I.R. No. 2006-8

STATE OF NEW JERSEY
PUBLIC EMPLOYMENT RELATIONS COMMISSION

In the Matter of

BRIDGETON BOARD OF EDUCATION,

Respondent,

-and-

Docket No. CO-2006-065

BRIDGETON EDUCATION ASSOCIATION,
BRIDGETON ASSOCIATION OF NON-TEACHING
SPECIALISTS, BRIDGETON SCHOOL
EMPLOYEES ASSOCIATION AND BRIDGETON
CUSTODIANS ASSOCIATION,

Charging Parties.

SYNOPSIS

A Commission Designee grants the Bridgeton Associations' application for interim relief on their charge that the Board unilaterally reduced the levels of health benefits when it changed health insurance carriers from the New Jersey State Health Benefits program to a group of Aetna plans. The Designee finds that the change in carrier offers no traditional plan and, therefore, affects the scope of health care providers, employees' ability to obtain medical treatment without incurring additional up-front expenses, co-pays and increased administrative burdens. Thus, the Associations have established a substantial likelihood of success on the merits of their charge. Since these effects may induce employees to delay or forego medical services, the Designee finds that the harm is not merely monetary. The Board is ordered to establish an interim program that guarantees that employees have funds available to them to pay any up-front or additional costs of medical treatment that would have been covered under the former plan. The Board is also ordered to negotiate procedures for processing employee claims for reimbursement.

I.R. No. 2006-8

STATE OF NEW JERSEY
PUBLIC EMPLOYMENT RELATIONS COMMISSION

In the Matter of

BRIDGETON BOARD OF EDUCATION,

Respondent,

-and-

Docket No. CO-2006-065

BRIDGETON EDUCATION ASSOCIATION, BRIDGETON ASSOCIATION OF NON-TEACHING SPECIALISTS, BRIDGETON SCHOOL EMPLOYEES ASSOCIATION AND BRIDGETON CUSTODIANS ASSOCIATION,

Charging Parties.

Appearances:

For the Respondent, Casarow, Kienzle & Raczenbek, attorneys (Paul Kienzle, of counsel)

For the Charging Parties, Selikoff & Cohen, attorneys (Keith Waldman, of counsel)

INTERLOCUTORY DECISION

On August 29, 2005, the Bridgeton Education Association, Bridgeton Association of Non-Teaching Specialists, Bridgeton School Employees Association, and Bridgeton Custodians Association (Bridgeton Associations or Associations) filed an unfair practice charge with the Public Employment Relations Commission alleging that the Bridgeton Board of Education violated 5.4a(1) and (5) of the New Jersey Employer-Employee

Relations Act, N.J.S.A. 34:13A-1 et seq.[1/], when on June 13, 2005, the Board voted to withdraw from the New Jersey State Health Benefits Program (SHBP), effective September 1, 2005, and change health insurance carriers from the SHBP to a group of Aetna health insurance plans. The Associations assert that the change in carriers reduced the level of contractual health benefits without negotiations with the Associations.

An application for interim relief accompanied the charge seeking an order directing the Board to: (a) negotiate in good faith with the Associations concerning health benefits; (b) meet with representatives of the Associations to exchange information and agree upon coverage gaps and any out-of-pocket expenditures covered by the SHBP Plans which are not covered by the replacement plans; (c) establish a fund, and compensate or reimburse employees for any coverage gaps and additional out-of-pocket expenditures until there is a mutual agreement regarding the level of benefits to be provided; and, (d) jointly establish a procedure, including an expeditious appeal process ending in binding arbitration, for disputed claims for compensation or

---

1/ These provisions prohibit public employers, their representatives or agents from: "(1) Interfering with, restraining or coercing employees in the exercise of the rights guaranteed to them by this act; (5) Refusing to negotiate in good faith with a majority representative of employees in an appropriate unit concerning terms and conditions of employment of employees in that unit, or refusing to process grievances presented by the majority representative."

reimbursement for any coverage gaps or additional expenditures required under the Aetna plans. On August 30, 2005, an Order to Show Cause was executed and a return date was set for September 19, 2005. At the Respondent's request, the return date was rescheduled to October 6, 2005. The parties submitted briefs, certifications, affidavits and exhibits in accordance with Commission rules and argued orally on the return date. The following relevant facts appear.

The Associations and Board are parties to collective negotiations agreements effective from July 1, 2003 through June 30, 2006. All of the agreements have insurance articles which provide that the Board agrees to pay the premium for Blue Cross/Blue Shield or equivalent medical plan, and full major medical for employee, family and dependent coverage for all employees who work more than 30 hours per week.[2/] Until the change in carriers in June 2005, the Board provided the benefits through the New Jersey SHBP plans: a traditional plan, a point of service plan (NJ Plus), and several SHBP-approved health maintenance organizations (HMOs).

2/ The Bridgeton School Employees insurance article is found at Article IX; the Bridgeton Non-Teaching Assistants' insurance article is found at Article VII; The Bridgeton Custodial Association's insurance article is found at Article XI and the Bridgeton Education Association's (BEA) insurance article is found at Article IX.

In October 2004, the Board notified the Associations that it could match the benefits provided by the SHBP plans and save money by switching to health insurance plans offered by Aetna. The Associations opposed any mid-contract changes in health insurance. On December 21, 2004, and February 3, 2005, informational meetings were held between representatives of an Aetna broker and the Associations.

On April 27, 2005, a meeting was held to address the Associations' concerns and requests for information about the Aetna plans. In attendance were representatives and members of the Associations, a Board representative and the Board's independent health insurance consultant, Kenneth W. Rudzinski.[3/] Rudzinski answered some questions and deferred answering others pending his further investigation.

On May 23, 2005, Rudzinski produced a lengthy report, "Bridgeton Board of Education Medical Benefits Comparison NJSHBP vs. Aetna-Only", which includes a side-by-side comparison of each SHBP plan to the Aetna plan proposed as its replacement. As of the date of the report, Board employees were enrolled in: the SHBP Traditional plan, NJ Plus plan, Aetna HMO, HealthNet HMO or Amerihealth HMO. On or about June 10, 2005, the Associations

---

3/ Rudzinski has no affiliation with the Aetna company or its broker, Allen Associates, in a representative, sales or supplier capacity. The Board retained Rudzinski to provide an independent evaluation of the differences between the SHBP and Aetna plans.

received the report. On June 13, 2005, the Board voted to approve the switch from SHBP to the Aetna Patriot V, Patriot X/Liberty A and Aetna HMO Flex/Liberty Custom plans. The Associations did not agree to the changes in benefits proposed by the Board.

The Associations allege, through the certifications of NJEA Associate Director of Research and Economic Service John O'Brien, NJEA Uniserv Representative Tom Myers, and BEA President Shirley Shaw, that the Aetna plans provide lower levels of benefits than the SHBP with respect to:

1. Aetna offers no traditional plan and, thus, provides fewer choices of health care providers. The SHBP traditional plan has no network, no requirement of referrals, and no requirement of prior approvals of members' choices of health care providers.

2. The Aetna plans have higher co-pays than some of the comparable SHBP plans co-pays. Under the SHBP plan, lab tests are paid at 100 percent; under the proposed plan, lab tests are paid at 100 percent but only after a $5.00 co-pay. Comparing HealthNet and the new Aetna HMO Flex/Liberty Custom, the plans are virtually identical with the following exceptions: emergency co-pay is $25.00 with HealthNet, $35.00 with Aetna; Outpatient mental health co-pay is $5.00 with HealthNet, $10.00 with Aetna; HealthNet imposes a $2700.00 per person per calendar year maximum

limit on total co-pays ($5400 per family), Aetna has no maximum. For those opting to use Patriot V, there is a co-payment of $5.00 for out-patient radiation/chemotherapy, which was not imposed under NJ Plus.

3. There are higher costs and greater administrative burdens to employees with some of the Aetna plans in that they require referrals from a primary care physician (PCP) before a patient can see a specialist. This could mean delays and/or deferment in obtaining health care.

4. The Aetna plans will require some employees (who were not required in the SHBP) to advance payments to providers up front out-of-pocket, and then seek reimbursement through the filing of a form. This adds an administrative burden, a degree of uncertainty and additional time in receiving reimbursement. There is also the possibility that some providers will not accept Aetna's reimbursement rate and will balance bill the employee/patient. This processing/billing factor could also mean delays and/or deferment in obtaining health care.

5. Under the extended basic benefits portion, the SHBP traditional plan provides first dollar coverage at a prescribed rate for some procedures and tests regardless of any deductible or co-payment. This is not so under the Aetna plan.

The Board submitted affidavits from Rudzinski and Rodina Murray, an Aetna broker, who did not specifically dispute the above alleged facts. In fact, in his report, Rudzinski noted:

> There is no Traditional plan among the Aetna alternatives. Therefore, all of the proposed Aetna alternatives require the selection of a primary care physician (PCP) and the use of referrals to in-network providers. However, this apparent limitation is mitigated by the use of an out-of network plan (Liberty A) that mimics the benefits of the SHBP traditional plan, and in some cases improves those benefits. Further, both the SHBP traditional plan and Aetna Liberty A out-of-network plans reimburse providers at virtually the same rate, i.e., at the 90th percentile of the Health Insurance Association of America's (HIAA) fee schedule. This is important in that the reimbursement percentile of a point of service product such as Liberty A is generally not paid at the same rate as a traditional plan. In the case of the proposed plan, however, it is. This does not mean that there might not be instances where there could be a differential between the SHBP Traditional plan and the proposed Aetna Liberty A regarding reimbursements for specific services; the fact that both are set up to reimburse at the 90th percentile means that major dissimilarities in reimbursements should be viewed as the exception not the rule.(emphasis added) and,
> We do not represent that all physicians, hospitals and other care providers in the plans offered by the SHBP are contained within the Aetna networks. In fact it would be a rarity if the two competing networks matched each other exactly.

The Associations also allege lower benefit levels in the following aspects of the Aetna plans, but these facts are disputed by the Board:

1. At least two hospitals accessible from Bridgeton, Burdette-Tomlin Memorial Hospital and Atlantic City Medical Center, are not included as network providers under either of the Aetna POS plans (Patriot V or Patriot X). Murray stated that while these hospitals are considered out-of-network, Aetna members may be covered in these hospitals for any emergencies or urgent care under the provisions of their plan, just as though they were in a participating hospital.

2. NJ Plus Plan provides coverage in New Jersey, Delaware, South Carolina, Florida, Virginia and the contiguous counties in New York and Pennsylvania. The traditional plan may be used anywhere. The Associations assert that the Aetna Plans may or may not have the same in-network out-of-state coverage. The Board disagrees. Rudzinski and Murray stated that Aetna has a national network and ,therefore, services are available in every state and participating providers are available in every state.

3. The Associations allege that co-pays may not apply to annual deductibles. The Board disputes this allegation also. It maintains that Aetna guarantees that all in-network co-pays are eligible for submission to the out-of-network deductible.

4. The allegation that infertility treatments will be diminished is disputed by the Board.

According to Rudzinski and Murray, in many areas of coverage the benefits under the Aetna Plans are better than those under the SHBP Plans.

ANALYSIS

To obtain interim relief, the moving party must demonstrate both that it has a substantial likelihood of prevailing in a final Commission decision on its legal and factual allegations, and that irreparable harm will occur if the requested relief is not granted. Further, the public interest must not be injured by an interim relief order and the relative hardship to the parties in granting or denying relief must be considered. Crowe v. De Gioia, 90 N.J. 126, 132-134 (1982); Whitmyer Bros., Inc. v. Doyle, 58 N.J. 25, 35 (1971); State of New Jersey (Stockton State College), P.E.R.C. No. 76-6, 1 NJPER 41 (1975); Little Egg Harbor Tp., P.E.R.C. No. 94, 1 NJPER 37 (1975).

A change in carrier resulting in a unilateral change in health benefits levels is an unfair practice. Union Tp., P.E.R.C. No. 2002-55, 28 NJPER 198 (¶33070 2002); City of South Amboy, P.E.R.C. No. 85-16, 10 NJPER 511 (¶15234 1984); Bor. of Metuchen, P.E.R.C. No. 84-91, 10 NJPER 127 (¶15065 1984); Piscataway Tp. Bd. of Ed., P.E.R.C. No. 91, 1 NJPER 49 (1975).

I find that the Associations have demonstrated a substantial likelihood of success on the merits of their claim that employee benefits are being reduced by the change in carriers. The

undisputed facts show that (1) the new Aetna plans do not include an equivalent to the SHBP Traditional plan, and some providers who were formerly available in SHBP will not now be available in Aetna's network; (2) certain co-pays are greater in the Aetna HMO than they were in certain SHBP HMOs and NJ Plus; (3) there are higher costs and greater administrative burdens to employees with some of the Aetna plans which require referrals from a primary care physician (PCP) before a patient can see a specialist; (4) some employees who were not balance-billed or required to make up-front payments to their health care providers will be so required under the Aetna plans; and, (5) the SHBP traditional plan provides first dollar coverage at a prescribed rate for some procedures and this is not so under the comparable Aetna plan.

In City of Newark, P.E.R.C. No. 82-5, 7 NJPER 439 (¶12195 1981) the Commission first considered whether the choice of the insurance carrier is a mandatory subject of negotiations. The Commission concluded that unless the change in carrier affects the level of benefits or the nature or administration of the coverage, the subject is not mandatorily negotiable. The Commission, however, did not find that the change in benefits standard was "substantial equivalence". The Commission never reached this issue. Contrast City of Orange, I.R. No. 2005-10, 31 NJPER 130 (¶56 2005)(Designee denied interim relief because the parties' collective agreement set the standard at

substantially equivalent and there was a factual dispute as to whether the new carrier provided substantially equivalent coverage.) Collective agreements may also set both the benefit level and the condition under which the employer may change benefits - e.g., to equivalent, substantially equivalent, equal to or better than, etc. levels of benefits. Here, the collective agreement sets "equivalence" as the condition under which the Board may change carriers unilaterally. Therefore, here, any demonstrable change which lessens benefits would prevent the Board from changing carriers unilaterally. Applying these standards, the undisputed facts here show that at least certain benefits levels have been reduced and that the administrative burdens as to certain employees will increase as a result of the change to the Aetna plan.

N.J.S.A. 34:13A-5.3 requires that mandatorily negotiable employment conditions be negotiated before they are implemented or changed. Unilateral implementation violates the obligation to negotiate in good faith. N.J.S.A. 34:13A-5.4 a(5). See Galloway Tp. Bd. of Ed. v. Galloway Tp. Ed. Ass'n, 78 N.J. 25, 48 (1978). A mid-contract repudiation can also undermine a collective negotiations agreement. The Board did not negotiate with the Associations before making the benefits change. Negotiations require that parties meet, exchange proposals and engage in give-and-take with an intent to reach agreement. Here, the Board

conducted informational meetings and provided a detailed report a mere three days before voting to approve the change. When the Board entered into the current collectively negotiated agreements with the Associations, both parties were entitled to the benefits of those bargains, no more and no less. The changes proposed in early 2005 by the Board are mid-contract changes. Having already agreed to terms and conditions of employment for a term certain, the Associations were not required to negotiate over new terms. It would be inconsistent with the purposes of the Act to permit one party to determine unilaterally which insurance plan is better for the other party, thus disturbing the other party's expectations. Galloway; Metuchen. This would be destructive of the process of collective negotiations, and of the parties' relationship.

The Board argues that the standard for assessing whether a change in health carriers raises the obligation to negotiate is whether the change results in benefits substantially equal to or better than the pre-existing plan. But here, the parties agreements provide that the Board will provide "equivalent" not substantially equivalent medical benefits. The fact that certain of the new Aetna plan benefits are enhancements of the prior SHBP plans is irrelevant in determining that there was an unfair practice. Metuchen, P.E.R.C. No. 84-91, 10 NJPER 127,128 (¶15065 1984).

Based on the foregoing, the Association has demonstrated a substantial likelihood of success in a final Commission decision. In lieu of ordering a return to a previous carrier or restraining an employer from contracting with a new insurance carrier, differences in benefits levels as a result of a change in carrier may be remedied by the creation of a fund from which to compensate or reimburse employees for additional out-of-pocket expenses. Union Tp.

The Association has also established irreparable harm. Under the Aetna plans, employees may be required to pay up-front the costs of treatment at the time services by health care providers are rendered rather than await reimbursements. The overall reimbursement may be less than in the past because a out-of-network provider may balance bill employees. Employees may forego treatments rather than pay up-front costs and thus, the harm is not merely monetary. Accord, Union Tp. at 200; and Bor. Of Closter, P.E.R.C. No. 2001-075, 27 NJPER 289 (¶32104 2001)(Commission finds irreparable harm in health plan which induced employees to forego or delay purchasing medically necessary drugs because they would have to pay up-front).

Next, in deciding whether to grant interim relief, the relative hardship to the parties must be considered and a determination made that the public interest will not be injured by the interim order. Crowe. The Board argues that if interim

relief is granted, it would have to continue to administer the costly SHBP and forego the savings available to it under the Aetna plans. In this case, the Associations are not seeking a return to the SHBP plans. The Board has not identified any specific harm to it from establishing a fund to ensure that employees are provided the level of health benefits negotiated by the parties. Further, in weighing the relative hardship to the parties, the establishment of the fund to recompense employees for demonstrable differences in the Plans will not overly burden the Board if, as it maintains, the Aetna Plans are equal to or better than the SHBP Plans. The relative burdens to the Board in granting relief will be small.

In considering the public interest, I find that it is furthered by adhering to the tenants expressed in the Act which require the parties to engage in collective negotiations prior to changing terms and conditions of employment. Adhering to the collective negotiations process results in labor stability and promotes the public interest.

ORDER

1. The Board is directed to establish an interim procedure that guarantees that employees have funds available to them to pay any up-front costs of medical care and any additional costs of medical treatment that would have been covered under the SHBP

Plans during the pendency of this litigation or until such time as this matter is resolved through collective negotiations.

2. The Board is directed to negotiate procedures for implementing a fund and for processing employee claims for reimbursement of monies expended as a result of any decrease in health benefits due to the change in insurance carriers.

Elizabeth J. McGoldrick
Commission Designee

Dated: October 17, 2005
Trenton, New Jersey