STATE OF WISCONSIN | CIRCUIT COURT Branch 11 | DANE COUNTY

MADISON METROPOLITAN SCHOOL DISTRICT,

Plaintiff,

-v-

WISCONSIN EMPLOYMENT RELATIONS COMMISSION,

Defendant.

MEMORANDUM DECISION

Case No. 84 CV 6920

Decision No. 22129 and 22130

The petitioner, Madison Metropolitan School District (District) seeks administrative review under Chapter 227 of a decision of the Wisconsin Employment Relations Commission (Commission) which held that the identity of a specific insurance carrier was the subject of mandatory bargaining under Section 111.70(1)(a) because it primarily related to wages, hours and conditions of employment.

Since I find that the Commission erroneously interpreted Section 111.70(1)(a) and since I find that the facts do not support the Commission's conclusions of law, I reverse the Commission's decision.

FACTS

On April 26, 1982, the Madison Metropolitan School District filed a petition for declaratory ruling with the Wisconsin Employment Relations Commission pursuant to Section 111.70(4)(b), Stats., regarding whether certain proposals made by Madison Teachers Incorporated (MTI) during negotiations for a successor agreement on behalf of school aides were subjects of mandatory bargaining. The specific proposals read as follows:

C. Section VII, Paragraph B - Health Insurance.

1. Coverage shall be optional and shall be the Dane County Health Maintenance Program (HMP) or conventional insurance coverage, which is currently in effect for those electing

such coverage other than HMP.

...

5. Effective January 1, 1979, school aides shall be included in WPS Group 1202.

The District filed a second petition for declaratory ruling on September 3, 1982, regarding whether certain proposals MTI made during negotiations for a successor agreement on behalf of certain clerical and technical employees were subjects of mandatory bargaining. Those proposals read as follows:

1. The Wisconsin Physicians Service, Dane County Health Maintenance Program (HMP) or the conventional program under WPS Policy Group #1202 is available to the eligible employees.

...

3. The coverage and benefits shall be established by the parties to this agreement.

After the second petition for declaratory ruling was filed, MTI and the District agreed that the evidence and arguments presented in the school aides case would be the same evidence and arguments that would be heard in the second case. Therefore, the parties stipulated that the petitions be joined and that a single decision be rendered based on the evidence presented in the school aides case.

A hearing regarding the school aides case was conducted on August 18, 19, 20 and 26, 1982, before Dennis P. McGilligan, an Examiner of the Wisconsin Employment Relations Commission. On November 21, 1984, the Commission issued its decision holding that the proposals set forth in the April 26, 1982 and September 3, 1982 petitions primarily relate to wages, hours and conditions of employment and are mandatory subjects of bargaining within the meaning of Section 111.70(1)(a), Stats.

In so ruling, the Commission considered evidence from the insurance industry and made the following findings:

> The instant record presents information about carriers and/or administrators who collectively do in excess of seventy (70%) percent of the group health insurance business in Wisconsin at a specific point in time which is proximate to the time frame within which the parties' dispute arose. As such we are satisfied that this record presents a representative view of the health insurance industry for the time frame in question.
>
> Our review of that record satisfies us that at the time in question, all insurance carriers and/or administrators involved herein provide unique benefit packages. We so find because, even where the policy provisions are identical, carriers and/or administrators frequently interpret and/or administer said provisions in different manners and these differing interpretations yield different benefits for employes. Tr. 101, 302, 320, 387-388, 425, 490-492, 516. For example, certain benefits in all policies are paid at a level specified as "usual, customary and reasonable" or "reasonable and customary." The evidence demonstrates that carriers utilize different procedures to generate the data upon which the "usual, customary and reasonable" payment level determinations are based, resulting in different payments for identical claims in at least some circumstances. Tr. 72, 86, 97, 129, 147, 173-177, 182-183, 223-224, 283-284, 326, 336, 364-365, 425-427, 496. Moreover, the record reveals that insurance policies typically limit certain benefits to medical procedures which are "medically necessary." The record establishes that the different decisionmakers for each carrier/administrator ultimately define the term "medically necessary" differently in at least some circumstances and thus the benefit levels related thereto are different from carrier to carrier. Tr. 64-65, 140, 318, 417, 488. MTI's proposals herein thus seek to maintain what are unique benefit packages and hence the proposals have a direct relationship to employe wages.
>
> The record demonstrates not only that the definition of key terms such as "usual, customary and reasonable" and "medically necessary" will vary from carrier but also, of course, that payment levels made by a given carrier as regards a given claim vary from one point in time to another. In our view that further supports our conclusion that the employes in the instant bargaining units have been shown to have substantial economic interests in the integrity, reliability and responsiveness of the carrier/administrator that is selected to be responsible for fair, accurate and prompt payment of employe health insurance claims.

ISSUE

Whether the Commission's decision that the identity of a specific insurance carrier is a subject of mandatory bargaining is erroneous as a matter of law.

DECISION

Under Section 227.20(5) the "court shall set aside or modify the agency action if it finds that the agency has erroneously

interpreted a provision of law and a correct interpretation compels a particular action." In this case, the question of whether the identity of a specific insurance carrier is subject to mandatory bargaining is a question of law. A court is not bound by an agency's decision regarding matters of law. However, an agency's long standing interpretation of law is entitled to great weight and deference. Therefore, the court should affirm an agency's decision "if a rational basis exists for them or, to state the rule in another way, if the agency's view of the law is reasonable even though an alternative view is also reasonable." West Bend Education Association v. Wisconsin Employment Relations Commission, 121 Wis. 2d 1, 13-14 (1984).

However, in this case, the Commission's decision is not reasonable because it is not supported by the Commission's own findings of fact. The Commission has addressed this same issue before in Walworth County Handicapped Children's Education v. Lakeland Education Association, Decision No. 17433 (Nov. 1979) and reached the opposite conclusion, that the identity of a specific insurance carrier was not a subject of mandatory bargaining. Thus, the Commission's decision is not a long standing agency interpretation of law and is not entitled to deference. Furthermore, the question is one of first impression in Wisconsin.

Section 111.70(1)(a) states that a municipal employer has an obligation to bargain in good faith with "respect to wages, hours and conditions of employment."

> The employer shall not be required to bargain on subjects reserved to management and direction of the governmental unit except insofar as the manner of exercise of such functions affects the wages, hours and conditions of employment of the employes. In creating this subchapter the legislature recognizes that the public employer must exercise its powers and responsibilities to act for the government and good order

> of the municipality, its commercial benefit and the health, safety and welfare of the public to assure orderly operations and functions within its jurisdiction, subject to those rights secured to public employes....

West Bend recognized that this section requires a balance between the competing interests of the employees and the government "when a proposal touches simultaneously upon wages, hours and conditions of employment and upon managerial decision making or public policy." Id. at 8. In balancing these competing interests, the decision maker must determine whether the proposal is primarily related to wages, hours and conditions of employment or primarily related to management, educational policy or public policy. "Primarily" has been construed to mean "fundamentally," "basically," or "essentially." Id.

Thus the Commission must first determine whether the proposal touches upon the wages, hours and conditions of employment. Only then need the Commission undertake the balancing test set forth in West Bend.

In this case, the Commission first determined that each insurance carrier's benefit contract was unique. The Commission reached this determination even when the policy provisions were identical, because each insurer interpreted its contract differently. The Commission found that different interpretations of "usual, customary and reasonable" payment levels and of the term "medically necessary" resulted in different payments for identical claims in at least some circumstances. After determining that each contract was unique, the Commission erroneously jumped to the conclusion that the proposal identifying a specific insurance carrier had a direct relationship to employee wages.

However, there is no logical basis in the record for this

conclusion. Obviously, each insurance carrier will administer their policies differently and will have their own procedures for payment of claims and for resolving payment disputes. Minor differences in administering insurance policies are to be expected in a competitive industry. Merely because benefit contracts are "unique" in the sense that each differs slightly from insurer to insurer does not mean that the benefits contracts, as a whole, are not comparable.

The employees are concerned about obtaining fringe benefits which are indisputably subject to mandatory bargaining. However, the identity of a specific insurance carrier is not a subject of mandatory bargaining unless the union can show that the particular benefits sought are inextricably linked to a particular carrier. The union has not shown that the differences between benefit packages are so substantial that the benefits cannot be separated from the identity of a specific carrier, or that comparable benefits cannot be supplied by other carriers.

The minor differences in the number of days that it takes to process a claim or the small difference in the number of operators available to answer calls regarding disputed benefits are all de minimus. As evidenced by the summary chart included in the brief of MTI most benefit contracts are very similar. The fact remains that under all the benefit contracts, 99.5% of the claims are paid in full. Moreover, the Commission based its decision on the finding that the employees have substantial economic interests in the integrity, reliability and responsiveness of the carrier for payment of health insurance claims. However, this is not the test. Employees probably have substantial economic interests in almost everything that the District does, but these other matters

are not automatically the subject of mandatory bargaining.

Furthermore, the Commission's own findings of fact undercut its conclusions. The Commission's decision is partially based on the assumption that the reliability and integrity of one particular insurer is intertwined with the insurance benefit package. Yet the Commission recognized that the interpretation of key terms such as "usual, customary and reasonable" and "medically necessary" vary with any given carrier over time. Thus even identifying a particular carrier will not ensure that the "unique" insurance contract will remain constant over time. Thus the Commission's assumption and conclusion simply is not supported by its findings of fact.

Even if the identity of a particular insurance carrier were related to wages, I find that the Commission has not properly considered the Board's interest in applying the balancing test. The Commission failed to consider the Board's obligation to act for the commercial benefit of the municipality. The Board has an obligation to manage the schools for the benefit of the taxpayers and the municipality and to obtain the most value for the citizen's tax dollar, even though the Board is not free to obtain all services at the lowest possible cost. While the level of benefits is primarily related to wages, the costs of those benefits and the ability to obtain them at competitive insurances rates is primarily related to the management and direction of the District. When the employees' interest in obtaining benefits from a certain insurance carrier where comparable benefits can be obtained from other carriers is balanced against the District's interest in supplying those benefits at the lowest cost, the balance clearly weighs in favor of the District's primary interest in managing the school budget.

Moreover, public policy dictates that the District should be free to shop for competitive insurance rates. Once a particular insurer is designed in the collective bargaining agreement, that insurance carrier has no incentive to keep costs down and to keep premiums down. Since the District is not free to switch carriers, the District is in effect held hostage to the carrier and the carrier is free to charge monopoly prices for insurance. Thus public policy also weighs against concluding that the identity of a specific carrier is a subject of mandatory bargaining.

CONCLUSION

For all the above reasons, I find that the decision of the Commission is not supported by its own findings of fact and that the Commission has erroneously interpreted Section 111.70(1)(a) in ruling that the identity of a particular insurance carrier is a subject of mandatory bargaining. Therefore, I reverse its decision.

Dated this 28th day of May, 1985.

~~BY THE COURT:~~

Daniel R. Moeser, Judge
Circuit Court Branch 11