STATE OF WISCONSIN

BEFORE THE WISCONSIN EMPLOYMENT RELATIONS COMMISSION

MAYVILLE EDUCATION ASSOCIATION AND LOUISE MACIEJEWSKI, PRESIDENT, MAYVILLE EDUCATION ASSOCIATION, Complainants, vs. MAYVILLE SCHOOL DISTRICT AND THE BOARD OF EDUCATION OF THE MAYVILLE SCHOOL DISTRICT, Respondents.	Case 17 No. 39952 MP-2052 Decision No. 25144-C

Appearances:
Ms. Ellen J. Henningsen, Staff Counsel, Wisconsin Education Association Council, 33 Nob Hill Drive, P.O. Box 8003, Madison, Wisconsin 53708-8003, on behalf of the Complainants.
Mulcahy & Wherry, S.C., by Mr. Edward J. Williams, 219 Washington Avenue, Oshkosh, Wisconsin 54902, and Mr. Kirk D. Strang, 131 West Wilson Street, Suite 202, Madison, Wisconsin 53701-1110, on behalf of the Respondents.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

AMEDEO GRECO - HEARING EXAMINER: Mayville Education Association and Louise Maciejewski, herein the Association, filed a prohibited practice complaint with the Wisconsin Employment Relations Commission on January 5, 1988, alleging that Mayville School District and the Board of Education of the Mayville School District, herein the District, had committed prohibited practices within the meaning of Sec. 111.70(3)(a)(4), Wis. Stats., by refusing to bargain over the District's decision to establish self-funded health and dental insurance plans and by refusing to supply certain requested information regarding same. The Commission on February 9, 1988, appointed the undersigned to make and issue Findings of Fact, Conclusions of Law and Order. Pursuant to the agreement of both parties, this matter was held in abeyance pending possible informal resolution, which ultimately proved unsuccessful.

The District on September 12, 1988, filed its Answer and Affirmative Defenses and hearing was held in Juneau, Wisconsin on March 7, 8 and 9, 1989, May 10, 11 and 12, 1989, July 24, 25, 26, and 27, 1989. The Association orally amended its complaint at hearing on May 10, 1989, charging that the District violated Sec. 111.70(3)(a)(4), Wis. Stats. by failing to maintain previously provided health insurance benefits during a contract hiatus period and it filed a written Amended Complaint on July 3, 1989. The District on July 21, 1989, filed an Amended Answer and Affirmative Defenses denying said charges. Briefs and reply briefs were received by December 11, 1989.

FINDINGS OF FACT

1. The Association - a labor organization which during all times herein has been affiliated with the Wisconsin Education Association Council, herein WEAC - has since at least 1961 represented for collective bargaining purposes certain teaching personnel employed by the District and it maintains its offices c/o Winnebagoland UniServ Units, 183 W. Scott Street, Fond du Lac, Wisconsin, 54935. Armin Blaufuss since 1977 has been employed by WEAC and Winnebagoland UniServ South, one of the regional offices in the State of Wisconsin. Throughout that time, he has serviced the Mayville Education Association and has assisted it in collective bargaining negotiations with the District, including those relating to insurance matters. Louise Maciejewski is a teacher employed by the District and has been President of the Association.

2. The District, a municipal employer, provides a general education program and maintains its principal offices at 500 Clark Street, Mayville, Wisconsin, 53050. At all times material hereto, Stephen L. Bushke has been the District Administrator.

3. The parties have been privy to a series of collective bargaining agreements dating back to about 1961. The 1972-1974 contract provided for a life insurance plan to "be endorsed by the Wisconsin Education Council". In 1975 and for all contracts thereafter, the reference to the Wisconsin Education Council was removed from the agreement.

4. The 1981-1982 agreement and all subsequent agreements provided for

dental coverage and listed a series of benefits covered by "Plan #702H," the dental plan offered by the Wisconsin Education Council Trust, herein the Trust. The Trust has never provided dental benefits to Mayville teachers. For the duration of the 1986-1987 contract, Blue Cross-Blue Shield United of Wisconsin, Inc., herein Blue Cross, was the dental carrier and it provided all of the dental benefits listed in Plan #702H.

5. Between 1962-1965 there was no identification of the health insurance carrier in the contract. From 1965-1973, Wisconsin Physician Service, herein WPS, was identified in the contract as the health care provider. In the 1973-74 contract, the Trust was named as the provider of health care coverage, the only time that the Trust has ever been so named in the contract. The 1974-1975 contract deleted any references to the Trust and the District switched coverage to Blue Cross under language providing: "The Board agrees to carry group hospital surgical insurance at not less than current benefit levels" and all subsequent contracts up to 1987 contained words to the same effect. The District between 1975 - January 1, 1988, subsequently selected the Trust as the health insurance carrier, even though it was not expressly designated in the contract.

6. The Trust, established by WEAC in 1970, prior to 1985 self-insured accident, health, dental, and long term disability insurance, during which time it maintained that it was not subject to any regulation by the Wisconsin Office of the Commissioner of Insurance, herein OCI. As a result, the Trust for over ten (10) years was not regulated by OCI or state insurance statutes while it provided health care benefits to bargaining unit members and teachers across the state. In addition, the Trust did not have stop-loss protection - which limits the amount of financial liability that a provider can incur - when it administered benefits for Mayville teachers. Neither the Association nor any employes ever complained that the Trust provided health insurance on a self-funded basis and no one in that time ever claimed that the health benefits provided did not constitute "insurance". The parties in their collective bargaining negotiations during that time never agreed that the references to "insurance" in the contract excluded self-funding by the Trust, the District, or any other health care provider, as the question of self-funding never came up.

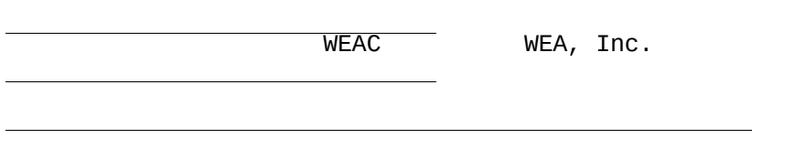
7. In 1985, after the United States Department of Labor questioned the Trust's ERISA status, the Trust created a wholly owned separate subsidiary called WEAIT Insurance Corporation, herein WEAIT, which writes insurance upon the lives and health of persons, along with bodily injury, disablement, or death by accident and against disablement resulting from sickness or old age. WEAIT became a duly licensed insurance company in May, 1985. The Trust elects all members of WEAIT's Board of Directors and the Trust's Board of Trustees, in turn, are appointed by WEAC, thereby giving WEAC effective control over both the Trust and WEAIT.

8. The Trust is the sole shareholder of WEAIT. The Board of Directors of WEAIT and the Board of Trustees for the Trust are comprised of the same people. The Trust determines insurance rates for WEAIT; secures all reinsurance; determines commissions; indemnifies WEAIT; and shares the same address as WEAIT. It had a revenue shortfall, which the Trust made up, of over $8,000,000 in 1986-1987 which was cased by deficient claim reserves, failure to account for inflation, and failure to provide sufficient margin to absorb risk for rate increases. It had a net operating loss of nearly $3,8000,000 in 1987 and in 1988 it experienced a net operating loss of over $800,000. In 1987 and 1988 it had about $24,695,005 and $27,796,506 in capital surplus and revenues respectively.

9. In its January 18, 1985, filing with OCI, WEAIT stated, inter alia, that it would "seek admission to do business, with the consent of the Wisconsin Education Association, Inc., in such other jurisdictions as WEAIT Company believes it can write profitable insurance business . . . ." In a May 15, 1985 letter from OCI staffer Robert Walker to fellow OCI employe Matthew C. Mandt, Walker stated that the proposed arrangement is similar to a "fronting agreement. As I interpret the contract, the insurer is a front for WEAIT." WEAIT in February, 1989 filed an annual report with OCI which included the following organizational chart:

III. AFFILIATED COMPANIES

The company is part of a holding company system. A chart of the system is show below:



WEAIT INSURANCE
CORPORATION (2)

(1)trustees are appointed by WEA, Inc. and other entities as noted below
(2)directors are elected by W.E.A. Insurance Trust, the sole shareholder

10. The District twice over the years changed the identity of the health insurance carrier without first bargaining with the Association; it did so in 1974 when it switched from the Trust to Blue Cross and again in 1975 when it switched from Blue Cross to the Trust. The Association never complained about these unilateral changes in the identity of the carrier or asked to bargain over them. There were changes in the unique benefits' packages offered by the previous providers and some delays in claims' processing when the District changed providers. In addition, there were a handful of problems a year regarding the way that the Trust and WEAIT provided health care benefits. Employes under those plans did not keep records of what those problems were and they did not know when their medical bills were paid. The District also once unilaterally changed the identity of its long term disability provider without any objection from the Association.

11. The 1986-1987 contract between the parties expired on June 30, 1987, and provided for health insurance in Article VI, Section L, as follows:

. . .

L.Health Insurance

1.The Board agrees to continue to carry group hospital/surgical insurance at not less than current benefit levels.

2.Any eligible teacher desiring to be covered by the group hospital/surgical insurance carried by the Board shall so elect in writing and the election shall be filed with the Board. An employee may elect single coverage (covering the employee only) or single and dependent coverage (covering the employee and his/her family). No election of the coverage shall be revoked except upon the notice and terms provided by the insurer and all rules, regulations and requirements of the insurer shall be made a part hereof by reference.

3.The Board agrees to pay the full premium cost for single coverage and for single and dependent coverage.

4.Teachers terminating their employment with the district shall at their option be entitled to coverage under the above program subject to the approval of the carrier providing that they reimburse the district for the cost of such coverage.

5.Inclusion of pre-admission hospital review program effective 9/1/85.

6.Effective October 1, 1986, the parties agree to implement the $100-200 up-front deductible health insurance plan. A summary of this plan Appendix D is attached.

Appendix C, in turn, spelled out the benefits to be provided under said plan.

12. Article VI, Section N, of said contract also provided for dental benefits and stated:

. . .

N.Dental Insurance

1.The Board agrees to make available to each teacher, dental insurance on the following basis:

The Board shall pay the full single and family monthly premium.

The benefits shall be as follows:

Plan #702H - Comprehensive coverage for you and your dependents (dependent children covered up to age 25).

Coverage:

A.Diagnostic and Preventative (100% paid)

1.Semi-annual examination (every 6 months)
2.Bitewing X-rays (every 6 months)
3.Cleaning and scaling (every 6 months)
4.Fluoride Treatment (under age 19)

B.Basic Services (80% paid)

1.Full series X-rays (every 24 months)
2.Anesthesia
3.Extractions
4.Oral surgery
5.Fillings (amalgam, silicate, acrylic and composites, including stainless steel crowns)
6.Space maintainers and repair (under age 19)
7.Root canal therapy
8.Periodontic treatment
9.Emergency relief of pain
10.Denture repair

C.Optional benefits available for:

1.Inlays, Onlays porcelain jackets and cast crowns (80% paid)

2.Bridgework and dentures (80% paid) Benefits paid on usual and customary charge. $1,000 maximum benefit per person per group contract year for all procedures except orthodontics. $1,500 per person lifetime maximum orthodontics.

13. WEAIT provided insurance to the District on a pooled basis - i.e. it included the District in a pool of other school districts for rating purposes. The District in the past has asked WEAIT for information regarding the claims' experience for its employes covered under the plan, but WEAIT has refused to supply it. Without said information, an insured such as the District is unable to determine whether it pays too much money or not enough money to cover its risk for the rating period involved and it is unable to determine exactly where its health care dollars go. In addition, by refusing to provide such information, WEAIT is able to charge one employe more money than it takes to support the risk of that employer and to then use those excess funds to offset losses on other contracts with other employers. WEAIT does not provide this information because "good clients," i.e. those with fewer health care costs, may drop out of the plan, thereby leaving it only with those school districts which have much higher costs, hence resulting in higher premiums for the teachers in said districts.

14. The expired 1986-1987 contract, like the subsequent 1987-1989 contract, provided for a grievance-arbitration procedure which culminated in final and binding arbitration. No grievances have ever been filed thereunder regarding any of the disputed matters in this proceeding.

15. The parties exchanged initial bargaining proposals on September 29, 1987, and engaged in negotiations over a successor to the 1986-1987 contract which expired on June 30, 1987, with the Association proposing language expressly identifying WEAIT as the health insurance carrier and Blue Cross-Blue Shield as the dental carrier. The District rejected said proposals in favor of the then current language in the contract giving it the right to select said carriers, provided that benefit levels remained the same.

16. Following unsuccessful efforts to reach a voluntary agreement on a two (2) year contract, the dispute was submitted to arbitrator Joseph B. Kerkman after the Association filed an Interest Arbitration petition on January 27, 1988. The two (2) issues before him involved wages and whether WEAIT and Blue Cross should be named in the contract as the health and dental insurance carriers. Arbitrator Kerkman conducted three (3) days of hearing on the matter, at which time various teachers represented by the Association related the difficulties they were encountering with the District's self-funded health plans. In an Award dated February 17, 1989, Arbitrator Kerkman selected the District's final offer, finding that although "the Association claims it is attempting to maintain the status quo, the undersigned disagrees and concludes the Association is proposing change" because it "proposes to negate the provision which permits the Employer to change insurance carriers during the life of the agreement so long as the benefit levels are maintained."

Going on, he stated: "the proposal of the Association here changes the terms of the Collective Bargaining Agreement, and, therefore, a change in the status quo is advocated by the Association." He also stated:

> Here, the Association asks an interest arbitrator to discontinue the self insured plan of the Employer and restore the prior carrier based at least in part on evidence it adduced at hearing in the interest arbitration purporting to show that the coverages are not the same. The Association makes that proposal even though the predecessor Agreement has a provision which requires the Employer to maintain benefits at not less than the current benefit levels which would have given the Association the means to pursue a grievance and arbitrate this issue. It is the opinion of the undersigned that the Association has failed to utilize the language presently in force in the Agreement when it failed to grieve and arbitrate, if necessary, the change which the Association asserts fails to maintain the present level of benefits. Thus, it would appear that the Association is asking this interest arbitrator to make a determination that would be more appropriately made by a rights arbitrator interpreting the terms of the predecessor Agreement. If the Association is correct in its allegations that the present benefits do not measure up to the prior level of benefits, then the Contract is violated, and a rights arbitrator under an arbitrator's broad remedial powers would have the authority to restore the status quo ante. The Association argues that to grieve and arbitrate on a case by case basis would have been a lengthy and costly exercise. The undersigned disagrees. It would have been sufficient for the Association to prove up before a rights arbitrator that the coverage under a self insured plan was not equal to that of the prior insured's plan, or that a self insured plan was not permissible under the language of the Contract. This could have been done more promptly than awaiting this interest arbitration. The fact that the Association failed to utilize the language presently in existence in the contract in an attempt to protect its interests militates against a change in the contract language in interest arbitration because there is no showing that the present language has been tried and found wanting. In fact, it has not been tried at all.

The 1987-1989 contract which was the subject of said Award provided that it was to be in effect from between July 1, 1987, to June 30, 1989.

17. The District on July 20, 1987, had earlier decided to self-fund health and dental benefits with four (4) other school districts and its Board of Education met with Association representatives on August 11, 1987, to inform them of the change which was slated to take place on September 1, 1987. Two (2) of the school districts in August 1987 pulled out of the proposed plan and the other two ultimately decided against joining with the District. The latter in November, 1987, decided to form its own self-funded plans effective January 1, 1988, when it terminated its prior health insurance coverage with the Trust and its dental insurance coverage with Blue Cross.

18. At that time, it entered into a contract on December 30, 1987, with Preferred Administrative Services, Inc., herein PAS, of Madison, Wisconsin, to be the third party administrator of its self-funded health and dental insurance plans to process and administer medical and dental claims and both parties entered in an Administrative Service Agreement providing, inter alia:

> SECTION 1: OBLIGATION OF PAS, INC.
>
> Subject to the terms and conditions of this agreement, and during any period of time for which the Sponsor's Master Plan Document obligates PAS, Inc. in regard to services to the Sponsor or covered persons, PAS, Inc. agrees:
>
> (a)to provide the services for, and assist the Sponsor in performing all normal administrative duties necessary to the installation of and smooth operation of the Sponsor's Plan as outlined in the Sponsor's Master Plan Document, inclusive of:
>
> (1)preparation of the Sponsor's Master Plan Document
> (2)preparation of employee benefit plan certificates and explanations of employee rights under

E.R.I.S.A. as required for distribution with the benefit plan certificates

(3)preparation of employee benefit I.D. cards

(4)enrolling new entrants to the plan, issuing new entrant benefit plan certificates and I.D. cards, as well as determining acceptability of health for late entrants to the Plan by means of medical underwriting, unless instructed by the Sponsor to do otherwise

(5)receiving and responding to all verbal and written requests made by providers of medical care or services in regard to benefits provided by the Sponsor's Plan and in regard to the enrollment status of a covered person or a dependent of a covered person

(6)receiving, reviewing and processing claims made against the Sponsor's Plan, adhering to the provisions outlined in the Sponsor's Master Plan Document in the determination of payable benefits

(7)drafting and distributing benefit payment checks for the purpose of employee benefit payments, in addition to preparing an explanation of each covered person's claim processing which lists any and all benefit payments made in the covered person's behalf

(8)maintaining claim files on all individuals who have ever been a covered person or dependent and who have ever submitted a claim while enrolled in the Sponsor's Plan, assuring the Sponsor access to those files in the office of PAS, Inc.

(9)providing a monthly paid claim register on behalf of the covered persons insured by the Sponsor's Plan.

10)providing a monthly claim check register for the Sponsor's review, listing the date of each check made, check number, name of check recipient and amount of each draft as appropriate or required

11)guidance to the Sponsor in filing of 5500 forms, filing of the Summary Plan Description, preparation of any 501 (c) (9) trust document the Sponsor may so desire in addition to the necessary 1024 forms or SS4 form, and the preparation of the appropriate 1099 forms

12)providing the Sponsor access to any and all documents in the possession of PAS, Inc. that have anything to do with the Sponsor's Plan and assuring full-disclosure of any and all pertinent information at all times without confidentiality disclosure

(b)to assist in the administration of the Sponsor's Plan in a responsible and business-like manner with the intent of providing fast and efficient services and with positive efforts to contain and control the net cost to the Sponsor

(c)to hold harmless the Sponsor or any of his designated representatives or employees in regards to any litigation, law suit or legal process taking any form and being brought against PAS, Inc. as a result of illegal, improper or imprudent actions on the part of PAS, Inc. or any of its designated representatives or employees, acting outside of the realm of any duties or authority to perform such duties as given to PAS, Inc. by the Sponsor herein or in any written form.

Said agreement also stated:

SECTION 2: OBLIGATIONS OF THE SPONSOR

> Subject to the terms and conditions of this agreement, and during any period of time for which the Sponsor's Master Plan Document obligates the Sponsor in regard to employee benefits or services, the Sponsor agrees:
>
> (a)to furnish for the use of PAS, Inc. any and all information and/or documents considered by PAS, Inc. to be necessary to assisting in the installation and administration of the Sponsor's Plan as outlined in the Sponsor's Master Plan Document.
>
> (b)to establish a checking account suitable to the needs of the plan and hold in such account sufficient funds for payment of all legitimate claims made by any covered person or dependent of the same, if eligible for benefits as defined by the provisions of the Sponsor's Master Plan Document, for losses deemed payable by PAS, Inc. after careful consideration and fair review of such claims.

19. Under said agreement, the District, rather than PAS, retains the liability for paying claims and to that end, the District regularly transfers money to PAS so that claims can be paid. PAS has recently installed a FAX machine to ensure that those claims are paid more quickly.

20. PAS itself bears no economic risk in paying out any claims incurred under the District's self-funded plans. PAS maintains an internal appeal procedure which enables employes to formally complain and to seek redress over any problems regarding the way that PAS is administering the District's self-funded health and dental plans. No employes herein have ever tried to use said appeal procedure.

21. The District also hired the Hierl Agency of Fond du Lac, Wisconsin, to help administer the plan locally by answering employe questions and resolving employe complaints or problems. At all times material herein, PAS and Hierl have acted on the District's behalf in administering its health and dental plans insurance plans. There is no contractual agreement between PAS and Hierl.

22. Under its self-funded plans, the District has specific stop-loss coverage to pay any claims which exceed $20,000 for any one individual covered under the plan and an aggregate of $294,233 which limits the District's total liability. The District is also covered by an approximately $900,000 super-aggregate (which it shares with other employers) which is to be used in the event of plan cancellation or for run-off claims, i.e. those claims which are incurred during the plans' coverage but which are not paid for until after its expiration. The super-aggregate covers both medical and dental claims; the normal industry practice is for such super-aggregates to only cover medical expenses. The specific stop-loss, aggregate, and super-aggregates, are provided by Transamerica Occidental Life, herein Transamerica, which bears the financial risk of paying for anything over those amounts and which is regulated by OCI. Said coverages are in line with generally accepted industry-wide standards.

23. The District's health care benefits' plan provides:

> This plan, The School District of Mayville Health Care Benefit Plan, is intended to duplicate the terms and coverage afforded by the predecessor plan of the WEAIT Insurance Corporation. To the extent that the terms expressed in this Plan may be inconsistent with the terms expressed in the predecessor plan, such inconsistencies shall be resolved in favor of the terms of the predecessor agreement. In addition, benefit levels and the interpretation of Plan language shall be consistent with that of the predecessor plan; the Plan shall incorporate state mandated benefits to the same extent as the predecessor plan; and the Plan Administrator shall hold in confidence health care information concerning Employees to the extent that such information was held confidential by the predecessor plan.

24. The District's dental plan similarly provides:

> This plan, the School District of Mayville Dental Plan, is intended to duplicate the terms and coverage afforded by the predecessor plan of the Blue Cross and Blue Shield United of Wisconsin Insurance Company. To the extent that the terms expressed in this Plan may be inconsistent with the terms expressed in the predecessor plan, such inconsistencies shall be

> resolved in favor of the terms of the predecessor agreement. In addition, benefit levels and the interpretation of Plan language shall be consistent with that of the predecessor plan; the Plan shall incorporate State Mandated Benefits to the same extent as the predecessor plan; and the Plan Administrator shall hold in confidence health care information concerning Employees to the extent that such information was held confidential by the predecessor plan.

The District did not distribute copies of said health and dental plans to teachers until the end of June, 1988.

25. Up until the time of the instant hearing, approximately 6,000 health and dental claims had been filed under the District's self-funded health and dental plans, with each employe averaging about sixty (60) claims. Throughout that time, the District has duplicated the health and dental benefits previously provided in the predecessor collective bargaining agreement. In addition, the District, PAS, and the Hierl Agency all have made good faith efforts to resolve any problems brought to their attention.

26. Different providers and/or interpretative entities cause differences in how benefit plans are administered, even if they on their face provide for identical benefits. Such differences include how such phrases as "reasonable and customary" and "medically necessary" are applied; the amount of information required from patients and providers; the speed in processing and paying claims; differences in applying coordination of benefits; under what circumstances late enrolles will be accepted; differences in underwriting standards; and differences in error rates.

27. Delays and problems in paying for medical services are inherent in any health care delivery system and are caused by such factors as inadequate or incorrect information; improper and/or lack of diagnosis; disputes over coordination of benefits and whether a particular service is covered under a particular plan; delays by the health care providers in submitting their bills; improper submission of bills to a prior carrier; the failure of some providers to direct bill; and the conduct of plan beneficiaries in making sure that they provide complete and accurate information.

28. PAS developed a backlog in claims processing in the beginning of 1988 and from November 1988 - February 1989 which delayed payment of some of the claims herein. PAS has taken reasonable steps to abolish those backlogs by authorizing overtime and creating another shift.

29. Richard Klopfer, a teacher employed by the District, in 1988 telephoned the Hierl Agency during the school day, while on pay status, from the teacher's lounge regarding the late payment of a medical bill incurred under the District's health plan, during which time he screamed so loud over the telephone that he was heard about 70-75 feet away in the school offices. Someone from the Hierl Agency telephoned Bushke regarding the call, complaining that Klopfer had been so belligerent and abusive toward a woman in her office that she was in tears. Bushke called Klopfer into his office and gave him a verbal reprimand for acting so unprofessionally. Said reprimand, which was never grieved, was not in any way related to any question of confidentiality or any insurance matter; it also was not the first time that Klopfer had been admonished for similar outbursts on other subjects.

30. Nancy Boeddicker, a German teacher employed by the District, has made several trips to Germany. She never incurred any medical bills in either Germany or any other foreign country since January 1, 1988; she has never tried to use her PAS identification card overseas; and her PAS card has never been rejected in any foreign country. Someone from PAS told Boeddicker that if she ever incurred any bills in Germany, they would have to be translated into English at the appropriate exchange rate; that she would have to pay for them herself; and that she then would get reimbursed by PAS. Boeddicker never brought this issue to the District's attention at the time. PAS, in fact, does not require either that such foreign claims be in English or that they be at the proper exchange rate. WEAIT's practice on this subject is to tell teachers that they may have to pay bills in a foreign country, as its identification card is not accepted in all foreign countries. Boeddicker received treatment at Froedtert Medical Center, at which time a question arose over whether the PAS card would be accepted and it eventually was. There was some delay in paying for two (2) of Boeddicker's other bills; all bills were eventually paid, however, and she does not know when the bills were submitted to PAS. Boeddicker claimed that she did not receive proper explanation from PAS regarding how to handle her deductible; she in fact was given this information by PAS and she could have obtained some from either the Association or her fellow teachers, had she so desired.

31. Joseph Breaden, a teacher employed by the District, experienced slow payment for some of his medical bills which were originally sent to WEAIT. PAS ultimately paid for them after they were received and once it was determined that PAS, not WEAIT, was responsible for paying for them.

32. Virginia Reehl, the wife of a teacher employed by the District, incurred medical expenses for her daughter which she paid for immediately, but were not paid for by PAS until several months later. On one occasion, a doctor sent her a note asking for payment even though he knew that financial times were hard. In response thereto, Reehl made partial payment on that bill. Reehl also experienced slow payment on other claims which were not submitted to PAS until several months after the medical services were rendered.

33. John Benishek, a teacher employed by the District, once had his PAS prescription drug card rejected at a K-Mart pharmacy near the beginning of 1988 and be paid cash for the prescription, for which he was reimbursed by the District. Benishek on another occasion also had his PAS card rejected by K-Mart. He has used the PAS card at other pharmacies without difficulty.

34. Calvin Geiger, a teacher employed by the District, once put checks from PAS in his pant's pocket and then washed the pants in a washing machine, thereby ruining the checks. PAS delayed issuing another check, apparently because there was no standard procedure dealing with washed-out checks. PAS also delayed paying for some of Geiger's drug prescription bills after they were received and for which Geiger received multiple billings.

35. Barbara McDaniels, a teacher employed by the District, twice had her PAS prescription drug card questioned, but it was subsequently accepted and the prescriptions were filled on the spot. McDaniels also contacted the Hierl Agency to see if oral contraceptives were covered under the PAS plan and was originally told no; after looking into the matter, the Hierl Agency told her that they were. PAS did not immediately pay for certain medical bills incurred by McDaniels' daughter until several months after they were received. It is unknown when those bills were sent to PAS. McDaniels during this time received several past due notices from a provider.

36. Jacqueline Schiess, a teacher employed by the District, for several years has ordered prescription drugs by mail under the WEAIT and District plans. Schiess had questions about how to order drugs under the District's plan and was told by the Hierl Agency that the District's plan does not provide for mail order drugs, even though it does. Schiess never brought this to the District's attention until the hearing before Arbitrator Kerkman, at which time she was told that the District's plan did have a mail order drug plan. Schiess thereafter made no efforts to contact PAS regarding how to use said plan until March 1989, after which PAS sent her the needed information in a day or two. Schiess never contacted PAS to see if it would waive a $2 deductible under a certain mail order plan and she has never used the District's mail order plan. PAS in fact would have waived that deductible had the matter been brought to its attention. Schiess' husband incurred medical bills of Russell Chiropractic Clinic in March, May, and June 1988 which were not paid by PAS until March, 1989. Schiess herself incurred bills at Dr. Sweda's which were not paid by PAS until seven (7) weeks after they were received. PAS made an error in paying one of those bills which it subsequently corrected.

37. Patricia Loest, a teacher employed by the District, incurred medical bills for her newborn child which PAS did not pay until at least six months after they were rendered. Loest never informed WEAIT that she had the child, (born in October, 1987 when the WEAIT plan was in effect) even though she was required to do so under a provision of WEAIT's plan and she likewise did not immediately inform PAS that she had the child. Once PAS learned about it, and once it corrected an administrative error, it paid those bills fairly promptly. There were delays in PAS's payment for certain prescription drugs because of a question over coordination of benefits and PAS paid these bills in issue once the matter was brought to its attention. Other prescription drug bills were not paid for until several months after they were incurred because they were not submitted to PAS until that time. Loest's PAS card was rejected several times when she tried to buy prescription drugs.

38. Kenneth Kaepernick, a teacher employed by the District, incurred a medical bill which was sent to the wrong administrator and which PAS paid once it was received. Kaepernick asserts that he once sent a letter to PAS inquiring whether it would pay for Optivite, a non-prescription drug. PAS has no record of receiving any such letter and Optivite was not covered under the WEAIT plan, and hence need not be provided under the District's plan. Kaepernick experienced problems with slow payment with several of his claims which PAS waited several months to pay which led him to complain to PAS, and he once received a delinquency notice from a provider. Kaepernick also once had his PAS card rejected in early January 1988, a matter he brought to Bushke's attention. His card was also questioned on another occasion but accepted, a matter he never brought to either Bushke's or PAS's attention.

39. Mary Ann Biertzer, a teacher employed by the District, incurred several medical bills which were not immediately sent to PAS and which PAS paid 3-4 weeks after they were received and for which Biertzer had earlier received several past due notices. Biertzer never complained to either PAS or the District over the fact that a local pharmacy charged her a $2 deductible rather than the $1 she had paid under the WEAIT plan.

40. Melissa Koepsel, a teacher aide employed by the District, is married to a teacher employed by the District. She incurred a medical bill in May 1988 which PAS did not pay until September 14, 1988. Prior to said payment, Koepsel was told by the health provider that his account would be turned over to a collection agency if the bill was not paid immediately. In order to avoid that, Koepsel paid the bill herself and was subsequently reimbursed after PAS paid the clinic Koepsel also had her PAS card rejected in Door County.

41. Louise Maciejewski received a notice from Fond du Lac Clinic that her account would be turned over to a collection agency if she did not immediately pay an overdue bill, which PAS ultimately paid several months later. PAS also once mistakenly issued a check to Maciejewski which she returned.

42. Jacqueline Berry, a teacher employed by the District, asked the Hierl Agency in the beginning of 1988 whether the District's plan covered the expenses incurred by her daughter for mandibular joint syndrome (TMJ) and was told it was not. Berry subsequently contacted PAs which told her that it would pay for said claim if she could provide written confirmation from WEAIT that said expenses were covered under its plan. Once Berry provided same, PAS paid the claim within a month.

43. Joseph Nied, a teacher employed by the District, incurred expenses for his orthotics' device (used for his foot) which is not expressly provided for on the face of the District's health plan. Nied contacted PAs which told him that it would pay for it if he obtained written confirmation that WEAIT would have paid for it under its prior policy. Nied then contacted James Utrie from the Trust who told him that he would have to get further information from his doctor before he could provide a definite response. After Nied obtained said information, Utrie told Maciejewski who told him that WEAIT would have paid for it. Nied then contacted PAs which paid the bill within a month after receiving it. Nied incurred several medical bills at St. Agnes Hospital which were not paid for until several months later.

44. WEAIT and Blue Cross maintained toll-free numbers for employes who had questions about the prior health and dental plans they provided. The Hierl Agency has a toll-free number and teachers can call PAS collect. Teachers were not told that they could call PAS collect and none ever asked whether they could.

45. The face of the prior WEAIT plan provided for coordination of benefits. The District's self-funded plan initially provided for the coordination of benefits and that resulted in Loest incurring out-of-pocket expenses for a drug and it also resulted in the delayed payment of bills incurred by Loest and Geiger. Once this was brought to Bushke's attention, he immediately told PAS that benefits were not to be coordinated under the District's plans, and they not been.

46. Kit Hardie, a teacher employed by the District, had oral surgery, the initial estimate of which was $1,775. PAS originally stated that it would pay $1,367 of that. After Hardie questioned the Hierl Agency about why it would not pay more of the bill, and after Hardie had the surgery, PAS paid all but $191. of the actual $1,850 bill. Hardie never complained to either PAS or the District about said payment. WEAIT would have paid for the entire bill and PAS itself eventually did once it learned of that fact in the interest arbitration hearing before Arbitrator Kerkman.

47. Schiess complained to PAS about an error it had made in paying a claim; PAS corrected it two (2) months later. Loest contacted the Hierl Agency in February, 1988 regarding a problem she had with prescription drugs; that problem was corrected in May, 1988. Reehl, Braedon, and Biertzer also had questions which were not properly answered for several months and Maciejewski asked PAS for certain information regarding employe claim which PAS never responded to because they were confidential in nature. A K-Mart pharmacist twice contacted PAS for authorization to accept PAS cads and had to wait several months before receiving same.

48. PAS sent checks to Geiger which should have been mailed to a pharmacy; it sent two refund checks to Maciejewski to which she was not entitled; it notified McDaniels that it had paid a K-Mart pharmacy for drugs which she had never purchased there; and PAS sent one of Kaepernicks' claims to the wrong pharmacy.

49. Paula Larson, a teacher employed by the District, successfully got PAS to cover her husband under the District's health plan even though he had a preexisting condition which, by a special rider, was excluded from coverage. Jeanette Harmon, a PAS benefit specialist, discussed said matter with Larson, and made said decision on her own without any input or direction from Bushke or anyone else acting on the District's behalf. PAS has the authority on its own to make such decisions without any direction from the District.

50. The District's dental plan, unlike WEAIT's plan, requires employes to pay for their own postage and it has a lower dispensing limit.

51. In the beginning of 1988, Bushke asked teachers for the names of their providers so that he could contact the providers to say that the District was switching to a self-funded plan and thereby facilitate use of the PAS card; said information had never been sought under prior health plans. PAS initially supplied the District with the names of the teachers, the dollar amount of medical services, and the names of providers, but not the diagnosis. It discontinued doing so after some teachers complained that they did not want the District to know what medical services they were receiving. PAS now only provides the District with the amount of each claim and the health care provider without identifying the teachers involved, thereby maintaining patient confidentiality. During the time that WEAIT and the Trust furnished insurance to the employes herein, it never provided such information to the District. Such information is routinely provided by other insurance carriers as part of their unique benefits' packages.

52. Regulatory differences exist between health plans which are self-funded and those that are not. The former, unlike the latter, are not covered by the Wisconsin Insurance Security Fund which provides a mechanism to pay claims if an insurer goes bankrupt and which has an internal complaint procedure; are not required to make payment in thirty days; are not required to have minimum capitalization, reserve, and surplus requirements; and are not subject to various other such requirements. OCI also requires companies under its jurisdiction to maintain a proper mix of investments; to follow certain claims' procedures and to respond to claims within ten (10) days; to not discriminate against insured; and to meet certain requirements before they can self-fund. In addition, OCI reviews insurance companies' marketing conduct and it has the power to investigate and resolve consumer complaints against companies and their agents. OCI does conduct financial audits for self-funded plans and it requires them to file certain annual statements. The District's plan on file with OCI states that it is on an incurred and paid basis, even though applicable regulations require that it be on an incurred basis - i.e. that all claims must be paid by the insurer during the plan's coverage, irrespective of when they are filed. The District also has not yet filed the required actuarial certification which must accompany said filing. The District, per OCI regulations, has established a separate Fund 74 account for the payment of any claims.

53. The Association on August 28, 1987, filed a lawsuit with the Circuit Court of Dodge County, Wisconsin, seeking an injunction against the District's proposed self-funding plan. The parties at that time agreed that the District would not self-fund pending a determination by the Commission over whether such a matter had to be bargained. 3/ The lawsuit was subsequently dismissed on January 9, 1989, without prejudice and without reaching the merits, pursuant to the agreement of both parties.

54. Earlier, Association President Maciejewski by letter dated June 18, 1987, to Bushke stated, inter alia, that the Association wanted to bargain with the District over any proposed decision to establish a self-funded health care plans. Bushke orally responded that the District still intended to go ahead with its self-funding plans. Once the aforementioned lawsuit was filed, the District suspended its plans to implement a self-funded plan with other school districts.

55. By letter dated August 15, 1987, Maciejewski informed Bushke, inter alia: "It is the position of the Association that the action of the District is in violation of the Master Agreement and the State Bargaining Law. It is our contention that the proper vehicle for such change is the bargaining process."

56. Bushke on December 1, 1987, informed Maciejewski that the District's self-funded health and dental plans would become effective January 1, 1988.

57. Maciejewski by letter dated December 21, 1987, to Bushke protested the District's decision to self-fund stating, inter alia, that "The Association presently has on the [bargaining] table a proposal that will prohibit the District from self-funding without the agreement of the Association"; that the District's unilateral decision to self-fund violated the contract and constituted a mandatory subject of bargaining; and that, "the District proceeds at its peril should it implement the self-funded health and dental plans without an agreement with the Association or, a grievance or interest arbitration award authorizing the District's action."

58. Maciejewski on August 11, 1987, verbally requested from Bushke certain information regarding the District's decision to self-fund and subsequently confirmed that request in an August 18, 1987, letter to Bushke which asked for the following information:

1. Estimated claims for year _____; 2. Administrative cost $_____ or _____%; 3.

1/ The Commission in November, 1987 announced that it would not rule on the matter in the declaratory ruling proceeding brought by other school districts.

Specific stop-loss $_____ per individual cost $_____; 4. Aggregate stop-loss % _____ _____ cost; 5. Commissions $_____; 6. Start up cost $_____; 7. Basis of stop-loss Paid and incurred; Incurred; Paid; 8. Rate (premium) $_____; 9. Amount of reserves $_____; 10. Copy of the proposal document including fee schedule and schedule of benefits; 11. Administrative services agreement; 12. Copies of the policies for stop-loss and aggregate insurances; and 13. Sample of information PAS will provide the District.

. . .

Bushke orally told Maciejewski at that time that he did not have said information.

59. Bushke by then had discussions with PAS President Eugene Jenson regarding PAS being the third party administrator for the District's proposed self-funded plan. When Jenson met with the District in August, 1987, he presented a preliminary conceptual discussion regarding self-funding. At that time, it would have taken another 2-3 months to obtain a contract from a reinsurance carrier such as Transamerica. Jenson then did not have any costing information regarding the stop-loss premium that the District would have to pay if it self-funded on its own.

60. Bushke did not forward Maciejewski's August 11, 1987, letter to PAS and he did not respond to it because he believed the issue was moot given the District's decision to delay self-funding; because the District in any event did not have the information requested; and because the data then available from PAS was based on the assumption that the self-funded plans also included two (2) other school districts which had decided to pull out of the proposed plan. Said data was never produced because Bushke told PAS that the District had changed its mind and would not switch to self-funding at the beginning of the 1987-1988 school year, as originally planed. Maciejewski subsequently orally asked Bushke for said information on three to four occasions and he replied that he did not have it. At no time did Maciejewski ever tell Bushke that he had a duty to obtain it and that the Association would file a prohibited practice complaint if it were not supplied.

61. By letter dated December 17, 1987, Maciejewski informed Bushke, inter alia, that: "I have repeatedly requested most of the following information" and requested that the District provide the following information by December 23, 1987:

1.What is the total budget for 1987-88 for health and dental insurance for employees of the Mayville School District? _____

2.What is the insurance premium cost for

Health
Single _____ Family _____
Dental
Single _____ Family _____
How was this figure arrived at? _____
_____
_____

3.What are the dates of the benefit year? _____ to _____

4.What amount have you estimated claims might be for the benefit year?
Health _____ Dental _____

5.What amount has been set aside for reserves?
_____

6.Please specify amounts of the components of administrative cost:
A. Printing _____
B. Start up _____
C. Processing _____
D. Consultation _____
E. Commission _____
F. Other Administrative Costs _____

7.Stop Loss Insurance
Name of carrier _____
On what basis is this carried? Incurred-Paid _____ or incurred and paid _____. If incurred and paid, specify months covered by the incurred period.
Attachment point of aggregate stop loss insurance _____
Attachment point of specific (personal) stop loss insurance _____
Premium for aggregate stop loss insurance _____

Premium for specific (personal) stop loss insurance
_____

Said letter also requested:

1.Complete copy of the plan to be administered.
2.Complete copy of the administrative services agreement.
3.A copy of the enrollment card.
4.Sample of all reports provided to the district.
5.Copy of PAS' initial proposal to the district and bid.
6.Copies of all correspondence between the district and PAS regarding the creation of a self-funded insurance and dental plan.
7.Copies of communication with legal counsel about the creation of a self-funding insurance plan.
8.Explanation of who is responsible and to what degree for legal costs heretofore borne by indemnified insurance carriers.

Thank you in advance for your prompt and courteous attention to this long overdue matter.

. . .

62. By letter dated December 22, 1987, Bushke informed Maciejewski that:

This letter is in regard to your December 17th letter, requesting information on our self-funded insurance. I note in the letter that you have asked I have this material to you by Wednesday, December 23rd. Please be

advised that I will not be able to have this information for you at this time. I have forwarded your letter to PAS in Madison for their completion of this letter as soon as I receive the completed information from them, I will forward a copy on to you.

By letter dated December 22, 1987, Bushke forwarded Maciejewski's request to PAS and asked PAS to respond to it.

63. Having not yet received any of the requested information, Attorney Ellen J. Henningsen on behalf of the Association by letter dated January 21, 1988, to Bushke complained about the District's failure to provide same information and stated that unless it was received by January 26, 1988, she would file a lawsuit to obtain same under Wisconsin's open records' law. Attorney Edward J. Williams on behalf of the District replied that all of the information had not yet been compiled and that as soon as it was, it would be supplied.

64. The District provided said information to the Association on or about February 2, 1988. Some of the information in Maciejewski's December 17, 1987, letter had to be supplied by the reinsurance carrier, as PAS at that time was unable to provide it on its own. The District on December 17, 1987, was able to provide the Association with requested information relating to the total budget for health and dental insurance in 1987-1989; the premium costs for the health and dental plans; the dates for the benefit year; the amount of expected health claims; the various components for administrative costs; and stop-loss insurance. It also could have provided the Association with a complete copy of the administrative services agreement; samples of reports; and a copy of PAS's initial proposal to the District and bid.

65. Maciejewski by letter dated January 11, 1988, advised the Association's membership: "If anybody experiences any problems with their health or dental insurance, please let me know. We are building a file on this." To that end, she prepared a form which teachers could fill out and she thereafter collected said complaints and forms regarding the District's self-funded health and dental plans. No previous effort had ever been made to track employe complaints during the time that the Trust or WEAIT provided insurance.

66. Maciewjewski brought about nine (9) to ten (10) complaints to PAS and Bushke's attention, all of which were eventually resolved.

Based upon the foregoing Findings of Fact, the Examiner makes and issues the following

CONCLUSIONS OF LAW

1. The Mayville School District and the Board of Education of the Mayville School District did not violate Sec. 111.70(3)(a)(4), Wis. Stats. when they terminated the previous health and dental plans offered by WEAIT and Blue Cross and when they unilaterally implemented self-funded health and dental insurance plans at the expiration of the 1986-1987 contract.

2. The Mayville School District and the Board of Education of the Mayville School District did not improperly reduce and/or change benefits in said plans and thus did not violate Sec. 111.70(3)(a)(4), Wis. Stats.

3. The Mayville School District and the Board of Education of the Mayville School District did not violate Sec. 111.70(3)(a)(4), Wis. Stats. when they failed to earlier provide the Mayville Education Association with certain requested information regarding its self-funded health and dental plans.

On the basis of the above and foregoing Findings of Fact and Conclusions of Law, the Examiner makes the following

ORDER 4/

IT IS ORDERED that the complaint filed in this matter be, and it hereby is, dismissed in its entirety.

Dated at Madison, Wisconsin this 20th day of June, 1990.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By _____
Amedeo Greco, 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.

(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 order 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.

MEMORANDUM ACCOMPANYING FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

BACKGROUND

The Association charges that the District acted unlawfully and violated Sec. 111.70(3)(a)(4), Wis. Stats. by: (1) unilaterally terminating the health and dental plans previously provided by the WEAIT and WPS at the termination of the 1986-1987 contract and by switching over to its self-funded health and dental plans without first bargaining with the Association; (2) reducing and/or changing benefits in said plans; and (3), refusing to supply the Association with certain information relating to the District's self-funded plans. As a remedy, it requests an order finding that these actions were unlawful; that a cease and desist order be issued which prohibits the District from doing so again; that bargaining unit members be made whole; that the status quo ante be restored by ordering the District to reinstate the insurance coverage previously provided by WEAIT and Blue Cross; and that an appropriate remedial order be posted.

It thus argues that the identity of an insurance carrier and/or administrator of a health benefit plan is a mandatory subject of bargaining under Madison Metropolitan School District Dec. No. 22129, 22130 (11/84) aff'd, Madison Metropolitan School District v. WERC, 133 Wis.2d 462 (CtApp, 1986), petition for review denied, 134 N.W. 2d 457 (1987), and Milwaukee Board of School Directors, Dec. No. 23208-A (2/87); that the decision to self-fund health and dental care benefits is a mandatory subject of bargaining; that the District was required to maintain the status quo during the contract hiatus by retaining its prior insurance coverage until the parties reached agreement or until an appropriate interest award was issued providing otherwise; and that it has never waived, "by contract language or past practice," its right to bargain over self-funding.

The Association also claims that the District unlawfully reduced and/or changed benefit levels by failing to promptly pay claims; by breaching the confidentiality of patient records; by failing to provide benefits covered by the plan and involving such matters as a mail order drug plan, birth control pills and orthotics; by issuing health care identification cards which were not as acceptable as the prior WEAIT and WPS cards; by failing to provide a toll-free number for teachers who had questions about the insurance plans; by incorrectly coordinating prescription drug benefits; by reducing reasonable and customary fee levels; by making ineffective and untimely response to inquiries; by improperly processing claims; and by shifting the burden to employes regarding payment problems. The Association also contends that the requested information was available "long before" February 2, 1988, when it was finally provided and that the District's failure to provide it before then was unlawful.

The District, in turn, maintains that its decision to self-fund health care and dental benefits is a permissive subject of bargaining because the Commission's decision in Madison cannot be applied in this case and because the Association's proposed expansion of Milwaukee should be rejected. It also states that it maintained the status quo during the contract hiatus because it was free under City of Brookfield, Dec. No. 19822-C (11/84), to exercise its contractual right to change carriers if benefit levels remained the same, which they have. Furthermore, the District states that these complaint allegations should be dismissed because the Association has waived its claim that benefits have been reduced; because some of its allegations are barred by the statute of limitations; because the Association's claim of reduced benefits is not credible and is not supported by the "totality of the record"; and because the few real problems are not representative of the parties' overall favorable experience under the plan and thus do not represent a change in the status quo. It also contends that it did not have all of the information sought by the Association dealing with its self-funded plans until February 2, 1988, when it gave the Association the information it had.

The District initially claimed that the Association should have grieved the issues herein. Later on, and after extensive testimony had been received, the District at the hearing dropped its deferral argument. Accordingly, and because the Association agreed at the hearing that it would not grieve any of the matters herein, and because there is no point in requiring the parties to relitigate these issues in yet another forum, it is appropriate to exercise the Commission's jurisdiction to resolve these issues in this proceeding.

As a preliminary matter, it must be noted that this is an extraordinarily complex record, with the transcript of the ten (10) days of hearing totaling 1924 pages. In addition, the District has filed a 134 page brief and the Association has filed a 50 page brief and 84 page reply brief. There are also about 142 exhibits.

In such circumstances, it is impossible here to answer every single argument advanced by the parties and to comment on the myriad factual issues raised by such a long and detailed record. It suffices to say that all such

matters have been considered and that the discussion herein is limited to the most salient aspects of this case.

1. THE DISTRICT'S DECISION TO SELF-FUND:

Both parties agree that the District was required during the contract hiatus to maintain the status quo. They differ, however, as to what constituted the status quo, with the Association claiming, and the District denying, that the decision to establish self-funded health and dental insurance plans represented a departure in the status quo. The parties also disagree over whether Madison dictates finding here that the identity of a health insurance provider constitutes a mandatory subject of bargaining.

In Madison, the Commission ruled that it was, because the record before it revealed that "all insurance carriers and/or administrators involved herein provide unique benefit packages" regarding how they administered and interpreted the provisions of even identical benefit plans. The Commission thus noted:

> 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 plans."

Madison was sustained on appeal, with the court of appeals ruling:

> There also was evidence that carriers' ability to respond to claims inquiries can vary. Some are able to respond immediately or within twenty-four hours, and other may take up to two weeks to do so. The insurers vary, too, in the manner in which employees are able to monitor the progress of their claims. Some carriers offer readily accessible assistance and information services to claimants, while others limit or deny direct access to claims personnel. There are differences, too, in the nature and cost of conversion plans upon termination of employment, in claim filing procedures, and in the procedures for obtaining review of denied claims." Id. at 469.

The Commission's decision in Madison was a narrow one and limited to the facts in that case, with the Commission stating: "Our conclusion herein is tied directly to this record and, while this record may be a relevant consideration in future cases, proof as to change or lack thereof in the industry will be necessary."

At the instant hearing, and after several days of testimony, I advised the parties that Madison indicated that a change in insurance carriers is a mandatory subject of bargaining because of the various changes incurred in administering even identical health insurance plans and that the record here showed that the Association had met its burden on that issue. The District takes issue with this and argues that reliance upon Madison violates its right to due process because it was not a party to that case; that it is inappropriate to consider what industry-wide evidence is on this matter; and that the Association has not met its burden of proof under Madison.

I disagree. Madison in fact, at least as I understand it, represents a generalized overview of what changes can occur under different health care providers, one which is not necessarily true in all instances and one which the parties themselves can challenge via the production of evidence in their own proceedings. In addition, I do not read Madison as shifting the burden of proof from a complainant, where it properly belongs, to a respondent.

Here, the Association has met its burden of proof in establishing that different providers and/or interpretative entities bring about changes in how benefit plans are administered, even if they on their face provide for identical benefits.

Thus, PAS President Eugene Jenson testified that "Every Company is different" because they have different personalities; because they have different underwriting standards; because they have different error rates; because they interpret identical insurance phrases differently; and because they differ among themselves on how fast to process claims. Jenson also testified "There's no two carriers that process the same timewise. There's different bureaucratic structures, different emphasis. Some emphasize marketing, other emphasize claims. Some emphasize both." The same, he said,

is also true of third party administrators.

Donald Cleasby, a Legislative Attorney with OCI, testified that various providers differently apply the terms "reasonable and customary" and "medically necessary," hence providing different payment practices; that they have different standards as to how much information they require before paying claims; and that they have different policies relating to employes who want to join a plan after the open enrollment has passed.

David Huttleston, President of Huttleston Associates, Inc. and a consulting actuary who has done work for WEAIT and the Trust, testified that there is much more diversity among insurance companies today than at the time of Madison because whereas only three (3) insurance companies had seventy (70) percent of Wisconsin's business in 1982, fifteen (15) to sixteen (16) companies today account for 70 percent of the business, hence producing much more diversity in the industry. He added that it thus is now impossible to obtain identical interpretation/administration of identical plan benefits regarding such issues as to what is "reasonable and customary," "medically necessary," and that there are significant differences in how different providers process claims. Indeed, Huttleson testified that it is impossible to even get the identical coverage from the same carrier for the same plan because court cases, changing medical technology, and changes in administration all serve to make this area one of considerable flux.

Maurice Nielsen, Senior Vice President and Manager of ALTA - the largest independent administrator of health care claims in the nation - and PAS Executive Vice President Thomas O'Meara, both essentially corroborated the foregoing testimony and said that entities vary in the amount of time they take to process claims. O'Meara also added "Interpretation is always a problem."

James Utrie, WEAIT's Director of Group Operations, testified to the same general effect and said that different carriers/administrators differ in how they administer identical language, in their billing cycles, in their acceptance of changing medical technology, and that different providers require different information for the payment of claims.

Given this exhaustive evidence that differences exist between WEAIT on the one hand, and the District and PAS on the other hand in how they administer the benefits' package herein, I find that said differences primarily impact upon the employes' wages and that they constitute a mandatory subject of bargaining. This finding is based upon the facts in this record and not the record developed in Madison. Thus, there is no merit to any assertion that mere consideration of Madison represents a per se violation of procedural due process.

In this connection, the Association points out that the Commission ruled in Milwaukee Board of School Directors, Dec. No. 22804-B, 24287-A, 3/89), that a decision to self-fund could be a mandatory subject of bargaining if there is a change in the entity that interprets the plan; if there is a chance that state mandated benefits could be lost; and if there is a risk that incurred claims would not be paid in the event of employer insolvency. The Association argues that the District's self-funded plans run afoul of Milwaukee because they do not automatically include mandated benefits and because the District's financial resources are not as strong as WEAIT's.

Here, though, the District's plans states that they "shall incorporate state mandated benefits to the same extent as the predecessor plan" and the District pursuant thereto is offering state mandated benefits as part of its health plans, a point not disputed by the Association. Accordingly, there is no basis for finding that it is violating the status quo in this regard. Furthermore, if the Association in the future ever feels that all mandated benefits are not being provided, it is free to grieve that issue under the contractual grievance-arbitration procedure, just as it is free to grieve over other claimed violations of the contract. 5/

There likewise is no merit to the Association's allegation that the financial underpinnings of the District's self-funded plans are shaky and warrant finding that employe claims might not be paid because of the District's insolvency. Thus, the District points out that it has the power to tax under Sec. 120.12(3), Wis. Stats. to meet its financial obligations; that it likewise has the statutory ability to engage in short-term borrowing under Sec. 120.13(29) Wis. Stats. to pay off any claims; and that unlike regular insurance carriers, it cannot as a practical matter go bankrupt. 6/ In addition, the District has taken reasonable steps to properly finance its self-funded health plans by taking out specific and aggregate stop loss coverage in

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3/ The legal question of whether state mandated benefits must be offered in self-funded plans pursuant to pertinent insurance statutes does not have to be resolved here inasmuch as the District has agreed to provide them and in fact is doing so.

4/ Cleasby acknowledged that he could not envision how a public sector self-funded plan could ever become bankrupt.

the amount of $20,000 and about $294,000 respectively, whereby the underwriter, Transamerica, will pay for claims over those amounts. The District is also covered by a super-aggregate of nearly $900,000 which is provided by the Transamerica to protect beneficiaries in the event of plan cancellation and claims' run-off. In addition, prudent funding rates for the plans were independently established by underwriters of Stop-Loss International on behalf of Transamerica.

Commenting on the financial validity of the District's plans, ALTA representative Nielsen testified:

> Well, the specific and aggregate stop-loss policies, the base are the typical level benefits that you expect to find except the specific stop-loss level of $20,000 given the paid claim level is probably a little bit conservative, but that's not at all that unusual, I guess.

Going on, he stated that "compared to a private sector employes, it would be considered to be conservative, I would guess." and that they were adequate. Since the record supports this assessment, I credit Nielsen's testimony in its entirety and find that the District's self-funded plans are financially strong enough to provide for the benefits in issue. 7/

To be sure, they do not answer all of the Association's concerns of what might happen under a Doomsday scenario which envisions the very worst and which involves such matters as the failure to provide for the litigation of claims; whether the stop-loss carrier will interpret the plan the same as the District; what happens if the District refuses to pay a claim; the failure of the stop-loss policy to pay for all prior claims; the exclusion of nervous and mental disorders from the stop-loss figure; the failure to count prescription drugs toward the deductibles; and the plan's failure to be established on an incurred basis (the District has stated it will cure this latter problem.)

But the District correctly notes that "The Commission's concern for adequate stop-loss insurance expressed in Milwaukee Board goes to sensibly insuring against definable risks. It does not go to insuring against any imaginable hypothetical risk that the Union can cook up." That is all the more so where, as here, the Association acknowledged at the hearing that it was not claiming that the District is facing any financial difficulties regarding any aspects of its operations. Hence, it must be concluded that the District's self-funded plans are financially sound.

In this connection, it also must be noted the status quo here involves more than adhering to the continuation of the wages, hours, and conditions of employment in effect at the time the 1986-1987 contract expired: As noted by the Commission in such cases as School District of Wisconsin Rapids, Dec. No. 19084-C (WERC, 3/83), the status quo is also determined "by its terms or as historically applied or as clarified by bargaining history. . . ." In the context here, it therefore is necessary to examine just how health and dental benefits have been provided to bargaining unit members in the past.

Said review shows that the Trust itself for about ten (10) years provided health benefits on a self-funded basis without any reinsurance or stop-loss coverage. In addition, WEAIT in 1986-1987 had a revenue short-fall of over $8,000,000 and a net operating loss of nearly $800,000 in 1988, thereby showing that it was not in the best financial shape. While WEAIT's financial strength has since improved, the District's self-funded plans here exceed the financial safeguards previously provided for by the Trust and WEAIT. In the face of this mixed practice dating back to 1974 - which shows that the District selected a self-funded insurance provider which did not meet all of the financial requirements now urged by the Association - there is no merit to the Association's assertion that the District is now, suddenly, required to match every single feature of WEAIT's present insurance program when those features have only been recently instituted and when the Association itself never once complained about either WEAIT's or the Trust's own financial shortcomings over a ten (10) year period.

The same is true for the Association's claim that the District has violated the status quo because self-funding is not as closely regulated by the OCI. In this connection, and as noted in Finding of Fact No. 52, the record indeed shows differences between how the OCI regulates self-funded plans and insurance carriers such as WEAIT, since regulated plans are covered by the Wisconsin Income Security Fund; are required to offer mandated benefits; to make payment within thirty (30) days; to have minimum capitalization, reserve, and surplus requirements; to maintain a certain mix of investments, etc.

5/ Huttleson testified that the plans were not financially strong. Since he has done work on a paid basis for WEAIT, I credit Nielsen's testimony over his since Nielsen has no self-interest in this matter and since the totality of Nielsen's testimony was more accurate.

However, the Association has failed to show how any of the employes herein have been adversely affected by these differences, thereby making its concerns more theoretical than real. Furthermore, the OCI does have regulatory authority over certain other matters by regulating Transamerica, the underwriter which has contracted with the District and by also exercising other enforcement power over self-funded plans. In addition, the record here shows a mixed past practice because the Trust itself for about ten (10) years asserted that it was not subject to OCI jurisdiction, thereby effectively denying to the employes herein the very protections which the Association now, suddenly, asserts are of such fundamental importance. Given all of this, it follows that total regulatory authority over the health plans herein was not part of the status quo, and that, as a result, it need not be provided now. 8/

The Association also argues that the District's self-funded plan is inadequate because it is not protected by the Wisconsin Insurance Security Fund and which is provided for under Ch. 646 Wis. Stats. Again, the Association has failed to prove that the Trust itself was ever covered by the Fund during the time it provided health insurance on a self-funded basis, hence failing to prove that this was part of the status quo which the District is now required to maintain. Moreover, even assuming arguendo that it was covered by the Fund, the District is not required to offer the same protection because, as noted below, the status quo doctrine enabled the District to switch over to self-funding and the accompanying regulatory differences it brings.

As to the decision to self-fund, the expired 1986-1987 collective bargaining agreement provided that "the Board agrees to continue to carry group hospital/surgical insurance at not less than current benefit levels." There is nothing in this language - or in any other part of the contract for that matter - which either names WEAIT or WPS as the health and dental insurance carriers or which precludes the District from providing such benefits on a self-funded basis if benefit levels remain the same. Indeed, even though the Association is now asserting that the District is required to provide insurance through WEAIT, it is undisputed that the Trust was only named in a contract once - and that was in 1972-1974.

In addition, the District in the past under this language has twice before unilaterally changed health insurance carriers without any objection from the Association. Furthermore, the Trust itself provided health insurance benefits between 1974-1985 on a self-funding basis without any objection from the Association or any employes. In such circumstances, it is clear that a practice arose whereby the District was free to unilaterally drop prior insurance carriers at the expiration of the 1986-1987 contract and to provide health care benefits on a self-funded basis, just as the Trust did for about ten (10) years.

It therefore was the Association, not the District, which tried to change the status quo at the expiration of the 1986-1987 contract when it unsuccessfully arbitrated the question of whether the WEAIT and WPS should be identified and retained as the health care providers in the contract. That is why Arbitrator Jos. B. Kerkman ruled in his February 17, 1989, interest arbitration award that "the Association has failed to make its case that a change is necessary" and that "the Association proposes a change in the language when it proposes to negate the provision which permits the Employer to change insurance carriers during the life of the Agreement so long as the benefit levels are maintained" (Emphasis added.) His ruling accurately describes what is really involved in this case and what is independently established in this record, i.e., that the Association is seeking to change the status quo under which the District for ten (10) years provided health care benefits on a self-funded basis.

The Association tries to get around this practice - which cuts this part of its case to shreds - by claiming that self-funding by the District is not "insurance" as that term is used in the contract and that it did not clearly and unmistakably waive its right to bargain over same because there are "just too many fundamental differences between insurance and self-funding" to find a waiver, particularly when it did not know anything about self-funding in 1974 and when this issue never arose in any subsequent contract negotiations before 1987. Going on, it asserts that the District has failed to prove that the Association ever knew that the Trust was self-funded and that, as a result, "it cannot be said that the Association accepted the practice. Although the Association was in some distant way associated with the Trust, this Association is too remote to impute knowledge."

"Some distant way"? The record here, in fact, establishes that the Association at all times material herein has been a WEAC local and that WEAC has controlled the Trust and WEAIT from their very inception - lock, stock, and barrel. Thus, WEAC appoints all of the Trust's trustees, who in turn, select all of WEAIT's Board of Directors. In addition, the Trust is WEAIT's sole shareholder; the directors for WEAIT and the Trust are comprised of the same individuals; WEAIT is under the exclusive management and control of the Trust;

6/ It thus is immaterial that the OCI may not regulate state mandated benefits under self-funded plans since the record here establishes that OCI did not regulate the Trust for the approximately ten (10) years that it provided health insurance and state mandated benefits on a self-funded basis, thereby establishing that the status quo does not require any such regulation now.

the Trust and WEAIT have the same business address; and the Trust determines insurance rates, secures all reinsurance, determines commissions and indemnifies WEAIT. All this is why WEAIT told OCI in 1985 that it might seek to do business in other jurisdictions "with the consent of the Wisconsin Education Association, Inc. . . ." and why an OCI staffer at the time described this relationship as a "fronting agreement."

The District is thus quite right when it states: "the people who serve as directors of the Wisconsin Education Association Council and the WEA, Inc., have appointed the Board of Directors for [WEAIT]. Therefore, while there may be a distinction between these entities on paper, they are closely tied and ultimately subject to the appointive control of the Mayville Education Association's parent organization." As a result, the Association and/or the WEAC representatives who service this local either knew, or should have known, that the health insurance benefits provided by the Trust between 1974-1985 were on a self-funded basis because they had the duty to find out just what kind of health benefits they were negotiating and how they were being provided.

Moreover, the Association agreed to let the District change insurance providers conditioned only on the District's obligation to maintain the present level of benefits which are spelled out in Appendix C of the contract. 9/ The reference to "insurance" in the contract therefore encompasses self-funding, because the latter is a form of insurance and because the two phrases are used interchangeably in common usage. Thus, Webster's Third New International Dictionary defines insurance as "coverage by contract whereby for a stipulated consideration one party undertakes to indemnify or guarantee another against loss by a specified contingency or peril." That is exactly the kind of guarantee and indemnification that the parties had here during the ten (10) years that the Trust provided insurance on a self-funded basis.

The Association itself tacitly recognizes this when it asserts in its brief that for the decade prior to January 1, 1988, bargaining unit members were covered by a health insurer which, in its words, "acted like an insurance company in terms of its policies and practices. . . " The Trust "acted" that way because it provided health "insurance" as that term is commonly understood without regard as to whether or not it did so on a self-funded basis. That is why Utrie admitted that the Trust "operated like an insurance company in all other respects."

Arbitrator Kerkman certainly recognized that the District's current self-funded plans constitute insurance, as he stated that the District under the expired contract was entitled to change insurance providers and to establish the self-funded plans in issue. The court in Lancaster Education Association v. Lancaster Community School District, Case No. 87-CU-575, November 30, 1987, reached the same conclusion when it ruled that a school district was not required to bargain over its decision to self-fund under contract language giving it the right to change insurance providers because: "the program of partially self-funded insurance contemplated by the defendants to provide health and dental coverage . . . is not prohibited by the 1986-1987 collective bargaining agreement and said insurance program does fit within the general definition of insurance . . ." Going on, the Court noted that:

> (a) There is no evidence that the meaning of the terms "insurance" and "premium" reflected in said collective bargaining agreement was understood by the parties in negotiations to be anything other than the commonly understood meaning of the terms "insurance and premium."

The same is true here.

In addition, Sec. 120.13(2) Wis. Stats. treats self-funding as insurance by providing:

> (2) INSURANCE. (a) Provide for accident insurance covering pupils in the school district. Such insurance shall not be paid from school district funds unless the expenditure in authorized by an annual meeting.
>
> (b) Provide health care benefits on a self-insured basis to the employes of the school district if the school district has at least 100 employes. In addition, any 2 or more school districts which together have at least 100 employes may jointly provide health care benefits on a self-insured basis to employes of the school districts.
>
> (c) Any self-insurance plan under par. (b) which covers less than 1,000 employes shall include excess of stoploss reinsurance obtained through an insurer authorized to do business in this state, for the

7/ While challenging the District's self-funded decision, Attorney Ellen J. Henningsen stipulated on the first day of hearing that the District under the contract had the right to change insurance carriers.

purpose of covering all eligible claims incurred during the term of the policy or contract.

(d) The commissioner of insurance may prescribe detained requirements for reinsurance under par. (c) by rule or by order. The commissioner of insurance may promulgate rules governing self-insurance plans under par. (b) to (f) to ensure that they comply with all applicable provisions of chs. 600 to 647.

(e) All personally identifiable medical and claims records relating to any self-insurance plan under par. (b) shall be kept confidential by the administrator of the self-insurance plan and shall exempt from disclosure pursuant to s. 19.36(1). This paragraph does not prohibit the release of personally identifiable records to school district personnel, to the extent that performance of their duties requires access to the records, but only with the prior written informed consent of the insured.

(f) A separate audit of the self-insurance plan shall be conducted annually and the results shall be made available to the school district and the department.

The Association asserts that because the District was not allowed to self-fund before Sec. 120.13, Wis. Stats. was enacted in 1985, it should not be charged with anticipating that the District might switch to self-funding at the expiration of the 1986-1987 contract. This argument overlooks the fact that the term "insurance" in the contract before then was interpreted by both parties to mean self-funding when the Trust provided same for about ten (10) years and that there is nothing in the contract which states that self-funding is to be allowed only when the Trust and/or WEAIT provide it. In addition, Sec. 120.13 Wis. Stats. became effective July 20, 1985, before the parties herein reached agreement on their 1985-1986 contract, 10/ thereby putting the Association on notice that the District was legally entitled to switch over to self-funding if it so desired.

In support of its contrary position, the Association cites County of Northhampton, PA, 87 LA 1051 (1986), where arbitrator Thomas J. DiLauro ruled that a county could not self-fund. That case is inapposite, however, because the Trust here provided self-funded insurance under the pertinent contract language for nearly a decade, hence establishing a well established practice to that effect; that was not the case in Northhampton. This is also why the Association's reliance on MTI Madison Metropolitan School District Dane County Circuit Court, Case No. 83-CV-3432, is misplaced.

Based upon the foregoing history - which shows that the District was free to choose whatever provider it wanted if it maintained current benefit levels and the (10) year practice in which health care benefits were provided on a self-funded basis without any complaint from either the Association or any teachers - it must be concluded the District was free to change health insurance providers at the expiration of the 1986-1987 contract and to establish its own self-funded health benefit plans without first bargaining with the Association, as that merely represented the status quo in this particular bargaining relationship.

The same is true for dental insurance because Article VI, Section N, of the 1986-1987 contract provides that:

> "The Board agrees to make available to each teacher, dental insurance on the following basis."
>
> . . .
>
> "Plan #702H. Comprehensive coverage for you and your dependents (dependent children covered up to age 25)."

Again, there is nothing in this language which requires the District to keep WPS or any other dental carrier so long as it provides the benefits bargained for - i.e. those spelled out in "Plan 702H." Thus, it is the benefits that have been bargained for, not the identity of the provider, as evidenced by the fact that "Plan 702H" is a Trust dental plan, one which under the 1986-1987 contract was provided by WPS, an entirely different insurance entity. Indeed, the record establishes that the Trust has never provided dental benefits to the teachers herein and that, furthermore, the Trust at the time this benefit was negotiated in the 1981-1982 contract provided dental benefits to employes in other school districts on a self-funded basis. Given all of this, the District was entitled at the expiration of the 1986-1987 contract to keep doing what it had always done, i.e. to unilaterally select a

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8/ I have taken administrative notice of Case No. 15, MED/ARB-3664 which shows that the Association filed a mediation/arbitration petition with the Commission on November 27, 1985, and that the parties thereafter reached agreement on a successor contract in April-May, 1986 - well after Section 120.13 Wis. Stats. became effective.

dental care provider which provided all of the benefits spelled out in "Plan 702H", even if it was on a self-funded basis.

In addition, there is yet another aspect of this controversy which must be considered - the Association's assertion that "the District never proposed to change the parties' contract language concerning health and dental insurance" and that "thus, Respondents never submitted to interest arbitration the issue of its right to self-fund."

This claim is only half true; for while the District did not propose a change, the Association most certainly did and it subsequently submitted this very issue to Arbitrator Kerkman who ruled against the Association on the self-funded issue and its attempt to change the status quo. This issue therefore was raised in the negotiations leading up to the successor 1987-1989 contract and it was ultimately resolved under Sec. 111.70(4)(cm), the statutory framework which provides for the resolution of such disputes before an interest arbitrator. As a result, the District's decision to self-fund for all practical purposes was subject to negotiations, with Arbitrator Kerkman upholding the District's right to self-fund throughout the duration of the 1987-1989 contract which runs from July 1, 1987 - June 30, 1989.

This complaint allegation therefore is dismissed.

2. THE ALLEGED CHANGES AND REDUCTION IN BENEFITS.

The Association's second major complaint allegation charges that the District changed and/or reduced health benefits during the contract hiatus when it turned to self-funding.

Some changes, of course, were to be expected because the changeover from WEAIT and WPS to self-funding entailed a switch in insurance providers and administrators, thereby bringing about changes in the unique health benefit packages previously offered. Since the District had the right to change providers and administrators during the contract hiatus for the reasons just noted, maintenance of the status quo therefore must allow for some changes in these benefit packages. That is why the District was not required to maintain the identical unique benefits' packages previously offered by WEAIT and WPS.

By the same token, it was only natural that changing insurance providers would create certain problems when the new health and dental plans were implemented in the beginning of 1988, as both employes and the providers became familiar with each other and how the new self-funding plans were to operate. Again, the status quo doctrine must allow for some reasonable changes in this area.

It also must recognize the problems and uncertainties which are inherent in any health care benefits plan and which include such matters as whether new medical services and new drugs are covered under the plan; whether doctor and hospital bills are in the right amount; whether a particular medical service is medically necessary; and whether medical services are to be paid for by either the prior carrier or the present carrier. This is why insurance providers such as WEAIT and PAS have established internal procedures which enable policy-holders to challenge and question any problems they have regarding the administration of their health care plans. The status quo therefore is not necessarily violated when these inevitable problems surface.

The record here also shows that about 6,000 claims were filed by the time of the instant hearing and that the Association only complains about forty (40) of them. Hence, the overwhelming majority of claims were processed without any difficulty, thereby establishing that the self-funded health and dental plans herein generally ran very well.

Insurance companies also routinely incur delays when they are faced with "unclean claims", i.e. claims which are incomplete and/or in dispute. Utrie thus testified that while "clean claims" at the WEAIT are usually processed within 12-20 days, "unclean claims" can take months and that payment practices at WEAIT at times are "all over the map." Here, about 95 percent of all claims filed with PAS were "clean" and thus were easily handled by computer; the others had to be adjusted and delayed, pending resolution of improper diagnosis, disputed claims, receipt of additional information, consolidation of bills, etc. In addition, payment delays occasionally are caused when the health care providers themselves delay in submitting their bills to PAS. As a result, some delays are to be expected under any health care plan.

The Association argues in this connection that since certain claims were received by PAS well before they were logged into its computer, "This testimony discredits every date of receipt that [Jenson] testified to." To the contrary, I credit Jenson's testimony in its entirety to the effect that claims were properly logged when they were submitted to PAS and that the few examples cited by the Association showing otherwise are exceptions to this general rule. 11/

9/ This finding is based upon Jenson's overall demeanor during the time that he testified, as he was totally candid and open in the face of very long, and detailed cross-examination which probed almost every aspect of PAS's

Furthermore, the record here establishes that any errors that did occur were inadvertent because the District throughout this matter has always taken the position that it is required to match the preexisting benefits offered by WEAIT and the WPS, and the record shows that it has always attempted to do so. That is why the District's health plan expressly provides:

> This plan, the School District of Mayville Health Care Benefit plan, is intended to duplicate the terms and conditions afforded by the predecessor plan of the WEAIT Corporation. To the extent that the terms expressed in this plan may be inconsistent with the terms expressed in the predecessor plan, such inconsistencies shall be resolved in favor of the terms of the predecessor agreement. (Emphasis added) 12/

The dental care plan has this same proviso.

The District and PAS therefore always have made good faith efforts to resolve any problems brought to their attention, a point acknowledged by Association President Maciejewski who testified that Bushke and PAS resolved all of the complaints she personally brought to their attention and that "if it is brought to the attention of PAS, "something is done about them eventually."

The same cannot be said for the Association. From almost the very first day that the District implemented its self-funded health and dental plans in January, 1988, it has made "book" on the District by cataloging every single employe complaint over the health and dental plans it could uncover pursuant to Maciejewski's January 11, 1988, letter to all employes stating: "If anybody experiences any problems with their health or dental insurance, please let me know. We are building a file on this."

These complaints were not amassed for the purpose of immediately bringing them to the District's attention so that they could be resolved as soon as possible; Maciejewski testified that they were prepared for the interest arbitration proceeding before Arbitrator Kerkman, apparently on the theory that he would select the Association's final offer dealing with the designation of the health care providers if it could prove that the District's self-funded plans are not working properly. While the Association certainly has the legal right to litigate in any forum it chooses, its lack of good faith in attempting to informally resolving these problems short of litigation and its microscopic examination for any flaws it could find in the District's self-funded plans must be factored into the question of whether some problems could have been worked out with some cooperation from either the Association or teachers herein 13/ and whether some of the alleged problems have been blown up out of proportion in order to achieve the overriding goal in this matter, i.e. to get rid of the District's self-funded plans at any cost.

It is within this framework - i.e. one which recognizes that the District had the right to change the unique benefits packages offered to its employes, that a change in health care providers inevitably generates some problems at the outset of the changeover, that questions and problems inevitably arise under almost any health care plans, and that the District and PAS made good faith efforts to resolve any problems brought to its attention, that the Association's allegations of reduced and changed benefits must be considered.

On the fourth day of hearing, and over the District's objection, I granted the Association's oral motion on May 10, 1989, to file an Amended Complaint which added some of these allegations, (the District subsequently filed a written Amended Complaint on July 3, 1989). The District argues that paragraphs 42 a, 45, 49 a, 49 b, 49 c, 50 a, 50 b, 52, and 55 a of the Amended Complaint fall outside the one (1) year statute of limitations spelled out in Sec. 111.07(14), Wis. Stats.; that the Association should not be permitted to amend the complaint more than a year after it has been filed to bring in entirely new claims which are different from the original complaint; and that the Association is barred from amending its existing complaint to challenge conduct which occurred more than one year prior to the amendment.

The law is otherwise. The original Complaint filed on January 5, 1988, centered on the District's self-funded health and dental plans and the

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operations.

10/ WEAIT representative Utrie acknowledged that the PAS plan and the predecessor WEAIT plan are identical as far as listing the required benefits, saying "The words say the same things."

11/ Arbitrator Kerkman himself commented on the Association's failure to informally resolve these problems, saying that "there is no showing that the present [grievance-arbitration] language has been tried and found wanting. In fact, it has not been tried at all."

amendments here all relate to that occurrence and the common set of facts which employes experienced once those plans were implemented. The matter therefore is governed by ERB 12.02(5) which provides:

> (5) AMENDMENT (a) WHO MAY AMEND Any complainant may amend the complaint upon motion, prior to the hearing by the commission, during the hearing by the commission if it is conducting the hearing, or by the commission member or examiner authorized by the board to conduct the hearing; and at any time prior to the issuance of an order based thereon by the commission, or commission member or examiner authorized to issue and make findings and orders." (Emphasis added).

ERB 1.01 also provides: "Purpose. These rules are adopted to aid the commission and interested persons in proceedings under the act. The commission may waive any requirement of these rules unless a party shows prejudice thereby." The Wisconsin Supreme Court under similar circumstances ruled in Korkow v. General Gas Co. of Wisconsin, 117 Wis.2d 187, at 189, 190, (1984)that "an amended pleading adding a separate claim by a different plaintiff may relate back to the date of filing of the original complaint if the requirements of Sec. 802.09(3), Stats. are satisfied and relation back will not cause unfairness or prejudice to the other party." It that is true for a different plaintiff, it obviously is also true when, as here, the complainants are the same.

Here, in granting the Association's Motion to Amend the Complaint at the hearing, the undersigned informed the District that it was entitled to take as much time as it wanted in presenting its defense to the Amended Complaint and that, if necessary, the hearing would be adjourned for that purpose. The District subsequently presented its defense without any apparent difficulty. Since the Amended Complaint therefore did not cause any unfairness or prejudice, it is proper to consider all of the Amended Complaint allegations.

As to the specific complaint allegations in issue, the Association asserts that the District violated patient confidentiality and breached Sec. 146.81(4) Wis. Stats., and Sec. 120.13(2)(e) Wis. Stats. 14/ in the beginning of 1988 when PAS supplied the District with claims' experience data showing the names of teachers and their health care providers (but not diagnosis).

This is one of the few issues the Association ever directly brought to Bushke's attention. He immediately responded by telling PAS that the District no longer wanted the identity of teachers and their medical providers. In this connection, Nielsen credibly testified such information was not confidential because it did not say what the diagnosis was, a point corroborated by O'Meara who credibly testified that when he worked at WPS, it regularly provided such information to employers because it was not considered a confidential disclosure. Jenson likewise credibly testified that such information is routinely provided in the insurance industry. Since different insurance providers do provide such information as part of their unique benefits' package, and since the District had the right to change insurance carriers, there was nothing wrong with the District receiving same particularly when, as here, it immediately stopped receiving said information after the Association complained about it.

Along the same line, the Association asserts that patient confidentiality was breached when the District - i.e. Bushke - had to personally approve whether to accept Paula Larson's husband into the health plan because of a preexisting condition. Ms. Larson testified here that PAS's representative Jeanette Harmon told her that Bushke had the final say in such matters. For her part, Harmon denied ever making any such statement and said that she, instead, told Larson that PAS, not the District, was ultimately responsible for making such determinations.

I credit Harmon's testimony because the plan, in fact, clearly lets PAS make this decision, and because Harmon's overall demeanor was more credible than Larson's. Accordingly, there is no basis for finding that patient confidentiality was breached in this instance.

The Association also asserts that the District improperly reduced and/or changed benefit levels in a number of areas:

It thus argues that the District improperly denied coverage for the treatment of TMJ - a facial bone condition - for teacher Jacqueline Berry's daughter. However, there was a bona fide dispute over whether the WEAIT would paid for same under its own plan and whether the treatment was medically necessary. That is why WEAIT at one point told Berry "Again, I must stress the need for pre-authorization, as many treatments that are being done are considered experimental and would not be a benefit regardless of the diagnosis." Once it was determined that WEAIT would have paid for this treatment, PAS paid it.

12/ The Association offers no case law to support its contention that the District's actions violated these provisions.

The Association also charges that PAS initially denied coverage for birth control pills even though WEAIT's plan provided for them. The District's plan in fact covers them, and the District has never claimed otherwise. Once this problem was brought to the District's attention, it told PAS that they were covered and PAS subsequently paid for them.

The Association also charges that the District has failed to duplicate the prior mail order drug plan. If fact, the District has always offered such a drug plan and, like WEAIT, it has waived the deductible. While the particular drug plans differ slightly in how they are ordered since employes now must pay for their own postage and since there is a limit on the quantity of drugs that can be ordered at one time, said administration forms part of a unique benefits' package which the District is not required to match in every detail.

The Association also charges that the District initially refused to pay for teacher Kit Hardie's orthodontics' treatment and that the District was very slow in paying a bill for same. In fact, the District does provide for this benefit and the slow payment was excused by the fact that PAS did not receive this bill until several months after this service was rendered.

The Association also charges that the District, unlike WEAIT, is not providing a toll-free number for teachers having questions or problems regarding the health care plans. In fact, the Hierl Agency does have a toll-free number and PAS accepts collect calls. Furthermore, providing a toll-free number is part of a unique benefits' package, one which the District does not have to match.

The Association also charges that the District improperly tried to coordinate benefits for prescription drugs even though the prior WEAIT plan provided otherwise. This confusion was largely attributed to the fact that the face of the WEAIT plan provided for the coordination of benefits, even though said provision was ignored. Once this was brought to the District's attention, it immediately rectified this situation by telling PAS that benefits should not be coordinated.

The Association also charges that the District reduced reasonable and customary fee levels by initially refusing to pay for certain medical services involving certain employes. Again, however, the record shows that the District did end up paying the proper amount in all these situations. Moreover, the District rightfully points out that fee levels are part of a unique benefits' package and that, as a result, the status quo does not require that they be identical to the prior plan.

The Association also charges that PAS unduly delayed paying certain claims, so much so that certain employes receiving dunning notices from certain medical providers. The record indeed shows, as noted in the foregoing Findings, that payment delays did occur. While some of those delays may be explained away because of the inherent payment problems found in any insurance plan, perhaps up to 10-15 claims can be attributed to carelessness or neglect on PAS's part. The number is relatively minuscule, however, when it is compared to the roughly 6,000 claims that PAS properly processed throughout this period. Furthermore, and as noted above, speed in the processing of claims is an integral part of any unique benefits' package, one which the District here was entitled to change at the expiration of the 1986-1987 contract. Accordingly, there is no basis for finding that these few delays represented any unlawful reduction or change of benefits.

The Association also charges that PAS did not properly process certain claims; that PAS's identification card was not as acceptable as the prior WEAIT and WPS cards; and that PAS make ineffective and untimely responses to certain employe complaints. The record bears out these complaints. Again, however, such matters form an integral part of any unique benefits' package offered by insurance providers, one which the District here was lawfully entitled to change.

The Association also asserts that the District unfairly placed an extra burden on employes to work out any problems they had regarding the administration of the District's self-funded plans and that said burden represented a change in benefits. But that, to one extent or the other, is true of any health care plan since employes everywhere must face the inevitable problems that go with them. That is why, for example, Utrie was a "troubleshooter" for WEAIT and why WEAIT, like PAS, maintains an internal appeals procedure to deal with them. This does not represent an alteration in benefits; it, instead, merely represents life.

Reviewing, we thus see that the District and PAs repeatedly rectified almost all problems brought to their attention and that, furthermore, questions and problems are inherent in any health delivery system, particularly when, as here, there is a change in carriers and when there is so much elasticity in providing and administering any health benefits' plan. Measured by this standard - which is the only one which can be properly applied as opposed to the absolute perfection test demanded by the Association - there is no merit to the claim that these relatively few problems rise to the level of any unlawful change or reduction in benefits.

In addition, if the overall totality of this record establishes one thing above all else, it is that the District and PAS have bent over backwards to accommodate and resolve all legitimate teacher concerns and that but for delayed payments in some cases, they have done a very good job in administering the plans herein.

Based upon the foregoing, this complaint allegation is therefore dismissed.

3. THE ALLEGED REFUSAL TO SUPPLY INFORMATION

Left, is the Association's assertion that the District refused to provide it with relevant information relating to the self-funded health and dental plans.

As to this, it is undisputed that Maciejewski by letter dated August 18, 1987, asked Bushke for certain detailed information; that the District did not supply it; that Maciejewski several times thereafter orally asked Bushke for it; and that Maciejewski followed up with a December 17, 1987, letter to Bushke asking for similar information; that Bushke replied in a December 22, 1987, letter that he did not have said information and that he was asking PAS to provide it; and that on the same day, he forwarded Maciejewski's request to PAS and asked it to respond to said request, which it subsequently did on February 2, 1988.

The District recognizes its duty to supply said information, but contends that it did not have all of the information sought when it was requested in August and December, 1987, and that it in fact supplied the Association with same as soon as it was obtained from PAS. The District thus argues: "When an employer explains why the requested information is unavailable and simultaneously takes steps to secure it, an employer does not breach the duty to provide information", and cites Racine Unified School District, Dec. No. 23094-A (6/86) in favor of said proposition. The Association disputes this claim and alleges that at least some of this information was available at the time it was requested and that the District acted unlawfully in delaying its production.

The Association's first request was made in August, 1987, when the District was considering establishing self-funded health and dental insurance plans with four (4) other school districts and at a time when the District was planning to switch to self-funding effective September 1, 1987. The information then requested was directly related to that joint plan and its implementation on that date. However, two (2) of the school districts decided in early August, 1987 against joining in with the District and the District decided against implementing self-funding at the beginning of the 1987-1988 school year after the Association brought the matter to court and after several school districts filed a declaratory ruling with the Commission regarding this general issue. That is why Bushke testified "the whole movement toward self-funding was at a standstill." Thereafter, the other two (2) school districts decided in the Fall of 1987 against giving self-funded with the District. The District therefore did not decide until late November, 1987 to self-fund on its own and it advised the Association of that fact on December 1, 1988.

This fluid situation prevented the District from obtaining most of the requested information when it was first requested. Thus, PAS representative O'Meara credibly testified that because some school districts changed their minds about joining in with the District in early August, 1987, he had to totally redo the original rating process all over again because his initial figures included the other school districts. However, he ceased those efforts once Bushke told him that the District in fact would not switch over to self-funding in September, 1987, as originally planned and that the court proceeding "stopped the rate making process." As a result, PAS never submitted any revised proposal to the District before November, 1987. O'Meara's testimony was corroborated by PAS President Jenson, whose testimony I credit, that as of August 1987, he could not provide the requested information because it is impossible to provide accurate rates and figures for a plan five months before its actual implementation and that, moreover, no formal proposal was made in to the District in September or October 1987 because other school districts were involved in discussions over pooling together for self-insurance purposes. He also pointed out that it would have taken about 2-3 months for underwriter Transamerica to provide much of the information the Association was seeking. Furthermore, even if Transamerica had provided said information at a later date, it would have been outdated and inaccurate because it could have had to be updated to take into account the fact that the District was establishing self-funded plans on its own, without the participation of any other school districts.

The District therefore rightfully notes "you can't give what you don't have" since it did not have the information sought in Maciejewski's August 18, 1987, letter at the time the request was made and since PAS at that time was unable to provide that information until it became clearer as to whether other school districts would be joining in with the District. Accordingly, the District's failure to immediately provide the information sought in the August 18, 1987, request was reasonable under these circumstances.

Maciejewski's December 22, 1987, request for similar information is another matter. By that time, the situation had become much clearer because the District by then had decided to self-fund on its own without the participation of any other school districts and because it had already decided to implement its self-funded plans effective January 1, 1988. The lack of certainty which surrounded Maciejewski's earlier August, 1987 request hence was entirely dissipated by the time she made her second request. In such circumstances, the District was required to provide said information because it was all relevant to the District's self-funded health and dental plans.

As noted in Finding of Fact No. 64, the District at that time was able to provide the Association with information relating to its health care budget; premium costs; the dates for the benefit year; the amount of expected health claims; administrative costs; the amount for stop-loss insurance; a complete copy of its administrative services agreement; samples of reports; and a copy of PAS's initial proposal to the District and bid. 15/

In certain situations the failure to immediately provide such information would be unlawful. Here, though, there are certain mitigating factors which must be considered, the primary one being that said information was ultimately supplied a little over a month later. Furthermore, there is no indication that this delay prejudiced the Association in any way. Lastly, it must be remembered that WEAIT itself refused to supply the District with needed relevant information regarding the details of its own health insurance plan. Since WEAIT is effectively controlled by WEAC, and since the Association itself is part of WEAC, WEAIT's outright refusal to provide similar information must be considered alongside the District's de minimus failure to provide its information earlier.

In light of all these circumstances, I find that the District's delay in providing the information sought in Maciejewski's December 17, 1987, letter was not u2nlawful and that, as a result, this complaint allegation is dismissed.

13/ While not specifically pleaded, the record also shows that the District did not provide teachers with copies of its health and dental plans until June, 1988. Said delay was simply inexcusable, as the District should have provided same at the very beginning of 1988.

CONCLUSION:

For the reasons noted above, the District therefore did not act unlawfully by: (1), terminating the health and dental plans previously provided by WEAIT and WPS and by switching over to self-funded health and dental plans in the beginning of 1988; (2), subsequently providing the benefits that it did under both plans; and (3), delaying in supplying the Association with certain requested information. 16/

The Complaint therefore is dismissed in its entirety.

Dated at Madison, Wisconsin this 20th day of June, 1990.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By _____
Amedeo Greco, Examiner

14/ The Association has moved to correct p. 1323, line 21, of the transcript to read: "was 10/5, processed 10/24, paid 11/23." Said motion is hereby granted.

The District has moved to strike from the Association's brief all references to a September 26, 1986, arbitration award issued by Arbitrator Byron Yaffe which centered upon whether the District had just cause to discharge a teacher, along with the attachment of said Award to the brief. Since the discharge is totally unrelated to the issues herein, and since the Yaffe decision was not submitted until after the hearing in this matter was concluded, said motion is hereby granted.