Memo

	Michael Zanyor – Public employee representative Co-chair, SHBP PDC
To	Andrea Spalla – State Co-chair, SHBP PDC
From	Aon Consulting, Inc.
Date	August 15, 2025
Re	Submission of SHBP Savings Proposals of Labor Representatives of the SHBP-PDC

This memo is in response to savings proposals provided by the Labor Representatives of the State Health Benefits Program Plan Design Committee ("SHBP-PDC") pursuant to the State of New Jersey Fiscal Year 2026 ("FY2026") Appropriations Act, P.L. 2025, c. 74, detailing cost saving plan design proposals for the New Jersey State Health Benefits Program ("SHBP") to achieve a total of $100 million in recurring State savings during the first six months of Plan Year ("PY") 2026.

Per the State of New Jersey Fiscal Year 2026 ("FY2026") Appropriations Act, P.L. 2025, c. 74, the plan actuary was asked to review the proposals submitted and determine whether they will result in recurring and actuarially verifiable savings. As such, Aon provided savings figures for plan design concepts that are verifiable based on the data and information available as of August 15, 2025. Strategies referenced within this document may achieve $100 million in savings during the first six months of Plan Year 2026. However, some strategies may require more information before they can be considered verifiable due to the nature of the program (i.e. retrospective analysis of a solution to evaluate verifiable efficacy, vendor administrative costs that may offset savings figures, etc.).

Below are the proposals provided by the Labor Representatives of the SHBP PDC. Savings assume each proposal is implemented effective January 1, 2026, or earlier, and are shown on a full calendar year basis. Savings for six months can be assumed to be equal to half of the full calendar year savings figures represented. Savings associated with each proposal are not additive due to the interrelatedness of certain plan changes:

1. Labor representative of the Plan Design Committee request a revised rate recommendation to be issued for the State group no later than August 15, 2025.

Aon Response: Based on current projections, if the PY2026 State Actives medical and prescription drug plan were to reduce projected costs by $200M, the total premium rate increase for PY2026 would be approximately 10-11%. However, Aon is unable to estimate increases separately by plan or by the medical versus prescription drug components without detailed proposals specifying how the $200M in savings would be achieved. Detailed scenarios are necessary to evaluate the impact on individual plans and components.

It is important to note that these estimates are based on current PY2026 cost and enrollment projections. Any plan changes that affect employee plan elections could further alter premium amounts and the projected rate increase.

Aon does not recommend revising the rate setting reports or recommended rates to reflect the $200M in savings without defined, agreed-upon plan design and/or program changes. Incorporating unspecified savings into the rates risks underfunding the plan, which could jeopardize its financial stability. As a reminder, the Plan Year 2026 rate setting process is designed to project the expected cost of the plan and premiums necessary to cover the expected cost based on available information. Accurate rate setting requires clarity on any proposed changes that would impact plan costs.

2. Outcomes and agreements from the NJ State bargaining unit reopener tables that require PDC approval shall be credited towards the FY2026 budget requirement and shall be scored to reduce premiums for PY2026.

   Aon Response: Aon does not have the necessary context specific to the bargaining tables to evaluate the savings associated with this proposal.

3. Claims Review – Mandate review of no less than 50% of all claims, in and out of network, and at least 50% of out of state claims.

   Aon Response: Aon cannot produce verifiable savings associated with 50% or more of all claims being reviewed by the State's claims reviewer, HMS.

4. Implement Reference Based Pricing across all SHBP Plans at 200% of CMS in- and out-of-network and prohibiting balance billing.

   Aon Response: Aon cannot produce a verifiable savings figure for this proposal. The concept of Reference Based Pricing, if administered properly, can produce significant savings. However, Aon does not have sufficient information to provide verifiable savings for

a proposed RBP solution. Provider acceptance is uncertain, and balance billing cannot be prohibited without contracts or legislation. These factors introduce significant unpredictability in both costs and member experience, making any savings projection speculative rather than verifiable.

The proposed solution cannot be verified, as it is written today, due to a variety of factors. A major concern with the proposed approach, based on Aon's interpretation, is the lack of provider contracting and acceptance data:

- RBP relies on paying providers a set percentage above CMS (Medicare) rates, rather than negotiated rates. Many providers are not contractually obligated to accept these payments, especially at the specified 200% of CMS within the existing network offered through the SHBP.
- Without provider contracts or historical acceptance data, it is impossible to predict how many claims will be paid at 200% of CMS, or whether providers will refuse payment and seek higher amounts.
- Without clarity on enforceability, the plan's actual payment outcomes and savings cannot be verified.

5. Provide incentives attached to lower cost plans, including HDHPs, by offering lower employee contribution rates and increase HRA and HSA plans.

   Aon Response: If 10% of State Active members currently enrolled in the PPO15 plan migrated to the HDLow plan, projected PY2026 costs are estimated to decrease by $4 million. Alternatively, if 10% of these members migrated to the HDHigh plan, projected PY2026 costs are estimated to decrease by $7 million. These savings estimates are based on the Draft PY2026 Rate Setting projections and Aon's Actuarial Value model.

   It is important to note that the savings figures above do not include the additional costs associated with employer-funded HSA seed contributions or other incentives that may be offered to encourage migration. To accurately assess the net financial impact, additional detail is needed regarding the type and value of incentives being considered. These additional costs could significantly offset the projected savings.

   Additionally, the Rate Setting process is designed to project the total cost of the plan, which encompasses all expected claims and administrative expenses. Employee contributions are outside the scope of the Rate Setting Analysis, and any reductions in contributions would offset some of the projected savings noted above. Additional data and details on proposed contribution changes would be needed to estimate their impact.

6. Implement site neutral payments.

   Aon Response: Aon cannot independently produce verifiable savings associated with site neutral payments. This level of information would require data requests from existing vendor partners and separate audit/data evaluation. Aon is unable to assess the verifiable impact of this change within the requested time period and without additional details.

7. Require and audit appropriate emergency room coding.

   Aon Response: Aon cannot independently produce verifiable savings associated with auditing the plan for appropriate emergency room coding. This level of information would require data requests from existing vendor partners and separate audit/data evaluation. Aon is unable to assess the verifiable impact of this change within the requested time period.

8. Implement Center of Excellence for Certain Surgical Procedures by January 1st, 2026.

   Aon Response: The Division of Pensions and Benefits is in the process of conducting a Request for Quotation (RFQ) for a Surgical Center of Excellence partner.

   Pending completion of the RFQ, a surgical center of excellence cannot be prospectively evaluated for verifiable savings because the actual cost reductions and clinical outcomes depend on a multitude of variables that cannot be fully predicted in advance. Prospective evaluation of this type of program heavily relies on assumptions and projections on the utilization of services, and the reimbursement rates agreed upon by the selected vendor partner. Currently SHBP Resolution 2024-7 allows for voluntary participation in the Surgical COE making savings impacts highly dependent on utilization. As a result, retrospective analyses—using actual utilization and cost data—can reliably determine whether a surgical center of excellence has achieved measurable and verifiable savings.

9. Expand Centers of Excellence Program
   - Expand COE to include colonoscopies, cataract surgery, and other routine procedures as defined by the Plan Design Committee no later than October 1st. Establish a single source Center of Excellence for transplants. Prices shall be set at the lower of billed charges, the TPA's contracted rate for the service, or 225% of CMS.
   - Pilot COE in year one with incentives, then implement higher-tiered copays if the procedure is done at a non-COE provider, for each procedure, in year 2 and year 3.
   - Specifically, in years one and two of the pilot program, members who utilize a COE network provider should obtain a Covered Service shall have no out of Pocket cost share.

In year 3 of the pilot, members who have access to a COE, including geographic access as defined in PDC Resolution 2024-7 and can obtain appointment within two months of the request, shall pay a copayment of $400. In year four and thereafter, the members meeting these conditions will have a copayment of $500.

Aon Response: The Division of Pensions and Benefits is in the process of conducting a Request for Quotation (RFQ) for a Surgical Center of Excellence partner.

Pending completion of the RFQ, a surgical center of excellence cannot be prospectively evaluated for verifiable savings because the actual cost reductions and clinical outcomes depend on a multitude of variables that cannot be fully predicted in advance. Prospective evaluation of this type of program heavily relies on assumptions and projections on the utilization of services, and the reimbursement rates agreed upon by the selected vendor partner. Currently SHBP Resolution 2024-7 allows for voluntary participation in the Surgical COE making savings impacts highly dependent on utilization. As a result, retrospective analyses—using actual utilization and cost data—can reliably determine whether a surgical center of excellence has achieved measurable and verifiable savings.

10. Competitive Plan Premium Rates

    Aon Response: Conducting separate premium rate analyses for the two Medical TPAs would require a comprehensive rate setting process. Currently, Aon does not recommend establishing different premium rates for the carriers due to insufficient credibility—specifically, limited enrollment and historical claims experience for Aetna. Currently, only six months of Aetna incurred claims data (plus three months of runout) are available, and only 4% of participants are enrolled with Aetna. This limited data does not provide a reliable basis for separate rate setting.

    For these reasons, Aon advises against separate rating for the two carriers until sufficient credible data is available to support such an approach.

11. Direct Primary Care Medical Home Referrals – The Division shall require referrals, where applicable, from the SHBP DPCMH providers be directed only to providers included in the COE as established under the SHBP.

    Aon Response: A retrospective detailed analysis could be completed to validate potential savings; however, prospective savings estimates for 2026 cannot be produced with verifiable savings. Furthermore, low historical utilization of the DPCMH program would limit savings opportunity through care coordination.

12. Evaluate Care Management Programs that are not generating ROI and renegotiate prices or terminate.

    Aon Response: A retrospective detailed analysis could be completed in order to validate any potential savings; however, a prospective savings estimate for 2026 cannot be produced with verifiable savings. Aon is unable to assess the verifiable impact of this change within the requested time period.

13. Audit all net prices for top 100 highest spend medications.
    - Audit the top 100 highest spend drugs to ensure all available discounts and maximum rebates are being applied. Apply reductions.
    - In the private market, there is a 55% discount on Amjevita effective August 2025. Score savings achieved in Plan Year 2025 and Plan Year 2026 towards the FY2026 budget requirement.
    - Implement policy by PDC to audit all medications on a quarterly basis for new rebates and discounts, comparing to private market.

    Aon Response: Aon cannot independently produce verifiable savings associated with an audit of the net prices of the top 100 highest spend medications. Aon is unable to assess the verifiable impact of this change within the requested time period.

14. Implement Clinical Effectiveness Based Formulary.

    Aon Response: Aon cannot independently produce verifiable savings associated with implementing a Clinical Effectiveness Based Formulary, without additional details. Aon is unable to assess the verifiable impact of this change within the requested time period.

15. Quarterly Review of FDA-approved medications

    Aon Response: Aon cannot produce verifiable savings associated with a Quarterly review of FDA-approved medications without additional details.

16. Reverse Auction of the Prescription Drug Contract

    Aon Response: Aon cannot prospectively produce verifiable savings associated with a Reverse Auction of the Prescription Drug Contract. Savings generated are solely dependent on the Bidder's responses to the reverse auction. Aon does not have any insight into the Truveris reverse auction platform.

17. End early refills for GLP-1 anti-obesity medications, effective September 1, 2025

    Aon Response: Per Optum, early refill caps for GLP-1's have been in place for the SHBP since June 2024.

18. Implement a GLP-1 anti-obesity counseling and monitoring program

    Aon Response: The implementation of behavioral modification/lifestyle management co-therapy point solution focused on weight management can generate savings for the plan. Prospective evaluation of this type of program is heavily dependent on the potential point solution partner's technical and financial approach. As a result, retrospective analyses—using actual utilization and cost data—can reliably determine whether a point solution has achieved measurable and verifiable savings.

19. Implement three-tiered copay for GLP-1s for anti-obesity, effective January 1, 2026:
    a. Brand Preferred: $35/month
    b. Brand non-Preferred: $50/month

    Aon Response: Note, Wegovy and Zepbound are currently co-preferred and both agents must be at the same cost-share level.

    Currently, anti-obesity drugs are identified as preferred medications so the proposed brand non-preferred copay for anti-obesity GLP-1 medications does not apply.

    Optum reports a current average copay for State Actives of $17 for anti-obesity GLP-1 drugs. Optum has confirmed that rebate guarantees may be impacted for copays exceeding $150 for anti-obesity GLP-1 drugs. If anti-obesity GLP-1 drugs were covered at a $35 preferred copay, PY2026 State Active costs would reduce $4M. As an additional scenario, if anti-obesity GLP-1 drugs were covered at a $50 preferred copay, State Active plan costs would reduce $20M. Projected savings are based on projected PY2026 membership in the draft Rate Setting Analysis and PMPM impacts provided by Optum. Optum's estimates include estimated savings due to both higher copays and reductions in utilization.

20. Reduce plan payment for Wegovy to $447.05 per month or no more than 90% of best negotiated pricing by utilizing rebates and other cost savings measures. Implement as of September 1, 2025.

Aon Response: Optum cannot guarantee a cap on Wegovy net cost. Wegovy and Zepbound must be treated the same as they are co-preferred agents. As such, Aon is unable to complete evaluation of the proposed strategy based on the existing contractual terms.

21. Identify high spend drugs to negotiate and purchase medications directly from manufacturer.

    Aon Response: Aon cannot independently produce verifiable savings associated with direct purchase arrangements with drug manufacturers.

22. Evaluate all medications through the medical side of the program to determine savings if charged through prescription drug side. Require least costly method.

    Aon Response: Aon cannot independently produce verifiable savings associated with the pharmacy benefit manager processing the medical pharmacy claims, without detailed data collection from the existing Medical plan TPA's and evaluation and comment from the PBM vendor. Some medications require specialized handling, monitoring, or administration (e.g., infusions, injections) that are best managed by healthcare professionals in a medical setting. Moving these to the prescription drug side may compromise patient safety if not administered correctly. Identifying any appropriate opportunities to move the supply of specific drugs to the PBM would require significant study outside of an actuarial analysis.

23. Implement mandatory step therapy program to require biosimilars first prior to any originator drugs; those already on specialty shall continue "as is".

    Aon Response: Per Optum, step therapy for biosimilars is already embedded in the Prior Authorization criteria for Humira and Stelara. The SHBP is currently at a 90% biosimilar adoption rate.

24. Institute cap on Medical Drug Prices (J drugs) at 120% of Average Sale Price.

    Aon Response: Aon is unable to assess the verifiable impact of this change within the requested time period and without additional details.

25. That State shall determine if the Diabetes/Insulin treatment category can be pulled out of medical claims and handled separately at a lower cost by a third-party vendor.

    Aon Response: Aon cannot independently produce verifiable savings associated with removing diabetes/insulin treatment outside of the medical claims and contracting with a

separate third-party vendor. Savings are dependent on vendor selection, contracting, and other factors. Aon is unable to assess the verifiable impact of this change within the requested time period and without additional details from a third-party vendor solution.

26. Implementation of two formulary advisors, one for general pharmaceutical that will make suggestions based on comparative effectiveness research who will make recommendations to the PDC on the drugs included in the formulary based on clinical efficacy, and one to assist with specialty medicines who will assist providers in finding the most effective drug for the members in their class. They shall be paid strictly on a PMPM or case basis.

    Aon Response: Aon cannot produce verifiable savings associated with the implementation of two formulary advisors. Savings are dependent on factors including the actual adoption rate of advisor recommendations by the Pharmacy and Therapeutics Committee (PDC) and providers, variations in member health profiles, differences in drug pricing and availability, and potential changes in prescribing patterns.