STATE OF WISCONSIN

BEFORE THE WISCONSIN EMPLOYMENT RELATIONS COMMISSION

RACINE EDUCATION ASSOCIATION, Complainant, vs. RACINE UNIFIED SCHOOL DISTRICT, and THE BOARD OF EDUCATION OF THE RACINE UNIFIED SCHOOL DISTRICT, Respondents.	Case 122 No. 44861 MP-2414 Decision No. 26816-B
RACINE EDUCATIONAL ASSISTANTS' ASSOCIATION, Complainant, vs. RACINE UNIFIED SCHOOL DISTRICT, and THE BOARD OF EDUCATION OF THE RACINE UNIFIED SCHOOL DISTRICT, Respondents.	Case 123 No. 45112 MP-2432 Decision No. 26817-B

Appearances:
Kelly & Haus, Attorneys at Law, by Mr. Robert C. Kelly, 121 East Wilson Street
Melli, Walker, Pease & Ruhly, S.C., by Mr. Jack D. Walker, 119 Martin Luther

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

On November 21, 1990, Racine Education Association filed a complaint with the Wisconsin Employment Relations Commission, alleging that Racine Unified School District was violating Sec. 111.70(3)(a)4, Wis. Stats., by unilaterally planning changes in the health insurance of employes represented by Complainant. On January 9, 1991, Racine Educational Assistants Association filed a similar complaint with respect to employes of the District which it represented. Subsequently, on May 10, 1991, amended complaints were filed alleging that the changes anticipated in the earlier complaints had been completed, and alleging related prohibited practices. The Commission appointed Christopher Honeyman, a member of its staff, to act as Examiner in this matter and to make and issue Findings of Fact, Conclusions of Law and Order as provided in Sec. 111.07, Wis. Stats. Hearings were held in Madison, Wisconsin on March 27 and 28, May 6, and September 12, 26 and 27, 1991, at which time the parties were given full opportunity to present their evidence and arguments. Both parties filed briefs, reply briefs and second reply briefs, and the record was closed on January 31, 1992. The Examiner, having considered the evidence and argument and being fully advised in the premises, makes and files the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Racine Education Association (herein REA) is a labor organization within the meaning of Sec. 111.70(1)(h), Wis. Stats., and has its principal office at 701 Grand Avenue, Racine, Wisconsin 53403. James J. Ennis is Executive Director of Racine Education Association and is its agent.

2. Racine Educational Assistants' Association (herein REAA) is a labor organization within the meaning of Sec. 111.70(1)(h), Wis. Stats., and has its principal office at 701 Grand Avenue, Racine, Wisconsin 53403. James J. Ennis is Executive Director of Racine Educational Assistants' Association and is its agent.

3. Racine Unified School District is a municipal employer within the meaning of Sec. 111.70(1)(j), Wis. Stats., and has its principal office at 2220 Northwestern Avenue, Racine, Wisconsin 53404. Frank L. Johnson is the Director of Labor Relations of the Racine Unified School District and is its agent.

4. At all times material to this proceeding, Complainant REA has been the certified exclusive bargaining representative of all regular full-time and regular part-time certified teaching personnel employed by Respondent, excluding on-call substitute teachers, interns, supervisors, administrators, and directors.

5. At all times material to this proceeding, Complainant REAA has been the certified exclusive bargaining representative of all full-time and part-time assistants employed by Respondent, excluding supervisors and confidential employes.

6. REA and the District have been parties to a 1988-90 collective bargaining agreement which provided in pertinent part as follows:

> 19.1 Group Hospitalization Surgical/Medical Plan
>
> 19.1.1 Cost to Teachers
>
> The Board shall provide each teacher [except where both spouses are employees, only one (1) will be eligible for family coverage] an opportunity to participate in a group hospitalization and surgical/medical benefit plan. Participants will pay ten dollars ($10.00) per month per year for single coverage and twenty dollars ($20.00) per month for family coverage through an automatic salary deduction established by the Payroll Department. The Board shall pay the balance of the cost of such group hospitalization and surgical/medical benefit plan.
>
> 19.1.2 Comparable Plan/Prescription Drug Plan
>
> The Board shall provide a plan comparable to that in effect August 24, 1988, plus a prescription drug plan with a two dollar ($2.00) deductible per prescription individual payment, during the term of this Agreement. The District will issue prescription insurance plan cards to teachers and retired teachers as part of its prescription insurance plan on or about November 1, 1988. Teachers will be responsible for the two dollar ($2.00) deductible payment at the time of purchase. Reimbursement for prescription purchases between August 25, 1988 and the date that the cards are issued will be made after submission to A & H Administrators

of the receipts for such purchases by the teachers under the same provisions as if the two dollar ($2.00) plan had been in effect August 25, 1988. . . .

. . .

19.4 Group Dental Benefit Plan

The Board shall provide each teacher the opportunity to participate in a group dental benefit plan comparable to that in effect August 24, 1988. Participants will pay one dollar ($1.00) per month per year for single coverage or three dollars ($3.00) per month per year for family coverage through an automatic salary deduction established by the Payroll Department.

. . .

7. REAA and the District have been parties to a 1987-89 collective bargaining agreement which provided in pertinent part:

1. Medical Insurance

a. The Board shall provide each assistant (except where both spouses are employees, only one will be eligible) an opportunity to participate in a group hospitalization and surgical-medical benefit plan.

b. The plan shall be comparable in benefits as the plan in effect during the school year 1984-85.

. . .

e. In the event an HMO or PPO health plan is made available and the employee elects such plan in lieu of the standard medical plan, the participant will pay any premium cost that exceeds the premium of the available standard medical plan. In addition, the participant will pay any contribution required in this contract for the standard medical plan.

. . .

8. At all times pertinent to this proceeding, the parties continued to be governed by the collective bargaining agreements respectively identified in Findings of Fact 6 and 7 above, following their expiration, since no new collective bargaining agreement had been reached in either bargaining unit by the date the record in this matter closed.

9. For a number of years, the District's health and dental insurance had been provided under the terms of a self-funded plan administered by a third-party administrator. From about 1986, when that plan was formulated, till early 1991, the third-party administrator was A & H Administrators, Inc. of Racine, Wisconsin. Beginning in the spring of 1990, the District participated in the formation of MEI, Inc., a corporation organized under the laws of the

State of Wisconsin and owned by Racine area employers including S.C. Johnson Wax, Modine Manufacturing Company and Western Publishing Company. MEI was organized for purposes of providing health care benefits information and consulting services to these employers. During 1990 and early 1991, MEI began to provide such services, and selected Wausau Insurance Companies to act as administrator of self-funded health insurance policies behalf of the employers who were participants in MEI, Inc. The District, on February 1, 1991, formally transferred the third-party administrator function from A & H Administrators to Wausau.

10. MEI, Inc. offered to provide medical case review management and other services, which at all material times were not adopted by the District, though their costs was included in the fees paid to MEI, Inc. The District transferred from A & H to Wausau the terms of the plan previously in effect. A & H had been paying the full amount of all non-surgical claims, and in two letters the District first instructed Wausau to continue said practice for the time being, and then extended that instruction past the close of the hearing herein.

11. REA and REAA both demanded to bargain concerning the selection of an insurance administrator/carrier, and neither agreed to the selection of Wausau or MEI.

12. The record fails to demonstrate any substantial change in the level of benefits or level of service provided to date as a result of the change from A & H to Wausau/MEI. The record thus demonstrates that the plan and its administration by Wausau/A & H are comparable to that in effect previously, within the terms of the collective bargaining agreements noted above at Findings of Fact 6 and 7. By agreeing to said collective bargaining agreements, Complainant Associations thereby authorized the change complained of here.

13. The record fails to demonstrate that the District engaged in dilatory conduct by declining to negotiate concerning a 1991-92 collective bargaining agreement with REAA pending receipt of an arbitrator's award specifying the terms of the 1989-91 agreement.

Upon the basis of the foregoing Findings of Fact, the Examiner makes and files the following

CONCLUSIONS OF LAW

1. Racine Unified School District did not violate Sec. 111.70(3)(a)4, Wis. Stats. when it transferred the administration of its health and dental insurance plans from A & H Administrators, Inc. to MEI/Wausau, because the new method of administration and plan were comparable to the old and were thus authorized under the terms of the collective bargaining agreements between Complainants and Respondents.

2. Racine Unified School District did not refuse to bargain in violation of Sec. 111.70(3)(a)4, Wis. Stats. by delaying bargaining with REAA pending receipt of an arbitrator's award specifying the terms of the 1989-91 collective bargaining agreement.

Upon the basis of the foregoing Findings of Fact and Conclusions of Law, the Examiner makes and renders the following

ORDER 1/

IT IS ORDERED that the complaints filed in this matter be, and they

hereby are, dismissed in their entirety.

Dated at Madison, Wisconsin this 16th day of April, 1992.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By _____
Christopher Honeyman, Examiner

(See footnote 1/ on page 6)

1/ 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.

RACINE UNIFIED SCHOOL DISTRICT

MEMORANDUM ACCOMPANYING
FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

BACKGROUND

In separate complaints, Racine Education Association and Racine Educational Assistants' Association charged that the District violated Sec. 111.70(3)(a)1 and 4, Wis. Stats. by taking actions preparatory to a unilateral change in the third-party health and dental insurance administrator handling the health plans of the employes represented by both Associations. In subsequent amended complaints, the Associations charged that the District had in fact replaced the insurance administrator unilaterally, and had failed and refused to bargain concerning the identity of the administrator and the method of administration. Racine Educational Assistants' Association also charged that the District refused to bargain the terms of a new agreement at all until such time as the interest arbitrator in the preceding collective bargaining dispute rendered the award. Complainants request an order requiring the District to bargain immediately as to the identity of the administrator, including replacement of the self-funded plan by a health and dental plan underwritten by WEAIT Insurance Company or another licensed insurance underwriter; a return to the status quo ante until such matter are resolved by mutual agreement or arbitration; and an appropriate notice to be posted.

Many of the facts are outlined in the Findings and will not be repeated below. It should be noted, however, that this is a relatively lengthy record comprising several days of hearing, 81 exhibits, and six briefs totalling approximately 170 pages. Of the plethora of factual issues raised, all have been considered, but only the salient ones will be discussed below.

For purposes of coherence, the arguments raised by the parties can be grouped into the following principal issues:

1. Is the identity of the plan administrator a mandatory subject of bargaining?

   a. Which is the "interpretive entity", the District itself or Wausau?

   b. Did the costs to employes, or the benefits, change materially as a result of the change in plan administrators?

2. Was the right to change plan administrators incorporated in the collective bargaining agreements between the parties?

3. Did the Associations waive the right to bargain over a change in administrators?
   a. Did the Associations engage in bad faith in their handling of the bargaining relationship in relevant part?

4. Was there a necessity for a change in administrators?

   a. Would the prior administrator itself have

refused to renew the contract?

5. Did the District unlawfully delay bargaining with Racine Educational Assistants' Association?

THE IDENTITY OF THE PLAN ADMINISTRATOR

The parties differ over whether the identify of the third-party administrator is a mandatory subject of bargaining. A long history of private- and public-sector disputes over this issue exists, but the parties agree that for practical purposes the discussion in the present context begins with the Commission's ruling in Madison Metropolitan School District. 2/ In that decision the Commission exhaustively reviewed practices in the health insurance industry, and held as follows:

> We commence our analysis of the specific proposals at issue herein by noting that the scope of insurance benefits available to employes as well as the cost, if any, of such benefits to employes are "wages" 3/

3/ While it can reasonably be concluded that such matters are also "conditions of employment", such a distinction is unnecessary and irrelevant to our task herein. See e.g., Pittsburgh Plate Glass, supra; Keystone, supra.

> within the meaning of Sec. 111.70(1)(a), Stats., and thus are mandatory subjects of bargaining. Mid-State VTAE, Dec. No. 14958-B, D (WERC, 4/78); Sewerage Commission of the City of Milwaukee, Dec. No. 17302 (WERC, 9/79). See also, Allied Chemical & Alkali Workers Local 1 v. Pittsburgh Plate Glass Co., 404 U.S. 157 (1971); Labor Board v. General Motors Corp., 179 F.2d 221 (CA-2 1950); W.W. Cross & Co. v. Labor Board, 174 F. 2d 875 (CA-1 1949); Inland Steel Co. v. Labor Board, 170 F.2d 247 (CA-7 1948). Mandatorily bargainable insurance benefit issues have been said to include not only the type and level of expenses to be covered by insurance but also the manner in which the insurance policy or plan is administered when said administration impacts upon wages, hours and conditions of employment. School District of Menomonie, supra; Keystone Steel and Wire v. NLRB, 606 F.2d 171 (CA-7 1974). Thus administrative matters such as speed of claims processing, availability of a labor consultant and claim filing procedures have been held to be mandatory subjects of bargaining because they determine the speed and ease with which employes may procure the bargained for benefits. Keystone supra. . . .

2/ Decision No. 22129, 22130 (11/84), aff'd, Madison Metropolitan School District v. WERC, 133 Wis.2d 462 (Ct. App., 1986), petition for review denied, 134 N.W. 2d 457.

In other jurisdictions, the identify of the insurance carrier and/or administrator has been found to be a mandatory subject of bargaining when the choice of one carrier over another or of one administrator over another yields different benefits or yields additional costs for the employes. Thus, an employer typically has been held to have a duty to bargain with the bargaining representative of its employes in instances where (1) the bargaining representative proposes to have the employer provide coverage from a new carrier whose benefit plan and manner of administrating same differ from that currently enjoyed by the employes, Houghton Lake Education Association v. Houghton Lake Community Schools, Board of Education, Case No. C79 I-250 (MERC, 7/80) aff'd 109 Mich. App. 1 (Mich. Ct. App. 8/81), cert. denied (Mich. Sup. Ct., 6/82); City of Roseville v. Local 1614, IAFF, AFL-CIO, 53 Mich. App. 547 (1974), or where (2) the employer alters the identity of the carrier or administrator and thereby alters the level of benefits or the cost of same to the employes. Bastian-Blessing v. NLRB, 474 Fed.2d 49, (CA-6 1973); Keystone, supra; Oilworkers (Kansas Refined Helium Co.) v. NLRB 547 Fed.2d 575 (CA-DC 1976), cert. denied sub. nom. Angle v. NLRB, 431 us 966 (1977). However, where the employer has bargained over the benefits as well as the cost of same to the employes or where there has been no showing that the identity of the carrier and/or administrator will impact upon these mandatorily bargainable matters, the employer has been found to have no duty to bargain with the bargaining representative over the identity of the insurance carrier and/or administrator. Connecticut Light, supra; Sioux City Community School District, supra.

Our decision in Walworth County, supra, is not inconsistent with the foregoing summary of the current status of the law in other jurisdictions.

Thus, it has been the presence or absence of a relationship of carrier/administrator identity to benefits or employe cost which has determined the mandatory or permissive status of that identity. Where the union has established that a change in carrier and/or administrator will result in a change of benefits or will affect the cost borne by the employes for the insurance benefits, the employer has been found to have a duty to bargain over the identity of the carrier and/or administrator. Conversely, where the union has not been able to demonstrate that there is a relationship to benefits or cost to employes, the identity of the insurance carrier and/or administrator has not been found to be a matter over which the employer is obligated to bargain.

The instant record presents information about carriers and/or administrators who collectively do in excess of seventy (70%) percent of the group health

insurance business in Wisconsin at a specific point in time which is proximate to the time frame within which the parties' dispute arose. As such we are satisfied that this record presents a representative view of the health insurance industry for the time frame in question.

Our review of that record satisfies us that at the time in question, all insurance carriers and/or administrators involved herein provide unique benefit packages. We so find because, even where the policy provisions are identical, carriers and/or administrators frequently interpret and/or administer said provisions in different manners and these differing interpretations yield different benefits for employes. Tr. 101, 302, 320, 387-388, 425, 490-492, 516. For example, certain benefits in all policies are paid at a level specified as "usual, customary and reasonable" or "reasonable and customary." The evidence demonstrates that carriers utilize different procedures to generate the data upon which the "usual, customary, and reasonable" payment level determinations are based, resulting in different payments for identical claims in at least some circumstances. Tr. 72, 86, 97, 129, 147, 173-177, 182-183, 223-224, 283-284, 326, 336, 364-365, 425-427, 496. Moreover, the record reveals that insurance policies typically limit certain benefits to medical procedures which are "medically necessary." The record establishes that the different decisionmakers for each carrier/ administrator ultimately define the term "medically necessary" differently in at least some circumstances and thus the benefit levels related thereto are different from carrier to carrier. Tr. 64-65, 140, 318, 417, 488. MTI's proposals herein thus seek to maintain what are unique benefit packages and hence the proposals have a direct relationship to employe wages.

The record demonstrates not only that the definition of key terms such as "usual, customary and reasonable" and "medically necessary" will vary from carrier but also, of course, that payment levels made by a given carrier as regards a given claim vary from one point in time to another. In our view that further supports our conclusion that the employes in the instant bargaining units have been shown to have substantial economic interests in the integrity, reliability and responsiveness of the carrier/administrator that is selected to be responsible for fair, accurate and prompt payment of employe health insurance claims. . . .

. . . . Nor does our holding herein mean that where a contract does not specify an insurance carrier and/or administrator, the employer necessarily commits a per se unilateral change refusal to bargain if, during the term of that contract, it chooses to purchase insurance from a different source. Whether such a change would

> be held unlawful in those circumstances, will depend on whether the union involved shows that a unilateral change in benefits (including coverage and/or administration) had occurred by means of specific proof. . . .

The Commission stated that its conclusion "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 same time, however, the very fact that so detailed a review of industry-wide practices was made tended to indicate that Madison would be treated as a leading case for purposes of similar litigation; and so it has proved.

Madison, however, differs from the present case in that here the carrier of risk is the District itself (except as to stop-loss), while in Madison the insurance firms involved were all acting in the classic fashion of a true insurance carrier. Thus, there is particular relevance to two other, more recent cases, Milwaukee Board of School Directors 3/ and Mayville School District. 4/

Milwaukee was a declaratory ruling proceeding involving (in pertinent part) whether the district would have to bargain with the teachers' association over a decision to self-fund insurance, which at the time in question was under a "cost-plus" arrangement. The Commission found that:

> The record herein demonstrates that the provision of health care benefits through self insurance under Sec. 120.13(2), Stats., 9/ as opposed to a cost plus or conventional insurance carrier may have the following consequences: (1) a change in the entity that interprets the provisions of the plan; (2) the loss of state mandated benefits; and (3) the risk that incurred claims would not be paid in the event of employer insolvency. In our judgement, if any or all of these potential consequences were to be the actual consequences of a decision to self-insure, the relationship of the decision to wages would predominate over its relationship management policy and thus the decision would be a mandatory subject of bargaining.
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> We have drawn the distinction in our analysis between potential and actual consequences because it would appear from the record that the Board could package self-insurance in such a way as to eliminate the wage relationship of the decision. We have also done so because although our decision in Madison Metropolitan School District, Dec. No. 22129 (WERC, 11/84), aff'd 113 Wis.2d 462 (CtApp, 1986), cert denied, (WisSupCt, 1/87), finding the identity of an insurance carrier to be mandatory has been affirmed, the "interpretative entity" factor identified above as consequence (1) which was critical to the result reached in Madison would need to be re-established

3/ Decision No. 23208-A (WERC 2/87).

4/ Decision No. 25144-C (Greco, 6/90).

> through proof regarding whether this aspect of the health insurance industry continues to be present. Madison, at 11 . . . . (Footnote omitted)

Mayville, meanwhile, is an examiner's decision, on review by the Commission at this writing. The examiner in Mayville reviewed an exhaustive record of actual health claims compiled after a unilateral change from a conventional plan to self-insurance, and concluded that the teachers' association had failed to meet its burden of proof as to any material change in benefit or service levels; he therefore dismissed the complaint, stating in pertinent part:

> 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. . . .
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> 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.
>
> . . .

This, then, is the background against which the present case arose. The parties not unexpectedly make a plethora of arguments concerning the principles derived from Madison, Milwaukee and Mayville, which follow.

The Associations argue initially that the administration of any benefit plan is unique to the administrator, and that a change of administrators "virtually always" affects the coverage and benefits of the plan. The Associations contend that whether or not the plan provisions are identical, as the Commission noted in Madison, administrators frequently interpret or administer the provisions in a different manner, yielding different benefits for employes. The Associations contend that the providers administratively determine benefits where there is no benefit plan language to guide them, but that their guidelines for so doing are established independently and differ from one provider to another. The Associations note that Wausau has developed an operations manual specifying techniques and resources for claims investigation, as well as written guidelines for medical review of specific types of claims while A & H never did.

The Associations note that in Dec. Nos. 26816-A and 26817-A of the same

title, the Examiner has already found certain guidelines and procedures used by Wausau, including medical and dental UCR guidelines, preadmission review guidelines, concurrent review guidelines, medical and dental consultant review guidelines and UCR determinations and claim flow, to be proprietary and confidential property constituting trade secrets under Section 134.90, Wis. Stats. The Associations argues that it would be "a very exceptional" case where a change in administrators failed to affect materially the coverage and benefits actually enjoyed under the plan concerned, citing City of Roseville v. Local 1614, IAFF, AFL-CIO 5/ and Sioux City Community School District, 6/, in both of which the neutral body concerned used similar language. The Associations note that at least as to the records involved in the Madison and Milwaukee cases, in both of which multiple insurers' practices were compared, the Commission found such differences to exist on an industry-wide basis. The Associations argue that the Commission's caveat in Madison that its decision was tied to the record involved is relevant, but that the record in the present case is replete with proof of a lack of change in the insurance industry since the Madison record was compiled.

The District contends that Madison requires case by case proof of whether UCR data results "in different payments for identical claims in at least some circumstances"; whether "different decisionmakers for each carrier/administrator ultimately defined the term "medical necessary" differently"; whether "payment levels made by a given carrier vary from one point in time to another", and, as a result of amendments by the court of appeals, whether claim response time, manner in which employes are able to monitor claims, nature and cost of conversion plans, and definitions of terms such as "dependent" are different. The District contends that the Associations have failed to prove any such differences in this case. In this context the District argues particularly that the only probative evidence which would even tend to demonstrate such differences was in the form of an affidavit from Delores Clancey, Vice President of Wausau. The District objected at the hearing when the Associations offered the affidavit as an exhibit, on grounds of hearsay because Clancey had already been excused as a witness prior to the time the document was offered. The District, in addition, objects to admission of a survey of insurance firms performed by Huttleston Associates, Inc., also on hearsay grounds.

I found Clancey's affidavit admissible as an exhibit, contrary to the District's objection. I note that when the District objected that it did not have the opportunity to cross-examine Clancey as to the affidavit, it had had such opportunity earlier in the proceeding, and failed to request that Clancey be recalled as a witness at the time the document was formally offered. I note also that the affidavit in question was the subject of extended discussion on two widely separated days of hearing, between which briefs were solicited and received from all parties as to the trade secret privilege argued by Wausau. During that period the District was silent as to any contention that the affidavit should not be considered. As to the Huttleston survey, while I must acknowledge the variety and ingenuity of the arguments raised by the District alleging hearsay on various grounds, similar arguments could be raised as to virtually any survey, or industry-wide data of many kinds that are routinely admitted into all sorts of legal proceedings. I will therefore treat the objection as applying to the level of reliability which might be ascribed to

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5/ 53 Michigan Appeals 547 (1974).

6/ Iowa PERB, 1980.

this document, but will admit it into evidence. 7/

Even allowing for some doubt as to the level of thoroughness and impartiality of the Huttleston survey, all of the evidence in the record supports the Associations' contention that the industry-wide pattern of differences found in Madison continues to exist today. The District made no effort to disprove this pattern, and the record as a whole is therefore on all fours with Madison.

This, however, is not sufficient to show that the employes of the Racine Unified School District are receiving, in practice, materially different benefits and/or costs as a result of the change actually made by the District. In this context it is particularly relevant that the District strenuously avers that A & H acted improperly when it paid all claims, other than surgical claims, at what the Union describes as 100 percent of "UCR". The District argues that this represented either incompetence, or breach of A & H's duty to apply UCR guidelines, which presuppose that something less is payable [though the guidelines vary from one carrier/administrator to another]. The District correctly points out that the Associations have not established in this record a single instance of actual payment of any claim by Wausau at less than A & H would have approved.

This is considerably undercut, however, by the fact that the District took specific and time-limited actions to assure that Wausau would continue to pay claims for the time being in the manner that A & H had. The record shows that when the District discovered that A & H had engaged in the practice of 100 percent payment, it issued an instruction to Wausau to do the same through a date certain, and later extended that date past the date at which the hearing in this matter closed. The District also declined to have the medical case management procedures proposed by MEI put into effect, for the time being. Thus it is hardly surprising that the Associations have not demonstrated any immediate effect on actual payment of specific claims.

It seems insufficient, however, to describe the matter as "unripe". I will address below the question of who is the "interpretive entity" as defined in Madison, partly because to close the inquiry as to the mandatory or permissive nature of the change merely upon a failure of the complaining party to demonstrate an immediate effect, where the responding party has given a time-limited instruction to maintain the former administrators' habits, could potentially result in piecemeal litigation of subsequent cases of this type. On this record, the District has forestalled any current proof by the Associations of an actual difference up to the date of expiration of the District's instructions to Wausau; but the long-term implications of the change in UCR guidelines, etc., are as intact as Madison would require. 8/

THE "INTERPRETIVE ENTITY"

7/ I note also that the same document, together with similar testimony from Huttleston as was received in the present case, was admitted in Mayville.

8/ Note, however, that this matter ultimately turns on an interpretation of contract, for reasons addressed below. Notwithstanding the important public policy aspects of the Madison line of cases, therefore, any further changes by the District, under the parties' current contract language, may well be deferrable to the agreements' grievance and arbitration procedures.

For all of the subtleties in its factual basis, Madison at least involved a clear change among true insurance carriers, and little analysis was thus necessary as to who, in fact, was interpreting the provisions of the health insurance plan involved. In Milwaukee, however, the Commission had to address this issue, and discussed the "interpretive entity" test:

> Looking first at the "interpretive entity" factor, if the Board were to self-insure in a manner which would have an entity other than Blue Cross interpreting policy provisions such as "usual and customary", a clear impact on benefits and wages would be created if the Madison Schools proof burden noted above was met. However, if the Board were to self-insure and retain Blue Cross as the "interpretive entity", this benefit consequence would not be present.

Even in Milwaukee, however, a change in the type of insurance plan was contemplated. Here, by contrast, however, the most minimal change in plan is involved. The change is from one third-party administrator, not carrying liability, to another, operating under precisely the same terms. This requires that the "interpretive entity" be analyzed to a greater degree than was necessary in Milwaukee, particularly as the nature of that proceeding (a declaratory ruling) made the Commission's analysis necessarily somewhat speculative.

In my view the question is a close one on these facts. The Associations and the District each marshal a substantial body of evidence favoring their respective positions. For example, the Associations point to the fact that the vast majority of claims are resolved without any direct input from the District. A & H, not the District, determined to use Health Insurance Association of America as the source for UCR data, and it, not the District, decided to add a 10 percent additional factor to those rates to make up for HIAA's six month reporting lag. A & H, not the District, determined later to switch its UCR source from HIAA to Medical Data Resources. And A & H determined to "apply reasonable and customary at 100 percent" in the case of non-surgical claims. Furthermore, A & H made determinations of what constituted "medical necessity", and decided when and to whom claims should be submitted for review. A number of other criteria referred to in the Madison and Milwaukee decisions also are demonstrated as having been handled by A & H, and subsequently by Wausau, rather than having been referred "upstairs" to the District. Indeed, this constitutes the ordinary course of day to day business of any insurance administrator, without which one might seriously question whether the client was receiving anything more than paperwork for its fees.

Yet the District has strenuously, and not without some factual basis, maintained that it is the ultimate interpreter of the provisions of the plan. Indeed Edwin Benter, Assistant Superintendent for Business Services, testified that he makes the final decision in the event of any dispute between the third party administrator and one of the District's employes as to the level or method of payment of a claim. 9/ Benter spends, on average, two to three days per month dealing with issues one way or another affecting the health and dental care plan. 10/ On the other hand, Benter also testified that he

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9/ Tr. 1, page 86.

10/ Tr. 1, page 97.

received "usual and customary" questions from A & H only if there was a dispute with a claimant, and he would side with the claimant "only if we had done something different in the past. Otherwise we accepted the usual and customary from A & H." 11/ This implies that A & H's determinations were deemed final in all situations which did not involve the possible contravening of a specific precedent.

Kathleen Niles, Account Manager for A & H Administrators, testified that "ultimately the client" has the job of interpreting and applying the language of a plan. 12/ Yet Niles also testified that over an extended period of association with the District, "all consultations" with Benter involving appeals of initial claimed determinations amounted to "maybe four or five times a year." 13/

Under these circumstances, the most accurate reflection on the "interpretive entity" question is to say that the function of interpreting and applying the terms of the District's health plan is shared between the third party plan administrator and Benter, a District official. But within that finding, I am struck by the number of decisions made by A & H over the years of which the District was apparently ignorant for an extended period.

Most conspicuous among these was the decision [in the Associations' terms] to pay non-surgical claims at 100 percent of UCR - characterized by the District as breach of duty or incompetence. Whether or not the practice reflected a proper understanding of the terms of the plan is not the point in this context, so much as is the fact that the District at once avers that it is the interpretive entity and that it was ignorant of this widespread practice of interpretation for years at a time. I resolve this inconsistency by finding that the District's role was marginal, and therefore that for practical purposes the interpretive entity was A & H and later Wausau, in the vast bulk of instances.

DID THE COSTS TO EMPLOYES OR THE BENEFITS CHANGE MATERIALLY?

The benefits to employes under the plans have not changed materially, for reasons already addressed. The record shows that the costs directly paid by employes have also not changed. The Associations make an intriguing argument, however, that under the Wisconsin public-sector bargaining system, any increased administrative cost of new insurance arrangements represents at least a potential cost to employes, because a union must bargain over the same "pot". The record establishes that while the direct cost of administration, per employe, of Wausau's services is in the same general range as A & H's had been, MEI represents a new cost of some $13,000 per month. Since the record also established that MEI's "case management" plans have not been implemented by the District, the Associations have a point in arguing that the net amount available for bargaining for salaries, etc. may be affected. Yet one could say the same about any expenditure made by an employer which could be argued to be excessive or unwise; and the right to manage must, regretfully, be recognized as occasionally involving some quantity of errors, even in Wisconsin. The fact that public employers do not always spend their money wisely, in other words, does not convert every management decision into a mandatory subject of

11/ Tr. 1, page 106.

12/ Tr. 1, page 138.

13/ Tr. 1, page 182.

bargaining.

WAS THE RIGHT TO CHANGE ADMINISTRATORS INCORPORATED IN THE COLLECTIVE BARGAINING AGREEMENT?

The applicable language of the collective bargaining agreements is included in Findings of Fact 6 and 7 above. If in fact that language presupposes that the District had a right to change third-party administrators, this is dispositive. This is true whether or not the contract in question was in effect on the date of the change: the "status quo" principle governing the parties' rights during a contractual hiatus cuts both ways, and if the union in question has agreed to contract language which permits an otherwise unilateral change to be made, that continues to be the case during the hiatus. 14/ Interpretation of the exact terms of the collective bargaining agreement is therefore in order.

The District contends that the Associations have tried often before to obtain a guarantee of benefits and carrier, beginning in the 1972-74 contract. 15/ The District cites that same decision to the effect that the REA attempted to get the entire insurance program made part of the contract in 1974, again unsuccessfully. 16/ The District argues that, in a 1986 declaratory ruling proceeding, the parties disputed the mandatory and non-mandatory status of each other's health insurance proposals, and both proposals were found mandatory. In that decision 17/ the Commission found, in response to an Association argument that the District's proposal made it "difficult to ascertain what benefit level must be maintained":

> [That argument] goes to the merits of the proposal, not its bargainable status. We also reject the Association's contention regarding the impropriety of a proposal which may allow for some change in benefit level. When bargaining a successor contract, both parties have the statutory right to seek changes in mandatory subjects of bargaining.

The District notes that the proposal under review in that section of the decision was the "comparable" language found in both of the contracts at issue here. The District further notes that when analyzing the Association proposal, the Commission said inter alia "The Association has clearly stated during this proceeding that the proposals do not require that any specific insurance carrier provides the "benefit plan".

In response, the Associations argue that the District in this context is making a waiver argument and that a waiver must be clear and unmistakable. 18/ The Associations contend that no clauses in the collective bargaining

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14/ Kenosha County, Dec. No. 22167-D (WERC, 7/87). See also cases cited in Dec. Nos. 22167-B and 22167-A of the same title, also NLRB v. Katz, 369 US 736; and City of Brookfield, Dec. No. 19822-C (WERC, 11/84).

15/ Decision Nos. 13696-C, 13876-B (Fleischli, 1978), at page 78.

16/ Id. at page 79-80.

17/ Decision Nos. 23380-A, 23381-A (WERC, 1986), at page 17.

18/ City of Wauwatosa, Dec. Nos. 19310-C, 19311-C, 19312-C (WERC, 4/84)

agreements explicitly authorize the District to change the administrator during the term of the agreement, while A & H is specifically named in both the individual insurance booklets and the plan document itself as the administrator. Further, the Associations argue, the collective bargaining agreements provide that the existing health care plan will remain in effect during the contract's term. The Associations also argue that in Keystone Consolidated Industries v. NLRB 19/ an employer was not permitted to change administrators even though the basic collective bargaining agreement made reference only to maintaining "insurance and health care", with the language of the insurance and health care agreement being separate from the contract.

The District, in reply, contends that Keystone involved an insurance plan booklet which was the sole expression of the intent of the parties in their vague contractual language, and that the booklet was replete with specific references to a named carrier, thus implying that the parties had bargained the carrier as part of the contract. Here, the District notes, the reference to A & H Administrators in the applicable section of the collective bargaining agreement is present, but the contractual language does not refer to "the plan", contrary to the Associations' representations, but instead refers to "a plan comparable to that in effect August 24, 1988 . . . ". The District further argues that the plan document itself identifies the following language providing for amendment:

> ADMINISTRATION OF THE PLAN
>
> The Plan is administered through the administration office of the Plan Administrator. The Plan Administrator has retained the services of A & H Administrators, Inc., experienced in claim processing.
>
> The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Supervisor, A & H Administrators, Inc., 2514 South 102nd Street, Suite 340, West Allis, WI 53227.
>
> PLAN MODIFICATION AND AMENDMENT
>
> The Plan Administrator may modify or amend the Plan from time to time at its sole discretion, and the amendments or modifications which affect Covered Persons will be communicated to them.
>
> PLAN TERMINATION
>
> The Plan Administrator may terminate the Plan at any time. Upon termination, the rights of the Covered Persons to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Covered Persons.
>
> ENTIRE PLAN AND CHANGES
>
> The Plan, including the riders and endorsements, the Schedule(s) of Benefits, the attached papers, the application of the Plan Administrator and the individual applications, if any, of the Employees,

19/ 102 LRRM 2664 (7th CirCt of Appeals, 9/74).

> constitute the entire description of benefits between the parties, and any statement made by that Plan Administrator shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the benefits or reduce the coverage under the Plan or be used in defense of a claim hereunder unless it is contained in a written application.
>
> No change in the Plan shall be valid unless approved by the employer and unless such change is endorsed thereon or attached thereto.

In reviewing the language of this collective bargaining agreement and the history of the parties' proposals, I am struck by the evidence that the Associations [particularly the REA] have attempted over a period of years to obtain stronger health insurance language in the collective bargaining agreement, and have been unsuccessful. By comparison with some other formulations often used in collective bargaining, such as "equal or better" or even "substantially equal or better", the word "comparable" is, to put it plainly, weak. Contract language which provides no stronger protection than this against employers' occasional desires to change plans is routinely recognized in labor relations as allowing the employer in question to make changes in the plan or its administrator, provided the general level of benefits is maintained. This general observation is underlined by the specific history of the parties' 1986 declaratory ruling clash, which clearly demonstrates that both parties understood that maintenance of the existing administrator or even the exact plan benefits was not contemplated by the use of the word "comparable". Also, the clear language in the plan document defines A & H as a company "retained by" the "plan administrator" (the District, in this usage), and reserves to the plan administrator the right to modify the plan. In this context, the references to A & H appear to be merely a matter of recording the current claims "supervisor", in the Plan's language, not the specific guarantee of keeping that supervisor/administrator which was implied by the plan language in Keystone.

The record in this case is far from establishing that the District acted outside the bounds of general comparability when it replaced A & H with Wausau. At best, a putative future change in UCR guidelines and various other technical aspects governing the review of claims is established. But it has often been observed that some degree of change is virtually inevitable upon replacement of any carrier or administrator with another, as in Madison and Milwaukee. The "comparable" standard in the contracts, however, does not act as the guarantee of a specific level of benefits which the contract language at issue in Madison and Milwaukee would have. This combines with the lack of evidence of substantial changes in the level of benefits - or even of administrative methods - to convince me that independently of the merits of all other contentions raised in this contentious proceeding, the particular collective bargaining agreements at issue did permit the particular change the District made. For this reason alone the complaints would have to be dismissed.

DID THE ASSOCIATIONS WAIVE THE RIGHT TO BARGAIN?

Separately from the arguments surrounding the interpretation of the existing collective bargaining agreements, the District makes a lengthy and elaborate waiver argument centered on the contention that the "modus operandi" of REA Executive Director Jim Ennis has been found, in many cases over many years, to amount to permanent constructive notice of all District actions affecting those he represents, and that any failure by REA or REAA to make a

specific and "relevant" collective bargaining proposal promptly upon notification of a District intent to do something constitutes waiver, in the unique circumstances of the parties' fractious relationship. In so claiming, the District makes the allegation that REA and REAA are engaged virtually permanently in attempts to "sandbag" the District, for the purpose of which the Associations routinely make delaying and obfuscatory arguments.

For purposes of the present case I find these arguments meritless. Whatever may be the history of motivations between these parties, it is clear that the District announced an inclination, then an intention, to change administrators; the Associations timely proposed WEA Insurance Trust as a replacement for the self-funded plan; 20/ and the Associations never specifically agreed to the selection of Wausau or MEI. Other than the form of waiver inherent in the existing contract language, it would therefore require an extraordinary exception to the doctrine that a waiver, under Wisconsin law, must be clear and unmistakable to find that the Associations waived the right to bargain concerning the change. 21/ I specifically reject the District's contention that the Associations were obligated to make a "relevant" proposal, i.e. one not including WEA Insurance Trust as a named carrier, in order to meet the test the District would set forth. While the District may be correct in asserting that WEAIT had been proposed and rejected before on numerous occasions, the fact that a proposal has been rejected does not make it irrelevant, and it is a fact of collective bargaining life that determination does sometimes win results. Unpalatable the Associations' proposal for WEAIT may therefore be; irrelevant it is not.

WAS THERE A NECESSITY FOR THE CHANGE IN ADMINISTRATORS?

The District has alluded to, but not stressed, an argument that the change to MEI/Wausau might have been required by virtue of A & H's reluctance to renew the existing contract, allegedly because it found REA tiresome to deal with. This, if made squarely, would be a "necessity" argument advanced to justify a unilateral act. 22/ It is sufficient to say that the record does not establish that A & H had cancelled or refused to renew the contract with the District and that the record leaves it speculative whether A & H would have done so. Necessity, which is in the nature of an affirmative defense, is therefore not proved.

20/ The parties rehearse at length their arguments concerning whether the Associations' fall, 1990 proposal was or was not a prompt response to the District's spring, 1990 plans. With respect to these I will note only the record evidence that District Labor Relations Director Johnson himself was for some time ignorant of the details of those plans, and that the Associations made their proposal within weeks of having the District's final plans in hand.

21/ City of Wauwatosa, supra.

22/ Brookfield, supra.

DID THE DISTRICT UNLAWFULLY DELAY BARGAINING WITH RACINE EDUCATIONAL ASSISTANTS ASSOCIATION?

The Assistants' complaint in part alleges that the District refused to bargain a new collective bargaining agreement with REAA until it had received the arbitration award setting the terms for the existing agreement. Little evidence or argument was adduced with respect to this contention; it is clear that it is not a primary focus of the complaints herein; and I find that complainants have not proved by a clear and satisfactory preponderance of the evidence that the District engaged in dilatory bargaining in violation of its duty to bargain.

Dated at Madison, Wisconsin this 16th day of April, 1992.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

By _____
Christopher Honeyman, Examiner