BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between KAUKAUNA CITY EMPLOYEES UNION, LOCAL 130, AFSCME, AFL-CIO and CITY OF KAUKAUNA	Case 62 No. 44426 MA-6597 (Health Insurance Grievance)

Appearances:

Wisconsin Council 40, AFSCME, AFL-CIO, 5 Odana Court, Madison, WI 53719, by Mr. Jack Bernfeld and Mr. Laurence S. Rodenstein, Staff Representatives, appearing on behalf of Local 130.

Davis & Kuelthau, S.C., 111 East Kilbourn Avenue, Suite 1400, Milwaukee, WI 53202, by Mr. Mark F. Vetter, Attorney at Law, appearing on behalf of the City of Kaukauna.

ARBITRATION AWARD

The City of Kaukauna (hereinafter referred to as the City) and Kaukauna City Employees Local 130, AFSCME, AFL-CIO (hereinafter referred to as the Union) jointly requested that the Wisconsin Employment Relations Commission designate Daniel Nielsen, an arbitrator on its staff, to hear and decide a dispute concerning the implementation of a self-funded insurance plan for City employees in August of 1990. A hearing was held on June 26, 1991 in Kaukauna, Wisconsin, at which time the parties were afforded full opportunity to present such testimony, exhibits, other evidence and arguments as were relevant. A stenographic record and transcript were made of the proceedings, which were received by the arbitrator on July 14, 1991. The parties submitted briefs and reply briefs, the last of which were exchanged through the arbitrator on October 2, 1991, whereupon the record was closed.

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

ISSUE

The parties were unable to stipulate to an issue and agreed that the undersigned should

frame the issue in his Award. The Union proposes the issues as:

GENERAL ISSUE: "Has the City violated the Collective Bargaining Agreement by replacing the WPS-HMP health insurance plan with a self-funded plan administered by American Medical Security (AMS)? If so, what is the appropriate remedy?"

SUB ISSUE (1): "Whether or not the benefits provided under the self-funded plan duplicate the benefits provided by WPS-HMP?"

SUB ISSUE (2): "Whether the administration of those benefits by AMS duplicate the administration under WPS-HMP?"

The City proposes that the issue be stated as follows:

> "Is the City making group health insurance available to all full-time bargaining unit employees pursuant to the requirement in Article XIII - INSURANCE, Section 1 in the Agreement? If not, what is the appropriate remedy?"

After consideration of both formulations, the undersigned believes that the issue may be fairly stated as follows:

> Did the City violate the collective bargaining agreement when it replaced the WPS-HMP health insurance plan with a self-funded insurance plan administered by American Medical Security? If so, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

ARTICLE IX

GRIEVANCE PROCEDURE

Section 1. The parties agree that the prompt and just settlement of grievances is of mutual interest and concern. Should a grievance arise, whether in reference to a question of interpretation of the agreement or to a question relating to safety and/or other matters, the grieving employee shall first bring the complaint to the Steward or Grievance Committee of the Union. If it is determined after investigation by the Union that a grievance does exist it shall be processed in the manner described below:

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ARTICLE XIII

INSURANCE

Section 1. Group health insurance will be available to all fulltime employees with the Employer paying ninety-five percent (95%) of the premium of the employee rate, single or family. The employee shall be required to pay the fifty dollar ($50.00) deductible. If an employee retires at age 62-65 and is not eligible for health insurance from any subsequent employer, the City will pay seventy-five (75%) of the premium for continuing under the group health insurance if the employee desires coverage.

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BACKGROUND FACTS

The City is a municipal corporation providing general governmental services to the people of Kaukauna, in east central Wisconsin. The Union is the exclusive bargaining representative for the employees of the City's Streets and Parks Departments.

For some years, the City and the Union have been parties to a collective bargaining agreement setting forth the wages, hours, working conditions and fringe benefits for employees. This agreement includes, at Article XIII, §1, a pledge to provide group health insurance:

> "Group health insurance will be available to all fulltime employees with the Employer paying ninety-five percent (95%) of the premium of the employee rate, single or family…."

This language has been in the agreement, unchanged, since 1972. Prior to 1973, the insurance was provided through Blue Cross. Blue Cross terminated the policy held by the City in 1973, and the parties negotiated a change to Wisconsin Physicians' Service (WPS). An HMP endorsement to the plan was later negotiated.

In 1984, the City proposed to change insurance carriers, and the Union objected to any change. Bruce Patterson, the City's labor representative, sent Union Staff Representative James W. Miller a letter, dated February 1, 1984, setting forth the City's position:

> ***
> The City of Kaukauna is currently reviewing the question of health insurance providers which is within its contractual and statutory rights. The City believes a change in the health insurance provider is not a violation of the labor agreement with Local 130. The City recognizes the Union's right to bargain on insurance benefit levels and also recognizes its contractual commitment as to the present

benefit levels.

Ultimately the City decided to self-fund the existing HMP benefits, rather than switch carriers. The change was instituted on or about April 1, 1984, over the objections of the Union. Among other things, the Union was concerned over the self-funded plan's failure to automatically incorporate state mandated benefits, the details of plan administration and the lack of regulation of self-funded plans by the Office of the Commissioner of Insurance. On March 11, 1985 a prohibited practice complaint was filed with the Wisconsin Employment Relations Commission, alleging that the City had self-insured and had thereby interfered with protected rights, discriminated against employees, refused to bargain, and violated the existing collective bargaining agreement. No meetings or hearings were conducted on the complaint, and it was held in abeyance. In 1987, the City returned to the WPS insurance plan, and the complaint was withdrawn.

In 1989, the City again addressed insurance, this time in negotiations over the 1989-90 labor agreement. The City proposed to switch from WPS-HMP to WPS Care Share, which would have featured a deductible provision, as well as several changes in coverage. As part of its proposal, the City offered to pay the deductible for employees. The parties reached impasse, and the City included the CareShare as part of its final offer. In discussing the insurance issue, Arbitrator Robert Reynolds commented that:

> A review of the present contract (Article XIII, Section 1) reveals no language relating to a specific health insurance contract or to the level of benefits to be provided under that contract. Here the City is making group health insurance available to its full-time employees, and the Careshare plan is surely a group health insurance plan. The only alteration in contract language relates to payment of the deductible, a change that would, on its face, benefit Union members. Were the group health plan suggested by the Employer specifically set forth in the cited Article, the rigorous standard would be appropriate to apply. In this case, that standard will not be invoked.
>
> That does not estop the arbitrator from considering the proposed final offer language. It merely allows application of a less ridged (sic) standard.

After discussing both parties' offers, Arbitrator Reynolds selected the Union's final offer, including status quo on the insurance in his Award dated February 9, 1990:

> The City of Kaukauna has made a well-reasoned and responsible final offer. It has not attempted to solve the very real problem of health care costs at the expense of its employees.
>
> On the other hand, the Union is correct in its ascertion (sic) that continuation of

HMP would be largely paid for by adoption of it (sic) lower wage request. The benefit level is so attractive to the employees that they would prefer to give up a substantial wage increase under this contract and the step up in wages to be in force at the beginning of bargaining for its next contract to retain those benefits.

In light of the substantial reduction in benefits under the City's offer, the final offer of the Union is found to be more reasonable and will be adopted here.

In 1989, the City's cost for the HMP plan increased by 38%. Effective June 1, 1990, the rates increased by an additional 25%. These increases motivated the City to explore alternatives to the HMP plan. On May 25, 1990, Patterson wrote to Miller:

Dear Mr. Miller:

This letter is written to advise you that the City of Kaukauna is considering changing the method of administering its health insurance program on or about July 1, 1990. The benefit levels will remain as they are under the present program offered by WPS.

If you desire to discuss this matter with City representatives, please contact me to arrange an appointment within the next ten days.

Thank you for your attention in this matter.

Sincerely,

/s/ Bruce K. Patterson
Bruce K. Patterson

Miller responded by letter dated June 4, 1990:

Dear Mr. Patterson:

I am in receipt of your letter dated May 25 concerning the health insurance for the City of Kaukauna and I believe in a previous conversation that I had indicated to you what the position of the Union is on this matter. If not, here it is.

The Union believes that the arbitration award or the labor agreement for the year 1989-90 has settled the insurance issue for the term of this agreement. The Union further believes that the decision as to who is going to administer the program is bargainable and that the Union does not wish to reopen the labor agreement at this time. The Union would be most happy to sit down with you and city representatives to discuss this issue; however, I must first inform you that that (sic)

Union does not agree that this would be a bargaining session nor does our meeting with city officials to discuss this issue in any way constitute a reopening of the labor agreement for negotiations of any kind. Please advise.

I am sorry I did not get to respond to your letter sooner but I have been away on vacation.

Sincerely,

James W. Miller
Staff Representative

Patterson and Miller met to discuss the City's self-funding plan, but the parties reached no agreement. On August 1, 1990, the City terminated the WPS-HMP plan and instituted a self-funded plan administered by American Medical Security (AMS), a third party administrator with claims processing offices in Green Bay. The Union filed a prohibited practice charge with WERC, but the parties agreed to withdrawal of the charge in favor of arbitration before the undersigned. Additional facts, as necessary, will be set forth below.

POSITIONS OF THE PARTIES

The Union's Brief

The Union takes the position that the City violated the collective bargaining agreement in switching to a self-funded plan. The parties have given meaning to the ambiguous term "group health insurance" through their negotiations. Historically, the insurance has not been changed except through negotiations, and thus the parties have agreed that their mutual intent governs the exact contours of "group health insurance" under the contract. Here the City has unilaterally changed the insurance, in violation of that agreement.

The parties have a long history of maintaining the negotiated levels of insurance coverage. When the City initially attempted self-funding, the WPS-HMP program was restored after a protest by the Union. Subsequently, the City unsuccessfully attempted to change insurances in an interest arbitration proceeding. Neither the abandonment of the initial attempt to self-fund, nor the recourse to the expense and risk of interest arbitration over this issue, are consistent with the City's current theory that offering any group health insurance, no matter what the specifics, satisfies the mandate of Article XIII.

Even if the City had the right to change carriers, the benefits under the self-funded system do not duplicate the previously existing coverage. The absence of state regulation of self-funded plans is, in and of itself, a critical shortcoming of the new insurance. State regulated insurance companies are subject to presumptions of coverage which do not apply to self-funded plans. Thus in the event of a dispute, the employee has important protections under standard insurance plans, including an appeals process sympathetic to the insured. The Office of the Commissioner of Insurance strictly regulates carriers under a system which is designed to favor the insured. This consumer protection system is an important benefit to employees. The self-insurance plan, including its reinsurance component, is not subject to OCI regulation, and therefore cannot ever

duplicate the previous benefit levels. Any dispute under the self-insurance scheme may be submitted to the contract's grievance procedure, but the burden of proof is on the employee and the employee is forced to proceed before an arbitrator who has far less expertise than the Office of the Commissioner of Insurance and who has a far more limited range of remedies available. Plainly this is an inadequate substitute for OCI regulation.

Aside from the implications of unregulated self-funding, the City's new plan fails to meet the contractual level of benefits in that its administration is different from and inferior to the plan administration under WPS. The self-funded plan has resulted in billing disputes with threats of collection actions against employees, and refusals by the City's plan to pay sums from which workers would have been held harmless under the WPS-HMP plan. Pharmacies which readily accepted the WPS drug card have refused to accept the AMS drug card. No guarantee of confidentiality is extended by AMS. Whereas WPS utilized methods of provider payment which did not involve making the provider wait for payment, AMS often requires additional information from the employee before paying claims. This not only raises the possibility of dunning notices to employes during the payment processing period, it adds a substantial inconvenience for employees which was not experienced under WPS. The WERC has ruled, in the Madison Metropolitan School District declaratory ruling (Dec. No. 22129/22130) that employees have "substantial interests in the integrity, reliability and responsiveness of the carrier/administrator that is selected to be responsible for fair, accurate and prompt payment of employee health insurance claims." The Union submits that the Commission's observation buttresses its position that plan administration is an important benefit, and one which has not been maintained in this case.

For all of the foregoing reasons, the Union asks that the grievance be sustained.

The City's Brief

The City takes the position that there has been no violation of Article XIII and that the grievance should be denied. This grievance involves an interpretation of the collective bargaining agreement, and the arbitrator has no authority to add terms to the contract or impose obligations upon the City which it has not agreed to in the body of the contract. The disputed provision is Article XIII, §1 which provides, in pertinent part:

> "Group health insurance will be available to all fulltime employees with the Employer paying ninety-five percent (95%) of the premium of the employee rate, single or family…"

This language does not require that insurance be provided by any specific carrier, nor that any specific level of benefits be maintained, nor that the insurance be provided through a traditional carrier rather than through self-funding, nor that any particular manner of administration be followed. The contract itself only requires that group insurance be made available.

There is no serious dispute over the continuing availability of group health insurance benefits to these bargaining unit employees. The City presented expert testimony to the effect that its self-insurance plan was group health insurance, as that term is commonly understood in the industry. The statutory definition of "group insurance" in §105 of the IRS Code is met by the self-funded plan, which would be subject to IRS regulation. Wisconsin Statutes, at §120.13(2), recognize that self-funded plans are group insurance, as has WERC Examiner Amedeo Greco in his Mayville School District decision (Dec. No. 25144-C (Greco, 6/90). Mayville is, the City asserts, the seminal Wisconsin case on whether self-funded plans are "insurance". The examiner squarely addressed the issue and, rejecting many of the same arguments which are raised here, held that there was no meaningful distinction between traditional "insurance" policies and "self-funded systems" and that the two were interchangeable terms in labor relations.

Inasmuch as the City only obligation is to provide group health insurance, and since the evidence clearly establishes that such insurance continues to be available, the City asks that the grievance be denied.

The Union's Reply Brief

The City completely ignores the bargaining history underlying the commitment to provide "group health insurance", and the meaning given that term by the parties in negotiating and administering the contract over the years. The City has, in the past, acknowledged that it did not have the right to unilaterally adopt a self-funding system, first when it backed away from an attempt to self-fund in the face of a prohibited practice charge, and second when it took the insurance issue to interest arbitration and lost.

The City's reliance on Mayville is completely misplaced. Mayville involved a school district whose attempt to self-fund was consistent with the interpretation given to the term "insurance" by both parties -- that it, that it included a self-funding option. This critical factual element is missing in this case and Mayville cannot control the outcome here.

Noting the City's attempt to cite its expert witness for the proposition that "self-funding" is equal to "insurance", the Union asserts that the City's actuary has no qualification to make such a legal opinion. On the other hand, the Union's expert witness is a former official of the OCI and a noted insurance attorney. Her opinion that self-funding is not insurance because it does not transfer risk to a third party is far more persuasive.

The history of this relationship is what is relevant here, and the outcome should be controlled by the meaning given the term "insurance" by these parties. As the record demonstrates that self-funding was never intended to be within the scope of that term, the grievance should be sustained, the employees made whole for any losses, and the WPS-HMP plan should be restored.

The City's Reply Brief

The Union's claim that bargaining history and/or past practice are relevant to this dispute assumes that the contract language is ambiguous. This assumption has no support in the record. The common and ordinary usage of the words in Article XIII, §1 leaves no doubt as to the provision's meaning -- it merely requires the City to make group health insurance available to employees. As discussed in the initial brief, this has been done, and there need be no reference to other indicators of the contract's meaning.

Assuming, arguendo, that there is some ambiguity in the language, the evidence of bargaining history and past practice in the record falls short of demonstrating some mutual agreement on the contract's meaning. For example, the City's prior introduction of self-funding in 1984, together with a contemporaneous pledge to maintain benefit levels, demonstrates that the City never considered OCI regulation or a traditional insurance format to be benefits under the contract. The subsequent decision to return to WPS-HMP was made unilaterally and, far from acknowledging any merit in the Union's prohibited practice complaint, reflected the fact that WPS dropped its rates below those offered by Fireman's Fund. Thus the decision was purely economic.

As to the Union's claim that some mutual intent is demonstrated by the City's proposal in interest arbitration over the 1989-90 contract to introduce the WPS CareShare insurance plan, the City asserts that the 1989-90 proposal is factually distinct from the self-funding plan at issue here. Care Share would simply have introduced deductibles to be paid by the City, with some minor benefit changes. By placing the proposal on the table for negotiations, the City acknowledged only that it has a duty bargain over annual deductibles. That duty says nothing about the City's right to go with a self-funded insurance plan.

Even if one assumes for the sake of argument that the OCI regulation discussed by the Union is a "benefit" under the insurance plan, the City has no obligation to maintain any specific level of benefits. This completely distinguishes the City of Richland Center case relied upon by the Union, where the contract clearly committed the City to make "no reduction in benefits" when changing insurance carriers. Absent such language in this case, Richland Center ,with its discussion of the "benefits" of OCI regulation, is irrelevant. The City notes, however, that it established through the testimony of its expert witness that the stop loss insurance for claims in excess of $15,000 per individual or 25% of aggregate expected claims is purchased through a traditional insurer and is subject to OCI regulation. Thus claims in excess of the stop-loss are regulated by OCI. In any event, there is no evidence of any loss to any employee as a result of the loss of OCI regulation over a portion of the insurance, and the Union's argument is therefore purely speculative.

While the Union pointed to some problems with the implementation of the self-funded

plan, the City points in turn to the Mayville decision, wherein the examiner found that the status quo doctrine of labor law could accommodate such difficulties as "inevitable" and "only natural" when a change in insurers took place. The occurrence of such problems as payment delays and disputes over covered charges during the implementation period should not be translated into a loss of benefits. In each specific case cited by the Union, the City has either resolved the dispute in favor of the employee or was still pursuing the matters at the time of the hearing. The record shows that benefit levels have been maintained, and the Union's argument in this regard must fail.

Responding to the Union's arguments concerning the administration of the insurance plan, the City reiterates its position that the contract makes no mention of guaranteeing any method or level of administration. However, the record evidence of administrative problems is limited to five employees/families. Given the large amount expended on paying insurance claims in the ten months under the plan and the number of employees in the City, one can only conclude that the plan is well administered and that the problems cited by the Union are de minimis.

The Union is attempting to gain through arbitration guarantees that it never secured in bargaining. The arbitrator is without authority to permit such a result and the grievance should be denied.

DISCUSSION

The dispute in this case centers on the City's unilateral decision to abandon the traditional WPS-HMP health insurance plan and to instead self-insure, with AMS as the third party administrator. The collective bargaining agreement addresses health insurance at Article XIII:

> Section 1. Group health insurance will be available to all fulltime employees with the Employer paying ninety-five percent (95%) of the premium of the employee rate, single or family. The employee shall be required to pay the fifty dollar ($50.00) deductible. If an employee retires at age 62-65 and is not eligible for health insurance from any subsequent employer, the City will pay seventy-five (75%) of the premium for continuing under the group health insurance if the employee desires coverage.

The first reference point in determining the meaning of a contract clause is the language used by the parties. If the parties have used language which is clear and unambiguous, so that it is not susceptible to more than one reasonable interpretation, no further inquiry need be made. Inferential evidence of intent, such as custom or negotiating history, cannot displace clear language. If, however, the contract language does not on its face settle the question, the arbitrator is obligated to apply recognized principles of interpretation in order to determine the correct meaning.

Clear Language

The City asserts that the language of Article XIII defines its obligations in clear and unambiguous terms, and limits those obligations to providing insurance and paying a portion of the premium. This argument sidesteps the central issue, which is what the parties meant by the term "group health insurance". The bottom line for the City's argument is that any bundle of benefits, coverages, administrative practices and government regulation is acceptable under the contract so long as it may fairly be termed "insurance". The Union argues that the intent of the term is far more precise, and must be read to mean the HMP plan offered by Wisconsin Physicians Service or, at the very least, the very same policy administered in exactly the same way, through a traditional insurance carrier.

The City is correct insofar as it argues that the contract is silent on the identity of the carrier/administrator and the precise contours of the health insurance benefits. Silence on these points, however, cannot be equated with clarity. Common experience does not support the notion that parties negotiate group health insurance -- generally the second most important and expensive element of the compensation package -- without having at least some basic understanding of what they are receiving for their money. Thus the undersigned rejects the City's contention that the contract clearly grants it a virtual carte blanche to unilaterally determine the content of the health insurance plan for represented employees.

The Union claims that the use of the term "group health insurance" cannot encompass self-insurance, since the latter does not have the characteristics of insurance in the state of Wisconsin, principally regulation by the Office of the Commissioner of Insurance and the automatic inclusion of state mandated benefits. While the undersigned agrees that there is a significant substantive difference in the administrative features of a policy purchased from a regulated carrier and a self-funded benefit plan, the initial question is not whether such differences exist. Instead, the question is whether the language of this contract clearly evinces an intent to preclude self-funding. Among other possible definitions, the term "insurance" may refer to protection against loss, or the contract which guarantees such protection. 1/ The former would clearly include the City's

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1/ The term "insurance" has been defined as: "A contract whereby, for a stipulated consideration, one party undertakes to compensate the other for loss on a specified subject by specific perils. … A contract whereby one undertakes to indemnify another against loss, damage, or liability arising from an unknown or contingent event and is applicable only to some contingency or act to occur in the future. An agreement by which one party for a consideration promises to pay money or its equivalent or to do an valuable to another party upon destruction, loss or injury of something in which the other party has an interest." Black's Law Dictionary, 5th Ed.; " 1. an insuring or being insured. 2. a contract (insurance policy) purchased to provide compensation for a specified loss by fire, death, etc. 3. the amount for which something is insured. 4. the business of insuring against loss…." Webster's New World Dictionary; "A means of providing or purchasing protection against some of the economic consequences of loss." Employee Benefit Plans:

self-funded plan, since it promises payment of health care costs to the same extent as the WPS-HMP plan. The latter is also susceptible to an interpretation embracing a self-funded plan, if one views the contract as being between the City and the employees. For these reasons, the undersigned concludes that the contract language standing alone does not unequivocally support the Union's position.

Whether the mutual understanding expressed by the term "group health insurance" extends only to some generalized consensus on levels of coverage or also includes agreement on specific benefits and administrative characteristics is a question that turns on the practices, negotiations and other evidence of intent available in this record. 2/

The wording of the contract does not foreclose either party's interpretation. Neither the almost limitless flexibility suggested by the City nor the complete rigidity urged by the Union would be self-evident simply from a reading of the contract language. These are two extremes on the same continuum, and the correctness of either one cannot be determined without reference to evidence of intent beyond the written words of Article XIII.

Bargaining History

A Glossary of Terms, 6th Ed. (International Foundation of Employee Benefit Plans).

2/ In concluding that the contract language is ambiguous, the undersigned has carefully considered whether the decisions of Examienr Greco in Mayville and Arbitrator Houlihan in Richland Center provide guidance as to a commonly understood meaning for the term "group health insurance." Examienr Greco dealt with the question of whether a switch to self-insuring benefit levels was consistent with the duty to maintain the status quo ante under Section 111.70. The issue in this case is not whether the parties have a duty to bargain over the identity of the insurance provider, but whetehr theyhave bargained over that topic and reached agreement. In other words, while Mayville dealt with the statutory obligations of the employer, the arbitrator in this case must determine the contractual duties of the employer. In Richland Center, Arbitrator Houlihan interpreted language which expressly allowed for a change in carriers, so long as there was no reduction in benefits. He was unable to determine whether the parties intended the third party administrator of a self-insurance plan to equate with a "carrier" and expressed no opinion on the question. He did determine that the self-insurance plan, in part by virtue of its unregulated nature, yielded a reduction in benefits for the employees. The contract language in Richland Center was substantially different from the contract language in this case, and the Award is not particularly helpful in establishing a clear meaning for the term "group health insurance".

Consideration of bargaining history leads to the conclusion that the City did not retain the wide discretion it claims over the content of the insurance program. The contract is silent as to the specific level of health insurance benefits. The WPS insurance plan was negotiated by the City and the Union in 1973 when Blue Cross cancelled its coverage of City employees, and the HMP endorsement was added in subsequent negotiations. At no point in bargaining did the parties expressly discuss the issues of whether self-insurance was the equivalent of traditional insurance and whether or how carriers could be changed in mid-contract term. What the parties did expressly discuss, and reach agreement on, was that the insurance for employees would be the WPS-HMP plan.

In the undersigned's view, the interest arbitration over the health insurance issue in 1989-90 contract negotiations confirms that the WPS-HMP plan represents the mutually recognized status quo on insurance benefits. Contrary to the City's argument that it proceeded to arbitration merely on the question of deductible increases, the record reflects that its final offer would have both changed the deductible and modified coverages. The Union devoted a good deal of attention to these benefit changes in its brief before the interest arbitrator. Notwithstanding Arbitrator Reynolds' dicta about the lack of a contractual guarantee of any specific benefit levels, his Award was expressly premised upon the "substantial reduction in benefits" worked by the City's proposed shift to the WPS CareShare plan:

> "In light of the substantial reduction in benefits under the City's offer, the final offer of the Union is found to be the more reasonable and will be adopted here." 3/

Rather clearly the interest arbitrator made a choice between two alternatives on insurance -- the City's proposal to switch to WPS CareShare and the Union's desire to retain WPS-HMP -- and concluded that the Union's status quo position was the more reasonable. The City's assertion in this proceeding that it may unilaterally change insurance benefit levels is completely inconsistent with the outcome of the 1989-90 negotiations.

The bargaining history persuades the undersigned that the term "group health insurance" as used in this contract means the benefits provided by the WPS-HMP policy. The question, however, remains as to whether the obligation to maintain benefit levels includes the obligation to insure through a carrier.

Past Practice

The best evidence of how ambiguous language is to be interpreted is the manner in which the parties themselves have interpreted it in the past. In this case, the term "group health insurance" has in practice meant WPS insurance since 1973, with the exception of a two to three

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3/ City of Kaukauna, Dec. No. 26074 (2/9/90), Union Exhibit #23, at page 5.

year period beginning in 1984, when the City unilaterally introduced self-insurance administered by Fireman's Fund. The Union objected to this change, and filed a complaint of prohibited practices against the City. The charge was neither actively pursued nor withdrawn, until the City offered to reinstate WPS.

Neither the Union's failure to prosecute the prohibited practice nor the City's decision to restore the status quo ante has particular probative value. The Union's complaint rather clearly establishes its belief that self-insurance, even with the promise of maintaining benefit levels, is inconsistent with the negotiated language. No reason was established for its inaction after the filing of the complaint, and no reliable inference may be drawn from the lack of prosecution. For the City's part, the reintroduction of WPS was allegedly prompted by the fact that the rates for HMP had become more attractive than the cost of self-insurance. Even though the mayor characterized the offer to return to WPS as an effort to "respond to the concerns" and "satisfy" the prohibited practice complaint, 4/ his letter can only fairly be read as an offer of settlement. It is a well accepted principle that an offer of settlement does not constitute an admission. The withdrawal of the complaint and the return to WPS were accomplished without any written settlement agreement, and neither party can be said to have prejudiced its position regarding the permissibility of a switch to self-insurance by its handling of the previous incident.

Although no reliable inference may be drawn from the previous switch to self-funding and subsequent return to WPS, the undersigned is of the opinion that the long history of contracting for insurance through WPS cuts in favor of the Union's position in this case. It is widely recognized that a long established practice may be binding upon the parties for the term of the agreement, even in cases where the contract is utterly silent on the condition of employment which is the subject of the practice. This principle is premised upon the fact that parties do not bargain in a vacuum, and are presumed to have negotiated their agreement in full recognition of existing benefits and working conditions. For that reason, the principle of enforceability has much greater force in the area of benefits than in areas more commonly identified with the prerogatives of management, and where the practice arises from a mutual agreement than a unilateral decision. Although expressed in a variety of ways, it also appears that most arbitrators who have addressed this issue recognize a practical distinction between "major" benefits, which the parties might be presumed to have weighed in bargaining, and "minor" benefits. 5/

In this case, the decision to insure through WPS was arrived at mutually in 1973. Every bargain since that time has been concluded with WPS as the carrier, although as previously discussed neither party expressly raised the identity or the nature of the carrier as an issue in

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4/ Union Exhibit #17

5/ See Elkouri & Elkouri, How Arbitration Works, 4th Ed. (hereinafter cited as "Elkouri") at pps. 437-49 and cases cited therein.

bargaining. Thus the practice of providing an agreed upon level of benefits through a traditional carrier arises from a mutual agreement of the parties.

The City has acknowledged, both in correspondence in 1984 and 1990 and in the testimony of its labor relations consultant at the hearing in this case, that it has an obligation to maintain the level of benefits that existed under WPS-HMP. This is consistent with the obligation to continue well established practices regarding benefits as discussed above. It is also consistent with the Reynolds' Award. The question is whether the the distinction between the carrier provided insurance plan and the self-insurance plan may be said to implicate employee "benefits" in this case. I conclude that it does, in that the regulation of insurance carriers by the State carries with it automatic extension of state mandated benefits and the application of a presumption of coverage in the event of disputes, features which are lacking in the City's current self-insurance plan. These are substantial benefits to employees. In the undersigned's view, they would constitute the type of "major" benefits that would reasonably be expected to carry over through the contract term. The extension of state mandates, although by its nature a speculative benefit, is nonetheless a valuable promise to employees that benefits may be maintained at the minimum standards set by the state without the necessity of reopening the contract or relying on the good intentions of the employer. The value to employees and the Union of being able to receive additional insurance benefits without bargaining is self evident. Likewise the availability of a forum for resolving disputes which applies a presumption of coverage is decidedly more desirable from the employee's point of view than a contractual grievance procedure in which the Union bears the burden of proof. The broader range of remedies available under OCI regulations than is typically found in grievance arbitration is another beneficial aspect of coverage through a regulated carrier which is missing from the City's self-funded plan.

With respect to the other areas in which the Union believes the self-funded plan is deficient, the undersigned concludes that these do not represent reductions in benefits which the parties might reasonably have expected to maintain during the term of the contract. While there were several bills identified as being the subject of disputes, in each instance the City persuasively demonstrated that it was making good faith efforts to resolve the disputes and pay the claims to the same extent that WPS would have paid them, including directives to its third party administrator to pay for procedures on an out-of-contract basis and to not apply a UCR reduction to bills. In addition, the City has directed its administrator to duplicate WPS-HMP benefits even where they are not mirrored in the AMS plan document and to make provision for maintaining patient confidentiality. The City makes a credible argument that the number of disputes is very small in relationship to the overall usage of the insurance, and that the administrative problems cited by the Union are transitional in nature.

CONCLUSION

The contract is ambiguous with respect to the level of benefits afforded by its guarantee of "group health insurance" and the permissibility of self-insurance. Bargaining history, and in

particular the outcome of the 1989-90 interest arbitration, demonstrates that the WPS-HMP plan constitutes the agreed upon level of benefits for unit employees. The City has attempted to maintain the coverage levels through its third party administrator. However, the lack of any pledge to incorporate state mandated benefits, the absence of a presumption of coverage in the event of a dispute and the narrower range of remedies available before a grievance arbitrator than could be had from the Office of the Commissioner of Insurance represent a reduction in the historical benefits employees have enjoyed for nearly twenty years. Thus the undersigned concludes that the City violated the collective bargaining agreement when it replaced the WPS-HMP health insurance plan with a self-funded insurance plan administered by American Medical Security.

The record does not reflect any actual monetary loss to any employee. In the event that such a loss has occurred, the appropriate remedy is to make the employee whole, by paying the difference between the benefits paid by AMS and/or the City, and the amount that would have been paid by WPS. With respect to the nature of the insurer, the violation flows from lack of protections under self-insurance that are available through state regulated insurers. The undersigned remands the issue to the parties for a period of thirty days to attempt to reach agreement on an insurance structure incorporating such protections. Absent agreement, the appropriate remedy is to reinstate the WPS-HMP policy.

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

AWARD

The City violated the collective bargaining agreement when it replaced the WPS-HMP health insurance plan with a self-funded insurance plan administered by American Medical Security. The appropriate remedy is to make employees whole for any losses which they may have suffered by virtue of payment of insurance benefits by AMS and/or the City at a level less than would have been paid under the WPS-HMP policy. The remedy question is remanded to the parties for a period of thirty days to allow for mutual agreement on an appropriate vehicle for providing insurance benefits in the future. Absent agreement on some other terms, the appropriate remedy will be the reinstatement of the WPS-HMP policy effective June 5, 1992. The undersigned will retain jurisdiction over the remedy question until June 19, 1992.

Signed this 5th day of May, 1992 at Racine, Wisconsin:

Daniel Nielsen /s/
Daniel Nielsen, Arbitrator