I.R. NO. 2010-4

STATE OF NEW JERSEY
PUBLIC EMPLOYMENT RELATIONS COMMISSION

In the Matter of

BAYONNE BOARD OF EDUCATION,

Respondent,

-and- Docket No. CO-2009-490

BAYONNE TEACHERS ASSOCIATION,

Charging Party.

SYNOPSIS

A Commission Designee denies an application for interim relief seeking to restrain an employer from changing health insurance carriers. The employer changed carriers as a result of an $8.2 million budget gap caused by a 68% increase in premiums under the old plan. The union alleged that the change in carriers resulted in at least 25 areas of inferiors coverage and that, by past practice, when the employer changed health carriers, it provided "equal to or better than" health coverage. There is no contractual language addressing the level of benefits upon change in carriers, and the employer denied that any past practice exists. Based on this material disputed fact, the designee found no substantial likelihood of success. She also determined that there was no irreparable harm demonstrated in light of a supplemental fund established by the employer to cover any up-front or out-of-pockets expenses incurred by employees for any coverage gap. Finally, in order to make up the $8.2 million budget deficit, the employer would have had to layoff 140 teaching staff, if it could not change carriers. Weighing the relative hardship to the parties and the public interest, the Designee determined that denying interim relief under these circumstances was appropriate.

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Appearances:

For the Respondent, Apruzzese, McDermott, Mastro and Murphy, P.C., attorneys (Robert J. Merryman, of counsel)

For the Charging Party, Selikoff and Cohen, attorneys (Steven R. Cohen, of counsel)

INTERLOCUTORY DECISION

On June 29, 2009, the Bayonne Teacher's Association (BTA) filed an unfair practice charge and a request for interim relief against the Bayonne Board of Education (Board). The BTA alleges that the Board violated the New Jersey Employer-Employee Relations Act, N.J.S.A. 34:13A-5.4a(1) and (5)[1/], when it

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."

announced a change in health insurance carriers effective August 1, 2009[2/], thereby changing the level of employee health benefits without negotiations. In particular, the BTA alleges that by past practice, when the Board changed insurance carriers, the level of benefits with the new carrier was equal to or better than the previous level of benefits. The change in insurance carriers from Horizon Blue Cross/Blue Shield Traditional Plan (BCBS) with a separate prescription plan provided by Garden State Pharmacy Owners Providers Services Corporation (Garden State) to health and prescription plans provided by the New Jersey School Employees Benefits Program (State Plan), the BTA contends, results in inferior benefits in at least 25 areas. Thus, it asserts, the new plan is not equal to or better than the previous plan.

The BTA seeks to restrain the Board from refusing to negotiate over changes in benefit levels. It also seeks an order requiring the Board (a) to negotiate over changes in levels of health benefits, (b) to exchange information about coverage gaps between the new and old plans, (c) to establish a fund to compensate employees for any additional out-of-pocket expenses as a result of coverage gaps, and (d) to negotiate a procedure, including an expeditious appeal process culminating in binding

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2/ The effective date for the change to the new insurance carrier was originally July 1, 2009 but was extended to August 1, 2009.

arbitration, for considering any claims for reimbursement of medical expenses arising out of coverage gaps. At oral argument, Counsel for the BTA asserted that the Board should be restrained from changing to the new plan and ordered to remain in the old plan pending negotiations.

An Order to Show Cause was signed on June 30, 2009 setting a return date of July 28, 2009 for oral argument. The parties submitted briefs, certifications and exhibits and argued orally on the scheduled return date. The following pertinent facts appear.

The Board and BTA entered into a memorandum of agreement (MOA) on January 28, 2008 setting forth the terms for a successor collective agreement effective from September 1, 2006 though August 31, 2010. The MOA provides for certain changes to the expired collective agreement but the article pertaining to health benefits has not been changed.

Article 7 of the 2002-2006 agreement is entitled "Health Care" and provides in pertinent part under paragraph 7:1 ("Medical Coverage") that "[t]he Board agrees to continue its policy of paying for the cost of employee coverage for Blue Cross (for Hospital Costs), and Prudential "Major Medical Wrap-Around Plan." The agreement also provides for 100% prescription plan family coverage with various co-pays. The Board most recently provided prescription coverage through Garden State. Paragraph

7.4 states that "[a]ny changes in coverage must be sent to the BTA prior to the implementation of the change." The agreement is silent as to the level of benefits to be provided in the event of a change in carriers.

The certification of NJEA UniServ Representative Thomas DeSocio who is assigned to represent the BTA states that the parties' established practice for the past 20 years is that if the Board changes health insurance carriers, the new plan must provide benefit levels equal to or better than the previous health plan. The certification of the Board's Business Administrator Clifford Doll states that he has negotiated and administered the collective negotiations agreements between the parties since at least 1980. Doll states that he is "unaware of any agreement, language, or practice whereby the Board has guaranteed that a change in health plans would result in equal to or better benefits."

Upon notification in April 2009 that the premium for BCBS would increase 68% or 8.2 million dollars effective July 1, 2009, the Board solicited quotes from other insurance carriers since it did not have sufficient funds in its proposed 2009-2010 budget to absorb this increase without massive layoffs of teaching staff. The Board had already reduced its staff in the 2009-2010 budget year by 17 teaching positions and 35 support staff positions due

to increased costs and reduced state aid anticipated for the 2009-2010 school year.

Based on the unanticipated 8.2 million dollar increase, the Board faced the choice to lay off an additional 140 teaching staff members or to move to a less costly insurance plan. The Board rejected the former option because it would be devastating to the educational program. Therefore, after seeking quotes from various insurance companies, the Board determined that the State Plan provided the most cost savings and chose to move to the State Plan, setting up a supplemental fund to cover any difference in benefits or costs between the old and new plans. Even with the supplemental fund to ensure that all medical procedures and services previously covered will continue to be covered, the total cost of the change in carriers is provided for in the proposed budget and does not necessitate teaching-staff layoffs that would have occurred if the Board chose to stay in the BCBS plan.

By resolution on April 30, 2009, the Board approved a change in health insurance carrier. The Board selected the Direct 10 plan with benefits provided by Horizon BCBS, the most generous plan offered by the State Plan. Direct 10 provides a network of more than 11,000 physicians, hospitals and other health care professionals. The Board contends that a review of the old and new plans demonstrates that for in-network providers there is

virtually no difference in coverage. In some instances, employees will receive savings because most medical services are covered by a $10 co-pay instead of a 20% cost for services under the old plan.

Kevin Kelleher is employed by the NJEA as Associate Director for Research and Economic Services and evaluated the old and new insurance plans, both medical and prescription. He found 25 areas wherein the new plan did not provide a level of benefits equal to or better than the old plan, including, among others, out-of-pockets maximums for individuals and families, overall lifetime benefit maximum for out-of-network services, $25 co-pay per emergency under the new plan versus no charge under old plan as well as increased costs for various out-of network services such as hospitalization, surgical centers, pre-admission testing, skilled nursing facilities, child immunizations/lead poisoning screening, adult routine physicals, prostate screening, adult routine OBGYN examinations, adult pap smears, mammography etc. He also identified a difference in how the plans calculate reasonable and customary rates.

By letter dated May 12, 2009, BTA Labor Counsel Steven Cohen wrote Board Secretary Gary Maita. The letter, entitled "Demand for Requested Information and Negotiations", quoted a letter from Mayor Mark Smith to Board President William Lawson about the change in carriers. Smith recommended that a thorough analysis

be undertaken of the new and old plans and that a supplemental fund be established to make employees whole where the State Plan did not meet the benefit levels of the old plan. Smith expressed that by undertaking the analysis and setting up the fund, the Board could assure that the State Plan provided benefit levels equal to or better than the old plan. Cohen's letter also explained that at the April 30th Board meeting approving the change in carriers Board Business Administrator Doll represented that $1.6 million would be earmarked for the supplemental fund.

Cohen then posed several questions including when the analysis would be undertaken, how reasonable and customary rates would be calculated, when the supplemental fund would be established and/or if already established that proof be provided that $1.6 million had been earmarked, and whether the Board would negotiate procedures with respect to the supplemental fund.

On May 29, 2009, the Board's Labor Counsel Robert Clark responded by letter. He addressed concerns raised by the BTA, explaining, in part, that the Board met twice with the BTA to discuss the change in carriers, that the reasonable and customary rates for the State plan were calculated by BCBS just as it had been under the old plan, that the special fund to compensate for any coverage gaps was included in the 2009-2010 budget line item for health benefits so for all practical purposes was currently

in effect and that the Board was willing to negotiate procedures to be utilized with respect to the special fund.

Representatives from the State plan met with BTA members on June 16, 17 and 18, 2009 to explain the change in health insurance plans, answer questions about the new coverage and provide applications to effectuate the change. All current employees have filled out the necessary paperwork to effectuate the change to the Direct 10 State Plan.

To date, although it intends to do so, the Board has not hired an insurance consultant or administrator who will manage the supplemental fund established to address any coverage gaps but is in the process of doing so. Also, it does not appear that the parties have, as yet, negotiated procedures for the administration of the supplemental fund, although the Board expressed in its May 29 letter that it is willing to do so.

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. DeGioia, 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). After reviewing the facts and considering the parties' legal arguments, I find that the BTA has not met the standards for interim relief and its application is, therefore, denied.

The Commission has long held that the level of health benefits is mandatorily negotiable and may not be changed by an employer unilaterally. Piscataway Tp. Bd. Of Ed., P.E.R.C. No. 91, 1 NJPER 49 (1975). See also, Union Tp., P.E.R.C. No. 2002-55, 28 NJPER 198 (¶33070 2002). The identity of an insurance carrier is not mandatorily negotiable for civilian employees and generally only permissibly negotiable for police and employees. City of Newark, P.E.R.C. No. 82-5, 7 NJPER 439, 440 (¶12195 1981). However, when a change in carriers changes the level of benefits, the change is mandatorily negotiable. Borough of Metuchen, P.E.R.C. No. 84-91, 10 NJPER 127 (¶15065 1984); Union Tp.

In Union Tp. at 200, the Commission stated:

> A contract clause requiring the employer to maintain the level of health benefits may create additional protections for employees. It may also provide a contractual defense for the employer to an unfair practice allegation that the employer violated the Act by acting unilaterally. Many contracts permit changes to, for example, equivalent or substantially equivalent benefit plans. An employer satisfies its negotiations obligation when it acts pursuant to the contract.

Even though health benefit changes may violate the Act, unfair practice charges alleging unilateral changes in health benefits will ordinarily be deferred to binding arbitration because the contract often sets the benefit level and the conditions under which the employer may change benefits. Stratford Tp. Bd. of Ed., P.E.R.C. No. 90-17, 15 NJPER 527 (¶20217 1988).

Here, the BTA contends generally that the parties' have a 20-year past practice of providing "equal to or better than" level of benefits when the Board has changed carriers. The Board asserts that the collective agreement does not support this standard and denies that there is a past practice as described by the BTA's uniserv representative. The Board relies on the certification of its business administrator who has represented the Board for at least 30 years. This is clearly a material disputed fact.

Moreover, although the BTA's analysis demonstrates 25 areas where the new plan provides lower benefit levels, the Board counters that the new plan provides a much greater in-network group of physicians, hospitals and other health care providers. It asserts, therefore, that the new plan is superior because instead of paying up to 20% of a benefit cost, employees will receive all medical care and services at a minimum co-pay, a considerable savings, as well as access to services not provided

or provided on a more costly basis under the old plan such as vision care, well-care child exams, chiropractic care and x-rays. The BTA's analysis ignore these increased benefits. The Board explains that the supplemental fund will provide for any coverage gaps. Thus, it asserts, the level of benefits has not changed. Whether the level of benefits has changed, therefore, is also a material disputed fact.

BTA relies on Borough of Metuchen, supra, in support of its application. There, the Commission, affirmed a Hearing Examiner's determination that the employer violated the Act when it changed insurance carriers, because the level of benefits was changed. That case is distinguishable because the determination of a change in levels of benefits was made after a full plenary hearing. In Little Egg Harbor Tp., P.E.R.C. No. 94, 1 NJPER 37 (1975), the Commission Designee stated that "[t]he Commission's exclusive remedial powers, normally intended to be exercised subsequent to a plenary hearing, will not be called into play for interim relief in advance of such hearing except in the most clear and compelling circumstances."

The BTA also relies on Union Tp., I.R. No. 2002-7, 28 NJPER 86 (¶33031 2001), wherein a Commission Designee refused to restrain the Township from changing health insurance carriers, but restrained the Township from changing the level of health care benefits through a change in the network of participating

providers. She also found irreparable harm because the change in provider network might force employees to pay up-front costs of treatment at the time of service which might discourage some from seeking health services and ordered the Township to set up a fund to pay any up-front costs resulting from the change in plans. The parties' collective agreements set the level of benefits as "at least equal to that which has heretofore been in effect". Id. at 87. This case is distinguishable.

Here, the collective agreement permits the employer to change plans upon notification to the BTA. Notification was given to the BTA. Unlike Union Tp., there is no contract language setting specific benefit levels upon a change of carriers, and the BTA relies on a disputed past practice to support an alleged equal-to-or-better-than benefit level. The Board asserts that it is simply providing the same health benefit through a different health insurance plan. Moreover, the supplemental fund, it contends, ensures the same level of benefits.

Based on these material disputed facts, at this juncture, the BTA has not established a substantial likelihood of success on prevailing in a final Commission decision on its legal and factual allegations. This matter is more appropriately decided in a full plenary hearing on the merits in grievance arbitration.

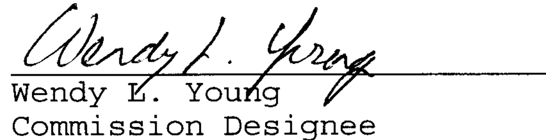
Additionally, the BTA has not demonstrated that it would be irreparably harmed if interim relief is not granted. De Socio's certification asserts generally that because 25 aspects of the new plan are inferior to the old plan, BTA members "may forego needed treatment or medication" because they will be required to pay up-front costs. The Board asserts that the in-network coverage is virtually identical and that indeed in most instances will be less costly. To address the issue of up-front costs and additional costs in the event of coverage gaps, the Board has established a supplemental fund to make employees' whole for any out-of-pocket and up-front expenses incurred by coverage gaps caused by the change in plans. It has also offered to negotiate procedures for administering the fund. Thus, there appears to be no harm to the employees. See generally, Union Tp., P.E.R.C. No. 2002-55, supra; Verona Bd. of Ed., I.R. No. 2009-4, 34 NJPER 264 (¶94 2008); Camden Cty. College, 34 NJPER 104 (¶45 2008). Moreover, at oral argument, Counsel for the Board and Mr. Doll agreed that until a permanent administrator of the fund is hired, Mr. Doll would accept and process employee claims as he has done in the past.

Finally, in weighing the relative hardship to the party's and the harm to the public interest, the Board has established that a restraint in this instance, forcing it to stay in the old plan pending negotiations, would result in massive layoffs of

teaching staff in the current budget year to address the 8.2 million dollar premium increase. This result would be devastating to the educational process.

ORDER

The Charging Party's application for interim relief is denied. However, I am strongly advising the parties to immediately commence negotiations regarding procedures for the administration of the supplemental fund to make employees whole for any coverage gaps between the new and old insurance plans and to address any up-front costs that may be incurred as a result of the change in insurance carriers.



Wendy L. Young
Commission Designee

DATED: July 29, 2009
Trenton, New Jersey