

BEFORE THE ARBITRATOR

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In the Matter of the Arbitration of a Dispute Between

**VILLAGE OF BAYSIDE**

and

**TEAMSTERS LOCAL UNION NO. 200**

Case 22  
No. 67087  
MA-13749

(Health Insurance Carrier)

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**Appearances:**

Previant, Goldberg, Uelman, Gratz, Miller & Brueggeman, S.C., Post Office 12993, Milwaukee, WI 53212, by **Sara J. Geenen**, appearing on behalf of Teamsters Local No. 200.

Davis & Kuelthau, S.C., 111 East Kilbourn Avenue, Suite 1400, Milwaukee, WI 53202-6613, by **Daniel Vliet**, appearing on behalf of the Village of Bayside.

**EXPEDITED ARBITRATION AWARD**

On June 29, 2007, the Labor Association of Wisconsin (hereinafter referred to as LAW) and the Village of Bayside (hereinafter referred to as the Employer or the Village) jointly requested the appointment of Marshall Gratz as arbitrator to hear and decide a dispute concerning a change in health insurance carrier for police officers and dispatchers employed by the Village. Arbitrator Gratz was not available and on August 15, 2007 the parties requested that Sharon Gallagher be substituted. A hearing was scheduled for December 11, 2007 before Arbitrator Gallagher. That hearing was postponed, and prior to any further proceedings, a representation petition was filed and Teamsters Local No. 200 ultimately assumed responsibility for representing the two bargaining units and administering the contracts. On August 29, 2008 the Union contacted Arbitrator Gallagher indicating it wished to proceed with the arbitration. Due to Arbitrator Gallagher's unavailability, in mid-September the parties requested that Daniel Nielsen serve as arbitrator. A hearing was scheduled for December 19, 2008 but was postponed due to inclement weather.

A hearing was held at the Village offices on March 12, 2009 at which time the parties were afforded full opportunity to present such testimony, exhibits, other evidence and arguments as were relevant. The parties submitted briefs and reply briefs, which were exchanged through the Arbitrator on May 27, 2009, whereupon the record was closed. The parties agreed that the Arbitrator would provide an expedited decision on the matter.

Now, having considered the evidence, the arguments of the parties, and the record as a whole, the Undersigned makes the following Award.

### ISSUES

The parties stipulated that the Arbitrator should frame the issue in his Award. The issue may be fairly stated as follows:

1. Did the Village violate the Police and Dispatchers collective bargaining agreements when it changed health insurance carriers effective February 1, 2007?
2. If so, what is the appropriate remedy?

The collective bargaining agreements in force at the time of the change both provided that the Village could self-fund insurance or change insurance carriers, "as long as equal to or better than existing coverage is provided." See Section 10.09 of the Police contract, and Section 9.05 of the Dispatchers' contract.

### STATEMENT OF THE CASE

#### Background

The Village provides general municipal services to the people of Bayside, located just north of Milwaukee, Wisconsin. The Union, Teamsters Local No. 200, is the exclusive bargaining representative for the Village's police officers and dispatchers, in two separate bargaining units. At the time these grievances arose, another labor organization, the Labor Association of Wisconsin, represented these employees. The Union subsequently assumed representation of the bargaining units, and administration of the contracts, including the prosecution of these grievances.

The collective bargaining agreements for these units specified that, effective January 1, 2006, or as soon thereafter as possible, the health insurance coverage would be Blue Cross/Blue Shield Point of Service Plan II. That coverage was put in place, but in the fall of that year, Anthem purchased Blue Cross/Blue Shield, and decided to discontinue offering the

plan effective December 31, 2006. Anthem offered a replacement plan, which would have increased the premium cost by 22% and reduced benefits. At the request of the Village, the carrier eventually agreed to provide stopgap coverage for the Village's employees for the month of January, 2007 under its new plan. As part of this transition, the Village agreed to hold employees harmless for any increased costs under the stopgap plan.

The Village and its various employee groups discussed a variety of options for replacing the POS Plan, including employee meetings, presentations and question and answer sessions. The AFSCME bargaining unit was agreeable to the State plan, which offers a standard benefits package through a menu of insurance carriers, each of which charges a different premium. Blue Cross/Blue Shield is one of the carriers available under the State plan, through the CompCare Blue option, although at a different service level than the old POS II Plan. The State plan places limits on the contribution levels of employers, based upon the premium cost of the lowest cost plan. An employer must contribute a minimum of 50% and a maximum of 105% of the lowest cost premium. The lowest cost plan available was United Health Care Southeast. As part of the process of considering and comparing plans, the Union brought in a consultant, who analyzed the various options. He incorrectly used a no deductible version of the State plan, instead of using a \$500/\$1000 up-front deductible plan.

The Police and Dispatcher units were not agreeable to the State plan and so informed the Village at a meeting on December 13, 2006. As the deadline for making a switch approached, the Village determined to move all of its employees into the State insurance plan. On December 15<sup>th</sup>, Village Manager Andy Pederson sent a memo to all employees, with copies to their union representatives, announcing that:

Effective February 1, 2007, the Village will transition to the State of Wisconsin Pool Plan – Deductible HMO Option Paired with the Standard PPP, of which you have all received information. The 7.5% premium share of the low cost plan (United Health Care SE) that all employees are scheduled to pay in 2007 will be deducted beginning the first payroll period in January, as we pay premiums one month in advance. Should anybody wish to select another carrier within the State plan, please contact me for your share of the premium. The Village will, as it did in January, pay the remaining 92.5% of the low cost premium for United Health Care SE, as we did for the current Anthem coverage.

As a result of the change, premiums paid by the Village decreased substantially, and with them, the employees' 7.5% share of the premium also decreased, for those enrolled in UHC SE.

The collective bargaining agreements allow the Village to change insurance carriers, or to self-insure, "as long as equal to or better than existing coverage is provided." The Labor Association filed a grievance on behalf of the Police officers, and an identical claim for the Dispatchers alleging that the new coverage failed to meet this standard. The grievance reads as follows:

ISSUE:

Is the Village of Bayside violating the collective bargaining agreement, by unilaterally changing the health insurance carrier to a carrier that does not provide equal or better benefits than the previous plan? If so, what is the appropriate remedy?

FACTS:

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3. That the Village's previous health insurance carrier (Blue Cross/Blue Shield) was purchased by Anthem Blue Cross.
4. That Anthem Blue Cross informed the Village of Bayside that it would no longer offer their current health insurance plan effective January 1, 2007. Subsequently, the Village received a one-month extension to February 1, 2007.
5. That the Association and the Village looked into the possibility of switching from Anthem Blue Cross to the Wisconsin Public Employers' Group Health Insurance Plan (State Plan), United Health Care or Humana.
6. During this review process, the Village informed the Association on December 15, 2006, that it was unilaterally switching the health insurance carrier from Anthem Blue Cross to the State Plan.
7. That on December 22, 2006, the parties agreed to hold open the time limits of the grievance procedure to see if an agreement could be reached regarding the change of carriers.
8. That Article X - *Insurance*, *Section* 10.09 reads as follows:

"The Village may change the insurance carrier(s) and/or self fund such coverage if it elects to do so, *as long as equal to or better than existing coverage is provided.*" (Emphasis added)

9. That the State Plan does not provide benefits that are equal to or better than the previous health insurance carrier.
10. That the Bayside Police and Firefighters' Association has not agreed to the unilateral switch to the State Plan or any reduction in the level of benefits provided by Blue Cross/Blue Shield prior to their purchase of Anthem Blue Cross.
11. That the employer is exercising its' management rights in an unreasonable manner by unilaterally changing the health insurance carriers to the State Plan without the mutual agreement of the Association.

REMEDY:

The grievant respectfully requests the Village of Bayside cease and desist from violating the expressed and implied terms of the collective bargaining agreement. The grievant further requests that the Village be ordered to stand in the shoes of the carrier and make all employees whole for any out-of-pocket expenses they incur because of the unilateral change.

In addition to the above remedy, if this grievance proceeds to arbitration, the Grievant requests that the Arbitrator award the above remedy, along with any other remedy deemed appropriate by the Arbitrator.

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In response the Village denied the grievance, stressing that there was no option to retain the POS Plan II and stating its belief that the State plan was the option that provided equal or better coverage:

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As you will all recall, the Village was notified in September, 2006, that Anthem, formerly Blue Cross Blue Shield and Compcare, would no longer offer the health plan the Village had been enrolled in; and forced the Village into making a decision about health coverage for the 97 employees, spouses, and dependents on the Plan. Upon both verbal and written requests to reconsider offering our coverage or extending the coverage for a greater period of time, all that Anthem was able to provide was a one month extension through January 31, 2007.

Due to Anthem's unilateral decision to not offer the Village's plan, or offer a feasible or acceptable plan to all parties involved, the Village was forced to examine many carriers and plan designs to best suit the needs of our group and meet the spirit of the agreements the Village has with its respective bargaining units.

As you know, we conducted a thorough, transparent, and exhaustive search of the marketplace to meet these goals. Collectively, we examined the five primary carriers in the area and over 30 plans to determine what best fit the organization's 2006 plan. This process included five employee meetings, three question and answer sessions, as well as numerous email and telephone correspondence on the subject. It also included a thorough and favorable analysis of the State Plan by your benefit consultant. At the time, the State Plan was determined to be the preferred plan by everyone involved. Ultimately, this plan was implemented effective February 1, 2007 out of necessity.

I was very much encouraged by our productive meetings both before and after the grievances were filed to determine if there was an opportunity to address the concerns the Association presented. I was disappointed that we could not come to a reasonable and practical solution, and that the two Associations felt it would be best to pursue arbitration to resolve this issue.

Ultimately, on behalf of the Village, the State of Wisconsin plan that is currently in place, inclusive of

- the same deductible amount as the previous plan,
- the Village's continued health reimbursement account contribution funding 80 percent of the deductible,
- elimination of office co-pays (\$0),
- lower emergency room co-pays and elimination of urgent care co-pays,
- reduced co-pays on prescription drugs to \$5 and \$15 for tier 1 and 2 drugs,
- a maximum out-of-pocket expense for tier 1 and 2 prescription drugs of \$320/single and \$640/family,
- the ability to choose multiple carriers,
- a reduction in the annual premium share in 2007 of \$36/single and \$144/family,
- enhanced coverage for ambulatory transportation, vision and hearing exams, hearing aids,
- an additional dental insurance plan for those who select particular health plans, and
- the other benefits afforded to in the Plan.

This plan provides a tremendous benefit to all of our employees, one that is equal to or better than the Village's previous coverage. If these grievances proceed to arbitration, the Village's position will be that the Plan that is equal to or better than the Village's previous coverage. Therefore, the grievance is denied.

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The grievance was not resolved in the lower steps of the grievance procedure and was referred to arbitration. At the hearing, the Union took the position that the Village had violated the contract by switching carriers, and had also failed to limit employee premium contributions to 7.5% as provided by the contract. This latter claim was based on the fact that employees who opted for insurance carriers other than the lowest cost carriers were exposed to employee premium costs in excess of 7.5%. This aspect of the claim was not discussed prior to the hearing.

At the arbitration hearing, Officer F\*\*E\*\* testified that the lowest cost option under the State Plan is United Health Care Southeast, which is an HMO, and that it does not provide benefits outside of a seven county service area in southeastern Wisconsin. F\*\*E\*\* explained that one of her children was in school in the LaCrosse area, and another was in school in Oshkosh. She is therefore responsible for 100% of their medical costs, unless they travel back to Milwaukee for medical care. The old plan covered 70% of the costs when services were obtained out of network. Her child in LaCrosse has a medical condition that both necessitates a special school and renders him dependent upon her for the span of his entire life, so she anticipates that these costs will be continuing. F\*\*E\*\* noted that the new insurance plan also has a much more extensive deductible than the old plan. Whereas mammograms and immunizations were \$20 under the old plan, under the new plan they are fully subject to the deductible. F\*\*E\*\* acknowledged that prescription drug co-payments under the State plan were capped at \$640 per year, while there was no cap under the Blue Cross Plan.

Officer M\*\*G\*\* testified that he has a severely disabled son and did not switch to UHC SE because he did not believe his son's cardiologist was in the HMO. He instead opted for Compcare Blue, the Blue Cross option under the State Plan. To his knowledge, he was the only employee who did not enroll in UHC SE. In 2007 this resulted in him paying more than 7.5% of the premium, even though the contract limits the employee to paying that percentage for health insurance. He complained about this to both the Village and to the LAW representative.

M\*\*G\*\* testified that the new plan exposed him to many more costs than the old Blue Cross plan, since many more items were subject to the deductible. He also expressed the opinion that the \$5 million lifetime benefits maximum under the old plan was superior to the \$2 million lifetime maximum under the State plans, noting that his son had incurred \$400,000 in medical bills in a single year after he was born.

M\*\*G\*\* acknowledged that the Village had probably told him to check on what doctors were available in the HMO and that he probably had not done so. He explained that he believed his costs would be capped at 7.5% of the premium so he did not investigate switching to UHC SE. He conceded that he had not filed any separate grievance concerning his premium costs after the switch.

Village Manager Andrew Pederson testified that he coordinated the effort to find new coverage when Anthem announced it was discontinuing POS Plan II. According to Pederson, it was not possible to exactly match the POS II Plan, but he felt that the State Plan came closest to equaling the benefits. While the deductible is more extensive, the State plan has features that were not available under the old plan, including a cap on prescription costs and mail-in service; a reduction in co-pays for the first two tiers of prescriptions; an improvement in skilled nursing care coverage; a \$15 reduction in emergency room co-pays; the elimination of the \$50 urgent care center co-pay; elimination of the \$20 hearing and vision test co-pays; coverage for hearing aids; a 25% increase in the number of allowable physical, occupational and speech therapy sessions; a 25% increase in the number of home healthcare visits; an improvement in transplant coverage; and the addition of dental benefits and orthodontia benefits to supplement the existing separate dental benefits under the labor agreements. He also noted that retirees could be covered under the State plan, whereas the Village had only offered them COBRA under the old plan. The only material reduction that Pederson identified under the State plan was that it had a \$35 third tier prescription co-pay, while the former plan had a \$30 co-pay.

Pederson expressed doubt that the UHC SE plan did not allow for services outside of southeastern Wisconsin, noting that he had received services in several different states. He suggested that employees were misreading the plan and confusing the area in which the plan was available and the area in which services were available. He stated that he was not aware of any situation in which students or employees who were traveling experienced problems getting health care services under the insurance.

Martin Tomcek testified that he was engaged by the Labor Association of Wisconsin to analyze the options for replacing the PPO Plan II, and appeared at the arbitration hearing pursuant to the Village's subpoena. Tomcek stated that the lifetime benefit maximum under the State plan was effectively \$8 million, since there was a \$2 million maximum for each of four plans, and employees could migrate to another plan if they exhausted their benefits under a single plan. Tomcek identified the only lesser benefits under the State plan as being the third tier of the prescription drugs, the breadth of the deductible and a 20% co-pay for durable medical supplies and prostheses. Tomcek stated that, in his experience, it was very nearly impossible to find identical insurance plans for a group of fewer than 100 employees, and insurers would not customize plans for a group that small.

Tomcek agreed that if money was no object, it would always be possible for an employer to find better insurance coverage for its employees. He also agreed that the out of network coverage under the old plan was superior to that available under the new plan, since the HMO had no out of network coverage.



At the close of the hearing, the arbitrator requested additional information from the parties to clarify certain aspects of the coverage available under the UHC Plan. In response, the following stipulation was supplied:

Dear Arbitrator Nielsen:

The parties have reached the following stipulation with regard to the coverage issues that remained outstanding at the close of the hearing. If this does not fully address the concerns you expressed at the close of the hearing, please advise. Thank you for your assistance in this matter.

At the request of the Arbitrator the parties agreed to clarify certain coverage issues following the conclusion of the hearing. The parties have agreed that the following accurately represents the coverage available to the bargaining unit employees effective February 1, 2007:

1. Attached below is an email from Joan Steele, the Manager of Alternate Health Plans at the Department of Employee Trust Funds. The parties agree that Ms. Steele's email accurately sets forth and explains the provider network available under the United Healthcare Southeast (UHC-SE) plan, one of the plans available under the State Health plan.
2. In the event an insured reaches the two million dollar cap for one of the plans available under the state plan, the insured can switch to another plan available under the state plan at that time. The insured would have up to eight million dollars in coverage available under the plans available under the State Plan.

Hi Sara,

This is in response to your voice mail message in which you asked about benefits under the State of WI group health insurance program for a subscriber that selects the United Healthcare Southeast (UHC-SE) plan.

UHC-SE is an HMO that has its provider network based in southeastern Wisconsin, primarily in the following counties: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington and Waukesha. Subscribers (and their insured dependents) that select UHC-SE as their plan must utilize the providers in the UHC-SE network in order to have benefits under the contract. Exceptions to this include emergencies, urgent care, and when prior authorized by UHC-SE. (Refer to page G-46 of the 2009 It's Your Choice booklet for a description on "How do I get care when I am outside the service area?") Please note that emergencies and urgent care are defined in the Uniform Benefits contract.

If a subscriber or an insured dependent resides outside UHC-SE's service area, for example, a dependent child that attends college in western Wisconsin, the insured has coverage for emergencies, urgent care and other care that UHC-SE may prior authorize. However, it is fairly standard for an HMO to not grant a prior authorization if there is a provider in its service area that can provide the necessary care. Hence, insureds residing outside the service area of their HMO should expect to have to return to the service area for routine or diagnostic type services. By utilizing the providers in the HMO's network, members are utilizing providers that the HMO has likely verified credentials and has arranged a more favorable payment structure, which helps to control health care costs.

Please note there are options in the State's program for subscribers who have insured dependents that may not all reside within an HMO's service area, and that is the Standard Plan that offers the freedom of choice in provider selection. With that freedom of choice comes a higher cost, as one can see when comparing the premium between the Standard Plan and the HMO. \*\*\*

Additional facts, as necessary, are set forth below.

### The Position of the Union

The Union argues that the Village has failed to meet its obligations under the collective bargaining agreement, in that the State plan is clearly not equal to or better than the coverage provided by the Blue Cross/Blue Shield PPO Plan II. The geographical limitations on the various HMO plans offered by the State essentially deny any and all non-emergency coverage to dependents living outside of southeastern Wisconsin. This compares to a 70% out of network benefit under the BCBS plan, which had a far broader network. Even if insurance benefits are available for a covered person, the \$500/\$1000 deductibles under the State plan are applicable to virtually every procedure and visit, as compared to the BCBS plan. While the deductibles were nominally the same, they had very limited applicability under the BCBS plan. Doctor's visits, mammograms, immunizations and a host of other items were excluded from the deductible, subject to a nominal per visit/procedure payment of \$20. Now employees who did not meet the deductible under the old plan are meeting it quite quickly.

While the Village claims that the lifetime maximum of \$2 million per plan is an improvement because there are multiple plans, the Union points out that an employee must switch plans and go through a 180 day exclusion period for pre-existing conditions in order to take advantage of such a switch if it is not done through the normal open enrollment process.

Finally, the Union observes that the Village failed to maintain its obligation to pay 92.5% of insurance costs when it unilaterally capped its contributions at 92.5% of the UHC plan, ignoring the fact that one of its employees, Officer M\*\*G\*\*, was enrolled in the more expensive Compcare Blue option. As a result, the Village paid only 83% of his premium.

The contract is clear and unambiguous. The right to change carriers is conditioned on providing equal or better coverage. The contract does not allow a waiver of this standard based on price or on the addition of some other benefits at the cost of curtailing others. Nor can the insurance coverage be said to be equal if it completely excludes those who were covered before, such as out-of-area dependents. Nor can it be said to be equal or better if it replaces a \$5 million lifetime benefit with a \$2 million maximum, even if an employee can move between plans and thereby refresh the maximum. There is no guarantee that the State Plan will always have three or more providers, and even if it does, an employee moving mid-year is subject to an exclusion period.

Coverage is not equal or better when the actual deductibles paid by employees are much more extensive than they were in the past. The BCBS plan limited deductibles to major medical procedures, while the State plan applies them to the first dollar of every medical expense. The increase in the third tier prescription co-pay also violates the equal or better standard in the collective bargaining agreement.

While the Village's switch in insurance coverage was initiated by Anthem's decision to cancel the former plan, the contractual obligation is clear-cut. The Village's contract with employees allows it to purchase whatever insurance it wishes, so long as the coverage is equal or better. This is not conditioned in any way on the circumstance leading to the change.

Finally, the Union argues that the portion of the grievance addressing M\*\*G\*\*'s claim for premium contributions is properly before the arbitrator. The Village's decision to limit its premium contributions to 92.5% of the UHC plan was part and parcel of the switch in carrier. While State regulations do limit employers to paying no more than 105% of the low cost premium, this rule would not have been violated had the Village paid its contractually required 92.5% of the premium for Compcare Blue.

### The Position of the Village

As an initial matter, the Village objects to any consideration of Officer M\*\*G\*\*'s complaint about the contributions the Village made to his insurance coverage in 2007. This issue was raised for the first time at arbitration. It is not stated in the grievance, nor is it even hinted at in the grievance. M\*\*G\*\* admits that he did not file a grievance over the matter. This is completely beyond the scope of the grievance that is before the arbitrator, and cannot legitimately be addressed.

The Village takes the position that the grievance over the change in carriers is without merit and should be denied. Anecdotal evidence was provided by Union witnesses to show that, in some circumstances, they paid more under the State plan than they would have under the BCBS plan, but the arbitrator must take cognizance of the plan as a whole. It represents an improvement in coverage. For example, the old plan had a \$500 major medical deductible, and a \$20 per visit co-pay. An employee who incurred the major medical deductible was still obligated to pay the \$20 for every office visit and procedure. This could easily far exceed the costs under the comprehensive deductible offered by the State plan. Likewise, the Union's witnesses complained of a \$5 increase in co-pay the third tier of prescription drugs, but ignored the \$5 decrease in the first and second tiers, as well as the mail-in option, which further decreases co-pays, and the annual cap on out-of-pocket costs for tier 1 and 2 prescriptions. Moreover, the State plan increased dental benefits by 67% beyond the current dental coverage, as well as significantly reducing employee premium contributions. Finally, the State plan allows retirees to continue in the group, whereas the former plan merely provided for the statutorily required eighteen months of COBRA coverage. By any objective measure, the State plan taken as a whole improves the coverage for employees.

The Union bears the burden of proof, and it has utterly failed to carry it. The commitment in the collective bargaining agreement is provide equal or better "coverage." "Coverage" is not the same as insurance benefits or plans. It is narrower and requires a comparison of the specific risks and procedures that are indemnified. Here, there are virtually no risks or procedures that were indemnified by the BCBS plan that are not also indemnified by the State plan. Indeed, the State plan has more extensive coverage. It offers multiple carriers, and the employees are free to choose among them. Thus in comparing the plans, the arbitrator must look to the features of all of the State plans, and how they measure up to the BCBS plan. For example, although some employees complained that the UHC-SE HMO option limited their choice of providers, employees freely chose to enter that plan. If geographic restrictions are a concern, they may elect the WPS Standard Plan, which offers virtually unlimited access to providers.

Should the arbitrator somehow conclude that the Village violated the collective bargaining agreement, he should not hold the Village responsible for the unreasonable lapse of time between the filing of this grievance and the arbitration hearing itself. These grievances were filed in April of 2007 and promptly advanced to the arbitration step. Thereafter, they simply languished, past the expiration of the labor agreement in 2007 and the end point of any plausible remedy. Negotiations over the 2008 collective bargaining agreement await the resolution of this grievance.

## DISCUSSION

### The 92.5% Contribution Rate

As a threshold matter, I conclude that M\*\*G\*\*'s complaint over the amount of premium contributions made on his behalf for the Compcare Blue plan is not properly before the arbitrator. His complaint arises under Section 10.02 of the collective bargaining

agreement, which obligates the Village to pay 92.5% of the premium. The grievance actually filed in April of 2007 points to Section 10.09 as the relevant contract provision, and discusses the equal or better coverage standard for switching carriers. It makes no mention of premium contributions. There is no plausible reading of the grievance that would encompass M\*\*G\*\*'s claim. The collective bargaining agreement limits the arbitrator to deciding "the express issue submitted for arbitration and [the arbitrator] shall have no authority to determine any issue not so submitted to him..." [Article 31, Section 31.03].

### **The Change in Insurance Coverage**

The collective bargaining agreements identify the Blue Cross/Blue Shield Point of Service Plan II as the health insurance plan for bargaining unit employees in 2006. They allow for a change in carriers, or for the Village to self-insure, "as long as equal to or better than existing coverage is provided." I have previously had occasion to discuss the scope of the term "coverage" in comparing insurance plans:

The contract requires that "coverages" be "equivalent". The charge to the arbitrator is to determine "whether changes are of such minute nature so as not to affect equivalency." Use of the term "coverages" rather than the broader terms "benefits" or "plans" indicates a comparison of the indemnification for specific risks and procedures under the two plans, and a decision whether employees are exposed to more than a minute increase in specific risks by reason of the change. The District urges that "minuteness" must measure the likelihood of a particular risk being realized. The undersigned agrees that a change in coverage which would expose the employee to potential liability under rare circumstances might well be minute, while the same increase in exposure for a more frequently occurring risk would not be minute. There is, however, an additional element to the measurement of whether a change is minute. The amount of financial exposure of the employee must be weighed. Even if a risk is very unlikely to ever be realized, a coverage which exposes employees to significant costs or even financial ruin once the risk is realized cannot be said to be a minute change. Beaver Dam Unified School District, WERC MA- 6639 (Nielsen, 5/14/91).

Here the standard for change is not "equivalency", but "equal to or better than existing coverage", which is a stricter standard. A purely nominal difference in coverage, or a specific coverage that on the whole matches the prior coverage notwithstanding some minor variations, may be said to be equal coverage. However, the Village does not have the ability, under an equal or better standard, to argue that a material lessening of coverage in one area should be treated as offset by an improved or added coverage elsewhere. That is a plausible argument for negotiations or for interest arbitration, but this is grievance arbitration and the test under the contract is not whether the overall package is reasonable. Thus, while I agree that there are features of the State plan which are clearly superior to the BCBS plan – most notably the

ability of retirees to participate in the plan – if the other coverages are not equal to or better than those formerly enjoyed, the employer has not carried its burden under Section 10.09 of the Police contract and Section 9.05 of the Dispatchers’ contract.

HMO Structure vs. PPO Structure and the Nature of the State Plan

The BCBS plan was a PPO. It had a network encompassing Wisconsin and portions of other states. For out of network services, it paid 70% of the costs after a deductible, with the employee paying 30% of the costs. The 2007 State Plan offered five options: the Standard Plan, an indemnity plan which has no specific geographical limitations; United Healthcare Southeast HMO with a provider network based in Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha counties; Compcare Blue Southeast HMO which has providers in the same seven counties; Humana Eastern HMO, which has providers in 15 counties roughly encompassing a triangle from Brown County to Rock County, and east to Lake Michigan; and WPS Patient Choice Plan 1 and Plan 2. Plan 1 is a PPO based in Milwaukee, Ozaukee, Washington and Waukesha Counties. Plan 2 adds Racine County, and has more providers in the network. Services received out of network are subject to a \$1000/\$2000 deductible and a 30% co-pay.

The 2007 premium rates for these plans were:

<b>Plan</b>	<b>Family</b>	<b>Single</b>	<b>92.5% of Premium – F/S</b>
UHC SE	\$1385.50	\$ 555.70	\$1281.59 / 514.02 <sup>1</sup>
Standard	\$2705.20	\$1083.30	\$2502.31 / 1002.05
Compcare	\$1616.90	\$ 648.00	\$1495.63 / 599.40
Humana	\$1645.50	\$ 659.70	\$1521.63 / 610.22
WPS PCP1	\$1531.50	\$ 614.10	\$1416.64 / 568.04
WPS PCP2	\$1669.00	\$ 669.10	\$1543.83 / 618.92

The Village argues that the unavailability of covered services outside of the seven county area is not an issue of equality of coverage, and that even if it were, the employees are free to forego UHC-SE in favor of the Standard Plan, which will provide payment for medical services on a statewide basis.

With respect to whether the difference in plan structures from a PPO to an HMO involves equality of coverage, that is a matter of degree. Certainly most insurance plans have service areas and networks, whereby patient choice is limited. That is how plans are able to

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<sup>1</sup> In the December 15, 2006 memo announcing the switch, Village Administrator Pederson stated the Village’s position that it would base its 92.5% contribution on the UHC-SE premium, rather than the premium charged for the insurance actually selected by employees. In 2007, all but one of the employees (Officer M\*\*G\*\*) selected UHC-SE.

negotiate favorable rates and reduce their premium costs. It will not be possible to precisely match the extent of those areas and networks when shopping insurance plans. These variations are virtually inevitable and do not in and of themselves implicate equality of coverage. However, the difference between a plan that has a reduced out of network payment, such as the former BCBS plan, and a plan that pays nothing *is* a difference in coverage. Coverage implicates the financial risks of the insured individuals.<sup>2</sup> People have dependents who attend school elsewhere. That is not an anomaly or an unexpected occurrence. A change to an HMO that will not pay anything for non-emergency services for a dependent child effectively eliminates the coverage for that child.<sup>3</sup>

Turning to the Village's appeal to the Standard plan as an alternative for employees with out-of-area dependents, I find that the Village itself has precluded the use of that as a basis for comparison. The discussions leading up to the change in carriers all focused on the United Healthcare Southeast HMO. The Village effectively designated that as the default insurance plan for employees in the December 15<sup>th</sup> memo, when it announced that the basis on which it would make the 92.5% premium contribution required by the contract was the UHC-SE plan. That amounted to \$1281.59 per month for family coverage. The premium for Standard Plan coverage cost \$2705.20 per month. Thus an employee opting for the Standard Plan would pay premiums of \$1424 per month, roughly 53% of the monthly premium. The monthly pay rate for top patrol officer in 2007 was \$5,072.80<sup>4</sup>, meaning that in order to obtain the "equal or better" coverage promised by the collective bargaining agreement, officers with dependents outside of southeastern Wisconsin would have to pay 28% of their gross income, while those without such dependents who could take advantage of the HMO would pay 2%. The contract provides that employees will pay "seven and one-half percent (7.5%) of *the plan* premium." Having capped its premium contributions on the basis of the UHC-SE option, the Village in every practical sense removed the Standard Plan from the table and established UHC-SE as "the plan." I conclude that the basis for comparison must be the UHC-SE plan, and that its lack of any out of network non-emergency coverage renders the coverage less than that provided by the former plan.

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<sup>2</sup> See Beaver Dam. *supra*, "As noted above, the contract language requires equivalency of 'coverages', which is a narrower term than 'benefits' or 'plans'. Usual and customary determinations are not coverages, since they do not offer protection against specific risk. *They do implicate coverages, in that a very strict application of usual and customary standards, or the use of a lower percentile for payment cutbacks, may effectively reduce the benefit otherwise payable for medical procedures, thus exposing the employee to increased financial risk.*" Emphasis added.

<sup>3</sup> This lends itself to factual disputes over how far away the child is and whether it is reasonable to expect the child to travel home for non-urgent medical care, but clearly in the case of Officer F\*\*E\*\*'s child in LaCrosse, the HMO plan provides no coverage, as a practical matter.

<sup>4</sup> Joint Exhibit 2A, Article V, page 4.

### Up-front Deductible vs. Major Medical Deductible and \$20 Per Visit Charges

The second major area of contention is the difference between the two plans as to deductible structures. The State plan features an up-front deductible of \$500 per individual and \$1000 per family. The former BCBS Plan had a \$500/\$1000 major medical deductible, plus an uncapped \$20 per visit charge for every office visit. Whether annual out-of-pocket costs for employees are greater or lesser depends upon what services the employee makes use of in the course of the year. An employee with frequent doctor visits might well incur enough per visit charges under the BCBS plan to exceed the out-of-pocket caps under the State plan, particularly if they also have any expenses arising under the major medical portion of the coverage.

To say that it is possible for the new plan to be less costly than the old plan is not to say that coverage is equal to or better than the old plan. The deductible under the new plan is more likely to be incurred, in that it applies to almost everything and no benefits are paid until the deductible is satisfied. As with the out of network benefits, the lack of payment for a service that would otherwise have been paid necessarily increases the financial risk of the insureds, and thereby reduces coverage. This increased risk is not premised upon some unusual usage pattern or unlikely event. It is the intended result of an up-front deductible. The fact that many employees are not adversely affected, or may only be adversely affected in some years, is relevant to remedy, but does not render the coverage equal.

### Lifetime Benefit Maximum

The Union argues that the \$5 million lifetime benefit maximum is substantially reduced under the State plan, because its constituent insurance policies have a \$2 million maximum. Even though an employee may switch to another plan if he or she reached the lifetime maximum, the Union is concerned that there is no guarantee that there will always be enough plans to aggregate to more than \$5 million and that an employee making that switch outside of the annual open enrollment period might be subject to an exclusion period for pre-existing conditions. With respect to the argument over the number of plans, it is purely speculative and unlikely in the extreme that a plan whose whole premise is competition among insurers will ever offer only two options in Milwaukee County. At the time of this grievance there were six available plans. Many things might happen at some point in the future, but for purposes of applying the "equal to or better than" standard, the arbitrator must confine himself to those that are realistic possibilities.

As for the concern that an employee who exhausts benefits under one plan will be subject to an exclusion period, I believe that misreads the plan. The exclusion period the Union refers to is for employees who voluntarily switch to the Standard Plan mid-year. Loss of coverage is an event that gives rise to an enrollment opportunity without a waiting period.



In either event, the possibility of accumulating \$2 million in costs in a period of time that leave an employee both unaware of the accumulating costs and unable to make use of the annual open enrollment opportunity to switch plans is remote enough that it cannot be said to affect the equality of coverage.

### Prescription Drug Benefit

The BCBS Plan had a three tiered drug plan, at co-pays of \$10, \$20 and \$30, with no annual maximum on out-of-pocket costs. The State plan is also three tiered, with co-pays of \$5, \$15 and \$35, and an annual out of pocket maximum of \$320 per individual and \$640 per family. The State plan also allows for mail order prescription drugs, which reduces the co-payment levels. I conclude that the difference between the two plans is that the State plan provides objectively better coverage.

### Durable Medical Equipment

The BCBS Plan paid for durable medical equipment, without co-pays or deductibles. The State plan pays for this at 80%, and it is subject to the front end deductible. Again, the transfer of financial risk to the employee is the mark of a reduced coverage, and the new plan fails to provide equal or better coverage in this area.

### Other Aspects of the Plan

All other aspects of the State plan provide equal or better coverage in comparison to the BCBS Plan.

### The Appropriate Remedy

I recognize that the Village had no option but to change health insurance plans, given the unavailability of the BCBS plan it offered in 2006. The contract language allowed it to make a change in response to such an eventually, or simply as a matter of economics, but in making the change it was obligated to select a plan with coverage that was equal to or better than the BCBS plan. Under this standard, I conclude that the Village violated the collective bargaining agreement when it unilaterally changed to the UHC-SE HMO as the health insurance for its employees, as that plan does not provide equal or better coverage in three areas:

- Out of Network benefits for non-resident insured persons
- Deductibles
- Durable Medical Devices

The appropriate remedy is to make employees whole for the costs they incurred which they would not have incurred but for the change in plan, and to hold them harmless from such costs going forward. There is no contractual necessity for the Village to change insurance plans in order to remedy the violation, as it has retained the right to self-insure and this would include the right to self-insure portions of health insurance risk.

Specifically, the Village is directed to (1) reimburse employees for medical care costs for non-resident dependents, at the rate of 70% as would have been paid had there been an out of network benefit available under UHC-SE; (2) reimburse employees who experienced greater out-of-pocket costs under the UHC-SE up-front deductible in any given plan year than they would have had they been subject to the major medical deductible and \$20 per visit system of payments under the BCBS Plan; and (3) reimburse employees for costs incurred as a result of the 80% co-payment for durable medical devices under the UHC-SE Plan.

The Village has argued that its liability should be limited to 2007, since the labor agreements at issue expired on December 31 of that year, and it has every expectation that the successor agreements will include the State Plan as the insurance carrier. That may well be, but the provisions of those agreements remain to be negotiated. The parties may well choose to make retroactive changes in their contracts or to modify this remedy in those negotiations, but my authority extends to remedying a violation of the existing agreements, which remain in effect until altered by the parties. Accordingly I decline the Village's invitation to so limit the Award.

On the basis of the foregoing, and the record as a whole, the undersigned makes the following

### AWARD

1. The Union's assertion of a violation in the payment of premiums for Officer M\*\*G\*\* was never actually filed as a grievance and is not properly before the arbitrator;
2. The Village violated the Police and Dispatchers collective bargaining agreements when it changed health insurance carriers effective February 1, 2007, in that the coverage under the new insurance was not equal to or better than the coverage under the Blue Cross/Blue Shield plan in the areas of out of network coverage, deductibles, and durable medical supplies;

3. The appropriate remedy is for the Village to make employees whole for their losses by:
- a. Reimbursing employees for medical care costs for non-resident insured persons at the rate of 70% as would have been paid had there been an out of network benefit available under UHC-SE;
  - b. Reimbursing employees who experienced greater out-of-pocket costs under the UHC-SE up-front deductible in any given plan year than they would have had they been subject to the major medical deductible and \$20 per visit system of payments under the BCBS Plan; and
  - c. Reimbursing employees for costs incurred as a result of the 80% co-payment for durable medical devices under the UHC-SE Plan;
  - d. Holding employees harmless for these costs in the manner described in subsections a, b and c of this remedial order. The hold harmless for the deductible as described in subsection b shall take place following the end of the calendar year. The other hold harmless provisions shall take place on the basis of the submissions of bills by the employees.

4. The arbitrator will retain jurisdiction over this matter for a period of sixty days following the date of issuance for the sole purpose of resolving disputes over the remedy, if any.

Dated at Racine, Wisconsin, this 3<sup>rd</sup> day of July, 2009.

Daniel Nielsen /s/

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Daniel Nielsen, Arbitrator