BEFORE THE ARBITRATOR

In the Matter of the Arbitration
of a Dispute Between

CLARK COUNTY DEPARTMENT OF
SOCIAL SERVICES SOCIAL WORKERS,
LOCAL NO. 546-D(2), AFSCME, AFL-CIO

and

CLARK COUNTY
(SOCIAL SERVICES DEPARTMENT)

Case 99
No. 53928
MA-9490

Appearances:

Mr. Philip Salamone, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, on behalf of Clark County Department of Social Services Social Workers, Local No. 546-D(2), AFSCME, AFL-CIO.

Weld, Riley, Prenn & Ricci, S.C., Attorneys at Law, by Ms. Kathryn J. Prenn, on behalf of the County.

ARBITRATION AWARD

Clark County Department of Social Services Social Workers Local No. 546-D(2), AFSCME, AFL-CIO, hereinafter the Union, requested that the Wisconsin Employment Relations Commission appoint a staff arbitrator to hear and decide the instant dispute between the Union and Clark County, hereinafter the County, in accordance with the grievance and arbitration procedures contained in the parties' labor agreement. The County 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 August 27, 1996 in Neillsville, Wisconsin. There was no stenographic transcript made of the hearing and the parties submitted post-hearing briefs in the matter by October 21, 1996. Based upon the evidence and the arguments of the parties, the undersigned makes and issues the following Award.

ISSUES

The parties stipulated there were no procedural issues, however, the County reserved the right to raise any substantive arbitrability arguments it might have depending on the Union's theory of the case. The parties were unable to stipulate to a statement of the substantive issues to be decided, and agreed that the arbitrator would frame the issues. The Union proposed the following statement of the issues:

"Did the County violate the collective bargaining agreement by

refusing to pay for the medical services provided on an emergency basis to the grievants, Mark Meshnick's daughter on February 12, 1995? If so, what is the appropriate remedy?"

The County frames the issues as follows:

A. Is the grievance substantively arbitrable?

B. If so, did the County violate the collective bargaining agreement with respect to the bill for medical services provided to the grievant's daughter on February 12, 1995?

C. If so, what is the appropriate remedy?

Based upon the parties' arguments and statements of the issues presented in this case, the Arbitrator frames the issues to be decided as follows:

(1) Is the grievance substantively arbitrable?

(2) If so, did the County violate the parties' collective bargaining agreement by refusing to take steps to have the medical services that were provided to the grievant's daughter on February 12, 1995 treated as "emergency medical care" so as to require that the care and treatment be fully covered under the County's self-funded health insurance plan? If so, what is the appropriate remedy?

CONTRACT PROVISIONS

The parties cite the following provisions of their 1994-1995 Agreement:

. . .

ARTICLE III - GRIEVANCE PROCEDURE

3.1 A grievance is defined to be any matter involving an alleged violation of this Agreement by the County as a result of which an aggrieved employee(s) maintains that their rights or privileges have been violated by reason of the County's interpretation or application of the provisions of this Agreement.

. . .

3.3 The County and the Union agree to the following system of presenting and adjusting grievances which must be presented or processed in accord with the following steps, time limits and conditions:

> Step 1: The aggrieved employee(s), with a Union steward, if desired, shall discuss the matter with the immediate supervisor. If the grievance is not settled within five (5) working days following this discussion, the grievance shall, within five (5) working days, be reduced to writing and submitted to the grievant's immediate supervisor. The grievance shall be on approved form, signed by the grievant and set forth the nature of the dispute, the relief sought and shall refer to the specific provision(s) of the contract alleged to have been violated. Within five (5) working days after receipt of a written grievance, the supervisor shall answer the grievance in writing, with a copy to the Union.
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> . . .
>
> Step 4: If the grievance is not settled in the preceding step, the Union may appeal the grievance to arbitration by giving written notice of its desire to arbitrate to the County within the ten (10) working days after the date of the County's final answer in the above step. If the grievance is appealed to arbitration, representatives of the County and the Union shall meet to select an arbitrator. If the parties are unable to agree on an arbitrator within ten (10) working days after the Union has served its written notice upon the County, the parties shall request the Wisconsin Employment Relations Commission to submit a list of seven (7) arbitrators. The parties shall choose the arbitrator by alternately striking from the list. The right of the first strike shall be determined by lot. The person whose name remains shall be the arbitrator, provided that either party, before striking any names, shall have the right to reject one (1) panel of arbitrators. The arbitrator shall be notified of his/her selection by a joint letter from the County and the Union requesting that he/she set a time/place for the hearing, subject to availability of the County and Union representatives; and the letter shall specify the issue(s) to the

arbitrator. The arbitrator shall have no right to amend, modify, nullify, ignore or add to the provisions of this Agreement. He/she shall consider and decide only the particular issue(s) presented to him/her in writing by the County and the Union, and his/her decision and award shall be based solely upon his/her interpretation of the meaning or applications of the terms of this Agreement to the facts of the grievance presented. The burden of proof in an arbitration matter shall be by clear and convincing evidence. If the matter sought to be arbitrated does not involve an interpretation of the terms or provisions of this Agreement, the Arbitrator shall so rule in his/her award. The award of the arbitrator shall be final and binding on the County, Union and the employee or employees involved. The expenses of the arbitrator, including his/her fee, shall be shared equally by the County and the Union. If the arbitrator requires a transcript, both parties shall equally bear the cost to furnish a copy to the arbitrator and the full cost of their own copy. Any party refusing to share in the costs of the arbitrator's copy shall not have access to the transcript for reference in its written brief, if such brief is required.

. . .

ARTICLE XIII - INSURANCE

13.1 Employees covered by the Agreement shall be covered by the group hospital and surgical plan. The County agrees to pay one hundred percent (100%) of the cost of the single premium and eighty-five percent (85%) of the family premium. Employes electing to participate in the HMO Marshfield Plan shall have the option to do so with the employer contributing the same dollar amount of the plan as in the group insurance and the employee bearing the additional cost of the respective premiums. For part-time employees first hired after the date of ratification of the 1992-93 contract, the County's contribution toward health insurance shall be prorated and said employees must work at least twenty (20) hours per week to be eligible for participation in the health insurance program.

13.2 The Employer may, from time to time, change the insurance

carrier and/or self-fund its health care programs if it elects to do so provided the level of benefits is equivalent to the current level of coverage. Any unpaid benefits at the time of a carrier change (i.e., from self-funding to a carrier) will be the responsibility of the County.

. . .

BACKGROUND

Since 1986, the County has self-funded its health insurance program and has contracted with a third party administrator (TPA) to administer the plan. Since 1990, the TPA has been Blue Cross/Blue Shield United of Wisconsin. The TPA's duties include processing claims and making determinations as to whether the claims are covered under the plan. The County's plan has a $100/$300 deductible on major medical expenses and 80/20 co-pay on major medical expenses thereafter. However, the plan provides for payment of "hospital services", which include outpatient "emergency medical care", without the application of the deductible and co-pay provisions.

The plan's schedule of benefits handbook defines "Emergency Medical Care" as follows:

C. Outpatient Medical Services

. . .

3. Emergency Medical Care

Medical care to treat a sudden onset of a medical condition showing itself by acute symptoms. The symptoms must be severe enough that, without immediate medical attention, they could reasonably cause:

a. Your health to be permanently in jeopardy;
b. other serious medical consequences;
c. serious impairment to bodily functions; or
d. serious and permanent dysfunction of any bodily organ or part.

. . .

The Grievant, Mark Meshnick, is employed by the County as a Social Worker in its Department of Social Services, and is a member of the bargaining unit represented by the Union

and covered by the parties' 1994-1995 Agreement. The Grievant is married with five children and resides in the City of Neillsville, Wisconsin. There is no walk-in clinic in the city and the local physicians do not have Sunday hours. On Sunday morning, February 12, 1995, the Grievant's 4-year old daughter awakened with an eye that was "very mattery". Concerned because it was an eye involved, and they feared that there could be permanent damage, the Grievant and his wife decided that it needed to be treated immediately. The Grievant's wife took their daughter to the local hospital where her condition was diagnosed as conjunctivitis or "pink eye", and an ointment was prescribed. The total bill for the services rendered was $97.00, and the bill was submitted to the TPA of the County's health insurance plan for payment. The TPA treated the care provided under the plan's major medical provisions, thus applying the deductible and co-pay requirements, resulting in the Grievant having to pay all of the bill except for $17.20 which the plan paid.

The Grievant appealed the treatment of his claim under the plan's internal appeal procedures. The Grievant's appeal was processed by the TPA. After reviewing the appeal, the medical records and the plan, Dr. Collentine, a consultant to the TPA regarding its "Managed Care" concluded that the treatment provided the Grievant's daughter on February 12, 1995 was not within the definition of "emergency medical care" as defined in the plan. He therefore recommended that the appeal be denied, that recommendation going to the TPA's Associate Medical Director, Dr. Travers, who then made the final recommendation and sent the following response to the Grievant denying his appeal:

> Dear Mr. Meshnick:
>
> Upon your request, a re-examination of our denial of benefits for emergency services rendered to your daughter, Angela, by the above-mentioned provider, on the previously mentioned date of service, has been completed. Our reimbursement resulted in $45.00 being applied toward your deductible.
>
> Your appeal and all the medical records were referred to our physician consultant and Claim Appeal Committee for further review and consideration. Our review determined that our original reimbursement was correct.
>
> Your health benefit plan, through Clark County Courthouse, only allows emergency care as follows:
>
> > "Outpatient emergency care by a Hospital or Physician to treat:
> >
> > . . .

A sudden onset of a medical condition which shows itself by acute symptoms. The symptoms must be severe enough that, without immediate medical attention, they could reasonably cause:

a. The Member's health to be permanently in jeopardy;

b. Other serious medical consequences;

c. Serious impairment to bodily functions; or

d. Serious and permanent dysfunction of any bodily organ or part."

A review of the records from Memorial Medical Center revealed that on Sunday morning, February 12, 1995, Angela was seen in the emergency room at Memorial Medical Center with complaints of flu-like symptoms of one week duration. The morning prior she woke up with a bloodshot right eye. The eye was "mattery" and a diagnosis of right conjunctivitis was confirmed. Her overall condition was documented as stable and Garamycin Ophthalmic solution was prescribed.

We have determined that the care Angela received was not a medical emergency as defined above. As symptoms were not of an acute nature, she could have reasonably been treated by her primary care physician by phone with follow-up in the office the next day if necessary. Therefore, we are unable to allow emergency medical benefits and the charges in question will remain applied toward your deductible.

If you have additional information that has not been forwarded to Blue Cross & Blue Shield United of Wisconsin and you believe such information establishes that the services Angela received qualifies as emergency care as defined in your policy, please send this new information to the address listed below. Your claim appeal will be re-opened upon receipt of this new information.

United Wisconsin Services, Inc.
Claim Appeal Unit - C9

401 W. Michigan St.
Milwaukee, WI 53203

We regret that our decision could not be more favorable, but we hope this letter helps to clarify our position in this matter. Should you have any additional questions or concerns, please feel free to contact our Customer Service Department located in the Eau Claire, Wisconsin Regional Service Center at 1-800-621-4560.

Sincerely,

Howard Travers /s/
Howard Travers, MD
Associate Medical Director

After receiving the denial of his appeal, the Grievant filed the instant grievance with the County, asserting that the service provided should be covered as a "basic benefit" under the "Emergency Medical Care" provision of the Plan. The grievance was processed through all steps of the grievance procedure, and being denied, was submitted to arbitration before the undersigned.

POSITIONS OF THE PARTIES

Union

The Union asserts that its arguments in this matter rely upon the concepts of "reasonableness" and "common sense". The parties' Agreement assumes that they will conduct themselves in a reasonable manner, the concept of reasonableness being either expressed or inferred throughout the Agreement. Further, the health insurance plan document contains the "Emergency Medical Care" provision, and relies upon reasonable assumptions. That section expressly states that such benefits are available where the symptoms "could reasonably" cause the patient certain physical consequences. The denial of the Grievant's appeal from the insurance company doctor also relies upon "reasonableness", stating that the child could have been "reasonably" treated by a physician by telephone.

The Union notes that it was the Grievant's child that was involved and that the condition involved the child's eyes, one of the most delicate and sensitive of the body's organs. In determining what is reasonable when it applies to a child's eyes, it is clearly better to err on the side of health and safety. A parent has no real choice but to seek appropriate medical care when their child has an undiagnosed eye problem. In this case, there was no other "reasonable" choice, since the City of Neillsville does not have a walk-in medical clinic and the condition manifested

itself on a Sunday morning. Since neither the Grievant nor his wife are trained medical practitioners, the only information they had available to them were the child's symptoms, and not a diagnosis of the condition.

The Union notes that the insurance plan book refers to symptoms in stating that the hospital benefit coverage extends to all "hospital services and supplies to treat a sudden onset of a medical condition which shows itself by acute symptoms. The symptoms must be severe enough that, without immediate attention, they could reasonably cause. . ." (Emphasis added). That approach makes sense, since symptoms are all one has to work with at that point, and one cannot make a determination based on a diagnosis which has not yet been made. The situation is analogous to that of a person suffering chest pains; the symptoms are consistent with the onset of a heart attack, however, they could also be merely indigestion. As with the symptoms that could indicate a heart attack, symptoms indicating affliction of a child's eye should also require erring on the side of safety. The insurance company and its doctors concluded that the care was not a medical emergency, but did so after the diagnosis of the condition was known. The Grievant could not know the diagnosis until the child had been seen by a physician.

The Union also questions how long a parent is supposed to wait to obtain medical treatment for a child, since only a trained physician could determine the cause and then only after examining the child. While the Grievant may have suspected conjunctivitis in this case, he could not confirm that suspicion nor treat the condition without first obtaining medical treatment for the child. Even if the Grievant knew the condition was conjunctivitis, household medical resource books such as the Family Medical and Health Guide, state:

> Conjunctivitis usually produces no permanent damage. However, if left untreated, the infection may lead to more serious eye problems (ulcers, eroded areas) may form on the cornea (the clear "window" in front of the iris and pupil of the eye). If these ulcers persist, they can scar the eye and interfere with vision." (Emphasis added).

The Union notes that the emergency medical care coverage in the plan book extends to circumstances where symptoms could reasonably cause "serious medical consequences, serious impairment to a bodily function, or serious and permanent dysfunction of any bodily organ or part."

The Union asserts that the only individuals that would expect parents in this case to gamble with their children's eyesight are the insurance company doctors and the county officials who have taken the position that the Grievant should have been able to diagnose the condition himself, and that it could have been easily treated by a doctor over the phone with a follow-up visit the next day, if needed. The optometrist, Dr. Greg Foster, testified that he did not believe it would be wise for a child in this instance to wait another day for medical attention and that it was his professional opinion that the child should have been seen as soon as possible by a doctor. Contrary to the

testimony of the insurance company's doctor, Dr. Foster testified that he would not issue a prescription in such a case without having first seen the child, except in very unusual circumstances not present in this case. He also testified that he believed the definition of "emergency" contained in the plan book was consistent with the child's symptoms in this case. Dr. Foster's testimony should be given far more weight than that of the insurance company doctors for a number of reasons. Dr. Foster is an eye care specialist, unlike Dr. Collentine or Dr. Travers for the insurance company. The Union cites arbitral awards where arbitrators favored the testimony of specialists over that of medical generalists in cases of conflicting opinions. Also, Dr. Collentine was mistaken as to when he believed the symptoms appeared in the child, testifying that he thought the symptoms developed Sunday evening. Thus, the Grievant's decision to seek immediate medical care was second guessed by a physician with a diagnosis in hand who based his determination on the inaccurate assumption that the symptoms developed on Sunday night and that the child could therefore have waited until Monday to be treated. Third, Dr. Collentine's testimony is not credible, since after it was pointed out to him that he was in error as to when the symptoms appeared, he indicated that waiting an even longer period to receive medical care might have been even more preferable to the child. Thus, indicating he was attempting to support the County's case in any way possible. Fourth, both Dr. Collentine and Dr. Travers are employed by the insurance company and both they and the Company have a vested financial interest in the County prevailing in the instant dispute. In contrast, Dr. Foster is an independent local eye specialist with no interest in the outcome of this dispute. Lastly, the Union asserts that Dr. Collentine's opinion "flies in the face of common sense" while Dr. Foster's "seems quite reasonable."

In its reply brief, the Union responds that the County's argument that the grievance is not substantively arbitrable is absurd. Health insurance is provided for in the Agreement and the County self-funds the plan with the specific benefits and coverage set forth in the insurance plan book. If the County does not provide those benefits, there is little doubt that the Agreement that provides health insurance benefits has been violated. By being self-funded, the County is in effect the insurer. The Union asserts that self-funded insurance plans are not regulated by the State's Office of the Commissioner of Insurance (OCI), whereas private insurance plans in this state are. In that case, appeals relating to inappropriate insurance practices of self-funded plans cannot go anywhere but to the employer, i.e., the insurer. Under the County's argument, employes cannot appeal under the contract and cannot appeal for relief to the OCI. The very matter is discussed by Arbitrator Houlihan in City of Richland Center, MA-5882, wherein that Arbitrator noted that a significant difference between self-insured and private plans is the "loss of comprehensive regulation, the appeals process with the Company, expertise and presumptions, the mandates and the administrative enforcement." The Union also asserts that the County's position leads to absurd and harsh consequences. Under the County's theory, any benefits provided in the insurance plan book could be ignored by the provider and/or County without recourse, employes being unable to go anywhere to achieve justice since the plan is not regulated by the OCI. The Union cites arbitral awards for the proposition that it is well recognized by arbitrators that where one interpretation of the contract provision would lead to an overly harsh or absurd result, while an alternative

interpretation, equally consistent, would lead to a reasonable result, the latter interpretation should be given effect.

The Union notes the arbitration awards cited by the County in support of its claim that the grievance is not arbitrable and asserts that each of those cases is distinguishable from the instant case. Whitehead & Kales Co., involved a private insurance carrier, whereas, in this case, the carrier and the County are the same, and the County signed the parties' Labor Agreement. The County's Personnel Coordinator, Tom Renne, acknowledged that the County could have directed the TPA to pay the claim or could have elected to pay it itself. In the second case cited by the County, Georgia-Pacific, the arbitrator specifically stated:

> ". . .Had the parties negotiated specific language into the agreement and for the express purpose of placing Company in the role of a Guarantor, or some other like position (e.g., Co-insurer) I would be of the mind that Union would have a case which would satisfy the contractually stated definition of a grievance, and, therefore, a matter that could be heard in arbitration."

The Union also asserts that in Rubbermaid, there was specific contract language exempting health insurance benefits from appeal through the grievance procedure, while there is no such provision in the Agreement in this case.

The Union asserts that the County has attempted a procedural roadblock and made arguments regarding the burden of proof and the credentials of the medical witness due to the lack of any case on the merits. Further, the argument that the care provided did not fall within the plan's definition of "emergency treatment" must be dismissed since the definition is symptom-based and does not rely on diagnosis or treatment. The argument that the Grievant has had other children with conjunctivitis in the past and did not take them to the emergency room, is specious. There is no evidence that such ailments appeared on a Sunday morning, the Grievant could not recall if he had taken his other children to the emergency room and the Grievant also testified that he was unsure of the diagnosis. The Union also takes issue with the attack on Dr. Foster's testimony on the basis that he had not reviewed the medical record, since no medical record existed at the time the symptoms appeared. The Union requests that the grievance be sustained and the Grievant made whole for all losses.

County

The County first takes the position that the grievance is not substantively arbitrable, citing Section 3.1 of the Agreement, which defines a grievance as follows:

> "A grievance is defined to be any matter involving an alleged violation of this Agreement by the County as a result of which an

> aggrieved employee(s) maintains that their rights or privileges have been violated by reason of the County's interpretation or application of the provisions of this Agreement." (Emphasis added).

The written grievance in this case does not allege any violation of the Agreement, nor has there been any such allegation at any point during the processing of the grievance, including the arbitration hearing. Rather, the Grievant's complaint has been that his claim should have been treated under the basic benefits in the plan, rather than under major medical. At no time has he been able to point to a provision in the Agreement which he believes has been violated. The County also asserts that the health insurance plan is not part of the Agreement. The County hired a TPA to administer the plan and the TPA has an appeal procedure. If an appeal is denied, the County is in no way the guarantor of the employe's claim.

The County cites a number of arbitration awards where arbitrators have held that a grievance involving an insurance company's denial of an employe's claim was not arbitrable. In Whitehead & Kales Co., 49 LA 1128 (Arbitrator Ryder, 1968), the arbitrator stated the following, holding that the grievance was not arbitrable:

> The denial of X--- claim arises under the applicable insurance policies and reflects only a judgmental decision and act of the insurance carrier and not that of the Company employer.
>
> The Union appears to argue in effect that each denial of an insurance claim by the insurance carrier could in some way redound to the Company employer and create liability for claim honoring on the theory that the Company has thereby not met its obligation to provide the benefits negotiated under Article IX of the basic labor agreement and under the Appendix B supplemental agreement. If whether Company purchased policies met negotiated levels and types of benefits was really the issue in the case at hand then arbitrability of such an issue would clearly be present. What would then be involved is the interpretation of an obligation of the Employer springing from the labor agreement. But here the Union stretches far out and unreasonably to bring the particular denial of claim under the coverage of this principle. This claim was denied by the insurer under the insurance contract not on the basis that the given benefit was not available to the insured by that he was not placed in a circumstance to qualify for that benefit. This is an issue of fact and law under the contract of insurance between the insured and the insurer and not under the labor agreement or its Supplement B. . . .What dissatisfied the Union was the interpretation by the insurance company of the applicability of the benefits to Mr. X --

> after it investigated the circumstances giving rise to his injuries. To place the Company employer behind the insurance carrier and privy to the insured and insuring parties with respect to all claims for benefits and subjecting the contractual grievance procedure up to and including arbitration to use where claims are denied by the insurance carrier, could load and burden a company-union grievance procedure with subject matter not clearly intended to be handled by this procedure under the applicable labor agreement involved here. A mere Union claim that a difference or dispute exists with the Company when in clear fact the difference exists between an insured employee and the insurance carrier over a denied claim does not bring such a dispute under the broad embrace of the language of Section 3 of Article XIV (cited in Part II hereof) dealing with any local misunderstanding of any kind in order to contractually warrant the utilization of the grievance procedure. To accept the Union's position in this connection would set a precedent for these parties that all insurance claim denials by the insurance company when processed to finality with the insurance company move over and become, in effect, grievable and arbitrable under the labor agreement. (Emphasis added.)

As in that case, the Grievant here has not alleged that the County has failed to comply with the Agreement with respect to the types and levels of benefits. The denial of the Grievant's claim does not mean that the benefit is not available, but that the circumstances did not meet the plan's criteria that would make him eligible for the benefit. A difference of opinion regarding the denial of a particular claim does not bring the dispute within the purview of the grievance procedure. The County also cites the following from Georgia-Pacific Corp., 79 LA 1308 (Arbitrator Nicholas, 1982):

> It is to be noted that any and all grievances must stem from differing interpretations or understandings of specific terms of the current Agreement. This is to say that the parties must be a cross purposes with one another on a particular aspect of said Agreement. At the same time, the parties are well aware that the Arbitrator's jurisdiction has been limited and he "shall have no power to add to or subtract from or modify any terms of this agreement or any agreement made supplementary hereto, nor to establish or change any rate, but shall interpret and adjust grievances in accordance therewith." Thus, with such clear cut definitions in mind, it must be asked: Are disputed claims of employees' insurance coverage a proper topic for the grievance procedure, including arbitration? I say no.

. . .

> Cases of the instant sort, while somewhat rarely seen in labor arbitral matters, have been considered by various arbitrators, including the undersigned. In its brief, Company has cited Decisions rendered in Whitehavn (sic) & Kales Co., 49 LA 1128 (1968); Drava Corporation, 67 LA 264 (1976); The International Paper Co., 70 LA 71 (1978) and Rubatex Corporation, 68 LA 780 (1977).
>
> Those cases illustrate, as does the matter before me, that the grievance (Submission Agreement) involves the application of an insurance plan independent of the labor agreement. Thus, it must be recognized that such is outside the providence of the Agreement that binds the Company and Union and can only be seen as a nonarbitrable matter.
>
> . . . had the parties negotiated specific language into the Agreement and for the expressed purpose of placing Company in the role of a Guarantor, or some other like position (e.g. Co-Insurer), I would be of the mind that Union would have a case that would satisfy the contractually stated definition of a grievance and, therefore, a matter that could be heard in arbitration. But your Arbitrator cannot read into the Agreement something that is not present therein or has been clearly omitted. He can only address language that the parties have set their hands to, which may include any and all amendments and/or modifications on certain provisions; perhaps even that of insurance benefits. However, until such action is taken, it is paramount that he recognizes his jurisdictional limitations and exercise his neutrality with extreme diligence. (Emphasis added).
>
> (At 1310-1312).

The County asserts that, as in Georgia-Pacific Corp., Section 3.3 of the grievance procedure in the Agreement provides that: "The arbitrator shall have no right to amend, modify, nullify, ignore or add to the provisions of this Agreement." The health insurance plan has not been incorporated into the Agreement, and while the Union bargained the guaranteed level of benefits, it did not bargain language that would provide that any and all claims will be covered. The Union has not alleged or shown that there has been any reduction in benefit levels. Therefore, the present dispute does not fall within the Agreement's definition of a grievance.

The County also cites an award involving a dispute arising under a self-funded insurance plan and a TPA, Rubbermaid, Inc., 103 LA 667 (Arbitrator Curry, 1994) wherein the arbitrator stated the following with regard to the TPA's decision denying a submitted claim:

> . . . While the Arbitrator may disagree with that determination he has no authority to change it. It appears to the Arbitrator that the appeal of the determination at question herein is to Travelers Insurance Company rather than to the Arbitrator.
>
> The parties agreed in their Labor Agreement that the "arbiter shall have no power to alter, amend, change, modify, add to or subtract from any provisions of this Agreement." Appendix "B" makes it clear that this covers the Benefits Agreement as well. To do that which the Union is asking here would require the Arbitrator to substitute his judgment for that of the agreed to administrator of the plan. He has no authority to do so. (Emphasis added.)

In this case, the County has contracted with a TPA to process claims and determine whether claims are covered under the plan, relying upon the TPA's medical expertise. For claims the TPA determines are covered, the TPA pays the claim and bills the County. While the County could direct the TPA to pay a claim regardless of its validity, since the plan is self-funded, such a payment would be outside of the negotiated benefit plan. The question, however, is not whether the County could direct the TPA to pay the Grievant's claim; rather, it is whether the claim is covered under the plan. The County relies on the TPA to make that determination, and in this case it determined that the claim is not covered. Thus, the grievance must be found to be not substantively arbitrable, and must therefore be dismissed.

The County also asserts that even if the dispute is held to be arbitrable, the Grievant has not met his burden of proof under Step 4 of the grievance procedure, which provides that the burden of proof in an arbitration shall be "by clear and convincing evidence". This is the "middle burden of proof" which requires that the trier of fact be convinced to a reasonable certainty by evidence that is clear, satisfactory and convincing. This is a greater degree of certainty than is required in ordinary civil cases, but lesser than that required in criminal cases. The Grievant's evidence falls far short of this evidentiary standard. The medical consultant relied upon by the TPA, Dr. Collentine, is an experienced family practitioner and general surgeon, and formerly was Medical Director of Blue Cross/Blue Shield United of Wisconsin and has also managed a national review organization for consulting regarding implementation of health insurance benefit plans. Dr. Collentine reviewed the Grievant's appeal of the denial of his claim, and determined that the care provided did not fall within the plan's definition of a "medical emergency". This conclusion was based upon his experience, a review of the emergency room report and the relevant portions of the insurance plan document. Dr. Collentine testified that the condition was such that he would have recommended that the child see a physician if it persisted for 24 hours and is not of the type

that requires emergency room treatment, and could even be handled by consulting with a doctor over the telephone. The County asserts that the Grievant testified his other children have had "pink-eye" and he could not recall whether he had taken any of them to the emergency room. He further testified that his real concern was that the pink-eye might spread to his other children. The County asserts that Dr. Foster's testimony that it was not unreasonable for the Grievant to take his daughter to the emergency room does not address the issue. The issue is not whether the Grievant's actions were reasonable; the issue is who is responsible for paying for the services rendered? Dr. Foster conceded he had not reviewed the girl's medical records; that there are over-the-counter treatments available for pink-eye; that he has consulted with parents over the phone regarding that condition and has prescribed on occasion over the phone; and that pink-eye is non-sight threatening. With regard to the Union's citation of the excerpt from a consumer's health and medical guide, a review of that information leads to the conclusion that pink-eye does not fall within the plan's definition of a medical condition requiring emergency medical care. Thus, the Grievant has not presented credible evidence that was medically necessary for his daughter to be taken to an emergency room the morning of February 12, 1995.

In its reply brief, the County notes the Union's assertion of the "reasonableness" of the Grievant's actions, and argues that whether those actions were reasonable is not the issue. Assuming, arguendo, that the grievance is arbitrable, the issue is whether the services provided fall within the insurance plan's definition of "emergency medical care."

The County notes the October 16, 1995 letter from Dr. Travers denying the Grievant's appeal wherein he stated that the Grievant's daughter did not present acute symptoms and asserts that there is nothing in the record to contradict Dr. Traver's finding. Not only were the symptoms not acute, there were no symptoms which were "severe" enough that without immediate medical attention, they could reasonably cause permanent jeopardy to one's health, serious medical consequences, serious impairment to bodily functions or serious and permanent dysfunction, rather, pink-eye is a common childhood infection. The Grievant testified that his other children have had pink-eye and could not recall whether he had taken any of them to the emergency room in that regard. The County's Personnel Coordinator testified that both of his children had pink-eye when they were growing up and he could not say that he had taken them to a doctor for that condition. The information in the consumer guide presented by the Union also stated that conjunctivitis usually produces no permanent damage and the Union's own expert witness, Dr. Foster, testified that pink-eye is non-sight threatening. With regard to the "reasonableness" standard, the County asserts that, relevant to this grievance, the standard is not applied against the actions of the Grievant, but rather is applied as a predictor of whether the acute symptoms could cause permanent or serious harm. In this case, there are no acute symptoms. The fact that the parents chose to take their daughter to the emergency room that morning, rather than to call a doctor or consult with a pharmacist or to wait to take the child to the clinic the following day, does not somehow transform non-emergency services into emergency services.

The County also disputes the Union's challenge to Dr. Collentine's expertise, noting his

experience as a family practitioner and his testimony that he has treated dozens of children with pink-eye. Dr. Collentine also reviewed the daughter's medical records, whereas the Union's witness, Dr. Foster, had not. The County also asserts that the fact that the condition occurred during the day rather than evening makes it less of an emergency, since during the day parents could monitor the condition and avail themselves of over-the-counter treatments and other recommended treatments, which they might have utilized but for their mistaken belief that the insurance plan would pay for everything. With regard to the Union's attempt to discredit Dr. Collentine's testimony on the basis that he is an employe of the insurance company, the County notes that Dr. Foster was reminded by the Union's representative to send his bill for testifying to the Union. Just as that fact alone does not impugn the integrity of Dr. Foster; neither does the fact that Dr. Collentine is a consultant for the insurance company impugn his. Unlike Dr. Foster, however, Dr. Collentine reviewed the child's medical records and applied the criteria set forth in the plan's definition of emergency medical care.

The County concludes that the Grievant has not met his burden of proving his case by clear and convincing evidence and that he has not presented evidence of acute symptoms, much less symptoms which could reasonably cause permanent or serious harm, nor has he presented evidence of other similar cases for which coverage was provided. The issue is not whether the Grievant is a caring parent or whether his actions were reasonable; the issue who is responsible for paying the bill for the services rendered. The County requests that the grievance be dismissed.

DISCUSSION

The first issue to be addressed is that of arbitrability raised by the County. The County essentially argues that the parties' Agreement defines a grievance as an alleged violation of the Agreement and that the instant grievance does not involve such an allegation, but instead disputes the denial of the Grievant's claim filed under the health insurance plan. The County also notes that the Agreement expressly precludes the Arbitrator from modifying, or adding to the Agreement. The County cites a number of arbitration awards in support of its position, which the Union asserts are distinguishable from this case based upon differing circumstances or contract language. The Union especially relies upon the fact that the County's health insurance plan is self-funded to distinguish this case from those cited by the County and as a basis for the right to challenge a denial of a claim through the parties' contractual grievance procedure. That reliance is misplaced.

The Arbitrator's role is limited to interpreting the parties' Agreement, as well as those matters they have incorporated into that Agreement. As the County has noted, the parties' Agreement expressly provides at Article III, 3.3, Step 4, that:

> The arbitrator shall have no right to amend, modify, nullify, ignore or add to the provisions of this Agreement. He/she shall consider and decide only the particular issue(s) presented to him/her in

> writing by the County and the Union, and his/her decision and award shall be based solely upon his/her interpretation of the meaning or applications of the terms of this Agreement to the facts of the grievance presented. The burden of proof in an arbitration matter shall be by clear and convincing evidence. If the matter sought to be arbitrated does not involve an interpretation of the terms or provisions of this Agreement, the Arbitrator shall so rule in his/her award
>
> . . .
>
> (Emphasis added).

That provision is consistent with the Agreement's definition of a grievance at Article III, 3.1, as "any matter involving an alleged violation of this Agreement by the County. . .by reason of the County's interpretation or application of the provisions of this Agreement."

The question to be answered then is whether the instant grievance may reasonably be read to allege a violation of the parties' Agreement. For the following reasons, the Arbitrator concludes that the question must be answered in the negative. First, the only relevant language in the Agreement referencing the County's obligations with regard to health insurance is the following at Article XIII:

> 13.1 Employees covered by the Agreement shall be covered by the group hospital and surgical plan. The County agrees to pay one hundred percent (100%) of the cost of the single premium and eighty-five percent (85%) of the family premium. . .
>
> . . .
>
> 13.2 The Employer may, from time to time, change the insurance carrier and/or self-fund its health care programs if it elects to do so provided the level of benefits is equivalent to the current level of coverage. Any unpaid benefits at the time of a carrier change (i.e., from self-funding to a carrier) will be the responsibility of the County.
>
> . . .

Thus, the Agreement requires that the County provide a group hospital and surgical plan and pay a certain percentage of the plan's premium, and also allows the County to change the carrier or to self-fund, provided the level of benefits is the equivalent of the current level. Other

than referencing the health insurance plan to establish the "current level of coverage", the Agreement does not incorporate by provision or attachment a specific health insurance plan or expressly state specific benefits to be provided. This point makes the case for arbitrability even weaker in this case than in those cited by the County. Those cases involved specific plans or a schedule of benefits that were appended to the labor agreement, which required consideration of either specific wording in the plans and/or the status of the party that took the disputed action in order to determine if the action was grievable.

In this case, the grievance does not allege that the County has failed to provide a health insurance plan with the required level of benefits, nor does it allege a violation of the provisions of the Agreement; rather, the grievance challenges the determination of the TPA that, based on the circumstances, the services provided to the Grievant's daughter did not qualify as "emergency medical care", as defined in the plan's benefit handbook. Although the Union makes much of the fact that the County self-funds its health insurance program, the Arbitrator does not find that fact to be a relevant distinction with regard to the arbitrability question. Just as in those cases where arbitrators relied upon the fact that the employer had chose to contract with a third party to provide the health insurance coverage and make determinations as to the application of the coverage to specific instances, the County has contracted with a third party to make such determinations. What is most relevant is that in each case the parties to the labor agreement understood that the employer had that option under the agreement 1/ and there was no showing, express or otherwise, that the parties agreed or understood that the third party's determination on individual claims would be subject to challenge under the parties' contractual grievance procedure. In this case, the County has self-funded its health insurance programs and contracted with a TPA to administer the plan since 1986. It is reasonable to presume that from that time to the occurrence of this matter in 1995 there have been other claims submitted by employes under the plan that have been denied by the TPA or treated otherwise than an employe wished, yet there is no evidence of other attempts to grieve the TPA's determinations during that time. 2/

It also must be noted that the instant case does not involve the wholesale denial of a benefit that employes once enjoyed under the plan. While the Union asserts that because the plan is self-funded, such could occur if the County prevails on its arbitrability argument, the Arbitrator would point out that the parties' Agreement does require the County to maintain the level of benefits

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1/ The Arbitrator does not read the Union's arguments as asserting that the County could not contract with a TPA to administer the plan. While the Union did note Renne's testimony that had the County ordered it to do so, the TPA would have treated the Grievant's claim as he wished, Renne also testified that the TPA would in that case likely advise the County to alter the plan's definitions accordingly.

2/ While certainly not dispositive of the issue, it is indicative of the parties' mutual intent in this regard.

"equivalent to the current level of coverage" and that such action would be the equivalent of eliminating or decreasing coverage and would be subject to challenge through the Agreement's grievance procedure.

Finally, the Union's reliance upon the statement in the Georgia-Pacific Corp. Award is noted. The arbitrator in that case, after finding that the grievance was not arbitrable, stated:

> . . .Had the parties negotiated specific language into the Agreement and for the expressed purpose of placing the Company in the role of a Guarantor, or some other like position (e.g., Co-Insurer), I would be of mind that Union would have a case that would satisfy the contractually stated definition of a grievance and, therefore, a matter that could be heard in arbitration. . .

Again relying upon the fact that the County self-funds its health insurance program, the Union asserts that the County is the "insurer", and that, therefore, the above reasoning would apply. The Arbitrator notes that there is no such express language in the parties' Agreement similar to that described above and the Arbitrator does not equate an employer's self-funding its insurance program with expressly placing it in the contractual position of guaranteeing that all claims will be paid to the individual claimant's satisfaction or automatically subjecting such determinations to the parties' contractual grievance procedure.

For the foregoing reasons, it is concluded that the instant grievance does not involve a dispute as to the interpretation or application of the provisions of the parties' Agreement, as required by Article III of that Agreement, and is, therefore, beyond the jurisdiction of this Arbitrator to address.

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

AWARD

The grievance is not arbitrable and must therefore be denied.

Dated at Madison, Wisconsin, this 21st day of May, 1997.

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