BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

HEART OF THE VALLEY METROPOLITAN SEWERAGE DISTRICT EMPLOYEES, LOCAL 130-B, AFSCME, AFL-CIO

and

HEART OF THE VALLEY METROPOLITAN SEWERAGE DISTRICT

Case 12
No. 67745
MA-14005

(Health Insurance Grievance)

Appearances:

Mark DeLorme, Staff Representative, AFSCME Council 40, appearing on behalf of the Union.

John Haase, Godfrey & Kahn, Attorneys at Law, appearing on behalf of the District.

ARBITRATION AWARD

The above-captioned parties, hereinafter the Union and District or the Employer, respectively, were parties to a collective bargaining agreement which provided for final and binding arbitration of grievances. Pursuant to the parties' request, the Wisconsin Employment Relations Commission appointed the undersigned to decide a grievance. A hearing, which was not transcribed, was held on August 12, 2008 in Kaukauna, Wisconsin. Afterwards, the parties filed briefs and reply briefs, whereupon the record was closed on November 6, 2008. Based on the entire record, the undersigned issues the following Award.

ISSUES

The parties were unable to stipulate to the issues to be decided in this case. The Union framed the issues as follows:

1) Did the Employer violate the terms of the collective bargaining agreement when it unilaterally changed its premium contribution from 93% for all plans to 93% of the lowest cost plan?

2) Did the Employer violate the collective bargaining agreement when it unilaterally switched to the Wisconsin Public Employers' Group Health Insurance?

3) If so, what is the appropriate remedy?

The Employer framed the issues as follows:

1. Is the Employer in violation of the collective bargaining agreement by paying 93% of the health insurance premiums for the LCQP under the State Health Plan?

2. Does the present grievance raise the issue of whether the Employer violated the contract by switching to the State Health Plan?

3. If the present grievance raises the issue of whether the Employer violated the collective bargaining agreement by switching to the State Health Plan, did the Union file such grievance in a timely fashion?

4. If the answer to issue number 3 is yes, then, did the Employer violate the collective bargaining agreement by switching to the State Health Plan?

I have not adopted either side's proposed issues. Based on the entire record, I find that the issues which are going to be decided herein are as follows:

1. Did the Employer violate Article XIV of the collective bargaining agreement by switching to the State Health Plan?

2. If not, did the Employer violate Article XIV of the collective bargaining agreement when it based its 93% premium contribution on the least costly qualified plan? If so, what is the appropriate remedy?

PERTINENT CONTRACT PROVISIONS

The parties' 2005-07 collective bargaining agreement contained the following pertinent provisions:

ARTICLE XIV
HEALTH INSURANCE

Group Health Insurance will be available to all full-time employees with the Employer paying ninety-five percent (95%) per month toward the premium of the employee rate, single or family. Effective January 1, 2007, the Employer shall pay ninety-three percent (93%) per month toward the premium for single or family health insurance.

In the event that the Network Health Plan and United Health HMO's are no longer available to employees of the Heart of the Valley Metropolitan Sewerage District because of the City of Kaukauna no longer being a participant in these plans, the Heart of the Valley Metropolitan Sewerage District shall guarantee that the employees covered by this contract will be made whole for any additional premium payment over the rate in effect at that time and any loss in coverage or benefits which occurs until such time that the contract expires or another insurance plan is negotiated and agreed to by the parties.

Nothing herein shall prevent the Heart of the Valley Metropolitan Sewerage District from changing carriers in the future provided there is no reduction in coverage or benefits.

Co-pay reimbursements-involving Network Plan and United Health Plan HMO's will be established at $240.00 per employee, per policy contract year.

. . .

ARTICLE XXIV
GRIEVANCE PROCEDURE

. . .

If it is determined, after investigation by the Union, that a grievance may exist, it may be processed in the grievance procedure. Such processing must be begun within five (5) work days of the alleged violation. Any alleged grievance not filed within the above stated limit shall be invalid.

. . .

FACTS

The District operates a sewerage district. It has about a dozen employees. The Union represents the District's waste water treatment plant employees. The Union and the District have been parties to a series of collective bargaining agreements.

Since about 1994, the District has provided health insurance coverage for its employees in tandem with the health benefits offered through its local municipality, the City of Kaukauna. Two health plans have historically been available to the District's employees through the City of Kaukauna's coverage – Network Health Plan and United Health HMO. District employees could select either the Network Health Plan or the United Health HMO. The District paid the same percentage of the premium, regardless of which plan the employee selected. For 2005 and 2006, the Employer paid 95% of the premium and the employees paid 5%. Beginning January 1, 2007, the Employer paid 93% of the premium and the employees paid 7%.

In August of 2007, the District learned that, effective October 1, 2007, the health insurance premium for the United plan was increasing by 50%, with the monthly family premium going from $1,263 per month to $1,899 per month. The increase for the Network Health Plan was 5.7%, with the monthly family premium going from $1240 per month to $1303 per month.

Upon learning of the premium increase for United, the District began a search for other health insurance options for all of its employees. Before it began that search, the District knew that it had the contractual right to change health insurance carriers provided, as the contract puts it, "there is no reduction in coverage or benefits." The Employer's insurance search ultimately led to the Wisconsin Department of Employee Trust Fund's State Health Plan.

The State Health Plan is an insurance program that is operated by the State of Wisconsin for its public sector participants. The State Health Plan is structured on a county-wide basis, aligning participating health care providers with each of the State's 72 counties. The State Health Plan consists of three types of plans: 1) alternate health plans (HMOs), 2) a standard plan, and 3) a state maintenance plan. The State Health Plan's HMO participants offer comprehensive benefits at lower costs than the standard plan in exchange for some health care provider limitations. Specifically, the participating HMO's are mandated to offer the same level of coverage, called Uniform Benefits. A plan is deemed "qualified", within the meaning of the State program, if it meets those specific benefit thresholds. Conversely, a plan is deemed "non-qualified" if it does not provide those minimum levels of provider availability mandated by the State of Wisconsin. The plans classified as non-qualified plans are also available to State Health Plan participants. With Uniform Benefits, employees can select a health plan based on costs without concern of a lower benefit level. Participating employers are prohibited from making any benefit design changes to the mandated Uniform Benefits as a tradeoff for the competitive premium costs associated with the program. Under the State Plan, an employer's contribution toward the premium is not based on the plan selected by the employee. Instead, the employer's contribution is based on the least costly qualified plan within the employer's service area (i.e. the County). Under the State Health Plan, the employer contribution toward the premium has to be between 50% and 105% of the "least costly qualified health plan" in the employer's service area and cannot be more than 105% of the least costly qualified plan. The least costly qualified plan is an important trigger for State Health Plan participating employers. It is the foundation for the cost calculations. This dollar amount remains unchanged regardless of the health plan chosen by the employee. Said another

way, the amount of money paid by the employer toward the premium remains constant, regardless of the plan selected by the employee. If an employee selects a plan costing more than the least costly health plan, they pay more of the premium than they would if they selected the plan that is the least costly health plan.

After considering the foregoing, the District decided to switch the health insurance coverage for its employees to the State Health Plan. It did so for the following reasons. First, while numerous insurers participate in the State Health Plan, two of the insurers that participate in the plan in the District's service area (i.e. Outagamie County) are United Health HMO and Network Health Plan. Those were the same insurers that were then providing health insurance for the District's employees, so if the District moved its coverage to the State Plan, the District's employees could continue with either of their existing carriers (namely United Health HMO or Network Health Plan) and would not have to switch to another carrier. Second, as noted above, the State Health Plan requires all insurers that participate in the plan to provide the same level of benefits. That meant there would be no difference in coverage between the United plan and the Network plan through the State Health Plan. Third, the District believed there would be no reduction in coverage or benefits as a result of moving to the State Health Plan. Fourth, the insurance premiums which were charged with the State Health Plan were lower than what would be charged through the City of Kaukauna's plan.

The Employer made its decision to switch the health insurance coverage for its employees to the State Health Plan unilaterally. The Employer did not consult or bargain with the Union about the matter prior to making the change.

On September 5, 2007, the District's General Manager, Mark Surwillo, met with the president of the local union, Jeff Vanden Huevel, and told him that the District was going to switch its health insurance coverage for 2008 to the State Health Plan. Surwillo also told Vanden Huevel that the Employer's interpretation was that the State Health Plan mandated a calculation off the least costly qualified plan and, whatever that amount was, it remained unchanged regardless of the health plan chosen by the employees. While this matter will be addressed in more detail below, the record indicates that in 2008, the least costly qualified plan in the District's service area (i.e. Outagamie County) was Network. Surwillo also indicated that the Employer's 93% contribution toward the health insurance premium was going to be based on Network's monthly premium – not United's monthly premium. Thus, Surwillo told Vanden Huevel that the Employer was going to pay 93% of the Network premium – not 93% of the United premium as it had been doing under the City of Kaukauna's plan. Surwillo also told Vanden Huevel that, by early October 2007, all bargaining unit employees would be required to complete enrollment application forms for the State Health Plan.

The Wisconsin Department of Employee Trust Funds requires public employers that participate in the Public Employers' Group Health Insurance Program to pass a resolution accepting the State Health Plan as its insurance provider. The District formally passed a resolution moving to the State Health Plan on September 11, 2007. In doing so, the District elected to participate in the traditional HMO paired with the Classic Standard Plan.

In early October, 2007, the District informed unit employees about the Employer's switch in health insurance coverage to the State Health Plan. That timetable corresponded with the State Health Plan's enrollment period for 2008. Unit employees received a booklet entitled "It's Your Choice" from the State Health Plan that included plan and program information. It also listed the monthly premium for each health plan offered. The Outagamie County service area provides four HMO options, along with the statewide Standard Plan. Three of the HMOs offered in Outagamie County are qualified plans; they were Network, United and Humana Eastern. The fourth HMO offered – Arise – is non-qualified. The 2008 monthly family premiums for the four HMOs, as well as the Standard Plan, are as follows:

Network	$1,219.30
United	$1,340.80
Arise	$1,427.10
Humana Eastern	$1,984.80
Standard	$2,250.40

As these numbers show, Network was the least costly qualified plan. Unit employees subsequently completed their insurance enrollment paperwork and decided which plan to select. Although the employees could have selected insurance coverage from any of the foregoing plans, the employees opted to stay with the plans they were already with. Two unit employees selected United and the other unit employees selected Network. The District subsequently notified employees it would pay 93% of the premium for Network since it was the least costly qualified plan in the Employer's service area. If the employee has family coverage through Network for 2008, the Employer is paying $1133.95 toward the monthly premium and the employee is paying $85.35 toward the monthly premium. If the employee has family coverage through United, the Employer is paying $1133.95 toward the monthly premium and the employee is paying $206.85 toward the monthly premium.

On December 4, 2007, the Union filed a grievance which contended that the District violated Article XIV of the collective bargaining agreement as a result of the "insurance premium charge". While the grievance made no reference to challenging the Employer's right to switch insurance plans, the Union told the Employer at the Step 3 grievance meeting that it intended the grievance to challenge the Employer's right to unilaterally change to the State Health Plan. At that meeting, the Union also told the Employer that it was the Union's position that after the Employer moved to the State Health Plan, the Employer had to pay 93% of the premium for both the Network plan and the United plan. Following that meeting, the District denied the grievance in a letter dated January 16, 2008. The grievance was subsequently appealed to arbitration.

POSITIONS OF THE PARTIES

Union

The Union's position is that the Employer violated the health insurance provision in the collective bargaining agreement in two respects by its actions herein. First, the Union contends that the Employer violated the contract by unilaterally switching to the State Health Plan. As part of its argument on this point, the Union avers that its grievance put the Employer on notice that it was challenging that action. Additionally, the Union disputes the Employer's assertion that the grievance was untimely. Second, the Union argues that after the Employer switched to the State Health Plan, it also violated the contract when it decided to pay 93% of the health insurance premium for just one plan, namely the lowest cost plan (Network). According to the Union, it should also have paid 93% of the premium for the United plan. The Union elaborates on these contentions as follows.

First, the Union disputes the Employer's assertion that its grievance did not challenge the District's decision to change to the State Health Plan. It avers that it did indeed raise that issue in the grievance, so it is properly before the arbitrator for a decision. While the Union acknowledges that its wording of the grievance was "not as specific as it could be", the Union submits that's because "union officers are not lawyers and they will not encompass every issue with as much specificity." Even if the original grievance did not expressly challenge the Employer's switching to the State Health Plan, the Union contends that it "clarified" the grievance to include its objection to changing to the State Health Plan no later than the Step 3 grievance meeting held January 18, 2008. Thus, the Union believes it put the Employer on notice of its inclusion in the grievance and, as a result, it is "now disingenuous to claim that the grievance is too vague to determine if the challenge to the State Plan is incorporated in it." To support that contention, the Union cites the fact that following that meeting, the Employer sent the Union a letter which stated in pertinent part; "You also made a comment that the union intends to challenge the HVMSD's right to change the insurance plan." According to the Union, this statement proves that the Employer knew that was part of the grievance. As for the ALMOND-BANCROFT SCHOOL DISTRICT arbitration award cited by the Employer for the proposition that a grievance cannot be expanded beyond what was referenced on the grievance form, the Union believes it is significant that the issue in that case was expanded the day before the hearing. Here, though, the Union amended its grievance seven months before the hearing. Additionally, the Union asserts that the Employer did not raise its procedural arbitrability argument involving this matter until the hearing. Building on that premise, it's the Union's view that the Employer's "lack of objection" until the hearing should result in a finding that the Employer's procedural objection was waived.

Second, the Union argues that the instant grievance was timely filed. It asserts that in this case, the action that triggered the grievance was the increased premium deduction from the employees' paychecks. According to the Union, this action demonstrated to the employees that "the District had unilaterally switched to the State Plan and that it had unilaterally switched its premium contribution from 93% for all plans to 93% of the lowest cost plan." Building on the foregoing, the Union submits this happened on November 28, 2007, so a grievance filed December 4, 2007 was filed within the five workday time limit. The Union argues in the alternative that the matter being grieved constitutes a continuing violation of the Agreement, so it is also timely under the recurring violation theory.

Third, the Union contends that the Employer violated Article XIV when it unilaterally switched to the State Health Plan without bargaining with the Union. In making this argument, the Union acknowledges that the contract allows the Employer to change health insurance carriers, but it emphasizes that the language then goes on to say: "provided there is no reduction in coverage or benefits." According to the Union, there was a reduction in benefits here when the Employer switched from the City of Kaukauna's insurance plan to the State Health Plan. To support that premise, it cites the chart in its initial brief which purports to show differences in five areas between the City of Kaukauna's plan and the State Health Plan. The five areas referenced on the chart are: Ambulance, Chiropractic Services, Durable Medical Equipment, Hospice Care and Non-Formulary Prescription Drugs. The Union opines that the differences noted on the chart constitute substantial reductions, even though "the District has denied it." As further support for its contention that the Employer violated the contract by unilaterally switching to the State Plan, the Union cites the fact that the Employer's initial brief contains just one paragraph on this topic. According to the Union, this establishes that "the Employer all but acknowledges that it violated the contract when it changed to the State Plan."

Next, the Union argues that after the Employer switched to the State Health Plan, it also violated the contract when it decided to pay 93% of the premium for just one plan (namely the lowest cost plan) instead of paying 93% of the premium for all the health plans offered. Here's why. First, the Union notes that the applicable contract language is the same now as it was before the Employer switched to the State Health Plan. Thus, the contract language has not changed. Second, with regard to the applicable language, the Union contends that the requirement therein that the Employer pay "93% per month toward the premium" is clear and unambiguous, and means that the Employer has to pay 93% of the premium for all plans offered – not just one plan. As the Union reads the language, "there is no limitation either express or implied that this only holds for one plan if multiple plans are offered." The Union notes in this regard that while some employers offer just one health plan to their employees, the history of this employer is that it has offered dual plans for years. Third, the Union opines that even if the language just noted is considered ambiguous, the best way to ascertain the parties' intent about its meaning is to look at their actions. According to the Union, the "longstanding interpretation of this language" by the parties – up until the Employer switched to the State Plan – was that the Employer always paid the same percentage for both plans (meaning the Employer contributed the same percentage for all the plans offered). The Union notes again that before the Employer switched to the State Health Plan it offered two plans – Network and United – and paid 93% of the premium for both of them. The Union opines that the Employer did not pay 93% of the premium for the second plan "out of the goodness of their hearts." The Union avers that employers "are cheap", and "if the Employer in this case was not required to pay" 93% of the premium "of both plans, rest assured they would not have." It's the Union's view that the foregoing establishes that the Employer's decision – after it switched to the State Health Plan – to limit its payment of 93% of the premium to just one plan is not "consistent with the contract", constitutes "an absurd reading of the Agreement", and leads to harsh and nonsensical results.

As part of its argument on this matter, the Union also contends that the Employer's interpretation of the State Health Plan's cost calculations are incorrect. According to the Union, "contrary to the District's assertion, the State Health Plan does not require premium contributions to be based on the lowest cost plan." The Union relies on the State Health Plan's "Employer Administration Manual" to support the proposition that the Employer can contribute the same percentage for all plans offered. Aside from that, the Union emphasizes that it is not contending "that the Employer is required to pay more than 105% of the lowest cost plan", because that "clearly violates the rules of the State Plan." However, as the Union sees it, "that is not an issue in this case."

Finally, the Union acknowledges that the Employer faced increased insurance costs if it had stayed with the City of Kaukauna's health plan. That said, the Union submits that the Employer's concerns about its health insurance costs should have been addressed in a different venue, namely at the bargaining table. However, as previously noted, that did not happen, and the Employer simply unilaterally changed to the State Health Plan. The Union calls attention to the fact that by doing that (i.e. switching plans), the Employer saved money for itself and then it passed along additional costs to the employees who picked United for their health care plan because the Employer did not pay 93% of the premium for that plan – instead, the Employer only paid 93% for the lowest cost plan (i.e. Network). The Union opines that if the Employer had not unilaterally changed to the State Health Plan, perhaps the parties could have reached agreement on different health insurance language. However, that did not happen, so the Employer is stuck with the existing language, and that language does not allow the Employer to base its 93% premium contribution on the lowest cost plan.

In sum then, the Union asks the arbitrator to find that the Employer violated the health insurance provision when it switched to the State Health Plan, and when it based its 93% premium contribution on the lowest cost plan. In order to remedy these contract violations, the Union asks that the Employer be ordered to do the following: 1) "immediately return to the dual choice plan it offered in 2007"; 2) "return to paying 93% of the premium for all plans"; and 3) make the affected employees whole.

Employer

The Employer's position is that it complied with all its contractual obligations dealing with health insurance and therefore did not violate the collective bargaining agreement by its actions herein. It elaborates as follows.

The Employer notes at the outset that while the Union contended at the hearing that the Employer's decision to switch to the State Health Plan violated the collective bargaining agreement, it's the Employer's view that the Union's grievance did not challenge the District's decision to change to the State Health Plan. To support that premise, it calls attention to the fact that the grievance simply contended that the contract was violated when the employees "received notice of insurance premium charge." According to the Employer, there is nothing in the wording just noted which raises the claim that the Employer's decision to switch to the

State Health Plan violated the contract. Rather, "the intent and scope of the Union's grievance was limited to the District's calculation of health insurance contributions based upon – and after – the implementation of the State Health Plan would be effective." The Employer therefore asks the arbitrator to reject the Union's attempt to expand the scope of the grievance to now contend that the District violated the contract by switching its health insurance to the State Plan. In support thereof, it cites an arbitration award by Arbitrator Sharon Gallagher in ALMOND-BANCROFT SCHOOL DISTRICT wherein she rejected the Union's attempt to expand the scope of the grievance to something beyond what was referenced on the grievance form. It asks this arbitrator to do likewise.

Next, the Employer argues in the alternative that even if the Union did expand the scope of their original grievance at the Step 3 grievance meeting to challenge the Employer's decision to move to the State Health Plan, it's the Employer's view that such an expansion/amendment was not filed in a timely fashion. To support that premise, it notes that the contractual grievance procedure requires a grievance to be filed within five working days of the alleged violation, and that "any alleged grievance not filed within the above-stated limit shall be invalid." According to the Employer, the Union's amendment to their original grievance was not filed in a timely fashion, because the Employer's decision to change insurance plans was made weeks prior to the filing of the grievance. The Employer argues it would be "inconsistent with the mandates established by the parties' grievance procedure" for the arbitrator to address the merits of the Union's amended grievance "at this juncture". Additionally, the Employer disputes the Union's contention that the Employer never raised an objection concerning the Union's amending of its grievance. As the Employer sees it, their January 16, 2008 letter clearly objected to the Union's expansion of the grievance.

If the arbitrator does address the merits of the Union's claim that the District's move to the State Health Plan violated the collective bargaining agreement, it's the Employer's view that no contract violation was shown. According to the Employer, it had the unilateral right to change health plans because the third paragraph of Article XIV expressly grants that right to the Employer, so long as there is not a reduction in coverage or benefits. The Employer contends that no reduction in coverage or benefits was proven. To support that premise, it avers that "the Union's witness even admitted that the change to the State Health Plan did not result in a reduction in benefits." To the extent that the Union's brief argues that there was a reduction in benefits, the Employer opines that "the minor difference argued in the Union's brief represents a deminimis change which is more than offset by the increase in dental benefits under the State Plan."

Finally, the Employer argues that after the Employer switched to the State Health Plan, the Union "accepted" this change. Building on that premise, the Employer further avers that by "accepting" the State Health Plan, they also "accepted" all of its requirements. According to the Employer, the Union "cannot undo its acceptance through the grievance process."

Next, the Employer disputes the Union's claim that the Employer erred "in its interpretation of the parties' 93% health insurance language when it implemented the premium

pricing structure of the State Health Plan." It contends that after it moved to the State Health Plan, its decision to pay 93% of the premium of the least costly qualified plan, regardless of the plan selected by the employee, complied with Article XIV for the following reasons.

First, it notes that the applicable language in Article XIV states that effective January 1, 2007, "the Employer shall pay 93% per month toward the premium for single and family coverage." It emphasizes that this language does not mandate that the District offer the United Plan. Building on that point, the District argues "it is inconceivable that the collective bargaining agreement would define 'the premium' as the United Health premium as the Union contends." Focusing further attention on the phrase "the premium", the Employer avers that the word "the" is singular (meaning one), as opposed to plural (meaning more than one). Building on the premise that its meaning is clear, the Employer submits this language only obligates it to provide one health insurance plan and pay 93% of its premium. As the Employer sees it, this language does not obligate it to pay 93% of any premium or all premiums. That said, the Employer acknowledges that in the past, it offered two plans (Network and United) and paid 93% of the premium for both those plans. According to the Employer, it went above its contractual obligation when it did so. However, it's the Employer's view that does not mean "it is forever obligated to do more than the contract requires", nor does it change the meaning of the contract language just noted, nor does it expand the Employer's obligation under that language. The District asserts that since it has the contractual right to select which insurance plan to offer to the employees, "it surely has the right to choose 'the premium' for which it is obligated to pay 93%." Building on the foregoing, it's the Employer's view that it could select the least costly qualified plan as "the premium" for which it would pay 93% of the premium.

Second, the District believes that its interpretation that "its contribution must be triggered by the least costly qualified plan" is not unreasonable and absurd as the Union argues, but rather is consistent with both the contract language and the mandates of the State Health Plan. It notes in this regard that under the State Plan, it has to pay just a percentage of the least costly qualified plan, and the specific percentage referenced in Article XIV for 2008 is 93%. Thus, it's the Employer's position that payment of 93% of "the premium" for 2008, within the framework of the State Health Plan, meant the 93% figure is to be based on the least costly qualified plan (which was Network). The Employer submits it is doing that regardless of the plan selected. That said, the Employer acknowledges that the employees who selected United are paying more than 7% of the premium, but it avers that is because they did not select the least costly qualified plan.

Third, the Employer argues that the Union's claim that the Employer must pay 93% of the premium for any of the plans available to employees through the State Health Plan is not permitted by the State Health Plan's rules. To support that premise, it cites the State Health Plan's regulations related to the employer premium rate contributions, specifically the language which specifies that employers cannot contribute more than 105% of the least costly qualified plan in the employer's service area. As will be noted in more detail below, while three other plans are available to the employees than just Network and United, the pricing structure for

those plans places them above the maximum 105% threshold. Thus, the Employer believes that the State Health Plan's rules make the Union's position legally impossible.

Next, elaborating further on the last point just referenced, the District argues that the Union's contention that the District must pay 93% of the premium of any plan selected by the employee creates an ambiguity in the calculation of its 93% payment. Here's why. As previously noted, in the Employer's service area, the employees could choose from five insurance options. While the employees choose to remain with Network and United (i.e. the two plans they had under the City's insurance framework), they could have moved to Arise, Humana, or the Standard Plan. Had that happened, and an employee moved to either Arise, Humana, or the Standard Plan, 93% of the monthly family premium for those plans would translate into a higher dollar amount than the figure of 105% of the least costly qualified plan (which is $1280 per month). The Employer characterizes that situation as "problematic" because it is inconsistent with the State Health Plan's rules if anyone elects coverage that exceeds the 105% threshold. The District contends that its interpretation of the contract language to require that it has to pay 93% of the premium of the least costly qualified plan "provides consistency regardless of the health plan that is selected", while "acceptance of the Union's interpretation is inconsistent with the State Health Plan and presents additional inconsistencies with the mandates of the State Health Plan."

In sum then, it's the Employer's position that it complied with all its contractual obligations dealing with health insurance. It therefore asks that the grievance be denied.

DISCUSSION

My discussion is structured as follows: In the first part, I address the Union's contention that the Employer violated the contract by switching to the State Health Plan. In the second part, I address the Union's contention that the Employer violated the contract when it based its 93% premium contribution on the least costly qualified plan.

The Employer's Decision to Switch to the State Health Plan

Inasmuch as the Employer has raised two procedural arbitrability defenses regarding this matter, they will be addressed first. One defense is that the grievance filed in this matter did not challenge the Employer's decision to change to the State Health Plan. The other defense is that even if the Union did expand the scope of their original grievance at the Step 3 grievance meeting to challenge the Employer's decision to move to the State Health Plan, the Employer contends that such an expansion/amendment was not filed in a timely fashion. As noted in the **POSITIONS OF THE PARTIES** section, both sides made numerous arguments about these contentions. However, I'm not going to address any of those arguments. The reason is this: I've decided to presume for the sake of discussion that the grievance did challenge the Employer's decision to change to the State Health Plan and/or that the Union's expansion/amendment of the grievance was done in a timely fashion. Thus, I'm presuming for the sake of discussion that both of the Employer's procedural arbitrability defenses are denied.

My reason for making these presumptions will become apparent at the end of this part of the discussion.

The following facts are pertinent to the discussion which follows. For about 15 years prior to 2008, the Employer provided health insurance coverage for its employees through the City of Kaukauna's health insurance plan. Under that plan, the employees could be covered by either Network or United. In mid-2007, the Employer learned that the premium for the United plan was increasing by 50%, so it began a search for other health insurance options. The Employer's insurance search ultimately led it to the State Health Plan, and it subsequently unilaterally switched from the City of Kaukauna's plan to the State Health Plan. At issue is whether that unilateral switch violated the collective bargaining agreement.

The language relevant to making this call is found in the third paragraph of Article XIV. It provides thus:

> Nothing herein shall prevent the Heart of the Valley Metropolitan Sewerage District from changing carriers in the future provided there is no reduction in coverage or benefits.

I'm going to analyze this sentence by dividing it into two parts: the first part sets forth the basic principle that the Employer can change (insurance) carriers. The second part of the sentence then goes on to set forth a condition to that principle, namely that there be "no reduction in coverage or benefits" as a result of this change. Putting these two points together, the plain meaning of this language is that the Employer can change (insurance) carriers so long as in doing so, "there is no reduction in coverage or benefits."

It stands to reason that when parties agree to this type of language which sets forth a principle so long as the condition is satisfied, the main focus of any dispute which subsequently arises is going to be on whether the condition was satisfied. That's the situation here.

Before I apply that language though, I've decided to first comment on the Union's assertion in its reply brief that the Employer's initial brief contained just one paragraph addressing this topic. According to the Union, the Employer's short argument on this point establishes that "the Employer all but acknowledged that it violated the contract when it changed to the State Plan." I reach a contrary conclusion. In my view, the Employer's short argument on this portion of the case simply reflects its confidence that its switching to the State Health Plan did not violate the collective bargaining agreement. The following discussion shows why its confidence was justified.

I begin my discussion on the language by addressing the first part of the sentence (i.e. the part saying the Employer can change carriers). That is what happened here in that the Employer changed from Plan "A" (the City of Kaukauna's plan) to Plan "B" (the State Health Plan). That said, there was no change in that the employees were with Network and United in 2007 (under the City of Kaukauna's plan) and they were still with Network and United in 2008

(under the State Health Plan). The following discussion explains how this happened. As previously noted, under the City of Kaukauna's plan, the employees had two options available to them: they could get their insurance coverage from either Network or United. After the Employer switched to the State Health Plan though, the employees were not limited to just two options anymore; instead, they had five options available to them. It so happened that two of the five plans available to the employees were Network and United. This was one reason why the Employer changed to the State Plan (i.e. so the employees could stay with either of the two plans they previously had, meaning Network and United). Not surprisingly, that's what happened after the Employer switched to the State Plan, and the employees opted to stay with Network and United.

The focus now turns to the second part of the sentence (i.e. the part saying "provided there is no reduction in coverage or benefits"). In their opening statement, the Employer averred there was no reduction in coverage or benefits as a result of switching to the State Health Plan. That assertion placed the ball in the Union's court, so to speak, to show how the new plan differed from the old plan. I find that the Union failed to do that. In so finding, it is expressly noted that while the Employer averred in both of their briefs that the local union president testified that he knew of no reduction in coverage or benefits as a result of the move to the State Health Plan, that "admission" is not contained in my hearing notes. What my notes reflect is that he testified that in his view, Network and United did not offer the same benefits. However, even if that's the case, that's not what's to be compared under this contract language. What's to be compared under this contract language is the difference in the Network plan under the City of Kaukauna's plan as compared to the State Health Plan. Ditto for the United plan. Here, though, there was no testimony or other evidence presented which established those differences. Additionally, the record does not contain either the 2007 or 2008 City of Kaukauna plan. As a result, there is no basepoint which can be used for comparison purposes. While the Union's brief contains a chart which purports to show some differences between the City of Kaukauna's plan and the State Health Plan, it suffices to say that that chart is insufficient to prove that there was a "reduction in coverage or benefits" as a result of the Employer's switching plans. Since "no reduction in coverage or benefits" was established, the Employer's decision to switch to the State Health Plan passes contractual muster. Given that finding, it follows that the Union's request that the Employer be ordered to return to the City of Kaukauna's health plan must be denied.

The Employer's Decision to Base Its 93% Premium Contribution on the Least Costly Qualified Plan

Given the finding above, this second part of the decision is based on the premise that the Employer was within its contractual rights to switch to the State Health Plan.

I've decided to comment at the outset on an assertion the Employer made in their initial brief that the Union "accepted" the change to the State Health Plan and, building on that point, it also "accepted" (all of) the requirements of the State Health Plan. As for the first assertion, it really doesn't matter if the Union "accepted" the change to the State Health Plan because, as

just noted, the Employer had the contractual right to switch carriers unilaterally, which is what it did. As for the second assertion, the only way the Employer could establish that the Union "accepted" (all of) the requirements of the State Health Plan is if it could point to a contract provision in the collective bargaining agreement which said that. Of course, it can't do so because there is no such provision. In fact, the collective bargaining agreement does not even reference the State Health Plan. That being so, the outcome in the second part of the case will be based on the contract language.

This part of the case, like the first part, also involves a question of contract interpretation. However, a different portion of Article XIV is implicated here. While this different paragraph will be reviewed in detail below, it suffices to say here that it's the language which requires the Employer to pay "93% per month toward the premium."

What happened here was that after the Employer moved to the State Health Plan, it decided to base its 93% premium contribution on the least costly qualified plan in the Employer's service area. The Employer obviously felt that this action complied with the contract language. The Union disagrees, and contends that action violates the collective bargaining agreement. Based on the rationale which follows, I find that Article XIV does not allow the Employer to base its 93% premium contribution on the least costly qualified plan.

My discussion begins with a review of the following facts. After the Employer switched to the State Health Plan, the employees could choose from five different options in the Employer's service area. The employees decided to stay though with the two plans they previously had, namely Network and United. Two of the employees went with United and the rest went with Network. Network turned out to be the least costly qualified plan in the Employer's service area for 2008. That meant the monthly premium for Network was lower than the monthly premium for United. As previously noted, the Employer decided to base its 93% premium contribution off the Network plan. Thus, for those employees who chose Network, the Employer is paying 93% of their premium (just as it did before the Employer switched to the State Health Plan). However, for the two employees who chose United, the Employer is not paying 93% of their premium; instead, the Employer is paying 93% of the Network premium, and the employees are paying everything above that.

Next, before I address the contract language, I've decided to note that the language which is going to be interpreted is the same now as it was before the Employer switched to the State Health Plan. Before this dispute arose, it does not appear there had ever been a disagreement over its meaning.

The relevant contract language is the second sentence of the first paragraph of Article XIV. It provides thus:

> Effective January 1, 2007, the Employer shall pay ninety-three percent (93%) per month toward the premium for single or family health insurance.

I begin my analysis of this language by noting what it does not address. First, it does not address who provides the insurance coverage. While some collective bargaining agreements contain language which mandates a specific carrier, the first paragraph of Article XIV does not do that. As was noted in the first part of this discussion, the Employer has the contractual right to select the carrier. Second, this language does not address how many insurance plans the Employer has to offer. While some collective bargaining agreements contain language which mandates a certain number of plans, the first paragraph of Article XIV does not do that either. Having just noted what this language does not address, the focus now turns to what it does address. All it addresses is how much of the premium the Employer has to pay (namely "93% per month toward the premium for single or family health insurance"). The Employer focuses attention on the phrase "the premium", and avers that the word "the" is singular (meaning one). Building on that premise, it's the Employer's view that this sentence only obligates it to pay 93% of the premium for one plan. That interpretation would certainly be plausible if the Employer offered just one insurance plan. However, the Employer has offered more than one insurance plan for years. Under the City of Kaukauna's plan it offered two plans, and now, under the State Health Plan, it offers five plans. Thus, the situation here is that even though the Employer currently offers multiple plans to the employees, it wants the above language to be interpreted so that it only has to pay 93% of the premium for one plan, with the one plan being the least costly qualified plan. The problem with this proposed interpretation is that the language simply does not say that. Neither of those limitations currently exist in the language, either implicitly or explicitly. By that, I mean there is nothing in the language that limits the Employer's 93% payment to just one plan when multiple plans are offered. Nor is there anything in the language that limits the Employer's 93% payment to just the least costly qualified plan. If the parties wanted, they certainly could have written language that said that the Employer's obligation to pay 93% of the premium is limited to just one plan. Additionally, the parties could have written language that said that the Employer's obligation to pay 93% of the premium is limited to the least costly qualified plan in the Employer's service area. They did not do either. Since those limitations do not currently exist, the arbitrator declines to read either of them into the language. I therefore conclude that the plain meaning of the contract language is that the Employer has to pay 93% of the premium for whatever plan, or plans, it chooses to offer to the employees. If the Employer offers one plan, it has to pay 93% of the premium. If the Employer offers two plans, it has to pay 93% of the premium for each one. The unit employees are currently enrolled in two plans – Network and United – so this language requires the Employer to pay the same percentage (93%) for each one.

Even if the above-referenced sentence is considered ambiguous, one way to ascertain what the parties intended it to mean is to look at their past action. Past practice is a form of evidence which is commonly used and applied in contract interpretation cases. As just noted, the rationale underlying its use is that the manner in which the parties have carried out the terms of their agreement in the past is indicative of the interpretation that should be given to the language. Said another way, the actual practice under an agreement may yield reliable evidence of what a particular provision means.

As already noted, the past practice is this: for years, the District offered its employees two choices for their health insurance – Network and United – and paid the same percentage for each one, even if that resulted in the Employer paying a different dollar amount for the second plan than it did for the first plan. Prior to 2007, when the contract language said that the Employer paid 95% of the premium, the Employer paid 95% for both plans and the employees paid the remaining 5%. In 2007, when the Employer's contribution dropped 2% pursuant to the contract language, the Employer paid 93% of the premium for both plans and the employees paid the remaining 7%. This past practice conclusively establishes that until the Employer switched to the State Health Plan, the parties had mutually interpreted the first paragraph in Article XIV to mean that the Employer pays the same percentage for each plan offered. While the Employer obviously tries to distance itself from this practice with the argument that it went above and beyond its contractual obligation when it paid the same percentage for the second plan as it did for the first plan, the problem with this contention is that the practice did not expand on what the contract language requires. Thus, this is not a situation where the practice was inconsistent with the contract language. Instead, the practice was fully consistent with the contract language.

Based on the contract interpretation and the past practice just referenced, I find that the Employer violated Article XIV when it based its 93% premium contribution on the least costly qualified plan. It lacked a sound contractual basis for doing so.

In so finding, I am well aware that this interpretation could prove problematic for the Employer in the future, so I've decided to comment further on whether my award obligates the Employer to pay 93% of the premium for just Network and United, or 93% of the premium for all five plans offered. Obviously, if it's the latter, it obligates the Employer to pay a much higher dollar amount for health insurance than what it is currently paying, particularly if an employee decides to go onto the Standard Plan (i.e. the highest cost plan) next year. In answering the question I just posed, I'm going to refer to one of the rules of the State Health Plan. The rule I'm going to refer to is the rule which says that participating employers cannot contribute more than 105% of the least costly qualified plan in the employer's service area. In this case, there is no question about the applicability of this rule and what it requires because in its reply brief, the Union acknowledged that the Employer is not "required to pay more than 105% of the lowest cost plan" because that "clearly violates the rules of the State Plan." Thus, under the State Health Plan's rules, an employer cannot pay more than that amount toward an employee's health insurance premium. The remainder of this paragraph deals with the numbers for 2008. The record indicates that in 2008, 105% of the least costly qualified plan (i.e. 105% of Network's monthly premium) generates a monthly figure of $1280. Thus, under the State Health Plan, $1280/month is the maximum amount the Employer can pay toward an employee's monthly insurance premium. When that number (i.e. $1280/month) is compared to 93% of the monthly family premium for the five plans offered in the Employer's service area, the results are as follows: two of the plans (Network and United) have amounts under $1280/month and three of the plans (Arise, Humana and the Standard Plan) have amounts over $1280/month. That means that if anyone had selected Arise, Humana or the Standard Plan for 2008, the Employer would not have been required to pay 93% of the

premium because all their numbers exceed the 105% maximum threshold allowed under the State Health Plan's rules. That is not the case with Network and United though, because both of their numbers are under the 105% maximum threshold. Thus, my answer to the question posed at the start of this paragraph is this: in 2008, my award obligates the Employer to pay 93% of the premium for just Network and United; it does not obligate the Employer to pay 93% of the premium for all five plans offered in the Employer's service area. Once again, the reason the Employer is not obligated to pay 93% of the premium for Arise, Humana and the Standard Plan is because those plans' premiums are above the 105% maximum threshold set by the State Health Plan's rules. Thus, this award does not stand for the proposition that the Employer henceforth has to pay 93% of the premium for all plans offered.

In order to remedy its contractual breach in this part of the case, the Employer shall take the following actions. First, it shall pay 93% of the premium for both Network and United for 2008. Second, it shall make the two employees covered by United whole, so that they pay 7% toward the premium.

In light of the above, it is my

AWARD

1. That the Employer did not violate Article XIV of the collective bargaining agreement by switching to the State Health Plan; and

2. That after the Employer switched to the State Health Plan, it violated Article XIV of the collective bargaining agreement when it based its 93% contribution on the least costly qualified plan. In order to remedy this contractual violation, the Employer shall take the following actions: (a) it shall pay 93% of the premium for both Network and United for 2008; and (b) it shall make the two employees covered by United whole, so that they pay 7% toward the premium.

Dated at Madison, Wisconsin, this 8th day of December, 2008.

Raleigh Jones /s/
Raleigh Jones, Arbitrator

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