Structural and Financial Challenges in the State Health Benefits Program for Local Government

Executive Summary

The State Health Benefits Program (SHBP) for Local Government (SHBP-LG) has reached an inflection point. What began as a commitment to offer affordable, high-quality coverage to public employees has become a structurally unstable and financially unsustainable system, due to adverse selection, diminished participation, and cost escalation. **The plan's very high actuarial values, a depleted and now insolvent cash management margin reserve (known as the Claims Stabilization Reserve), and a static governance structure have created a self-reinforcing loop of premium increases and employer exits—what actuaries commonly refer to as a "death spiral."**

Under the current governance structure of the plan per P.L. 2011, Chapter 78, neither the Governor, State Treasurer, nor Director of the Division of Pensions and Benefits have any authority to make plan design changes in response to changing conditions or increasing costs. This authority is granted by the Legislature solely to the Plan Design Committee – an entity that due to its structure further entrenches the costly and unsustainable status quo.

Notably, even the most aggressive plan design changes likely will not be enough to reverse the systemic unraveling underway. The conditions mentioned above have contributed to worsening **adverse selection**, as local employers with better risk profiles increasingly leave the plan or remain outside the plan. Making matters worse, those same employers can return to the SHBP-LG when their risk or healthcare costs increase, placing a further burden on the system. This dynamic has eroded the SHBP-LG's viability as a stable, broad-based risk pool and underscores the urgent need for structural reform.

The challenges currently faced by the SHBP-LG are not unique. The School Employees' Health Benefits Program (SEHBP) is also experiencing structural issues stemming from adverse selection, an unstable risk pool, high utilization, and benefit plans with very high actuarial values (AVs). While P.L. 2020, Chapter 44 provided temporary stabilization, it did not resolve these underlying dynamics. As a result, the SEHBP now faces significant financial and actuarial risks and may be on a similar trajectory as SHBP-LG—potentially entering a death spiral in the medium-term or experiencing serious affordability issues for its members.

The following document presents explanations for the current, urgent situation, a set of findings, and proposed policy responses.

Specifically, **policymakers should consider significant reforms to transition to an alternative delivery mechanism, or to partially stabilize the volatile enrollment pool and provide more agile governance.**

1. Background

The State Health Benefits Program (SHBP) for Local Government (SHBP-LG) has experienced significant structural and financial strain over the past decade. Originally designed for State employees to provide cost-effective, high-quality healthcare, the State later opened participation in the SHBP to local government employees and retirees. Local Government employers have the option to contract for coverage through private insurance plans or other arrangements, as is discussed later in this document. The SHBP-State is a standalone plan, and does not benefit financially, or otherwise, from the participation of local employers in the SHBP-LG. The SHBP-LG now faces shrinking enrollment, escalating costs and premiums, and concerns about long-term sustainability.

The SHBP-LG is a large ($2.0 billion in annual premiums), self-insured health benefits plan, covering 689 local employers and an average membership of approximately 156,000, including Active, Early Retirees, Medicare-eligible Retirees, and their dependents. The only resources available to sustain the program are premiums paid by the employers and employees that participate in the SHBP-LG. Deposited funds in the SHBP-LG fund are solely dedicated to paying Local Government members' health benefits claims. The plan is complex. Following the addition of a second Third Party Administrator in July 2024, the number of plan options effectively doubled. SHBP-LG now offers 26 plan options for Active employees, 28 for Early Retirees, and 9 for Medicare Retirees[1]. In addition, there are 3 dental plan options.

2. Actuarial Value of the Plan

Some of the above challenges stem from policy and legislative developments, such as Chapter 78 (2011), which established the Plan Design Committee (PDC), composed equally of labor and management representatives. This change entrenched a *status quo* of generous and high-cost benefits. Chapter 78 did not mandate any redesign of plan benefits, and the SHBP-LG has continued to maintain plan design with very high actuarial values. Making plan design changes through the PDC has proven difficult, even as plan costs increase. As a result, most local employees have opted to remain in health care plans created 18 years ago, whose plan designs have remained largely unchanged.

Historically, plans under SHBP (State and Local) and the School Employees' Health Benefits Program (SEHBP) have maintained actuarial values (AV) between 93% and 98%, exceeding the ACA Platinum-tier threshold of 90%. **Approximately 95% of the SHBP-LG enrollees are in plans with an AV exceeding 97%.**

The AV reflects the percentage of total average health care costs a plan is expected to cover for a standard population. A higher AV translates to lower out-of-pocket costs for members. For instance, a 98% AV plan means that for every $10,000 in expected medical expenses, the plan covers $9,800, while the member pays $200 in copays, deductibles, or

[1] Despite offering a significant number of plan options—which increases complexity and administrative costs and makes decision-making more difficult for members—all plan options provide very rich benefits with actuarial values at the highest end (Platinum level).

coinsurance. (This excludes the member's premium contributions via payroll deduction.) The predominance of higher AV plans among those who remain means that the brunt of annual cost increases is passed on to employers. In turn, many employers share a portion of that cost with employees in the form of premium contributions. However, the majority of the cost is borne by the taxpayers who fund these employer contributions.

A May 2023 report by Aon, the plan's actuary, indicated that the total cost of providing healthcare, on average, for each active SHBP member is approximately 60% higher than the comparable national average cost for active employees in employer-sponsored plans.[2] The report attributes this to three main drivers: high benefits utilization, generous plan features, and the limited use of mandatory utilization management strategies.

3. Adverse Selection

Unlike the SHBP-State plan, the SHBP-LG lacks stability in enrollment and risk pooling. This is due to local government employers' ability to exit the plan at any time during the year, contributing to **adverse selection**. Over the past several years, employers with healthier, lower-cost employees (i.e., lower loss ratios) have exited the plan, leaving behind a population with higher health care utilization and associated costs. This trend has contributed to premium volatility and an increasingly unstable financial position for the remaining employers.

Below is a list of the top 10 local employers (ranked by enrolled members) that exited the plan in 2024:

	Enrolled Members	Loss Ratio
1	722	0.748
2	525	0.729
3	504	0.940
4	487	0.857
5	463	0.758
6	420	0.807
7	334	0.763
8	334	0.788
9	266	0.717
10	175	0.628
Weighted Average Loss Ratio		**78.50%**

Source: DPB

As shown, employers with lower loss ratios are exiting the plan, exacerbating adverse selection and weakening the SHBP-LG risk pool. On average, the plans presented in the table above have a loss ratio of 78.5%. This means that the premiums paid by these employers exceeded the claims incurred by their populations by approximately 21.5%, and therefore they were able to contract for health insurance in the commercial market with

[2] In 2023, the average national cost for an active employee in an employer sponsored health plan was roughly $14,000 Per Employee Per Year (PEPY). This figure considers both private and public employers. State Actives within the SHBP were projected to have PEPY costs of roughly $22,000, or $8,000 and 60% higher.

lower premiums compared to those that stayed in the SHBP-LG. This loss of membership weakens the overall risk pool of the SHBP-LG, as smaller, less diversified pools are less able to spread the risk, smooth the premiums over time, and act as natural cross-mechanism to subsidize events and risks within the group, where younger and healthier members contribute to keep the plans stable and affordable. **This dynamic contributes to rising plan costs of the SHBP-LG, independent of changes in price or utilization.** If these employers experience higher-than-expected claims in the commercial market, they will likely return to the SHBP-LG with worse loss ratios, further straining the risk pool.

The table below shows how SHBP-LG has seen steady declines in participation in recent years, reaching a participation of 56.2% by the beginning of this year:

January of each Year	Employers Participating in SHBP-LG	Employers with Prior Enrollment in the SHBP-LG	Never Participated	Total Employers	% Participating	Net YoY Change %
2021	768	281	177	1,226	62.6%	
2022	758	296	175	1,229	61.7%	-1.0%
2023	758	304	169	1,231	61.6%	-0.1%
2024	715	350	167	1,232	58.0%	-3.5%
2025	692[3]	374	166	1,232	**56.2%**	-1.9%

Source: DPB

4. Current Financial Status by Plan

Over the past four years, from 2022 to 2025, the SHBP and the SEHBP have experienced significant premium increases. The financial situation is more critical for SHBP-LG; premiums have increased by 59 percent, while for all plans combined—including SHBP-State and SEHBP—the increase has been 44 percent.

The financial situation and cost pressures have not improved. According to the actuary, average annual cost growth in 2025 is exceeding 8% for medical and 12–20% for prescription drugs. All three public health benefit programs administered by the State of New Jersey — SHBP-State, SHBP-LG, and SEHBP — are experiencing these cost pressures at different magnitudes. As of the end of last year, the financial situation of each plan can be summarized as follows:

SHBP-State:

- Net loss of approximately $113 million in 2024.
- Prescription drug spend is 23.6% higher than projected.
- Requires premium increases in future years but remains more stable due to larger scale and controlled entry.

[3] At the end of March 2025, there are 689 local employers participating in the SHBP-LG.

SEHBP:

- Some temporary relief from Chapter 44 (2020), which encouraged migration of 60% of its membership into more cost-effective plans.
- The Claims Stabilization Reserve (CSR) has fallen 60% since 2023, and the actuary estimates the CSR balance will be only $80 million at the end of this year (which represents roughly 0.6 months of plan costs).
- By legislating SEHBP plan design, Chapter 44 precludes plan design changes by the SEHBP PDC in response to health care cost increases until 2028.
- On current trajectory, SEHBP is likely to follow SHBP-LG's deterioration.

SHBP-LG:

- In the most critical financial condition.
- Net loss of $48 million in 2024, with CSR fully depleted despite expectations that a margin on premiums would generate $60 million in additional revenue.
- Required cumulative net $120 million transfers from November 2024 to April 2025 from SHBP-State under Chapter 86 just to pay claims.
- Current actuarial projections estimate that 2025 premiums would need to be 19.5% higher to increase the CSR to the target level of 2 months of plan costs on top of the rate increase required to keep up with underlying medical and Rx trend increase.
- **Four-year cumulative premium increases expected to significantly exceed 60% by 2029.**

5. Short-Term Cost Drivers and Financial Outlook

Building on the current financial status described above, this section outlines short-term projections and the primary cost drivers contributing to the financial pressures facing SHBP-LG.

Given the continued erosion of the plan's risk pool, the depletion of the CSR, and the high actuarial value of the plan's benefit offerings, the SHBP-LG is on a trajectory that threatens its long-term solvency. Without meaningful intervention, current trends in enrollment, utilization, and health care cost inflation will continue to drive unsustainable premium increases. The situation is not one of temporary imbalance—it reflects deep-seated structural challenges that, if unaddressed, will further destabilize the plan. The following section outlines the projected financial outlook under these conditions and explores the key drivers behind escalating costs.

Cost Drivers

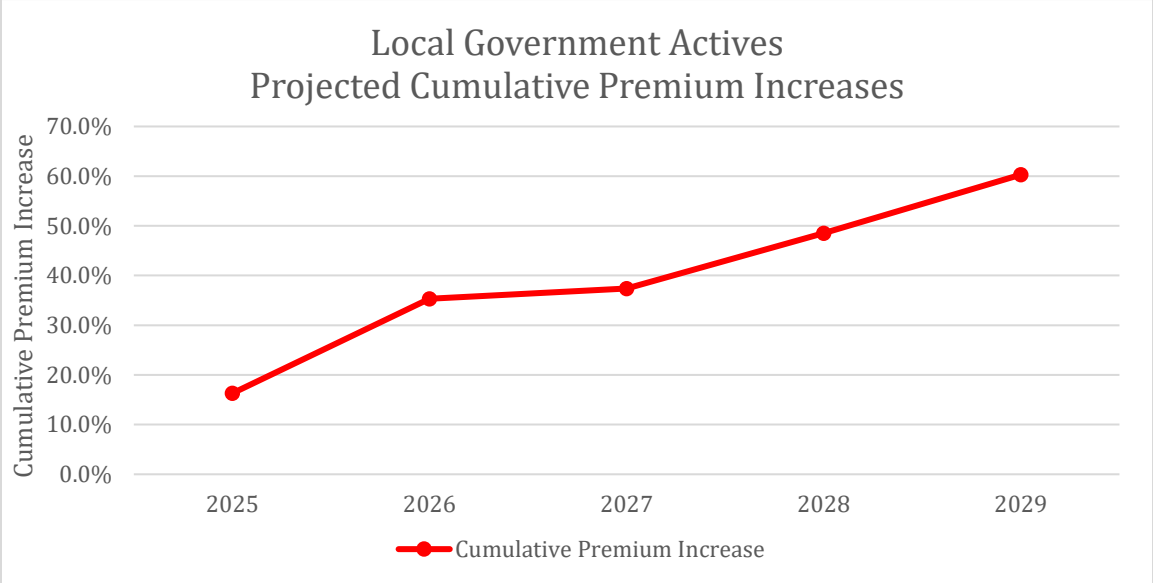
The primary drivers of this upward cost trajectory include medical inflation (i.e., the increase in costs of healthcare services), the growing cost of prescription drugs, and increased utilization of high-cost healthcare services and prescription drugs. In particular, the introduction of new pharmaceuticals and the expansion of indications for existing medications have contributed significantly to premium increases. One clear example is

GLP-1 medications, originally developed for diabetes and weight loss, which are now being explored for cardiovascular risk reduction, sleep apnea, fatty liver disease, and Alzheimer's disease. These drugs, while offering potential health benefits, represent a significant financial challenge due to their high cost and expanding utilization (e.g., 99% increase in utilization observed by the SHBP for January-September of 2024 compared to the same period in 2023). Given the continual development and introduction of new, high-cost medications, often launched with limited or no market competition, these trends are likely to persist, sustaining upward pressure on the plans' costs for the foreseeable future.

It is important to note that the current financial condition of the SHBP-LG now is more critical than the condition of the SEHBP was prior to the enactment of Chapter 44. Thus, merely mirroring measures included in Chapter 44 for the SHBP-LG will not be sufficient.

Financial Outlook

Preliminary estimates indicate that without a significant overhaul of the plan design and other measures to address the adverse selection and the very high actuarial value of the plan, cumulative premium increases exceeding 60 percent are likely over the next four years, from 2025 to 2029 (refer to chart below). These increases include margins to offset adverse selection costs. Such increases would impose substantial financial burdens on local government employers and employees alike and would likely make the plan unaffordable, requiring stricter reforms that reduce benefits more drastically. The chart below illustrates the trend of premium rate increases that SHBP-LG could likely follow if no corrective measures are introduced to correct structural issues of the plan.



Source: Aon

6. Chapter 86

Compounding the financial pressures of adverse selection and a high trend of medical and prescription drug costs is the depletion of the CSR, which has historically served as an operational cash flow reserve for SHBP-LG to cover daily payment of claims. A two-month reserve is a common actuarial standard, providing protection against unexpected cost volatility, delayed reimbursements, or spikes in large claims. This reserve had been the only "buffer" or mechanism available to the plan to meet variances between premium estimates and actual costs incurred and paid, or temporary cash flow gaps between the collection of contributions and payment of claims.

However, this reserve was exhausted principally due to actuarial losses (i.e., actual claims costs exceeding premiums paid by employers and employees) experienced in 2023 and 2024. In response, the Legislature enacted Chapter 86 in October 2024 to address cash flow challenges within SHBP-LG. This legislation permits the temporary transfer of funds from the State fund of the SHBP to the SHBP-LG fund to cover temporary cash flow shortfalls in lieu of emergency (mid-plan year) premium increases. Since the enactment of Chapter 86 the plan has had to rely on transfers from the SHBP-State fund to meet its contractual obligations.

By the end of March 2025, transfers in the cumulative amount of $258 million were approved, with reimbursements made in the amount of $138 million, leaving an outstanding balance of $120 million to be reimbursed.

While this measure has allowed SHBP-LG to meet its immediate obligations and most importantly continue to provide health care benefits to its members, it does not constitute a long-term solution. The borrowed funds will need to be repaid.[4] Based on the amounts borrowed to date that exceed available balances, barring a mid-year rate increase sometime in 2025, the SHBP-LG fund will not have sufficient resources to pay the outstanding balance owed to the SHBP-State. The plan's Actuary estimates that for Plan Year 2026 a premium rate increase of around 7 percent above the normal trend growth will be required to repay the current outstanding balance. The Actuary also estimates that an additional 19.5 percent premium increase will be needed to replenish the CSR to the recommended level of 2 months' worth of claims. **That is, there could be a 26.5 percent "floor" to 2026 premium increases for the SHBP-LG, in addition to the "regular" medical and prescription drug trend rates.** While it is unlikely that the full 26.5 percent increase—on top of medical and prescription drug trends—would be approved all at once, it is essential to incorporate the repayment portion (7 percent) into the premium approval process for Plan Year 2026 to comply with Chapter 86. The remaining 19.5 percent needed to rebuild the CSR can be gradually phased in over multiple years, aligning with sound fiscal planning practices. As noted above, a two-month reserve is a common actuarial standard, and could be achieved through a gradual, consistent application of smaller rate margins.

[4] Under Chapter 86, transfers must be repaid to the SHBP-State fund within 120 days. However, in extraordinary circumstances, the Director of DPB may authorize an extension of up to 365 days.

7. Plan Governance

The governance of the SHBP-LG is closely tied to the Plan Design Committee (PDC), established under Chapter 78 (2011) with equal representation from labor and management[5]. In response to the financial challenges faced by the SHBP/SEHBP, various savings plan initiatives and concepts have been presented to the PDC. (See Appendix A).

The primary objective of these initiatives has been to improve care management and encourage member utilization of higher quality medical services at lower costs, such as approval of a limited pilot Centers of Excellence program, or the utilization of lower cost alternatives that possess the same medical and clinical efficacy, such as the generic drug substitution preference policy, first adopted in 2019 and renewed annually. Under this policy, members who choose a brand-name drug when an FDA-approved generic is available must pay the cost difference, unless the brand-name drug is deemed medically necessary. This approach promotes the use of safe, effective, and lower-cost generic medications to help control rising prescription drug expenses of the SHBP. While these modifications do not entirely offset future cost trends, evidence suggests that plan design adjustments, such as cost sharing changes, incentivize members to make cost-effective healthcare choices. For example, when the PDC implemented higher copay differentials for specialist and urgent care visits in 2023 (for SHBP-State), these changes led to improved utilization patterns for the second consecutive year compared to SHBP-LG and SEHBP.

While plan design adjustments such as introducing higher deductibles and copays generate short-term cost reductions, they do not sufficiently offset the long-term cost curve of the plan. As a result, changes need to be more frequent and substantial, and must be accompanied by other measures that address the structural problems of the plan mentioned above, including issues such as adverse selection.

Addressing the financial challenges facing SHBP-LG requires a balanced and strategic approach that considers a combination of structural reforms and cost-containment strategies, including: aligning plan actuarial values with national benchmarks; designing and introducing structural changes to increase population stability for the local plans to limit adverse selection (e.g. entry and exit waiting periods for employers); encouraging the utilization of cost-efficient services; and implementing plan design changes that encourage the most effective utilization of services (for example, copay differentials for non-preferred drugs that have higher net cost and the same clinical efficacy).

[5] The SHBP PDC's governance structure is an outlier among state-administered public employee health benefit programs, with an equal labor and management representation and without binding mechanism to resolve deadlocks, an arrangement that has impeded timely adjustments to plan design. A review of peer governance models found only Oregon Public Employees' Benefit Board (PEBB) to have a similarly balanced composition. However, the PEBB's bylaws provide a tiebreaking mechanism. This ensures that the PEBB can make decisions when consensus is not reached. This is a key distinction that gives Oregon's model greater governance agility compared to the PDC.

Absent these measures, the SHBP-LG's current deterioration will continue and in fact accelerate, wherein rising costs outstrip available funding, employers continue to exit, and the only available remedy is dramatic premium increases that further exacerbate the adverse selection.

PDC Modernization

One area for potential improvement is the introduction of delegated authority from the PDC to the State Treasurer or the Director of the Division of Pensions and Benefits (DPB), within defined parameters and subject to periodic reporting. The absence of such a delegation has restricted the plan's ability to respond quickly and effectively to external pressures and has constrained responsiveness to the fast-evolving landscape of medical and pharmaceutical innovation. The health care delivery system, in New Jersey and nationally, is also undergoing major shifts, including a move toward outpatient surgical and diagnostic centers and the rise of new investor-driven ownership models with shorter return horizons which tend to add cost pressures to the plan. These shifts require a more agile governance framework.

An example of this governance model is North Carolina's State Health Plan for Teachers and State Employees.[6] Under North Carolina General Statutes § 135-48.30(a)(2), the State Treasurer of North Carolina has clear authority to set benefits, premium rates, copayments, deductibles, and coinsurance maximums for this plan. This governance structure enables more responsive and informed plan design adjustments while preserving institutional checks and balances. It offers a useful model for New Jersey to consider. As noted, the current SHBP governance model established under Chapter 78, the authority to approve plan design changes rests solely with the Plan Design Committee (PDC) or the Legislature, not with the Governor, the State Treasurer, or the Director of the Division of Pensions and Benefits.

8. Membership Stability and Risk Pooling

Another area that requires significant change is membership stability and risk pooling. There has been growing concern over adverse selection, particularly as participating local employers have increasingly opted to leave the plan based on short-term cost considerations. This undermines the stability of the plan's risk pool and contributes to premium volatility, ultimately placing upward pressure on costs for those who remain.

A policy response worth consideration is the introduction of a waiting period for re-entry following voluntary withdrawal. This would deter opportunistic participation and foster long-term commitment to the plan. This has already been implemented in other states. For example in the California Public Employees' Retirement System (CalPERS) Health Benefits Program, which administers health coverage for over 1,100 local affiliated public entities and provides health care to more than 1.5 million public employees, retirees, and

[6] New Jersey and North Carolina's state health plans have comparable enrollment of public employees under self-insured models.

their families. CalPERS enforces that a terminated agency may not re-enter the plan for five years from the termination date.[7]

This five-year re-entry waiting period was specifically adopted to protect the program against adverse selection, reduce volatility, and ensure that participants maintain a stable, long-term presence in the plan. It promotes shared responsibility across agencies and protects the financial health of the program by minimizing the risk of selective enrollment based on market fluctuations or annual budget conditions. Horizon (one of the SHBP's third party administrators) estimates that if a similar policy were to be implemented over a period of years this could reduce SHBP-LG costs by 10-14% over that time.

9. Death Spiral

The cumulative effect of adverse selection, escalating premiums, and a depleted CSR has now triggered what actuaries commonly refer to as a "death spiral." This dynamic arises when the financial sustainability of a health benefits program deteriorates in a self-reinforcing cycle, each worsening cycle compounding the next.

First, adverse selection continues unabated. Healthier local employers exit the SHBP-LG plan in search of lower-cost coverage, leaving behind a population with higher medical utilization. This worsens the risk pool and drives up premiums.

Second, these rising premiums in turn prompt further exits, as more employers find the plan unaffordable and opt out. This creates an accelerating erosion of membership and decreasing premium revenues.

Third, the depletion of the CSR removes the only financial buffer available to mitigate premium spikes, actuarial losses, or cash flow needs. The plan is now reliant on Chapter 86 transfers from SHBP-State, which are temporary and unsustainable.

Fourth, the current governance structure, requiring consensus between labor and management on the PDC, prevents timely, meaningful reform. Critical cost-containment and risk-stabilization measures remain undecided due to lack of delegation and structural rigidity.

Finally, the plan options under SHBP-LG remain unusually generous, with actuarial values approaching 98%. These designs are increasingly out of step with national trends and fiscal realities. As detailed in the actuary's "Plan Design Comparison Analysis" dated May 15, 2023, the cost of the SHBP is 60% higher than those offered nationwide by other large private and public employers. This is due to higher level of member utilization of services, the richness of the plan designs, and the limited incorporation of mandatory utilization management incorporated into the plan.

[7] CalPERS Circular Letter No. 600-034-24, available at: https://www.calpers.ca.gov/employers/policies-and-procedures/circular-letters/600-034-24

The convergence of these factors signals a systemic failure. The SHBP-LG is not merely facing a financial problem—it is confronting a structural unraveling that, left unaddressed, will lead to collapse. Urgent and decisive intervention is required by the Legislature, potentially including the restructuring of the plan or transitioning local employers to alternative pooling arrangements as it is explored in the sections below.

While the School Employees' Health Benefits Program (SEHBP) experienced temporary relief under Chapter 44, its underlying trajectory bears similarity to SHBP-LG. This should serve as a cautionary signal to policymakers, and changes to that program should also be considered. As it stands, although SEHBP faces similar cost pressures, its Plan Design Committee is statutorily prohibited under Chapter 44 from implementing any plan changes until 2028, leaving the program with few tools to manage escalating costs. The plan's governance, the PDC and Commission, as well the Legislature should be aware that limited policy decisions or fixes will have a limited chance of success. A coordinated, multi-dimensional response—encompassing governance reform, structural risk pooling, actuarial value alignment, and care management innovation—is essential to avoid the plan's failure.

11. Policy Options

The preceding sections have outlined a stark and deteriorating landscape for the SHBP-LG. Key challenges include diminishing participation, unsustainable cost trends, a depleted Claims Stabilization Reserve, an extremely rich plan design that has not been meaningfully updated in over a decade, and a governance structure that lacks agility. Together, these elements have pushed the SHBP-LG into a structural and financial crisis. Addressing these problems requires an ambitious and comprehensive reform package that simultaneously strengthens plan stability, improves risk management, introduces financial predictability, and modernizes governance.

Informed by actuarial analysis, comparative practices in other states, the adverse selection trends described in Section 3, the practically unaffordable rate increases projected due to the need to repay Chapter 86 transfers and replenish the CSR, and the dynamics observed in SHBP-State and SEHBP post-Chapter 44, a comprehensive legislative reform for SHBP-LG is urgently needed. Failure to reform will lead to ongoing price increases and employer exits, and eventually a complete and disorderly collapse of the plan.

The first option presented here would authorize a phased and orderly closing of the SHBP-LG, enabling local entities to transition into self-governed collectives, such as Group Insurance Funds (GIFs) or Multiple Employer Welfare Arrangements (MEWAs). The local employers could be provided with technical and financial support during the implementation period, including temporary stop-loss reinsurance, regulatory safeguards, and optional buy-in with third-party vendors to ensure coverage continuity and market stability.

Importantly, GIFs are already functioning across New Jersey among local government employers that never joined SHBP-LG or have exited the plan. According to data from the

New Jersey Department of Banking and Insurance and shared industry research, dozens of GIFs exist statewide, serving municipalities, counties, and local authorities. These arrangements offer pooled purchasing power, customized governance, and better risk alignment. Approximately 45% of New Jersey's 1,200 eligible local public entities currently receive health benefits outside the SHBP-LG, many through these GIFs or commercial carriers.

This reality reflects the extent of SHBP-LG's erosion and further validates the need for a legislative framework that facilitates its replacement, not just its reform. **Phasing out the plan in an orderly, supported, and equitable manner will mitigate further destabilization and align the State's policy approach with prevailing market conditions and local preferences.**

To support an orderly and financially stable transition out of the SHBP-LG, the State could consider establishing a transitional premium stabilization backstop, functionally analogous to aggregate stop-loss reinsurance. Under this mechanism, if a local employer group exiting SHBP-LG due to its closing experiences a year-over-year premium increase exceeding a set threshold, for example 15%, the State, or a contracted reinsurer with demonstrated solvency, credit worthiness and experience in public-sector health risk management, would absorb the actuarially certified portion of premiums above that threshold. This temporary mechanism could operate for an adequate transitional multi-year period, providing essential financial predictability and budgetary support as local authorities develop more robust pooling arrangements, such as consolidating into GIFs.

The primary objective is to mitigate financial volatility and avoid "sticker shock" during the shift away from a pooled State plan. The stabilization mechanism would act as a financial bridge, supporting the formation of locally governed, risk-aware health benefits structures to ensure an orderly and managed termination of the SHBP-LG. It would also incentivize sustainable pooling behavior by offering short-term support while limiting dependency. The program could include clear eligibility criteria, actuarial certification of excess premium growth, and annual fiscal caps to ensure cost containment and prevent moral hazard.

This approach would be similar to and consistent with the concept underlying Alaska's federally approved Section 1332 reinsurance program, albeit with a focus on local entities and aggregate annual costs, rather than the Alaska program's focus on individuals' insurance. The Alaska program thus provides a strategic model that adapted to New Jersey circumstances could support reduced premium volatility. A transitional premium backstop for SHBP-LG would similarly support financial stability while the broader system moves toward long-term reform.

There are alternative policy options to provide short-term stabilization measures that may help the finances and resolve some of problems of the plan in the medium-term. However, it is important to note that even taken together, these policy options will not fully resolve the structural deficiencies or halt the death spiral described earlier. These measures include the following:

Withdrawal and Entry Policy Reform: A minimum lock-in period of three to five years could be established for SHBP–LG employers, along with a mandatory re-entry waiting period for those who voluntarily exit. These rules would discourage opportunistic participation and promote long-term risk pooling stability.

Delegated Plan Design Authority: The Plan Design Committee (PDC) could be reformed to include delegated authority to the State Treasurer or the Director of the Division of Pensions and Benefits for routine plan changes—e.g., copay tiers, deductibles, and tiered networks—subject to regular reporting to the Governor and the Legislature. This would improve responsiveness to health care cost trends and innovation.

CSR Expansion: Consider rebuilding the Claims Stabilization Reserve to the recommended two-month level. Legislative support and significant State funding would be required, as the plan cannot generate sufficient surpluses under current premium projections to do this organically in the short-term.

Savings from potential plan design changes discussed in PDC meetings would be far too limited to absorb the expected increases over the next years. Even migrating all plans to Actuarial Values below 90 percent (Gold level) would yield only about 10 percent in premium savings. (See Appendix A for suggested savings initiatives). Limiting the size and scope of the provider network to reduce or cap in-network prices (such as a reference-based pricing model), as a potential savings strategy, could negatively impact members by shrinking their healthcare options and creating bottlenecks. Furthermore, while it might generate short-term savings, this approach likely will not significantly improve the plan's long-term financial stability. These short-term measures are independent of the more comprehensive solution of dissolution of the SHBP-LG. However, the simultaneous introduction of all of the three short-term measures will have a cumulative positive effect, since governance modernization alone cannot succeed without risk stabilization, and rebuilding the CSR alone will not halt the collapse if adverse selection and plan generosity remain unchecked. An effective solution to the SHBP-LG problems must be comprehensive, data-informed, and implemented with urgency and cohesion.

12. Conclusion

The SHBP-Local Government program has reached an inflection point. What began as a commitment to offer affordable, high-quality coverage to public employees has become a structurally unstable system, driven by adverse selection, diminished participation, and cost escalation. The plan’s very high actuarial values, a depleted Claims Stabilization Reserve, and a static governance model have created a self-reinforcing loop of premium increases and employer exits—what actuaries commonly refer to as a "death spiral."

This document has presented a clear set of findings and interlocking policy responses, from delegated governance to reinsurance protections. These reforms are not hypothetical —they are drawn from successful implementations in peer jurisdictions and reflect best practices from both the private and public sectors.

Notably, even the most aggressive plan design changes will likely not be enough to reverse the systemic unraveling now underway. The conditions mentioned above have contributed to worsening adverse selection, as local employers with better risk profiles increasingly opt to remain outside the plan or never consider entry in the first place. This dynamic has eroded the program's viability as a stable, broad-based risk pool and underscores the urgency of a structural reform. Accordingly, policymakers should now consider significant reforms to transition to an alternative delivery mechanism, or to partially stabilize the volatile enrollment pool and provide more agile governance.

Appendix A: Savings Opportunities

As presented to SHBP Plan Design Committee

Plan Design Change	Description
Increase Emergency Room Copay	Raises ER copay to $150 to reduce misuse and encourage urgent care/primary care use.
Increase Urgent Care Copay	Raises urgent care copay to $50 to promote cost awareness and appropriate utilization.
Limit Physical Therapy to 30 Visits	Caps physical therapy (PT) and chiropractic visits to 30/year to limit overutilization of rehab services.
Rx Copay Differentials	Adjusts prescription copays by tier: generic/preferred/non-preferred/specialty.
Increase OON Deductible & MOOP	Increases out-of-network (OON) deductible and maximum out-of-pocket (MOOP) to encourage in-network usage.
Out-of-Network Reimbursement at 175% of CMS	Caps OON reimbursement to 175% of CMS rates across pre-65 retiree/active plans.
Increase INN/OON Deductibles & MOOP	Raises both in-network (INN) and out-of-network (OON) deductibles and MOOP.
Migration to Modernized PPO (Gold Level)	Moves actives to a single PPO plan with an Actuarial Value lower than 90 percent (Gold Level), eliminating legacy plans.
Eliminate Active PPO10 and PPO15	Removes PPO10 and PPO15, leaving only plans with stricter cost controls.
Eliminate Medicare Supplemental Plans	Requires Medicare-eligible retirees to enroll in Medicare Advantage plans only.

Appendix B: Glossary

Term	Definition
Actuarial Value (AV)	The percentage of total average costs for covered benefits that a health plan is expected to pay for a standard population. A plan with an AV of 98% means the plan pays, on average, 98% of covered healthcare expenses while the member pays 2% via cost-sharing mechanisms like deductibles or copays. The AV does not take into account the employee's contribution to premiums.
Adverse Selection	A condition in which higher-risk individuals or groups are more likely to enroll in or remain in a health insurance plan, while healthier members exit. This imbalance leads to higher overall costs and destabilizes the plan's risk pool.
Claims Stabilization Reserve (CSR)	A financial reserve designed to serve as a buffer for health plans, allowing them to manage fluctuations in claims expenses and temporary mismatches between premium collections and payouts.
Copay	A flat fee a member pays at the time of the covered health service.
Coinsurance	The member's share of the cost of a covered health service, calculated as a percentage of the allowed amount for that service.
Deductible	The amount a member must pay out-of-pocket for covered healthcare services before the health insurance plan begins to pay.
Group Insurance Fund (GIF)	A self-governed pooling arrangement formed by multiple public employers to provide health benefits collectively. GIFs allow for local governance, customized benefit design, and collective purchasing power.
Multiple Employer Welfare Arrangement (MEWA)	A health benefits arrangement in which multiple employers pool together to offer healthcare benefits to employees. MEWAs may offer cost-efficiencies and broader risk distribution across members.
Plan Design Committee (PDC)	A statutory body, established under Chapter 78 (P.L. 2011, c.78), composed equally of labor and management representatives responsible for making plan design decisions under SHBP and SEHBP. The PDC has the authority to modify benefit structures, subject to statutory limitations.

Preferred Provider Organization (PPO)	A preferred provider organization (PPO) is a health insurance plan that offers flexibility in choosing healthcare providers.
Premium Contribution	The amount a member pays for health insurance from payroll deductions.
Premium Stabilization Backstop	A proposed transitional financial mechanism in which the State or a reinsurer absorbs a portion of excess premium growth experienced by SHBP-LG employers transitioning out of the plan. This aims to reduce financial shocks and support orderly exits.
Reference-Based Pricing Model	A health insurance payment model in which the insurer (or health plan) reimburses providers based on a multiple of what Medicare would pay for the same service. Healthcare providers may then seek the balance of the cost directly from the member. While mechanisms are available to limit the rate of balance billing, the risk remains.
Reinsurance	Insurance purchased by an insurer (or health plan) from a third party to protect against significant losses. In the SHBP context, reinsurance is considered to stabilize costs when high-cost claims exceed expected thresholds.
Risk Pool	The collective body of enrollees in a health plan, whose medical costs are aggregated to determine overall premium levels. A broad, stable, and diverse risk pool helps distribute costs and maintain premium stability.
Self-insured Health Benefits Plan	A self-insured health benefits plan is one in which the employer assumes the financial risk of providing healthcare benefits by paying claims directly, rather than purchasing insurance from a carrier. These plans do not maintain reserves beyond the Claims Stabilization Reserve (CSR), meaning that premiums are the sole source of funding for the payment of net claims (i.e., the portion of healthcare costs not covered by member cost-sharing such as copays). As such, premium setting must account not only for expected net medical and prescription drug costs, but also for maintaining the CSR, mitigating adverse selection, and addressing other financial and actuarial risks.
Third Party Administrator (TPA)	An external organization contracted to manage claims processing, customer service, and administrative functions of a health insurance plan. In SHBP-LG, multiple TPAs (e.g., Horizon, Aetna) oversee plan administration.
Utilization Management	Utilization management (UM) refers to a set of strategies and processes used by health plans to control

	healthcare costs, promote clinically appropriate care, and ensure that services provided to members are medically necessary. UM programs apply evidence-based guidelines and clinical review to determine the appropriateness, efficiency, and medical necessity of healthcare services and prescription drugs. Common UM tools include prior authorizations (requiring insurer approval before a service is rendered), step therapy (requiring patients to try lower-cost or first-line treatments before progressing to costlier or riskier alternatives), and quantity limits. In addition, cost-sharing structures, such as copays, deductibles, and coinsurance, also help incentivize members to make more reasoned decisions about when, where and how to access care. This reduces unnecessary utilization, lowers overall plan expenditures benefiting both members and employers by helping to limit premium increases.
Chapter 44 / Chapter 78 / Chapter 86	- Chapter 44 (2020): Promoted migration to more cost-effective plans in SEHBP. - Chapter 78 (2011): Created the PDC and restructured public employee contributions. - Chapter 86 (2024): Authorized temporary transfers from SHBP-State to SHBP-LG in certain circumstances.