BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

MERRILL TEACHERS ASSOCIATION

and

MERRILL AREA SCHOOL DISTRICT

Case 45
No. 68107
MA-14123

(Change In Retirement Health Insurance Drug Card)

Appearances:

Mr. Thomas S. Ivey Jr., UniServ Director, Central Wisconsin UniServ Council, 370 Orbiting Drive, P.O. Box 158, Mosinee, Wisconsin 54455, appeared on behalf of the Association

Mr. David Rohrer, Lathrop & Clark, LLP, Attorneys at Law, 740 Regent Street, Suite 400, Madison, Wisconsin 53701-1507, appeared on behalf of the District

ARBITRATION AWARD

On June 23, 2008 the Merrill Teachers Association and the Merrill Area Public Schools filed a request with the Wisconsin Employment Relations Commission seeking to have the Commission appoint William C. Houlihan, a member of its staff, to hear and decide a grievance pending between the parties. Hearing on the matter was held on July 15, 2008, in Merrill, Wisconsin. No formal record was taken. The parties submitted post-hearing briefs and reply briefs, which were received and exchanged by March 4, 2009.

This Award addresses prescription drug card coverage for Medicare eligible dependents of retirees.

BACKGROUND AND FACTS

The Association and the District have been signatories to a series of collective bargaining agreements, the most recent of which covers the period 2007-09. Among the provisions of the Agreement include those set forth below relative to health insurance.

Historically Medicare eligible spouses of retirees or still active district employees, who were not themselves Medicare eligible, were covered by the drug card benefit provided by contract. Under the terms of the collective bargaining agreement, the District's post-retirement health insurance obligations end when the employee attains Medicare eligibility. And so, a spouse who is older than an active/retired district employee received a benefit which the Medicare-eligible retiree would not, when the spouse became Medicare-eligible.

The parties changed their approach to retirement benefits in the negotiations leading to the 2007–09 collective bargaining agreement. The applicable provisions from the 2005-07 and 2007-09 contracts are both set forth below. The change did not impact the relevant language relating to benefit eligibility.

In 2005, the federal government determined to offer all Medicare participants access to prescription drug coverage. The Medicare drug plan, Medicare Part D, took effect on January 1, 2006. In response to the federal initiative, the parties health insurance provider, the Wisconsin Education Association Insurance Trust, determined to change the terms of its policies to exclude prescription drug coverage for Medicare eligible participants. The Trust subsequently concluded that its initial determination should be modified to permit coverage under circumstances where the parties collective bargaining agreements so required.

Against this background, Greg Kuelz, WEAIT Field Operations Director, sent school districts, including the Merrill district the following letter:

> October 2005
>
> Dear School District Official:
>
> I am writing to provide some important information that affects school district employees and their dependents who are eligible for Medicare as their primary health plan and have a WEA Trust health plan as their secondary Coverage. There are two things I want to explain.
>
> **New insurance agreement**
> First, as you will recall from previous communications, the Trust health plan will exclude prescription drug coverage for retirees, non-active employees, and dependents who are eligible for Medicare as their primary insurer, beginning January 1, 2006 - the date that Medicare will begin offering a prescription drug plan for these individuals. As you may expect health insurance premiums for these individuals will go down because prescription drug coverage is no longer available through the Trust.
>
> However, we will continue to provide drug coverage for Medicare-eligible active employees and their dependents. In addition, health plan participants with

Medicare as their primary insurer who are enrolled in the family rate class will retain their Trust drug coverage.

We will soon be mailing District Administrators new insurance agreements to sign and return to our office.

Post-employment health insurance coverage
The second issue revolves around contractual obligations that require school districts to make premium payments for health insurance, including drug coverage, for non-active or retired employees. We have been asked to consider allowing such individuals to continue the prescription drug plan through the District's Trust health plan. We are willing to work with school districts to offer this provided:

- You have retired employees for whom you are contractually obligated to provide a premium payment and you request that the Trust continue their drug coverage (that is, make an exception to the exclusion of drug coverage described above).
- You identify in writing to the Trust those who are eligible for the exception on January 1, 2006. For those individuals who are eligible in the future, you notify the Trust in writing 90 days in advance that an individual is eligible for this exception.
- You identify for the Trust the terms of your premium obligation and the description of the "group" to whom it applies.
- You notify those who are eligible for this exception and let them know for how long.
- You notify the Trust **and** those receiving continued prescription drug benefits 90 days in advance of when your premium obligation ends. We will not be able to accept retroactive terminations.
- All those receiving continued Trust prescription drug coverage must be on the school bill; we will not be able to make exceptions for those who are billed directly by the Trust.

If you want the Trust to continue to provide proscription drug coverage for Medicare-eligible retirees for whom the District has a contractual premium obligation, please contact your field representative and request a copy of the *Memorandum of Understanding Re: Exception to Health Plan Exclusion of Prescription Drug Coverage for Medicare-Eligible Retirees and Non-active Employees*.

In order for us to implement requested exceptions by January 1, 2006, we need the signed *Memorandum of Understanding* and required information no later than December 1, 2005.

Sincerely,

Greg Kuelz /s/
Greg Kuelz
Field Operations Director

cc: UniServ Directors
Field Representatives

The second section of the Kuelz letter specifically addresses the circumstance where the parties have "…contractual obligations that require school districts to make premium payments for health insurance, including drug coverage, for non-active or retired employees." It conditions the extension of this coverage on a series of provisions, including; " You have retired employees for whom you are contractually obligated to provide a premium payment and you request that the Trust continue their drug coverage…" The letter finally directs "If you want the Trust to continue to provide prescription drug coverage for Medicare-eligible retirees for whom the District has a contractual premium obligation, …". The letter mentions Medicare eligible dependents, but only in the paragraph defining the scope of exclusions from the plan. They are not referenced in the communications dealing with the memorandum nor in the direction provided the District. The letter addressed the case where the District had a contractual obligation to provide coverage for Medicare eligible retirees. There is no dispute in this proceeding that Medicare-eligible retirees are not subject to a contractual obligation. This dispute concerns a certain class of spouses who suffer a loss of benefits.

Paul Klippel, the District's Human Resource Director, responded by e-mail to Sue Laulainen, a WEAIT Field Representative, as follows:

Sue Laulainen/WEA

. . .

Sue-
I received a copy of the letter from Greg Kuelz concerning prescription drug coverage for Medicare-eligible retirees. I would like to request a copy of the "Memorandum of Understanding Re: Exception to Health Plan. ." Merrill Area Public Schools would like to offer this benefit for our retirees who are eligible. Attached is a list of retirees we feel will be eligible. A couple of questions…

1. The letter indicates "you identify in writing to the Trust the terms of your premium obligation and the description of the group to whom it applies."

What specific information do you need about the premium obligation? Also, does "group" refer to administrator, teacher, custodian, etc.?
The typical groups would be bargaining groups (i.e., teachers, custodians, etc.) and/or administrators and non-represented staff.

2. In the past, WEA has notified retirees before they turn 65 that they need to sign up far Medicare. Is this something WEA will continue to do?

Yes, we will continue to notify people when they are eligible for Medicare.

If you have any other questions, please let me know. Thanks.
Thanks for your help Sue.

Klippel's response addresses retirees, consistent with Kuelz's letter.

Laulainen replied by sending the referenced Memorandum to Klippel over the following cover letter:

October 2005

Dear School District Official:

Per your request, we are sending you a copy of the *Memorandum of Understanding Re: Exception to Health Plan Exclusion of Prescription Drug Coverage for Medicare-Eligible Retirees and Non-active Employees*. In order for us to continue to offer prescription drug coverage to retirees, non-active employees, and dependents who are eligible for Medicare as their primary insurer, please sign and return this document along with the information requested below.

This process is fairly simple and is spelled out in the *Memorandum*. I will summarize the main points for you:

- We need a list of those employees for whom the Trust prescription drug coverage will continue beyond Medicare eligibility for either themselves or their dependents, as an exception effective January 1, 2006.
- When you give us this information, please let us know the terms of your premium obligation and the description of the "group" to whom it applies, and when this exception no longer applies to them. Please provide this information by December 1, 2005. For those individuals who are eligible for this exception in the future, we need to get this same information 90 days in advance.

- You must inform the Trust at least 90 days in advance of when the district's contractual premium obligation for continued health insurance ends.
- Please remember that you need to let these individuals know that they will continue WEA Trust prescription drug coverage.

Let me know if you have any questions.

Sincerely,

Sue Laulainen /s/
Sue Laulainen
Field Representative

It is the Laulainen letter that really distinguishes between employees and dependents and provides that the drug coverage may extend to employees "...or their dependents...". The District received the letter on, or about November 11, 2005. There is no indication the Association was copied on the letter.

On November 30, 2005 Klippel met with Tom Andreska, the Association's chief negotiator. It was Andreska's testimony that Klippel indicated that the District was not going to sign the memo. Andreska testified that it was his belief that he and Klippel shared the view that there was no impact on the district. It was Klippel's testimony that in order to sign the Memo, the District had to have a contractual obligation to provide drug coverage after Medicare eligibility. He did not believe such an obligation existed, and thus felt he was not obligated to sign the Memo, and that he could not sign the Memo.

A couple of days later Klippel talked with Janeen LaBorde, Association President. Her testimony was that in her conversations with Klippel and also with Tom Ivey no one believed that the change in policy had any impact on the District. Klippel acknowledged that the conversation occurred, but could recall no details.

On or about December 5, 2005 the WEAIT sent the District the following letter:

December 5, 2005

Re: Premium Rate Class Split Effective January 1, 2006

On January 1, 2006, the Trust will no longer provide prescription drug coverage for participants with Medicare as their primary payer of benefits. As a result, there will be a change reflected on your premium billing. Please let me explain.

A Medicare special premium rate is used when one participant is Medicare eligible and the other is not. In order for the Trust to continue providing drug coverage to the participant who is not eligible for Medicare, it is necessary for us to split the premium rate class into a single and a single Medicare rate.

The net amount of the premium will remain unchanged; however, you will see the participant and his or her spouse printed separately on your invoice. I have listed the affected participants and their ID numbers on the enclosed spreadsheet.

When both participants become eligible for Medicare, the Trust will rejoin the coverage under one rate class.

Please feel free to contact the Eligibility Services Department at (800) 279-4000, Extension 8540, with your questions.

Sincerely,

Brad Fox
Eligibility Services Manager

Attached to the letter was a list of subscribers and spouses referenced in the third paragraph of the December 5 letter. This letter makes clear that the Trust will split the subscriber from the spouse where one is Medicare eligible and the other is not for purposes of drug coverage. There is no indication the Association was copied on this letter or on any subsequent invoices.

In response to the WEAIT letter the District contacted the retiree group with the following letter:

December 9, 2005

To: All MAPS Retirees

Re: Medicare Prescription Drug Coverage

I am writing to provide you with important information about your prescription drug coverage under the WEA Trust group health insurance policy ("Health Plan") that *you* participate in as a retiree or non-active employee of the School District. Specifically, the WEA Trust had made a change to its Health Plan that affects the prescription drug coverage for Medicare-eligible retirees and non-active employees and their Medicare-eligible dependents.

As you may be aware, starting January 1, 2006, the federal government will provide Medicare participants prescription drug coverage through a new Medicare drug insurance program called Medicare Part D. Because of this new government program, the WEA Trust decided to amend the District's Health Plan and exclude prescription drug coverage for Medicare-eligible retirees, non-active employees, and their dependents for whom Medicare would be the primary insurer. As a result, effective January 1, 2006, the health insurance coverage you have under the District's WEA Trust Health Plan will no longer include prescription drug coverage for you and your Medicare-eligible dependents when you become eligible for Medicare. Therefore, if you are now Medicare-eligible, in order to continue to have prescription drug insurance coverage after December 31, 2005, you must obtain your own prescription drug insurance. This can be done by signing up for Medicare Part D as soon as possible, but no later than December 31, 2005.

Because, as a Medicare-eligible person, you will no longer have prescription drug coverage under the WEA Trust Health Plan as of January 1, 2006, the federal government will consider you to be a person without "creditable coverage." This is significant because whether you have creditable coverage on January 1, 2006, may affect the premiums you will pay if you decide to enroll in a Medicare Part D prescription drug plan after the initial enrollment period. The initial enrollment period for enrollment in a Medicare Part D prescription drug plan without a premium penalty is between November 15, 2005, and May 15, 2006. If you wait until after May 15, 2006, to enroll in a Medicare Part D plan, your monthly premium under the plan could be much higher than it would have been if you had enrolled by May 15, 2006.

. . .

However, to continue to have prescription drug insurance coverage after December 31, 2005, you must enroll in a health insurance plan that will provide you with coverage beginning January 1, 2006. Enrollment in a Medicare Part D plan is voluntary, but it provides a viable option for your continued coverage. Additionally, it is anticipated that for most Medicare-eligible retirees, the premium for a Medicare Part D prescription drug plan will be considerably lower than under the WEA Trust Health Plan.

More detailed information about Medicare plans that offer prescription drug coverage is available through the "Medicare & You 2006" handbook from Medicare. You can also get more information about Medicare prescription drug plans from these places:

. . .

Very truly yours,

SALLY SARNSTROM
Superintendent of Schools

Sarnstrom's letter is addressed to "All MAPS Retirees". It thus follows the format of previous correspondence which focused on the retiree, as opposed to the spouse. The underlined sentence at the bottom of the first paragraph described the change in plan. It describes the change as affecting the "…prescription drug coverage for Medicare-eligible retirees…and their Medicare-eligible dependents." The sentence presumes that the retiree and dependent are linked, when in fact the Medicare eligible dependent stood to lose insurance coverage even if the retiree was not Medicare eligible. In the second paragraph, Sarnstrom's letter describes the change as one which would;"…exclude prescription drug coverage for Medicare-eligible retirees...and their dependents for whom Medicare would be the primary insurer." The sentence is misleading. It focuses on the retiree and his/her status. It does not independently note that the Medicare-eligible dependent will lose benefits even if the retiree is not Medicare-eligible. Similarly, the sentence that follows is similarly misleading when it declares that the Retiree and Medicare-eligible dependent will lose drug coverage when the retiree becomes eligible for Medicare.

The Sarnstrom letter does not identify the Medicare-eligible dependent spouse of a non-Medicare eligible retiree. It appears to me that Sarnstrom did not have that scenario in mind as of December, 2005. There is no indication the Sarnstrom letter was sent to the Association.

Some time in early 2007 Andreska had a conversation with a retiree who explained to him that there was a class of Medicare eligible retirees who would lose benefits under the change. The date of this conversation was unclear. Some time in January, 2007 Janeen LaBorde was contacted by an employee who complained about the impact of the change. LaBorde testified that at the time she didn't understand the concern. At the time the employee was not yet impacted, but expressed concern that she would be. It was LaBorde's testimony that in January, 2007 there was no one actually impacted, and that the concerns being expressed related to a future loss of benefits.

LaBorde contacted her UniServ Director, Tom Ivey, who advised her to file a grievance. At hearing, it was LaBorde's testimony that at the time of the filing of the grievance, March 7, 2007 no one had actually incurred out-of-pocket costs.

The following grievance was filed on March 7, 2007:

Date: **March 7, 2007**
Grievant: **Merrill Teachers Association**
Contact Person: **Janet Wardall**

. . .

Statement of Grievance:

The District refused to enter into a Memo of Understanding with the WEAIT which enabled retirees and their spouses to continue to receive drug coverage under the District's health care plan. As a result, the Association has been made aware of at least two spouses of retired employees, covered by the District's health care plan, who were dropped from the WEAIT prescription drug coverage.

The Association believes this unilateral decision to eliminate continue prescription drug coverage under the District's health plan for retirees/spouses who are eligible for Medicare violates the terms and conditions of the Master Agreement between the parties.

. . .

Remedy Requested:

1. The District will sign the WEAIT Memo of Understanding allowing retirees and spouses to continue with the health plan drug card.

2. The District will make whole any expenses for employees and/or spouses incurred as a result of the District's failure to sign the WEAIT Memo of Understanding allowing retirees and spouses to continue with the health plan drug card.

The grievance indicates that the Association is aware of two spouses who have been dropped from insurance coverage. This appears to be contrary to LaBorde's testimony.

The grievance was denied by the following letter on March 15, 2007:

To: Janet Wardall, MTA Grievance Chair
From: Paul Klippel
Re: MOU Grievance Dated March 7, 2007
Date: March 15, 2007

This memo is in regards to the attached grievance received by me on March 8, 2007. The MTA is asserting the district violated the terms and conditions of the Master Agreement between the parties by not entering into a Memorandum of Understanding with WEAI Trust for continuation of drug benefits for two spouses of retired employees covered by the District's health care plan. For the

reasons outlined below, and without limiting any applicable reasons in the future, the grievance is denied.

1. The grievance is without merit and the district did not violate the terms of Master Agreement. Under Wisconsin law, the MTA does not represent retirees and/or their spouses. Further, the MTA chief negotiator knew of the district's decision not to sign the MOU on November 30, 2005, and did not object. The District did not make the change in the health insurance benefit, rather it was made by the WEAIT. Also, prior changes to the health benefit plan have been made impacting retirees without dispute or challenges.

2. The grievance is procedurally defective because under the definition of "grievant" in the Master Agreement, Section 13.2 (terms), the MTA is not a grievant. The definition provides that a grievant is the "person or persons making the claim." Also, the grievance is not timely under the terms of the Master Agreement and because an unreasonable length of time has occurred since the drug coverage for retirees was eliminated. Section 13.3 of the 2005-2007 Master Agreement states that the grievant must present the grievance within 20 days after he/she knew or should have known the cause of the grievance. As noted above, the MTA chief negotiator knew of the district's decision not to sign the MOU on November 30, 2005, and affected persons were notified directly of WEAIT changes in December 2005. Further, health benefits for eligible retirees have remained available and used by those choosing to participate.

ISSUE

The parties did not agree upon the issue to be decided. It is the view of the District that the issues for decision include the following;

A. Was the grievance Timely filed?

B. Did the School District Violate the Collective Bargaining Agreement When it Declined to Sign the Memorandum of Understanding Re: Exception to health Plan Exclusion of Prescription Drug Coverage for Medicare Eligible Retirees and Non-Active Employees Proposed by the WEA Insurance Trust?

The Association regards the following as the sole issue for decision:

Did the District violate the collective bargaining agreement by failing to continue to provide prescription drug coverage to dependents of covered retirees who reach Medicare eligibility?

RELEVANT PROVISIONS OF THE COLLECTIVE BARGAINING AGREEMENTS

PROVISIONS OF THE 2005 – 2007 COLLECTIVE BARGAINING AGREEMENT

Article 13.0: Grievance Procedure

Section 13.1

Definition:

For the purpose of this agreement, a grievance is defined as any problem involving the meaning, interpretation, and application of the provisions of this agreement.

Section 13.2

Terms:

(1) A grievant is the person or persons making the claim.

(2) A "Party in Interest" is the grievant and any person who might be required to take action or against whom action might be taken in order to resolve the claim.

(3) The term days when used in this article shall mean normal business days, Monday through Friday, excluding holidays and vacation days that occur during the teacher's work year.

Section 13.3

Procedures:

In order that grievances be processed as rapidly as possible, the number of days indicated at each level should be considered as a maximum and every effort should be made to expedite the process.

STEP I. The grievant should advise his/her immediate supervisor and present his/her grievance in writing identifying the issue and its relation to the agreement with or without

counsel within twenty (20) days after he/she knew or should have known the cause of such grievance. The immediate supervisor shall give his/her written answer within seven (7) days of the time it was presented to him/her. The written grievance shall include the facts of the grievance, the issue involved, the provisions of the contract allegedly violated, the remedy requested, and the signature of the grievant.

. . .

STEP V. Within ten days after such written request of submission to arbitration and approval, the Board of Education and the Board of Directors will agree upon a mutually acceptable arbitrator and will obtain a commitment from said arbitrator to serve. . . .

The arbitrator so selected will confer with representatives of the Board of Education and the Board of Directors and hold hearings promptly and will issue his/her decision on a timely basis. The arbitrator's decision will be in writing and will set forth his/her findings of fact, reasoning and conclusions of the issues submitted. The arbitrator will be without power or authority to make any decision which requires the commission of an act prohibited by law or which is in violation of the terms of this agreement. The decision of the arbitrator shall be binding to both parties.

Article 21.0: Insurance and Retirement Benefits

Section 21.1

Health Insurance:

The Board of Education shall pay ninety (90%) of the cost of each teacher's group hospitalization-surgical insurance. Except as the MTA shall otherwise specifically agree in writing, the benefits shall be no less than those that are currently in effect.

Section 21.2

Dental Insurance:

The Board of Education shall pay seventy-five (75%) of the cost of each individual or family group dental plan. Except as the MTA shall otherwise specifically agree in writing, the benefits shall be no less than those that are currently in effect.

Section 21.3

Insurance Committee:

The parties (MTA and Board) shall meet at least once each fiscal year (more if necessary) to continue to explore options and alternatives to existing schedule of benefits related to health, dental, life and disability insurance coverage. In the event the Board or MTA does not ratify a change proposed by either party, current insurance benefits and carriers will remain in effect.

. . .

Section 21.7

Voluntary Early Retirement Incentive:

> **Eligibility**: Retirement benefits shall be available to all full time employees who are at least fifty-five (55) years of age and have served in the district for no less than fifteen (15) years.
>
> . . .
>
> **Insurance:** The District shall pay ninety (90%) of the health insurance contribution on behalf of the early retiree(s), to the existing plan. The Board's obligation will end upon employee attainment of eligibility for Medicare.
>
> In the event the spouse is younger than the retiree, the spouse, if eligible by carrier standards, shall be able to remain in the insurance plan until attaining eligibility for Medicare. The spouse shall reimburse the Board for the full cost of the Health Insurance.
>
> In the event the retired employee dies before attaining eligibility for Medicare and the surviving spouse is eligible by carrier standards, the Board shall pay ninety (90%) of the health contributions for a single plan on behalf of the spouse to the existing plan for the remaining years allowed as a benefit for the retired employee. If there are eligible

dependents by carrier standards, the Board will pay ninety (90%) of the health insurance contributions for a family plan on behalf of the spouse to the existing plan for the remaining years allowed as a benefit for the retired employee.

. . .

PROVISIONS OF THE 2007-2009 COLLECTIVE BARGAINING AGREEMENT

Article 21.0: Insurance and Retirement Benefits

Section 21.1

Health Insurance:

The Board of Education shall pay ninety (90%) of the cost of each teacher's group hospitalization-surgical insurance. Except as the MTA shall otherwise specifically agree in writing, the benefits shall be no less than those that are currently in effect.

Alternative Benefit Arrangement

Each employee shall elect annually, subject to a qualifying event, under the District's Internal Revenue Code ("IRC") § 125 cafeteria plan, prior to the start of each cafeteria plan year, either the health insurance benefit provided above or $4,000. If an employee elects the $4,000, it shall be paid to the employee in four (4) equal quarterly payments through out the year (November 30th February 28th, May 31st and August 31) and the payments will be subject to all applicable payroll taxes.

This Alternate Benefit Arrangement provision does not apply to a spouse of a current or former district employee who is receiving a family health insurance benefit from the District.

Employees wishing to resume receiving health insurance under this section are subject to waiting period and insurability provisions imposed by the carrier.

Section 21.2

Dental Insurance:

The Board of Education shall pay seventy-five (75%) of the cost of each individual or family group dental plan. Except as the MTA shall otherwise

specifically agree in writing, the benefits shall be no less than those that are currently in effect.

Section 21.3

Insurance Committee:

The parties (MTA and Board) shall meet at least once each fiscal year (more if necessary) to continue to explore options and alternatives to existing schedule of benefits related to health, dental, life and disability insurance coverage. In the event the Board or MTA does not ratify a change purposed by either party, current insurance benefits and carriers will remain in effect.

. . .

Section 21.7

Voluntary Early Retirement Incentive:

Eligibility: Retirement benefits shall be available to all full time employees who are at least fifty-five (55) years of age, have served in the district for no less than fifteen (15) years and are enrolled in the Merrill Area Public Schools health insurance program for their final contact year of employment.

. . .

Benefit
Upon retirement, the Board shall establish a Health Reimbursement Arrangement ("HRA") for the retiring employee and shall credit the HRA with the amount equal to ninety percent (90%) of the then existing monthly premium for health insurance under the District health insurance plan for active employees, for single or family coverage, as applicable. This amount will continue to be credited monthly until the retiree attains eligibility for Medicare. The amount credited to the HRA shall change with changes to the monthly health insurance premium.

The retiree may submit evidence of medical expenses as defined in IRC § 213(d) that are paid by the retiree for the retiree, the retiree's spouse and the retiree's dependents as defined in the IRC, including health insurance premium payments (which includes the health insurance plan for active employees). The District shall reimburse approved medical expenses from the retiree's HRA, until the balance is exhausted. Reimbursement shall be made by the 15th day of the month following the month in which the reimbursement request is submitted.

If the retiree dies prior to exhaustion of his or her HRA balance, the retiree's spouse may continue to submit medical expenses for reimbursement, until exhaustion of the HRA. If the retiree and the retiree's spouse die prior to exhaustion of the retiree's HRA, the dependents of the retiree may continue to submit medical expenses for reimbursement until exhaustion of the HRA. If the retiree dies prior to the District crediting all amount provided for above to his or her HRA, the District shall continue to make the credits to the HRA for the benefit of the retiree's surviving spouse and/or dependents at 90% of the single rate (for one eligible family member) or 90% of the family rate (for two or more eligible family members). The District will cease credits to the HRA when the deceased retiree would have been eligible for Medicare.

In the event the retiree, the retiree's spouse, if applicable, and the retiree's dependents die prior to exhaustion of his or her HRA, the HRA shall revert to the District and the Board shall have no obligation to make further credits to the HRA.

POSITIONS OF THE PARTIES

The Association points out that post-retirement benefits of the Agreement have always included drug card benefits for dependents of District retirees regardless of whether the dependents were eligible for Medicare. It is the view of the Association that the District should have signed the MOU with the Trust to preserve those benefits. In the alternative, the District had the option of convening the Insurance Committee to discuss other options. Absent an agreement under Sec. 21.3, the District was required to maintain the same level of benefits with the same carrier.

The Association contends that sometime in January, 2007 Janeen LaBorde, the MTA president, talked with a retiree who was concerned about Medicare D. The retiree's husband was attaining Medicare eligibility in September of 2007. When she (LaBorde) realized that the spouse would have to pay out-of-pocket costs for drugs once he turned 65 she instituted the grievance.

The Association contends that Article 21.3 of the Agreement provides for an avenue to change benefit levels with the agreement of the MTA and the Board. It is the view of the Association that absent such an agreement this section requires a maintenance of benefits at the existing level with the existing carrier.

The Association contends that it was in the fall of 2007 that a retired teacher's spouse attained Medicare eligibility, lost the Trust drug card coverage and was forced to take Medicare D.

The Association argues that the grievance is timely and properly before the Arbitrator. The Association cites authority for the proposition that forfeiture should be avoided and the

grievance should be presumed to be arbitrable if there is a question as to whether or not time limits have been met. It is the view of the Association that Article 13, the grievance procedure, does not provide for a forfeiture where timelines have been missed.

It is the view of the Association that the MTA filed a grievance when it became apparent that what the District led the Association to believe was not true. The Association contends that the November 30, 2005 meeting between Klippel and Andreska should not trigger the duty to file a grievance. Both described the discussion as brief, no documents relating to the MOU were shared, and there was no discussion of potential problems. Andreska came away from the meeting believing the change had no impact.

The same is true of the subsequent conversation between LaBorde and Klippel. The Association contends that the District was in possession of information as to which retirees were affected by the Disrict's failure to sign the MOU. That information was not shared with the MTA.

It is the view of the Association that the District bears the burden of proof in its timeliness defense, and that the District has failed to carry that burden.

The Association contends that the District violated Article 21 by not providing a health plan with prescription drug benefits to retirees, with dependents eligible for Medicare. It is the view of the Association that Article 21 clearly requires that the District provide health insurance to retirees that are the same as is provided to active employees. The record establishes that there is one health plan which covers both active and retired employees. The Association acknowledges that the Trust was the moving party in this affair, having initially removed certain prescription drug coverage. However, the Trust subsequently amended its position to accommodate locally-bargained benefits. Had the District signed the proffered MOU, Medicare-eligible dependents of the employees/retirees would continue to be eligible for the prescription drug plan.

The District could have signed the MOU. In the alternative, the District could have exercised its options under Article 21.3 to meet with the Association and discuss the matter. It is the futher contention of the Association that the District withheld relevant documentation from the Association.

The Association concludes that the District has enriched itself at the expense of retirees. The District has saved premium monies, while exposing retirees to a significantly inferior drug card benefit in the Medicare D program. As a remedy, the Association seeks to have the District ordered to sign the MOU and make whole any retiree who has expended funds beyond that which they would have incurred if covered by the Trust.

It is the position of the District that upon review of the Kuelz and Laulainen letters, Klippel reviewed the collective bargaining agreement and determined that the District was not contractually obligated to continue the prescription drug coverage, and that he could therefore

not sign the MOU. Klippel's view was shaped by his reading of the contract and his experience that past benefit plan changes had been passed along to retirees without objection. Klippel informed both Andreska and LaBorde that the District would not be signing the MOU. 15 months passed before a grievance was filed.

It is the view of the District that the grievance is untimely because the Master Agreement clearly states that a grievance must be filed within a certain time period, and the Union failed to meet the required timeline. It is the view of the District that the 20-day time period for filing a grievance commenced on November 30, 2005 when the District notified the MTA it would not sign the MOU. The District points to Article 13's declaration that "The number of days indicated at each level should be considered as a maximum. . ." The District cites authority for the proposition that Arbitrators should pay due respect to the provisions of the grievance procedure.

It is the view of the District that the MTA did not make further inquiry of Klippel nor did it contact the UniServ Director, Ivey, to inquire about possible impact of the District decision not to sign the MOU. The District cites both arbitration and EEOC cases in support of its claim that the grievance is not timely.

The District complains that the MTA has been "understandably vague about the date, or even approximate time period, when the MTA learned that the District's decision not to sign the Memorandum of Understanding did have a negative effect." It is the view of the District that ". . .even after learning sometime in the period between December 2006 to January 2007 that the District's decision was allegedly having an adverse impact on the spouses of two retirees, the MTA failed to file a grievance until March, 2007. The initial delay was inexcusable, but the futher delay was even more so. The District should not suffer the consequences of the MTA's utter lack of due diligence."

The District points to the November 30, 2005 meeting where the District put the Association on notice that it was not going to sign the MOU as the event that created a duty on the part of the MTA to conduct a reasonable inquiry. The Association failed to do so.

It is the District's view that the continuing violation theory does not apply to this circumstance. This matter involved a discrete act, the decision not to sign the MOU. It is not the classic failure to pay a proper wage rate.

As to the merits of the dispute, the District contends that there is nothing in the collective bargaining agreement that requires the District to modify its group insurance plan by signing a new contract addendum with the carrier. To sign the MOU would mean that the retirees would no longer have the same plan as the active employees. It is the District's view that it had an obligation to provide coverage under the Trust plan. The Trust changed the plan and both the Association and the District were bound by that change. Had the District signed the MOU it would have been tantamount to changing the insurance plan, which would have violated Art. 21.3 in that it would have been a non-ratified change.

DISCUSSION

Timeliness

I do not believe this matter is appropriately dismissed on the basis of timeliness. The grievance was filed on March 7, 2007. At the time the parties were governed by the 2005-2007 Collective Bargaining Agreement, which ran at least through June 30, 2007. The applicable collective bargaining provision was Article 13, Grievance Procedure, the relevant provisions of which are set forth above. The definition of a grievance is "any problem involving the meaning, interpretation, and application of the provisions of this agreement." Under Step I of the grievance procedure a grievant should proceed within 20 days after he/she knew or should have known of the cause of such grievance. The written grievance is to include the facts of the grievance, the issue involved, the provisions of the contract allegedly violated.

For a good deal of the time preceding the grievance, I do not believe the parties understood that there was a "problem". I do not believe that they understood the impact of the drug card change, nor the relationship of the change to the collective bargaining agreement. Step I of the grievance procedure requires the grievant to detail the claim being advanced. That detailing is not possible until such time as the "problem" underlying the dispute is understood.

When the WEAIT initially advised the parties that it was making a change to the plan neither party understood the impact of the change on district insurance subscribers, and their dependents. Under the terms of the collective bargaining agreement the District's obligation for retiree benefits terminate when the employee reaches Medicare eligibility. This is true under both the 2005-07 and 2007-09 contracts. The key to entitlement to post retirement benefits is the employee's eligibility for Medicare. The age of the spouse is irrelevant. The spouse takes benefits only where the employee/retiree is eligible. The District's responsibility is not a function of the age of the spouse.

The Kuelz letter set this dispute in motion. The October 2005 letter went to the District and to Tom Ivey, the Uni-Serve Director. The introductory paragraph talks about school district employees and their dependents who are eligible for Medicare. The first substantive provision follows in similar fashion, describing the upcoming exclusion of retirees, non-active employees, and dependents who are eligible for Medicare as their primary insurer.

The second substantive section of the letter, titled "Post-employment health insurance coverage" addressed Districts with contractual obligations. This is the paragraph that addresses the focus of the parties, as they considered whether or not their contract required modification. The first sentence of the paragraph addresses "…contractual obligations that require school districts to make premium payments for health insurance, including drug coverage, for non-active or retired employees." Under the terms of the collective bargaining agreement, Merrill's obligation to make such payments ends at the employee/retiree Medicare eligibility. The letter goes on to offer to work with Districts, provided "You have retired

employees for whom you are contractually obligated to provide a premium payment..." This would be the basis for an exception the Trust would allow. Again, there are no such "retired employees" in Merrill. Finally the letter advises, "If you want the Trust to continue to provide prescription coverage for Medicare-eligible retirees for whom the District has a contractual premium obligation,...".

Read literally, the contractual obligation paragraph does not address the Medicare eligible spouses of non-Medicare eligible employees/retirees. The District contends this letter, sent to Ivey, was sufficient notice that a problem existed. I do not believe the contractual obligation paragraph puts anyone on notice of the consequences to the spouses. Such notice would have to come from the earlier paragraphs. I think they are too general to be effective notice of the circumstances giving rise to this grievance. All parties reactions confirm this conclusion.

Klippel responds, and his response is welcoming to the inclusion of retirees to the plan. Nothing in his letter indicates that he is aware that certain spouses of actives/retirees will lose benefits. To the contrary he expresses interest in offering the benefit to "our retirees".

Laulainen responds to Klippel. The body of her letter includes a reference to dependents, but does not single them out. Similarly, her summary of process list refers to dependents. However, the document is titled "Memorandum of Understanding Re; exception to Health Plan Exclusion of Prescription Drug Coverage for Medicare-Eligible Retirees and Non-Active Employees". There is no reference to dependents in the document title. Her summary process requests a list of employees for whom the drug coverage would continue beyond Medicare, for either themselves or their dependents. I do not believe this letter draws out the Medicare-eligibility distinction between employee and spouse that is key to this proceeding. What would cause a critical look is the production of the list requested in the first bullet paragraph. Nothing in the record suggests the Association received Laulainen's letter.

There was a meeting on November 30. From the testimony, I believe that both Klippel and Andreska focused on the status of the employee/retiree. Both men read the contract to terminate an employees eligibility for district paid health insurance when the employee attained eligibility for Medicare. The conclusion that the district was not required, or was ineligible to sign the Memorandum is not shocking when the contractual language is measured against the eligibility standard set forth in Kuelz October letter; "You have retired employees for whom you are contractually obligated to provide a premium payment..." Unless one were to focus on the older spouse circumstance, the conclusion seems obvious.

I credit the testimony of Andreska that both men felt that the Trust decision had no impact on their contract. Klippel did not contradict that testimony. LaBorde essentially corroborated Andreska's testimony in that regard. The factual underpinning of all of the testimony as to these meetings is that no one was sensitive to the older dependant circumstance. To that end, there was no "problem" within the meaning of the contract.

The December 5 WEAIT letter, and its attachment, expressly splits the participant and spouse/dependent. This document lists subscribers and dependents who had different Medicare eligibility dates. To a critical reader, i.e. one sensitive to the contractual standard, there appeared examples of dependents who would become eligible for Medicare before their employee spouse. It was sent to the District. There is no indication it was sent to the Association. There is no indication the District called the separate status of the dependents to the attention of the Association. It is unclear whether the District realized the significance of the relative ages of the subscribers and their dependents.

Sarnstrom sent a letter to District retirees on December 9, 2005. Nothing in that letter suggests that the District was aware of the consequence of the insurance change on Medicare-eligible dependents of non-Medicare eligible retirees. I disagree that there was a lack of due diligence on the part of the Association. The Association had talked with the District. No one appreciated the adverse impact of the insurance change.

The record is unclear as to when the Union first learned of the benefit loss to retiree spouses. It appears that sometime in January, 2007 LaBorde was contacted by a co-worker. As the District notes, January is more than 20 work days before March 7. LaBorde testified that at the time of the filing of the grievance, no one had been adversely impacted. She testified that the spouse of a retiree reached Medicare age in the fall of 2007, and so incurred out-of-pocket costs. This contradicts the assertion in the first paragraph of the grievance that "…the Association has been made aware of at least two spouses of retired employees, covered by the District's health care plan, who were dropped from the WEAIT prescription drug coverage." I think there was a great deal of confusion over who was impacted, and how.

The grievance procedure indicates that a grievance is a "problem involving the meaning, interpretation, and application of the provisions of this agreement." I am reluctant to conclude that the "problem" referred to is the discovery that there may be individuals adversely impacted by the change in plan. The grievance procedure requires that the "…grievance shall include the facts of the grievance, the issue involved, the provisions of the contract allegedly violated, the remedy requested, and the signature…" The grievance cannot proceed until the factual basis for the claim is known.

Given all the confusion surrounding this matter I believe the "problem", as the term is used in Section 13.1, arose when someone was denied the benefit, and came forward to put the parties on notice. It is unclear to me when that happened. I do not believe LaBorde's testimony can be reconciled with the grievance. If I credit LaBorde, the grievance is anticipatory, in that no one had been impacted as of March 7, 2007. If I credit the declaration in the grievance, the record is silent as to when the two referenced spouses of retired employees were dropped, or when they came forward.

The grievance procedure sets a 20 work day standard for presenting a grievance. The purpose of that timeline is so "…that grievances be processed as rapidly as possible, the number of days indicated at each level should be considered as a maximum…" The grievance

procedure does not articulate the consequences for a grievance filed after the 20 work day period. There is no firm date identified in this proceeding, where someone came forward to complain of a loss of benefit, to start the 20 work day filing period.

The District had the information about older spouses, and didn't share that information with the Association. Either the District didn't realize the impact of the Trust decision under the terms of the collective bargaining agreement, or it did realize the impact and declined to tell the Association. In either event it is not well positioned to demand that this matter be dismissed for delay attributable to the Association.

The Trust changed the plan on January 1, 2006. The grievance was filed on March 7, 2007, some 14 months later. The delay was attributable to the mutual misunderstanding of the parties as to the impact of the change.

Merits

Article 21.1 of the collective bargaining agreement provides that "Except as the MTA shall otherwise specifically agree in writing, the benefits shall be no less than those that are currently in effect." The sentence is found in the Health Insurance provision. The District contends that the collective bargaining agreement cannot be read to require it to modify the negotiated agreement. I do not believe that to be the case here. The agreement requires that the benefits be no less than those that are currently in effect. Once drug benefits were removed from the class of dependents, the benefits were less than those previously in effect. No modification of the collective bargaining agreement is required. The proposed Memorandum of Agreement is but one method of maintaining the benefit level.

Section 21.3 has a provision that permits either party to bring proposed health insurance changes to the forefront. Neither party did so. This change was initiated by the carrier. The clause is thus inapplicable to this dispute.

I do not believe that by signing the Memorandum the District creates a disparity between active and retired employees. This Award addresses the status of certain spouses of retired employees. The effect of this decision is to restore them to the status quo.

The District contends that it is obligated to provide the Trust as the carrier, and that the parties are thereafter bound by changes made by the carrier. Whatever the obligation of the parties to retain the Trust, Article 21.1 addresses the level of benefits. The contract says that the benefits shall be no less, and the elimination of coverage for drugs for a certain class of beneficiaries represents a reduction in the benefit level. There is reference to the Trust previously changing benefits without objection. There is no detail offered. It is difficult to address the claim without knowing what the changes were, and how subscribers were impacted. If the changes were benefit neutral or provided for increases in benefits, their treatment under Article 21.1 would be different.

The District contends that had it signed the Memorandum it would have unilaterally changed the insurance plan and such change would constitute a non-ratified change within the meaning of Sec. 21.3. This is a sort of chicken and egg analysis. The Trust changed the plan. The act of signing the Memorandum would restore the original benefit. It is hard to construe that as a violation of Sec. 21.3. Had the District invoked Sec. 21.3 it is speculative to contend that the Association would have rejected the overture and failed to ratify the change. This proceeding suggests to the contrary.

AWARD

The grievance is sustained.

REMEDY

The District is directed to reinstate the drug benefit for dependents of employees or retirees who qualify for District paid health insurance. This includes the dependents of those employees and retirees who are entitled to an HRA contribution from the District. For those dependents who have incurred out-of-pocket costs they would not have otherwise experienced, beginning March 7, 2007 the District shall make those individuals whole.

Dated at Madison, Wisconsin, this 22nd day of July, 2009.

William C. Houlihan /s/
William C. Houlihan, Arbitrator

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