

KEYS TO PENSION & HEALTH BENEFIT REFORMS (P.L. 2011 c. 78)

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THE DISCLAIMER!

- This presentation is guidance and is provided as assistance to local units administering the health insurance law changes in P.L. 2011, c. 78.
- The Division of Pensions and Benefits and the Division of Local Government Services may issue further guidance as necessary, and interested parties should visit the Division websites periodically for updates.
- Finally, this guidance does not constitute legal advice, and you should consult with your attorney as necessary for such advice.

CHAPTER 78 AND HEALTH BENEFITS

- Increases the share of health benefits coverage paid by public employees and retirees
- Covers all local units that provide health care coverage to employees.
 - Boards of Education, municipalities, counties, local authorities, and related public agencies.
- Law covers all forms of health insurance in any mix:
 - State-run (i.e., SHBP)
 - Commercial insurer
 - Jointly with other local units (through a Health Insurance Fund)
 - Self-insured
- Requires attention to recordkeeping and tracking employee information

ONLINE RESOURCES

- Local Finance Notice 2011-20
- Division of Pensions and Benefits (DPB) regularly updated & FAQ web pages:
 - Pensions information site:
www.nj.gov/treasury/pensions/reform-2011.shtml
 - Summary of full law at
www.nj.gov/treasury/pensions/newlaw11.shtml#chap78
 - Full text of c.78:
www.nj.gov/treasury/pensions/pdf/laws/chapt78-2011.pdf
- DLGS site:
www.nj.gov/dca/lgs/research/reschmenu.shtml/#health

KEY HEALTH COVERAGE SECTIONS

- **Section 39 – % of salary used to calculate contribution for each coverage level**
- **Section 40 – SHBP employers**
- **Section 41 - local boards of education**
- **Section 42 – local government employers**
- Section 43 - covers independent state entities
- Section 44 - covers entities under the Local Authorities Fiscal Control Act, and relates them back to Section 42
- Section 51 and 52 – Changes in Section 125 Cafeteria plan requirements
- Section 78 and 79 – impact on future negotiations
- Section 80 and 83 – implementation and effective dates

TERMINOLOGY

- *Base salary* is the “pensionable” salary reported for pension purposes (and base plus DCRP amount for those employees)
 - For hourly, part-time employees use pension base salary
- *Chapter 2* refers to 2010 law requiring employee health care contribution of 1.5% of their base salary
- *CNA* refers to “collective negotiations agreement”
- *Effective date* is 6/28/11 or the first pay period in July as warranted by circumstances
- *Implementation date*: Section 80 of the law permits a delay for administrative “implementation”
- *SEHBP* refers to State Health Benefits Program and the School Employees Health Benefit Program (SEHBP)
- *Standard contribution* is the amount an employee pays for health care

HEALTH BENEFIT CONTRIBUTION SCHEDULE (s. 39)

- Based on:
 - Type of coverage: family, employee plus (children, spouse), or employee or their equivalent; and
 - Base salary – which determines the percent of premium for each type of coverage
 - Cost of coverage

Type of Coverage	First Salary Bracket	Lowest % of benefit cost paid	Highest Salary (and over)	Maximum % of benefit cost paid
Employee	< than \$20,000	4.5%	\$95,000	35%
Employee plus	< than \$25,000	3.5%	\$100,000	35%
Family	< than \$25,000	3%	\$110,000	35%

HEALTH BENEFIT CONTRIBUTIONS

- Percentages increase at \$5,000 increments in salary
- Full tables are in 2011-20 as Appendix A & online on Pensions site
- Cost of Coverage is the premium or periodic charges as follows:
 - SEHBP employers = medical and prescription coverage
 - Non-SEHBP = everything health care: medical, prescription, dental, vision, etc.

HEALTH BENEFIT CONTRIBUTION

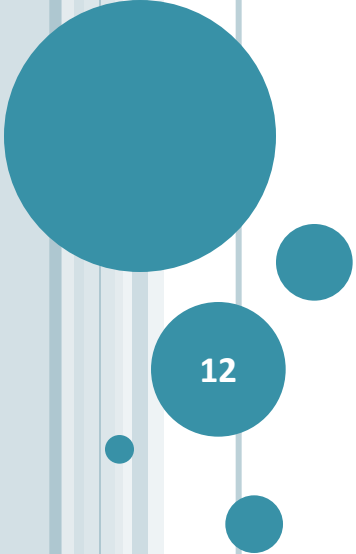
- The percent of contribution (determined from base salary) is multiplied by the cost of coverage for each employee and deducted from salary, or, for those covered, retirement allowance
 - Example: individual with family coverage with base salary of \$72,500 pays 22% of the cost of the family coverage, when fully implemented
- Treated as another payroll deduction (i.e., like pensions) and remitted as the health care provider requires
 - Self-insured programs should transfer funds from payroll agency to the self-insured trust fund no less than quarterly
- The health insurance budget line item should only include the net amount of the employers cost.

IMPACT ON LOCAL UNIT SELF-INSURED PROGRAMS

- Chapter 78 may require these programs to develop a set of premiums on which the employee contributions will be calculated
- Programs may need to calculate valid employee contribution models for the three coverage models:
 - Individual, employee plus, and family or equivalents
- Contribution models based on
 1. Actuary driven rates; or
 2. COBRA premiums calculated pursuant one of the two permitted models under Internal Revenue Code Section 4980B(f)(4) – actuarial or experience based

MORE ON SELF-INSURED

- COBRA rates should exclude the 2% admin fee charged to separated employees who receive COBRA benefits
- Consult with third-party administrators or plan designers to develop an acceptable premium model.
- Or 1.5% under Chapter 2
- We are looking at alternatives for dealing with reimbursement based benefits



CONTRIBUTION REQUIREMENTS OF EMPLOYEES WHO RECEIVE HEALTH BENEFITS (SECTION 40 AND 41)

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AFFECTING ALL EMPLOYEES

- Section 40 & 41 contain two key elements regarding employee health care contribution:
 - A 25%/year phase-in of Sec. 39 for existing employees, and
 - Different treatment of employees with or without CNAs
 - Calculations for 10 vs. 12 month employees
- What about the Chapter 2, 1.5%?
 - c.2, 1.5% or existing contract requirements that exceed the c.78 are continued until c.78 amount is greater
 - c. 78 is not another layer of contribution on top of c.2, and it does not reduce any locally negotiated higher amount
 - **This means you have to test all employees; c.2 vs. c.78 vs. any local to see which is higher! (worksheet may come soon)**
- Contribution starts as soon as locally implemented without any retroactive payment
- Full phase in means end of year 4 – 100% for one year

EMPLOYEES WHO ARE NOT COVERED BY A CNA IN EFFECT ON THE EFFECTIVE DATE...

- Existing employees make phased-in standard contributions (against the “test”):
 - Includes employees covered by an expired CNA
 - Regardless of local policy or practice that “relates” an employee to a CNA.
- Contribution takes effect as soon as implemented; no retro payment
 - 25% annual phase-in increases on pay of 7/1 each year until at 100%
- New employees who begin work on or after effective date pays at fully phased-in, year 4 contribution
 - Even if they fall under an expired contract when hired
- Employment is based on the employer: changes in employer result in full Year 4 imposition

EMPLOYEES WHO ARE COVERED BY A CNA (IN EFFECT) ON THE EFFECTIVE DATE:

- Four-year phase in starts upon expiration of current contract; then increments annually on anniversary date
- New employees under an in-place contract are covered by the contract
- Once a contract is settled, if it includes retroactive salaries, health care contribution must take into account salary increases back to the implementation date
- Employees that change bargaining units immediately follow the new bargaining unit.
- Coming soon: guidance on re-employment (are former employees new?)

NEGOTIATION OF FUTURE CNAs (S.77 AND 79)

- At end of 4th year, c.78 provides that:
 - All provisions of sections 39, 40 & 42 remain in place until fully phased-in
 - Negotiation for next contract is conducted as if the full contribution was a part of the previous contract
 - The contribution structure is negotiable
 - Future retiree benefit contribution structure can be negotiated; but employees who retired cannot have their contributions changed

OTHER FEATURES

- Existing contracts that are extended, altered, reopened, amended, or have other adjustments are considered **new agreements**
 - Meaning, phase-in starts immediately
- Employees with separate individual employment agreements:
 - Must be considered individually
 - Review agreement per LFN 2010-12, FAQ #29, then pay pursuant to the review
 - When expired, then start with standard contributions or the Chapter 2 required 1.5%, whichever is greater
- New employees: contribution starts when coverage kicks in

IN SUMMARY - CORE CONCEPTS

- As of 6/28/11 health benefits contributions are not negotiable or locally set for four years, or four years from the expiration of any contracts in effect on 6/28/11
 - All employees receiving health benefits will contribute to the cost of health benefits, if not right away, later.
 - When salary or health costs change; employee contribution changes
- The contribution is phased in equally over four years :
 - Immediately (when implemented), if you were an employee on 6/28 and not subject to a CNA that is in effect
 - When a CNA that is in effect on 6/28 expires or is in almost any way modified
 - Individual Employment Agreements require legal review
- The contribution takes effect immediately for employees hired after 6/28/11 who are not covered by a CNA or would be covered by a CNA that has expired.

BUT THERE ARE SOME UNCERTAINTIES...

- We are asking for AG guidance on several issues:
 - Questions related to when contracts negotiated or settled prior to 6/28 that take effect later
 - How much employees pay when they waiver coverage and take limited benefits
 - Self-insurance “premiums” for reimbursement programs
 - When employees are rehired – are they considered to be “new”
- So, its hard for us to give definitive guidance on these issues
- Guidance to come soon...



RETIREE HEALTH BENEFITS

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ABOUT RETIREMENT HEALTH BENEFITS

- N.J.S.A. 52:14-17.38 (for SHBP employers) which covers school retirees (TPAF and PERS) authorizes employers to offer retirees **employer paid** post-retirement medical benefits (PRM).
 - Can include disability retirements, 25 years with employer or pension system, and if employee reaches 62 years old and have 15 years of service with employer (62/15)
- c.78 requires public employees who retire after the effective date to make standard contribution for PRM, **EXCEPT...**
- ...In absence of local unit requirement to make contribution, **employees as of effective date who have more than 20 years and who retire after 25 do not make a contribution.**
 - Most State employees will pay 1.5% of allowance in retirement for PRM – does not apply to locals or boards of education employees.

SO, WHO PAYS FOR EMPLOYER APPROVED POST-RETIREMENT MEDICAL BENEFITS?

- **CNA Covered Employees** that reach 25 years or 62/15 (if approved) after 6/28/11 or after expiration of contract
- **Employees NOT Covered by a CNA** that reach 25 or 62/15 (if approved) after 6/28/11; or, if their benefit is connected to a CNA, after expiration of that contract.
- Except for employees choosing deferred retirement; they are not eligible for PRM
- Again, 20 years as of 6/28 that retire after 25 do not pay

WHAT DO THEY PAY?

- Standard contribution is deducted from retirement allowance, unless local requirement is greater
- Contribution depends on the benefit in effect at the time the employee **becomes eligible for the benefit**
 - As long as the retiree pays at a minimum the contribution required by Chapter 78
 - i.e., an employee who reaches a locally approved PRM threshold in Year 2, pays at 50% of standard contribution
 - Tier 4 employees (c.2; enrolled between 5/21/10 and 6/28/11): pay 1.5% of retirement allowance
 - As these can vary case-by-case, diligently maintained records of benefits in effect when employees reach retirement benefit eligibility are crucial!

SUMMARY OF RETIREE OBLIGATIONS

- Employees that receive employer paid retirement medical benefits **are exempt** from the standard contribution if:
 - They are covered or connected to a CNA; **and**,
 - They reach the age/years of service requirements (at least 20/25 or, if approved, 62/15, pursuant to local policy) for the **benefit before or no later** than the expiration of the current contract; or
 - In the absence of a contract, they reached the required age/years of service requirement prior to the effective date.
- Local units with PRM plans or practices not consistent with NJSA 18A:16-17.1...
 - ...should have their legal advisors carefully review the law to determine how it should be applied.



OTHER FEATURES:

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SECTION 125 PLANS

- “Cafeteria plans” pursuant to Section 125 of the Internal Revenue Code:
 - Plans allow employee benefit payments to be taken as “pre-tax” benefits and not subject to federal income taxes
 - Also necessary when health benefit waiver payments are made
 - Finance Notice has references on 125 Plans
- 18A:16-19.1 authorizes cafeteria plans on a voluntary basis.
 - Was needed for c.2, 1.5% deductions and waivers back to 2007.
 - c.78 now **requires** adoption of Section 125 plans for two purposes and one voluntary
 - Appendix C has Section 125 requirements and shows changes from the original 2007 language

REQUIRED SECTION 125 PLAN ELEMENTS

- Required: “Premium Only Plan” (POP)
 - Employee’s option to direct health benefits contributions before federal income and FICA (Social Security and Medicare) taxes are calculated
 - Participation is voluntary
- Required: (Medical) Flexible Spending Account (FSA)
 - Allows employee to set aside a portion of earnings to pay qualified medical expenses
 - Not subject to payroll taxes
 - Likely requires contract with 3rd party to administer
- OPTIONAL: Dependent Care Flexible Spending Accounts
 - Expenses to care for dependents who live with employee
 - Must be able to claim as a dependent on the employee's federal tax return

RECAP - SECTION 125 PLANS

- If local unit did not establish a Section 125 Plan to accommodate the 1.5% of salary employee health cost contributions or waivers, it **must now** establish a plan as a POP and create an FSA program (and cover waivers if necessary)
- If employee does not use their full FSA allocation, it is lost and returned to employer (can be used to offset employer plan costs)
- See Pensions and Benefits Tax\$ave Fact Sheet
- Consult auditor, risk manager, or legal advisor for guidance
- Don't forget appropriate competition; there may be a State contract available

ALTERNATE EMPLOYEE CONTRIBUTION PLANS

- Law permits development of “alternate contribution” plans in CNAs:
 - Employee and/or retiree contribution schedules, plan designs, or both that are different from standard contribution or where they are now
 - Can include non-CNA members in the alternate.

AN ALTERNATE PLAN IS

- ...an agreement providing non-standard contributions by employees and retirees, IF
 - Total aggregate savings during the term of that agreement for the
 - Covered lives (employees, retirees, and others that fall under it);
 - EQUALS or exceeds the annual savings if they had used standard contribution; PLUS...
 - ...difference between employer plan and cost of enrolling in new SHBP designs

ALTERNATE PLANS

- The Department of Education must approve or deny the plan within 30 days of filing or it will be deemed approved.
- **But**, don't rush to file:
 - Due to the requirement that alternate plans must be compared to savings developed from SHBP design changes, this provision is effectively inoperative until those plans and their rates are determined.

OTHER HEALTH BENEFIT RELATED ELEMENTS:

- Retiree health care contributions to be deducted from retirement allowance
 - Remitted to employer
 - New process needed by DPB to account for non-SHBP retirees
- Health benefit waivers
 - Amount of waiver calculation uses the net benefit cost to the employer – the premium less the employee's contribution.

OTHER HEALTH BENEFIT RELATED ELEMENTS:

- Employees with zero salary
 - Owe money based on lowest percent of benefit for each coverage category; billing required, treat like COBRA
- What happens when the employer switches from SHBP to a non-SHBP provider?
 - if management has the right to change the provider while maintaining equal coverage, it can be done without the contract being “opened, adjusted, etc.” Management is merely executing the contract, not modifying it.
 - But, you might wind up in PERC anyway

OTHER HEALTH BENEFIT RELATED ELEMENTS:

- Non-SHBP members are not required to provide alternate plan designs, but nothing prevents them from doing so

THAT'S ENOUGH.

- Questions

- Contact us:

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