STATE OP CALIFORNIA
DECISION OF THE
PUBLIC EMPLOYMENT RELATIONS BOARD

YUBA COLLEGE FACULTY ASSOCIATION,	)	
	)	
Charging Party,	)	Case No. S-CE-1308
	)	
v.	)	PERB Decision No. 855
	)	
YUBA COMMUNITY COLLEGE DISTRICT,	)	December 14, 1990
	)	
Respondent.	)	
	)	

Appearances: Robert J. Bezemek, Attorney, for Yuba College Faculty Association; Kronick, Moskovitz, Tiedemann & Girard by Robert A. Rundstrom, Attorney, for Yuba Community College District.

Before Shank, Camilli and Cunningham, Members.

DECISION

CUNNINGHAM, Member: This case is before the Public Employment Relations Board (PERB or Board) on exceptions filed by the Yuba College Faculty Association (Association) to an administrative law judge's (ALJ) proposed decision (attached) dismissing the underlying unfair practice charge and complaint alleging that the Yuba Community College District (District) failed to negotiate in good faith by unilaterally changing a health benefit plan during the life of a contract. The ALJ based this decision on his finding that the Association failed to meet its burden of proof as to the issue of whether any unilateral change was made by the District, thereby resulting in the District's failure to meet and confer in good faith in violation

of the Educational Employment Relations Act (EERA) section 3543.5(a), (b) and (c).[1]

In its exceptions, the Association contends that the status quo, in this instance, was the District's provision of the cluster of benefits in effect at the commencement of the agreement, and the District's unilateral reduction in the scope of benefits during the course of the agreement constituted an unlawful unilateral change. Additionally, the Association argues that the ALJ incorrectly interpreted the collective bargaining agreement in concluding that the language was intended to allow

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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. Prior to January 1, 1990, section 3543.5 stated, in pertinent part:

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

Although both the charge and the proposed decision define the (a) and (b) violations as derivative, it should be noted for clarification that, while these facts support an allegation of an independent (b) violation, there is no support for an allegation of a derivative violation of (a) based solely on a finding of a (c) violation. (Tahoe-Truckee Unified School District (1988) PERB Decision No. 668; Regents of the University of California (1989) PERB Decision No. 722-H.)

for some flexibility, with respect to the terms and conditions of the medical plan.

We have reviewed the entire case record, including the proposed decision, the Association's exceptions and the District's responses thereto. The exceptions to the proposed decision raise the same arguments previously presented to and considered by the ALJ. Therefore, the Board finds the ALJ's statement of facts and conclusions of law to be free from prejudicial error and adopts the proposed decision as the decision of the Board itself.

ORDER

Based on the foregoing, Unfair Practice Charge No. S-CE-1308, Yuba College Faculty Association v. Yuba Community College District, and the companion PERB complaint, are hereby DISMISSED.

Members Shank and Camilli joined in this Decision.

STATE OF CALIFORNIA
PUBLIC EMPLOYMENT RELATIONS BOARD

YUBA COLLEGE FACULTY ASSOCIATION,	)	
	)	
Charging Party,	)	Unfair Practice
	)	Case No. S-CE-1308
v.	)	
	)	PROPOSED DECISION
YUBA COMMUNITY COLLEGE DISTRICT,	)	(8/6/90)
	)	
Respondent.	)	
	)	

Appearances; Robert J. Bezemek, Attorney, for the Yuba College Faculty Association; Kronick, Moskovitz, Tiedemann & Girard by Robert A. Runstrom, for the Yuba Community College District.

Before Ronald E. Blubaugh, Administrative Law Judge.

PROCEDURAL HISTORY

An exclusive representative contends here that a public school employer failed to negotiate in good faith by unilaterally changing a health benefit plan during the life of a contract. The employer replies that the changes were imposed by the insurance carrier and that the union declined its offer to negotiate about the carrier's action.

The Yuba College Faculty Association (Association) commenced this action on September 26, 1989, by filing an unfair practice charge against the Yuba Community College District (District). The Association amended the charge on December 19, 1989, to correct a mistaken code section. The General Counsel of the Public Employment Relations Board (PERB) issued a complaint on January 10, 1990. The complaint alleges that the District made various unilateral changes in the health benefit program in violation of Educational Employment Relations Act sections

3543.5(a), (b) and (c).[1] The District answered the complaint on January 29, 1990, denying that it had committed an unfair practice.

A hearing was conducted in Sacramento on May 14, 1990. With the filing of briefs, the matter was submitted for decision on July 25, 1990.

FINDINGS OF FACT

The Yuba Community College District is a public school employer under the EERA. At all times relevant, the Yuba College Faculty Association has been the exclusive representative of the District's teaching staff.

Since 1984, the negotiated agreement between the parties has provided specifically for employee health coverage under a plan known as Blue Cross 365 Plus.[2] Unit members were covered under

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[1]Unless otherwise indicated, all statutory references are to the Government Code. The Educational Employment Relations Act (EERA) is found at Government Code section 3540 et seq. In relevant part, section 3543.5 provides 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.
>
> (c) Refuse or fail to meet and negotiate in good faith with an exclusive representative.

[2]Section 14.1 of the 1987-1990 contract provides as follows:

> Health Benefits.--The Board shall provide all unit members and their eligible dependents

the same plan since prior to 1976, although it was not specifically identified in the contract until 1984.

The District is one of 50 Sacramento Valley school districts that have entered a joint powers agreement to provide health, dental and vision insurance for their employees. The organization created by the 50 districts is known as the Tri-County Schools Insurance Group. Tri-County collects fees from the various districts and pools the money into a self-insurance fund. It contracts with Blue Cross and Gallagher Bassett for claims administration. Under Tri-County's agreement with Blue Cross, the insurance company provides a health plan essentially identical to that it provides to employers who do not self insure. Blue Cross collects a fee to cover the cost of administration and re-insurance.

At one time, Tri-County's contract with Blue Cross covered some 600 to 800 employees, a substantial segment of the work force in the participating districts. Over the years the number of districts with Blue Cross plans dropped so that by early 1989, only six districts continued to have Blue Cross coverage. With an increase in fees to $37.03 per employee per month which Blue Cross announced in mid-1989, all but Yuba Community College District dropped the carrier. The other districts switched to a

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with a fully paid health insurance plan, including an annual routine physical examination benefit for the unit member and spouse. The carrier of the plan shall be Blue Cross and the specific coverage shall be Plan 365 Plus. Supplier of named plan to be determined by the District.

competing plan offered by Gallagher Bassett which came with a monthly administrative fee of only $12.

After the mid-1989 rate increase, only the faculty unit at Yuba Community College District remained with the Blue Cross plan. The faculty unit comprises some 174 participants, 124 of whom are current employees with the rest being retired employees or surviving spouses. Under Blue Cross corporate guidelines, the company generally will not write health plans that cover less than 60 per cent of an employer's work force. This rule is due in part to the economics of administering a plan where the larger the group, the smaller the cost per employee.

It has been the practice for Blue Cross to periodically make changes in its insurance plans. Even since the Blue Cross 365 Plus plan has been written into the Yuba faculty contract, Blue Cross has made changes in the plan. George Shaw, the District's chief negotiator, testified that Blue Cross unilaterally made several enhancements to the plan between 1984 when it was first written into the contract and 1987 when it was renewed. He said these changes were made without complaint from the faculty. On these occasions, he testified, faculty members simply received notices of amendments to the health plan.

By letter of August 29, 1988, Blue Cross notified Tri-County that it planned to make three changes effective October 1, 1988. Blue Cross proposed to: 1) more closely monitor hospitalizations through a system of case management, 2) reduce payments for

services rendered in non-contracting hospitals,[3] and 3) impose a ninety-day limit for the filing of claims. The letter advised Tri-County that although it could refuse the changes initially, the changes would be included as a condition of the next renewal.[4]

District Superintendent Patricia Wirth thereafter called a faculty meeting where business manager Ruby Henry described the District's health insurance program. Ms. Henry went through the covered benefits and explained how health plans are funded through Tri-County and the relationship with Blue Cross. She described each of the changes which Blue Cross was attempting to secure. She also described the Gallagher Bassett plan which had recently been adopted for the District's classified employees. Association President Jim Finstad was present at the meeting and asked questions.

The Blue Cross request for change was refused by Don Soli, executive director for Tri-County. He took the position that Tri-County had a valid contract with Blue Cross which Blue Cross could not change unilaterally. He insisted that Blue Cross could not change the plan until after the expiration of the insurance

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[3]Non-contracting hospitals are those which have no cost limitation agreements with Blue Cross.

[4]Blue Cross regional sales manager Bob DeTour testified that Blue Cross knew that the school districts had labor agreements, "so basically what we did is we gave them a two-year window period and we said in the first year you can . . . put any of these, all of these, or none of these in; but, the next time around, when we renew, we need to include these into the fee for service environments . . . ." (Reporter's Transcript, p. 78)

carrier's contract with Tri-County on June 30, 1989. Blue Cross then dropped its demand for changes in 1988.

Some time prior to April 4, 1989, Blue Cross sent Tri-County an amendment to its contract entitled "Coverage During a Labor Dispute." The amendment provides that eligible subscribers could arrange for continued health coverage during a strike by paying a fee to Blue Cross. The amendment fixes responsibility for collecting the fees and remitting them to Blue Cross on the union. The amendment further provides that a minimum of 75 percent of the subscribers on strike would have to participate for the coverage to be effective. Coverage would last throughout the labor dispute up to a maximum of six months.

On April 11, 1989, District business manager Ruby Henry gave Association President Jim Finstad a copy of the amendment pertaining to coverage in a labor dispute. She asked him what the District should do with it. He told her to simply send it out which she did on April 18.[5]

Bob DeTour, regional sales manager for Blue Cross, testified that the provision for coverage during strikes was amended by Blue Cross into all policies issued by the company. He said Blue Cross viewed the coverage as mandatory under state law. Mr. Soli testified that Tri-County did not solicit the change and had no

[5]Initially, Mr. Finstad testified that he was not notified about the amendment prior to its distribution among faculty members. On cross-examination he modified his testimony to say that he could not say for sure whether or not he met with Ms. Henry prior to distribution of the amendment. Ms. Henry testified about the discussion without any uncertainty.

conversations with anyone at Blue Cross prior to its implementation. After Tri-County learned of the change, it notified the District which then notified faculty members.

On April 28, 1989, Blue Cross notified Tri-County of the monthly rate increase to $37.03 per employee and its insistence on a series of changes in the plan. These included all of the changes first requested in August of 1988 plus a reduction in coverage for nervous, mental and substance abuse benefits.

By letter of May 2, 1989, the District notified the Association about the health plan changes Blue Cross planned to insert into the contract. The letter invited the Association to contact the District business manager if it had concerns "about the fiscal impact on faculty members."[6] The District followed on May 8, 1989, with a letter advising that it was "ready and willing to continue bargaining the changes" if the Association desired to do so. George Shaw, the District's chief negotiator, testified that the District viewed the changes as something imposed by a third party which in effect reopened the contract if the union wished to negotiate. The Association, however, did not respond to the offer to negotiate.

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[6]The District describes this letter as the first of "seven letters to the Charging Party informing it of changes and offering to discuss and negotiate those changes with the Charging Party." I believe that four of the letters reasonably can be read as offering the Association the opportunity to begin negotiations. These are the letters of May 2, 1989, (Charging Party Exhibit no. 3); May 8, 1989, (Charging Party Exhibit no. 4); May 17, 1989, (Charging Party Exhibit no. 5); and July 17, 1989, (Charging Party Exhibit no. 13).

On May 15, 1989, Blue Cross sales manager DeTour notified Tri-County that Blue Cross would not renew its contract, thereby cancelling its insurance effective July 1, 1990. He attributed the decision not to renew to low participation of Tri-County employees[7] in Blue Cross. On May 17, District administrator George Souza wrote Association President Finstad about the Blue Cross cancellation and proposed shifting coverage to Gallagher Bassett. He invited the Association to offer alternative proposals and offered to meet and negotiate about the issue.

The Association did not immediately reply to the District's letter, but Mr. Finstad did promptly contact Mr. DeTour of Blue Cross. He urged Mr. DeTour to rescind his cancellation of insurance and warned that Blue Cross would be drawn into a labor dispute if it did not. District business manager Ruby Henry, by separate communications, also urged Mr. DeTour to rescind the cancellation of insurance.

By letter of May 22, 1989, Mr. DeTour rescinded cancellation of the Blue Cross Tri-County Schools plan. However, he adhered to the schedule of charges set out in his April 28 letter and described the following contractual changes as "mandated and will be implemented:"

1) A 25 percent cutback in payments for non-contracting hospitals;

2) A ninety-day limit for claims submission;

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[7]In his letter of cancellation, Mr. DeTour put the level of participation at between 5 percent and 6 percent.

3) Institution of a managed care package.

He waived his earlier insistence on a reduction in nervous and mental benefits.

District administrator Souza testified that the changes were imposed by Blue Cross. He said he asked if the plan the District previously enjoyed could be obtained at any price but was told that it could not. Mr. DeTour confirmed in testimony that the changes were mandatory, citing the language of his letter. He said the changes were going into all 365 Plus plans which Blue Cross had in effect. He said that company policy demanded that the changes be made.

Association President Finstad consulted with the union's representative council, first about the threatened cancellation of the Blue Cross plan, and then about the subsequent changes in coverage. The council concluded that the union should not negotiate with the District and directed Mr. Finstad to press for continued coverage under the existing plan. The union officers concluded that they were under no obligation to negotiate because of the existence of a zipper clause in their contract with the District.[8]

By letter of May 22, Association President Finstad informed the District that it declined to meet and negotiate regarding

[8]Article 17.3 of the agreement provides that during the life of the contract, "the Board and the Association expressly waive and relinquish the right to bargaining collectively on matters" except for certain specified exceptions. The Association concluded that the proposed Blue Cross changes did not fit into any of the listed categories.

alternative health insurance. He asserted that the District had engineered the changes in order to unilaterally impose the Gallagher Bassett plan on the faculty. He insisted that the District continue to offer the Blue Cross 365 Plus plan as required under the contract between the parties.

By letter of June 27, Association attorney Robert J. Bezemek advised the District that the union considered the changes in the plan to be mid-term unilateral changes. He demanded that the District restore the benefits that existed prior to the unilateral changes. He warned that a failure to make the change would result in the filing of an unfair practice.

At least one unit member was negatively affected by the change in health plan coverage. That member's son was treated in a non-contracting hospital. Under the revised plan, the unit member was reimbursed for only 75 percent of the costs.

LEGAL ISSUE

Did the District unilaterally change health benefit coverage and thereby fail to negotiate in good faith in violation of Section 3543.5(c) and, derivatively, (a) and (b)?

CONCLUSIONS OF LAW

It is well settled that an employer that makes a pre-impasse unilateral change in an established, negotiable practice violates its duty to meet and negotiate in good faith. NLRB v. Katz (1962) 369 U.S. 736 [50 LRRM 2177]. Such unilateral changes are inherently destructive of employee rights and are a failure per se of the duty to negotiate in good faith. See Davis Unified

School District, et al. (1980) PERB Decision No. 116; State of California (Department of Transportation) (1983) PERB Decision No. 361-S.

Established practice may be reflected in a collective bargaining agreement (Grant Joint Union High School District (1982) PERB Decision No. 196) or where the agreement is vague or ambiguous, it may be determined by an examination of bargaining history (Colusa Unified School District (1983) PERB Decisions No. 296 and 296(a)) or the past practice (Rio Hondo Community College District (1982) PERB Decision No. 279, Pajaro Valley Unified School District (1978) PERB Decision No. 51).

An employer makes no unilateral change, however, where an action the employer takes does not alter the status quo. "[T]he 'status quo' against which an employer's conduct is evaluated must take into account the regular and consistent past patterns of changes in the conditions of employment." Pajaro Valley Unified School District, supra. PERB Decision No. 51. Thus, where an employer's action was consistent with the past practice, no violation was found in a change that was not a change in the status quo. Oak Grove School District (1985) PERB Decision No. 503.

The Association argues that health benefits are negotiable subjects under the EERA. Any unilateral change in health benefits which intimately affects employees, the Association continues, is a failure to negotiate in good faith and an unfair practice. The union contends that the status quo was the level

of benefits outlined in the certificate of coverage at the time the contract was signed. The union argues that the employer was obligated to maintain those benefits for the life of the contract. In addition, the Association rejects the contention that the changes were mandated by Blue Cross. It argues instead that the District used the changes as part of a strategy to convince employees to agree to a different carrier.

The District sets out a multi-faceted defense. There has been no unilateral change, the District argues first, because it at all times has been in compliance with the contract. The contract requires only that it furnish the Blue Cross 365 Plus plan and, the District argues, it has done this. The District contends that the contract does not require the maintenance of any specific medical coverage without the possibility of modification. Thus, changes in the plan did not, in the District's view, change the status quo.[9]

It is undisputed that the subject of health benefits is clearly negotiable under the EERA.[10] The key question in these

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[9]The District sets out three additional arguments: 1) that the Association waived its right to bargain when, after receiving notice of the impending changes, it made no demand to negotiate; 2) that the changes in the health care plan were implemented as a business necessity, and 3) that its actions were excused under the doctrine of impossibility of performance. As will be seen, it is unnecessary to reach any of these contentions.

[10]In relevant part, EERA section 3543.2 provides as follows:

> (a) The scope of representation shall be limited to matters relating to wages, hours of employment, and other terms and conditions of employment. "Terms and conditions of employment" mean health and welfare benefits as defined by Section 53200 . . . .

facts is whether the employer made a unilateral change. The answer lies in determining the nature of the status quo prior to the change in benefits. If, as the Association argues, the status quo was the exact set of insurance benefits in place at the time of the signing of the contract, then the District made a change. If, as the District argues, the status quo was the particular plan in its continuously evolving form, then the District made no change.

The prevailing weight of the evidence lies with the District. The status quo was, as the District argues, the Blue Cross 365 Plus plan, a plan whose terms had evolved over the years. The status quo was not a particular set of benefits in place on the date the contract was entered in 1987. Both the text of the applicable contract clause and the past practice support this finding.

As the District argues, the very wording of the applicable contractual clause implies that the plan could change. The contract requires only one specific type of benefit, an annual physical exam for member and spouse. Reference to such a specific benefit implies the possibility of plan changes but ensures retention of annual physical exams, regardless. If the contract were intended to preclude all changes, one might expect it to incorporate the plan's benefits as contained in plan documents as of a certain date. Or, one might expect the contract to set out a more detailed listing of health benefits. The contract clause does neither.

Moreover, District negotiator George Shaw testified without contradiction that Blue Cross had made several uncontested changes since the plan was written into the contract. Thus the status quo was a "regular and consistent past pattern. . . of changes"[11] in the health plan. At any given time, the 365 Plus plan in effect was different from the plan by the same name in effect at an earlier time. There is no evidence that the changes of 1989 were in any way inconsistent with past changes.[12]

The burden of proof for showing a change in the past practice is that of the charging party. Oak Grove School District, supra, PERB Decision No. 503. On this set of facts, I cannot conclude that the Association has met its burden of proof. The charging party has failed to establish by a preponderance of the evidence that the District made any unilateral change and thereby failed to meet and confer in good faith. Accordingly, I conclude that the complaint must be dismissed.

PROPOSED ORDER

Based upon the foregoing findings of fact and conclusions of law and the entire record in this matter, unfair practice charge S-CE-1308, Yuba College Faculty Association v. Yuba Community

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[11]Pajaro Valley Unified School District, supra, PERB Decision No. 51.

[12]The Association presented no evidence to counter testimony that the changes were consistent with a past practice of changes in the health plan. Changes that so deviate from the past practice as to change its "quantity and kind" are inconsistent with the status quo and constitute a failure to negotiate in good faith. Oakland Unified School District (1983) PERB Decision No. 367.

College District, and the companion PERB complaint are hereby DISMISSED.

Pursuant to California Administrative Code, title 8, part III, section 32305, this Proposed Decision and Order shall become final unless a party files a statement of exceptions with the Board itself at the headquarters office in Sacramento within 20 days of service of this Decision. In accordance with PERB Regulations, the statement of exceptions should identify by page citation or exhibit number the portions of the record, if any, relied upon for such exceptions. See California Administrative Code, title 8, part III, section 32300. A document is considered "filed" when actually received before the close of business (5:00 p.m.) on the last day set for filing ". . .or when sent by telegraph or certified or Express United States mail, postmarked not later than the last day set for filing. . . ." See California Administrative Code, title 8, part III, section 32135. Code of Civil Procedure section 1013 shall apply. Any statement of exceptions and supporting brief must be served concurrently with its filing upon each party to this proceeding. Proof of service shall accompany each copy served on a party or filed with the Board itself. See California Administrative Code, title 8, part III, sections 32300, 32305 and 32140.

Dated: August 6, 1990

RONALD E. BLUBAUGH
Administrative Law Judge