BOARD OF REGENTS OF HIGHER EDUCATION AND UNIVERSITY STAFF ASSOCIATION/MTA/NEA, SUP-3267 AND 3268 AND 3269 AND 3270 AND 3271 AND 3272 (8/24/92).

28.	Relationship Between c.150E and Other Statutes Not Enforced by Commission
54.611	health insurance
54.6111	health insurance trust fund
54.8	mandatory subjects
67.15	union waiver of bargaining rights
67.162	preemption by other legislation
67.163	"substantial detriment" test
67.8	unilateral change by employer
82.3	status quo ante

Commissioners Participating:

Maria C. Walsh, Chairperson
Haidee A. Morris, Commissioner
William G. Hayward, Jr., Commissioner

Appearances:

Margery Williams, Esq.	- Representing the University Staff Association/MTA/NEA, et al.
Joyce Kirby, Esq.	- Representing the Board of Regents of Higher Education

DECISION

Statement of the Case

On June 1, 1988, the Massachusetts Community College Council/MTA/NEA (MCCC), the Massachusetts Society of Professors/University of Lowell/MTA/NEA (MPS Lowell), the University Staff Association/MTA/NEA (USA), and the Association of Professional Administrators/MTA/NEA (APA), filed charges with the Labor Relations Commission (Commission) alleging that the Board of Regents for Higher Education (Board of Regents or Regents) had engaged in prohibited practices within the meaning of Sections 10(a)(5) and (a)(1) of Massachusetts General Laws Chapter 150E (the Law) by: 1) unilaterally changing health insurance carriers without affording the Unions prior notice and an opportunity to bargain over the decision and its impacts; 2) failing and refusing to bargain on demand over the mandatory subjects of the decision to change health insurance carriers and its impacts; and 3) failing to provide the Unions with copies of a requested insurance policy. On June 2, 1988, the Massachusetts Society of Professors/Faculty Staff Union/MTA/NEA (MSP/FSU) and the Massachusetts State College Association/MTA/NEA (MSCA) filed charges making the same allegations with the Commission.

Following an investigation, the Commission issued Complaints of Prohibited Practice on December 22, 1988 in each of the cases. The Unions (MCCC, MSP Lowell,

USA, APA, MSP/FSU, and the MSCA) filed a Motion to Amend the Complaints on April 7, 1989, and the Commission issued amended Complaints on April 13. As amended, the Complains alleged that the Board of Regents violated Sections 10(a)(5) and (1) of the Law by: 1) unilaterally changing the carrier of the indemnity insurance plan and the plan itself without bargaining to impasse or resolution with the Unions over the decision and its impacts; 2) refusing to bargain in good faith regarding the decision to change the carrier of the indemnity health insurance plan, the plan itself and its impacts; and 3) refusing to provide the Unions with requested information.

The Board of Regents filed a Motion to Dismiss the Complaints in cases numbered MUP-3267 and 3271 on April 12, 1989. By letter dated April 19, 1989, the Commission notified the parties that it had deferred action on the Motion until after the close of the hearing.

At the request of the parties, the Commission redesignated the case "formal" pursuant to 456 CMR 13:02(1) and informed the parties that it would defer issuing its decision in the case until the Hearing Officer issued Recommended Findings of Fact. The hearing took place before Hearing Officer Susan Atwater, Esq. on April 12, June 5, September 20, October 23 and October 25, 1989. On April 18, 1990 the hearing officer issued her Recommended Findings of Fact. Both parties filed objections to the Findings of Fact and supplementary statements on the legal issue.[1] Based upon all of the evidence presented and in consideration of the parties' supplementary statements, the Commission makes the following findings of fact and renders the following opinion.

Findings of Fact

A. The Group Insurance Commission

The Group Insurance Commission (GIC), an agency of the Commonwealth, was established pursuant to M.G.L. c.32A (Chapter 32A), Section 3 in order to provide policies of group insurance for Commonwealth employees, retirees, and their dependents. Section 4 of Chapter 32A empowers the GIC to negotiate and purchase policies of insurance on the terms it deems to be in the best interests of the Commonwealth and its employees and to execute all agreements or contracts pertaining to insurance for, on behalf of, and in the name of the Commonwealth. The GIC is established within the Executive Office of Administration and Finance but is not subject to its jurisdiction. The GIC is comprised of the Commissioner of Administration and Finance, the Commissioner of Insurance, and nine members appointed by the Governor. Of the nine members, one must be a retired state

---

[1] The issue of the Employer's identity for the purposes of any remedial order is discussed below.

employee, one a health economist, and at least three must be full-time state employees. Of the three state employees, one must be a member of the Massachusetts Public Employees Council 93, AFSCME, AFL-CIO, one must be a member of the Massachusetts State Employees Association, NAGE, and one must be a member of Local 254, S.E.I.U., AFL-CIO. Section 3A of Chapter 32A provides for an employees' advisory committee (EAC) consisting of representatives of insured employees and retirees.[2]

Presently, the GIC has a staff of approximately sixty-eight people. The GIC staff is responsible for, among other things, handling funds, paying premiums and claims, recording coverage selection information and responding to citizen information requests. Each month, the GIC receives approximately 5,000 telephone inquiries, 1,000 written inquiries and 500 in-person inquiries.

The GIC offers eligible employees, retirees, and their dependents one indemnity insurance plan[3] and a variety of health maintenance organization plans. The indemnity plan is funded by state appropriations and employee contributions and is specifically designed by the GIC to meet the varying needs of its subscribers.[4] The indemnity plan is administered by third-party health insurance providers. The GIC is able to design a unique indemnity plan because of the large number of individuals covered by the GIC plan. Of the 270,000 people covered by GIC insurance plans, 71,000 are covered by the indemnity plan.[5] It has been the GIC's long-standing position that the Commonwealth's health insurance plans are not subject to collective bargaining.[6]

---

2 The EAC has been inactive since 1983

3 When questioned concerning the possible result of offering more than one indemnity insurance plan, GIC Executive Director Dolores Mitchell testified that premium rates could increase since a reduction in size of the pool of subscribers would place a greater burden of protection against the risk of high utilization. She also stated that an increase in the number of indemnity plans offered could affect the cost of the plans if it required the employment of additional staff, or if the distribution of subscribers within each plan was not random. The Union correctly, albeit narrowly, notes that her testimony did not directly address the effect of collective bargaining on the GIC's indemnity insurance plan(s).

4 After the GIC designed the indemnity plan, it selected the plan administrator in accordance with a competitive bidding procedure.

5 137,000 of the 270,000 are active or retired state employees and approximately 7,000 are represented by the charging party unions in this case. There is no evidence of how many of those 7,000 employees are covered by the indemnity health insurance plan. The GIC maintains no records of which employees are represented by which unions and they are not indexed by union membership in the GIC's computers.

6 (see page 1251)

B. The Parties

The Board of Regents of Higher Education is an agency of the Commonwealth that administers the system of public higher education in Massachusetts and is a public employer within the meaning of M.G.L. c.150E §1. The Board is independent of the GIC and the Executive Office of Administration and Finance. The Board of Regents is required to submit a detailed estimate of the costs of maintaining the public education system and requests for capital outlays pursuant to Section 6 of M.G.L. 15A. There is no other statutory reporting requirement between the Regents and the Executive Office of Administration and Finance.[7]

The charging parties (Unions) are employee organizations within the meaning of Section 1 of the Law which represent certain groups of employees in the public higher education system administered by the Board of Regents. The University Staff Association/MTA/NEA (USA) represents the support staff at the University of Massachusetts, the Association of Professional Administrators/MTA/NEA (APA) represents certain state college administrators, the Massachusetts Community College Council/MTA/NEA (MCCC) represents community college faculty and certain professional staff, the Massachusetts Society of Professors/University of Lowell/MTA/NEA (MSP Lowell) represents the faculty and librarians at the University of Lowell, the Massachusetts Society of Professors/Faculty Staff Union/MTA/NEA (MSP-FSU) represents the faculty and librarians at the University of Massachusetts and the Massachusetts State College Association/MTA/NEA (MSCA) represents state college faculty and librarians. All of the Unions are affiliated with the Massachusetts Teachers Association (MTA) and the National Education Association (NEA).[8]

---

6 (from page 1250)
The GIC regulations provide in pertinent part:

Nothing in M.G.L. c.32A (public employees' group insurance) shall be construed as being within the jurisdiction of any of the provisions of M.G.L. c.150E (public employees' collective bargaining) as may be amended from time to time. These are two separate and distinct laws without any relationship to each other. The group insurance law sets forth a declared legislative purpose and a statutory scheme that excludes any and all collective bargaining agreements; it is a statewide system, uniform as to rates, risks and coverages. It encompasses all eligible insureds irrespective of any collective bargaining affiliation and of no collective bargaining affiliation. Any reference to group insurance in a collective bargaining agreement shall be informational only and shall not be binding or have any force or effect upon the Group Insurance Commission. 805 C.M.R. 5.08.

7
The Unions requested certain findings pertaining to the employment background of the previous Secretary of Administration and Finance, as well as the cooperation between the Board of Regents and the GIC in the litigation of this case. Because such facts are not germane to our discussion, we decline to make the requested findings.

8 (see page 1252)

C. Past Insurance Carriers and Benefits

Between July 1, 1973 and September 30, 1977, the GIC offered employees of the public higher education system an indemnity insurance plan administered by Aetna Life Insurance Company. From October 1, 1977 to June 30, 1988, Blue Cross/Blue Shield administered the GIC's indemnity insurance plan. On December 16, 1987, the GIC voted to award the indemnity insurance contract to the John Hancock Mutual Life Insurance Company (John Hancock). Consequently, effective July 1, 1988, employees represented by the charging parties were eligible to be covered by the John Hancock plan.

Periodically, each of the indemnity health insurance plans offered by the GIC from July 1, 1974 to June 30, 1988 was amended to reflect changes in premium rats and benefits. Statutory changes mandated some of the amendments and the GIC initiated others.[9] Over time, the substantive amendments embodied a trend of gradually increasing coverage. Changes in premium rates resulted from negotiations between the GIC and the incumbent insurance carrier. The GIC did not notify any of the Unions when these plans were amended and the Unions did not know that these changes were made.[10]

---

8 (from page 1251)

The MTA, not the MSCA, is the certified bargaining agent for the state college faculty and librarians. The MSCA is a subgroup through which the MTA negotiates and manages labor agreements.

The charging parties were certified as the bargaining representatives of the employees involved on the following dates:

1. MTA (MSCA):
   a. for the employees of Westfield, North Adams and Salem State Colleges, on or before July 1, 1974;
   b. for employees of Framingham State College, December 2, 1975;
   c. for all employees of all State Colleges, December 27, 1977.
2. APA: June 6, 1980
3. MCCC: February 10, 1976
4. MSP/Lowell: April 28, 1976
5. USA: April 10, 1980
6. MSP/FSU: March 10, 1977

9

The amendments to the indemnity plans offered by GIC from July 1, 1974 to June 30, 1988 are listed in Appendix A. The amendments marked with an asterisk (*) resulted from a statutory mandate.

10

The Regents have asked us to discredit the testimony of a Union witness and find that the Unions knew or should have known of some or all of the changes in (continued)

Some of the amendments may have been listed in plan summary booklets printed and distributed periodically by Blue Cross/Blue Shield, and some of the benefit changes were detailed in notices enclosed in employee and retiree paychecks.[11] Changes in premiums were reflected in employee paychecks, as payroll deduction adjustments.

The Unions did not demand to bargain over the changes made by the GIC between 1974 and June 30, 1988 in the carriers or plans and never bargained with the Board of Regents over any of the changes in carriers or benefits.[12] Instead, at the bargaining table,[13] the parties agreed to continue the provisions concerning insurance in the various collective bargaining agreement from year to year.[14]

---

10 (continued)
group health insurance between 1974 - 1988. we decline to discredit a witness in the absence of a recommendation from the hearing officer, but note that even if we assume that the witness's testimony is wrong, the evidence does not establish that the Unions received adequate notice of the relevant insurance changes. Further, the Unions' failure to demand bargaining over past changes did not waive their right to bargain over the change in plans and carriers at issue here. E.g., Burlington School Committee, 7 MLC 1273, 1275 (1980).

11 The record does not indicate which, or how many of the benefit changes listed in Appendix A were described in these "payroll stuffers."

12 During negotiations for the 1983-1986 collective bargaining agreements, the parties agreed to establish a Health and Welfare Trust Fund. This Trust Fund was established on March 7, 1985 and covers Board of Regents employees who are represented by the Unions. The purposes of the fund include providing, at the Trustees' discretion, life insurance, weekly sickness and accident benefits, medical, surgical, hospitalization and similar forms of coverage, including drug prescription coverage, eyeglass benefits, dental care and Medicare to employees and their beneficiaries. The Health and Welfare Trust Fund provides benefits that supplement those provided by GIC insurance plans.

13 At the bargaining table, either a consultant for Higher Education or a spokesperson for the local affiliate represents the Unions. They bargain from proposals and positions developed by the local affiliate's negotiations committee or executive board. Neither the MTA's Director of Governmental Services, Arlene Isaacson, its Executive Director and Treasurer, Edward Sullivan, nor Legislative Agent John Flannagan, Jr. have represented any MTA local affiliate for the purpose of negotiating a collective bargaining agreement. It is apparent that the MTA lobbyists' interests often coincide with the interests of the negotiators because they lobby for or against legislation affecting wages, hours or other terms and conditions of employment.

14 (see page 1254)

D. The Change from Blue Cross/Blue Shield to John Hancock

For approximately two years prior to designing a new indemnity plan, the GIC reviewed and analyzed certain aspects of the Blue Cross/Blue Shield plan such as cost and usage. Using the results of studies it had commissioned, the GIC and an outside consultant designed a new indemnity plan and incorporated it into a "Request for Proposals" (RFP). The new plan design and RFP detailed the benefits, procedures and provisions for deductibles, co-insurance and managed care that companies responding to the RFP were required to include.[15] The GIC approved the new plan and the RFP on September 23, 1987, and distributed it to 40 prospective bidders on September 30, 1987.

Six companies, including Blue Cross/blue Shield and John Hancock, responded to the RFP. Between November 4, the date on which the GIC received the proposals, and December 16, the GIC evaluated the six proposals as to net cost and administration.[16] On December 16, 1987, the GIC voted to award the indemnity contract to John Hancock. The GIC and John Hancock signed the indemnity insurance contract six months later, after finalizing details concerning funding, reporting, staffing and administration. The Hancock plan took effect on July 1, 1988.

The Board of Regents did not participate in any aspect of the GIC's decision to change the indemnity insurance carrier or plan, and played no role in the plan design or the RFP. Other than distributing the "For Your Benefit" and "It's Your Choice" brochures to Regents employees, the GIC did not notify the Board of Regents of the change from the Blue Cross/Blue Shield plan to the John Hancock Plan. The GIC never notified the Board of Regents that it was considering modifying the plan, nor did it supply to the Board a copy of the final contract or any previous drafts.[17] Neither the GIC nor the Regents' Office of Employee Relations notified

---

14 (from page 1253)

The insurance provisions contained in the 1986-89 collective bargaining agreements between the Board of Regents and the charging parties are reproduced in Appendix B.

15

The managed care provisions of the RFP included pre-admission and on-going hospitalization reviews, second surgical opinion requirements and case management for catastrophic or chronic illnesses. The proposal that Blue Cross/Blue Shield submitted in response to the RFP contained the required managed care provisions.

16

The RFP solicited bids for all of the Commonwealth's health insurance options, including HMOs. The seven-week analysis was devoted to the 31 proposals received from all types of providers.

17

The MTA made a public records request to the GIC for the Blue Cross/Blue Shield policy in June, 1989 but did not request a copy of the John Hancock policy from the GIC at any time. The Board of Regents did not receive a copy of the final

(continued)

any of the Unions of the pending changes in indemnity carrier and/or plan, and at no time prior to the GIC's decision to implement the changes in carrier and plans did any authorized collective bargaining designee of the Board of Regents formally notify any president or field representative of the Unions that a change in carrier and plan was contemplated or would be implemented. Also, at no time did the Board of Regents bargain with the Unions over the selection of John Hancock as the plan administrator, or over any changes in the plans or any impact of the change in administrator.

After the GIC awarded the contract to John Hancock, it publicized the decision through various means. It issued a press release on December 17, 1987, and announced the change in its March 1988 edition of "For Your Benefit," the GIC newsletter for employees and retirees. The GIC sent the March "For Your Benefit" newsletter to employees of the Commonwealth, including employees represented by the Unions. The newsletter described certain new benefits added to the plans, such as coverage for adult physicals and well-baby checkups. The newsletter's complete description of the managed care program was as follows:

> Assistance in Coordinating Your Health Care Decisions -- The new plan is designed to include the assistance of a registered nurse, called a Patient Advocate. The Patient Advocate will help you and your doctor coordinate your health care needs with your plan's benefits.
>
> The new plan is designed to include the assistance of a Patient Advocate. You must call your Patient Advocate if your doctor recommends a hospital stay. If you do not call your Patient Advocate, the plan will not cover the first $500 of the expenses you incur.

The newsletter did not mention balance billing or claim procedures. It stated: "All of the services that Blue Cross and Blue Shield were able to provide you and the Group Insurance Commission will be provided by John Hancock." In April 1988 the GIC distributed a more extensive brochure entitled "It's Your Choice." This brochure described the managed care program in greater detail and addressed balanced billing by stating: "Providers, in most cases, will accept the amounts the State Hancock Plan determines to be reasonable... Therefore, we anticipate that there will be almost no instances in which you will be sent an additional bill." The brochure did not discuss claim procedures. It did describe another new feature, the "sliding-scale" deductible:

> For the first time this year, your deductible -- the amount you pay

---

17 (continued)
Hancock contract until October 1988, four months after the contract was signed. On November 2, 1988, Joyce Kirby, an attorney for the Board of Regents, sent Margery Williams, an attorney for the MTA, copies of the Hancock and 1983-1988 Blue Cross/Blue Shield policies.

> before the State Hancock Plan pays -- will be tied to your salary or pension. For example, the deductible amount for a person who makes $20,000 a year will be lower than for a person who makes $60.000.

The GIC also planned to implement sliding-scale co-insurance amounts.

Following distribution of "It's Your Choice," in April the GIC sent a brochure entitled "It's Your Choice Update" to Commonwealth employees, including employees represented by the Unions.[18] In addition to distributing these publications, the GIC scheduled informational meetings and health fairs. Employees did not receive a description of the actual plan benefits until the open enrollment period in April 1988.

MTA lobbyist John Flannagan, Jr. (Flannagan), learned of the GIC's decision to change the indemnity plan carrier in late February 1988, and representatives from each of the Unions learned of the decision by April 6, 1988. Upon learning of the change in carrier, representatives from each of the Unions wrote to representatives of the Board of Regents and demanded to bargain over the decision to change the carrier and the impacts of the decision on terms and conditions of employment.[19] In addition, each Union representative requested a copy of the John Hancock policy which was slated to take effect on July 1, 1988. The Regents did not supply the Unions with the requested information until November 2, 1988. The GIC would have supplied copies of the Hancock contract to anyone who asked for them because the GIC considered them to be public records. However, there is no evidence that the Regents directed the Unions to the GIC to secure copies of the Hancock plan. The Board of Regents never responded to the Unions' letters and did not bargain with the Unions at any time over either the selection of John Hancock as the plan administrator or the impact of that decision.

---

[18] "It's Your Choice Update" announced an extension in the enrollment period, and contained information concerning changes to the Hancock plan that were made after the "It's Your Choice" brochure was published. The cover of the "Update" contains the statement "[t]he public employee unions made substantial contributions to improving the original plan design." Neither the Unions nor the MTA lobbyists had asked for this language or had anything to do with redrafting the brochure.

[19] The demands to bargain were included in the following communications: on March 31, 1988, USA representative Michelle Gallagher wrote to Chris Nelson, Assistant Director of Employee Relations of the Board of Regents; on March 25, 1988 MSP/FSU representative Richard Rivers wrote to University of Massachusetts Associate Vice President Billie Willits; on March 28, 1988, MSCA representative Frederick Doherty wrote to Regents representative Charles Mahoney; on April 5, 1988, APA and MSP/Lowell representative Ellen Suarez wrote to Regents representative Charles Mahoney and University of Lowell President William Hogan; and also on April 5, 1988, MCCC representative John Carpenter wrote to Employee Relations Director Carleton LaPorte.

In the spring of 1988, MTA lobbyists Flannagan and Arlene Isaacson (Isaacson) lobbied for two pieces of legislation: the so-called "Universal Health Care Bill"[20] and the so-called "anti-rollback" amendment to the Universal Health Care Bill.[21] Isaacson's and Flannagan's efforts on behalf of the anti-rollback amendment acquired a new significance, however, after they learned of the GIC's decision to change indemnity insurance carriers. In April 1988, Flannagan, Isaacson and MTA Executive Director and Treasurer Edward Sullivan (Sullivan) attended a series of meetings on the anti-rollback amendment and the indemnity insurance carrier change with then Secretary of Administration and Finance Frank Keefe (Keefe). In addition to Flannagan, Isaacson and Sullivan, GIC Policy Director Alexandra Schweitzer, GIC Executive Director Dolores Mitchell and representatives from the American Federation of State, County and Municipal Employees (AFSCME), Massachusetts Organization of State Engineers and Scientists (MOSES), Service Employees International Union (S.E.I.U.) and National Association of Government Employees (NAGE) attended the meetings. No representative of the Board of Regents attended any of these meetings.

At a meeting held on April 19, 1988, the discussion concerned the effect of the Hancock plan on the anti-rollback amendment and the statutory ban on "balance billing."[22] Flannagan and Isaacson expressed their opposition to the change in the indemnity carrier because they believed it represented a "roll-back" in insurance benefits that contravened the anti-rollback amendment. They also discussed the absence of a balance billing ban from the Hancock plan, and advised the Regents that they had not yet completed their analysis of the changes in the plan. The April 19 discussion continued on April 21, 1988, after Flannagan discussed his interpretation of the anti-rollback amendment with the Senate president. At the April 21st meeting, Flannagan, Isaacson and Sullivan again objected to the absence of a statutory ban on balance billing in the Hancock plan and Sullivan stated that he was not waiving any collective bargaining rights. Keefe then announced his intention to add certain benefits to the Hancock plan, such as lower deductibles and co-insurance payments. Flannagan, Sullivan and Isaacson responded that they could not know whether all the lost benefits had been returned because they had not completed their analysis of the Hancock Plan. At neither of these meetings did Flannagan, Isaacson or Sullivan agree to change the indemnity carrier from Blue Cross/Blue Shield to John Hancock. Nor did the MTA representatives object to the fact that these issues were raised at that forum rather than at the collective

---

20 Subsequently enacted and codified as M.G.L. c.118F.

21 1988 Mass. Stat. c.23, §77A, as amended by St. 1988 c.29, §3. The anti-rollback amendment was subsequently repeated in 1991, Mass. Stat. c.6, §52.

22 See M.G.L. c.176B, §7. In general, M.G.L. c.176B, §7 prohibits participating physicians and health care providers from charging subscribers or their dependents in excess of the compensation determined and allowed by a medical service corporation, except in certain enumerated circumstances.

bargaining table, or that no representative from the Board of Regents was present.[23]

Approximately one week after the April 21st meeting, Isaacson and Sullivan attended a meeting with Senator Patricia McGovern (McGovern) and representatives of S.E.I.U., the Massachusetts Federation of Teachers, and certain police and fire fighter unions. No representative of the Board of Regents attended. At this meeting, McGovern asked each union whether they were "on board" with the change of carriers from Blue Cross/Blue Shield to John Hancock. Most of the unions indicated their assent to the change. Sullivan, however, stated that the MTA would not commit to the change until they had completed their analysis of it. Neither Isaacson nor Sullivan agreed to the change in carrier at this meeting.[24] The evidence does not indicate that Sullivan or Isaacson agreed to the change in plan design at any of the above-described meetings.

After these meetings, Flannagan lobbied in support of two pieces of pending legislation that concerned the John Hancock Plan. He wrote to the members of the House of Representatives and the Senate Ways and Means Committee in support of an amendment to the state budget filed by Representative Timothy O'Leary, and testified before the Committee on Public Service in support of a bill filed by Thomas McGee on April 26, 1988.[25] Flannagan never spoke to any representative of the Board of Regents during the period in which he was lobbying concerning the change in insurance plans and carriers.

As a result of these meetings, the GIC and John Hancock amended the Hancock plan by changing the deductible and co-insurance payment levels established in the original plan design and RFP. Whereas the initial Hancock Plan required higher deductibles and out-of-pocket expenses than did the former Blue Cross/Blue Shield plan, the amended plan provided the same deductibles and co-insurance payments as had been required under the Blue Cross/Blue Shield plan.[26] The GIC described these

---

23 There is no evidence that Flannagan, Sullivan or Isaacson stated at either of these meetings that they represented the Unions as bargaining agents.

24 As each of the unions answered McGovern's question, she put a check mark next to their name on a list she had of all the unions present. When Sullivan responded to McGovern's question, McGovern put an "X" next to the MTA's name.

25 The O'Leary amendment, House No. 5600, proposed to continue Blue Cross/Blue Shield as the indemnity insurance carrier, reinstate the ban on balance billing, provide a reserve fund for John Hancock and reduce the GIC budget line item. It was subsequently defeated in the House. The McGee bill, House No. 5492, unsuccessfully proposed to extend the then existing Blue Cross/Blue Shield health insurance contract for an additional year.

26 (see page 1259)

amendments in the informational brochure "It's Your Choice Update" that it distributed in April 1988.

E. The Differences Between the Plans

There are numerous differences between the Blue Cross/Blue Shield plan in effect prior to July 1, 1988, and the Hancock Plan, particularly in the area of benefits. The four major differences are in the following areas: patient advocate requirements, second surgical opinion requirements, balance billing and claim procedures.

1. The Blue Cross/Blue Shield Plan

Under the Blue Cross/Blue Shield Plan in effect between October 1977 and June 30, 1988, no Blue Cross/Blue Shield employee was required to intercede or become involved in a subscriber's decision to be admitted to a hospital, prior to hospitalization. Similarly, no Blue Cross/Blue Shield employee was required to confirm the necessity of hospitalization or the number of days of hospitalization that the insurance plan would cover, nor were subscribers required to contact a Blue Cross/Blue Shield employee prior to a regular hospital admission or within two days of an emergency admission. Subscribers were not required to obtain a second surgical opinion from a doctor prior to undergoing certain kinds of surgery to avoid reduced insurance coverage.

Before July 1, 1988, the Blue Cross/Blue Shield indemnity plan had two unique features: its claims procedure; and balance billing. All Massachusetts hospitals accept reimbursement from Blur Cross/Blue Shield. As a condition of receiving Blue Cross/Blue Shield reimbursement, the hospitals must submit all claim forms on behalf of an insured. The insured need not complete or submit claim forms, and need not pay hospital bills subject to reimbursement from the insurer. Blue Cross/Blue Shield has a similar agreement with nearly all Massachusetts doctors. The doctors, rather than the patients, must submit claim forms for a range of common services such as inpatient services, inpatient and outpatient surgical services, ambulatory, psychiatric, x-ray, and physician-provided lab

---

26 (from page 1258)

The record discloses few details concerning the circumstances surrounding the amendments to the Hancock plan. These changes were discussed at some of the April 1988 meetings between Frank Keefe and representatives of the GIC and the public employee unions in attendance. It is unclear who requested the amendments, whether all the requested amendments were implemented or who authorized the amendments. Although the record indicates that Flannagan, Isaacson and Sullivan participated in some of the discussion surrounding the amendments, there is no evidence that they played a role in effectuating the amendments.

services. No other health insurance provider has such an agreement with all of Massachusetts hospitals and close to 100% of Massachusetts doctors.

Blue Cross/Blue Shield also protects subscribers against "balance billing." Over 98% of Massachusetts doctors are parties to contracts with Blue Cross/Blue Shield under which they agree to accept reimbursement from Blue Cross/Blue Shield. These doctors are called "participating physicians." Blue Cross/Blue Shield reimburses participating physicians at a predetermined rate for each service, that rate being the lesser of the "usual" or "customary" charge.[27] A participating physician fee for a given procedure might be higher than the Blue Cross/Blue Shield rate, but his contract with Blue Cross/Blue Shield obliges him, as a condition of receiving reimbursement, to refrain from billing the patient for the difference between the Blue Cross/Blue Shield reimbursement rate and the fee, unless the patient has agreed in advance to pay the difference.[28] This contractual ban on balance billing has been part of Blue Cross/Blue Shield's contract with doctors since the late 1960s. Blue Cross/Blue Shield has internal mechanisms for enforcing the ban, triggered by customer complaints.[29] No other health insurance provider in Massachusetts has contracts with 98% or more of Massachusetts doctors protecting patients from balance billing.[30]

2. The John Hancock Plan

The John Hancock plan requires subscribers to use the services of a "Patient Advocate" in certain instances or risk reduced insurance coverage. Subscribers must contact a patient advocate prior to a planned, non-emergency hospitalization, and within two business days of an emergency admission.[31] The patient advocate

---

27 "Usual" and "customary" are terms of art, signifying respectively the particular doctor's average fee for a given service and the maximum allowable charge for a particular service in a particular region of the state.

28 These agreements need not be filed with Blue Cross/Blue Shield. Also, under certain limited circumstances, the one or two percent of doctors who are non-participating physicians can receive reimbursement through Blue Cross, rather than Blue Shield. These doctors can balance bill because they are not bound by an agreement with Blue Shield. Out-of-state doctors are not necessarily prohibited from balance billing.

29 Patients complained to the G.I.C. about receiving balance bills approximately once per month.

30 The ban on balance billing was enacted into law in 1984. M.G.L. c.176B, §7. The evidence does not indicate that the ban applies to anyone else.

31 Subscribers who fail to obtain this "pre-admission review" must pay the first $500 of covered charges relating to the hospital stay.

then contacts the subscriber's physician, discusses whether tests can be performed on an outpatient basis, confirms the necessity for a hospital admission, and determines how many days of hospitalization the plan will cover. Once the subscriber is hospitalized, if a doctor recommends a hospitalization stay that is longer than originally planned, the patient advocate must confirm that the extended stay is appropriate. If a subscriber's doctor recommends hospitalization for certain surgical procedures, the patient advocate will discuss possible outpatient alternatives with the subscriber and will help obtain a second surgical opinion.[32] Finally, patient advocates assist subscribers' physicians in coordinating specialized care for long term illness or injury and evaluating cost-effective treatment for serious mental and nervous disorders. The evidence revealed that compliance with the Hancock Plan requirements can be time-consuming. One employee spent eight hours on the phone and took one day off from work to comply with John Hancock's pre-admission review procedures.

Although Hancock plan documents and promotional materials state that claim payments will be made directly to the hospital or other provider unless the subscriber has already rendered payment. One health care provider has required payment directly from a subscriber at the time service was rendered. Dr. Keenan of Westfield, Massachusetts, required Beverly Premo, an employee at Springfield Community College and a member of MCCC, to pay his office directly for her daughter's allergy treatments while she was insured by the John Hancock plan.[33]

The John Hancock plan does not prohibit balance billing.[34] Plan documents and promotional materials state that balance billing will be rare because Hancock's payment scale for provider services is higher than was the scale for Blue Cross/Blue Shield and because in most cases, providers will accept the amounts determined

---

[32] Second surgical opinions are required for the following inpatient surgical procedures: bypass for obesity, planned repeat caesarean section, carotid endarterectomy, cholecystectomy, coronary artery bypass graft, hysterectomy, meniscstomy, pacema implant, sub-mucous resection, total hip arthroplasty, total knee arthroplasty and varicose vein resection. If a second surgical opinion is required but not obtained, the John Hancock plan pays only 50% of regular plan surgical benefits and related covered charges.

[33] When Premo and her daughter were covered by the Blue Cross/Blue Shield plan, Dr. Keenan's office billed Blue Cross/Blue Shield directly.

[34] A document entitled "Final Evaluation of RFP Bids" prepared by the GIC to describe the 1988 plan changes states:

> "The one significant difference (between the bidders) is that BC/BS #1 offers contractual protection against balance billing, while the other bidders (including the BC/BS ASO plan) cannot."

by the Hancock plan to be reasonable. Some employees have, however, been balance billed. Richard Grozier, an employee of Framingham State College, received a bill dated May 5, 1989, for that portion of a charge for medical care that exceeded the reasonable and customary charge requirements of the Hancock benefit provisions. Ann Marie Hurley, an employee of the University of Lowell, and a member of MSP, received a bill dated May 24, 1989, for a portion of a charge for medical care that the Hancock plan determined exceeded the reasonable and customary charge requirements. Carol McDonough, an employee of the University of Lowell and a member of MSP, received a bill on May 3, 1989, for that portion of a charge for her son's medical treatment that was ineligible for payment by Hancock under the reasonable and customary care requirements. Similarly, Beverly Premo received a bill dated August 24, 1988, from Drs. McGill and Stechenberg for that portion of a charge for medical treatment that was ineligible for payment under the reasonable and customary charge provisions of the Hancock Plan.[35]

MAJORITY OPINION[36]

A. The Duty to Bargain over the Decision to change Insurance Plans and Carriers

Public employers may not change a pre-existing condition of employment affecting a mandatory subject of bargaining without providing the exclusive collective bargaining representative with prior notice and an opportunity to bargain. City of Newton, 16 MLC 1036, 1042 (1989). Under M.G.L. c.150E, public employers must bargain concerning the terms and costs of health insurance coverage provided pursuant to M.G.L. c.32B. Kerrigan v. City of Boston, 361 Mass. 24 (1972); Town of Ludlow, 17 MLC 1191 (1990). See generally, School Committee of Medford v. Labor Relations Commission, 380 Mass. 932 (1980) (rescript); Teamsters, Chauffeurs, Warehousemen & Helpers Union, Local No. 59 v. Chatham, 404 Mass. 365 (1989).

In Commonwealth of Massachusetts, 4 MLC 1869 (1978),[37] the Commission held

---

[35] Darlene Therrien, an employee of Bunker Hill Community College and a member of the MTA and MCCC received a benefit statement explaining that $80.00 of a $530.00 charge for surgery was ineligible under the reasonable and customary charge provisions of the Hancock plan. As of the date of her testimony in the hearing, however, she had not received a bill for this amount from her health care provider.

[36] Because of an unforeseen leave of absence, prior to her departure Chairperson Walsh signed a draft opinion in this case which had not yet been approved by the majority of the Commissioners. Her opinion follows the majority's opinion and order.

[37] The Commission's decision in 4 MLC 1869 was appealed by the G.I.C. and reversed by the Appeals Court, Group Insurance Commission v. Labor Relations (continued)

that the Commonwealth had violated the Law by unilaterally implementing a GIC decision to withhold an alleged overpayment in health insurance premiums from subscriber employee paychecks without first having negotiated with the employees' union. While noting that payroll deductions are mandatory subjects of bargaining, the Commission expressly declined to reach the issue of the negotiability of G.I.C. decisions regarding group insurance carriers or coverage for state employees. 4 MLC at 1876 and at n.9.[38] This case involves the interplay between M.G.L. c.150E, the public employee collective bargaining statute and M.G.L. c.32A, the state employee group insurance statute. The Commission has held that a municipal employer must bargain over a decision to change insurance plans pursuant to M.G.L. c.32B. Town of Ludlow, supra.

Chapter 32A of the General Laws establishes a scheme for the provision of group insurance benefits to state employees, retirees, and their dependents. It was enacted in 1955, before state employees received statutorily enforceable collective bargaining rights.[39] Consequently, it is understandable that c.32A, as enacted, neither addressed nor anticipated collective bargaining over group insurance plans. A subsequent amendment to the statute, the Anti-Rollback Amendment (ARA),[40] referenced the collective bargaining process. Although the Anti-Rollback Amendment did not compel collective bargaining, the Commission noted in Ludlow that the ARA language "indicate[d] that the Legislature contemplated that the selection of health insurance coverage remain[ed] subject ... to the collective bargaining process mandated by G.L. c.150E..." 17 MLC at 1198

Although c.32A establishes a structure for securing insurance benefits that

---

37 (continued)
Commission, 8 Mass. App. Ct. 753 (1979). The S.J.C. subsequently vacated the decision of the Appeals Court because the G.I.C. lacked standing to appeal the Commission's order. 381 Mass. 199 (1980).

38 Similarly, the S.J.C. declined to reach that issue. 381 Mass. at 202.

39 State employees were given the right to bargain over certain working conditions in 1964, pursuant to M.G.L. c.149 Section 178F. State and municipal employees received more extensive collective bargaining rights in 1974 after the enactment of M.G.L. c.150E.

40 1988 Mass. Stat. c.23, §77A, as amended by 1988 Mass. Stat. c.29, §3, provided in relevant part: "nothing in this section shall preclude the parties to a collective bargaining agreement under ... [M.G.L. ch.50E] from agreeing to any change in the premium percentage, deductible or coinsurance amount which an employee is required to pay or to a change in benefits provided in a health plan established under the provisions of [M.G.L. c.32A] ..." The statute subsequently was repealed by 1991 Mass. Stat. ch.6, §52. See also 1989 Mass. Stat. ch.653 Sections 72, 36, 37, 217 and 218.

is independent of collective bargaining, nothing in the statute or in subsequent amendments prevents or necessarily conflicts with collective bargaining about health benefits. The statute establishes the Group Insurance Commission (GIC) as the entity responsible for negotiating and purchasing various plans of group insurance. Section 4 of c.32A authorizes the GIC "to negotiate with and purchase, on such terms as it deems to be in the best interest of the Commonwealth and its employees, from one or more insurance companies, savings banks or non-profit hospital or medical service corporations, a policy or policies of group life and accidental death and dismemberment insurance..., and group general or blanket insurance providing hospital, surgical, medical, dental and other health insurance benefits..." Section 6 specified that "the amount of the hospital, surgical, medical, dental and other health insurance benefits to be provided each employee and his dependents shall be determined by the Commission as provided under sections four and ten C."

While the statute appears to contemplate that the GIC is authorized to determine the "amount of ... benefits" to be provided pursuant to the plans of insurance referenced in section 4, the statute does not preclude the Commonwealth, or, as in this case, the Board of Regents, from entering into other arrangements to provide insurance benefits to employees. Indeed, the Commonwealth has entered into agreements to provide payments to cover the costs of certain health benefits through health and welfare trust funds. See Commonwealth of Massachusetts (Massachusetts Correction Officers Federated Union), 18 MLC ___ (SUP-3461, April 24, 1992). Such agreements are independent of the GIC's exercise of its statutory authority pursuant to Sections 4 and 6 of M.G.L. c.32A. Thus, nothing in c.32A exempts health benefits for state employees from the scope of mandatory subjects of bargaining pursuant to Section 6 of c.150E.

Whether the GIC's decisions concerning health benefits are exempt from collective bargaining, however, is a separate question. Nothing in c.32A prohibits or restricts collective bargaining about health benefits between the statutory employer and the exclusive collective bargaining representative(s) of state employees.[41]

---

[41] The Regents have argued that certain regulations of the GIC suggest that the insurance scheme established in c.32A is incompatible with the collective bargaining process. Recently, the Commission had occasion to observe that a G.I.C. regulation that purports to limit the scope of M.G.L. c.150E by removing from the "jurisdiction" of M.G.L. c.150E issues that arise under c.32A did "not comport with the Commission's interpretation of the Law." Commonwealth of Massachusetts (Mass. Correction Officers Federated Union), 18 MLC ___, SI. op. n.12 (April 24, 1992). The Regents also point to an Opinion of the Attorney General that states that a collective bargaining agreement could not supersede the GIC's implementation of a statutory mandate regarding a specific insurance provision. 1979 Op. Attorney General No. 26 at 146. The Attorney General's Opinion declined to comment on whether the GIC was subject to any of the collective bargaining obligations imposed by chapter 150E. Op. Attorney General at 151.

The GIC, however, is not the statutory employer of the employees at issue in this case, nor does the record permit a conclusion that the GIC is an agent for whose acts the Regents are responsible. Instead the record demonstrates that the GIC and the decisions made by it are not within the control of the Board of Regents. Because the Board of Regents had no ability to control the decision of the GIC, it had no duty to bargain about the GIC's decision to change insurance. Although the Regents and the GIC may interact and cooperate, as they did during the litigation of this case, nothing in this record demonstrates that the Regents have the authority to control the decisions of the GIC. Accordingly, that portion of the complaint that alleges that the Regents failed to bargain about the GIC's decision to change health insurance benefits and carriers must be dismissed.

B. The Duty to Bargain over the Impact of the Decision to Change Insurance Plans and Carriers

1. The Duty to Bargain Mandatory Subjects

The Regents, like all employers who are parties to a collective bargaining relationship, have a continuing statutory duty to bargain prospectively on demand about mandatory subjects. The subject of insurance plans and carriers is a mandatory subject of bargaining because it affects wages and other terms and conditions of employment. Town of Ludlow, 17 MLC 1191, 1196(1990); School Committee of Medford v. Labor Relations Commission, 8 Mass. App. Ct. 139, 140 (1979), aff'd 380 Mass. 932 (1980). Moreover, employer-subsidized health insurance is a form of compensation. Changes in health insurance impact employees' compensation and are mandatory subjects of bargaining. See generally Anderson v. Board of Selectmen of Wrentham, 406 Mass. 508 (1990) (premium contributions of municipal employees are mandatory subjects of bargaining); Ludlow Education Association v. Ludlow, 31 Mass. App. Ct. 110 (1991) (obligation of Selectmen to bargain pursuant to Mass. Gen. L. c.328).

The Regents argue that the impacts of the GIC's decision to change the insurance plan and carrier are inseparable from the decision itself. It must be noted, however, that although the substantive insurance benefits offered by the GIC's plan are incorporated into the plan, the Regents can, and do, negotiate insurance benefits separately through the vehicle of a health and welfare trust fund independent of the GIC's authority.[42] Although the Regents cannot control the GIC's decisions, the impact of the GIC's change on terms and conditions of employment are within the scope of mandatory subjects about which the Regents must bargain. These conditions are not within the control of the GIC, and are separate from the decision.[43]

---

[42] At the time of the hearing in this matter the Regents maintained a trust fund that provided optical benefits to employees.

[43] (see page 1266)

2. Notice and Demand to Bargain

Informational GIC brochures distributed in March and April 1988 by the GIC indicated that the Hancock plan would take effect on July 1, 1988. Consequently, there was sufficient time between the Unions' March and early April 1988 demands to bargain and the effective date of the new Hancock plan to permit meaningful bargaining on the impact of the new plan.

The Regents contend that bargaining is not required because the Unions requested bargaining solely over the change in carrier,[44] and the impacts on mandatory subjects resulted from the change in plan rather than carrier. Specifically, the Regents point to the Union's failure to request bargaining over benefits, changes in benefits, the scope of benefits, or the benefit plan design. In their letters of March and April, 1988, the Unions demanded to bargain over the "decision to change the insurance carrier, as well as the impact on terms and conditions of employment." First we note that the GIC's own "Final Evaluation of RFP Bids" indicates that some plan characteristics were inextricably linked to the identity of the carrier. Further, we find that the demand was a sufficient response to the information that the Unions possessed at that time to notify the Regents of the Unions' desire to bargain. When the Unions demanded bargaining, the only material they had received regarding the new plan was the description contained in the brochure "For Your Benefit." This brochure did not detail the benefits contained in the new plan but merely summarized some of its procedures and costs. Details concerning benefits were not publicized until the GIC subsequently published "It's Your Choice" and "It's Your Choice Update." Given the minimal information that the Unions possessed at the time of their demand, the Unions' request to bargain over the impacts of changes in the "carrier" reasonably must be construed as a request to bargain over the impact of the changes in the plan. The Unions had received no notice of the GIC's intent to change the "plan" of insurance except insofar as the change in benefits appeared to result from the change in carrier.

---

43 (from pate 1265)

The Regents also argue that they had no duty to bargain over the impact of the GIC's decision because the impacts of the change in carrier and plan were insubstantial and immaterial. They do not dispute that a change in plan and carrier occurred. The evidence demonstrates sufficient impact on costs to employees for health benefits to warrant the conclusion that the changes were not insubstantial and immaterial. Specifically, the evidence demonstrates that the procedures for securing certain medical services were changed and the prohibition against balance billing was terminated.

44

The National Labor Relations Board has recognized that an employer's unilateral change in insurance carriers implicates the duty to bargain. E.g., Lawrenceville Ready-Mix, 305 NLRB No. 156 (1991).

3. Public Policy and Statutory Considerations

It is undisputed that the Union made a demand to bargain. However, the Board of Regents maintains that it was not obligated to bargain about the impact of the GIC's decisions regarding health insurance plans and carriers for several reasons. We examine the statutory and public policy reasons first.

The Regents argue that impact bargaining is prohibited by the Supreme Judicial Court's decision in Watertown Firefighters v. Town of Watertown, 376 Mass. 706 (1978). The Regents contend that Watertown prohibits interference by the collective bargaining process with the insurance procedures established pursuant to M.G.L. c.32B, and argue that impact bargaining should be prohibited in this case.

The Watertown decision held that the terms of a collective bargaining agreement could not superseded a statutory limitation on premium percentage contributions. In fact, footnote 19 of the court's opinion states that "[t]he statutory regulation of group insurance for municipal employees does not exclude all collective bargaining by a union on the subject...." 376 Mass. at 715. Thus, while the Court invalidated an interest arbitration award that required the Town to increase its insurance contribution rate for one group of employees above the rate established for other municipal employees, it nonetheless sanctioned collective bargaining about insurance.

Thus, the group insurance procedures outlined in chapter 32B do not preclude collective bargaining about those aspects of insurance coverage that impact wages and other mandatory subjects of bargaining.

The Regents also make related arguments that 1) there can be no duty to bargain about health insurance because c.32A cannot be superseded by a collective bargaining agreement by operation of section 7(d) of c.150E; and 2) public policy considerations preclude bargaining about group insurance for state employees.

In Town of Ludlow, supra, the Commission concluded that c.32B did not preclude bargaining about health insurance. Collective bargaining agreements can incorporate insurance benefit provisions that do not conflict directly with c.32B. 17 MLC 1196-1198. The same principle applies here. Unless the terms of the parties' collective bargaining agreement directly conflicts with specific provisions of ch.32A, collective bargaining over the impact of the GIC's decision to change insurance plans and carriers is not prohibited by operation of Section 7(d) of c.150E.

The Regents argue that public policy should preclude collective bargaining about the GIC's plan(s) of insurance. It is clear that the Regents cannot bargain directly about the GIC's insurance plan or the GIC's selection of carriers because the Regents do not control the GIC. However, there is no indication that any agreements that might be negotiated between the Regents and the Unions concerning supplemental insurance benefits, such as those administered through a health and

welfare trust fund will affect the GIC's insurance plans. In the absence of such evidence there appears no public policy reason to exempt the employer from its duty to bargain about the impact of the GIC's insurance change on mandatory subjects.

4. Waiver of Bargaining Rights

The Regents argue that the Unions contractually waived any right to bargain over the impact of the GIC's change in insurance plan and carrier. In support of their position they argue that the insurance articles of the six applicable agreements between the Board of Regents and the Charging Parties should be read in conjunction with the so-called "zipper clauses" to preclude bargaining.

The Commission has long held that a party asserting contractual waiver as an affirmative defense must demonstrate that the parties "consciously considered the situation that has arisen, and that the Union knowingly waived its bargaining rights." Town of Marblehead, 12 MLC 1667 (1986). The waiver must be conscious and unmistakable. Town of Marblehead, at 1670 citing Town of Andover, 4 MLC 1086 (1977) and Melrose School Committee, 3 MLC 1299 (1976). If the contract language is ambiguous or too vague to demonstrate a clear and conscious waiver, bargaining history may be examined to determine if the parties mutually understood and intended to apply the ambiguous contract language to the issue in dispute. Town of Marblehead, supra.

Consistent with this standard we analyze the language of the contractual provisions listed below:

1. During the term of this Agreement, the Board shall continue to cover all administrators of the bargaining unit under the plan now in effect pursuant to the provisions of Chapter 32A, Sections 5, 6, 8, and 10A of the General Laws.[45]

2. The Board shall continue to cover all employees [members] of the Bargaining Unit under the plan now in effect during the term of this Agreement, pursuant to the provisions of Chapter 32A, Sections 5, 6, 8, and 10A of the General Laws;[46,47]

---

45 Article VII, D.2 entitled "Health and Accident Insurance" contained in the contract between the Regents and the Association of Professional Administrators, MTA/NEA (July 1, 1986 - June 30, 1989).

46 There are minor language differences between the contracts which have been noted in brackets.

47 This provision is contained in the contracts between the Regents and the (continued)

3. Unit members shall continue to be covered under the State's Group Health and Accident Insurance plan currently in effect pursuant to the provisions of Chapter 32A of the General Laws as amended amended or as such plan may be made available under applicable law of the Commonwealth.[48]

4. Group Health Insurance Contributions. The Commonwealth shall pay ninety (90) percent of the monthly premium rate for the Group Insurance [Group Health Insurance] Plan and each bargaining unit member [employee] covered shall pay ten (10) percent of this premium rate for the type of coverage that is provided for him/her and his/her dependent(s) under the plan.[49]

Agreements #1 and #3 contain language that implicitly or explicitly refers to the employer's continued provision of insurance, implying that it is the employer's responsibility to maintain health insurance coverage. For instance, Agreements #1 and #2 state that "The Board shall continue to cover...", agreement #4 says that "Unit members shall continue to be covered..." However this language is modified by phrases referring to the insurance purchased by the GIC. Agreements #1 - 3 contain the modifier "pursuant to the provisions of Chapter 32A..." This language is contradictory because it implies that the Regents will ensure coverage of a plan which is purchased, pursuant to Chapter 32A, by the GIC, an entity over which the Regents have no control. This language suggests that there could not have been a meeting of the minds.

Moreover, the language of all six agreements is ambiguous concerning the meaning of the word "plan." Agreement #1 refers to the "plan now in effect pursuant to the provisions of Chapter 32A..." Agreements #2 and #3 refer to the plan "now" or "currently" in effect during the term of this Agreement, pursuant to the provisions of Chapter 32A...", and Agreement #4 refers simply to the "Group [Health] Insurance Plan." From this language it is not possible to determine if the parties were referring to Blue Cross/Blue Shield, the plan in effect at the

---

47 (continued)
Massachusetts Society of Professors at the University of Lowell (July 1, 1986 - June 30, 1989) and the Regents and the Massachusetts State College Association (MSCA)/MTA - State College (April 23, 1987 - June 30, 1989).

48 This provision is contained in the contract between the Regents and the Massachusetts Community College Council/MTA/NEA (July 1, 1986 - June 30, 1989).

49 This provision is contained in the contracts between the Board of Trustees of the University of Massachusetts, on behalf of the Regents, and the Massachusetts Society of Professors Faculty Staff Union/MTA/NEA (July 1, 1986 - June 30, 1989) and between the Regents and the University Staff Association/MTA/NEA (July 1, 1986 - June 30, 1989).

time the agreements were negotiated, or if the parties contemplated any changes in the plan. There is no evidence of bargaining history which would indicate what the parties intended. Consequently, we cannot determine that the parties had a mutual intent to waive bargaining over change in health insurance plans.

The Regents have not met the burden of proving that the language was intended by the parties to constitute a waiver of the right to bargain on the subject. Accordingly, the Unions cannot be found to have contractually waived their right to bargain regarding the impact of changes in health insurance.

The Regents further argue that the bargaining history of the parties demonstrates that the subject of health insurance plans and carriers is not a mandatory subject of bargaining. It is undisputed that the parties have not previously bargained over changes in health insurance plans or carriers.[50] The Regents contend that this inaction, as well as the Unions' lobbying efforts[51] reflect the Unions' recognition that bargaining was not required.

However, it is the language of chapter 150E, §6, rather than the conduct of the parties, that determines whether a topic is a mandatory subject of bargaining. Although the right to bargain about a mandatory subject can be waived, the waiver does not render a mandatory subject nonmandatory. Rather, the wavier merely relieves the parties of their bargaining obligation. We have determined that the subject of insurance plans and carriers and their impact on terms and conditions of employment is a mandatory subject of bargaining. We have determined that there was no contractual waiver. Consequently, neither the Unions' past silence nor their lobbying efforts extinguished the Regents' bargaining obligation.

In summary, we conclude that the Regents violated Sections 10(a)(5) and (1) of the Law when it failed and refused to bargain over the impact of the GIC's decision to change insurance plan and carrier.

---

50 Indeed, in 1989 an MTA attorney, during a court proceeding, stated that group health insurance was not a matter of collective bargaining.

51 The Regents also suggest that the Unions' lobbying efforts should preclude their participation in collective bargaining in light of the SJC's decision in Anderson v. Board of Selectmen of Wrentham, 407 Mass. 508 (1990). Anderson did not prohibit a union from lobbying before a legislative body in conjunction with negotiations. Rather, Anderson recognized that certain terms of employment are subject to the collective bargaining process and cannot be superseded by a conflicting municipal ordinance. The Unions' lobbying activities here did not relieve the Regents of their duty to respond to the Unions' requests to bargain the impacts of the change in plans.

C. The Duty to Provide Information

An employer's duty to bargain in good faith includes a duty to supply the union, upon request, with information that is relevant and reasonably necessary to the Union's task of performing its responsibilities as exclusive bargaining representative. Board of Trustees, University of Massachusetts (Amherst), 8 MLC 1139 (1981). The fact that information is a "public record," or is available from another source is no defense to an employer's refusal to provide information in its possession that is otherwise relevant and reasonably necessary. Commonwealth of Massachusetts, 12 MLC 1590 (1986).

The Unions requested copies of the new Hancock policy. The Board of Regents first received a copy of the Hancock plan in October of 1988, and mailed it to the Unions' attorney on November 2, 1988. The Unions contend that the Regents unlawfully delayed their transmittal of the requested information.[52]

In Woods' Hole, Martha's Vineyard and Nantucket Steamship Authority, 12 MLC 1531 (1986), the Commission held that the Union was not obligated to provide certain requested financial information to the Employer concerning a pension plan where the Union neither controlled the plan nor possessed the requested information. The same principle is applicable here. The Regents did not possess a copy of the insurance contract until October, 1988, when they secured a copy from the GIC. They were not a party to the insurance negotiations between the GIC and John Hancock and had no control over the information. Consequently, the Regents did not violate their duty to bargain by failing to provide the Unions with a copy of the Hancock contract until November 1988.

Therefore, we dismiss this aspect of the Complaint of Prohibited Practice.

D. Remedy

In determining the appropriate remedy in the instant case, we have considered Commission precedent in analogous situations. In a previous case involving the Group Insurance Commission the employer unilaterally deducted a lump sum from the weekly paychecks of employees in order to recoup an overpayment for group health insurance. Comm. of Mass., Comm., et al., 4 MLC 1869, 1878 (1978) (hereinafter GIC). In that case the Commission expressed concern about imposing employer liability in situations where the employer has no control or discretion over the actions giving rise to the liability. Although the employer in GIC had a bargaining obligation because the subject was mandatory, the Commission noted that imposing liability could be unjust and unfair in certain situations, stating,

---

52 The Regents do not dispute that the Hancock contract was relevant and reasonably necessary to the Unions' duties as exclusive bargaining representative.

> "In situations where those having an obligation to bargain have no control or discretion over the actions giving rise to the liability, we cannot be bound to the realities of the situation. Under such circumstances, we will find the violation -- any other result would eliminate the subject matter from the scope of bargaining -- and exercise our remedial discretion to fashion the most satisfactory remedy possible under the circumstances." GIC at 1878.

Even though in GIC the payroll recoupment was within the control of the employer, the Commission limited its remedy to ordering the employer to bargain and post notice and did not order the employer to repay the monies deducted from the employees' paychecks.

Similarly, in City of Springfield, 12 MLC 1021, 1025 (1985), a statutory amendment superseded the City's collectively bargained provision for including sick leave buyback in retirement benefit calculations. The Commission found that the City could not control the statutory requirements for retirement benefit calculations, but did have the power to mitigate the effects of the statute. Accordingly, the Commission limited its remedy to an order that the City bargain about the impact of the decision it made in order to conform with the statute, but it did not order the City to compensate employees for monies that it had recouped from overpayments it had made to employees.

Although the instant case does not involve an alleged overpayment, the Commission's considerations in fashioning appropriate remedies in the cases discussed above, especially the GIC decision, are particularly relevant to the liability issue here. In the case before us the Regents had no control over the GIC's decision to change its plan and carrier and had no ability to affect the implementation of the GIC's decision or make changes to the GIC carrier and plan.[53] Because the parties' contract language indicates that they have differing, if not conflicting, understandings of their respective rights and responsibilities regarding health insurance, it is appropriate that they attempt to resolve the issue through bargaining. Accordingly, we order the Regents to bargain over the impact of the GIC's change in health insurance plan(s) and carrier(s) on mandatory subjects of bargaining.

ORDER[54]

WHEREFORE, based upon the foregoing, IT IS HEREBY ORDERED that the Board of Regents, and its successors, shall:

---

[53] This case differs from cases involving municipalities because municipalities have responsibility both for procurement of health insurance and collective bargaining.

[54] (see page 1273)

1. Cease and desist from:

   a. Refusing to bargain in good faith about the impact on terms and conditions of employment of decisions by the Group Insurance Commission to change health insurance plans and/or carriers with the following unions: University Staff Association/MTA/NEA (USA), Association of Professional Administrators/MTA/NEA (APA), Massachusetts Community College Council/MTA/NEA (MCCC), Massachusetts Society of Professors/University of Lowell/MTA/NEA (SMP Lowell), Massachusetts Society of Professors/Faculty Staff Union/MTA/NEA (MSP/FSU), and the Massachusetts State College Association/MTA/NEA (MSCA).

   b. In like or related manner, interfering with, restraining, or coercing employees in the exercise of their rights under the Law.

2. Take the following affirmative action which will effectuate the purposes of the Law:

---

54 (from page 1272)

On July 1, 1991, after the hearing closed, Chapter 142 of the Acts of 1991 became law. Section 25 of Chapter 142 struck out references to the Board of Regents as the employer for purposes of Chapter 150E and substituted the Higher Education Coordinating Council (HECC) for certain employees and the board of trustees of the University of Massachusetts (U. Mass. Trustees) for university employees.

In February 1992, the Charging Parties requested that in the event that they prevailed that any order run against the HECC and the U. Mass Trustees. It is undisputed that the Higher Education Coordinating Council (HECC) is the successor employer to the Board of Regents for employees of all state and community colleges. However, the U. Mass. Trustees argues that it is an "inappropriate party to be substituted for the Board of Regents...[because] the University is not responsible for or accountable for the Regents' alleged actions." Our statutory analysis leads us to conclude that the U. Mass. Trustees is the successor employer to the Regents for employees of the University of Massachusetts. Section 33 of chapter 142 states that the U. Mass. Trustees succeed to "[t]he rights, powers, duties and properties ..." of the Board of Regents for employees of Southeastern Massachusetts University, the University of Lowell, and the University of Massachusetts. section 37 provides that "no existing right of any character shall be lost, impaired or affected by the provisions of this act," and sections 34 and 35 preserve employee rights and benefits.

Accordingly, in the Order and Notice references to the "Board of Regents or its successors," shall be construed as references to the HECC and the Board of Trustees of the University of Massachusetts.

a. Upon the request of each Union, bargain with each Union in good faith about the impact on employees' wages, hours, and other terms and conditions of employment of the GIC's July 1, 1988 change in health insurance plan(s) and carrier(s), until one of the following occurs:

(1) The employer and the Union representing the bargaining unit reach mutual agreement regarding the impact of the change in health insurance coverage;

(2) The employer and the Union representing the bargaining unit reach impasse after bargaining in good faith;

(3) The Union representing the bargaining unit fails to commence negotiations within five (5) days of receipt of the Employer's notice of its willingness to bargain with the Union; or

(4) The Union representing the bargaining unit subsequently fails to bargain in good faith.

b. Post in all conspicuous places where employees in each bargaining unit usually congregate and where notices to employees are usually posed, and maintain for a period of thirty (30) days thereafter, copies of the attached Notice to Employees; and take reasonable steps to ensure that these notices are not altered, defaced or covered by any other material.

c. Notify the Commission in writing of the steps taken to comply with this decision within thirty (30) days after the date of the receipt of this decision.

SO ORDERED.

COMMONWEALTH OF MASSACHUSETTS
LABOR RELATIONS COMMISSION

HAIDEE A. MORRIS, COMMISSIONER

WILLIAM G. HAYWARD, JR., COMMISSIONER

Board of Regents of Higher Education and University Staff Association/MTA/NEA, 19 MLC 1248

NOTICE TO EMPLOYEES
POSTED BY ORDER OF
THE MASSACHUSETTS LABOR RELATIONS COMMISSION
AN AGENCY OF THE COMMONWEALTH OF MASSACHUSETTS

The Massachusetts Labor Relations Commission has held that the Board of Regents of Higher Education violated Mass. Gen. Laws c.150E, Sections 10(a)(1) and (5) when it failed or refused to bargain over the impact of the Group Insurance Commission's decision, effective July 1, 1988, to change the indemnity health insurance plan and carrier, with the following unions: University Staff Association/MTA/NEA (USA), Association of Professional Administrators/MTA/NEA (APA), Massachusetts Community College Council/MTA/NEA (MCCC), Massachusetts Society of Professors/University of Lowell/MTA/NEA (SMP Lowell), Massachusetts Society of Professors/Faculty Staff Union/MTA/NEA (MSP/FSU), and the Massachusetts State College Association/MTA/NEA (MSCA). The Commission has concluded that the Regents had no duty to bargain over the Group Insurance Commission's (GIC's) decision to change the plan(s) and carrier(s) that it offered. However, the Board of Regents has a legal duty to negotiate with the Union(s) about the impact of the GIC's decision on the wages, hours and other terms and conditions of employment of bargaining unit employees.

Therefore, the Commission has ordered the Board of Regents through its successors, the Higher Education Coordinating Council or the Board of Trustees of the University of Massachusetts, to remedy the Regents' unlawful act by ceasing to refuse to bargain about the impact on employee wages, hours and terms and conditions of employment of the Group Insurance Commission's decision to change health insurance plans effective July 1, 1988.

In addition the Commission has ordered the Board of Regents through its successors, to post this Notice and abide by what it says:

> The Massachusetts Public Employee Collective Bargaining Law (Mass. Gen. Laws c.150E) gives employees the following rights: the right to form, join and assist unions or to refrain from such activity; the right to join with other employees to protect wages, hours and working conditions; the right to be free from discrimination based upon union or other protected, concerted activity, the right to be represented by a union for the purposes of bargaining collectively about wages, hours, terms and conditions of employment.

WE WILL NOT interfere with any of the rights guaranteed by the Law;

WE WILL NOT fail or refuse to bargain in good faith with the charging party unions with whom we have an obligation to bargain about the impact of decisions by the Group Insurance Commission to change health insurance plans and carriers on mandatory subjects of bargaining;

WE WILL upon the request of each Union, bargain with each Union in good faith about the impact on employees' wages, hours, and other terms and conditions of employment of the GIC's July 1, 1988 change in health insurance plan(s) and carrier(s).

AS SUCCESSOR TO BOARD OF REGENTS

BY:_____

APPENDIX A

Aetna Life Insurance co.
Policy #GC-375,001
"Under 65" July 1, 1974 - June 30, 1975

1. Monthly premium rates for single employee increased from $22.58 to $23.77.

2. Monthly premium rate for employee with dependents increased from $53.04 to $55.84.

3. Definition of Christian Science Practitioner added to definition section. (Narrowed definition to limit abuse.)

4. Dental coverage added with restrictions to surgical services and emergency services in case of accident.

5. Catastrophic Illness Coverage added. Monthly premium rate $.95 for single employee, $2.35 for employee with dependents.

Aetna Life Insurance Co.
Policy #GC-375,003
"OME" July 1, 1974 - June 30, 1975

1. Optometrists payments restricted to 80% of reasonable and customary charge.

Aetna Life Insurance Co.
Policy #GC-375,001
"Under 65" July 1, 1975 - June 30, 1976

1. Monthly premium rates for single employee increased from $23.77 to $34.72.

2. Monthly premium rate for employee with dependents increased from $55.84 to $82.00.

3. Definition of medical appliances changed to include initial cost of prescribed breast prosthesis, of prescribed elastic stockings, and of prescribed orthopedic shoes.

4. Specified conversion factors for Group Insurance Commission Relative Value Schedule.

5. Included psychiatrically necessary services in the definition of medically necessary services.

6. Included medically necessary maternity related services obtained within 60 days before the date of delivery in the definition of covered medical services.

7. Definition of obstetrical services changed to include certain complications of pregnancy.

8. Adds two fully paid postoperative visits after surgical services conducted with certain diagnoses.

9. Added hemodialysis facilities and surgicenters to list of facilities whose charges will be covered under the policy.

10. Added eligible students to catastrophic illness coverage.

11. Added minimum enrollment requirement of 50% of eligible employees for continuation of Catastrophic Illness Coverage.

12. Monthly premium rate for Catastrophic Illness Coverage increased from $.95 for single employee to $1.40. Rate for employees with dependents increased from $2.35 to $3.55.

Aetna Life Insurance Co.
Policy #GC-375,003
"OME" July 1, 1975 - June 30, 1976

1. Monthly premium rate increased from $10.44 to $15.24.

2. Added provision that the monthly premium rate will not be adjusted as a result of increase in level of coverage under Medicare.

3. Included psychiatrically necessary services in the definition of medically necessary services.

4. Adds two postoperative visits to definition of surgical services in hospital services for which policy will pay reasonable charges.

5. Added hospitalization in a VA hospital to the prerequisite hospitalization prior to eligibility for inpatient nursing home benefits.

6. Added hemodialysis facilities and surgicenters to list of facilities whose charges will be covered under the policy.

7. Dental benefits available at surgicenter limited to emergency surgery within 72 hours following an accident.

Aetna Life Insurance Co.
Policy #GC-375,001
"Under 65"

July 1, 1976 - June 30, (1981)
(Terminated September 30, 1977)

1. Added grandchildren to definition of covered dependents.

2. Monthly premium rates for single employee decreased from $34.72 to $34.52. As of 2/1/77, the rate increased to $36.26.

3. Monthly premium rate for employee with dependents increased from $82.00 to $82.09. As of 2/1/77, the rate increased to $86.25.

4. Definition of medical appliances changed to include initial cost of glasses or contact lenses prescribed as a result of cataract surgery; exclusions on benefits paid for lenses or glasses changed accordingly.

5. Added definition of approved outpatient psychiatric facility.

6. Added out-patient psychiatric facility to list of facilities whose charges will be covered under the policy.

7. Monthly premium rate for Catastrophic Illness Coverage increased from $1.40 for single employee to $1.60. Rate for employee with dependents increased from $3.55 to $4.00.

Aetna Life Insurance Co.
Policy #GD-375,003
"OME"

July 1, 1976 - June 30, (1981)
(Terminated September 30, 1977)

1. Monthly premium rate decreased from $15.24 to $14.94.

2. Added coverage and limited payment for initial cost of prescribed breast prosthesis and of prescribed orthopedic shoes when attached to a leg brace.

3. Monthly premium rate increased on 1/1/77 from $14.94 to $18.79.

4. Added gingevectomies and radicular cysts to definition of covered oral surgical services.

5.* Added coverage and limited payment for treatment in psychiatric outpatient facility.

6. Added chemotherapy as part of covered hospital services.

Blue Cross - Blue Shield
Policy #2229300
"Under 65" October 1, 1977 - June 30, 1981

1. Carrier changed from Aetna to Blue Cross - Blue Shield.

2. Monthly premium rates for single employee increased from $36.26 to $43.76.

3. Monthly premium rate for family increased from $86.25 to $103.34.

4. Monthly premium rate for eligible students increased from$4.00 to $18.74.

5. Monthly premium rate for Catastrophic Illness Coverage for individual employee increased from $1.60 to $2.95. Rate for family increased from $4.00 to $7.48. Rate for each student added - $1.26.

6. Added medically necessary abortion to definition of medical services covered.

7. Added medically necessary abortion to definition of obstetrical services covered.

8. 3/1/79 coverage for abortion restricted to abortions necessary to save mother's life or abortions performed as treatment after reported rape or incest.

9. Monthly premium rates for single employee increased from $43.76 to $52.66 as of 7/1/79.

10. Monthly premium rate for family increased from $103.34 to $113.82 as of 7/1/79.

11. Monthly premium rate for eligible students increased from $18.74 to $33.68 as of 7/1/79.

12. Monthly premium rate for Catastrophic Illness Coverage for individual employee increased from $2.95 to $3.51. Rate for family decreased from $7.48 to $5.71. Rate for each student increased from $1.26 to $1.82.

13. 7/1/79 coverage for abortion restricted to abortions necessary to save mother's life.

14. Monthly premium rates for single employee decreased from $52.66 to $52.41 as of 7/1/80.

15. Monthly premium rate for family increased from $113.82 to $121.53 as of 7/1/80.

16. Monthly premium rate for eligible students increased from $22.68 to $38.04 as of 7/1/80.

17. Monthly premium for Catastrophic Illness Coverage for individual employee decreased from $3.51 to $3.15. Rate for family increased from $5.71 to $5.93.

18. Monthly premium for Catastrophic Illness Coverage for family with abortion coverage increased from $5.71 to $6.30.

19. Monthly premium for Catastrophic Illness Coverage for student increased from $1.82 to $2.09.

20. Services for newborns added to definition of obstetrical services.

21. Speech therapy and occupational therapy added as covered benefits.

Blue Cross-Blue Shield
Policy #2229310
"OME" October 1, 1977 - June 30, 1981

1. Carrier changed from Aetna to Blue Cross - Blue Shield.

2. Monthly premium rates increased from $14.94 to $16.71.

3. Monthly premium rate increased from $16.71 to $17.53 as of 7/1/79.

4. Monthly premium rate for Catastrophic Illness Coverage decreased from $2.75 to $.69.

5. Monthly premium rate for Catastrophic Illness Coverage increased from $.69 to $.71 as of 7/1/79.

6. Monthly premium rate increased from $17.53 to $24.03 as of 7/1/80.

7. Monthly premium rate for Catastrophic Illness Coverage decreased from $.71 to $.64 as of 7/1/80.

8. Changed definition of special services to include services by physicians with whom a hospital has a contractual arrangement.

9. Changed definition of outpatient coverage.

10. Added occupational therapy as a benefit.

Blue Cross - Blue Shield
Police #2229300-2
"Under 65" July 1, 1981 - June 30, 1983

1. Monthly premium rate changed annually. The rates were as follows:

   a. Individual rate increased from $52.41 to $63.35 as of 7/1/81. Rate increased to $74.88 as of 7/1/82.

   b. Family rate increased from $113.82 to $132.92 as of 7/1/81. Rate increased to $157.11 as of 7/1/82.

   c. Student rate decreased from $33.63 to 1$30147 as of 7/1/81. Rate increased to $36.01 as of 7/1/82.

2. Monthly premium rate for Catastrophic Illness Coverage changed annually. The rates were as follows:

   a. Individual rate increased from $3.15 to $3.98 as of 7/1/81. Rate decreased to $3.89 as of 7/1/82.

   b. Family rate increased from $5.93 to $8.29 as of 7/1/81. Rate decreased to $8.11 as of 7/1/82.

   c. Family rate with abortion coverage increased from $6.30 to $8.54 as of 7/1/81. Rate decreased to $8.36 as of 7/1/82.

   d. Student rate decreased from $2.09 to $1.89 as of 7/1/81. Rate decreased to $1.85 as of 7/1/82.

3. Added inpatient admissions to rehabilitation hospital as covered benefit.

4. Definition of medical appliances changed to include hearing aids.

5. Added prescribed weight control chemical supplements to definition of covered services and supplies.

6. Added private room coverage where patient's condition requires private room.

7. Added ultrasound as covered procedure.

8. Added coverage for ambulance transportation to places other than hospital where ambulance medically necessary; included air ambulance and chair-car ambulance service.

9. Added cardiopulmonary enhancement services as covered benefit.

10. Increased limit on amount covered for services provided by nursing homes, chronic disease hospital, detoxification centers.

11. Renewed $250,000 lifetime maximum for Catastrophic Illness Coverage. (All covered persons received an additional $250,000 lifetime maximum.)

12. Renewed $50,000 annual major medical maximum.

Blue Cross - Blue Shield
Policy #22293I0-2
"OME" July 1, 1981 - June 30, 1983

1. Monthly premium rate increased from $24.03 to $28.31 as of 7/1/81. Rate increased to $36.49 as of 7/1/82.

2. Definition of medical appliances changed to include hearing aids.

3. Added ultrasound as covered procedure.

4. Added prescribed weight control chemical supplements to definition of covered services and supplies.

5. Permitted application of satisfied deductible from one covered service to another.

6. Increased coverage for cage from private duty nurses.

7. Added coverage for ambulance transportation to places other than hospital where ambulance medically necessary; included air ambulance and chair-car ambulance service.

8. Added speech therapy as covered benefit.

9. Extended coverage for cosmetic services to correction for physical defects first showing after effective date of policy.

10. Increased daily allowance for nursing home fees.

11. Increased coverage under Catastrophic Illness Coverage for out-patient mental illness treatment.

12. Reduced the Catastrophic Illness Coverage deductible.

Blue Cross - Blue Shield
Policy #2229300-3
"Under 65" July 1, 1983 - June 30, 1988

1. Monthly premium rate changed annually. The rate were as follows:

   a. Individual rate increased from $74.88 to $95.53 as of 7/1/83. Rate decreased to $94.98 as of 7/1/84. Rate increased to $100.46 on 7/1/85. Rate increased to $116.49 on 7/1/86. Rate increased to $146.59 on 7/1/87.

   b. Family rate increased from $157.11 to $200.58 as of 7/1/83. Rate increased to $205.15 as of 7/1/84. Rate increased to $217.94 on 7/1/85. Rate increased to $256.08 on 7/1/86. Rate increased to $323.09 on 7/1/87.

   c. Student rate increased from $36.01 to $45.79 as of 7/1/83. Rate decreased to $46.62 as of 7/1/84. Rate increased to $49.54 on 7/1/85. Rate increased to $57.78 on 7/1/86. Rate increased to $72.57 on 7/1/87.

2. Maternity leave coverage added to individual benefits (had already been part of family benefits.)

3.* Added coverage for special medical formulas for the treatment of certain conditions whether or not the formulas require a prescription.

4. Added 80% coverage for services of a coordinated home health agency.

5. Added coverage for certain hospice services.

6.* Added coverage for services of a certified nurse/midwife.

7. Renewed $250,000 lifetime maximum for Catastrophic Illness Coverage. (All covered persons received an additional $250,000 lifetime maximum.)

8. Added coverage for services of licensed independent social worker.

9. Added coverage for services of clinical specialists in psychiatric and mental health nursing.

10. Extended coverage for dependents from nineteenth birthday until end of the month in which they reach nineteen.

11. Added coverage for medically necessary wigs.

APPENDIX B

1. Agreement Between the Board of Regents of Higher Education and the Association of Professional Administrators, MTA/NEA (July 1, 1986 I- June 30, 1989)

Article VII - Holidays and Supplemental Benefits

D. Insurance and Annuities

2. Health and Accident Insurance

During the term of this Agreement, the Board shall continue to cover all administrators of the bargaining unit under the plan now in effect pursuant to the provisions of Chapter 32A, Sections 5, 6, 8 and 10A of the General Laws.

2. Agreement between the Board of Regents and the Massachusetts Community College Council/MTA/NEA (July 1, 1986 - June 30, 1989)

Article IX - Supplemental Benefits

9.03 Insurance and Other Benefits

A. Health and Accident Insurance

Unit members shall continue to be covered under the State's Group Health and Accident Insurance plan currently in effect pursuant to the provisions of Chapter 32A of the General Laws as amended or as such plan may be made available under applicable law of the Commonwealth.

3. Agreement between the Board of Regents of Higher Education and the Massachusetts Society of Professors at the University of Lowell (July 1, 1986 - June 30, 1989)

Article XX - Supplemental Benefits

C. Insurance

1. Health and Accident Insurance

The Board shall continue to cover all employees of the Bargaining Unit under the plan now in effect during the term of this Agreement, pursuant to the provisions of Chapter 32A, Sections 5, 6, 8, and 10A of the General Laws; provided, however, that any legislation which is enacted during the term of this Agreement and by which it is provided that the Commonwealth shall pay an increased share of the premium payable in respect of any Unit member covered by the terms of the Group Health Insurance Plan shall be deemed to amend this Section C.2. to the extent that such legislation is applicable to such faculty member.

The Commonwealth shall pay eight percent of the monthly premium rate for the Group Health Insurance Plan effective July 1, 1977. Effective January 1, 1978, the Commonwealth's contribution shall increase to 85% and effective January 1, 1979 the Commonwealth's contribution shall increase to 90%.

4. Agreement between the Board of Trustees of the University of Massachusetts on Behalf of the Board of Regents of Higher Education and the Massachusetts Society of Professors Faculty Staff Union/MTA/NEA
(July 1, 1986 - June 30, 1989)

Article XXVII Supplemental Compensation (Benefits)

27.4 Group Health Insurance Contributions. The Commonwealth shall pay ninety (90) percent of the monthly premium rate for the Group Insurance Plan and each bargaining unit member covered shall pay ten (10) percent of this premium rate for the type of coverage that is provided for him/her and his/her dependent(s) under the plan.

5. Agreement Between the Board of Regents of Higher Education and the Massachusetts State College Association (MSCA)/MTA - State Colleges
(April 23, 1987 - June 30, 1989)

Article IV - Supplemental Benefits and Holidays

C. Insurance

2. Health and Accident Insurance

The Board shall continue to cover all members of the bargaining unit, under the plan now in effect, during the term of this

Agreement, pursuant to the provisions of Chapter 32A, Sections 5, 6, 8 and 10A of the General Laws; provided, however, that any legislation which is enacted during the term of this Agreement and by which it is provided that the Commonwealth shall pay an increased share of any premium payable in respect of any employee covered by the terms of the Group Health Insurance Plan shall be deemed to amend this Section 2 to the extent such legislation is applicable to such employee.

6. Agreement between the Board of Regents of Higher Education and the University Staff Association MTA/NEA (July 1, 1986 - June 30, 1989)

Article 16 Health and Welfare

Section 1 Group Health Insurance Contributions

The Commonwealth shall pay ninety (90) percent of the monthly premium rate for the Group Health Insurance Plan, and each employee covered shall pay ten (10) percent of this premium rate for the type of coverage that is provided for him/her and his/her dependent(s) under the Plan.

Board of Regents of Higher Education and University Staff Association/MTA/NEA, 19 MLC 1248

OPINION OF CHAIRPERSON WALSH[37]

1. The Duty to Bargain over the Decision to change Insurance Plans and Carriers

Public employers may not change a pre-existing condition of employment affecting a mandatory subject of bargaining without providing the exclusive collective bargaining representative with prior notice and an opportunity to bargain. City of Newton, 16 MLC 1036, 1042 (1989). Under M.G.L. c.150E, public employers must bargain concerning the terms and costs of health insurance coverage provided pursuant to M.G.L. c.32B. Kerrigan v. City of Boston, 361 Mass. 24 (1972); Town of Ludlow, 17 MLC 1191 (1990). See generally, School Committee of Medford v. Labor Relations Commission, 380 Mass. 932 (1980) (rescript); Teamsters, Chauffeurs, Warehousemen & Helpers Union, Local No. 59 v. Chatham, 404 Mass. 365 (1989).

In Commonwealth of Massachusetts, 4 MLC 1869 (1978),[38] the Commission held that the Commonwealth had violated the Law by unilaterally implementing a GIC decision to withhold an alleged overpayment in health insurance premiums from subscriber employee paychecks without first having negotiated with the employees' union. While noting that payroll deductions are mandatory subjects of bargaining, the Commission expressly declined to reach the issue of the negotiability of G.I.C. decisions regarding group insurance carriers or coverage for state employees. 4 MLC at 1876 and at n.9.[39] This case involves the interplay between M.G.L. c.150E, the public employee collective bargaining statute and M.G.L. c.32A, the state employee group insurance statute. The Commission has held that a municipal employer must bargain over a decision to change insurance plans pursuant to M.G.L. c.32B. Town of Ludlow, supra.

Chapter 32A of the General Laws establishes a scheme for the provision of group insurance benefits to state employees, retirees, and their dependents. It was enacted in 1955, before state employees received statutorily enforceable collective bargaining rights.[40] Consequently, it is understandable that c.32A, as

---

37 Although all three Commissioners participated in the deliberation and decision in this case Chairperson Walsh signed her opinion separately in order to record her opinion prior to taking a short leave of absence.

38 The Commission's decision in 4 MLC 1869 was appealed by the G.I.C. and reversed by the Appeals Court, Group Insurance Commission v. Labor Relations Commission, 8 Mass. App. Ct. 753 (1979). The S.J.C. subsequently vacated the decision of the Appeals Court because the G.I.C. lacked standing to appeal the Commission's order. 381 Mass. 199 (1980).

39 Similarly, the S.J.C. declined to reach that issue. 381 Mass. at 202.

40 State employees were given the right to bargain over certain working (continued)

enacted, neither addressed nor anticipated collective bargaining over group insurance plans. A subsequent amendment to the statute, the Anti-Rollback Amendment (ARA),[41] referenced the collective bargaining process. Although the Anti-Rollback Amendment did not compel collective bargaining, the Commission noted in Ludlow that the ARA language "indicate[d] that the Legislature contemplated that the selection of health insurance coverage remain[ed] subject ... to the collective bargaining process mandated by G.L. c.150E..." 17 MLC at 1198

Although c.32A establishes a structure for securing insurance benefits that is independent of collective bargaining, nothing in the statute or in subsequent amendments prevents or necessarily conflicts with collective bargaining about health benefits. The statute establishes the Group Insurance Commission (GIC) as the entity responsible for negotiating and purchasing various plans of group insurance. Section 4 of c.32A authorizes the GIC "to negotiate with and purchase, on such terms as it deems to be in the best interest of the Commonwealth and its employees, from one or more insurance companies, savings banks or non-profit hospital or medical service corporations, a policy or policies of group life and accidental death and dismemberment insurance..., and group general or blanket insurance providing hospital, surgical, medical, dental and other health insurance benefits..." Section 6 specified that "the amount of the hospital, surgical, medical, dental and other health insurance benefits to be provided each employee and his dependents shall be determined by the Commission as provided under sections four and ten C."

While the statute appears to contemplate that the GIC is authorized to determine the "amount of ... benefits" to be provided pursuant to the plans of insurance referenced in section 4, the statute does not preclude the Commonwealth, or, as in this case, the Board of Regents, from entering into other arrangements to provide insurance benefits to employees. Indeed, the Commonwealth has entered into agreements to provide payments to cover the costs of certain health benefits through health and welfare trust funds. See Commonwealth of Massachusetts (Massachusetts Correction Officers Federated Union), 18 MLC ___ (SUP-3461, April 24,

40 (continued)
conditions in 1964, pursuant to M.G.L. c.149 Section 178F. State and municipal employees received more extensive collective bargaining rights in 1974 after the enactment of M.G.L. c.150E.

41 1988 Mass. Stat. c.23, §77A, as amended by 1988 Mass. Stat. c.29, §3, provided in relevant part: "nothing in this section shall preclude the parties to a collective bargaining agreement under ... [M.G.L. ch.50E] from agreeing to any change in the premium percentage, deductible or coinsurance amount which an employee is required to pay or to a change in benefits provided in a health plan established under the provisions of [M.G.L. c.32A] ..." The statute subsequently was repealed by 1991 Mass. Stat. ch.6, §52. See also 1989 Mass. Stat. ch.653 Sections 72, 36, 37, 217 and 218.

1992). Such agreements are independent of the GIC's exercise of its statutory authority pursuant to Sections 4 and 6 of M.G.L. c.32A. Thus, nothing in c.32A exempts health benefits for state employees from the scope of mandatory subjects of bargaining pursuant to Section 6 of c.150E.

Whether the GIC's decisions concerning health benefits are exempt from collective bargaining, however, is a separate question. Nothing in c.32A prohibits or restricts collective bargaining about health benefits between the statutory employer and the exclusive collective bargaining representative(s) of state employees.[42]

The GIC, however, is not the statutory employer of the employees at issue in this case, nor does the record permit a conclusion that the GIC is an agent for whose acts the Regents are responsible. Instead the record demonstrates that the GIC and the decisions made by it are not within the control of the Board of Regents. Because the Board of Regents had no ability to control the decision of the GIC, it had no duty to bargain about the GIC's decision to change insurance. Although the Regents and the GIC may interact and cooperate, as they did during the litigation of this case, nothing in this record demonstrates that the Regents have the authority to control the decisions of the GIC. Accordingly, that portion of the complaint that alleges that the Regents failed to bargain about the GIC's decision to change health insurance benefits and carriers must be dismissed.

2. The Duty to Bargain over the Impact of the Decision to Change Insurance Plans and Carriers

The Regents' inability to bargain with the Unions over the GIC's decisions concerning the selection of insurance plans and carriers does not restrict their ability to bargain over the impact of the GIC's decisions on employee wages and health insurance benefits, however. As the statutory employer, the Regents have a

---

[42] The Regents have argued that certain regulations of the GIC suggest that the insurance scheme established in c.32A is incompatible with the collective bargaining process. Recently, the Commission had occasion to observe that a G.I.C. regulation that purports to limit the scope of M.G.L. c.150E by removing from the "jurisdiction" of M.G.L. c.150E issues that arise under c.32A did "not comport with the Commission's interpretation of the Law." Commonwealth of Massachusetts (Mass. Correction Officers Federated Union), 18 MLC ___, SI. op. n.12 (April 24, 1992). The Regents also point to an Opinion of the Attorney General that states that a collective bargaining agreement could not supersede the GIC's implementation of a statutory mandate regarding a specific insurance provision. 1979 Op. Attorney General No. 26 at 146. The Attorney General's Opinion declined to comment on whether the GIC was subject to any of the collective bargaining obligations imposed by chapter 150E. Op. Attorney General at 151.

statutory obligation to bargain with the Unions about the impact of the GIC's decisions on all mandatory subjects of bargaining. School Committee of Newton v. Labor Relations Commission, 388 Mass. 557 (1983); Town of Dennis, 12 MLC 1027 (1985).

Informational GIC brochures distributed in March and April 1988 by the GIC indicated that the Hancock plan would take effect on July 1, 1988. Consequently, there was sufficient time between the Unions' March and early April 1988 demands to bargain and the effective date of the new Hancock plan to permit meaningful bargaining on the impact of the new plan.

The Board of Regents maintains that it was not obligated to bargain about the impact of the GIC's decisions regarding health insurance plans and carriers for several reasons. First, it argues that the impacts of the GIC's decision to change the insurance plan and carrier are inseparable from the decision itself. It must be noted, however, that although the substantive insurance benefits offered by the GIC's plan are incorporated into the plan, the Regents can, and do, negotiate insurance benefits separately through the vehicle of a health and welfare trust fund.[43] Moreover, employer-subsidized health insurance is a form of compensation. Changes in health insurance costs impact employees' compensation and are mandatory subjects of bargaining. See generally Anderson v. Board of Selectmen of Wrentham, 406 Mass. 508 (1990) (premium contributions of municipal employees are mandatory subjects of bargaining); Ludlow Education Association v. Ludlow, 31 Mass. App. Ct. 110 (1991) (obligation of Selectmen to bargain pursuant to Mass. Gen. L. c.32B).

The Regents also contend that impact bargaining is not required because the Unions requested bargaining solely over the change in carrier,[44] and the impacts on mandatory subjects resulted from the change in plan rather than carrier. Specifically, the Regents point to the Unions' failure to request bargaining over benefits, changes in benefits, the scope of benefits, or the benefit plan design. In their letters of March and April, 1988, the Unions demanded to bargain over the "decision to change the insurance carrier, as well as the impact on terms and conditions of employment." Although this demand may have lacked the specificity desired by the Regents, it was a sufficient response to the information that the Unions possessed at that time to notify the Regents of the Unions' desire to bargain. When the Unions demanded bargaining, the only material they had received regarding the new plan was the description contained in the brochure "For Your Benefit." This brochure did not detail the benefits contained in the new plan but

---

[43] At the time of the hearing in this matter the Regents maintained a trust fund that provided optical benefits to employees.

[44] The National Labor Relations Board has recognized that an employer's unilateral change in insurance carriers implicates the duty to bargain. E.g., Lawrenceville Ready-Mix, 305 NLRB No. 156 (1991).

merely summarized some of its procedures and costs. Details concerning benefits were not publicized until the GIC subsequently published "It's Your Choice" and "It's Your Choice Update." Given the minimal information that the Unions possessed at the time of their demand, the Unions' request to bargain over the impacts of changes in the "carrier" reasonably must be construed as a request to bargain over the impact of the changes in the plan. The Unions had received no notice of the GIC's intent to change the "plan" of insurance except insofar as the change in benefits appeared to result from the change in carrier. Moreover, the GIC's own "Final Evaluation of RFP Bids" indicates that some plan characteristics were inextricably linked to the identity of the carrier.

The Regents next argue that impact bargaining is prohibited by the Supreme Judicial Court's decision in Watertown Firefighters v. Town of Watertown, 376 Mass. 706 (1978). The Regents contend that Watertown prohibits interference by the collective bargaining process with the insurance procedures established pursuant to M.G.L. c.32B, and argue that impact bargaining should be prohibited in this case.

The Watertown decision held that the terms of a collective bargaining agreement could not superseded a statutory limitation on premium percentage contributions. In fact, footnote 19 of the court's opinion states that "[t]he statutory regulation of group insurance for municipal employees does not exclude all collective bargaining by a union on the subject...." 376 Mass. at 715. Thus, while the Court invalidated an interest arbitration award that required the Town to increase its insurance contribution rate for one group of employees above the rate established for other municipal employees, it nonetheless sanctioned collective bargaining about insurance.

Similarly, in a more recent decision the SJC acknowledged that a public employer could negotiate to provide other benefits to redress dollar differentials between the contributions made by the employer to one employee group's insurance policies and the contribution made to another group's policies. Teamsters, Chauffeurs, Warehousemen & Helpers Union, Local No. 59 v. Chatham, 404 Mass. 365, 370, n.2. (1989). Thus, the group insurance procedures outlined in chapter 32B do not preclude collective bargaining about those aspects of insurance coverage that impact wages and other mandatory subjects of bargaining.

The Regents argue that the Unions contractually waived any right to bargain over the impact of the GIC's change in insurance plan and carrier. In support of their position they point to so-called "zipper clauses" in the six applicable collective bargaining agreements between the Board of Regents and the Charging Parties. The Regents argue that the Zipper Clauses, which are appended hereto as Appendix B, should be read in conjunction with the insurance articles of the agreements to preclude collective bargaining.

The Commission has long held that an employer asserting contractual waiver as an affirmative defense must demonstrate that the parties "consciously considered the situation that has arisen, and that the Union knowingly waived its bargaining

rights." Town of Marblehead, 12 MLC 1667 (1986). The waiver must be conscious and unmistakable. Town of Marblehead, at 1670 citing Town of Andover, 4 MLC 1086 (1977) and Melrose School Committee, 3 MLC 1299 (1976). If the contract language is ambiguous or too vague to demonstrate a clear and conscious waiver, bargaining history may be examined to determine if the parties mutually understood and intended to apply the ambiguous contract language to the issue in dispute. Town of Marblehead, supra.

The Agreement between the Board of Regents of Higher Education and the Association of Professional Administrators, MTA/NEA (July 1, 1986 - June 30, 1989), Article VII D.2 titled Health and Accident Insurance, provides that:

> During the term of this Agreement, the Board shall continue to cover all administrators of the bargaining unit under the plan now in effect pursuant to the provisions of Chapter 32A, Sections 5, 6, 8, and 10A of the General Laws.

The words "the plan now in effect" can reasonably be read to refer to the plan in effect at the time the agreement was negotiated: the Blue Cross/Blue Shield plan. There is no evidence of bargaining history indicating that the parties mutually intended another interpretation of this language. Thus, in the absence of bargaining history indicating otherwise, no waiver of the right to bargain about a change from the blue Cross/Blue Shield plan in effect at the time of the contract can be found in this language.

The Agreement between the Board of Regents of Higher Education and the Massachusetts Society of Professors at the University of Lowell (July 1, 1986 - June 30, 1989) and the Agreement Between the Board of Regents of Higher Education and the Massachusetts State College Association (MSCA)/MTA - State colleges (April 23, 1987 - June 30, 1989) contain language similar to the language analyzed above:

> The Board shall continue to cover all employees (members) of the Bargaining Unit under the plan now in effect during the term of this Agreement, pursuant to the provisions of Chapter 32A, Sections 5, 6/ 8 and 10A of the General Laws;[45] ...

The plan language of this clause states that "the plan" in effect at the time the contract was negotiated, the Blue Cross/Blue Shield plan, would continue during the term of the contract. The language does not indicate that either the MSP-Lowell or the MSCA waived the right to bargain about changes in the Blue Cross/Blue Shield plan during the term of the contract.[46] Neither proviso authorizes unilateral

---

[45] There are minor language differences between the two contracts which have been noted in brackets.

[46] (see page 1293)

changes in either the carrier or the benefits of the plan, but only in the premium percentage contribution. Thus, neither constitutes a waiver of the bargaining rights at issue in this case.

The Agreement between the Board of Regents and the Massachusetts Community College Council/MTA/NEA (July 1, 1986 - June 30, 1989) differs from the prior contracts. It provides that:

> Unit members shall continue to be covered under the State's Group Health and Accident Insurance plan currently in effect pursuant to the provisions of Chapter 32A of the General Laws as amended or as such plan may be made available under applicable law of the Commonwealth.

The inclusion of the language "as such plan may be made available..." is susceptible of various interpretation. It could mean that the parties anticipated changes in premiums, in benefits, or in carriers from the then-existing Blue Cross/Blue Shield plan. No evidence, such as evidence of bargaining history, was introduced to clarify the parties' intended meaning of the clause, however. In the absence of other evidence the plain language of the clause does not clearly reflect a knowing and conscious waiver by the union of the right to bargain about changes in the plan.

The agreements between the Board of Trustees of the University of Massachusetts on behalf of the Board of regents of Higher Education and the Massachusetts Society of Professors Faculty Staff Union/MTA/NEA (July 1, 1986 - June 30, 1989) and between the Board of Regents of Higher Education and the University Staff Association/MTA/NEA (July 1, 1986 - June 30, 1989) both contain the following language:

> Group Health Insurance Contributions. The Commonwealth shall pay ninety (90) percent of the monthly premium rate for the Group Insurance [Group Health Insurance] Plan and each bargaining unit member [employee] covered shall pay ten (10) percent of this premium rate for

---

46 (from page 1292)
The two contracts have additional provisos as follows:

> ...provided, however, that any legislation which is enacted during the term of this Agreement and by which it is provided that the Commonwealth shall pay an increased share of the premium payable in respect of any employee [unit member] covered by the terms of the Group Health Insurance Plan shall be deemed to amend this Section...to the extent that such legislation is applicable to such employee [faculty member].

There are minor language differences between these two contracts which have been noted in brackets...

> the type of coverage that is provided for him/her and his/her dependent(s) under the plan.[47]

This language can be interpreted to reference "the" Blue Cross/Blue Shield "plan" in effect at the time of the contracts. Because it is reasonably susceptible of this interpretation it does not constitute a conscious and unequivocal waiver of the Unions' rights to negotiate about changes in the plan. The Employer bears the burden of proving the affirmative defense of contract waiver of the Union's right to bargain. No evidence of bargaining history or other evidence was introduced to demonstrate that the language was intended by the parties to constitute a waiver of the Unions' rights to bargain. Accordingly, the Unions cannot be found to have contractually waived their rights to bargain regarding insurance plans.

The Regents also raised the following additional arguments: 1) there an be no duty to bargain about health insurance because c.32A cannot be superseded by a collective bargaining agreement by operation of section 7(d) of c.150E; 2) public policy considerations preclude bargaining over group insurance for state employees; and 3) the past practice of the parties demonstrates that bargaining cannot be required.

In Town of Ludlow, supra, the Commission concluded that c.32B did not preclude bargaining about health insurance. Collective bargaining agreements can incorporate insurance benefit provisions that do not conflict directly with c.32B. 17 MLC 1196-1198. The same principle applies here. Unless the terms of the parties' collective bargaining agreement directly conflicts with specific provisions of c.32A, collective bargaining over the impact of the GIC's decision to change insurance plans and carriers is not prohibited by operation of Section 7(d) of c.150E.

The Regents also argue that public policy should preclude collective bargaining about the GIC's plan(s) of insurance. It is clear that the Regents cannot bargain directly about the GIC's insurance plan or the GIC's selection of carriers because the Regents do not control the GIC. The record does not establish that the GIC's insurance plans will be directly affected by any agreements that might be negotiated between the Regents and the Unions concerning supplemental insurance benefits, such as those administered through a health and welfare trust fund. In the absence of such evidence there appears on this record no reason to ignore the mandates of the collective bargaining law by excusing the statutory employer from its duty to bargain about mandatory subjects of bargaining.

Finally, the Regents argue that the past practice of the parties demonstrates that the subject of health insurance plans and carriers is not a mandatory subject of bargaining. It is undisputed that the parties have not previously

---

[47] Bracketed language reflects the differences between the two contracts.

bargained over changes in health insurance plans or carriers.[48] The Regents contend that this inaction, as well as the Unions' lobbying efforts[49] reflect the Unions' recognition that bargaining was not required.

It is the language of Chapter 150E, §6, rather than the conduct of the parties, that determines whether a topic is a mandatory subject of bargaining. In determining whether an issue constitutes a mandatory subject of bargaining, the Commission balances the employer's interest in maintaining managerial prerogatives with the interests of employees in bargaining about the subject. The Commission considers both the impact of the issue on terms and conditions of employment and the extent to which the issue involves a core managerial decision. City of Boston, 16 MLC 1437, 1444 (1989); Town of Danvers, 3 MLC 1559 (1977). Although the right to bargain about a mandatory subject can be waived, the waiver does not render a mandatory subject nonmandatory. Rather, the waiver merely relieves the parties of their bargaining obligation. The subject of insurance plans and carriers is a mandatory subject of bargaining because it impacts wages and terms and conditions of employment. Town of Ludlow, 17 MLC 1191, 1196 (1990); School Committee of Medford v. Labor Relations Commission, 8 Mass. App. Ct. 139, 140 (1979), aff'd 380 Mass. 932 (1980). Consequently, neither the Unions' past silence nor their lobbying efforts excuse the Regents from their obligation to bargain.

3. Conclusions Regarding the Regents' Failure to Bargain

The Board of Regents' failure to bargain over the GIC's decision to change the insurance plan and carrier did not violate the Law because the Regents had no duty to bargain over the GIC's decision. Although the Regents argue that the impacts of the change in plan and carrier are insubstantial and immaterial, they do not dispute that a change in carrier and plan occurred. It is undisputed that the Regents failed to bargain with the Unions over the impact of the GIC's change. The evidence demonstrates sufficient impact on employee health benefits[50] to warrant

---

[48] Indeed, in 1989 the MTA attorney, during a court proceeding, opined that group health insurance was not a matter of collective bargaining.

[49] The Regents also suggest that the Unions' lobbying efforts should preclude their participation in collective bargaining in light of the SJC's decision in Anderson v. Board of Selectmen of Wrentham, 406 Mass. 508 (1990). Anderson did not prohibit a union from lobbying before a legislative body in conjunction with negotiations. Rather, Anderson recognized that certain terms of employment are subject to the collective bargaining process and cannot be superseded by a conflicting municipal ordinance. The Unions' lobbying activities here did not relieve the Regents' of their duty to respond to the Unions' requests to bargain the impacts of the change of plan.

50 (see page 1296)

the conclusion that the Regents had a duty to bargain over the impact of the GIC's decision to change health insurance plans and carriers. The Regents' failure to do so violated their duty to bargain in good faith. Moreover, the Regents, like any party to a collective bargaining relationship, have a continuing statutory duty to bargain prospectively on demand about mandatory subjects affecting employees in the absence of contractual agreements waiving the obligation.

4. The Duty to Provide Information

An employer's duty to bargain in good faith includes a duty to supply the union, upon request, with information that is relevant and reasonably necessary to the Union's task of performing its responsibilities as exclusive bargaining representative. Board of Trustees, University of Massachusetts (Amherst), 8 MLC 1139 (1981). The fact that information is a "public record," or is available from another source is no defense to an employer's refusal to provide information in its possession that is otherwise relevant and reasonably necessary. Commonwealth of Massachusetts, 12 MLC 1590 (1986).

The Unions requested copies of the new Hancock policy. The Board of Regents first received a copy of the Hancock plan in October of 1988, and mailed it to the Unions' attorney on November 2, 1988. The Unions contend that the Regents unlawfully delayed their transmittal of the requested information.[51]

In Woods' Hole, Martha's Vineyard and Nantucket Steamship Authority, 12 MLC 1531 (1986), the Commission held that the Union was not obligated to provide certain requested financial information to the Employer concerning a pension plan where the Union neither controlled the plan nor possessed the requested information. The same principle is applicable here. The Regents did not possess a copy of the insurance contract until October, 1988, when they secured a copy from the GIC. They were not a party to the insurance negotiations between the GIC and John Hancock and had no control over the information. Consequently, the Regents did not violate their duty to bargain by failing to provide the Unions with a copy of the Hancock contract until November 1988.

---

50 (from page 1295)

Specifically, the evidence demonstrates that the procedures for securing certain medical services were changed and the prohibition against balance billing was terminated, thus creating a potential for higher health care costs.

51

The Regents do not dispute that the Hancock contract was relevant and reasonably necessary to the Unions' duties as exclusive bargaining representative.

REMEDY

Because the Regents failed to bargain in good faith with the Unions concerning the impact of the GIC's decision to change insurance coverage applicable to the Regents' employees, the Regents, or their successors, must cease and desist from refusing to bargain about the impact of the change on wages, hours, and other terms and conditions of employment and must bargain with the Unions upon demand. School Committee of Newton v. Labor Relations Commission, 388 Mass. 557 (1983). Specifically, the Regents, or their successors, must bargain over the impacts of the changes in both plan and carrier on working conditions, which may include the changes in claim procedures, managed care provisions, balance billing restrictions, substantive benefits and costs. To this end the Regents, or their successors, must notify each Union that represents their employees within thirty (30) days of receipt of this Decision and Order and must offer to bargain. In addition, the Regents, or their successors, must post the Notice to Employees appended to this Decision.

The traditional remedy for an unlawful unilateral change includes an order restoring the status quo ante until the bargaining obligation is fulfilled. City of Newton, 16 MLC 1036 (1989). Where the bargaining obligation encompasses only the impact of a decision to change a mandatory subject of bargaining, rather than the underlying decision, the Commission has tailored the remedy to restore employees to the relative bargaining position they were in prior to the employer's refusal to bargain. Town of Dennis, 12 MLC at 1033. See generally, City of Quincy, 8 MLC 1217, 1220 (1981); Transmarine Navigation Corp., 170 NLRB 389 (1968).

In the instant case, had the Regents fulfilled their bargaining obligation negotiations would have been initiated while employees were still covered by the BC/BS plan. Reinstatement of the status quo ante therefore requires that employees must be restored during the period of bargaining to the same monetary position they enjoyed as a result of the insurance coverage that was in effect in March 1988. Since the Board of Regents cannot cause the GIC to reinstate the BC/BS plan in effect in late March 1988, the Regents, or their successors, must compensate employees for the monetary difference between the cost to employees of the BC/BS coverage in effect in March 1988 (including differences in deductions, covered benefits, co-payments, balance billing, claim procedures and premium percentage contributions) and the cost to employees of the insurance plan(s) in effect during bargaining.

An adequate remedy also must recognize that when the GIC changed the plan of insurance from BC/BS coverage effective July 1, 1988, the status quo ante also changed. Had the Regents negotiated with the Unions beyond July 1, 1988, the employees would have been subject to the new plan(s) of insurance. Therefore, the Regents, or their successors, must compensate employees in each bargaining unit for the monetary difference between the March 1988 BC/BS plan coverage and the coverage in effect during bargaining pursuant to this Order for a period of no more than

three months beginning five (5) days after the date that each Union demands to bargain pursuant to this Order. If bargaining pursuant to this Order continues more than three months the Regents, or their successors, will be obligated to compensate employees for the monetary difference, if any, between the plan(s) instituted July 1, 1988 and the plan(s) in effect after three months' of bargaining. The obligation to make employees whole pursuant to the terms of the Order will begin in each bargaining unit five (5) days after the date of each Union's demand to bargain and will continue in each bargaining unit until the earliest of the following events:

1. The parties reach mutual agreement regarding the impact of the change in health insurance coverage;

2. The parties reach impasse after bargaining in good faith;

3. The Union fails to commence negotiations within five (5) days of receipt of notice of the Employer's willingness to bargain with the Union; or

4. The Union subsequently fails to bargain in good faith.

See Town of Dennis, 12 MLC 1027, 1033, 1034.

SUCCESSORS TO THE REGENTS

Following the close of the hearing, the General Court enacted and on July 1, 1991, the Governor signed, chapter 142 of the Acts of 1991, an act reorganizing the administration of the Commonwealth's system of higher education. Section 25 of chapter 142 redefined the employer of employees of the system of public institutions of higher education for the purposes of chapter 150E of the General Laws by striking out references to the Board of Regents of Higher Education. Instead, 1991 Mass. Stat. c.142, §25 defines the public employer for the purposes of collective bargaining as "the higher education coordinating council or any individual who is designated to represent it and act in its interest in dealing with employees, except that the employer of employees of the University of Massachusetts shall be the board of trustees of the university or any individual who is designated to represent it and act in its interest in dealing with employees."

On or about February 20, 1992, the Unions wrote to the Commission to request that in the event that the Charging Parties prevail that any order run against the Higher Education Coordinating Council or in the case of employees of the University of Massachusetts, the Board of Trustees of the University of Massachusetts. The Commission issued a notice to the parties on May 19, 1992, inviting statements of position from the parties and requesting the attorney of record for the Board of Regents to notify the Commission of whether he or she represents the Higher Education Coordinating Council and the Board of Trustees of the University of Massachusetts for the purpose of this case.

By letter dated June 12, 1992, the Unions responded to the Commission's notice by arguing that the Higher Education Coordinating Council and the Board of Trustees of the University of Massachusetts are "joint successors to the Board of Regents," and constitute "two public employers, for the purposes of G.L. c.150E," and, pursuant to 1991 Mass. Stat. c.142, §34, the Board of Trustees succeeds to the obligations of any collective bargaining agreement in effect as of August 31, 1991.

The Board of Trustees of the University of Massachusetts responded by letter dated May 26, 1992 by arguing that it was an"inappropriate party to be substituted for the Board of Regents of Higher Education ... [because] the University was not responsible for or accountable for the Regents' alleged actions." The Board of Trustees of the University of Massachusetts argued that it had not violated the Law and therefore that no remedial order should run to it.

In contrast, the Higher Education Coordinating Council, by letter dated June 2, 1992, notified the Commission that it did not oppose the Unions' motion to substitute it for the Board of Regents. The Higher Education Coordinating Council acknowledged that 1991 Mass. Stat. c.142 made the Council the "statutory successor to the Board of Regents of Higher Education unless otherwise enumerated by law." Moreover, the Council took the position that "any future order may run against the Council for state and community college employees and against the University Board of Trustees for University employees."

The Regents also responded by letter dated June 12, 1992, but took no position concerning the liability of the Higher Education Coordinating Council or the Board of Trustees of the University of Massachusetts.

Chapter 142 of the Acts of 1991 supports the contention of the Higher Education Coordinating Council that it is the statutory successor to the Board of Regents. Section 28 of chapter 142 of the Acts of 1991 specifies, inter alia, that "[a]ll duly existing contracts, leases and obligations of the board of regents in force immediately prior to the effective date of this act shall thereafter be performed by the council. No existing right or remedy of any character shall be lost, impaired or affected by the provisions of this act." By the plain language of Section 28, the Higher Education Coordinating Council succeeds to all the obligations of the Board of Regents. Thus, to the extent that the Board of Regents had an obligation to bargain with the Unions, Section 28 establishes that the Higher Education Coordinating Council now must assume that obligation. The only disputed issue concerns the obligations of the University of Massachusetts Board of Trustees.

The Higher Education Coordinating Council (HECC) argues that its succession to the obligations of the Board of Regents is limited to employees of all state colleges and all community colleges. Employees of the University of Massachusetts, the HECC contends, are the responsibility of the Board of Trustees of the University of Massachusetts.

Section 29 of chapter 142 of the Acts of 1991 specifies, inter alia, that "[r]ights and obligations under collective bargaining agreements with respect to employees of all state colleges and all community colleges transferred from the board of regents to said [higher education coordinating] council shall be assumed by and imposed upon the council ..." Section 34 of chapter 142 of the Acts of 1991 specifies, inter alia, that "[t]he staff of Southeastern Massachusetts University and the University of Lowell on August 32, 1991 shall be and are hereby transferred to the staff of the University of Massachusetts without impairment of status, tenure, seniority, retirement, insurance, industrial accident coverage and all other rights and benefits to which such staff are entitled on said date ..." Similarly, Section 35 of chapter 142 of the Acts of 1991 specifies that "[t]he terms of any collective bargaining agreement in existence on August thirty-first, nineteen hundred and ninety-one between any employee organization and the board of regents of higher education concerning Southeastern Massachusetts University, the University of Lowell, and the University of Massachusetts shall continue in full force and effect until the expiration of said agreement, subject to the provisions of this act." Section 37 of chapter 142 of the Acts of 1991 specifies, inter alia, that "[a]ll duly existing contracts, leases and obligations of the board of trustees of Southeastern Massachusetts University, the board of trustees of the University of Lowell and the board of trustees of the University of Massachusetts which are in force and effect on August 31, 991, shall thereafter be performed by the board of trustees of the University of Massachusetts ..., and no existing right of any character shall be lost, impaired, or affected by the provisions of this act." When coupled with the language of Section 25, described above, the statutory scheme details a transfer of responsibility for the wages, hours and working conditions of Southeastern Massachusetts University, University of Lowell and University of Massachusetts employees (hereinafter referred to a University of Massachusetts employees) to the Board of Trustees of the University of Massachusetts, rather than to the HECC. Although there is no section identical to Section 28 to describe the obligations of the Board of Trustees of the University of Massachusetts, the statute makes repeated reference to the fact that no rights are to be lost by the provisions of the act.[52] Therefore it must be concluded that there was no legislative intent to extinguish the pre-existing collective bargaining rights of employees of the University of Massachusetts merely because the identity of the representative of the public employer was changed. Accordingly, the Board of Trustees of the University of Massachusetts, as the statutory employer of University of Massachusetts employees, succeeds to the obligations of the Board of Regents concerning University of Massachusetts employees.[53]

---

[52] Section 33 of 1991 Mass. Stat. c.142, for example, indicates that the University of Massachusetts Board of Trustees succeeds to "[t]he rights, powers, duties, and properties..." (emphasis added) of the Board of Regents vis-a-vis employees of Southeastern Massachusetts University, University of Lowell, and the University of Massachusetts.

53 (see page 1301)

Accordingly, in the discussion of the remedy and in the Order, references to the "Board of Regents of its successors," should be construed as referenced to the HECC, when applicable to the employees of all state and community colleges, and to the Board of Trustees of the University of Massachusetts, when applicable to all University of Massachusetts employees.

By their letter dated June 12, 1992, the Regents also requested the Commission to reopen the record to receive evidence concerning the repeal of 1988 Mass. Stats. c.23, §77A by 1991 Mass. Stat. c.6, §52, and other evidence concerning post-hearing negotiations between the parties. The Commission has taken administrative notice of the repeal of 199 Mass. Stat. c.23, §77A, and since neither the passage of 199 Mass. Stat. c.23, §77A, nor its repeal was dispositive of the merits of this case, there is no need to reopen the record to receive further argument concerning the statutes.

Whether the parties have, through negotiations subsequent to the date of the hearing in this matter, rendered the remedial Order moot is a question best left to compliance proceedings, if necessary. Negotiations that succeeded the date of the unlawful actions in this case may render parts of the remedial order unnecessary, but, under the circumstances of this case, do not obviate the legal obligations of the parties that are herein adjudicated. Accordingly, the record will not be reopened to receive evidence of post-hearing negotiations.

ORDER

WHEREFORE, based upon the foregoing, IT IS HEREBY ORDERED the the Board of Regents, and its successors, shall:

1. Cease and desist from:

   a. Refusing to bargain in good faith about the impact on employee wages and other working conditions of decisions by the Group Insurance Commission to change health insurance plans and/or carriers with the following charging party unions: University Staff Association/MTA/NEA (USA), Association of Professional Administrators/MTA/NEA (APA), Massachusetts Community College Council/MTA/NEA (MCCC), Massachusetts Society of Professors/ University of Lowell/MTA/NEA (MSP Lowell), Massachusetts Society of Professors/Faculty Staff Union/MTA/NEA (MSP/FSU), and the Massachusetts State College Association/MTA/NEA (MSCA).

---

53 Whether the Board of Trustees of the University of Massachusetts may have some right pursuant to 1991 Mass. Stat. c.142, §28 to seek indemnification from the HECC for the acts of the Board of Regents is beyond the scope of the submissions of the parties and need not be considered here.

b. In like or related manner, interfering with, restraining, or coercing employees in the exercise of their rights under the Law.

2. Take the following affirmative action which will effectuate the purposes of the Law:

a. Upon the request of each Union, bargain with each Union in good faith to agreement or impasse about the impact on employees' wages, hours, and other terms and conditions of employment of the GIC's July 1, 1988 change in health insurance plan(s) and carrier(s).

b. Restore the status quo ante by compensating bargaining unit employees represented by each Union for the monetary difference between the cost to employees of the BC/BS coverage in effect in March 1988 (including differences in covered benefits, deductibles, co-payments, balance billing, and premium percentage contributions) and the cost to employees of the insurance plan(s) in effect during bargaining. The obligation to make employees whole will begin in each bargaining unit five (5)days after the Union representing that unit demands to bargain; and will continue in each bargaining unit until the earliest of the following events:

1) The employer and the Union representing the bargaining unit reach mutual agreement regarding the impact of the change in health insurance coverage;

2) The employer and the Union representing the bargaining unit reach impasse after bargaining in good faith;

3) The Union representing the bargaining unit fails to commence negotiations within five (5) days of receipt of the Employer's notice of its willingness to bargain with the Union; or

4) The Union representing the bargaining unit subsequently fails to bargain in good faith.

If the bargaining continues pursuant to this Order for more than three months the obligation of the Employer to compensate employees in the affected bargaining unit will change. After three months' of bargaining the Employer must compensate employees in the affected bargaining unit(s) for the monetary difference between the cost to employees of the health plan(s) coverage in effect July 1, 1988 (including differences in covered benefits, deductibles, co-payments, balance billing, claim procedures, and

premium percentage contributions) and the cost to employees of the insurance plan(s) in effect after three months' of bargaining. The obligation to make employees whole will continue until the earliest of the events described above.

c. Post in all conspicuous places where employees in each bargaining unit usually congregate and where notices to employees are usually posted, and maintain for a period of thirty (30) days thereafter, copies of the attached Notice to Employees; and take reasonable steps to ensure that these notices are not altered, defaced or covered by any other material.

d. Notify the Commission in writing of the steps taken to comply with this decision within thirty (30) days after the date of the receipt of this decision.

SO ORDERED.

Maria C. Walsh, Chairperson