BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

VILLAGE OF EAST TROY PROFESSIONAL POLICE ASSOCIATION, LAW LOCAL NO. 310

and

VILLAGE OF EAST TROY

Case 51
No. 59783
MA-11407

In the Matter of the Arbitration of a Dispute Between

VILLAGE OF EAST TROY CLERCIAL EMPLOYEES, LAW LOCAL 815 and VILLAGE OF EAST TROY DEPARTMENT OF PUBLIC WORKS EMPLOYEES, LAW LOCAL 719

and

VILLAGE OF EAST TROY

Case 52
No. 59784
MA-11408

Appearances:

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

Gray, Hudec and Oleniczak, S.C., Attorneys at Law, 2847C Buell Drive, P.O. Box 287, East Troy, Wisconsin 53120, by **Ms. Linda L. Gray**, appearing on behalf of the Village.

ARBITRATION AWARD

The Labor Association of Wisconsin (LAW), hereafter Association, represents Village of East Troy Professional Police Association, Local No. 310; Village of East Troy Clerical Employees, Local 815; and Village of East Troy Department of Public Works Employees, Local 719. Each of these collective bargaining units is covered by a collective bargaining agreement that provides for final and binding grievance arbitration. The Association, with the concurrence of the Village, requested the Wisconsin Employment Relations Commission to appoint a staff member as impartial arbitrator to decide two grievances involving insurance coverage. The Commission appointed Coleen A. Burns. Pursuant to an agreement of the parties, the two grievances were consolidated for purposes of hearing and decision. Hearing in the matter was held on July 19, 2001 in East Troy, Wisconsin. The hearing was not transcribed. The record was closed on October 26, 2001. On November 19, 2001, this matter was held in abeyance pending settlement discussions between the parties. On December 13, 2001, the parties advised the arbitrator that they required a decision on these grievances.

ISSUES

The parties have stipulated to the following statement of the issues:

> Does the Village of East Troy's current health insurance plan comply with Article 23(1) of the collective bargaining agreement with the East Troy Clerical Employees which requires the Village to provide insurance which has "comparable benefits to the current level of the health and dental benefits"?
>
> Does the Village of East Troy's current health insurance plan comply with Article 27(1) of the collective bargaining agreement with the East Troy Department of Public Works which requires the Village to provide insurance which has "comparable benefits to the current level of the health and dental benefits"?
>
> Does the Village of East Troy's current health insurance plan comply with Article XX, Section 20.01, of the collective bargaining agreement with the East Troy Professional Police Association which requires the Village to "continue in effect at Employer's cost the medical insurance plan in effect on December 31, 1991, or its equivalent...?"
>
> If not, what is the appropriate remedy?

RELEVANT CONTRACT LANGUAGE

The Police contract contains the following:

ARTICLE XX – HEALTH AND WELFARE

SECTION 20.01. Subject to further agreement of the parties, the Employer will continue in effect at Employer's cost the medical insurance plan in effect on December 31, 1991, or its equivalent, with the employee responsible for an annual Two Hundred ($200.00 Dollar per person, Six Hundred ($600.00) Dollar per family front-end deductible, a prescription drug co-payment of Five ($5.00) Dollars for generic prescriptions and Ten ($10.00) Dollars for non-generic prescriptions, and pre-certification as required by the insurance carrier, provided, however, that the Employer has the right to change carriers or administrators as long as the benefits are comparable. The present premiums for the coverage will be paid for by the Employer. The coverage shall be available for each Employee covered by this Agreement who has been an Employee for thirty (30) days or more.

. . .

The DPW contract contains the following:

ARTICLE 27 – HEALTH AND WELFARE

Section 1. Village will select the Health and Welfare provider with comparable benefits to the current level of benefits at no cost to the employees. Effective 1/1/95 Employees will be responsible for the first $200.00 per person, $600.00 per family deductible portion of the health insurance plan. The employee's will participate in a 5/10 co-pay drug plan.

. . .

The Clerical contract contains the following:

ARTICLE 23 – HEALTH AND WELFARE

1. The Employer will select the Health and Welfare provider with comparable benefits to the current level of health and dental benefits. The Employer will pay the full cost of the health plan. The Employer will pay the full cost of the dental plan for full-time employees. Effective on the first day of the second month following the date of the Arbitrator's award relating to the 1991-1993 Agreement, the Employer will pay the full cost of the health plan for full-time employees. Effective January 1, 1995, employees will be responsible for the first two hundred ($200.00) dollars per person or six hundred ($600.00) dollars per family deductible portion of the health insurance plan. The Employees will participate in the 5/10 co-pay drug plan.

. . .

RELEVANT BACKGROUND

Prior to January 1, 2001, the Village provided its employees with a self-funded health plan, hereinafter referred to as the "self-funded plan", with claim services provided through a third party claim administrator, H.E.P. Administrators, Inc. In November, 2000, the Village notified members of the Police, Clerical and DPW bargaining units that it was considering changing from the self-funded plan to a plan offered through Starmark. Thereafter, the Association commissioned TOMAR Company to perform a health plan analysis comparing the Village's self-funded plan to the proposed Starmark plan.

This analysis was forwarded to Association Representative Naylor in a letter dated December 6, 2000, which states as follows:

TO: Kevin Naylor, Labor Association of Wisconsin

FROM: Martin Tomcek

RE: Village of East Troy Health Insurance Plan

Currently, the Village has a self-insured plan with a Preferred Provider benefit design. The In-Network benefits are covered at 90%, with the Out-of-Network benefits covered at 80%. The maximum calendar year out of pocket cost, for covered expenses, are as follows: Individual - $200; Family - $600. The one exception to the out of pocket limit is the co-pay for prescription drugs. The

plan has a separate prescription drug benefit. There is a $5 co-pay for generic drugs; $10 co-pay for brand name drugs. These co-pays do not apply to the out of pocket limit.

The Village is considering implementing a high deductible benefit design and combining it with a Medical Savings Account (MSA) for each participating employee. This plan would have a $1550 calendar year deductible per single subscriber and a $3100 calendar year deductible per family subscriber. The Village would fund 65% of the single deductible and deposit the money into an MSA. This amounts to $1007.50 per calendar year. The Village would fund 75% of the family deductible and deposit the money into an MSA. This amounts to $2325.00 per calendar year. The participants may use the MSA for expenses subject to the deductible and eligible expenses that may not be covered by the insurance policy and therefore not applied to the deductible. The Village intends to limit a single subscriber's calendar year out of pocket limit to the current limit of $200, and a family subscriber's calendar year out of pocket limit to the current limit of $600. However, this $200 and $600 out of pocket limit would only apply to eligible expenses under the insurance policy, not all the qualified expenses defined under the MSA. In addition, the new policy excludes certain expenses which are covered under the current policy.

The following outline lists the major differences between the current policy and the proposed policy covered benefits:

. . .

	Current Plan	Proposed Plan
Maximum Lifetime Benefit	$2,000,000	$5,000,000 In and Out Network Combined $2,000,000Out of Network only

Prescription Drugs:	$5 co-pay generic $10 co-pay Brand name Co-pays don't apply to out of pocket limit. (Participant pays co-pay at pharmacy and is not responsible for any submission for reimbursement	Applied toward deductible; Eligible for reimbursement from MSA. Out of pocket maximum limit applies to drugs. (Participant must first pay for prescription and submit for reimbursement
Routine Physicals: (Includes well baby care; immunizations)	Covered IN-Network to a maximum benefit of $300 per participant.	Not a covered benefit under the insurance contract. Eligible MSA expense.
Oral Surgery:	14 procedures covered	Not covered benefit under the insurance contract. Eligible MSA expense.
Oral Contraceptives:	Covered expense	Not covered benefit under the insurance contract. Eligible MSA expense.
Hospice Care:	Covered up to 6 months per lifetime	Covered up to 60 days under the insurance contract. Eligible MSA expense.

Unused funds in an individual's MSA are rolled over to the next year. If funds are withdrawn prior to age 65 for items other than qualified medical expenses, the individual pays a 15% penalty plus the applicable income tax on the funds withdrawn. If an individual becomes totally disabled before age 65, he/she may withdraw the funds without being subject to the 15% penalty. An individual may also withdraw the funds in the MSA at age 65 without being subject to the 15% penalty. The applicable income taxes would apply in both examples, if the withdrawn funds are not used for qualified medical expenses.

In a letter of the same date, Tomcek states as follows:

TO: Kevin Naylor, Labor Association of Wisconsin

FROM: Martin Tomcek

RE: Village of East Troy Health Insurance Plan

If the Village implements the MSA benefit plan, the participants will encounter more involvement with administration of their own individual coverage (i.e. Submission of expenses, already paid for by the participant, for reimbursement). In addition, a participant may have expenses, that are eligible for reimbursement under the MSA, but are not covered expenses under the insurance contract. This would result in a higher out of pocket cost for a participant. Therefore, what is excluded under the insurance contract, but a qualified benefit under the MSA, may confuse a participant. On the other hand, if a participant doesn't utilize much of their MSA, they can accumulate additional funds to help supplement their retirement plan.

Kevin, if you have any questions, or need any additional information, please call my office.

Sincerely,

Martin H. Tomcek /s/
Martin H. Tomcek

On or about December 8, 2000, Association Representative Naylor sent a letter to Village Administrator Witt, which states as follows:

As you know the Labor Association of Wisconsin, Inc. hired Martin Tomcek of the Tomar Company to do an analysis of the Village's currant (sic) health plan and the proposed MSA benefit plan.

I have enclosed a copy of the comparison for your review. I believe that the study demonstrates that the MSA plan is not comparable in several areas.

Please contact the undersigned with your thoughts on this matter.

By letter dated December 27, 2000, Village Administrator issued the following letter to Association Representative Naylor:

RE: Grievance 2000-62

> The union contracts require the health insurance benefits to be comparable to the current level of benefits. The Village argues that (1) the health insurance benefits are to be comparable and not identical. Some changes to various benefit levels may go up or down slightly, but be offsetting.
>
> The Village also argues that (2) the level of benefits is a negotiable item and that benefit levels cannot increase without being negotiated. Because a Village insurance policy required certain benefits different than the previous policy does not entitle the employees to the extra benefits unless they are negotiated into the contract. The benefit levels listed as current in the contract refer to the benefit levels at the time the health insurance was last negotiated in 1991.
>
> The Village denies this grievance. Please contact me within 10 working days to schedule a meeting to discuss this further per the grievance procedure. I am available January 10th and 11th.

Effective January 1, 2001, the Village implemented the Starmark plan.

On or about January 1, 2001, the Association filed a written grievance on behalf of the DPW and Clerical units and a written grievance on behalf of the Police unit, alleging that, by implementing the Starmark plan on January 1, 2001, the Village violated the collective bargaining agreement of each of these units. With respect to the DPW and Clerical units, the Association asserted that the violation of the collective bargaining agreement arose from the fact that the insurance benefits provided within the Starmark plan were not comparable to the benefits provided in the HEP-PPO plan that was in effect in 2000. With respect to the Police unit, the Association asserted that the violation of the collective bargaining agreement arose from the fact that the insurance benefits provided within the Starmark plan were not equivalent to the benefits provided in the medical insurance plan that was in effect on December 31, 1991. The grievances were denied at all steps, and thereafter submitted to arbitration.

On May 31, 2001, Mr. Tomcek issued a letter to Association Representative Naylor that states as follows:

RE: Village of East Troy Health Insurance Plan – Analysis of prior Wisconsin Physicians Service Plan (WPS), Group #27695.0, effective July 1, 1992 and the current MSA plan underwritten by Starmark. The information (documents) was provided to me by Ken Witt, Village Administrator. I contacted WPS for clarification on the information I received from the Village. WPS gave me the Group #, and effective date. Wps would not disclose any further information or answer any of my questions, leaving certain questions on the WPS plan still unanswered. Those questions are as follows:

1) Limit on Transplant procedures; Section 15 – See #3 below
*2) Co-pays for prescriptions;
*3) There may be a second page to the schedule of benefits, because the plan information references Section 16 (Schedule of Benefits) however, the information I received only goes as far as Section 14 on one page.

The prior WPS plan was a traditional major medical plan, with a calendar year deductible of $500 per individual; $1,500 per family. After the calendar year deductible was satisfied, the plan paid 100% of covered expenses for the remainder of the calendar year. The covered participants could utilize the services of any qualified provider. It was not a PPO or Hmo or POS type of plan. There are no co-pays for prescription drugs (See questions unanswered above); physician office visits; emergency room visits, etc. The plan had a lifetime maximum benefit per individual of $1,000,000. This traditional fee for service major medical plan paid claims on a usual/customary/reasonable basis (UCR). A participant could receive a balance billing from a provider of service, if the original billing exceeded the UCR parameters, as determined by WPS.

Effective January 1, 2001, the Village implemented a high deductible benefit plan and combining it with a Medical Savings Account (MSA) for each participating employee.

This plan has a $1,600 calendar year deductible per single subscriber and a $3,200 calendar year deductible per family subscriber. The Village contributes $1,400 to a single subscriber's MSA account, and the Village contributes $2,600 to a family subscriber's MSA account. This results in a out-of-pocket maximum, for covered expenses under the insurance contract, of $200 per calendar year per single subscriber; $600 per calendar year per family subscriber.

NOTE: The key words in the out-of-pocket maximum are: **Covered expenses under the insurance contract.** If a participant applies money in their MSA account toward an eligible expense under the rules for MSA's, but not an eligible expense under the insurance contract, that amount would not apply toward the insurance company deductible and therefore would not apply to the subscriber's maximum out-of-pocket. This was confirmed by Ken Witt, Village Administrator.

The following outline lists the major differences between the MSA plan and the WPS plan effective July 1, 1992.

	Current Plan	WPS Plan
Maximum Lifetime Benefit:	$5,000,000 In and Out of Network Combined $2,000,000 Out of Network only.	$1,000,000
PPO level of benefits:	After the deductible The plan pays 100% In Network; 90% Out of Network to $5,500 of covered expenses. The village pays the 10% co-insurance for out of network expenses. No balance billing liability In network; possible balance billing Out of network – based on UCR parameters.	Fee for service plan. 100% of UCR after the deductible. (Any provider Possible balance billing liability.

Out of Pocket Maximum: (Based on covered expenses as defined in the insurance contract)	$200 single subscriber $600 family subscriber	$500 per individual $1500 per family **Note**: $500 maximum per individual in family.
Routine Examinations:	Covered expense	Not covered
Oral Surgery:	Not covered under the insurance contract. Eligible MSA expense	13 oral surgical procedures are covered.
Home Health Care	40 visits per cal/year.	100 visits per cal/year.
Approved Transplants:	Designated facility - Center of excellence: Heart Kidney Bone Marrow	Bone Marrow Corneal Heart Heart/Lung Liver Lung Pancreas
	Non-designated facility: Heart Kidney Bone Marrow Liver	**Note:** May have limitation on procedures; section 15 in the schedule of benefits was not included in plan information.
Transplant Lifetime Benefit Maximum:	Designated facility – Same as any other benefit	No separate limit indicated, however section 15 may reference a limit but was not included in plan info.
	Non-designated facility – Heart: $180,000 Bone Marrow: $170,000 Liver: $210,000	

Note: Kidney has a contract Limit of $70,000, however, Wisconsin mandate requires a Annual minimum Kidney benefit of $30,000.

Kevin, if you have any questions, or need any additional information, please call my office.

POSITIONS OF THE PARTIES

Association

Martin H. Tomcek of the TOMAR Company performed a benefit analysis of the relevant health plans. This analysis demonstrates that the Starmark plan is not comparable to the 2000 self-funded plan or equivalent to the plan that was in effect in 1991.

Mr. Tomcek reduced the significant differences between the Starmark plan and the self-funded plan to writing and this information was shared with Village Administrator Kenneth L. Witt. Without further discussion with the Association's representative, the Village unilaterally implemented the Starmark plan.

Mr. Tomcek's comparisons address only benefit levels that have either increased or decreased through the Starmark plan. If a benefit level was unchanged, it was not discussed in Mr. Tomcek's analysis. For example, Union Exhibit 5, which is a comparison of the Starmark plan and the 1991 plan, indicates that home health care visits were reduced from 100 to 40 visits per year. However, Union Exhibit 1, which is a comparison of the Starmark plan and the self-funded plan, does not contain any reference to home health care visits. This failure to reference would indicate that the number of home health care visits under the self-funded plan is identical to the number of home health care visits provided by the Starmark plan.

Prior to the implementation of the Starmark plan, employees were contractually required to pay annual front-end deductibles of $200 per single plan, and $600 per family plan. An individual participant in a family plan was considered to have met his or her front-end deductible after paying the first $200. Under Starmark, a single family member could incur the entire $600 deductible. This difference in the administration of family plan deductibles exposes the employee to an additional $400 per year in out-of-pocket costs. Clearly, the administration of the family plan deductible found in the Starmark plan is not comparable or equivalent to the previous plan. Accordingly, the Association requests that the arbitrator order

the Village to reimburse individuals for all deductibles that exceed the amount they would have paid under the previous plans.

Both Union Exhibit 1 and Village Exhibit 1 indicate that Starmark's plan currently provides participants with up to two (2) months of hospice care. The self-funded plan provided up to six (6) months of hospice care. Therefore, the DPW and clerical employees have suffered a significant reduction in the number of months that are available for hospice care. This reduction in benefit not only exposes the membership to severe financial hardships, but also exposes the individual to increased emotional hardship at a time when an individual would be least able to cope with such hardship. The Association requests the Arbitrator to order the Village to "stand in the shoes of the carrier" and provide employees covered by the DPW and clerical agreements with an additional four (4) months of hospice care.

Union Exhibit 5 indicates that the Starmark plan provides participants with a maximum of forty (40) home health care visits per calendar year. This amount is identical to the number of annual health care visits provided by the Village's self-funded plan. However, the 1991 WPS plan provided participants with up to one hundred (100) home health care visits per calendar year. The fact that an individual could require home health care visits for many years, coupled with the fact that the home health care visits benefit regenerates on an annual basis, makes this reduction in home health care all the more significant. The Association requests the Arbitrator to order the Village to "stand in the shoes of the carrier" and provide employees covered by the Police agreement with an additional sixty (60) home health care visits per year.

Both Village Exhibit 1 and Association Exhibit 1 indicate that the Starmark plan has eliminated the oral contraceptive benefits previously made available under the Village's self-funded plan. The Association asks the Arbitrator to order the Village to "stand in the shoes of the carrier" and provide its employees covered by the DPW and Clerical agreements with the oral contraceptive benefit that had been provided in the 2000 self-funded plan.

The Village's self-funded plan covered fourteen (14) oral surgical procedures and the WPS 1991 plan covered thirteen (13) oral surgical procedures. The Starmark plan fails to cover any oral surgical procedures. The fact that the Village provides employees with dental coverage through a separate provision in the Agreement does not alter the fact that there has been a significant reduction in employee benefits. The issue before the Arbitrator is to interpret the level of benefits offered through health plans.

The dental benefits offered through the Village's dental plan are limited to a maximum of one thousand dollars ($1,000.00) annually. However, calendar year limits on the oral surgical procedures described in the 1991 WPS plan and the self-funded plan are non-existent. Therefore, employees who incur more than one thousand dollars ($1,000.00) in oral surgical procedures must now pay the difference with their own money.

The Village's dental plan was negotiated and codified in the labor agreement as an additional benefit to the health plan and was not meant to be a surrogate for the oral surgical procedures defined in the self-funded and the 1991 WPS health plans. The Association respectfully requests the Arbitrator to order the Village to "stand in the shoes of the carrier" and to reimburse its employees for the costs of any oral surgical procedures they incur which would have been covered by the previous plans.

The lifetime maximum under the 1991 plan was one million dollars ($1,000,000.00) per participant. The lifetime maximum under the self-funded plan was two million dollars ($2,000,000.00) per participant. The lifetime maximum under the Starmark plan is five million dollars ($5,000,000.00) per participant. While this may seem like a significant improvement, it is very unlikely that an individual would need more than one million dollars ($1,000,000.00).

The Association's membership has determined that the benefits of an additional lifetime maximum did not make up for the overall reduction in benefit levels such as discussed above. Moreover, it is the Village's position that the increase in lifetime benefits is not a guaranteed benefit. Mr. Witt's response to Grievance 2062 clearly indicates that the Village does not believe that it is bound to provide a five million dollar ($5,000,000.00) lifetime benefit and that it has a right to unilaterally reduce this benefit in the future.

Even more significant than the reduction in the benefit levels discussed above is the increased burden placed upon employees in the administration and processing of claims under the Starmark plan. As the testimony of Association witnesses demonstrates, they are unsure of their rights and responsibilities under the Starmark plan; they were not informed of the additional record keeping responsibilities imposed upon them by the IRS as a result of their participation in an MSA account, or their inability to file tax forms 1040-EZ or 1040-A; and they have found that paying medical bills under the Starmark plan is more cumbersome. These employees fully expect to deplete their MSA accounts and do not view the Starmark plan as a viable enhancement to their retirement. Mr. Tomcek testified that, for the very reasons listed above, he would not recommend any health plan that contained MSA accounts.

Officer Ziementz was required, on his own time and at his own expense, to drive to a Racine hospital, approximately 35 miles from his home, to pay a bill in person because the facility would not accept his Starmark card over the phone, which task would not have been necessary under the previous plan. Mr. Joyce testified that he has outstanding bills dating back to January, 2001 that have yet to be paid by Starmark, while he had no such problems under the previous plan.

As these witnesses testified, the administrator of the Starmark plan charges a monthly fee for maintaining an MSA account and participants are required to pay a processing fee of two dollars each time they make a withdrawal from their MSA account. In addition to the above charges, participants are forced to pay an additional fee of one dollar after they have depleted their MSA accounts. At the presentation to the Village's employees that was given by the Starmark representative, these charges were not discussed.

Employees who are covered under a spouse's plan are not allowed to participate in an MSA plan. The Starmark representative at the presentation given to Village employees did not discuss these requirements and limitations.

Obtaining prescription drugs is more time-consuming and difficult under the Starmark plan. Previously, a participant would pay either a five-dollar ($5.00) or ten-dollar ($10.00) co-pay at the pharmacy and the insurance company would handle the remainder of the cost. Under Starmark, the participant must use a debit card issued through Starmark, and the money is then subtracted from the participant's MSA account.

The Village correctly argues that it has a right to change health insurance providers without the consent of the Association. However, the collective bargaining agreements contain provisions that require the Village to meet certain standards of coverage. In the instant case, the Village made the conscious and deliberate decision to change plans without providing the Association with an opportunity to negotiate or discuss alternative solutions.

The Village violated its contractual obligation to provide comparable coverage to the DPW and Clerical employees when it made the unilateral decision to contract with the providers of the Starmark plan. The Village violated its contractual obligation to provide equivalent coverage to the Police employees when it made the unilateral decision to contract with the providers of the Starmark plan. The Arbitrator should uphold the grievances and award a remedy that would require the Village to reimburse the Association's memberships for any increased costs incurred as a result of the Village's unilateral decision to obtain insurance coverage through Starmark.

Village

For the years 1999 and 2000, the Village provided coverage through a self-insured plan administered through HEP/PPO. For the year 1997, the Village provided coverage through WPS/PPO. No grievances were filed when the Village switched from the WPS plan to the self-funded plan in 1999.

For the year 2001, the Village received quotes from various carriers for insurance plans with comparable benefits to the employees. The employees and their bargaining representatives were provided with copies of possible plans being considered by the Village. Among those plans was the medical savings plan through Starmark.

The Starmark plan provided health benefits which were comparable to those benefits provided by the plan in existence in 1997 when the current collective bargaining agreements were entered into by the clerical and DPW employees. With respect to the police unit, the Village takes the position that the Starmark plan provides health benefits that were equivalent to those benefits provided for as of December 31, 1991. Accordingly, effective as of January 1, 2001, the Village exercised its management right to manage its affairs efficiently and economically and switched insurance carriers from a self-funded plan to the Starmark plan with a medical savings plan.

Article 10(G) of the Clerical and DPW agreements designates the authority of the arbitrator. Article 9.02(E) of the Police agreement also designates the authority of the arbitrator. The arbitrator's decision must draw its essence from the collective bargaining agreement. The arbitrator does not have power to change, modify, nullify, ignore or add to the provisions of the Agreement.

Contract language that is clear must be given its plain meaning. Under each provision of the relevant collective bargaining agreements, the Village has the ability and right to change insurance carriers provided the benefits are comparable, as it relates to clerical and DPW employees, and equivalent to the benefits provided as of December 31, 1991, as it relates to the police officers.

Given the clear contract language, when defining the words "comparable" and "equivalent," the Arbitrator must use the plain meaning of those words. The plain meaning of those words is not identical, but rather, is similar in kind, quality, quantity or degree. If the Association wished benefits to remain the same, it should have used words such as "same" or "identical".

Health benefits provided to the Clerical and Department of Public Works employees are comparable to those benefits provided in 1997. In comparing the plan in effect in 1997 to the 2001 Starmark plan, the actual benefits were greater than those provided in 1997. The only difference is in the actual administration of the plan. A medical savings plan has been established for each employee, which can be used for non-covered medical expenses. The actual deductible or out-of-pocket cost to the employees was $200 for the single and $600 for the family plan, with the medical savings plan available for non-covered expenses.

There was no testimony that out-of-pocket costs were more than the $200/$600 deductible. Therefore, it is the position of the Village that the Starmark plan provides benefits to the DPW and Clerical bargaining unit employees that are comparable, if not better, than those provided in 1997 as well as those provided in 2000.

The language in the police collective bargaining agreement requires benefits provided to the employees covered by the Agreement be equivalent to those benefits provided as of December 31, 1991 and provides the Village with the right to "change carriers or administrators as long as the benefits are comparable." The Village's analysis reveals that the Starmark plan provides benefits that are substantially greater than those provided as of December 31, 1991. This was undisputed by the Association.

There was no testimony by any bargaining unit employee that the out-of-pocket costs were greater than $200 for single coverage and $600 for family. The Starmark plan provided benefits to the police bargaining unit employees that were comparable if not better, than those provided in 1991 as well as those provided in 2000.

The Village has not violated the specific terms of the collective bargaining agreement; benefits are comparable. The two grievances should be denied and dismissed.

DISCUSSION

Police Contract

The parties agree that the Village has the right to change health insurance providers. The Association asserts that the Village is required to provide benefits that are "equivalent" to those provided to the Police unit on December 31, 1991. While the Village's position is less clear, it appears that the Village is arguing that the health insurance benefits provided by Starmark are "equivalent" to those provided to the Police unit on December 31, 1991, but that the Village is only required to provide benefits that are "comparable" to those provided on December 31, 1991.

In making these arguments, each party relies upon the language of Section 20.01 of their 1998-2000 collective bargaining agreement, which states as follows:

> **SECTION 20.01.** Subject to further agreement of the parties, the Employer will continue in effect at Employer's cost the medical insurance plan in effect on December 31, 1991, or its equivalent, with the employee responsible for an annual Two Hundred ($200.00 Dollar per person, Six Hundred ($600.00) Dollar per family front-end deductible, a prescription drug co-payment of Five ($5.00) Dollars for generic prescriptions and Ten ($10.00) Dollars for non-generic prescriptions, and pre-certification as required by the insurance carrier, provided, however, that the Employer has the right to change carriers or administrators as long as the benefits are comparable. The present premiums for the coverage will be paid for by the Employer. The coverage shall be available for each Employee covered by this Agreement who has been an Employee for thirty (30) days or more.

The above language requires the Village to continue the "medical insurance plan" that is in effect on December 31, 1991, or its "equivalent," unless the Village changes "carriers or administrators." If the Village changes "carriers or administrators," then the Village is required to provide "comparable" benefits.

The above language is not a model of clarity. Inasmuch as neither party offered any evidence with respect to the bargaining history of Section 20.01, the best evidence of the parties' intent at the time that they negotiated Section 20.01 is the plain language of this section.

The "medical insurance plan" in effect on December 31, 1991 was a WPS plan. The most reasonable construction of the plain language of Section 20.01 is that, as long as the Village continues with a WPS plan, then it must provide "the medical insurance plan in effect on December 31, 1991, or its equivalent." However, when the Village no longer provides a WPS plan, but rather, "changes carriers or administrators," then the Village has a duty to provide "benefits" that are "comparable." The question becomes, "comparable" to what?

Section 20.01 does not expressly state that the "benefits" provided by a change in "carriers or administrators" must be "comparable" to those provided by WPS on December 31, 1991. Moreover, the Village's right to provide an "equivalent" medical insurance plan, as well as the Village's right to change "carriers or administrators," demonstrates that Section 20.01 does not provide a static health insurance benefit.

Given the fact that the Article 20.01 health insurance benefit is subject to change, the most reasonable construction of the plain language of Section 20.01 is that, when the Village unilaterally changes "carriers or administrators," it is not required to provide "benefits" that are "equivalent" or "comparable" to those in effect on December 31, 1991. Rather, the Village is required to provide "benefits" that are "comparable" to those in effect at the time that the Village changes "carriers or administrators."

In summary, the Village unilaterally changed "carriers or administrators" when it implemented the Starmark plan on January 1, 2001. To comply with the provisions of Section 20.01, this change in "carriers or administrators" must result in the provision of "benefits" that are "comparable" to those benefits in effect at the time that the Village made the change to Starmark, i.e., those benefits provided in the 2000 HEP-PPO plan. Thus, the undersigned turns to a comparison of the benefits of the Starmark plan and the 2000 HEP-PPO plan.

The Association asserts that the exhibits prepared by its health care analyst, Mr. Tomcek, have addressed the benefits that have either increased or decreased under the Starmark plan and that, if a benefit has not been addressed, then that benefit has remained unchanged. With the exception of "Routine Examinations", which Mr. Tomcek corrected on the record by acknowledging that there was no material change in this benefit, the record does not demonstrate otherwise.

Relying upon Mr. Tomcek's analysis, the Association claims that the Starmark plan violates the requirements of the Police contract because it is deficient in the following areas: home health care visits; prescription drug costs; front-end deductibles; hospice care; oral contraceptives; oral surgical procedures; and administrative costs borne by the employee. Thus, the undersigned turns first to a comparison of these benefits.

Home Health Care Visits

In arguing that the home health care visits benefit is deficient, the Association relies upon Union Exhibit #5, which is a comparative benefits analysis of the Starmark policy and the WPS policy that was in effect on July 1, 1992. For the reasons discussed above, the relevant comparison is between the Starmark plan and the 2000 HEP-PPO plan.

Union Exhibit #1 contains the comparison of the 2000 HEP-PPO plan and the Starmark plan. As the Association recognizes, there is no significant difference in the home health care benefits provided by the 2000 HEP-PPO plan and the Starmark plan.

Prescription Drug Costs

It is undisputed that the 2000 HEP-PPO plan provided co-pays of $5 for generic and $10 for brand name prescription drugs and that these co-pays did not apply toward the out-of-pocket maximums. It is also undisputed that the Starmark plan does not have co-pays on prescription drugs and that prescription drug costs apply towards the out-of-pocket maximums.

The $5/10 prescription drug co-pay is one of three benefits expressly referenced in Section 20.01. By this express reference, the parties have recognized that this is a significant health insurance benefit.

The $5/10 prescription co-pay subjects all employees to the same cost per prescription; places a cap on the out-of-pocket cost of each prescription; and, by providing a different benefit for generic and brand name drugs, encourages the use of generic and, thus generally less costly, drugs. The Starmark plan does not subject all employees to the same out-of-pocket cost per prescription, nor does it provide a cap on the out-of-pocket costs of each prescription. Rather, an employee's out-of-pocket prescription drug cost is determined by the individual employees use of medical services. For example, under the Starmark plan, an employee with no other covered medical expenses could be required to expend the entire front-end deductible, ranging from $200 to $600, before the insurance would pick up the cost of any of the prescription drugs. Another employee could have the entire deductible applied towards other covered medical expenses; with the result that an employee would not have any prescription drug costs. The prescription drug benefit provided by the Starmark plan is not comparable to the prescription drug benefit provided by the 2000 HEP-PPO plan.

Hospice Care

The Village and the Association agree that the 2000 HEP-PPO plan provided coverage for up to 6 months of hospice care and that the Starmark plan provides coverage for up to 60 days of hospice care. Given this difference, the hospice care benefit provided by the Starmark plan is not comparable to the hospice care benefit provided by the 2000 HEP-PPO plan.

Oral Contraceptives

The parties agree that the 2000 HEP-PPO plan covered the costs of oral contraceptives and that the Starmark plan does not cover the costs of oral contraceptives. Given this difference, the oral contraceptives benefit provided by the Starmark plan is not comparable to the oral contraceptives benefit provided by the 2000 HEP-PPO plan.

Oral Surgical Procedures

The Association's evidence that the 2000 HEP-PPO plan covered the costs of fourteen oral surgical procedures and that the Starmark plan does not cover the costs of any oral surgical procedures is not rebutted. Thus, it must be concluded that the oral surgical procedures benefit provided by the Starmark plan is not comparable to the oral surgical procedures benefit provided by the 2000 HEP-PPO plan.

The Village argues, however, that it provides a Dental Insurance plan that provides coverage for oral surgical procedures. Notwithstanding the Association's arguments to the contrary, the Village may use this dental insurance plan to provide coverage for oral surgical procedures required by Section 20.01. However, given the evidence that the Village's Dental Insurance plan, unlike the 2000 HEP-PPO plan, limits the maximum benefit payable in any calendar year to $1,000 per person, the Village's Dental Insurance plan does not provide an oral surgical benefit that is comparable to that provided by the 2000 HEP-PPO plan.

Front-end Deductibles

Section 20.01 expressly requires that the employee be responsible for an annual front-end deductible of $200.00 per person and $600.00 per family. It is undisputed that the 2000 HEP-PPO policy provided an annual front-end deductible of $200 per person, with a maximum of $600 per family, and that the $200 per person deductible applied to each family member.

The Starmark plan provides for a $1,600 calendar year deductible per single subscriber and $3,200 per family subscriber. The Village and the Association agree that the Village limits the cost of this deductible to $200 per single subscriber and $600 per family subscriber. The record demonstrates, however, that, unlike the 2000 HEP-PPO plan, an individual family member's deductible is not capped at $200, but rather, may be the entire $600 family deductible.

The Starmark plan exposes an individual family member to a front-end deductible that is three times that which is provided for in the 2000 HEP-PPO plan. The front-end deductible benefit of the Starmark plan is not comparable to that of the 2000 HEP-PPO plan. Moreover, it is inconsistent with the language of Section 20.01, which expressly references a $200 "per person" deductible, rather than a $200 per single subscriber deductible.

Administrative Costs

Under the Starmark plan, the Village funds the high single subscriber deductible and the high family subscriber deductible by placing money into a Medical Savings Account (MSA). Monies in the MSA earn tax-deferred interest. Employees are charged $1/month for maintaining this account.

Employees are provided with a credit card that may be used to withdraw monies from the MSA. When a health care provider does not accept this card, the employee may withdraw payment monies from the account by submitting the appropriate form. A fee of $2 is assessed for each submission.

MSA funds may be used to pay any medical expense that is allowable by the IRS and expenditures made for such purposes are with pre-tax dollars. Not all expenses allowed by the IRS are also "covered" expenses under the Starmark plan. Depending upon the sophistication of the individual employee, employees may, wittingly or unwittingly, use MSA monies to pay for expenses that are not covered by Starmark and, thus, do not count towards the Starmark deductible.

Each year, any unused MSA funds are rolled over. If funds remain in the account at the time that the participant reaches the age of 65, or becomes disabled, then the funds may be withdrawn and used for non-medical purposes, without penalty. Prior to that time, funds withdrawn for expenses not allowed by the IRS are subject to a penalty. Funds withdrawn for reasons other than IRS allowable medical expenses are subject to income taxes. A Village employee that is covered by another health insurance plan, such as that of a spouse, could be ineligible for the MSA. Additionally, the provision of the MSA has certain tax consequences, including the requirement that individuals file certain tax forms.

Under the 2000 HEP-PPO plan, employees were responsible for paying their drug co-pay and the medical expenses that were subject to their deductible. Normally, all other expenses were billed to the plan administrator by the health care provider and paid directly to the health care provider by the plan administrator, with the effect that the employee expended little, if any, time or monies on the administration of the health insurance benefit.

The Starmark plan shifts certain health administration costs to the employee. This cost-shifting primarily occurs as a result of the establishment of the Medical Savings Account.

When an employee is assessed the $2 submission fee, as well as when an employee is assessed the $1 monthly fee for maintaining the MSA, costs of administering the plan are shifted to the employee. Although the Association argues that employees are required to expend an additional fee of $1 after they have depleted their MSA accounts, such a fact is not clearly established in the record evidence. If employees were required to make such expenditure, then this would be a cost of administering the plan that has been shifted to the employee.

The effect of shifting these administration costs to the individual employee is that the Village has made the employee pay for a portion of the "cost" of their medical insurance plan. Under Section 20.01, the Village, and not the employee, must pay for the "cost" of the medical insurance plan provided by the Village. Accordingly, when the Village shifted administration costs of the medical insurance to the individual employee, the Village not only failed to provide an administrative benefit that is comparable to that provided by the 2000 HEP-PPO plan, but also, failed to the pay the "cost" of the medical insurance plan, as required by Section 20.01.

When the MSA card is not accepted, an employee is required to expend time in filling out the appropriate reimbursement forms that the employee would not have expended under the 2000 HEP-PPO plan. It is not evident, however, that there has been a significant expenditure of employee time on such activity.

To be sure, Mr. Tom Zimentz was required to make a round trip of 72 miles to make a payment to a health care provider that would not accept a credit card over the telephone. However, the record indicates that this problem arose during the transition period, when employees had not yet received the MSA card. If Mr. Zimentz had been able to present the MSA card to the provider at the time that he received the health insurance service, then he would not have had to return to pay his bill. While Mr. Zimentz was undoubtedly inconvenienced, it is not evident that his experience was typical.

Maximum Lifetime Benefit

The Village and the Association agree that the 2000 HEP-PPO plan had a maximum lifetime benefit of $2,000,000 and that the Starmark plan has a $5,000,000 In and Out of Network combined and $2,000,000 Out of Network only. Thus, the Starmark plan does not provide a "comparable" maximum lifetime benefit, but rather, provides a better maximum lifetime benefit.

% Payment of Covered Costs

The Village and the Association agree that the 2000 HEP-PPO plan paid 90% of the covered costs of network providers and 80% of covered costs of the out-of-network providers and the Starmark plan pays 100% of the covered costs of network providers and 90% of the covered costs of out-of-network providers. Thus, with respect to % of covered costs that are paid by the insurer, the Starmark plan is not comparable to that of the 2000 HEP-PPO plan, but rather, provides a better benefit.

Summary

As discussed above, the Starmark plan does not provide any prescription drug co-pay or coverage for oral contraceptives; provides significantly reduced coverage for hospice care and oral surgical procedures; fails to limit the per person front-end deductible to $200; and shifts "costs" of the "medical insurance" from the Village to the employee. The Starmark plan has improved the % payment of covered costs and the maximum lifetime benefit. However, given the evidence that few, if any, individuals require a maximum lifetime benefit of more than $2,000,000, the undersigned is not persuaded that the improvement in lifetime maximum benefit is significant.

To be sure, employees who do not expend all of the MSA monies on medical expenses will have monies available for use at their retirement. However, when the parties negotiated Section 20.01, they were not negotiating a retirement benefit. Thus, any retirement benefit that accrues from the MSA plan is not an improvement in the health insurance benefits required by Section 20.01 and does not serve to offset any loss in health insurance benefits required by Section 20.01.

In summary, the Village has the right to change carriers or administrators "as long as the benefits are comparable" to that of the 2000 HEP-PPO plan. A comparison of the Starmark plan to the 2000 HEP-PPO plan reveals that the Starmark plan is significantly deficient in a number of "benefits" and significantly improved in only one benefit. Thus, the benefits of the Starmark plan are not comparable to those of the 2000 HEP-PPO plan.

DPW Contract

The parties agree that the Village has the right to change health insurance providers. The Association and the Village also agree that, when changing health insurance providers, the Village must provide the benefits required by Article 27 of the 1998-2000 collective bargaining agreement. The parties disagree as to what benefits are required to be maintained by Article 27.

The Association maintains that the Village is required to provide health insurance benefits that are "comparable" to those of the 2000 HEP-PPO plan. The Village argues that it is required to provide benefits that are comparable to those provided in 1997.

Neither party offered any evidence with respect to the bargaining history of Article 27. Thus, the best evidence of the parties' intent at the time that they negotiated Article 27 is the plain language of this section, which states as follows:

> ARTICLE 27 – HEALTH AND WELFARE
>
> Section 1. Village will select the Health and Welfare provider with comparable benefits to the current level of benefits at no cost to the employees. Effective 1/1/95 Employees will be responsible for the first $200.00 per person, $600.00 per family deductible portion of the health insurance plan. The employee's will participate in a 5/10 co-pay drug plan.
>
> . . .

Article 27 provides the Village with the right to select "the Health and Welfare provider" that has "comparable benefits to the current level of benefits." Article 27 does not expressly define "the current level of benefits" as those provided to the DPW unit in 1997. Nor, given the absence of any bargaining history on the 1998-2000 DPW collective bargaining agreement, as well as the evidence that this agreement was executed in late May of 1998, would it be reasonable to conclude that the parties intended such a definition.

By providing the Village with the right to select the "Health and Welfare" provider and the right to provide "comparable" benefits, the parties have recognized that Article 27 does not require a static health insurance benefit. Given the fact that the Article 27 health insurance benefit is subject to change, the most reasonable construction of the term "current level of benefits" is that it refers to those benefits that are in effect at the time that the Village "selects" the new "Health and Welfare provider."

Given the Village Administrator's letter of December 27, 2000, it is evident that the Village believes that, when it changes the health insurance plan during the term of the contract, any improvement in benefit levels resulting from the change have not been negotiated by the parties and, thus, need not be maintained by the Village. This belief is erroneous.

When the Village and the Association expressly agree to a change in the health insurance plan during the term of the contract, then any improvement in the benefits have, of course, been negotiated by the parties. When the Village unilaterally changes the health insurance plan, without objection from the Association, then the Association has agreed that this change is consistent with the Village's contractual right to provide "comparable benefits." In determining the "comparability of benefits," one balances improvements in the benefits against losses in benefits. It is reasonable to conclude, therefore, that any change in the health insurance plan that occurs either with the express agreement of the Association, or without objection from the Association, establishes the "current level of benefits," as that term is used in Article 27.

At the time that the Village "selected" Starmark as the "Health and Welfare provider," the "current level of benefits," as that term is used in Article 27, were those provided in the 2000 HEP-PPO plan. As discussed above, Starmark does not provide benefits that are comparable to the benefits provided in the 2000 HEP-PPO plan.

Article 27 requires that the employees covered by the contract be responsible for a front-end deductible of $200 per person and does not provide for a front-end deductible of $200 per single subscriber. Article 27 also requires that the employees covered by the contract participate in a 5/10 co-pay drug plan. By failing to provide the 5/10 co-pay drug plan and by not capping the front-end deductible at $200 per person, the Village has failed to comply with these provisions of Article 27.

Article 27 requires the Village to provide the mandated health insurance benefits at no cost to the employee. As discussed above, in implementing the Starmark plan, the Village has shifted certain costs of administering the health insurance to the individual employee. As is also discussed above, the effect of shifting these administration costs to the individual employee is that the Village has made the employee pay for a portion of the "cost" of providing the mandated health insurance benefits. Thus, by shifting administration costs to the individual employee, the Village has not only failed to provide a "comparable" administration benefit, but also, has failed to comply with the Article 27 requirement that the Village provide the mandated health insurance benefits at no cost to the employee.

Clerical Contract

The parties agree that the Village has the right to change health insurance providers. The Association and the Village also agree that, when changing health insurance providers, the Village must provide the benefits required by Article 23 of the 1998-2000 collective bargaining agreement. The parties disagree as to what benefits are required to be maintained by Article 23.

The Association maintains that the Village is required to provide health insurance benefits that are "comparable" to those of the 2000 HEP-PPO plan. The Village argues that it is required to provide benefits that are comparable to those provided in 1997.

Neither party offered any evidence with respect to the bargaining history of Article 23. Thus, the best evidence of the parties' intent at the time that they negotiated Section 23 is the plain language of this section, which states as follows:

ARTICLE 23 – HEALTH AND WELFARE

1. The Employer will select the Health and Welfare provider with comparable benefits to the current level of health and dental benefits. The Employer will pay the full cost of the health plan. The Employer will pay the full cost of the dental plan for full-time employees. Effective on the first day of the second month following the date of the Arbitrator's award relating to the 1991-1993 Agreement, the Employer will pay the full cost of the health plan for full-time employees. Effective January 1, 1995, employees will be responsible for the first two hundred ($200.00) dollars per person or six hundred ($600.00) dollars per family deductible portion of the health insurance plan. The Employees will participate in the 5/10 co-pay drug plan.

. . .

Under Article 23, the Village has the right to select "the Health and Welfare provider." In doing so, the Village must provide "comparable benefits to the current level of health and dental benefits."

Article 23 does not expressly define "the current level of health and dental benefits" as those provided to the Clerical unit in 1997. Nor, given the absence of any bargaining history on the 1998-2000 Clerical collective bargaining agreement, as well as the evidence that this agreement was executed at the end of May, 1998, would it be reasonable to conclude that the parties' intended such a definition.

By providing the Village with the right to select the "Health and Welfare" provider and the right to provide "comparable" benefits, the parties have recognized that Article 23 does not require static health and dental benefits. Given the fact that the Article 23 health and dental benefits are subject to change, the most reasonable construction of the term "current level of health and dental benefits" is that it refers to those benefits that are in effect at the time that the Village "selects the Health and Welfare provider."

The benefits in effect at the time that the Village "selected" Starmark as the "Health and Welfare provider" were those provided in the 2000 HEP-PPO plan. Thus, when selecting Starmark as the "Health and Welfare provider," the Village is required to provide health and dental benefits that are comparable to those provided in the 2000 HEP-PPO plan. As discussed above, Starmark does not provide health and dental insurance benefits that are comparable to the benefits provided in the 2000 HEP-PPO plan.

As with the DPW contract discussed above, the Clerical contract expressly requires that the employees covered by the contract be responsible for a $200 per person deductible, as well as a 5/10 co-pay drug plan. For the reasons discussed above, by failing to provide the 5/10 co-pay drug plan and by not capping the front-end deductible at $200 per person, the Village has failed to comply with the provisions of Article 23.

Article 23 expressly recognizes that the Village will pay the full cost of providing the health plan. As discussed above, in implementing the Starmark plan, the Village has shifted certain costs of providing the mandated health plan to the individual employee. As is also discussed above, the effect of shifting these administration costs to the individual employee is that the Village has made the employee pay for a portion of the "cost" of providing the mandated health plan. By shifting these administration costs to the individual employee, the Village has not only failed to provide a "comparable" administration benefit, but also, has failed to comply with the Article 23 requirement that the Village pay the full cost of providing the health plan.

Conclusion

By unilaterally implementing the Starmark plan, the Village has violated Section 20.01 of the Police contract; Article 27 of the DPW contract; and Article 23 of the Clerical contract. As remedy for these contract violations, the Association does not ask that the Village be ordered to reinstate any prior health insurance plan. Rather, the Association asks that the Village "stand in the shoes" of the carrier and reimburse the Association's bargaining unit members for any costs incurred from the Village's violation of the collective bargaining agreements.

In remedy of these contractual violations, the Village is hereby directed to make the Association's bargaining unit employees whole for losses resulting from the Village's unilateral implementation of the Starmark plan by immediately:

1. Reimbursing employees for the costs of all prescription drugs that would have been paid for by the Village under the 2000 HEP-PPO plan and which exceed $5 per generic drug and $10 per brand name drug.

2. Reimbursing employees for the cost of any oral contraceptive that would have been paid for by the Village under the 2000 HEP-PPO plan, but is not paid by Starmark.

3. Reimbursing employees for the cost of any hospice care that would have been paid for by the Village under the 2000 HEP-PPO plan, but is not paid by Starmark.

4. Reimbursing employees for the cost of any oral surgical procedure that would have been paid for by the Village under the 2000 HEP-PPO plan, but is not paid by Starmark, or the Village's Dental Health Insurance plan.

5. Administering the $600 front-end family deductible in such a manner that an individual family member's deductible is capped at $200 and reimburse the employee for any cost resulting from the failure of the Starmark plan to cap the front-end deductible at $200 per family member.

6. Reimbursing each employee for the monthly fee for maintaining the MSA, currently at $1, and for the fee that accompanies a request for a withdrawal of monies from the MSA, currently at $2, as well as for any fee assessed by Starmark as a result of an employee depleting their MSA account.

In making the employee whole, the Village may offset the reimbursements required in Paragraph's One through Six, supra, by deducting any expenses for which the employee would have been liable under the 2000 HEP-PPO plan, but which were paid by Starmark. Additionally, if at the end of a calendar year, the monies placed by the Village into the employee's MSA exceeds the monies required to be expended by the employee for coverage provided by Starmark during that calendar year, then these excess monies may be used by the Village to offset any reimbursement required in Paragraph's One through Six, supra.

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

AWARD

1. The Village of East Troy's current health insurance plan does not comply with Article 23(1) of the collective bargaining agreement with the East Troy Clerical Employees.

2. The Village of East Troy's current health insurance plan does not comply with Article 27(1) of the collective bargaining agreement with the East Troy Department of Public Works.

3. The Village of East Troy's current health insurance plan does not comply with Article XX, Section 20.01, of the collective bargaining agreement with the East Troy Professional Police Association.

4. To rectify the Village's failure to comply with the collective bargaining agreements of the East Troy Professional Police Association, the East Troy Department of Public Works, and the East Troy Clerical Employees, the Village shall immediately take the remedial action stated above.

Dated at Madison, Wisconsin this 30th day of May, 2002.

Coleen A. Burns /s/

Coleen A. Burns, Arbitrator

CAB/gjc
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