STATE OF MICHIGAN
EMPLOYMENT RELATIONS COMMISSION
LABOR RELATIONS DIVISION

In the Matter of:

BERRIEN COUNTY INTERMEDIATE SCHOOL DISTRICT,
Public Employer - Respondent,

-and-

MICHIGAN EDUCATIONAL SUPPORT PERSONNEL ASSOCIATION,
Labor Organization - Charging Party in Case No. C04 G-203,

-and-

BERRIEN COUNTY INTERMEDIATE PARAPROFESSIONAL PERSONNEL ASSOCIATION,
Labor Organization - Charging Party in Case No. C04 H-206.
_____/

APPEARANCES:

Thrun Law Firm, P.C., by Kevin S. Harty, Esq., for Respondent

White, Schneider, Young & Chiodini, P.C., by Jeffrey S. Donahue, Esq., for Charging Parties

DECISION AND ORDER

On May 31, 2006, Administrative Law Judge (ALJ) David M. Peltz issued his Decision and Recommended Order in the above matter finding that Respondent, Berrien County Intermediate School District (Employer), did not violate its duty to bargain in good faith when it replaced a fully funded health insurance program with a self-funded one for members of the bargaining units represented by Charging Parties, the Michigan Educational Support Personnel Association (MESPA) and the Berrien County Intermediate Paraprofessional Personnel Association (BCIPPA). The ALJ found that Respondent had not violated Section 10(1)(e) of the Public Employment Relations Act (PERA), 1965 PA 379 as amended, MCL 423.210(1)(e), as alleged in the charges, and recommended that the charges be dismissed. The Decision and Recommended Order of the ALJ was served upon the interested parties in accordance with Section 16 of PERA. Charging Parties were granted an extension until July 21, 2006 to file exceptions to the ALJ's Decision and Recommended Order. On July 21, 2006, Charging Parties filed exceptions and a brief in support of the exceptions. Respondent was granted an extension

to file a response to the exceptions, and its brief in support of the ALJ's Decision and Recommended Order was filed on August 28, 2006.

In their exceptions, Charging Parties contend that the ALJ erred when he found that Respondent's change from a fully insured health-care plan to a self-funded plan was not a violation of the duty to bargain, because health insurance was a matter covered by the parties' collective bargaining agreements and Charging Parties had already exercised their bargaining rights with respect to the matter. Charging Parties assert that the ALJ erred in finding that there had been no substantive changes to the health insurance program that would give rise to a duty to bargain. Further, Charging Parties argue that the ALJ erred by relying on this Commission's decision in *Gogebic Cmty College*, 1999 MERC Lab Op 28, and by failing to find persuasive the arbitration decisions they have cited. We have reviewed the Charging Parties' exceptions and find them to be without merit.

Factual Summary:

We adopt the findings of fact contained in the ALJ's Decision and Recommended Order and will not repeat them herein except as necessary. BCIPPA and MESPA each represent a bargaining unit of Respondent's employees and have entered into collective bargaining agreements with Respondent on behalf of those units. BCIPPA's contract with Respondent, on behalf of its unit of paraprofessional employees, covered the period of July 1, 2003 through June 30, 2005. The contract between the Employer and MESPA, on behalf of bus drivers and bus attendants ran from 2001 to 2005. Both agreements required Respondent to provide health insurance coverage that included a specific level of benefits but did not identify any particular insurance carrier.

The contract between the Employer and BCIPPA provides, at Article XV, Section 6, that it constitutes the parties' "sole and existing agreement." Article XV, Section 7, entitled "Waiver Clause," states that the Employer and BCIPPA each waive the right to further bargaining regarding "any subject or matter referred to, or covered in this Agreement" or matters not specifically referred to therein. Article XII, Sections 4 and 5 of MESPA's collective bargaining agreement with the Employer contains similar language.

When Charging Parties learned, in June 2004, that the Employer was changing from the fully insured health-care plan to a self-funded plan, Charging Parties demanded bargaining over the issue. Respondent refused to negotiate the change, asserting that it was unnecessary because coverages and benefits would not be altered by the change to a self-funded plan. The self-funded plan became effective for both bargaining units on July 1, 2004.

The main difference between the fully insured health care plan and the self-funded plan is the assignment of risk. With the self-funded plan, it became the Employer's responsibility to pay the first $75,000 of individual claims made per year by plan participants. For individual claims totaling more than $75,000 per year and

aggregate claims of over $2.88 million per year, Respondent purchased excess loss insurance. In addition, Respondent has set aside a $100,000 reserve in its general fund and a $300,000 reserve in its special education fund to protect itself against unanticipated or catastrophic claims.

There have been no changes in benefits or coverages and no substantive changes in the processing or adjudication of claims since the Employer moved to the self-funded plan. The self-funded plan is administered by a third party, Administrative Systems Research (A.S.R.), the insurer who administered the former, insured plan. Under the self-funded plan, participants retain the right to appeal adverse claim decisions and obtain an independent review of the decision by a plan fiduciary. The review must be done by an individual who is neither the original decision maker nor a subordinate of the original decision maker. Further, where the appeal challenges a medical judgment, the fiduciary must consult with a healthcare professional who has training and experience in the relevant field of medicine.

Since Respondent is now an entity that provides or pays for the cost of medical care, it is subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Publ L 104-191, and its related privacy rule, 65 FR 82462, which protect the confidentiality and security of medical records and other personal health information. Moreover, the school district has entered into a business associate agreement with A.S.R., a third party administrator. HIPAA, requires the third party administrator to use appropriate safeguards to prevent the unauthorized disclosure of personal health information.

Discussion and Conclusions of Law:

Charging Parties cite two arbitration decisions in support of their exception that the ALJ erred by following this Commission's previous decision in *Gogebic Cmty College*, 1999 MERC Lab Op 28. We disagree. The issues in *Gogebic* are analogous to those presently before us, that is, whether a public employer violated its duty to bargain by unilaterally changing from a fully insured plan to a self-funded one. In that case, we held that the employer did not unlawfully modify its collective bargaining agreement by unilaterally replacing a fully insured, dental insurance plan with a self-funded plan. In *Gogebic*, health, vision, and dental insurance benefits were set forth in a contract provision entitled "Insurance Protection" that named a specific insurer for health and vision benefits. Although the employer had used the same dental insurer for many years, no specific insurer was named for dental coverage. When the employer unilaterally changed to a self-funded dental plan, the union charged that the employer had breached its duty to bargain. Since no particular dental insurer was specified in the collective bargaining agreement, we concluded that the contract permitted the employer to unilaterally determine the identity of the insurer. Our decision was affirmed by the Court of Appeals in *Gogebic Cmty College Mich Ed Support Personnel Ass'n v Gogebic Cmty College*, 246 Mich App 342 (1999).

Charging Parties contend that the ALJ erred by failing to find persuasive two

grievance arbitration decisions, *Waterford Sch Dist*, 101 LA 628 (Daniel, 1993), and *Milbank Mfg Co*, 102 LA 385 (High, 1994). They rely upon the two decisions for the proposition that a change to self-funding constitutes a breach of contract where the agreement requires the employer to provide "insurance" to members of the bargaining unit. However, it is for MERC to determine violations of PERA; an arbitrator who is deciding an alleged breach of contract does not have this authority. *Lamphere Sch v Lamphere Federation of Teachers*, 400 Mich 104, 118 (1977); *Rockwell v Crestwood Sch Dist Bd of Ed*, 393 Mich 616, 630 (1975). Thus, we find no error in the ALJ's reliance on our decision in *Gogebic* and his refusal to rely on the arbitration decision cited by Charging Parties.

We agree with the ALJ that where the collective bargaining agreements between the school district and the Unions use the terms "insurance," "hospitalization coverage," "health coverage," and "health and medical benefits" interchangeably, the Respondent did not unlawfully modify the terms of its contracts by switching to a self-funded plan. This is particularly so because neither collective bargaining agreement identifies a specific insurer or the particular method by which coverages and benefits are to be funded, and both contracts contain waiver clauses stating that they constitute the full agreement of the parties. Because Charging Parties had the opportunity to bargain more specific language pertaining to such funding, they have already exercised their bargaining rights. *Houghton Lake Cmty Sch*, 1997 MERC Lab Op 42, 47; *West Bloomfield Twp*, 1991 MERC Lab Op 525 (no exceptions).

Charging Parties assert that the ALJ erred in finding that there had been no substantive changes to the health insurance program that would give rise to a duty to bargain. We agree with the ALJ that Charging Parties have not established such changes. The record does not show that there have been substantive changes made to healthcare coverages or benefits. Neither has there been any change in the claim forms or procedures. While the Employer has now assumed responsibility for the cost of healthcare claims, the Employer has also purchased excess loss insurance and designated reserve funds to cover those costs. We note Charging Parties' concerns that the Employer now has access to employees' private health information, which may be misused by the Employer. However, the Employer's use of such information is restricted by HIPPA, and there has been no showing that any misuse of private information has occurred.

We have carefully considered all other arguments offered by Charging Parties and conclude that Charging Parties have failed to establish a violation of Section 10(1)(e) of PERA.

ORDER

IT IS HEREBY ORDERED that the Order recommended by the Administrative Law Judge shall become the Order of the Commission.

MICHIGAN EMPLOYMENT RELATIONS COMMISSION

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Christine A. Derdarian, Commission Chair

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Nino E. Green, Commission Member

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Eugene Lumberg, Commission Member

Dated: _____

STATE OF MICHIGAN
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In the Matter of:

BERRIEN COUNTY INTERMEDIATE SCHOOL DISTRICT,
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APPEARANCES:

Thrun Law Firm, P.C., by Kevin S. Harty, Esq., for Respondent

White, Schneider, Young & Chiodini, P.C., by Jeffrey S. Donahue, Esq., for Charging Parties

DECISION AND RECOMMENDED ORDER OF ADMINISTRATIVE LAW JUDGE

Pursuant to Sections 10 and 16 of the Public Employment Relations Act (PERA), 1965 PA 379, as amended, MCL 423.210 and 423.216, this case was heard at Lansing, Michigan on February 7, 2005, before David M. Peltz, Administrative Law Judge (ALJ) for the Michigan Employment Relations Commission. Based upon the entire record, including the pleadings, transcript and post-hearing briefs filed by the parties on or before April 5, 2005, I make the following findings of fact, conclusions of law, and recommended order.

The Unfair Labor Practice Charges:

The charge in Case No. C04 G-203 was filed by Michigan Educational Support Personnel Association, MEA/NEA (MESPA) on July 30, 2004, and amended on September 22, 2004. Berrien County Intermediate Professional Personnel Association, MEA/NEA (BCIPPA) filed its charge in Case No. C04 H-206 on August 2, 2004. The Unions allege that Respondent Berrien County Intermediate School District violated Section 10(1)(e) of PERA by terminating a fully

insured health insurance plan for members of their respective bargaining units and replacing it with a self-funded program.

Findings of Fact:

I. Background

A. BCIPPA Bargaining Unit

Charging Party BCIPPA represents a bargaining unit consisting of all paraprofessionals employed by the Berrien County Intermediate School District. At the time of the hearing in this matter, there were approximately 63 employees in the BCIPPA unit. BCIPPA and the Employer were parties to a collective bargaining agreement covering the period July 1, 2003 to June 30, 2005. Article XIV of that contract, which was entitled "Insurance," contained the following language:

> **Section 1**: During the term of this Agreement, except during any withholding of services, the Board shall purchase insurance coverage as follows:
>
> A.S.R. Physicians Care POS 100 ($-0-Deductible, $10/$25 co-pay)
> Prescription card ($10 co-pay; $-0- mail order co-pay)
> Negotiated Life $40,000 (as per letter of understanding)
> LTD @ 66-2/3%
> Dental (75% - including implants; Preventative @ 70%-80%-90%-100%; $1,500 annual max.)
> Vision (maximum reimbursement as follows): Exams - $75/year; Frames - $150/2 years; Lenses: regular lenses - $140/2 years; bi-focals - $150/2 years; tri-focals - $200/2 years; progressive - $250/2years; disposable contacts - $350/2 years; and non-disposable contacts - $150/year.
>
> Employees shall not be entitled to hospitalization coverage through the Board when substantially equivalent coverage is available through other employment or relative.
>
> Employees who are not eligible for hospitalization coverage, or who choose not to take such coverage, may subscribe to the following option plan:
>
> $200 per month tax shelter annuity
> LTD
> Life $40,000
> Plus options which may include Dental, Vision, and/or Rx Card as described above.
>
> * * *
>
> **Section 2**: For employees electing health coverage, the Board will pay 95% of the premium per month and the employee shall pay 5% of the premium per month. These percentages shall continue through the term of this Agreement.

Section 3: The Board shall purchase insurance coverage under this Article for each full-time staff member.

* * *

Section 5: The surviving spouse and/or dependent children (as per the IRS definition) of a staff member who dies during the term of employment with the District shall receive all health and medical benefits (including dental and vision) which were in place at the time of death for one (1) calendar year.

Article XV, Section 6 of the collective bargaining agreement between BCIPPA and Respondent acknowledged that the contract constituted the "sole and existing agreement" of the parties. Article XV, Section 7, which was entitled "Waiver Clause," provided that each side waived the right to further collective bargaining over "any subject or matter referred to, or covered in this Agreement" or matters not specifically referred to therein.

B. MESPA Bargaining Unit

Charging Party MESPA represents a bargaining unit consisting of approximately 32 regular and permanent substitute bus drivers and bus attendants employed by Respondent. MESPA and the school district were parties to a collective bargaining agreement covering the period 2001 to 2005. Health and medical benefits were set forth in Addendum C, Section 2 of the contract, which provided, in pertinent part:

SECTION 2: INSURANCE

A. During the term of this Agreement, except during any withholding of services, the Board shall purchase insurance coverage as follows: Set Ultra Med Health ($50/%100 deductible); negotiated life of $40,000; 66-2/3% LTD; Set Ultra Dent (60%-60%-60%); Set Ultra Vision (Max. reimbursement: exams - $75.00; frames - $80.00; regular lenses - $100.00; bi-focal - $115.00; tri-focal - $140.00; lenticular - $170.00; contacts - $237.00); and prescription card ($10.00 co-pay) to meet the requirements of each employee. Employees shall not be entitled to hospitalization coverage through the Board when substantially equivalent coverage is available through other employment or relative.

* * *

B. For employees electing health coverage, the Board shall pay 95% of the premium per month, and the employee shall pay 5% of the premium per month.
C. The Board shall purchase insurance coverage under this Article for each full-time staff member.

Addendum C, Section 3 of the MESPA contract states that the surviving family members of an employee who dies during the term of employment with the school district shall receive, for one calendar year "all health and medical benefits (including dental and vision) which were in place at the time of death." Article XII, Sections 4 and 5 of the contract contain language concerning waiver of bargaining rights similar to the waiver provisions in the BCIPPA agreement quoted above.

Sometime during the term of the agreement between MESPA and the school district, the parties learned that the Set Ultra Med Health plan was having difficulty finding an underwriter and might go out of business. For that reason, MESPA and Respondent agreed to change from Set Ultra Med Health to the A.S.R. Physicians Care POS 100 health plan, the same plan which was already in effect for members of the BCIPPA bargaining unit. The change, which became effective October 1, 2002, was memorialized in a Letter of Understanding signed by representatives of MESPA and the school district in September of 2002.

II. Change to Self-Funded Plan

Administrative Systems Research (A.S.R.) is a third party administrator which markets the A.S.R. Physicians Care POS 100 health plan. A.S.R. Physicians Care POS 100 is a product which provides specific health care benefits and coverages to plan participants. When A.S.R. Physicians Care POS 100 became effective for members of Charging Parties' bargaining units in 2002, AP Capitol was the underwriter of the plan. At that time, AP Capital purchased excess loss coverage to protect itself from catastrophic claims arising under the plan.

In June of 2004, Charging Parties became aware that Respondent intended to change from the traditional, fully insured health care plan to a self-funded program. Charging Parties demanded to negotiate with Respondent over the change, but the school district took the position that it was not required to bargain over the issue because the coverages and benefits for bargaining unit members would not change as a result of the implementation of the self-funded plan. The self-funded plan went into effect for the BCIPPA and MESPA bargaining units on July 1, 2004.

The principle difference between the fully insured plan and the new self-funded program is the assignment of risk. Under the fully insured plan, AP Capitol was responsible for paying claims arising under the A.S.R. Physicians Care POS 100 plan. Under the new self-funded plan, the school district is now responsible for paying the first $75,000 of individual claims made per year by the plan participants. The district has purchased an excess loss insurance policy to protect itself against individual claims totaling more than $75,000 in one year, and against aggregate claims in excess of $2.88 million annually. If claims payable exceed the agreed-upon limits, the excess loss carrier insurer will reimburse the school district for the covered expenses beyond those limits.

The change in the assignment of risk resulting from the implementation of the self-funded plan is explicitly referenced in the plan document, which sets forth the benefits and coverages of the school district's new health care program. The introductory section of the plan document provides, in pertinent part:

> This Plan is not an arrangement whereby each enrollee is covered by insurance. Instead, the Employer funds claims. Insurance may be purchased to protect the Employer against large claims. However, if for some reason the medical expenses that are eligible for payment under the Plan are not paid, the individuals covered by the Plan could ultimately be responsible for those expenses.

Under the self-funded plan, Respondent no longer pays a true "premium." Rather, the school district, in conjunction with A.S.R., established a "premium equivalent" or "illustrative premium" based upon actuarial studies and projected plan costs. For 2004-2005, the premium equivalent under the new plan per month was $908.28 per employee. Each month, Respondent transfers that amount for each participant, minus administrative fees and excess loss premiums, to an internal fund maintained specifically to pay medical claims. The total amount transferred into the fund per month is approximately $215,000. Individual plan participants continue to pay a monthly co-pay of $45.41, the same amount as before the change to the self-funded plan.

In addition to purchasing excess loss coverage, Respondent has set aside a $100,000 reserve in its general fund and a $300,000 reserve in its special education fund to protect itself against unanticipated or catastrophic claims. If necessary, the school district may also utilize its unrestricted general fund balance and its special education fund balance to satisfy its financial obligations under the self-funded plan. As of June of 2004, when the most recent audit of Respondent's finances was completed, the district's unrestricted general fund balance was $1,602,697, with a total fund equity of $2,021,470. The school district's unrestricted fund balance for the special education fund as of June of 2004 was $4,682,496.

The implementation of the self-funded plan has not resulted in any modifications to the benefits and coverages associated with the A.S.R. Physicians Care POS 100 plan. In fact, A.S.R. copied the specifications verbatim from the old plan to ensure that benefits and coverages would remain the same. Similarly, there have been no substantive changes with respect to the processing and adjudication of claims. Claims are submitted to A.S.R. by the health care provider or individual employee on an identical claim form. Upon receipt of a claim, A.S.R. utilizes a computer to make the initial claim adjudication, which is then reviewed by an A.S.R. claims analyst. The analyst assigned to Berrien County ISD at the time of hearing is the same individual who reviewed claims for the school district prior to July 1, 2004. For individual claims up to $75,000 year, claims are paid to the service providers by A.S.R. on Berrien County ISD checks.

The plan document gives the school district, as plan administrator, the right to have a claimant examined "as often as reasonably required" during the pendency of a claim and "the discretionary authority to decide all questions of eligibility for benefit payments and to determine the amount and manner of payment of claims." However, the plan document also allows the plan administrator the option to delegate all or a portion of its duties under the plan to other parties, including to the claim administrator, A.S.R. Respondent's human resources director, Lynda Hurlow, testified credibly that A.S.R. in fact makes all claim decisions for the school district and that her office has never been contacted by A.S.R. to discuss the adjudication of a particular claim.

The plan document gives individual participants the right to seek an internal appeal of any adverse claim decision within 180 days following the denial of a claim. In such situations, the claim determination is independently reviewed by a plan fiduciary who is neither the individual who made the initial adverse benefit determination, nor a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment, the named fiduciary is required to consult with a health care professional who has the proper training and experience in the relevant field of medicine.

Under the fully insured plan which was in place for bargaining unit members prior to July 1, 2004, adverse claim decisions could be appealed to the State of Michigan's insurance commissioner for an independent review. At the hearing in this matter, Lawrence Banek, a field representative for Michigan Education Special Services Association (MESSA), testified that the same right does not apply where the claimant is a participant in a self-funded plan. However, Ami McCulloch, an account representative with A.S.R., disputed Banek's testimony and asserted that participants in self-funded plans administered by A.S.R. have previously had their appeals heard by the insurance commissioner.

Banek testified that in the self-funded insurance arena, employers typically receive more detailed claim information than in connection with traditional, fully insured plans. In the instant case, Respondent is provided certain information by A.S.R. whenever an individual claimant exceeds the $75,000 annual limit under the excess loss policy. In such situation, the school district is notified of the claimant's name, the dates and amounts of the claims, and the identity of the service providers.

As an entity which provides or pays for the cost of medical care, Respondent is subject to the privacy standards set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Publ L 104-191, and its related privacy rule, 65 FR 82462, which protect the confidentiality and security of medical records and other personal health information. Moreover, the school district has entered into a business associate agreement with A.S.R. which, under HIPAA, requires the third party administrator to use appropriate safeguards to prevent the unauthorized disclosure of personal health information.

The school district has self-funded the vision and dental components of its health and medical benefit plans for Charging Parties' bargaining units since approximately 1987. The vision and dental plans are administered by SET/SEG, and there is no excess loss coverage in place for either plan.

Discussion and Conclusions of Law:

Charging Parties contend that Respondent violated its bargaining obligation under Section 15 of PERA by changing from a fully insured health plan to a self-funded program. Under Section 15 of the Act, public employers and labor organizations have a duty to bargain in good faith over "wages, hours and other terms and conditions of employment." Such issues are mandatory subjects of bargaining. *Detroit Police Officers Ass'n v Detroit*, 391 Mich 44, 54-55 (1974). A party violates Section 10(1)(e) of PERA if, before bargaining, it unilaterally modifies

a term or condition of employment, unless that party has fulfilled its statutory obligation or has been freed from it. *Port Huron Education Ass'n v Port Huron Area Sch Dist*, 452 Mich 309, 317 (1996). A party can fulfill its obligation under the Act by bargaining about a subject and memorializing the resolution of that subject in the contract. Under such circumstances, the matter is "covered by" the agreement. *Port Huron*, *supra* at 318; *St. Clair ISD*, 2000 MERC Lab Op 55, 61-62. Once the employer has fulfilled its duty to bargain, it has a right to rely on the contract as the statement of its obligations on any topic "covered by" that agreement. *Port Huron*, *supra* at 327.

It is well established that the benefits, coverage, and administration of a health insurance plan are mandatory subjects of bargaining under Section 15 of PERA. See e.g. *Taylor Sch Dist*, 1976 MERC Lab Op 693; *Houghton Lake Ed Ass'n v Houghton Lake Bd of Ed*, 109 Mich App 1, 7 (1981). In fact, Section 15(3)(a) of the Act explicitly recognizes the obligation of both public employers and labor organizations to bargain with respect to "types and levels of benefits and coverages for employee group insurance." MCL 423.215(3)(a). See also *St. Clair County ISD*, 2000 MERC Lab Op 55, 61-62. The Commission has recognized that the method used in processing employee claims, the carrier's practices and procedures in allowing or disallowing claims, and the dispatch and efficiency of personnel in processing such claims are factors which intimately affect employees under a collective bargaining agreement. *Taylor Sch Dist*, *supra* at 697. Although public employers are not required under PERA to bargain over the identity or selection of a particular insurance carrier, a bargaining duty does exist where a change of carrier entails a substantive alteration of benefit levels and plan administration. *Taylor Sch Dist*, *supra* at 697.

The Commission has previously considered whether a public employer violates its bargaining obligation under Section 15 of PERA by unilaterally changing from a traditional, fully insured insurance plan to a self-funded program. In *Gogebic Cmty College*, 1999 MERC Lab Op 28, the Commission held that the employer did not unlawfully modify its contract with the union when it unilaterally terminated a privately-written, fully insured, dental insurance plan and replaced it with an uninsured, self-funded dental plan. The contract in *Gogebic* contained a waiver clause which stated that the document constituted the full agreement of the parties. Health, vision, and dental insurance benefits were set forth in a contract provision entitled "Insurance Protection." Although the contract provided that a specific insurance carrier was to be used for health and vision benefits, no particular dental insurance carrier was identified. Rather, the contract simply required the employer to pay the full premium cost for all full-time employees and maintain a specified level of benefits. After using the same dental carrier for many years, the employer changed to a self-insured dental program without bargaining with the union. In a letter notifying the union of the change, the employer stated that the new plan "will not be insured" and that the third-party administrator "does not guarantee payment of any covered claim without receipt of college funds to adequately cover outstanding claims."

The Commission held that the employer's imposition of a self-funded dental plan did not constitute a midterm unilateral change in violation of PERA. Specifically, the Commission found that because the contract did not specify any particular dental carrier, the agreement gave the college the unilateral right to select a carrier for the dental insurance program. According to the Commission, the union had the opportunity to bargain for more specific language, as it did

for the health insurance plan and the vision program, but failed to do so. The Commission also rejected the union's contention that the change from a privately written, fully insured, plan to an uninsured, self-funded dental plan materially altered existing benefit levels and plan administration. The Commission noted that the college continued to pay the full cost associated with the program, there had been no change in benefits, claim forms or procedures, and the employer had in place a contingency fund to insure the financial security of the plan's coverage. In so holding, the Commission cited the testimony of the college's dean of business services, who asserted that the employer would not, as a result of the change, become involved with decisions relating to the approval or denial of particular claims. On appeal, the Court affirmed the Commission's findings and conclusions of law. *Gogebic Cmty College Mich Educational Support Personnel Ass'n v Gogebic Cmty College*, 246 Mich App 342 (1999).

In the instant case, neither Addendum C, Section 2 of the support unit contract, nor Article XIV of the paraprofessional contract, specifically identify a particular method by which the health insurance plan is to be funded. Rather, the contracts, in conjunction with the October 2002 Letter of Understanding covering the MESPA unit, merely identify the deductibles and co-pays required of bargaining unit members and mandate that Respondent provide A.S.R. Physicians Care POS 100, with the school district responsible for paying 95 percent of the monthly premium and employees responsible for the remaining 5 percent. As in *Gogebic*, Charging Parties had the opportunity to bargain more specific language pertaining to the funding of the health insurance plan, the identity of the underwriter, and the financial obligations of the school district, but failed to do so. Moreover, the contracts between the Unions and the school district each contain waiver clauses stating that the contracts constitute the full agreement of the parties. Under such circumstances, I conclude that health insurance is a matter "covered by" the collective bargaining agreements and that Charging Parties have already exercised their bargaining rights regarding funding of the health insurance plan. *Houghton Lake Cmty Schools*, 1997 MERC Lab Op 42, 47; *Twp of West Bloomfield*, 1991 MERC Lab Op 525.

In so holding, I explicitly reject Charging Parties' contention that the various references in the collective bargaining agreements to "insurance" prohibit the school district from implementing a self-funded health plan. Charging Parties argue that the self-funded program which the Employer implemented in July of 2004 is not "insurance" as envisioned under the contracts because Respondent is not required to pay a fixed monthly premium, and because individual bargaining unit members may be liable for the full cost of claims arising under the self-funded plan if the school district fails to make the required payments. In support of this contention, Charging Parties rely upon two grievance arbitration decisions which arguably stand for the proposition that the change to self-funding constitutes a breach of contract where the agreement requires the employer to provide "insurance" to members of the bargaining unit. See *Waterford Sch Dist*, 101 LA 628 (Daniel, 1993); *Milbank Manufacturing Co*, 102 LA 385 (High, 1994).

The decisions cited by Charging Parties notwithstanding, MERC possesses the exclusive jurisdiction to determine violations of PERA. *Lamphere Sch v Lamphere Federation of Teachers*, 400 Mich 104, 118 (1977); *Rockwell v Crestwood Sch Dist Bd of Ed*, 393 Mich 616, 630 (1975). As noted, the Commission in *Gogebic* held that no PERA violation resulted from the employer's unilateral imposition of a self-funded medical plan. The Commission made such

a finding even though the parties' agreement with respect to health, vision and dental benefits was embodied in an article of the contract entitled "Insurance Protection" and despite the employer's concession to the union that the new plan would not be "insured." Charging Parties' argument also overlooks the fact that the collective bargaining agreements between the school district and the Unions apparently use the terms "insurance," "hospitalization coverage," "health coverage" and "health and medical benefits" interchangeably. Moreover, despite reference in the agreements to "insurance," Respondent has self-funded its dental and visions benefits for many years. For these reasons, I conclude that the school district did not unlawfully modify the terms of its contracts by implementing a self-funded plan.

I further conclude that Charging Parties have not established that any substantive changes have been made to the health insurance program so as to give rise to a bargaining duty on the part of the school district. Respondent still provides the A.S.R. Physicians Care POS 100 health plan to bargaining unit members, with the school district continuing to be responsible for paying 95 percent of the monthly "premium." The five percent employee co-pay remains $45.41 per month, just as it was prior to the implementation of the self-funded program. The benefits and coverages as set forth in the plan document have not been modified. Moreover, there has also been no change in the claim forms or procedures. Although Respondent is now responsible for the cost of all claims associated with the program, the district has taken steps to insure the financial security of the plan's coverage. Respondent has purchased excess loss insurance coverage which protects the district against catastrophic claims over $75,000 per participant in a given year, or aggregate claims totaling over $2.88 million per year. In addition, Respondent has designated reserves within its general and special education funds to cover expenditures relating to the health program. In the event that these reserves prove insufficient to cover medical expenses, Respondent may also draw from its unrestricted fund equity. Accordingly, I find no evidence that Respondent's change to self-funding presents a significant risk to the financial stability of the plan.

Charging Parties contend that the change to a self-funded plan materially altered the existing benefits of its members because, as a result of the implementation of the program, Respondent now has the authority to unilaterally deny payment of specific claims. In support of this contention, Charging Parties refer to specific provisions in the plan document giving the plan administrator, i.e. the school district, the authority to decide all questions of eligibility for participation and benefit payments and to determine the amount and manner of such payments. However, the Unions concede that they have no knowledge that any bargaining unit member has been improperly denied benefits under the plan, and there is no evidence in the record suggesting that Respondent has ever exercised its authority under the plan document to deny or limit payment of any claim. To the contrary, the record establishes that claim determinations are made solely by A.S.R., just as they were prior to the implementation of the self-funded plan. The determination is initially made by a computer and then reviewed by an A.S.R. claim analyst, who examines the information to ensure that the claim was properly adjudicated. The claim analyst assigned to the school district is the same individual who reviewed claims for Respondent prior to July 1, 2004. In fact, Respondent's human resources director testified that

her office has never been contacted by A.S.R. to discuss a specific claim involving a bargaining unit member.[1]

Finally, I find no merit to Charging Parties' contention that the change to a self-funded plan materially altered terms and conditions of employment by giving Respondent access to the personal health information of its employees. Although the record indicates that employers generally receive more detailed claim information under a self-funded plan than with a traditional, fully insured plan, Charging Parties failed to establish exactly what type of information was available to Berrien County ISD prior to the change. There is also nothing in the record identifying the specific type and nature of information currently provided to the school district for ordinary claims. Although Respondent does receive certain information once its excess loss policy has been invoked, the district is not privy to any information concerning the claimant's health history or medical condition. Moreover, as a "covered entity" under HIPAA, Respondent is legally required to protect the confidentiality and security of medical records and other personal health information. Respondent has also entered into a business associate agreement with A.S.R. which sets limitations on the third party administrator's use of personal health information. I find that Charging Parties have failed to establish that any significant change occurred with respect to the Employer's access to claim information so as to give rise to a bargaining obligation on the part of the school district.

I have carefully considered all other arguments of the parties and conclude that they do not warrant a change in the outcome. Based upon the above facts and conclusions of law, I find that Charging Parties have failed to establish a violation of Sections 10(1)(e) of PERA. It is therefore recommended that the Commission issue the order set forth below:

RECOMMENDED ORDER

The unfair labor practice charges are hereby dismissed in their entirety.

MICHIGAN EMPLOYMENT RELATIONS COMMISSION

_____

David M. Peltz
Administrative Law Judge

Dated: _____

[1] In a further attempt to establish that implementation of the self-funded plan resulted in a substantial change to the claim review process, Charging Parties assert that bargaining unit members no longer have the right to seek an impartial review of an adverse claim determination. The *Patient's Right to Independent Review Act* (PRIRA), MCL 550.901 *et seq.*, provides that any individual covered by a health plan who has had a claim denied or reduced by a "health carrier" may initiate a request for review with the insurance commissioner. MCL 550.1911. The PRIRA defines "health carrier" to include any entity "providing a plan of health insurance, health benefits or health services." MCL 550.1903(s). Assuming arguendo that the transition to a self-funded plan had the effect of precluding PRIRA appeals, I find that such a result constitutes, at most, a *de minimis* change in terms and conditions of employment. In so holding, I note that the plan document contains an internal appeal process pursuant to which a bargaining unit member may seek an independent review of an adverse claim determination by a plan fiduciary.