BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

LABOR ASSOCIATION OF WISCONSIN, INC.

and

VILLAGE OF BUTLER (POLICE DEPARTMENT)

Case 21
No. 59025
MA-11155

Appearances:

Mr. Kevin Naylor, Labor Consultant, Labor Association of Wisconsin, Inc., 2835 North Mayfair Road, Suite 24, Wauwatosa, Wisconsin 53222, appearing on behalf of the Association.

Mr. Larry Plaster, Village Administrator, Village of Butler, 12621 West Hampton Avenue, Butler, Wisconsin 53007, appearing on behalf of the Village.

ARBITRATION AWARD

The Village of Butler, hereafter Village or Employer, and Labor Association of Wisconsin, Inc., hereafter the Association, are parties to a collective bargaining agreement which provides for final and binding arbitration. The Association, with the concurrence of the Village, requested the Wisconsin Employment Relations Commission to appoint a member of its staff to hear and decide the instant grievance. Coleen A. Burns was so designated on August 2, 2000. The hearing was held in Butler, Wisconsin on September 28, 2000. The record was closed on December 10, 2000, upon receipt of post-hearing written arguments.

ISSUE

The parties stipulated to the following statement of the issue:

> Did the Village of Butler violate the terms and conditions of the collective bargaining agreement by unilaterally instituting important benefit plan changes without the Association's knowledge or consent?
>
> If so, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

ARTICLE 1 – MANAGEMENT RIGHTS

SECTION 1.01: Except as otherwise specifically provided herein, the management of the Village of Butler and the direction of the work force, including but not limited to, the right to hire, the right to promote, suspend, discipline and discharge for just cause, the right to decide job qualifications for hiring, the right to lay off for lack of work or funds, the right to abolish and/or create positions, the right to introduce new or improved operational methods, training and evaluation techniques, equipment or facilities, the right to make reasonable rules and regulations governing day to day operations, conduct and safety, and the right to determine schedules of work, shall be vested in management. Management, in exercising these functions, will not discriminate against any employee because of his/her representation by any Union, if so represented.

. . .

ARTICLE 2 – RECOGNITION

SECTION 2.01: The municipal employer recognizes the Labor Association of Wisconsin, Inc. as the exclusive bargaining representative of all employees of the Police Department, except the Chief of Police, Lieutenant, Police clerical and meter persons, who have chosen the Union to represent them for the purpose of negotiating in relation to wages, hours, and conditions of employment.

. . .

ARTICLE 3 – EXISTING PRACTICES

SECTION 3.01: In the interpretation of this agreement, nothing shall be construed as an existing practice unless it meets each of the following tests: It must be:

[a] Long continued

[b] Certain and uniform

[c] Consistently followed

[d] Generally known by the parties hereto

[e] Must not be in opposition to the terms and conditions of this contract.

. . .

ARTICLE 17 – INSURANCE

SECTION 17.01: The Village will maintain the present State Group Life Insurance program covering all department personnel eligible therefor. The premium cost will be paid by the Village.

SECTION 17:02: The Village shall maintain the existing health insurance coverage or its equivalent for all employees and their dependents, commencing on the first day of the month following a thirty (30) day waiting period, with the premium costs to be paid by the Village.

a] Coverage will be provided by an HMO type insurance plan comparable to the Prime Care Plus Plan or insurance of an equivalent nature. The full cost of the premiums shall be paid by the Village.

b] The Village agrees to reimburse each employee and, if covered, members of the employee's family, for emergency room visits which require a co-payment by the employee. Receipts for such visit must be turned over to the Village for reimbursement.

c] The Village shall supplement the health insurance plan in the are (sic) of vision as follows: Contact lenses up to On (sic) Hundred Dollars ($100.00) per paid each twelve (12) months with new or changed prescription. Use of this benefit exhausts lens and frame benefits for twelve (12) months. Lenses, including single vision, bifocal, trifocal, lenticular and rose tints 1 and 2 are covered in full every twelve (12) month (sic) with new or changed prescription. There is also an annual Seventy Dollar ($70.00) retail frame allowance. Any additional costs will be paid by the employee.

. . .

RELEVANT BACKGROUND

The Village and the Association executed their January 1, 1999 – December 31, 2001 collective bargaining agreement on April 28, 1999. On or about March 17, 2000, members of the Association received a notice entitled Important Benefit Plan Changes with their paychecks. The relevant portion of the attached notice states as follows:

IMPORTANT BENEFIT PLAN CHANGES
Please notify your affected employees of these changes

ALL GROUPS:

All groups will be renewed into a new pharmacy rider (with no change in copays other than those listed below) that will allow for prescriptions written by any primary or specialty physician – not just those who participate in our network – to be filled at the applicable copayment at a network pharmacy. This will eliminate the need for the member to file claim forms to have a prescription paid. Members will be able to choose nearly 50,000 network pharmacies located across the country, including both independent and chain pharmacies. To take advantage of this enhancement, members must always present their ID card when having a prescription filled. The implementation of this rider will also eliminate the ancillary charge – the difference between the generic and brand name that the member would pay if they requested the brand name. Both of these changes mean that the member will never pay more than the highest copayment for covered drugs.

SPECIFIC BENEFIT PLAN CHANGES:

High Option Select Plus Value or Choice Plus: The out-of-network (Tier 3) deductible and out-of-pocket maximum will change to $250/750, $1500/3000 (previously $200/600, $1500/3000) and the prescription drug copays will change to $7/12/25.

. . .

Previously, the prescription drug co-pay had been $5-$10-$25.

On or about March 17, 2000, the Association filed a grievance alleging that the Village had violated the terms and conditions of the collective bargaining agreement by unilaterally instituting important benefit plan changes without the Association's knowledge or consent. By letter dated April 7, 2000, Village Administrator Larry Plaster denied the grievance as follows:

The Village of Butler has not violated the terms and conditions of the Collective Bargaining Agreement between Local N. 312 and the Village of Butler.

With respect to Section 17.02 of the agreement, the Village of Butler has not changed the existing health insurance coverage. We continue to offer the same Prime Care Plan (now United Health Care) that was offered when the agreement

was signed in 1999, namely the High Option Select Plus Value Plan. In fact, it is the same Prime Care plan we enrolled in when we started with Prime Care in 1995.

Subsequently, the grievance was submitted to grievance arbitration.

POSITIONS OF THE PARTIES

Association

The Village does not have the right to pass important benefit changes instituted by the insurance carrier onto the Association's membership. Rather, it is the obligation of the Village to obtain an insurance contract that confers the benefits negotiated by the parties and provided for in the parties' collective bargaining agreement.

The Village mistakenly assumes that its contractual obligation regarding health insurance care is limited to maintaining a specific plan. Section 17.02, in fact, imposes upon the Village the duty to maintain "existing health insurance coverage or its equivalent." Thus, the Village has a contractual duty to maintain a specific level of benefits, rather than a specific provider or plan.

To the Village's argument that the level of health insurance coverage has not been significantly reduced, the Association responds that a twenty-five percent increase in out-of-network deductibles, coupled with up to a forty percent increase in drug co-payments, is a significant reduction in benefits. Moreover, although the Village's argument would be of relevance if the collective bargaining agreement required the Village to maintain "substantially equivalent" coverage, the contractual requirement is to maintain "equivalent" coverage.

The parties bargained the quality of the health insurance plan, as well as the Village's obligation to pay 100% of the health insurance plan premiums. While such arguments may be appropriate for the bargaining table, they are not justification for the Village to provide less than the contractually mandated health insurance coverage.

The Village is not a helpless bystander. Upon receiving the renewal notice indicating that the health insurance carrier was changing plan benefits, the Village could have complied with its contractual obligation by absorbing the increased costs, rather than passing on the increased costs to the Association's bargaining unit members. Alternatively, the Village could have contracted with another carrier to provide the contractually required health insurance coverage.

The Village suggests that there is a past practice of unilaterally changing the level of health insurance benefits. Section 3.01 identifies five (5) tests that must be met before a past practice may be established. Application of these tests to the established facts requires the conclusion that any allegation of a past practice is without foundation.

The Arbitrator should sustain the grievance. As remedy, the Arbitrator should order the Village to cease and desist from violating the collective bargaining agreement and to reimburse the Association's bargaining unit members for any expenses incurred as a result of the unilaterally imposed increase in out-of-network deductibles and drug co-payments.

Village

Effective January 1, 1996, the Village enrolled in a Prime Care health plan entitled Prime Care Plus. Although there have been changes in the name of the health plan and the plan provider, the same health plan has been renewed annually.

Section 17.02 states that health insurance "will be provided by an HMO type insurance plan comparable to the Prime Care Plus Plan or insurance of an equivalent nature." The Village not only provides an HMO type insurance plan comparable to the Prime Care Plus Plan, but for a name change, the Village provides the exact same plan.

The health insurance company has the sole responsibility to determine the content of the health insurance plans offered by the company. Indeed, over time, the Village's insurance company has instituted a number of plan changes and the Butler Police Professional Association was notified of these changes. For example, when the Village initially enrolled in January of 1996, there was a $5 prescription co-payment. In 1998, this co-payment was changed to a 3 tier system and the co-payments were $5-$10-$25.

None of the changes were a result of any action, request or decision of the Village. Rather, all of the changes were imposed unilaterally by the health insurance provider. The Village's group policy has, and continues to, expressly state that no one other than an officer of the health insurance company has authority to change or amend the policy and that no changes can be made without a signature from an executive officer of the HMO.

In arguing that there have been significant reductions in benefits, the Association ignores those benefits that have been unilaterally increased by the insurance provider. The Village cannot guarantee that, at any point in time, a specific physician will be in or out of network. Members of the bargaining unit, however, decide whether or not they choose to use an in network provider.

Construing Section 17.02 as a whole, it is apparent that the Village is not required to maintain identical health insurance. Rather, the Village is only required to provide insurance comparable to the Prime Care Plus Plan. It is significant that, although the agreement specifically addresses the issue of payments of premiums and reimbursements for emergency room visits, the agreement is silent as to the issue of prescription drug co-payments and co-payments for out of network providers.

The Village continues to provide an HMO type health insurance plan comparable to the Prime Care Plus plan, as required by the parties' collective bargaining agreement. The plan provided by the Village is UnitedHealthCare's best health insurance plan (most coverage, least co-payments). The Village has acted in good faith; has not made any unilateral changes to the health insurance plan; and has met its obligations under the terms of the collective bargaining agreement. The grievance should be denied.

DISCUSSION

Section 17.02 of the parties' collective bargaining agreement governs the provision of health insurance benefits. The first sentence of Section 17.02, which is the primary clause, requires the Village to maintain the "existing health insurance coverage or its equivalent for all employees and their dependents."

With respect to insurance issues, the word "coverage" is commonly and ordinarily understood to mean "inclusion in an insurance policy or protective plan" or "the extent of protection afforded by an insurance policy." See The American Heritage College Dictionary (Third Edition, 2000). Thus, the most reasonable interpretation of the first sentence of Section 17.02 is that the Village is required to maintain certain health insurance benefits, rather than a specific policy or a named insurance carrier.

Section 17.02(a) states as follows:

> a] Coverage will be provided by an HMO type insurance plan comparable to the Prime Care Plus Plan or insurance of an equivalent nature.

The language of Section 17.02(a) is not a model of clarity. However, given the fact that Paragraph (a) is a subordinate clause, the most reasonable construction of this language is that "coverage" refers back to the "coverage" required by the first sentence of Section 17.02. Thus, it is the first sentence of Section 17.02, and not Paragraph (a), that identifies the required health insurance "coverage." Paragraph (a) identifies the vehicle by which this "coverage" is to be provided, **i.e.,** an HMO type insurance plan comparable to the Prime Care Plus Plan.

Notwithstanding the Village's assertion to the contrary, it is not significant that Section 17.02 addresses the payment of premiums and reimbursements for emergency room visits, but is silent with respect to the issue of prescription drug co-pays or deductibles for out-of-network providers. The failure to address prescription drug co-pays or out-of-network deductibles would only be significant if the contract contained an exhaustive list of the benefits included in the "existing health insurance coverage."

In summary, Section 17.02, construed as a whole, requires the Village to maintain the "existing health insurance coverage, or its equivalent." The parties' 1999-01 collective bargaining agreement was executed on April 28, 1999. At that time, the out-of-network deductible was $200 per individual and $600 per family and the prescription drug co-pay was $5-$10-$25. Inasmuch as these are the out-of-network deductibles and prescription drug co-pays that existed at the time that the parties entered into the collective bargaining agreement, these deductibles and co-pays are part of the "existing health insurance coverage", as that term is used in Section 17.02.

As the Village argues, UnitedHealthCare unilaterally determined that the 2000 health insurance plan, unlike the 1999 health insurance plan, would have an out-of-network deductible of $250 per individual and $750 per family and a prescription drug co-pay of $7-$12-$25. UnitedHealthCare also unilaterally determined that it had the sole responsibility to determine the content of the health insurance plans offered by UnitedHealthCare. Inasmuch as the Association contracts with the Village, and not the insurance carrier, the obligation to provide the contracted health insurance coverage rests upon the Village and not the insurance carrier. Thus, the fact that UnitedHealthCare did not, or would not, provide the health insurance coverage required under the parties' collective bargaining agreement does not relieve the Village of its obligation to provide the required health insurance coverage.

Changes that occurred prior to the time that the parties entered into their 1999-01 collective bargaining agreement are part of the "existing health insurance coverage." Thus, the argument that the Village has provided "equivalent" coverage because the increases in the out-of-network deductible and the prescription drug co-pay have been offset by prior years' benefit increases is without merit.

It is not evident that the increase in the out-of-network deductibles and the prescription drug co-pays were accompanied by any improvement in benefits. It is true that, in August of 2000, UnitedHealthCare announced that it was entering into a multi-year contract with Merck-Medco. This announcement, however, expressly recognizes that the "benefit program remains unchanged." Assuming arguendo, that the use of the word "equivalent" permits some balancing of health insurance coverage gains and losses, the record fails to demonstrate that the loss in health coverage resulting from the increase in the out-of-network deductibles and the prescription drug co-pays have been offset by any gain in health insurance coverage.

The Physician and Provider Directory specifically states that "All published information is subject to change without notice." It is not evident that such a disclosure is new to the 2000 health insurance plan. Thus, for the purposes of this grievance, it is immaterial that the Village cannot guarantee that, at any point in time, a specific physician will be in or out of the network.

As the Association recognizes, the Village is not contractually obligated to have the required health insurance coverage provided by UnitedHealthCare. Thus, upon learning that UnitedHealthCare would not provide the health insurance coverage required by the collective

bargaining agreement, the Village had the contractual right to purchase the required coverage from another carrier, in accordance with the provisions of Section 17.02(a). It is not evident that the Village made such an attempt.

Section 17.02 does not require the Village to notify the Association of health insurance changes. The Village, however, has the right to notify the Association that the health insurance carrier is modifying the existing health insurance coverage and to request that the Association reopen negotiations on health insurance. Although the Association is not contractually obligated to reopen negotiations, such a request by the Village may have produced a mutually agreeable resolution of the issue.

As the Village argues, in prior contract years, the Village received notice that its health insurance carrier was amending the health insurance plan during the term of a collective bargaining agreement. Contrary to the argument of the Village, the record does not demonstrate that the Association was aware on any of these amendments, other than the amendment that occurred in January of 1999.

As stated above, the Association was aware of the health insurance amendment that occurred in 1999. The testimony of Dave Wentland, the acting President of the Association, demonstrates that the 1999 amendment was not a unilateral amendment because the Association's membership knowingly accepted this amendment.

The failure of the Association to grieve unilateral amendments of the health insurance that occurred in prior contract years does not waive the Association's right to grieve unilateral amendments that occur during the current contract term. Additionally, where the Association did not have knowledge of a unilateral amendment in the health insurance plan, the failure to grieve the amendment is not evidence that the Association agrees that the collective bargaining agreement permits such unilateral amendments.

As the Association argues, the out-of-network deductibles increased by twenty-five percent and the prescription drug co-pays increased by twenty to forty percent. Contrary to the argument of the Village, such increases are significant.

In conclusion, when the Village entered into the 1999-01 collective bargaining agreement, it obligated itself to provide "the existing health insurance coverage or its equivalent." When the Village provided health insurance coverage with an out-of-network deductible of $250 per individual and $750 per family and prescription drug co-pay of $7-$12-$25, the Village failed to provide "the existing health insurance coverage, or its equivalent. "

By failing to maintain the out-of-network deductible of $200 per individual and $600 per family and the prescription drug co-pay of $5-$10-$25, the Village has violated the parties' collective bargaining agreement. The appropriate remedy for this contract violation is to order the Village to reimburse all employees covered by the Village of Butler Professional Police Association collective bargaining agreement for all expenditures incurred as a result of the unilateral increase in the existing out-of-network deductibles and prescription drug co-pays.

Based upon the foregoing, and the record as a whole, the undersigned issues the following

AWARD

1. The Village of Butler violated the terms and conditions of the collective bargaining agreement by unilaterally instituting important benefit plan changes without the Association's consent.

2. In remedy of this violation, the Village is to reimburse all bargaining unit employees for all expenditures incurred as a result of:

(a) the unilateral requirement that these employees pay an out-of-network deductible of more than $200 per individual and $600 per family and

(b) the unilateral requirement that these employees pay a prescription drug co-pay of more than $5-$10-$25.

Dated at Madison, Wisconsin this 20th day of April, 2001.

Coleen A. Burns /s/

Coleen A. Burns, Arbitrator

rb
6215.doc