Latest Trends
Collective Bargaining and Healthcare Strategies for Public Entities
Topics

Legislative
- Chapter 78 “sunset”
- Key PERC decisions
- Changing Retiree benefits
- Unilateral addition of low cost plan
- Structuring contract language

Strategies
- “Dream list” and practical list
- Buying back benefits
- Defined Contribution vs. Defined Benefits
- Medical and pharmacy management
- Wellness programs
- Narrow networks
Governor’s challenge: cut $250M from state employees’ health benefits
He suggests reasonable reforms, such as
- Requiring generic drugs
- New delivery methods for primary care
Needs to find dollars to fund pension payment
Nearly 10% of NJ’s budget pays for health benefits for active & retired state workers and retired teachers
Chapter 78

- 4 year phase-in Effective June 28, 2011
  - Unless in a contract effective beyond that date without being reopened or modified.
  - Many bargaining units settled by May 2010 to avoid 1.5%, which delayed the phase in.

- First groups completed their phase-in June 28, 2015
The premium sharing mandate ended June 28, 2015 or upon completion of the “Year 4” phase in.

- The statutory requirement ends upon the full completion of Year 4.
- However, the sunset provision indicates that the current level of premium sharing must be negotiated from that level before it may be reduced or modified.
  - i.e. The employees don’t start at 0, rather the discussion begins at their Year 4 level.
  - This is applicable to Active and Retirees.
Negotiations After the Sunset

- Most Public Sector Unions are resigned to the fact that Year 4 premium sharing amounts or their Dollar equivalents are here to stay.
- However, the parties are able to negotiate to the old statutory minimum of 1.5%, which did not sunset.
- There is no reasonable basis given the ever rising costs of healthcare to reduce the Chapter 78 premium sharing, unless there are offsetting concession elsewhere in the benefits package.
Union Positions

- All bargaining units view Chapter 78 as a reduction of pay that was not negotiated.
  - They disregard the countless years where no public employees contributed to benefits while these lucrative insurance plans increased well over the rate of inflation.
  - It is not their concern over the increases, rather the focus is over the $$$ Chapter 78 removed.

- Union Representatives understand that there isn’t going to be a rollback of premium share and salary increase will not offset C.78… Though they may never acknowledge it to their groups.
NJEA

- At the outset is seeking drastic reductions to Year 4 premium sharing rates.
  - Even in advance of the full phase in
    - Proposing shortened or split contract terms to avoid sunset condition of a full 4th year of contributions before negotiations
- The fallback position is capitating the contribution at a flat dollar amount for each employee.
  - Eliminates the potential for annual increases due to premium costs and salary.
FOP/PBA

- Taking an initial position of rollbacks to 1.5%.
- Settling for status quo or capitating the current rate with a flat dollar amount.
- Most recognize that a drastic departure from C.78 is a difficult sell in interest arbitration.
  - Must be prepared to defend regardless.
Management can apply the following approaches:

- Maintain the Chapter 78 structure as if there was never any sunset in the statute.
  - Even at full implementation some employers are not even recovering the rate of increase on their benefit plans.
  - Percentage of premium is a concept that provides flexibility.
Equal Premium Contributions

- Utilize a flat percentage(s) to equalize contribution
  - Besides being an administrative inconvenience, Chapter 78’s varying percentages based on salary and coverage level can limit flexibility for employers.
    - Less incentive on lower paid workforce to modify plan offerings.
    - Flat percentages have the potential to preserve Chapter 78 savings, while incentivizing plan design changes.
    - Easier concept to present to employees.
    - Need to calculate the average rate to generate appropriate savings.
Institute base plan designs with employee paying the “up charge” for upgraded plans.

- Will appeal to higher paid employees (25%-35% levels)
- Employees save on the upfront contributions.
  - HSA eligible
- Not a viable option for employers that have high utilization rates among their employees.
Incentivize High Deductible or Alternative Plans

- Most employers offer multiple plan offerings and some of those are high deductible plans.
- However, those plans are among the most underutilized throughout the State, even among low utilization employees.
  - 90% of all non-state public employees in NJ are in Direct 10 Plans.
- These plans may save an employer 20%-30% of the annual premiums.
- With the sunset of Chapter 78, employers may incentivize the selection of an insurance plan.
- Invest some of those savings into the employees by offering a “bonus” for enrolling in a high deductible or tiered plan.
  - Avoid base salary increases if possible.
If all else fails stick with Chapter 78

- It remains part of your agreement until it is negotiated out.
- The employees have now adjusted to the rates.
- It is easier to say “no” to a change, than to sell a new concept.
- Any capping or reductions with one unit sets the pattern in the wrong direction.
- There is no reasonable basis to reduce or cap the employee’s contribution with the ever rising costs of healthcare.
Plan Provider Changes

Health Insurance Provider Changes

- Flexibility to change providers is essential
- The ability to change providers is a managerial prerogative.
  - However, plan design, network, and copays are negotiable issues for collective bargaining.
- With the sunset of Chapter 78 there is no longer a mandate to match savings of plan with the SHBP or SEHBP.
  - Free to select any plan without considering the State plans.
Plan Provider Change Considerations

Contract Language

- “Equal to or better than”
  - With the exception of creating a match plan through a different provider, plans are almost never equal.
    - Different networks, different Rx brands categories, different services.

- “Equivalent or better” is preferable language.
  - Accounts for variations between providers and plans.
  - This language DOES NOT alleviate the employer’s need to negotiate changes, rather it provides a certain level of flexibility.
    - Always dependent on the facts and circumstances of the change in plans.
Plan Provider Change Considerations

Plan Identification in Contract

- The less language the better
  - Some contracts incorporate plan design in the insurance article.
    - Throwback to self insured plans
- Need to balance identification of the plan/benefits against the preservation of managerial prerogative to change providers.
  - Copay amounts
    - Before public employee premium sharing, copays were the most commonly negotiated aspect of health insurance plans.
    - Today, copay changes have less impact on the cost of healthcare plans.
    - Most contracts include copay amounts within the insurance article.
- Include language for future retirees.
  - Benefits and Copays will match active employees.
- Rx Costs
  - Generic/Brand
  - Generic/Formulary/Non-Formulary
Premium sharing changes

- What impact will changing plans have on employee premium sharing?
  - Chapter 78 charges percentage of the premium.
  - If premiums increase, so does the employee’s contribution.
  - May be negotiable depending on the circumstances.
    - Coverage type (single, family, etc.)
    - Employee groups – retirees

- Across the board decreases in premiums are never a problem for all parties.
Retiree Considerations

Retirees

- Standard is the contract the employee retired under.
  - Must match to the best of your ability or reimburse to status quo.
  - What was the plan design 5 administrations ago?
  - Likely only need to go back to the most recent change in plans for retirees.
  - Reimbursement may ultimately cost less.
  - Puts responsibility on retiree to seek reimbursement.
    - Retiree group may litigate an attempt to raise a copay from $5 to $20, but individual retirees may not bother to seek $15 reimbursement for their doctor appointments.

- Factor that group into your analysis.
  - Does change in providers still provide an overall savings even if there is an increased cost to match/reimburse retiree plans?
Let’s Move

Transition

- Lead time is golden
  - The more you get the better it will go.
    - Help your elected officials understand.
  - SHBP and SEHBP
    - 75 to 90 days from passage of resolution
  - Coordination with insurance brokers
  - Open enrollment
  - Providers need time to process employees
  - The better informed employees are the less contentious the process is.
Knowledge is Power

- Dissemination of Information
  - Develop plan with insurance broker/plan representative
    - Plan design documents
    - Summaries
    - Comparison/analysis
    - Rx classification
    - Comprehensive plan documents
    - Projected employee savings
  - Links to webpages are good to supplement printed documentation, but are not adequate replacements for documentation
- Meet with Union representatives
  - Most representatives are knowledgeable and experienced.
  - Don’t mistake understanding for support.
  - Some contracts require meetings within a certain time period in advance of the change.
  - Regardless of contract language, some notice to unions is required.
Patience is a Virtue

Employee Meetings

- Union executive board/negotiating team members.
  - Provide information
  - Point out positives of changes
    - Reduced premiums = Reduced contributions
    - Lesser of two evils
  - Discuss employee meetings

- Employee meetings
  - Be prepared for the worst
    - Repeated questions
    - Obscure hypotheticals
    - “Will I be covered if I contract a rare illness like Sealpox?”
  - Just the facts
Unilateral Changes to Benefit Plans

- In the event that a change is necessary before all interested parties can or will consent, then an employer may choose to take unilateral action pending a negotiated resolution.
  - Providers may always be changed unilaterally.
  - Levels of benefits and copayments/deductibles are negotiable.
    - Contractual Language may alleviate to an extent.
  - Will result in litigation – Cost/Benefit Analysis
Unfair Labor Practice before PERC

- An employer taking unilateral action without matching coverage or adhering to the language can expect to have a ULP filed against them.
  - Along with a request for Interim Relief (PERC Injunction).

- PERC has granted interim relief where the employer has not provided employees with at least “status quo” reimbursement for plan changes.
  - Along with Plan Comparisons, reimbursement plans should be considered in advance of taking unilateral action.

- Assuming interim relief is denied or held in abeyance, the ULP process should allow Management/Labor to reach a negotiated settlement to any outstanding issues, especially where it is tied to any overall contract settlement.
Questions & Answers
The Problem

- Multi-Year Collective Bargaining Contract
- Single-Year “Known” Benefits Spend
- Defined Benefit, not Defined Contribution
Cost Increases Over Time

**Employer**
- Change carrier
- Change provider networks
- Change management protocols
- Change plan design
- Add new options
- Enter or exit SHBP/SEHBP
- Modify employee contributions

**Bargaining Units**
- ETBT
Pharmacy Techniques

- Step Therapy
- Prior Authorization
- Mandatory Mail Order
- Formulary Exclusions
Step Therapy Example
Acid Reflux – Proton Pump Inhibitors

- Omeprazole (generic for Prilosec)
- Prilosec OTC
- Pantoprazole (generic for Protonix)

$0.50 per 20 milligram tablet

$13.29 per 20 milligram tablet

Nexium
Prevacid
Prilosec
Specialty Medications

- Used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia
  - High cost
  - Injectable
  - Bio-engineered (genetically modified living cells)
  - Require special handling
- By 2018 specialty spend is expected to be **50% of total spend**
- Cost will be driven by approximately **2% of the members**
- Average chronic specialty medication spend is **$48,000 per claimant per year**

**Grandfather and consider implementing all Specialty Management programs**
Prior Authorization

- Typically focused on Specialty Medications
- Requires pre-approval from the Pharmacy Benefits Manager before dispensing the drug
- List of Prior Authorization drugs can be customized depending upon employer size and funding method
Injectable Drug

- There are 25 indications for which Remicade has been approved; commonly Adults with rheumatoid arthritis (RA) and Crohn’s Disease.

- There are 18 off-label uses for Remicade. The more prevalent off label uses for Remicade are Asthma, COPD (Chronic Obstructive Pulmonary Disease), and atopic dermatitis.

- The AWP for Remicade is $828.13; the average dispensing requires 2 boxes or $1,656; if you stop 1 inappropriate use, you stop the spend of at least $1,656 to $19,875 (1 year’s worth).
Mandatory Mail Order Program
Specific List of drugs from Chronic Categories

- Savings on ingredient cost
- Increases compliance with medication
- 10% increase in mail order usage = 1% claim cost savings
- Typical arrangement:
  - Up to 2 refills via retail pharmacy
  - 3rd fill must be via mail order or penalty:
    - Member pays cost difference or
    - No access to retail
## Sample Formulary Exclusions
### Partial List

**Excluded Medications With Covered Preferred Alternatives**

The following is a list of excluded brand-name medications with covered preferred alternatives that are on the formulary. Column 1 lists excluded medications. Column 2 lists covered preferred alternatives that can be prescribed.

<table>
<thead>
<tr>
<th>Excluded Medications</th>
<th>Covered Preferred Alternative(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRAL</td>
<td>fentanyl citrate lozenges, LAZANDA</td>
</tr>
<tr>
<td>ACCU-CHEK METERS/STRIPS</td>
<td>ONETOUCH METERS/STRIPS</td>
</tr>
<tr>
<td>ACUVAIL</td>
<td>bromfenac, diclofenac, ketorolac, ILEVRO, NEVANAC, PROLENSA</td>
</tr>
<tr>
<td>ADVocate METERS/STRIPS</td>
<td>ONETOUCH METERS/STRIPS</td>
</tr>
<tr>
<td>ALVESCO</td>
<td>ASMANEX HFA/TWISTHALE, PULMICORT FLEXHALER, QVAR</td>
</tr>
<tr>
<td>APIDRA</td>
<td>HUMALOG</td>
</tr>
<tr>
<td>ARANESP</td>
<td>PROCRIT</td>
</tr>
<tr>
<td>ARNUNITY ELLIPTA</td>
<td>ASMANEX HFA/TWISTHALE, PULMICORT FLEXHALER, QVAR</td>
</tr>
<tr>
<td>ASACOL HD</td>
<td>balsalazide disodium, APRISO, LIALDA, PENTASA</td>
</tr>
<tr>
<td>BECONASE AQ</td>
<td>flumisolide, fluticasone, triamcinolone acetonide, NASONEX, QNASL</td>
</tr>
<tr>
<td>BENZACLIN GEL PUMP</td>
<td>clindamycin phosphate/benzoyl peroxide, ACANYA, ONEXTON, ZIANA</td>
</tr>
<tr>
<td>BRAVELLE</td>
<td>GONAL-F, GONAL-F RFF</td>
</tr>
<tr>
<td>BREEZE, CONTOUR METERS/STRIPS</td>
<td>ONETOUCH METERS/STRIPS</td>
</tr>
<tr>
<td>CETRAXAL</td>
<td>ciprofloxacin ear solution, ofloxacin ear solution, CIPRODEX</td>
</tr>
<tr>
<td>CIMZIA</td>
<td>ENBREL, HUMIRA</td>
</tr>
<tr>
<td>DELZICOL</td>
<td>balsalazide disodium, APRISO, LIALDA, PENTASA</td>
</tr>
<tr>
<td>DIPENTUM</td>
<td>balsalazide disodium, APRISO, LIALDA, PENTASA</td>
</tr>
<tr>
<td>DOXYCYCLINE 40 MG CAPSULE</td>
<td>ORACEA</td>
</tr>
<tr>
<td>DUEXIS</td>
<td>ibuprofen + famotidine</td>
</tr>
</tbody>
</table>
Narrow Networks

- Smaller network size
- More advantageous discounts
- Reduce claim spend
- Widely publicized Horizon Omnia Health Plans
  - In-Network **Tier 1**
    - More favorable negotiated discounts with providers
    - Lower copays and deductibles for members
  - In-Network **Tier 2**
    - “Regular” negotiated discounts with providers
    - Higher copays and deductibles for members
  - Out-of-Network **Tier 3**
Out-of-Network Reimbursement Rates

SHBP and SEHBP uses 90% of FAIRHEALTH

- Other options:
  - Lower % of FAIRHEALTH
  - 150% of Medicare for service providers
  - 175% of Medicare for facilities
“Buying Back” Benefits aka Opt-Out Program

- Concept started when employees had no or extremely small premium contributions - “carrot”
- Chapter 78 creates a private sector environment - “stick”
- Opt-Out likely not needed - smaller carrots / no carrots
Spousal Coverage

- Not required by PPACA
- If spouse has access to employer coverage
  - Surcharge
  - Not eligible (UPS implemented in 2014)
# Coordination of Benefits

<table>
<thead>
<tr>
<th>Standard</th>
<th>Fully Insured</th>
<th>Self Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Employer plan is primary</td>
<td>- Full COB / 100% Allowable</td>
<td>- Full COB / 100% Allowable</td>
</tr>
<tr>
<td>- Birthday rule applies for children</td>
<td></td>
<td>- Non-Duplication</td>
</tr>
</tbody>
</table>

Medicare COB not considered
# COB Illustration – Office Visit

<table>
<thead>
<tr>
<th></th>
<th>PRIMARY INSURANCE</th>
<th>SECONDARY INSURANCE FULL COB / 100% Allowable</th>
<th>SECONDARY INSURANCE NON-DUPLICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER CHARGE</td>
<td>$150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEGOTIATED PRICE</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>PRIMARY INSURANCE PAYS</td>
<td>$75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MEMBER PAYS ($25 COPAYMENT)</td>
<td>$25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NORMAL PAYMENT ($25 COPAYMENT)</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>SECONDARY PAYS</td>
<td>$25</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>FINAL MEMBER COST</td>
<td>$0</td>
<td>$25</td>
<td></td>
</tr>
</tbody>
</table>
Cadillac Tax

40% levy on high-cost employer-sponsored health plans
$10,200 for individuals, $27,000 for families

- Likely will not survive
  - Neither Party in favor
  - Postponed to 2020
- Address in contract language?
- Who pays?
  - Include in contribution schedule?
  - Employee pays all?
  - Employer pays all?
To Avoid in Contract Language

- Carrier names
- Plan names
- Naming SEHBP, SHBP
Create a Health & Benefits Advisory Board

- Ongoing collaboration between management and union
- Review plan performance
- Create health & wellness initiatives
- Set number of meetings per year, i.e. 4
Questions & Answers