STATE OF CALIFORNIA
DECISION OF THE
PUBLIC EMPLOYMENT RELATIONS BOARD

CALIFORNIA SCHOOL EMPLOYEES ASSOCIATION AND ITS PLUMAS CHAPTER NO. 193,	)	
Charging Party,	)	Case No. S-CE-877
v.	)	PERB Decision No. 578
PLUMAS UNIFIED SCHOOL DISTRICT,	)	June 26, 1986
Respondent.	)	

Appearances; Maureen C. Whelan, Attorney for California School Employees Association and its Plumas Chapter No. 193; Kronick, Moskovitz, Tiedemann & Girard by Robert A. Rundstrom for Plumas Unified School District.

Before Hesse, Chairperson; Burt and Craib, Members.

DECISION

HESSE, Chairperson: California School Employees Association and its Plumas Chapter No. 193 (CSEA) appeal the dismissal of an unfair practice charge filed against the Plumas Unified School District (District). A regional attorney of the Public Employment Relations Board (PERB or Board) ruled that CSEA failed to state a prima facie violation of Educational Employment Relations Act (EERA or Act) section 3543.5(a), (b) and (c).[1]

[1]EERA is codified at Government Code section 3540 et seq.

PROCEDURAL HISTORY

CSEA and the District have been signatories to a series of collective bargaining agreements. On August 27, 1984, they began negotiations for a new contract, and the parties reached impasse on October 31, 1984. A new contract was agreed to on January 16, 1985. The contract language concerning benefits was unchanged.

In September 1984, the District informed CSEA that it had elected to provide medical insurance for unit employees partially on a "self-funded" basis, effective October 1, 1984. The District would be liable for claims up to a certain amount, with the carrier paying for claims beyond this "stop-loss" cap. The partially self-funded plan would be administered by Equitable Benefit Plan (EBP), the same administrator of the prior plan. Neither the charge nor the dismissal specified the carrier, only the administrator.

Under the "old plan" (the plan ending September 30, 1984), the District paid premiums of $101 per employee per month to EBP. All claims were filed with EBP, and the District reimbursed EBP for the first $500 in claims per year per employee. Beyond the initial $500 claim, EBP was responsible for all claims. The District paid approximately $846,000 in premiums and claims under the old plan in 1983-84. The estimated liability for 1984-85 under the old plan was in excess of $1,000,000.

Under the "new plan," the District would assume responsibility for the payment of claims up to $50,000 per year per employee, or up to an aggregate amount of $619,000. Beyond that amount (the "stop-loss" amount), EBP bills the appropriate carrier for claims payment. In addition to payment of claims up to $619,000, the District would also pay to EBP a fee of $127,000 for the administration of both parts of the new plan (the self-funded portion and the portion beyond the "stop-loss" amount). There would be no change in the manner by which employees made claims, as they would continue to apply to EBP. The new plan was expected to save the District at least $100,000 the first year over 1983-84 amounts, as it is ultimately cheaper to pay employee medical expenses directly than it is to pay premiums for like coverage.

The regional attorney dismissed the charge on the grounds that there was no change in the carrier or in the benefits, but rather there was merely a shifting of the financial responsibility for claims from the commercial carrier to the District (up\ to the stop-loss amount), resulting in the District lowering its total financial burden by $100,000. Furthermore, the mere shift in the financial burden produced no evidence or allegations that the new plan materially affected the claims process. Thus, the District did not make a unilateral change in the terms of employment.

DISCUSSION

On appeal, CSEA argues that the Board should issue an unfair practice charge based on the District's alleged unilateral action in adopting a self-funded plan, thereby "changing" the insurance carrier.[2]

This Board has ruled in the past that a change in health plan administrators, even where benefits remain the same, is a negotiable subject. (Oakland Unified School District (1980) PERB Decision No. 126, aff'd in Oakland Unified School District v. PERB (1981) 120 Cal.App.3d 1007.) That ruling drew on precedent established by the National Labor Relations Board (NLRB).[3] The case before us, however, does not present the same facts as in Oakland. Here, the District has kept the same administrator and the same benefits. Indeed, the contract language remained identical, even after the change in financial responsibility, so CSEA cannot argue that the insurance plan changed. The employees will continue to make claims and have benefits paid exactly as before. The sole difference is that the District's liability for premiums now becomes liability for

---

[2]If actual changes in services rendered occur, or if the stop-loss insurance is cancelled, a new charge could be filed. CSEA alleged, but only on appeal, that the District did indeed lose its stop-loss coverage. But it would be inappropriate for PERB to consider allegations raised on appeal for the first time, when the correct procedure is to file a charge or amend a charge already filed.

[3]See Keystone Steel and Wire v. NLRB (7th Cir. 1979) 606 F.2d 171, enforcing Keystone Steel and Wire (1978) 237 NLRB 763.

direct payment of claims, up to the stop-loss amount. This difference alone does not constitute a change in a negotiable subject.

If CSEA had alleged that the change to a self-funded plan resulted in significant differences in services, or in the employees having to make greater contributions to the insurer (in other words, if the change had an impact on a subject within the scope of representation), then the duty to bargain may have been violated. (Palo Verde Unified School District (1983) PERB Decision No. 321.)[4]

In the case before us, nothing in CSEA's charge indicates that the employees have been affected by the shift in financial payments. Indeed, the contract language remains the same. The claims filed by an employee continue to be filed in the same manner, with the same administrator (EBP). Without more, we are unwilling to say that a change in funding responsibility will always give rise to a duty to bargain.

---

[4]Compare Bastien-Blessing v. NLRB (6th Cir. 1975) 474 F.2d 49 with Connecticut Light and Power Co. v. NLRB (2nd Cir. 1975) 476 F.2d 1079. In the former, a change to a self-funded plan resulted in several changes to the employees. In the latter case, the court ruled that the employer was free to make changes in carrier as long as no change in coverage, benefits, or administration occurred.

Furthermore, we note that in Palo Verde, the Board did not rule that a change in carriers results in a per se violation of the Act. Rather, the carrier change that results in an impact on services or benefits will give rise to a violation. That is not the situation here.

ORDER

The Board hereby AFFIRMS the decision of the regional attorney and ORDERS the unfair charge in Case No. S-CE-877 DISMISSED.

Member Craib joined in this Decision. Member Burt's dissent begins on page 7.

BURT, Member, dissenting:

I dissent. In my opinion, the District's change to a self-funded medical insurance plan constitutes a unilateral change in a negotiated term or condition of employment. Although there is no dictionary definition of the term "insurance carrier," the entity that carries the risk of liability must logically be the carrier. Under a self-funded plan, then, the District is the carrier.

In Palo Verde Unified School District (1983) PERB Decision No. 321, we indicated that coverage levels were not the only aspects of insurance plans that are negotiable; the identity of the insurer may well be equally significant. We said:

> . . . A change to a less well established carrier, or one which is less reliable or less able to perform, would result in a materially lower quality of health benefits for employees, even if the policies were facially identical. Under any such circumstances, a unilateral change of carrier identification would in and of itself materially affect health care benefits, and thus would violate EERA . . . (p. 10).

Clearly, a self-funded district is such a "less well established carrier." I find the employee representative's concern over the District's willingness and ability to properly fund its medical insurance program to be reasonable under the circumstances. Unlike established insurance companies and health maintenance organizations which are regulated by state

agencies, self-insured public entities like the District are not regulated by anyone. Moreover, the District showed itself unwilling in the negotiations that did take place to agree to a trust or other arrangement to insure that the necessary monies for claims would be regularly set aside.

Although the issue has arisen only once, the National Labor Relations Board (NLRB) has also found a change to a self-funded insurance plan to be a negotiable subject. In Golconda Corp. (Bastian-Blessing Div.) (1971) 194 NLRB 95, enfd Bastian-Blessing v. NLRB (6th Cir. 1973) 474 F.2d 49 [82 LLRM 2689], the NLRB found a mid-contract change to self-funding to be unlawful. While additional changes in benefits were involved in that case (which was decided after a hearing), uncertainty over the funding was deemed a legitimate concern.

The court's decision in Connecticut Light and Power Co. v. NLRB (2d Cir. 1973) 476 F.2d 1079 is not inconsistent. There, a change in carriers from Aetna to Blue Shield was alleged to be unlawful. The NLRB relied on Bastian-Blessing, supra, and found the identity of the carrier to be a mandatory subject of bargaining and that the employer's refusal to bargain was, therefore, unlawful. On appeal to the court, the NLRB's determination was reversed. The court said that the selection of the carrier was not a mandatory subject of bargaining under those circumstances because the union had merely alleged undefined "dissatisfaction" with the carrier selected by the employer and the employer had bargained in good faith

concerning coverage and administration. The court distinguished Bastian-Blessing because, in that case, adverse affects on employee benefits had been found in that benefits were omitted, enforcement was changed and there was a degree of uncertainty regarding the funding. The court explicitly confined its decision to the facts of that case.

Significantly, the court disapproved the NLRB's rule that the identity of the carrier is a mandatory subject of bargaining only where the change was from one established carrier, Aetna, to another established carrier, Blue Shield. Even then, the court indicated that a concern over funding was a legitimate factor to consider.

In the instant case, the concern over the District's ability to fulfill its obligations under a self-funded plan is even more reasonable if, in fact, the District has no stop-loss coverage applicable to this plan. Although the District originally stated that it had such coverage, the CSEA claims that the stop-loss plan the District had was cancelled and provides a letter that arguably substantiates its statement. The District denies that the cancellation letter applies to the medical insurance plan at issue but provides no information to support their original statement that they do have stop-loss coverage.

Such factual disputes are normally and most appropriately resolved at a hearing on the merits. The majority ignores this

dispute, however, and simply assumes that the District's statement is correct. It states in the facts section that the District has stop-loss coverage; it assumes the District has such coverage when it discusses the District's liability under the new plan. The majority states that the sole difference resulting from the District's action is that the District's liability for premiums now becomes liability for direct payment of claims, up to the stop-loss amount and that this difference alone does not constitute a change in a negotiable subject.

The majority justifies its unwillingness to consider this factual dispute by saying that CSEA raises the issue in its appeal and, thus, it may not be considered here. I disagree. I think it must be accepted as newly-discovered evidence that could not previously have been obtained by due diligence, and which is material to this case. San Joaquin Delta Community College District (1983) PERB Decision No. 261b.

CSEA stated that it did not obtain a copy of the letter it submits to support its allegation until after the change was dismissed. The letter in question was dated March 25, 1985, and was directed not to CSEA, but rather to the Executive Director of the California School Boards Association. The regional attorney dismissed CSEA's allegations on April 16, 1985.

CSEA apparently did not learn of the dismissal until around five weeks later, on or before May 1, 1985. I find it quite reasonable to believe that CSEA did not, in fact, obtain a copy

of a letter not addressed to it until several weeks after it was mailed. The majority states no facts or reasons on which to base a conclusion that CSEA could have, much less did, discover the letter earlier.

In addition, the allegation and evidence are clearly material to this case. If the District has not obtained any stop-loss coverage, then its description of the plan to the CSEA and to PERB is of questionable validity, its risk of liability under the new plan is greatly enhanced, and its potential savings may be much less. Thus, the language in Palo Verde, supra, is that much more apt.

For the above reasons, I would hold that a prima facie case of unlawful unilateral change has been stated and order a complaint to issue.