I.R. No. 2019-019

STATE OF NEW JERSEY
PUBLIC EMPLOYMENT RELATIONS COMMISSION

In the Matter of

BELVIDERE BOARD OF EDUCATION,

Respondent,

-and- Docket No. CO-2019-221

BELVIDERE EDUCATION ASSOCIATION,

Charging Party.

**SYNOPSIS**

A Commission Designee grants, in part, and denies, in part, an application for interim relief filed by the Association against the Board alleging that the Board violated the New Jersey Employer-Employee Relations Act, N.J.S.A. 34:13A-1 et seq., specifically subsections 5.4a(1) and (5), by unilaterally changing health insurance carriers/plans from Horizon to AmeriHealth during negotiations for a successor agreement. The Association alleges that the change in carriers reduced the level of health insurance benefits and is not "equal to or better than the current coverage" as mandated in the parties' expired collective negotiations agreement. The Designee finds that the Association has demonstrated a substantial likelihood of prevailing in a final Commission decision, that unit members and/or covered dependents may suffer irreparable harm absent the imposition of interim relief, relative hardship, and that the public interest will not be injured by an interim relief order. The Designee directs the Board to establish and fund an interim program guaranteeing that unit members and/or their covered dependents may available themselves of funds to pay up-front costs of medical care and any additional costs of medical treatment that would have been covered under the Horizon plan, with disbursement of funds contingent upon the submission of a written certification. The unfair practice charge was transferred to the Director of Unfair Practices for further processing.

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Appearances:

For the Respondent, Weiner Law Group LLP, attorneys (Stephen J. Edelstein, of counsel and on the brief; Joshua I. Savitz, of counsel and on the brief)

For the Charging Party, Oxfeld Cohen, P.C., attorneys (Randi Doner April, of counsel and on the brief; Sanford R. Oxfeld, of counsel)

**INTERLOCUTORY DECISION**

On March 1, 2019, Belvidere Education Association (Association) filed an unfair practice charge against Belvidere Board of Education (Board) alleging that the Board violated the New Jersey Employer-Employee Relations Act (Act), N.J.S.A. 34:13A-1 et seq., specifically subsections 5.4a(1) and (5),[1/] by

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"; and "(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 (continued...)

unilaterally changing health insurance carriers/plans from Horizon Healthcare Services, Inc. (Horizon) to AmeriHealth Insurance Company, Inc. (AmeriHealth) during negotiations for a successor agreement. The Association alleges that the change in carriers reduced the level of health insurance benefits and is not "equal to or better than the current coverage" as mandated in the parties' expired collective negotiations agreement (CNA).

The Association's unfair practice charge was accompanied by an application for interim relief requesting that the Board be directed to:

> -rescind its agreement with AmeriHealth;
> -return to the previous health insurance carrier, Horizon; and
> -cease/desist from any further actions or activities that serve primarily to coerce the Association from exercising the rights guaranteed to it under the Act.[2/]

PROCEDURAL HISTORY

On March 4, 2019, I signed an Order to Show Cause directing the Board to file any opposition by March 11; the Association to

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1/ (...continued)
representative."

2/ During oral argument, the Association's counsel acknowledged that directing the Board to reimburse unit members for out-of-pocket costs related to the change in level of benefits would be an alternative remedy for purposes of interim relief. "Although the Commission has not regularly restrained employers from making a change in carriers, it has ordered interim relief by requiring them to create a fund to reimburse employees for any differences in benefit levels." Franklin Lakes Bd. of Ed., I.R. No. 2010-8, 35 NJPER 465 (¶153 2009).

file any reply by March 15; and set March 20 as the return date for oral argument. On March 20, counsel engaged in oral argument during a telephone conference call. On March 26, pursuant to N.J.A.C. 19:14-9.3©,[3/] I directed the parties to provide me with certifications and/or other evidence regarding emergency care benefits.

In support of the application for interim relief, the Association submitted a brief, exhibits, and the certification of Michael Salerno (Salerno), Associate Director of Research and Economic Services for the New Jersey Education Association (NJEA). In opposition, the Board submitted a brief, exhibits, the certification of Paul C. Kalac, Esq. (Kalac), and the certification of Stephen Edelstein, Esq. (Edelstein). The Association also filed the supplemental certification of Salerno. The Board also filed a letter from AmeriHealth dated March 27, 2019.

## FINDINGS OF FACT

The Board and the Association are parties to an expired CNA in effect from July 1, 2015 through June 30, 2018. The grievance procedure ends in binding arbitration.

Article XVIII of the expired CNA, entitled “Insurance Coverage,” provides in pertinent part:

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3/ N.J.A.C. 19:14-9.3© grants the Commission Chair or Designee with the authority to permit additional briefing in an interim relief proceeding.

> A. The Board agrees that it will provide full family coverage health care insurance. All employees shall be provided with Board paid School Employee Health Benefits Plan (SEHBP) health insurance coverage. School employees eligible for medical benefits may select any medical plan within the School Employee Health Benefits Plan (SEHBP).
>
> B. The Board shall request the carrier to provide to each employee a description of the health care insurance coverage provided under this Article, setting forth a clear description of the conditions and limits of the policy.
>
> C. The Board has the option of selecting a different insurance plan during the life of the current collective bargaining agreement. If the Board chooses to move to another insurance carrier, the new coverage shall be equal to or better than the current coverage.

Paul C. Kalac, Esq. (Kalac), one of the Board's negotiators, certifies that the parties held negotiations sessions on January 30, February 26, March 12, April 16, April 30, May 23, and June 7, 2018. According to Kalac, the Association declared impasse on June 18, 2018 and mediation sessions were held on October 8, 2018 and January 14, 2019. Kalac certifies that "[i]n the fall of 2018, the Board discussed publicly its plan to change insurance carriers in order to recognize a significant financial savings" and "advised that a vote would be taken at the December 12, 2018 Board meeting." According to Kalac, "the Association requested information from the Board" on November 15, 2018 and "[t]he Board cooperated."

Kalac certifies that "[t]he Board . . . obtained an 'equal

to or better than' letter from AmeriHealth dated October 11, 2018 . . . [which] was [also] provided to the Association" and provides in pertinent part:

> AmeriHealth is pleased to have the opportunity to present a medical and prescription proposal for Belvidere Board of Education. AmeriHealth offers excellent service and has one of the largest networks in the area to serve the needs of Belvidere Board of Education employees. For the past five years, AmeriHealth has received top ratings in the New Jersey Performance Report released by the state's Department of Health and Senior Services. The complete text of the report can be viewed at http://www.state.nj.us/health.
>
> AmeriHealth has designed a plan providing benefits for Belvidere Board of Education, which is based on the benefits provided. We guarantee the benefits are equal to or better than the current benefit program offered to Belvidere Board of Education.
>
> Notwithstanding the above, in the absence of specific documented administrative practices, AmeriHealth's medical policy and administrative procedures will apply.
>
> On behalf of AmeriHealth, I thank you for this opportunity. I am confident that the guarantee of benefits, quality service and financial savings will demonstrate AmeriHealth's commitment to you.

Kalac certifies that "[p]rior to the Board meeting of December 12, 2018, the Association requested a face to face meeting . . . [which] took place on December 10, 2018." According to Kalac, "[a]t that meeting . . . the Board offered not to switch carriers and to forego the financial savings if the

Association would lower its salary demands" but "[t]he Association was unwilling to do this."

On December 12, 2018, the Board passed "A Resolution Concerning Group Medical Insurance Carrier" that provides in pertinent part:

> The Board of Education hereby resolves, effective February 1, 2019, to make the following changes to its group medical insurance carrier:
>
> 1. Terminate its group medical insurance policy with Horizon Healthcare Services, Inc., group number 86646.
>
> 2. Select AmeriHealth Insurance Company, Inc. as its group medical insurance carrier, via the Public Employer Trust, at the rates, benefits, terms, and conditions represented in the report from Brown & Brown Benefit Advisors, Inc. The AmeriHealth "equal to or better than" guarantee letter is enclosed herein and included as part of this resolution.
>
> 3. Designate Brown & Brown Benefit Advisors, Inc. as broker-of-record for our new AmeriHealth group medical insurance program.
>
> 4. Authorize all appropriate Board of Education staff to take such action and affect such documentation as necessary to implement this change, including execution of a Public Employer Trust Agreement by the appropriate Board of Education representative.
>
> 5. Establish a supplemental fund to indemnify and reimburse staff members in situations where their Horizon in-network health care provider is not a provider with AmeriHealth or Multiplan/PHCS. The parameters of such fund will be as follows:

a. The fund will be administered by Brown & Brown Benefit Advisors, Inc. (BBBA), who will advise the Board's Business Administrator twice monthly on the dollar amount due to eligible employees.

b. The fund will be open for dates of service 2/1/19 through 1/31/20, with an additional 60 days beyond 1/31/20 for employees to submit the required documentation to BBBA, with a final submission deadline of 4/1/20.

c. The maximum allotted for total disbursement will be $30,000.

d. Required documentation will include: provider invoice(s), AmeriHealth explanation of benefits (EOB) statement(s), proof that the provider(s) in question were previously utilized on an in-network basis by the employer or their dependent(s) for dates of service 1/1/18 - 1/31/19, and completion of a form to be developed by BBBA.

e. All transactions other than the reimbursement will occur directly between employees and BBBA in order to preserve the privacy of Protected Health Information (PHI) as defined by HIPAA. Board of Education employees will be required to return or destroy or delete all PHI submitted to them by other employees.

f. Employees may appeal an adverse determination by BBBA to the Board's Business Administrator but would first be required to complete a waiver allowing the Board's Business Administrator to receive and archive their PHI.

On February 14, 2019, the Association sent correspondence to Superintendent Christopher Carrubba (Carrubba) that provides in pertinent part:

> On February 1, 2019, the existing insurance coverage with Horizon Blue Cross/Blue Shield was replaced with coverage with AmeriHealth. In accordance with Article XVIII, Section C replacing Horizon Blue Cross/Blue Shield with AmeriHealth is in violation of our contract as the new coverage is NOT equal to or better than the coverage it replaces. We are submitting the above matter as a Grievance Level Three. We are requesting that the Board provide us with equal to or better than health insurance coverage as per contract.

Stephen Edelstein, Esq. (Edelstein), an attorney for the Board, certifies that "the grievance was heard on February 27, 2019 at the Board level" and "the Association presented exactly the same arguments it presents now." According to Edelstein, "[t]he grievance, while denied, has not been withdrawn and the Association is well within time to file a demand for binding arbitration."[4/]

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4/ On March 22, 2019, the Association sent correspondence to Superintendent Carrubba that provides in pertinent part:

> On February 1, 2019, the existing insurance coverage with Horizon Blue Cross/Blue Shield was replaced with coverage with AmeriHealth. In accordance with Article XVIII, Section C, replacing Horizon Blue Cross/Blue Shield with AmeriHealth is in violation of our contract as the new coverage is NOT equal to or better than the coverage it replaces. We are submitting the above matter as a Grievance Level Five and requesting a review by a third

(continued...)

On March 1, 2019, the underlying unfair practice charge was filed together with the instant application for interim relief.[5/]

Michael Salerno (Salerno), NJEA's Associate Director of Research and Economic Services, certifies that he has "compare[d] the level of benefits between AmeriHealth and Horizon" and "concluded that the level of benefit[s] is significantly less and, accordingly, is not equal to or better than as required by the CNA." According to Salerno, "[t]he two major areas in which there is a diminution of level of benefit[s] are the hospitals in the State of Pennsylvania that are in-network and the number of urgent care facilities . . . in Pennsylvania." Salerno certifies that although "a comparison of the number of specialists in Pennsylvania [under AmeriHealth] as opposed to [Horizon] . . . shows that there are fewer specialists, the numbers are sufficiently close [such] that [the Association] is not asserting that as evidence of diminution of level of benefit[s]."

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4/ (...continued)
party. We are requesting that the Board provide us with equal to or better than health insurance coverage as per contract.

5/ On March 11, 2019, the Board filed an unfair practice charge (CE-2019-012) alleging that after the parties reached a successor memorandum of agreement (MOA) in effect from July 1, 2018 through June 30, 2021, the Association violated the Act by refusing to execute same. On March 14, given that the Association executed the MOA, the Board withdrew its charge. The parties' 2018-2021 MOA does not modify Article III (Grievance Procedure) or Article XVIII (Insurance Coverage) of the parties' expired 2015-2018 CNA.

Salerno certifies that Belvidere, New Jersey "is close to the Delaware River and . . . the State of Pennsylvania" and "[a] significant number of teachers and other employees in the Belvidere School District (over 2%) reside in the two Pennsylvania counties contiguous to the Belvidere area, e.g., Northampton County and Monroe County." According to Salerno, "Northampton County presents no issues whatsoever in terms of diminution of level of benefit[s]"; however, "Monroe County . . . has only two hospitals, both of which were in the Horizon Plan's Blue Card Network" - namely, St. Luke's Hospital (St. Luke's) and Lehigh Valley Hospital/Pocono (Pocono). Salerno certifies that only St. Luke's "[is] in AmeriHealth's PHCS Network" but it "is not a full-service hospital" because "[it] does not provide maternity, cardiac or cancer treatment services." According to Salerno, Pocono "is [the] only . . . full-service hospital in Monroe County" which "provide[s] maternity, cardiac and cancer treatment services."

Salerno certifies that "[i]f an individual is having a cardiac issue or . . . a pregnant individual is about to give birth, that individual could live 10 minutes or less from St. Luke's and not be able to use their facilities" because St. Luke's does not offer cardiac or maternity services; "[l]ikewise, that individual might only live about 10 minutes away from Pocono but cannot use [their facilities]" because Pocono "is not in the

[AmeriHealth] plan" and "pregnancy is not treated as an emergency." According to Salerno, "not having a full-service [in-network] hospital in all of Monroe County [under AmeriHealth], whe[n] there [previously] was a full-service [in-network] hospital [under Horizon], in and of itself must constitute a diminution of level of benefit[s] . . . ."

Salerno certifies that "the Association does not have direct information about the AmeriHealth plan" but that "most plans follow the same policy for [e]mergency procedures." According to Salerno, "the policy for Horizon members in the School Employees Health Benefit Plan" is the following:

> With respect to emergency services furnished in a hospital emergency department, Horizon BCBSNJ shall not require prior authorization for the provision of such services if the member arrived a[t] the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered. If you find yourself in an emergency situation and notification prior to treatment is not reasonably possible, go directly to the nearest emergency facility. All such treatment received during the first 48 hours after the onset of the medical emergency will be eligible for in-network benefits, regardless of whether such treatment is received in or out of the service area or whether such treatment is furnished by a network provider.

Salerno certifies that "[i]f the matter extends past what is covered in-network, the member would need to transfer to an in-

network hospital or incur out-of-network charges." According to Salerno, "[t]hese charges are a percentage of the payment the insurance company pays to the providers" and "[t]he providers can then charge the member the difference between that bill and what the insurance company paid (balance billing)." Salerno certifies that with respect to the instant matter, "if one of our pregnant members is brought to Pocono hospital, she may incur expenses [because] maternity is never considered an emergency and Pocono hospital is out-of-network." Salerno also certifies that "if one of our members who has a cardiac condition is brought to Pocono, he/she will be treated as an emergency and will then have to transfer to the in-network hospital which does not support cardiac treatment."

Salerno certifies that "there are [also] many fewer urgent care facilities in Monroe County." According to Salerno, this issue "was discussed at [a] February 1 meeting with the Board and its insurance brokers" and the Association was "advised that [the Board] did not dispute that there were many fewer urgent care facilities . . . but that member[s] should simply go to the nearest emergency room" because "[a]ll emergency rooms are covered." Salerno certifies that "[t]he issue is that a deductible for an emergency room visit far exceeds the deductible for an urgent care visit" and "[t]his increase . . . constitutes a diminution of level of benefit[s]."

Kalac certifies that "[t]here are 103 covered employees" in the Belvidere school district. According to Kalac, "24 [of the total covered employees] live in Pennsylvania and the balance live in New Jersey"; "10 [of the Pennsylvania residents] live in Monroe County" and the balance live in Northampton County. Kalac certifies that "[t]here is no change in the network hospitals in Northampton County and the full range of hospital services is available." Kalac also certifies that "the worst that could happen is that a Monroe County resident might have to drive or be driven to a hospital in the very next [c]ounty, a drive which . . . would be approximately 30 minutes." According to Kalac, "this is not a change which in and of itself would support a finding that the new coverage was not equal to or better than the prior coverage . . . since it is clear under the law that the coverage need not be identical." Kalac also asserts that "[t]here is absolutely nothing about this case which suggests or supports immediate or irreparable harm." According to Kalac, "the Board established a Supplemental Fund" despite the fact that "[t]here is no allegation made of a change in copays, deductibles, or any other financial aspect."

In a letter dated March 27, 2019, AmeriHealth summarized the emergency care benefits that it provides to participating school district employees; the letter provides in pertinent part:

> Benefits for emergency care provided by a hospital emergency room or other outpatient

emergency facility are provided by AmeriHealth at the in-network level of benefits if services are performed within two (2) days of the emergency, regardless of whether the patient is treated by a preferred or non-preferred provider. If emergency care is required, whether the covered person is inside or outside the AmeriHealth PPO network service area, the covered person should seek treatment at the emergency department of the closest hospital or outpatient emergency facility.

Emergency care is any outpatient service or supply provided by a hospital or facility provider and/or professional provider for initial treatment of the emergency. A medical emergency can be defined as a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the covered person’s health, or in the case of a pregnant covered person, the health of the unborn child, in jeopardy;

B. Serious impairment to bodily functions; or

C. Serious dysfunction of any bodily organ or part.

Examples of emergency include heart attack, loss of consciousness or respiration, cardiovascular accident, convulsions, severed accidental injury, and other acute medical conditions as determined by AmeriHealth.

In the event a covered person seeks treatment through a non-preferred facility and AmeriHealth determines that covered services were for emergency care (based on the subsequently submitted provider and/or facility diagnosis and billing codes), the

> covered person will not be subject to the cost-sharing that would ordinarily be applicable to non-preferred services. A non-preferred provider who provided emergency care can bill a covered person directly for their services, for either the provider's charges or amounts in excess of AmeriHealth's payment for the emergency care, i.e., "balance billing." In such situations, the covered person should contact AmeriHealth customer service at the phone number listed on the back of their I.D. card in order to resolve the balance-billing.
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> Benefits are payable for ambulance services that are medically appropriate/medically necessary. In the event of emergency ambulance transport, the ambulance must be transporting the covered person from the covered person's home or the scene of an accident or emergency to the nearest hospital or other emergency care facility that can provide the medically appropriate/medically necessary covered service for the covered person's condition.
>
> Should a covered person seek care at a non-preferred facility for a condition later determined to be non-emergent, based on the submitted provider and/or facility diagnosis and billing codes or other factors, that claim may process at the non-preferred level of benefits. If the covered person or their authorized representative wishes, they may dispute adverse benefit determinations. An appeal may be filed within one hundred eighty (180) days of the receipt of the adverse benefit determination by calling or writing to AmeriHealth, as defined in the letter notifying the covered person of the decision . . . .

LEGAL ARGUMENTS

The Association argues that it has satisfied the standard for interim relief. Specifically, the Association maintains that

it has a substantial likelihood of prevailing in a final Commission decision because "the Board unilaterally changed health coverage from Horizon to AmeriHealth" and this "substantially decreased the level of benefits due to the failure to provide a full service hospital in Monroe County and due to the decrease in urgent care facilities." The Association contends that "PERC [has] found that unilateral changes in health benefits violate the obligation to negotiate in good faith" and the fact that "certain benefits of [a] new plan are greater is essentially irrelevant in determining whether there has been an unfair practice."[6/] The Association asserts that "[this] case . . . differs in one respect from the [cases cited]" – "[n]ot only are individual parts of the new plan[] simply not equal to or better than the old plan, some members are not even getting appropriate access to medical facilities" and "are [therefore] paying for services that they are not getting." The Association also argues that its members will suffer irreparable harm if interim relief is not granted because "members are unable to seek treatment." The Association contends that "[t]his case is not

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6/ In support of its position, the Association cites Avalon Bor., I.R. No. 2012-10, 40 NJPER 107 (¶42 2011), Galloway Tp. Bd. of Ed. v. Galloway Tp. Ed. Ass'n, 78 N.J. 25 (1978), Chatham Bd. of Ed., I.R. 2002-5, 28 NJPER 84 (¶33030 2001), City of South Amboy, P.E.R.C. No. 85-16, 10 NJPER 511 (¶15234 1984), Metuchen Bor., P.E.R.C. No. 84-91, 10 NJPER 127 (¶15065 1984), and Bridgeton Bd. of Ed., I.R. No. 2006-8, 31 NJPER 315 (¶123 2005).

simply [about] reimbursing members for medical expenses" because "[i]t is not yet known if this will lead directly to health issues as the change just occurred." The Association maintains that "unilateral changes in terms and conditions of employment during any stage of negotiations can shift the balance of power and have a chilling effect on employee rights guaranteed under the Act and undermine labor stability." The Association asserts that "[i]rreparable harm has . . . been done to the negotiations process herein as the Board unilaterally changed carriers without regard to the incompetency that has followed" and "[a]s negotiations continue, each day that passes compounds these issues and leaves an unbalanced playing field." The Association notes that "[c]ourts in other jurisdictions have also held that losing health benefits constitute[s] irreparable harm."[7/] The Association also argues that the relative hardship weighs in its favor and that the public interest is not harmed by a grant of interim relief because "[t]he public is best served by a system that promotes labor stability" and "[h]aving a work force that is deemed uninsured . . . does not protect the public interest."

In response, initially the Board maintains that "the

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7/ In support of its position, the Association cites Closter Bor., P.E.R.C. 2001-75, 27 NJPER 289 (¶32104 2001), Shultz v. Teledyne, Inc., 657 F.Supp. 289, 293 (W.D.Pa. 1987), Whelan v. Colgan, 602 F.2d 1060, 1062 (2d Cir. 1979), and United Auto Workers v. White Farm Equipment Co., 119 L.R.R.M. 2878, 1984 U.S. Dist. LEXIS 22636, 1984 WL 4605, at *4 (D.Minn. 1984).

[underlying] unfair practice charge [should] be deferred or dismissed." The Board asserts that "what is alleged to be violated in both the grievance and the unfair practice charge is Article XVIII© of the [parties'] CNA" and "[w]hen the . . . basis for an unfair practice claim arises out of the interpretation of language in the collective negotiations agreement, the matter is not properly heard by the Commission."[8/] The Board also argues that the Association has not satisfied the standard for interim relief. Specifically, the Board maintains that the Association has not demonstrated a substantial likelihood of prevailing in a final Commission decision because "[t]he Board has the managerial prerogative to choose [a] health insurance carrier" and that determination "is not mandatorily negotiable so long as a change in carriers does not change the level of benefits provided." The Board asserts that it "sought and received a letter of guarantee

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8/ In support of its position, the Board cites Brookdale Comm. College, P.E.R.C. No. 83-131, 9 NJPER 266 (¶14122 1983), Jersey City Bd. of Ed., D.U.P. No. 80-5, 5 NJPER 405 (¶10211 1979), Pennsauken Tp., P.E.R.C. No. 88-53, 14 NJPER 61 (¶19020 1987), Southampton Tp., D.U.P. No. 97-34, 23 NJPER 258 (¶28124 1997), State of New Jersey (Dep't of Human Services), P.E.R.C. No. 84-148, 10 NJPER 419 (¶15191 1984), State of New Jersey (Dep't of Corrections), D.U.P. No. 2006-13, 32 NJPER 195 (¶85 2006), Morris Cty. Sheriff's Office, P.E.R.C. No. 2010-16, 35 NJPER 348 (¶117 2009), recon. den. P.E.R.C. No. 2010-52, 36 NJPER 24 (¶11 2010), rev'd 418 N.J. Super. 64 (App. Div. 2011), Hillsborough Tp., P.E.R.C. No. 2005-1, 30 NJPER 293 (¶101 2004), Union Tp., I.R. No. 2002-7, 28 NJPER 86 (¶3031 2001), recon. den. P.E.R.C. No. 2002-55, 28 NJPER 198 (¶33070 2002), and Stafford Tp. Bd. of Ed., P.E.R.C. No. 90-17, 15 NJPER 527 (¶20217 1989).

from AmeriHealth that its plan was equal to or better than Horizon" such that there is a factual dispute precluding interim relief and the "unfair practice c[harge] must be dismissed or [d]eferred [to] arbitration" given that it is "based solely on whether or not the new carrier's benefits are 'equal to or better' than the former insurance carrier's plan as required by the [CNA]." The Board contends that "[t]he [CNA] reserved to the Board the right to change the insurance carrier provided that the coverage is equal to or better than the current plan" and here "there is no allegation of a change in copays, deductibles or any other financial aspect." The Board maintains that "there is no right to a particular health care provider" such as Pocono and "it cannot be an unfair practice for there to be a change in one provider" given that "any doctor, hospital or clinic could decide tomorrow not to contract with AmeriHealth, Horizon or any other carrier and there is nothing the employer or carrier could do about that." The Board asserts that "the worst that could happen is that a Monroe County resident might have to drive or be driven to a hospital

. . . approximately 30 minutes [away]" and "[t]he mere inconvenience of having to go to a different hospital does not constitute a diminution of benefits." The Board also argues that "the Association is at no risk of sustaining immediate irreparable harm" given that "AmeriHealth has promised to provide

equal to or better than coverage," "[t]he Association has not demonstrated that any member has been harmed by a change in carriers," and "no Association member is being denied any benefit." The Board asserts that "[t]here are numerous providers for the members to seek treatment . . . even if a handful of members have to go to a hospital a few miles from the one they prefer . . . or have to cross-over the border into another county for certain services." The Board maintains that "[i]f there is an emergency, the members who live in Monroe County can go to the Emergency Room at in-network St. Luke's . . . [and] even if they choose to go to Pocono, the emergency co-pay would still not be out-of-network under AmeriHealth." The Board contends that "any need for interim relief is negated by the fact that the Board preemptively established [a] supplemental fund." The Board also asserts that the Association has failed "to put forth even one scintilla of evidence to substantiate [its] claim" that "there will be a 'chilling effect' amongst other employees" particularly given that "the parties continued to negotiate after the Board passed the resolution . . . and . . . agreed to an MOA." The Board also argues that "a balancing of the equities . . . favors the Board" given that "requir[ing] [the Board] to rescind its agreement with AmeriHealth and return to Horizon . . . would most assuredly result in economic hardship to the Board and the Association members through a substantial loss in premium

reductions and may subject the Board to additional claims of denied benefits should the transition back to Horizon experience unanticipated problems."

STANDARD OF REVIEW

To obtain interim relief, the moving party must demonstrate 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; in certain circumstances, severe personal inconvenience can constitute irreparable injury justifying issuance of injunctive relief. 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. See Crowe v. De Gioia, 90 N.J. 126, 132-134 (1982); Whitmyer Bros., Inc. v. Doyle, 58 N.J. 25, 35 (1971); Burlington Cty., P.E.R.C. No. 2010-33, 35 NJPER 428 (¶139 2009) (citing Ispahani v. Allied Domecq Retailing United States, 320 N.J. Super. 494 (App. Div. 1999) (federal court requirement of showing a substantial likelihood of success on the merits is similar to Crowe)); State of New Jersey (Stockton 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). In Little Egg Harbor Tp., the Commission Designee stated:

> [T]he undersigned is most cognizant of and sensitive to the extraordinary nature of the

> remedy sought to be invoked and the limited circumstances under which its invocation is necessary and appropriate. The 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.

N.J.S.A. 34:13A-5.3, entitled "Employee organizations; right to form or join; collective negotiations; grievance procedures", provides in pertinent part:

> Proposed new rules or modifications of existing rules governing working conditions shall be negotiated with the majority representative before they are established.

Public employers are prohibiting from "[i]nterfering with, restraining or coercing employees in the exercise of the rights guaranteed to them by this Act." N.J.S.A. 34:13A-5.4a(1). "It shall be an unfair practice for an employer to engage in activities which, regardless of the absence of direct proof of anti-union bias, tend to interfere with, restrain or coerce an employee in the exercise of rights guaranteed by the Act, provided the actions taken lack a legitimate and substantial business justification." State of New Jersey (Dep't of Corrections), H.E. No. 2014-9, 40 NJPER 534 (¶173 2014) (citing New Jersey College of Medicine and Dentistry, P.E.R.C. No. 79-11, 4 NJPER 421 (¶4189 1978)). The Commission has held that a violation of another unfair practice provision derivatively violates subsection 5.4a(1). Lakehurst Bd. of Ed., P.E.R.C. No.

2004-74, 30 NJPER 186 (¶69 2004).

Public employers are also prohibited from "[r]efusing 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 . . . ." N.J.S.A. 34:13A-5.4a(5). A determination that a party has refused to negotiate in good faith will depend upon an analysis of the overall conduct and attitude of the party charged. Teaneck Tp., P.E.R.C. No. 2011-33, 36 NJPER 403 (¶156 2010). The Commission has held that "a breach of contract may also rise to the level of a refusal to negotiate in good faith" and that it "ha[s] the authority to remedy that violation under subsection a(5)." State of New Jersey (Dep't of Human Services), P.E.R.C. 84-148, 10 NJPER 419 (¶15191 1984).

ANALYSIS

At issue in this interim relief application is whether, when an expired CNA requires that new health insurance coverage shall be "equal to or better than" the current coverage and the parties are in negotiations for a successor agreement, a public employer's selection of a new health insurance carrier that results in the following modifications in coverage constitutes a unilateral change in the level of benefits:

> -a 50% reduction in the number of in-network hospitals (i.e., from two to one) in a particular area such that there is no longer an in-network hospital that provides non-emergent maternity, cardiac, and/or cancer

> treatment services in that area and the nearest in-network full-service hospital is now approximately 30 minutes away in an adjacent area; and
>
> -a decreased number of urgent care facilities in a particular area such that a visit to the emergency room, including a more expensive co-pay, for urgent care treatment is more likely.

The Commission has held that "[a]n employer's choice of health insurance carriers is not mandatorily negotiable so long as the negotiated level of benefits is not changed." Rockaway Bor. Bd. of Ed., P.E.R.C. No. 2010-9, 35 NJPER 293 (¶102 2009) (citing City of Newark, P.E.R.C. No. 82-5, 7 NJPER 439 (¶12195 1981)). "Once an employer and a union agree upon a level of benefits, the employer has discretion to choose a health insurance carrier, and the employer is not normally required to negotiate over which health insurance carrier it contracts with to provide those benefits." Id. "[P]arties can agree to permit an employer to change carriers consistent with the collective negotiations agreement." Id. (citing Camden Cty. College, P.E.R.C. No. 2008-67, 34 NJPER 254 (¶89 2008)). However, "[w]here changing the identity of the carrier changes terms and conditions of employment, i.e., the level of insurance benefits, and the administration of the plan, it becomes a mandatory subject for negotiations." Id. (citing Metuchen Bor., P.E.R.C. No. 84-91, 10 NJPER 127 (¶15065 1984)); see also Piscataway Tp. Bd. of Ed., P.E.R.C. No. 91, 1 NJPER 49 (1975) (holding that "hospitalization and medical coverage is a term or condition of

employment . . . which cannot be changed unilaterally . . .”). The Commission has held that “[i]t 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.” Metuchen Bor., H.E. No. 84-15, 9 NJPER 567 (¶14237 1983), adopted P.E.R.C. No. 84-91, 10 NJPER 127 (¶15065 1984). “That certain benefits of the new plan are greater is essentially irrelevant in determining whether there has been an unfair practice.” Id.

The Commission has held that “[a] contract clause requiring the employer to maintain the level of health benefits may create additional protections for employees” and “may also provide a contractual defense for the employer to an unfair practice allegation that the employer violated the Act by acting unilaterally.” Camden Cty. College, P.E.R.C. No. 2008-67, 34 NJPER 254 (¶89 2008). “An employer will not be found to have acted unilaterally if the contract authorizes a particular change in health benefits.” Id. (citing City of South Amboy, P.E.R.C. No. 85-16, 10 NJPER 511 (¶15234 1984)). “[T]he ‘equivalence’ standard, as opposed to the ‘equal to’ or ‘equal to or better than’ standards, for example, allows some room for evaluating particular plan factors to determine whether the contractual standard has been maintained.” Camden Cty. College, I.R. No. 2008-18, 34 NJPER 104 (¶45 2008). “[W]here . . . the collective

agreement sets 'equivalence' as the condition under which the [employer] may change carriers unilaterally[,] . . . any demonstrable change which lessens benefits would prevent the [employer] from changing carriers unilaterally." Bridegton Bd. of Ed., I.R. No. 2006-8, 31 NJPER 315 (¶123 2005).

Given these legal precepts, I find that the Association has established a substantial likelihood of prevailing in a final Commission decision on its legal and factual allegations. In City of Newark, H.E. No. 95-11, 20 NJPER 446 (¶25230 1994), rev'd in pt. P.E.R.C. No. 95-108, 21 NJPER 229 (¶26146 1995), the union alleged that the City had violated the Act by unilaterally changing the level of health insurance benefits (i.e., reducing the number of acute care hospitals in New Jersey covered in full from 85 to 56 hospitals, or by 34%) after the parties' CNA expired during the pendency of interest arbitration proceedings.[9/] The parties' CNA "provide[d] that the terms of the contract [would] continue during negotiations" and that the

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9/ N.J.S.A. 34:13A-21, entitled "Change in conditions during pendency of proceedings; prohibition without consent," provides:

> During the pendency of proceedings before the arbitrator, existing wages, hours and other conditions of employment shall not be changed by action fo either party without the consent of the other, any change in or of the public employer or employee representative notwithstanding; but a party may so consent without prejudice to his rights or position under this supplementary act.

"current . . . hospitalization plan [would] remain in effect during the lifetimes of the agreements." Id. After the hearing examiner issued his decision and the union filed exceptions, the Commission was notified that a grievance arbitration award involving three other City unions asserting similar claims had been confirmed in Superior Court. The Commission adopted the grievance arbitrator's contractual interpretation and held that the City's unilateral decision "[not] to retain full coverage at all 85 hospitals" and "select[ion] [of a] 56 hospital network instead" constituted a change that "reduced the level of benefits available to unit employees." Id. The Commission issued an order requiring the City to "[r]estore 100% reimbursement for, and use of, all 85 acute care hospitals" and to "[m]ake whole employees who paid higher premiums for health care coverage[,] were charged higher costs for health care coverage[,] or sustained calculable out-of-pocket losses as a result of the reduction of the health care benefit." Id. Compare Lakeland Reg. Bd. of Ed., H.E. No. 2012-11, 39 NJPER 71 (¶28 2012), adopted P.E.R.C. No. 2014-38, 40 NJPER 278 (¶107 2013) (finding that the parties' contract required the employer to provide "[insurance] coverage equal to or better than the health plan currently in effect" and that "as [a] result of [a] change in insurance carriers, the level of benefits changed . . . [with] some improved [and] some diminished" including "elimination of

the traditional plan"; holding that "unilaterally reducing the level of health insurance benefits" mid-contract constituted a violation of N.J.S.A. 34:13A-5.4a(1) and (5); ordering the employer to "[e]stablish a fund upon which employees may draw to cover medical costs which would have been, but were not, paid under [the pre-existing health plans]"), and Union Tp., I.R. No. 2002-7, 28 NJPER 86 (¶33031 2001), recon. den. P.E.R.C. No. 2002-55, 28 NJPER 198 (¶33070 2002) (finding that the parties' contract required the employer to provide "health insurance . . . [coverage] . . . at least equal to that which ha[d] . . . been in effect" and that as a result of a change in health insurance carriers, "14% of the providers in the [pre-existing] network [were] not in the [new] network" and there were "71" hospitals in the pre-existing network compared to "87" in the new network"; referencing City of Newark and holding that the employer's "change in carrier demonstrably change[d] the network of participating providers so as to constitute a change in employee benefits"; granting interim relief and ordering the employer to "establish an interim program that guarantee[d] that employees ha[d] funds available to pay any up-front costs of medical and any additional costs of medical treatment that would have been covered under the [pre-existing] plan" or, in the alternative, "[to] maintain the [pre-existing] plan"), with Bayonne Bd. of Ed., I.R. No. 2010-4, 35 NJPER 247 (¶90 2009) (denying interim

relief where the parties' collective negotiations agreement permitted the employer to change health insurance plans upon notification to the union and was silent as to the level of health benefits to be provided in the event of a change in carriers; finding that there was a factual dispute regarding an alleged past practice requiring an "equal-to-or-better than benefit level"; also finding that the employer "ha[d] 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" and "offered to negotiate procedures for administering the fund"), and Buena Reg. Bd. of Ed., I.R. No. 2010-7, 35 NJPER 326 (¶111 2009) (denying interim relief where the parties' collective negotiations agreement required the employer to provide "insurance coverage equal to or greater than N.J. State Health Benefits Plan"; finding that the "contract language provided a defense" given that the employer "switched from plans administered by Horizon/Blue Cross/Blue Shield to the New Jersey School Employees Health Benefits Plan, a plan administered by the New Jersey State Health Benefits Program"), and South Orange-Maplewood Bd. of Ed., I.R. No. 82-6, 8 NJPER 272 (¶13118 1982) (denying interim relief where the parties' collective negotiations agreement required the employer to provide "insurance coverage and service . . . equal to or better than . . . the New Jersey State Health Benefits Program"; finding

that the "very nature of [the contract] language recognize[d] the viability of alternative insurance programs" given that the employer switched from the State Health Benefits Plan to "[a] self-insured, reinsurance benefit plan" where "the benefits . . . track[ed] those of the State Health Benefits Plan").

Here, it is undisputed that effective February 1, 2019, the Board terminated its health insurance policy with Horizon and selected AmeriHealth as its new carrier. It is also undisputed that as a result of this change in carriers, there has been a 50% reduction in the number of in-network hospitals in Monroe County (i.e., from two to one) such that there is no longer an in-network hospital that provides non-emergent maternity, cardiac, and/or cancer treatment services in Monroe County and the nearest in-network full-service hospital is now approximately 30 minutes away in an adjacent county; and that there has been a reduction in the number of urgent care facilities in Monroe County such that a visit to the emergency room, including a more expensive co-pay, for urgent care treatment is more likely. I take administrative notice that Monroe County, Pennsylvania is approximately 611 square miles with an approximate population of 169,842 people,[10/] or 277 people/mi$^2$; the State of Pennsylvania is approximately 44,742 square miles with an approximate population

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10/ See http://www.monroecountypa.gov/Pages/AboutUs.aspx

of 12,807,060 people,[11/] or 286 people/mi$^2$; Essex County, New Jersey is approximately 127 square miles with an approximate population of 765,348 people,[12/] or 6,026 people/mi$^2$; and the State of New Jersey is approximately 7,354 square miles with an approximate population of 8,908,520 people,[13/] or 1,211 people/mi$^2$. See N.J.A.C. 19:14-6.6(a) ("[n]otice may be taken of administratively noticeable facts").

The parties' 2015-2018 CNA requires the Board to provide "new coverage . . . [that is] equal to or better than the current coverage" if, "during the life of the current collective bargaining agreement[,] . . .[it] chooses to move to another insurance carrier." See 2015-2018 CNA, Art. XVIII© (emphasis added). After the 2015-2018 CNA expired, the Board was prohibited from unilaterally modifying terms and conditions of employment absent specific agreement of the Association. See N.J.S.A. 34:13A-33.[14/] While I acknowledge that there is a

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11/ See http://www.census.gov/quickfacts/fact/table/pa/PST045218

12/ See http://essexcountynj.org/history/

13/ See http://www.census.gov/quickfacts/fact/table/nj

14/ N.J.S.A. 34:13A-33, entitled "Terms, conditions of employment under expired agreements," provides:

> Notwithstanding the expiration of a collective negotiations agreement, an impasse in negotiations, an exhaustion of the commission's impasse procedures, or the utilization or completion of the procedures

(continued...)

difference between a 34% reduction in the number of in-network hospitals in New Jersey compared to a 50% reduction in the number of in-network hospitals in Monroe County, I find that the City of Newark case is sufficiently analogous to this matter to support a substantial likelihood of success given the disparities in geographic size and population (i.e., geographically, Monroe County is nearly 5 times the size of Essex County but Essex County's population is 4.5 times that of Monroe County; geographically, Pennsylvania is 6 times the size of New Jersey and Pennsylvania's population is nearly 1.5 times that of New Jersey). That is to say, a 50% reduction in the number of in-network hospitals in a larger, less densely populated area can be analogized to a 34% reduction in the number of in-network hospitals in a smaller, more densely populated area particularly when the parties' agreement requires "new coverage . . . [that is] equal to or better than the current coverage." See 2015-2018 CNA, Art. XVIII© (emphasis added). As the Commission Designee

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14/ (...continued)

> required by this act, and notwithstanding any law or regulation to the contrary, no public employer, its representatives, or its agents shall unilaterally impose, modify, amend, delete or alter any terms and conditions of employment as set forth in the expired or expiring collective negotiations agreement, or unilaterally impose, modify, amend, delete, or alter any other negotiable terms and conditions of employment, without specific agreement of the majority representative.

stated in Greater Egg Harbor Reg. Bd. of Ed., I.R. No. 2011-8, 36 NJPER 268 (¶101 2010) (emphasis added), "[i]f the contract permits the employer to change benefits if the new plan is 'substantially equivalent' to existing benefits, it may provide a defense to a charge that a carrier change should have been negotiated . . . [b]ut, in the absence of such latitude, a unilateral move to a new carrier that changes benefits, even if some are improved, violates the Act."

Even assuming, arguendo, that the Board's selection of AmeriHealth has only resulted in some unit members and/or their covered dependents experiencing the mere inconvenience of traveling an additional 30 minutes for non-emergent maternity, cardiac, and/or cancer treatment services and other unit members and/or their covered dependents paying a more expensive co-pay in order to utilize the emergency room more frequently for urgent care treatment, the Commission has held that unilaterally changing a term and condition of employment and/or past practice that results in inconvenience that "directly affect[s] . . . financial and personal welfare" of unit members constitutes a violation of N.J.S.A. 34:13A-5.4a(5). Jackson Tp., H.E. No. 81-12, 6 NJPER 533 (¶11272 1980), adopted P.E.R.C. No. 81-76, 7 NJPER 31 (¶12013 1980) (the union alleged that the Township "unilaterally implemented a new procedure for the purchase of uniforms in violation of the provisions of the contract . . .

without negotiations"; finding that the parties' CNA included clothing allowances for all uniformed employees, that the parties' past practice was for officers to "purchase[] their own uniforms as they saw fit," and that the employer unilaterally "adopted a resolution requiring all uniformed personnel to purchase uniforms from a specified dealer" including "[o]ne particular dealer . . . [that was] approximately 80 miles from Jackson Township"; holding that "[a] uniform allowance is a term and condition of employment and the inconvenience to some officers brought about by having to travel 80 miles (one way) for their uniform purchases does directly affect their financial and personal welfare"; holding that the employer "was in no way obligated to purchase the uniforms directly" but "was required to continue the system of reimbursing officers for their uniform purchases . . . up to the monetary limit in the agreement . . . unless it secured the agreement of the [union] to alter this term and condition of employment"); cf. City of Perth Amboy, H.E. No. 97-5, 22 NJPER 349 (¶27181 1996), adopted P.E.R.C. No. 97-138, 23 NJPER 345 (¶28159 1997), aff'd 24 NJPER 531 (¶29247 App. Div. 1998) (the union alleged that the City's selection of a new workers' compensation claims administrator resulted in "changes in the established list of physicians, the imposition of precertification requirements and increases in time and travel expenses"; holding that "N.J.S.A. 34:15-15 preempts collective

negotiations over the selection and number of physicians designated to treat an employee injured on the job . . . includ[ing] the 'precertification' procedure" and that "N.J.S.A. 34:15-19 preempts negotiations over distances traveled by injured employees to visiting physicians . . . [given that] [u]nreasonable employer choices may be appealed under [N.J.S.A. 34:15-49]"; holding that "even if the distance an injured employee must travel to a treating physician were mandatorily negotiable, the charging party has not proven that employees must now travel farther").

Consistent with the Board's assertion, I acknowledge that "[i]t is Commission policy to defer allegations of a unilateral alteration of health insurance benefits to the parties' grievance arbitration process where the health insurance coverage is a contractually set benefit and it is reasonably probable that the dispute underlying the charge will be resolved in arbitration." Wanaque Bor. Bd. of Ed., D.U.P. No. 98-1, 23 NJPER 418 (¶28195 1997) (citing Hazlet Tp. Bd. of Ed., P.E.R.C. No. 95-78, 21 NJPER 164 (¶26101 1995); Stafford Tp. Bd. of Ed., P.E.R.C. No. 90-17, 15 NJPER 527 (¶20217 1989); Morris Cty., P.E.R.C. No. 94-103, 20 NJPER 227 (¶25111 1994)); accord Town of Kearny, I.R. No. 96-24, 22 NJPER 206 (¶27108 1996); Pennsauken Tp., P.E.R.C. No. 88-53, 14 NJPER 61 (¶19020 1987). "Deferral to binding arbitration is the preferred processing mechanism when a charge essentially

alleges a violation of subsection 5.4a(5) interrelated with a potential breach of the contract." Id. (citing State of New Jersey (Dep't of Human Services), P.E.R.C. No. 84-148, 10 NJPER 419 (¶15191 1984); Brookdale Comm. College, P.E.R.C. No. 83-131, 9 NJPER 267 (¶14122 1983)).

However, contrary to the Board's assertion, "[e]ven though we may defer an allegation of a unilateral change [in health benefits] to binding arbitration, we may still order interim relief in appropriate cases pending completion of the arbitration process." Union Tp., I.R. No. 2002-7, 28 NJPER 86 (¶33031 2001), recon. den. P.E.R.C. No. 2002-55, 28 NJPER 198 (¶33070 2002) (finding that "the Township's change in carrier demonstrably changes the network of participating providers so as to constitute a change in employee benefits" and granting interim relief that "will remain in effect until the conclusion of proceedings before the Commission or before an arbitrator . . . should the issues be deferred to arbitration"); see also Springfield Tp., I.R. No. 2011-21, 36 NJPER 444 (¶172 2010) (finding "a substantial likelihood that the [charging party] would succeed in proving a unilateral change" and granting interim relief despite the fact that "the charging party [had] filed a request for submission of a panel of arbitrators . . . concern[ing] 'changing health coverage to lesser coverage levels'" and the fact that "[t]he determination of whether the

[new plan] is 'substantially equivalent' to the [old] plan[] is a matter of contract interpretation and resolvable by an arbitrator after a comparative analysis of both plans"); Bridegton Bd. of Ed., I.R. No. 2006-8, 31 NJPER 315 (¶123 2005) (finding that "employee benefits are being reduced by the change in carriers" and granting interim relief "during the pendency of [the] litigation or until such time as [the] matter is resolved through collective negotiations").

Accordingly, I find that the Association has established a substantial likelihood of prevailing in a final Commission decision on its legal and factual allegations. As the Commission stated in Union Tp., I.R. No. 2002-7, 28 NJPER 86 (¶33031 2001), recon. den. P.E.R.C. No. 2002-55, 28 NJPER 198 (¶33070 2002) (emphasis added),

> The employer argues that the designee's decision effectively means that an employer can never switch health insurance carriers without negotiations because no two carriers' networks are identical. We disagree. The employer is contractually obligated to maintain "at least equal" benefits. Had it negotiated different contract language, it would have been able to argue that the contract authorized the current change. For example, the employer might have been able to argue that this change as to an "equivalent," or "substantially equivalent" health plan, had the contract provided that defense.

I also find that the Association has established that absent the imposition of an interim relief program, unit members and/or their covered dependents may suffer irreparable harm. In Chatham

Bd. of Ed., I.R. No. 2002-5, 28 NJPER 84 (¶33030 2001), the union filed an unfair practice charge together with an application for interim relief alleging that the board violated the Act when it "unilaterally decreased the level of health benefits provided to unit employees" by switching from "a prescription drug card" (i.e., "employees presented a prescription card at designated pharmacies allowing them to pay only a copay for the prescription") to a "prescription drug reimbursement program" (i.e., "requir[ing] the employee to pay 100% of the cost of the prescription and then apply to the health insurance carrier for reimbursement of the cost of the prescription . . . minus any copay"). Finding that board was required to "provide[] . . . benefits . . . equivalent to those specified within [existing] plans should the board seek coverage with another provider," the Commission Designee granted interim relief based in part upon his determination that "the change in the prescription drug program . . . might serve as an inducement to employees to forego or delay purchasing medically necessary medications" which would "irreparably harm[] employees."[15/] Id. (emphasis added); accord

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15/ In Chatham Bd. of Ed., the Commission Designee ordered the following interim relief:

> The Board will create a fund available to immediately pay the up-front costs of prescription medications, minus the applicable copayment, to unit employees who chose not to use the prescription by mail

(continued...)

Closter Bor., I.R. No. 2001-11, 27 NJPER 225 (¶32077 2001), recon. granted P.E.R.C. No. 2001-75, 27 NJPER 289 (¶32104 2001) (emphasis added) (noting that "[p]rescription drugs are often very costly and having to pay these costs up front may well induce employees to forego or delay purchasing medically necessary drugs"; holding that "[t]he substantial costs associated with prescription drugs has changed the type of harm an employee may suffer from mere monetary damages to losing access to necessary medications" when/if "a prescription plan is terminated . . .[or] employees are required to pay 100 percent, rather than 20 percent, of the cost of a prescription up front"); Union Tp., I.R. No. 2002-7, 28 NJPER 86 (¶33031 2001), recon. den. P.E.R.C. No. 2002-55, 28 NJPER 198 (¶33070 2002) (emphasis added) (noting that "[i]f the Township proceeds to switch carriers . . . , the employees may well be required to pay the up-front cost of treatment at the time service is rendered rather

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15/ (...continued)
> program and instead submit written certification to the board indicating that they are unable to charge a credit card for the up-front cost of the prescription, or if they charged the cost of the prescription, that they have not yet received reimbursement from the insurance carrier by the time the payment for the charged prescription is due, provided the employee has made timely application to the insurance carrier for reimbursement. This interim order will remain in effect pending a final Commission order in this matter.

and then await partial reimbursement . . . [a]nd even then, the reimbursement level is uncertain . . . since [a] non-network provider may bill the employee for the balance"; referencing Closter Bor. and holding that "the issue is not merely one of money damages that could be remedied at the conclusion of the case" given that "the cost of medical care today is such that an employee may forego treatment rather than pay up-front costs and await reimbursement").

Here, the Board was required to provide "new coverage . . . [that is] equal to or better than the current coverage" upon the selection of AmeriHealth as its new health insurance carrier. See 2015-2018 CNA, Art. XVIII©. I find that the Board's selection of AmeriHealth has resulted in a unilateral change in the level of benefits that may irreparably harm unit members and/or their covered dependents. Specifically, a 50% reduction in the number of in-network hospitals in Monroe County, particularly the absence of an in-network hospital that provides non-emergent maternity, cardiac, and/or cancer treatment services in Monroe County, may serve as an inducement to unit members and/or their covered dependents to forego or delay non-emergent maternity, cardiac, and/or cancer treatment rather than pay up-front or out-of-network costs and await reimbursement or travel to the nearest in-network full-service hospital. Similarly, the reduction in the number of urgent care facilities in Monroe

County may serve as an inducement to employees to forego or delay urgent care treatment rather than pay a more expensive emergency room co-pay or travel to the nearest urgent care facility. See Chatham Bd. of Ed.; Closter Bor.; Union Tp. While I acknowledge that the Board's December 12, 2018 "Resolution Concerning Group Medical Insurance Carrier" created a supplemental fund, I find that same is insufficient to mitigate the harm identified above given that the fund was established "to indemnify and reimburse staff members in situations where their Horizon in-network health care provider is not a provider with AmeriHealth or Multiplan/PHCS" and is capped at "$30,000."

In addition, although it is undisputed that the parties reached a successor agreement that was executed in March 2019, the Board's selection of AmeriHealth and the resulting unilateral change in the level of benefits may have had an impact on contract negotiations. New Jersey courts and the Commission have held that "employers are barred from 'unilaterally altering mandatory bargaining topics, whether established by expired contract or by past practice, without first bargaining to impasse.'" In re Atlantic Cty., 230 N.J. 237, 252 (2017) (citing Bd. of Educ. v. Neptune Twp. Educ. Ass'n, 144 N.J. 16, 22 (1996)); accord Closter Bor., I.R. No. 2001-11, 27 NJPER 225 (¶32077 2001), recon. granted P.E.R.C. No. 2001-75, 27 NJPER 289 (¶32104 2001) (holding that "[u]nilateral changes in [mandatorily

negotiable terms and conditions of employment] violate the obligation to negotiate in good faith" and "can shift the balance of power in the collective negotiations process"; holding that "[i]f a change occurs during contract negotiations, the harm is exacerbated"); Galloway Twp. Bd. of Educ. v. Galloway Twp. Educ. Ass'n, 78 N.J. 25, 48 (1978) (finding that the Legislature, through enactment of the Act, "recognized that the unilateral imposition of working conditions is the antithesis of its goal that the terms and conditions of public employment be established through bilateral negotiation").

In Galloway, a decision recently cited with approval by the Appellate Division for the same proposition set forth below, the Supreme Court of New Jersey stated:

> Indisputably, the amount of an employee's compensation is an important condition of his employment. If a scheduled annual step increment in an employee's salary is an "existing rule governing working conditions," the unilateral denial of that increment would constitute a modification thereof without the negotiation mandated by N.J.S.A. 34:13A-5.3 and would thus violate N.J.S.A. 34:13A-5.4a(5). Such conduct by a public employer would also have the effect of coercing its employees in their exercise of the organizational rights guaranteed them by the Act because of its inherent repudiation of and chilling effect on the exercise of their statutory right to have such issues negotiated on their behalf by their majority representative.
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> [Galloway, 78 N.J. at 49 (emphasis added).]

Accord In re Atlantic Cty., 445 N.J. Super. 1, 17-18 (App. Div.

2016) (noting that "even if the Court's analysis in Galloway was no more than dictum unnecessary to the ultimate ruling applying N.J.S.A. 18A:29-4.1, we must follow it").

Accordingly, I find that the Association has established that absent the imposition of an interim relief program, unit members and/or their dependents may suffer irreparable harm.

I also find that the Association has demonstrated relative hardship and that the public interest will not be injured by an interim relief order. In Edison Tp., I.R. No. 2010-3, 35 NJPER 241 (¶86 2009), the union filed an unfair practice charge alleging that the employer violated the Act when it "unilaterally altered unit employees' vacation schedule selection policy" and sought interim relief. Finding that the parties' most recent CNA had "expired" and that the parties were "in the midst of collective negotiations for a successor agreement" at the time the employer changed the policy, the Commission Designee ordered the employer to "maintain the vacation leave policy that was in effect at the expiration of the collective negotiations agreement provided minimum staffing levels [were] maintained." Id. The Commission Designee noted the following:

> . . .[T]he public interest is furthered by requiring adherence to the tenets expressed in the Act which require parties to negotiate prior to implementing changes in terms and conditions of employment. Maintaining the collective negotiations process results in labor stability and thus promotes the public interest.

[35 NJPER at 243.]

Accord Winslow Tp., I.R. No. 2007-7, 33 NJPER 39 (¶16 2007).

Given the unilateral change in level of benefits set forth above, requiring the Board to establish an interim relief program during the pendency of this litigation or until this matter is otherwise resolved will facilitate the purposes of the Act. See N.J.S.A. 34:13A-2 (declaring that the public policy of the State of New Jersey is "the prevention or prompt settlement of labor disputes" and "to promote permanent, public and private employer-employee peace and the health, welfare, comfort and safety of the people of the State"); accord Chatham Bd. of Ed. The Board has not sufficiently demonstrated that it will endure any harm if an interim relief program is established. See Closter Bor., I.R. No. 2001-11, 27 NJPER 225 (¶32077 2001), recon. granted P.E.R.C. No. 2001-75, 27 NJPER 289 (¶32104 2001) (noting that "[t]he employer has not identified any specific harm to it from restoring the status quo"; finding that "[t]he hardship that employees may suffer far outweighs any hardship on the employer resulting from an order requiring it to ensure that employees are not bearing the full cost of prescriptions, even for a limited time . . . [n]or would granting interim relief harm the public interest"). Moreover, the Appellate Division has held that "the fiscal health of municipalities and tax rates are not within PERC's charge." In re Atlantic Cty., 445 N.J. Super. at 22; see

also Robbinsville Twp. Bd. of Educ. v. Washington Twp. Educ. Ass'n, 227 N.J. 192, 204 (2016) (rejecting the holding that "the economic crisis present in [a] school district permitted the [b]oard to forego negotiations" because "[a]llowing a claimed need for management prerogative to prevail in tight budgetary times in order for municipal governmental policy to be properly determined would eviscerate the durability of collective negotiated agreements").

Accordingly, I find that the Association has demonstrated relative hardship and that the public interest will not be injured by an interim relief order.

Under these circumstances, I find that the Association has sustained the heavy burden required for interim relief under the Crowe factors and grant, in part, the application for interim relief pursuant to N.J.A.C. 19:14-9.5(a). This case will be transferred to the Director of Unfair Practices for further processing.

**ORDER**

The Belvidere Education Association's (Association) application for interim relief is granted, in part, and denied, in part. The Belvidere Board of Education (Board) is directed to:

> (1) establish and fund an interim program guaranteeing that during the pendency of this litigation or until this matter is otherwise resolved, unit members and/or their covered dependents may avail themselves of funds to pay up-front costs of medical care and any additional costs of medical treatment that would have been covered under the Horizon plan. Disbursement of funds will be contingent upon the submission of a written certification to the Board indicating that, due to an inconvenience that directly affects their financial and personal welfare, a unit member and/or their covered dependent(s) would forego or delay:
>
> > (A) non-emergent maternity, cardiac, and/or cancer treatment rather than (I) pay up-front or out-of-network costs and await reimbursement or (ii) travel to the nearest in-network full-service hospital; or
> >
> > (B) urgent care treatment rather than (a) pay a more expensive emergency room co-pay or (b) travel to the nearest urgent care facility;
>
> (2) negotiate with the Association regarding the procedures for implementing the fund and for processing claims.

The Association's request that the Board be directed to return to its previous health insurance carrier, Horizon, is denied.

/s/ Joseph P. Blaney
Joseph P. Blaney
Commission Designee

DATED: April 2, 2019
Trenton, New Jersey