick	Conn. General	$1,555.68	$3,935.64

*Rates effective July 1, 1990

(As per NJEA Research Bulletin A0-61, June 1991)

6585H

DISTRICT		HEALTH INSURANCE: EFFECTIVE DATE	CARRIER/PLAN (State Plan*): BASIC (Hospital and Medical Surgical)	MAJOR MEDICAL	ANNUAL PREMIUM (Regardless of amt. paid by board) E+ 1	ANNUAL PREMIUM (Regardless of amt. paid by board) D+ 1	MAXIMUM AMOUNT PAID BY BOARD+ 2	DENTAL: CARRIER	ANNUAL PREMIUM (Regardless of amt. paid by board) E+ 3	ANNUAL PREMIUM (Regardless of amt. paid by board) D+ 3
▷MORRIS (cont.)										
NETCONG		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	$245.00	$ 783.00
PRSPNY-TROY HLS		7/90	------Connecticut General-----		$1,416.72	$4,826.64	100% E & D	Connecticut General	330.96	1,120.68
PASSAIC		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	256.56	677.52
PEQUANNOCK		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	211.92	----
RANDOLPH		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	314.76	823.92
RIVERDALE	(0)	*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	437.28	----
ROCKAWAY BORO		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	247.20	720.60
ROCKAWAY TWP		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	190.92	576.60
ROXBURY		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	428.16	428.16
WASHINGTON	(0)	7/90	Blue Cross/Blue Shield/Rider J		1,961.28@	4,753.68@	100% E & D	Delta Dental of N.J.	616.94	616.94
WEST MORRIS REG		7/90	Blue Cross/Blue Shield/Rider J		1,807.80	5,129.40	55% E & D	Connecticut General	193.80	566.88
WHARTON		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	138.84	----
▷OCEAN										
BARNEGAT	(0)	8/90	Blue Cross/Blue Shield/Rider J		1,569.00	4,740.00	100% E & D	Delta Dental of N.J.	210.48	609.60
BAY HEAD	(0)	*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	312.00	----
BEACH HAVEN	(0)	*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	308.64	----
BERKELEY		11/90	Blue Cross/Blue Shield/Rider J		1,564.92	4,518.72	100% E & D	Connecticut General	178.08	556.80
BRICK		7/90	------Connecticut General-----		986.40	2,872.80	100% E & D	Connecticut General	270.24	666.60
CENTRAL REG	(0)	9/90	------Connecticut General-----		1,186.80@	3,378.00@	100% E & D	Connecticut General	171.36	458.76
EAGLESWOOD		*	----------State Plan----------		*	*	100% E & D	----	----	----
ISLAND HEIGHTS	(0)	*	----------State Plan----------		*	*	100% E & D	Connecticut General	172.44	514.80
JACKSON		7/90	Blue Cross/Blue Shield/Rider J		----	----	100% E & D	Delta Dental of N.J.	----	----
LACEY		*	----------State Plan----------		*	*	100% E & D	Connecticut General	215.40	639.24
LAKEHURST		*	----------State Plan----------		*	*	100% E & D	Connecticut General	118.08	350.64
LAKEWOOD	(0)	7/90	------Connecticut General-----		1,972.68	5,312.16	100% E & D	Connecticut General	339.48	911.76
LAVALLETTE		12/90	----------Travelers----------		2,884.56@	7,148.76@	100% E & D	Travelers	@	@
LITTLE EGG HRBR		4/90	------Connecticut General-----		1,867.32	5,316.00	100% E & D	Connecticut General	377.28	377.28
LONG BEACH IS	(0)	*	----------State Plan----------		*	*	100% E & D	Connecticut General	----	----
MANCHESTER	(0)	5/90	Blue Cross/Blue Shield/Rider J		1,515.72	4,054.56	100% E & D	Delta Dental of N.J.	186.00	540.48
OCEAN CO VOC		*	----------State Plan----------		*	*	100% E & D	Blue Shield	----	----
OCEAN GATE		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	199.08	552.84
OCEAN TWP		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	238.80	676.08
PINELANDS REG		*	----------State Plan----------		*	*	100% E & D	Delta Dental of N.J.	385.00	385.00
PLUMSTED		*	----------State Plan----------		*	*	100% E & D	Hartford Dental	238.20	331.08
PT PLEASANT	(0)	7/90	Blue Cross/Blue Shield/Rider J		1,642.20	4,060.56	100% E & D	Delta Dental of N.J.	348.12	865.92
PT PLEASANT BCH		*	----------State Plan----------		*	*	100% E & D	Connecticut General	----	----

* - N.J. State Health Benefits (State Plan) - see pages 6 and 7.

(0) - Optical plan in effect - See Part II

Group Insurance Plans

Health, Dental, Prescription, Optical

1990-91 Edition

School Districts & County Colleges

NJEA RESEARCH

20X

Circular A0-61/June 1991

Pennsauken, Camden

ARTICLE XV — INSURANCE PROTECTION

A. The Board of Education will provide, at no cost to the teachers, New Jersey Blue Cross/Blue Shield, PACE coverage and Major Medical, including family and dependents as defined and provided by the Plans, or substantially equivalent coverage. There shall be no duplication of this coverage. For example, if a teacher's spouse has equivalent thereof, either for himself, herself and/or dependents, the Board will not be required to duplicate and the teacher shall not be eligible hereunder for such coverage. Any teacher who applies for such duplicate coverage shall be required to reimburse the Board for the difference between the cost of the individual and family coverage.

West Morris Regional, Morris

II. For 89-90

From July 1, 1989 through June 30, 1990, the Board agrees to pay a combined monthly rate for Medical, Dental and Prescription Plan coverage up to the sum of the amounts listed in lines a, b and c for specific coverage options. Should the cost exceed that sum, the employee will be responsible for any additional cost to be deducted from payroll beginning October 15, 1989.

		Single	P/C	Family
a.	Medical	$74.22	$157.78	$210.36
b.	Dental	13.55	39.65	39.65
c.	Prescription	14.28	38.08	38.08

III. For 90-91

From July 1, 1990 through June 30, 1991, the Board agrees to pay a combined monthly rate for Medical, Dental and Prescription Plan coverage up to the sum of the amounts listed in lines a, b and c for specific coverage options. Should the cost exceed that sum, the employee will be responsible for any additional cost to be deducted from payroll beginning October 15, 1990.

		Single	P/C	Family
a.	Medical	$83.13	$176.71	$235.60
b.	Dental	15.18	44.40	44.40
c.	Prescription	15.99	42.65	42.65

Woodbridge Twp., Middlesex

J. Insurance Waiver Option

Employees shall be offered the option of waiving all health insurance benefits as set forth in the Agreement. Any employee who executes an appropriate waiver provided by the Board will, for the school year to which the waiver applies, receive a lump sum check on the July 1 following conclusion of that school year in the amount of two thousand dollars ($2,000) for the family plan or twelve hundred dollars ($1,200) for the single plan. Once an employee makes an election to waive insurance coverage, s/he may not return at any time during that year. Employees hired during the year who elect not to take coverage shall have the above payments prorated.

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17:9-5.6 Health maintenance organization charges

For purposes of State and local coverage, the employee who pays any portion of the cost for the employee and for dependent coverage cannot pay any more for the same type of coverage if the employee enrolls himself or herself and his or her dependents in a health maintenance organization as an alternative program. If the cost of the coverage in the alternative plan exceeds the cost of the State program, the additional charge would be collected by payroll deductions from the employee.

As amended, R.1974 d.228, eff. August 19, 1974.
See: 6 N.J.R. 156(a), 6 N.J.R. 360(c).
As amended, R.1983 d.44, eff. March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).
The word "premiums" was changed to "charges" and "his" to "his or her".

17:9-5.7 State and local; multiple coverage refunds

In the case of State and local coverage, when a husband and wife have secured coverage in the health benefits program as a result of one of them being employed by the State and the other by a local employer who has adopted the program, a refund is possible in the case of an employee of a local employer who is paying the full cost of dependent coverage for a spouse, who is an employee of the State and eligible for coverage but who has rejected such coverage.

As amended, R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).

17:9-5.8 Medicare refunds

(a) Each active employee, as well as the employee's spouse, who is covered under Part B of the Federal Medicare program, shall receive a refund of the amount paid for Part B semiannually.

(b) All refunds for subgroups of the State are accomplished with the preparation and submission to the Health Benefits Bureau of a claim for refund form duly signed by the employee claiming the refund as verified from the records of the program.

(c) The State centralized payroll unit will process similar claims for refund by State employees paid by that agency.

(d) The local employer is responsible for refunds to any of his or her active employees, as well as the employee's spouse, who are covered under Part B of the Federal Medicare Program.

(e) All refunds will be made payable to the active or retired employee constituting the most timely charge payment for Part B coverage.

(f) Similar reimbursement will be made by the state and local employers, who have adopted the necessary resolution, to eligible retired

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employees for himself or herself and the retired employee's spouse, but in no event shall duplicate refunds be made to any employee for himself or herself or his or her spouse.

(g) Since Medicare premiums reimbursements are dependent upon sufficient, annual appropriations from the legislature, eligible reimbursements regarding Medicare Part B premiums will include only those premiums that have been paid within the 12 months immediately preceding the date of submission for the appropriate claim for refund form by the employee. Medicare Part B premiums paid prior to the 12 months immediately preceding the date of submission of the appropriate claim for refund form are not eligible for reimbursement.

As amended, R.1973 d.285, eff. October 2, 1973.
See: 5 N.J.R. 243(a), 5 N.J.R. 393(a).
As amended, R.1978 d.442, eff. December 26, 1978.
See: 10 N.J.R. 456(a), 11 N.J.R. 105(b).
As amended, R.1981 d.139, eff. June 4, 1981.
See: 13 N.J.R. 110(c), 13 N.J.R. 376(c).
(g) added.
As amended, R.1983 d.44, eff. March 7, 1983.
See: 14 N.J.R. 1293(b), 15 N.J.R. 343(b).
The word "premium" was changed to "charges" and "his" to "his or her".

17:9-5.9 Refunds rejected

Any request for refund not specified in N.J.A.C. 17:9-5.7 and 5.8 shall be denied. For example, a husband and wife many be employed in the same or in different locations, each location participating in the State Health Benefits Program and both having family coverage, or both having husband and wife coverage; in spite of the apparent duplication of coverage, neither of the covered employees would be eligible for a refund. Or, the wife carries only single employee coverage under the State program while her husband is covered by a plan in private industry where the employer pays for employee and dependent coverage; no refund would be payable since both would have to have been in public employment covered by the State program. Or, if one spouse applies for Medicare reimbursement for himself or herself and his or her spouse, the other shall not receive duplicate reimbursement.

As amended, R.1973 d.8, eff. January 4, 1973.
See: 4 N.J.R. 282(a), 5 N.J.R. 59(b).
As amended, R.1976 d.313, eff. October 8, 1976.
See: 8 N.J.R. 443(c), 8 N.J.R. 539(a).

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GOVERNOR'S MANAGEMENT REVIEW COMMISSION

COMPARATIVE STUDY OF TOTAL COMPENSATION

January 9, 1992

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REPORT TO THE GOVERNOR'S MANAGEMENT REVIEW COMMISSION

Comparative Study of Total Compensation

January, 1992

Submitted by

PSE&G
Gerald Clearwater

The Prudential
Charles Ardman
David Renz, F.S.A.

SONY Corporation
Thomas Huban

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GOVERNOR'S MANAGEMENT REVIEW COMMISSION
CN-001
Trenton, New Jersey 08625
609-777-1374

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GOVERNOR'S MANAGEMENT REVIEW COMMISSION

COMPARATIVE STUDY

OF

TOTAL COMPENSATION

This study combines the findings of the Operational Reviews of the "...State Compensation System" with those of "..Fringe Benefits". The purpose of this study is to develop an understanding of the total compensation of employees in the State of New Jersey. Our approach was to examine a sampling of Job Classifications that were identified to us as representative of the diverse population of approximately 71,000 active employees currently employed by the State. Our goal was to review specific positions through which we could give an understandable and realistic picture of the "typical" State employee.

The scope and structure of this review is designed to compare and contrast the major components of total compensation (direct and indirect) for active employees of the State of New Jersey with their peers in both the public and private sectors. We created our typical employees for each job class from what we learned in our previous efforts. In addition, a further analysis of participation trends and associated specific costs to the State for the spectrum of benefits available to State employees was undertaken. Through this process we developed an anecdotal approach to quantifying the total compensation system in New Jersey, i.e., the value of the direct and indirect compensation a State employee receives.

The job classifications we chose to typify represent two thirds of the 71,000 State employees and are as follows:

Classification	# Employees	% Employees
Clerical	**10,379**	**14.6%**
Professional	**12,428**	**17.5%**
Supervisory	**14,108**	**19.9%**
Mid Manager	**4,641**	**6.6%**
State Trooper	**2,539**	**3.6%**
Service Aide	**3,336**	**4.7%**

CASH (DIRECT) COMPENSATION

Overall, New Jersey pay levels for State employees is lagging the private sector by average of slightly less than 5% (4.7%). This determination was made using generally available published surveys and a sample size of 147 jobs covering 12,000 State employees. In gross terms, this position relative to the private sector is neither undesirable nor incompatible with an overall public employer compensation strategy. However, once one looks below the surface and examines the next level of detail, a number of incongruities become apparent.

The primary incongruity encountered is the range of State employee salaries around the average. The Compensation System Review quantified the range from +34.8% to -38.8%. In addition, the distribution of the salaries is not in a traditional bell curve across all (or most) job categories. Instead, the disparities occur in a job-by-job comparison with the private sector that result in some positions being grossly overpaid or underpaid relative to the competitive marketplace.

At this point, it is worth mentioning three of the most common types of positions that appear to be out of sync with the marketplace as well as contributing to the larger problem of the degree salaries range around the average.

- Clerical - pay lags the market by 5.6% but the deviation around the average ranges from +33.1% (overpaid) to -28.8% (underpaid).

- Technical - although survey data was limited, the anecdotal evidence indicates the State is paying over 12% above market rates.

- Professional - market lag is 5.5% but the dispersion around the average ranges from +23.1% to -30.0%.

While the above issues are important and need to be resolved as part of a long term, coordinated and coherent compensation strategy, it is not the objective of this document to propose solutions. Instead, the focus is on benchmarking. Expressed in a somewhat different fashion, we are looking at what is, not what can be. To this end, there were a number of compensation surveys reviewed, the results of which were included in the Compensation System Review. They are summarized below:

HOSPITAL COMPENSATION SURVEY

Managers and professionals in New Jersey were measured against a national sample of proprietary and non-profit institutions. The results showed New Jersey at an average of almost 5% below market.

MERCER SURVEY

New Jersey upper middle manager and professional salaries were very unfavorable measured against the private sector. Attorney compensation is especially non-competitive.

NORTH JERSEY SURVEY

State pay lags the sample in 13 of 15 professional comparisons by a weighted factor of slightly over 6%.

PORT AUTHORITY SURVEY

A comparison of the premium payers in the area, e.g., pharmaceuticals, utilities, media, major money center banks, etc. New Jersey clerical pay lags in 20 of 24 comparisons.

BUREAU OF LABOR STATISTICS SURVEY

New Jersey pay is competitive against central and southern private sector employers for clerical positions but lags northern by 13%.

AMERICAN MANAGEMENT SOCIETY SURVEY

This survey focuses on Trenton and Newark exclusively. Technical and clerical are significantly favorable in both areas. Professional comparisons are significantly unfavorable in both areas.

NON-CASH (INDIRECT) COMPENSATION

This category includes life, health and retirement benefits, paid holidays and vacations. While most of these indirect compensation categories readily lend themselves to being expressed as an average cost, we developed estimated pension costs both as a function of the age/sex/length of service characteristics of the specific employee examples we've used as well as developing an average cost for all employees. While the former approach may have legitimate use in other contexts, we felt that it was best to use a consistent, i.e., average, cost approach when developing our comparative cost tables. As such, the pension costs are also shown as an average instead of the "true" cost per individual that one would incur when purchasing an identical benefit in the private market.

While we have identified and included gross data relating to pension costs, paid holidays and vacations, our primary focus in this section will be on the costs associated with the SHBP health care coverage.

A survey by the Martin E. Segal Company of all State health benefit plans in 1990 showed all have experienced a sharp cost increase over the past three years. Measured relative to the medical component of the CPI, the Segal survey shows actual plan cost increases at the approximate rate of twice the increase in the CPI.

Year Ended January	CPI Medical Care Component	Average Cost All State Plans	Average Cost SHBP
1990	8.4%	15.7%	15.8%
1989	7.0%	20.6%	16.6%
1988	6.2%	13.2%	14.1%

A common basis of comparison of health plan costs is to measure on a per capita basis, i.e., the total cost divided by the number of active employees. The current New Jersey enrollment results of 30% of the employees having single coverage and 70% with family coverage are very similar to enrollment results nationally. This comparability allows for per capita comparisons to be made both with other State governments as employers as well as with private employers in various industries.

Note that in the following table, health care costs are adjusted to a "100% basis". The reason for this is that certain other specific public sector employers require employee contributions to the health plan. The SHBP essentially provides a fully paid benefit. Thus, the adjustment allows for a common basis of comparison. The costs in the following table are from both the Segal Survey (noted above) and the Foster Higgins Health Care Benefits Survey - 1990.

Category	Annual Cost to Employer	Cost Adjusted to 100% Basis	New Jersey Cost	100% Cost vs. New Jersey Cost
Public Sector				
New York (1)	$3,026	$3,648	$2,978	122.5%
Pennsylvania (2)	2,767	2,767	2,978	92.9%
Maryland (3)	2,456	3,697	2,978	124.1%
All Public Sector	(4)	3,239	2,978	108.8%
Private Sector				
Consumer Products	(4)	3,250	2,978	109.1%
Wholesale/Retail	(4)	2,494	2,978	83.7%
Utilities	(4)	4,363	2,978	146.5%
Insurance	(4)	3,180	2,978	106.8%

(1) State assumes 90% of employee cost, 82% of dependent cost

(2) State assumes 100% of all cost

(3) State assumes 66% of all cost

(4) Unknown

From a "snapshot" perspective, New Jersey's costs compared favorably with both the public and private sector. However, as the "Operational Review of Fringe Benefits" pointed out, the SHBP plan design and cost sharing realities are such that future increases will be significant and consistent. Two compelling examples of this forecast are (i) the actual increase in the SHBP plan costs in 1991 of almost 27% (aggregate) and (ii) a very early projection of the 1992 increase points to a magnitude in the high teens. If the 1992 cost projection holds true, the net result will be that the SHBP costs will have increased by approximately 50% between 1990 and 1992 making New Jersey's SHBP one of the most expensive public sector programs. Compared to average cost increases for similarly sized employers, the SHBP two year increases are significantly higher. As was highlighted in the original Fringe Benefit Study, this degree of cost escalation can be expected in the future unless fundamental changes are implemented in both design and funding. These types of changes would include requiring employees to contribute toward their coverage and to change some basic plan design features that currently encourage over utilization. Examples of the latter would be to implement a mandatory precertification of mental health benefits.

When viewed by size of workforce, the largest employers generated the highest per capita costs ($3,999). One reason for an almost 1:1 correlation between size of employer and per capita cost is that larger employers tend to offer richer benefit plan, e.g., including Rx drug coverage and dental.

Health benefit costs as a percentage of payroll for all employers averaged 10.8% nationally. Public sectors costs nationwide were higher than average (13.3%). Contributing to the differential is a generally lower cash compensation base (denominator) in the public

sector. The average of all public and private sector employers in the Mid-Atlantic region generate a benefit cost of 11.2% of payroll. When benefit costs as a percentage of payroll are measured against the size of the workforce, the largest employers (40,000+ employees) generate the smallest cost (9.0%).

Our final review was done from the perspective of benchmarking public sector employer costs with those businesses most likely to be competing with the State for employees. While we were unable to identify a survey that incorporated this approach from a New Jersey specific perspective, we believe that national and regional survey results can be extrapolated and reasonably applied to the New Jersey specific situation. We have chosen a comparison group to include consumer products, utilities, health services and financial services.

	Average Annual Cost Per Employee	**Health Program Cost as Percent of Payroll**
National Average	$3,217	10.8%
Public Sector	$3,239	13.3%
Consumer Products	$3,250	16.4%
Utilities	$4,363	12.0%
Health Services	$2,665	9.7%
Financial Services	$2,850	10.3%
New Jersey SHBP	$2,978	9.2%
Mid-Atlantic Region	$3,553	11.2%

We looked at data related to comparative pension costs and associated employer contributions and found that there were too many variables impacting both specific employer and industry sector results to produce a meaningful comparison. An employer's contribution in any one year may be affected by many factors, e.g., contributions to fully funded plans are not tax deductible and are subject to a 10% excise tax so affected employers would not make contributions in a given year. Generally speaking, we found that

almost half (49%) of all employers surveyed by The Wyatt Company in their 1990 Survey of Retirement and Capital Accumulation Plans made no contribution in the last plan year. Fifteen percent contributed between .01-2.99% of payroll and another 15% contributed between 3.00-4.99% of payroll. Ten percent contributed between 5.00-6.99% of payroll and eleven percent funded their plans at a level of 7.00% or more. We believe that the significant number of employers who made little or no contribution last year represent employers who realized significantly better investment results in the mid and late '80's than their actuarial assumptions contained. Contrast this with the costs to New Jersey last year and the recommendations made in the Fringe Benefit Review to consider more current portfolio management techniques and to involve outside investment expertise.

Paid leave (holidays and vacations) for State employees is on the liberal end of the spectrum of data we reviewed. A Bureau of Labor Statistics survey found that the average of all office workers in all metropolitan areas received a total of 20.6 paid leave days annually. (In this case, office workers is used to differentiate from skilled maintenance and unskilled plant workers. For our purposes, we equate this category to State employees.) The average varied by section of the country with the highest total in the northeast (21.7) and the lowest in the south (19.4). Interestingly enough, the survey found the highest paid leave days anywhere in the country to be in Trenton. The general observations were that leave levels are influenced by the same forces that influence pay, namely areas with concentrations of larger employers and areas with greater degrees of unionization.

CONCLUSIONS

There are no surprises in this data. We have been able to identify and review independent data that reaffirms what the individual compensation and fringe benefit task force efforts found relative to public sector employees.

- Public sector employees on average are compensated less than their private sector counterparts

- Indirect compensation costs are typically higher than average

- The combination of direct and indirect compensation elements of public sector employees compares favorably with private sector counterparts for classifications other than professional or management.

The objective of this report was to combine the distinct elements of compensation addressed in the two original Studies done for the Governor's Management Review Commission. While further recommendations were not contemplated, we do believe that the perspective this report provides underscores what has been recommended in the previous two efforts. Specifically, a more rational and competitive total compensation strategy is needed by New Jersey. The new strategy must incorporate the means to control total expenditures going forward while retaining the flexibility to spend dollars where they have the most efficient investment payback. Expressed in other terms, be less beneficent with indirect compensation where the long term costs are less under direct control and recipients tend to be unaware (if not unappreciative) of the true costs of such benefits. Use the budget to hire and retain (and reward) State employees on a basis comparable with the private sector as appropriate.

NEW JERSEY STATE EMPLOYEES DIRECT AND INDIRECT COMPENSATION - 1991

JOB DESCRIPTION	SYSTEM	SALARY RANGE	CASH COMPENSATION	LIFE & HEALTH EXCL DISABILITY (a)	RETIREMENT (b)	PAID TIME OFF (c)	HOLIDAYS AND VACATIONS (d)	TAXES (e)	TOTAL INCL BENEFITS	TOTAL INDIRECT COMP	PERCENTAGE O DIRECT TO INDIRECT
ENTRY LEVEL CLERK-STENO	PERS	13,544-18,971	17,152	5,191	686	443	1,461	1,427	24,456	7,304	42.6
ATT'Y GEN'L, GRADE 4	JRS	41,664-58,329	52,747	5,531	2,110	1,362	4,492	4,389	64,776	12,029	22 8
SUPERVISOR, BLDG SVCS	PERS	29,607-41,464	37,485	5,347	1,499	988	3,192	3,119	47,450	9,965	26 6
SUPERVISOR, DATA I/P	PERS	32,641-45,706	39,174	5,360	1,567	1,012	3,336	3,259	49,360	10,186	26 0
STATE TROOPER	SPRS	29,886-43,503	37,848	5,348	9,935	977	3,223	3,054	56,185	18,337	48 5
NURSES AIDE (GENERIC)	PERS	18,237-25,515	22,617	5,233	1,583	584	1,926	1,882	31,315	8,698	38 5

(a) See Exhibit II for detail of calculation.
(b) Average 4% salary load except for State Trooper (26.25%).
(c) Equates to sick days. Average used per year = 9.4 days
(d) Assumes average of 13 paid holidays and 18 vacation and ALS days.
(e) Represents FICA of 7.65% and WC of .42% for SPRS and .67% for all others.

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Life, Retirement, Medical and Dental Benefit Summary

	Entry Level Clerk Steno	Att'y General Grade 4	Supervisor Building Services	Supervisor Data Input	State Trooper	Nurses Aide (Generic)
Life Insurance	1.5 times salary	1.5 times salary	1.5 times salary	1.5 times salary	3.5 times salary	1.5 times salary
Retirement	Retirement Age Normal – 60 Early – Any age after 25 years of service	Retirement Age Normal – 60 Early – Any age after 25 years of service	Retirement Age Normal – 60 Early – Any age after 25 years of service	Retirement Age Normal – 60 Early – Any age after 25 years of service	Retirement Age Mandatory – 55 Deferred – Any age after 10 years service	Retirement Age Normal – 60 Early – Any age after 25 years of service
	Normal Benefit 1.67% of avg salary/ each year of service	Normal Benefit 1.67% of avg salary/ each year of service	Normal Benefit 1.67% of avg salary/ each year of service	Normal Benefit 1.67% of avg salary/ each year of service	Normal Benefit 50% of final salary after 20 years service	Normal Benefit 1.67% of avg salary/ each year of service
Medical	$1 Million Maximum $100 deductible $200 family deductible	$1 Million Maximum $100 deductible $200 family deductible	$1 Million Maximum $100 deductible $200 family deductible	$1 Million Maximum $100 deductible $200 family deductible	$1 Million Maximum $100 deductible $200 family deductible	$1 Million Maximum $100 deductible $200 family deductible
	80% benefit payment 100% payment after $2,000 of eligible charges	80% benefit payment 100% payment after $2,000 of eligible charges	80% benefit payment 100% payment after $2,000 of eligible charges	80% benefit payment 100% payment after $2,000 of eligible charges	80% benefit payment 100% payment after $2,000 of eligible charges	80% benefit payment 100% payment after $2,000 of eligible charges
	Includes certain first dollar coverages	Includes certain first dollar coverages	Includes certain first dollar coverages	Includes certain first dollar coverages	Includes certain first dollar coverages	Includes certain first dollar coverages
	Option to elect an HMO or the PPO plan	Option to elect an HMO or the PPO plan	Option to elect an HMO or the PPO plan	Option to elect an HMO or the PPO plan	Option to elect an HMO or the PPO plan	Option to elect an HMO or the PPO plan
Dental	80% Benefit $25 Annual Deductible	80% Benefit $25 Annual Deductible	80% Benefit $25 Annual Deductible	80% Benefit $25 Annual Deductible	80% Benefit $25 Annual Deductible	80% Benefit $25 Annual Deductible
	$700 Lifetime Ortho Benefit for Children	$700 Lifetime Ortho Benefit for Children	$700 Lifetime Ortho Benefit for Children	$700 Lifetime Ortho Benefit for Children	$700 Lifetime Ortho Benefit for Children	$700 Lifetime Ortho Benefit for Children

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Governor's Management Review Commission

Operational Review of Fringe Benefits

October 19, 1990

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Public Service Electric & Gas

Gloria Bonilla-Santiago, Ph D.
Rutgers University

Commission Staff Members

Michael J. Scheiring, Executive Director

Hugh H Annett
Assistant Executive Director

John Gagliardi
Technical Director of Special Projects

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Management Analyst

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John K I Walsh
Management Analyst

The Honorable Jim Florio
Governor
State of New Jersey

Report To The Governor's Management Review Commission

Review of The State Health Benefit Program
and
Pension and Retirement Systems

September, 1990

Submitted By

The Prudential
Charles Ardman
David Renz, F.S.A.

Wang Laboratories, Inc.
Carol Marshall
Kathleen Sheldon

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Executive Summary

This task force was formed to support the efforts of the Governor's Management Review Commission. Our charge was to review the State Health Benefits Program and Pension and Retirement Systems and recommend how to effect immediate and long term savings by changing plan design elements and redefining eligibility for specific benefits.

Estimates of the cost to the State to sponsor the PPO, HMO and traditional medical plan for State and Local employees project an expenditure of approximately $970 million for the twelve month period beginning July 1, 1990. Maintaining the status quo could cost as much as $2.1 billion annually 5 years hence.

The results of the review of the health care plan and associated recommendations can be summarized as follows:

- Total potential savings is approximately $162 million.
- The savings are generated by three distinct types of changes:
  (1) Limit the eligibility for the Rx drug benefit to employees who are not members of HMOs.
  (2) Institute contributions for employee and dependent medical coverage at levels of 10% and 30%, respectively.
  (3) Implement various plan design changes to both share costs (e.g., increase deductibles, co-insurance amounts, etc.) and control utilization (e.g., implement a mandatory mental health and substance abuse precertification and concurrent review program).

Non-quantifiable suggested changes include implementation of a minimum level of benefits that an HMO must provide in order to be offered to State and Local employees, revision of the current HMO contribution methodology, establishing a Flexible Benefit Program to allow employees to contribute toward their medical coverage on a pre-tax basis, negotiated discounts with the hospitals that receive the most revenue from the SHBP and review the current PPO plan in the context of using it to replace the existing traditional medical benefits.

The Pension System is comprised of six components plus the Alternate Benefit Program (ABP). Each component incorporates certain unique characteristics while at the same time a degree of commonality exists throughout. This report limits its review to plan elements that are associated with the majority of State liabilities. As such, the focus is primarily confined to the Public Employees' Retirement System and Teacher's Pension and Annuity Fund.

The four general areas we reviewed are:

- Plan Features - Those aspects of a plan that include attainment of eligibility defined by age as well as eligibility for "special" benefits and provisions associated with loans to participants.
- Plan Design - The basic structure of the vehicle providing the benefits. The typical choice is between a defined benefit and a defined contribution plan.
- Plan Administration - Who does it and how cost effective are the results.
- Investments - An examination of the techniques, asset mix, yield and fund management.

Our recommendations include revising many aspects of the foundations of the various plans. Those aspects likely to produce the most significant improvements include:

Features

- Increasing early and normal retirement ages
- Redefining final salary
- Revising the interest rate on loans to participants

Administration

- Purchasing outside programming expertise

Investments

- Change accounting basis from book value to market value
- Review and modify asset mix on a more frequent, flexible basis
- Retain outside managers to manage at least a portion of the plan design

The cost projections done for proposed changes in the State Health Benefits Program encompass relatively few variables when compared to a formal actuarial valuation of a pension plan. Therefore, this report includes sample actuarial calculations in the Pension section. The State Health Benefits Program cost savings are based upon actual results and generally acceptable forecasting methodologies.

Health Care Overview

Health care costs in this country are escalating to unprecedented levels. Over 11 5% of the 1989 GNP represented health care expenditures. The U S. Department of Commerce is estimating that over $661 billion will be spent for health care in 1990, up 10% from 1989. Average group insurance expenditures per employee have increased from $1,956 in 1987 to $2,748 in 1989 and are expected to surpass $3,200 in 1990. Expressed in a different context, over 10% of payroll expenses are required to fund medical insurance coverage for the average public sector group.[13]

There are many reasons for the rising health care costs, the more significant including:

- **Aging Population** - As the population ages, higher utilization of more intensive (expensive) services results.
- **Technology** - Many new methods of diagnosis and treatment are made possible by technological advances in both equipment and drugs, e.g., Magnetic Resonance Imaging and AZT.
- **Cost Shifting** - The Federal government is assuming an ever decreasing share of the nation's health care bill. Uncompensated costs are passed along to the remaining pool of privately insured patients.
- **Malpractice** - Even though malpractice premiums represent less than 1% of the total cost of health care, the costs associated with the practice of defensive medicine to safeguard against possible malpractice suits is estimated to cost $20 billion to $200 billion annually.[17]
- **Mandated Benefits** - State regulations mandating minimum levels of benefits for insured plans tend to increase costs, especially in the areas of psychiatric care and substance abuse treatment.
- **Dual Coverage** - The increasing number of dual income families has expanded group health coverage so now many people are covered under two plans, frequently resulting in 100% coverage. This reduces any incentive to use the cost containment aspects of current plan designs such as hospital pre-admission programs and second surgical opinion programs.
- **Billing Practices** - There is a quantifiable increase in the number of ambulatory services that are being "upcoded" by providers to maximize reimbursement.

Fundamental changes in the health resource allocation and reimbursement systems are needed before systemic cost containment can be realized. There is excess capacity throughout the entire superstructure, most notably in hospitals and specialty care, that continues to contribute to an inflated underlying fixed cost. Regulatory attempts to deal with the hospital situation include instituting DRGs and requiring a certificate of need for expansion or new construction. However, these measures in combination with a shift in hospital usage (declining lengths of stay, declining admissions, sicker patients being admitted thus generating a higher cost per case) have not produced the degree of anticipated shrinkage of available beds.

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Medical education programs continue to produce far more specialists than can be efficiently assimilated into the delivery system. The absolute number of specialists compounds the cost dilemma in two ways:

- Specialists are procedurally oriented. Historical plan design bias has been to reimburse technicians at a relative level in excess of the typical primary care professional.
- A glut of physicians in a geographic area generates a reverse supply-demand curve. As supply increases, so do costs because there are more units of fixed overhead spread across a smaller patient base per practitioner.

Expectations play an equally important role in the rise in health care costs. Americans believe that only the best in health care is good enough. The historical disassociation between the consumer of health care services and the payor is not a solid framework within which to expect an increasing degree of responsible use of the health care system's finite resources.

Arnold Relman, M D., editor of **The New England Journal of Medicine**, has characterized the development of the health care system in this country as occurring in three distinct stages. The "Era of Expansion" (1940-1970) was represented by rapid growth of hospital facilities, the number of physicians, developments in science and technology and the extension of health insurance to the majority of the population. With the advent of Medicare and Medicaid in the 1960's, nearly 85% of Americans had some form of medical insurance.

The "Era of Cost Containment" (1970-1989) was in reaction to the aggregate increase of health care cost relative to the GNP (4% in 1966 to over 11% in 1988) and the downstream impact upon public and private plan sponsors. The introduction of various pricing mechanisms (e.g., DRG's) as well as service frequency controls (e g., hospital pre-admission and concurrent review processes) were predictable reactions to the symptoms.

Dr. Relman contends that we are now entering the "Era of Assessment and Accountability", a time in which we must learn much more about the safety, effectiveness and appropriateness of the components of health care in order to control costs without arbitrarily limiting access or lowering the quality of care provided.

Regardless of the structure and process that will support the long term solutions to the health care cost and access challenges, it is clear that important roles will be assumed by Federal and State government, the private sector, the health care delivery system and the insurance/HMO industries. However, as we move toward systemic solutions, one cannot disregard current effective approaches to controlling and sharing costs as a reasonable starting point for modifying the State Health Benefits Program.

In 1982, the New Jersey State Pension Study Commission was formed. Their efforts encompassed a review, analysis and recommendations for changes in the state sponsored health care benefit structure. The Commission's response was delivered in 1984. The Executive Summary contained a Background section that we believe is worthwhile restating and updating. When reviewing the historical comparisons the following paragraphs contain, we note with special interest the absolute and relative magnitude of the costs associated with maintaining a core plan design that has remained essentially unchanged for three decades.

Background

"On October 1, 1961, Chapter 49 of the Laws of 1961 established a State program of health benefits for State employees and their dependents. On July 1, 1964 this plan was

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extended to all local public employees at the option of each public employer. The plan consisted of hospital, surgical/medical and major medical benefits.

In 1974, the State offered a Prescription Drug Plan to certain State employees and in 1976 it was extended to all State employees. The health benefit package was improved again for State employees on February 1, 1978 when a Dental Plan was implemented.

In 1975, the State began to allow employees to choose between the traditional State Health Benefits Plan and Health Maintenance Organizations (HMOs). Today, approximately 15,000 State employees and 11,000 local employees are enrolled in HMOs. [In 1989, the comparable enrollment results were 45,000 and 34,000 respectively.]

In 1983, the State Health Benefits Plan covered approximately 80,000 State employees and 160,000 local employees. [In 1989, the comparable covered population was 68,000 State employees and 160,000 local employees. Another 79,000 employees were members of HMOs.]

As these benefit programs were improved and liberalized over the years, and as medical care inflation and plan utilization increased, costs skyrocketed. For example, in plan year 1971, the annual premium per employee in the traditional State Health Benefits Plan was $270; in 1981 it was $656, an increase of 143%. By plan year 1984, however, costs are expected to almost double again to $1,217 per employee. If this trend continues, the State and participating local employers will find it difficult to meet their health benefit obligations without cutting other services." [For the period May, 1989-90, the plan cost exclusive of investment income was $2,489 per employee. It is projected to increase to $3,150 for July, 1990-91.]

The balance of this report contains an analysis of three primary areas: design, contributions and utilization. We believe that the proposed changes in these areas have the greatest likelihood of producing significant savings to the State, both on a short and long term basis. Additionally, we believe the recommendations:

- Represent modifications that can be easily monitored to allow a continuous evaluation and quantification of their ongoing effectiveness.
- Result in a benefit plan that will continue to allow the State to be competitive in the labor market.
- Frame a revised plan design that will readily accomodate an orientation to quality assurance as the pre-eminent cost containment feature.

Finally, we note with interest that the recommendations contained in the 198 - Pension Study Commission Report, while not implemented, are still valid. When we began the formal problem identification/resolution process that generated the suggested changes, we had not reviewed the 1984 recommendations. A subsequent comparison showed a large degree of commonality. We believe that the independent identification of many of the same recommendations six years removed partially validates the premise that the State Health Benefits Plan design can be far more effectively designed to take advantage of proven cost containment and cost sharing strategies.

Plan Design

The SHBP health plan design has remained essentially unchanged for two decades. While the plan is generous when compared to a cross section of business and industry, its design is incompatible with any reasonable expectation of containing costs by direct or indirect behavior modification. Furthermore, the absolute level of reimbursement afforded the covered individuals is one of the higher found either regionally or nationally.

The typical contemporary plan design contains elements of cost sharing and cost control that are intended to achieve multiple objectives:

- educate employees to become wiser consumers of medical care by creating a financial awareness of the true resource cost
- create a vehicle that regularly revises the cost sharing components of the plan design, e.g., the deductible and co-insurance amounts, to balance the desire to provide comprehensive coverage with the fiscal reality of the need to share health care expenses with the recipients to a degree that does not unduly strain a family budget
- assure that the health care delivery system's finite resources are utilized in the most effective and efficient manner.

We have focused our review and recommendations on areas of the existing plan design that we have concluded no longer produce the previously expected degree of cost containment. Concurrently, we have attempted to recognize that the State and municipalities operate in a competitive labor market and that health plan design is a critical and highly visible component of total compensation.

RESULTS OF REVIEW

Medical

- The SHBP Medical Plan costs are approximately at the level being experienced by other large plan sponsors. Costs have increased at an annual rate of 16.1% between and 1987 and 1989 with the 1989 cost per employee at $2,550. Comparable industry results reflected an annual trend of 17.5% and a 1989 cost of approximately $2,750 per employee [13]
- The number of individuals utilizing the Major Medical plan and receiving a benefit is increasing at a 7.5% rate annually.
- The benefit paid under the Major Medical plan increased by $129 per capita between 1987-88 and $204 per capita between 1988-89. These results are after the application of the deductible, co-insurance and Co-ordination of Benefits provisions. The results reflect annual increases of 21% and 27.5% respectively.
- The current alcoholism treatment benefit design strongly encourages an individual to seek all care in an inpatient setting. It does so by reimbursing at 100% for all facility and professional charges. It is therefore not surprising to find that alcoholism dependence has been the number one identifiable substance abuse diagnosis for hospital admissions in each of the past three years. Over 40% of all psych and substance abuse admissions are for this single diagnosis and it represents over 56% of all psych and substance abuse bed days for the past three years. This issue is addressed in more detail in the Utilization section.

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- The medical deductible is generous when compared to employer plans regionally and nationally. Various surveys show the percentage of employers retaining a $100 deductible has decreased by 1/3 over the past four years. Only 40% of employers continue to maintain a $100 deductible.[11]
- The medical plan out-of-pocket limit of $400 per person is generous when compared to employer plans regionally and nationally. Over two-thirds of all plans contain on out-of-pocket limit of $1,000 or more per person.[13]
- The continuation of the fixed dollar deductible and out-of-pocket limit creates a leveraging effect against the Major Medical plan that alone has increased costs by $3.5 million in each of the last two years.
- The 80% benefit for outpatient psych care is very generous outside of the context of a managed care plan.

Prescription Drugs

- The current plan provides for a maximum 34 day supply to be obtained at a local pharmacy (except for certain maintenance medications). The current trend is toward a lower limit, typically 20-30 days for most prescriptions.
- Generic drug usage as a percent of total prescriptions filled in the plan has been a relatively constant 21% over the past three years. Blue Cross/Blue Shield estimates another 25% of all prescriptions could have been filled by generics. However, the current plan design contains a minimal financial incentive for the use of generics.
- The per prescription co-pay of $3 50 is generous compared both to all employers with such plans as well as other public employee groups serviced by Medco.
- The current program eligibility includes all active State employees, even those enrolled in an HMO with its own Rx drug plan. This appears to be unnecessary coverage.
- In addition to the Rx drug card plan, drugs are also eligible under the Major Medical plan.

RECOMMENDATIONS

Medical

- Terminate the first dollar surgical-medical benefit and consider all such expenses eligible under the Major Medical subject to a deductible and co-insurance.
- Increase the deductible to $200 per person. Change the family deductible exposure to 2X the individual deductible.
- Increase the amount at which the plan begins to reimburse at 100% from $2,000 of eligible charges to $10,000.
- Include a separate $50 Rx drug deductible per person in the Major Medical Plan.

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Rx Drugs

- Increase the Rx drug co-payment to at least $5 excluding mail order prescriptions and generics.
- Change the current voluntary generic differential co-pay to mandatory. One approach would be to increase the co-pays to $10 for any drug prescribed with a brand name when a generic is available; $5 otherwise. In order to effectively administer this change, all participating pharmacies would need to work from the same formulary.
- Limit plan eligibility to non-HMO members.

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Contributions

As the absolute costs of providing health benefits increased dramatically during the 1980s, a growing number of employers examined their operational expenses and found that the health care plan was the fastest growing segment of their variable costs. As a practical matter, many employers who historically required little or no cost sharing by the plan participants embraced the belief that a change in this philosophy would produce two desirable effects. The first was that expanded contributions would create dollar-for-dollar relief to apply to other line item budgetary expenses. The second was that when the participant had a larger financial stake in the cost of the plan, he would become a more efficient purchaser thus limiting future cost increases.

Cost sharing in the form of contributions, while administratively easy to implement, does not represent a solution to the root cause of the problem of escalating health care costs. However, with the cost of health benefits representing 33% to 40% of the cost of all fringe benefits, the majority of employers in all industries and all regions of the country sought relief by instituting a contribution requirement where none existed previously, expanded the scope of who was required to contribute and increased the amounts of contributions already being required.

Recent surveys show that in 1989, between 45-50% of employers required employees to contribute for their own coverage and 73-75% required contributions for dependent coverage. This is in contrast to 1985, when 39-41% of employers required employee contributions and 65-70% required contributions for dependents.[11,12,13]

A contribution requirement is utilized to accomplish more than to simply shift part of the plan cost to the participants. With the significant number of working couples today, the likelihood of each being eligible for a benefit plan is greater than ever. When two plans cover one family, the plans typically provide a combined reimbursement level of 100% of actual expenses. This occurs by application of the Coordination of Benefits (COB) provision, a standard in virtually all group plans that both limits the reimbursement to 100% and determines the order of payment.

Dual coverage minimizes at best the impact of cost control features of a well designed benefit plan since there is no financial incentive for the covered individual to be a discriminating health care consumer. Many employers have taken the position that the contribution should be set at an amount that an employee in a potential dual coverage situation will likely choose not to pay.

With the growth and acceptance of HMOs and the PPO as coverage options, the methodology for determining contributions takes on added importance. When only one plan of benefits is available to an employee and a contribution is required, the employee chooses to participate or not. However, when a choice of coverage is offered, e.g., the SHBP, the PPO and the HMOs, the total risk the employee population represents will become segmented. In other words, the risk the total population represents is reduced into smaller pools without benefit of cross application of the total group's premium to the total group's claims.

When this occurs, it is not unusual to find a significant concentration of younger employees enrolling in the managed care options. Foster Higgins' **1990 State and Local HMO Renewal Analysis** documented that of the combined State and Local HMO enrollment, the age groups with the highest HMO enrollment are under 40, ranging from 47.4% in the under age 20 category to 34.2% in the 35-39 bracket.

These population subsets tend to reflect a better than average risk. Differentiating contribution amounts between a traditional plan and HMOs thus becomes critical from a strategic perspective for two reasons. The first is to establish and maintain the appropriate differential between the relative values of the plans; the second is to ensure that specific plan enrollment is not improperly encouraged at the expense of another plan option.

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RESULTS OF REVIEW

- Over 175,000 New Jersey State and Local active employees have free coverage. Over 120,000 of these employees receive free dependent coverage.
- Over 4,600 New Jersey State and Local active employees contribute 25% or less to the cost of dependent coverage. The 25% level equates to monthly contributions between $14 and $46.
- When contributions are required of State and Local employees for dependent coverage, they are typically increased each year to the same extent the total plan costs increase.
- When the suggestion to require contributions for dependent coverage is initially proposed, a typical concern is whether or not the financial liability will be so great as to prevent an individual from covering his/her family. The enrollment data we reviewed indicates that virtually all Local employees who must contribute for dependent coverage choose to do so. This group is comprised of far fewer bodies than the number of State and Local employees who qualify for free dependent coverage. Even with the disparity in population size, we believe the results are indicative of the fact that all who have a single source of group medical coverage (i.e., the SHBP) find a way to budget for the costs and will not be left without protection.
- There was a distinct movement by employers during the 1980's to require contributions for both employee and dependent coverage. In 1985, over 60% of employers paid the cost of employee coverage in full. In 1989, only 50% did so. Likewise, 65% of employers required contributions for dependent coverage in 1985. In 1989, 75% required some contribution.[11,13]

RECOMMENDATIONS

- Implement a contribution requirement of 10% for employee coverage and 30% for dependent coverage.
- Re-evaluate the methodology currently used to determine HMO contributions. Incorporating an approach that reflects the impact of risk segmentation by the HMO's on the risk characteristics of the remaining group should produce a more equitable determination of contributions for all participants.
- Introduce a Flexible Benefit Program structured according to Section 125 of the Internal Revenue Code. Limit the scope of the Program to allow employees to use pre-tax income to fund required contributions. Make participation mandatory. Assuming an average salary of $35,000 and a marginal tax rate of 25% (FWT, Social Security and NJIT), the benefit of using this approach is that each $1 of revenue generated from employee contributions is the equivalent of a $.75 reduction to the employee's takehome. Absent this approach, each $1 of contribution revenue costs the employee $1 of after tax income.

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Utilization

The past decade has produced an increasing number of studies testifying to the magnitude of "waste" in the medical delivery system. Examples include physicians doing too much and, even worse, performing procedures that are inappropriate or ineffective relative to the particular complaint they are treating. Over-utilization of services is commonplace in the hospital setting leading to poor quality care and contributing directly to rising medical expenses. While a "pure" approach to ensuring the appropriateness and efficacy of each aspect in the continuum of a course of treatment can be acheived only in a managed care product, many employers have incorporated active and passive utilization controls in their traditional plan designs in an attempt to impact rising costs.

Active utilization controls may be defined as those aspects of plan design that require a positive action on the part of either the covered individual or provider to guarantee receipt of the plan's basic level of benefits. By not initiating the action, the covered individual may receive a lesser benefit or no benefit at all. The positive action required is typically a telephone call to a utilization review unit. The resultant effect is an external validation of the efficacy of the proposed treatment. The validation criteria used are documented in scientific literature.

Active controls take the form of hospital utilization review programs designed to require precertification of both the need and length of stay, ambulatory services pre-certification programs, second surgical opinion programs and catastrophic case management programs. Some form of an active utilization program exists in almost 75% of all plans, up from 35% in the mid-1980s.[11,13]

The integration of a utilization review program with a traditional plan design is in itself no panacea. While it is relatively easy to document that high quality care is optimally efficient, the critical elements that distinguish the effective UR programs are the education, professional training and experience of the staff, how they are perceived by the medical community with whom they interact and the underlying structure and processes that create the framework within which the UR effort is discharged.

Recent publications have contained articles questioning the effectiveness of outpatient surgery incentives and second surgical opinion programs. Hewitt Associates conducted a survey in late 1989 and found 36% of employers believed outpatient incentive programs did not save money while 42% believed that they saved as much as 3% of claims. These types of programs were first introduced in the late 1970's and they were demonstrably effective upon inception. However, their effectiveness went beyond results that could be quantified; these programs also created a sentinel effect. Providers proposed procedures of questionable effectiveness less frequently because they knew the likelihood of reimbursement was diminishing. While the sentinel effect continues to exist in today's medical delivery system, we also believe that the medical community practices a "questionable procedure shift" against plans such as the SHBP that do not contain any type of utilization review. Information in the Results of Review section that follows seems to support this hypothesis.

Passive controls more accurately fall into the category of plan design modification, e.g., higher deductibles, increased out-of-pocket liability, lower co-insurance factors, etc. While a correlation between increasing the cost sharing aspects of a plan's design and a decrease in the utilization of discretionary services can be quantified, it is tenuous at best to extend this logic to assume that the care being rendered is effective and efficient.[16]

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The challenge facing the SHBP in controlling utilization is how to measurably impact the aggregate cost of the program by changing design elements while maintaining the basic freedom-of-choice, fee-for-service orientation of the program. Of the numerous areas to review, we refined our focus to those aspects that are most highly leveraged, i.e., where the biggest potential payback exists. Absent the ability to literally "manage" the care being delivered, one needs to identify the areas of the current plan design that are generally recognized to be the areas of greatest potential overutilization. In plan designs such as the traditional program, these areas include:

- Psychiatric and substance abuse treatment. The average per diem cost for hospitalizations nationally has increased 50% between 1987 and 1989. Concurrently, employers have seen the dollar allocation for all psych and substance abuse services increase from 10-15% of plan costs in 1985 to upwards of 30% in 1989.[10] There are many reasons for this cost spiral including (i) substance abuse is recognized as a growing problem among the workforce and many employers believe it is worthwhile to spend the money to rehabilitate, (ii) benefit plans have historically contained a perverse incentive to render treatment in an inpatient setting, and (iii) a slow rate of acceptance research that supported alternative treatment plans.
- Specific elective surgical procedures that have a high non-confirmation rate when a second opinion is obtained including umbilical hernia repair, prostatectomies, disc/spine procedures, joint surgeries of the knee and foot, hysterectomies and tonsillectomies/adenoidectomies.
- Caesarean deliveries reimbursed without question. This procedure was performed in 24.7% of all American births in 1988 (the last year for which complete figures are available) making it the most frequent major surgical procedure for women of childbearing age.[14,15]
- Catastrophic case management, where the potential payback can generate an average of $50 of benefits saved for each $1 expended for CCM activities, while the outcome for the patient is at least as good, if not better, than an unmanaged course of treatment.
- Specific diagnostic tests and procedures, e.g., echocardiagrams, MRI's, chest Xrays, sigmoidoscopies, colonoscopies, etc., where externally validated published standards currently exist but are rarely followed.

The insurance and managed care industries along with employers are not alone in their concern and actions to impact utilization. HCFA has created a list of procedures for review in FY 1990, geared to Medicare Part B enrollees, that they deem worthy of close, continuous review for possible overutilization. While many of the tests and procedures listed above are of mutual concern, it is interesting to note that HCFA has also included six different categories of physician office visits and two categories of hospital consultations they consider as potential major areas of offense.

RESULTS OF REVIEW

- Over 52,000 electrocardiagrams were performed in 1989, approximately evenly distributed between being done in a hospital and a physician's office.

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- Out of 18,506 claims identified as physician consultation in a hospital, over 13,700 were billed as "comprehensive". The definition of comprehensive includes an in depth patient evaluation requiring the development and documentation of complete medical data, establishing (or verifying) a plan for management of the patient and the preparation of a written report. This is one of the target consultations included on the previously referenced HCFA list.
- There are 17 general hospital admission diagnosis categories that are indicators of potential catastrophic cases including AIDS, burns, head injury/coma and neonatal/pediatric complications. Expense for a total course of care can readily exceed $50,000 and it is not unusual to for the total expenses to exceed $100,000. The 1987-1989 Blue Cross admission statistics for the SHBP showed an increasing incidence of these occurrences. While our view was limited only to hospital expenses, we believe that the data are indicative of catastrophic cases that would benefit from active, continuous management.

Qualifying Diagnoses

	One Year Hospital Expenses of $50,000 or more	**One Year Hospital Expenses of $25,000 - $50,000**
1989	41	129
1988	35	114
1987	22	72

We note that a voluntary Catastrophic Case Management referral service was implemented in 1990 for State and Local employees. The CCM service is activated only upon employee request. Through August, the service has received 3 referrals.

- Of the 511,000 diagnostic tests and procedures paid for by the SHBP in 1989, eight of the nine most frequent match the target list of questionable need released by HCFA. These eight procedures alone accounted for 33% (166,900) of all tests and non-surgical diagnostic procedures performed on all SHBP participants. The corresponding Blue Shield claim dollars exceeded $2,274,000 or 24% of all expenditures for tests. The additional expenses paid under the Prudential Major Medical plan could not be quantified.
- Alcohol dependence has been the most frequent diagnosis for all psych and substance abuse admissions since 1987. Drug dependence has been the third most frequent since 1987. Together, these two diagnoses comprise 51% of all psych and substance abuse hospitalization dollars spent in the past three years ($17,737,200 out of $34,778,900) and 62.8% of psych and substance abuse hospital days (87,126 out of 138,571).
- The average length of stay for alcoholism dependence has decreased from 20 to 15 days between 1987-1989. Drug dependence stays have decreased from 13 to 11 days. Concurrently, the average hospital benefit paid for alcoholism has increased from $3,500 to $4,100 and from $3,300 to $3,900 for drug dependence. On a per diem basis, the cost to treat alcoholism in a hospital has risen 56% in three years. Drug dependence costs have risen 40%

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RECOMMENDATIONS

- Implement a mandatory pre-certification and concurrent review program for all proposed medical-surgical hospitalizations. The design must include a non-compliance penalty.
- Implement a psych and substance abuse pre-certification and concurrent review program. The scope should encompass all treatment, i.e., inpatient, partial hospitalization, and ambulatory care. The design must include a penalty for non-compliance in order to create the proper incentive. Voluntary programs are proven to be ineffective and inefficient. Concurrently, the plan must be redesigned to remove the current incentives for receiving care in an inpatient facility.
- Institute a mandatory second surgical opinion program designed to focus on a small, select list of procedures with the highest potential for abuse. A non-compliance penalty is a basic requirement.
- Institute a formal process that identifies potential catastrophic cases as close to the time of the initial admission as possible and communicates this information to the Catastrophic Case Management team. Allow the unit to initiate activity without the specific request currently required from the employee.
- Formally pursue the design and implementation of a process to monitor (and possibly authorize) the performance of a select list of diagnostic tests and procedures that have been demonstrated as having the potential for abuse.

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Other

There are other factors we believe need to be recognized and considered when attempting to refine a strategic plan that the design and administration of the State Health Benefit Plan will support.

Examples of these include:

- The growing impact of the HMO option should be continuously evaluated in the context of how the HMOs compliment the State's benefit strategy. One criterion might be that each HMO available to State and Local employees offer a plan of benefits that is "comprehensive" as defined by the Department of Pensions. Comprehensive could be equated to some combination of scope and level of benefits. This approach will protect the SHBP from HMOs that implement substantive, arbitrary benefit reductions from year to year in an attempt to make themselves an unattractive option to employees with specific medical problems.
- A three-year review of in-state hospitals that received the greatest amount of benefits paid on behalf of the SHBP shows a remarkable consistency of recipients. Between 21-22% of all Blue Cross benefits paid in each of the last three years have been directed to virtually the same ten institutions. The equivalent dollar amounts are $31 5 million in 1987, $35 2 million in 1988 and $41 6 million in 1989. With this volume of business being concentrated among a relatively few suppliers, it would be worthwhile to explore what type of preferred financial arrangements may be negotiated that are not in conflict with the regulated component of hospital revenue.
- There are 17 HMOs currently offered to State and Local employees. The smallest number of HMOs available in any county is 4. There are seven or more HMOs to choose from in 19 of the 21 counties. There are ten or more HMOs to choose from in 12 of the 21 counties. In 1989, one HMO enrolled seven State and Local employees; the next smallest enrollment was 159 employees. We believe the State would be well served to evaluate its policy that determines the number of HMOs offered to State and Local employees. There are hard and soft dollar expenses associated with maintaining HMOs with marginal enrollments or offering HMOs whose costs, benefit design, scope of physician network and general quality are very similar

In 1984, the New Jersey State Pension Study Commission's collective recommendations represented the then contemporary approach to cost containment that was attainable within the context of a traditional indemnity plan design. Since 1984, product design has evolved to the point that it is now common (and many employers believe desirable) to adopt a medical plan design that incorporates a managed care point of service option. This type of plan incorporates many of the attributes found in the more progressive HMO's including:

- each member selects their own primary care physician
- a formal, written quality assurance program overlaid upon all components of care
- a rigorous and ongoing credentialing and recredentialing program applying to all participating medical professionals
- a customer service unit accessed by an 800 number and available to assist any member with a problem or question
- a cost containment philosophy that is based upon the premise that high quality care is optimally efficient

Concurrently, a managed point of service program allows a member to self-refer to any non-participating provider, receive treatment and be reimbursed under a traditional indemnity

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plan design The concept of offering both a managed and indemnity option in the same package is based upon the premise that over time, more employees will become comfortable with the program and seek more care under the managed component. Benefit differentials need to be in place to incent the member to use the managed network, e.g., 100% coverage with minimal or no co-payments for network benefits vs. a deductible and co-insurance applicable to self-referral benefits. The current PPO option is an example of this type of plan design.

We recommend that the PPO plan be evaluated in the context of totally replacing the existing SHBP indemnity plan

While the PPO option has the potential to produce a significant long term impact from a cost containment perspective, we also believe that adopting the PPO as the primary SHBP plan will improve the typical covered individual's situation. The majority of the recommendations we've included are changes to the current benefit structure to control excessive costs and utilization. These recommendations are consistent with approaches used in private and public sector plans today. The associated cost savings are realized by a one-time cost shift to the individual. The PPO approach results in a lower absolute cost to the State, and creates the connection between plan change and plan improvement for the employee. The benefits associated with the PPO are:

- a layering of clinical oversight and accountability on the current health care delivery system to ensure appropriate care is available and delivered to State and Local employees and their dependents,
- the economic power of being able to negotiate competitive prices from all sectors of the health care system by virtue of the PPO representing hundreds of thousands of medical consumers, and
- the establishment of an accessible, responsive, experienced outside organization in the de facto role of ombudsman for each State and local covered employee, and
- the creation of the opportunity for each covered individual to receive better benefits than currently available under the SHBP by using the PPO delivery network.

This approach has been successfully implemented with many large employers that have a significant population of employees subject to collective bargaining, AT&T being the most recent and perhaps most notable. One key to a successful implementation is that the point-of-service managed care concept is communicated and perceived as adding value to the health care delivery process. There is no other approach that can assure both the quality and appropriateness of care as well as the credentials of those delivering care while concurrently allowing an individual to self-refer to any legitimate provider based on personal need or preference and still receive a fair reimbursement.

Our final recommendation is to establish a standing commission whose primary function is to continually evaluate the design and delivery and the health care benefits available to State and Local employees. The objective of this group would be to review what exists with the goal of making the benefit configuration and support system more efficient, more effective and more compatible with the needs of both the State and its employees. Our exposure to many State employees during the process of creating this report convinces us that the necessary talent to successfully support this task exists.

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HEALTH PLAN CHANGE RECOMMENDATION SUMMARY

	Category	Current	Preferred	Alternate
Funding	• Contributions Required of Participants	None - State Employees and Dependents (Active) Varying - Local Employees and Dependents (Active)	10% employee, 30% dependent (All)	Same as Preferred
	• Vehicle	After tax basis, where applicable, to Local and Retired employees and dependents	Implement Flexible Benefit Plan to allow pre-tax deductions for all Actives	Require contributions on an after tax basis
Hospital	• Implement mandatory precertification and concurrent review program for medical-surgical admissions	N/A	50% non-compliance penalty	Same as Preferred
	• Catastrophic Case Management	Voluntary; Employee must initiate request	Revise process to eliminate need for employee to initiate request	Same as Preferred
Major Medical	• Increase deductible	$100/ind., $200/family	$200/ind., $400/family	$150/ind., $300/family
	• Increase out-of-pocket maximum	$400/yr	$2,000/yr	$1,000/yr
	• Scheduled benefits for surgical and medical	Applicable	Eliminate	Same as Preferred
	• Implement mandatory second surgical opinion program	N/A	30% non-compliance penalty	Same as Preferred
	• Implement separate annual Rx drug deductible	N/A	$50/yr	Same as Preferred
Prescription Drugs	• Increase co-pays	$3 50 per Rx ($1 00 mail order)	$10 for substitutable drugs; $5 otherwise	$5 excluding generic and mail order
	• Limit initial quantity	34 day supply	20-30 day supply	Same as Preferred
	• Eligibility	All active State employees	Limit to employees not enrolled in HMOs	Same as Preferred
Other	• Implement mandatory psych and substance abuse precertification and concurrent review program to apply to all inpatient and ambulatory services	N/A	Redesign current benefits and incorporate a non-compliance penalty	Maintain current benefit levels and incorporate a non-compliance penalty

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Pension and Retirement Plan Overview

The following review is intended to identify areas of potential cost reductions with particular attention to identifying plan practices and provisions which may differ from those found in the plans of competing private sector employers. No attempt has been made to consider existing legislative requirements or terms of current labor contracts.

In a number of areas, sample actuarial calculations are provided. The calculations are solely intended to clarify certain observations. They do not represent an actuarial opinion nor are they necessarily representative of the cost of specific features in the New Jersey plans. A formal actuarial valuation (considering actual population distribution, withdrawal and disability rates, employee contributions, etc) would be required to quantify the value of any actual changes. Such analysis was beyond the scope of this review.

The review has been primarily confined to the PERS and Teachers Plan which constitute the bulk of the state liabilities.

The Pension and Retirement Systems include a multitude of areas that would appear to benefit from revisions to current design framework and supporting administrative and professional services. These areas may be categorized as:

- Plan Features - Those aspects of a plan that include attainment of eligibility defined by age as well as eligibility for "special" benefits and provisions associated with loans to participants.
- Plan Design - The basic structure of the vehicle providing the benefits. The typical choice is between a defined benefit and a defined contribution plan.
- Plan Administration - Who does it and how cost effective are the results.
- Investments - An examination of the techniques, asset mix, yield and fund management

NORMAL RETIREMENT AGE

The Normal Retirement Age (NRA) in most private plans is age 65. The state plans have a NRA of 60 [1] The difference in cost to provide these benefits can be substantial. In the example below [2], the present value at age 30 of a benefit commencing at age 60 NRA is 65.6% higher than the same benefit starting at age 65. 13% represents the fact that payments will begin five years sooner and hence there will be more years of payments and COLA adjustments. The balance primarily represents the five years less of assumed interest earnings.

	-Cost of $1 per year @ assumed-ret. age	entry age (30)	additional cost @ entry vs NRA of age 65
50	$16 22	$4.11	302 3%
51	16.00	3.78	270.0%
52	15 77	3.47	240.1%
53	15 53	3.19	212.2%
54	15 28	2 92	186.3%
55	15 02	2 68	162 2%
56	14 76	2.45	139 9%
57	14 48	2 24	119.2%
58	14 20	2.04	99 9%
59	13 91	1 86	82.1%
60	13 62	1 69	65 6%
61	13 31	1 53	50 3%
62	13 00	1.39	36.2%
63	12 69	1 26	23.1%
64	12 37	1.13	11.1%
65	12.05	1 02	0.0%

ERISA presumes a NRA of 65 for private plans. More recently, the "normal retirement date" under social security has been raised from 65 to as high as 67 for some participants.

EARLY RETIREMENT

N.J. allows early retirement with 25 years of service. At age 55 or older, there is no reduction in benefit.

A Hewitt survey [3] of 774 leading employers with Defined Benefit plans indicates that the earliest age for unreduced benefits with **30 years** of service is 60 or higher in 93% of the companies.

* References are shown at the end of the report.

A Wyatt survey [4] of 50 leading companies shows that, on average, the companies pay only 71% of accrued benefit to employees retiring at age 55 with 25 years of service (this increases to 78% for age 55 with 30 years and 95% for age 60 with 30 years).

For early retirement prior to age 55, benefits are reduced 3% for each year under age 55 that benefits commence. This is considerably less than the actuarial reduction factors, as shown below:

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Age	Present Value @ age 50 of $1/yr commencing at	-Actuarial Reduction Factors- -vs Retirement Age of- 55	60	65	State Plan Reduction Factors
50	$16 22	35%	59%	75%	15%
51	14 92	29%	55%	73%	12%
52	13 71	23%	51%	71%	9%
53	12 59	16%	47%	68%	6%
54	11 54	8%	42%	65%	3%
55	10 57		37%	62%	0%
56	9 67		31%	58%	0%
57	8 84		24%	54%	0%
58	8 06		17%	50%	0%
59	7 34		9%	45%	0%
60	6 68			40%	0%
61	6 06			33%	0%
62	5 49			27%	0%
63	4 96			19%	0%
64	4 48			10%	0%
65	4 03				

The actuarial reduction factor is the amount a benefit should be reduced to be economically equivalent to a later benefit For example the cost of a $100/year benefit starting at age 55 for someone now age 50 would be $1057 33 That same amount would only purchase a benefit of $65 19 if payments began at age 50 Thus the actuarial reduction factor would be 35% The state plan would use a reduction of 15% As shown above, the reduction is steeper if measured against a higher Retirement Age.

DEFINITION OF SALARY

New Jersey uses a "three highest consecutive years" definition of final salary to determine pension benefits Only 15% of the companies in the Hewitt survey use this definition, the balance are more restrictive with five years being most common (66%) As shown below, with a 4% annual salary increase, this would increase starting benefits almost 4% Among Public plans, only 15% use a final three years definition, with 15% using final year or final two [5]

1	$1,000 00	Average of final 3 =	$1,125
2	1,040 00		
3	1,081 60	Average of final 5 =	$1,083
4	1,124 86		
5	1,169 86	Difference =	3 9%

COST OF LIVING ADJUSTMENTS

N J has an automatic COLA equal to 60% of the CPI This benefit is now being advance funded Only 5% of surveyed private employers had automatic COLAs However, many of the

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remainder make use of "ad hoc" adjustments. Hence, it is difficult to determine whether the state COLA is "liberal" or not.

VETERAN'S ADJUSTMENTS

The state plans have special benefits applicable to veterans (as defined.) In the latest PERS actuarial report, the normal cost for veterans was 0.21% higher than for non-veterans (0.17% - 0.27% for local governments.) Private plans do not provide such benefits. In fact, the practice would not be permitted under ERISA.

COORDINATION OF BENEFITS WITH SOCIAL SECURITY

88% of surveyed companies use integration (coordination of plan benefits with those payable from social security.) Under integrated plans, benefits based on compensation below a given point are lower than those based on higher amounts of compensation. This is permitted under the Internal Revenue Code to reflect the fact that the employer "provides" for a portion of the social security benefit based on the employer share of FICA taxes and recognizes that social security provides greater benefits, as a percentage of salary, at lower income levels than at higher levels. The main rationale for integration is to lower the employer's cost for pensions. It also allows the employer to develop a "target" retirement income goal reflecting both pension and social security benefits.

New Jersey reduces the required employee contributions by 2% on earnings below the FICA limit. In essence, this increases the employer's cost and represents a form of "reverse integration."

LOANS

The plans permit loans to participants at a 4% interest rate. The effect of this provision is to reduce plan income by the difference between the market rate of return and 4%. This reduction results in increased employer contributions. Department of Labor regulations require that plan loans to participants of ERISA plans, even when secured with their account balances, reflect a market rate of interest.

LIFE INSURANCE

The contributory life insurance benefit makes no distinction in premium on account of age. Thus, younger employees will be able to purchase insurance at lower rates outside of the plan, while older employees and those in poor health will find the coverage to be a bargain. The anti-selection inherent in this arrangement is likely to lead to losses on the voluntary coverage (the present carrier should be able to determine the plans most recent experience). Any losses will be borne by the plan.

Private companies typically have separate plans for life insurance rather than including them in the pension plan.

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The plans provide a survivor's benefit (annuity) for accidental death on the job. Private employers more typically provide a lump sum (flat or multiple of salary) and do not differentiate between on-the-job and off. Again, this is normally separate from the pension plan.

DISABILITY

Only 15% of surveyed employers provide a disability benefit beginning at time of disability (with half of these limiting it to the accrued benefit). 17% provide no special disability benefit and 60% provide only the normal retirement benefit starting at the retirement age. The state plan has a minimum of 40% of final compensation (equal to 24 years of service, ie. 24/60 = 40%.) Of course, private companies may have Long Term Disability coverage separate from the pension plan.

HEALTH INSURANCE

New Jersey provides health insurance to retirees, a not uncommon practice. In the latest PERS valuation, the present value of this benefit to active employees is over $1.6 billion. The cost of retiree health coverage tends to be especially high for people under age 65, due primarily to the fact that Medicare is not available. (Benefits for those over 65 are coordinated with Medicare reducing the employer's costs.) The age 60 NRA and the early retirement provisions in the N.J. plan encourage employees to retire during this period, thus increasing health costs. Retiree health costs can be expected to be an increasing proportion of expenditures over time. The situation will be aggravated if medical costs continue to rise faster than general inflation.

BUY INS

The state plans allow participants to "buy in" with additional years of service under the plan in certain circumstances. These would include former membership in a state plan, military service or service with another state.

The employee bears the cost of purchasing credit for military service before enrollment, but the other instances will involve a cost to the employer. While some private plans may allow employees to receive credit for prior service under the plan or military service after employment, they do not allow purchase of credit for time with other employers (note that this concept differs from merely allowing rollovers into a Defined Contribution plan, which has almost no cost to the new employer).

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GENERAL CONSIDERATIONS

Pension plans constitute an extremely important employee benefit. However, it is important to recognize that such plans represent merely one portion of the employee's overall compensation package. In particular, the pension plans should be considered in conjunction with salary plans to determine if the combination is meeting the goals of attracting and retaining staff.

In general, certain features and plan designs tend to appeal to different groups. For example, defined contribution (DC) plans tend to be more attractive to younger employees and those with shorter service (including new hires), while defined benefit (DB) plans are more attractive to older, longer service employees.

The state plan is similar to the combination of a defined contribution plan and a defined benefit plan. Employee contributions are required and, under certain circumstances, may be available for withdrawal. However the New Jersey plan clearly is more attractive to longer service employees. No interest is available on contributions for the first three years; thereafter a fixed (currently below market) rate is applicable thereafter. (Private plans are required to credit interest on employee contributions at no less 120% of the federal midterm rate.) Vesting requires ten years of service. Withdrawal of contributions leads to forfeiture of the defined benefit entitlements.

In its role as employer, the State would have more flexibility if it employed separate DB and DC plans. Among major employers offering defined benefit plans, the vast majority (99%) offered at least one separate defined contribution plan. Thus the State is at a disadvantage in competing for new employees in this area.

Please note that providing separate DB and DC plans is not necessarily a cost saving measure. The resultant plans could be designed to cost more, less or the same as a contributory DB plan.

The State retirement plan was studied extensively in 1983-84. A major recommendation of that Commission was the separation of the New Jersey plan into separate DB and DC plans.[6]

The latest redesign of the Federal Employees pension plan split it into separate DC and DB plans.

64X

ADMINISTRATION

Currently, a staff of 400 administers the state plans at a cost of over $20,000,000 per year This includes the cost of computer programming. An area which could be investigated for savings is the possibility of purchasing existing software and/or contracting work out to professional organizations. This is most likely in situations where the provider can spread the cost of developing computer systems over many clients.

Savings in this area may be limited due to the differences between the state and private plans (for which most software was developed) Any investigation of new plan designs should consider ease of administration.

As examples:

In the area of Defined Contribution recordkeeping, many providers include such services along with their investment products. Should the state decide to separate the DC and DB elements, this is a potential source of savings.

Many banks, insurance companies and data processing firms have the capability of producing monthly checks. Additionally, the state could contract with an insurance company for purchase of retiree liabilities, transferring investment risk along with processing responsibility.

In any event, it is important that any vendor under consideration should have a demonstrated capability to adequately provide such services.

ACTUARIAL

The actuarial funding method being employed is reasonable. The prefunding of COLAs is valuable in the sense of matching contributions to the periods when benefits are accrued. The same holds true for the use of a 401(h) funding of the post-retirement medical insurance costs.

65X

Investments

Enhancing investment income is just as effective as reducing expenses or other outflows as a method of controlling employer contributions.

BOOK VALUE ACCOUNTING

Investments are valued at "book" for purposes of determining the limitations on common stock holdings and other purposes.[7] This is not in keeping with modern investment techniques. A share of AT&T held today is worth the same whether it was purchased in 1969 or 1989. Use of book value distorts the purposes of the limitations since selective sales of holdings with embedded gains or losses allows vastly differing holdings to appear to be at the same level of stock exposure. Also, if the plans are at the limits, book value accounting may force managers to base asset sales decisions on capital gain status rather than investment merits.

Use of book value in reporting returns is also flawed. This approach only considers dividend and coupon yields. When purchasing stocks, more overall return is expected from appreciation than dividends. Book returns are not particularly meaningful. "In dealing with the investment portfolio itself, the appropriate objective is what securities analysts call total return, which is the change in value of existing assets (appreciation-depreciation) plus payments of dividends and interest".[9]

The state has recognized these points in its regulation of insurance companies. While insurance company reports to Insurance Department are based on "book value" reporting, "book" for common stock is essentially redefined as market value.

ASSET MIX

As with any "final average" pension plan, liabilities of the N.J. plans are quite sensitive to inflation. The inclusion of an automatic COLA increases this relationship. However, the asset mix of the N.J. plans are limited to 40% (book value) common stock, the balance being invested in fixed income vehicles (bonds, mortgages, money market.) Fixed income investments are weakly, or even negatively, correlated with inflation. Stocks are positively correlated with inflation over longer periods of time. Real estate is also positively correlated with inflation.

At the end of 1989, the asset mix for private trusteed funds was:[8]

EQUITIES 53%
BONDS 26%
CASH ITEMS 12%
OTHER INVESTMENTS 9%

Hence the state appears underweighted in equities. Historically, equities have outperformed fixed income securities over longer periods of time (but are much more volatile in the short run). Based on this, the state may wish to reconsider its limitations on asset mix.

USE OF OUTSIDE MANAGERS

Opinions of the Attorney General's office have indicated that the use of outside managers is not legal under existing law.[6] 93% of public plans employ professional investment managers and consultants.[5] Consideration should be given to enacting appropriate changes. It is likely that outside managers may be useful in managing at least a portion of plan assets for the following reasons:

ECONOMIES OF SCALE: Using outside manager allows the costs of the research and the professionals employed to be spread over a number of clients, allowing the use of expertise that a single plan could not afford to hire on a full time basis.

DIVERSIFICATION: The plan may wish to invest in areas where specific expertise and costs are required (e.g. foreign equities or bonds) but not in a large enough amount to justify hiring full time professionals. Outside management can be a solution. Similarly, the use of outside management might permit investment in real estate, where the cost of developing the appraisal, management, etc. staff might be prohibitive unless done on a commingled basis.

THE STATE MAY HAVE DIFFICULTY matching salaries being paid to investment professionals (whose costs are being spread over multiple clients when working for outside managers). Also, in the event of unsatisfactory performance, it is easier to dismiss an outside manager than an employee.

POSSIBLE ENHANCED RETURNS: Over the period 1984-88 the Common Fund has tended to lag the market[7] as shown below:

	Common Pension Fund A	S&P 500	TIAA/ CREF	Common Fund VS. S&P 500	Common Fund VS. TIAA/CREF
1984	-7.7%	-4.6%	4.9%	-3.1%	-12.6%
1985	27.6%	31.0%	32.9%	-3.4%	-5.3%
1986	38.4%	35.9%	22.0%	2.5%	16.4%
1987	23.8%	25.2%	5.1%	-1.4%	18.7%
1988	-10.2%	-6.9%	17.5%	-3.3%	-27.7%

Outside managers should be expected to beat the standard agreed upon (e.g. the S&P 500 or the Wilshire 5000 or any mutually agreeable target). As a minimum, there are many index managers available who will manage funds to match any index. Index managers have lower fees than active managers. Many will agree to no fee unless they at least match the index. The final test should be that an outside manager should be able to outperform inside management after considering fees.

INVESTMENT TECHNIQUES

Recent years have seen rapid development in the realm of portfolio management. Techniques such as contingent immunization, tactical asset allocation, option theory, asset/liability matching, etc. may be profitably used to maximize portfolio value in relation to liabilities. Such techniques do not seem to be extensively utilized in the state plans.

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PENSION PLAN CHANGE RECOMMENDATION SUMMARY

	CURRENT	PROPOSED
FEATURES		
• Normal Retirement	NRA = 60	NRA = 65
• Early Retirement	25 years of service and age 55, no reduction	30 years of service and age 60
• Final Salary Definition	3 year basis	5 year basis
• Coordination with Social Security	Reverse Integration	Positive Integration
• Loans	4% fixed interest	Market rate
• Life Insurance	Contained in Pension Plan and no age adjusted rates	Separate from Plan and use age adjusted rates
• Disability	Minimum 40% beginning at time of disability	Provide normal benefit beginning at normal retirement age. Consider purchase of separate Long Term Disability coverage
• Buy-Ins	Employee may purchase credit for time with other employers	Limit buy-in to time in military service
DESIGN		
• Vehicle	Combined DB and DC plan	Create separate DB and DC plans
ADMINISTRATION		
• Programming	Performed in house	Investigate outside contracting
INVESTMENTS		
• Accounting Basis	Book Value	Market Value
• Asset Mix	Limited to 40% equities	Increase or remove 40% limitation
• Outside Managers	Use prohibited	Enact appropriate change to allow use for at least a portion of plan assets

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EXHIBITS

HEALTH PLAN ESTIMATED ANNUAL SAVINGS

SHBP and Rx Drug plan, active only, State and Local employees.

PROJECTED PER CAPITA SHBP COSTS

Reflects SHBP Plan, active and retired, State and Local employees. Excludes HMO's and Rx Drug plan

ANNUALIZED SHBP AND HMO COST COMPARISON

Based upon November, 1989 enrollment and 1989 rates.

CURRENT SHBP COSTS VS. PROPOSED CONTRIBUTIONS

Five year projection (base year 1989) showing a 10% employee, 30% dependent SHBP contribution requirement. No other plan changes are assumed.

IMPACT OF PROPOSED SHBP PLAN CHANGES

Five year projection (base year 1989) identifying the value of the proposed plan changes and contribution requirements relative to future core plan costs. Rx drug plan recommendations excluded.

PREFERRED HEALTH PLAN RECOMMENDATION

Relationship of the savings to the current total cost (base year 1989) of each major component of the recommendations (Eligibility, Plan Design and Contributions).

PENSION PLAN INTEREST ON LOANS

Comparison of market rate to current plan loan rate by quarter beginning 1-1-88

69x

NEW JERSEY

STATE HEALTH BENEFITS PROGRAM

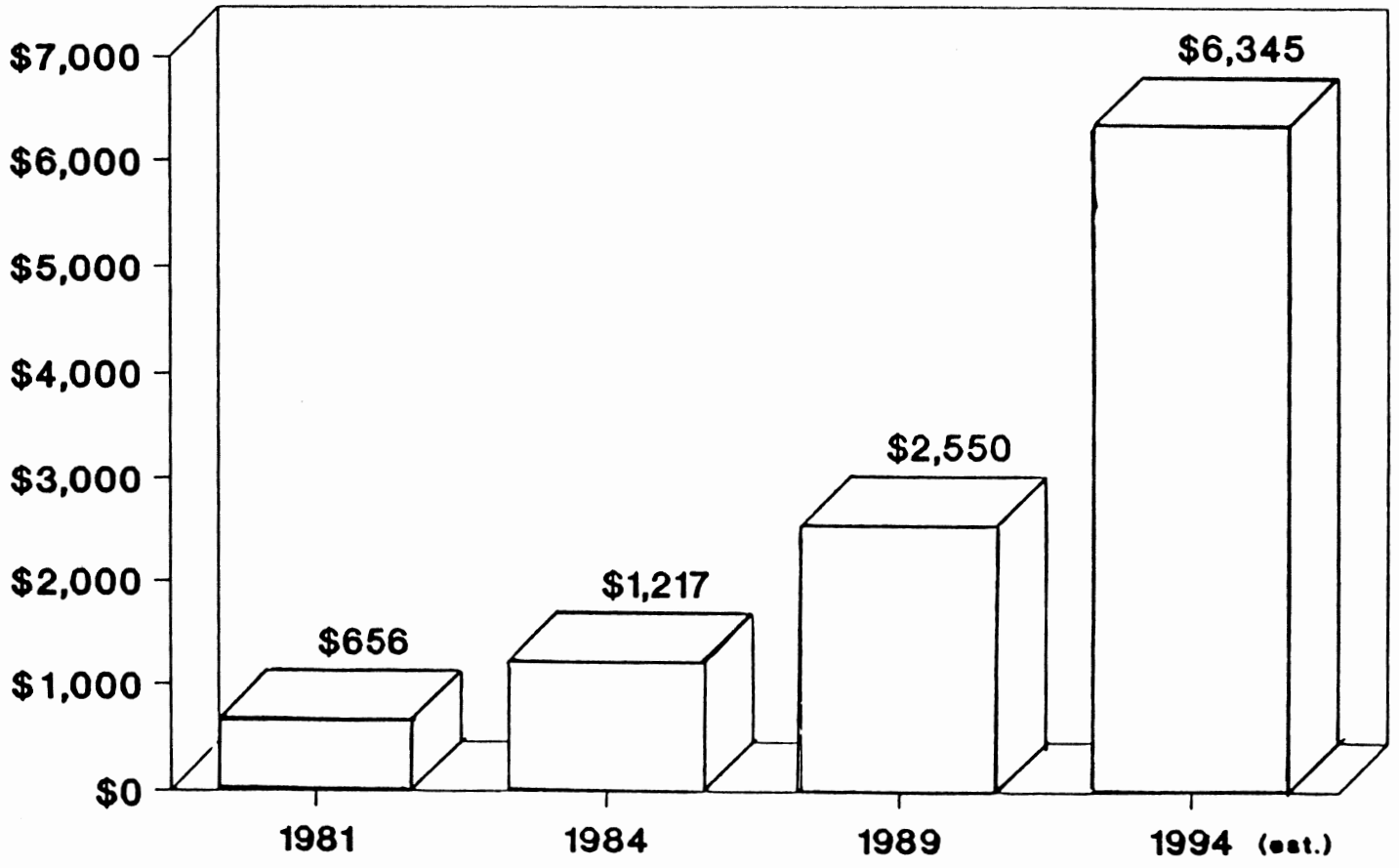
($ Amounts Omit OOO's)

ESTIMATED ANNUAL SAVINGS - MEDICAL AND RX DRUG PLANS

	PREFERRED	ALTERNATE
HOSPITALIZATION		
Mandatory pre-certification medical & surgical	$ 3,555	$ 3,555
MAJOR MEDICAL		
Terminate scheduled benefits	7,708	7,708
$150 deductible	-	7,398
$200 deductible	14,180	-
Increase co-insurance to $5,000	-	9,659
Increase co-insurance to $10,000	13,974	-
Mandatory second surgical opinion	4,110	4,110
Separate $50 Rx drug deductible	8,015	8,015
PRESCRIPTION DRUGS		
$5 co-pay	1,449	1,449
Remove HMO participants from eligibility	15,314	15,314
OTHER		
Mandatory psych and substance abuse pre-certification and concurrent review	6,738	1,356
SUBTOTAL - ELIGIBILITY CHANGE (Rx)	15,314	15,314
SUBTOTAL - PLAN CHANGES	59,729	43,250
SUBTOTAL - CONTRIBUTIONS	86,746	89,890
TOTAL SAVINGS	$161,789	$148,454

70X

New Jersey
State Health Benefits Program



Projected Per Capita Cost - No Plan Changes Implemented

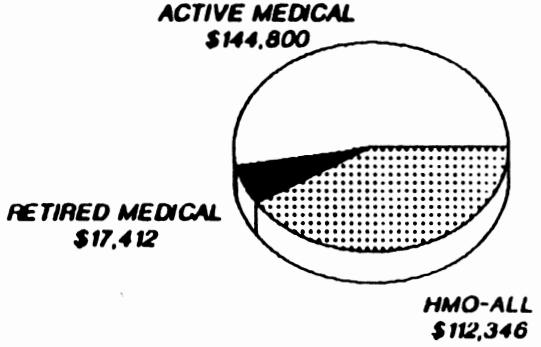
XIL

NEW JERSEY

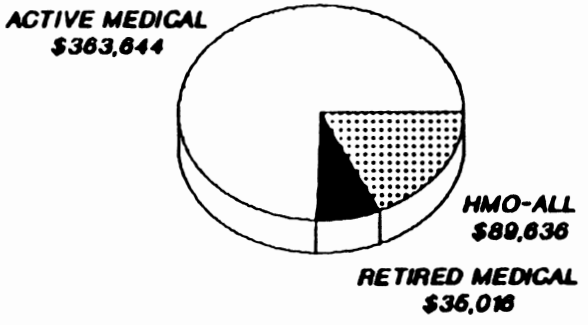
State Health Benefits Program

Medical - Annualized Cost Basis

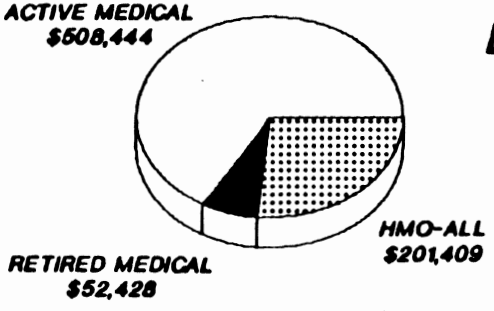
	State	Local	Total
Active Medical	$144,800	$363,644	$508,444
Retired Medical	$ 17,412	$ 35,016	$ 52,428
HMO - ALL	$112,346	$ 89,063	$201,409



STATE



LOCAL



TOTAL

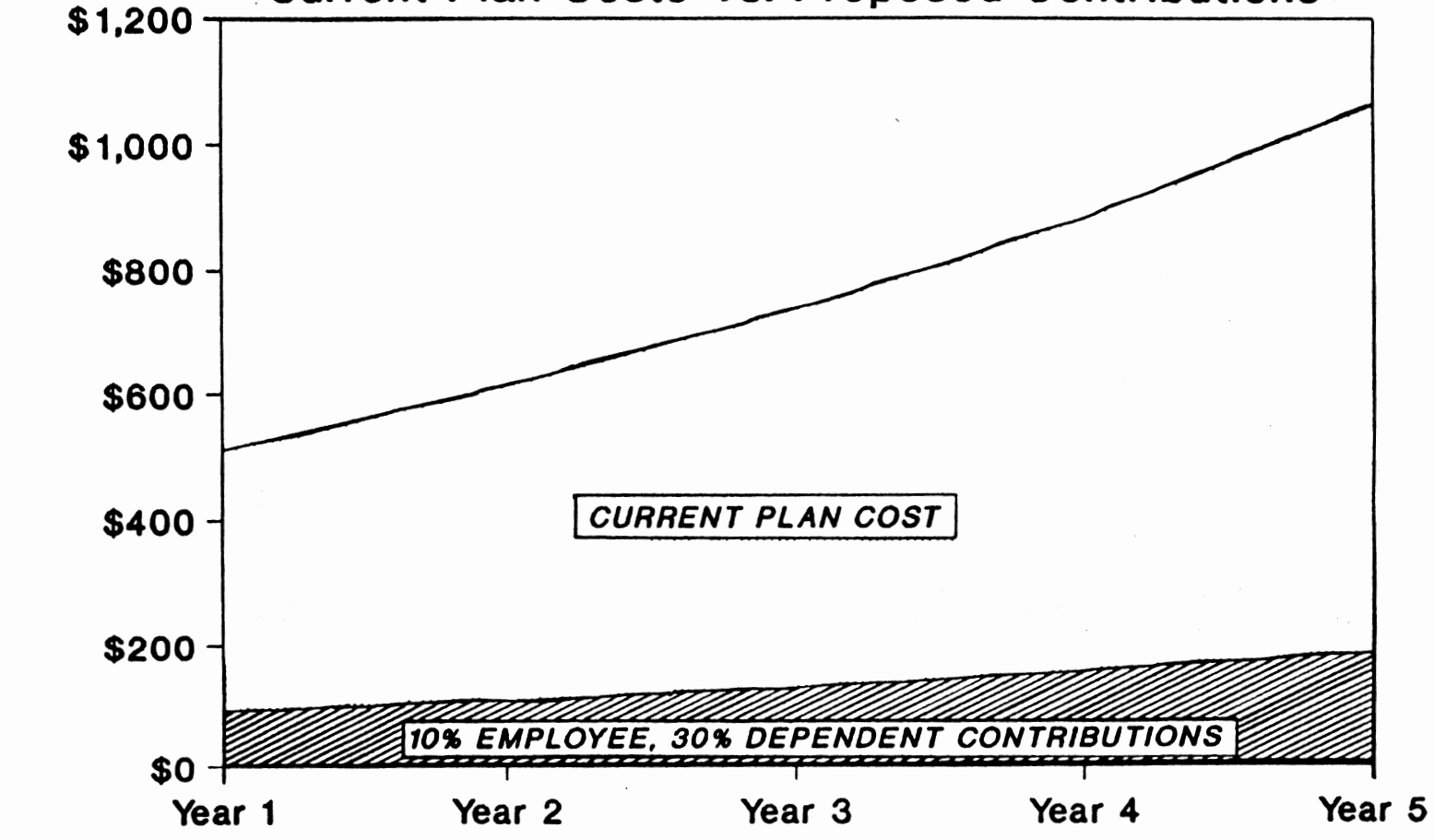
Excludes required current employee and dependent contributions

72 X

NEW JERSEY

State Health Benefit Program

Current Plan Costs Vs. Proposed Contributions



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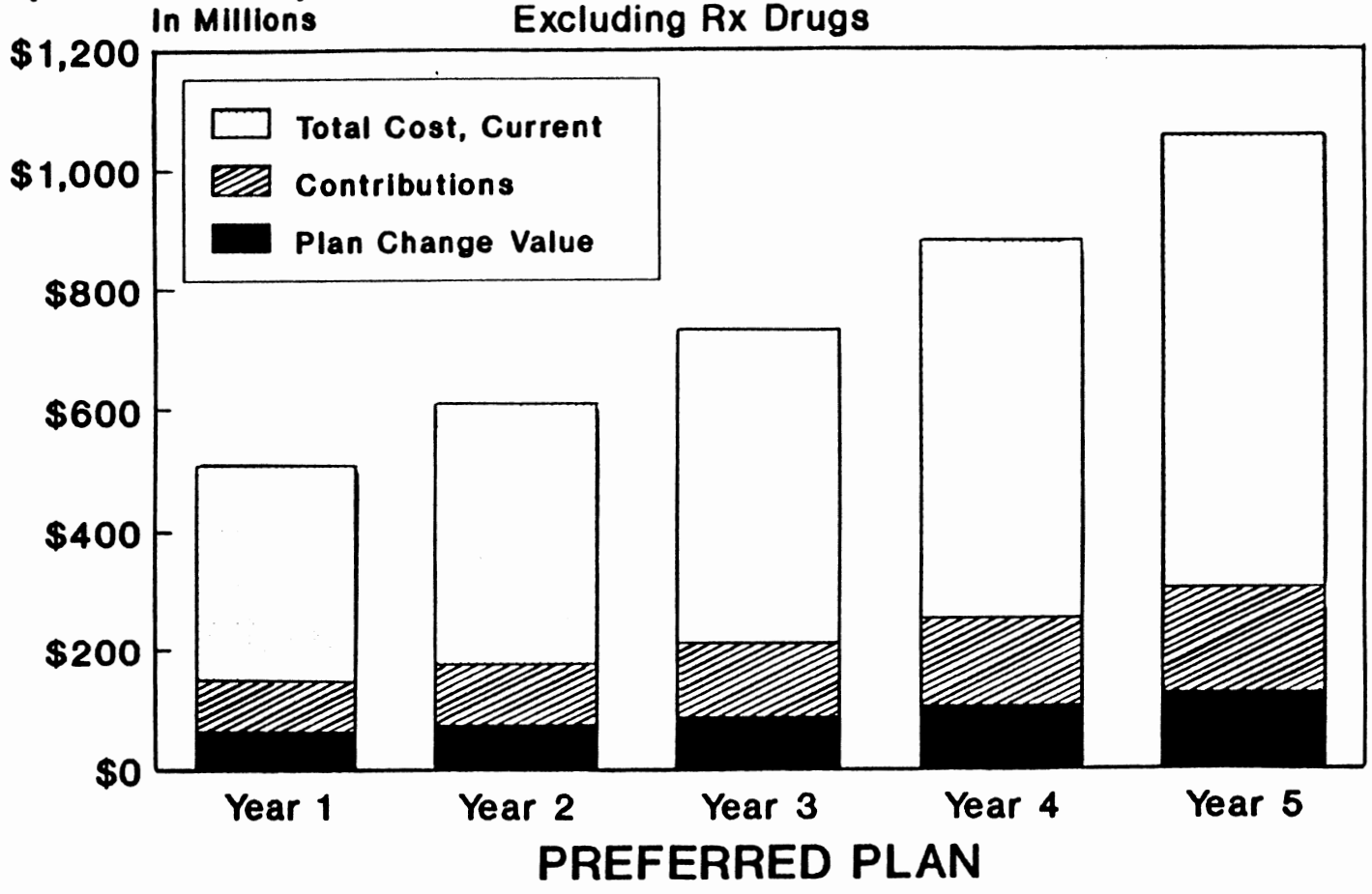
NEW JERSEY

State Health Benefits Program

Impact of Proposed Medical Plan Changes on Current Costs



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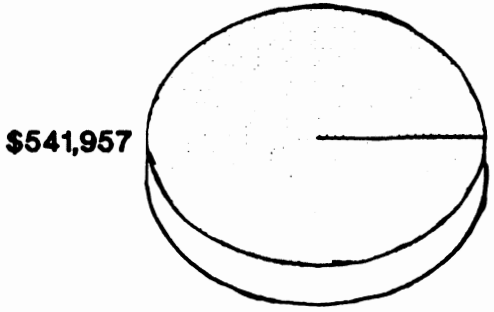
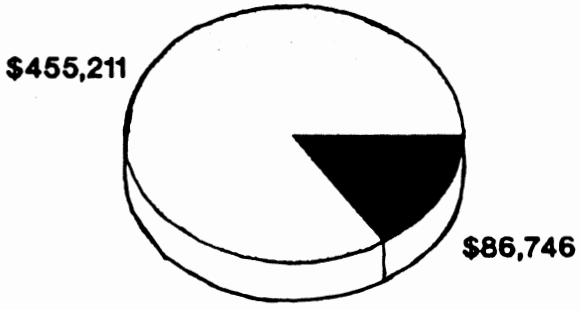
New Jersey State Health Benefits Program

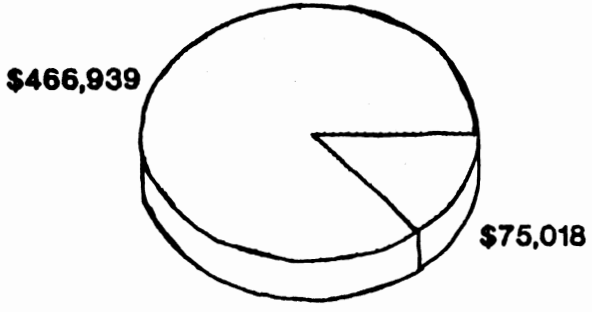


Current Cost

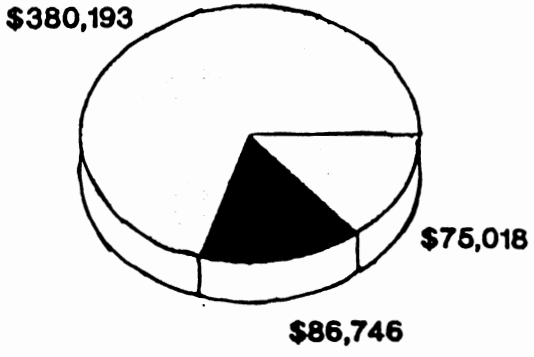


Effect of Proposed Contributions

Impact of Preferred Plan Recommendations
Traditional SHBP and Rx Drugs Only



Effect of Proposed Eligibility & Plan Changes

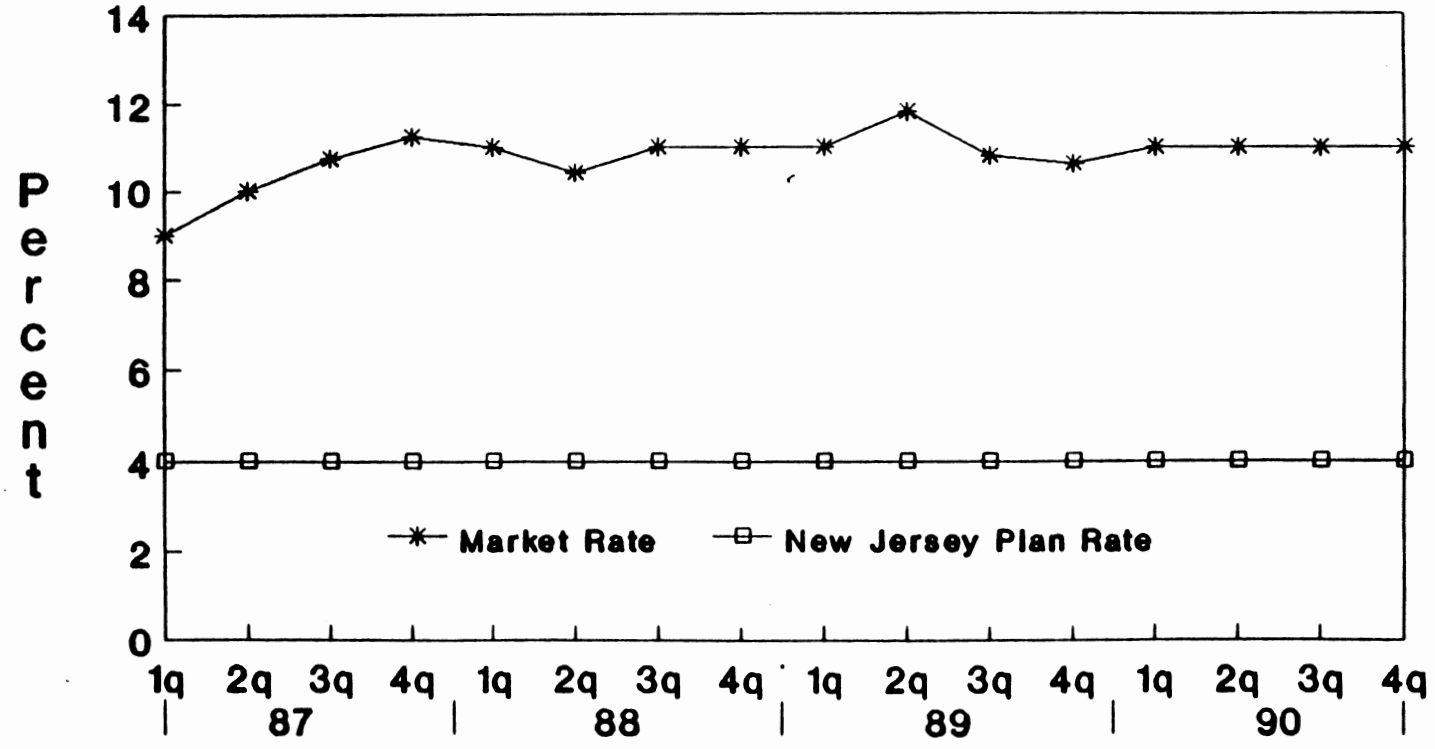


Effect of All Proposed Changes

(000's Omitted)

75 X

Interest Rate Comparison
Market Rate vs. New Jersey Pension Plan Rate



Market Rate = Prudential Defined Contribution Product Rate

REFERENCES

(1) Plan provisions based on state actuarial reports and N J Division of Pensions publications P-30-217-986 (Public Retirement in New Jersey) and T-30-185-587 (Teacher's Retirement in New Jersey.)

(2) ASSUMPTIONS: UNLESS OTHERWISE SPECIFIED, THE CALCULATIONS SHOWN REPRESENT the following:

INTEREST:	7 0%
Mortality:	1989 George Buck Tables: 40% Male + 60% Female
COLA:	2 5%
Salary Scale	4 17%
Withdrawal	0%
Disability	0%

Annual payment frequency, no supplemental benefits or optional forms.

(3) SALARIED EMPLOYEE BENEFITS PROVIDED BY MAJOR U.S. EMPLOYERS IN 1989; Hewitt Associates; 1990

(4) A SURVEY OF RETIREMENT, THRIFT, AND PROFIT SHARING PLANS COVERING Salaried Employees of 50 Large U S. Industrial Companies as of January 1, 1989; The Wyatt Company; 1989

(5) NCPERS SURVEY OF MEMBER PLANS, NATIONAL CONFERENCE ON PUBLIC EMPLOYEE Retirement Systems, January, 1990.

(6) REPORT TO THE GOVERNOR, NEW JERSEY STATE PENSION STUDY COMMISSION; MARCH 15, 1984.

(7) 38TH ANNUAL REPORT; STATE INVESTMENT COUNCIL; DEPARTMENT OF THE TREASURY.

(8) EBRI QUARTERLY PENSION INVESTMENT REPORT, 4TH QUARTER, 1989.

(9) THE FUTURE OF STATE AND LOCAL PENSIONS, THE URBAN INSTITUTE, ET AL, 1981

(10) BENEFITS QUARTERLY, A Managed Care Approach to Outpatient Substance Abuse Treatment, Grant D. Lawless, First Quarter, 1990

(11) 1989 HAY/HUGGINS BENEFITS REPORT

(12) FOSTER HIGGINS HEALTH CARE BENEFIT SURVER 1988

(13) FOSTER HIGGINS HEALTH CARE BENEFIT SURVEY 1989

(14) HCHS, National Hospital Discharge Surveys

(15) Selma Taffel, STATISTICAL BULLETIN, October - November, 1989

(16) Committee of Utilization Management by Third Parties, Institutes of Medicine, November 1989

(17) MODERN HEALTHCARE, Volume 20/No. 36, September 1990

77X