CONTROLLING THE COST OF INSURANCE: PART I

A CHANGING ENVIRONMENT

Reducing, or at least containing, the costs of health insurance benefits has long been a major concern for boards of education. In the 1990's, declining resources and spiraling costs of providing health insurance coverage, led boards to search for means to reduce, contain or at least achieve a degree of control over their health insurance costs. Yet, in those years, boards' efforts were frequently thwarted by powerful forces that strongly supported the status quo: a burdensome, outmoded legislative and regulatory structure that precluded certain approaches; and a general pattern of health insurance coverage in school districts throughout New Jersey that was resistant to change.

Starting in mid – 2000's, economic realities led to intensified public pressure to contain the cost of public employment. In light of this public awareness, the Legislature enacted a series of laws designed to reduce the costs of public employment, generally, and the cost of public employer provided health insurance specifically. These reform measures culminated on June 28, 2011 when Governor Chris Christie signed the landmark pension and health benefits reform legislation into law.

Health insurance is a significant cost driver in local school districts and has historically been a critical part of the collective negotiations process. This article is designed to help boards navigate the new environment created by these reform measures. Keep in mind, however, that the environment created by the recent legislation is fluid and continues to evolve. For example, implementation and clarification of the laws' provisions will require the finalization of the Administrative Code's rules and regulations. These rules and regulations (as well as the underlying statutory provisions) are subject to different interpretations. Such disputes will likely result in litigation and, ultimately, in the development of a body of case-law. Moreover, facets of the federal Affordable Care Act passed by Congress and signed into law by the President in 2010 will become effective in 2014.[1]

Consequently, this article will include websites and useful links that will help board members keep up to date on the latest developments and trends in the volatile area of health insurance. Board members and their administrators are urged to check the websites included in this article and to continuously seek the input of their legal and labor relations resources, as well as their insurance consultants, as they consider their own local approaches to containing the costs of their insurance coverage.

Background and Legal Framework

The reform legislation referenced above and explained in greater detail below did not take place in a vacuum. The relationship between boards of education and school employees is highly regulated in New Jersey. Not surprisingly, this legal and regulatory environment limits local board actions in regards to providing health insurance. There are statutes, case law, and regulations governing boards' ability to provide health insurance. Historically, the fundamental authority for boards to provide health insurance benefits is rooted in *N.J.S.A* 18A:16-13. This statute permits boards to enter into contracts to provide, among other types of insurance, health care benefits. Virtually all boards of education opted, at one time or another, to exercise those rights and, over the years, a host of medical benefits, including basic medical/surgical coverage, dental, prescription, and optical coverage (frequently all at the board's expense) have been provided to school employees.

Boards' past agreements to provide generous health benefit packages to their employees were not, at the time of adoption, seen to be fiscally irresponsible decisions. Rather, these decisions reflected the then current pattern of public employees' compensation: providing employment security and excellent benefits to offset salaries that were then significantly lower than that of the private sector. In those days, providing and improving health insurance coverage was often more cost-effective than granting salary increases. As a result (either through contract language or binding past practices) school boards became committed to providing comprehensive and generous health insurance coverage to their employees.

As salaries became more competitive and the cost of health insurance benefits began to dramatically rise, the existing legal framework precluded unilateral changes to the now expensive health insurance coverage. The PERC law (*N.J.S.A.* 34:13A-1 *et seq.*) requires public employers, including boards of education, to negotiate in good faith over "terms and conditions of employment." Benefits,

1 Check the labor relations section of www.njsba.org for updates on the law's implementation.

including health insurance, are deemed terms and conditions of employment. As such, boards could not, and still cannot, unilaterally change the health insurance coverage provided to its employees. Rather, changes in those terms of employment require legislative changes or unions to voluntarily agree to reduce what they perceive to be their rightful entitlement earned in prior negotiations.

Negotiability of Health Insurance Coverage

The holding that health insurance is a mandatory topic of negotiation extends to the level and type of insurance coverage, employee eligibility, payment obligations and so on. Not all insurance issues, however, are subject to negotiations. PERC has long held that the identity of the carrier, in and of itself, is not a term and condition of employment, and thus not negotiable, as long as the selection of the carrier does not change or modify employees' levels of benefits.[2] Therefore, negotiations over health insurance is limited to the level of benefits, but the choice of the carrier remains a board function that is not subject to negotiations as long as the choice does not change the level of negotiated benefits.[3]

Most health insurance articles have a standard of comparison negotiated into the contract. Often the parties will agree to coverage that is "equal to or better than" a certain plan. For instance, "equal to or better than the School Employees Health Benefits Plan." The "equal to or better" than standard is not advantageous to the Board. Better standards that provide more flexibility to the Board are the "substantially equivalent" or "comparable to" standards.

Absent a statutory change, any change in employees' current benefit package, established either by specific contract language or through a binding past practice,[4] must be determined through the process of negotiations. Any modification in school employees' type and level of coverage, any change in employee eligibility, any change in the obligation to cover the costs of coverage, and even the addition of a new benefit, must be the result of an agreement reached between the board and the union at the bargaining table. Thus, unlike non-unionized employers, boards of education cannot respond to changing economic conditions by taking unilateral action to reduce their costs of providing health insurance.

The only exceptions to this well-established rule occurs when the term and condition of employment is clearly preempted from negotiations by specific and imperative statutory or regulatory language, or when the change is totally outside the board's control. A board and an association may not negotiate an agreement that is inconsistent with a statute or regulation. If a statute or regulation speak in the imperative and expressly, specifically and comprehensively sets an employment condition, the parties may not negotiate a provision that is inconsistent with that law.

S-17, the 2007 Reform Legislation

The major reforms to the public school employer provided health insurance started with S-17, P.L. 2007 c. 92. Before the 2007 amendments, the law required employers in the State Health Benefits Plan (SHBP)5, to pay the full cost of their employees' own individual coverage, mandated that all covered employees be treated uniformly in regards to cost-sharing arrangements, and specifically prohibited negotiations over incentives for non-enrollment. In contrast, boards that purchased their insurance coverage from private carriers could negotiate over these issues and could obtain cost-savings measures that were not available to participants in the SHBP.

These legislative and regulatory limitations on boards' ability to negotiate cost savings provisions resulted in a mass exodus from the SHBP. The percentage of New Jersey's school boards enrolled in the SHBP dropped precipitously from 77% in July 1991 to 30% in 2006. Boards' "mass exodus" from the Plan, the non-competitiveness of the SHBP's inflexible structure, and the State's own search for a reduction in the costs of their employees' health insurance coverage were motivating forces in the long-overdue 2007 changes to the SHBP's, which eliminated these preemptive limitations to negotiations.

The 2007 legislative package of reforms to the SHBP brought an end to a significant number of the strict limitations on negotiability within the State Plan. The scope of negotiations within the SHBP has been significantly extended and boards participating in the State Plan now possess much of the same flexibility to pursue cost containment in negotiations as districts that obtain medical insurance through a private carrier.

This new broader scope of negotiations also applies to the newly configured School Employees Health Benefits Program (SEHBP). In accordance with Chapter 103, P.L. 2007, as of July 1, 2008, all school employees who were covered under the SHBP were transferred to the SEHBP and all future school districts choosing to participate in the State Plan will be enrolled in the SEHBP. While the SEHBP has a different commission governing its administration, the plan is still administered by the Division of Pensions and Benefits and is required to provide, as a minimum, all conditions of the SHBP.[6]

2 City of Newark, PERC No. 82-5, 7 NJPER 12195.

3 See discussion on "Board's Rights to Select An Insurance Carrier" later on in this article.

4 For information on what constitutes a binding past practice, please see the article "The Meaning and Relevance of Past Practice" in *The Negotiations Advisor Online*.

5 As explained later, the SHBP was the forerunner of the School Employees Health Benefits Plan (SEHBP)

6 The separate SEHBP commission has the authority to develop its own regulations. However, until such rules are established, the rules and regulations of the SHBP Commission apply to the SEHBP. To remain aware of the latest developments, check with your resources and visit NJSBA's Labor Relations web site (http://www.njsba.org/labor_rel_03) and The Division of Pensions and Benefits web site (http://www.state.nj.us/treasury/pensions/.)

S-17 also made important changes to the negotiability of waiver incentives. Waiver incentives are financial incentives provided by school districts to employees in exchange for those employees foregoing the insurance coverage provided by the district. S-17 granted boards of education participating in the State Plan the authority to provide, without negotiations, a financial incentive for employees not exercising their rights to enroll in the insurance plan. Boards were authorized to unilaterally offer employees up to 50% of the amount saved by the board as a result of the employee's non-enrollment. Limits financial incentives to waive SEHBP coverage were reduced to 25% of the health insurance premium of $5,000, whichever is less in 2010. The law specifically directs that, within the legal limits above, the amount of the waiver is to be established "in the sole discretion of the employer."[7] Thus, the clear and express language of the statute, not only authorizes waivers in the State Plans, but preempts the entire issue from being the subject of negotiations for boards that participate in the SEHBP. By contrast, incentives for non-enrollment remain a negotiable topic for boards that obtain their health insurance coverage from a private carrier.

Chapter 2, the 2010 Reforms

The second waves of reforms were contained in Chapter 2, P.L. 2010. These changes became effective on March 22, 2010. This law enacted six major changes as they relate to board-provided health insurance:

- Required school employees to pay 1.5% of their base salary toward health benefits, regardless of whether coverage is provided through the School Employees Health Benefits Plan (SEHBP) or a private carrier;
- School employees hired after the effective date must work a minimum 25 hours per week to participate in SEHBP;
- Mandated that any changes in State Health Benefits Plan (SHBP) negotiated for State employees (e.g. changes in co-pays) automatically apply (without negotiations) to SEHBP; and
- Limited financial incentives to waive SEHBP coverage to 25% of the health insurance premium of $5,000, whichever is less.

The law bars individuals from being covered under more than one SEHBP and/or SHBP program. For example, an individual who works for the state may not receive SHBP at his work and also be covered by his spouse's SEHBP provided by a local board.

Districts are now permitted to negotiate provisions that restrict employees plan options within the SEHBP. For instance, districts could negotiate that their employees would have access to only the HMO portion of SEHBP and not NJDIRECT10 or NJDIRECT15.

7 Section 36 of P.L.1995, c.259 (C.52:14-17.31a)

Chapter 78, The 2011 Reforms

The landmark pension and health benefits reform, Chapter 78, P.L. 2011, signed into law on June 28, 2011, resulted in the most significant changes to New Jersey's public sector health benefits.

The pension changes include the elimination of cost of living adjustments for current and future retirees and an increased employee contribution rate. Since teachers and other certified staff, who make up the bulk of school employees belong to the Teachers' Pension and Annuity Fund (TPAF). For these employees, the state pays the employers' annual contribution. Thus, for local school boards the greatest financial impact of the 2011 reforms is a function of its health benefits provisions. The law requires that employees pay a percentage of their health care premiums in a tiered system based on salaries and the level of coverage that the employee chooses. The increased contribution rates apply to all school employees—those in districts served by the state-operated School Employees Health Benefits Program, those that use private insurance carriers, and those that are covered under self-insured plans.

The new contribution rates become effective immediately for some public employees and become effective upon the expiration of collective negotiation agreements for others:

- For non-unionized staff, the general rule is that the new premium sharing is effective immediately;
- For employees who are subject to individual employment contracts entered into prior to June 28, 2011, there are additional considerations. The Department of Community Affairs has indicated in its guidance that these employees "will pay pursuant to the [individual employment] agreement" and that once those contracts expire these employees will be subject to the standard phase in. See § III, No. 4 of Local Finance Notice (July 25, 2011), available at http://www.nj.gov/dca/lgs/;
- For union employees, the contributions are effective immediately for bargaining units which were working under an expired agreement on June 28, 2011;
- Unionized employees are shielded from the new contributions until the collective negotiation agreement in force on June 28, 2011 expires;
- If, for example, the collective negotiations agreement expires on June 30, 2012, the new contributions will commence on July 1, 2012; and
- If the collective negotiations agreement expired on June 30, 2011, the new contributions became effective on July 1, 2011. The Division of Pensions and Benefits is seeking guidance from the Attorney General's office on how to treat collective negotiations agreements that were fully ratified prior to the effective date of the law (June 28, 2011) and went into effect on July 1, 2011.

The new contributions require that school employees pay a percentage of aggregate health insurance premiums.

The aggregate cost of providing health insurance is calculated differently depending how the insurance is provided:.

- For districts that participate in the School Employees Health Benefits Program (SEHBP), the cost of coverage is defined as the premium for medical and prescription drug plan coverage, but excluding dental, vision, or other health care provided
- For districts that are not participants in the SEHBP, the cost of coverage is defined as the premium or periodic charges for health care, prescription drug, dental, and vision benefits, and for any health care benefit.

For those employees who were employed on the date that the new contribution commenced, the new contributions were phased-in as follows:

- In the first year the employee will pay 25 percent of the cost of coverage called for in the chart;
- In the second year, that employee will pay half of the contribution specified in the chart;
- In the third year the employee will pay 75 percent of the specified contribution; and
- In the fourth year, the employee will pay the entire contribution called for in the chart.

Employees hired after June 28, 2011, must contribute at the full percentage immediately. There is no phase-in for such employees.[8]

Regardless of contribution called for under the law's phase-in provision, under no circumstances, shall such an employee pay less than 1.5 percent of their base salary for public employer provided health insurance. The 1.5 percent, however, is not in addition to the new contributions.

Once fully phased-in, the employee contribution will be calculated as shown in the chart below:

8 The only exception is for new employees hired into a bargaining unit which was operating under an unexpired collective negotiations agreement (that was in force on June 28, 2011). Those employees are treated like their fellow bargaining unit members. If an employee is hired into a collective negotiations unit that is operating under an expired collective negotiations agreement they must contribute the full percentage immediately.

INDIVIDUAL COVERAGE		MBR & CHILD OR SPOUSE		FAMILY COVERAGE	
Base Salary	**Percent of Premium**	**Base Salary**	**Percent of Premium**	**Base Salary**	**Percent of Premium**
< $20,000	4.5%	< $25,000	3.5%	< $25,000	3%
$20,000 - $24,999	5.5%	$25,000 - $29,999	4.5%	$25,000 - $29,999	4%
$25,000 - $29,999	7.5%	$30,000 - $34,999	6%	$30,000 - $34,999	5%
$30,000 - $34,999	10%	$35,000 - $39,999	7%	$35,000 - $39,999	6%
$35,000 - $39,999	11%	$40,000 - $44,999	8%	$40,000 - $44,999	7%
$40,000 - $44,999	12%	$45,000 - $49,999	10%	$45,000 - $49,999	9%
$45,000 - $49,999	14%	$50,000 - $54,999	15%	$50,000 - $54,999	12%
$50,000 - $54,999	20%	$55,000 - $59,999	17%	$55,000 - $59,999	14%
$55,000 - $59,999	23%	$60,000 - $64,999	21%	$60,000 - $64,999	17%
$60,000 - $64,999	27%	$65,000 - $69,999	23%	$65,000 - $69,999	19%
$65,000 - $69,999	29%	$70,000 - $74,999	26%	$70,000 - $74,999	22%
$70,000 - $74,999	32%	$75,000 - $79,999	27%	$75,000 - $79,999	23%
$75,000 - $79,999	33%	$80,000 - $84,999	28%	$80,000 - $84,999	24%
$80,000 - $94,999	34%	$85,000 - $99,999	30%	$85,000 - $89,999	26%
> $95,000	35%	> $100,000	35%	$90,000 - $94,999	28%
				$95,000 - $99,999	29%
				$100,000 - $109,999	32%
				> $110,000	35%

The new contribution requirements are minimum requirements and the parties are free to enter into a collective negotiations agreement that requires greater employee contributions based on premium sharing, percentage of premium or otherwise.[9] Once the new contributions are triggered, the employee contribution is the higher of the

9 The law also mandates that boards of education establish a Section 125, Cafeteria Plan (IRS Code, 26 U.S.C. § 125), so that employees can pay for medical and dental expenses with pre-tax dollars.

premium contribution required under the new law, 1.5% of their base salary or the contribution required under the applicable collective negotiations agreement.[10]

The health care premium sharing component of the law expires on June 28, 2015. However, districts and their employees are bound by the contribution levels required in the law until the contributions are fully phased-in (four years after the new contributions commence) for a full year. For example, if the applicable contract expires on June 30, 2012, the phase in starts on July 1, 2012, the Year 4 of the phase –in starts on July 1, 2015, and the premium sharing component of the law expire on June 30, 2016. The fully phased-in premium sharing rates are the basis for future negotiations.

Factors to Consider When Selecting the District's Insurance Carrier: Defining the Level of Benefits

Negotiations proposals can address the levels of benefits that will be included in the district's insurance package. Again, the selection of the carrier that will provide the negotiated level of coverage is a non-negotiable board function.[11] Therefore, boards remain free to change carriers, as long as the level of benefits provided in a negotiated agreement or through past practice is not affected by the change in the insurance carrier. The key, therefore, in the board's unilateral selection of a new carrier is what constitutes the level of benefits that must be maintained. Unfortunately, this is a somewhat nebulous concept.

Defining the Level of Benefits

A definition of the term "level of benefits" remains an on-going work-in-progress that is dependent on the circumstances of each case. The following changes resulting from a new carrier's coverage have been found to require negotiations: different cost-sharing arrangements that resulted in greater out-of-pocket costs for employees, such as increased co-pays or deductibles in a new plan; new employee and dependent eligibility for coverage; and different types or level of covered services.

In addition, changes in other aspects of health insurance coverage have also been found to constitute "levels of benefits" that cannot be changed without prior negotiations. For example, the following areas have been seen as benefits that cannot be changed without prior negotiations: the network of providers;[12] the size of the network;[13] and the method of reimbursement for medical services.[14] In these cases, PERC's remedies for changes that occurred as a result of employers' unilateral change in carriers ranged from orders to find new carriers to provide the past level of benefits, to negotiate the changes, and to establish a fund to reimburse employees for the out-of-pocket costs that resulted from the change in carrier.

Bear in mind future litigation may address other possible changes in terms of existing insurance benefits.[15] An additional complication in defining changes in the levels of benefits rests in PERC's determination that the assessment of whether a change has occurred is a matter of contract interpretation and rests with an arbitrator should a union seek to challenge or appeal. Thus, PERC has deferred resolution of such disputes to arbitrators.[16]

PERC has held that while the employer has the unilateral right to change carriers, the union has the right to demand negotiations or to seek arbitration.[17] And boards of education must note that changing carriers may result in grievances and arbitration. The union's right to initiate challenges to perceived changes can lead to the introduction of an arbitrator who will have the authority to determine whether the selection of a new carrier resulted in a change to the negotiated levels of benefits.

At arbitration, the union cannot just claim dissatisfaction with the new plan. Rather it must demonstrate that changes have actually occurred as a result of the board's selection of a new carrier. Arbitrators will scrutinize the details of coverage provided by both the old and new carrier. The arbitrator will also judge whether the differences, if any, are in accordance with the terms of the locally negotiated agreement. Boards that understand their contractual commitments will be well-informed and well-prepared to select appropriate carriers, to defend their actions and prevail in arbitration proceedings.

Understanding Contractual Commitments to

10 The New Jersey Department of Education (NJDOE) may approve a waiver for a board of education so that it can implement a collective negotiations agreement that provides for employee contributions that are different from those required under the law. To apply for the waiver, the board must certify in writing that the aggregate savings during the term of the contract from plan changes and contributions are equal to or exceed the savings that would result from the employees making the contributions required by the law. And, the board must certify that the cost of the employer's plan is equal to or less than the cost of enrolling employees in the newly designed SEHBP.

11 *City of Newark*, PERC No. 82-5, 7 NJPER 12195

12 *Newark Board of Education*, PERC No. 94-52. 19 NJPER 24282

13 *City of Newark*, PERC No. 95-108, 21 NJPER 26146

14 *Borough of Metuchen*, PERC No. 84-91, 10 NJPER 15065

15 Summaries of recent PERC decisions and arbitration findings concerning these issues are provided under Critical Issues in the Labor Relations section of the NJSBA web site. (found at http://www.njsba.org/labor_rel_03)

16 However, in unfair labor practice cases which involve an allegation of a board's violation of its legal obligation to negotiate, PERC will entertain that petition and make the determination of whether there has been a refusal to negotiate over a mandatory topic of negotiations.

17 *Borough of Metuchen*, supra. Note that unions also have the right to demand, and receive, information concerning any changes in the health insurance plan. A board's refusal to provide that information violates its negotiations obligation. *Lakewood Board of Education*, PERC No. 97-44, 22 NJPER 27215.

Maintain Levels of Benefits

The language addressing boards' contractual commitments to maintain certain benefit levels vary from district to district. Contract provisions include a variety of approaches to local districts' definitions of the degree of change that can occur without triggering an obligation to negotiate. These standards range from PERC's "substantially equivalent" standard to commitments to maintain benefits that are "equal to or better than" the existing levels of benefits. In addition, some contracts commit to maintaining benefits that are linked to a specific insurance plan, such as the SEHBP.[18]

The Meaning of "Substantially Equivalent" Benefits

PERC has long held that a board is required to maintain a "substantially equivalent" level of benefits and many boards have incorporated this standard in their local agreements. At first blush, this approach appears to provide boards with a high level of flexibility. However, this type of language can be open to a variety of interpretations and permits arbitrators to use their subjective judgment to define the meaning of "substantial equivalence." Some arbitrators have looked at the totality of the plans and have found that some losses in benefits were off-set by improved benefits in other areas. Other arbitrators have required far more uniformity among the various components of the plans. Still other arbitrators have looked at the impact of the changes on individual employees, rather than the bargaining unit as a whole, to find that improvements for some unit members (i.e., those in a specific managed care plan) but reductions for other unit members (those enrolled in another type of coverage) did not constitute "substantial equivalence" for all unit employees.

The Meaning of "Equal to or Better Than" Benefits

This language is very restrictive of boards' ability to select an alternative carrier without prior negotiations. Some contracts are even more restrictive in that the language specifies that any change in benefits must be "Equal to or Better Than" the SHBP as of a certain date. For instance, Boards that had the "Equal to or Better Than" language and left the SHBP prior to 2007 were obligated to find insurance carriers that provided the same level of benefits offered in the State Plan. Many of these boards (even those that have since negotiated cost-savings measures with their private carriers) were saddled with many benefits that had been provided by the State Plan, including the Traditional Plan option for an extended period of time and had to give up something in negotiations to kill traditional coverage. This type of language is far less open to arbitrators' subjective judgment but severely restricts boards' flexibility to switch plans and should be avoided. (See discussion on negotiations in *The Negotiations Advisor Online* article "Controlling the Cost of Insurance: Part II, A Guide to Effective Negotiations.")

Assessing The Options

The State Plan's extended scope of negotiable topics, its elimination of traditional coverage, as well as the inherent benefits of a large insurance pool, may make the SEHBP an attractive option for local boards of education that are currently served by a private carrier. Likewise, boards of education that currently participate in the State Plan may find, in spite of the reforms to the State Plan, a private carrier would be most advantageous and beneficial to their local circumstances. Each board of education, regardless of its current carrier, will want to carefully examine and assess the advantages and disadvantages offered by each type of carrier.

Waiver incentive plans is one area where boards that participate in the State Plan have more flexibility than those who obtain their coverage from private carriers. State Plan participants are authorized to unilaterally initiate an incentive which offers employees a cash bonus not to exceed to 25% of the premium or $5,000, whichever is less of the board's savings for their non-enrollment in the plan. This can provide immediate, and possibly significant, cost-savings if a large number of employees choose to take advantage of the board's waiver incentive because they can get insurance coverage somewhere else (i.e. through a spouses' employer).

The reform measures have made the State Plan a more attractive option for boards. As of 2013, fifty-five percent of school districts are in the state plan. The size of the SEHBP means it benefits from the advantages of a large insurance pool. A large insurance group insulates districts (particularly small districts) from the potentially disastrous impact of one or two employees' catastrophic illnesses. In addition, the large pool may permit the State Plan to negotiate better terms with managed care plans and providers. The School Employees' Health Benefit Plan (SEHBP) is governed by its own Commission[19] that is not completely immune from political considerations. The Commission has the authority to provide benefits that are "equal to or exceed" the standards of the SHBP. However, unlike those covered by private carriers, state participants cannot negotiate the levels of their overall premiums or the increases in those rates.[20]

Unlike under the State Plan with private carriers, boards can negotiate different types of coverage and premium levels in response to differing local district circum-

18 In the absence of contract language, it is likely that PERC's standard of "substantially equivalent" benefits will be used to determine whether the change is, or is not, permitted.

19 The SEHBP is administered by the School Employees Health Benefits Commission within the Division of Pension and Benefits. It has nine members, including three members representing the NJEA, one member representing the AFL-CIO, and one member representing N.J.S.B.A.. The full composition of the commission is delineated in *N.J.S.A.* 52:14-17.46.3

20 While state participants cannot negotiate the levels of their overall premiums or the increases, as explained *supra*, employers can negotiate cost sharing arrangements with their employees.

stances. However, this flexibility is not unlimited. While boards can "shop" for an accommodating carrier, carriers themselves are limited by the general trends of the insurance industry and their profit motives. For example, the general trend is away from traditional coverage to more managed care options. The traditional form of indemnity coverage is fast becoming very costly and a rare offering. Notwithstanding these market constraints, boards that obtain their health insurance from private carriers have much greater latitude and flexibility in establishing different co-pays and deductibles with their private carriers and greater options in drafting the negotiations proposals they bring to their local bargaining tables.

In assessing the possibility of insuring through a private carrier, boards need to consider the following factors:

- *Size of the insurance group and its impact on rates:* As noted above, premium rates are largely affected by the group's experience and utilization ratings. A district whose employees experience prolonged or catastrophic illnesses may suddenly be faced by an astronomical increase in its next year's costs of premium coverage. Boards, particularly those in small districts, must therefore discuss the type of group that the carrier will be using.
- *Teaser rates:* Frequently, new carriers quote low rates for the first year in order to win a district's contract. Unfortunately, these "low ball" premiums may not be guaranteed in future insurance contracts and boards may find themselves facing significant increases in insurance premiums in the future. A number of years down the road, a board may therefore be searching for another new "low ball" bid from a different carrier. The willingness to engage in a cyclical search for insurance carriers, and the ability to obtain competitive bids from private carriers, will differ among districts. In the past, a number of boards reported that they had frequently changed carriers to better control their insurance premiums, without difficulty (other than the search process) since there had always been a sufficient number of other interested private carriers who were eager to obtain the board's business. Whether this pattern will continue remains to be seen.
- *Instability of the insurance industry:* Private carriers have been known to quickly enter, and exit, the school district market. Unlike the State Plans, private carriers can decide that it is no longer profitable to do business with school districts or within the State of New Jersey. Occasionally, their exit has not given boards' sufficient time to carefully explore their options to provide uninterrupted insurance coverage. Under these circumstances, boards may find themselves forced into expensive interim coverage in order to meet their contractual obligations.
- *Impact, if any, of the insurance "surcharge:"* Since the early 1990's, school districts' private carriers are accessed a surcharge to offset the state's cost of providing health insurance for retired school district employees. This surcharge provision has been included in the law creating the SEHBP.[21] The amount of the surcharge is determined annually, based upon retirees' "excess claim costs." In its early years, the rapidly increasing costs of the surcharge disturbed private carriers and their school district clients. Subsequently, the charge was reduced and has remained stable after the SHBP created a special insurance group for school districts. While it is not illogical to believe that the latest trends of stabilized increases will continue under the SEHBP, the future cost of the surcharge is unpredictable. Carriers pass this surcharge on to the district, so boards need to be aware of this provision as they consider their choice of a private carrier.
- *Negotiability of private carrier waivers:* As noted above, boards using private carriers must negotiate waiver incentives for non-enrollment. Remember, if the distict participates in the SEHBP, these waivers can be implemented unilaterally, without negotiation. Although this is a consideration, it does not seem that this obligation places a significant road-block to choosing to select a private carrier. In fact, a majority of districts that have private carriers already have waiver incentive plans in place. Furthermore, the savings achieved through waivers may be temporary and relatively small in comparison to savings available through negotiating higher co-pays or other changes in the structure of the plan.

Additionally, boards should note that when a waiver incentive plan is implemented with a private carriers, the savings can dissipate over time because the healthier less expensive to insure employees are usually those that take advantage of the waiver. Thus, waivers can result in an insurance pool that is primarily composed of individuals, and their dependents, who will need and will use the benefits provided by the group plan. This pattern will increase the group's experience and utilization ratings and result in higher premium increases than would have been experienced in a "normal" group composed of both users and non-users.

Summary

Boards' decision as to what insurance carrier to use has never been an easy task. Now, Boards must factor in the new flexibilities of the SEHBP and the expanded negotiability provided under the reform legislation when they exercise their rights to unilaterally select their districts' insurance carrier. An awareness of the insurance industry as a whole, a full understanding of the conditions of each carrier, are all necessary considerations for boards. Although selecting an insurance carrier is one of the tools the Board has, changing carriers is not the only tool in the toolbox that can be used to reduce or contain the costs of providing health insurance coverage.

21 *N.J.S.A.* 52:14-17.38c

Other Areas of Possible Cost-Savings

There are myriad ways boards can reduce the cost of providing insurance for its employees. Some involve controlling the structure of the plan. An example of this would be limiting coverage to managed care options. These structural changes can affect the overall cost of the program.[22] Redirecting employees into more managed care architecture is one of the most effective way of reducing actual costs. For example, indemnity plans, also known as "traditional coverage," are based on the carrier's guarantee to insured all covered individuals for certain defined services provided by the individual's chosen health care provider. In other words, in these plans, insured individuals managed the delivery of their own health care needs. These plans once were the most prevalent forms of insurance coverage. However, as the costs of health care soared, indemnity plans were supplanted by "managed care" options where the carriers' rules controlled or limited the insured individuals' choice and the reimbursement to health care providers. As pointed out earlier, elimination of traditional plan was a central cost saving feature in the 2007 reforms to the State Plan. The 2007 "reform" measures eliminated the traditional plan and created managed care options.

Boards covered by private carriers may negotiate over cost savings measures that include, but are not limited to: restricting the policy's coverage to managed care plans; decreasing the level of services covered by the plan, decreasing the yearly benefit maximums, and restricting employee eligibility for coverage. Other options, such as increasing deductibles and co-pays, may also result in cost savings, but do not reduce the overall cost of the plan, only the employer's portion.

There is now a wide-range of opportunities and additional options for boards of education to contain, and even reduce their costs of providing health insurance coverage. The extended options and intricacies of the many components of insurance policies require a lot of board attention, time, and effort. Yet, without this essential groundwork, boards will not be able to make sound, cost-effective and productive decisions that lead to the most effective approach to meet their districts' own circumstances. Boards are strongly urged to seek the expert assistance of an insurance consultant, when contemplating how to achieve their insurance goals,

The Importance of an Insurance Consultant

The expertise of an insurance consult is an essential ingredient in any board's preparations to address their insurance needs. Understanding insurance has always been a complicated business that required specialized knowledge. With the additional options and opportunities facing boards of education, the issue of how to best achieve cost containment has become even more complex. In addition, insurance carriers themselves are under increasing cost pressures. To reduce their costs, carriers have changed their rules as well as their plans: some are only offering managed care options; some have changed their defined usual customary rates (UCRs); others are limiting their levels of covered services and reimbursements; still others are no longer offering their services to New Jersey school districts. It is expected that health insurance coverage will continue to be a highly volatile area in coming years. Therefore, boards would be extremely well-served by seeking expert advice and guidance in understanding their specific insurance packages, their locally viable options, and the short and long term implications of their choices.

There are a number of different types of insurance consultants who have a great deal of expertise and experience in working with school districts. There are consultants who specialize in insurance planning, but who are not involved in the sale of policies and are available on a retainer basis. There also are insurance brokers, who give advice and also sell policies and who may be available to review a district's insurance package without a fee. Boards can find a consultant they trust through a variety of means, including their Business Administrator's and Superintendent's contacts and networking with other boards.

Insurance consultants are a tremendously valuable resource to local boards. They can help boards to understand their own insurance packages, the various opportunities presented by different plan structures and carriers, and the short and long-term implications of different options. Consultants can also help boards to design an approach that is tailored to the circumstances in its district.

Expert review of insurance packages typically includes a thorough analysis and evaluation of existing policies, comparisons of the district's premium increases with overall insurance trends, and an assessment of the cost effectiveness of the district's insurance package. Insurance experts can also provide valuable information concerning alternative approaches to providing contractual benefits. Their knowledge of the industry can help boards identify potential problems inherent in certain options and to identify other possibilities for real cost saving solutions, tailored to districts' specific situations. In addition, and most important in this changing environment, consultants' experience and familiarity with the industry, its emerging patterns, and knowledge of key decision-makers, can be particularly useful in boards' attempts to forecast future actions of the SEHBP Commission.

Consultants' suggestions can also address possible accommodations with individual private carriers. Carriers may be willing to tailor specific administrative procedures to meet a district's needs, such as coordination of notification of rate increases with budget time lines or schedules of premium payments that can ease a district's cash flow problems. This area of consultants' expertise, as well as their on-going working relationships with individual carriers, can be very helpful to local boards.

Consultants can be involved in a variety of ways

22 For a full description of all approaches mentioned above, and their implications to boards of education, please see the article "Controlling the Costs of Health Insurance: Effective Negotiations Approaches" in *The Negotiations Advisor Online.*

depending on local circumstances. The timing and extent of a consultant's involvement is strictly a board decision, based on its local needs. For example, consultants can meet with the board once early on to lay the groundwork for boards' future preparation for negotiations. They can (and should) be involved when a board is considering changing carriers and when a board is entering negotiations.

Conferring with a consultant should be the first step in boards' exploration of the possibilities of changing insurance carriers. Not only can a consultant provide the analyses suggested above, but a consultant can also meet with the union and the district's employees to help facilitate their acceptance of the new carrier.

The advice of an insurance consultant is an essential step in boards' preparation to enter a new round of bargaining. The importance of obtaining information concerning expected costs of continued coverage with the current carrier is obvious; but boards must also make sure that they are taking a productive approach that will yield the desired results. Unfortunately, some boards that have proceeded without the expertise of a consultant have embraced cost-savings approaches that were not permitted by the rules of the carrier or that held unforeseen negative long-term implications. Furthermore, and most damaging, boards that did not have sufficient knowledge of insurance trends and practices, have fought bitterly in bargaining in support of their proposed cost-savings measures, only to find out late in the negotiations process that the approach they were pursuing would not yield significant cost savings. Timely involvement of a consultant, before the start of negotiations and the drafting of board proposals, will assure that board proposals (and negotiations efforts) yield meaningful results.

A consultant's expertise can be of great value throughout the entire bargaining process. In the give-and-take of negotiations, proposals will be modified and new approaches to providing cost-containments will emerge. A consultant's review and recommendations at those times can be very helpful. In fact, a consultant may suggest a feasible approach that can address both parties' concerns. These types of involvement do not require the consultant to come to the bargaining table. However, there have been occasions where a consultant has attended bargaining sessions in order to explain the board's proposal and to provide expert answers to the union's questions.

In short, an insurance consultant's expertise can be of invaluable assistance to boards of education. The consultant's specialized knowledge, experience, and connections can help boards avoid miscalculations, false assumptions and expensive errors. Given the increasing complexities and uncertainties of providing health insurance, all boards should give serious considerations to establishing a close working relationship with an insurance consultant.