

BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

CITY OF KENOSHA

and

**INTERNATIONAL ASSOCIATION
OF FIREFIGHTERS, LOCAL 414**

Case 218
No. 67022
MA-13713

Appearances:

Timothy E. Hawks, Hawks, Quindel, Ehlke & Perry, S.C., Attorneys at Law, 700 North Michigan Street, Suite 700, Milwaukee, Wisconsin, appeared on behalf of the Union.¹

Daniel G. Vliet, Davis & Kuelthau, S.C., Attorneys at Law, 111 East Kilbourn Avenue, Suite 1400, Milwaukee, Wisconsin, appeared on behalf of the Employer.

INTERIM ARBITRATION AWARD

International Association of Firefighters, Local 414, herein referred to as the “Union,” and City of Kenosha, herein referred to as the “Employer,” jointly selected the undersigned from a panel of arbitrators from the staff of the Wisconsin Employment Relations Commission to serve as the impartial arbitrator to hear and decide the dispute specified below. The arbitrator held a hearing in Kenosha, Wisconsin, on December 5, 2007. Each party filed a post-hearing brief, the last of which was received February 25, 2008. On February 21, 2008, the Union moved to strike the Employer’s primary brief because it was filed late. The parties were afforded an opportunity to argue the motion and I issued a decision allowing the brief on February 29, 2008, and the record was closed as of that date.

ISSUES

The parties were unable to agree to a statement of the issues, but agreed that I might state them. I state them as follows:

¹ Richard Saks, Attorney at Law, participated in the briefing.

1. Was the grievance timely filed?
2. Did the Employer violate the side letter of agreement between the parties² dated November 7, 2006, by adopting the current prescription drug coverage?
3. If so, what is the appropriate remedy?

RELEVANT AGREEMENT PROVISIONS³

“ . . .

ARTICLE 20 – INSURANCE

20.01 For the duration of this current Labor Agreement, the City shall pay the full cost of the single or family contract for the group hospital-surgical insurance benefits now in effect as revised for 1976, except as modified by the changes listed in the following:

A. Health Insurance Coverage changes to be effective not earlier than January 1, 1984:

1. Increase the \$25.00 deductible in Part VI, Section 10.02 of the Benefit booklet to \$100.00. Section 10.02 will then read:

“10.02 – Deductible. The first \$100 of the cost of the following services shall be the responsibility of the subscriber. This deductible amount applies to each participant for each illness and must be satisfied within a consecutive 30 day period. The \$100.00 may include any combination of Major Illness expense items as listed below. Any difference in charges between the contract’s room allowance and the occupancy of a private room cannot be credited toward the major illness deductible.”

(Also revise any reference to this deductible in any other sections, such as 10.03 and 10.04, from \$25.00 to \$100.00).

2. Hospice Care.
3. A pre-existing condition limitation clause of 180 days for all new hires after January 1, 1984.

² The side letter of agreement is herein referred to as a “Memorandum of Understanding” or “MOU.”

³ The terms of the Memorandum of Understanding and other documents are stated in the Facts section of this award.

4. (Note: This inclusion and continuation of the following coverage change is at the option of the City).
A Mandatory second opinion on a specified list of elective surgeries (plan pays for second opinion). This list shall include, but not be limited to, the following:
 - a. Surgery of the knee;
 - b. Surgery of the back;
 - c. Tonsillectomy;
 - d. D & C's;
 - e. Removal of gall bladder;
 - f. Coronary bypass;
 - g. Hysterectomy;
 - h. Bunionectomy;
 - i. Gastric bypass;
 - j. Jaw Joint Problems

5. Effective as soon as possible after the City Council approves the 1992-1994 Agreement:
 - a. The \$100 deductible, referred to in Item 1 of this Section 20.01 A and on page 32 of the Benefit booklet will be eliminated and the following front-end deductible applying to all health care expenses covered by the City's Health Care Program will be put into effect;

 - b. Provide payment for examinations by low-dose mammography performed at the direction of a licensed physician or licensed nurse practitioner in the following situations: These charges are not subject to the annual front-end deductible.
 - Once every two (2) years for women age 40 through 49, and

- Once every year for women age 50 or over.
- c. Provide for a mandatory second opinion (plan pays for the second opinion) for treatment of Jaw Joint Problems.
- d. Add the following Catastrophic Case Management:

Catastrophic case management is designed to help manage the care of patients who have catastrophic or extended care illnesses or injuries. The primary objective of catastrophic care management is to identify and coordinate cost effective medical care alternatives meeting accepted standards of medical practice. Catastrophic case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients and others. These objectives will be met through contractual benefits to patients who are eligible and voluntarily agree to the alternate benefits plan. Examples of illness or injuries, that would be appropriate for catastrophic case management includes, but are not limited to:

Terminal Illnesses

Cancer

AIDS

Chronic Illnesses

Multiple Sclerosis

Renal Failure

Obstructive Pulmonary Disease

Cardiac Conditions

Accident Victims Requiring Long-Term Rehabilitative Therapy

Newborns with high risk complications or multiple birth defects

Diagnosis involving long-term IV therapy.

Illnesses not responding to medical care

Child and adolescent mental/nervous disorders

- e. Provide payment for the usual and customary fee, up to \$100 per year for the employee and each eligible covered dependent, for physician's charges for physical exams not required for the treatment of an illness. These charges are not subject to the annual front end deductible. Charges in excess of the above \$100.00 amount for the employee and each eligible covered dependent shall be the responsibility of the employee and shall not be applied to the annual front-end deductible. Diagnostic lab and x-ray charges associated with the above physical exams are subject to the annual front-end deductible, but are not subject to the above \$100.00 per year maximum amount.
- f. Any deductible under the \$100.00 per illness major illness deductible provisions that was applied to covered charges incurred on and after January 1, 1992 until the effective date of the new \$200/\$600 front-end deductible will be credited toward the \$200 per person, \$600 per family front-end deductible for calendar year 1992.

Effective not earlier than 1/01/01 a \$600 per person per year with a maximum of \$1800 per family, per year deductible will be in effect. Also in effect employees will be responsible for a 25% co-pay on prescriptions.

B. After July 31, 1995, the following precertification and concurrent review procedures and coverage changes will be implemented.

- 1. Utilization Management including hospital precertification. \$100 subscriber penalty for non-compliance.
- 2. Non-life threatening emergency room precertification. \$50 subscriber penalty for non-compliance.
- 3. Out-patient precertification. \$50 subscriber penalty for non-compliance.

4. Physical, speech and occupational therapy precertification. \$10 per visit subscriber penalty for non-compliance.
5. Transition period. Once implemented, the above procedures and penalties shall be phased in over a 90 day period with warning to subscribers prior to implementation of penalties.
6. Effective January 1, 2004 the elimination of per illness or per disability maximum, coverage limitations capped at not less than \$2 million.
7. Effective January 1, 2004 the elimination of base/major medical rollover per illness or per disability, maximum coverage limitations capped at not less than \$2 million.
8. Implementation of State mandated benefits.
9. Precertification of "Usual, Reasonable and Customary" charges. Precertification shall include an estimate of any charges over URC for the proposed procedure that is the responsibility of the employee.

C. Medical Guidance and Referral 800 toll free number (on a voluntary basis);

D. Employee Hospital Audit Bonus. The City will pay to an employee an amount equal to 50% of the savings, up to a maximum of \$500 per year realized by an employee's discovery of an error or errors in hospital bills other than mathematical errors. If an employee detects an error, the employee is to notify the insurance carrier and substantiate the error and cooperate in the investigation thereof. Payment will be made when the City receives confirmation that the bill has been adjusted to correct the error.

20.02 Retirees shall receive the same health insurance benefits as active employees.

20.03 Any employee retiring prior to age sixty (60) shall have the privilege of retaining such health insurance coverage provided he/she so notify the Fire Chief thirty (30) days before his/her retirement date and provided further that each retiring employee who elects to continue said coverage shall pay the entire cost for such coverage and shall be billed directly by the insurance company.

20.04 Any employee retiring on or after January 1, 1974, shall have the privilege of retaining such health insurance, the premium cost up to the amounts specified in 20.01 being paid by the City from the first of the month following the retiree's sixtieth (60th) birthday until either the retiree becomes eligible for other paid hospital-surgical insurance, becomes eligible for Medicare, or until the employee attains age sixty-five (65), whichever occurs first.

20.05 A. Any employee voluntarily retiring on or after January 1, 1976, upon reaching the age of fifty-five (55), shall have the privilege of retaining City hospital-surgical insurance, the premium cost up to the amounts specified in 20.01 being paid by the City from the first of the month following such employee's retirement until either the retiree becomes eligible for other hospital-surgical insurance, becomes eligible for Medicare or other government furnished hospital-surgical insurance.

B. Any employee voluntarily retiring on or after August 1, 1995 with fifteen (15) years of service, upon reaching the age of fifty-three (53) shall have the privilege of retaining City hospital-surgical insurance, the premium cost up to the amounts specified in 20.01 being paid by the City from the first month following such employees' retirement until either the retiree becomes eligible for other paid hospital-surgical insurance or becomes eligible for Medicare or other government furnished hospital-surgical insurance.

C. Employees voluntarily retiring on or after August 1, 1995, with less than 15 years shall be eligible for benefits under 20.05A.

20.06 A. Any retiree under 20.05A above who has reached the age of fifty-five (55) but not reached the age of sixty-five (65), who has become eligible for other hospital-surgical insurance and loses that eligibility, shall, upon written request to the City Personnel Department be reinstated in the City's hospital-surgical insurance plan without a physician examination or waiting period. The premium cost, up to the amounts specified in 20.01, shall be paid by the City.

B. Any retiree under 20.05B, who has reached the age of fifty-three (53) but not reached the age of sixty-five (65), who has become eligible for other hospital-surgical insurance and loses that eligibility, shall, upon written request to the City Personnel Department be reinstated in the City's hospital-surgical insurance plan without a physician examination or waiting period. The premium cost up to the amounts specified in 20.01, shall be paid by the City.

20.07 The widow/widower of any employee who dies on or after January 1, 1972, shall have the privilege of retaining such health insurance coverage provided that each such widow/widower who elects to continue said

coverage shall pay the entire cost for such coverage and shall be billed directly by the insurance company.

20.08 The widow/widower of any employee who dies on or after January 1, 1973, shall have the further privilege of retaining such health insurance coverage; such coverage to be paid for by the City, up to the amounts specified in 20.01, until said widow/widower remarries or until his/her deceased husband/wife would have attained the age of sixty (60) years.

20.09 Duty Disability. Effective January 1, 2004, employees in active service who commence receiving a duty disability retirement allowance (as defined in Section 40.65 of the Wisconsin State Statutes), shall be entitled to City paid health insurance so long as they continue to receive such duty disability retirement allowance and so long as they are under age 65. Such qualifying employee is only eligible for single health insurance coverage. The City will contribute an amount up to the subscriber cost for single enrollment in the least costly plan offered to City employees. Should the employee wish to enroll in a more expensive plan, the employee shall pay to the City the difference between the two plans. Such qualifying employee must not be eligible for health insurance benefits through his/her current employer.

20.10 The City agrees to inform the insurance carrier of the active members' right to pay premiums directly to the company.

20.11 The City agrees to investigate all complaints of employees in regard to failure of the insurance carrier to make payments for the coverage provided in its policy with the City.

20.12 The City shall also provide and pay premiums for a term life insurance policy in the amount of the employee's annual salary rounded off to the next highest one thousand dollar (\$1,000.00), as currently in effect. As soon as possible after ratification of this agreement in 1995, the City will allow added participation in the State of Wisconsin Life Insurance program in the Supplemental and Additional Plans. The employee will make 100% of the contributions required under the Supplemental and Additional Plans.

20.13 The City agrees to permit a member on leave of absence to continue in all the above insurance coverage for a period not to exceed one year, if he/she so elects. Premiums are to be paid by said member to the City on a monthly basis.

ARTICLE 21 – GRIEVANCE PROCEDURE

21.01 Any violation of this Agreement or any supplement thereto shall be deemed subject to the grievance procedure as follows:

21.02 Step 1. Within ten (10) days of the occurrence of the grievance, the employee or employees and the Union shall present a statement of the same in writing to his/her Battalion Chief. No sooner than three (3) days nor later than five (5) days said officer will make his answer thereto in writing and provide copies to the grievant or grievants, the Union and the Chief.

21.03 Step 2. If the grievant, grievants, or the Union is not satisfied with the disposition of the grievance at Step 1, it shall be presented to the Chief in writing within five (5) days. The Chief shall schedule a meeting to be held within five (5) days of receipt of the written grievance which shall be attended by the grievant or grievants, up to two (2) on duty Union representatives, and the officer involved, if any. Within five (5) days after said meeting, the Chief shall make his/her answer in writing and provide copies to the grievant or grievants and the Union.

21.04 Step 3. If the grievant, grievants, or the Union is not satisfied with the disposition of the grievance or dispute at Step 2, it shall be appealed as follows:

A. If the subject matter of the grievance or dispute involves a subject over which the Board of Police and Fire Commissioners has jurisdiction under Wisconsin Statutes, Section 62.13, it shall be appealed to the Board of Police and Fire Commissioners by filing written notice of the same with the Secretary of the Board within ten (10) days after receipt of the Chief's decision. The Board shall then act upon the same at its next regular meeting or sooner if the Board should so decide. Before rendering its decision, the Board shall give reasonable notice and opportunity to be heard to all parties in interest. As soon thereafter as practicable, the Board shall reduce its decision to writing and provide copies to all parties in interest.

B. If the subject matter of the grievance or dispute involves a subject over which the Board of Police and Fire Commissioners does not have jurisdiction under Wisconsin Statutes, Section 62.13, it shall be appealed to the Mayor or his/her designate by filing written notice of the same with him/her within ten (10) days after receipt of the Chief's decision. The Mayor or his/her designate shall hold a meeting with all parties in interest in attendance within seven (7) days thereafter. Within five (5) days of the said meeting, the Mayor or his/her designate will reduce his/her decision in writing and provide copies to all parties in interest.

21.05 Step 4. If any party is dissatisfied with either the Mayor's or his/her designate's disposition or the disposition of the Board of Police and Fire Commissioners at Step 3, said party may invoke final and binding arbitration of the grievance or dispute by serving written notice of intention to do so within fifteen (15) days following receipt of the written decision of either the Mayor or his/her designate, or the Board of Police and Fire Commissioners. The arbitrator shall then be selected by a joint written request to the Chairman of the Wisconsin Employment Relations Commission to appoint a member of his staff as arbitrator. After the arbitrator is appointed, the parties shall agree on a hearing date as soon as is mutually convenient. The arbitrator shall have jurisdiction to rule on the arbitrability of the dispute, to issue subpoenas, to define the questions involved, to make rulings on procedure and evidence according to the equities of the situation, and to render a decision on the merits which will be final and binding on the parties. The authority of the arbitrator shall be limited to the above and he/she shall have no authority to add to, detract from, or amend the agreement. The costs and expenses, if any, of such arbitrations shall be shared equally by the City and the Union, except that each party shall pay its witness and attorney's expenses.

21.06 The purpose of the time limits in the foregoing paragraphs is to provide a procedure for dispute settlement that will be prompt and expeditious. However, where extenuating circumstances prevail, any of the said time limits may be modified or extended by written mutual agreement of the parties.

21.07 The parties agree that they will jointly compose a written grievance form to be used in processing grievances under this Article.

21.08 If any grievance or dispute shall originate directly from action of the Fire Department, the procedure may be commenced at Step 2 in paragraph 21.03 above. If any grievance or dispute shall originate directly from the action of the Mayor or the Board of Police and Fire Commissioners, the procedure may be commenced at Step 3 in paragraph 21.04 above. In either event, the officer involved under Step 1 and the Chief shall be given notice of the same exhibiting to them the written grievance form. Said officer and Chief shall admit notice of the same by initialing the appropriate space on the form.

. . . . “

FACTS

The Employer is a Wisconsin municipality. It operates a fire department that employs full-time fire fighters. The Union is the collective bargaining representative of professional fire fighters of the Employer. The collective bargaining relationship of the parties is long and involves many successive comprehensive collective bargaining agreements. Christopher Bigley

is a Lieutenant in the Employer's fire department. He is member of the bargaining unit and Vice President of the Union. The Employer has a number of other bargaining units with which it also has long standing collective bargaining relationships. The other collective bargaining units are colloquially known as: building inspectors, transit, police, AFSCME, crossing guards and Teamsters. There are also two library units which are separate from the City but share benefits with City units.

The Employer and its recognized unions have generally maintained uniform health insurance provisions among the various collective bargaining units. As of 2006, the Employer and its various unions maintained two health insurance plans, an indemnity plan and an HMO/EPO plan, the latter of which was contracted through Aurora Direct. The plans were offered through Kenosha Health Care Partners, an organization created by the Employer and other local employers for health insurance purposes. Both plans were self-funded by the Employer. Both plans included a prescription drug benefit, but were not limited to that benefit. These plans were projected to become expensive for the years 2007 and beyond in large part because it was difficult to competitively bid their benefits and because health insurance costs had risen substantially. The indemnity plan was particularly expensive because it did not take advantage of potential discounts. About 22% of the Employer's employees were in the indemnity plan. The plan, however, accounted for 40% of the Employer's cost of health insurance benefits. Throughout the administration of the old plans and during the negotiations for the successor plan, the Employer, its unions and other interested persons formed a committee focused on the quality of the administration of the Partners plan. Lieutenant Bigley was the Union's representative to that committee⁴ and was its Chairman at all relevant times.

In 2005, the Employer began a unilateral process to review its health plans to make them marketable, comparable to health plans of local private employers, and cost efficient. The Employer hired Health Care System Consultants, Inc. (herein "HCSC") as a consultant in order to assist it in revising its health insurance plans and to supervise the bidding process for the selection of a new plan and carrier (administrator). The new plans were to be effective January 1, 2007. The plans were to be primarily self-funded by the Employer, but administered by the bidder.

In March, 2006, the Employer began the process of giving its unions an opportunity to bargain over the changes which would be made to the health insurance plans. It requested to bargain with its unions on this issue as a whole group, rather than dealing with each individual unit. Although the unions were in negotiations leading to a successor to the collective bargaining agreements expiring at the end of calendar 2006, the Employer sought to obtain through these earlier negotiation an agreement between it and the collected unions allowing it to implement the changes in health insurance before January 1, 2007, even if the negotiations

⁴ He represented not only this Union but the labor organizations representing other units of the City of Kenosha, as well.

for the comprehensive collective bargaining agreements were not completed at this time. This would enable the parties to enjoy the full savings from the contemplated changes.

The unions all agreed to meet collectively with the Employer for that purpose. The Employer was represented in the negotiations by its Personnel Director, Steve Stanczak. The Union was represented in these negotiations by Lt. Bigley and Clay Lagerwell, a member of the Union's Board of Directors. Lieutenant Bigley was a major leader on behalf of all of the collected unions. The Employer negotiated on the basis of a general outline of the benefits for which it would seek proposals from insurers. Its position, among other things, was that;

1. The current plans contained a level of benefits which was higher than found elsewhere in employment in the Kenosha area.
2. The current plan's benefit structure was unusual and costly to administer such that it was unlikely that the Employer could find a commercial health insurance company willing to even submit a bid to become the new health insurance plan administrator.
3. It also sought make changes to cause employees to be cost conscious in their health care decisions.
4. The changes it was proposing were subject to a degree of variation as a result of the bidding process.
5. The Employer wanted to have one single health insurance plan, rather than multiple health insurance plans.

The unions' representatives met collectively with HCSC in April and May, 2006, to obtain information about the changes proposed by the Employer.

The matters in dispute herein involve the change to the prescription coverage aspect of the health plans. Under the plans in existence before 2007, the traditional plan passed through all prescription costs. Under the Partners Plan, employees paid a \$5 co-payment for a thirty days' supply of all generic drugs. They were required to use generic drugs where they were available. If they did not, they paid the \$5 co-payment and the difference between the generic and the name-brand drug. All prescription drugs were covered. Employees could obtain a ninety day supply for the equivalent of two co-payments from the plan's pharmacy. Employees were required to use step-therapy whereby their physician would attempt to resolve medical conditions using less expensive drugs and step up to more expensive drugs only if the less expensive drugs did not produce the therapeutic results.

In August, 2006, the Employer presented an outline of its proposed changes. As it pertained to the prescription drug coverage, the Employer proposed that the new plan be a three tier plan. The meaning of the proposal was that drugs deemed by the prescription benefit

manager to be “generic” were in Tier 1. A “generic” drug is a drug which is no longer subject to a patent and which is sold according to its chemical name. In most cases, but not all, there were different drug manufactures which made the same generic drug. Tier 2 was to include many, but not all, drugs which were name-brand drugs. These were drugs which were usually under patent by one drug manufacturer and sold by the drug name, rather than its chemical compound. Tier 3 was to involve other name-brand drugs which the insurer would deem were expensive and not as effective as drugs costing less. The drug plan administrator would maintain a drug “formulary” which, among other things, classified which drugs belonged in which tier. Under the plan, the employee was to pay a set co-payment for each 30-day supply of prescribed drug. The co-payment for Tier 1 (generic drugs) was \$5, Tier 2 (formulary name-brand), \$20, and Tier 3 (non-formulary name-brand), \$35. Employees could obtain a 90 day supply of any drug for the equivalent of two co-payments at the appropriate tier co-payment from the plan’s mail-in pharmacy. The Union interpreted the proposal to mean that employees would have to pay a co-payment of only \$5 for all generic drugs.

The position of the collective unions was to limit the costs to employees of, among other things, the prescription drug co-payments. Christopher Bigley, the Firefighters representative, stated the position as one of cost containment for the employees. He specifically stated that they wanted employees to know that as long as they took generic drugs, for example, their co-payment would only be \$5 and they would have no other cost. The Employer emphasized its position as one of modifying the behavior of the beneficiaries so that they would be more cost-conscious consumers. The Employer revised its position in late August, 2006, and proposed to reduce the co-payment for non-formulary brand-name drugs from the previously proposed \$40 to \$35. It also responded to unions’ concerns by clarifying its position as follows:

After you pay copay (sic), we pay 100% of the balance of the charges. Generic substitution and step therapy required. Rx Drugs dispensed by a network pharmacy. Oral contraceptives are covered.

Other notes indicate that the Employer proposed to continue the option of purchasing 90 days’ supply of drugs through the mail with only two months’ co-payment. This proposal did not immediately result in a resolution of the issues.

On August 24, 2006, the Employer met with the unions and again revised its offer to lower the prescription costs to employees. The substance of its offer was as follows:

Prescription Drugs: \$5/\$20/30. With mail order or (sic) maintenance drugs, employee pays the equivalent of 2 co-pays for 90 day supply.

[It is unclear whether the Employer proposed \$30 or \$35 for the third Tier. The writing may have been in error on this point.] The parties did not reach agreement at that meeting.

As of the meeting of September 5, 2006, the Employer proposed to add an over-the-counter drugs benefit”

Prescription Drugs: \$5/\$20/30. With mail order for maintenance drugs, employee pays the equivalent of 2 co-pays for 90 day supply. The City offers an over-the-counter (OTC) drug benefit for drugs allowed by a new pharmacy

benefit manager. Said plan would be modeled similar to the following: \$5 co-pay for OTC drugs that exceed \$5 and \$0 co-pay for drugs that are less than \$5 retail cost.

The collected unions responded to this by proposing that employees who could not obtain a generic substitute for a prescription drug only be required to pay the \$5 co-payment normally reserved for generic drugs. The Employer did not agree to the collected unions' proposal and no agreement was reached.

The negotiations were then at a critical point in that the Employer had to issue a “request for proposals”⁵ in order to have a new plan of insurance in sufficient time for the January 1, 2007, effective date. The Employer and its unions last met on September 5, 2006, at which time the Employer made a “final offer” which provided in relevant part as follows:

Should the parties agree to changes in its health plan, the City will propose language that specifies benefit changes but that it cannot promise the manner of administrative control that will always rest with the plan administrator.

OFFER

...

3. Prescription Drugs: \$5/\$20/\$35/ With mail order for maintenance drugs, employee pays the equivalent of 2 co-pays for 90 day supply. The city offers and over-the-counter (OTC) drug plan as allowed by a new pharmacy benefit manager. Said plan would be modeled similar to the following; \$5 co-pay for OTC drugs that exceed \$5 retail cost and \$0 co-pay for OTC drugs that are less than \$5 retail cost.

...

The following day the Employer issued a revision to its proposed summary plan description. This summary plan description is part of the Employer’s September 5, 2006, final offer. It states in relevant part:

⁵ Herein referred to as a “RFP”. A RFP is a specification of the buyer’s terms for a contract or goods.

On September 6, 2006, the Employer made a final offer to all of the unions in which it specified the benefits it intended to include in the RFP and health plan. Included in that extensive specification was the following specification for the prescription medication plan:

***Proposed
In-Network***

\$5 generic
*\$5 generic

\$20 Brand
*20 Brand

\$35 Brand Non-Formulary
\$35 Non-Formulary

After you pay copay, we pay 100% of the balance of the charges. Generic substitution and step therapy required. Rx Drugs dispensed by a network pharmacy. Oral contraceptives are covered.

*With Mail Order for maintenance drugs, EE pays equivalent of 2 copays for 90 day supply. City offers OTC drug plan as allowed by a new pharmacy benefit manager. Plan will be modeled similar to the following: \$5 copay for drugs that exceed \$5 retail cost and \$0 copay for OTC drugs that are less than \$5 retail cost.

***Proposed
Out of Network***

\$5 generic
*\$5 generic

\$20 Brand
*20 Brand

\$35 Brand Non-Formulary
\$35 Brand Non-Formulary

After you pay copay, we pay 100% of the balance of the charges. Generic substitution and step therapy required. Rx Drugs dispensed by a network pharmacy. Oral contraceptives are covered.

*With Mail Order for maintenance drugs, EE pays equivalent of 2 copays for 90 day supply. City offers OTC drug plan as allowed by a new pharmacy benefit manager. Plan will be modeled similar to the following: \$5 copay for drugs that exceed \$5 retail cost and \$0 copay for OTC drugs that are less than \$5 retail cost.

By this reference Mr. Stanczak and the collected unions expected that all generic drugs would be paid under the five dollar deductible plan. The unions did not immediately accept the Employer's final offer. The Employer, however, decided to obtain bids based upon its final offer.

At about the same time, or very shortly thereafter in September, 2006, HCSC acting on behalf of the Employer drafted a RFP for the new plan. It was sent to prospective bidders during the first two weeks of September, 2006. The Employer's negotiators informed HCSC of the terms they negotiated in the outline form as noted in the paragraph immediately above. The RFP did not require that the insurer adopt the parties' current prescription drug plan. With respect to the prescription drug plan, the RFP stated:

RX Co-pay . . .	\$5/\$20/\$35
	Generic substitution required
OTC	Listed OTC RX

The RFP allowed for proposal to include clearly identified "variances." It did not include the detailed specifications of the Employer's former plans. The terms of the RFP were understood in the health insurance industry to call for a plan of administration that met the specifications in the RFP alone. It appears that the Employer's collective bargaining team did not review the RFP itself. HCSC apparently knew that the specification above was ambiguous enough to allow for a benefit plan of the type listed in paragraph above or for the plan which was ultimately adopted, as specified below. In any event, United Health Care, (herein "United") the successful bidder, understood the plan it proposed was within the meaning of the specification even though it did not require that all prescription generic drugs be covered at the \$5 co-payment. Either type of plan was, in fact, commercially available from the bidder who ultimately was selected to administer the plan, United.

The RFP was sent out sometime in the first two weeks of September, 2006. The bidding process closed October 20, 2006. On October 20, 2006, HCSC received bids from various health insurers. The proposed plans were not distributed to Mr. Stanczak or the unions. United was one of the bidders who submitted a proposal in response to the RFP. It was ultimately adopted by the Employer and its various unions. The United plan was not the same as the prescription coverage of the existing plan. The United plan placed various drugs in "tiers." Most, but not all, generic drugs were in Tier 1, proving for a \$5 co-payment. Others were not covered at all or were included in Tier 2 at a higher co-payment.⁶

⁶ The plan is more fully described below.

The Employer received a "bid summary" from HCSC which was also provided to each of the applicable unions in a meeting with the Employer on October 31, 2006. The bid summary concentrated largely on the cost of the benefit and did not provide the plan benefits. The bid summary was reviewed by a committee consisting of Director of Finance Carol Stancato, City Administrator Nick Arnold and Personnel Director Steve Stanczak. There were four bids, two of which were not deemed competitive. The committee preferred the lower cost bid, the bid provided by United Health Care. That bid would have resulted in the Employer's insurance costs being about the same as in 2006.

As of that date, none of the unions had agreed to the proposed changes. However, all of the affected unions verbally committed to accept the bid by United Health Care on November 1 or 2, 2006. As of that time, neither Mr. Stanczak, nor any of the unions recognized that United's bid was based upon the prescription drug plan which varied from that contemplated by the Employer's final offer.

In response to the verbal commitment Mr. Stanczak prepared a draft of the memorandum of understanding. He met with each of the individual unions and negotiated the final MOU which was signed by each of the affected unions. The MOU with the Union was signed November 7, 2006, and provides substantively in its entirety:

The City and the Union are currently engaged in negotiating a successor to the 2004-2006 collective bargaining agreement. The City and the Union agree that due to the complexity of the issues facing the parties it is possible that the new agreement will not be reached prior to December 31, 2006. As a result, the parties have entered into this Memorandum of Understanding regarding health insurance coverage to be provided by the City on or after January 1, 2007.

Both the Union and the City recognize that maintaining high quality health insurance for City employees, their families and retirees is a priority for both parties. Further, both parties recognize the fiscal responsiveness that is necessary to effectively manage the cost of health insurance coverage and the benefits provided under the City's health insurance coverage.

Regardless of whether a successor collective bargaining agreement is in place as of January 1, 2007, the Union and the City agree that the City can modify the health insurance coverage provided by the City to the coverage provided under the terms of the City's health insurance proposal dated September 6, 2006, no sooner than January 1, 2007. This Memorandum of Understanding serves as official notice of said change in coverage.

The City also recognizes that the Union retains the right to negotiate a quid pro quo for any changes regarding health insurance coverage while negotiating a successor to the 2004-2006 collective bargaining agreement.

The Union agrees that, to the extent necessary, Article 20 of the 2004-2006 labor agreement shall be modified to reference the City of Kenosha Summary Plan Description – short form (dated September 6, 2006). The parties agree that the City may change health insurance carriers, third party administrator's (sic) or implement a self-funded health insurance plan if it gives the Union at least thirty (30) days written notice of changes and maintains coverage substantially similar to the prior plan.

The MOU is substantively the same as that signed by the other unions, except the fourth paragraph is not in any of the others. This agreement is not a complete integration of the agreement of the parties. The agreement assumed and continued the Employer's caveat that there might be "minor variations."⁷

On the following day, November 8, 2006, United met with Employer officials, including Mr. Stanczak, but without any representative of any of the affected unions. At that time, Mr. Stanczak first learned the terms of United's bid with respect to prescription coverage. Neither Mr. Stanczak, nor anyone on behalf of the Employer ever told any of the union representatives in any specific way about the variance between the agreed upon prescription drug plan and the one which was ultimately adopted.

The new prescription drug plan provided for three tiers, the bottom tier of which called for a \$5 co-payment. Most, but not all generic drugs were included in Tier 1. Some drugs were included in a higher Tier based upon the fact that they were too expensive. United reserved the right to change the placement of drugs periodically based upon United's committees' view of the therapeutic value of the drug and the availability of suitable

⁷ This concept was noted in the Employer's August 24, 2006 proposal which stated in relevant part:

The intended mission of management and labor, and thus was the goal of the City, is to make the new health plan marketable. There has been much discussion concerning setting parameters for administering various health benefits. The City's consultants have strongly cautioned that much of the discussion in these health benefit negotiations cannot be administered – there are just some things either presently in the City's plan or that have been discussed that are not standard plan benefits or administrative protocol. Thus, an RFP will be mailed that the City desires a plan as close or similar to the one that is attached. The City, however, cannot be boxed into a situation that limits its choices as some of the proposed language will.

Should the parties agree to changes in its health plan, the City will propose language that specifies specific benefit changes but that it cannot promise the manner of administrative control that will always rest with a plan administrator.

This position was stated in the Employer's September 5, 2006, proposal as:

Should the parties agree to changes in its health plan, the City will propose language that specifies specific benefit changes but that it cannot promise the manner of administrative control that will always rest with a plan administrator.

alternatives. Some were not covered at all. In a few cases United covered over-the-counter drugs. The plan is described more below.

On November 29, 2006, the Employer distributed a letter to all its employees and retirees explaining that the health insurance plan was changing and to invite them to attend informational meetings. The plan changes were not provided in the notice. The meetings were held at various times in December. United prepared a brochure which was distributed at all of those meetings and had a representative present. At least some member of the Union attended, but it is unclear if any of the Union leadership attended any of these meetings. The information distributed at the meetings provided in relevant part:

City of Kenosha

Pharmacy Management Program *Plan 17M*

The pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 56,000 nationwide) to provide convenient access to medications.

While most pharmacies participate in the network, you should check first. Call your pharmacist or visit the online pharmacy service at www.myuhc.com. The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

Copayment per Prescription Order or Refill

Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment of the Home Delivery Pharmacy's Prescription Drug Cost.

Also note that some Prescription Drug Products require that you notify the Claims Administrator's designee in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

	Retail Network Pharmacy For up to a 31 day supply	Home Network Delivery Pharmacy For up to a 90 day supply
Tier 1	\$5	\$10
Tier 2	\$20	\$40
Tier 3	\$35	\$70

*A Tier 1 will apply to the following OTC drugs when prescribed by a physician: Prilosec, Claritan, and Loratidine.

The Union leadership did not become aware of the difference in the generic drug coverage which is the subject of this dispute until individual employees began to notice that some of their generic drug prescriptions were not being covered at all or at Tier 1. The Union learned of these complaints less than ten days before March 8, 2007.

On March 8, 2007, the Union filed the instant grievance. The substance of the grievance states:

...

Chris Bigley and Local 414 members are being charged generic drug co-pays in excess of those agreed to between the City and Local 414.

Relief Sought

Cease and desist overcharging Local 414 members for generic drug. Make overcharged Local 414 members whole.

At the time the Union filed this grievance it did not know of the difference between the negotiated prescription drug and the prescription plan ultimately adopted. The parties first met over this grievance at the third step. The Employer took the position that it has taken herein, that the benefits listed in negotiations were desirable, but not necessarily achievable. It also argued that the grievance was not timely because the United benefit plan was distributed to all employees as early as December, 2006. The grievance was thereafter properly processed to arbitration.

POSITIONS OF THE PARTIES

Union

The parties' bargaining history and plain language of the November 7, Memorandum of Understanding (MOU) is that generic drugs are only subject to a \$5 co-pay requirement. Each of the principal negotiators for both parties clearly and unequivocally testified that their understanding of the agreement was the new prescription drug benefit would be limited to a co-payment of \$5 for generic drugs. The plan, however, intersperses generic drugs across all three tiers and refuses to cover some generic drugs. The Employer is incorrect on its two theories. First, the difference is not in the category of "minor" differences which the Employer told Union negotiators might occur when their proposal was bid. The costs for a family may be substantial. Further, the Union bargained for, and obtained, the right of employees' own doctors to decide which drugs have "health care value." The Employer could have, but did not, negotiate the right to make changes of this nature in the plan. Even if one views the negotiation history as preserving the right of the Employer to have variations resulting from "administrative control," the change with respect to generic drugs does not fall within that concept. Second, the difference is not the result of the impossibility of obtaining

coverage of the type proposed, but merely the result of the fact that the Employer failed to specify this benefit in the request for proposals it created to get bids to provide the agreed-upon insurance.

The Union seeks to have all recipients, including retirees, made whole for all lost benefits. Retirees are entitled to a remedy under the parties' collective bargaining agreement. The Employer's reliance upon *ALLIED CHEMICAL & ALKALI WORKERS V. PITTSBURGH PLATE GLASS CO.*, 404 U.S. 157 (1971) is misplaced. Federal courts have interpreted the holding to allow the enforcement in arbitration of contractual benefits created for retirees. Absent an exclusion contained in the contractual arbitration clause or elsewhere, a union may seek arbitration for contract violations which related to negotiated and vested benefits for retirees. There is no relevant exclusion from arbitration in the parties' agreement.

The grievance is timely as a continuing violation for adversely affected bargaining unit members. It is also timely because the Union grieved upon learning that Lt. Bigley was charged \$20 for Fexofenadine. The Employer contended in its March 30, 2007, response that the grievance was not timely because all employees were provided with the health plan benefits by memorandum dated November 29, 2006. However, Personnel Director Stanczk conceded that the memorandum did not notify employees that all generic drugs were not subject to a \$5 co-pay. The first time employees received a plan description was in June, 2007.

The Employer's alternative position based upon mutual mistake is without merit. Mr. Kiser testified that if the Employer had placed the generic drug benefit in its request for proposals, the insurance company could have included that benefit. Personnel Director Stanczak testified that he did not realize the insurance proposal did not include the generic benefit until November 8. Contrary to his assertion that he gave the Union notice of the differing benefit in his November 29, 2006, notifying employees of the meetings to explain benefits, the language of that communication does not reasonably convey that information. In fact, the Employer never gave the Union notice of the change in benefits before the grievance was filed. The Employer has not demonstrated that it has clean hands and, therefore, is not entitled to the equitable remedy of reformation. In any event, the arbitrator lacks the authority to order the parties to negotiate a new benefit. The Union requests that the arbitrator sustain the grievance and order that the Employer repay all affected current and retired employees, order the Employer to cease and desist from violating the agreement and retain jurisdiction over issues arising from the remedy.

Employer

The agreement requires that the grievance be filed within 10 days of the occurrence. The grievance was not filed within ten days of January 1, 2007, the date the new health insurance plan took effect. The documents distributed to unit employees in December, 2006, state in relevant part:

Your Copayment is determined by the tier to which the Prescription Drug List Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

. . . .

The Union sought no clarification and did not seek to bargain with respect to the drug plan described there. The Union first filed the grievance on March 8, 2007. The Union has offered no plausible reason for this delay. It is undisputed that the Union never sought, and the Employer never granted, an extension of the time to file a grievance.

The issue before the Arbitrator is limited to the issue presented in the grievance; namely, whether “local 414 members are being charged generic drug co-pays in excess of those agreed to” At hearing, the Union attempted to expand the scope of the grievance to include retirees and other issues about how United manages its prescription drug program. Therefore, the only issues that are properly before the arbitrator are the generic drug co-pay and the appropriate remedy for current employees only.

The Union has failed to prove that the Employer violated the agreement. Specifically, Mr. Bigley testified about his family’s use of Fexofenadine which is a generic drug. He purchased this drug and paid the Tier 2 deductible instead of the Tier 1 deductible. However, Claritin is an equivalent over-the-counter medication. This was always available to him at Tier 1 co-pay. Claritin was not a covered drug under the former prescription plan. Mr. Bigley testified that the payment for some prescriptions were entirely denied by United but failed to provide any written evidence of that allegation. He also admitted that he did not appeal the denial of his prescription requests even though he was fully aware of the appeals process. The Union also offered hearsay testimony from a retired fire fighter over the Employer’s objection of a denial of his prescription claim. This fails to establish any violation by the Employer.

The Union obtained the benefit of the bargain. The Union relies upon the Employer’s health insurance proposal of September 6, 2006. This not only requires a co-pay of \$5 for generic drugs, but also requires “generic substitution” by which employees are required to substitute a generic for a name brand whenever one is available. This is exactly what the Union seeks. Under the United plan employees are required to substitute an over-the-counter drug for a generic when one is equally effective as the other. The Union’s contention that every generic must be available under Tier 1 is not supported by the September proposal.

Alternatively, the MOU should be reformed because it was a product of mutual mistake. Both parties believed that the prescription drug plan in place called for a \$5 generic co-pay. In fact, it appears that the Union ended up with a better drug plan than they originally bargained for: some brand name, non-generic drugs are covered under Tier 1 of the new plan. If the arbitrator finds that the benefit was not what the parties intended, then the arbitrator must find that a mutual mistake occurred. There is no testimony that Mr. Stanczak had any knowledge at the time he signed the MOU that the generic drug benefit was not identical to the

benefits specified in the Employer's September 6, 2006, proposal. He learned of the differences subsequent to the execution of the document. The Union is claiming ignorance of the differences until sometime in June, 2007. The mutual mistake is that both parties thought that the prescription drug benefit reflected the terms of the United plan. The arbitrator should reform the agreement to the current drug plan which would allow the parties to move on from what is, in fact, a rather minor difference. Alternatively, the Arbitrator could remand the dispute to the parties for resolution through negotiations. This resolution has some merit because the parties must still bargain a new contract for 2007 and beyond.

The Employer has the right to change the terms of the plan provided that it is substantially similar to the prior plan. The MOU provides that the Employer may make changes in health insurance so long as it ". . . maintains coverage substantially similar to the prior plan." The new prescription coverage is "substantially similar" to the prior plan. This determination is based on the overall plan and not each part of the plan. In fact, the United benefit is a better benefit than the former prescription plan. Specifically, the goal of the plan was to encourage employees to take lower cost alternatives to some generics which would otherwise be in tier 1. This is an updated and more sophisticated version of the old plan. Insurers went to this type of plan to counter price problems with some generic drugs. Further, there are many name brand drugs in Tier 1, a benefit to employees. Accordingly, the Union has failed to show that the new benefit is not "substantially similar" within the meaning of the agreement.

Union Reply

The Employer's brief has a number of significant positions not supported in the record. First, the Employer takes the position that the reason that Mr. Stanczak failed to act after learning the United prescription benefit was different than was bargained is because it was "too late" to make any changes in the health plan. There is no evidence in the record that the situation could not have been remedied. Similarly, there is no support for the Employer's assertion that Mr. Stanczak considered the matter insignificant. He testified that he understood the benefit was important to the Union and that the Employer's objective was to provide a \$5 drug benefit. The second erroneous factual assertion posited by the Employer is that the November 29 memo clearly specified the drug benefits provided under the United plan. In fact, Mr. Stanczak conceded that the November 29 memo did not explain to employees that not all generic drugs were covered at the \$5 level.

The Employer erroneously argues that the November 7, MOU affords it the right to make changes to the negotiated plan as long as the coverage is "substantially similar." The language referred to in the MOU did not apply to the changes which were subject to this dispute, but to future changes following the adoption of the new plan. The Employer could have bargained for such language in the November 7 MOU or placed such language in its September 6, final offer, but it did not do so.

Employer Reply

The Union refers to Union Exhibit 12 as a “summary plan” description.” Union Exhibit 14 is a comprehensive plan description prepared by United. Union Exhibit 12 was used by the parties in negotiations to compare the financial impact of the plans in effect during 2006, with the proposed plans. It provided costs estimates with regard to the different benefits.

The Union’s statement of facts refers to the Employer’s final offer as consisting of Union Exhibit 12 summary plan description. The Union ignores that Union Exhibit 10 which was also provided to the Union during the same session. This proposal states:

Prescription Drugs: \$5/\$20/\$25. With mail order for maintenance drugs, employee pays the equivalent of 2 co-pays for 90 day supply. The City offers an over-the-counter (OC) drug plan as allowed by a new pharmacy benefit manager. Said plan would be modeled similar to the following: \$5 co-pay for OTC drugs that exceed \$5 retail cost and \$0 co-pay for OTC drugs that are less than \$5 retain cost. [Emphasis Employer’s reply brief.]

The Employer’s final offer was not as definitive as the Union would like to think.

Lieutenant Bigley’s testimony about attempting to obtain Fexofenadine through United failed to note that an over-the-counter medication was available which was as effective. If Lt Bigley’s doctor concluded that it was not, Lt. Bigley could, but admittedly did not, appeal the rejection by United as provided in the plan description.

The Union claims that it was unaware of the terms of the new prescription benefit until, at the earliest, March, 2007. The Union does this by minimizing the impact of the November 29 memorandum to all plan participants. The Union argues that Employer Exhibit 2, the November 29, 2006 memorandum of benefits distributed to employees only “generally” described the prescription benefit of the new United plan. In fact, with its reference to United’s website it was a complete description. The Union willfully ignored the information in that document.

The Union asserts that drugs were moved from one Tier to another. There is no evidence in the record that this occurred. The drug tiers were set as of January 1, 2007. Nothing in the record supports the Union’s position that United drug plan is a “significant cost factor affecting a wide range of prescription drugs.” The Union’s case rests on one employee’s troubles navigating through the plan. Mr. Kisser’s testimony negates the Union’s factual theory of the case.

The Union faults the Employer for not providing it with a copy of the RFP and argues that this failure negates any notion that the Union ratified or approved the drug plan which was adopted. The Union cannot complain about not receiving the RFP because it never made a request to see it until after the grievance was filed. The Employer was forced to go through

the RFP process without an agreement from its unions. The Union simply failed to keep itself informed about the new health insurance process.

The benefit for retirees is not within the scope of the issue presented here. The grievance did not mention a remedy for retirees. The Union's statement of the issues did not mention retirees. The Union did not discuss retirees in the grievance procedure.

The Union does not represent retirees. Sec. 111.70(1)(i) excludes former or retired employees from the definition of "employee." See, CITY OF MILWAUKEE, DEC. NO. 19091 (WERC, 1/81). BENCE V. CITY OF MILWAUKEE, 107 Wis.2D 469 (1982) and ROTH, ET AL. V. CIT OF GLENDALE, 224 Wis.2D 800 (Ct. of App., 1999) concluded that retirees were not entitled to be represented in contract negotiations. Therefore, the arbitrator cannot fashion a remedy which includes retirees.

DISCUSSION

1. Statement of the Issue/Scope of the Grievance

The parties were unable to agree to a statement of the issues in the case, but agreed that I might state them. The Union stated the issues as:

Did the Employer violate the agreement with the Union when it contracted for health insurance coverages which included some generic drugs in Tier 2 of a health insurance prescription drug coverage, such that employees were required to pay \$20 for a generic drug rather than \$5?

If so, what is the appropriate remedy?

The Employer stated the issues as:

Whether the prescription drug plan implemented by the Employer on January 1, 2007, violated the terms of the side letter between the parties of November, 7, 2006?

If so, what is the appropriate remedy?

However, after the Employer stated its proposed issue, it raised a number of positions which were not reflected in its statement of the issue. First, shortly after it stated the issue, it noted that it was its position that the grievance was not timely filed and amended its position as to the statement of the issues to include timeliness. I have added an issue to that effect.

Second, it argued that the issue in this case should be limited to the scope of the grievance presented. This is essentially the same as arguing for the Union's statement of the

issue. It is, therefore necessary to address the proper scope of the grievance in order to decide the proper statement of the issue.

The grievance procedure does not state the degree with which the written grievance must be specific. It does provide that the parties will mutually agree on a grievance form. Under those provisions, the grievance need only be drafted in sufficient form to give the Employer adequate notice of the nature of the dispute. Technical drafting is not required and grievances should be broadly construed so long as the Employer is not prejudiced or misled by the statement of the grievance. The grievance was substantively stated as follows:

Chris Bigley and Local 414 members are being charged generic drug co-pays in excess of those agreed to between the City and Local 414.

The better view of the circumstances of this case is that the Union did not fully understand the nature of the issue at the time it filed the grievance. The Union did not then recognize that the reason that the generics were not treated at the \$5 level was that the prescription coverage which was adopted was different than what the Union had believed had been agreed upon. The record at hearing indicates that the parties first discussed the grievance at the third step. Mr. Stanczack was personally aware of why generics were treated differently than the Union expected. It is clear from Mr. Stanczack's answer that he recognized the underlying reason and that the parties discussed the grievance on the basis of the difference between the Union's view of what had been agreed upon and the difference in the insurance plan which was adopted. Accordingly, I am satisfied that the grievance which was filed gave the Employer adequate notice of the existence of the broader issue. I am also satisfied that, as of the time the parties discussed the grievance in the grievance procedure, they both focused on the broader issue. Accordingly, the broader substantive issue I have stated above was within the scope of the grievance as the parties understood it in the grievance procedure.

The Employer also objected to the Union's attempt to include retired employees within the scope of this grievance. I have concluded that the issue as to whether or not I have jurisdiction over the retirees is properly before me, but it is no necessary to decide at this time whether I have that jurisdiction.

2. *Timeliness*

The Employer has contended that the grievance filed in this action is untimely because it was not filed within the ten day limit of the first step of the grievance procedure, Section 21.02. The Union contended that it was timely because this was a continuing grievance or, in the alternative, that it was timely because the grievance was presented within ten days of when the Union learned of the violation.

There is a serious question as to when the violation "occurred." The policy of insurance differs from that agreed upon by the parties. The Union might have filed a grievance then, but until there was a situation in which employees were actually denied

coverage of a generic at a \$5 co-payment, the grievance would have involved solely different wording, but not necessarily different benefits. The plan administrator had unilateral control over the generic prescription drugs which were to be covered and had the authority to change that coverage away from or into Tier 1. Although the Union might have filed a grievance within 10 days of the time the plan was adopted, it might also have waited to see if there really was any difference in the administration. Under that scenario, the actual violation might only occur when the plan administrator first denied coverage of a generic prescription drug at Tier 1. I conclude that a violation occurred only after a beneficiary was denied a \$5 co-payment. There is no evidence that this occurred more than ten days before the grievance was filed. I conclude that the Union filed this grievance within 10 days of when it “occurred.”

The 10-day limit applies to contract violations in which the Employer does not act to interfere with the Association’s gaining knowledge of the violation of the agreement. Thus, for example, if the Employer willfully conceals its violation, the time limit might not apply. The Employer did not willfully conceal its violation here. However, this is a situation which arose in the context of negotiating a provision. The nature of the negotiation was such that the Union might reasonably have expected that the Employer would have notified it if the prescription coverage obtained varied from that which was negotiated. It is unclear whether Union representatives were at the meetings in which explanatory information was distributed. Even if they were, this problem was not readily apparent on the face of the information distributed. It is reasonable to conclude in this case that the Employer unintentionally, inordinately contributed to the Association’s failure to recognize the issue

3. *Burden of Proof*

It is well established that ordinarily the party filing a grievance has the “burden of proof.” The burden of proof includes the duty to produce evidence to demonstrate that a violation has occurred and the burden of persuasion to demonstrate by at least a preponderance of the evidence that a violation has occurred. Parties to a collective bargaining agreement can by express agreement, implicit agreement, or custom and practice in labor arbitration vary either burden. A common example is that most parties recognize that an agreement to discharge an employee only for just cause places both burdens upon the Employer even though the Union may have filed the grievance.

I conclude that burden of proof is divided between the Employer and the Union by implication of the terms of the MOU. The Union bears the burden to prove that the Employer violated the MOU by adopting a prescription drug plan which had terms which differed from that agreed upon. As I discuss more below, the terms of the specific benefit employees were to receive were relatively specific. The Union had ready access to the information necessary to prove its case. It accomplishes its proof by affirmatively demonstrating that certain facts occurred.

As I discuss more below, I conclude that the parties created an express exception to the Employer’s duty to adopt all or part of those specific terms. The better view is to treat this

exception as placing both burdens upon the party seeking to avail itself of the exception, the Employer. This is more consistent with the ability of the Employer to produce evidence of its own actions and its reasons for those actions. The Employer alone had control over the bidding process and HCSC was the Employer's consultant. Placing the burden of proceeding and persuasion on the Union with respect to the exception would have the impact of forcing the Union to essentially prove a negative: i.e., that there was nothing which fell within the exception. Similarly, I place both burdens upon the Employer with respect to its argument concerning mutual mistake.⁸

4. *Violation of the MOU*

The Union met its burden to establish that the Employer violated the express terms of the MOU with respect to prescription coverage. The positions of the parties reflect a fundamental disagreement as to the meaning of the MOU. It is important to summarize the responsibility of the arbitrator in this situation. The arbitrator is responsible to interpret and apply the parties' agreement as they have written it. If an agreement is ambiguous⁹ it is the arbitrator's responsibility to determine which of the differing interpretations is the correct one. The arbitrator accomplishes this by using the principles of contract interpretation and construction ordinarily used by the courts, including, but not limited to, looking at the negotiation history or other extrinsic evidence

The Employer's final offer of September 6 is quoted above, in relevant part. The use of the form "\$5 generic" is a form of shortened notation customarily used by experienced negotiators in Wisconsin and well known to this arbitrator through his experience mediating labor disputes. This shorthand is not necessarily meant as a total integration of a proposal but meant to refer to its main features and to incorporate the oral understandings between the parties. While this shorthand notation on its face has substantial ambiguity, it is well explained as it relates to the subject dispute by the bargaining history.

There is no dispute about the nature of the expired prescription drug plans maintained by the parties. Further, Mr. Bigley testified without significant contradiction from any witness as to the negotiations surrounding the Employer's final offer of September 6 which, as modified, was incorporated by reference in the third paragraph of the MOU. Prior to that time, employee prescription drug costs under the Partners plan were fixed. Employees' prescription drug expenses were always fixed at a co-payment of \$5 where a generic equivalent to a prescribed drug was available. All generic drugs were covered irrespective of their cost. The parties conducted their negotiations based upon their experience under the Partners plan and the Employer's offer is correctly construed as assuming all generic drugs would be covered at a \$5 co-payment regardless of costs.

The Union met its burden of proof to establish that the administration plan adopted by the Employer varied from that plan. The Union attempted with some difficulty to establish that

⁸ GORTON V. HOSTAK, HENZEL & BICHLER, S.C., 217 Wis. 2D 493 (1998).

⁹ That is, fairly susceptible to two different interpretations.

there were some generic prescription drugs which were not covered at Tier 1. However, Mr. Kisser testified on behalf of the Employer in its case-in-chief. He and the written evidence as to the plan which was adopted demonstrated that the plan which was ultimately adopted is different than the prescription drug coverage the parties mutually expected under the MOU.

Specifically, he acknowledged that not all generic drugs are covered. There are some which the plan administrators exclude because they conclude they can be replaced with chemically different compounds which are just as effective. In this regard, plan administrators have an impact over the beneficiary's physician's choice as to what drug he or she determines will have therapeutic value. Further, some generic drugs are placed in a higher tier because the plan administrator concludes they are unreasonably priced. Finally, the plan administrator has retained the right to make changes up to six times per year and as to how difficult it would be for an individual beneficiary to make a decision as to whether to return to his or her medical care provider to advocate for a specific prescription under that beneficiary's own particular circumstances. I conclude the plan adopted is inconsistent with that contemplated by the express terms of the MOU.

5. *Applicability of Variation Exception of the MOU*

The MOU incorporates by reference the Employer's offer of September 6 which includes a provision providing for an exception should the bidding process yield a "manner of administrative control" which conflicts with the benefits stated in the offer as follows:

Should the parties agree to changes in its health plan, the City will propose language that specifies specific benefit changes but that it cannot promise the manner of administrative control that will always rest with a plan administrator.

Mr. Stanczak's testimony is somewhat ambiguous about what he understood that provision to mean. At one point he stated his view that it meant that if the bidding process yielded a plan with different benefits at all, then those benefits would govern.¹⁰ The Union took the view that the foregoing did not authorize a variation from the specific benefit which the parties negotiated. The foregoing is reasonably susceptible to a meaning which allows the method of administration to result in slightly different benefits or a meaning which will not affect the level of benefits.

The use of agreements in the process of negotiating complex benefits packages which allow some form of leeway is very important in collective bargaining. It is important to give those agreements their fair meaning. The bargaining history is very helpful in understanding this ambiguity. First, Mr. Stanczak credibly testified that he frequently explained to the collected unions his concern that the terms that they submitted for bid would be "marketable." The collected unions' negotiators understood the Employer's concern was that that it was

¹⁰ See, for example, his testimony at transcript page 87.

seeking to obtain bids from commercial insurers to administer the new plan and both sides understood that it would be difficult or very expensive to obtain bids if the bidders were faced with provisions which were not consistent with the nature of insurance plans customarily offered by insurance companies to employers elsewhere.

Second, Mr. Stanczak changed to the final paragraph above by eliminating the paragraph before it from his previous offer. [See, note 7, above.] The first proposal granted broader discretion to the Employer. This occurred at a time when Mr. Stanczak was under considerable negotiation pressure. At the same time, he continued to make very specific proposals with respect to benefit levels. Under the circumstances, the ambiguity of the above language is properly construed against the Employer.

I conclude that the generic prescription benefit specified in the MOU was marketable. I make this conclusion for several reasons. I don't believe either negotiator¹¹ expected the issue which is the subject of this dispute to occur. Mr. Kissel testified that the tier system contemplated by the MOU placing all generics in Tier 1 is available from United. About 15% of its plans still have a fixed generic benefit. However, United prefers now to use its newer and more aggressive Tier system. The new system gives it more cost control over prescriptions. Accordingly, United read the RFP broadly to allow the more recent type. Approximately 85% of its plans are of the more recent type. Under the circumstances, I conclude that fixed generic benefit plan was "marketable," even though not then highly preferred by insurers. I note that the ambiguity should be construed against the Employer because the Employer had its consultant, HCSC, at its disposal. HCSC was certainly in a position to understand the insurance market. Accordingly, I conclude that the exception does not apply. One of the key elements in the exception is that it was designed to deal with a potential circumstance in which a benefit the parties were negotiating turned out to not be "marketable." In some cases, HCSC could have determined whether a benefit was likely to be marketable. However, in some cases HCSC could not because some of the factors which affected marketability were not reasonably ascertainable at the time of the negotiations.¹²

The Employer argues that there were other additional exceptions. I conclude that there are no other applicable exceptions. The Employer argued that the last paragraph of the MOU authorizes the subject variation. That provision reads in relevant part:

The Union agrees that, to the extent necessary, Article 20 of the 2004-2006 labor agreement shall be modified to reference the City of Kenosha Summary Plan Description – short form (dated September 6, 2006). The parties agree that the City may change health insurance carriers, third party administrator's (sic) or implement a self-funded health insurance plan if it gives

¹¹ HCSC had to be familiar with the types of prescription drug plans that United elsewhere. That knowledge is a fundamental component of their business.

¹² An example of this concept of unforeseeability would be a situation in which United offered generic coverage of the type contemplated to other employers but would not do so for this Employer because of factors related to the unique nature of the claims experience under the Employer's former plans.

the Union at least thirty (30) days written notice of changes and maintains coverage substantially similar to the prior plan.

The Union is correct that this provision does not apply to this dispute. The provision applies to changes to an existing plan and not to a proposed plan. The Employer agreed in this case to essentially use its best efforts to implement the benefits it proposed. While it is unclear why it did not occur, it is clear that the Employer failed to do so. The parties understood what the MOU meant. Although the RFP was phrased in the same language as the settlement, HCSC failed to make clear to prospective bidders that the RFP was for a fixed \$5 co-payment as to all generic drugs in the original RFP or an amendment thereto. In this regard I attribute the knowledge of the Employer's negotiators to HCSC because HCSC was the Employer's agent in this process. Mr. Kissler's testimony on this point makes it very likely that industry representatives would not have viewed the RFP as it was drafted as calling for a fixed \$5 co-payment for all generic drugs.

In any event, Mr. Stanczak never gave the Union a notice under the foregoing provision that he was going to change the agreed-upon generic drug plan to the one which was adopted.¹³

6. *Mutual Mistake/Reformation*

The Employer also sought reformation of the agreement because of an alleged mutual mistake. No decision is made concerning the authority of the arbitrator to reform the agreement under which he is arbitrating. I conclude that there was no mutual mistake. The assumption underlying the Employer's position is that the agreed-upon plan is not marketable or available in the market place. I conclude that it was available and remains available. The mistake which has occurred here is solely that of the Employer in not adequately seeking to implement the MOU as to generic drugs. On the basis of all of the foregoing, I conclude that the Employer violated the MOU when it adopted a health and prescription plan which was inconsistent with the terms of the MOU relating to the limit of a \$5 drug co-payment.

7. *Remedy*

The Union has sought the customary make-whole remedy and an order to implement the MOU's generic drug benefit. It has sought the make whole remedy with respect to current employees and retirees. I conclude that the imposition of a make-whole remedy is premature. The purpose of a remedy in contract disputes is to put the parties in the same position they would have been had a party not violated the agreement. The better view is that the parties would have at least attempted to negotiate a resolution of the disparity. This is true because the parties intended to negotiate a health plan which was uniform across all units. This is why the parties met on a multi-unit basis. The establishment of different terms for this bargaining

¹³ Although the exception does not expressly apply, the fact that the Employer has the authority to make some changes under this provision can be considered in fashioning a remedy.

unit would violate the structure clearly intended by the parties. Mr. Kisser's testimony indicated that the benefit is commercially available from United, but it is unclear how much that benefit would cost. The rating of this unit might make the benefit inordinately expensive. It is also conceivable that a less intrusive remedy might be appropriate. For example, it might be possible to fashion a remedy affecting only those who are substantially affected by the different plan or change the administration of the plan so that beneficiaries can notify their medical provider of drugs which are disadvantaged in the plan at the time of their first visit. It is pre-mature to determine if any monetary remedy should include retirees.

Accordingly, I have today issued an interim award which remands the matter to the parties for further negotiation for a set period of time. I have set a pre-hearing telephone conference for the purpose of scheduling, making appropriate orders about obtaining cost information, claims experience and other discovery information and such other matters as may aid in the final disposition of this matter. I have tentatively set a hearing date which may be postponed for good cause shown only.

INTERIM AWARD

1. That the Employer violated the Memorandum of Understanding by not implementing the \$5 co-payment for all prescription drugs.

2. A pre-hearing telephonic conference will be held on June 30, 2008 at 9:30 a.m. The parties shall notify by e-mail at stanley.michelstetter@werc.state.wi.us of the telephone number they will be at, at the time of the call. I will initiate the call.

3. Further hearing as to remedy in this matter will be held at Kenosha City Hall, on August 22, 2008, at 9:00 a.m.

4. The Employer shall forthwith obtain information as to the cost of modifying its plan to be consistent with a \$5 fixed co-payment for prescription generic drugs.

5. The matter is remanded to the parties for further negotiation as a remedy.

Dated at Madison, Wisconsin, this 16th day of May, 2008.

Stanley H. Michelstetter II /s/

Stanley H. Michelstetter II, Arbitrator

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