P.E.R.C. NO. 2002-55

STATE OF NEW JERSEY
BEFORE THE PUBLIC EMPLOYMENT RELATIONS COMMISSION

In the Matter of

TOWNSHIP OF UNION,
Respondent,
-and- Docket No. CO-2002-152

FMBA LOCAL NO. 46,
Charging Party.

TOWNSHIP OF UNION,
Respondent,
-and- Docket No. CO-2002-153

FMBA LOCAL NO. 246,
Charging Party.

TOWNSHIP OF UNION,
Respondent,
-and- Docket No. CO-2002-163

PBA LOCAL NO. 69,
Charging Party.

SYNOPSIS

The Public Employment Relations Commission denies the Township of Union's motion for reconsideration, motion to supplement the record, and request for a stay of I.R. No. 2002-7. The Commission also denies PBA Local No. 69's cross-motion for reconsideration. In that case, a Commission designee found that the change in health insurance carrier would demonstrably change the network of participating providers so as to constitute a change in employee benefits. The Commission finds no extraordinary circumstances to supplement the record or reconsider the designee's decision. The Commission denies the request for a stay of the order pending emergent review in the Appellate Division because it is not convinced that the harm to the employer in implementing an interim program outweighs the harm to employees who may face up-front costs and balance billing. The Commission also denies the cross-motion for reconsideration. Given her findings, the Commission assumes that the designee should have found that the change in carriers was mandatorily negotiable, but the interim program she ordered maintains the level of benefits pending a final determination.

This synopsis is not part of the Commission decision. It has been prepared for the convenience of the reader. It has been neither reviewed nor approved by the Commission.

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Appearances:

For the Respondent, Stanton, Hughes, Diana, Cerra, Mariani & Margello, PC, attorneys (Mark Diana, of counsel)

For the Charging Party, FMBA Local No. 46, Fox & Fox, attorneys (David I. Fox, of counsel)

For the Charging Party, FMBA Local No. 246, Fox & Fox, attorneys (David I. Fox, of counsel)

For Charging Party, PBA Local No. 69, Zazzali, Fagella, Nowak, Kleinbaum & Friedman, attorneys (Paul L. Kleinbaum, of counsel)

DECISION

On November 30, 2001, FMBA Local No. 46 and FMBA Local No. 246 filed unfair practice charges against the Township of Union. The charges allege that the employer violated the New Jersey Employer-Employee Relations Act, N.J.S.A. 34:13A-1 et seq., specifically 5.4a(1) and (5),[1/] by announcing its intention to change health insurance carriers from Horizon Blue Cross/Blue Shield to Oxford Medical effective January 1, 2002. The charges also allege that the employer failed to provide the unions with adequate information concerning the proposed change. On December 4, 2001, PBA Local No. 69 filed a similar charge.

Applications for interim relief seeking a restraint of the change in carrier accompanied the charges. The parties filed briefs, affidavits and exhibits, and argued orally.

On December 28, 2001, Commission Designee Susan Wood Osborn issued an interlocutory decision. I.R. No. 2002-7, 28 NJPER 86 (¶33031 2001). She found that the change in carrier would demonstrably change the network of participating providers so as to constitute a change in employee benefits. The designee

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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."

found that the Horizon Blue Cross/Blue Shield plan has a network of approximately 17,200 providers and 71 hospitals in New Jersey. In addition, Horizon has 603,500 in-network providers and 6,100 hospitals in its national network. According to the designee, Oxford Medical's network includes 11,500 providers and an unknown number of hospitals in New Jersey. In addition, Oxford contracted with another carrier, Multi-Plan, to provide coverage outside New Jersey. Multi-plan's network has 390,000 providers and 3,100 hospitals. In-network physicians bill the carrier and are paid a fee established by the carrier. There is no "balance billing" or up-front costs to the employee. Out-of-network providers can require up-front payment from the patient who is reimbursed by the carrier at a "usual and customary" rate established by the carrier. If the provider bills at a rate higher than the reimbursement rate, the employee may have to pay the difference.

Given the evidence showing that the pool of network providers would shrink significantly, the designee concluded that the unions had demonstrated a substantial likelihood of success on the merits of their claims that employee benefits were being changed by the change in carriers. The designee also found irreparable harm since employees may be required to pay the up-front cost of treatment at the time of service and therefore forego treatment.

The designee denied the unions' request that the Township be restrained from changing carriers, but she ordered the Township

to establish an interim program that guarantees that employees have funds available to them to pay any up-front costs of medical care and any additional costs of medical treatment that would have been covered under the Horizon plan, during the pendency of this litigation. She further directed the Township to negotiate the procedures for implementing the interim program with the charging parties. Alternatively, the Township could maintain the Horizon plan pending compliance with any statutory or contractual obligations. Finally, the designee ordered the Township to provide the charging parties with all relevant documents concerning the insurance coverage.

The designee denied the charging parties' request for interim relief concerning current retirees. She found that retirees are not "employees" covered by the Act.

On January 25, 2002, the Township moved to have the record supplemented and to have the interim relief decision reconsidered by the full Commission.

The Township seeks to supplement the record to show that Oxford's New Jersey network includes 16,148 providers; Multi-Plan's New Jersey network includes 5,081 providers; and the combined total of 21,229 New Jersey providers exceeds Horizon's 17,200. The Township also seeks to supplement the record to show that Oxford has a network of 82 New Jersey hospitals; and Multi-Plan has a network of 5 New Jersey hospitals for a total of 87 New Jersey hospitals as compared to Horizon's 71.

The Township further seeks to supplement the record to show that it conducted a detailed comparative analysis of the networks and found that 58% of its employees' doctors are in both networks; 17% are in the Oxford/Multi-Plan network, but not the Horizon network; 14% are in the Horizon network, but not the Oxford/Multi-Plan network; and 11% are in neither network. In addition, the Township seeks to supplement the record to show that many doctors who are not in the Oxford/Multi-Plan network nonetheless agree to submit their claims to Oxford for payment, rather than require the employee to pay the bill up-front; and that the designee's concern about "balance billing" was greatly exaggerated.

The Township admits that its pre-hearing presentation to the designee was incomplete; it failed to explain that the combined Oxford/Multi-Plan network in New Jersey is larger than Horizon's network in New Jersey; and it failed to explain that there are relatively few Township employees whose doctors were in the Horizon network but are not in the Oxford/Multi-Plan network. According to the Township, at hearing, the designee refused to consider the Township attorney's representation that the combined Oxford/Multi-Plan network was larger than the Horizon network and to permit the Township's insurance broker to speak on the record. It argues that the combination of events has resulted in a ruling that is based on incorrect facts.

The Township further argues that given the additional facts, the fact that some employees have doctors who were in the Horizon network but are not in the Oxford/Multi-Plan network is not enough to support a finding that the Township unlawfully changed benefits. Also, the potential for up-front payment and balance billing cannot rise to the level of a change in benefits or plan administration.

Finally, the Township requests that should reconsideration be denied, we stay the interlocutory decision pending its application for emergent review in the Appellate Division.

On January 14, 2002, the PBA filed a cross-motion for reconsideration. It argues that: the designee erred in concluding that the change in carriers is not mandatorily negotiable, or in failing to consider whether it is permissively negotiable; and the Township has not presented any extraordinary circumstances justifying reconsideration or reasons justifying a stay.

According to the PBA, even if the Oxford/Multi-Plan network is larger, there are still many doctors in the Horizon network who are not in the Oxford/Multi-Plan network. Thus, the Township cannot disturb the premise of the designee's decision - that there will be a change of benefits at the very least for those employees whose doctors were participants in the Horizon network, but who do not participate in the Oxford/Multi-Plan network.

On January 18, 2002, the FMBA locals filed a brief opposing the Township's requests. They argue that the Township has not provided any documentation supporting the alleged number of physicians in the Oxford/Multi-Plan network and there are no extraordinary circumstances warranting supplementation of the record. The FMBA locals also join the PBA's cross-motion for reconsideration and, in addition, ask us to reconsider the designee's ruling on retirees. Finally, the FMBA locals assert that the Township has not established the interim program required by the designee and they seek counsel fees. The FMBA locals have submitted a number of documents and certifications.

On January 25, 2002, the Township filed a brief in further support of its motion to supplement the record and for reconsideration and in opposition to the charging parties' cross-motions for reconsideration. It argues that the charging parties have not undermined its showing that extraordinary circumstances warrant supplementation of the record and reconsideration. The Township also argues that the charging parties are attempting to supplement the record without a proper motion and that their cross-motions are untimely and an attempt to relitigate a decision with which they disagree. Finally, the Township asserts that it has negotiated diligently and in good faith with the charging parties to establish the procedures for implementation of the interim fund.

We can reconsider interim relief decisions, but will do so only in extraordinary circumstances. N.J.A.C. 19:14-8.4. Likewise, we can supplement the record in an interim relief proceeding, but will do so only in extraordinary circumstances. Compare N.J.A.C. 19:14-8.1.

We begin with an overview of our approach to unilateral changes in health benefits. 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). For police and firefighters, the identity of the carrier is a permissive, not mandatory, subject of negotiations. City of Newark, P.E.R.C No. 82-5, 7 NJPER 439, 440 (¶12195 1981). However, where changing the identity of the carrier affects terms and conditions of employment, e.g., the level of insurance benefits or the administration of the plan, an alternative carrier is a mandatory subject for negotiations. Ibid.

In Borough of Metuchen, P.E.R.C. No. 84-91, 10 NJPER 127 (¶15065 1984), we found that a unilateral change in insurance carriers violated the obligation to negotiate in good faith. The level of insurance benefits under the new plan was different from and, in certain important respects, lower than that previously provided. That certain benefits of the new plan were greater was irrelevant in determining that there was an unfair practice. Id. at 128. We ordered the employer to reimburse employees for any financial losses incurred due to the change in carriers. In that

case, no employees had to pay money up front under either plan, and we did not consider whether it would have been appropriate to require a return to the previous plan in the absence of a specific exception raising that point. Id. at 128, 130 n.5.

After Metuchen, we issued an important decision holding that a mere breach of contract does not amount to an unfair practice. State of New Jersey (Human Services), P.E.R.C. No. 84-148, 10 NJPER 419 (¶15191 1984). Health benefit levels are often set by contract. One might have thought, after Human Services, that a unilateral change in the level of health benefits would be viewed as a mere breach of contract, not an unfair practice. City of South Amboy, P.E.R.C. No. 85-16, 10 NJPER 511 (¶15234 1984), however, clarified that we are not divested of our unfair practice jurisdiction simply because the employer asserts that the contract permits the unilateral action or because the unfair practice, if proved, may also breach the contract. Employees have a statutory right not to have health benefits unilaterally reduced when the employer changes carriers. As we said in South Amboy, a unilateral reduction in insurance protection which would affect every member of the negotiations unit is akin to an employer's decision to reduce wages unilaterally. Id. at 512. If proved, both would amount to a statutory violation.

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. Id. at 512.

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. Stafford Tp. Bd. of Ed., P.E.R.C. No. 90-17, 15 NJPER 527 (¶20217 1989). We will, however, retain jurisdiction so that, if the arbitrator's award is challenged, we can assure ourselves that the procedures were fair and regular and the result not repugnant to the Act.

Even though we may defer an allegation of a unilateral change to binding arbitration, we may still order interim relief in appropriate cases pending completion of the arbitration process. To obtain interim relief, a charging party must first demonstrate that it has a substantial likelihood of success on the merits. Crowe v. De Gioia, 90 N.J. 126, 132-134 (1982). A charging party must also demonstrate that irreparable harm will occur if the requested relief is not granted. Ibid. Finally, 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. Ibid.

This employer announced a unilateral change in carriers from Horizon to Oxford/Multi-Plan. The designee found that the unions demonstrated a substantial likelihood of showing that employee benefits would be changed by the change in carriers. The employer asks us to supplement the record to show that the Oxford/Multi-Plan network is significantly larger than shown by the evidence presented to the designee.

We are reluctant to allow a party to supplement a record in an interim relief proceeding after receiving an adverse ruling, particularly when that evidence was available at the time of the initial proceeding. Even if we were to accept that new evidence, however, it would not change the fact that benefits have changed. The employer acknowledges that 14% of the providers in the Horizon network are not in the Oxford/Multi-Plan network. The magnitude of the change may be less than previously thought. But benefits have nonetheless changed.

The Hearing Examiner also found irreparable harm. Employees who visit a Horizon network provider not in the Oxford/Multi-Plan network may be required to pay the up-front cost of treatment at the time service is rendered rather than await partial reimbursement. And reimbursement may be less because a non-network provider may balance bill. The designee found that employees may forego treatment rather than pay the up-front costs and await reimbursement and that the harm was therefore not merely monetary. Even if we supplemented the record and found that the

Oxford/Multi-Plan network is considerably larger than the designee indicated, the fact that 14% of the Horizon network providers are not in the Oxford/Multi-Plan network demonstrates that some employees may face up-front payment and balance billing for the first time. That other employees may experience greater coverage does not change the fact that the employer changed benefits. Metuchen, 10 NJPER at 128-129.

The designee ordered the employer to establish an interim program that guarantees that employees have funds to pay any up-front costs and any additional costs of medical treatment that would have been covered under the Horizon plan, during this litigation. 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.

This 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 was to an "equivalent," or "substantially equivalent" health plan, had the contract provided that defense.

The employer also argues that the interim program will not be easy to administer. That argument seems to undermine its argument that very few employees will suffer any detrimental

change in health coverage. If the employer is correct in its prediction that most employees' providers are in the Oxford/Multi-Plan network, few employees will need to seek funds from the employer to cover up-front payments and the burden of the interim relief order on the employer will be small.

Given that the proffered evidence suggests that the burden of the order to the employer will be less than the designee expected, but that there was, nevertheless, a change in health benefits, we find no extraordinary circumstances to supplement the record or reconsider the designee's decision.

Finally, we deny the employer's request for a stay of the order pending emergent review in the Appellate Division. We are not convinced that the harm to the employer in implementing an interim program outweighs the harm to employees who will now be going "out-of-network" and may face up-front costs and balance billing. If the employer is correct and the number of affected employees is small, then the burden on the employer will be equally small.

We also deny the cross-motions for reconsideration. There are no extraordinary circumstances warranting reconsideration of the designee's order requiring the employer to create an interim program during this litigation. Given our case law and her finding that the change in carriers changed benefits, we assume that the designee should have found that the change in carriers was mandatorily negotiable. The designee did, however, require the employer to create an interim program that maintains

the level of benefits for current employees pending final consideration of whether the unilateral change in carriers was unauthorized. Under these circumstances, there is no need to disturb the current status quo.

There are also no extraordinary circumstances warranting reconsideration of her decision denying interim relief as to retirees. Borough of Belmar, P.E.R.C. No. 89-27, 14 NJPER 625 (¶19262 1988), a case relied on by the FMBA locals, does not suggest that a unilateral change in current retiree health benefits violates the Act. Accord Allied Chemical & Alkali Workers Local 1 v. Pittsburgh Plate Glass Co., 404 U.S. 157 (1971).

Finally, a motion for reconsideration is not the proper mechanism to seek compliance with a designee's interim order. See N.J.A.C. 19:14-10.2.[2/]

ORDER

The motions for reconsideration and to supplement the record, the cross-motions for reconsideration, and the request for a stay are denied.

BY ORDER OF THE COMMISSION

Millicent A. Wasell
Chair

Chair Wasell, Commissioners Buchanan, Katz, McGlynn, Muscato, Ricci and Sandman voted in favor of this decision. None opposed.

DATED: March 27, 2002
Trenton, New Jersey
ISSUED: March 28, 2002

2/ Given our ruling, we need not consider the employer's arguments that the cross-motions are untimely and that the unions are seeking to supplement the record without a proper motion.