HOW ARE HEALTH BENEFITS ADMINISTERED IN THE STATE OF NEW JERSEY?

BACKGROUND:

- Benefits for State employees and many municipal and county employees are administered through The State Health Benefits Program ("SHBP").

- The SHBP was established in 1961 under N.J.S.A. 52:14-17.25, et seq. to provide health benefits to State employees, retirees, and their dependents.

- The SHBP was extended to employees, retirees, and dependents of participating local and county public employers in 1964.

- Local and county employers must adopt a resolution to participate in the SHBP. In essence, when a local or county employer opts into the SHBP, they pay the State a premium for the benefits that their employees receive.

- Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

PURPOSE & OPERATION OF THE SHBP:

- The goal of the SHBP is to provide comprehensive health benefits for eligible public employees and their families at "tolerable" cost. In short, it establishes a plan for state funding and private administration of a health benefits program which will protect public employees from catastrophic health expenses. In addition, it encourages public employees to rely on the SHBP instead of seeking protection in the commercial insurance market. Heaton v. State Health Benefits Commission, 264 N.J. Super. 141, 151 (App. Div. 1993).

- The Act also spawned the State Health Benefits Commission (hereinafter referred to as "SHBC"). The SHBC is entrusted to establish the program by negotiating and purchasing medical,

surgical, hospital, and major medical benefits for participating public employees and their families, "in the best interests of the State and its employees" as well as retaining exclusive jurisdiction to determine disputed matters under the plan. N.J.S.A. 52:14-17.27 to -17.28.

- The SHBC is entitled to establish rules and regulations as deemed reasonable and necessary for the administration of the Act. See N.J.A.C. 17:9-1.1 to -7.4. The Act also states that the SHBC may set forth limitations and exclusions in coverage as it finds necessary to administer the SHBP:

> Benefits under the contract or contracts purchased as authorized by this act may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, and duplication of services or benefits otherwise available.
>
> [N.J.S.A. 52:14-17.29(D).]

PAYMENT OBLIGATIONS PRIOR TO REFORM:

- N.J.S.A. 52:14-17.28b articulated the payment obligations for health benefits coverage under the Program. With regard to the State, the statute provides in pertinent part:

> Notwithstanding the provisions of any other law to the contrary, the obligations of the State or an independent State authority, board, commission, corporation, agency, or organization to pay the premium or periodic charges for health benefits coverage provided under P.L.1961, c. 49 (C.52:14-17.25 et seq.) **may be determined by the means of a binding collective negotiations agreement**, including any agreements in force at the time of the adoption of P.L.1996, c. 8...
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> [N.J.S.A. 52:14-17.28b(a) (emphasis added).]

- Subsection (c) of N.J.S.A. 52:14-17.28b described the payment obligations for certain public employees. Specifically, N.J.S.A. 52:14-17.28b(c)(2) provided:

> The amount of the contribution required pursuant to paragraph (1) of this subsection as to State employees and employees of an independent State authority, board, commission, corporation, agency, or organization for whom there is a majority representative for collective negotiations purposes **shall be determined by means of a binding collective negotiations agreement.** The amount of the contribution required pursuant to paragraph (1) of this subsection as to State employees or employees of an independent State authority, board, commission, corporation, agency, or organization for whom there is no majority representative for collective negotiations purposes shall be **1.5 % of base salary**.
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> [N.J.S.A. 52:14-17.28b(c)(2) (emphasis added).]

THE ENACTMENT OF CHAPTER 2, P.L. 2010:

- In early 2010, passage of Chapter 2, P.L. 2010, made numerous changes to public employee health benefits — including those provided through the State Health Benefits Program ("SHBP") and the School Employees' Health Benefits Program ("SEHBP"). The changes affected the following:

  - Shared Costs
  - Employee Eligibility
  - Multiple Coverage
  - Waiver Incentives.

- Most of the changes became effective May 21, 2010, while others will not be effective until current labor contracts expire.

IMPACT OF REFORM:

- The enactment of Chapter 2, of P.L. 2010, has had the far reaching effect of removing the power and authority from both the employer (State, County and Local Governments) and employees (certified collective bargaining units) with the ability to negotiate compensation and benefits as authorized under the New Jersey Employer–Employee Relations Act, N.J.S.A. 34:13A–1.

- Prior to the enactment of Chapter 2 of P.L. 2010, healthcare benefits, to include the payment and contribution of the cost to the same, has always been a mandatorily, bargained-for benefit of employment.

REFORM SPECIFICS:

- By way of background, Senate Bill No. 3, which when enacted became Chapter 2, of P.L. 2010, was introduced on February 8, 2010.

- The bill makes various changes to the State Health Benefits Program ("SHBP") and the School Employees' Health Benefits Program ("SEHBP") concerning:
  - Eligibility of Receiving Coverage
  - Cost-sharing of Premium Payments
  - Choice of a Plan
  - The Application of Benefit Changes
  - The Waiver of Coverage and Multiple Coverage

- The bill also requires contributions toward the cost of health care benefits coverage by public employees and certain retirees.

- Specifically, the bill requires all public employees, including current state, school district, and local employees, to pay at least 1.5 percent of their base salary towards health benefits.

- The bill also requires all newly-hired employees to pay at least 1.5 percent of their base pension toward health benefits upon retirement.

- State employees are now required to work at least 35 hours per week to qualify for health benefits, with local and school employees having to meet a minimum 25 hour per-week standard to receive benefits.

- In pertinent part, Chapter 2 or P.L. 2010 provides the following:

> Commencing on May 21, 2010, the effective date of P.L. 2010, Chapter 2. and upon the expiration of any applicable binding collective negotiations agreement in force on that effective date, the amount of the contribution required pursuant to paragraph (1) of this subsection by State employees and employees of an independent State authority, board, commission, corporation, agency, or organization for whom there is a majority representative for collective negotiations purposes shall be 1.5% of base salary, notwithstanding any other amount that may be required additionally pursuant to this paragraph by means of a binding collective negotiations agreement.

KEY POINTS:

- The two important points to remember regarding this particular law is:
  - It only goes into effect at the conclusion or expiration of any collective bargaining agreements that were in effect prior to May 21, 2010; and

  - The contribution of 1.5% of one's base salary for payment of healthcare is a floor,no t a ceiling.

- What we mean by stating that it is a floor: the government has the ability to negotiate for higher contributions or request an award from an arbitrator greater than the 1.5% contribution.

QUESTIONS AND ANSWERS
REGARDING P.L. 2010, CHAPTER 2.

QUESTION 1: A collective bargaining agreement is scheduled to expire on June 11, 2011. The members of the bargaining unit which the agreement covers are presently making healthcare contributions in the amounts of either $20.00, $30.00, and $40.00, under the current agreement. The amounts paid towards the premium are dependent on whether they have selected healthcare coverage for a single employee, a single employee and spouse, or family coverage. Once the collective bargaining agreement expires, a contractual provision states that all terms and conditions of the agreement will remain in full force and effect until a new agreement is negotiated by the parties. Therefore, when the CBA expires, will the members be required to pay $20.00, $30.00, or $40.00 plus 1.5% of their base salary as a premium-sharing measure.

ANSWER: The State of New Jersey's Office of Employee Relations has stated that they interpret Chapter 2 of P.L. 2010 as requiring such employees to pay 1.5% plus $20.00, $30.00, or $40.00 towards the premium.

Whether their interpretation of Chapter 2 of P.L. 2010 is correct or not is unknown at this time. The law is virtually unknown and its applicability has not been fully tested yet. Only time will tell how the New Jersey Public Employment Relations Commission ("PERC") and New Jersey courts will interpret the application of the law.

QUESTION 2: Do the changes in Chapter 2 apply only to members enrolled in the State Health Benefits Program and the School Employees' Health Benefits Program ("SHBP/SEHBP")?

ANSWER: Most of the provisions of Chapter 2 affect only members of the SHBP/SEHBP. However, in two areas, changes were also made to the statutes which govern the purchase of public employee health benefits outside of the SHBP/SEHBP. The minimum employee requirements for medical coverage of 1.5% of base pay will apply to both SHBP/SEHBP and non-SHBP/SEHBP members.

Therefore, if the municipality you are employed in does not participate in obtaining health benefits through the SHBP, you and your collective bargaining unit are still subject to premium-share at 1.5% of your base salary.

MINIMUM EMPLOYEE CONTRIBUTION FOR MEDICAL BENEFITS

QUESTION 3: Is the 1.5% of base pay contribution in addition to previously negotiated premium contributions?

ANSWER: No. The 1.5% contribution is intended to be a floor, or minimum, contribution that an employee will make toward medical and/or prescription drug plan coverage. If another contribution arrangement has been negotiated, the higher of the two will prevail. All employees must contribute an amount equivalent to at least 1.5% of the employee's base pay. Any premium contributions for dental or vision care are in addition to the 1.5% contribution.

QUESTION 4: A local police unit is currently in contract negotiations. Employees currently contribute 15% of dependent premium under the old contract that just expired - how would the 1.5% be applied?

ANSWER: If the 15% of dependent premium is greater than 1.5% of the employee's base salary, then no additional contribution is required of that employee. However, if the 15% is less, the employee will have to supplement the same up to 1.5% of their salary from the time the contract expires until a new agreement is executed.

QUESTION 5: On what salary is the calculation of the 1.5% contribution based?

ANSWER. The calculation is based on the employee's base contractual salary. In most instances, that means the salary on which pension contributions are based. As an employee receives salary increases during the year, the amount of contribution would need to be adjusted accordingly.

QUESTION 6: Is the 1.5% contribution paid before or after taxes?

ANSWER.T he 1.5% will be deducted and paid for with "pre-tax" dollars.

QUESTION 7: Will non-SHBP/SEHBP participating employers be required to follow the 1.5% minimum contribution?

ANSWER: Yes. Chapter 2 stipulates that employees of non-participating employers must pay a minimum of 1.5% of annual base salary as a health benefits contribution.

QUESTION 8: Will current retirees who are receiving employer or State-paid medical coverage be required to pay the 1.5% minimum contribution?

ANSWER: No, current retirees will not be required to make a minimum contribution for health coverage if they are currently receiving employer or State-paid coverage.

QUESTIONS REGARDING MULTIPLE COVERAGE

QUESTION 9: An employee works for a municipality and is enrolled in the SHBP and the spouse works for the State or Board of Education and is enrolled in either the SHBP or SEHBP. Does this mean the family may only chose one plan for coverage?

ANSWER: If the employee is covered as a dependent under a spouse's SHBP/SEHBP coverage, the employee is not eligible for coverage as an employee. The employee may choose single coverage provided the spouse terminates the employee's dependent coverage; or, the spouse could waive coverage and the employee could cover the spouse as a dependent as well as any other eligible dependents previously covered under the spouse.

QUESTION 10: Can each choose single coverage and remain enrolled separately?

ANSWER. Yes. Each may choose single coverage and remain enrolled separately.

THE LEGALITY OF CHAPTER 2, P.L. 2010

APPLICATION FOR INJUNCTIVE RELIEF

- In April, several unions, including the New Jersey Policemen's Benevolent Association, filed a lawsuit against the State of New Jersey in Mercer County Superior Court seeking to halt the implementation of the 1.5% wage deduction for contribution toward health benefits. In summary, the unions argued that P.L. 2010, Chapter 2 violates the New Jersey Constitution and statutes by requiring a health benefits contribution, while ignoring the negotiation process and interest arbitration process, the mandated proceeding for resolving an impasse with fire and police employees. On May 21, 2010, the Honorable Linda Feinberg denied the union's request to enjoin the implementation of the P.L. 2010, Chapter 2.

GRIEVANCE LITIGATION

- A number of local unions have filed grievances and unfair practice charges against public employers for implementing the 1.5% wage deduction for medical benefits. The Public Employment Relations Commission ("PERC") recently issued two decisions with respect to a public employer's unilateral imposition of the legislated 1.5% of base salary contribution towards the cost of medical insurance benefits.

- In Township of South Orange, P.E.R.C. No. 2011-47, Docket No. SN-2011-004 (November 23, 2010) and Township of Edison, P.E.R.C. No. 2011-49, Docket No. SN-2011-014, PERC declined to restrain arbitration over a grievance filed by the police and fire unions over the Townships' imposition of the 1.5% base salary contribution towards medical insurance finding that "this raises an issue of contract interpretation best suited for an arbitrator."

- In South Orange, the Township and PBAs collective negotiations agreements expired on December 31, 2007. In Edison, the agreement with the IAFF expired December 31, 2009. The agreements provided that they would remain in full force and effect until a successor agreement was executed. In accordance with P.L.

2010, c. 2, the Townships implemented a 1.5% of base salary contribution towards medical insurance benefits. The unions filed grievances challenging the application of the statute and the Township's deduction of the 1.5% of base salary towards the cost of medical benefits. The Townships filed scope of negotiations petitions seeking to restrain arbitration of the grievances.

- The Townships argued that since the parties' collective negotiations agreement expired they were required by statute to implement the 1.5% contribution. The Union argued that an arbitrator should determine whether the terms of the agreement extends the life of the agreement until a successor agreement is negotiated and whether the employer violated the agreement by implementing deductions.

- PERC recognized that local government employees must begin contributing at least 1.5% of base salary upon the expiration of any collective negotiations agreement in effect on May 21, 2010. PERC also recognized that by operation of statute, unit members will be required to make contributions when their collective negotiations agreements expire.

- However, PERC found that nothing in P.L. 2010, c. 2 controls the answer to the question of when the collective negotiation agreement expires. PERC found that this raises a question of contract interpretation best suited for an arbitrator. PERC concluded that the unions may legally arbitrate their claim that the parties agreements remain in full force and effect until the execution of new agreements and, if true, that the employer violated the agreements by initiating a health benefits contribution of 1.5% of base pay.

LITIGATION IN THE SUPERIOR COURT OF NEW JERSEY

- On October 12, 2010, Judge Robert P. Contillo, P.J. Ch., issued a decision involving the Borough of Fort Lee and P.B.A. Local 245 finding that the Borough was required to withhold the 1.5% medical contribution from the PBA members as "there is in place no unexpired collective negotiations agreement between the Borough of Fort Lee

and the PBA." In Fort Lee, the PBA and Borough were involved in interest arbitration proceedings and received an award from the arbitrator in December 2008, which the Borough appealed to PERC. In May 2009, PERC remanded the matter to the arbitrator for additional consideration on two issues. In July, 2009, the arbitrator issued a supplemental award which PERC affirmed in September 2009. In October 2009, the P.B.A. filed an Order to Show Cause to compel enforcement of the award, and in November 2009, the Borough filed an appeal of the award with the Appellate Division.

- On October 12, 2010, Judge Contillo found that there had not been a collective negotiations agreement in place since December 2006, and that "under those circumstances a public employer like the Borough of Fort Lee is required to withhold from the member of the PBA the mandated 1.5% contribution."

WHERE DO WE GO FROM HERE:

- According to the Center for American Progress, a progressive think-tank in Washington D.C., health care costs are expected to grow 71 percent over the next decade. The report estimates New Jersey's premiums per employee would increase to an average of $17,862 by 2014 and $24,119 by 2019.

- The healthcare cost for State and local employees and retirees accounted for eight (8) percent or $2.36 billion of the State Budget in FY2010. According to the Christie Administration, given the current financial crisis, the State budget does not have the flexibility it once had to take on the additional costs for employees and retirees' rising health care expenses. It is for this reason that the State has moved to ensure that all employees contribute 1.5% of their salaries towards the cost of healthcare.

- In the future one can reasonably predict that as the cost of healthcare increases, the State is going to look to public employees to contribute more than 1.5% towards healthcare.

HOW WILL THE STATE LOOK TO ACCOMPLISH THIS GOAL:

- Legislative Enactment. Either amending Chapter 2 of P.L. 2010 to increase the employees contribution towards the cost of healthcare. This will hopefully be met by opposition from the legislature.

- The State can bypass the increase through legislative enactment by controlling the costs through the healthcare product that is offered through the SHBP.

    - To understand what we are speaking about,on e can look at the history of the health care products offered by the New Jersey SHBP.

    - For many years, the New Jersey SHBP offered a traditional indemnity plan as health insurance benefits. The "Traditional Plan," as it was referred to, was a Blue Cross/Blue Shield product that provided direct access coverage which allowed employees and their dependants to choose any physician to treat with and the bills for treatment were then submitted to the SHBP for payment. Specialist referrals and choosing a doctor or medical provider from within an access group or plan was not necessary or even heard of.

    - Several years ago, in the mid 2000's, New Jersey did away with the Traditional Plan and offered New Jersey Plus and an assortment of HMO products. NJ PLUS is a point-of-service plan that provides both in-network managed care similar to an HMO plan and out-of-network care similar to a traditional indemnity plan. In network service was covered at 100% plus co-pay. Out of network treatment was reimbursed at 70% of the reasonable and customary allowance after an annual deductible was met.

        - NJ PLUS was self-funded. Funds for the payment of claims and services come from funds supplied by the State, participating local employers, and members. NJ PLUS was administered for the SHBP by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ).

- HMO coverage was and is still available. An HMO, or Health Maintenance Organization, is a specific type of health care plan that unlike traditional health coverage, sets out guidelines under which doctors can operate. On average, health care coverage through the use of an HMO costs less than comparable traditional health insurance, with a trade-off of limitations on the range of treatments available.

    - The ways in which an HMO is able to offer cheaper health care are twofold. First, by contracting with specific providers of health care and dealing with large quantities of patients, the HMO is able to negotiate for more affordable health care than the patients would otherwise receive. Secondly, by eliminating treatments that the HMO views as unnecessary, and by focusing on preventative health care with an eye toward the long-term health of their members, the HMO reduces costs.

    - When one joins an HMO, one is usually asked to choose a primary care physician. This doctor then acts in part as the HMO's agent in determining what treatments the patient does and does not need. When the primary care physician determines that the patient needs care they cannot offer, they give a referral to a specialist that can address the patient's concerns.

- Presently, through the SHBP, New Jersey offers NJ DIRECT10, NJ DIRECT15, Aetna HMO, and CIGNA. Under NJ DIRECT, members may see any physician, nationwide, and do not need to select a Primary Care Physician (PCP) for in-network care. NJ DIRECT has in-network benefits which apply when you select and use participating providers. NJ DIRECT also offers out-of-network benefits that allow you to use any licensed medical provider or hospital facility. In-network benefits are provided subject to the payment of the applicable co-payment. Out-of-network benefits are payable subject to a deductible and co-insurance.

- Copayments for **NJ DIRECT10** are $10.00; and **NJ DIRECT15** are $15.00.
    - Most **NJ DIRECT10** out-of-network services are reimbursed at 80% of the "reasonable and customary" allowance after annual deductibles are met.
    - Most **NJ DIRECT15** out-of-network services are reimbursed at 70% of the "reasonable and customary" allowance after annual deductibles are met.
        - This particular history demonstrates how benefits have changed over the years without negotiation in an attempt to control the costs of health insurance.
- In addition to controlling costs through the plans offered through the SHBP, local and county governments may attempt to control costs of health insurance through the availability of plans offered to eligible employees through the binding collective bargaining process. Thus, local bargaining units do still have the ability to bargain for the type of plans that will be offered by their local employer through the SHBP or private insurance.
    - For example, the SHBP currently offers NJ DIRECT10, NJ DIRECT15, Aetna HMO, and CIGNA HealthCare HMO to local employers. The local employer may, through the collective bargaining process, offer employees all, a combination of plans, or one plan. The plans offered may be different for each bargaining group.

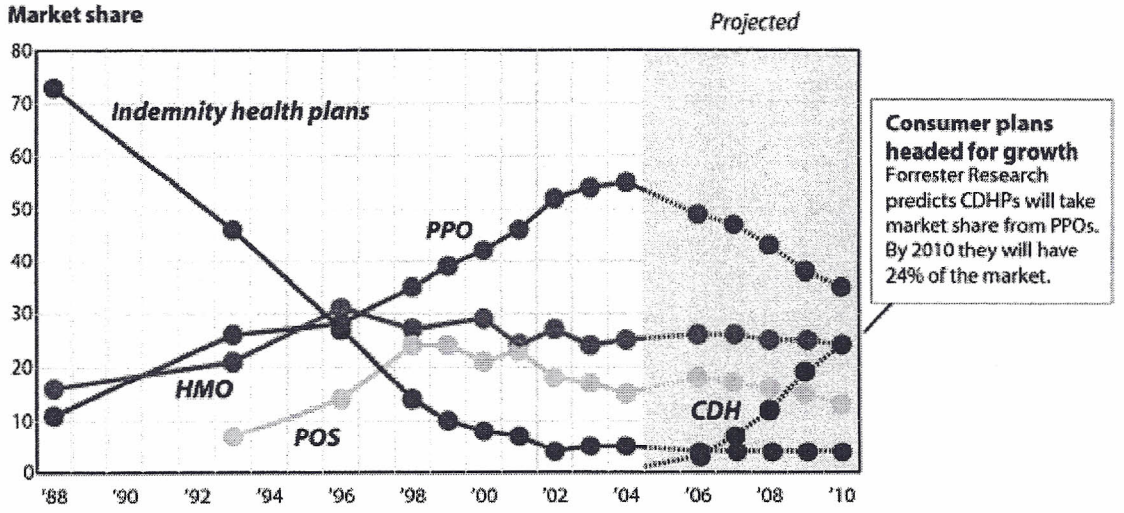
NATIONWIDE TRENDS IN HEALTHCARE

- In 2004, 55 percent of employees were enrolled in PPOs, 25 percent were enrolled in HMOs, 15 percent were enrolled in point-of-service plans, and 5 percent had traditional indemnity coverage, according to the 2004 Annual Survey of Employer Health Benefits conducted by the Kaiser Family Foundation and the Health Research and Educational Trust, or HRET.

- That mix had been holding steady for several years, but it has changed recently, and will change even more going forward, with a higher number of people being enrolled in Consumer-Directed Health Plans ("CDHP") that feature high deductibles and health reimbursement accounts or health savings accounts. In 2010,C DHPs garnered 24 percent of the market share, taking most enrollees largely from PPOs.

Evolution of the health care market

Health plan enrollment shifts from indemnity to managed care, and PPOs gain greatest share of market between 1988 and 2004.



Sources: Kaiser Family Foundation/Health Research and Educational Trust "Employer Health Benefits, 2004 Annual Survey" (historical data); Forrester Research Inc. (projections)
Note: Because of rounding, some totals are not 100%

- A CDHP is defined as a health insurance plan with an annual deductible of at least $1,000 for an individual and $2,000 for a family.

- CDHPs must be tied to a tax exempt Health Savings Account ("HSA"), in which your employer deposits money to use for medical expenses.

- An HSA is like a bank account in which the Company will contribute

money on a monthly basis. The employee also has the ability to contribute pre-tax dollars from your paycheck to the HSA.

- In any one year, an employee electing single coverage may contribute a combined $3,050 to an HSA and an employee electing family coverage may contribute a combined $6,150.

- If an employee is over the age of 55, an additional $1,000 may be contributed to the HSA per year.

- The purpose of establishing an HSA is to defray very high deductible amounts associated with the insurance that is offered.

- It is not uncommon for a CDHP to have a $2,000.00 deductible for single coverage and $4,000.00 for family coverage.

- In addition, after the deductible is reached, there is also often either an 80-20 co-insurance for in-network care or sometimes even a 50% co-insurance payment for out-of-network care.

- These payments can result in Annual Max Out-of-Pocket Expenses of over $5,000.00 for an individual and $9,000.00 for a family.

- The deductibles do not include wellness and preventative care visits such as annual physicals, colonoscopies and mammograms.

- However, the deductibles do include prescription costs, ER visits and hospital stays.

- CDHPs are often coupled with comprehensive wellness programs that offer reductions in premiums to individuals that are in good health and make a conscientious effort to take care of themselves.

- CDHPs will also force individuals to shop for medication often purchasing the same on-line in bulk to save money from the out of pocket costs.

- CDHPs are often coupled with comprehensive wellness programs that often reductions in premiums to individuals that are in good health and make a conscientious effort to take care of themselves.

- The State has already moved towards requiring the participation in a wellness program for retirees receiving benefits under the SHBP.

- If there is a trend or movement towards a CDHP we will see our bargaining units negotiating the cost of deductibles and contributions made to HSAs.

- In the end, while the coverage level may remain the same, the employees will pay significantly more in out-of-pocket expenses associated with deductibles and co-insurance payments.