# Affordable Care Act Compliance & School Employee Health Benefits: *Planning for a Healthy 2016*

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## Key Provisions of the ACA for School Districts & BOCES

- **The Employer Shared Responsibility Provisions** (also known as Pay or Play, Employer Mandate, or 4980H) require large employers to offer affordable, ACA-compliant health insurance coverage to full-time employees and their dependents or pay penalties. The pay or play employer mandate became effective beginning January 1, 2015 and continues to be in effect.
  - **Look-Back Measurement Method** for determining whether an employee is a full-time employee who must receive an offer of coverage (or the employer pays a penalty)
  - **Affordability safe harbors** for determining whether the coverage offered to an employee is affordable
  - Regulations re: counting employees' hours of service that significantly affect employers such as school districts

## Key Provisions of the ACA for School Districts & BOCES

- **Section 6056 Large Employer Reporting to the IRS** about the employer's full-time employees and the coverage offered to those employees. Returns for 2015 must be filed with IRS and furnished to employee in early 2016.
- **Section 6055 Reporting to the IRS** on minimum essential coverage provided to an individual. **Applies to districts & BOCES providing coverage through a self-insured plan, such as NYSHIP Empire**
- **90-Day Waiting Period Limitation:** Effective January 1, 2014, maximum waiting period an employer offering a group health plan can have in effect before a full-time employee eligible for coverage can enroll is 90 days.

## Key Provisions of the ACA for School Districts & BOCES

- **FLSA 18B Notices (Exchange notices / Marketplace Notices)** given to all employees about their coverage options on the Exchange – began October 2013, now an ongoing obligation as new employees are hired
- **Non-discrimination provisions** for group health plans that prohibit discrimination in favor of highly-compensated employees – delayed indefinitely
- **Whistleblower & Non-Discrimination Protections** for employees who receive a premium tax credit or subsidy to subsidize coverage
- **Excise Tax on High Cost Plans (Cadillac Tax)**
- **Summary of Benefits & Coverage (SBC)** plain language description of basic terms of health insurance plan; must be provided to plan enrollees ** obligations for districts & BOCES providing coverage through a self-insured plan, such as NYSHIP Empire**


## Roadmap for 2016

- Furnish and file 6056 (& 6055, if applicable) reporting for 2015
- Full compliance with 4980H
- Full compliance with 90-day waiting period limitation
- Continue to comply with SBC, FLSA 18B obligations
- Stay abreast of special obligations for employers offering coverage through self-insured plans such as NYSHIP Empire:
  - 6055 reporting (don't forget retirees!)
  - Summaries of Benefits & Coverage (SBCs)
- Two more years to plan for Cadillac Tax (now effective January 1, 2020)

## Section 6056 Reporting

## Understanding Section 6056 Reporting

- Large employers subject to 4980H must submit an information return to the IRS about the employer's full-time employees and the coverage the employer offered to those employees (and dependents) during the reporting period (calendar year).
- A report with similar information must also be furnished to the subject employees.
- This reporting is necessary for the IRS to administer the Employer Shared Responsibility provisions, and it provides the IRS with the information it needs to assess 4980H penalties.
- It is also the employer's opportunity to establish what safe harbors applied for this employee (for individual months or the entire year) or whether the employee was not employed full-time in a particular month
- First months for which information must be reported are months in 2015

## Completing Section 6056 Reporting

- Form 1095-C must be completed for each individual full-time employee to document:
  - Whether coverage was offered for each month of calendar year (Line 14)
  - Employee's share of lowest cost monthly premium for self-only coverage (Line 15)
  - Whether 4980H safe harbor applied for each month (Line 16)
- Form 1094-C is used to transmit all 1095-C forms to IRS and report overall information on employer's workforce during the calendar year
- Deadlines for 2015 returns only (recently extended by IRS Notice 2016-4):
  - Furnish to employees by March 31, 2016
  - File with IRS by May 31, 2016 (June 30, 2016 if e-filing)
- Deadlines for returns in subsequent years:
  - Furnish to employees by February 1
  - File with IRS by February 28 (March 31 if e-filing)
- Penalties incurred with IRS if employer fails to file (26 USC § § 6721, 6722)
  - Amounts vary by nature of failure but were recently increased by Congress

# Section 6055 Reporting

## Understanding Section 6055 Reporting

- Applies to providers of minimum essential coverage (MEC)
- Assists IRS in determining whether an individual had MEC during the year (i.e., whether person is responsible for an individual penalty)
- For employers providing coverage through a fully insured plan, the health insurance carrier will report (caveat: confirm with carrier)
- Employers providing coverage through a self-insured plan (such as NYSHIP Empire) are responsible for their own 6055 reporting
  - Another entity could assume responsibility for reporting, but NYSHIP, for example, has not done so
  - Don't forget about retirees covered under self-insured plan
  - Availability of data on non-employees has been a concern
    - Don't wait until the last minute to compile

## Completing Section 6055 Reporting

- Large employers will use Form 1095-C (same form used for Section 6056 reporting)
  - Must report on other individuals covered through the employee's coverage (need their SSN or DOB if SSN not available) and months they were covered
- Small employers will use Form 1095-B (for each covered individual employee & the individuals covered through employee) and Form 1094-B (transmittal form)
- Same deadlines for 6056 reporting:
  - For 2015 returns only:
    - Furnish to employees by March 31, 2016
    - File with IRS by May 31, 2016 (June 30, 2016 if e-filing)
  - In subsequent years:
    - Furnish to employees by February 1
    - File with IRS by February 28 (March 31 if e-filing)

## Tips for Responding to 6056 & 6055 Reporting Questions


- Review IRS forms, instructions, notices:
  - Forms 1094-C & 1095-C for 6056/6055 large employer reporting
  - Forms 1094-B & 1095-B for 6055 small employer reporting
  - IRS has thorough instructions for both forms:
    - https://www.irs.gov/instructions/i109495c/ar01.html
    - https://www.irs.gov/instructions/i109495b/ar01.html
- Commentary to IRS Regulations is helpful as well:
  - Section 6055 Regulations: 79 Fed. Reg. 13220 (Mar. 10, 2014)
  - Section 6056 Regulations: 79 Fed. Reg. 13231 (Mar. 10, 2014)
- Review guidance from health insurance plan (NYSHIP, SSEHP, etc.)
  - NYSHIP memos are a good source of information; available online
  - Benefits personnel have direct access to additional sources of information

## Summary of Benefits & Coverage (SBC)

## What is an SBC?

- Summary document which describes, in relatively plain language, the benefits and coverage under the applicable plan
- Describes, for example, the plan's deductible, out-of-pocket maximums, provider network, and coverage of example common medical events (such as visiting a doctor's office, having a medical test done, pregnancy, outpatient surgery, etc.), as well as the costs associated with the event under the terms of the plan
- Model forms from federal government

## Who must provide the SBC?

- Obligation to provide an SBC rests with:
  - The health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage, or,
  - *In the case of a self-insured group health plan*, the plan sponsor or designated administrator of the plan (typically the employer).
- Either the insurer or employer can deliver the SBC, but the employer is responsible to ensure that all individuals entitled to receive the SBC actually receive it.
- Under the anti-duplication provisions of the SBC regulations, the requirement to provide an SBC is met for all entities if a single entity provides the SBC.

## SBCs & NYSHIP

- A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, upon request, upon renewal, and by the first day of coverage (if there are changes).
- NYSHIP has continued to create and make available the SBC on its website
- NYSHIP has also continued to send SBCs to *current* enrollees
- However, NYSHIP has otherwise relied upon individual participating agencies and employers to distribute SBCs to new hires offered coverage and previously eligible employees seeking to enroll in coverage

## When must an SBC be provided?

- SBCs must be provided to at certain specified times, including:
  - Upon application for coverage
  - By the first day of coverage (if there are any changes)
  - Annually at renewal
  - Upon request (SBC must be sent no later than 7 business days after request)
  - At special enrollment (within 90 days after special enrollment)

*Refer to 26 CFR 54.9815-2715(a)(1)(ii) for specifics*

## Who must receive an SBC?

- SBC must be provided to:
  - all applicants at the time of application and enrollees (including beneficiaries) at initial enrollment and annual re-enrollment
  - each participant or beneficiary who is enrolled in a group health plan.
- However, a single SBC may be provided to a family unless any beneficiaries are known to reside at a different address.

## Keep in mind

- SBCs can be provided electronically under the conditions outlined in 26 CFR 54.9815-2715(a)(4)(ii)(A)-(B); different conditions for:
  - Participants & beneficiaries eligible for but not enrolled in coverage
  - Participants & beneficiaries currently enrolled in coverage
- Willful violation of SBC requirement can result in $1,000 penalty for each affected individual, including beneficiaries
  - However, federal regulators continue to take assistive approach to implementation of SBC requirement
  - Strive for good faith compliance as soon as possible

## Employer Shared Responsibility

Pay or Play

Employer Mandate

4980H

## Employer Shared Responsibility: An Overview

- Took effect January 1, 2015
- Final regulations were adopted in February 2014 (26 CFR § § 54.4980H-0 – 54.4980H-6)
- Large employers (those with 50 or more full-time employees) must offer full-time employees (and their dependents) affordable minimum essential coverage which provides minimum value or
- Face potential penalties:
  - 4980H(a) penalty (large penalty incurred when employer does not offer coverage to at least 95%** of its full-time employees)
  - 4980H(b) penalty (smaller penalty incurred for particular full-time employees to whom coverage is not offered)

**70% for 2015 only due to transition relief; must meet 95% or pay penalty for 2016 onward

## Coverage Basics: Minimum Essential Coverage

- Minimum essential coverage (MEC): any one of several broad categories of coverage, provided that coverage does not consist solely of "excepted benefits"
  - Does not address certain industry-wide standards created by the ACA that apply to health plans in general (e.g. the coverage for pre-existing conditions). However, these standards are a burden placed on the insurance plan issuer rather than the employer.
  - MEC includes, for example, coverage under government-sponsored programs (such as Medicare, Medicaid, CHIP, & Tricare), coverage under an employer-sponsored plan, coverage under a health plan offered in the individual market within a state.
  - "Excepted benefits" means accident/disability only insurance, liability insurance, workers' compensation insurance, automobile medical payment insurance, coverage for on-site medical clinics, or other insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits, or separate policies that consist only of limited-scope dental, vision, Medicare supplemental plans, etc. *See* 26 U.S.C. § 5000A(f)(3); 42 U.S.C. § 300gg-91(c)(1)–(4) (definition of "excepted benefits" referred to by the ACA).

## Coverage Basics: Minimum Value

- Minimum value is provided by an employer-sponsored health plan if the plan's share of the total allowed costs of benefits provided under the plan is 60% or more.
  - Calculation made by insurer
  - Insurer should be able to advise whether a plan provides minimum value

## Coverage Basics: Affordability

- Eligible full-time employee's required contribution toward the cost of the individual (self-only) premium must be 9.5% or less of the applicable taxpayer's household income in order to be considered affordable
- The problem of using "household income"
  - Employers don't know it, and they can't require employees to disclose it.
  - Instead, employers can take advantage of three safe harbor methods for determining affordability:
    - W-2: Employee premium share for self-only coverage does not exceed 9.5% of the amount in Box 1 of the employee's W-2
    - Rate of Pay: Monthly portion of employee premium share for self-only coverage does not exceed 9.5% of the total of the employee's hourly rate of pay multiplied by 130 hours per month (for hourly employees) or 9.5% of the monthly salary (for salaried employees)
    - Federal Poverty Line: Employee premium share for self-only coverage does not exceed 9.5% of the federal poverty line for one person
- Only the premium for self-only coverage with the employer's lowest-cost minimum value plan needs to be "affordable"

# Identifying Full-Time Employees

- For purposes of the ACA, a "full-time" employee is one who, with respect to any one month, works on average thirty (30) or more hours per week (or 130 hrs / month).
- Employers must calculate "hours of service" (each hour for which an employee is paid or entitled to payment for performance of duties for employer, as well as *paid* leave for vacation, holiday, illness, incapacity, jury duty, layoff, military duty, or leave of absence)
  - Hourly employees: Employers must calculate actual hours of service from records of hours worked and hours for which payment is made or due.
  - Non-hourly employees: Employers must calculate actual hours of service from records of hours worked and hours for which payment is made or due, or employers may use daily (8-hr day) or weekly equivalency (40-hr week) where actual hours are not recorded.
- District data needs to reflect the total number of hours worked by the employee (e.g., substitute + coach)

# Identifying Full-Time Employees: The Look-Back Method

- Method by which you evaluate an employee's hours of service over a given period of time (measurement period), determine whether the employee averaged 30+ hrs/wk (or 130+ hrs/month) during that period, and either offer coverage (or not) during the corresponding stability period
- New employees:
  - Measure hours over "initial measurement period"
  - Offer coverage (or not) during corresponding "stability period"
- Ongoing employees:
  - Measure hours over "standard measurement period"
  - Offer coverage (or not) during corresponding "stability period"

## Identifying Full-Time Employees: The Look-Back Method

- Initial measurement period: 3-12 months, chosen by employer, during which new employees' hours are measured
- Standard measurement period: 3-12 months, chosen by employer, during which ongoing variable hour employees' hours are measured
- Administrative period: optional period, up to 90 days, beginning immediately after measurement period and ending immediately before the start of the stability period
- Stability period: 6-12 months, chosen by employer, beginning immediately after measurement period (+ administrative period, if used) during which employee either receives or does not receive an offer of coverage based upon hours of service during associated measurement period; length of stability period is based upon length of associated measurement period (must be at least 6 consecutive calendar months and no shorter than measurement period)

## Identifying Full-Time Employees: The Look-Back Method

- New employee: employed less than standard measurement period
- Ongoing employee: employed for at least one complete standard measurement period
- Variable hour employee: based on facts & circumstances at employee's start date, employer cannot determine whether the employee is reasonably expected to be employed, on average, at least 30 hours of service per week during initial measurement period because employee's hours are variable or uncertain, based on factors such as:
  - Whether employee is replacing an employee who was a full-time employee or variable hour employee
  - Extent to which hours of service of employees in same or comparable positions have varied above/below 30 hours/wk
  - Whether job was advertised or otherwise communicated as requiring hours of service that would average at least 30 hrs/wk, less than 30 hrs/wk, variable hours, etc.
  - Employer cannot take into account the likelihood that employee may terminate employment before end of initial measurement period.

## Identifying Full-Time Employees: The Look-Back Method

- Employers may use measurement periods and stability periods that differ either in length or in their starting and ending dates for the following categories of employees:
  - Each group of collectively bargained employees covered by a separate collective bargaining agreement
  - Collectively bargained employees and non-collectively bargained employees
  - Salaried employees and hourly employees
  - Employees located in different states.

## Identifying Full-Time Employees: Applying the Look-Back Method

- **New employees:**
  - Regular, full-time hours: offer coverage within 3 months
  - Variable hours: measure hours over initial measurement period
    - If employee found to be full-time during standard measurement period, employee is full-time during stability period, regardless of number of hours of service during stability period
    - If employee is not full-time during standard measurement period, then not full-time during stability period—which can be no longer than standard measurement period
    - As employee transitions from new employee to ongoing employee, hours get measured over standard measurement period
- **Ongoing employees:**
  - Measure hours over standard measurement period
  - If employee found to be full-time during standard measurement period, employee is full-time during stability period, regardless of number of hours of service during stability period
  - If employee is not full-time during standard measurement period, then not full-time during stability period—which can be no longer than standard measurement period

## Identifying Full-Time Employees: Monthly Measurement Method

- For employers opting not to use the look-back measurement method for determining employees' full-time status,
- Employer determines individual employee's full-time status based on the employee's hours of service during each calendar month
- Employers are also given flexibility to apply the look-back measurement method to certain categories of employees while using the monthly measurement method for others (salaried employees vs. hourly employees; employees in different states; collectively bargaining employees vs. non-collectively bargained employees; and each group of employees covered by a separate CBA)
- If using the monthly measurement method, the employer must offer ACA-compliant coverage within three (3) calendar months of the full-time employee first becoming otherwise eligible for an offer of coverage under the terms of the employer's group health plan in order to avoid 4980H penalties
- Optional weekly rule: employer can determine an employee's full-time status for a calendar month based on the employee's hours of service over successive one-week periods (allows employer to approximate payroll periods)
- Note: averaging method does not apply when using monthly measurement method

## 4980H Penalties

- If an employer does not provide MEC to at least 95% (70% for 2015 only) of its full-time employees (and their dependents), and at least one full-time employee receives the premium tax credit, the employer will owe a 4980H(a) penalty as follows:
  - The number of full-time employees employed during the year (excluding part-timers aggregated into a full-time calculation), minus 30, multiplied by $2,000 (e.g. a district with 300 full-time employees would pay 270 x $2,000 = $540,000) (penalty is less for 2015 only based upon the 70% coverage threshold transition relief)
  - Calculated on monthly basis (employer owes only for periods of non-compliance)
- Alternatively, if the employer offers health insurance to at least 95% of its full-time employees (and their dependents), but has at least one full-time employee who receives the premium tax credit, the 4980H(b) penalty is computed separately for each month as follows:
  - The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000. Total assessment payable under 4980H(b) may not exceed the amount that would be payable under 4980H(a).

## Keep in Mind Transition Relief which was Offered for 2015

- Large Employers with 50-99 Full-Time Employees: No 4980H penalties in 2015 for large employers with less than 100 full-time employees (including full-time equivalents), provided the employer can certify that it:
  - Has a workforce of 50-99 full-time employees
  - Has not reduced their workforce or the hours of service of their workforce to bring the number of full-time employees to 50-99; and
  - Has not eliminated or materially reduced the health coverage offered, if any, as of 2/9/2014.
  - Employers meeting these eligibility requirements will still report on their workforce and the coverage they offer in 2015, but they will not be assessed 4980H penalties until 2016.
- 70% Coverage Threshold: Large employers with 100+ full-time employees (incl. FTEs) incur the 4980H(a) penalty (the large penalty) in 2015 only if coverage is not offered to at least 70% of full-time employees (and their dependents), rather than 95% of full-time employees; 4980H(b) penalty not affected by relief
  - The 4980H(a) penalty has was reduced for 2015 to reflect the 70% threshold, rather than the original 95% threshold

## Keep in Mind Transition Relief which was Offered for 2015 (there's more)

- Shorter Look-Back Option: If utilizing the look-back method, employers may use a 6-month measurement period but a 1-year corresponding stability period for 2015 only
- Non-Calendar Year Plans: Delayed assessment of 4980H penalties for employers offering non-calendar year plans as of 12/27/2012, provided certain conditions are met, such that 4980H penalties are not incurred until the first day of the plan year which begins in 2015 if ACA-compliant coverage is offered no later than the first day of the 2015 plan year
- Dependent Coverage: Transition relief from the requirement to offer coverage to full-time employees' dependents in 2015 if the employer is taking steps to arrange for dependent coverage to begin in 2016

# 90-Day Waiting Period Limitation

## What is the 90-day waiting period limitation?

- This is a requirement separate from the Employer Shared Responsibility provisions.
- For plan years beginning on or after January 1, 2014, a group health plan or health insurance issuer offering group health insurance coverage cannot apply any "waiting period" that exceeds 90 days.
- The 90-day waiting period limitation does not require that any particular employee be offered coverage in order to avoid a penalty; instead, it simply prohibits an employee otherwise eligible for coverage from having to wait more than 90 days for that coverage to become effective.

## Compliance with 90-day waiting period limitation

- Districts should confirm with insurance carrier(s) that the plans they offer employees are in compliance with the 90-day waiting period limitation.
- Districts should review internal rules and CBAs governing employees' eligibility for health insurance to ensure that district is in compliance with the 90-day waiting period limitation.
- Any internal policies that conflict with the 90-day waiting period rules would need to be modified.
- To the extent a CBA is inconsistent with the 90-day waiting period limitation, changes may need to be negotiated with the affected bargaining units

## Other ACA Requirements to Remember

Marketplace Notices (FLSA § 18b)
Whistleblower Protections (FLSA § 18c)
Nondiscrimination Provisions
Cadillac Tax

## FLSA 18B Marketplace Notices

- To assist efforts to direct individuals toward the purchase affordable coverage on the Exchange, the ACA added a new section 18b to the Fair Labor Standards Act (FLSA) to require FLSA-covered employers to provide all employees with notice of their coverage options on the Exchange (Marketplace).
- These notices were to be provided by October 1, 2013 for current employees, and must be provided to new employees going forward at the time of hiring within 14 days of the employee's start date.
- Form notice is published by U.S. Department of Labor and available online.

## Whistleblower Protections (FLSA § 18C)

- Employers are prohibited from discharging or discriminating against an employee with respect to the employee's compensation, terms, conditions, or other privileges of employment because:
  - the employee has received a premium tax credit or subsidy to assist in the purchase of affordable coverage
  - or has engaged in protected conduct, such as reporting or providing information about a violation of the FLSA

# Nondiscrimination Provisions

- The ACA added a non-discrimination requirement for group health plans similar to that already required for self-insured plans.
- Prohibits discrimination in favor of highly-compensated employees; thus, a group health plan cannot discriminate in favor of highly compensated individuals as to eligibility to participate and the benefits provided under the plan cannot discriminate in favor of participants who are highly compensated individuals.
- Exactly how this rule will apply to group health plans is unclear
- Compliance with this requirement has been delayed indefinitely until guidance or regulations are issued

# Cadillac Tax

- Thanks to a recent two-year delay (The Consolidated Appropriations Act of 2016), on January 1, 2020, an excise tax on high-cost health insurance plans will go into effect.
- Employer health insurance plans with premiums that exceed $10,200 for individual, self-only coverage or $27,500 for coverage other than individual, self-only coverage (such as spousal, dependent, and family coverage) will be charged a 40% excise tax on the portion of the premiums over the applicable dollar limits.
  - These initial dollar thresholds were set when tax was scheduled to take effect on January 1, 2018; may change before tax goes into effect in 2020
- The dollar limits will be adjusted in years after based on the Consumer Price Index.
- This excise tax is imposed on insurance plan issuers, plan administrators, or plan sponsors, but anticipate that it could be passed on to employers.

# Collective Bargaining & Retiree Health Insurance Issues

## Health Insurance is a Mandatory Subject of Bargaining

- PERB has held that health insurance is a term and condition of employment and, therefore, a mandatory subject of bargaining.
- Thus, changes in the kind and level of health insurance benefits offered to employees by a public employer, including enhancements of plan benefits, are a mandatory subject of negotiations.
- To the extent that the identity of an insurance carrier is material to the benefits received or to the administration of a health insurance plan provided to employees, that in and of itself is a mandatory subject of bargaining and may not be changed unilaterally.

# Retiree Health Insurance Issues

- The New York State retiree "moratorium" prohibits New York school districts and BOCES from diminishing retiree health benefits ***unless*** the same change is made for active employees. Ch. 504, Laws of 2009.
- New York school districts and BOCES may not unilaterally diminish retiree ***health insurance contributions.*** *See Jones v. Board of Education of Watertown City School District,* 30 A.D.3d 967 (4th Dep't 2006) (holding that the board of education violated the law when it sought to diminish the district's contributions for health care premiums on behalf of retirees by 10% and only diminish the district contributions for health care premiums on behalf of current employees by 4%).
- New York school districts and BOCES may not unilaterally diminish retiree ***health insurance benefits***. *See Hustleby v. Byron-Bergen Cent. School Dist.*, 24 A.D.3d 1308 (4th Dept. 2005) (holding that the decision by school district to deny reimbursement to retirees for co-payments when allowing it for current employees violated chapter 405 of the Laws of 2009).

# Retiree Health Insurance Issues

- The New York Court of Appeals ruled that the Newfane Central School District could not unilaterally alter vested retiree health insurance benefits. *Kolbe v. Tibbetts,* 22 N.Y.3d 344 (2013).
- Facts: The District informed the four retired employees that their health insurance co-pays would be increased under the terms of a collective bargaining agreement, which was a successor to the collective bargaining agreement of their retirement. The retirees brought a lawsuit alleging that the District breached the collective bargaining agreement.
- The operative language of the contract stated: '[t]he coverage provided shall be the coverage which is in effect for the unit at such time as the employee retires.' [citations omitted]

# Retiree Health Insurance Issues

- District's position: The District was authorized under the terms of the New York State Insurance Moratorium to unilaterally reduce retiree health benefits when those benefits have be diminished for current employees.
- The Court held:
  1. "the Insurance Moratorium Law's [relied on by Newfane] primary purpose was to prevent school districts from eliminating or reducing retiree health insurance benefits that were *voluntarily conferred as a matter of school district policy, not rights negotiated in the collective bargaining context"; and*
  2. The District could not unilaterally diminish the health insurance coverage for retirees when the collective bargaining agreement confers upon retirees a vested right to the same health insurance coverage they had when they retired; and
  3. The issue of whether the word "same coverage" precluded modifications to the benefits or their attendant costs, including prescription co-pays, required a hearing.