STATE OF CALIFORNIA
DECISION OF THE
PUBLIC EMPLOYMENT RELATIONS BOARD

TRINIDAD TEACHERS ASSOCIATION, CTA/NEA, Charging Party, **v.** TRINIDAD UNION ELEMENTARY SCHOOL DISTRICT, Respondent.	)	Case No. SF-CE-1052 PERB Decision No. 629 July 8, 1987
PENINSULA TEACHERS, NHTA/CTA/NEA, Charging Party, v. PENINSULA UNION SCHOOL DISTRICT, Respondent.	)	Case No. SF-CE-1076

Appearances; Ramon E. Romero, California Teachers Association, for the Trinidad Teachers Association, CTA/NEA, and for the Peninsula Teachers, NHTA/CTA/NEA; Littler, Mendelson, Fastiff & Tichy by Charlotte Addington and Larry P. Schapiro for the Trinidad Union Elementary School District; Harland & Gromala by Richard A. Smith for the Peninsula Union School District.

Before Hesse, Chairperson; Porter and Shank, Members.

DECISION

SHANK, Member: These cases are before the Public Employment Relations Board (PERB or Board) on exceptions filed by the Trinidad Union Elementary School District and the Peninsula Union School District (Districts) to the decisions of

the administrative law judge (ALJ) who found that the Districts' unilateral decisions to join the North Coast Schools Medical Insurance Group, a multi-employer self-funded insurance group, for dental coverage violated section 3543.5(c) and, concurrently, sections 3543.5(a) and (b), of the Educational Employment Relations Act (EERA or Act).[1] Although separate decisions were rendered involving each District, they are considered together in this decision because of the identity of the issues and facts in both cases. We affirm both decisions in part and reverse them in part.

PROCEDURAL HISTORY

On September 16, 1985, the Trinidad Teachers Association, CTA/NEA, filed a charge alleging unfair practices by the Trinidad Union Elementary School District, and on October 30,

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[1]EERA is codified at Government Code section 3540 et seq. Unless otherwise indicated, all statutory references herein are to the Government Code.

Section 3543.5 provides, in pertinent part, as follows:

> It shall be unlawful for a public school employer to:
>
> (a) Impose or threaten to impose reprisals on employees, to discriminate or threaten to discriminate against employees, or otherwise to interfere with, restrain, or coerce employees because of their exercise of rights guaranteed by this chapter.
>
> (b) Deny to employee organizations rights guaranteed to them by this chapter.

1985, the Peninsula Teachers, NHTA/CTA/NEA filed a charge alleging unfair practices by the Peninsula Union School District. Both associations alleged that the respective Districts joined the North Coast Schools Medical Insurance Group to provide dental insurance benefits without first negotiating the decision to join and its effects. A third and separate complaint of a similar alleged unfair practice involving Southern Humboldt Joint Unified School District was consolidated for hearing with the Districts' cases.[2] Hearing was held March 24 to March 27, 1986, and concluded on April 28 and 29, 1986. Separate decisions were issued in each of the cases, but only the Districts have filed exceptions with the Board.

FACTUAL SUMMARY

In 1979 three school districts in Humboldt County organized the North Coast Schools Medical Insurance Group (NCSMIG) joint powers agreement (JPA) to provide medical insurance benefits for their employees. In October 1984 the medical JPA expanded its membership to 26 districts in Humboldt County. The medical

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(c) Refuse or fail to meet and negotiate in good faith with an exclusive representative.

2The ALJ's proposed decision in Southern Humboldt Teachers Association, CTA/NEA v. Southern Humboldt Joint Unified School District, Case No. SF-CE-1069, which dismissed the unfair practice charge, was not appealed by the Southern Humboldt Teachers Association, and is now final. See PERB Decision No. HO-U-307 (1986).

JPA currently covers approximately 2,059 lives. Because of the successful six-year history of the medical JPA, the NCSMIG board of trustees decided to investigate the possibility of dental coverage through the JPA. In April 1985, the JPA board appointed a subcommittee to conduct initial investigations and report its recommendations to the full board. The subcommittee included Barney Finlay, JPA board president, Fran Taplan, the certificated representative to the board's Advisory Committee, and Jan Smittle, staff assistant to the NCSMIG JPA.

The subcommittee specifically considered two proposals, one from California Dental Service/Delta Dental Plan (CDS) and the other from Robert Shirrell Associates. The proposal from Shirrell Associates projected lower rates than those projected under the CDS plan, but the carrier, the administrator, and to some degree the benefits, would have changed. On the other hand, the CDS proposal incorporated the existing insurance contracts between the individual districts and CDS, which meant that there would be no changes in benefits or coverage. In addition, because CDS proposed to administer the plan, there would be no change in either the plan's administrator, the method of submitting claims, or in the dentists who provided the services.

Pursuant to the subcommittee's investigations, CDS' marketing representative, Nancie Mazer, made several presentations to the JPA board concerning the CDS proposal.

Although Ms. Mazer did not disclose specific information regarding the districts' claims experience, she informed the board that the CDS actuarial department reported that the dental claims experience of the districts in the NCSMIG was very satisfactory and, in fact, was better than that experienced by the entire statewide CDS school pool. On the basis of the CDS data, Mazer predicted that the NCSMIG would do well as a self-insured entity. In fact, Mazer predicted that the dental JPA would save at least 10 percent over the statewide pool.

Relying primarily upon the continuity of benefits, coverage and administration provided under the CDS proposal, the subcommittee recommended, and the JPA board ultimately adopted, the CDS proposal. Accordingly, in June Barney Finlay sent to the NCSMIG member districts a letter informing them about the dental JPA and offering the districts an opportunity to enter the program. Finlay explained that the JPA board selected the CDS program because there would be no changes in benefits, rates, servicing dentists, carrier or plan administrator.

Those districts who joined the dental JPA continued the coverage and benefits which they had individually negotiated with CDS. CDS provided the JPA with data about its various programs, and identified the districts enrolled in each program. The districts individually negotiated contracts with CDS based on the variations of several master plans CDS had to

offer. Premium rates varied from district to district, dependent upon the selected benefits. The average premium of the NCSMIG districts was $41.77 per employee per month. The JPA decided to assess district members at their existing premium rates for at least the first year, even though CDS predicted that because of the savings effected through the JPA, a lesser amount ($31.00) would cover all claims and the requisite administration fee to CDS. According to Finlay, the board preferred to take a conservative approach to funding the dental JPA until such time as they could evaluate the JPA's claims experience.

With respect to the benefits enjoyed by the individual employee, the dental JPA has made no changes whatsoever. Each covered employee continues to go to the same dentist, is entitled to receive the same level of services and, as before, submits all dental bills to CDS, which administers all claims. CDS continues to monitor all billings to ensure that they conform with billing rates established by CDS, then pays the dentists for their services. Each month, CDS submits a bill to the JPA for reimbursement for all claims paid by CDS on behalf of the JPA, including an administrative fee of 9.2 percent on paid claims.

CDS requires self-insured programs such as the JPA to establish a deposit with CDS to prefund the coverage, as a guarantee that CDS will not be required to pay claims from its

own resources in the program's first months. CDS offered the JPA three prefunding alternatives under which the amount of the deposit varied according to the transferability of funds. The JPA opted to prefund in the amount of $75,000, which amount is still on deposit with CDS and an existing asset of the JPA. The JPA obtained the $75,000 by collecting double premiums from the member districts the first month of the program. The JPA will not collect a premium in the last month of the year; the districts will make only 12 premium payments during the year.

The JPA/CDS agreement provides a 150 percent stop loss at no cost to the JPA. Insurance expert and JPA consultant, Robert Shirrell, explained the stop-loss provisions and their ultimate effect on the JPA. There are presently 1,250 employees covered under the dental JPA. During a contract year, the JPA will collect premiums in the amount of $626,000, which represents $41.77 (the average premium amount), times 12 months, times 1,250 covered lives. CDS will pay all dental claims in excess of $761,000, or $50.77 (the stop-loss provision), times 12 months, times 1,250. The difference between $761,000 (when CDS becomes liable) and $626,000 (the amount the JPA will collect) is $135,000, or the maximum amount for which the JPA could be liable over and above the premiums the JPA collects. Shirrell testified that CDS could afford to offer a 150 percent stop loss at no cost to the JPA because,

based on its claims experience in Humboldt County, CDS knew the stop loss would never be implemented.[3]

Shirrell also reviewed and analyzed both the JPA's financial statements and its claims history through March 1986. Based on calculations standard to the industry, he projected that the average cost per family per month would be $28.19, and that the total of the claims costs and the administrative fees would be $30.78 per family per month. Shirrell testified that the amount of the JPA's reserves ($103,000 as of January 31, 1986) was more than sufficient to cover any contingencies which might occur in the first year. More precisely, Shirrell testified that the JPA's reserves were almost double what the JPA would need, and predicted a surplus of $9.00 per member per month at the end of the current year. Shirrell agreed that it was prudent of the JPA to overfund the first year to handle unforeseen contingencies, and noted that the surplus can be used to stabilize rates for the second year and to avoid increases to the member districts. Such an action would be in keeping with the purpose of the dental JPA, which is to effect cost reductions for the member districts.

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[3]According to Shirrell, dental costs are very predictable, particularly after several years of coverage, because of the nature of the treatment and the ceilings imposed in the insurance contracts. Thus, CDS knows precisely what the risks are for the dental JPA, and accurately projected that the cost of claims per family per month would be about $31.00.

DISCUSSION

Our analysis of this Board's precedent relating to a unilateral change in providers of health care benefits must begin with Oakland Unified School Dist, v. Public Employment Relations Bd. (1981) 120 Cal.App.3d 1007. In Oakland, the Court of Appeal considered a PERB decision in which an unfair labor practice was found where a school district unilaterally terminated Blue Cross and substituted Western Administration Company as the district's medical claims processor. The court in Oakland found that the district's unilateral action had deprived the covered employees of two actual benefits which they had received under the prior administration. Specifically, the Blue Cross plan included an agreement by the district to continue medical coverage for terminated employees pending their coverage by some other health plan carrier and the use of Blue Cross identification cards which allowed for simplified billing procedures. Neither benefit was provided by the new carrier.

The significant language in Oakland reads, at page 1012, as follows:

> The question is whether the change in administrators had a "material and significant effect or impact upon the terms and conditions of employment."

This statement was taken from doctrine set out in Westinghouse v. NLRB (4th Cir. 1967) 387 Fed.2d 542, at 548, which states:

> . . . [S]ince practically every managerial decision has some impact on wages, hours, or other conditions of employment, the determination of which decisions are mandatory bargaining subjects must depend upon whether a given subject has a significant or material relationship to wages, hours, or other conditions of employment.

In 1983, this Board decided Palo Verde Unified School District, PERB Decision No. 321. There, the district unilaterally changed insurance companies (from Blue Cross to Blue Shield), which actually afforded a higher level of benefits to employees. In finding a violation of EERA, this Board in Palo Verde reiterated the proposition for which Oakland Unified School District, supra, stands: Where a change in administrators has a material or significant effect upon the terms and conditions of employment, it must be negotiated. Although the District's change to Blue Shield actually increased the level of benefits, this did not insulate it from committing an unfair practice under our statute. This was so, reasoned the Board, because management's unilateral action to increase benefits would exert as material and significant a change on a matter within scope as would a decrease in the level of benefits. Thus, the test articulated in Oakland was met, and management was required to bargain. After finding a violation of EERA because of the change in benefits, this Board in Palo Verde secondarily theorized, at page 10:

> 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 identity would in and of itself materially affect health care benefits, and thus would violate EERA. [Emphasis added.]

However, in Palo Verde, there was no finding that the new carrier would provide a materially lower quality of health care benefits. The Board's decision was thus grounded upon a change in the benefits.[4] 4

> This Board has ruled in the past that a change in health plan administrators, even where benefits remain the same, is a negotiable subject. [Citations omitted.] That ruling drew on precedent established by the National Labor Relations Board (NLRB). The case before us, however, does not present the same facts as in Oakland. Here,

[4]A mere change in the identity of the carrier is not a per se violation. Instead, there must be a material or significant change in the level or quality of the benefits.

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

Perhaps the true essence of Plumas, however, was contained in footnote no. 4, at page 5, which reads as follows:

> 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.
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> 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.

Thus, it is the position of the Board that a change to a self-funded plan does not, without more, result in a per se violation of EERA.

The instant case is almost identical to the facts in Plumas, supra. Here, neither the level of benefits nor the quality of services to covered employees was changed in any

way. The Districts assumed financial responsibility for all claims which reach the amount covered by the stop-loss plan agreed to by CDS, at no cost to the Districts. The one factual difference is that, in the instant case, the self-funded plan consists of a joint powers entity composed of a group of districts formed for the purpose of providing dental benefits. For the reasons which follow, we find this distinction inconsequential.

In the view of the ALJ, the JPA creates an increased "risk" to the Districts' ability to provide dental coverage in the future, thus requiring negotiations over the change. We find no evidence in the record to support such a conclusion. Plumas was issued after the hearing in the instant case was conducted, but before the ALJ issued his proposed decision. Plumas laid to rest any contention that the mere change to a self-funded program is a per se violation of EERA. Similarly, a change to a less well-established carrier, without also showing an actual difference in benefits or services, or significant unreliability, does not constitute a violation.

The Board has considered the factors upon which the ALJ relied in reaching his conclusion that the JPA is less reliable, less well-established and constitutes a greater risk to providing future dental benefits to covered employees.

1. The Districts Have Not Relinquished Control.

The ALJ found that the "NCSMIG agreement and bylaws demonstrate that the Districts [have] delegated full authority over dental insurance for a definite period of time to an entity other than the employer." This has not occurred. The Districts have not changed their relationship to their employees in any way. Regardless of what the JPA decides to do with respect to dental benefits, the Districts are bound by the terms of their respective collective bargaining agreements, and the benefits negotiated therein cannot be unilaterally changed by them. If actions of the JPA are not satisfactory to the Districts, they may withdraw in the manner prescribed in the JPA bylaws. However, they remain obligated under the collective bargaining agreements in effect and must find adequate providers to supply the benefits as contracted. Before the Districts joined the JPA, it was CDS which decided the cost of rates and the type of services provided and not the Districts. The Districts, because of their small size, were only able to negotiate with those companies which supplied the benefits. The JPA's ability to negotiate is certainly better than that of the individual Districts, were they each to undertake self-funded programs.

In sum, the evidence in the record supports the conclusion that the Districts have improved the ability to supply benefits at a reduced cost to themselves. It is not enough to theorize

whether the JPA arrangement could potentially cause problems for its members, or whether the JPA resulted in a less well-established or less reliable carrier.[5]

2. The JPA Does Not Result In Less Reliability Or Greater Risk.

There was no evidence produced by the Charging Parties that the JPA was not reliable. The preponderance of the evidence was to the contrary. The JPA, as a self-funded entity, had been operating since 1979 to supply medical benefits and services. The only evidence produced on the subject indicated that the cost of dental services was more predictable and accurate than that for medical services, which is a very volatile area.

The risk here was limited by the stop-loss plan as it was in Plumas. Moreover, financial resources of the JPA were more than adequate to cover the worst contingencies.

3. The Lack of State Regulation.

Lack of state regulation was of concern to the ALJ. By concluding that the Knox-Keene Act (Health & Saf. Code, sec. 1340 et seq.) probably does not apply to the regulation of joint power agencies supplying health services, the ALJ reasoned that the JPA was less reliable than CDS. We do not

[5]There must be some cogent evidence that changes have happened or will happen, which have significantly changed or will significantly change employee benefits.

find, however, that the lack of regulation is of consequence in this case. If the Legislature has not seen fit to regulate such agencies, it is not within the province of this Board to do so.

4. The Experience of the JPA Board of Directors.

A final concern of the ALJ was the lack of experience in the field of health insurance of some members of the board of the JPA. There is no evidence of any sort in the record indicating that the lack of experience, if true, had any impact on the capacity of the JPA to provide dental coverage. Indeed, the ALJ's findings were to the contrary. The proposed decision reads as follows:

> Still, at the hearing, this fear of enhanced risk did not appear justified based on the NCSMIG's first several months of dental operations, in which costs were running about even with initial estimates.

We find persuasive the fact that the JPA has been operating in the medical field since 1979 without any difficulties under the same board, which is responsible for both the medical and dental programs. All evidence indicates that the medical field is far more volatile than the dental field.

We therefore reject those portions of the decisions of the ALJ which held that the Districts' unilateral actions in joining the JPA constituted unilateral changes requiring negotiations with the exclusive representatives under section 3543.5(c).

With respect to Charging Parties' contention that they were deprived of services extended voluntarily by CDS (which provided a method of reviewing claims disputes and a procedure for reviewing proposed rate increases), we affirm the ALJ's determination that Charging Parties failed to demonstrate any type of enforceable benefit or entitlement of which they were dispossessed.

ORDER

The unfair practice charges in Case Nos. SF-CE-1052 and SF-CE-1056 are hereby DISMISSED.

Chairperson Hesse and Member Porter joined in this Decision.