# State of New Jersey

## Plan Design Comparison Analysis

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**Executive Summary**

Most U.S. employers mitigate cost by updating plan designs over time to incent more cost-effective consumer behavior which leads to cost reductions. By contrast, the State Health Benefits Program (SHBP) / School Employees' Health Benefits Program (SEHBP) plan designs have not seen substantial updates over the past few years and still pay between 97-98% of all healthcare costs before member cost sharing. The high percentage of costs paid by the plan (known as the actuarial value) results in the SHBP/SEHBP absorbing more of the healthcare cost burden compared to employees. The actuarial value likely contributes to members over-utilizing services due to a lack of financial responsibility by the member. The lack of financial responsibility by the member is driven by the following factors: richness of the plan designs; and the low level of mandatory utilization management tools incorporated into the SHBP/SEHBP plan design. Members are not incentivized to make cost-effective healthcare consumer choices which further results in higher utilization of all services. These components drive the total healthcare cost of the SHBP/SEHBP for both the State and Member.

The analysis outlined below is a summary comparison of medical plan designs and strategy insights for employer-sponsored healthcare plans in both the public and private sectors. The analysis is intended to provide valuable insights into how the highest enrolled plans offered to State, Local Government, and Local Education members compare to private and public sector industry employer group peers, including the identification of outliers regarding plan design or overall strategy. Some of the observations are outlined below:

- The majority of employer groups included within Exhibit A include an in-network deductible while each of the plan design options with the highest enrollment for State, Local Government, and Local Education groups for the State of New Jersey include no in-network deductible. Adding a deductible to each of the three illustrated plan options would result in the member being required to satisfy the full deductible before the SHBP/SEHBP begins to pay for services in accordance with the plan design. This change may yield immediate savings to the SHBP/SEHBP plan, while also driving indirect savings through promoting more appropriate, and cost-effective consumer behavior within the healthcare system. The addition of a deductible to the existing plan design and increasing the financial responsibility for the member prior to the coverage of healthcare expenses results in short term cost shifting but may also impact long-term behavior through identification of the appropriate site of care for non-emergent services.
- Significant copay differentials between Primary Care Physician (PCP), Specialist, Urgent Care, and Emergency Room services is a strategy most employers utilize to steer participants to the appropriate site of care for the appropriate service. Proper site of care steerage reduces overall plan costs through more appropriate, and cost-effective consumer behavior and allows the healthcare system to operate more efficiently.

- The rise of Prescription Drug (Rx) costs and specialty medications nationwide has resulted in employers changing their Rx copay structure to encourage members to utilize cost-effective clinically equivalent options when available. Restructuring copays to be properly aligned with the additional expected ongoing future cost absorbed by Employers for specialty medications will encourage members to make better medication decisions due to the additional financial responsibility by the member.

All solutions require effective communication, proper utilization, and member adoption through effective incentives, including cost-shifting for members who choose not to participate, or mandatory participation requirements of the solution in order to realize savings and reduce cost.

Aon has gathered benchmarking data by leveraging our large internal network of public and private sector clients that are similar size or scope to the State of New Jersey Health Benefits Plan.

- **Plan Design Comparison – Active Employees:**
  - Aon gathered data to complete a comparative crosswalk of the plan design components of the SHBP/SEHBP against the plan design components of other State entities, and several other large employer plans with bargained benefits, throughout the country. This data has been collected and illustrated based on each employer's plan option with the highest average enrollment in order to illustrate the differences in the core benefits offering amongst each population.
  - The reference to "Plan design" in this analysis is broadly defined and detailed to include all plan design elements which directly impact the actuarial value, and the aspects of those plan design elements, cost-sharing and other plan programs that have an impact on the cost of an employer's plan.
- **Strategy and Innovation Observations:**
  - In addition to the comparative analysis detailed in Exhibit A, this analysis also includes commentary regarding the general utilization management programs and tools, comparison to Horizon's Book-of-Business averages, and other innovative plan pricing controls employers have leveraged to reduce the cost of their plan.
    - The data collected for this analysis illustrates two main focus areas for comparison purposes. Exhibit A focuses on plan design illustrating the higher-than-average actuarial value of similar groups of size. The higher actuarial value results in the SHBP/SEHBP absorbing more of the healthcare cost burden compared to employees and contributes to members over-utilizing services, and making less cost-effective consumer choices, due to a lack of financial responsibility by the member.
  - Lastly, included within this analysis are specific plan design or new programmatic changes, along with the potential cost savings for the SHBP/SEHBP based on short-term (within 3-12 months); medium-term (12-24 months); and longer-term (24+ months) implementation goals.

**Plan Design Comparison – Active Employees**

Aon collected information from select clients of similar size or scope to the State of New Jersey to compare plan designs across employers nationally. The plan design comparison exhibit below highlights how the State compares to its private and public sector industry employer group peers in the following categories:

- Deductibles
- Out-of-Pocket Maximums
- Professional Services Cost Share
- Facility Services Cost Share
- Prescription Drug Cost Share
- Employee Contribution Percentage
- Employer Contribution Percentage
- Actuarial Value of Plan

Actuarial Value is defined as the percentage of total average costs for covered benefits that will be paid by the health benefits plan specific to the plan design offered to members. For example, a plan that has an actuarial value of 85%, would result in the average participant being responsible for 15% of the cost of all covered benefits.

While actuarial value is not the only measurement contributing to an Employer's total healthcare spend, the actuarial value of a plan correlates to total healthcare spend due to the lack of incentive for members to seek more cost-effective care. Moreover, two plans with the same actuarial value may have significantly different total healthcare spend due to additional variables such as cost of care in specific geographic regions, over-utilization of services and utilization of higher cost services by members, and effectiveness of utilization management tools within the plan.

For comparison purposes, the SEHBP Local Education Educators Health Plan, SHBP State CWA/NJDIRECT, and SHBP Local Government PPO10 (each of the plan design options with the highest enrollment) Plan Year 2023 plan design information is shown along with benchmarking results. All the benchmarking information shown is for Plan Year 2023.

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# Exhibit A: Plan Design Comparison Chart

| Employer | State Health Benefits Program | | State Health Benefits Program | | School Employees Health Benefits Program | | Large Private Employer | | Large Public Employer | Large Public Employer | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan Name | (SHBP - State) CWA / NJDIRECT Actives | | (SHBP - Local Government) PPO10 Plan | | (SEHBP) Educators Health Plan Actives | | Southeast Region HDHP | | Southeast Region HMO | Southeast Region PPO | |
| Plan Tier | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | In-Network | Out-of-Network |
| **Medical Deductible, OOP Max, Coinsurance** | | | | | | | | | | | |
| Member Coinsurance | 0% | 30% | 0% | 20% | 0% | 30% | 30% | 50% | 20% | 30% | 50% |
| Deductible/Out-of-Pocket Maximum Type | Embedded | Embedded | Embedded | Embedded | Embedded | Embedded | Family/Embedd | Family/Embedd | Embedded | Embedded | Embedded |
| Individual Deductible | None | $400 | None | $100 | None | $350 | $1,500 | $2,500 | $1,300 | $550 | $1,100 |
| Family Deductible | None | $1,000 | None | $250 | None | $700 | $3,000 | $5,000 | $2,600 | $1,100 | $2,200 |
| Individual Out-of-Pocket Maximum | $7,280 Med / $1,820 Rx | $2,000 Med / $1,820 Rx | $400 Med / $1,820 Rx | $2,000 Med / $1,820 Rx | $500 Med / $1,600 Rx | $2,000 Med / $1,600 Rx | $5,000 | $9,500 | $4,000 | $3,100 | $6,200 |
| Family Out-of-Pocket Maximum | $14,560 Med / $3,640 Rx | $5,000 Med / $3,640 Rx | $1,000 Med / $3,640 Rx | $5,000 Med / $3,640 Rx | $1,000 Med / $3,200 Rx | $5,000 Med / $3,200 Rx | $10,000 | $19,000 | $9,000 | $6,200 | $12,400 |
| **Inpatient / Outpatient Facility** | | | | | | | | | | | |
| Inpatient Hospital | No charge | 30% plus $500 per stay | No charge | 20% plus $200 per stay | No charge | 30% | 30% | 50% | 20% | 30% | 50% |
| Emergency Room | $150 | $150 | $75 | $75 | $125 | $125 | 30% | 30% | $150 | $375 | $375 |
| Urgent Care | $45 | 30% | $10 | 20% | $15 | 30% | 30% | 50% | $35 | $45 | $45 |
| Outpatient Surgery | No charge | 30% | No charge | 20% | No charge | 30% | 30% | 50% | 20% | $150 | 50% |
| Advanced Radiology | No charge | 30% | No charge | 20% | No charge | 30% | 30% | 50% | 20% | $100 | 50% |
| **Professional** | | | | | | | | | | | |
| Primary Care Physician Office Visit | $15 | 30% | $10 | 20% | $10 | 30% | 30% | 50% | $35 | $25 | 50% |
| Specialist Office Visit | $30 | 30% | $10 | 20% | $15 | 30% | 30% | 50% | $45 | $50 | 50% |
| Psychiatry | $15 | 30% | $10 | 20% | $15 | 30% | 30% | 50% | 20% | No Charge | 50% |
| Physical Medicine/Rehab | $30 | 30% | $10 | 20% | $15 | 30% | 30% | 50% | 20% | $35 | 50% |
| Chiropractic | $30 | 30% | $10 | 20% | $15 | 30% | 30% | 50% | 20% | $60 | 50% |
| **Other Medical** | | | | | | | | | | | |
| Durable Medical Equipment | 10%; deductible does not apply | 30% | 10%; deductible does not apply | 20% | 10%; deductible does not apply | 30% | 30% | 50% | 20% | 30% | 50% |
| Telehealth | $15 | 30% | $10 | 20% | $10 | 30% | 30% | 50% | 20% | 30% | Not Covered |
| **Prescription Drug** | | | | | | | | | | | |
| Retail Generic | $7 | $7 | $3 | $3 | $5 | $5 | 30% | 30% | $20 | $20 | 50% |
| Retail Brand Formulary | $16 | $16 | $10 | $10 | $10 | $10 | 30% | 30% | $50 | $55 | 50% |
| Retail Non-Formulary | $16 | $16 | $10 | $10 | $10 | $10 | 30% | 30% | $90 | $150 | 50% |
| Retail Specialty | $16 | Not Covered | $10 | Not Covered | $10 | Not Covered | 30% | 30% | $90 | $150 | 50% |
| Mail Generic (90-day) | $0 | $0 | $0 | $0 | $10 | $10 | 30% | 30% | $50 | $40 | Not Covered |
| Mail Brand Formulary (90-day) | $40 | $40 | $15 | $15 | $20 | $20 | 30% | 30% | $125 | $140 | Not Covered |
| Mail Non-Formulary (90-day) | $40 | $40 | $15 | $15 | $20 | $20 | 30% | 30% | $225 | $375 | Not Covered |
| Mail Specialty (90-day) | $40 | Not Covered | $15 | Not Covered | $20 | Not Covered | 30% | 30% | $225 | $375 | Not Covered |
| **Employee Count** | **47,200** | | **30,400** | | **31,400** | | **12,000** | | **260,000** | **28,000** | |
| **Actuarial Value of Plan** | **96.4%** | | **98.3%** | | **97.7%** | | **82.3%** | | **86.7%** | **88.4%** | |

*Deductible is waived where copays apply unless otherwise noted

**Coinsurance applies after deductible unless otherwise noted

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# Exhibit A: Plan Design Comparison Chart (cont.)

| Employer | Large Public Employer | Large Private Employer | | Large Public Employer | | Large Public Employer | Large Public Employer | | Large Public Employer | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Mid-Atlantic Region | Southwest Region | | Mid-Atlantic Region | | Mid-Atlantic Region | Southwest Region | | Southeast Region | |
| Plan Name | PPO w/ Elective OON | PPO | | POS | | EPO | PPO | | PPO | |
| Plan Tier | In-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Medical Deductible, OOP Max, Coinsurance** | | | | | | | | | | |
| Member Coinsurance | 20% | 20% | 40% | 10% | 30% | 0% | 20% | 50% | 15% | 40% |
| Deductible/Out-of-Pocket Maximum Type | Embedded | Embedded | Embedded | Embedded | Embedded | Family | Embedded | Embedded | Embedded | Embedded |
| Individual Deductible | $300 | $850 | $3,000 | $0 | $0 | $100 | $750 Med / $100 Rx | $750 | $750 | $1,500 |
| Family Deductible | $600 | $2,550 | $9,000 | $0 | $0 | $200 | $2000 Med / $300 | $2,000 | $1,875 | $3,750 |
| Individual Out-of-Pocket Maximum | $1,500 | $2,850 | $9,000 | $1,000 | Unlimited | $1,100 | $3,300 | $3,800 | $3,600 | $7,200 |
| Family Out-of-Pocket Maximum | $3,000 | $7,550 | $24,000 | $2,000 | Unlimited | $3,600 | $8,400 | $9,900 | $9,000 | $18,000 |
| **Inpatient / Outpatient Facility** | | | | | | | | | | |
| Inpatient Hospital | $300 per stay | 20% | 40% | 10% | 30% | No Charge | 20% | 50% | 15% | 40% |
| Emergency Room | $150 | $100 plus 20% | $100 plus 20% | $100 | $100 | $75 | $200 | $200 | 15% | 40% |
| Urgent Care | $40 | 20% | 40% | $10 | $10 | $35 | $30 | $30 | $45 | $45 |
| Outpatient Surgery | $125 | 20% | 40% | 10% | 30% | $25 | 20% | 50% | 15% | 40% |
| Advanced Radiology | 20% | 20% | 40% | 10% | 30% | No Charge | 20% | 50% | 15% | 40% |
| **Professional** | | | | | | | | | | |
| Primary Care Physician Office Visit | $25 | $30 | 40% | $10 | 30% | $15 | $30 | 50% | $25 | $25 |
| Specialist Office Visit | $40 | 20% | 40% | $20 | 30% | $15 | $50 | 50% | $45 | $70 |
| Psychiatry | $25 | 20% | 40% | 10% | 30% | $15 | 20% | 50% | $25 | $45 |
| Physical Medicine/Rehab | $35 | 20% | 40% | 10% | 30% | $15 | 20% | 50% | 15% | 40% |
| Chiropractic | $35 | 20% | 40% | 10% | 30% | $15 | 20% | 50% | $25 | $45 |
| **Other Medical** | | | | | | | | | | |
| Durable Medical Equipment | 20% | 20% | 40% | 10% | 30% | No Charge; deductible waived | 20% | 50% | 15% | 40% |
| Telehealth | $0 (via livehealthonline.com) | $20 | Not covered | 10% | 30% | $15 + 30%, deductible waived | 20% | 50% | $15 | Not Covered |
| **Prescription Drug** | | | | | | | | | | |
| Retail Generic | $15 | 20% ($10 min/$40 max) | 20% ($10 min/$40 max) | $10 | Not Covered | $5 | $10 | 50% | $7 | $7 |
| Retail Brand Formulary | $30 | 30% ($30 min/$100 max) | 30% ($30 min/$100 max) | $15 | Not Covered | $25 | $45 | 50% | $40 | $40 |
| Retail Non-Formulary | $45 | 50% ($45 min/$150 max) | 50% ($45 min/$150 max) | $30 | Not Covered | $35 | $75 | 75% | $90 | $90 |
| Retail Specialty | $55 | Not covered | Not covered | $30 | Not Covered | $35 | $100 | Not Covered | 25% ($100 min/$180 | Not Covered |
| Mail Generic (90-day) | $30 | 20% ($5 min/$80 max) | Not covered | $10 | Not Covered | $10 | $25 | 50% | $14 | Not Covered |
| Mail Brand Formulary (90-day) | $60 | 30% ($45 min/$150 max) | Not covered | $15 | Not Covered | $50 | $90 | 50% | $80 | Not Covered |
| Mail Non-Formulary (90-day) | $90 | 50% ($90 min/$300 max) | Not covered | $30 | Not Covered | $70 | $150 | 75% | $180 | Not Covered |
| Mail Specialty (90-day) | $110 | 20% ($5 min/$80 max) | Not covered | $30 | Not Covered | $70 | $200 | Not Covered | 25% ($300 min/$540 | Not Covered |
| **Employee Count** | **85,000** | **88,000** | | **10,000** | | **5,100** | **140,000** | | **140,000** | |
| **Actuarial Value of Plan** | **93.6%** | **86.2%** | | **95.3%** | | **96.9%** | **88.3%** | | **88.5%** | |

*Deductible is waived where copays apply unless otherwise noted

**Coinsurance applies after deductible unless otherwise noted

**Strategy and Innovation Observations:**

The member utilization of the healthcare system is one of the primary drivers of the State's annual cost increases. The average national cost for an active employee in an employer sponsored health plan is roughly $14,000 Per Employee Per Year (PEPY). Current State Actives within the SHBP are projected to have PEPY costs of roughly $22,000, or $8,000 and 60% higher. When compared to other employers, the SHBP/SEHBP PEPY is higher due to the level of member utilization of services, the richness of the plan designs, and the low level of mandatory utilization management incorporated into the SHBP/SEHBP.

SHBP/SEHBP members are not utilizing healthcare in a comparable fashion to most U.S. employer plan participants. The SHBP/SEHBP plans have few mechanisms in place to encourage utilization of the most cost-efficient services. Many of the enhanced programs, implemented to save costs and improve health, are not mandatory for members, and members' engagement in those programs has been and remains relatively low despite marketing efforts. Without the appropriate cost controls members utilize higher cost delivery care channels, as exhibited in the increased per employee cost. There are very few mandatory utilization management features in the State plans. Examples of mandatory utilization management strategies offered by other employer plans, not broadly adopted by the SHBP/SEHBP, include required designation of a PCP, precertification of complex or advanced procedures, PCP referral requirements prior to receiving specialist care, prior authorizations, and other measures. These features are common in other U.S. plans and would be expected to significantly lower cost increases if implemented by the SHBP/SEHBP.

The chart outlined below details recent data provided by Horizon Blue Cross Blue Shield of instances where the State's Plan Year 2022 utilization varies significantly from Horizon Book-of-Business averages. Plan design change has a short-term impact on overall cost. Over the longer term, plan design change could impact member utilization due to the requirement for member behavior change resulting in subsequent cost reductions. Therefore, the State may consider plan design changes in this section that can impact the above average utilization of the specific services/conditions referenced below. A few considerations for utilization management could be through the implementation of prior authorizations for services such as acupuncture, or site of care and provider management for dialysis treatments.

The information presented below combines both the SHBP/SEHBP Active and Early Retiree populations and highlights some of the largest variances comparing the SHBP/SEHBP to Horizon's book-of-business. Although the metrics highlighted within the chart below do not necessarily represent all of the services that drive trend increases among the SHBP/SEHBP, they do highlight the opportunity for cost reduction opportunities through mitigating over-utilization of the plan by members compared to private and public sector industry employer group peers within the geographic region.

| Service Category | State of New Jersey SHBP/SEHBP Metrics | Horizon Book-of-Business Metrics |
|---|---|---|
| Inpatient | | |
| Average Length of Stay | 7.8 days | 6.7 days |
| Outpatient | | |
| Behavioral Health | $13.52 PMPM | $6.58 PMPM |
| Professional | | |
| Evaluation and Management (E&M) (utilization/1,000) | 6,158 | 4,597 |
| Physical Medicine and Rehab (utilization/1,000) | 2,031 | 1,240 |
| Urgent Care (utilization/1,000) | 618.7 | 340.2 |
| Virtual Utilization (utilization/1,000) | 681.4 | 477.2 |
| Acupuncture (utilization/1,000) | 307.1 | 101.2 |
| Ancillary Durable Medical Equipment (DME) | $12.43 PMPM | $7.12 PMPM |
| Mental Health Visits (utilization/1,000) | 978.8 | 574 |
| Network Utilization | | |
| In-Network Utilization Percentage | 87.8% | 91.7% |

*Utilization/1,000 is defined as total claim count/1,000 members

In addition to the variances listed above, neonatal care, acute dialysis, and professional audiology are also driving trend for the SHBP/SEHBP based on Horizon's Full Year 2022 medical cost trend reporting. Note, some of these trend drivers are unavoidable such as neonatal care, however, other services, such as dialysis, may have opportunity for improvement through site of care coordination.

Increases in utilization above Book-of-Business averages can contribute to the rising cost of plan sponsored healthcare. Considering plan design changes in order to promote more appropriate, and cost-effective consumer behavior by the member and steer participants to more appropriate sites of care or types of services can result in reducing the overutilization of certain higher cost services. For example, redirecting to Physical Therapy as a first option rather than surgical intervention may have a positive impact on total claim costs.

However, high utilization for certain services such as Virtual (or Telehealth) care or Mental Health Visits, can positively impact the total cost of care as members are seeking more appropriate service options for non-emergent issues.

Amongst the clients surveyed in Exhibit A, Aon has gathered the following statistics regarding innovative solutions implemented across each of the populations in order to provide insight into how employers are approaching the growing cost of healthcare.

- Of the clients listed in Exhibit A, over 50% have implemented strategies around Centers of Excellence and Telemedicine. Both strategies are focused on providing members with opportunities to access cost-effective and high-quality care. Providing these alternative programs can impact overall plan utilization and plan cost.
- While Centers of Excellence and Telemedicine may be widely adopted, less than 25% have implemented Direct Contracting strategies with providers and only 11% have implemented Reference Based Pricing strategies to control costs. These methods drive savings through revised pricing arrangements with the provider community. These strategies, although more disruptive to members, can be the most direct way to control costs compared to existing negotiated contracts through the medical vendor partnership. Implementation of a targeted Center of Excellence strategy related to a specific hospital system or condition can drive savings for the SHBP/SEHBP through member steerage to cost effective providers with improved quality metrics such as lower readmission rates and lower infection or complication rates which may impact avoidable claim costs.
- Musculoskeletal services are a top cost driver amongst the majority of employer participants which has driven some to find alternative solutions to address the rising cost. A musculoskeletal service includes diagnosis and treatment of injuries and diseases affecting the muscles, bones and joints of the limbs and spine.
- Employers have approached directing care in a variety of ways including decision making support tools, navigation programs, and narrow network solutions to steer members to the most cost-effective and higher quality care. These methods may lower costs. However, all solutions require effective communication, proper utilization, and member adoption through effective incentives, including cost-shifting for members who choose not to participate, or mandatory participation requirements of the solution in order to realize savings and reduce cost.

Outlined below are short-term (within 3-12 months); medium-term (12-24 months); and longer-term (24+ months) opportunities that could reduce health plan costs. These methods may lower costs. However, all solutions require effective communication, proper utilization, and member adoption through effective incentives, including cost-shifting for members who choose not to participate, or mandatory participation requirements of the solution in order to realize savings and reduce cost. The solutions outlined in the section below are meant to provide innovative recommendations that may yield savings with successful implementation. However, some of the savings' initiatives may not immediately result in a reduction in cost, and may require initial investment.

**Short-term (within 3-12 months):**

- **Spousal Surcharge of $50 per month –** The spousal premium surcharge encourages those participants who are eligible for other group coverage to take advantage of their employer sponsored plan, and it also allows the SHBP/SEHBP to share healthcare costs with other employers. Since SHBP/SEHBP medical plans are self-insured and pay a portion of the cost of the member's medical coverage and actual claims, if the spouse moves to her/his employer's plan and utilizes that benefit instead it saves the SHBP/SEHBP on future plan costs. If the spouse

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decides to elect the SHBP/SEHBP plan coverage rather than her/his employer plan, funds available through member contributions will increase.

- **Revise Rx Copay Structure –** As evident in the plan design comparison chart outlined in Exhibit A, the SHBP/SEHBP Rx copays are an outlier compared to private and public sector industry employer group peers, specifically as you compare to Brand and Specialty medication costs. The SHBP/SEHBP has not updated Specialty copays, however, making this change to reflect proper cost share and promote more cost-effective consumer behavior may drive cost savings for the SHBP/SEHBP. Specialty medication is defined as high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis.
- **Increase In-Network/Out-of-Network (INN/OON) deductibles for each plan $200 (applicable for all services) –** A majority of private and public employers require deductibles on all plan options. Increasing deductibles may encourage employees to better manage how and where they receive medical care. Currently, a significant percentage of SHBP/SEHBP members do not have a significant In-Network (INN) or Out-of-Network (OON) deductible level. The current deductible level may encourage members to over utilize the healthcare system; a higher deductible for members could encourage member behavior when deciding site of care for non-emergent services.

**Medium-term (12-24 months):**

- **Value Based Care Initiatives –** Value-Based Care aligns provider reimbursement to the quality of care provided and rewards providers for both efficiency and effectiveness. This strategy would replace or supplement the more widespread practice of fee-for-service reimbursement, which pays providers retrospectively for services delivered based on bill charges or annual fee schedules. Realigning payment for services based on value can, if members are required or strongly incentivized to use those providers. This strategy can drive members to high-quality and more cost-effective providers generating savings through lower re-admission rates, lower negotiated rates, and population health improvements over time.
- **Reference-Based Pricing (RBP) for Knee Replacement, Hip Replacement, Bariatric Surgery, and Colonoscopies –** Reference Based Pricing would not technically impact network access since the change in strategy is tied to the financial reimbursement the State is willing to pay for certain services (e.g. knee and hip replacements.) Although this may require a separate RBP vendor/solution to administer, it could yield savings both through limiting the allowed amount for these procedures and impacting long-term healthcare costs by steering participants to lower-cost yet equal-quality providers for certain services. RBP strategies require effective communication, proper utilization, and member adoption through effective incentives, including cost-shifting for members who choose not to participate, or mandatory participation requirements of the solution in order to realize savings and reduce cost.
- **Update OON reimbursement to 175% of CMS for applicable plan options –** A change to the out-of-network reimbursement is meant to improve provider accountability, pricing transparency, and manage plan cost. This strategy is tied to the financial reimbursement the State is willing to pay for certain services. If the SHBP/SEHBP were to implement a change of this kind, this could yield

savings both through limiting the allowed amount the State is willing to pay and have a long-term effect by steering participants towards INN providers . This change would not apply to the CWA Unity/NJDIRECT plan options.

**Long-term (24+ months):**

- **Alternative Health Plan Models –** Alternative Health Plan Models encourage ongoing Primary Care Physician (PCP) relationships, or a Virtual First care approach to transform delivery by expanding access, improving quality, and reducing cost of care. The financial impact of these types of solutions is driven through the reduction of unnecessary use of services, steerage to lower cost/high quality care, and better management of chronic conditions through ongoing PCP relationships. Savings may not immediately result in a reduction in cost, and may require initial investment.
- **Mandatory Biosimilars –** This change would result in requiring members to utilize a biosimilar, which is considered to have the same efficacy and safety as a biologic medication with likely a significantly reduced cost. Biosimilars are safe and effective treatment options for many illnesses such as chronic skin, bowel diseases, arthritis, kidney conditions, and cancer. Biosimilars increase access to lifesaving medications at potentially lower costs. The impact to members in this scenario would be at the service level since they may need to change prescriptions compared to what is currently prescribed for them today. The savings would be generated through the lower total healthcare claims cost the State would be responsible for paying as members are prescribed lower cost prescriptions.