BEFORE THE ARBITRATOR

In the Matter of the Arbitration
of a Dispute Between

NEW BERLIN PROFESSIONAL POLICE ASSOCIATION

and

CITY OF NEW BERLIN (POLICE DEPARTMENT)

Case 84
No. 52198
MA-8870

Appearances:

Mr. Patrick J. Coraggio, Labor Consultant, Labor Association of Wisconsin, Inc., on behalf of the New Berlin Professional Police Association.

Davis & Kuelthau, S.C., Attorneys at Law, by Mr. Roger E. Walsh, on behalf of the City of New Berlin.

ARBITRATION AWARD

The New Berlin Professional Police Association, hereinafter the Association, requested that the Wisconsin Employment Relations Commission appoint a staff arbitrator to hear and decide the instant dispute between the Association and the City of New Berlin, hereinafter the City, in accordance with the grievance and arbitration procedures contained in the parties' labor agreement. The City subsequently concurred in the request and the undersigned, David E. Shaw, of the Commission's staff, was designated to arbitrate in the dispute. A hearing was held before the undersigned on July 11, 1995 in New Berlin, Wisconsin. A stenographic transcript was made of the hearing and the parties submitted post-hearing briefs in the matter by September 11, 1995. Based upon the evidence and the arguments of the parties, the undersigned makes and issues the following Award.

ISSUES:

As part of their stipulation, the parties stipulated to the following with regard to the issues before the Arbitrator:

> 22. *That neither the City nor the Association have raised any procedural arguments relative to this dispute.*
>
> 23. *That the sole question before the arbitrator is whether the City's change to Prime Care Plus was consistent with the standards set forth in the collective bargaining agreement in Section 5.02, and if not, what is the appropriate remedy*

under the Agreement?

CONTRACT PROVISIONS:

The following are the applicable provisions of the parties' 1994-1995 Agreement:

ARTICLE V - INSURANCE

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Section 5.02 - Hospitalization & Health Insurance: The City shall pay the monthly premium for hospitalization and surgical care insurance. Employees may select coverage for a single person or for family coverage. The City shall have the right to change carriers for its standard health insurance program provided the coverage is substantially equivalent to that in effect on December 31, 1990, except as modified below in section 5.03, and there is no lapse of coverage. In the event an employee has a spouse that is also a City employee, that employee and the employee's spouse will be entitled to only one family health insurance contract between them from the City.

Section 5.03 - Insurance out of Pocket Costs: On or after January 1, 1994, the City's standard health insurance program will be the Blue Cross/Blue Shield Tradition Plus PPO and non-PPO, with a $200.00 per person, $400.00 per family annual deductible, an 80%/20% co-insurance provision, and an annual out-of-pocket maximum payment of $600.00 per person and $1,200.00 per family. The specific provisions of the Blue Cross/Blue Shield Tradition Plus Plan are as listed in the plan document initialed by both parties.

Section 5.04 - Insurance After Retirement: Members of the bargaining unit who are retired involuntarily by the City will be covered by hospital and surgical insurance benefits until a maximum age of sixty-five (65) years or until eligibility for Medicare, whichever occurs earliest. This benefit shall cover dependents of retiree while he is eligible. It is understood this benefit shall not be available to voluntary retirees. If the retired employee is eligible for fully paid hospitalization insurance through another employer or through his spouse's employer, the obligation of the City will cease.

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BACKGROUND:

The parties entered into the following stipulation, set forth below in relevant part: 1/

STIPULATION OF FACTS

Grievance #94-124
Case 84 No. 52198 MA 8870

This Stipulation of Fact is entered into voluntarily by the City of New Berlin, hereinafter referred to as the "City", and the New Berlin Professional Police Association, hereinafter referred to as the "Association".

1. That the City of New Berlin and the New Berlin Professional Police Association have a collective bargaining agreement in full force and effect at all times material to the above referenced grievance, a copy of which is attached hereto as Appendix "A". 2/

2. That the members of the Association included in the above referenced grievance are covered under the terms and conditions of the collective bargaining agreement referenced in paragraph 1.

3. That the City, on or about October 17, 1994, issued a memorandum regarding the open enrollment for health insurance for 1995, which memorandum indicated a change in health insurance from the current Blue Cross/Blue Shield Tradition Plus Plan and CompCare Elite to the Prime Care Point of Service Plan, a copy of which is attached hereto as Appendix "B".

4. That on October 27, 1994, the Association sent a letter to Lowell E. Clapp, Director of Human Resources, requesting a copy of the plan document for the new insurance plan, a

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1/ Those paragraphs pertaining to the issues and already set forth above, as well as those pertaining to procedural aspects of the case not in issue, are omitted.

2/ The appendices have been omitted for the sake of brevity.

copy of which is attached hereto as Appendix "C".

5. That on or about December 9, 1994, the Association filed a grievance with the City claiming that the change in insurance carriers did not meet the standard of being substantially equivalent as set forth in the collective bargaining agreement, a copy of which is attached hereto as Appendix "D".

6. That on or about December 13, 1994, Mr. Clapp responded to the grievance suggesting that Steps 1 and 2 be waived and that a meeting be set up to discuss the grievance, a copy of which is attached hereto as Appendix "E".

7. That on or about December 21, 1994, the Association sent a certified letter to Mr. Clapp advising that the Association is moving the grievance to Step 3, a copy of which is attached hereto as Appendix "F".

8. That on January 10, 1995, a meeting was held between representatives of the City and the Association to discuss the differences in the new insurance, and the Association provided a handout to the City identifying 18 areas of change, a copy of which is attached hereto as Appendix "G".

9. That on January 11, 1995, the Association sent a letter to Mr. Clapp identifying additional concerns that were being brought forward by the Association relative to the change in health insurance carriers, a copy of which is attached hereto as Appendix "H".

10. That on January 19, 1995, Mr. Clapp called to set up a meeting to discuss the differences enumerated by the Association at which time a representative from the insurance company would be there to address the Association's concerns.

11. That on February 1, 1995, a meeting was held between the City and the Association to discuss the differences enumerated by the Association.

12. That the meeting held on February 1, 1995, did not resolve or change the position of the City or the Association.

13. That on February 8, 1995, the Association filed a Petition for Arbitration with the Wisconsin Employment Relations Commission, a copy of which is attached hereto as Appendix "I".

14. That on February 10, 1995, the Association received a letter from the City acknowledging the request for arbitration, a copy of which is attached hereto as Appendix "J".

15. That on February 15, 1995, Mr. Clapp called the Association requesting a list of changes that would be needed to resolve the dispute.

16. That on February 16, 1995, the Association responded to the City's request regarding a resolution to the grievance, a copy of which is attached hereto as Appendix "K".

17. That on February 21, 1995, the Association sent a follow-up letter regarding the request made by the City on February 15, 1995, enumerating 13 areas that should be modified to resolve the dispute, a copy of which is attached hereto as Appendix "L".

18. That on February 28, 1995, the Association received a letter from Mr. Clapp indicating that the insurance carrier was reviewing the list of revisions requested by the Association, a copy of which is attached hereto as Appendix "M".

19. That the City did not provide any offer of change in the insurance program as requested by the Association on February 21, 1995.

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POSITIONS OF THE PARTIES:

Association

The Association asserts that the language in Section 5.02 of the parties' Agreement is clear and unequivocal and cites arbitral precedent, as well as Elkouri and Elkouri, How Arbitration Works, (4th ed.) (1985), for the principal that "the clear meaning of the contract must be enforced even though the results may be harsh or contrary to the original expectations of one of the parties". Citing Elkouri & Elkouri at page 349. The pertinent language in Section 5.02 states that "the City shall have the right to change carriers for its standard health insurance program provided the coverage is substantially equivalent to that in effect on December 31, 1990, . . ."

While the City has the right to change insurance carriers for its standard health insurance plan, the change in carriers must provide "substantially equivalent coverage". The term "substantially" is defined in the Lexicon Webster Dictionary (copyright 1989) as "in a substantial manner, essentially to a large degree". The term "equivalent" is defined as

a. equal in substance, degree, value, force or meaning;
b. having similar or identical effects;
c. practically equal

Thus, the phrase "substantially equivalent" means the change in coverage must be to a large degree, equal in substance or practically equal and that is the question posed before the Arbitrator.

While Section 5.02 gives the City the right to change carriers, it must be viewed in conjunction with Appendix "A" of the 1991-1993 Agreement, which identified the Blue Cross/Blue Shield Tradition Plus PPO and non-PPO (BC/BS plan) as the standard health insurance plan referenced in Article V, Section 5.02, for the purpose of determining whether the level of benefits in the new plan is substantially equivalent. While "substantially equivalent" allows for some modification in the coverage which could arguably produce a level of coverage of a lesser degree than the previous carrier provided, such a reduction may only be of a minor nature and not to the "great degree" the City has unilaterally imposed by changing to the Prime Care Plus (Prime Care) health insurance program.

Although the Prime Care plan is better in a few "insignificant areas", the change has exposed employes to a reduction in the level of coverage in a number of areas. Citing the testimony of Association expert witness, Martin Tomcek, the Association asserts that numerous areas of lesser coverage provided to Association members under the Prime Care plan have been identified and for the most part were unrefuted by the City. Tomcek's testimony was also corroborated by documentation. The City's witnesses offered little rebuttal to the specific areas of loss and in many instances Tomcek's testimony was unrefuted. The Association also asserts that while it is the grieving party in this matter, it is the City that took the initial action to change the

carrier/coverage and, being the proponent of change, the City must carry the burden of proving that the change meets the standard of being "substantially equivalent".

The Association cites Tomcek's testimony regarding a number of areas it alleges the Prime Care plan provides a lower level of coverage than that provided by the BC/BS plan:

1. Out-of-Pocket Maximums

The Association asserts there is a substantial difference in the level of benefits in this area. An individual with a maximum out-of-pocket exposure of $600 under the BC/BS plan could have his exposure increased to $1,000 under the Prime Care plan and an officer with a family would go from a maximum exposure of $1,200 to $2,200. That additional $1,000 of exposure would have the equivalent affect of a 2 1/2 percent loss of wages and would be after tax dollars as well.

2. Pre-Existing Conditions

Under the BC/BS program the pre-existing limitation was defined as a 12-3-9, while under the Prime Care plan it is a 12-6-12 out-of-network. The first number refers to the period preceding the effective date of coverage, i.e. a pre-existing condition would be a condition for which the individual received medical attention during that twelve months prior to his/her effective date of coverage. The last number in the series refers to the number of months during which services for that pre-existing condition would not be covered, i.e. the first nine months in the case of the BC/BS plan and the first twelve months in the case of Prime Care if out-of-network. The middle number refers to the number of months the individual must go without receiving any medical attention for the pre-existing condition during that time period that it is not covered, i.e. under the BC/BS plan, if the individual goes three consecutive months during that nine-month period without receiving any medical attention for that pre-existing condition, the limitation is waived and the condition is covered. In the case of Prime Care, out-of-network an individual must go six continuous months during the twelve-month period in order for the limitation to be waived.

3. Preventive Care: Routine Physicals, Well Baby Care, Immunizations

Under the BC/BS plan, preventive care was a separate benefit and covered up to 100 percent to a maximum of $150 per calendar year. Under the Prime Care program, in-network, there was no dollar limit, however, out-of-network, there is no coverage. Thus, under Prime Care the individual must see a doctor in-network in order to have coverage and if an employe wanted to utilize their own physician and their physician was not part of the network, they would be responsible for the entire cost.

4. Oral Surgery

The BC/BS plan covers fifteen specific procedures under this category, while the Prime Care plan covers only seven. Thus, if an employe needed to have one of the eight services not covered under Prime Care, the employe would be responsible for the additional out-of-pocket expenses.

5. Transplants

Expenses for transplants under the BC/BS plan are covered whether in-network or out- of-network, while under Prime Care, if the employe goes out of network, the employe would bear the entire cost. Thus, there is a tremendous potential for loss in this category alone.

6. Occupational, Speech, Physical Therapy

Under the Prime Care plan there is a limit of 60 visits per illness under Tiers I and II and an additional 60 visits per year available under Tier III. Under the BC/BS plan, there is no maximum limit except for a 12 week maximum for cardiac rehabilitation.

7. Supplemental Accident Benefit

The BC/BS plan provided a supplemental accident benefit which paid 100 percent of the first $300 of covered expenses per incident, whether in or out-of-network. Under the Prime Care plan, in-network has a $25 co-pay per visit and out-of-network there is no supplemental benefit.

8. Skilled Nursing Facility

Under the BC/BS plan there was skilled nursing allowed for 100 days per individual per calendar year. Under Prime Care there is a 30 days per individual per calendar year limit under Tier I and Tier II and an additional 30 days per individual under Tier III, after the deductible and co-insurance. Thus, there would at best be a 40-day difference in the level of the benefit.

9. Home Health Care

The BC/BS plan provided 40 visits per calendar year, with an additional 40 visits if the illness is terminal. The Prime Care plan offers 40 visits per calendar year and under Tier III provides an additional 40 visits per calendar year after the deductible and co-insurance. While the two plans are close as to this benefit, the edge goes to the BC/BS plan.

10. Penalty for Non-Compliance

Under the BC/BS plan, if an employe does not comply with the pre-authorization requirement, the first $500 of covered expenses would not be covered and the employe would be responsible for that amount. Under the Prime Care plan, for out-of-network services the penalty is that the employe would be responsible for 50 percent of all otherwise covered expenses with no limit on what that amount might be. The situation would not occur under the CompCare program or the Prime Care plan in network, since those are managed care systems. The Association asserts that the unlimited financial exposure an employe would be subject to under the Prime Care plan again demonstrates the difference in the level of benefit under the new carrier.

11. Prescription Drugs

The Association asserts that this is a benefit which the majority of the bargaining unit will feel first hand and that the change in this area depicts the "wide sweeping affect" of the change in carriers on the vast majority of the employes in the unit. Under the BC/BS plan, the individual presents their prescription drug card and if they purchase a generic drug, the individual pays $5.00 of the cost, whereas if they purchase a brand name drug, they pay $10.00 of that cost, whether the doctor who wrote the prescription was a network provider or out of network. Under the CompCare program the co-payment was $7.00 for generic drugs and $12.00 for brand name drugs. Under the Prime Care plan, in-network, there is a $5.00 co-payment. Where the physician writing the prescription is an out-of-network provider, the prescription would be subject to the deductible and co-insurance, i.e. a $200 deductible per individual and a maximum on the co-insurance of $400, for a total of $600 of exposure for going out of network under Prime Care. Another difference is that Prime Care plan utilizes a drug formulary system whereby the insurance company specifies what prescriptions a participating provider should prescribe for certain diagnoses and the drugs that fall under certain categories, and only those drugs that the company certifies to be prescribed for a diagnosis are within the formulary and covered. If a drug is prescribed that is not covered by the formulary, the employe is responsible for the full cost of that prescription or else must settle for an alternative drug that is within the formulary. Also, Prime Care charges a $5.00 co-payment for each and every item that is required in a diabetic package, causing increased costs to the individual in that area. Prime Care also limits the amount of pills that can be received at one time to 30, while under the BC/BS plan an individual could purchase 100 pills at a time. Thus, under Prime Care, the individual has to pay three drug co-payments, instead of the one under Blue Cross.

12. Lost Freedom of Choice

The Association also asserts that the change from two health care providers to one restricted the choice employes had in selecting a health care provider best suited to meet the needs of the employes and their families. Prior to the change, employes could choose between the Blue

Cross program and the CompCare HMO and now can only select among those providers participating in the Prime Care program. While the freedom of choice may technically not be an issue the Arbitrator is required to address in this case, an arbitrator's decision must conform to some boundaries of reasonableness and an employe's inability to no longer see the physician or gynecologist they have routinely seen for years is a "drastic and potentially expensive change from the status quo".

The Association also asserts that the City was more interested in providing the most economically beneficial program to the City, rather than attempting to maintain the substantially equivalent level of benefits as required by the Agreement. That the rest of the City's represented employes feel the same way is demonstrated by the fact that the other bargaining units have also grieved the change in carriers. That essentially means that over three-quarters of the City's work force is unhappy with the change in benefits.

City

The City notes that Section 5.03 provides that "on or after January 1, 1994, the City's standard health insurance program will be the Blue Cross/Blue Shield Tradition Plus PPO and non-PPO, . . ." The City also notes that prior to January 1, 1995 it made available two health insurance programs to its employes, the BC/BS Tradition Plus plan, its standard health insurance plan, and the CompCare HMO plan which was separate. It asserts that the Agreement does not require the City to either offer or to maintain the CompCare HMO plan, and that, therefore, the grievance is limited solely to determining whether the coverage under the Prime Care plan is "substantially equivalent" to the BC/BS Tradition Plus plan.

The City next asserts that while the contract does not define the term "substantially equivalent", the use of that phrase clearly indicates the parties did not intend that the new coverage would be "exactly the same as" the old coverage. The City cites the award in Illinois Fraternal Order of Police Labor Council and City of Harvard, 93-2 ARB para 3550 (Arbitrator Briggs, 1993) in which the arbitrator, applying the same standard as in this case, found that the "overwhelming majority of the total health insurance benefit package was not altered" by the change and denied the grievance. By using the phrase "substantially equivalent" the parties recognized that no two insurance policies are exactly alike and allowed the City some flexibility in obtaining replacement coverage. That certain changes, even changes resulting in an employe incurring some additional cost, must be overlooked is supported by the testimony of the Association's expert witness, Tomcek. Asked on cross-examination why he did not list a $25 co-payment for emergency out-patient services as one of the changes under the Prime Care plan from the Blue Cross plan, which had no such co-payment, Tomcek replied that he did not list it because he did not view it as a "substantial difference".

The City recounts the developments that led to the change in carrier, beginning with an indication from Blue Cross/Blue Shield representative Stemberger that BC/BS was concerned that

most of the employes, especially the healthy ones, were electing to be covered under the CompCare HMO rather than the BC/BS Tradition Plus plan, resulting in what it felt was "adverse selection", meaning that the smaller number of employes with higher medical costs were remaining in the BC/BS plan. Stemberger indicated that there was some question whether BC/BS would even submit a renewal quotation for 1995. In 1994 only 32 percent of the 170 employes under the health plans participated in the BC/BS plan. The City also notes that when it switched to the BC/BS Tradition Plus plan in 1992, it also offered a CompCare HMO plan which was then a division of BC/BS. By 1994 CompCare and BC/BS were two separate and independent entities. BC/BS did submit a proposal for a renewal of the Tradition Plus Plan in 1995 with a premium increase of 43.3 percent and suggested changing to PPO benefits and included an alternative PPO plan to be considered by the City. Two groups of the City's employes are required to pay any premium cost in excess of 107 percent of the lowest premium cost for the health plan the City offered. Since the CompCare premium did not increase for 1995, it was likely that most of the employes in those two groups would switch to the CompCare plan. Stemberger indicated that if additional employes left the Tradition Plus plan, BC/BS would not offer the plan for 1995. After considering point of service plans proposed by Stemberger and by CompCare, and concluding that they were not a close enough match for the Tradition Plus plan, the City contacted Prime Care to obtain a proposal. After receiving that proposal, the City considered it to be "substantially equivalent" to the Tradition Plus plan. The City's Human Resource Director and the Human Resources Coordinator then met with representatives of the Association to explain the situation and to discuss the different plans. As it was clear that BC/BS was not going to offer the Tradition Plus plan to the City for 1995, the City selected the Prime Care plan since it was the closest plan to the Tradition Plus plan available.

The City notes that in a November 28, 1994 letter to Association representative Coraggio, Tomcek outlined the "basic benefits difference between the current plans and the proposed plan", listing fourteen specific differences. Since there is duplication regarding temporomandibular joint disorder, there are really only thirteen alleged differences. Tomcek testified on both direct and cross-examination that those were the only differences he saw between the two plans. Thus, analysis of the alleged differences should be limited to those listed by Tomcek in his letter.

The City next asserts that of those alleged differences in coverage, they either do not exist or do not result in a determination that the Prime Care Plus plan is not "substantially equivalent" to the Tradition Plus plan. The City asserts the following with regard to those alleged differences:

1. Life Time Maximum

BC/BS provided a lifetime maximum benefit of one million dollars for both in-network and out of network services combined. Prime Care provided unlimited benefits for in-network services and a lifetime maximum of one million dollars for out-of-network services. Tomcek conceded that was better coverage than the BC/BS plan.

2. Calendar Year Out-Of-Pocket Maximum

BC/BS had a $200 per person, $400 per family deductible cost and a 20 percent co-insurance cost, with a $600 individual and $1,200 family calendar year out-of-pocket maximum deductible and co-insurance cost for all services, whether in-network or out-of- network. Prime Care has no deductible or co-insurance cost for Tier I services and no deductible or co-insurance costs for Tier II services, except for a twenty percent co-insurance cost on physician's office visits, immunizations, routine physical exams and well baby care, with a $500 individual and $1,000 family maximum for Tier II in network services. Tier III (out-of- network) under Prime Care has a $200 per person, $400 per family deductible cost and a 20 percent co-insurance cost with a $600 individual and $1,200 family maximum for Tier III out- of-network services. Thus, if in-network services only are used under Tier I or Tier II benefits, the Prime Care benefit is better than the BC/BS benefit. If Tier III out-of-network services only are utilized, the Prime Care benefit is the same as the BC/BS benefit. If both in-network and out-of-network services are utilized, the employe could ultimately pay less, the same or more under Prime Care, depending upon the extent of services needed and where they were performed. The maximum additional cost would be $500 per individual and $1,000 per family, however, the chances of incurring additional out-of-pocket costs are slim. Prime Care's experience, and an analysis of the claims and payments to City participants from January through April 1995 indicate that out-of-network services comprise only three to three and one-half percent of the amounts billed. Since in 97 percent of the cases in-network services are utilized, City participants will in almost all cases have less out-of-pocket expenses under Prime Care than they did under the BC/BS plan.

3. Pre-Existing Condition Limitation for New Employees

The BC/BS plan had a 12-3-9 provision restricting coverage for any pre-existing condition which had manifested itself within 12 months prior to the effective date of the coverage, while Prime Care has no pre-existing condition limitation for in-network services and for out-of-network services has a 12-6-12 provision for any condition that was treated within 12 months prior to the effective date of the coverage. Since out-of-network services occur in only approximately three percent of the cases, for all practical purposes Prime Care has no pre-existing condition limitation and therefore provides a better benefit than the BC/BS plan.

4. Preventive Care: Routine Physicals, Well-Baby Care, Immunizations

The BC/BS plan provided 100 percent coverage up to a maximum of $150 per calendar year for these preventative care services. Under Prime Care there is 100 percent coverage, with no maximum, for in-network services. This care is not covered if it is performed out-of-network under Prime Care. Since there is full coverage with no maximum on this care under Prime Care, the in network limitation should not be considered to be significant. Thus, Prime Care provides a better benefit.

5. Vision/Hearing Exam

The BC/BS plan did not provide coverage for either of these examinations. In-network, hearing and vision exams are covered 100 percent under Prime Care. Even Tomcek conceded the Prime Care benefit is better than under Blue Cross.

6. Prescription Drugs

The City notes there are two issues under this topic, the employe co-pay for prescription drugs and the Prime Care drug formulary. As to the co-pay, the BC/BS plan had a co-pay of $5 for each prescription of generic drugs and a co-pay of $10 for each prescription of brand- name drugs, regardless of whether they were obtained in-network or out-of-network. Under Prime Care, if the drugs are obtained from an in-network provider, there is a co-pay of $5 for each prescription, regardless of whether it is for generic or brand-name drugs. If the drugs are obtained out-of-network, Prime Care covers the prescription subject to the deductible and co-insurance provisions. Thus, if the drugs are obtained from an in-network provider, Prime Care's benefit is better than the BC/BS plan. If the drugs are obtained from an out-of-network provider, the participant's cost may be more, the same, or less than the cost under the BC/BS plan, depending on whether the participant had already satisfied the maximum deductible and co-insurance out-of-pocket costs. If only the deductible had been satisfied and the 20 percent co-insurance amount applied, that could still result in a participant paying less under Prime Care than under the BC/BS plan for brand-name drugs.

With regard to the drug formulary, both Tomcek and Prime Care's Manager of Marketing Services, Kathleen Pralle, testified that drug formularies are becoming the trend among insurance companies. Tomcek also conceded that while a drug formulary may not contain every drug manufactured for a particular condition, it would contain at least one or more drugs that could be used for each medical condition. Further, there is a procedure under Prime Care whereby if an employe's physician wants the participant to use a particular drug that is not on the formulary, the physician can contact the Plan's pharmacist and discuss the situation. If the Plan pharmacist agrees with the physician, a medical exception will be authorized and Prime Care will cover the non-formulary drug. The fact that Prime Care utilizes a drug formulary is immaterial. Under the Prime Care plan, benefits are provided for drugs necessary to treat all medical conditions and the formulary only applies to in-network providers and exceptions can be authorized to provide for payment of non-formulary drugs.

7. Oral Surgery

The BC/BS plan provides coverage for 15 specific procedures, while Prime Care provides coverage for seven specific procedures. Tomcek testified that other than the number of procedures covered under each plan, there are not other differences worth noting. The City asserts that there

is nothing in the record to indicate the likelihood of occurrences of those other eight procedures or the costs involved, and thus, it is impossible to determine whether this is a significant difference.

8. Transplants

The BC/BS plan covers transplants regardless of whether the service is performed in-network or out-of-network, while Prime Care provides benefits only if performed in-network. The only difference then being that under Prime Care, the services must be performed in network and that restriction is "insignificant and immaterial".

9. Occupational/Speech/Physical Therapy

The BC/BS plan had no limitations on the number of visits, except for cardiac rehabilitation (12-week period maximum). Under the Prime Care plan, which is made up of two separate insuring contracts, there is a 60-day per episode or illness limitation under the Tier I and II contract and an additional 60 days per episode or illness limitation under the Tier III contract, the latter being consecutive to the Tier II benefit. Thus, there is a 120-day per episode or illness limitation under Prime Care. Pralle testified that, in her experience, that coverage has been adequate and that as Chair of the Complaints and Appeals Section of Prime Care, she has not experienced any complaint regarding this benefit. The City also asserts that the Association has presented no evidence that the 120-day coverage is inadequate. Thus, while Prime Care has a limitation, it provides adequate coverage for the condition.

10. Skilled Nursing Facility

The BC/BS plan had a limit of 100 days per individual per calendar year. Contrary to Tomcek's testimony, Prime Care has a limit of 30 days per individual per confinement, not 30 days per calendar year. Further, there is a 30 day per confinement benefit under Tiers I and II and an additional 30 days per confinement under Tier III, totalling 60 days per confinement under Prime Care. Since there could be more than one confinement in a calendar year, the Prime Care benefit would provide more than the 100 days per calendar year provided by BC/BS. Further, the Association presented no evidence that 60 days per confinement is inadequate.

11. Home Health Care

The BC/BS plan provided for 40 visits per calendar year, with an additional 40 visits if the illness is terminal. Under Prime Care, there are 40 visits per calendar year under Tiers I and II and an additional 40 visits per calendar year under Tier III, and the illness does not have to be terminal to receive the additional 40 visits. Therefore, the Prime Care plan provides the better benefit in this area.

12. Supplemental Accident Benefit

The BC/BS plan provided 100 percent coverage for the first $300 of covered expenses per incident. While Tomcek testified that Prime Care provides 100 percent coverage for in- network services, but no coverage for out-of-network, Pralle testified that Prime Care treats all emergency and urgent care services on the same basis, and regardless if they are performed in- network or out-of-network they are covered as Tier I benefits at 100 percent payment. There is no $300 per incident limitation as under BC/BS, although Prime Care does have a $25 emergency room charge. However, even Tomcek conceded that is not a significant difference. Thus, the Prime Care benefit is better in this area.

13. Penalty for Non-Compliance of Pre-Authorization Requirement

The penalty under the BC/BS plan for failure to pre-authorize non-emergency in-patient admissions was that there would be no coverage for the first $500 of covered expenses. Under Prime Care, there is no penalty for failure to pre-authorize in-network services, however, there is a penalty of 50 percent of all covered expenses for failure to pre-authorize for out-of-network services. Tomcek conceded that pre-authorization is a fairly standard provision in health insurance contracts and both Tomcek and Pralle testified that many out-of-network providers assist their patients in handling the pre-authorization requirements. Pralle also testified she was not aware of any situation where the pre-authorization penalty had actually been imposed by Prime Care. Since in 97 percent of the cases in-network services are utilized, the Prime Care benefit is better than the Blue Cross benefit in those 97 percent of the cases. And in the three percent involving out-of-network situations, the pre-authorization requirements are not onerous and in many cases are handled by the out-of-network provider.

The City concludes that in ten of the thirteen alleged differences the Prime Care plan actually provides an equal or better benefit than the BC/BS plan and in the other three areas the coverage is almost the same. The coverage under Prime Care is not only "substantially equivalent" to the Blue Cross coverage, it is actually better.

The City notes the testimony of Association President Blunt regarding being contacted by members of the bargaining unit about problems with the coverage under Prime Care, especially with regard to the drug formulary. Several of the problems noted involved employes who have previously been covered under CompCare. Those problems are immaterial to this dispute. Blunt also testified that with the exception of the drug formulary problem on Jansen, he did not bring these other problems to the attention of the City or Prime Care. Pralle testified that most of the problems regarding the drug formulary could have been resolved if the problems had been brought to her attention. Potkay also testified that while employes in this bargaining unit did not contact her regarding problems with Prime Care, other employes did and their problems, most relating to the drug formulary, were resolved. As to the problem Blunt testified to regarding the retiree who has to utilize out-of-network services, the retiree has the same out- of-pocket maximums under Prime Care that he had under the BC/BS plan. Similarly, as to Johnson's drug supply problem

regarding Prime Care's 34-day limitation per prescription, that is the same as the limit under the BC/BS plan. Therefore, the complaints raised by Blunt are not sufficient to support a conclusion that coverage under Prime Care is not "substantially equivalent" to the BC/BS plan.

The City also asserts that there are improvements under the Prime Care plan that were not available under BC/BS, the most significant being the ability to utilize HMO services, PPO services, and out of network services all under the same plan, while under the previous plan employes had to chose between an HMO and a PPO/non-PPO plan. Another area of improvement was the doubling of the mental health benefit. Under the Prime Care plan, the participant is initially eligible under the Tier I/II benefit and when that is exhausted, has a duplication of that benefit under Tier III. Prime Care also offers "Nursline" whereby a participant can contact a nurse for guidance on medical problems 24 hours a day, OPTUM, an employe assistance program, a health magazine and a $25 reimbursement plan for attendance at any one of several health maintenance programs.

Reply Briefs

In its reply brief, the Association asserts there is nothing in record to substantiate the City's allegation that the BC/BS plan may not even have been in existence as an option in 1995. The record indicates there were 55 employes in the City under the BC/BS plan and undoubtedly BC/BS would have attempted to renew its contract with the City. Even if BC/BS would have submitted a quote substantially higher than the prior year, that would have been an issue for contract negotiations.

The Association asserts that the City's brief made numerous references to reductions in the level of benefits which the City tried to play down by simply stating that the coverage provided is "adequate". The question before the Arbitrator is not whether there is adequate coverage, rather it is whether or not the change in carriers meets the "substantially equivalent" standard set forth in the parties' Agreement.

The Association asserts that there are several areas of tremendous exposure for employes under the new plan that did not exist under the BC/BS plan: transplants, prescription drugs and coverage for retirees who move out of the Prime Care area. With regard to transplants, the BC/BS plan paid for all transplants whether in or out-of-network, while Prime Care only pays for those covered in network and has no coverage whatsoever for out-of-network services in this area. While the City asserts that 97 percent of the employes stay within the Prime Care network and only three percent go out-of-network, that is obviously due to the fact that people cannot afford to go out of the Prime Care system, as it would be too costly. In a transplant situation, however, there may not be a choice. Assuming arguendo that the City's percentages are accurate, three percent of the employes in this unit going out of network would mean that two people would be incurring transplant operations without any assistance from Prime Care and would be experiencing a tremendous financial expenditure. Another area of reduction in benefits felt by all members of

the unit is prescription drugs and the drug formulary. Under the drug formulary, the insurance company controls the type of drugs offered and thus affords a reduced level of benefit in this area. The Association asserts that there was testimony at hearing that even Prime Care physicians prescribe medicine not part of the drug formulary, leading one to speculate that those doctors must feel that the medicine on the Prime Care formulary is not adequate to treat his/her patients. Another area of reduced benefits is with regard to retirees, a group of people being penalized because of their location outside of the Prime Care plus area. This puts them in a financially vulnerable position of having to utilize services out-of-network on a regular basis, constituting a considerable increase in their financial exposure.

The Association also asserts that the City contradicts itself in several areas when it argues that only three percent of the employes use out-of-network benefits, then later argues that the benefits available under Tier III for out-of-network services must be considered in addition to the in-network coverage in comparing the level of benefits available under the two plans, e.g., in the areas of occupational/speech/physical therapy, skilled nursing and home health care benefits. Further, it is unrealistic to believe that employes would utilize a physician or therapist for 30 days or 60 days and then switch out-of-network to incur deductibles and co-pays by utilizing a new physician or therapist. Expecting individuals to exhaust their in-network benefits and then switch out-of- network does not meet the test of reasonableness. The Association concludes that the City has not met the "substantially equivalent" standard in the Agreement and requests as a remedy that the City be ordered to stand in the shoes of the insurer with regard to those benefits where coverage is less under the Prime Care plan and to make whole those employes who have suffered losses in that regard.

In its reply brief, the City asserts that the instant grievance only affects 16 of the 52 members in the unit, since 70 percent of the employes were covered under the CompCare program in 1994, not under the "standard health insurance program". Further, the Association's arguments are based on the worst case scenario involving utilization of out-of-network or Tier III benefits. Prime Care's experience indicates that approximately only three percent of the benefits provided are related to Tier III benefits. Thus, for the most part the employes receive greater benefits under the Prime Care program than they did under the combination BC/BS Tradition Plus and the CompCare HMO programs. Seventy percent of the unit has expanded coverage beyond an HMO and the ability of the other 30 percent to have the benefits of an HMO program are significant improvements and amounts to a betterment of the City's standard insurance program.

The City notes that while the parties' interpretation of "substantially equivalent" is generally consistent with each other, the City disagrees that any change "can only be a reduction in coverage that is of a minor nature". It cites Arbitrator Briggs' award wherein he found compliance with the substantially equivalent standard if the bulk of the new plan would be the same and the "overwhelming majority of the total health insurance benefit package" was not altered. Thus, some changes can occur, other than "minor changes", as long as the "bulk" or the "overwhelming majority" of the health insurance program remains the same. The Association

only listed thirteen items it considered to be differences out of the hundreds of benefit provisions under the programs. Even if all thirteen items were different, that would still not constitute the "bulk" or "overwhelming majority" of the total health insurance package. Further, in ten out of the thirteen alleged differences, the Prime Care plan is actually equal to or better than the Blue Cross benefit and almost the same in the other three.

With regard to the alleged differences, the City responds that as to out-of-pocket maximums, there is no deductible or co-insurance cost under the Tier I benefits, and the maximum out-of-pocket costs under the Tier II benefits is still less than that under the BC/BS plan. It is only when there is a combination of Tier II and Tier III benefits that there is potentially a greater out-of-pocket cost under the Prime Care plan. Since 97 percent of the benefits will be under Tier I and Tier II, the employes will be better off under Prime Care in almost all cases. With regard to pre-existing conditions, again, in 97 percent of the cases there is no pre-existing condition restriction, since Tier I and II benefits are not subject to that provision under Prime Care. Thus, Prime Care is better than the BC/BS plan. The Association conceded that Prime Care provides a better benefit under Tier I and Tier II as far as preventive care and, contrary to the Association's allegation, there is considerable choice under Tier I and II. As to oral surgery, there is not any evidence of the likely occurrence of the eight services not covered by Prime Care and it would be conjecture to determine whether this constitutes a substantial deficiency. Transplants are covered under Tier I and II in the Prime Care plan and, therefore, the coverage is at least substantially equivalent. The fact that there is some restriction on which provider can be utilized does not detract from that fact. As to occupational/speech/physical therapy, the Association has not showed that the coverage under Prime Care is inadequate for these services. With regard to the supplemental accident benefit, the City asserts that the Association is in error, since Prime Care treats all emergency and urgent care services, where ever performed and whether performed by a Tier I, II or III provider, at 100 percent coverage. The only patient cost is the $25 emergency room charge if the patient is not admitted as an in-patient. As to coverage for skilled nursing facility, that is a "very limited benefit" regardless of which plan it utilized. As to home health care, Prime Care's benefit is in all cases, except terminal cases, double the benefit offered under BC/BS and therefore is the better benefit. As to the penalty for non-compliance, there is no penalty under Tier I or II under Prime Care, and even under Tier III the pre-certification requirement is not burdensome and many Tier III providers make sure the patient is in fact pre-authorized. Thus, any penalty in that regard is unlikely.

The Association has alleged that the problems with the prescription drugs and the drug formulary constitute the "major complaint" of its members. However, with the possible exception of one, none of those members have contacted either Prime Care or the City's Human Resource Department to resolve their problem, whereas other employes of the City have done so and those problems have for the most part been resolved. Prime Care has a lower co-payment under Tier I and II than does BC/BS and in certain situations there could be no co-payment costs under Tier III. Of those employes referenced by the Association as having problems in this area, Osborne, Friese and Noordyk were covered under the CompCare program prior to 1995 and therefore their

complaints are immaterial in this proceeding. Further, in all three instances Prime Care was not contacted to obtain either an alternative prescription or medical exception. Also, the BC/BS drug program provides for the same 34-day supply provision as contained in the Prime Care plan. The complaint regarding the failure of a Prime Care representative to get back to Jansen was not substantiated. However, the Prime Care representative, Pralle, stated she would be willing to review his problem. The complaint regarding Goodman having to make payment up front and then be reimbursed for his out-of-network drug purchase does not constitute a substantial difference since the benefit is eventually paid. With regard to the retiree, Baldridge, if the only providers that he utilizes are out-of- network, the out-of-pocket maximums are the same under Prime Care as under Blue Cross and it is only when both Tier II and Tier III benefits are used that the out-of-pocket maximum under Prime Care could exceed those of Blue Cross.

With regard to the Association's assertion that the employes have lost freedom of choice, the City asserts that in the past employes had to choose between an HMO and a PPO and out- of-network-type plan and could not take both programs. Under the Prime Care point of service plan, employes have the benefits of an HMO program and at the same time the benefits of a PPO and out-of-network program. The 70 percent of the employes who were formerly in the HMO program retain those benefits and now have the additional benefits of a PPO and out-of- network plan. The 30 percent who were in the BC/BS Tradition Plus plan retain their PPO and out-of-network coverage and now may utilize an HMO program. Employes now are able to select on a case-by-case basis which plan they wish to utilize, whereas in the past they could only make that selection once a year. There is nothing in the record to substantiate the Association's claim that members are now limited to a handful of doctors picked by Prime Care for their primary physician. The reference to primary physician is a concept under an HMO program and in addition to the Tier I primary physician, employes may select from numerous physicians for Tier II benefits. Under the CompCare program, it was CompCare who selected the physicians who would be primary physicians under that HMO. Under the BC/BS plan it was neither the Association, nor the City, but Blue Cross who selected the physicians who would be considered as in-network PPO providers. There is no evidence to indicate that there is a significant change in the identity of the network doctors that are being utilized by City employes under the Prime Care plan. Even if there has been some change, that does not prevent Prime Care from being considered "substantially equivalent". Insurance carriers offering PPO or out- of-network programs are constantly revising their list of network providers and providers often do not renew their contract with the carrier. Hence, even if an employe had remained under the BC/BS program, there is no guarantee the employe's physician would continue to be in-network.

As to the Association's claim that their position is supported by the fact that the unions representing other City employes have filed grievances, the City asserts that the basis for those grievances is not in the record and the fact that there was a protest does not mean the protest is valid. Contrary to the Association's assertions, the City's Human Resource Coordinator credibly testified that employes had come to her early in 1995 regarding the prescription drug issues and that she was able to work out solutions to their problems and that those complaints had subsided. The City asserts in conclusion that the Association misunderstands the benefits provided under the

Prime Care plan and that it has "squirreled away" employe complaints in order to build some case of unrest for this arbitration. Had those problems been raised with the City prior to hearing, as was the case with other City employes, most, if not all, of those problems could have been resolved. The City concludes that the Prime Care plan provides a better benefit than the former Blue Cross plan and it is clearly at least "substantially equivalent" to the latter.

DISCUSSION

As other arbitrators have noted regarding this type of dispute, this is a highly complex, yet vital, area that has a significant financial impact upon both parties.

There are a number of sub-issues that must be addressed in deciding this dispute. The first involves the comparison to be made. Both parties cite the "substantially equivalent" standard contained in Sec. 5.02 of their Agreement; however, unlike the City, the Association involves the Compcare HMO plan in the comparison of coverage of the old plan with the coverage of the Prime Care plan. Section 5.02 of the 1994-1995 Agreement provides that the City "may change carriers for its standard health insurance program provided the coverage is substantially equivalent to that in effect on December 31, 1990, except as modified below in Section 5.03, and there is no lapse of coverage." (Emphasis added). Section 5.03 in turn, provides:

> Section 5.03 - Insurance out of Pocket Costs: On or after January 1, 1994, the City's standard health insurance program will be the Blue Cross/Blue Shield Tradition Plus PPO and non-PPO, with a $200.00 per person, $400.00 per family annual deductible, an 80%/20% co-insurance provision, and an annual out-of-pocket maximum payment of $600.00 per person and $1,200.00 per family. The specific provisions of the Blue Cross/Blue Shield Tradition Plus Plan are listed in the plan document initialed by both parties.

There is no mention of the Compcare HMO Plan in either Sec. 5.02 or Sec. 5.03. The record indicates that prior to 1992 the health insurance plan covering these employes was the WPS-HIP plan and that pursuant to Appendix "A" of the parties' 1991-1993 Agreement, it was agreed that

> ". . .effective January 1, 1992, the City's standard health insurance program will be the Blue Cross/Blue Shield Tradition Plus PPO and non-PPO, with a $200.00 per person, $400.00 per family annual deductible, an 80%/20% co-insurance provision, and an annual out-of-pocket maximum payment of $600.00 per person and $1,200.00 per family. The specific provisions of the Blue Cross/Blue Shield Tradition Plus Plan are listed in the plan document initialed by both parties. On and after January 1, 1992, this Blue Cross/Blue Shield Tradition Plus Plan will be the standard health insurance program referred to in Article V, Section 5.02." (Emphasis added)

It appears from the record that BC/BS also offered the Compcare HMO plan initially and that Compcare was then a division of BC/BS, but that by 1994 Compcare was a separate company

and no longer part of BC/BS. Therefore, it would not be reasonable to assume that the parties somehow intended that their reference to the BC/BS Tradition Plus PPO and non-PPO plan somehow included the Compcare HMO plan as part of the City's standard health insurance program for purposes of Sec. 5.02 of the Agreement.

Given the above, it is concluded that it is the BC/BS Tradition Plus plan that establishes the level of coverages with which the new plan must be compared and that the Compcare HMO plan is not relevant in that regard. Thus, the City may change the carrier for its standard health insurance program provided the coverage is "substantially equivalent" to that provided by the Blue Cross/Blue Shield Tradition Plus PPO and non-PPO plan. 3/

What then, does the term "substantially equivalent" mean in terms of the coverage required of a replacement plan? The Association cites dictionary definitions of "substantially" and "equivalent" and concludes the coverage must be "to a large degree, equal in substance, or practically equal", while the City relies upon an arbitration award in which the arbitrator interpreted "substantially equivalent" to mean that the "bulk" of the amended plan must remain the same as the predecessor. As both parties note, the term "substantially equivalent" is not defined in the Agreement. In the absence of evidence of a mutual understanding to the contrary, words will be given their usual and ordinary meaning as defined by a reliable dictionary. 4/ The definitions cited by the Association are from the Lexicon Webster's Dictionary and are essentially the same as those found in the Arbitrator's copy of Webster's New World Dictionary (Second College Edition), and provide the appropriate definition of "substantially equivalent" as "to a large degree, equal in substance, or practically equal". While the Arbitrator agrees that the coverage does not have to be identical to that of the BC/BS plan, and that lesser coverage in one area may, in some degree, be offset by better coverage in another area, these variations must be minor in nature. Whether the difference is found to be minor will depend both on the extent of the difference in coverage and the area of benefits involved, some areas and aspects of a plan being more significant than others.

The undersigned reviewed the two plan documents and, in doing so, it became apparent that in a number of areas of coverage in dispute, it would be difficult, if not impossible, to make a meaningful comparison. For example, is BC/BS's 100 days per individual, per calendar year coverage for skilled nursing facility superior to 30 days per individual, per confinement under Tiers I and II, and an additional 30 days under Tier III under the Prime Care plan? Whether an individual would fare better under one plan than under the other in that regard would depend upon

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3/ However, it must be pointed out that by virtue of the elimination of the CompCare HMO option, those employes who had been in the CompCare HMO would now have been in the BC/BS plan, but for the change to Prime Care.

4/ Elkouri and Elkouri, How Arbitration Works, Third Edition, at p. 307.

the circumstances. Perhaps one could show statistically that the coverage under one plan would generally provide the better benefit to more people, but such evidence is not in the record.

After reviewing the coverage of the two plans in the areas in dispute, it also became apparent that while there are only minor differences in some areas, there are a number of areas or aspects of the Prime Care plan that differ significantly from the coverage of the BC/BS plan to the detriment of the individuals covered by the plan. That being the case, it finally dawned on the Arbitrator that an attempt at comparing the areas of minor differences to determine whether, on balance, the coverage was "substantially equivalent", was a meaningless exercise, given the major differences identified and discussed below.

First, in comparing the two plans, it is noted that the BC/BS Tradition Plus plan is a "PPO" and "non-PPO" plan under which the level of benefits available for those covered services listed as "Tradition Plus Provider Services" 5/ depends upon whether the services are rendered by a plan provider (in-network), or a non-plan provider (out-of-network). The deductible and co-insurance are waived for those services, if they are performed by a plan provider. Members may self-refer in-network without affecting the level of benefits or the waiver of the deductible and co-insurance. The Prime Care plan is a "point of service" plan which requires a member to sign up with a primary care physician. Prime Care has three tiers of benefit levels as follows:

5/ The following are designated as "Tradition Plus Provider Services" in the plan:

1. Inpatient Hospital services.
2. Outpatient Hospital services for:
   a. Emergency accident care
   b. Emergency medical care
   c. Surgery
   d. Diagnostic Services
   e. Radiation therapy
   f. Chemotherapy
3. Physician's Professional Other Provider's services for:
   a. Surgery
   b. Assistant at Surgery
   c. Inpatient consultation
   d. Inpatient medical care
   e. Inpatient, Outpatient, and office Diagnostic Services
   f. Radiation therapy
   g. Chemotherapy
   h. Outpatient emergency care

> The I HMO Benefits - These benefits are Health Maintenance Organization ("HMO") benefits offered by PrimeCare Health Plan, Inc. and must be coordinated by your Primary Care Physician. Medically Necessary Emergency Health Services and referrals by your Primary Care Physician are also considered Tier I HMO Benefits. . .Tier I HMO Benefits are not subject to payment of a Deductible and provide Coverage at the highest level of all three Tiers.
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> The II HMO Benefits - These benefits are Health Maintenance Organization ("HMO") benefits offered by PrimeCare Health Plan, Inc. and apply when you choose to obtain Health Services from a Participating provider without coordinating health services through your Primary Care Physician. . .Tier II HMO Benefits are [not] subject to payment of a Deductible. In most cases, the Tier II HMO Benefits are subject to larger Copayments than Tier I HMO Benefits but are Covered at a higher level than Tier III UHL Benefits.
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> Tier III UHL Benefits - These benefits are insurance benefits underwritten by United Health and Life Insurance Company ("UHL") and apply when you decide to obtain Health Services (1) from non-Participating providers, (2) directed by a non-Participating Physician to a Participating provider or (3) provided by a Participating Physician at a non-Participating provider when requested by you or your Enrolled Dependent. . .Tier III UHL Benefits are subject to a Deductible and are Covered at the lowest level. Generally, Tier III UHL Benefits are also subject to Coninsurance and require you to obtain prior authorization for certain Health Services. In addition, when you obtain Health Services from non-Participating providers, you must file a claim with PLAN to be reimbursed for Eligible Expenses.

As can be seen from the above, while a member may self-refer in-network under the Prime Care plan (Tier II), the amount of co-insurance required is higher than if the member had been referred by his/her primary care physician (Tier I). Thus, unlike the BC/BS Tradition Plus plan, there is a monetary "penalty" for self-referring in-network under the Prime Care plan. By itself, that is a significant difference in the coverage of the two plans.

Another area of significant difference is the out-of-pocket maximums under the two plans. The BC/BS plan waives the deductible and co-insurance for "Tradition Plus Provider Services" if rendered by an in-network provider and for "Special Services" (diagnostic services performed by

an independent laboratory), and has a combined (deductible and co-insurance costs) maximum of $600 per person, $1,200 per family, per year, whether in or out-of-network. The Prime Care Plan has no deductible or co-insurance for Tier I coverage; has no deductible, but has a $500 per person, $1,000 per family annual maximums on co-insurance for Tier II coverage for physician's office visits and preventive care; and has a $600 per person, $1,200 per family annual maximums for Tier III coverage. The maximums under Tier II and Tier III are separate, so that if both Tier II and Tier III benefits were used, the combined maximum out-of-pocket costs could be as high as $1,100/person and $2,200/family. The City asserts that while it is possible an employe could end up paying more out of pocket under the Prime Care plan, it is unlikely, since Prime Care's experience under this plan indicates that only three percent of its claims (in both dollars and numbers) involve out-of-network services. Assuming the three percent figure is accurate, as the Union notes, a possible explanation for this is the additional expense that is incurred in deductibles and co-insurance by going out-of-network under the Prime Care plan. The fact remains, however, that under the BC/BS plan, the most expense an employe would incur annually for deductibles and co-insurance is $600/person and $1,200/family, whether in-network or out-of-network services are utilized and whether or not the member self-referred in-network. Under the Prime Care plan, those maximums are $500/person and $1,000/family higher. The parties apparently felt that capping the employes' out-of-pocket expenses for deductibles and co-insurance sufficiently important to include the $600 per person, $1,200 per family maximums in the description of the City's "standard health insurance program" in Sec. 5.03, Insurance Out-Of-Pocket Costs, of their Agreement. The difference in the annual out-of-pocket maximums that may be incurred under the two plans is therefore considered to be significant.

Another area where the plans differ significantly is the lack of coverage for certain services if one goes out-of-network. Under the Prime Care plan, there is 100 percent coverage with no cap in-network, but no coverage out-of-network, in the area of preventive care (routine physical examinations, well baby care and immunizations). Under the BC/BS plan there is 100 percent coverage with a $150 per year cap on coverage for preventive care, whether obtained in or out-of-network. While this difference may not be as significant for employes and their families who live in the area, it especially affects the retirees covered by the City's health insurance plan 6/ who have moved out of the area. Similarly, with regard to transplants, the BC/BS plan coverage was the same in this area whether in-network or out-of-network, while the Prime Care plan covers these expenses only in-network. Thus, the difference in the two plans is the ability to obtain these services out-of-network without incurring additional cost under the BC/BS plan. The City asserts that the restriction that services be performed in-network under the Prime Care plan in order to be covered is "insignificant". It would seem, however, that while this is an area that will likely not affect a large number of employes in the bargaining unit or their families, it is an area where one

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6/ Sec. 5.04 of the Agreement provides that members of the bargaining unit who are involuntarily retired by the City, and their dependents, will be covered by hospital and surgical benefits until a maximum age of 65 or until they are eligible for Medicare.

would particularly want the freedom and ability, within reason, to select the services of the best in the field. For that reason, the restriction under the Prime Care plan that the care be obtained in-network in order to be covered is deemed to be a significant difference.

There is also a significant difference between the two plans in the coverage for occupational, speech or physical therapy. The BC/BS plan had no limitation in this area except for a twelve week maximum for cardiac rehabilitation. The Prime Care plan has a 60 days per episode or illness limit under Tier I and Tier II, and an additional 60 days per episode or illness available under Tier III consecutive to the Tier II benefit. The City's assertion that there has been no showing that 120 days per illness or episode is inadequate ignores the contractual standard. The parties' Agreement does not require that the coverage of the replacement plan only be adequate, it requires that the coverage be "substantially equivalent" to the coverage provided under the BC/BS plan. While 120 days per illness or episode may be "adequate" in most cases, it is significantly less than the generally unlimited coverage provided by the BC/BS plan.

The coverage of the two plans for prescription drugs also differs significantly in at least two aspects, i.e., the coverage if the prescribing physician is out-of-network, and the utilization of a drug formulary system. With regard to the former, the BC/BS plan requires that individuals present their prescription drug card, and pay $5.00 of the cost of purchasing a generic drug and $10.00 of the cost if they purchase a brand name drug, regardless of whether the physician who wrote the prescription was a network provider or out-of-network. Under the Prime Care plan, there is a $5.00 co-pay for generic or brand name drugs if the physician writing the prescription is an in-network provider; however, if the prescribing physician is out-of network, the prescriptions are subject to the deductible and co-insurance provisions, but the formulary does not apply. Retirees covered by the plan who have moved out of the area are again significantly impacted by the difference in Prime Care's coverage out-of-network.

Prime Care also utilizes a drug formulary whereby the Prime Care Plan specifies what drugs are to be prescribed for a particular medical condition and only those drugs within the formulary are covered. If an individual's physician feels that a drug not specified on the formulary for the condition should be used, there is a procedure for contacting the Plan's pharmacist to discuss the matter, and if the Plan pharmacist agrees with the physician, a medical exception will be authorized and the non-formulary drug will be covered. The Association produced several complaints from its members where they have been required to have an alternative drug prescribed or have not had their prescription covered due to the application of the formulary. 7/ While the co-pay amount is lower under Prime Care for brand name drugs, it is

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7/ The fact that some of those individuals had previously been covered by CompCare, rather than the BC/BS plan, is not relevant to this point. They are examples of how utilizing a drug formulary system has worked, not as a comparison of benefits between CompCare and Prime Care.

only if the prescription is obtained and filled in-network and the prescribed drug is on the formulary. Those restrictions overshadow the possible savings and are considered to constitute significant differences in the two plans. 8/

Finally, the coverage in the area of oral surgery under the Prime Care Plan is significantly less than that of the BC/BS plan. The BC/BS plan provided coverage for fifteen specific procedures, while the Prime Care plan only provides coverage for seven procedures in this area. The City asserts there is no evidence in the record regarding the likelihood of the occurrence of the other eight procedures or the costs, and that, therefore, it is not possible to determine whether there is a significant difference between the two plans in this area. On its face, the Prime Care plan provides less coverage, i.e., no coverage for eight of the fifteen specific procedures for which the BC/BS plan provides coverage. That being the case, it was up to the City to establish that those eight areas do not constitute a significant difference. There being no evidence in that regard in this record, it is concluded that the Prime Care plan provides significantly less coverage in this area.

The City has asserted that while the Prime Care plan might provide somewhat less coverage in a particular area, this is offset by its providing better coverage than the BC/BS plan in other areas. Having reviewed all of the areas of coverage in dispute, the undersigned finds that Prime Care's coverage is better than that of the BC/BS plan in the areas of the pre-existing condition limitation (there is no limitation if one obtains services in-network and thus one can be immediately covered for that condition, while one must wait at least three months to be covered under BC/BS); home health care (both plans provide for 40 visits per calendar year, but an additional 40 days are available, subject to deductibles and co-insurance, under Tier III of Prime Care, while one could only receive an additional 40 days under BC/BS if the illness were terminal); mental health (BC/BS coverage is less or the same as Prime Care for in-patient services and significantly less for outpatient and transitional care than Prime Care's coverage); and vision/hearing examinations (Prime Care covers in-network, while BC/BS does not cover at all). The better coverage in these areas under Prime Care is not sufficient to offset its significant deficiencies in those areas discussed above. As to the coverage in those other areas the Association asserts is inferior to the coverage under the BC/BS plan, the undersigned has reviewed the coverage under the two plans and concluded that the differences in coverage in those other areas are not significant or that a meaningful comparison could not be made based upon the record.

8/ The Association also asserts that Prime Care limits its prescription drug coverage to purchases of 30 pills at a time, thereby increasing the number of co-pays. However, the coverage under both plans appears to be in terms of a limitation on the number of days for which a single prescription may be filled and the evidence is considered to be inconclusive as to any significant difference in this area.

It also must be noted that, to the extent the Association asserts as another deficiency resulting from the changes that the employes lost their freedom to choose between two plans and thus their freedom to select the physicians they wished to see, the freedom to go out-of-network without loss of coverage in certain areas has been addressed above. Beyond that difference, however, the undersigned does not consider the fact that a particular physician is a network provider under the BC/BS plan, but not under Prime Care, to be an aspect of coverage. Both plans have providers who are considered to be in-network and both plans generally provide a higher level of benefits if the care is obtained from a network provider. The existing plan utilized the plan provider system and distinguished between in-network and out-of-network with regard to the level of coverage available just as Prime Care does. However, it is the ability to go in or out-of-network and the impact on coverage of doing so that is to be compared, and not whether one's physician is now an out-of-network provider under the new plan, whereas he/she was a network provider under the old plan. If the latter were the comparison to be made, a plan with network providers could never be substantially equivalent to another plan that had its own network providers, as each has its own plan providers.

Based upon the record and the above conclusions, it is concluded that the coverage provided under the Prime Care Plus plan is not substantially equivalent to the coverage provided by the BC/BS Tradition Plus plan, and that, therefore, the City violated Sec. 5.02 of the parties' Agreement when it switched to the Prime Care Plus plan.

Remedy

The Association has requested that, rather than ordering the BC/BS plan reinstated, the City be required to "stand in the shoes of the insurer" as to those areas where the coverage of the Prime Care Plan has been found to be deficient, and to make employes whole who have incurred financial losses or hardships as a result. That remedy appears to be appropriate in this case and has been awarded. Thus, the City has been ordered to provide the same coverage as that provided under the BC/BS Tradition Plus plan in those areas that it has been found that the Prime Care Plus plan is significantly deficient, and to make whole those employes who have suffered financial losses as a result of those deficiencies so as to place them in the same position as they would have been under the BC/BS plan's coverage in those areas. Contrary to the City's assertion, the remedy is not restricted to only those employes who had been in the BC/BS plan at the time of the change. As noted previously, by virtue of the elimination of their HMO option, the employes in CompCare would have been entitled to be in the BC/BS plan, but for the City's change to the Prime Care plan.

Based upon the above and foregoing, the record and the arguments of the parties, the undersigned makes and issues the following

AWARD

The grievance is sustained. The City is directed to immediately provide the substantially equivalent coverage as that provided under the Blue Cross/Blue Shield Tradition Plus plan in the areas noted in this Award as having significantly lesser coverage under the Prime Care Plus plan, and to immediately make whole financially those employes who have incurred financial loss or losses as a result of that lesser coverage in those areas, upon substantiation of those losses, from the date the Prime Care Plus plan was implemented to the date the City establishes the substantially equivalent coverage in those areas.

Due to the complexity of this area, the undersigned will retain jurisdiction in this matter for forty-five (45) days from the date of this Award for the sole purpose of resolving any disputes that might arise between the parties with regard to remedy. If the undersigned is not contacted in that regard on or before the forty-fifth (45th) day, he will relinquish his jurisdiction in this matter.

Dated at Madison, Wisconsin, this 9th day of April, 1996.

By David E. Shaw /s/
David E. Shaw, Arbitrator