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-D

Appearances:

Ms. Ellen J. Henningsen, Staff Counsel, Wisconsin Education Association Council, P.O. Box 8003, Madison, Wisconsin 53708-8003, on behalf of the Complainants.

Godfrey & Kahn, S.C., by Mr. Edward J. Williams, 219 Washington Avenue, Oshkosh, Wisconsin 54902, and Mr. Kirk D. Strang, Suite 202, 131 West Wilson Street, Madison, Wisconsin 53701-1110, on behalf of the Respondents.

ORDER AFFIRMING IN PART AND REVERSING IN PART EXAMINER'S FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

On June 20, 1990, Examiner Amedeo Greco issued Findings of Fact, Conclusions of Law and Order with Accompanying Memorandum in the above-entitled matter. In his decision, the Examiner concluded that the Respondents Mayville School District and the Board of Education of the Mayville School District had not committed prohibited practices within the meaning of Sec. 111.70(3)(a)4, Stats. when they: (1) unilaterally implemented self-funded health and dental benefit plans; and (2) failed to initially provide the Mayville Education Association with certain requested information regarding the self-funded benefit plans. Therefore, the Examiner dismissed the prohibited practice complaint.

On June 29, 1990, Complainants timely filed a petition with the Wisconsin Employment Relations Commission seeking Commission review of the Examiner's decision pursuant to Secs. 111.70(4)(a) and 111.07(5), Stats. The parties thereafter filed written argument in support of and in opposition to the petition for review, the last of which was received December 17, 1990.

The Commission has considered the evidence and argument presented by the parties and hereby makes the following

ORDER 1/

1/ Pursuant to Sec. 227.48(2), Stats., the Commission hereby notifies the parties that a petition for rehearing may be filed with the Commission by following the procedures set forth in Sec. 227.49 and that a petition for judicial review naming the Commission as Respondent, may be filed by

following the procedures set forth in Sec. 227.53, Stats.

227.49 Petitions for rehearing in contested cases. (1) A petition for rehearing shall not be prerequisite for appeal or review. Any person aggrieved by a final order may, within 20 days after service of the order, file a written petition for rehearing which shall specify in detail the grounds for the relief sought and supporting authorities. An agency may order a rehearing on its own motion within 20 days after service of a final order. This subsection does not apply to s. 17.025(3)(e). No agency is required to conduct more than one rehearing based on a petition for rehearing filed under this subsection in any contested case.

227.53 Parties and proceedings for review. (1) Except as otherwise specifically provided by law, any person aggrieved by a decision specified in s. 227.52 shall be entitled to judicial review thereof as provided in this chapter.

Continued

A. Examiner Findings of Fact 1 - 3 are affirmed.

B. Examiner Finding of Fact 4 is modified to read:

> Under the terms of the parties' 1981-1982 agreement, dental benefits first became available to employes represented by the Association. When bargaining the 1981-1982 agreement, the parties identified the desired benefits as those then contained in a Wisconsin Education Association Insurance Trust (the Trust) Plan #702H. However, the parties agreed that because the Plan 702H benefits could be provided at lesser cost by Blue Cross and Blue Shield United of Wisconsin, Inc. (Blue Cross), Blue Cross would provide the benefits. Blue Cross continued to provide dental benefits under succeeding bargaining agreements until the District began to self-fund dental benefits on January 1, 1988. During all times material herein, Blue Cross was subject to full regulation by the State of Wisconsin as an insurance carrier. The question of the presence or absence of State regulation was never discussed by the parties during collective bargaining.

1/ Continued

(a) Proceedings for review shall be instituted by serving a petition therefore personally or by certified mail upon the agency or one of its officials, and filing the petition in the office of the clerk of the circuit court for the county where the judicial review proceedings are to be held. Unless a rehearing is requested under s. 227.49, petitions for review under this paragraph shall be served and filed within 30 days after the service of the decision of the agency upon all parties under s. 227.48. If a rehearing is requested under s. 227.49, any party desiring judicial review shall serve and file a petition for review within 30 days after service of the order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. The 30-day period for serving and filing a petition under this paragraph commences on the day after personal service or mailing of the decision by the agency. If the petitioner is a resident, the proceedings shall be held in the circuit court for the county where the petitioner resides, except that if the petitioner is an agency, the proceedings shall be in the circuit court for the county where the respondent resides and except as provided in ss. 77.59(6)(b), 182.70(6) and 182.71(5)(g). The proceedings shall be in the circuit court for Dane county if the petitioner is a nonresident. If all parties stipulate and the court to which the parties desire to transfer the proceedings agrees, the proceedings may be held in the county designated by the parties. If 2 or more petitions for review of the same decision are filed in different counties, the circuit judge for the county in which a petition for review of the decision was first filed shall determine the venue for judicial review of the decision, and shall order transfer or consolidation where appropriate.

(b) The petition shall state the nature of the petitioner's interest, the facts showing that petitioner is a person aggrieved by the decision, and the grounds specified in s. 227.57 upon which petitioner contends that the decision should be reversed or modified.

. . .

(c) Copies of the petition shall be served, personally or by certified mail, or, when service is timely admitted in writing, by first class mail, not later than 30 days after the institution of the proceeding, upon all parties who appeared before the agency in the proceeding in which the order sought to be reviewed was made.

Note: For purposes of the above-noted statutory time-limits, the date of Commission service of this decision is the date it is placed in the mail (in this case the date appearing immediately above the signatures); the date of filing of a rehearing petition is the date of actual receipt by the Commission; and the service date of a judicial review petition is the date of actual receipt by the Court and placement in the mail to the Commission.

C. Examiner Finding of Fact 5 is affirmed.

D. Examiner Finding of Fact 6 is modified to read:

> 6. Prior to 1985, the Trust was not fully regulated as an insurance carrier by the State of Wisconsin. Thus, prior to 1985 employes represented by the Association who were receiving health insurance benefits through the Trust: (1) did not have entitlement as a matter of insurance law to State mandated benefits; (2) did not have significant access to the Wisconsin Office of the Commissioner of Insurance (OCI) as a regulatory forum; and (3) did not enjoy the protection of the Wisconsin Insurance Security Fund. In 1985, the Trust became fully regulated by the State of Wisconsin as an insurance carrier. The question of the presence or absence of State regulation was never discussed by the parties during collective bargaining.

E. Examiner Findings of Fact 7 - 9 are set aside.

F. Examiner Finding of Fact 10 is renumbered Finding of Fact 7 and modified to read:

> 7. When the identity of the provider of health insurance benefits changed from the Trust to Blue Cross under the 1974-1975 agreement and from Blue Cross to the Trust under the 1975-1976 agreement, the Association was aware of the change and did not demand bargaining over same.

G. Examiner Findings of Fact 11 - 12 are renumbered Findings of Fact 8 - 9 and affirmed.

H. Examiner Findings of Fact 13 - 14 are set aside.

I. Examiner Findings of Fact 15 - 21 are renumbered Findings of Fact 10 - 16 and affirmed.

J. Examiner Finding of Fact 22 is set aside.

K. Examiner Findings of Fact 23 - 24 are renumbered Findings of Fact 17 - 18 and affirmed.

L. Examiner Finding of Fact 25 is renumbered Finding of Fact 19 and modified to read:

> 19. The District has provided the health and dental benefits set forth on the face of the parties' 1986-1987 contract and the underlying insurance policies.

M. Examiner Findings of Fact 26 - 27 are renumbered Findings of Fact 19 - 20 and affirmed.

N. Examiner Findings of Fact 28 - 34 are set aside.

O. Examiner Findings of Fact 35 - 36 are renumbered Findings of Fact 21 - 22 and affirmed.

P. Examiner Findings of Fact 37 - 50 are set aside.

Q. Examiner Finding of Fact 51 is renumbered Finding of Fact 23 and affirmed.

R. Examiner Finding of Fact 52 is renumbered Finding of Fact 24 and modified to read:

> 24. Regulatory differences exist between health and dental 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.
>
> There is also a difference between health and dental plans which are self-funded and those that are not with respect to remedies available to employes covered by the plan. Under Sec. 893.80, Stats., the remedies available against a municipal employer are more restrictive than those available when suing an insurance company. For instance, unlike the situation with a private carrier, an employe must file a notice of claim within 120 days; is subject to a $50,000 damage limitation for tort actions; and is precluded from recovery for intentional torts.

S. Examiner Findings of Fact 53 - 57 are renumbered Findings of Fact 25 - 29 and affirmed.

T. Examiner Findings of Fact 58 - 60 are set aside and Findings of Fact 30 - 31 are hereby made:

> 30. During an August 11, 1987 meeting,

District Administrator Bushke advised employes represented by the Association that the District intended to self-fund health and dental benefits effective September 1, 1987. During the August 11, 1987 meeting, Association President Maciejewski verbally asked Bushke for information regarding the self-funding decision.

On August 18, 1987, Maciejewski hand delivered the following letter to Bushke:

> Dear Mr. Bushke:
>
> As a followup to the verbal request I made on behalf of the Association last week, I am formally requesting the following information in regard to the self-funding of dental and health insurance. I would like this information in writing by Monday, August 24, 1987. If any of this information is unavailable to you at the present time, please indicate when you think it will be available.
>
> 1. Estimated claims for year ______________________
> 2. Administrative cost $__________ or ________%
> 3. 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

13. Sample of the information PAS will provide the District.

Thank you for your cooperation.

Bushke reviewed the letter and told Maciejewski that he did not have the information. Maciejewski told Bushke that she did not believe that he did not have the information citing the September 1, 1987 implementation date.

On August 18, 1987, Bushke at a minimum had certain stop-loss information requested by Maciejewski. Bushke did not provide that information to Maciejewski.

31. Until the District was served on August 28, 1987 with the Association's pleadings which sought to enjoin the District from self-funding, it was the District's intention to self-fund effective September 1, 1987. Between August 18, 1987 and August 28, 1987, the District: (1) did not take any action to obtain that information sought by the Association which the District did not possess and (2) did not provide the Association with any information. After the injunction pleadings were filed, the District temporarily suspended its plans to self-fund. In November 1987, the District decided to proceed with self-funding effective January 1, 1988 and on December 1, 1987, Bushke advised Maciejewski of the District's plans. Between August 18, 1987 and December 17, 1987, Maciejewski unsuccessfully asked Bushke several time for the information contained in her August 18 letter request. During one such conversation, Bushke told Maciejewski that he had some of the information Maciejewski sought but was awaiting advice from District legal counsel as to whether the information should be provided to the Association.

U. Examiner Findings of Facts 61 - 64 are renumbered Findings of Fact 32 - 35 and affirmed.

V. Examiner Findings of Fact 65 - 66 are set aside.

W. Examiner Conclusions of Law 1 and 3 are reversed and the following Conclusions of Law substituted:

1. The Mayville School District and the Board of Education of the Mayville School District committed prohibited practices within the meaning of Sec. 111.70(3)(a)4, Stats. when they self-funded health and dental benefits on January 1, 1988.

3. The Mayville School District and the Board of Education of the Mayville School District committed prohibited practices within the meaning of Sec. 111.70(3)(a)4, Stats. by failing to timely provide the Mayville Education Association with relevant and

necessary information regarding the District's intended implementation of self-funded health and dental benefits.

X. Examiner Conclusion of Law 2 is affirmed.

Y. Examiner Order is set aside and the following substituted:

ORDER

The Mayville School District and the Board of Education of the Mayville School District shall immediately take the following action which will effectuate the purposes of the Municipal Employment Relations Act.

1. Cease and desist from:

   a. Unilaterally altering the status quo as to wages.

   b. Failing to provide the Mayville Education Association with requested information which is relevant and reasonably necessary to the Association's representation of employes.

2. Restore the wage status quo by providing the health and dental benefits set forth in the parties' collective bargaining agreement and underlying insurance policy to employes through a source for which the requirements and limitations of Sec. 893.80 Stats, are not applicable.

3. Post the Notice attached hereto as Appendix A in conspicuous places in the work place. The Notice shall be signed by the President of the Board of Education and shall remain posted for a period of 30 days. Reasonable steps shall be taken to insure that the Notice is not altered, defaced or covered by other material.

4. Notify the Wisconsin Employment Relations Commission within 20 days of this Order what steps have been taken to comply herewith.

Given under our hands and seal at the City of Madison, Wisconsin this 5th day of May, 1992.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By ______________________________
A. Henry Hempe, Chairperson

____
Herman Torosian, Commissioner

William K. Strycker, Commissioner

APPENDIX A

Notice to All Employes

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

> We will provide the health and dental benefits set forth in our collective bargaining agreement with the Mayville Education Association and underlying insurance policy to employes through a source for which the requirements and limitations of Sec. 893.80, Stats. are not applicable.
>
> We will timely provide the Mayville Education Association with requested information which is relevant and reasonably necessary to the Association's represent-ation of employes.

Dated at Mayville, Wisconsin this _____ day of _______________, 1992.

By ____________________________________
President
Mayville Board of Education

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

MAYVILLE SCHOOL DISTRICT

MEMORANDUM ACCOMPANYING ORDER AFFIRMING IN PART
AND REVERSING IN PART EXAMINER'S FINDINGS
OF FACT, CONCLUSIONS OF LAW AND ORDER

The complaint, as amended during the hearing, alleges that the District committed prohibited practices within the meaning of Sec. 111.70(3)(a)4, Stats. by self-funding health and dental benefits during a contract hiatus and by providing the Association with requested information in an untimely manner.

Self-funding

As to the issue of whether the self-funding of health and dental benefits violated the District's obligation to maintain the wage status quo, the Examiner concluded that no violation of Sec. 111.70(3)(a)4, Stats. occurred. In reaching this conclusion he determined:

-- Self-funding health and dental benefits primarily related to wages given the change in the entity interpreting the benefits plan.

-- State mandated benefits continue to be provided by the District.

-- The District's self-funded plans are financially sound particularly when compared to the financial position of the Trust.

-- The extent of State regulation is not part of the status quo because: (1) there has been no showing that the regulatory differences have adversely affected employes; (2) some regulation of the District's self-funded plans exists; and (3) the Trust was not subject to extensive State regulation during some of the years when the Trust was the health insurance carrier.

-- The language of the expired contract and the parties' past practice support the District's right to self-fund health benefits.

-- The Association's relationship with the Trust is sufficient to warrant a conclusion that the Association knew or should have known about the Trust's largely unregulated status during some of the years the Trust was the health insurance carrier.

-- State law recognizes self-funding as a form of insurance.

-- Because the Trust did not have re-insurance or stop-loss coverage, it was providing benefits on a "self-funded" basis in the same sense that the District is now "self-funding" benefits.

-- The parties bargained over the District's decision to self-fund and Interest Arbitrator

Kerkman upheld the District's right to self-fund.

-- The language of the expired contract and the parties' past practice support the District's right to self-fund dental benefits.

-- Because the District has the right to change the entity administering the benefit plans, the changes in benefits and plan administration which flow from the exercise of that right do not violate the status quo.

-- The District made good faith efforts to resolve the inevitable problems created by the change from the Trust to self-funding.

In its petition for review and extensive supporting briefs, the Association asks the Commission to reverse the Examiner. In its equally extensive responsive brief, the Respondent urges affirmance of the Examiner.

DISCUSSION

It is well settled that, absent a valid defense, a unilateral change in the status quo wages, hours or conditions of employment during a contractual hiatus is a per se violation of the employer's duty to bargain under the Municipal Employment Relations Act. Such unilateral changes are tantamount to an outright refusal to bargain about a mandatory subject of bargaining because they undercut the integrity of the collective bargaining process in a manner inherently inconsistent with the statutory mandate to bargain in good faith. 2/ In addition, such an employer unilateral change evidences a disregard for the role and status of the majority representative which is inherently inconsistent with good faith bargaining. 3/

Here, the parties disagree about what the status quo as to health and dental benefits was on December 31, 1987, i.e., whether the District changed or operated within the status quo as to wages when it began to provide certain health and dental benefits on a self-funded basis using Preferred Administrative Services, Inc. (PAS) as a third party administrator. The District asserts that the status quo as to wages allowed it to provide health and dental benefits on a self-funded basis and that it maintained the employe's health and dental benefits to the extent it was required to do so. The Union contends that status quo as to wages did not allow the District to self-fund health and dental benefits and further that benefit levels were altered in a manner inconsistent with the District's status quo obligations.

Before examining the specifics of the parties dispute in this regard, it

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2/ E.g., NLRB v. Katz, 396 U.S. 736 (1962); City of Brookfield, Dec. No. 19822-C (WERC, 11/84) at 12; Green County, Dec. No. 20308-B (WERC, 11/84) at 18-19; and School District of Wisconsin Rapids, Dec. No. 19084-C (WERC, 3/85) at 14.

3/ School District of Wisconsin Rapids, supra, at 14.

is worth noting that the *status quo* is a dynamic concept which can allow or mandate change in employe wages, hours and conditions of employment. For instance, the *status quo* may dictate that additional compensation be paid to employes during a hiatus upon attainment of additional experience or education. 4/ Or the *status quo* may give the employer discretion to change work schedules during a hiatus. 5/ When determining what the *status quo* is in the context of a contract hiatus, we consider relevant language from the expired contract as historically applied or as clarified by bargaining history, if any. 6/

It is also important to keep sight of the fundamental principle that the employer's *status quo* obligation only applies to matters which *primarily* relate to employe wages, hours and conditions of employment. Here, it is clear that the *benefits* explicitly listed in the expired bargaining agreement and/or set forth on the face of the health and dental policies primarily relate to wages. However, in the context of the instant dispute, if the *identity of the provider* of the health and dental *benefits* did not primarily relate to employe wages, then the *status quo* would not limit the District's choice of benefit providers during the hiatus. However, we have previously concluded that the identity of the insurance carrier/administrator providing/administering health benefits is primarily related to employe wages because each carrier/administrator interprets and administers even identical benefit provisions in a unique manner, thus producing different benefits/wages. 7/ The record herein regarding the current status of the health and dental insurance industry establishes that our prior holding in this regard continues to be correct as to health benefits and is applicable to dental benefits as well. Thus, it is clear that the identity of the provider of health and dental benefits to employes must be part of our *status quo* analysis herein.

We have also previously held that providing health benefits on a self-funded basis primarily relates to employe wages *if* self-funding produces: (1) a change in the entity interpreting the benefit provisions; (2) the loss of State mandated benefits; or (3) the risk that incurred claims would not be paid in the event of employer insolvency. 8/ The record herein establishes that our prior holding continues to be correct as to these additional wage impacts of self-funding and that our holding is applicable to both health and dental benefits. The record herein also warrants the additional holding that in addition to the three attributes noted above, providing health or dental benefits on a self-funded basis also primarily relates to employe wages because

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4/ *School District of Wisconsin Rapids*, *supra*; *Manitowoc Schools*, Dec. No. 24205-B (WERC, 3/88), *aff'd* Dec. No. 88-CV-173 (CirCt Manitowoc 1/89).

5/ *City of Brookfield*, *supra* note 3; *Washington County*, Dec. No. 23770-D (WERC, 10/87).

6/ *School District of Wisconsin Rapids*, *supra*, note 2.

7/ *Madison Metropolitan School District*, Dec. No. 22129 (WERC, 11/84), *aff'd* 133 Wis.2d 462 (CtApp Dist. IV, 1986), *cert denied*, (Wis. SupCt, 1/87).

8/ *Milwaukee Board of School Directors*, Dec. No. 23208-A (WERC, 2/87). In *Milwaukee* we concluded that these *wage* impacts would be eliminated if the employer self-funded but: (1) retained the same interpretative entity; (2) provided State mandated benefits; and (3) obtained supplemental insurance to meet the insolvency risk.

self-funding produces a substantial loss of employe access to the regulatory structure provided through Wisconsin's Office of the Commissioner of Insurance (OCI) which is present when benefits are provided by regulated insurance carriers. We reach this conclusion because access to a regulatory forum and structure which protects/provides access to the benefits themselves has a "wage" impact which predominates over management interests. 9/

On review, the Union for the first time also argues that self-funding is a mandatory subject of bargaining because an employe seeking redress for benefit denial no longer can simply file a civil action against an insurance company but now must sue both the third party administrator and his or her employer. The Union asserts that not only will employes be hesitant to take such action against their employer but that those who do take such action confront a shorter statute of limitations and more restrictive remedies than are available where the insurance company is the sole respondent.

The District did not respond to this argument in its brief.

Having considered this additional argument, we find that it persuasively identifies an additional wage impact of a self-funding decision. As noted by the Court of Appeals in Madison and by our earlier discussion herein regarding access to OCI, the means and ease by which an employe can acquire access to the underlying benefits has a wage impact. Citing Smith v. WPS, 152 Wis.2d 25 (CtApp Dist. IV 1989), the Union persuasively contends that employes with a civil cause of action seeking redress for benefit denial in a self-funding setting must now sue their employer and credibly asserts that employes will thus be less likely to pursue such causes of actions. Further, as argued by the Union under Sec. 893.80, Stats., the remedies available against a municipal employer are more restrictive than those available when suing an insurance company. Thus, this is an additional "wage" impact of self-funding which must be considered herein.

Applying these general principles to the case at hand, it is apparent that on December 31, 1987, during the contract hiatus, the "wages" employes were receiving included: (1) the health and dental benefits listed on the face of the expired 1986-87 contract supplemented by the insurance policy provisions; (2) the unique health and dental benefits established by the manner in which WEAIT and Blue Cross, respectively, administered/interpreted the insurance policies; 10/ (3) the benefits which State law requires regulated insurance carriers to provide; (4) as set forth earlier herein in modified Finding of Fact 24, access to OCI as a forum available to employes who were dissatisfied with the identity of and the manner in which benefits were provided; (5) by operation of State law, access to the Wisconsin Insurance Security Fund to meet the risk that benefits would not be paid in the event of provider insolvency; and (6) avail-ability of civil causes of action for breach of contract and/or tortious bad faith claims processing which did not require the employe to sue the employer.

9/ Madison Schools, supra, note 6, at 469.

10/ We need not decide whether the Union is also correct when it argues that the level of confidentiality enjoyed by employes vis-a-vis employer access to individual claims experience information is also primarily related to employe wages, and thus subject to a status quo analysis. Assuming arguendo that confidentiality is primarily related to wages, we conclude that in the context of this dispute, the level of confidentiality is a "unique" benefit dependent upon the administration of a particular provider.

However, as noted earlier herein, although these wages are generally subject to the employer's status quo obligations, the status quo is not a static concept and can allow or mandate wage changes. Thus, even if any or all of these above-noted wages changed when the District began to self-fund benefits on January 1, 1988, the status quo for these parties may have given the District discretion to make said changes without violating Sec. 111.70(3)(a)4, Stats. We now proceed to identify the wage changes produced by the District's action on January 1, 1988 and then to determine whether any such changes were allowed under the status quo.

Health Insurance

The language of the expired agreement as to health benefits states:

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 deduct-ible health insurance plan. A summary of this plan Appendix C (sic) is attached.

APPENDIX - E
GROUP HEALTH PROPOSAL SUMMARY

ELIGIBLE CLASS: (Current Health Plan Participants)

BENEFIT PERIOD: Calendar Year

MAXIMUM DEDUCTIBLE: $100 Per Individual $200 Per Family

STOP LOSS: $100 Per Individual $200 Per Family Includes Ded.

MAXIMUM AGGREGATE BENEFIT: $1,000,000

BENEFIT PROVISIONS	SUBJECT TO DEDUCTIBLE	PAYABLE AT	INCLUDED IN MAX-AGG
A. Surgical	Yes	100%	Yes
B. Anesthesia	Yes	100%	Yes

C. Inpatient Hospital	Yes	100%	Yes
D. Outpatient Hospital	Yes	100%	Yes
E. In Hospital Medical	Yes	100%	Yes
F. Diagnostic X-Ray & Lab (Routine physical - NO)	Yes	100%	Yes
G. X-Ray/Radioactive Therapy	Yes	100%	Yes
H. Accident/Emergency Medical Treatment	Yes	100%	Yes

MISCELLANEOUS BENEFIT PROVISIONS

A. Physician's Office Calls (Routine Physical - NO)	Yes	100%	Yes
B. Other Medical Expenses	Yes	100%	Yes
C. Outpatient/Office Treatment of Chemical Dependency or Abuse, Nervous or Mental Disorder:			
1. First $1,000 for Chemical Dependency or Abuse/ Nervous or Mental Disorder	No	100%	Yes
2. Other Charges For Nervous or Mental Disorders, Limited to $20 Per Visit For 52 Visits Per Benefit Period	Yes	50%	Yes
D. Treatment of Kidney Diseases			
1. Basic Expense	Yes	100%	Yes
2. Other Expense	Yes	100%	Yes
E. Covered Dental Expenses	Yes	100%	Yes
F. Optional Benefits			
1. Limited Chiropractic	Yes	100%	Yes
2. Chiropractic	NA	NC	NA
3. Dental Extraction & Initial Replacement	Yes	100%	Yes

OTHER BENEFITS:
Prescription Drug $2.00 Ded./Prescription - Mail Order $0.00 ded.

IMPORTANT NOTE:
All benefits are subject to all provisions, exclusions and limitations contained in the policy.

First for our consideration is the question of whether the District maintained the health benefits which are set forth on the face of the expired 1986-87 contract and underlying insurance policy. The Union asserts that the District failed to provide benefits explicitly set forth in the contract and underlying policy as to: (1) mail order drugs; and (2) birth control pills.

As to the mail order drug issue, the 1986-87 contract identifies the benefit as "Prescription - Mail Order $0.00 ded." The Union argues that no mail order benefit was initially available to employes and that the mail order plan ultimately made available through PAS had a $2.00 deductible. The District claims that a mail order benefit has always been available and that it was willing to waive the $2.00 deductible.

It is clear from the record that after the District began to self-fund benefits, one of the District's agents in this matter, the Hierl Agency, initially advised employe Schiess that a mail order drug benefit was not available. It is also clear that when employe Schiess ultimately received information regarding a mail order drug plan, the plan included a $2.00 deductible. However, the record establishes that: (1) the District has entered into a contract with PAS which obligates the District/third party administrator to duplicate health benefits previously provided by WEAIT and thus to provide a mail order benefit with no deductible; (2) PAS instructed the mail order provider, Prime Pharmacare, to have no deductible; (3) Schiess never actually utilized the mail order drug benefit; and (4) there is no persuasive evidence that the inaccurate information she received deterred Schiess from utilizing the benefit. Thus, we do not find the District violated its Sec. 111.70(3)(a)4, Stats. obligation to provide "Prescription - Mail Order $0.00 ded." as a benefit. This conclusion is consistent with our holding in School District of Menomonie, Dec. No. 16724-B (WERC, 1/81) where we were confronted with a situation in which it was alleged that a municipal employer had improperly changed insurance benefits in violation of its duty to bargain when it switched to a new carrier. The employer had instructed the new carrier to provide the same benefits as had been provided by the prior carrier. When it learned of discrepancies between the new plan and the old, the employer in Menomonie took action to provide the benefits retroactively. No evidence of any employe loss of benefits existed. Under these circumstances, no violation of the duty to bargain was found.

As to birth control pills, the District concedes that the benefit in question was available on the face of the underlying policy with WEA Trust. As was the case with the mail order drug benefit, the District's agents gave employes inaccurate information about this benefit. However, (1) the District's contract with PAS required that birth control bills be covered; (2) no employe was ultimately denied reimbursement; and (3) there is no persuasive evidence that the inaccurate information received by employes deterred them from using the benefit. Thus, we also conclude that no violation of Sec. 111.70(3)(a)4, Stats. occurred as to this benefit.

We next turn to the question of whether other "wage" changes occurred and, if so, whether such changes violated the status quo.

As discussed earlier herein, health benefits received by employes through December 31, 1987 were defined by the 1986-87 contract and the underlying insurance policy provisions as administered and interpreted by WEA Insurance Corporation. Given the previously discussed nexus between benefits and the identity of providers/administrators, it is clear that when the District began to have PAS administer and interpret the insurance policy provisions on January 1, 1988, employes lost the "unique" benefits received solely by virtue of the administration and interpretation of policy provision by WEA. We proceed to determine whether the status quo for these employes allowed loss of these "unique" benefits.

The language of the parties' expired agreement does not identify the source from which the District is to provide "group hospital/surgical insurance." Thus, the language on its face gives the District discretion as to the benefit source. Bargaining history establishes that this language first appeared in the 1974-75 contract and replaced language which specified a source for health insurance (WEA Insurance Trust). As to the historical application of the contract language, the District changed health insurance providers in 1974-75 (from WEA Insurance Trust to Blue Cross) and 1975-76 (from Blue Cross back to WEA Insurance Trust). In each instance, the Union was aware of the

change and did not object. Thus, twice prior to self-funding, the District has changed the entity interpreting/administering health insurance benefits with resultant benefit/wage impacts on employes without protest from the Union. Acknowledging all of the foregoing, the Union concedes that the District can change the entity interpreting/administering benefits but only if the new provider can produce the same "benefit levels, including administration, interpretation and process." However, as the record in Madison and the record herein establish that no two providers can produce the same "benefit levels, including administration, interpretation and processes," the Union's concession is an empty one which does not do justice to the reality of the parties' past history and which would render meaningless the discretion the District acquired at the bargaining table. Given all of the foregoing, we conclude that the status quo allows for changes in the entity interpreting/administering health benefits and thus does not mandate continuance of the "unique" benefits produced by WEA Insurance Corporation's administration/interpretation of the existing policy. Thus, this wage impact on employes produced by the change from WEA Insurance Corporation to the District/PAS did not violate the District's obligation to maintain the status quo.

On this basis, we have affirmed the Examiner's dismissal of the Union allegations which involve: (1) failure to promptly pay claims; (2) reduced level of confidentiality; (3) denial of coverage for TMJ; (4) denial of coverage for orthotic's; (5) reduced acceptability of identification cards; (6) absence of a toll-free number; (7) incorrect coordination of prescription drug benefits; (8) reduced reasonable and customary fee levels; (9) ineffective and untimely response to inquiries; (10) improper claims processing; and (11) administration of a mail order drug benefit.

Looking at the third, fourth and fifth wage impacts identified above, the record establishes that for the period of 1975-1985, health insurance benefits were provided through WEA Insurance Trust. During this period, the Trust was not regulated as an insurance carrier by the State of Wisconsin. Therefore, during this period employes (1) were not entitled as a matter of insurance law to "mandated benefits"; (2) did not have significant access to OCI as a regulatory forum; and (3) did not enjoy the protection of the Wisconsin Insurance Security Fund. Nor was there any Union protest made over the loss of these employe "wages" when the District shifted from Blue Cross to WEA for the 1975-76 contract. From this evidence we conclude that under the contract language as historically applied, these three additional wage impacts of the self-funding of health insurance benefits were not part of the status quo the District was obligated to maintain. Thus, although these were "wage" benefits enjoyed by employes prior to January 1, 1988, they were "wages" the District had discretion to change. Thus, we have dismissed these aspects of the Union's complaint as well.

Turning to the sixth and last wage impact, when the District began to self-fund health benefits, employes who previously could, if necessary, seek redress for unpaid claims through civil actions against the insurance company were now confronted with the need to sue their employer and with access to less desirable remedies due to the requirements and limitations of Sec. 893.80, Stats.

The language of the expired agreement does not deal with this "wage" on its face. However, unlike the third, fourth and fifth wage impacts discussed above, the Trust's unregulated status during 1975-1985 had not served to deprive employes of this "wage." Thus, prior to self-funding, employes have always been able to file civil suits seeking redress for unpaid claims without having to sue the District and without being subject to the requirements and limitations of Sec. 893.80, Stats. which include a $50,000 damage limitation

for tort actions and the need to file a notice of claim within 120 days. 11/
Thus, the

11/ Section 893.80, Stats. provides:

893.80 Claims against governmental bodies or officers, agents or employes; notice of injury; limitation or damages and suits. (1) Except as provided in subs. (lm) and (lp), no action may be brought or maintained against any volunteer fire company organized under ch. 213, political corporation, governmental subdivision or agency thereof nor against any officer, official, agent or employe of the corporation, subdivision or agency for acts done in their official capacity or in the course of their agency or employment upon a claim or cause of action unless:

(a) Within 120 days after the happening of the event giving rise to the claim, written notice of the circumstances of the claim signed by the party, agent or attorney is served on the volunteer fire company, political corporation,

Continued

11/ Continued

governmental subdivision or agency and on the officer, official, agent or employe under s. 801.11. Failure to give the requisite notice shall not bar action on the claim if the fire company, corporation, subdivision or agency had actual notice of the claim and the claimant shows to the satisfaction of the court that the delay or failure to give the requisite notice has not been prejudicial to the defendant fire company, corporation, subdivision or agency or to the defendant officer, official, agent or employe; and

. . .

(3) The amount recoverable by any person for any damages, injuries or death in any action founded on tort against any volunteer fire company organized under ch. 213, political corporation, governmental subdivision or agency thereof and against their officers, officials, agents or employes for acts done in their official capacity or in the course of their agency or employment, whether proceeded against jointly or severally, shall not exceed $50,000, except that the amount recoverable shall not exceed $25,000 in any such action against a volunteer fire company organized under ch. 213 or its officers, officials, agents or employes. If the volunteer fire company is part of a combined fire department, the $25,000 limit still applies to actions against the volunteer fire company or its officers, officials, agents or employes. No punitive damages may be allowed or recoverable in any such action under this subsection.

(4) No suit may be brought against any volunteer fire company organized under ch. 213, political corporation, governmental subdivision or any agency thereof for the intentional torts of its officers, officials, agents or employes nor may any suit be brought against such corporation, subdivision or agency or volunteer fire company or against its officers, officials, agents or employes for acts done in the exercise of legislative, quasi-legislative, judicial or quasi-judicial functions.

. . .

historical application of the insurance language is supportive of the position that the status quo does not give the District the right to eliminate this wage. No evidence of bargaining history bears on this question.

Given the foregoing, we are satisfied that the historical application of the language warrants the conclusion that the District's unilateral self-funding of health benefits did violate its status quo obligations as to this sixth wage impact. Thus, we have entered an appropriate remedial Order.

Dental Insurance

The language of the expired agreement as to dental benefits states:

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.

This language has existed since 1981 when the benefit first appeared in the parties' contract. Although Plan #702H is a WEAIT dental insurance plan, dental benefits were always provided through Blue Cross until the District began to self-fund.

There is no allegation that the District failed to maintain the dental benefits set forth in the language of the expired 1986-87 contract or the underlying insurance policy when it began to self-fund dental benefits through PAS on January 1, 1988. However, as discussed earlier herein, employe "wages" on December 31, 1987 included: (1) unique dental benefits established by the manner in which Blue Cross administered/interpreted the underlying insurance policy; (2) access to the Office of the Commissioner of Insurance as a forum for employes dissatisfied with the identity of and the manner in which benefits were provided; (3) access as a matter of law to State mandated benefits; (4) access to the Wisconsin Insurance Security Fund to meet the risk that benefits would not be paid in the event of provider insolvency; and (5) availability of civil causes of action for breach of contract and/or tortious bad faith claims processing which did not require the employe to sue the employer. As we did with health benefits, we now proceed to identify the wage changes produced by the commencement of self-funding on January 1, 1988 and to determine whether any such changes were allowed under the status quo.

Given the previously discussed nexus between benefits and the identity of providers/administrators, it is clear that when the District began to have PAS administer and interpret the insurance policy provisions on January 1, 1988, employes lost the "unique" dental benefits received solely by virtue of the administration and interpretation of the policy provisions by Blue Cross. As discussed earlier, whether the status quo allows for loss of these unique benefits is determined by reference to the language of the expired agreement as historically applied or as clarified by any bargaining history.

The language of the expired agreement does not identify the source from which the District is to "make available . . . dental insurance . . ." Thus the language on its face gives the District discretion as to the benefit source. As historically applied, the District has always utilized Blue Cross for dental benefits until it began to self-fund.

However, as noted earlier herein, the dental policy/plan which Blue Cross has administered is a WEAIT plan. Bargaining history establishes that this situation was produced by a scenario in which the parties bargained a benefit package and then agreed that the District could bid the package and contract with the low bidder to provide the benefits. Blue Cross was the low bidder and has continued to provide the dental benefits ever since. Given the foregoing, bargaining history supports the view that the District has discretion as to the identity of the dental benefit provider.

Given the contract language and bargaining history, we conclude that the status quo allows for changes in the entity interpreting/administering dental benefits and thus does not mandate continuance of the unique dental benefits produced by Blue Cross administration/interpretation of the existing policy.

However, as was true for our analysis of status quo health benefits, prior to self-funding, employes have always been able to file civil suits seeking redress for unpaid claims without having to sue the District and without being subject to the requirements and limitations of Sec. 893.80, Stats. which include a $50,000 damage limitation for tort actions and the need to file a notice of claim within 120 days. The language of the expired agreement does not deal with this "wage" on its face and no evidence of bargaining history bears on this question. However, the historical application of the insurance language is supportive of the position that the status quo does not give the District the right to eliminate this wage.

As was the case with health benefits, we find the practice under the language to be the most reliable status quo indicator. We therefore conclude that for dental benefits, the status quo did not give the District the right to eliminate this wage. Given this conclusion, we thus find that the District violated Sec. 111.70(3)(a)4, Stats. when it self-insured dental benefits and have entered an appropriate remedial order.

Because our analysis and resolution of the issues differs from the Examiner's, we deleted those Examiner Findings of Fact which are not relevant or necessary for our decision. These deleted Findings include those detailing the financial status of the Trust and its relationship to WEAC, discussing the District's stop-loss aggregrate and super-aggregrate coverage, and detailing specific employe complaints related to those changes in benefits and benefit administration attributable to the change in the entity interpreting the benefit plans. We have also modified certain Examiner Findings to provide greater detail or more accurately reflect the content of the record. While we retained those Findings which discuss the parties' unsuccessful negotiations for a 1987-1989 contract and the resultant interest arbitration proceedings before Arbitrator Kerkman, our analysis makes clear that we have rejected the Examiner's view that the Kerkman Award held that the District could self-fund. As the following portion of the Kerkman Award makes clear, Arbitrator Kerkman only concluded that the existing insurance language should not change.

> Therefore, after considering all of the arguments of the parties and the record evidence, the undersigned concludes that the language of the predecessor Agreement with respect to change of insurance carrier should remain in place, and the Association proposal is rejected. It is possible that the prior insurance carrier may be reinstated as a result of the prohibited practice case now pending before the Wisconsin Employment Relations Commission, or because a rights arbitrator so orders if a timely grievance can be filed alleging that the change to the self insured plan violates the provisions of the Collective Bargaining AGreement (sic) which permits a change of carrier by the Employer if benefit levels are maintained. Those decisions, however, are for forums other than the instant arbitration, and if the Association is to prevail in its endeavor to restore the WEAIT and Blue Cross-Blue Shield as the insurance carriers for health and dental insurance they will have to do so in those forums.

Duty to Supply Information

It is undisputed that:

> Intertwined with the duty to bargain in good faith is a duty on the part of an Employer to supply a labor organization representing employes, upon request, with sufficient information to enable the labor organization to understand and intelligently discuss issues raised in bargaining. . . . Information requested by a labor organization must be relevant and reasonably necessary to its dealings in its capacity as the representative of the employes. 12/

Here, no one disputes that the information sought by the Association was "relevant and reasonably necessary." Rather the question is whether the District's failure to provide the requested information until February 1988 effectively breached its duty to supply same.

As to this aspect of the parties' dispute, the Examiner made the following Findings of Fact:

> 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. 1/ 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,

12/ _Sheboygan School District_, Dec. No. 11990 (WERC, 1/76).

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

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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.

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. 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. Administra-tive services agreement; 12. Copies of the policies for stop-loss and aggregate insurances; and 13. Sample of the inform-ation 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.

Based on these Findings, he made the following Conclusion of Law:

> 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.

In his Memorandum, the Examiner reasoned:

> 3. <u>THE ALLEGED REFUSAL TO SUPPLY INFORMATION</u>
>
> 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 (sic) 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. 13/

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.

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.

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 unlawful and that, as a result, this complaint allegation is dismissed.

On review, the Association argues the Examiner should be reversed. It contends that the Examiner's Conclusion of Law is founded on an incomplete assessment of the applicable case law and inaccurate Findings. More specifically, the Association asserts:

1. In June 1987, the Association advised the District that the Association wanted to bargain over any decision to self-fund.

2. By August 11, 1987, when the Association verbally requested specific information, the District had studied self-funding, negotiated with other Districts and PAS, and announced its intent to self-fund effective September 1, 1987.

3. By August 18, 1987, when the Association reduced its' verbal request to written form, the District knew but would not provide information

relating to administrative costs and start-up costs, the administrative services agreement and sample informational documents from PAS.

4. During the period prior to the Association's August 28, 1987 injunction request, the District took no action to obtain any information it did not possess and did not explain to the Association why the information was unavailable.

5. Even after August 28, 1987, the District continued to contemplate self-funding. In November 1987, the District decided to self-fund effective January 1, 1988. The District continued to ignore the Association's August requests.

6. When the Association renewed its information request in a December 17 letter, the District had the majority of the information requested but did not provide it to the Association.

Given the foregoing, the Association argues that the District unnecessarily and inexcusably delayed providing necessary and relevant information to the Association, thereby prejudicing the Association's ability to fulfill its obligation as bargaining agent to inform itself, assess the District's position and act. Thus, the Association contends the District thereby violated Sec. 111.70(3)(a)4, Stats.

Lastly, the Association asserts that the District's action also violated the District's obligation to maintain the status quo during the contract hiatus. In this regard, the Association contends that the District had contractually obligated itself to furnish information under Wisconsin's Open Records Law, that the information requested was a public record, and that the failure to provide the information thus constituted a breach of the status quo.

It is clear that in August, when the Association made its first information requests, the District had some of the information which the Association sought. District Administrator Bushke testified that as of August 18, 1987 he knew the "specific" stop-loss information and may have had samples of PAS literature. It is undisputed that the District did not provide this information to the Association, and took no action to obtain the information it did not possess. Instead the District simply told the Association that it did not have the information.

The District reasons that because the Association wanted all of the information requested, the District had no obligation to respond until it had all of the answers. This reasoning is hardly persuasive when matched against the District's failure to take any action to procure information it asserts it did not have and the terms of the Association's request. The Association's information request asked that the information be provided by August 24, 1987 and that "if any of the information is unavailable to you at the present time please indicate when you think it will be available." The most reasonable interpretation of this request is that the Association was asking for all available information by August 24. Thus, we find the District's apparent "all or nothing" view totally unpersuasive.

Equally lacking in merit is the District argument and the Examiner rationale that the "fluid" nature of the situation excused the District's

actions. Between the August 11 verbal request and the August 28 injunction lawsuit, the District was fully intending to implement self-funding September 1. The Association's request sought information relevant and necessary to the Association's role as the collective bargaining representative of District employes vis-a-vis a significant action the District was about to take. Thus between August 11 and August 28 there was nothing particularly "fluid" about the District's intentions and time was of the essence.

Because the District did not provide the Association with the information it possessed in August 1987 and because the District took no action to acquire the information it did not possess in response to the Association's August 1987 informational requests, we find the District thereby violated its duty to supply information under Sec. 111.70(3)(a)4, Stats.

We reach the same conclusion as to the District's conduct vis-a-vis the Association's December 17 request for information. As the Examiner correctly found, on December 17 the District could have but did not provide the Association with some of the requested information. Time was again of the essence given the January 1, 1988 implementation date. Despite the foregoing the Examiner concluded that no violation occurred because: (1) the information was ultimately provided; (2) WEAIT had previously refused to provide information to the District; and (3) there was no prejudice to the Association.

We do not find the Examiner's rationale persuasive. As argued by the Association, the delay in providing available information prejudiced the Association's ability to act as the employes' representative at a critical juncture. Contrary to the Examiner, any prior action by WEAIT is irrelevant to the issue of whether the District met its obligation to provide information. Under the facts of this case, the District's ultimate provision of the information under threat of an open records lawsuit is also of no consequence. It had some of the information on December 17 and chose not to provide it. The District thereby violated Sec. 111.70(3)(a)4, Stats.

Dated at Madison, Wisconsin this 5th day of May, 1992.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By ________________________________
A. Henry Hempe, Chairperson

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Herman Torosian, Commissioner

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William K. Strycker, Commissioner