

BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

**MANITOWOC COUNTY SHERIFF DEPARTMENT EMPLOYEES,
WISCONSIN PROFESSIONAL POLICE ASSOCIATION**

and

MANITOWOC COUNTY (SHERIFF DEPARTMENT)

Case 68
No. 59857
MA-11431

Appearances:

Attorney Richard Thal, General Counsel, Wisconsin Professional Police Association/Law Enforcement Employment Relations Division, 340 Coyier Lane, Madison, Wisconsin 53713, appearing on behalf of Manitowoc County Sheriff Department Employees.

Attorney James R. Korom, von Briesen, Purtell & Roper, S.C., Attorneys at Law, 411 Building Office, Suite 700, 411 East Wisconsin Avenue, P.O. Box 3262, Milwaukee, Wisconsin 53201-3262, appearing on behalf of Manitowoc County (Sheriff Department).

ARBITRATION AWARD

The Association and the County are parties to a collective bargaining agreement which was in effect at all times relevant to this proceeding and which provides for the final and binding arbitration of certain disputes. The Association and the County jointly requested that the Wisconsin Employment Relations Commission appoint the undersigned as Arbitrator to resolve a dispute as set forth below. By letter dated May 23, 2001, the Commission appointed the undersigned as Arbitrator. Hearing on the matter was held on August 8, 2001, at the Administrative Building, Manitowoc, Wisconsin. The hearing was transcribed. The parties completed their briefing schedule on October 23, 2001.

After considering the entire record, I issue the following decision and Award.

ISSUES

The parties were not able to stipulate the issues for decision. The Association poses the following issues:

Did the County violate the parties' Collective Bargaining Agreement when it unilaterally discontinued the preferred provider network level of benefits for prescription drugs? If so, what is the appropriate remedy?

The County frames the issues in the following manner:

Did the County violate the parties' Collective Bargaining Agreement as alleged in the grievance when the insurance company took the action identified in its letter of March 2, 2001? If so, what is the appropriate remedy?

Having reviewed the entire record, the Arbitrator frames the issues as follows:

1. Did the County violate the parties' collective bargaining agreement when Blue Cross and Blue Shield United of Wisconsin notified plan members "that effective April 1, 2001, there is no longer a preferred provider network for pharmaceutical services", and began processing prescriptions at the out-of-network reimbursement level?

2. If so, what is the appropriate remedy?

FACTUAL BACKGROUND

Background of the Disputed Contract Language

Article 13, Section A of the agreement sets forth a summary of the parties' agreement on the level of benefits received by the employees. Under this agreement the County pays ninety-five percent (95%) of the hospital and surgical insurance premium; the employees pay five percent (5%). The benefit design provides that employees must first pay the \$250 (individual) or \$500 (family) deductible before Blue Cross & Blue Shield United of Wisconsin ("BCBSUW") pays anything for covered services. After the deductible is met, employees' claims are processed at two different reimbursement levels: 100 percent (100%) for all services provided within the preferred provider network; and eighty percent (80%) for services provided outside of the network. The agreement further provides that for services processed at the eighty percent (80%) level, an employee's twenty percent (20%) co-payment is limited to no more than \$200 per individual or \$600 per family.

The language found in Article 13, Section B states that “the insurance coverage shall not be changed without the mutual written consent of the parties” except that the County is “free to improve the insurance coverage at any time.” This language was first put into the contract in negotiations between the County and AFSCME, a predecessor union to the Association. Jerry Ugland was the AFSCME representative at the time.

In 1992, the Association took over representation of this bargaining unit. During 1995, the County attempted to negotiate modifications to the health insurance program to introduce a Preferred Provider component to the system. Sandra Reblin, an account executive for BCBSUW, testified that providers negotiate discounts for their services in return for being placed on the “Preferred Provider” list. Because employees pay less out of their own pocket when they use a “Preferred Provider,” the provider will get an increase in the volume of their business. Discounting the price for services is normally a necessary prerequisite to “preferred” status.

The County’s efforts in 1995 included negotiations with all County bargaining units, as well as non-represented employees. Sharon Cornils, County Personnel Director, testified that in 1995 she specifically discussed the PPO list with the Association representative at the time, Richard Daily. One “concern” he expressed about the PPO was “who’s in, who’s out.” In response, Cornils provided the Association bargaining team with a Provider Directory stating: “This is subject to change at any time.” She also told the Association that this was something the County couldn’t control and couldn’t make “any promises” on.

At no time material herein, did the County guarantee to the Association’s bargaining representative that the people listed on the PPO list would not be changed.

Cornils also testified about negotiations with AFSCME representative Gerald Ugland. Ugland proposed language in a revised final offer received by the County on April 24, 1999, stating “If the current statewide PPO is deleted, another statewide PPO shall be made available.” By letter dated April 26, 1999, Cornils responded noting that this “was something that was discussed in depth at the March 7th mediation session.” Cornils added that the County had “not agreed to this or any similar provision in the four settlements that have been negotiated to date” and was “not interested in adding this language to the Supportive Services bargaining unit.” The County rejected the union proposal, and AFSCME ultimately dropped it.

The County and the Association voluntarily agreed to a 1996-1997 collective bargaining agreement. The health insurance benefit design was changed to include co-pays, limits on the co-pays, deductibles and a Preferred Provider Network. As a result of creating the PPO network, Cornils testified that Association members received several important benefits. One, the amount of money employees were allowed to place into a medical reimbursement account

was increased from \$1,000 to \$2000. Two, after the introduction of the PPO, employees who used in-network providers did not have to worry about UCR calculations. Three, the rate of increase of health insurance premiums for 1996 was lower than it otherwise would have been without the PPO so that employees' contribution to total costs through their payment of 5% of the premium would be lower. Four, employees received a new long-term disability insurance program, paid for by the County. Five, employees received a higher across-the-board increase than would otherwise have been given without the creation of the PPO system.

The WPPN List of Providers

In 1994 a coalition of local employers formed a consortium called the Lakeshore Health Care Coalition for the purpose of trying to access discounts from local providers. Wisconsin Preferred Provider Network ("WPPN") was the network being used at that time by the Coalition. There was "interest in being able to tap into these discounts" by the County. Initial efforts were made by the County to gain access, but because there was no "steerage," (creating an incentive for employees to use WPPN providers in preference to others) the County was initially not allowed to use the WPPN network.

Subsequently, when the non-represented employees in the County received a PPO program with necessary steerage, and later when the PPO network was introduced and agreed upon between the parties in negotiations, the possibility of approaching WPPN again became a viable alternative. At that time BCBSUW already had its own PPO network. BCBSUW told representatives of the County that it would explore the possibility of including WPPN providers as an in-network service.

Reblin testified that BCBSUW had a contract with WPPN "back in 1995." By letter dated June 1, 1995, from Pam Hartman, Employer Relations Consultant for BCBSUW, BCBSUW informed the County of "the understanding the County of Manitowoc and Blue Cross & Blue Shield United of Wisconsin have regarding access to the Blue Cross Network and the WPPN network." The letter stated in pertinent part:

The original intent of obtaining access to the WPPN network was to make the Blue Cross network "whole" in Manitowoc County in reference to utilizing Holy Family Hospital. We have sent a stock of 800 directories to the County recently and are asking that the directories be distributed to the County subscribers to utilize. The entire directory may be used statewide and services provided by any Blue Cross PPO provider will be paid at 100% after deductible.

In addition, any care sought by a WPPN provider outside of Manitowoc County will be paid on an exception basis at 100% after deductible until July 1, 1995. After this date, services by a WPPN provider outside of Manitowoc County will be paid at 90% after the deductible. Your employees may still continue to utilize WPPN providers in Manitowoc County, with services being paid at 100% after deductible.

Since 1995 the WPPN list of providers has included pharmacies in Manitowoc County. BCBSUW made this list of providers available to bargaining unit employees even though no pharmacies were included in the BCBSUW network of providers.

Events Leading up to the Instant Dispute

By letter dated August 8, 2000, from Paulette Ruminski, Sales Director, Northeast Regional Service Center, BCBSUW, to Cornils, BCBSUW informed Cornils, in material part, that “effective October 1, 2000 we will no longer utilize the Wisconsin Preferred Provider Network (WPPN) agreements for our PPO network in Manitowoc County.” Ruminski added: “We have identified seven providers that are in the WPPN Network but not the BCBSUW PPO network. . . . These providers are primarily specialty care providers for behavioral health, chiropractic, and eye care. We are extending provider contracts to each of these providers to join our BCBSUW PPO network.”

In September 2000, Lisa R. Halbach, Director of Operations, Northeast Regional Service Center, BCBSUW, wrote to subscribers stating, in material part:

Blue Cross Blue Shield of Wisconsin (BCBSUW) continues to look for ways to improve our service to you. To align with this services commitment, effective October 1, 2000, we will utilize our direct PPO network in Manitowoc County. We will no longer utilize the Wisconsin Preferred Provider Network (WPPN). This direct relationship with BCBSUW contracted PPO providers will improve timeliness of claims processing. Your medical benefits are not changing due to this announcement.

PPO providers in both networks are nearly identical with a few exceptions. A summary of providers is listed on the reverse side of this letter. These providers are primarily specialty care providers for behavioral health, chiropractic, and eye care. They will no longer be paid at the PPO benefit level for medical services beginning October 1, 2000. We have offered provider contracts to each of these providers to join our BCBSUW PPO network.

...

Following the BCBSUW decision in the fall of 2000 to drop all WPPN providers from the BCBSUW Preferred Provider list, including those within Manitowoc County, seven specific named providers were dropped, and most of them remained non-PPO providers. This decision applied to all BCBSUW customers, not just Manitowoc County.

Although bargaining unit employees were notified of the BCBSUW decision to drop the seven providers within Manitowoc County that were part of the WPPN network from the BCBSUW list, no grievances were filed.

After the September, 2000 letter, the County decided to check with BCBSUW about how they were “handling” the pharmacies. Cornils was concerned because “the only providers we had were part of a preferred provider association with WPPN pharmacies.” Cornils called BCBSUW “to try to find out how they were treating those benefits.” She discovered BCBSUW was “treating benefits now out-of-network as in-network benefits. So they were continuing to pay them at 100 percent but no longer getting a discount; that 100 percent of that charge was being charged” to the County. The County wanted to ensure that BCBSUW was living up to their insurance contract with the County. Cornils testified the contract provided that “PPO is paid at this level, non-PPO is paid at a different level.”

The County met several times with BCBSUW “to decide what we should do.” Cornils testified that “we tried to see if there was any way we could provide prescription drugs as a in-network benefit. That is something we talked about with WellPoint.” In the end, “the decision was made not to pursue the WellPoint thing because it wasn’t advantageous to our employees.”

After September 2000 employees continued to receive services from the WPPN pharmacies in Manitowoc County, and BCBSUW continued to reimburse these services at the in-network level.

By letter dated March 2, 2001, BCBSUW informed employees that effective April 1, 2001, “there is no longer a preferred provider network for pharmaceutical services.” The letter added: “Prescriptions will continue to be processed as a benefit under your health insurance plan, but will be processed at the out-of-network reimbursement level.” The March 2 letter also listed twelve WPPN pharmacies that could continue to submit charges directly to BCBSUW.

On March 22, 2001, the Association filed a grievance alleging that the County violated “Article 13, and any other applicable provisions of the 2000-2001 collective bargaining agreement by changing the levels of reimbursement for prescription drugs.” The grievance stated: “Association members received notice that payment of drug prescriptions are now

based upon 20% co-payment, to a maximum out of pocket of \$600.00, after first satisfying the \$200.00 deductible.” For a remedy, the Association requested to “maintain current level of benefits regarding prescription drugs.”

Remedy Issues

The parties stipulated at hearing “that there is a class of employees in the county that will pay more for prescription drugs in 2001 as a result of this change than they otherwise would have.” The stipulation continued: “We cannot yet calculate who that is or how much it is, but we acknowledge there is a class of employees that will be harmed and will pay more for prescription drugs.”

PERTINENT CONTRACTUAL PROVISIONS

. . .

ARTICLE 13 – HOSPITAL AND SURGICAL INSURANCE – LIFE INSURANCE

- A. Hospital and Surgical Insurance: In the area of hospital and surgical insurance, the County agrees to pay the following premiums:

Single Plan: Ninety-five percent (95%) of the premium.

Family Plan: Ninety-five percent (95%) of the premium.

Benefit design is as follows:

\$250 deductible per individual, \$500 per family; coverage will be at 100% (after deductible is met) for all services provided within the preferred provider network. Services provided outside of the network will be paid 80% by the County and 20% by the employee. The 20% co-pay is limited to \$200 per individual, \$600 per family. Effective January 1, 1998 the fourth quarter deductible carryover provision is eliminated.

The Employer agrees to make an annual contribution of \$150 to a health care reimbursement account for employees with single health insurance coverage, and to make an annual contribution of \$200 to a health care reimbursement account for employees with family coverage. This contribution will be available to employees as of January 1st of each year

and will be made on the basis of what type of health insurance plan the employee has as of January 1st.

- B. Change in Coverage: The insurance coverage shall not be changed without the mutual written consent of the parties except that the Employer shall be free to improve the insurance coverage at any time.

...

- D. Retirees: Retirees shall be entitled to continue their coverage under the County Group Health and Medical Insurance Plan at the employee's expense. The County shall not be held responsible if the employee fails to pay his or her monthly amount due to the County Treasurer's office and his or her policy coverage lapses. All such payments shall be made by the employee to the County Treasurer's office fifteen (15) days prior to the date the policy premium is due to the carrier.

- E. Open Enrollment: At any time the insurance carrier is changed, employees shall be entitled to enroll for coverage under the group insurance policy (single plan or family plan) without requirement of physical examination or restriction as to coverage within an "open enrollment" period of fourteen (14) to thirty (30) days as arranged between the Employer and the insurance carrier.

...

- H. Long Term Disability Insurance: Long term disability insurance to be provided at the Employer's expense. Employees would become eligible for benefits following 120 continuous certified days of disability, and provides payment of 60% of monthly earnings while disabled from own occupation for 24 months; after benefits have been paid for 24 months must be disabled from all occupations for which the employee is "reasonably fitted" by education, training and experience.

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POSITIONS OF THE PARTIES

Association's Position

The Association basically argues that the County violated the clear language of the parties' collective bargaining agreement when it eliminated the preferred provider reimbursement level for prescription drugs. In support thereof, the Association makes the following principal arguments.

The County violated Article 13, Section B, which provides that the insurance coverage shall not be changed without the mutual written consent of the parties.

The word "coverage" is defined in the dictionary as "the protection given by an insurance policy." *The American Heritage Dictionary* (3rd Ed. 1994). The word "coverage" as used in contractual health insurance provisions refers to particular protections, including protection against an employer (or its insurance carrier) unilaterally increasing employees' co-payments for covered services. CITY OF DELAFIELD, (Rice, 9/88); and VILLAGE OF BUTLER, Case 21, No. 59025, MA-11155 (Burns, 4/01).

The Association also relies on CITY OF NEW BERLIN, Case 84, No. 52198, MA-8870 (Shaw, 4/96) wherein Arbitrator Shaw interpreted the word "coverage" in a manner that shows co-payment levels are part of health insurance "coverage."

The Association argues that even where arbitrators have interpreted the term "coverage" more narrowly than the arbitrators mentioned above those cases support its position.

The Association maintains that the County has confused the term "coverage" with the term "covered service." The Association believes that "coverage" within the meaning of Article 13, Section B refers to the amalgam of particular protections including protection against a unilateral reduction in the payment level for a covered service. The Association believes, on the other hand, that a "covered" service is a service or supply set forth in the County's contract with BCBSUW for which the carrier provides benefits. The Association states that both parties recognize that pharmaceutical services are covered services and that is not the dispute herein contrary to the County's assertion.

The Association also rejects the County's position that because preferred providers have often been dropped from the list of in-network providers, this past practice may be used to interpret the word "coverage." In this regard, the Association first argues that practice cannot be used to change the explicit terms of the contract. However, assuming that the term "coverage" is ambiguous, the Association argues that the parties' practice with respect to

prescription drugs demonstrates that the health insurance “coverage” the County must maintain includes the in-network level of payment (coverage at 100 percent) for prescription drugs.

The Association further argues that it is an established principle of contract interpretation that contractual terms should be construed to avoid harsh or nonsensical results. The Association opines that if the County’s argument herein were to be accepted, the County would be free to eliminate the in-network level of payment whenever it desired to achieve cost savings. The Association concludes that clearly the parties’ agreement should be interpreted to avoid this nonsensical result.

In addition, the Association argues that it is assumed that when parties use a word in a contract, that word has its normal interpretation. It is clear, according to the Association, that when that word is used in Article 13, Section A – “**coverage** will be at 100%” – it refers to the employer’s cost or the level of payment that the County must make. As a result, the Association concludes that the payment level for a covered service falls within the meaning of “coverage” as that term is used in Article 13.

Finally, the Association argues that it is undisputed that the Association never agreed to allow the County and BCBSUW to change the employee’s level of payments for prescription drugs. Therefore, the Association argues that the County violated Article 13, Section B, which prohibits such a change without the written consent of the Association.

The Association makes the following principal rebuttal arguments.

The County’s interpretation of the word “coverage” is ludicrous because it erroneously equates the term “coverage” with the term “covered service.”

The County fails to address the fundamental issue in this case which is the County’s unilateral discontinuation of the preferred provider (or the PPO) payment level for prescriptions.

The Association has met its burden of proving that the County improperly changed health insurance coverage.

Moreover, since the parties bargained a maintenance of health insurance coverage provision (Article 13, Section B), the Association did not need to get any specific agreements protecting specific types of health care services.

There is no evidence that the parties ever intended that Article 13, Section B give the County the right to eliminate the preferred provider reimbursement level for prescription drugs.

There is no evidence that the County's failure to include certain Manitowoc County pharmacies on a PPO list will result in insurance premiums going through the roof.

Even consideration of DOOR COUNTY, Case 124, No. 58912, MA-11105 (Nielsen, 12/2000) (the one case cited by the County in its initial brief) shows that under established industry practice language that prohibits a change of "coverage" requires an employer to maintain all health insurance benefits. DOOR COUNTY, SUPRA, p. 3.

More significantly, in this case the County's previous use of the word "coverage" is consistent with the Association's definition of that word.

The County's arguments concerning "economic realities" are misplaced.

For all the foregoing reasons, the Association requests that the Arbitrator sustain the grievance.

For a remedy, the Association requests an order directing the County to reimburse all bargaining unit employees who paid co-payments for prescription drugs that they would not have paid if BCBSUW had continued to process prescription drug purchases after April 1, 2001 as purchases of in-network services.

County's Position

The County initially argues that this case involves the decision by an outside insurance carrier, BCBSUW, to move approximately 12 Manitowoc County pharmacies from their list of Preferred Providers to their list of non-Preferred Providers under the Manitowoc County Health Insurance Plan. The County contends that an analysis of past practice, bargaining history, principles of contract interpretation, and common sense, leads to the conclusion that this action by BCBSUW is not a violation of the agreement.

The County adds that this case comes down to a simple question of whether the word "coverage" should be expanded to include any and all benefits employees have ever received in the past, or whether it should be interpreted more narrowly. More importantly, the County believes that the case hinges on whether the Arbitrator will succumb to the temptation to impose his own version of what that word means to him, or whether he will follow the traditional principles of contract construction used by arbitrators for many years. The County states that if the Arbitrator follows traditional rules of contract construction, and views his job as trying to determine what the parties intended, he will analyze the criteria set forth below, and conclude that the parties never intended to prohibit the action of BCBSUW at issue.

In support of the above, the County first argues that the purpose of arbitration is to discern the intent of the parties. In determining the parties' mutual intent, the County claims that arbitrators look to several factors to determine whether the parties clearly intended the word "coverage" would limit flexibility on maintenance of the list of Preferred Providers.

The first factor is internal consistency. In this regard, the County argues that the parties have drawn a distinction between coverage and benefits in various provisions of the agreement. The County argues that in Paragraph B the parties mutually agreed that the types (i.e. pharmaceutical coverage) of items "covered" under the insurance contract would not change. However, once it is decided a matter is "covered," the plan's "benefit design," kicks in and the benefit design does not limit or control which providers are considered preferred, and which are not.

The County next relies on past practice in support of its position.

The County also relies on the plain meaning of the contract language.

In support thereof, the County argues that even when viewed in a vacuum, the term "coverage" is a relatively specific term. If you were going to have a service provided by your physician, you would want to know whether it was "covered" or not. The County contends that this common, everyday understanding of the concept of "coverage" ought to be used by the Arbitrator.

The County further argues that the commonly understood meaning of the word "coverage" happens to be consistent with the meaning of that term in the insurance industry.

The County rejects the Association's argument that because the Association is not a signatory to the insurance contract, they are not bound by it.

In addition, the County relies on bargaining history to support its position.

Finally, the County argues that no insurance language can effectively be interpreted in a labor contract without reference to the economic realities that support the contract language. In this regard, the County claims that arbitrators understand that there are certain components of the insurance system that must be taken "part and parcel" when generic language is negotiated. One important example of this principle, according to the County, is the decision by Arbitrator Dan Nielsen in DOOR COUNTY COURTHOUSE EMPLOYEES, LOCAL 1658, AFSCME, AFL-CIO AND DOOR COUNTY, Case 124, No. 8912, MA-11105 (December 8, 2000). In that decision, according to the County, Arbitrator Nielsen ultimately concluded that merely because the precise application of "medical necessity" may have changed, that did not change the fact the medical necessity determination was a fundamental part of the insurance

company's rights and obligations under the insurance contract. Arbitrator Nielsen added: "The determination of medical necessity in individual cases may be challenged through the appeal procedures of the plan administrator, but is not a grievable issue under the labor contract. DOOR COUNTY, SUPRA, p. 9.

The County maintains that similarly in this case, the ability of the insurance company to modify the list of preferred providers, especially depending on the ability to negotiate discounts with those providers, was an "inherent feature" of the insurance contract all along.

The County argues that if this grievance is successful every pharmacy in Manitowoc County could quadruple their prices for prescription drugs, and the County would have to absorb that additional cost.

The County rejects the Association's claim that by eliminating all providers of a particular type of service from the PPO network, the insurance company is forcing employees to pay part of that service, and not giving them an option to access a preferred provider. The County states that this is not true since the County and BCBSUW are ready to negotiate a drug card that will enable bargaining unit employees to access these pharmacies at substantially discounted rates.

The County also rejects the primary cases relied upon by the Association to make its argument that charging non-PPO rates for certain expenses when PPO rates formerly applied is a violation of the contract. To the contrary, the County believes that said cases actually support its position.

The County further contends that the Association's "past practice" argument (i.e. because certain pharmacies were treated as in-network for "the six month period of time from September 2000 until April 2001" a practice was established) is invalid for two primary reasons. One, how can the Association argue on the one hand that the terms of the insurance contract are irrelevant, yet argue on the other hand that said terms create a binding past practice. Also, why should the practice of six years of moving providers on and off the PPO list be ignored? Two, Article 3 of the agreement specifically requires that amenities and practices in effect for a minimum period of twelve months shall continue. The parties have specifically agreed that a practice lasting only six months is not binding. To enforce the practice, as suggested by the Association, would violate the terms of the contract.

The County is mystified by the Association's continued suggestion that it has the contractual right to change some providers from the PPO to the non-PPO list, but that it has violated the contract in this case. The Association is asking the Arbitrator to draw an arbitrary line between moving single providers from one list to the other, and moving an entire class of providers. This distinction appears nowhere in the face of the agreement, and such arbitrary

line drawing by the Arbitrator would violate the duty he owes to the parties to enforce the terms of the agreement.

Finally, the County claims that it has not acted arbitrarily or in a mean-spirited fashion when making decisions in this case.

Based on all of the above, the County requests that the grievance be denied.

DISCUSSION

At issue is whether the County violated Article 13, Section B, of the collective bargaining agreement when BCBSUW took the action described in its letter of March 2, 2001.

The Association argues for such a violation while the County takes the opposite position.

As stated in BARRON AREA SCHOOL DISTRICT, CASE 44, No. 59352, MA-11262 pp. 8-9 (McGilligan, 9/01), contract interpretation involves giving meaning to the words and conduct used by the parties in their collective bargaining agreement. Labor and Employment Arbitration, Volume 1, Tim Bornstein, Ann Gosline and Marc Greenbaum General Editors, Chapter 9, Contract Interpretation and Respect for Prior Proceedings by Jay E. Grenig, s. 9.01[1], 9-3 (1998). Ideally, contract interpretation results in a determination of exactly what both parties in fact had in mind or intended. This ideal is seldom attainable:

In the first place, it is impossible to know exactly what the parties did have in mind. Moreover, even if this could be determined, it may be doubted whether very many cases would be found in which both parties did have exactly the same things in mind. The best we can do is to approximate that ideal by adopting as a goal something that is more nearly possible of attainment. That goal, must, however, be fair to both parties to the contract. 2/ Labor and Employment Arbitration, Id., and the cases cited therein. (Footnote omitted).

Over the years, arbitrators have looked to the principles of contract interpretation for guidance in interpreting collective bargaining agreements. In the instant case, both parties cite various standards of contract interpretation to support their position. However, the principles of contract interpretation serve only as guides and should not be used as rigid or undeviating rules to be followed as methodically as though labor relations were an exact science. Labor and Employment Arbitration, supra, 9-3 and 9-4.

Many arbitration awards interpreting contracts focus on the intent of the parties. *Labor and Employment Arbitration*, supra, s. 9.01[2], 9-4. Here, both parties rely on the parties' intent when they negotiated the disputed contract language in support of their respective positions. However, they differ strongly as to what was intended when the parties agreed to the disputed contract language. Consequently, the Arbitrator will consider the purpose of the disputed contractual provision as a basis for its interpretation. The purpose may be ascertained from the language of the contract as well as evidence of bargaining history and the parties' administration of the contract. *Labor and Employment Arbitration*, supra, 9-5. The Arbitrator will also consider the arbitration awards cited by the parties in support of their position as well as other arbitral precedent.

The Association first argues that the clear meaning of Article 13, Section B, is that the County cannot unilaterally reduce the insurance protections enjoyed by employees including specified levels of payments for covered services. The Association maintains that the County violated this clear contractual provision when it unilaterally discontinued the preferred provider network reimbursement level for pharmaceutical services.

The first part of Article 13, Section B, poses the interpretive issue, and cannot be considered clear and unambiguous since both parties have made plausible, but conflicting, arguments regarding its interpretation. The ambiguity flows from the term "coverage," and what is meant by the parties' agreement that "the insurance coverage shall not be changed without the mutual written consent of the parties." The Association believes that the County violated this contractual provision when it eliminated the preferred provider reimbursement level for prescription drugs without first obtaining the required consent. Under the County's view, the parties mutually agreed under Article 13, Section B, that the types of items that would be "covered" under the insurance contract would not change. For example, the County could not eliminate psychiatric coverage, or maternity coverage, or pharmaceutical coverage under the insurance contract. The County maintains that the parties did not agree that the word "coverage" included all benefits previously enjoyed by the employees. The parties arguments demonstrate that the disputed contractual provision, however, does not clearly and unambiguously provide an answer to what is meant by the requirement that "the insurance coverage shall not be changed without the mutual written consent of the parties." The Arbitrator turns his attention to the other criteria set forth above.

The County initially argues that its definition of the word "coverage" is more consistent with the overall agreement of the parties. In this regard, the County argues that the parties have drawn a distinction between coverage and benefits in various provisions of the contract. The County cites Article 13, Sections D, E and H in support thereof.

The County points out that the parties described the long term disability insurance program in Article 13, Section H. That provision provides that long term disability insurance is “to be provided at the Employer’s expense.” It also provides that employees are “eligible for benefits” or “covered” by the program following 120 continuous certified days of disability. The “benefits” or what they get are described in detail elsewhere in that provision.

While it is true that the aforesaid provision describes the long term disability insurance benefits received by unit employees, there is no mention of the word “coverage”. Nor is there any persuasive evidence in the record that eligibility for benefits under said provision equates with the term “coverage” as used in Article 13, Section B.

Article 13, Sections D and E also do not explain the difference between “coverage” and “benefits.” It is true, as pointed out by the County, that both Sections reference the term “coverage.” It is also true both sections do not refer to the specific benefits employees are entitled to receive once they are “covered.” However, neither section draws an express distinction between insurance “coverage” and the specific benefits to be received under that plan.

Both parties argue that their interpretation of the term “coverage” in Article 13, Section B, is consistent with the use of that term in Article 13, Section A.

That section provides, in part, that “coverage will be at 100% (after deductible is met) for all services provided within the preferred network.” The Association argues that since “coverage” for covered services must be either at the 100% (in-network) or the 80% (out-of-network) payments, it is clear that “coverage” as used in the phrase “coverage will be at 100%” refers to the employer’s cost – or the level of payment that the County must make. Hence, according to the Association, the payment level for a covered service falls within the meaning of “coverage” as that term is used in Article 13. For the reasons discussed below, the Arbitrator agrees.

The County argues that under Article 13, Section A, that once it is decided a matter is “covered,” the plan’s “benefit design” kicks in. According to the County, the “benefit design,” described in Section A clearly contemplates that even if “covered,” the employee must pay for the first \$250 or \$500 of that “covered” expense. Even after the deductible is met, the employee must still pay for 20% of any such “covered” services received from a provider outside the network. The County maintains that the language of this provision does not limit or control which providers are considered preferred, and which are not. Again, the Arbitrator agrees. However, said language does not expressly address the issue in dispute – whether, or not, the County is contractually able to eliminate an entire group of preferred providers.

Because the use of the term “coverage” in other contractual provisions does not give meaning to the use of that word in Article 13, Section B, the Arbitrator must look elsewhere in order to determine its meaning.

Both parties rely on past practice in support of their positions.

The County defines the term “past practice” to be “unequivocal, clearly enunciated and acted upon, readily ascertainable over a reasonable period of time, and accepted by both parties.” The County states that acceptance is assumed based on the actions of the parties.

The County believes that the above definition has been met in this case. It submits that the unequivocal, clearly and consistently followed practice in the County is that movement of providers on and off the PPO list is a matter of routine. It points out that since 1995, when the WPPN network was first made available to County employees, BCBSUW has routinely removed providers from the PPO list for whom they could not secure adequate cost discounts without objection from the Association. The County argues that this is strong evidence that the mutual intent of the parties is the term “coverage” does not limit the insurance company’s decision to place providers on, or remove them from, a preferred provider list.

The Arbitrator agrees that since 1995 BCBSUW has routinely removed providers from the PPO list. However, BCBSUW has never removed an entire class of providers from a PPO list at any time material herein. The question is whether that action is proper under the terms of Article 13, Section B of the agreement.

The County argues that removal of all pharmacies from the PPO list is like other actions taken by BCBSUW. In particular, the County cites the actions of BCBSUW to modify its interpretation of medically necessary (especially in the area of maternity benefits), and the calculation of UCR charges.

However, as pointed out by the Association, this case is not about medical necessity determinations or the calculation of UCR. Nor is it about adding or removing providers from the PPO list. Rather, it is about whether the County can unilaterally eliminate one entire class of providers (i.e., pharmacies) from its list of providers who are reimbursed at the in-network level.

The WPPN network was first made available to County employees on March 1, 1995. (Union Exhibit No. 1, p. 6). BCBSUW entered into a contract with WPPN, and all of the WPPN providers were included in the BCBSUW PPO directory, except for the pharmacies. (Tr. p. 51).

The County specifically requested that the pharmacies listed in the WPPN directory be included in the BCBSUW plan. (Union Exhibit No. 1, p. 7). In response to this request, BCBSUW made an exception to process prescription drug claims at the in-network level for County plan members. Id. County employees only got to use the pharmacies by virtue of their being in the WPPN network. (Tr. p. 52). There were about 10 or 12 pharmacies in the network. (Tr. p. 51). They were listed in the WPPN book, not the BCBSUW book. (Tr. p. 52).

From 1995 through September 2000, BCBSUW processed all covered services from pharmacies at the in network reimbursement level of 100% based on the foregoing arrangement.

Effective October 1, 2000, BCBSUW no longer utilized the WPPN network for its PPO network in Manitowoc County. BCBSUW made a corporate decision to terminate the agreement with the WPPN network and directly contract with providers within the County. (Union Exhibit No. 1, p. 5). BCBSUW dropped WPPN because of complaints on claims processing turn around and pricing delays. (Tr. p. 29). Once BCBSUW got rid of WPPN, timelines became more streamlined. Id. From October, 2000 to March, 2001, BCBSUW continued to pay for PPO prescriptions as a network provider even though BCBSUW was not otherwise honoring other WPPN providers. (Tr. p. 30). This was essentially a business decision by BCBSUW as a service to County members. Id.

Effective April 1, 2001, BCBSUW notified plan members that there would no longer be a preferred provider network for pharmaceutical services.

Based on the foregoing, and applying the definition of a past practice advanced by the County, the Arbitrator finds that there was a past practice of about six years whereby the County and BCBSUW provided employees the opportunity to buy prescription drugs at the in network reimbursement level of 100%. Contrary to the County's assertion, this service was provided to employees independent of the BCBSUW PPO directory and its discount pricing system. BCBSUW simply contracted with WPPN to provide these pharmaceutical services to plan members, and continued to pay for prescriptions at the PPO level of reimbursement (100%) even when it discontinued its contract with WPPN.

The Association also points out that the County's previous use of the word "coverage" is consistent with the Association's definition of that word. The Association cites a memo dated February 22, 1995 wherein the County Personnel Coordinator wrote to "All County Retirees and Individuals on Extended Coverage" about "Health Insurance Coverage." (Emphasis added). (Union Exhibit No. 1, p. 15). The memo outlined some changes in health insurance "coverage" to those non-bargaining unit employees. The memo stated that the County Board passed a resolution "which makes some changes in the health insurance

coverage you currently have” effective March 1, 1995. Id. The first change listed is a decrease of the premium amounts. Id. This change in “coverage” was a change of the retirees’ level of payment for health insurance. The County Personnel Coordinator’s use of the word “coverage” is consistent with the Association’s interpretation of the word.

The memo goes on to state that the County was now a member of the Lakeshore Health Care Coalition, and that “services provided to you are discounted when you seek medical attention from someone covered in the Wisconsin Preferred Provider Network (WPPN).” Id. The memo added: “A list of the network providers in Manitowoc is attached for your reference.” Id. The memo also provided:

You are free to continue to see whomever you choose for your medical care. If you go to someone in the network, your coverage will be no different than what it was prior to March 1, 1995. (In other words, once you have met your deductible the insurance will cover 100% of the usual and customary charges.) If you choose to go to someone who is not in the network, you will be responsible for 10% of the charges to a maximum out of pocket of \$200 for single coverage and \$600 for family coverage. This is in addition to your deductible.

Regardless as to your reason for seeking medical attention outside the network (i.e., being referred by a physician within the network), you will be subject to the 10% co-pay.

The above statements concerning “coverage” at the in-network level are also consistent with the Association’s interpretation of the word “coverage.” Specifically, “if you go to someone in the network, your coverage will be no different than what it was prior to March 1, 1995.” (Emphasis added). This is consistent with the contractual mandate found in Article 13, Section B which provides that the “insurance coverage shall not be changed” except by agreement of the parties. In addition, “once you have met your deductible the insurance will cover 100% of the usual and customary charges.” (Emphasis added). This is consistent with the Association’s argument that BCBSUW must continue coverage which includes an in-network payment level for prescription drugs. As noted above, the County and BCBSUW have consistently maintained since 1995 an in-network list of pharmacies or an in-network payment level where once an employee met the deductible, the insurance covered 100% of the prescription drug costs.

Both parties also cite bargaining history in support of their positions.

The County first argues that to demonstrate that the term “coverage” should be interpreted in the manner described in the grievance, the Association must show there was communication between the parties that said term should include limits on the insurance company’s ability to delete an individual provider, or even an entire class of providers, from the Preferred Provider network. The County states that there was no such communication or understanding.

There is no persuasive evidence in the record as to what the parties meant when they first agreed to the term “coverage” in Article 13, Section B. Nor do the parties agree as to the plain meaning of the term. Since the term is not defined elsewhere in the agreement, the Arbitrator turns to the dictionary definition of the word. *The American Heritage Dictionary of the English Language, New College Edition*, (10th Ed. 1981) p. 334 defines “coverage” as “The extent of protection afforded by an insurance policy.” This definition is supportive of the broader definition of the term “coverage” put forward by the Association. When the term “coverage” is interpreted broadly, the Association is correct in pointing out that since the parties bargained a maintenance of health insurance coverage provision (Article 13, Section B), there was no need to get any specific agreements protecting specific types of health care services.

The County next references a bargaining proposal made in 1995 by AFSCME which provided that if the County eliminated the PPO network entirely, leaving only non-PPO providers available to unit employees, that the employer must make another statewide PPO available. The County states this demonstrates that the Union that negotiated the term “coverage” in the first instance, understood that the term “coverage” does not prohibit the maintenance of, or elimination of, the PPO organization.

At first glance this bargaining proposal does appear to support the County’s more narrow interpretation of the term “coverage” because AFSCME was recognizing through its offer on April 24, 1996, the County’s ability to eliminate a statewide PPO. (Employer Exhibit No. 9). In addition, the AFSCME representative who made this proposal did bargain the language of Article 13, Section B, in the first place. (Tr. pp. 86-87). However, the statewide WPPN network was first made available to County of Manitowoc employees on March 1, 1995. (Union Exhibit No. 1, p. 6). BCBSUW also had its own PPO directory at the time. (Union Exhibit No. 1, p. 7). While the County introduced no evidence as to what exactly AFSCME meant when it made the aforesaid proposal, it may be that AFSCME was trying to prevent what BCBSUW eventually did – eliminate the WPPN network so that employees would be able to use only its own PPO directory. (Tr. p. 29). However, the aforesaid AFSCME proposal does not specifically address the dispute before the Arbitrator concerning the elimination of an entire group of providers (pharmacies) from the in network level of providers which BCBSUW made available to plan members irregardless of whether there was a contract with WPPN.

In addition, AFSCME representative Jerry Ugland made the aforesaid proposal on behalf of the Support Services bargaining unit and with respect to their collective bargaining agreement. (Emphasis added). There has been no showing by the County that the parties have mutually considered that bargaining unit linked to the law enforcement bargaining unit as to the meaning of the term “coverage” or the County’s ability to remove pharmacies from the in-network level of providers.

Based on the above, the Arbitrator likewise rejects this argument of the County.

The County also points out that County Personnel Director Sharon Cornils testified that in 1995 she specifically discussed the PPO list with the Association representative at the time and refused to guarantee “that the people listed on the PPO list would not be changed.” (Tr. p. 94). The Association representative then expressed a concern about the list: “who’s in, who’s out.” Id. In response, Cornils “provided the bargaining team at that time a directory to show who was in at the same time.” Id. Cornils added: “the directory states clearly, ‘this is subject to change at any time.’ That is something Manitowoc County could not control. That’s why we couldn’t make any promises.” Id.

The importance of the above statements by County Personnel Director Cornils cannot be overstated. If, in fact, she was informing the Association that an entire group of providers could be moved off the PPO list at the discretion of BCBSUW, then the County’s position prevails. However, if she was just talking about individual providers, then the Association’s position prevails.

In order to explain what she meant, the County’s attorney asked her to look at Employer Exhibit No. 8. He then asked: “Is that the kind of language you’re referring to that was exchanged at the table?” County Personnel Director Cornils answered “Yes.”

Employer Exhibit No. 8 states: “Because of continual additions, resignations and changes in practice arrangements, we cannot guarantee that a provider listed here will always be available to you.” (Emphasis added). The record is clear that County Personnel Director Cornils informed the Association above that individual providers could be moved on and off the list but made no statements regarding the removal of an entire group of providers. Consequently, this bargaining history does not support the County’s position, and is consistent with the Association’s definition of the term “coverage.”

The Arbitrator next turns his attention to the cases relied upon by the parties in support of their positions.

The first case cited by the Association is VILLAGE OF BUTLER, CASE 21, NO. 59025, MA-11155 (Burns, 4/01). In VILLAGE OF BUTLER, Arbitrator Coleen Burns found that the Village violated the collective bargaining agreement when its health insurance carrier unilaterally established a requirement that the employees pay out-of-network deductibles and prescription drug co-payments greater than those required under the previous health insurance coverage. In that case Arbitrator Burns interpreted contractual language that required the Village to “maintain the existing health insurance coverage or its equivalent. . . .” In interpreting that language, Arbitrator Burns held:

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.

VILLAGE OF BUTLER, SUPRA, p. 7. In VILLAGE OF BUTLER, Arbitrator Burns found that the extent of protection afforded by a health insurance policy includes protection against a carrier unilaterally increasing prescription drug co-payments. Hence, in the VILLAGE OF BUTLER, Arbitrator Burns reasoned that the Village was obligated to maintain the \$5-\$10-\$25 level of drug co-payments that was in existence when the parties entered into the existing collective bargaining agreement which provided that the “Village shall maintain the existing health insurance coverage or its equivalent for all employees.” VILLAGE OF BUTLER, SUPRA, p. 9. Thus, when the insurance carrier established a new \$7-\$12-\$25 level of drug co-payments, she found that the Village had failed to maintain existing coverage. Id.

The Association argues that in the instant dispute BCBSUW and the County eliminated 100% paid prescription drugs by eliminating the in-network reimbursement level for pharmaceutical services. Under VILLAGE OF BUTLER, the Association claims that such a change in the level of payment for prescriptions is a change in coverage and, therefore, a violation of Article 13, Section B of the agreement. The Arbitrator agrees.

The County, on the other hand, argues that VILLAGE OF BUTLER actually supports its position. The County points out that in VILLAGE OF BUTLER the arbitrator “had no trouble finding a violation of the old plan” where specific drug co-pays were increased. The County submits that the outcome of the arbitrator’s decision would have been different if the insurance contract specifically provided that the carrier had the discretion to determine whether a particular type of medication was considered generic or name-brand, and made a decision to move a particular type of drug into the name-brand category pursuant to that insurance contract. For the reasons discussed below, the Arbitrator disagrees.

In VILLAGE OF BUTLER, Arbitrator Burns specifically stated:

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. (Emphasis added).

Thus, contrary to the County's assertion, the insurance contract has nothing to do with the County's contractual obligation herein that "The insurance coverage shall not be changed without the mutual written consent of the parties."

In addition, Arbitrator Burns in VILLAGE OF BUTLER interpreted the term "coverage" broadly to mean "the extent of protection afforded by an insurance policy." VILLAGE OF BUTLER, SUPRA, p. 7. Arbitrator Burns also found that changes that occurred prior to the time that the parties entered into their agreement were part of the "existing health insurance coverage." There is no dispute that employees represented by the Association have been able to buy prescription drugs in the in-network reimbursement level (100%) at all times material herein. Under the standard established in VILLAGE OF BUTLER, the Arbitrator finds that the County's elimination of in-network drug co-pays is a violation of the contractual protections mandated in Article 13, Section B requiring that "insurance coverage shall not be changed without the mutual consent of the parties."

The next case relied upon by the Association is CITY OF DELAFIELD, (Rice, 9/88).

In CITY OF DELAFIELD, the parties' contractual health insurance language provided that "coverage shall not be less than that in effect and provided by the insurance policy in effect on January 1, 1987." CITY OF DELAFIELD, SUPRA p. 1. That policy allowed each employee to choose between a full service plan (which allowed employees to choose their own doctor) or an HMO plan. The employer dropped the old insurance and offered a new one that did not have the full service option. In interpreting that provision, Arbitrator Zel Rice held:

The word coverage as used in the Article XVI, Section 16.01 is a general term that is commonly understood to refer to the overall scope of insurance protection. It refers to the amalgam of particular protections provided by the insurance program. The term coverage as used in the collective bargaining agreement identifies the health insurance program in affect on January 1, 1987.

SUPRA, p. 5. Because “coverage” is a broad term that refers to the overall scope of insurance protection and identifies the health insurance program in effect, Arbitrator Rice found that the City of Delafield violated the agreement when it no longer gave employees the option of selecting either an HMO plan or a full service plan (which allowed employees to choose their own doctor).

The County contends that DELAFIELD does not apply to instant dispute. The County submits that if the facts were similar to those found in Manitowoc County, the employer would have moved a specific physician or medical group from the full service plan to the HMO plan or *vice versa*. “If the insurance contract in place on January 1, 1987 specifically authorized the carrier to make that change, the County contends the result in DELAFIELD would have been radically different.” Then, according to the County, the employer would have been complying with discretion granted under the insurance contract, not violating it.

In the instant case, there is no dispute that BCBSUW can add or remove an individual provider from the PPO list. However, contrary to the County’s assertion, Article 13 does not specifically authorize the County to remove the entire list of pharmacy providers from its PPO list or eliminate prescription drug costs from the in-network level of reimbursement.

DELAFIELD, like VILLAGE OF BUTLER, defines the term “coverage” very broadly. Arbitrator Rice found: “The word “coverage” as used in the collective bargaining agreement refers to all of the particular protections included within the Employer’s Health Insurance Company insurance policies” in effect on January 1, 1987. (Emphasis added). The Association argues that among these protections are specified levels of payment for covered services. In the instant case, pursuant to Article 13, Section A, after the deductible has been met, coverage must be at 100% for all services provided within the preferred provider network. At the time the agreement went into effect, this “coverage” included pharmaceutical services. The Association argues that the County violated the agreement when it unilaterally discontinued the preferred provider network reimbursement level (100%) for pharmaceutical services. Based on the standard set forth above, the Arbitrator agrees.

This is particularly true here because the contract clause in question is broader than the clause interpreted by Arbitrator Rice in DELAFIELD. In DELAFIELD, the contract clause provided that “coverage shall not be less than that in effect and provided by the insurance policy in effect on January 1, 1987.” (Emphasis added). Arbitrator Rice found that the elimination of a full service plan violated that contractual requirement. In the instant case, Article 13, Section B provides that insurance “coverage” shall not be changed period unless by written agreement of the parties except that the Employer can improve it. The County makes no argument that it is improving the insurance “coverage” by its elimination of the in-network reimbursement level for prescription drugs.

The Association also relies on CITY OF NEW BERLIN, CASE 84, NO. 52198, MA-8870 (Shaw, 4/96). In that case, Arbitrator David Shaw also interpreted the word “coverage” in a manner that shows co-payment levels are a part of health insurance “coverage.” He found that a pre-existing Blue Cross and Blue Shield plan established “a number of areas of coverage.” CITY OF NEW BERLIN, SUPRA, p. 21. He determined that BC/BS “coverage” was much better than new insurance plan (Prime Care) in a several areas including the “coverage” for prescription drugs. CITY OF NEW BERLIN, SUPRA, pp. 22-26. Regarding “coverage” for prescription drugs, Arbitrator Shaw stated: “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.” CITY OF NEW BERLIN, SUPRA, p. 25. With regard to the former, he explained:

. . . , 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 provider. 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 differences in Prime Care’s coverage out-of-network.

Id. In other words, Arbitrator Shaw found in the aforesaid case that “coverage” differs when payment levels differ. As pointed out by the Association, Arbitrator Shaw’s use of the word “coverage” clearly shows that protections against unilateral changes in coverage include protection against unilateral changes of the levels of payment for prescription drugs.

The County argues that the facts are different in this case compared to the facts in NEW BERLIN. The County states that it has no quarrel with Arbitrator Shaw’s decision finding that the new plan was a violation of the old plan. However, the County submits that if the old plan specifically authorized the insurance company to determine whether a specific doctor or medical group was in or out of the PPO network, and as a result of that decision, an employee had to pay additional money for the non-PPO treatments, the County believes the outcome of that case would have been different.

Arbitrator Shaw compared the two plans in question in order to determine what the term “substantially equivalent” meant in terms of the coverage required of a replacement plan. CITY OF NEW BERLIN, SUPRA, p. 21. In comparing the two plans, he reviewed the “coverage” of the two plans focusing on “areas of coverage” where “major differences” between the two

plans were found. One of these “areas of coverage” was prescription drugs as noted above. While the aforesaid contractual dispute was before Arbitrator Shaw because the employer changed insurance plans, the focus of his review was on changes in “coverage”. His analysis of this problem is applicable to the present dispute regardless of whether the background involves a change in plans or a change in “coverage” by the insurance company.

Like CITY OF NEW BERLIN, there is a major change in “coverage” of prescription drugs in the present case. That occurred on March 2, 2001, when BCBSUW provided notification to employees that as of April 1, 2001, there would no longer be “a preferred provider network for pharmaceutical services. Prescriptions will continued to be processed as a benefit under your health insurance plan, but will be processed at the out-of-network reimbursement level.” (Joint Exhibit No. 3). The parties stipulated at hearing:

MR. THAL: Also, what the parties agreed while we were off the record, rather than call a bargaining member to put in bills and whatever to establish payments have been paid, we would stipulate that bargaining unit members who have exceeded their individual or family deductible have been charged and have in fact paid the 20 percent co-payment amounts to pharmacies that used to be in-network providers and are no longer in-network providers. This does not mean the County has pointed out at the end of the year they would necessarily have been affected adversely by this change, only that they – there is a likelihood that they would be affected adversely by this change.

MR. KOROM: Yeah. And we can stipulate that there is a class of employees in the county that will pay more for prescription drugs in 2001 as a result of this change than they otherwise would have. We cannot yet calculate who that is or how much it is, but we acknowledge there is a class of employees that will be harmed and will pay more for prescription drugs.

In CITY OF BROOKFIELD, Arbitrator Shaw found “major differences” in “coverage” in a number of different “areas of benefits.” CITY OF BROOKFIELD, SUPRA, pp. 21-27. Arbitrator Shaw determined that “some areas and aspects of a plan” were “more significant than others,” including prescription drugs. CITY OF BROOKFIELD, SUPRA, pp. 21, 25. Based on “significant deficiencies” in those areas discussed including payment for prescription drugs, Arbitrator Shaw concluded that the coverage provided under the new plan was not substantially equivalent to the coverage provided by the old plan. CITY OF BROOKFIELD, SUPRA, pp. 26-27. Based on the parties’ stipulations, the Arbitrator finds “major differences” in coverage between the old BCBSUW method of payment for prescription drugs, and the new method announced on March 2, 2001.

The County points out that in all three cases noted above, the employer developed an entirely new insurance program different than the terms of the old one. The County argues that here it and BCBSUW are following the clear language of the insurance contract. However, inasmuch as the Association contracts with Manitowoc County, and not the insurance carrier, the obligation to provide the contracted health insurance coverage rests with Manitowoc County and not the insurance carrier. VILLAGE OF BUTLER, SUPRA, p. 8. Therefore, the language of the insurance contract is not relevant to the question of whether the County violated Article 13, Section B by its actions on March 2, 2001.

The County also argues that the ability to make the decision about PPO versus non-PPO alignment is an “inherent feature” of the insurance contract.

It is undisputed that BCBSUW can move providers off and on the PPO list as part of the insurance contract. However, the issue of whether BCBSUW can eliminate the preferred provider network for pharmaceutical services must be addressed under Article 13, Section B which mandates that the County shall not change insurance coverage without written agreement of the parties. In all three cases discussed above, the arbitrators define the word “coverage” broadly, contrary to the County’s position, to include protection against adverse changes in prescription drug costs as a result of the changes announced in the BCBSUW letter of March 2, 2001. (Joint Exhibit No. 3).

For the reasons discussed below, the Arbitrator must also reject the County’s reliance on DOOR COUNTY, CASE 124, No. 58912, MA-11105 (Nielsen, 12/00).

The County argues that arbitrators understand that there are certain components of the insurance system that must be taken “part and parcel” when generic language is negotiated. An important example of this principle, according to the County, is the decision by Arbitrator Dan Nielsen in DOOR COUNTY. In that case, an employee had made claims for chiropractic care for many years under the old insurance plan administered by an insurance carrier. No request for benefits was ever denied for those chiropractic benefits. When the employer changed to a self-funded plan, the employer’s third party administrator denied the same request for chiropractic benefits as not being “medically necessary.” Other employees had similar experiences.

As pointed out by the County, the contract language in that case used the more restrictive term “benefits” rather than the term “coverage,” requiring the employer to maintain all “benefits” that were covered by Blue Cross as of 1986. After determining that the dispute was substantively arbitrable, Arbitrator Nielsen found both the old plan and the County’s self-insurance plan excluded payment for services that were not medically necessary. In other words, medical necessity was a condition precedent to the payment of a claim under both plans. Arbitrator Nielsen added: “While the right to determine medical necessity may not have

been invoked in the past, the decision to invoke it” cannot now be characterized as a change in benefits. DOOR COUNTY, SUPRA, p. 9. “It has always been a part of the benefit package.” Id.

In DOOR COUNTY, the right to determine medical necessity was part of the benefit package under both plans. Here, employees had a preferred provider network for pharmaceutical services (or continued to receive services from the WPPN pharmacies in Manitowoc County with reimbursement for these services at the in-network level of 100%) prior to April 1, 2001. After that date, prescriptions were processed at the out-of-network reimbursement level. (Joint Exhibit No. 3). In DOOR COUNTY, the contract required the County to “maintain all benefits that were **covered** by Blue Cross as of 1986.” (Emphasis added). In the instant case, the County did not maintain all benefits (pharmaceutical services reimbursed at the 100% level) that employees had previously enjoyed as part of their “coverage” despite a contractual requirement not to change coverage except by written agreement of the parties.

The County quotes approvingly the following statements of Arbitrator Nielsen:

However, the right to require that treatments and procedures be medically necessary in order to be covered by insurance was an inherent feature of the Blue Cross insurance policy and has been carried over into the County’s self-funded plan. Although it may have come as an unwelcome surprise to these employees, it is not a change or reduction in the level of benefits. The determination of medical necessity in individual cases may be challenged through the appeal procedures of the plan administrator, but is not a grievable issue under the labor contract.

DOOR COUNTY, SUPRA, p. 10.

The County argues similarly, in this case, the ability of the insurance company to modify the list of preferred providers, especially depending upon the ability to negotiate discounts with those providers, was an “inherent feature” of the insurance contract all along. The County adds:

While that issue can be disputed in a grievance under the insurance contract, it is fundamentally not a “grievable issue” under the labor contract. Mr. Nielsen (sic) understood, and this arbitrator should as well, that to conclude that Blue Cross & Blue Shield, through its relationship with the County, has lost the ability to negotiate effectively with any preferred provider or group of providers who refuse to offer discounts for their services, would be fundamentally altering the delicate economic relationship between the insurance carrier, provider, employer and insured employee.

Contrary to the County's assertion, the ability of the insurance company to modify the list of preferred providers has never been at issue herein. (Emphasis added). Modify is defined in *The American Heritage Dictionary of the English Language, New College Edition*, supra, p. 806 as "To change in form or character; alter." Modify doesn't mean eliminate something entirely so you don't recognize it anymore. Here, the County eliminated an entire group of providers (i.e., pharmacies) from its list of providers who are reimbursed at the in-network level. The County did this despite the inclusion of a "Benefit design" in Article 13, Section A which included both preferred provider services and services outside of the network. At the time the parties entered into their collective bargaining agreement this "Benefit design" included the benefit of pharmaceutical services reimbursed at the in-network level. Unlike "RAPER" providers (radiology, anesthesiology, pathology and emergency room physicians) which have not been preferred providers "for many years," pharmaceutical services have been provided as a benefit at the in-network level at all times material herein prior to the instant dispute. In DOOR COUNTY, contract language that prohibited a change in coverage required an employer to maintain all health insurance benefits. Applying that standard herein, the County is required to maintain all health insurance benefits at the time the parties' collective bargaining agreement was entered into including a "Benefit design" which included prescription drug reimbursement at the in-network level.

The County believes that the term "benefit" is more restrictive than the term "coverage." In the present case, Article 13, Section B requires that the "insurance coverage shall not be changed." If the County violates the contract applying the standard set forth in DOOR COUNTY, it certainly commits a violation under the broader standard contained in the instant agreement.

The County also asks the Arbitrator to consider what it calls "economic realities" in support of its argument that this grievance should be denied. In particular, the County argues that if the instant grievance is successful, every pharmacy in Manitowoc County could quadruple their prices for prescription drugs, and the County would have to absorb that additional cost. However, there is no persuasive record evidence to support a finding that Manitowoc County pharmacies would fix prices in the manner suggested by the County and force the County to absorb any more costs than the County was absorbing prior to April 2, 2001. Nor is there any persuasive evidence that indicates market forces will no longer be "available to keep those prices down, because those pharmacies would know that Blue Cross & Blue Shield, and Manitowoc County, were powerless to negotiate a better deal." In addition, there is no persuasive evidence that BCBSUW would be unable, if it chose, to contract with WPPN as it once did to provide pharmaceutical services at the in network level. Finally, if the County stopped its opposition to BCBSUW processing pharmacy claims at the in-network level despite a lack of discounts (Tr. pp. 103-104), BCBSUW might be free to again implement a business decision to provide pharmaceutical services at the 100% reimbursement level independent of any business decision to contract with WPPN.

The County further indicates that economic realities should result in the parties modifying their current agreement and bargaining a drug card. The Arbitrator agrees with the County's position that this issue is better resolved at the bargaining table. Article 13, Section B certainly recognizes the importance of the bargaining process as it provides that "insurance coverage shall not be changed without the mutual written consent of the parties. . . ." (Emphasis added). Unfortunately, the County did not explain on the record why it made the disputed change in insurance coverage without first negotiating this change with the Association. As pointed out by the Association, changes to the agreement are "more likely to happen if the County lives up to its obligations under the existing Collective Bargaining Agreement."

As pointed out by the Association, some arbitrators have interpreted the term "coverage" more narrowly than Arbitrators Burns, Rice and Shaw. In CRAWFORD COUNTY, CASE 56, NO. 45781, MA-6748, CASE 57, NO. 45782, MA-6749, CASE 58, NO. 45783, MA-6570 (Davis, 11/91), Arbitrator Peter Davis concluded that the term "coverage" is more restrictive than the term "benefits" in its scope. The contractual provision in question provided that the employer had "the right to change insurance carriers for the plan, provided that coverage is substantially equal or greater than the previous plan." Utilizing a more restrictive definition of the term "coverage," Arbitrator Davis rejected the claim by three AFSCME locals that among other changes a restriction on physician choice was a change in coverage. In that decision Arbitrator Davis did not address the issue at hand here (i.e., whether a change in the reimbursement level for pharmaceutical services constitutes a change in coverage); but he did indicate that a change that results in substantially higher costs would be a change in coverage. CRAWFORD COUNTY, SUPRA, p. 5. Thus, the Association submits that even under the more restrictive definition of "coverage" found in CRAWFORD COUNTY it is clear that a change that results in a higher payment level for covered services is a change in coverage. The Arbitrator agrees.

As noted above, Arbitrator Davis in CRAWFORD COUNTY interpreted the term "coverage" more narrowly than the term "benefits" to mean "the risks and procedures covered by the insurance plan or policy." SUPRA, p. 4. He arrived at this definition based on the term's "commonly accepted meaning." As pointed out by the County, in the instant case Association representative Tom Bahr testified that in the about eleven years that he has been doing this job "more often than not, the level of benefits has been synonymous with coverage." (Tr. p. 114). On the other hand, County Personnel Director Sharon Cornils "testified that she does not believe it to be so." (Tr. pp. 92-93). Obviously, the parties herein do not have a "commonly accepted meaning" of the term "coverage."

In reaching the above conclusions, Arbitrator Davis cited with approval Arbitrator Dan Nielsen: "Like Arbitrator Nielsen in his Beaver Dam Schools award, 2/ I conclude that "coverage" is more restrictive than "benefits" in its scope. CRAWFORD COUNTY, SUPRA, 4. In footnote 2, Arbitrator Davis stated that Arbitrator Nielsen held in BEAVER DAM:

. . . Use of the term ‘coverages’ rather than the broader terms ‘benefits’ or ‘plans’ indicates a comparison of the indemnification for specific risks and procedures under the two plans, . . . “

Id.

In BEAVER DAM UNIFIED SCHOOL DISTRICT, CASE 19, NO. 45546, MA-6639 (Nielsen, 5/91), Arbitrator Dan Nielsen found that equivalency of “coverage” between the WPS plan and the Trust plan existed in all areas of comparison except two. BEAVER DAM, SUPRA, p. 12. In reaching this conclusion, he defined “coverage” as follows:

Use of the term “coverage” rather than the broader terms “benefits” or “plans” indicates a comparison of the indemnification for specific risks and procedures under the two plans, and a decision whether employees are exposed to more than a minute increase in specific risks by reason of the change.

BEAVER DAM, SUPRA, p. 6.

Like Arbitrator Davis, he also talked about higher costs impacting “coverage” for employees:

The amount of financial exposure of the employee must be weighed. Even if a risk is very unlikely to ever be realized, a coverage which exposes employees to significant costs or even financial ruin once the risk is realized cannot be said to be a minute change.

Id. He found the differences in cost of drug prescriptions between the two plans as minute. BEAVER DAM, SUPRA, p. 11.

If the Arbitrator applied the more narrow definition of the term “coverage” found in BEAVER DAM to the facts present in the instant dispute, the Arbitrator would still find a contract violation. As noted above, the parties stipulated that a certain class of employees would pay more for prescription drugs in 2001, as a result of the change effective April 1, 2001. In other words, these employees now have to pay 20 percent co-payment on prescription drugs where before the employer paid 100% of the reimbursement. On its face, there are significant addition costs to a certain group of employees. As such, the County violated the Article 13, Section B mandate not to change health insurance “coverage.”

In sum, whether you apply the more narrow definition of the term “coverage” found in CRAWFORD COUNTY and BEAVER DAM, or the broader definition found in the three cases cited by the Association, the record supports a finding that the County violated the agreement. The parties stipulated that some employees will pay more for prescription drugs in 2001 as a result of the action taken by BCBSUW effective April 1, 2001. Specifically, a class of employees will pay a 20% co-payment for prescription drugs under certain circumstances where in the past the County reimbursed these costs at 100%. On its face, the Arbitrator is of the opinion that this change has a significant, adverse impact on these employees.

There is an additional basis for finding a contractual violation herein. Unlike CRAWFORD COUNTY and BEAVER DAM, the disputed contract provision in the present case prohibits any change in coverage unless it is an improvement. (Emphasis added). It is undisputed that the County’s change in the reimbursement level for prescription drugs is not an improvement. (Emphasis added).

Both parties argue that their meaning of the term “coverage” is consistent with industry use of that term and the BCBSUW definition of “coverage.”

In this regard, the County argues that while “Article XIII purports to define what employees get in the area of insurance” it makes sense that the parties would use a term in that article that are consistent with, and interpreted in the same manner as those terms in that industry. The County claims that the terms of the insurance contract between the County and BCBSUW clearly define what the word “coverage” means. The County admits that the Union did not sign the insurance contract. However, the County contends that “the Union cannot purport to negotiate contract language governing insurance benefits, and then choose to ignore” the clear language of the insurance contract “which provides the benefits they purport to be defining.”

However, the Comprehensive Health Care Co-Pay Preferred Provider Group Contract does not provide any definition of the term “coverage.” (Employer Exhibit No. 6). It does define the term “Covered Service” as a “service or supply set forth in this Contract for which We provide benefits.” (Employer Exhibit No. 6, p. 6).

County Personnel Director Sharon Cornils defined “coverage” as “a service that has benefits – it’s a service which is eligible for processing under our health insurance plan.” This is consistent with the definition of the term “Covered Service” contained in the aforesaid plan and noted above. “Covered Services” are described in the plan beginning at page 19. (Employer Exhibit No. 6). There is no persuasive evidence in the record, however, that the parties defined the term “coverage” contained in Article 13, Section B of the agreement to mean the same as “Covered Service” which is defined in the health insurance contract.

As indicated above, “coverage” within the meaning of Article 13, Section B refers to the amalgam of particular protections including protection against a unilateral reduction in the payment level for a covered service like prescription drugs. Both parties recognize that pharmaceutical services are covered services. Thus, as pointed out by the Association, this dispute does not present the issue of whether pharmaceutical services are covered services. The issue herein is whether the County changed coverage when it changed the payment level for pharmaceutical services. For all the reasons stated above, the Arbitrator finds that the County did change the coverage.

The County claims that every effort was made to maintain pharmacies on its PPO list but that was impossible because pharmacies have jointed that “elite group” of people who do not have to negotiate discounted rates for their services. However, the record contains no persuasive evidence in support of this claim. To the contrary, BCBSUW Account Executive Sandra Reblin testified, in response to a question as to why didn’t BCBSUW go out and contract with pharmacies so that they would be part of the BCBSUW network: “We don’t have direct contracts with pharmacies for PPO benefits.” (Tr. p. 53).

The County also suggests that it had nothing to do with the change in coverage. However, that is not true. The County was involved in the decision to discontinue the processing of prescription drug claims as in-network effective April 1, 2001. (Tr. pp. 56-57, 103). There was a very good reason for this involvement. At the same time that some employees would be paying more for prescription drugs, the County was concerned about future higher costs for health insurance coverage that it would have to pay. (Tr. p. 73).

Finally, the County argues that if the Arbitrator finds for the Association he would be violating the Grievance Arbitration clause, paragraph (f) which prohibits the arbitrator from modifying, adding to, or deleting from the terms of the agreement. However, there is nothing in the agreement which restricts the Arbitrator’s authority to interpret contract language based on the entire record and using past practice, arbitral precedent and the other criteria as argued by the parties so long as the Arbitrator does not modify, add to, or delete from the terms of the agreement. The parties presented the disputed issue to the Arbitrator for decision. Therefore, the Arbitrator does not violate the aforesaid contractual provision or exceed his authority by deciding whether the County violated Article 13, Section B by its actions based on the foregoing criteria.

Based on all of the foregoing, and the record as a whole, the Arbitrator finds that the answer to the issue as framed by the undersigned is YES, the County violated the parties’ collective bargaining agreement when BCBSUW eliminated the preferred provider network for pharmaceutical services effective April 1, 2001, and began processing prescriptions at the out-of-network reimbursement level.

In reaching the above conclusion, the Arbitrator has addressed the major arguments of the parties. All other arguments, although not specifically discussed above, have been considered in reaching the Arbitrator's decision.

A question remains as to the appropriate remedy.

The parties stipulated at hearing that "there is a class of employees in the County that will pay more for prescription drugs in 2001 as a result of this change than they otherwise would have." (Tr. p. 13).

For a remedy, the Association requests that the Arbitrator sustain the grievance and order the following relief:

. . . an order directing the County to reimburse all bargaining unit employees who paid co-payments for prescription drugs that they would not have paid if BCBSUW had continued to process prescription drug purchases after April 1, 2001 as purchases of in-network services.

The County makes no persuasive arguments against the above remedy.

Therefore, the Arbitrator will grant the remedy requested by the Association.

Based on all of the above and the record as a whole, it is my

AWARD

That the grievance is sustained and the County is ordered to reimburse all bargaining unit employees who paid co-payments for prescription drugs that they would not have paid if BCBSUW had continued to process prescription drug purchases after April 1, 2001 as purchases of in-network services.

The Arbitrator will retain jurisdiction over the application of the remedy portion of the Award for at least ninety (90) days to address any issues over remedy that the parties are unable to resolve.

Dated at Madison, Wisconsin, this 23rd day of January, 2002.

Dennis P. McGilligan /s/
Dennis P. McGilligan, Arbitrator

