
Committee Meeting

of

JOINT LEGISLATIVE COMMITTEE ON PUBLIC EMPLOYEE BENEFITS REFORM

*"Presentation by Frederick J. Beaver, Director of the New Jersey
Division of Pensions and Benefits, to discuss the State Health Benefits Program
for State and local government participants"*

LOCATION: Committee Room 11
State House Annex
Trenton, New Jersey

DATE: September 13, 2006
1:00 p.m.

MEMBERS OF JOINT COMMITTEE PRESENT:

Senator Nicholas P. Scutari, Co-Chair
Assemblywoman Nellie Pou, Co-Chair
Senator Ronald L. Rice
Assemblyman Thomas P. Giblin
Assemblyman Kevin J. O'Toole



ALSO PRESENT:

Pamela H. Espenshade
James F. Vari
*Office of Legislative Services
Committee Aides*

Christian Martin
George LeBlanc
Senate Majority
Aaron Binder
Karina Fuentes
*Assembly Majority
Committee Aides*

Laurine Purola
Olga Betz
Senate Republican
John Kingston
Jerry Traino
*Assembly Republican
Committee Aides*

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SENATOR NICHOLAS P. SCUTARI (Co-Chair): Good afternoon and welcome, everyone, to today's meeting of the Joint Committee on Public Employee Benefits Reform. Welcome back.

Today we will begin our discussion of health benefits for public employees and how they figure into the larger picture of benefits reform. The health-care crisis is not merely confined to the State Health Benefits Program, nor are its negative effects experienced solely by public employers. It's obviously experienced by employers all across the State of New Jersey and all across the nation.

As the cost of providing quality health care has skyrocketed, all New Jerseyans and all Americans are faced with the fear that they will not have adequate insurance coverage in the future. Employers, both private and public, are straining to meet the needs of their employees, sagging under the duress of ever-increasing premiums with no imaginable end in sight. Insuring public employees is a necessity. The State benefits from having a healthy, productive workforce; and it also benefits from being able to attract skilled and talented employees into our system. The challenge, therefore, is to make the State Health Benefits Program more efficient and more affordable. Too much public money is being wasted providing outcomes that could be easily achieved at a far lower cost to taxpayers.

Fred Beaver, Director of the Division of Pension and Benefits, is here with us again, and he has prepared a presentation explaining the health benefits program and outlining some of the Division's recommendations on how it can be more affordable. In future meetings, the public will have an opportunity to address the Committee, and I will also take questions from all of our members today.

Before we begin, before I bring the Director up, if everyone could just check their cell phones, and please turn them onto vibrate or silent, I would appreciate that and so would the members of the Committee.

Director Beaver, would you please come forward.

Director, welcome back. Would you just reintroduce the members of your staff to your right and left, just in case people have forgotten?

FREDERICK J. BEAVER: Yes. Thank you very much.

To my right is John Megariotis. He's Deputy Director for--

SENATOR SCUTARI: Slower, I could barely-- (laughter)

MR. BEAVER: John Megariotis, Deputy Director for Fiscal Operations in the Division of Pension and Benefits; and to my left is Florence Sheppard, the Deputy Director of Benefits -- two key people, as I've mentioned before.

SENATOR SCUTARI: Obviously.

Thank you very much for joining us again. And if you want to begin your presentation, we'll take questions at the end of the presentation.

MR. BEAVER: Thank you.

And I appreciate the opportunity to be here again today.

The thing is today, is we're taking the Committee back through some basic or some of the essential facts in administrative operations in the State Health Benefits Plan, and also address some of the recommendations that were made by the Benefits Task Force in the Murphy report that was issued late last year.

Again, you've seen some of this information at a prior meeting, a previous meeting, but there's a little more detail this time. New Jersey State Health Benefits Program covers about 804,000 people in the State of New Jersey, including the employees and retirees, and their dependents. It's comprised of seven health plans, 11 dental plans, a prescription drug plan for both the active and retired group. And basically, you've got a \$3.6 billion program. That's both local and State dollars included in that number.

In the State and local employer groups, you have the State employees, and that also includes the college and university employees, local education, and local government. And in terms of State contracts, on the active group side, we have 115,000 lives covered, contracts, for medical and prescription drugs. One hundred and four thousand lives are covered, or contracts are issued, for dental coverage as well. It's an optional benefit. On the retired side for the State, we've got 34,000 contracts for medical and prescription drugs; and about 9,900 for dental -- and that's all paid for by the retirees; that's all retiree money. And that's a fairly new option within the last two years.

On the local education and local government side, you've got 934 participating employers in the active group, with about 127,000 medical contracts, 34,000 prescription drug contracts, and 1,100 dental contracts; with about 88,000 retirees, and about 28,000 retirees put (indiscernible) in dental. When you look at this and you compare -- again, I mentioned this before -- when you compare this to the pension system with about over 1,500 employers, you can see that only about two-thirds of the employers in the State are participating in the State Health Benefits

Plan. And of the 600 school districts in the State, or more than 600 districts, about 246 participate in the State Health Benefits Program.

The medical plan offerings for both active and retired: We've got the Traditional Plan -- the indemnity plan, which is long-standing. Everybody is familiar with the -- it's the plan that pays you when you get sick. There are 128,000 total contracts. In NJ PLUS, we've got 160,000 contracts. And the combination of HMOs, all five of them -- we've got about 76,000 contracts in total.

On the prescription drug side, active members: Co-payments and retiree co-payments -- I just want you to have some of the essentials here. It's a two-tier co-pay for the active covered employees. It is a \$3 co-pay for generic and a \$10 co-pay for name brands. At the retail pharmacy, you can get a 30-day supply; at the mail order pharmacy, you get a 90-day supply. There are differences in the co-pays for the mail order as well. On the traditional NJ PLUS, for the retirees for example, at retail the retirees are paying \$8, \$17, and \$34, depending on whether they get generic brand or nonbrand. Mail order, it's an \$8, \$25, and \$42 co-pay for a 90-day supply, again for generic brand or nonbrand.

The active employee dental coverage: There's a number of options available to employees. The Dental Expense Plan, which is like a traditional indemnity insurance plan; and there's also 10 dental plan organizations, as you can see on the screen (indicating PowerPoint presentation) that really address a lot of the geographic differences. They don't serve statewide, but will serve specific geographic regions.

The program management is charged -- that responsibility lies with the Division of Pension and Benefits, for overall plan administration.

The plans are self-funded for both medical and prescription drugs. And we need to take a minute for that one. There are no insurance premiums involved with these plans. Whatever claims are incurred is what we pay to the providers of the services of the Horizons and the Aetnas. They delivery coverage to the employee. Whatever treatments are delivered, we render payment for those services, and we pay an administrative fee to manage the plans for us. So, basically, you have a self-funded program. There are no insurance premiums involved.

The State Health Benefits Commission is also responsible for oversight of the plans; and they will look at periodic health bidding of the programs. Typically, the plans are bid every five years. And as a matter of fact, the current contracts will expire at the end of December '07, so we need to get ready to start bidding contracts now.

We do not pay any commissions to insurance agents, brokers, or consultants. If we retain a consultant to assist us with a bid evaluation, they're paid for their services. So there is no incentive for anybody to steer us, and it's typically an evaluation committee comprised of various representatives of the Treasury Department and other agencies, including the Department of Banking and Insurance.

There's a uniform bidding process where we go out for a common contract, but we rate the State and local employers separately. And I'll show you a little bit of that later on in the presentation. But you are rated -- the experience rate -- the local employers and the education groups, based on their actual claims experience, and they're rated separately from State employees.

If you look at the total contract participation over time, as you can see, for the medical it's been rising. We went from 359,000 contracts in '04; we're up to 364,000 in '06. For prescription drugs, 148 to 151; and the dental plans from 99 to about 143,000. There's been some increase in participation over time.

The active employee costs over time, again: Health benefits rose from \$661 million in '04, up to \$734 million in '07. Prescription drugs from 221 to 190 -- that's an actual decrease. And State Employee Dental Plan went from 30 million up to 38 million.

And what's interesting here, if you look at the 912 spend in '04 -- that's an actual spend -- and compare that to the budget for Fiscal '07 -- that is a budget number. I just want to be clear about that, because it does not reflect -- there's \$118 million in programmatic changes that still have to be implemented to meet that target. Things like bulk purchasing, pharmacy management, use of fund balances, mandatory mail order, mandatory generics -- things of that sort -- are not included in the 962. So if you looked at what we're expecting to spend without those changes, you'd have to add another \$118 million to that number.

On the retiree cost side of the equation, we thought it important if we showed you where the money is being spent. If you look at the State employees, if you wanted to effect changes to State employees, as you can see that spend was about \$169 million in Fiscal '04, going to 227 in Fiscal '07. But it's 227 million out of a total of \$1,082,000,000. So if you looked at where the money is being spent: the Teachers' pension system or the retirees, \$629 million; and then you've got smaller numbers as you get down the page. The one number I think is significant, if you

look at Chapter 330, the second bullet from the bottom, these are retired police and firefighters who have some form of State-paid coverage, which is significantly less than any other systems.

Again, a comparison of the active employee/retiree costs: Again, look at 913 up to 962; 742 up to \$1,081,000,000. And we were actually, when I testified before the Senate State Government Committee, we were talking about a billion dollars in each side of the equation. So again, there's \$118 million missing from that discussion.

Again, this is just a comparison -- obviously, it did not show up well. We're just trying to show you that we are now at a point where we are actually paying more for the retirees than we are for active employees. I apologize for the slide. It looks fine on our computer screen at home.

The next slide, I wanted to talk about who pays for the retiree medical coverage in the State Health Benefits Plan. And if you look at this slide, I think what's important here -- the slide to the far left, it's 27,000 lives. They're the State retirees -- State employees retired. The next column is about 60,000 lives; they're the retired teachers and board of education employees. The next line over is the local government employees. And you can see that's a fairly small population. It does not reflect those who are not covered -- or covered, but outside of the State Health Benefits Plan. Remember, many employers do have coverage outside the Plan.

And the last group is the surviving spouses and retirees who are paying for their coverage. What's interesting here, I think, is if you look at the average cost for participating -- the two largest groups -- the State retiree-- If you go back to the numbers I cited earlier, the total spend, and

you compare them to these numbers, the average cost per participant for a State retiree -- and this is a simple average, it's not a weighted average and reflecting a contract, the numbers of dependents, etc. -- for the State retirees, we've got \$11,300 a year. And the local education and school board employee is about \$12,172 a year.

This chart never shows. I'm going to go past this one. Again, the idea here is that the top segment represents the spend for retirees and the blue portion represents the spend for active employees. We definitely need to find out why these things don't show up on your computers. But these are based on the fund projections and the growth projections provided to us by Aon. And to give you a sense: Aon's projection in the Traditional active plan -- to grow at the rate of 13 percent; NJ PLUS active to grow at a rate of 8 percent per year; and NJ PLUS retired to grow at either 9 percent, at under 65, or 10 percent at over 65. So we do have the actuaries' rates factored into the diagram.

We thought it would be helpful to give you a rate example. And if we take a look at NJ PLUS, which is the free coverage -- no matter where you are, for the most part -- and you look at what the costs are-- This is what I talked to -- we rate the groups separately or we go out and bid the contracts as a group. Each year the actuaries take out the experience for that population and they develop what the appropriate rate would be. So if you look at the State side for a single employee for Fiscal '07, the monthly cost for that employee would be \$346. For the family of the employee, it would be \$899. If you go down to the municipalities -- and I apologize for some of the abbreviations -- their experience is a little worse, so they're at

377 a month for single, and 976 for family. And boards of education are at 325 a month single, and 842 a month for family.

The cost drivers: So what keeps driving these costs? And these things tend to be pretty constant from year to year. We have utilization. We have an increasing -- we have a higher population. We have an older population -- we'll talk to some more of that. But we -- it just basically-- What is our experience, our claims experience, from year to year? With a population of our size, we would have a credibility factor as an underwriter of one. So whatever the experience was last year, it will be replicated next year, plus some, through inflation and such. We have the improvements in technology. Actually, people are living longer because of the advances in medical technology. Again, medical price inflation; malpractice costs. The availability and use of more expensive drug therapy and changes in the mix of medical services.

Some more cost drivers: Again, we have increased enrollments. We have more people on both the active and retired side of the equation. The aging population: Obviously, we've got the baby boomer effect -- it's like we pay through the pipeline. We have a huge growth in the baby boomers in the State. And the mandated benefits: We have a lot of bills out there that just drive benefit costs up. I'm not saying they're right or wrong, but there are a lot of mandated benefits out there that just add to our cost on an annual basis. And the current plan design and the cost-sharing arrangements, low deductibles, and co-pays are surely not an incentive to use benefits differently.

What we do, to try to manage some of those costs, we have a periodic health plan bidding, as I said, and typically it's a five-year contract.

Health contracts are very difficult to move, obviously. There's a lot of dislocation. For example, if you moved an NJ PLUS to a totally different service, it would result in some dislocations possibly, and so you've got to be sensitive to that fact. And the fact that in the insurance market, you don't look like you're flitting around from plan to plan trying to get the best deal for a short term.

We have a large-group purchasing power. Obviously, as I said, a \$3.6 billion spend. We are 25 percent of the Horizon book of business. So to give you a sense, we are a huge marketplace in the State of New Jersey. We negotiate performance standards in all our contracts. So that's both standards and how administration is conducted, how fast claims are paid, claim accuracy, how telephones are answered and such, as well as medical care standards.

We audit the health plans, both our internal group audits, as well as we retain external auditors through our consultants to take a look at what's going on. We review the utilization and we develop disease management programs. Things like diabetes management, things like obesity management -- these are all programs that the plans are sponsoring, and we are actively involved with development of those programs. And we do our best to communicate information to our membership as often as we can, either directly through the Division or through the various carriers.

"Putting on the Brakes:" This slide really refers to -- there's a lot of plan modification proposals that have been floated over time. Several years ago, Mercer Consulting was retained to do a study of the State Health Benefits Program and actually issued a report in early '04. They talked to things like plan design and alternative plan design. This is whether you

want to have a traditional plan or some other form; competitiveness of the program from an employee attraction standpoint; what was the funding and the financial soundness of the plan? They took a look at how the actuaries are doing their jobs in predicting future rate growth and predicting future rate of increase. The actuarial support -- were we getting the appropriate support from the various actuaries that do business with the Plan? And then, also, the provisions for local employers. And this was really largely around some discussions they had with the local -- the mayors and the local business administrators, talking about what they thought they needed to be participating in the State Health Benefits Plan.

The purchasing: The State Health Benefits Commission has the authority, under statute, to do its own purchasing. So we have moved the purchase authority out of the Purchase Bureau into the Commission, and we retain consultants to assist us. We actually do a best and final bid process now, to make sure we get the best deal we possibly can, and negotiating pricing.

Next part of this discussion, I'd like to just talk to some of the recommendations that were presented in the Task Force report in December of '05. The first recommendation, I guess I'm separating out -- you remember a couple of weeks ago I talked to some of the recommendations on the pension side. These will be purely under the health benefits side. But the Committee recommended all employees and retirees should be required to contribute toward the cost of health insurance coverage. And they cited the fact that costs have risen by 150 percent over the past five years and will double by 2010. The majority of the taxpaying public is required to make contributions for their health care. And also, the

report cited some savings that you could expect at different levels of contribution. So at 5 percent, the State and local savings would be about \$348 million; and at 10 percent, the savings would be above -- or just under \$500 million a year.

The Task Force report also recommended that we discontinue offering of the Traditional Plan option, and also offer a PPO in place of NJ PLUS. Indemnity are really a dying breed. And it's very difficult to secure competitive bids for indemnity insurance plans of this size. As a matter of fact, in the last bid-go-round, people talked about submitting proposals and Horizon was really the only bid we received. So we're kind of captive to the marketplace for that particular contract.

PPOs are far more prevalent than plans such as NJ PLUS. And when I talk about PPOs, I'm talking about the plans to be offered on a national basis, where you got a -- like an Aetna, Prudential, or United Healthcare, Horizon. Whoever has it in the marketplace will be a potential bidder for us.

The annual savings, if we end the Traditional and the NJ PLUS and just consolidate that offering into a PPO, combined for State and local, we've got \$100 million a year.

Reduce Rx costs: And again, I want to talk to some of these, in the sense of these are what the Task Force recommended; and I'll also update you with some recent action by the State Health Benefits Commission. Contract directly with a PBM. Currently, the prescription drug programs are offered through a health plan, so there is not a separate direct contract with the PBMs in the world. There's a sense or a feeling that perhaps if we bid directly and contracted directly, there could be some

savings realized -- maybe anywhere from \$27 to \$45 million, by direct contracting.

To encourage generic drug utilization. Again, this was a Task Force recommendation. This actually was a piece of the '07 budget that required the use of mandatory generic and mail-order drugs. That recommendation was taken to the State Health Benefits Commission last week, and the Commission, under advice from the Division, recommended that we delay a vote to implement until January of '07, which will allow us time to do some communications and some educational campaigns to make sure that everybody understood what that process looked like.

Again, that also applied to the requirement for mandatory mail order. We have -- more than 55 percent of drug spending is for maintenance drugs. So these are the things you see on the nightly news, the Lipitor commercials, and all the Cialis, and the sleeping aid kind of things -- the stuff that's grown up over the last few years as a popular business. That was estimated that those two would save us about \$35 million a year. And again, they will be going back before the State Health Benefits Commission for action in January, after the education information campaign is concluded.

The State Health Benefits Program has also suggested we apply State-negotiated changes in health benefits to local employers. Prior to 2003, there was a common program designed for both State and local employers. So no matter where you worked, if you had NJ PLUS, you had the same deductible whether you were a local board of ed employee, municipal employee, or a State employee. That changed with the implementation of the '03 State employee contracts, and then subsequently

with the State Police and correction officer contracts. The Commission did take action last week to require that those benefits be restored to the local level as well. So that action was taken last week. That will result in local savings for medical of about \$25 million, for the post-retirement medical about 5 million; and for prescription drugs about \$13 million. That is one small piece of tax relief, I guess.

There's also a recommendation to end dual coverage within the SHBP. Now, this actually was put into the budget, back in '04, so its State employees would not have dual coverage. So this means that if you have a husband and wife working for the State, they cannot cross-cover each other under their own contracts. So a husband, for our example, who enrolled in NJ PLUS and put his wife down as a dependent, and then the spouse would put down -- would sign up for some Aetna HMO Plan and would do the same thing, put herself down as primary and the husband down as dependent. So it prohibits that activity.

It's tough for us to do it on a statewide basis, unless we take it down to the local level. Because you have so many cases where people are working -- you've got one spouse working for the State and another working for a local employer, an educational employer. There was a -- the Commission also took action last week to publish a regulation, for comment, to prohibit that at the local level, which means it would be common across the state if the regulation were to be adopted. And again, the savings here, and while they're not that great, are about \$18 million between coordination of benefits and the reduction in administration.

And with that, I would just ask for any questions from the-- There are very few recommendations from the Task Force with regard to the health benefit side of the equation.

SENATOR SCUTARI: Director, thank you.

I have a few questions for you on some of the areas that you talked about. You talked about prescriptions for a minute. I've been told that 48 percent of first-time prescriptions are basically discarded by individuals based upon the fact that they consulted their doctor -- and they're told that there are side effects or allergic reactions -- and they can't take those pills. So, "Discard them and I'll give you a new prescription." Have you heard that statistic? It's been told to me by--

MR. BEAVER: I can't answer with a certainly, but we can certainly check into that with our providers.

SENATOR SCUTARI: Well, based upon that, would there be a savings for a limited prescription-type program where someone got a 10-day prescription and then refilled it for the full 30-day period?

MR. BEAVER: Well, there's no reason they can't do that today, that an individual-- We could certainly consider that as part of an education program. There's no reason that somebody can't get a 10-day prescription today. I guess it's a standard medical practice to start with a 30-day. But I guess we could certainly provide some educational effort in that regard.

SENATOR SCUTARI: Well, if that statistic bears out to be true, then I would assume that there will be a measurable cost savings as a result of that, because that 48 percent would be a less of a cost to the State -- that had to be discarded and represcribed.

Let me move on to a couple of other areas you touched upon. You pointed out that the police and fire programs were much less costly than the other programs. Can you explain that?

MR. BEAVER: The police and fire: There's what's called Chapter 330 -- is a piece of legislation that provided coverage for certain police and fire, retired police and firefighters who did not have coverage at the local level. So if their employer was not providing benefits at retirement, the State agreed to pay 80 percent of their cost to the lowest level of coverage, depending on their category. It's a very complicated piece of legislation. But it basically said that if a retired firefighter, for example, elected to join the Traditional Plan, and that had a cost of \$1,000 a month, but the lowest cost plan for that firefighter was maybe \$800 a month -- to stay with the 80 percent of \$800, or 640. The retiree would be on the hook for the balance. If you look at the other State employees, everybody is -- both the State employees have free coverage and the retired teachers have free coverage as well. So it's really just this one outlying group, where they were left out, with this other very convoluted formula; which is a very costly item for them.

SENATOR SCUTARI: Continuing on with comparisons, as you just started to do, can you tell me the post-retirement health benefits for a teacher with 25 years of service versus a State employee with the same length of service? I mean, do retired teachers pay anything toward their insurance premium versus a State employee?

MR. BEAVER: The retired State employee, depending on when they obtained their 25 years of service-- Let me presume they attained it in 1997, or before 1997 -- would qualify for free health coverage.

A retired employee, after that time, would have a premium sharing, depending on what they elected. So you might be paying -- for a Traditional Plan, for example, you would have to pay for 25 percent of the premium. A retired teacher would have free coverage.

SENATOR SCUTARI: Okay. Can a teacher choose the Traditional Plan up -- and even during a retirement, regardless of the health plan?

MR. BEAVER: Yes.

SENATOR SCUTARI: Do you know what percentage of teachers have chosen that Traditional Plan as their health plan in retirement?

MR. BEAVER: Seventy-seven percent of the retired teachers have chosen the Traditional Plan.

SENATOR SCUTARI: Can a retired State employee choose the Traditional Plan at retirement?

FLORENCE SHEPPARD: It depends on what they had as an active employee. In certain contracts, it stipulates that as of a certain date they can no longer have the Traditional Plan -- in some of the Correction contracts. So it depends on who the State employee is.

SENATOR SCUTARI: Okay. But in the Teachers plan, it doesn't depend. It's just whenever they'd like.

MS. SHEPPARD: Whenever, yes. That's correct.

SENATOR SCUTARI: Did this -- this is seemingly a bit of a disparity in benefits, I would think, between teachers and State employees. Did this always exist, or where did that arise? How did this historically take place?

MR. BEAVER: Let me ask Ms. Sheppard to address that, if I may.

MS. SHEPPARD: Disparity in the premium share?

SENATOR SCUTARI: Yes.

MS. SHEPPARD: That started in 1996, I believe, for State employees. But remember, we negotiate -- we, meaning the State -- negotiate with the unions that represent the State employees. We do not negotiate with the local employees. So that's why there is a disparity.

Now in the past, what usually happened is, when decisions were made for the State unions, we would then -- the State, meaning we -- would go to the State Health Benefit Commission, and then those changes would then be imposed upon anybody else that was in the State Health Benefits Program. That didn't happen with premium share.

SENATOR SCUTARI: You talked about the State Health Benefits Commission. So I just wanted you to try and ferret this out for me for a second. Because currently, the Public Employees Health Benefits package is determined by basically three factors: the statute; action taken by the State Health Benefits Commission, as authorized by statute; and through the collective bargaining negotiations. Can you explain what areas of the package are governed by law versus collective bargaining, and what role and what authority the State Health Benefits Commission has?

MR. BEAVER: Just give me one second, sir?

SENATOR SCUTARI: Sure.

MR. BEAVER: Let me be real clear on one point of the premium sharing. What the enabling legislation for the premium sharing -- was not -- there was a point in time where the teachers were not treated the

same as a State employee. Prior to the premium sharing, there was a case made that they should have the same kind of treatment as a State employee. So at that point, they'd have free coverage. When the premium sharing was enacted in the '96/'97 time frame through legislation, that same argument that, "treat us as a State employee," was not made. So there was a differentiation at that point, and when premium sharing was applied on a broad base to those who were covered under the State Health Benefits Plan at the State level, that did not slide down to the teachers.

With regard to what is -- there's a lot of differentiation. There's a lot of stuff that's in legislation. For example, the requirement to offer traditional indemnity plan is in legislation. Premium sharing, to some extent, is in legislation. Not to some extent, it is in legislation at the State level; it's in regulation at the local level. So there's a lot-- I'd probably rather give you some write-up on what we think is in there and what's not, because it's very complicated as to what's in the contract, what's in the statute, and then what the Commission has the authority to do. It's very complicated.

SENATOR SCUTARI: Yes. Because you can't answer it.
(laughter)

MR. BEAVER: I need to sit down and write it up.

SENATOR SCUTARI: Well, please do that.

MR. BEAVER: Okay.

SENATOR SCUTARI: And you can be as simplistic or as expansive as you need to be, but I think that the Committee needs to know the answer to that. Because I've had inquiry to that as well, as to what role

each of these particular portions of law control. And if you're not going to be able to explain it here, then certainly I--

MR. BEAVER: Well, the problem is that there's certain things I would tell you-- There were certain -- things were negotiated. Just as an example, in the '03 labor contracts: While they were negotiated and agreed to, they could not be effective without the Commission's approval. So it's kind of like -- it's almost a chicken and egg kind of relationship. I'd rather just give you some sense -- and look at some options for some provisions within the programs, and give you some sense of how they occurred. It might be a little easier to do that.

SENATOR SCUTARI: Let me ask you another question: Would the State save money if all retirees were required to accept the health benefit equivalent to what State employees are currently being provided? Meaning, they wouldn't be able to jump around from plan to plan as they got into retirement? Would there be a savings there?

MR. BEAVER: I would say yes. Clearly, I mean, the big ticket item out there today is the Traditional Plan. If there was some requirement that drove people or scared people to the more cost-effective programs that had more control in it, clearly we'd save some money.

SENATOR SCUTARI: How does this body, or any body -- the Governor's office -- if they chose to make those restrictions, how would they do it? Would they have to be done by statutory authority? Would it be done through the State Health Benefits Commission? Would it be done through the collective negotiation process?

MR. BEAVER: I believe that the plans that are -- for the most part, the plans that are available today are driven by statute.

MS. SHEPPARD: I'd say it's a combination of all three.

MR. BEAVER: If you wanted to change the Traditional Plan, for example, you have to repeal the statute that requires us to offer it. NJ PLUS is a name -- it's our name. You could actually put some other product underneath it that didn't look like NJ PLUS, and say there's a requirement to offer a free plan, for example. Does it need to look like NJ PLUS today? That's a negotiated item. And they covered these things like co-pays and deductibles in the negotiations of the contracts. So it's -- as I said, I'd rather -- it might be more helpful to lay out a matrix and give you some sense of where we think changes could occur and what would be required from the legal perspective.

SENATOR SCUTARI: Okay.

Chairwoman Pou.

ASSEMBLYWOMAN POU: Thank you, Mr. Chairman.

Actually, I'm glad that we just had that discussion. I was thinking along the very same line. I was actually whispering to Co-Chair Scutari with regard to that particular question. And while I understand that you are really trying to provide us with the best possible information -- just in response to Ms. Sheppard's comment, she indicated that it's a combination of both. Are you saying that you would not be in -- that you would not be able to provide us with an explanation that could really provide us with some specific ideas in terms of what particular items or benefits are provided by statute and what specifically is done solely by the bargaining unit?

MR. BEAVER: I think we can deliver something that will make sense. I just need some time to lay it out. Because I think it is important --

that there are certain things that sit within the contract, there are certain things that sit within legislation. But what I'd rather do is maybe lay out a matrix of what we think is doable, and then present it back to the Committee. And again, where we think action will need to be taken, be it commission, legislation, or negotiation.

ASSEMBLYWOMAN POU: Okay. And you'll be providing those particular -- formatted information in that way, where it can easily be understood so that we are able to kind of look in terms of what those recommendations are?

MR. BEAVER: Actually, yes.

ASSEMBLYWOMAN POU: Okay. Good.

I'd like to maybe go on-- There was a series of questions, and I think maybe during your presentation you might have answered some of them on Page 11. We talked about -- you talked about the costs of various services, both from the health benefit, the prescription, and the dental plan. Let me take the first one, for example: Page 11, the cost of the health benefit for the active employees in '05, for example. The reason for the decrease, in '06, was due to what?

MR. BEAVER: Just experience -- I think favorable experience. We actually had better experience than we expected.

ASSEMBLYWOMAN POU: Okay.

MR. BEAVER: We also used some fund balances to bail us out. So we have what's called a *reserve*, so we-- Both the local employers and the State had some reserve established to deal with unexpected claims. So some of those moneys were used to lower our cost.

ASSEMBLYWOMAN POU: Okay. All right. On that very same page, in terms of the prescription, if we look at your -- just based on your chart specifically. If you look at the prescription, it went up significantly from '05 to '06, but you're predicting a dramatic change in '07. Could you explain that pattern for us?

MR. BEAVER: Again, we have, for Fiscal '07, we've actually-- There are items included in the budget that dealt with things like bulk purchase, improvements in pharmacy management -- in other words, bidding our contracts -- some use of fund balances, the mandatory mail order, the mandatory generics. So all those would tend to bring those costs down. We still have to see how we're going to implement those, given that we've had some delays already.

ASSEMBLYWOMAN POU: Okay. So are you attributing the additional \$118 million, that you made reference to, towards the end of your total figure -- would it be related to some of the things that you've just talked about -- with the bulk purchase, and the fund balances, and all of the new changes that you're referring to? Is that where the \$118 million comes?

MR. BEAVER: Most of that is within the Rx program. There were some smaller numbers related to cost sharing for certain employees -- it was included in the budget -- that we don't think is going to happen. It was actually stricken at the last minute. And then some reductions in full-time equivalents. So some -- the hiring freeze on today, so the expectation is we'd be funding for fewer employees. But the majority of the number is related to the prescription drug program.

ASSEMBLYWOMAN POU: The reverse is happening with the dental plan, where there might be -- there's an increase that you're talking about from '05 to '07. Why do you attribute that change?

MR. BEAVER: Again, we used fund balance in '05 to offset some of the cost. So we had some reserves that were starting to climb up a little bit. We were able to use those dollars to offset the State's cost.

ASSEMBLYWOMAN POU: So can we say then that the actual cost is really not a -- the cost that is currently presented to us is really not the true cost? That you're using some of the fund balances that you have today, that obviously you may not have next year or the year after? So these costs are not truly representative of the actual experience?

MR. BEAVER: Exactly. So we'd like to-- As you said, when you go from 36 million to 38 million--

ASSEMBLYWOMAN POU: Right.

MR. BEAVER: --in '06 and '07, that's more representative of where we expect the cost to be. If you look at -- in '05, we used--

ASSEMBLYWOMAN POU: Right.

MR. BEAVER: --to lower the number, but it's not going to be a recurring asset.

ASSEMBLYWOMAN POU: So it was a one-time--

MR. BEAVER: Yes.

ASSEMBLYWOMAN POU: Okay. I'm just trying to kind of look at some of your chart information here that you used. Let me see.

Mr. Chairman, let me come back to some of the other questions, as I take a look at this.

Thank you very much.

MR. BEAVER: Thank you.

SENATOR SCUTARI: Sure. Absolutely.

Senator Rice.

SENATOR RICE: Thank you, Mr. Chairman.

How are you doing?

MR. BEAVER: (indiscernible)

SENATOR RICE: I'm still a little confused because it's not my field of expertise, and I try to stay healthy and just spend money into the system, but--

MR. BEAVER: We appreciate that. (laughter)

SENATOR RICE: I know you do.

Could you explain to me again -- and I'm trying to go slowly with the "State Plan," the cost of the various plans. If I heard correctly, you weighed in the State being somewhat cheaper, two-thirds of a (indiscernible) plan versus local, versus-- Could you kind of go through it again? You can see I'm a little confused.

MR. BEAVER: I think -- I would ask you to take a look at the slides -- 17, I guess it is -- where we show the rate structures, the rate structure example. Basically, when you look at the population for your utilization experience, what this chart says -- that in order to deliver benefits to the State employees, through NJ PLUS as an example, for a single employee, it's going to cost about 346 a month. Now let's stay with that one just for a minute. If you look at the municipal side, to that same single employee, it's going to be \$377 a month. So what the actuaries do is look at what were the claims utilization experience for those particular populations in the last rating period. Because you can see, also, the board

of education is a little cheaper, at 325 a month. So we're taking the actual experience for each group and then developing rates separately. So we're (indiscernible) the groups -- good experience or bad experience -- reflect what the cost should be for that particular population.

SENATOR RICE: So, Mr. Chairman, you've got to bear with me, I'm a little slow these days. All right. So we're saying that this rate-- You're saying that the workers and local government, the local workers, are becoming more ill or reporting more illness than State workers?

MR. BEAVER: They're utilizing more benefits, yes. But it's not a real big number, if you look at the differentiation. But, yes, they're using more benefits than the State employees and less benefits -- or more benefits than the board of education.

SENATOR RICE: Okay. And so, based on that, the industry structured a rate accordingly, and said we're going to pass more on in terms of cost.

MR. BEAVER: It's not the industry, it's us. We develop the rates. We just take our claims experience -- it's totally isolated from the rest of the insurance industry.

SENATOR RICE: So the 377 versus 346 is a rate you developed?

MR. BEAVER: It's a rate developed by our actuaries based on our actual experience for each group, yes.

SENATOR RICE: Okay. We're still one State, right?

MR. BEAVER: Yep.

SENATOR RICE: Okay. (laughter)

I'm trying to get this right, and I'm getting confused.

Okay, so going back to the question then of -- I believe the Chairman, Co-Chairman Scutari raised, maybe I misunderstood him. If the structure was the same across the board, whether the high side or the low side, is there any way to do that? Would that save dollars? And I believe your response was probably, "Yes." Is that correct?

MR. BEAVER: In total, no. It would shift around who was paying for what. I mean, the claims are what they are. These dollars here do nothing more than represent or reflect the expected claims experience for these populations. If you look at the total -- just as another example -- we mentioned the total spend for the program is \$3.6 billion each year, State and local. How you structure the rates to support that is marginal. You could take one common rate for single and one for family, and apply them to everybody, whether you be municipal or school board or State employee. That's one way of doing it. But the bottom line is, you've got to come up with \$3.6 billion.

SENATOR RICE: Okay. This 346, any of these numbers, that's the cost? That would reflect the cost to the State or the cost for that particular individual?

MR. BEAVER: That's the cost to the State to deliver NJ PLUS coverage for a single State employees, yes, monthly.

SENATOR RICE: Okay. And you're saying that the individual pays nothing into the 346?

MR. BEAVER: Yes, sir.

SENATOR RICE: That's what you're saying?

MR. BEAVER: Yes.

SENATOR RICE: So the State completely pays it?

MR. BEAVER: Yes.

SENATOR RICE: And on the municipal side, the 377, who is paying that?

MR. BEAVER: The municipal employer.

SENATOR RICE: The municipal employer.

MR. BEAVER: Yes.

SENATOR RICE: But you set the rate?

MR. BEAVER: Well, no. That's for single employees -- the municipal employer's required to pay the full cost for a single employee. There could be some cost sharing on the dependent's side, but for this particular case, that 377 would be born by the municipality.

SENATOR RICE: But did you not say that the State determined the 377 versus the 346?

MR. BEAVER: The State Health Benefits Commission sets the rate. These are for municipalities who are participating in the State Health Benefits Commission -- Plan -- the State Health Benefits Plan. If a municipal employer is not participating in the program, I can't speak to their rates. These are just strictly the rates within our plan.

SENATOR RICE: So, in theory, if we made everything -- the commission got religious and made everything one nice figure to apply to everybody -- 346, 377-- What you're saying is there's still no savings.

MR. BEAVER: No.

SENATOR RICE: Okay.

MR. BEAVER: And I would suggest that perhaps you would lose some municipal employers, because now they're being forced to pay a

rate higher than -- and some school boards especially -- will be forced to pay rates higher than our experience would dictate otherwise.

SENATOR RICE: No, that was your assumption. See, the 377 could very well be 346. I was just trying to find a (indiscernible) as you're going in the opposite direction.

Let me try to conclude this with some clarity, because, thus far, I think I've made every meeting. And I'm really trying to get those of you who are the professionals at this, with the expertise-- You want to talk criminal justice, I can talk to you. But I'm trying to figure out, where are the areas -- because I'm looking at the recommendations, too -- of real savings. Thus far, I don't see any savings in anything we're doing that are substantial or significant. And anything above zero is, obviously, a plus. We want to save what we can and maybe piece some of this thing together.

But between now and November 15, the taxpayers and the public, based on the message we sent -- which I thought was the wrong message -- whoever sent -- is that we're going to do all these wonderful, great things. And now I'm getting a little concerned and disappointed that we're not going to accomplish very much from this Committee's perspective -- there are other Committees functioning.

Are there any areas -- and I've read the recommendations, but I've got to go back -- where working-class people, middle-class, and particularly low-income wage earners don't get harmed? Because it's nice to say-- We have high property taxes, we have all these taxes, but one day everybody retires. And those people who are saying what we shouldn't do or what we should do with benefits, that are somewhat extreme, need to look at the benefits that their parents and others are receiving and can

barely make it. We don't want to put our workers in a position where there aren't benefits upon retirement that make sense for people to survive and not become a part of the system on the other side, one way or the other, or die because they're not getting what's necessary. By the same token, we don't want to give windfalls. And I can appreciate that.

Saying that, where can we really look, if anyplace at all? Because we're going around in circles. I look at the Commission recommendations, and I'm adding this stuff up. Is it \$118 million that can be saved? I'm not sure. And maybe I'm the only confused person up here, but I'm a little older, so you have to forgive me.

MR. BEAVER: I'll just offer that, what we've presented today was really the Benefits Review Task Force's recommendation, in terms of potential savings. If you looked at the potential savings if you implemented employee cost-sharing on a broad-based level for State, for local, for all employees and retirees at 5 percent, you're looking at savings of about \$340 million a year.

Now, admittedly, that's really a cost shift. And at 10 percent, the savings would be close to \$500 million a year. If you look at it at a total spend of \$3.6 million (*sic*), I would say that's a fairly significant reduction in program costs for the State and local employers. And then, couple that with the -- if you shifted around what was available to employees, whether it's traditional, or PPO, or New Jersey PLUS -- if some of those changes were implemented, you're looking at another \$100 million.

So I think there's a combination of things that the Committee may want to consider. But there are certainly savings opportunities available.

SENATOR RICE: Well, I'm going to end on this. I guess that's what I'm trying to get to. There are a lot of plans out there. Is there a plan that can provide the kinds of things people need, if we found a way to get a plan? I really-- I may be wrong, but I don't think that unions, or employers, anyone has a problem. The problem is not having health care and having sufficient health care for families. It's not how we get it. A doctor is a doctor, a treatment is a treatment. But is there one plan -- or a plan? I'm trying to get to this savings piece. Because it sounds good, what you're saying, but like I said, I'm a little slow. But it sounds like we're going up and down, we're shifting costs, which means no savings. We're not getting to a point to say, "If we went this way, we know, and we can measure out long-term, that's a tremendous savings, or a substantial savings. And everybody has the same thing to some degree."

MR. BEAVER: Again, from an underwriting perspective, the bottom line is, if you spent \$3 billion for health benefits last year, you're going to spend \$3 billion-plus the next year. Regardless of the design of the program, who offers the program, it's the delivery of the services.

Again, we've got an aging population, we've got a growing workforce, growing retiree workforce. It's very difficult to effect meaningful changes without changing the design of the programs.

SENATOR RICE: So technically then, the bottom line is that, as a Committee, we can't do anything, basically, but pass on some recent substantial costs to the employees, to pay for benefits that some may not be able to pay for at the salaries they make across the board; or accept the reality that we give them no benefits upon retirement, or give them small benefits. And they get \$1,000 a month, and no health care, and they die. I

mean, I'm just trying to put it in perspective. I'm being very sincere about that. I know what my parents get at 81. I know what people who work in an office get. My seniors over at Saint Mary Villa, across from my office, they come in, and we talk to the State about programs to help them be on Medicare, what they get. And that's my greatest concern about this area. How do we stop-- And we have to find a way to stop or slow the growth. But how do we provide the kinds of health care benefits and the pension benefits that people, in my estimation, in this country are rightfully deserving of?

I'll leave the question there. If you could go back, talk to your colleagues, put your best mind on that, and get back to the Chair, I'd really appreciate that.

MR. BEAVER: Thank you.

SENATOR SCUTARI: Director, have we been provided a copy of the 2004 Mercer Consultants report that you mentioned earlier?

MR. BEAVER: I'm not sure. I know we had it posted on our Web site. It was issued again -- 2004. I can get copies to the Committee.

SENATOR SCUTARI: Maybe we have-- How about the 2005 Task Force recommendations? Have we gotten that as well?

MR. BEAVER: That's the Murphy report.

SENATOR SCUTARI: We've got-- Okay. I wasn't sure what you were talking about, if that was something separate.

MR. BEAVER: Yes.

SENATOR SCUTARI: Before I get to the Assemblyman, you had one follow-up, Madam Chair.

ASSEMBLYWOMAN POU: Just real quickly.

Thank you, Mr. Chairman.

We talked about -- and just something that Senator Rice mentioned -- can employees opt out of medical coverage if they are covered by their spouse's insurance?

MR. BEAVER: Yes.

ASSEMBLYWOMAN POU: They can.

MR. BEAVER: Yes.

ASSEMBLYWOMAN POU: So under our State Health Plan, they can opt out.

Are there any kind--

MS. SHEPPARD: What they do is they waive their coverage. And then, if their spouse loses their coverage, they can reenroll in the State Health Benefits Plan.

ASSEMBLYWOMAN POU: Okay.

MR. BEAVER: What's different is, I think -- and I-- If you're a State employee there is no real incentive to do that. And some of the local employers -- they do provide some cash considerations for an employee to opt out of the program, generally less than the cost of the program. But the expectation is you get some shared savings.

ASSEMBLYWOMAN POU: Do we provide any incentives to the employee to opt out or not?

MR. BEAVER: Not at the State level. Well, actually, it's in statute now.

ASSEMBLYWOMAN POU: I'm sorry?

MR. BEAVER: It's in statute that you can't have dual coverage. But there's no incentive not to do it; it's just restricted.

ASSEMBLYWOMAN POU: But they're able to opt out if they'd like to.

MR. BEAVER: Yes.

ASSEMBLYWOMAN POU: Okay. Thank you.

SENATOR SCUTARI: You said it's in the statute that you can't have dual coverage, in terms of the State. But you can have dual coverage if your husband or wife works for a private corporation and gets coverage that way.

MR. BEAVER: Yes.

SENATOR SCUTARI: And local municipalities have given incentives that say that, "If you want to take your husband's or wife's, we'll give you \$2,000 annually to opt out of our coverage."

MR. BEAVER: Yes.

SENATOR SCUTARI: The State has not done that.

MR. BEAVER: No. And I think the boards of ed also do not have that opportunity.

ASSEMBLYWOMAN POU: Say that again.

SENATOR SCUTARI: What was that?

ASSEMBLYWOMAN POU: Repeat that.

MR. BEAVER: The boards of ed also cannot do that. So it's really restricted to municipalities.

SENATOR SCUTARI: Municipalities are the only ones who offer a--

MR. BEAVER: And county colleges.

Municipalities can offer the incentive, and county colleges.

SENATOR SCUTARI: And that's it?

MR. BEAVER: That's it.

SENATOR SCUTARI: Just one thing in addition to that. You talked earlier about, if we replace New Jersey PLUS with a PPO plan, we'd save a substantial amount of money. Did you not say that?

MR. BEAVER: Yes.

SENATOR SCUTARI: How is that?

MR. BEAVER: Well, I think there are two things coming into consideration. One would be that, right now, we're pretty much a captive program. You could actually get a true competitive bid going if you could invite multiple participants in. And, in fact, I think we'd offer better coverage, because it's a more -- national coverage, which would solve some of the retiree problems with relocation.

We think, through the competitive bid process, which-- We're kind of, again, captive in New Jersey, with the Traditional Plan being Horizon, the only bidder. The New Jersey PLUS is pretty much a Horizon product. The expectation would be that if you could bring Aetna, Prudential, UnitedHealthcare, and some of the other big programs -- national programs -- into the fray, we'd realize some competitive advantages.

SENATOR SCUTARI: And you're talking about doing away with New Jersey PLUS altogether--

MR. BEAVER: Yes.

SENATOR SCUTARI: --and replacing it. What would be your estimated cost if you did that -- savings? I'm sorry -- not cost, savings?

MR. BEAVER: Well, we'd combine the two savings. What we looked at is a package deal. If we got rid of Traditional, we got rid of New

Jersey PLUS, and introduced a PPO as a replacement, at the State level it would be about \$40 million in savings; at the local level, about \$64 million. That's \$100 million on a \$3.6 billion plan.

SENATOR SCUTARI: Assemblyman O'Toole.

ASSEMBLYMAN O'TOOLE: Thanks, Chairman.

Director, good seeing you again for the fourth time.

I appreciate your expertise in this. And, like Senator Rice, I don't have an expertise. But I've gathered lots of information, so I have some questions for you.

Having read the Murphy report -- and I think a lot of the ideas that we've talked about have emanated from the Murphy report. Page 26 of that report, it states, "Post-retirement medical liability, with regard to the State plan, has initially been estimated to exceed \$20 billion." Are you familiar with that?

MR. BEAVER: Yes.

ASSEMBLYMAN O'TOOLE: Is that number an accurate number? And tell me, if it's 5, or 10, or 20, what does that number really mean?

MR. BEAVER: I'll let Mr. Megariotis address this one, if I may.

ASSEMBLYMAN O'TOOLE: Sure.

JOHN D. MEGARIOTIS: The estimate of the liability is on a present-value basis. The value of all the retiree health benefits that have been promised or earned by individuals, and the promise of that benefit -- what the value of that is, in today's dollars.

The \$20 billion estimate was done several years ago. And it was not based on the entire population that gets retiree medical from the State, nor was it based on the regulations that have been recently promulgated by the Government Accounting Standards Board, which we are just now starting to work on to develop the actual liabilities that we're required to disclose within the next year or two.

ASSEMBLYMAN O'TOOLE: By next year.

MR. MEGARIOTIS: Yes.

ASSEMBLYMAN O'TOOLE: Last couple of times, through the Chair, we had heard about the unfunded liability with the pension. I've heard that number from \$18 billion to \$20 billion. And I think the effort is to try to make up what is owed to the pension fund. The question is, whether this number is \$10 billion or \$20 billion, is there some mentality that that number has to be met in some future--

MR. BEAVER: There's no absolute requirement to fund it, as you would with the pension plan. It really doesn't affect your pay-as-you-go cost. But there are some accounting implications and some potential implications to the State's debt if you're not trying to pre-fund some of the obligation, in terms of what kind of discount rate you use to value your overall obligation. But there is no-- You don't have the same kinds of requirements you would have on the pension side. And it doesn't really affect your stream of payments.

ASSEMBLYMAN O'TOOLE: What I find interesting is the numbers. Let's just walk through your testimony, because I have a couple of questions that -- I hope not to skip too far around.

But, roughly, one in 10 New Jersey residents rely upon the State Health Benefit Program in some manner.

MR. BEAVER: Yes.

ASSEMBLYMAN O'TOOLE: That seems to be-- Is that in line with other states? That seems to be a pretty gigantic number.

MR. BEAVER: I couldn't answer that specifically. We could try to find out. But it is a very large number, I would agree.

ASSEMBLYMAN O'TOOLE: The \$3.6 billion sited for the program -- for the local and State component. And there's been talk about this thing escalating through 2010. How much of that is the State component, and how much of that is the local component?

MR. BEAVER: This year, just under \$2 billion is the State component. And the difference would be the locals.

ASSEMBLYMAN O'TOOLE: In the fifth page of your--

Before we get to there, the ratio of active to retired group is roughly three to one. On Page 4, you talked about State contracts -- active groups. With the aging baby boomers that you cited in your testimony, would there be a spike in retirees anytime soon? We have seen this program -- the one that did not show up on your graph there -- had a huge escalation of cost. And that's on Page 16, for those who are following.

The actives, more or less, stay the same, at .6 in 2002, and goes to better than \$1.5 billion in 2010. That seems to be somewhat of a controlled growth of sorts. But when you look at the retired benefits, in 2002, you're at roughly \$.75 billion, or three-quarters of a billion dollars -- in 2002. In 2007, it's topping over \$2 billion. And in 2010, you're looking at \$3.6 billion. And I'm just trying to understand how we get our arms

around that rapid growth from 2002 to 2007, and then a huge up-tick to 2010.

MR. BEAVER: Well, the 3. -- I think it's -- you've got a pretty steady growth rate in terms of your inflation expectation of 12 percent. It's also, I think, a reflection of increased participation. So, again, that baby boomer population is coming due to retire. So we will be seeing a sharp up-tick in the number of retirees, as compared to the active workforce.

ASSEMBLYMAN O'TOOLE: Now, projecting beyond 2010, is there a significant increase or decrease? Does it level out? Have we looked beyond, in actuarial terms, to the next few years?

MR. BEAVER: I don't believe-- I have not asked anyone to look past then. I guess we could. Obviously, the further out you look, the more the data could become questioned. But we can certainly do that for you.

ASSEMBLYMAN O'TOOLE: Look, in a couple of months we're looking at 2007. And you're three years away from the end of your graph.

MR. BEAVER: Yes.

ASSEMBLYMAN O'TOOLE: And if we're looking for long-term solutions, I don't think we can look at a two- or three-year snapshot. I'd like to look at the next seven to 10 years. And we just can't have a three-year solution. I think we have to have a much more permanent solution.

MR. BEAVER: We'll be happy to do that for you.

ASSEMBLYMAN O'TOOLE: Page 5-- I think you're testimony, Mr. Beaver, was that only two-thirds of the employers -- or

providers -- are participating in the State Health Benefits Program. Presumably one-third have opted out.

MR. BEAVER: Yes, sir.

ASSEMBLYMAN O'TOOLE: Tell me, why have they opted out, largely?

MR. BEAVER: Well, if you look at the one-third-- If you look at the school districts themselves, you only have about 246 school districts participating. I think there's about 660 school districts in the state. I guess that's the number that keeps getting cited on the radio.

What they do is, they'll look at their experience for their particular group. As I said, we rate our experience in groups, in buckets of State, municipal, and board of education groups. If a particular-- If a broker walks into a city council meeting and says, "I can get you a better deal on health insurance, let's get your experience from Horizon," they look at their particular claims data for that group. If they're doing better than the numbers you saw on the other slide, of the 377 a month, they will actually go out and buy their contracts directly. Now, that's not to say their group will stay at those rates for a long period of time. We tend to see groups coming in and out of the plans. The larger employers can be more stable. They've got a bigger population to spread the risk over. But the smaller employers will come in and out of the program, depending on what their financials look like.

ASSEMBLYMAN O'TOOLE: So you're telling me they're leaving because of price.

MR. BEAVER: Absolutely.

ASSEMBLYMAN O'TOOLE: Okay.

MR. BEAVER: And, also, there's more flexibility when they get outside our program. Remember, our program is one-size-fits-all, for the most part, because you can't be managing a thousand different programs.

ASSEMBLYMAN O'TOOLE: And if a local employer unit leaves the State Health Benefits, are they precluded from coming back?

MR. BEAVER: No.

ASSEMBLYMAN O'TOOLE: They're not. Is there a two-year or three-year statutory period they are to exist outside the unit?

MR. BEAVER: There is no limitation whatsoever.

ASSEMBLYMAN O'TOOLE: Moving ahead to some of the cost drivers, because it is alarming to see that we're going to be doubling our costs by 2010, in terms of the health benefit program.

Cost drivers: I think this needs to be examined, perhaps not in this forum, but in another. You cite five areas where it's -- the utilization. Explain to me what that is. Is that what-- There's just-- I mean, it's almost as if the pharmaceutical unit just created a market. Is it just because science has advanced, that there are more diverse medicines that are available? When you say *utilization*, what does that actually mean?

MR. BEAVER: It's exactly that. I mean, you create the marketplace. I mean, if you look at just-- To give you one example, the commercials you hear on the radio for gastric bypass surgery-- You didn't hear those things five, six, seven years ago. Now you've got full clinics up, and that's their line of business. The drug market, and what they're advertising for on the nightly news every night -- they create the market, they drive the utilization. So the medical community itself is actually helping to drive our costs forward, which is not unlike it was in the past.

But I think there's far more opportunities to, with the increases in technology today.

ASSEMBLYMAN O'TOOLE: So if you create an edge, or another drug, or another operation, or something else, it seems that the masses will be drawn to those -- to utilize those.

MR. BEAVER: Yes.

ASSEMBLYMAN O'TOOLE: Improvements in technology: Explain how that is a cost driver. And how is that wrapped into the cost -- the escalation that we're seeing?

MR. BEAVER: Any of the technological advances-- The hospitals want to go out and buy some new piece of equipment for some new 3-D CAT scans, or 3-D MRI imaging, or whatever. All those costs are built in. As those pieces of technology are delivered to the providers of the service, obviously those costs have to be reflected back in the charges to the individuals who are utilizing those facilities.

I guess I would compare it to-- If you think back, in the early '70s, when everybody wanted to get CAT scans in all of the hospitals -- and a lot of the studies said that, "Everybody doesn't need one. If everybody has one, you'll be underutilized." Well, a lot of those controls have gone by the wayside. And everybody wants the latest technology. And that's what helps them draw their physicians to practice at their facilities.

ASSEMBLYMAN O'TOOLE: The medical malpractice component -- how much of an influence is that in the increase?

MR. BEAVER: That's probably not as great as it was in the past, but it's still out there, because, obviously, some of these facilities and the doctors -- the services they charge have to reflect their total cost of

doing business. And as malpractice rates increase, it's reflected back in the charges to the individuals and to the insurance companies.

ASSEMBLYMAN O'TOOLE: So is it the premiums themselves that are causing this escalation?

MR. BEAVER: Sure.

ASSEMBLYMAN O'TOOLE: It's not -- okay -- the actual malpractice?

MR. BEAVER: Not the actual malpractice.

ASSEMBLYMAN O'TOOLE: Okay. The last area that I want to touch upon-- The Murphy plan talks about eliminating NJ PLUS and putting in this other hybrid that is, I guess, tailor-made or more customized for an individual. And I'm trying to understand. If we take that Murphy recommendation-- And you're saying we're going to realize about \$104 million in just direct savings -- both the State and local component.

Above and beyond that, if we go to an individual, free-agent prescription benefit manager, which we don't have right now, is there an additional savings above and beyond that?

MR. BEAVER: Yes.

ASSEMBLYMAN O'TOOLE: Okay.

MR. BEAVER: Well, we had-- Our estimates for the budget this year are about a \$10 million savings, if we were able to direct contract--

ASSEMBLYMAN O'TOOLE: Right.

MR. BEAVER: --with a pharmacy benefit manager; at the minimum.

ASSEMBLYMAN O'TOOLE: But if we allow the program that we're talking about, that's been recommended and referenced in the

Murphy report, is that really a utilization of the current NJ PLUS, but we're taking out some of the restrictions and we're making it more user-friendly? Are we giving the same services?

MR. BEAVER: The coverage levels within the program would look much as they do today. So the co-pays, the deductibles, the kinds of service that are available could be identical to exactly what NJ PLUS provides.

ASSEMBLYMAN O'TOOLE: Now, we have seen, in the private sector -- and I'm hoping at some point we can look at this -- and maybe it works, and maybe it doesn't work, in a public form. People having used this Murphy model in the private sector have realized savings. And the numbers that I have seen, which knocked me over -- it was a 75 percent savings over -- in the private sector, from going from an NJ PLUS model to a hybrid Murphy model, so to speak. And the reason they're allowing -- they're introducing competition into the workforce, and they're saying-- Right now, we're captive. Horizon has it all. We're one of one. We can't go to AmeriHealth, or Prudential, or Joe Blow, or whatever it is. We have one of one. So it seems to me, by limiting choice, we limit the ability to save money.

So my question to you is: Have we allowed ourselves to look at the private sector experiment? I mean, there are folks that have literally gone from the way they've done business for 30 years, and they have customized their health benefit program for the employees and saved substantial amounts of money without compromising the services being rendered to the employees.

MR. BEAVER: We can certainly look at that. I mean, I had some experience with that model. But typically, what you'll see happening-- Let me give you one example.

ASSEMBLYMAN O'TOOLE: Sure.

MR. BEAVER: I've seen plans out there that have a PPO that has a 90 percent coverage level, for example. But that's considered the "high-level" plan. And at the same time -- offer the employees maybe an 80 percent or 70 percent option. And then you let the employees decide what -- do you want to take the risk? Do you want to pay more for that better-level plan, or do you want to take the risk that you're not going to need treatment, so you'll take the lower-level coverage plan -- the 70 percent plan, for example.

ASSEMBLYMAN O'TOOLE: Right.

MR. BEAVER: But it really drives around plan design change, to get those kinds of savings, I think.

ASSEMBLYMAN O'TOOLE: Right. You have a core plan. And if you want to have specialized -- for acupuncture, or for special services, or home health care -- you have separate riders above and beyond what that core safety net plan has provided.

MR. BEAVER: That's certainly a doable option.

ASSEMBLYMAN O'TOOLE: Well, I think we really need to look at that.

Mr. Beaver, you talk about the proposal. Currently, employees -- if it's a Traditional Plan -- they pay 25 percent of their premium, right? And the HMO it's 5 percent; and New Jersey PLUS, there's no percentage.

MR. BEAVER: Correct.

ASSEMBLYMAN O'TOOLE: All right. Now, with the NJ PLUS, I think your numbers extrapolate out-- If it's 5 percent you're asked to pay, we'll save roughly \$348 million per year.

MR. BEAVER: Yes.

ASSEMBLYMAN O'TOOLE: Okay. And if it's 10 percent, it's almost a half-a-billion.

MR. BEAVER: Right.

ASSEMBLYMAN O'TOOLE: All right. Now, if you move that number out 15 percent, 20 percent, is that-- I mean, is that diminishing returns at a certain point?

MR. BEAVER: We would have to go back and check that, because what you're doing is-- Now you're affecting some of the other coverages out there -- the Traditional Plan and-- We expect to see people shifting around in some way. But we could certainly model that for you.

ASSEMBLYMAN O'TOOLE: The last question-- I thank you for your comments. That was very educational.

Right now, the health benefit -- Traditional, for instance -- it really starts in statute, from what you're telling me. We can, right now, say statutorily, "We no longer are going to allow the Traditional Plan to exist." And we're going to essentially force everybody to go into NJ PLUS, an HMO, or some other plan. Is that-- Statutorily it came about, as opposed to regulatory or negotiated? Is that--

MS. SHEPPARD: It's in the statute.

ASSEMBLYMAN O'TOOLE: It's in statute.

MR. BEAVER: Technically, yes. But I would like to just *caveat* that with-- I'd like to put that in the matrix, because I think there's also

been some statements made that this should also be subject to some discussion or negotiation. So I'd like to just be careful about that.

ASSEMBLYMAN O'TOOLE: Okay. I'm not saying--

MR. BEAVER: Statutorily, yes. You could repeal the statute.

ASSEMBLYMAN O'TOOLE: I'm not saying it's exclusively statutory, but it's got its basis and genesis in the statute.

MR. BEAVER: Yes.

ASSEMBLYMAN O'TOOLE: And through that, there's a negotiation as to benefits taken or given away. There is a negotiation, but it has to start statutorily.

MR. BEAVER: Yes.

ASSEMBLYMAN O'TOOLE: And the same would hold true, I suspect, of an HMO, Traditional, the Murphy plan -- the hybrid that we have alluded to. It derives its root in statute.

MR. BEAVER: The statutes in the other plans deal with managed care. So, yes, I would agree.

ASSEMBLYMAN O'TOOLE: Great. Thank you very much.

Thank you, Chairman.

SENATOR SCUTARI: Thank you.

Before I get to Assemblyman Giblin, I just wanted to ask you a question.

Is any particular group given a better benefit package than another -- meaning PERS people, local, State government workers, teachers, police, fire? Are any of the health coverages better as a group than others?

MR. BEAVER: What's available to the individuals -- I'd say no. It's how you pay for it that -- there's some differentiation there.

SENATOR SCUTARI: Okay.

Assemblyman GIBLIN.

ASSEMBLYMAN GIBLIN: Mr. Beaver, a new employee comes on for employment in the State. How long do they wait for coverage?

MR. BEAVER: Sixty days.

ASSEMBLYMAN GIBLIN: And it's not retroactive.

MR. BEAVER: No.

ASSEMBLYMAN GIBLIN: Okay.

When somebody terminates their employment, say December 31 this year, when is their coverage terminated?

MR. BEAVER: There's some prepayment because of the way the pay structure works. So it's about two months of coverage.

ASSEMBLYMAN GIBLIN: So they get an additional two months?

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: When some of the groups-- First of all, I noticed with groups covered, there's no mention of autonomous agencies. Am I correct to believe that a lot of the agencies like Turnpike, Passaic Valley Sewage, Delaware River Port Authority -- they're not in the State Health Benefits Plan?

MR. BEAVER: Many are outside, yes, sir.

ASSEMBLYMAN GIBLIN: Okay. So, for example, if an employer -- a board of education -- terminates their coverage as of December 31, when do they stop paying?

MR. BEAVER: I mean, their coverage is terminated effective December 31. They would be paying for premiums through December 31.

ASSEMBLYMAN GIBLIN: No--

MR. BEAVER: They're required to give us certain notice in advance.

ASSEMBLYMAN GIBLIN: Okay. Granted they gave you the certain notice in advance--

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: What I'm trying to get at -- with insurance claims, sometimes you'll notice on a statement it will say, "Date claim incurred, date claim paid," and sometimes there's a lag time of 30 days, 60 days. Say, hypothetically, I'm a board of education. One of my employees develops a substantial claim. It was incurred 12/27. You don't get the bill until March 1. Does that revert back, in terms of any type of settlement? In other words, they're leaving you in the bag, so to speak, with bad claims. I mean, do you have any mechanism in place for that?

MR. BEAVER: That case you're describing would be the responsibility of the State Health Benefits program. It was incurred while coverage was in force. The SHBP would be responsible for paying.

ASSEMBLYMAN GIBLIN: Okay. Well, I'm going by this issue of experience rating that you talked about before. There's really no true insurance anymore, except for the indemnity plan, right?

MR. BEAVER: No, even the indemnity is self-funded.

ASSEMBLYMAN GIBLIN: So you're paying as you go, so to speak.

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: Because the only thing I'm looking at is, if some of these plans are exiting, there's a reason for it. You

mentioned you had less than 50 percent of the boards of education that were enrolled. I think you mentioned 250 out of 600. And then you talked about-- I noticed the number that has been bantered around was -- the last five years -- 56,000 more State employees. And I don't see that reflected in the overall number of employees that have increased. I thought the number over the last five years only increased by about 12. Is that-- I just looked at those numbers quick.

MR. BEAVER: Well, it's the employers coming in and going out, depending on the size of the employer. We lost some very large school boards in the last two or three years.

ASSEMBLYMAN GIBLIN: What I'm trying to get at is that the number I saw, going back, was 56,000 new public employees. And all your numbers are showing, over the same period of time, is 12,000-plus people more in the health benefits plan. So these folks are going somewhere else.

MR. BEAVER: Right.

ASSEMBLYMAN GIBLIN: So I'm trying to tack on, maybe, what was said before. What's the reason? Is it the flexibility issue? Is it -- they have different programs they want to avail themselves of?

MR. BEAVER: I think it's a couple -- it's a combination of those factors. I think the flexibility is one issue. But also, if you recall, when I showed you the chart that described the rates for the different groups, it showed the boards of education -- just an example -- single at 325 a month, which is the lowest of the single coverages.

Those boards of ed that tend to leave us could probably do better than 325 a month. So their experience-- When they go out and get

the experience, their utilization-- Remember, school boards are the best utilizers, right now, in terms of the health of the employees and the premium requirements. The best of the best are leaving the program.

ASSEMBLYMAN GIBLIN: Yes, but I've seen situations-- And maybe you can tell me I'm wrong in this. I've seen situations where local employers have been enrolled in the State Health Benefits Plan, their folks are covered by Horizon Blue Cross, they terminate with the State Health Benefits Plan, and then they go with Horizon Blue Cross again, and they have a tremendous cost savings. I've seen that happen. Can you explain to me how we let our insurance carrier get away with that? In other words, it's like they're undercutting you. You're saying on the one hand, they're your biggest insurer, and at the same time I've seen them go to work in other public employers'-- I mean, that has happened, right, what I'm saying?

MR. BEAVER: And I would agree. And I think, again, part of the problem is, if that local employer has better experience than the other local employers, they can get a better deal. And, quite frankly, we look-- Horizon has a staff of people. And their charge is to go out and do their best to retain the membership that's currently in the State Health Benefits program, and to counter any other proposals.

When they bid against-- When they bid for a local employer, they're really doing that at the request of a broker. And they recognize that if they don't get the business, it's going to go to Aetna, or Prudential, or somebody else. Those folks, at that point in time, are going to move their business. So it's just a matter of their seeking competitive bids to do so.

ASSEMBLYMAN GIBLIN: Okay. This issue of individual participants, with the auditing of their, I guess, status-- People die, people

get divorced, their kids get to be a certain age. How is that monitored? In other words -- where you could have, theoretically-- I've seen it myself. It's no different in the pension -- but even with health benefits. You probably have the situation where you're mailing pension checks, or e-mailing checks to deceased people. And you don't find out about it -- six months, or nine months down the road. It does happen, right, with your pension fund?

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: Maybe not to a great -- but it can happen.

MR. BEAVER: We do have some programs in place that go back and work with these organizations to provide data on deceit -- in the Social Security Administration, for example. So we try to do our best to track. We also rely, to a large extent -- if you remember -- on the local employers to report accurately. But we do do periodic audits. And we do find out things. We get a remarkable amount of anonymous mail to tell us what's going right and what's going wrong. But we do have audit controls in place to try to identify the potential risk, as you described, with misreporting.

ASSEMBLYMAN GIBLIN: Well, like, for example-- There is a municipality in northern New Jersey right now-- There's an active investigation on, about people who are left on that were no longer working -- whether it was by accident or something like that. I mean, without getting into any names-- But I'm looking at the auditing of this and -- how does this happen?

I'm not laying this at your doorstep. Is this all local fault, so to speak?

MR. BEAVER: The local employers are responsible for reporting to the Division. And we lay out the groundwork and the rules. But they are responsible for certifying eligibility for health benefits, and also certifying that somebody is either on or off the payroll.

ASSEMBLYMAN GIBLIN: Okay.

MR. BEAVER: We send--

ASSEMBLYMAN GIBLIN: When somebody is terminated, for example, do you get a hard copy, or is this e-mailed to you?

MR. BEAVER: We get-- Well, right now, we have a process put in place where we can actually do some of that through electronic means. But generally it's been done by hard copy, with a certification from an employing officer or attesting officer.

ASSEMBLYMAN GIBLIN: Is there any way of mandating, when a person is terminated, that it be done electronically?

MR. BEAVER: Well, we just got that capability recently. So we just got a new process in place where they can do deletions electronically, which should allow it to happen faster.

ASSEMBLYMAN GIBLIN: Well, what I'm getting at is this issue -- I'll take, like, a prescription card. Somebody is terminated 12/31. The process takes its normal time. They could have the benefit of that prescription card a couple of months. You have no way of trying to recoup that money -- you said before you can't get it back. In other words, somebody has a prescription card, they can go out and do a lot of things. You know, yourself, the cost of prescriptions. And you have to eat that? You can't go back to the participant that -- "You used your card wrong," or go back to their previous employer?

MR. BEAVER: Let me ask Ms. Sheppard to address that, if I may.

MS. SHEPPARD: Once we receive the information from the local employer, and it's keyed into the system, we have real-time update. So that information is then transmitted to the carriers within 24 hours, and the coverage is terminated.

ASSEMBLYMAN GIBLIN: Okay. Well that's important.

There was a new initiative put forth about raising dependents -- age 30. I believe the State's subject to that. The number for that-- My first belief would be that people who would stay on to age 30 are people who have severe health issues. That would be my inclination. Have we cost that out -- what that legislation has meant, hypothetically? In other words, first of all, how many people have taken advantage of this? Then the second thing is, are there claims against that?

MR. BEAVER: Let me--

ASSEMBLYMAN GIBLIN: And how do you determine the number?

MR. BEAVER: Well, let me just-- The Commission just-- Part of last week's rate action included -- developed a premium for those particular cases. These are the under-30 dependents. The actuaries, again not knowing what the potential population is, set that rate for the first year at 110 percent of the single employee cost. And that will be solely the responsibility of the individual. The State is not supposed to bear any costs for this program. As you recall, no employer is supposed to be at risk. We are the only self-insured plan that was included in the legislation.

So, for the first year, if a single employee rate, as you saw on that chart, was \$344 a month-- If an individual elects coverage under that program, they're going to pay \$344 plus another 10 percent premium for the first year. At the end of the first year, once we get a better feel from the enrollment utilization and the experience data, we'll then be able to adjust that rate accordingly. We're trying to set it so that the State is not at risk for losing any money at all.

But I would agree with your premise that they are probably more likely to be people who are in need of the insurance coverage.

ASSEMBLYMAN GIBLIN: Mr. Beaver, you're familiar with health savings accounts that are used in the private sector?

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: Okay. You mentioned this issue about the dual coverage of husband and wife. We cover domestic partners, right?

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: Okay. That's what I thought we did.

But use that scenario. You said that we can mandate that a spouse be terminated from coverage? Is that correct, what you said?

MR. BEAVER: What the State mandate requires is that if you have two employees of the State, both eligible for health insurance coverage, they could not cross-cover each other. So if I, for example, decide to enroll with NJ PLUS, and I have a spouse that enrolled in Aetna, I could not put her on my plan as a dependent while she has her own coverage under a separate program.

ASSEMBLYMAN GIBLIN: Okay. Well, the only thing-- I'm looking at this issue. You mentioned before that some municipalities do this -- about trying to give people some financial incentives. Do we have, like, a mechanism in place where, if you had that scenario of a husband and wife working, where if they wanted to eliminate the second coverage, that some of those dollars could be put into a health savings account where they could utilize -- dental work or orthopedic work, or some kind of real specialty, acupuncture?

MR. BEAVER: Anything to offset their out-of-pocket expenses.

ASSEMBLYMAN GIBLIN: I know, but do we have something like that in place?

MR. BEAVER: No, not at this time.

ASSEMBLYMAN GIBLIN: Because I don't know about the legality of what you're doing here -- I'll be frank with you, I'm not trying to be -- if that's on solid ground, as far as that's concerned. And a lot of these other issues, like with the-- I don't know if we do this -- just asking aloud. But like, say, like in vitro fertilization. Do we do that, under the State Plan? Is that covered?

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: Okay. So local groups, would they have the flexibility if they were carved out? You know, some of these issues here, they're a big cost item. But isn't this what a lot of these boards of education are clamoring for, that they want to have the ability to carve out their own plans and leave some of these -- a bare bones thing? And they want to have give and take as far as their level of coverage.

MR. BEAVER: One second.

There's a responsibility for local employers, even when they leave the State Health Benefits Plan, to maintain some similarities, a similar program. They can't go completely off, I think, and get rid of the some of the higher cost programs, such as in vitro fertilization. So there is a requirement that they stay within certain bounds. I guess you could argue what is similar, but they cannot go completely off the reservation.

ASSEMBLYMAN GIBLIN: The administrative fee that we pay to these different carriers, whether it's Horizon, do we have any idea in the aggregate what those administrative fees are?

MR. BEAVER: In a dollar value, I don't know -- I can't give you an exact number. I can get that for you, in terms of dollar value. It's somewhere in the area of around 4 or 5 percent.

ASSEMBLYMAN GIBLIN: So the total amount would be -- just a ballpark number overall? What's our total bill? You mentioned 3.6.

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: So that's--

MR. BEAVER: Five percent of that would be \$150 million, \$200 million a year. I'd rather get just specific numbers, because they are differentiated between the plans. So I'd be happy to deliver that to the Chair. There's different percentages and--

ASSEMBLYMAN GIBLIN: A couple things with retirees: When retirees move out of state, what's your feedback as far as our health plan is concerned? Do they have any type of difficulties with a prescription plan, or hospitalization, or medical? Do you hear any complaints like that?

MR. BEAVER: I think the prescription plans are the least of the problems; but depending on the area they move to, there are certainly

potential problems. If you're in an NJ PLUS plan, for example, it's very strong in this area. It has some presence in some of the southern states, but we're starting to lose some of that. And that's another reason I think it would be helpful to go to a PPO -- to get a national product. But we do get periodic complaints depending on where the individual is residing.

ASSEMBLYMAN GIBLIN: Okay. That number that you're going to develop with the 2007 budget, as far as the unfunded liability for health benefits--

MR. BEAVER: Yes.

ASSEMBLYMAN GIBLIN: Do you know how you're going to determine that? I know there's like generally accepted standards as far as the accountants are concerned, but I'm looking at some of these numbers here. There's 88,000 retirees, and I'm trying to look at the average cost. I'm trying to multiply this out -- how you come up with that 20 million -- 20 billion -- excuse me -- a number. Do you have any idea how you come up with that?

MR. BEAVER: As Mr. Megariotis mentioned, I think the 20 billion was a kind of a back-of-the-envelope kind of guesstimate before the final regulations were issued by GASBY. What we need to do now, and it's going to take a little time, is we provide all the demographic data regarding this population to the actuaries. They would then do their magic and look at things like life expectancy, utilization, experience over time; and present-value that back to today's dollar and come up with a number. But it's a pretty arduous exercise. And it's really taken -- it's going to take -- each cut of age is-- And say if you're at age 62, and we expect you to live to 82,

you've got a 20-year expected future utilization. So I have to develop all those costs.

ASSEMBLYMAN GIBLIN: Wellness programs, like with flu shots, do we do those for free?

MR. BEAVER: Some will have office visit co-pays, but some are pretty much covered; but they might have the office visit co-pay -- \$5 or \$10.

ASSEMBLYMAN GIBLIN: Well, the only thing-- In the private sector, I've seen employers give free flu shots because they said it was more cost-effective. They were able to go to a hospital or to -- even Horizon, I think, offers a program in South Jersey, where they charge like 10 or 12 bucks. And it's cheaper than going to a doctor, pay the co-pay, whatever they charge. They don't get involved with an office visit; and that's the reason that they opted in that particular direction. So I just wanted to maybe end on that note, that this is what they're doing in the private sector.

Thank you.

MR. BEAVER: Thank you.

SENATOR SCUTARI: Okay. Thank you, Director, members of the Committee.

We stand in recess.

Thank you.

(MEETING CONCLUDED)