BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

BROWN COUNTY (SHERIFF'S DEPARTMENT)

and

BROWN COUNTY SHERIFF'S DEPARTMENT NON-SUPERVISORY LABOR ASSOCIATION

Case 796
No. 70694
MA-15027

Appearances:

Cermele & Associates, SC, by **Jonathan Cermele**, Attorney at Law, 6310 West Bluemound Road, Milwaukee, Wisconsin, appeared on behalf of the Association.

Frederick J. Mohr, LLC, by **Frederic J. Mohr**, Attorney at Law, 414 East Walnut Street, Suite 101, Green Bay, Wisconsin, appeared on behalf of the Employer.

ARBITRATION AWARD

Brown County Sheriff's Department Non-Supervisory Labor Association, herein referred to as the "Association" and Brown County (Sheriff's Department), herein referred to as the "Employer," jointly selected the undersigned from a panel of arbitrators from the staff of the Wisconsin Employment Relations Commission to serve as the impartial arbitrator to hear and decide the dispute specified below. The parties waived hearing and submitted a stipulation of facts in lieu of the hearing. Each party submitted a written argument, the last of which was received on March 8, 2012.

ISSUES

The parties did not stipulate to the statement of the issues? I state them as follows:

1. Whether the Employer breached the parties' collective bargaining agreement by changing the "terms and conditions" of the dental policy in effect after the expiration of the 2009 agreement.

2. If so, what is the appropriate remedy?

FACTS

The Employer is a Wisconsin county. It operates a sheriff's department which employs sworn law enforcement personnel. The Association is the collective bargaining representative of sworn law enforcement personnel in certain positions. Sergeant Gregory Rabas is a member of the bargaining unit represented by the Association. The parties' 2010-11 collective bargaining agreement was ratified in June, 2010, but not signed until March, 2011. After the ratification of that agreement, but before the end of 2010, the Employer with advance notice to the Association changed dental insurance carriers to Delta Dental effective January 1, 2011. Delta Dental did become the carrier on that date. Under the old plan, the dental insurance provider reimbursed all providing dentists directly to the extent of the benefits allowed under that plan. Under the new plan, Delta Dental does not reimburse dentists who are not on their preferred provider or premier provider network directly. The plan beneficiary must submit the claim for benefits and is then reimbursed by Delta Dental.

On January 17, 2011, Sgt. Rabas received dental services from his regular dentist. His regular dentist is not on the Delta Dental preferred provider list. The dentist is not a signatory to any agreement with Delta Dental. The cost for those services was $307. Delta paid only $184.00 of this claim after it was duly submitted. Delta stated that it paid the limited amount because the dentist was "not in its provider network" and was above its "usual and customary fee" for that service.

RELEVANT AGREEMENT PROVISIONS

. . .

2010-2011 Agreement

. . .

Article 35. HEALTH AND DENTAL INSURANCE

Coverage shall be as outlined in the final document.

The County agrees to continue to make available to the employees, a group insurance program. Such plan shall retain the terms and conditions in effect as of the date of the signing of this Agreement and benefits shall be improved as negotiated by the County and Association.

New employees will be eligible for insurance coverage the first of the month following 30 days of employment.

Health insurance contributions shall be made through the Section 125 plan as pre-tax contributions.

PPO Plan

Premiums:

Effective May 1, 2010, the employee shall pay ten percent (10%) of the single or family premium per month for the PPO Plan. The County shall pay ninety percent (90%) of the single or family premium for the PPO Plan.

Effective January 1, 2011, the employee shall pay twelve percent (12%) of the single or family premium per month for the PPO Plan. The County shall pay eighty-eight percent (88%) of the single or family premium for the PPO Plan.

. . .

High Deductible Plan:

HRA/HSA/VEBA would be funded on January 1 each year at the following levels:

100% for year 2010
90% for year 2011

The HRA would be converted to an HSA or VEBA Account beginning on or before December 31, 2011, and all funds that are in the HRA at that time will be converted to the HSA/VEBA. The HSA or VEBA would be negotiated with the bargaining unit.

Premiums:

Effective May 1, 2010, the employee shall pay ten percent (10%) of the single or family premium per month for the High Deductible Plan. The County shall pay ninety percent (90%) of the single or family premium for the High Deductible Plan.

Effective January 1, 2011, the employee shall pay twelve percent (12%) of the single or family premium per month for the High Deductible Plan. The County shall pay eighty-eight percent (88%) of the single or family premium for the High Deductible Plan.

. . .

Maximum allowable fees and Usual and Customary fees are intended to be synonymous terms.

There shall be no guarantee that the provider networks will remain the same or will be continued during or after the term of this agreement. Notice will be required prior to discontinuance of any change to the provider networks in sufficient time to allow employees to opt into another plan at the time of the change or annually during the open enrollment period before the change is implemented. If the County continues to offer this plan after the expiration of this contract, the County agrees that coverage will be negotiable. Individual providers will not be guaranteed.

Medically necessary disputes will upon appeal ultimately be determined by a third party qualified caregiver. The third party administrator of the employer's health plan will determine claims based on the plan document. Decisions not to pay claims other than those determined to be medically necessary may be overturned by the County Risk Manager at his/her discretion. (There is no intent with the foregoing language to add to or remove any rights or obligations of the parties, only to clarify practice).

The union acknowledges the settlement of the U&C grievance and agrees to dismiss the grievance agreeing to the use of the 85th percentile for surgical and non-surgical claims.

The County shall make available a Long-Term Care insurance policy in which employees may participate at the employee's own cost.

If an employee is laid off, the County shall pay its share of the insurance premium for any premiums due for the month following the month for which the layoff occurred.

Retired personnel are to remain in the plan, if they so desire, to age 65, provided they pay the entire costs of all premiums, except as may be otherwise specifically provided for in this Agreement.

The parties agree that any changes made with the existing plans must be agreed to by the employer and the union.

Dental:

The employer shall pay seven and one-half percent (7½%) of the single or family premium per month for the Dental Plan. The County shall pay ninety-two and one-half percent (92½%) of the single or family premium for the Dental Plan.

Effective January 1, 2010, the annual dental maximum is $1,250.

. . .

2009 Agreement

Article 35. **HEALTH AND DENTAL INSURANCE**

Coverage shall be as outlined in the final document.

The County agrees to continue to make available to the employees, a group insurance program. Such plan shall retain the terms and conditions in effect as of the date of the signing of this Agreement and benefits shall be improved as negotiated by the County and Association.

New employees will be eligible for insurance coverage the first of the month following 30 days of employment.

Insurance Deductibles:

Effective January 1, 2005, the employee shall pay seven and one-half (7½%) of their premium per month on all dental and health plans. The County shall pay ninety-two and one-half percent (92½%) of the single or family premium.

Health insurance contributions shall be made through the Section 125 plan as pre-tax contributions.

An employee will have a choice of participating in either the PPO or Co-Pay HSP.

The following changes to the PPO Plan are effective midnight, December 31, 2006:

- Increase the PPO in-network office co-pay from $10 to $15.
- Establish a Prescription Drug out-of-pocket per person maximum at $1,000.
- Ambulance usage for medically necessary events will be paid at 95%

Effective January 1, 2008, the PPO out-of-network deductible and HSP deductible will change as follows:

Individual from $200 to $250

Family aggregate from $600 to $700

The following changes to the HSP Plan are effective midnight, December 31, 2006:

- Establish a Prescription Drug out-of-pocket per person maximum at $1,000.

- A 3-tier formulary will be followed for all prescriptions effective the first day of the month following ratification by the parties:

  - Generic 20% employee co-pay
  - Preferred 25% employee co-pay + cost difference
  - Non-Preferred 25% employee co-pay + cost difference + $15.00 surcharge

- There will be a $50.00 penalty charged for non-emergency use of the emergency room. Emergency (defined as): An acute, sudden onset of a sickness or bodily injury which is life threatening or will significantly worsen without immediate medical or surgical treatment. (Regardless of final diagnosis).

Based on the 2007 HSP enrollments, should the number fall below 10% of total Brown County Sheriff's Department Non-Supervisory Employees, the HSP will discontinue January 1, 2008.

Maximum allowable fees as used in the PPO and Usual and Customary fee as used in the HSP plan are intended to be synonymous terms.

There shall be no guarantee that the provider networks will remain the same or will be discontinued during or after the term of this agreement. Notice will be required prior to discontinuance of any change to the provider networks in sufficient time to allow employees to opt into another plan at the time of the change or annually during the open enrollment period before the change is implemented. If the County continues to offer this plan after the expiration of this contract, the County agrees that coverage will be negotiable. Individual providers will not be guaranteed.

Medically necessary disputes will upon appeal ultimately be determined by a third party qualified caregiver. The third party administrator of the employer's health plan will determine claims paid based on the plan document. Decisions to not pay claims other than those determined to be medically necessary may be overturned by the County Risk Manager at his/her discretion. (There is no intent with the foregoing language to add or remove any rights or obligations of the parties, only to clarify practice).

The union acknowledges the settlement of the U&C grievance and agrees to dismiss the grievance agreeing to the use of the 85th percentile for surgical and non-surgical claims.

The County shall make available a Long-Term Care insurance policy in which employees may participate at the employee's own cost.

If an employee is laid off, the County shall pay its share of the insurance premium for any premiums due for the month following the month for which the layoff occurred.

Retired personnel are to remain in the plan, if they so desire, to age 65, provided they pay the entire costs of all premiums, except as may be otherwise specifically provided for in this Agreement.

The parties agree that any changes made with the existing plans must be agreed to by the employer and the union.

POSITIONS OF THE PARTIES

Association

The Employer violated Article 35 of the agreements by changing dental insurance carriers to a plan which provided lower benefits. Article 35 is clear. Any new plan must retain the same benefits. The new Delta Dental plan does not. Article 35's prohibition can only be viewed as applying to dental plans because the dental provisions are in the same article. While the Article does not make specific references to dental insurance other than headings and for premium contributions, there is no dispute that the Employer has provided dental coverage before and after that time frame.

The Employer has used three different providers between the signing of the 2009 agreement, and the signing of the 2010-11 agreement, Wausau Benefit Plan (herein "Wausau"), UMR, and Delta Dental. Of these the Wausau Benefits Plan should be viewed as the basis of establishing benefits. The terms and conditions in effect were those of the Wausau plan when the 2009, agreement was signed. The UMR plan was put in place after the 2009, agreement had been signed and expired prior to the 2010-11 agreement had been signed. Therefore, it is irrelevant.

Delta's reasons for paying less than the 80% are that the dentist was outside their network and that the fee charged was in excess of the fee they consider "usual and customary." Nowhere in the Wausau plan is there any mention of a "network" or "usual and customary" limit on fees.[1] The Employer is expected to argue that the terms "usual and customary" and

[1] Wausau did provide that: "[a] covered expense is payable at 80% coinsurance on a maximum allowable basis."

"maximum allowable" are synonymous. While that may be true there is no evidence in the record that Wausau ever considered the fees submitted by Sgt. Rabas' dentist to be in excess of what Wausau considered allowable. Thus, there is no basis for Delta to have considered the fee for service to be in excess of what was considered the "maximum" allowable fee unless it changed the terms and conditions of the prior policy.

Article 35's reference to "maximum allowable fee" only refers to health insurance and not to dental insurance. The 2009 agreement specifically states that "[m]aximum allowable fees as used in the PPO and Usual and Customary fee as used in the HSP plan are intended to be synonymous. The 2010-11 agreement uses the same language, but includes that language only under the subsection addressing the "High Deductible Plan" (i.e., health insurance) and is not referenced in the section addressing the "Dental" plan.

The Employer is also expected to assert that Delta's denial was appropriate because there is language in Article 35 which states that there is no guarantee that "provider networks will remain the same or be continued during or after the term of this agreement." The 2009, agreement specifically requires the Employer to give notice prior to discontinuing any provider network. There is nothing in evidence to show that the Employer ever gave any notice of a change in the dental plan network. When it comes to the 2010-11 agreement, that specific language is limited to the "High Deductible" medical plan.

Second, there is nothing in the Wausau Benefits Plan that even comes close to addressing a "network." As a result, any denial based upon Sgt. Rabas' dentist being out of Delta's network must fail.

The Employer violated the plain meaning of the agreement when Delta Dental denied the part of the claim in dispute. The Arbitrator should require that Sgt. Rabas be made whole for the violation.

Employer

The parties were operating under the 2010-11 collective bargaining agreement. Article 35 provides "maximum allowable" fees and "usual and customary fees" are intended to be synonymous. Prior to January 1, 2011, UMW was the plan administrator for the dental plan. It had a PPO network. The Employer changed network providers effective January 1, 2011. Rabas' dentist was not in Delta's network. Article 35 allows the parties to chose the provider network and that there is no guarantee whether individual providers would be deemed in a network. The agreement provides that coverage is outlined in the final insurance document. The plan specifies that if a dentist has not signed a contract with Delta, he or she is deemed out of the network. It provides that the dentist's fees will be reimbursed at the plan's Maximum Plan Allowance (herein "MPA"), less deductibles and co-pays, but that payment will be sent to the patient and not the doctor. The fee in dispute was $307. The maximum allowed by the plan was $230. It is undisputed that Delta paid 80% of the MPA.

This case is a claim that the Employer made a unilateral change in an existing benefit during a contractual hiatus in violation of Sec. 111.70(3)(a)3, Stats. However the duty is overridden by a specific provision of the prior agreement. The 2009 agreement specified that the Employer was allowed to change providers.

Rabas' dental benefits did not change when the Employer changed providers. The Employer did not violate the agreement. It asks that the grievance be dismissed.

DISCUSSION

1. Standards

The Association has advanced two legal theories to support its claim. The first theory is that the Employer's actions in dispute violated the collective bargaining agreement. However, the current contract had not been signed as of the time the factual circumstances underlying the grievance occurred. Accordingly, the Association has also proceeded under the theory that the Employer's actions were a unilateral change in violation of Sec. 111.70(3)(a)4, Wis. Stats. Under that doctrine an employer is required to maintain the "status quo" as to wages, hours and working conditions which were in effect at the expiration of the prior agreement until the parties have exhausted their duty to bargain. In Dodgeland School District, Dec. No. 31098-C (WERC, 2/2007) the WERC stated the doctrine as follows:

> The duty to maintain the status quo applies whenever there is a duty to bargain, including a situation, like this, that arises during the "hiatus" between the expiration of a predecessor contract and the execution of a successor. During such a hiatus, the Commission has long held that the duty to bargain requires that the status quo be maintained until a new contract is finalized, even if the matter proceeds to interest arbitration and even if the parties have tentatively agreed that certain changes will be included in the next agreement.

The WERC has long recognized that the circumstances do change in a hiatus period and ordinarily when the parties' expired agreement recognizes a right in an employer to make changes, the "dynamic status quo" doctrine allows the employer to exercise the mutually agreed right. See, for example, Village of Saukville, Dec. No. 28032-B, pp. 21-22 (WERC, 3/96). As it relates here, the issue under the dynamic status quo doctrine is the same as the first, do the circumstances of this case demonstrate that the Employer violated the terms of the parties' agreement even if that agreement might technically be expired. Under either theory, the Association must demonstrate that the Employer violated Article 35's requirement that the new plan "retain the terms and conditions in effect as of the date of signing of the [2009] Agreement.."

Under both the expired and new agreements, Article 35 specifies that:

> The third party administrator of the employer's health plans will determine claims paid based on the plan document.

All three dental plans involved in this case contained internal procedures to resolve disputes over payment of claims. Because the Association bears the burden of proof, it must demonstrate that the failure to pay the expected amount in this case occurred because the Delta Dental plan has a significantly lower range of benefits. In other words, Delta paid less on this claim because it has a system of paying less benefits and not, for example, because it made a clerical error in determining the correct benefit in this one situation.

2. Change of Benefits

Article 35 of the 2009 agreement provides that the Employer's group insurance program (which includes dental coverage) "shall retain the terms and conditions in effect as of the date of the signing of this agreement. Sergeant Rabas' experience with his provider was that its charges had always been accepted for full reimbursement less deductible and co-pays in the past. Delta Dental did not accept the charges in question for similar full reimbursement. The Delta Dental response indicates that it "allowed" only $230 of the $307 billed. It is undisputed that when Sgt. Rabas made an inquiry to Delta Dental, Delta Dental made mention of the fact that the provider was not part of its preferred provider network[2] and that the charges were above those which are "usual and customary."

I address the Association's arguments that the foregoing denial effectively demonstrates a change in benefits. The Association's first argument is that because Delta Dental has a preferred provider network and Wausau did not, that the benefits of the Delta Dental plan are necessarily lower. I conclude that the fact that the Delta Dental plan has a preferred provider does not affect the level of benefits paid to out of network providers. This conclusion is supported by the plan documents.

The Delta Dental "Summary Plan Description" (herein "Plan Summary") uses the concept of "Maximum Plan Allowance" as its method of determining what fees are "allowed." In Section II, Description of Benefits it specifies that preferred provider dentists had agreed to accept less than "Maximum Plan Allowance." It provides that its "Delta Dental Premier Dentists" have agreed to accept Maximum Plan Allowance and dentists who are outside the plan are "allowed" the same amount. Under the circumstances the fact that Delta Dental has a preferred provider provision and Wausau does not establish any negative change in benefits. The operative term is the "Maximum Plan Allowance." If the "Maximum Plan Allowance" is generally equivalent to that of Wausau's "Maximum Allowable Fee" the benefit is the same.[3]

The second argument the Association makes is that fees Delta Dental considers as "Maximum Plan Allowance" are less than those which Wausau considered as "Maximum

[2] Preferred Provider Option is herein abbreviated "PPO."

[3] "Maximum Allowable Fee" is explained in the next paragraph.

Allowable Fee" and, therefore, constitute a lower benefit. I conclude that the preponderance of evidence available from the respective plan documents indicates that the standards applied both carriers are both relatively the same and intended to be consistent with the insurance industry concept of "usual and customary" fees.

The Wausau Plan determined the maximum charge it would accept for benefits by applying its concept of "Maximum Allowable Fee." It defines how it determines "Maximum Allowable Fee" as follows:

1. The fee most often charged in the geographic area where the service is performed.

2. The fee most often charged by the provider;

3. The fee which is recognized as reasonable by a prudent person;

4. The fee determined by comparing charges for similar services to a national data base adjusted to the geographic area where the services or procedures were performed; or

5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and services relative to each other that includes, but is not limited to a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the services as adjusted to the geographic area where the services or procedures were performed.

This is equivalent to the ordinary language in insurance contracts of "usual and customary."

The Delta Plan does not clearly define "Maximum Plan Allowance." However, a review of its terms makes it likely that the term is essentially equivalent to the similar term in the Wausau Plan and consistent with the way "usual and customary" is used in the dental insurance industry. The only available evidence of the Delta Dental plan is its Plan Summary. This document does not use the term "usual and customary" as its standard for determining the appropriateness of dentists' fees. Instead it uses the term "Maximum Plan Allowance" as its standard for those determinations. The plan summary, Section II, defines the term "Maximum Plan Allowance as follows:

> Maximum Plan Allowance is the total dollar amount allowed for a specific benefit. The Maximum Plan Allowance will be reduced by any deductible and coinsurance you are required to pay.

The foregoing does not provide any information as to how Maximum Plan Allowance is calculated. There is no other specific description in the Plan Summary as to how it is

calculated. The nature of the fee structure in Section II as to how preferred provider and premier providers are compensated establishes that the Maximum Plan Allowance is higher than the amounts paid to preferred providers.[4] However, the "Coordination of Benefits" provision uses the term "Allowable Expense" for the purpose of determining appropriateness of dental fees. It defines "Allowable Expense" as follows:

> "Allowable Expense" means a necessary, reasonable, and customary item of dental expense that is covered at least in part by one or more of the Plans covering the person for whom the claim is made. . . . .

This term is equivalent to the "usual and customary" terms ordinarily found in insurance contracts.

In the "Coordination of Benefits" provision, the plan summary states how benefits are determined when Delta Dental is secondary.

> The amount by which the secondary Plan's benefits are reduced shall be used by the secondary Plan to pay allowable expenses not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the secondary Plan determines it obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the Claim Determination Period. [Emphasis supplied.]

It is highly unlikely that "Maximum Plan Allowance" is significantly lower than "Allowable Expense" because the foregoing would mathematically result in Delta Dental paying a greater proportion of expenses when it is secondary than applying Maximum Plan Allowance. Accordingly, the preponderance of the evidence indicates that Maximum Plan Allowance is essentially the same as Wausau's "Maximum Allowable Fee" and what is "usual and customary" as that term is used in the dental insurance industry.

Under the circumstances, the evidence is insufficient to show that the difference in payment suffered by Sgt. Rabas was the result of a systemic difference between the two plans. The grievance is, therefore, denied.

[4] Discussed in more detail above.

AWARD

That since the Employer did not violate the collective bargaining agreement with respect to the dental charges in dispute, the grievance is hereby denied.

Dated at Madison, Wisconsin, this 12th day of July, 2012.

Stanley H. Michelstetter II /s/
Stanley H. Michelstetter II, Arbitrator

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