STATE OF WISCONSIN

BEFORE THE WISCONSIN EMPLOYMENT RELATIONS COMMISSION

MADISON TEACHERS INCORPORATED, Complainant, vs. MADISON METROPOLITAN SCHOOL DISTRICT, and the BOARD OF EDUCATION OF THE MADISON METROPOLITAN SCHOOL DISTRICT, Respondents.	Case 174 No. 38915 MP-1984 Decision No. 24827-A

Appearances:

Kelly & Haus, Attorneys at Law, Lake Terrace, 121 East Wilson Street, Madison, Wisconsin 53703-3422, by Mr. Robert C. Kelly, on behalf of Madison Teachers Incorporated.

Ms. Susan Hawley, Labor Contract Manager, and Ms. Norma Briggs, Attorney, Madison Metropolitan School District, 545 West Dayton Street, Madison, Wisconsin 53703-1967, on behalf of Madison Metropolitan School District.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

The above-named Complainant, Madison Teachers Incorporated, hereinafter Complainant, having, on June 10, 1987, filed a complaint with the Wisconsin Employment Relations Commission, hereinafter Commission, wherein Complainant alleged that Respondent, Madison Metropolitan School District and its Board of Education, hereinafter Respondent, had committed prohibited practices within the meaning of Secs. 111.70(3)(a)1 and 4 of the Municipal Employment Relations Act (MERA); and the Respondent having, on September 28, 1987, filed an answer, wherein it denied that it committed any prohibited practices; and the Commission having appointed David E. Shaw, a member of its staff to act as Examiner and to make and issue Findings of Fact, Conclusions of Law and Order as provided in Sec. 111.07(5) of the Wisconsin Statutes; and a hearing on said complaint having been held at Madison, Wisconsin on September 29, 1987; and the parties having filed post-hearing briefs herein by November 23, 1987; and the Examiner, having considered the evidence and the arguments of the parties and being fully advised of the premises, makes and files the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. That Complainant is a labor organization and at all times material herein has been the certified exclusive collective bargaining representative of all regular full-time and regular part-time teaching and other related professional personnel who are employed in a professional capacity to work with students and teachers, employed by the District including psychologists, psychometrists, social workers, attendants and visitation workers, work experience coordinator, remedial reading teacher, University Hospital teachers, trainable group teachers, librarians, cataloger, educational reference librarian, text librarian, Title I coordinator, guidance counselors, teaching assistant principals (except at Sunnyside School), teachers on leave of absence, and teachers under temporary contract, but excluding supervisor - cataloging and processing, on-call substitute teachers, interns and all other employes, principals, supervisors and administrators; and that Complainant's principal office is located at 821 Williamson Street, Madison, Wisconsin 53703.

2. That Respondent is a unified school district operating under Subchapter III of Chapter 120, Stats., and is a municipal employer with its principal offices located at 545 West Dayton Street, Madison, Wisconsin 53703-1967.

3. That Complainant and Respondent have been parties to a series of collective bargaining agreements covering the wages, hours and conditions of employment for the employes in the bargaining unit described in Finding of Fact 2; that at the time of hearing in this case Complainant and Respondent were parties to a collective bargaining agreement effective from October 16, 1985 through October 15, 1987; and that said agreement provides, in relevant part, that:

VII - Insurance - B

B. GROUP HOSPITAL AND SURGICAL INSURANCE

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

2. Teachers new to the Madison Metropolitan School District who are hired to begin at the beginning of the school year shall have such coverage available effective September 1, provided they opt for such coverage on or before the first day of New Teacher Orientation. For teachers beginning employment after the first day of New Teacher Orientation, such coverage shall be available the 1st day of the month following 31 calendar days of employment.

3. Participation in the program is optional.

4. The monthly premium payment by the Board of Education for teachers participating in the programs shall be as follows for the duration of this contract:

   The District shall contribute to the monthly premium cost as follows through February 1, 1987:

Single Coverage:	$67.50 or 90% of the total premium, whichever is less.
Family Coverage:	$169.78 or 90% of the total premium, whichever is less.

   Effective February 1, 1987 for coverage commencing March 1, 1987, the District shall contribute to the monthly premium cost as follows:

Single coverage:	$77.00
Family coverage:	$180.00

   a. The contract will be reopened should the Federal Law mandate the inclusion of HMO(s) in addition to that already included in the contract.

5. The benefit structure of the group hospital and surgical plan shall be that announced as effective April 1, 1974, i.e. under WPS Policy Group #1202.

6. It is understood that any changes in benefits of the announced program requiring premium increases or any premium increased for the same program required in the future will not necessarily increase the individual or family contribution by the Board of Education.

7. The Board shall offer the teachers the option of membership in a qualified health maintenance organization which is engaged in the provision of basic and supplemental health services in the areas in which the teacher resides, all in accordance with P.L. 93-222 and such regulations as the Secretary of Labor

shall prescribe thereunder. The Board shall pay the premium up to the amount paid for the regular group hospital and surgical insurance but shall not be required to pay any more to such health maintenance organization than it is required to pay under provision VII-B-4.

8. Early retirees may continue with Group Health Insurance Program currently available through the master contract provided they pay 100% of the premiums for same directly to the insurance carrier, further provided they are over 50 years of age upon retirement, have been employed in the Madison Metropolitan School District at least ten (10) years and are an immediate annuitant of STRS.

9. The District shall continue to contribute to health insurance premiums at the above rates through the month of August for teacher(s) who are laid off at the end of the prior school year. Teacher(s) who remain on the layoff (recall) list at the commencement of the following school year may continue their group health insurance while on layoff, for the period of time required by law provided they timely pay the full monthly premium beginning in the month of September.

10. Resignations:

    a. If a teacher holding a regular contract submits a resignation with an effective date prior to the end of the school year, health insurance benefits cease at the end of the month following the month in whcih the termination is effective.

    b. If a teacher holding a regular contrat submits a resignation

        1) during the school year and with an effective date after the end of the school year,

        2) submits a resignation effective with the conclusion of the last day of the school year,

        3) does not sign a contrat for the next school year,

        health insurance benefits continue through the end of August.

11. Teachers on Long Term Disability

    After a teacher has been on long term disability for a period of three (3) consecutive months, the District will pay the Board's premium contribution as set forth in subsection 4, for a period of up to one year.

. . .

D. MEDICARE

1. A teacher who becomes 65 years of age during his last contract year before retirement may enroll in Medicare and withdraw from the hospital-surgical (Blue Cross/Wisconsin Physicians Service)* group insurance program.

    a. The teacher, rather than the Board of Education, makes payment for insurance coverage.

2. The equivalent of the premium that would have been paid for the teacher had the teacher remained in the hospital - surgical (Blue Cross/Wisconsin Physicians Service) group

program, will be paid to the teacher who elects the Medicare Program at the end of the last contract year.

. . .

F. DENTAL INSURANCE

The District shall sponsor the following Dental Insurance Plan with the following benefits:

1. General Provisions

   a. Eligibility and Coverage: Current teachers and their dependents who are eligible and who are covered by the group health insurance program, including teachers opting for GHC, are eligible and are covered by this dental insurance program. Teachers employed after the effective date of this plan shall become eligible to participate after one full year of employment. Employees hired after October 15, 1983 must complete the dental education program to be eligible for the dental insurance program. Those employees with family health insurance coverage may elect family or single dental insurance coverage. Those employees with single health insurance coverage may elect only single dental insurance coverage.

   b. Leave of Absence, Layoff and Retirement: Teachers on leave of absence or layoff, or who retire, may continue their coverage under this dental insurance program on the same basis as they would continue their health insurance coverage while on leave of absence, layoff, or upon retirement.

   c. Termination of Coverage: When a teacher's coverage under the group health insurance program terminates, so shall his/her coverage under this dental insurance program terminate.

   d. Prevention: A teacher participant of this plan must use the preventative benefits at least annually before the other benefits provided hereunder may be utilized for each benefit year.

2. Benefit Structure

   a. Maximums: $1,000 per person per year
   Orthodontia: $1,500 lifetime per person with Dental Education Program participation; $750 without.
   Preventative: Twice per year

. . .

   e. Exclusions: No benefit will be provided for dental service if:

      1) Covered by Worker's Compensation or similar legislation, regardless of whether the participant elects to claim its benefits.

      2) Furnished by the United States Veterans Administration, any federal or state agency, or any local political subdivision, when the participant or his property is not liable for their costs.

      3) Required because of an injury, sickness or disease caused by atomic or thermonuclear explosion, or

radiation resulting therefrom, or any type of military action whether friendly or hostile.

4) Performed for cosmetic purposes.

5) Performed either before the effective date or after the termination date of the participant's coverage under this contract.

6) For replacement of lost or stolen dentures or other prosthetic devices.

7) For dentures unless the participant has been insured for twelve (12) consecutive months under this plan.

f. Coordination of Benefits: If a participant in this program is also covered under another policy, whether it be with the carrier or another insurance company, payment for a service will be proportionate to that available under other coverage. If payment made under this program is prorated, a refund will be made on the portion of the premium which applies to the portion of the benefit not paid under this program.

3. Employer Premium

The District shall contribute:

a. For single coverage: 75% of the montly premium cost.

b. For family coverage: 75% of the monthly premium cost for each eligible participant.

In addition, the District shall pay the full cost of the Dental Education Program.

Should the premium be increased for the premium to be paid in October, 1984 (for November, 1984), and/or thereafter, the Board's contribution will be reopened for negotiation with final offer resolution available pursuant to Wis. Stat. 111.70 with negotiations on this issue to commence on September 1, 1984.

. . . ;

that at the times material herein the total 1/ monthly premium amounts for the group health plan were $196.62 for family coverage and $77.64 for single coverage and for the gruop dental plan were $32.86 for family coverage and $10.52 for single coverage; that the WPS group health and medical plan defines "dependent" as follows:

6. **"Dependent"** means a subscriber's spouse, a subscriber's unmarried child who has not completed the calendar year of his or her twenty-fifth (25th) birthday, or a subscriber's unmarried child who has completed the calendar year of his or her twenty-fifth (25th) birthday and is totally and permanently disabled. The terms "totally and permanently disabled" and "total and permanent disability" as used in this paragraph, mean any medically determinable physical or mental condition which can be expected to result in death or to be of long continued or indefinite duration. WPS may require, from time to time, proof of the continued disability of the dependent. The determination of dependent status is as established by the Internal Revenue Code;

1/ The amount including both the employer's share and the employe's share.

and that the WEAIT group dental plan defines "dependent" as follows:

> DEPENDENT
>
> Dependents are:
>
> 1. your lawful spouse; and
>
> 2. any unmarried Dependent Child of yours through the calendar year in which s/he is 25 and claimed on your most recent Federal Tax Return.
>
> 3. 25 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted within 31 days after the date the child ceases to qualify as a dependent under paragraph 2 above. During the next two years, from time to time, proof of the continuation of such condition may be required. After that, proof may be required no more than once a year.
>
> A "Child" includes a legally adopted child, foster child or stepchild.
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> No one may be considered as a Dependent of more than one Employee.
>
> No one who is a member of the country's armed forces will be considered as a Dependent.

4. That Respondent, as a political subdivision of the State, is subject to the continuation coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99-272) (attached in relevant part as "Appendix B") which requires that the Respondent provide for the right to elect continued coverage under its group health plan to its employes and their dependents covered by said plan upon the occurrence of a "qualifying event" that results in the individual and/or his/her dependent(s) no longer being eligible for coverage under the plan's eligibility requirements; that Respondent began effective January 1, 1987, to provide the right to elect such continuation coverage; that the Respondent's group health plan policy was amended to provide for such coverage and the Respondent's group dental plan policy and benefits handbook also incorporated such coverage; that an individual who is eligible for such continuation coverage is required to pay the full premium for such coverage, thich may be made on a monthly basis; that the carrier for the Respondent's group health plan, Wisconsin Physicians Service (WPS), informed the Respondent that it would not adminster the continuation coverage and would not accept direct payment of premiums from individuals for such coverage, thereby requiring the Respondent to administer such coverage and to collect the premium payments and forward them to WPS; that the carrier for the Respondent's group dental plan, WEAIT Insurance Corporation (WEAIT), informed the Respondents that it was willing to administer the continuation coverage and would accept direct payment of monthly premiums from the individuals; and that the Respondent has, at all times material, administered the contribution coverage and collected the payments of monthly premiums from individuals under such coverage for both its group health plan and group dental plan.

5. That by a written notice dated December 29, 1986, the Respondent notified its employes, their spouses and their dependents, of their rights to the continuation of their group health and dental insurance coverage upon the occurrence of specified events; that as of the date of the hearing twelve individuals had "qualifying events" that made them eligible for continuation coverage: David Mitchell (dependent), Kristen Clatanoff (dependent), Karen Harvey (terminated employe), Jean Grams (terminated employe), Robert Branstad (terminated employe), Cindy Haack (terminated employe), Judy Lee (terminated employe), Judy Grobe (hours reduced below 50%), Mary Pat Chvala (hours reduced below 50%), Linda Scovill (terminated employe), Debra Alldredge (terminated employe) and Jonathan

Coleman (terminated employe); that Grobe and Chvala continue to be employed by the Respondent in the bargaining unit represented by Complainant; that said "qualifying events" took place after January 1, 1987; and that upon receiving notification of the "qualifying event" the Respondent sent the individual the following notice and attached election forms:

NOTICE OF YOUR RIGHTS TO
CONTINUATION OF HEALTH INSURANCE

As an EMPLOYEE covered by the Madison Metropolitan School District health care plan, you have the right to choose to continue your coverage if you would otherwise lose your health plan benefits because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the SPOUSE of an employee covered by the Madison Metropolitan School District health care plan, you have the right to choose to continue coverage for yourself and for your dependents if you lost health plan benefits for any of the following four reasons:

1. The death of your spouse;
2. The termination of your spouse's employment for (reasons other than gross misconduct) or a reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes eligible for Medicare.

If you are a DEPENDENT CHILD of an employee covered by the Madison Metropolitan School District health care plan, you have the right to continue health plan benefits if coverage is lost for any of the following five reasons:

1. The death of a parent employed by the school district;
2. Termination of the parent's employment (for reasons other than gross misconduct) or a reduction in the parent's hours of employment;
3. Parent's divorce or legal separation;
4. Parent becomes eligible for Medicare; or
5. You cease to be a dependent child under the Madison Metropolitan School District health care plan.

YOU HAVE 60 DAYS TO NOTIFY THE MADISON METROPOLITAN SCHOOL DISTRICT BENEFITS OFFICE THAT YOU WANT CONTINUATION COVERAGE UNDER ITS HEALTH CARE PLAN ON THE ENCLOSED FORM. IF YOU DO NOT CHOOSE CONTINUATION COVERAGE BY _____ (date) YOUR GROUP HEALTH INSURANCE BENEFITS WILL END.

Period of Continuation Coverage

You may elect to continue coverage for a maximum of 18 months after a termination or reduction in hours. You may elect to continue coverage for a maximum of 36 months after a death, divorce, legal separation, the employee's eligibility for Medicare or, if you were a dependent child, your graduation to an independent status.

Your period of continuation coverage will only be cut short if you become covered under another employer provided group health plan, you become eligible for Medicare, the District ceases to provide a group health plan to any of its employees or you fail to pay your monthly premiums for the health insurance.

If you elect continuation coverage after a termination or reduction in hours, and during that 18 month period you are affected by a death, divorce, legal separation, employe's eligibility for Medicare or graduation from dependent child to independent status, you may apply to continue your coverage under the health plan for up to a maximum of 36 months, so long as you notify the Benefits Department within 60 days of the event.

The Terms of the Continued Coverage

YOU and your dependents ARE ENTITLED to the same benefits and coverage as Madison Metropolitan School District employes. Like employes, you may drop dental coverage at any time, by writing the Benefits Office, and at Annual Choice you may change the insurer with whom you are enrolled. You may make your own independent choice of insurer or health plan package from those available to District employes. For example, after a divorce the employe may choose the basic single health plan only, while the ex-spouse and dependent children choose the family health plan and dental coverage.

YOU MUST prepay the entire monthly premium, including the amount the District previously paid, plus an additional 2% for administrative expenses. You must send a check payable to the Madison Metropolitan School District, to arrive at the Benefits Office no later than the 10th day of each month. Your first check must include the premiums due from the date your health insurance coverage would otherwise have ended (usually a period of several months).

If benefits or coverage under the District Health Plan are modified for employes, or if the cost of the month (sic) premium is raised, these changes will also apply to you.

Conversion After Continuation Policy Ends

When your continued rights to health plan coverage expire, you will be offered the oportunity to covert (sic) your group plan health insurance to an individual insurance policy, with no break in coverage and no need to prove insurability by submitting to a medical examination.

IF YOU HAVE ANY QUESTIONS ABOUT CONTINUATION COVERAGE UNDER THE DISTRICT'S HEALTH PLAN, CALL 266-6060.

(Attached Election Form)

CONTINUATION COVERAGE FOR HEALTH PLAN BENEFITS

I wish to continue coverage under the Madison Metropolitan School District's group health plan. My choice is checked below:

_____ 1. Family health plan at $200.54 plus family dental at $33.46 for a current total monthly cost of $234.00.

_____ 2. Family health plan at $200.54 plus single dental at $10.73 for a current total monthly cost of $211.27.

_____ 3. Family health plan at $200.54 and no dental for a current total monthly cost fo $200.54.

_____ 4. Single health plan at $79.19 plus single dental at $10.73 for a current total monthly cost of $89.92.

_____ 5. Single health plan at $79.19 and no dental for a current monthly cost of $79.19.

I enclose/will send within 45 days _____ monthly premiums for a total of $_____ to cover the premiums owing from the date my health insurance coverage would otherwise have terminated until _____.

From now on I will send each monthly premium to arrive by the 10th day of each month to:

Madison Metropolitan School District
Benefits Office, Room 126
545 West Dayton Street
Madison, WI 53703

Here is information the Benefits Office needs to continue health insurance coverage:

Name of employe whose health plan benefits are being continued: _____

List of all who will be covered under the plan checked above:

Name	Address	Sex	Birthdate	SS #	Relationship to covered Employe

This form must be signed by all adults who wish to be covered as members of one family under a family health plan.

_____
Signed Date

_____
Signed Date

6. That, at all times material herein, the Respondent has charged an administrative fee equal to two percent (2%) of the total monthly premium to those individuals covered under the continuation coverage in the following amounts: group health: family - $3.92, single - $1.55, and group dental: family - $.60, and - single $.21; that the Respondent has not offered or attempted to bargain the charging of said administrative fee with Complainant prior to imposing the fee; and that the charging of an administrative fee to those individuals who qualify under COBRA for the continuation coverage of the group health insurance and group dental insurance plans provided for by the parties' Agreement through the occurrence of a "qualifying event" is primarily related to wages, hours and conditions of employment.

Based upon the above and foregoing Findings of Fact, the undersigned makes the following

CONCLUSIONS OF LAW

1. That the charging of an administrative fee to those individuals who, pursuant to the requirements of COBRA, qualify for, and elect to receive, continuation coverage of the group health insurance and group dental insurance

plans set forth in Respondent's Agreement with Complainant due to the occurrence of a "qualifying event", is a mandatory subject of bargaining within the meaning of Sec. 111.70(3)(a)4, Stats.

2. That Respondent Madison Metropolitan School District, its officers and agents, by unilaterally imposing the administrative fee on those individuals described in Conclusion of Law 1 without bargaining collectively with Complainant Madison Teacher, Inc., violated Sec. 111.70(3)(a)4, Stats., and derivatively, Sec. 111.70(3)(a)1, Stats.

Based upon the above and foregoing Findings of Fact and Conclusions of Law, the undersigned makes and issues the following

ORDER 2/

It is ordered that the Respondent Madison Metropolitan School District, its officers and agents, shall immediately:

1. Cease and desist from violating its duty to bargain under the Municipal Employment Relations Act by unilaterally implementing an administrative fee for continuation coverage of the group health and medical insurance and the group dental insurance plans covering the employes in the bargaining unit represented by Complainant Madison Teachers, Inc.

2. Take the following affirmative action which the Examiner finds will effectuate the purposes of the Municipal Employment Relations Act:

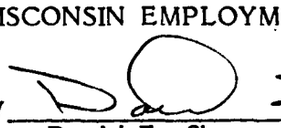
(a) Make whole all of those individuals who, due to the occurrence of a "qualifying event" within the meaning of COBRA after January 1, 1987, were charged an administrative fee by Respondent due to their receiving continuation coverage of the group health and medical insurance and group dental insurance plans covering the employes in the bargaining unit represented by Complainant Madison Teachers, Inc., plus pay interest 3/ on the amounts charged from the date the fees were collected until the date they are refunded.

(b) Notify all of its employes by posting, in conspicuous places in its place of business where employes are employed, copies of the notice attached hereto and marked "Appendix A." That notice shall be signed by the District Administrator and shall be posted immediately upon receipt of a copy of this Order and shall remain posted for thirty (30) days thereafter. Reasonable steps shall be taken to ensure that said notices are not altered, defaced or covered by other material.

(c) Notify the Wisconsin Employment Relations Commission, in writing, within twenty (20) days following the date of the Order, as to what steps have been taken to comply herewith.

Dated at Madison, Wisconsin this 29th day of February, 1988.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By 
David E. Shaw, Examiner

2/ Any party may file a petition for review with the Commission by following the procedures set forth in Sec. 111.07(5), Stats.

Section 111.07(5), Stats.

(Footnote two continued on page eleven.)

(Footnote two continued from page ten.)

(5) The commission may authorize a commissioner or examiner to make findings and orders. Any party in interest who is dissatisfied with the findings or order of a commissioner or examiner may file a written petition with the commission as a body to review the findings or order. If no petition is filed within 20 days from the date that a copy of the findings or order of the commissioner or examiner was mailed to the last known address of the parties in interest, such findings or sorder shall be considered the findings or order of the commission as a body unless set aside, reversed or modified by such commissioner or examiner within such time. If the findings or order are set aside by the commissioner or examiner the status shall be the same as prior to the findings or order set aside. If the findings or order are reversed or modified by the commissioner or examiner the time for filing petition with the commission shall run from the time that notice of such reversal or modification is mailed to the last known address of the parties in interest. Within 45 days after the filing of such petition with the commission, the commission shall either affirm, reverse, set aside or modify such findings or order, in whole or in part, or direct the taking of additional testimony. Such action shall be based on a review of the evidence submitted. If the commission is satisfied that a party in interest has been prejudiced because of exceptional delay in the receipt of a copy of any findings or order it may extend the time another 20 days for filing a petition with the commission.

3/ The applicable interest rate set forth in Sec. 814.04(4), Stats., at the time this complaint was filed was twelve percent (12%) per annum.

"APPENDIX A"

NOTICE TO ALL EMPLOYES

Pursuant to an Order of the Wisconsin Employment Relations Commission, and in order to effectuate the policies of the Wisconsin Municipal Employment Relations Act, we hereby notify our employes that:

WE WILL NOT impose an administrative fee on those individuals who elect continuation coverage of the group health and medical insurance and group dental insurance plans, upon becoming eligible for such coverage due to the occurrence of a "qualifying event" which makes them otherwise ineligible for group coverage under the eligibility rules of such plan, without fulfilling our duty to bargain over said fee with the exclusive bargaining representative, Madison Teachers, Inc.

WE WILL reimburse those individuals whom we have charged such an administrative fee since January 1. 1987.

WE WILL NOT change any matters primarily related to wages, hours or conditions of employment without fulfilling our duty to bargain with the exclusive bargaining representative, Madison Teachers, Inc.

Madison Metropolitan School District

By _____
, District Administrator

Dated this ____ day of _____, 1988.

THIS NOTICE MUST REMAIN POSTED FOR THIRTY (30) DAYS FROM THE DATE HEREOF AND MUST NOT BE ALTERED, DEFACED OR COVERED BY ANY OTHER MATERIAL.

MADISON METROPOLITAN SCHOOL DISTRICT

MEMORANDUM ACCOMPANYING
FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER

In its complaint, Complainant alleges that Respondent violated Secs. 111.70(3)(a)1 and 4, Stats., by unilaterally imposing, as of January 1, 1987, a two percent (2%) of premium administrative fee on those bargaining unit employes or their dependents who are permitted to continue group health and surgical, group dental or group life insurance 4/ coverage under those benefit programs upon self-payment of the established single or family premium without bargaining with Complainant. In its answer, Respondent asserts that such continued coverage is not available as to group life insurance and that the parties' Agreement only addresses the continuation of group health insurance coverage for early retirees, teachers who are laid off, teachers who resign and teachers on long-term disability. Respondent also raises as affirmative defenses that the administrative fee was imposed pursuant to federal law, i.e., COBRA, to cover the Respondent's additional administrative costs for maintaining continued group health coverage for persons who never were or who were and no longer are, members of the bargaining unit; that two bargaining unit members were inadvertently charged the fee, which mistake Respondent will immediately correct; that ex-dependents of employes are not in the bargaining unit and, therefore, Complainant has no standing to raise issues on their behalf; and that the charging of an administrative fee under COBRA to persons not in the bargaining unit is not a mandatory subject of bargaining.

Complainant

In support of its position Complainant contends first that under the provisions of COBRA the group health plan, and not the employer, may charge a qualified individual with payment of a premium not to exceed one hundred two percent (102%) of the "applicable premium." The "applicable premium" is defined under the law as the cost to the plan for the period of coverage for a "similarly situated" beneficiary to whom a qualifying event has not occurred (without regard to whether the cost is paid by the employer or employe). Complainant asserts that Wisconsin law, Sec. 632.897(2)(d), Stats., does not permit a charge for continuation coverage for group health to exceed "the group rate in effect for a group member including an employer's contribution, if any; for a group policy." Citing the wording of the statute and the May 1984 Interpretive Bulletin prepared by the Office of the Insurance Commissioner. While the Respondent met its obligations under the law by having the WPS group health policy amended to provide such continuation coverage and by including it in the WEAIT group dental policy and handbook, the Respondent also decided to charge covered employes, and their covered spouses and dependants, an administrative fee in addition to the applicable premium without first bargaining with Complainant. Despite Complainant's objections, Respondent has continued to charge such a fee.

Regarding the Respondent's duty to bargain with Complainant over the imposition of the administrative fee for the continuation coverage, Complainant contends that it is a mandatory subject of bargaining. Citing federal decisions and Commission decisions, it is asserted that, in both the public and private sectors, "virtually every facet of group health insurance or benefit programs have been found to be a mandatory subject of bargaining." This is true of the cost of such benefit programs, premium contributions, identity of carrier and level of benefits. Similarly, continuation and conversion rights are "insurance benefits." Just as employes are concerned with the level of benefits to be provided to his/her spouse and dependents, employes are legitimately concerned with the ability of their family members to maintain insurance coverage in case of a "qualifying event" such as the employe's death, termination, lay off, divorce, etc. Employes can agree, through their collective bargaining representative, to have a portion of their wages go to protecting their family member's access to group insurance coverage. Further, the scope of continuation coverage and

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4/ Complainant presented no evidence and no further argument regarding the group life insurance and it is, therefore, not dealt with in this decision.

conversion rights can vary from insurer to insurer, with one offering only the minimum required by law and another exceeding those requirements. Thus, continuation rights are similar to benefits like dental or vision coverage, substance abuse counseling, etc., which may vary depending on the carrier.

The fact that state or federal laws mandate minimum continuation/conversion benefits does not render such benefits a permissive subject of bargaining. Numerous mandatory subjects of bargaining are regulated or have minimums established by state and/or federal law, e.g., pension plans, early retirement, and substance abuse counseling as a benefit under a group health plan.

Complainant also takes issue with the Respondent's contention that employes' spouses and dependents or employes who have had their employment terminated are not "employes," and that, therefore, the levying of an administrative fee against them is not a mandatoy subject of bargaining. It is argued that the U.S. Supreme Court's decision in Allied Chemical and Alkali Workers Local 1 v. Pittsburgh Plate Glass Co., 404 U.S. 157 (1971) is not dispositive as that case turned on whether the issue of benefits for already retired employes was a mandatory subject of bargaining. Conversely, this case involves the benefits of active employes and their spouses and dependent children, and the issue is whether the benefits of spouses and dependent children of active employes is a mandatory subject of bargaining. Medical or dental coverage for an active employe's spouse or dependents benefits the employe who is legally obligated to provide the necessities for his/her family, and proposals that would require a school district to provide health and medical insurance to its employes' dependents are mandatory subjects of bargaining. In this regard Complainant cites Charles City School District v. PERB, 100 LRRM 3163 (Iowa S.Ct. 2/79) where the Court stated: ". . . any distinction between employees and their dependents with regard to insurance coverage would be spurious where the practical effect of dependent coverage is of direct and immediate benefit to the employees." Complainant asserts the Commission has impliedly made a similar determination by its decision in Racine Unified School District, Dec. No. 23381-A (WERC, 11/86), where the Commission held that proposals that included the entire insurance policies (which in turn included provisions for family coverage) were a mandatory subject of bargaining. Just as family coverage is a benefit to the employe, the right of a family member to continue coverage upon a "qualifying event" occurring is also a benefit. The family members obtain their right to continuation coverage because they are the spouse or dependent of an active employe. Similarly, the active employe obtains the right to continuation coverage upon the "qualifying event" occurring when they are a covered employe.

The COBRA only extends prior coverage and does not create a new class of covered individuals. To be eligible for continuation coverage the individual must be an active employe or the spouse or dependent of a covered employe when the "qualifying event" occurs. In other words, the right to the continuation benefit arises out of the group plan in effect and rests in the employe and his/her family prior to, rather than after, the "qualifying event's" occurrence. The right to continuation coverage is an economic benefit flowing from the employment relationship and, therefore, is a mandatory subject of bargaining. Mid-State VTAE, Dec. No. 14958-B (Yaeger, 5/77).

Complainant also contends that the Public Health Services Act, which COBRA amended, does not relieve the Respondent of its duty to bargain with Complainant over the imposition of the administrative fee. The Act, at Sec. 2202(c), provides:

> "C. Premium Requirements - The plan may require payment of a premium for any period of continuation coverage except that such premium -
>
> (i) shall not exceed 102 percent of the applicable premium for such period and ****"

The language of the statute is clear and unambiguous. The plan "may" require payment of a premium. It is permitted to charge a premium, not required to, and if it does, it cannot exceed one hundred two percent (102%) of the "applicable premium." Although the Act speaks of a plan charging a premium, rather than an employer charging an administrative fee, assuming arguendo that the latter is permissible, the imposition of such a fee is a mandatory subject of bargaining. Menominee Indian School District, Dec. No. 23849-A (Buffett, 8/87). There is

nothing in the Act that relieves Respondent of its duty to bargain concerning the imposition of the fee. Therefore, Respondent has violated Secs. 111.70(3)(a)1 and 4, Stats., by unilaterally imposing the fee.

Respondent

The Respondent makes a number of arguments in support of its position that it did not commit any prohibited practices by unilaterally imposing the two percent (2%) monthly administrative fee for continuation coverage for ex-employes or ex-dependents of employes.

First, Wisconsin law requires that an employer must bargain with a union only when it represents the interests of current members of the bargaining unit. Citing, Sec. 111.01(3), Stats., and Secs. 111.02(2) and (6), Stats. In accord with those statutes, the parties' Agreement recognizes the Complainant as the exclusive collective bargaining representative for:

> All regular full-time and regular part-time certificated teaching and other related professional personnel who are . . . employed by MMSD . . . (emphasis supplied)

There is no authorization in Chapter 111 for a union to represent the interests of individuals who are not members of the bargaining unit and this has been confirmed by the Commission's decisions in City of Sheboygan, Dec. No. 19421 (WERC, 3/82) and School District of Wisconsin Rapids, Dec. No. 17887 (WERC, 6/80). The Commission has also held that "an individual who is no longer employed due to retirement and without an expectation of further employment is not an 'employe' within the meaning of MERA, nor is that person a member of the bargaining unit." City of Milwaukee, Dec. No. 19091 (WERC, 10/81).

Next, the Respondent asserts that while a bargaining unit member's interests may extend to health care protection for his/her spouse and dependent children, that interest is not considered to extend beyond such dependents to other persons or relations. This is demonstrated by the fact that health insurance companies do not offer any option for coverage to include any other independent adults, such as friends, lovers, aunts, grown children, etc. Citing, Barbara J. Cox, "Alternative Families: Obtaining Traditional Family Benefits Through Litigation, Legislation and Collective Bargaining," Wisconsin Women's Law Journal, vol. II (Spring 1986), 33-34, as demonstrating the almost total exclusion of such individuals outside the traditional nuclear family from family coverage under group health insurance plans. According to the Respondent, Complainant is trying to argue that the interests of its members extends to ex-spouses (widows, widowers and divorcees). A "divorcee" is a person who has legally, and usually factually, terminated any domestic relationship with the member. Any interest of a member in an ex-spouse's health protection ended with the termination of the marriage. It is in the government's, not the member's, interest to ensure such coverage to avoid having to pay the cost of health care for the ex-spouse, and it was Congress, and not the members, that extended the coverage. Respondent similarly argues that Complainant is attempting to extend the interests of its members to independent adults who were once dependent children. Such adults may be married and have children of their own. There is no precedent or support for a finding that the interests of a member extend to providing group health insurance coverage to such individuals.

Respondent contends that group health coverage for ex-employes and for ex-dependents of employes are not mandatory subjects of bargaining. In West Bend Education Association v. WERC, 121 Wis.2d 1 (1984) the Wisconsin Supreme Court discussed the process by which it is determined whether a bargaining proposal is a mandatory or permissive subject of bargaining. Section 111.70(1)(a), Stats., must be interpreted, and the Court recognized that a school district has a dual role under the statute, as an employer with a duty to bargain and as a political entity responsible for determining public policy and managing district programs. The mechanism for resolving conflicts that arise due to that dual role was described by the Court:

> In recognizing the interests of the employees and the interests of the municipal employer as manager and political entity, the statute necessarily presents certain tensions and difficulties in its application. Such tension arises principally when a proposal touches

> simultaneously upon wages, hours, and conditions of employment and upon managerial decision making or public policy. To resolve these conflict situations this court has interpreted sec. 111.70(1)(d) as setting forth a "primarily related" standard. Applied to the case at bar, the standard requires WERC in the first instance (and a court on review thereafter) to determine whether the proposals are "primarily related" to "wages, hours and conditions of employment," to "educational policy and school management and operation," to "management and direction' of the school system" or to "formulation or management of public policy." Unified School District No. 1 of Racine County v. WERC, 81 Wis. 2d (sic) 89, 95-96, 102, 259 N.W.2d 724 (1977). This court has construed "primarily" to mean "fundamentally," "basically," or "essentially," Beloit Education Asso. v. WERC, 73 Wis. 2d (sic) 43, 54, 242 N.W.2d 231 (1976).

Id. at 8-9. The Court recognized that since some bargaining matters deal with more than one area, the "primarily related" standard may not be applied mechanically:

> As applied on a case-by-case basis, this primarily related standard is a balancing test which recognizes that the municipal employer, the employees, and the public have significant interests at stake and that their competing interests should be weighed to determine whether a proposed subject for bargaining should be characterized as mandatory. If the employees' legitimate interest in wages, hours, and conditions of employment outweighs the employer's concerns about the restriction on managerial prerogatives or public policy, the proposal is a mandatory subject of bargaining. In contrast, where the management and direction of the school system or the formulation of public policy predominates, the matter is not a mandatory subject of bargaining . . .

Id. at 9. (Emphasis added)

Respondent cites the U.S. Supreme Court's decision in Pittsburgh Plate Glass as holding that a person who was previously a member of the bargaining unit has insufficient community of interest with present members to continue to be represented by the union. The Court held that it was not an unfair labor practice for an employer to unilaterally offer retirees an exchange for their withdrawing from an already negotiated health insurance plan since that was a permissive subject of bargaining. The Court noted the lack of the impact of benefits of non-members on the terms and conditions of employment of members and the lack of a statutory duty on the union's part to represent retirees since they are not members of the bargaining unit. Respondent asserts that the facts in that case and in this case are directly comparable. As in Pittsburgh Plate Glass, here the non-members were offered an additional option under certain conditions and the non-members are ex-employes who have terminated their employment and lost any rights they had under the labor agreement as current members, as well as persons who never were members of the bargaining unit. The latter group have "an even more tenuous connection" with current members' interests then did the retirees in Pittsburgh Plate Glass. In both cases the union has no statutory duty to represent non-members and any effort to do so results, at most, in a non-mandatory subject of bargaining.

The Commission's decision in City of Milwaukee is cited by Respondent as demonstrating the application of Pittsburgh Plate Glass to this area of the law in Wisconsin. While the interest of current bargaining unit members may extend to fringe benefits that continue beyond their period of employment or membership in the unit, group health benefits for non-members are not mandatory subjects of bargaining under either Pittsburgh Plate Glass or the Commission's decisions. Citing also, Green County, Dec. No. 21144 (WERC, 11/83). Relying on those cases, Respondent asserts that it is clear under both state and federal law that if Complainant has any standing to bargain for the interests of ex-employes or ex-dependents, any changes placed upon a group health plan for them has only an indirect impact on current members and is a permissive subject of bargaining. Further, any proposal to non-members that has a primary impact upon them, and only an indirect on current unit members, also is a permissive subject of bargaining. Therefore, Respondent did not commit a prohibited practice by failing to bargain with Complainant over continuation of group health coverage for ex-employes and ex-dependents of employes.

Respondent also contends that the continuation/conversion rights of beneficiaries of group health and group dental plans were created by enactment of COBRA and not through collective bargaining. Those rights are mandated by federal law and cannot be traded away in a subsequent bargain. The rights were created to "specifically protect the interests of persons who were not members of the bargaining unit (where one existed)." COBRA applies to all employers with twenty or more employes (with certain exceptions not relevant here), including non-unionized employes. This makes the Complainant's contention that the rights of the individuals involved herein arise out of the policy provided through the parties' Agreement nonsense. The continuation rights of ex-employes and ex-spouses and ex-dependents of employes arise from federal law, not the parties' Agreement. COBRA also recognized that the new mandates would be burdensome to employers and provides that an employer may impose a two percent (2%) administrative fee to defray its costs. In this case that fee amounts to a total of $27.21 for all twelve individuals who opted to continue their coverage. The evidence showed that this amount is only a fraction of the Respondent's cost of administering the continuation coverage.

It is further contended by Respondent that application of the balancing test demonstrates that by imposing the two percent (2%) fee, the Respondent did not violate any "significant employe interest" primarily related to wages, hours or conditions of employment. The fee represents a "de minimis charge that is authorized by federal law." Respondent's interest in this case is its obligation to act for the community's commercial benefit and, as a matter of public policy, to seek to avoid spending tax dollars on matters not related to its educational purpose. Respondent should not be required to absorb all of the administrative costs of providing the continuation benefit to persons who have, for the most part, severed their relationship with Respondent and whom, but for federal law, would not be eligible for those benefits under the Agreement. Conversely, the employe interest involved here is "extraordinarily insignificant." Over a period of ten months twelve individuals paid a minimal fee for continued coverage, and no current employe eligible to participate in the group health and group dental insurance plans has to pay the fee. Employe interest in the imposition of the fee is so tenuous that the Respondent did not even consider its duty to bargain the matter when it included two unit members on lay off with those to whom it charged the fee. Respondent has conceded that it made an error in including those two individuals, whose rights were pursuant to contract, with those who continued coverage pursuant to COBRA, however, it does not concede that it committed a prohibited practice by doing so, given such as minimal fee. It is argued that the "de minimus" rule should apply in this case. In that regard, it must be concluded that the Respondent's action is such a "slight departure" from what the Agreement generally requires that it must be viewed as either "a permissible exception or as not constituting an injury to bargaining unit members at all."

Lastly, Respondent contends that Chapter 632 of the Wisconsin Statutes and the related administrative rules do not prohibit an employer from charging such an administrative fee for processing continuation coverage of group health plans. It cites the statutory sections that require such continuation rights and define who is eligible for such continuation coverage. Respondent cites the language of Secs. 632.897(8) and 632.897(2)(d), Stats., as setting forth the premium payments to be required for such coverage and collected by the employer. According to Respondent, Sec. 632.897(2)(d), Stats., does not prohibit an employer from charging a fee to cover its costs in processing the premium payments, rather, the provision is silent in that regard. Respondent asserts there is no administrative rule from the Office of Commissioner of Insurance that interprets the above-cited provisions. Respondent also argues that the Examiner may not take administrative notice of the document submitted by the Complainant and titled Health Insurance Continuation and Conversion Rights, Section 632.897, Wisconsin Statutes, Questions and Answers for Employers, since it is not an administraive rule promulgated in accord with Chapter 227, Wisconsin Statutes. As the memorandum constitutes improperly adopted standards or interpretations of statutes, it is invalid and without any force in law. Citing, State, ex. rel. Clifton v. Young, 133 Wis.2d 193, 200 (Ct. App. 1986).

DISCUSSION

As stated in the Findings of Fact, Congress passed P.L. 99-272 (COBRA), which among other things required school districts in Wisconsin, as political subdivisions of a state, to provide to qualified beneficiaries under their group

health plans who would lose coverage under the plan as a result of a "qualifying event," the right to elect continuation coverage so as to remain covered under the plan. Respondent began offering the right to elect such coverage on January 1, 1987. Since that time twelve individuals who were qualified beneficiaries under the group health and group dental plans provided for by the parties' Agreement, had "qualifying events" occur which made them no longer eligible under the plans for the group coverage. Those individuals were notified by Respondent of their right to elect continuation coverage provided they pay the entire monthly premium for the coverage, plus an administrative fee equal to two percent (2%) of the premiums for such coverage. There was no attempt made by the Respondent to bargain with the Complainant with regard to imposing that administrative fee.

COBRA defines "covered employee" and "qualified benficiaries" for purposes of the ACT as follows:

> (7) DEFINITIONS. -- For purposes of this subsection --
>
> (A) COVERED EMPLOYEE. -- The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.
>
> (B) QUALIFIED BENEFICIARY. --
>
> (i) IN GENERAL. -- The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan --
>
> (I) as the spouse of the covered employee, or
>
> (II) as the dependent child of the employee.
>
> (ii) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT. -- In the case of a qualifying event described in paragraph (3)(B), the term "qualified beneficiary" includes the covered employee.

"Qualifying event" is defined by the Act as follows:

> (3) QUALIFYING EVENT. -- For purposes of this subsection, the term "qualifying event" means with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subsection, would result in the loss of coverage of a qualified beneficiary:
>
> (A) The death of the covered employee.
>
> (B) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.
>
> (C) The divorce or legal separation of the covered employee from the employee's spouse.
>
> (D) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.
>
> (E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan. 5/

The continuation coverage requirements are prospective in that the right to elect such coverage is only offered to those individuals who lose their eligibility for group coverage by reason of a "qualifying event" after the effective date. The group coverage that is to be continued is that which is provided for by the parties' Agreement, and in order to be qualified for the right to elect continuation coverage, the individual must be a beneficiary under the group plan when the "qualifying event" occurs. On the day before the "qualifying event" those individuals are either current employes or dependents (including spouses) of current employes. Therefore, this case does not involve offering continuation coverage to individuals who had lost their eligibility for group

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5/ The group health and dental plans in effect define a "dependent" as a subscriber's unmarried child who has not completed the calendar year of his/her 25th birthday or who is 25 or over but totally adn permanently disabled.

health and group dental coverage prior to January 1, 1987, and in that respect this case is distinguishable from City of Milwaukee 6/ where bargaining of a benefit for already retired employes was involved. Rather, this case is more analogous to Green County, where the Commission held that a proposal to provide health insurance for employes upon their retirement was a mandatory subject of bargaining. 7/ This case involves what happens to current beneficiaries, i.e., current employes and their spouses and covered dependents, upon the occurrence of a "qualifying event." The Respondent's arguments as to the insufficiency of the interest of an employe in an ex-spouse or a dependent who is no longer eligible under the group plan is irrelevant, as those individuals' rights are obtained directly through the covered employe.

While it is the passage of the federal law that extended the benefit, the benefit that is the subject of the law is in this case provided for by the parties' negotiated Agreement. Moreover, it is the charging of an administrative fee, and not the continuation coverage, that is in issue. What is critical, however, is the economic impact of the imposed administrative fee. Albeit a small amount, it is nonetheless a cost to the employe or the employe's dependent upon the occurrence of a "qualifying event." The Respondent's argument that the amount is "de minimis," especially when viewed in relation to the cost to Respondent of administering the continued coverage, goes to the merits of Respondent's position that such a fee is justified, and not to the fee's mandatory or permissive status. It is a matter of who is going to pick up the added cost of providing a benefit upon a "qualifying event," and while the Respondent obviously has a legitimate interest in minimizing its costs in this regard, the issue primarily relates to "wages", rather than to Respondent's interest in the management of the District and the formulation of policy.

It is also noted that the provision of COBRA upon which Respondent relies as authorizing to charge an administrative fee, states:

> (C) PREMIUM REQUIREMENTS. -- The plan may require payment of a premium for any period of continuation coverage, except that such premium --
>
> (i) shall not exceed 102 percent of the applicable premium for such period,

(Emphasis added)

Assuming that statutory provision permits Respondent to charge such an administrative fee, the fee is not required, rather it is permissible up to a maximum of two percent (2%) of the applicable premium. That discretionary authority under the federal statute must, if possible, be harmonized with Respondent's duties under the Municipal Employment Relations Act (MERA). 8/ The Examiner finds nothing that would distinguish that discretionary authority from other statutory authority of the Respondent that concerns a subject that primarily relates to "wages, hours or conditions of employment," and which is therefore manditorily bargainable, e.g. the authority of a school board under Wisconsin's school statutes to set the compensation of its employes.

Therefore, to the extent the Respondent is permitted by law 9/ to charge a fee for administering the continuation coverage for the group health and group dental plans covering the employes in the bargaining unit represented by Complainant and their spouses and dependents, the imposition of that fee is a

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6/ Dec. No. 19091.

7/ Dec. No. 21144 at 8-9.

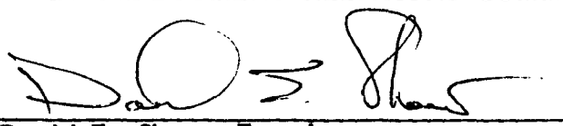
8/ Glendale Prof. Policemen's Assoc. v. Glendale, 83 Wis.2d 90 (1978).

9/ While Complainant contends that Respondent is not authorized by COBRA to charge such a fee and is prohibited by Sec. 632.897(2)(d), Stats., from charging such a fee, it makes no claim that such a fee is an illegal subject of bargaining. Absent such an allegation, and given the Complainant's claim that the fee is a mandatory subject of bargaining about which Respondent was required to bargain, the Examiner declines to address that issue.

mandatory subject of bargaining within the meaning of Sec. 111.70(3)(a)4, Stats., about which Respondent is required to bargain. By implementing such a fee without first bargaining, or offering to bargain, the matter with Complainant, Respondent violated Sec. 111.70(3)(a)4, and derivatively, Sec. 111.70(3)(a)1, Stats.

Dated at Madison, Wisconsin this 29th day of February, 1988.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By 
David E. Shaw, Examiner

"TITLE XXII—REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE AND LOCAL EMPLOYEES

"SEC. 2201. STATE AND LOCAL GOVERNMENTAL GROUP HEALTH PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.

"(a) IN GENERAL.—In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this Act, by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this title, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan.

"(b) EXCEPTION FOR CERTAIN PLANS.—Subsection (a) shall not apply to—

"(1) any group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year, or

"(2) any group health plan maintained for employees by the government of the District of Columbia or any territory or possession of the United States or any agency or instrumentality.

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 of the Internal Revenue Code of 1954 (relating to employers under common control) shall apply for purposes of paragraph (1).

* * *

SECS. 2202-2206. [Public Health Service Act Secs. 2202-2206 are omitted because they are substantively the same as Code Secs. 162(k)(2)-(6) at ¶ 16.]

"SEC. 2207. ENFORCEMENT.

"Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of this title may bring an action for appropriate equitable relief.

"SEC. 2208. DEFINITIONS.

"For purposes of this title—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 162(i)(3) of the Internal Revenue Code of 1954.

* * *

[Public Health Service Act Secs. 2208(2)-(4) are omitted because they are substantively the same as Code Secs. 162(k)(7)(A)-(C) at ¶ 16.]

* * *

(b) EFFECTIVE DATES.—[Substantively the same as Act Sec. 10002(d) at ¶ 22.]

(c) NOTIFICATION TO COVERED EMPLOYEES.—At the time that the amendments made by this section apply to a group health plan (covered under section 2201 of the Public Health Service Act), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under title XXII of such Act. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 2206(1) [substantively the same as Code Sec. 162(k)(6)(A)] of such Act with respect to such individuals.

Law Provisions Involved

INTERNAL REVENUE CODE of 1954

("ACT SECTIONS" REFER TO THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 [P. L. 99-272])

[¶ 15] SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS

(a) IN GENERAL.—Gross income does not include contributions by the employer to accident or health plans for compensation (through insurance or otherwise) to his employees for personal injuries or sickness.

(b) EXCEPTION FOR HIGHLY COMPENSATED INDIVIDUALS WHERE PLAN FAILS TO PROVIDE CERTAIN CONTINUATION COVERAGE.—

(1) IN GENERAL.—Subsection (a) shall not apply to any amount contributed by an employer on behalf of a highly compensated individual (within the meaning of section 105(h)(5)) to a group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of section 162(k).

(2) EXCEPTION FOR CERTAIN PLANS.—Paragraph (1) shall not apply to any—

(A) group health plan for any calendar year if all employers maintaining such plan normally employed fewer than 20 employees on a typical business day during the preceding calendar year,

(B) governmental plan (within the meaning of section 414(d)), or

(C) church plan (within the meaning of section 414(e)).

Under regulations, rules similar to the rules of subsections (a) and (b) of section 52 (relating to employers under common control) shall apply for purposes of subparagraph (A).

(3) GROUP HEALTH PLAN.—For purposes of this subsection, the term "group health plan" has the meaning given such term by section 162(i)(3).

Amendment Note

Act Sec. 10001(b) amended Code Sec. 106 by inserting "(a) In general.—" before "Gross" and adding new subsection (b) to read as above, effective for plan years beginning on or after July 1, 1986 except for a special rule applicable to collective bargaining agreements.

Act Sec. 10001(e)(2) provides:

(2) Special Rule for Collective Bargaining Agreements.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

[¶ 16] SEC. 162. BUSINESS EXPENSES

* * *

(i) GROUP HEALTH PLANS.—

* * *

(2) PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.—

(A) IN GENERAL.—No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of subsection (k).

(B) EXCEPTION FOR CERTAIN SMALL EMPLOYERS, ETC.—Subparagraph (A) shall not apply to any plan described in section 106(b)(2).

(3) GROUP HEALTH PLAN.—For purposes of this subsection the term "group health plan" means any plan of, or contributed to by, an employer to provide medical care

(as defined in section 213(d)) to his employees, former employees, or the families of such employees or former employees, directly or through insurance, reimbursement, or otherwise.

* * *

(k) CONTINUATION COVERAGE REQUIREMENTS OF GROUP HEALTH PLANS.—

(1) IN GENERAL.—For purposes of subsection (i)(2) and section 106(b)(1), a group health plan meets the requirements of this subsection only if each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled to elect, within the election period, continuation coverage under the plan.

(2) CONTINUATION COVERAGE.—For purposes of paragraph (1), the term "continuation coverage" means coverage under the plan which meets the following requirements:

(A) TYPE OF BENEFIT COVERAGE.—The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

(B) PERIOD OF COVERAGE.—The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(i) MAXIMUM PERIOD.—In the case of—

(I) a qualifying event described in paragraph (3)(B) (relating to terminations and reduced hours), the date which is 18 months after the date of the qualifying event, and

(II) any qualifying event not described in subclause (I), the date which is 36 months after the date of the qualifying event.

(ii) END OF PLAN.—The date on which the employer ceases to provide any group health plan to any employee.

(iii) FAILURE TO PAY PREMIUM.—The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.

(iv) REEMPLOYMENT OR MEDICARE ELIGIBILITY.—The date on which the qualified beneficiary first becomes, after the date of the election—

(I) a covered employee under any other group health plan, or

(II) entitled to benefits under title XVIII of the Social Security Act.

(v) REMARRIAGE OF SPOUSE.—In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which the beneficiary remarries and becomes covered under a group health plan.

(C) PREMIUM REQUIREMENTS.—The plan may require payment of a premium for any period of continuation coverage, except that such premium—

(i) shall not exceed 102 percent of the applicable premium for such period, and

(ii) may, at the election of the payor, be made in monthly installments.

If an election is made after the qualifying event, the plan shall permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

(D) NO REQUIREMENT OF INSURABILITY.—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(E) CONVERSION OPTION.—In the case of a qualified beneficiary whose period of continuation coverage expires under subparagraph (B)(i), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

(3) QUALIFYING EVENT.—For purposes of this subsection, the term "qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subsection, would result in the loss of coverage of a qualified beneficiary:

(A) The death of the covered employee.

(B) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.

(C) The divorce or legal separation of the covered employee from the employee's spouse.

(D) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

(E) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

(4) APPLICABLE PREMIUM.—For purposes of this subsection—

(A) IN GENERAL.—The term "applicable premium" means, with respect to any period of continuation coverage of qualified beneficiaries, the cost to the plan for such period of the coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred (without regard to whether such cost is paid by the employer or employee).

(B) SPECIAL RULE FOR SELF-INSURED PLANS.—To the extent that a plan is a self-insured plan—

(i) IN GENERAL.—Except as provided in clause (ii), the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to a reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries which—

(I) is determined on an actuarial basis, and

(II) takes into account such factors as the Secretary may prescribe in regulations.

(ii) DETERMINATION ON BASIS OF PAST COST.—If a plan administrator elects to have this clause apply, the applicable premium for any period of continuation coverage of qualified beneficiaries shall be equal to—

(I) the cost to the plan for similarly situated beneficiaries for the same period occurring during the preceding determination period under subparagraph (C), adjusted by

(II) the percentage increase or decrease in the implicit price deflator of the gross national product (calculated by the Department of Commerce and published in the Survey of Current Business) for the 12-month period ending on the last day of the sixth month of such preceding determination period.

(iii) CLAUSE (ii) NOT TO APPLY WHERE SIGNIFICANT CHANGE.—A plan administrator may not elect to have clause (ii) apply in any case in which there is any significant difference, between the determination period and the preceding determination period, in coverage under, or in employees covered by, the plan. The determination under the preceding sentence for any determination period shall be made at the same time as the determination under subparagraph (C).

(C) DETERMINATION PERIOD.—The determination of any applicable premium shall be made for a period of 12 months and shall be made before the beginning of such period.

(5) ELECTION.—For purposes of this subsection—

(A) ELECTION PERIOD.—The term "election period" means the period which—

(i) begins not later than the date on which coverage terminates under the plan by reasons of a qualifying event,

(ii) is of at least 60 days' duration, and

(iii) ends not earlier than 60 days after the later of—

(I) the date described in clause (i), or

(II) in the case of any qualified beneficiary who receives notice under paragraph (6)(D), the date of such notice.

(B) EFFECT OF ELECTION ON OTHER BENEFICIARIES.—Except as otherwise specified in an election, any election by a qualified beneficiary described in clause (i)(I) or (ii) of paragraph (7)(B) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary who would lose coverage under the plan by reason of the qualifying event.

(6) NOTICE REQUIREMENTS.—In accordance with regulations prescribed by the Secretary—

(A) the group health plan shall provide, at the time of commencement of coverage under the plan, written notice to each covered employee and spouse of the employee (if any) of the rights provided under this subsection,

(B) the employer of an employee under a plan must notify the plan administrator of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3) with respect to such employee within 30 days of the date of the qualifying event,

(C) each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of any qualifying event described in subparagraph (C) or (E) of paragraph (3), and

(D) the plan administrator shall notify—

(i) in the case of a qualifying event described in subparagraph (A), (B), or (D) of paragraph (3), any qualified beneficiary with respect to such event, and

(ii) in the case of a qualifying event described in subparagraph (C) or (E) of paragraph (3) where the covered employee notifies the plan administrator under subparagraph (C), any qualified beneficiary with respect to such event,

of such beneficiary's rights under this subsection.

For purposes of subparagraph (D), any notification shall be made within 14 days of the date on which the plan administrator is notified under subparagraph (B) or (C), whichever is applicable, and any such notification to an individual who is a qualified beneficiary as the spouse of the covered employee shall be treated as notification to all other qualified beneficiaries residing with such spouse at the time such notification is made.

(7) DEFINITIONS.—For purposes of this subsection—

(A) COVERED EMPLOYEE.—The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

(B) QUALIFIED BENEFICIARY.—

(i) IN GENERAL.—The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

(I) as the spouse of the covered employee, or

(II) as the dependent child of the employee.

(ii) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in paragraph (3)(B), the term "qualified beneficiary" includes the covered employee.

(C) PLAN ADMINISTRATOR.—The term "plan administrator" has the meaning given the term "administrator" by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

Amendment Notes

Act Sec. 10001(a) redesignated Code Sec. 162(i)(2) as (3) and added a new paragraph (2) to read as above.

Act Sec. 10001(c) amended Code Sec. 162 by redesignating subsection (k) as (l) and adding new subsection (k) to read as above.

The above amendments are effective for plan years beginning on or after July 1, 1986 except for the special rule applicable to collective bargaining agreements (see ¶ 15).

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

"ACT SECTIONS" REFER TO CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 [P. L. 99-272]

CIVIL ENFORCEMENT

[¶ 17] Sec. 502.

* * *

(c) Any administrator *(1) who fails to meet the requirements of paragraph (1) or (4) of section 606* [substantively the same as Code Sec. 162(k)(6)(A) and (D)] *with respect to a participant or beneficiary, or (2)* who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

Amendment Note

Act Sec. 10002(b) amended ERISA Sec. 502(c) by inserting after "any administrator" "(1) who fails to meet the requirements of paragraph (1) or (4) of section 606 with respect to a participant or beneficiary, or (2),".

ACT SECTIONS NOT AMENDING ERISA OR 1954 CODE

("ACT SECTIONS" REFER TO CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 [P. L. 99-272])

[¶ 21] SEC. 10001.

* * *

(e) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

[¶ 22] SEC. 10002.

* * *

(d) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after July 1, 1986.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(e) NOTIFICATION TO COVERED EMPLOYEES.—At the time that the amendments made by this section apply to a group health plan (within the meaning of section 607(1) of the Employee Retirement Income Security Act of 1974), the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage required under part 6 of subtitle B of title I of such Act. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 606(1) [substantively the same as Code Sec. 162(k)(6)(A)] or such Act with respect to such individuals.

[¶ 23] SEC. 10003. CONTINUATION OF HEALTH INSURANCE FOR STATE AND LOCAL EMPLOYEES WHO LOST EMPLOYMENT-RELATED COVERAGE (PUBLIC HEALTH SERVICE ACT AMENDMENTS).

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title: