BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between BEAVER DAM UNIFIED SCHOOL DISTRICT and BEAVER DAM EDUCATION ASSOCIATION	Case 19 No. 45546 MA-6639

Appearances:

Wisconsin Education Association Council by Ms. Ellen Henningsen, and Winnebagoland UniServ Council, by Mr. Armin Blaufuss, appearing on behalf of the Association.

Davis and Kuelthau, S.C., by Mr. Clifford Buelow, appearing on behalf of the District.

ARBITRATION AWARD

The Beaver Dam Education Association (hereinafter referred to as the Association) and the Beaver Dam Unified School District (hereinafter referred to as the District) jointly selected the undersigned to hear a dispute over whether the District's choice of the Wisconsin Physician's Service (WPS) as the health and dental carrier would lead to more than minute differences in equivalencies of coverage from those coverages available to employees under the current carrier, Wisconsin Education Association Insurance Group (the Trust).

A pre-hearing conference was conducted on April 15 and 18 in Beaver Dam, Wisconsin. A hearing was held on April 19, at which time the parties were afforded full opportunity to present such testimony, exhibits or other evidence, and arguments as were relevant. The parties submitted pre-hearing briefs and oral arguments.

On April 24, 1991, the undersigned issued his Expedited Award, consisting of Section VI - CONCLUSION, the Award and Appendix "A" of the Supplementary Award. On issuing the Expedited Award, the undersigned indicated that he would issue a supplementary Award more fully setting forth the background, arguments of the parties amd rationale for the Expedited Award.

Now, having considered the evidence, the arguments of the parties, the contract language and the record as a whole, the undersigned makes the following Supplementary Award.

BACKGROUND

The District is a municipal employer which provides educational services to the citizens of Beaver Dam, Wisconsin. In providing these services, the District employs some 200 teachers who are represented by the Association.

The District and the Association are parties to a collective bargaining agreement which provides for health and dental insurance. The Board pays 90% of the cost for health insurance premiums and 100% of the cost for dental insurance premiums. The carrier for these plans is the Trust.

The contract gives the Board the right to change insurance carriers, with the caveat that the "coverage of the new plan(s) must be at least equivalent to the coverage(s) of the existing plan(s). Minute differences as to the equivalency of coverages will not be contested."

In the Fall of 1990, the District hired Fringe Benefit Planning, Inc. (FBP) as an insurance consultant. Following a study of recent claims experience, bidding among alternate insurance carriers, and meetings with the Board, carrier representatives and Association representatives, FBP reported that the District could save money on insurance by switching carriers. The District notified the Association on March 7, 1991 that it intended to switch from the Trust to WPS.

A meeting was held on March 20 with representatives of the District, FBP, the Association and WPS. At that meeting, the Association's representatives raised concerns regarding the equivalency of the WPS plan to the existing Trust plan. Additional concerns were raised on April 12, April 15 and April 17.

The contract has, since 1981-82, contained the aforementioned language concerning changes in carrier. The full provision reads as follows:

> I. The Board shall notify the BDEA of any proposed change in the insurance carrier. The BDEA shall have the opportunity to discuss the change and to make recommendations. In the event the Board determines it will change insurance carriers, coverages of the new plan(s) must be at least equivalent to the coverages of the existing plan(s). Minute differences as to the equivalency of coverages will not be contested. In the event of a dispute over whether the differences are minute, the parties agree to invoke expedited arbitration pursuant to the procedure below. The arbitrator shall base his/her decision on whether the changes are of such minute nature so as not to affect equivalency. No change will be made if there is a dispute as to the above prior to the arbitrator's award.
>
> **Expedited arbitration procedure**
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> The parties will get together within one (1) week upon the demand of either party to attempt to choose a mutually agreeable arbitrator. If the parties cannot agree, they shall immediately request that the WERC furnish them with a list of five (5) non-staff arbitrators to arbitrate the dispute. The parties will be allowed to file pre-hearing briefs so that the arbitrator can, if he/she so desires, render a bench decision.

This language was a compromise reached in mediation with Mediator/Arbitrator Joseph Kerkman. It resolved an issue created by the Association's demand to name the insurance carrier in the contract.

The expedited arbitration provision was invoked by the Association at the conclusion of the meeting on March 20. A pre-hearing conference was held by the undersigned on April 15, in the course of which the District and WPS made several modifications in the proposed insurance plan to meet Association concerns. The pre-hearing conference was continued to April 18, when additional talks were held and additional modifications were made. The Association and the District disagreed at the end of the discussions, both as to the equivalency of the plan as modified and over whether the District could litigate the modified plan or was instead bound to the WPS plan as it stood prior to April 15.

Additional facts as necessary will be set forth below.

PERTINENT CONTRACT LANGUAGE

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to discuss the change and to make recommendations. In the event the Board determines it will change insurance carriers, coverages of the new plan(s) must be at least equivalent to the coverages of the existing plan(s). Minute differences as to the equivalency of coverages will not be contested. In the event of a dispute over whether the differences are minute, the parties agree to invoke expedited arbitration pursuant to the procedure below. The arbitrator shall base his/her decision on whether changes are of such minute nature so as not to affect equivalency. No change will be made if there is a dispute as to the above prior to the arbitrator's award.

ISSUES

1. Is the District bound to the WPS insurance plan as it was proposed prior to April 15, 1991, or may it submit a modified plan?

2. Are the changes in coverage under the WPS plan so minute as not to affect equivalency?

POSITIONS OF THE PARTIES

The Position of the Association

1. Modification of The Plan

a. Non-admissibility of Changes: The changes in the WPS/District plan were part of settlement discussions and are not admissable in arbitration.

b. Estoppel: The District had previously indicated that it intended to implement the plan without any changes. WPS and FBP both knew the plan to be non-equivalent in important areas. Their representations that the modifications of April 15 and 18 will yield equivalency are not supported by riders or written documents. Given their past unreliability, the District should not be allowed to rely on these representations and should be estopped from presenting the modified plan.

c. Admission of Non-Equivalency: The changes in the plan on April 15 and 18 are admissions of non-equivalency, and undercut the credibility of WPS, FBP and the District.

2. Substantive Issue

a. The Standard to Be Applied: The contract language demands equivalency ("Equal in value, force, measure, volume, power and effect or having equal or corresponding import, meaning or significance.") of coverage ("all the risks covered by the terms of an insurance contract") and allows only minute ("very small; infinitesimal") differences. Thus, the new plan must cover all of the risks of the old plan, with the same value, effect and significance as the old plan, and with only infinitesimal differences.

b. Application of the Standard: The WPS plan does not meet this test:

- WPS has higher cutbacks in applying UCR - $5500 (projected) vs. $0 for the Trust.

- WPS's UCR determinations are unique because of different data base. The

Trust pays the higher of its data or the Health Insurance Association of America data for UCR.

- WPS's UCR determinations are more broadly applicable than Trust's -- the Trust applies UCR only to surgical expenses.

- It is not clear that a toll-free telephone number is available for covered employes to call WPS.

- The "foregiveness factor" in claims administration is a flat $10 for WPS but a more generous percentage based formula for Trust.

- Restoration of the lifetime maximum under WPS requires proof of insurability, while the Trust automatically credits $2000 per year.

- WPS places dollar limits on some transplant expenses; the Trust does not.

- WPS places a pre-existing condition limitation on transplant coverage. The Trust does not.

- WPS limits transplants to listed organs, while the Trust allows all non-experimental procedures.

- WPS limits pre-admission authorizations to a period at least 24 hours prior to admission, while the Trust does not.

- WPS covers only 365 days of in-patient psychiatric care for nervous and mental, while the Trust does not limit such coverage.

- WPS has a limit of 90 days supply on mail-order drugs, while the Trust limits to 180 days.

- WPS has a far smaller out-of-state network for prescriptions, while the Trust has a large network.

- WPS is not widely known for allowing prescriptions in excess of 34 days supply, raising potential problems with pharmacists.

- WPS limits ambulance coverage to $5000 while the Trust is unlimited.

- WPS does not offer COBRA administration to the District.

The reasons for the dollar limitations, time limitations and service limitations under the WPS plan are obviously to switch risks from the carrier to the employee. Thus, all risks are not covered under the new plan as they would have been under the old. The contract standard is therefore not met.

c. Reliability and Credibility of the Carrier: The employes currently have the benefit of a carrier with credibility and proven reliability. The conduct of WPS shows repeated claims of inability to match benefits, followed by a rush of compromises forced by the arbitration hearing. Further, WPS and FBP both claimed the plans were equivalent prior to modification, even though they knew they were not. This shows a lack of reliability and credibility.

d. Lack of Good Faith: The contract has an inherent requirement of good faith in its administration, just as in the bargaining process that produces it. While the Association sought involvement in the decision-making process,

the District sought only to achieve a pre-ordained end --- the ouster of the Trust. This is motivated by animus to the Union, and is evidenced by the rigging of the bidding process. WPS's amendments to its plan, including boosting benefit levels and lowering the dental premiums, amount to a rebidding after the fact. Its claim that the amendments do not affect cost is ludicrous and merely lays the ground work for a ruinous increase at the end of the insurance contract.

The District's willingness to contract with WPS under these circumstances is strong proof of animus to the Union and the Trust.

The Position of the District

1. Modification of The Plan

The District takes the position that the WPS plan, prior to the modifications made in the pre-hearing procedure, was equivalent to the Trust plan. Nevertheless, the District made modifications to meet objections of the Association, many of which were not raised until immediately before the pre-hearing process. In requiring discussion prior to a switch in carriers, the contract presumes give and take and adjustments. Furthermore, the District has the right to settle portions of a dispute prior to hearing if it so chooses and it cannot be frozen into defending or presenting an insurance plan which no longer represents the plan it intends to implement. Such a procedural ruling would merely prompt immediate resubmission of the modified plan and a second, unnecessary use of the expedited arbitration machinery.

2. Substance of the Dispute

a. The Standard to be Applied: Equivalency and equality are two very different concepts. Equivalency assumes differences in detail, but an overall equality of value, measure or force. The WPS plan is superior or identical to the Trust plan in many respects. It is equivalent in total, and thus the District must be allowed to change carriers.

b. Administrative Differences: The Association admitted it failed in its effort to gain identification of the carrier during bargaining. Its attempt to hinge equivalency on administrative practices such as determinations of usual and customary charge levels and forgiveness factors is a back door effort to, in effect, name the Trust as the carrier. This is so because the information about these features is proprietary and secret. These administrative features cannot therefore ever be duplicated. If they are critical "coverages" within the meaning of the contract, no switch of carrier would be possible. This is contrary to the contract's grant of a right to change carriers. Other arbitrators/examiners have held that changes in administrative features are inevitable in switching carriers and these differences should not prevent such changes.

c. Substantive Differences: The non-administrative differences in the two insurance plans, where the coverage is not superior or identical under WPS, are "minute" in that the dissimilarities are slight and the likelihood of any loss to employees is remote. Examples of this include a $5,000 cap on ambulance service under WPS, when the District's experience shows $900 in total claims over the past two years. The $25,000 cap on harvesting organs from live transplant donors is another illusory difference, since even the Trust's experts acknowledged $17,000 as the upper limit on what had ever been paid for such organ procurement. The out-of-state drug network is another obscure benefit where the difference in coverage has no bearing on the equivalency of the plans.

Balanced against the unlikely detriments, which the District characterizes as failures to cover expenses during a rocket ride to Mars, are substantial improvements under WPS. The lifetime maximum is doubled to $2 million, which may be restored to its full amount upon proof on insurability, as opposed to $1 million under the Trust, which is restored only at a rate of $2,000 per year. The WPS plan offers well baby care, a feature wholly lacking in the Trust plan. Further, by adding a transplant rider, the WPS plan's benefit maximum is unaffected by transplant costs. The only unbiased expert to testify stated that the two plans were identical in 99 1/2% of their areas, and that the sum of the differences in the remaining areas favored the WPS plan. For all of the foregoing reasons, the District asks that it be allowed to exercise its right to switch carriers.

DISCUSSION

A. Modification of the WPS Plan

At the outset of the hearing, the undersigned ruled that the District was entitled to make the modifications in the insurance plan it proposed after the pre-hearing process had begun, and to have the plan as modified used for comparison purposes in the hearing. In making this ruling, the undersigned was mindful of the tactical difficulties such changes might create for the Association in litigating the dispute. Balanced against this tactical problem was the fact that many of the Association's specific objections to the plan were not expressed until immediately before the pre-hearing conference, and the District had not therefore had a reasonable opportunity to respond until the pre-hearing process had commenced. In addition, the tactical difficulties for the Association were substantially reduced by the fact that the changes made by the District served to narrow the scope of the dispute rather than to enlarge it, thus obviating the need for additional testimony and preparation.

The evident purpose of Article XI (I) is to balance the right of the District to change carriers with the right of the employees to maintain long-established benefits. Allowing the District to modify its plan to answer Association objections, many of them not known until the pre-hearing conference, serves this purpose. Furthermore, refusing to consider the modifications in the face of the District's representation that the modifications would be part and parcel of the plan it proposed to implement would have rendered the resultant award a purely abstract document, resolving a dispute that did not exist and leaving unresolved the actual dispute.

B. The Merits

1. Equivalent Coverages

The contract requires that "coverages" be "equivalent". The charge to the arbitrator is to determine "whether changes are of such minute nature so as not to affect equivalency." Use of the term "coverages" rather than the broader terms "benefits" or "plans" indicates a comparison of the indemnification for specific risks and procedures under the two plans, and a decision whether employees are exposed to more than a minute increase in specific risks by reason of the change. The District urges that "minuteness" must measure the likelihood of a particular risk being realized. The undersigned agrees that a change in coverage which would expose the employee to potential liability under rare circumstances might well be minute, while the same increase in exposure for a more frequently occurring risk would not be minute. There is, however, an additional element to the measurement of whether a change is minute. The amount of financial exposure of the employee must be weighed. Even if a risk is very unlikely to ever be realized, a coverage which exposes employees to significant costs or even financial ruin once the risk is realized cannot be said to be a minute change.

The District has urged that improvements in benefits, such as Well-Baby Care and the increase to a $2 million lifetime maximum benefit, should cut in favor of its overall proposal. The undersigned cannot agree. As discussed above, the contract mandates a comparison of specific coverages rather than overall plans. The improvements noted might well be selling points in a negotiation over changing the plans, but do not bear on equivalency of coverage in a unilateral

change of carriers under Article IX.

The Association, for its part, urges that the "reliability and credibility" of the carrier and the "good faith" (or lack thereof) on the part of the District be read into the standard for allowing changes under Article IX. The undersigned rejects these contentions, because the contract rejects them. The standard in the contract is an objective standard. If the District operates in perfect good faith and through a completely reliable and trustworthy carrier, but does not offer equivalent coverages, it may not change carriers. If, on the other hand, the District proceeds from an evil intent and contracts with scoundrels, but achieves equivalency with no differences or only minor differences in coverage, the plain language will allow the change in carrier. 1/

The record here shows that the District was determined to switch carriers, and does suggest some hostility to the Trust. There was also some delay in sharing information between the parties, and what appears to be "puffing" by WPS representatives during meetings over the insurance change. The failure to share information in a timely manner occurred on both sides of this dispute, and may be in part attributable to the fairly rapid pace of events from the first decision to investigate a carrier change through the decision that WPS could offer equivalent coverages. The claim of the WPS representatives that coverages were equivalent even prior to the changes made in the pre-hearing process is in part a judgment call, very likely salted with a certain amount of salesmanship. It does not provide a basis for doubting the carrier's specific promises to match existing coverages or modify their standard coverages to replicate Trust benefits.

Despite the Association claim of anti-union animus in the decision to switch carriers, there is no evidence whatsoever that the District's hostility to the Trust was in any way related to the Trust's ties with the Association's parent organization, WEAC. The record more strongly indicates that the District felt that the Trust had been overcharging it for premiums. Whether this was true or not (and the record is far from conclusive, given the errors admitted by the District's consultant), the reason for the hostility is not attributable to any prohibited discrimination or animus. Thus even if there were some contractual basis for raising the issue of "good faith" and "reliability and credibility" of the carrier, the record would not support the conclusions on those issues urged by the Association. 2/

2. Administrative Features of the Two Plans

1/ If, of course, the evidence showed that the carrier was unreliable to the point of not actually making good on its promised coverages and benefits, the Association would have the right to raise this issue and have it weighed as part of the process of making a decision as to whether the coverages truly were equivalent. Furthermore, should it develop at some later time that the carrier was either incapable or unwilling to extend the promised coverages, the Association would have recourse under the grievance procedure to challenge this as a reduction in contracted benefits. There is no evidence in this record to suggest that WPS is incapable of, or unwilling to live up to promises made by its representative regarding benefits.

2/ The undersigned acknowledges the extensive discussion of good faith engaged in by Arbitrator Kerkman in Fort Atkinson School District (1984). That discussion was tied to a consent award provision requiring the employer to solicit a certain number of bids and allowing for "reasonable deviation" from existing benefits if the employer was unable to secure two competing bids offering to match current coverages. The Association in that case asserted that the employer had discouraged bidders from matching coverages and had allowed changes in the bids outside the bidding period. The arbitrator's discussion of good faith as a factor in his analysis apparently went to the procedural regularity of the selection process. In this case, the selection process is not featured in the contract language. The focus of the language is instead on the substance of the coverages offered, and the two cases are therefore distinct.

The Association places great emphasis on the differences between the Trust's method of determining whether a charge is payable in full and the WPS method ("usual and customary" and "forgiveness factors"), as well as distinctions in the means by which decisions are made on the medical necessity of procedures. The Association also points to the fact that the Trust administers documents related to conversion rights under COBRA for employees leaving the District, while WPS does not provide such services. 3/

Both carriers use the 90th percentile of charges on their fee profiles as a cutback point for "usual and customary" determinations. Both employ data generated by the Health Insurance Association of America. The two carriers also maintain their own separate data bases reflecting their experience with claims and charges from a given geographic area for procedures, as well as information gleaned from providers and other sources. These fee profiles are proprietary information, not shared and essentially impossible to duplicate. Determinations of whether a charge falls within the "usual and customary" rate for such procedures is made by comparing the charge with the proprietary data and the HIAA data, whichever appears to be more reliable. The Trust has a more liberal policy than does WPS, in that the Trust will, as a usual practice, rely on the higher of the HIAA data or its own data. In the event that a charge exceeds the "usual and customary" rate, both carriers hold the employee harmless for the charge, unless the employee has separately signed a fee agreement with the provider committing to pay in excess of what insurance will cover. In that event, both carriers commit to contacting the provider and attempting to negotiate a reduction of the fee to within the usual and customary range. The Trust applies a usual and customary review to all procedures under its health plan for tracking purposes, but only makes cutbacks in surgical procedures. Cutbacks are made in only 0.1% of the Trust's total annual payouts. WPS applies the usual customary review and cutbacks in payment in all areas other than hospitalization, and applies a cutback to 0.5 - 0.7% of its total annual payouts.

In addition to the usual and customary review, both carriers apply a forgiveness factor to claims. WPS will pay a claim coming within $10 of its usual and customary rate if it is resubmitted after an initial rejection. The Trust represented its forgiveness factor to be in many cases more generous because it was based upon a percentage of the total claim, but refused to reveal the details of its system, characterizing it as proprietary information.

The refusal of the Trust representative to discuss the details of the forgiveness factor precludes any determination of whether that feature of the Trust plan is equivalent to the WPS plan. Putting that element aside, the undersigned agrees with the Association that the policies of the Trust are somewhat more liberal with respect to usual and customary determinations than the policies of WPS both in the amount allowed for procedures and the range of procedures subject to such determinations. Having so concluded, the question remains whether differences in policies guiding usual and customary determinations are differences in "coverages" within the meaning of Article IX.

Many decision makers have discussed the procedures for making usual and customary determinations in the context of whether insurance "plans" or "benefits" were equivalent. Mere differences in such procedures have generally been held not to prevent a switch in carrier, since such differences are inevitable given the uniqueness and secrecy of each carrier's data base and internal procedures. 4/ The parties are presumed to intend that language have meaning, and

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3/ There was also a disparity in the rates charged to retired employees for Medicare supplements. Prior to the hearing, the District and WPS committed to matching the rates offered by the Trust. During the hearing, the WPS representative, in sworn testimony, reaffirmed the commitment. Notwithstanding the conclusion in this section that the premium rates are not "coverages", the undersigned understands WPS to be committed to maintaining the lower Medicare rates promised in the hearing should it come to be the District's carrier.

4/ See Economy Bushings, 78 ARB Par. 8162 (Krinsky, 1978); Mayville School District, Dec. No. 25144-C (Greco, 6/20/90) at p. 26.

Article IX would be meaningless if the District's right to switch carriers could be frustrated by the existence of procedural differences which are inherent in any switch. Determinations of usual and customary charges, as well as other administrative procedures, can however serve to erode benefits, through incompetent administration or through lowering the permissible charges to the point of effectively and regularly transferring a portion of the costs to the employee. 5/

As noted above, the contract language requires equivalency of "coverages", which is a narrower term than "benefits" or "plans". Usual and customary determinations are not coverages, since they do not offer protection against specific risks. They do implicate coverages, in that a very strict application of usual and customary standards, or the use of a lower percentile for payment cutbacks, may effectively reduce the benefit otherwise payable for medical procedures, thus exposing the employee to increased financial risk. In this case, the evidence does not support the conclusion that WPS usual and customary standards will lead to a reduction in coverage. Both carriers use the 90th percentile for cutbacks, and use similar data bases. Although the Trust does not apply a cutback to anything beyond surgical procedures under its health plan, the broader scope of the WPS usual and customary cutback does not necessarily mean a reduction of coverage for employees, other than on a theoretical basis. The testimony of the District's actuarial expert was that 99 and 1/2 percent of the coverages would be unaffected by the switch in carriers, and that the remaining areas would be affected by specific plan differences rather than distinctions in the administration of the insurance policies.

The usual and customary payment cutback affects employees only if they sign separate fee agreements with their medical providers. Otherwise they are held harmless for charges either under the Trust or WPS, and the dispute is confined to the provider and the insurer. As a practical matter, many employees do sign fee agreements when they see doctors, and there is greater potential for individual liability than the "separate fee agreement" provision would suggest. This exposure is present under both plans, however, and both respond to such situations by negotiating with the provider to reduce the fees charged for the procedure.

Given the narrow language of the contract and the sworn testimony of the District's expert, the undersigned concludes that the inevitable differences in the administrative practices of WPS and the Trust do not rise to the level of a change in coverage. Should it develop at a later time that the practical effect of the differences in making usual and customary determinations is greater than has been represented in these proceedings, rising to level of a reduction in coverage, the employees have recourse to the grievance procedure.

For the same reasons stated above, the undersigned concludes that other administrative features of the WPS and Trust insurance plans, such as "medically necessary" determinations, "COBRA administration" and "Retiree Medicare Rates" do not, on the record evidence, rise to the level of coverages, and do not therefore fall within the scope of Article IX.

3. Substantive Areas of Difference

The Association has pointed to numerous areas of distinction between the two plans. Each is briefly addressed:

a. Toll-Free Number: Both the Trust and WPS maintain toll free numbers for subscribers to call with questions. The fact that the WPS representative could not recite the number is irrelevant. The coverage in this area is equivalent.

b. Dependent coverage, Retiree participation, Disabled Employee participation, Surviving Spouse participation, Therapeutic abortion,

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5/ See Celina City Schools, 94 LA 1001 (Dworkin, 1990) at 1009; Milwaukee Faucets, 65 LA 1221 (Krinsky, 1975) at 1227-28; Beecher, Peck & Lewis, 74 LA 489 (Lipson, 1980) at 493; see also Ad-Art, Inc., 78 LA 533 (Randall, 1982); Keystone Consolidated Industries, 99 LRRM 1036 (1978).

Congenital anaomolies, etc.: In each of the listed areas, as well as others, the District and WPS pledged to match the existing coverages, but did not present specific contract riders or other documents to that effect. In all of the areas in which a match of coverages was pledged, the undersigned finds that the coverages are equivalent. This finding is contingent upon the production of a written commitment in a form generally acceptable in the industry which reflects a match in the coverage between the coverage under the Trust and/or District policy and the WPS plan.

c. Restoration Benefit: WPS restores the full $2 million lifetime benefit upon recovery from an illness and proof of insurability. The Trust credits its $1 million maximum with up to $2,000 per year without proof of insurability. The higher maximum benefit under the WPS plan together with the more likely generous recrediting renders these coverages equivalent.

d. Pre-Admission Notice Period: WPS requires that at least 24 hours in advance for non-emergency admissions, while the Trust allows advance notice to be a matter of seconds. As a practical matter, this is not a reduction in coverage because the penalty for failing to give notice it is quite easily avoided simply by making a telephone call. (No reduction is realized in an insurance change where loss can be avoided simply by following specified procedures. (Freidrich Air Conditioning, 87 LA 661 (Bailey, 1986)).

e. Transplant coverage: There are several areas of distinction between the two plans in coverage for transplants.

i. WPS has a specific listing of transplants which are covered, while the Trust simply covers non-experiential procedures. This allows for the automatic addition of procedures once they become generally accepted. This does not represent a reduction in coverage, but a potential in the future for not expanding coverage. This difference is minute in that it is quite unlikely to impact any covered employee, and works no actual reduction.

ii. WPS limits the amount it will pay for "harvesting" organs for transplant, while the Trust places no limits on procurement costs. The Trust representative testified that the top of the actual range for procuring organs from a live donor was $17,000, while the WPS plan allows $25,000 for such purposes. The Association is correct that dollar limits on costs are an attempt to cap the insurer's liability, but where those limits are set bears on the likelihood of any covered employee actually suffering a loss. Given that transplants are rare procedures, and that the limits set are 50% above the top of actual cost experience, the difference in the area of organ procurement qualifies as "minute".

iii. The WPS plan sets an upper limit of $10,000 on private nursing costs for transplant patients, while the Trust plan does not. No evidence was provided to indicate what the actual cost of such care would be in the case of a transplant, or the likely necessity of such care. The parties treated this as a minor point in litigating the case, and absent evidence that the $10,000 is inadequate, the undersigned cannot conclude that the coverage is not equivalent.

iv. WPS places a pre-existing condition limitation on its coverage of transplant costs while the Trust does not. Granting the District's argument that transplants are rare procedures, the likelihood of loss

from this limitation is small. Should that loss be realized, however, the burden of bearing the full cost of transplant procedures during the period of the limitations listed in the WPS policy would be ruinous. The denial of coverage, even though under unlikely circumstances, renders this limitation a greater than minute difference in coverage. The two insurance plans are not equivalent in this coverage area.

f. Out of State Drug Network: The Trust maintains a much larger network of pharmacies around the country honoring its insurance card than does WPS. A covered employee going to a pharmacy that does not accept his/her drug card will need to pay for the prescription and then seek reimbursement from WPS. This reimbursement is pegged to the average wholesale rate, which may or may not be less than the price paid by the employee. The fact of the matter is that there is only one bargaining unit employee who resides outside the state of Wisconsin -- a teacher who is on leave. The likelihood of exposure and the amount of exposure are so speculative and small from this difference that it cannot be characterized as affecting equivalency.

g. Mail Order Drugs: The Trust will allow the purchase of up to 180 days worth of drugs at a time, while WPS allows only 90 days supply to be purchased at a time. The practical effect is to expose employees to ordering their prescriptions twice more each year. This has no effect on the equivalency of the mail order drug benefit.

h. Ambulance Coverage: WPS limits ambulance charges to $5,000 per occurrence, while the Trust does not limit these charges. The total charges for the entire District over the two years preceding this arbitration were $900 - $300 in one year and $600 in the other. The impact of a limit of $5000 for ambulance services would appear to be negligible.

i. Dental Insurance: No area of distinction was identified with respect to Dental Coverage.

j. Nervous and Mental Disorders: WPS terminates coverage for hospitalization for nervous and mental disorders at 365 days, while the Trust applies no such limits. Like the pre-existing limitation on transplants, this shifts the entire, virtually unlimited cost of a treatment to the employee, exposing the employee to financial ruin. Granting that there is a small likelihood of an employee needing coverage beyond 365 days, the potential cost exposure persuades the undersigned that this exceeds the standard of "minute" changes in the contract, and is not equivalent.

CONCLUSION

A. The exercise of the right to change insurance carriers is not contingent upon the employees' perceptions of the credibility and reliability of the proposed new carriers or its agents. Reliability may become a factor to the extent that a carrier proves itself incapable of delivering the level of benefits it has contracted to provide. There is no evidence in the record to indicate that WPS cannot provide the level of benefits it has promised. Were it to develop that WPS could not provide the promised benefits in the future, the remedy of a grievance by employees provides sufficient protection. Absent proof of unreliability, the mere suspicion that the carrier lacks integrity or reliability does not affect the District's contractual right to change insurance carriers.

B. The contract specifically directs the Arbitrator to base his decision on whether the changes are of such minute nature so as not to affect equivalency of coverage. The Association's proposed addition of a "good faith" dealing standard is not within the scope of the arbitration clause. The motives of the District are irrelevant under the contract so long as the product -- insurance coverages -- is equivalent. In any event, the District's apparent determination to exercise its contractual right to oust the Trust as the insurance carrier does not rise to the level of bad faith, nor does the record support the Association's claim of Union animus.

C. The contract requires equivalency of "coverages", rather than equivalency of "plans" or "benefits". The focus must be on each area of risk currently covered. For this reason, the additional benefits, such as well baby care, do not influence this decision. Those go to the equivalency of the two plans. Similarly, the focus on coverages rather than benefits excludes "usual and customary", "medically necessary", "forgiveness factors", "COBRA administration" and "retiree medicare rates" from this analysis. The administrative features concerning when payments are made or denied implicate coverages, but are not themselves coverages. Thus the only inquiry in those areas is whether the different interpretations and practices would effectively reduce the employees' coverages. On the record, the undersigned finds that such reductions are unlikely; that if they occur, they may not expose the employee to financial loss; and that if it develops that the policies of WPS are not as presented in the evidence, leading to a loss of coverage, there is an adequate remedy in the grievance procedure.

D. The coverage areas in which differences were pointed out and/or argued in the hearing or the pre-hearing briefs are listed on Appendix "A" of this Award. The District and WPS represented in numerous areas of coverage during the pre-hearing conference, and during the hearing, that modifications would be made to the WPS plan to meet Association concerns. In every area where such representation was made, whether listed or not, the finding of equivalence is contingent upon the production of written riders and/or contract documents confirming the modifications.

E. The coverages under the WPS Plan are equivalent to those under the Trust plan, with only minor differences not affecting equivalency, in all respects with the exception of (1) Hospitalization benefits for nervous and mental disorders; and (2) pre-existing condition limitations on transplants.

On the basis of the foregoing, and the record as a whole, the undersigned makes the following

AWARD

The WPS Dental Insurance Plan is equivalent to the WEAIG ("Trust") plan. The WPS Health Insurance Plan is not equivalent, within the meaning of the contract, to the Trust health plan, because of greater than minute differences in the areas of nervous and mental disorders and pre-existing condition limitations on transplant benefits.

Dated at Madison, Wisconsin this 14th day of May, 1991.

By Daniel J. Nielsen /s/
Daniel J. Nielsen, Arbitrator