BEFORE THE ARBITRATOR

In the Matter of a Dispute Between

WAUPUN AREA SCHOOL DISTRICT NON-CERTIFIED EMPLOYEES UNION, LOCAL 1112-B, and WAUPUN AREA SCHOOL DISTRICT CUSTODIAL AND MAINTENANCE EMPLOYEES UNION, LOCAL 1112, AFSCME, AFL-CIO

and

WAUPUN AREA SCHOOL DISTRICT

Case 56
No. 72187
MA-15254

(Health Insurance Grievance)

AWARD NO. 7894

Appearances:

David Dorn, Staff Representative, Wisconsin Council 40, AFSCME, AFL-CIO, 336 Doty Street, Fond du Lac, Wisconsin, 54935, appearing on behalf of the Waupun Area School District Non-Certified Employees Union, Local 1112-B and Waupun Area School District Custodial and Maintenance Employees Union, Local 1112, AFSCME, AFL-CIO.

Mark Olson and Alana Leffler, Attorneys, Buelow Vetter Buikema Olson & Vliet LLC, 20855 Watertown Road, Suite 200, Waukesha, Wisconsin, 53186, appearing on behalf of the Waupun Area School District.

ARBITRATION AWARD

The Waupun Area School District Non-Certified Employees Union, Local 1112-B, and Waupun Area School District Custodial and Maintenance Employees Union, Local 1112, AFSCME, AFL-CIO, hereinafter referred to as the Unions, and the Waupun Area School District, hereinafter referred to as the District or Employer, were parties to collective bargaining agreements that provided for final and binding arbitration of unresolved grievances. One agreement covered the clerical bargaining unit and one agreement covered the custodial/maintenance bargaining unit. Pursuant to the parties' request, the Wisconsin Employment Relations Commission appointed the undersigned to decide what came to be denominated as the Health Insurance Grievance. Technically, two separate health insurance

grievances were filed, one in each bargaining unit. The parties agreed to consolidate the two grievances for purposes of hearing and decision. A hearing was held in Waupun, Wisconsin, on December 12, 2013 and February 13, 2014. The hearing was transcribed. Afterwards, the parties filed briefs and reply briefs, whereupon the record was closed on May 30, 2014. Having considered the evidence, the arguments of the parties and the record as a whole, the undersigned issues the following Award.

ISSUE

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

> Did the District violate the collective bargaining agreement when it changed health insurance plans on July 1, 2013, and, if so, what is the proper remedy?

The District framed the issue as follows:

> Did the Waupun Area School District violate Article 23 of the 2010-2014 clerical collective bargaining agreement and Article 21 of the 2010-2014 custodial collective bargaining agreement when it changed health insurance carriers from DeanCare to WEA Trust in July of 2013?

While the two proposed issues are closely worded, I have adopted the District's proposed issue because it references the health insurance provisions in both of the applicable collective bargaining agreements. Thus, I'm going to decide the District's proposed wording of the issue.

PERTINENT CONTRACT PROVISIONS

The parties' 2010-2014 collective bargaining agreement for the clerical bargaining unit provided thus:

ARTICLE 23
INSURANCE

HEALTH INSURANCE

A. The Board shall pay the premium for the single plan for employees without dependents and the premium for employees covered under the family plan for hospital and surgical insurance during the term of this Agreement.

B. Employees hired on or after January 1, 1990, shall be eligible for health insurance benefits pursuant to the following:

Twelve Month Full-time	12 months of premium at 100%
Twelve Month Part-time	12 months of premium at pro-rata%
School Year Full-time	10 months of premium at 100%
School Year Part-time	10 months of premium at pro-rata%

For health insurance the following definitions will apply:

Full-time:	35 through 40 hours per week	1.00
Part-time:	30 but less than 35 hours per week	.75
Part-time:	20 but less than 30 hours per week	.50

C. The Employer may from time to time change the insurance carrier and/or self-fund its health care program if it elects to do so, as long as coverage under such carrier or self-funded plan is substantially equivalent or better to the insurance coverage in effect **as of January 1, 2011, which is the WEA Trust Preferred Plan 7 with a $1,000/$2,000 deductible and 10/25/25/100 co-pays. The district (through a third party vendor) will reimburse the employee up to $900 for single and $1,800 for family with each calendar year. Savings from the HRA deductible self-insurance will be retained by the district.** (Bold in original.)

Effective 1/1/04, adopt $0 (generic), $5 (brand name formulary), $20 (brand name non-formulary) co-pays on prescription drug card.

The Board and Union agree to re-open the contract for the 2012-2013 and/or 2013-2014 benefit year if the health insurance renewal is less than a 4% increase or more than an 8% increase. (Bold in original.)

The parties' 2010-2014 collective bargaining agreement for the custodial/maintenance bargaining unit provides thus:

ARTICLE TWENTY-ONE
INSURANCE

A. HEALTH INSURANCE

The Board shall pay the premium for the single plan for employees without dependents and the entire premium for employees covered under the family plan.

The employer may from time to time change the insurance carrier and/or self-fund its health care program if it elects to do so, as long as coverage under such carrier or self-funded plan is substantially equivalent or better to the insurance coverage in effect **as of January 1, 2011, which is the WEA Trust Preferred Plan 7 with a $1,000/$2,000 deductible and 10/25/25/100 co-pays. The district (through a third party vendor) will reimburse the employee up to $900 for single and $1,800 for family with each calendar year. Savings from the HRA deductible self-insurance will be retained by the district.** (Bold in original.)

Effective 10/1/06, adopt $0 (generic), $5 (brand name formulary), $20 (brand name non-formulary), co-pays on prescription drug card.

The Board and Union agree to re-open the contract for the 2012-2013 and/or 2013-2014 benefit year if the health insurance renewal is less than a 4% increase or more than an 8% increase. (Bold in original.)

FACTS

The District operates a public school system in Waupun, Wisconsin. About 200 of its employees receive health insurance through the District. Of that number, about 30 are clerical, custodial and maintenance employees.

As noted in the prefatory paragraph, AFSCME represents a clerical bargaining unit and a custodial/maintenance bargaining unit in the District. In 2010, the parties negotiated and agreed to separate collective bargaining agreements for the two bargaining units just noted. Both agreements ran from July 1, 2010 through June 30, 2014.

When the parties negotiated those contracts, one of the topics they addressed was health insurance. At the time, the insurance provided was from WEA Trust and the policy had a deductible of $100 for single coverage and $200 for family coverage. The record does not identify the name of the WEA Trust plan. In negotiations, the parties agreed to switch from the existing WEA Trust plan to a different WEA Trust plan which went by the name Preferred Plan 7. This plan had a deductible of $1,000 for single coverage and $2,000 for family coverage. In an effort to offset the costs of the increased deductible to employees, the parties agreed to establish Health Reimbursement Accounts (hereinafter HRAs) and have $900 contributed by the District for employees with single plans and $1,800 contributed for employees with family plans, so that the employees' liability with regard to deductibles effectively remained unchanged (i.e. at $100/$200). Thus, while the deductions were officially at $1,000/$2,000, the employees paid only $100/$200 of the $1,000/$2,000 deductible. The parties memorialized their agreement with the following contract language which they placed in both agreements (i.e. the new clerical agreement and the new custodial agreement):

> The Employer may from time to time change the insurance carrier and/or self-fund its health care program if it elects to do so, as long as coverage under such carrier or self-funded plan is substantially equivalent or better to the insurance coverage in effect as of January 1, 2011, which is the WEA Trust Preferred Plan 7 with a $1,000/$2,000 deductible and 10/25/25/100 co-pays. The district (through a third party vendor) will reimburse the employee up to $900 for single and $1,800 for family with each calendar year. Savings from the HRA deductible self-insurance will be retained by the District

The record indicates that the plan just referenced (i.e. the WEA Trust Preferred Plan 7) provided coverage for office visits, urgent care visits, emergency room visits, maternity care, laboratory services, radiology services, inpatient hospitalization, surgery, advanced imaging, diagnostic testing, prescriptions drugs, durable medical equipment, hospice care, home health care, transplantation services, hearing aids, and treatment of temporomandibular disorders.

The first sentence in the contract language previously quoted specifies that the District had the contractual authority to change health insurance carriers, as long as the new coverage was "substantially equivalent or better" to the WEA Trust Preferred Plan 7.

Effective September 1, 2011, the District changed health insurance carriers from WEA Trust to DeanCare. The specifics of the DeanCare plan are not contained in the record.

The Unions could have grieved this change in insurance from the WEA Trust to DeanCare on the grounds that the DeanCare plan was not "substantially equivalent or better" to the WEA Trust Preferred Plan 7. That didn't happen. Thus, the Unions did not grieve the change from the WEA Trust Preferred Plan 7 to DeanCare in 2011. What they did do, though, was discuss one aspect of the DeanCare plan with the District's business manager. The aspect of the

DeanCare plan which was discussed was the prescription drug portion of the plan. Following that discussion, the business office established a reimbursement system to pay the difference between the cost of prescription drugs under the DeanCare plan and the WEA Trust Preferred Plan 7 to which the benefit level was tied.

* * *

In early 2013, the District faced a large projected deficit. Specifically, the District projected a deficit of approximately $650,000 for the already existing 2012-2013 school year, and a deficit of nearly $1.2 million for the forthcoming 2013-2014 school year. About one-third of the deficit for the 2013-2014 school year was attributable to projected increased health insurance premiums. DeanCare reported that the District's premiums would increase by 12 percent upon renewal of the plan. A 12 percent increase in health insurance premiums would have cost the District about $385,000 for the 2013-2014 school year. While DeanCare later reduced the projected rate increase to 10.9 percent, and then to 10.1 percent, that reduction was a reaction to the fact that the District was changing the renewal date to July 1, 2013, instead of September 1, 2013, in order to keep the plan year consistent with the fiscal year. As a result, the 2013-2014 plan year would be shorter than the typical plan year.

The District then explored a variety of options for reducing the projected $1.2 million deficit for the 2013-2014 school year. One option which the District considered was laying off District employees, including employees in the custodial and clerical bargaining units. In an effort to avoid layoffs, the District decided to pursue the option of changing health insurance carriers from DeanCare to another health insurance carrier, in order to avoid the projected premium increase which would have been implemented by DeanCare for 2013-14.

To effectuate same, the District worked with insurance consultant Rae Anne Beaudry. Beaudry, who is Executive Vice President of the Horton Group, has an extensive occupational background dealing with public sector health insurance. She first reviewed the standard identified in the collective bargaining agreements for changing insurance carriers (i.e. that the District could change insurance carriers, as long as coverage was substantially equivalent or better to the WEA Trust Preferred Plan 7 which had been in effect on January 1, 2011). Then, the District sought bids from various health insurance carriers. One of the carriers that the District sought bids from was WEA Trust. In the course of working with them, the District learned that the WEA Trust no longer offered the plan that is referenced in the two support staff collective bargaining agreements (i.e. the Preferred Plan 7). Since that plan no longer exists, it was impossible for the District to select that particular plan again. The District further concluded that it was impossible for it (i.e. the District) to obtain coverage that was identical to the coverage which was in effect as of January 1, 2011, due to constant changes in the health care industry and the way in which health insurance carriers interpret and administer their plans. The District therefore sought coverage that was "substantially equivalent or better" than the WEA Trust Preferred Plan 7, as authorized by the two collective bargaining agreements.

The District received quotes from Unity, DeanCare and WEA Trust.

Beaudry and District officials then reviewed the quotes which were received, and the coverage which the plans provided. According to Beaudry, they considered the following: (1) they wanted to maintain physician and hospital (provider) access or improve it; (2) they wanted to maintain or lower plan deductibles; (3) they wanted to keep employee/retiree premium contributions and costs down; and (4) they wanted to not dramatically decrease benefits for those employees no longer covered by a collective bargaining agreement to maintain a budget.

After considering the foregoing, Beaudry and District officials recommended a plan offered by the WEA Trust which was named the WEA Trust Base Plan. They selected that plan for the following reasons. First, they though it improved physician and hospital (provider) access, both in-state and nationally, and ensured that plan participants had access to what are considered "centers of excellence for chronic disease," such as Children's Hospital. Second, while the plan identified in the two collective bargaining agreements referenced a deductible of $1,000 single/$2,000 family, the WEA Trust Base Plan had a deductible of $500 single/$1,000 family. Third, they thought it improved prescription drug coverage for employees because the Value Choice Drug Tier (which is a part of the WEA Trust Base Plan) allows 58 drugs (most maintenance medications) to be obtained with no copayment.

The record indicates that just like the WEA Trust Preferred Plan 7, the WEA Trust Base Plan provides coverage for office visits, urgent care visits, emergency room visits, maternity care, laboratory services, radiology services, inpatient hospitalization, surgery, advanced imaging, diagnostic testing, prescriptions drugs, durable medical equipment, hospice care, home health care, transplantation services, hearing aids, and treatment of temporomandibular disorders.

The WEA Trust Base Plan also provides coverage for mental health and substance abuse services, hearing and vision exams for those under age 18, and all age/gender appropriate routine services (e.g. colonoscopy) with no out-of-pocket costs if rendered in-network.

Beaudry and District administrators ultimately recommended to the School Board that the District switch from DeanCare to WEA Trust for the plan known as the Base Plan. The School Board adopted that recommendation and changed health insurance plans effective July 1, 2013. This change applied to all District employees (i.e. administrators, teachers and support staff). It was not possible to carve out a small group of employees (such as the custodians and clericals) and exclude them from the change in insurance carriers. Thus, all District employees had to move from DeanCare to the WEA Trust Base Plan.

In the summer of 2013, the District notified the Unions that it was changing health insurance plans again effective July 1, 2013.

After receiving that notification, the Unions filed two grievances on July 12, 2013 (one for each bargaining unit). These grievances challenged the switch in insurance plans. The District denied the grievances, and the grievances were appealed to arbitration.

After the District switched to the WEA Trust Base Plan effective July 1, 2013, it stopped contributing to employee HRAs. As previously noted, the health plan identified in the two

collective bargaining agreements required the District to provide, through an HRA mechanism, calendar year deductible reimbursements of $900 single, and $1,800 family. When the District stopped contributing to these HRAs, it shifted this financial burden to the employees. At the hearing, District officials averred that the reason these payments had not been made was because of complications created by this grievance and the transition from a school year to a calendar year deductible year. District officials further averred at the hearing that despite the fact that it had not made these HRA contributions/deductible reimbursements since July 2013, the District had nonetheless budgeted for these payments and had transferred the money into a liability account for that purpose. Thus, they averred that the District intends to meet its contractual obligation to provide these payments to the employees of these bargaining units.

By switching from DeanCare to the WEA Trust Base Plan, the District achieved significant cost savings in that it avoided the 10 percent premium increase which was projected by DeanCare. In addition, by returning to the WEA Trust and leaving the class action lawsuit relating to the Early Retiree Reinsurance Program, the District received premium credits in the amount of $140,000.

* * *

At the hearing, the District had Beaudry testify as an expert witness. She testified in detail about the coverage provided by the WEA Trust Base Plan and why she considered it "substantially equivalent" to the WEA Trust Preferred Plan 7. The Unions presented no expert witness at the hearing. Instead, the Unions' witnesses were three bargaining unit employees who testified about their individual claims experience under the new plan. They did not testify about the new plan's overall coverage.

Employee Brad Bille testified that his family has a lot of medical issues, and that he and his wife recently had surgery. He further testified that as of the date of the hearing, his out-of-pocket medical expenses for his family totaled $4,300.

Employee Adam Holzman testified that his wife has serious health issues. He further testified that after the District switched to the new insurance plan, he was paying $286 a month for his wife's arthritis infusions. He further testified that as of the date of the hearing, his out-of-pocket medical expenses for his family totaled $3,600.

Employee Pat TerBeest testified that her out-of-pocket cost for certain medications that she takes use to be $15 for a three-month supply under the old medical plan. Now, though, under the new plan, she's paying $228 for a three month supply of those same medications.

POSITIONS OF THE PARTIES

Union

It's the Unions' position that the District committed an egregious violation of the collective bargaining agreements when it changed health insurance plans on July 1, 2013.

Here's an overview of the Unions' case. The Unions note that the applicable contract language allows the District to change carriers so long as the new plan is "substantially equivalent" to the one named in the collective bargaining agreements (i.e. the WEA Trust Preferred Plan 7). According to the Unions, that means that the District has to maintain a plan with coverage that is equal, in substance, to the one identified in the agreements. The Unions contend that the new plan which the District has selected and imposed is far inferior to the old plan and imposes significantly increased expenses and costs for employees. They argue that even with the contractual HRA payments, which the District continues to withhold, the new insurance plan fails to provide the employees with the insurance benefits they negotiated with the District in 2010. The Unions believe that they met their burden of proving a violation of the contract. In their view, the Employer's violation of the contract is so blatantly obvious and harmful to the employees that they did not need to rely on expert testimony to make their case. Additionally, they contend that the District's efforts to refute the Unions' position rely on a distortion of the facts, promises of further payments and above all, an absurd interpretation of the contractual language that not only could, but has led to excessively harsh results. They therefore ask that the grievances be sustained, and that the employees be made whole and restored to the position they would have been in if not for the District's violation of the contract.

The Unions note at the outset that the "substantially equivalent" standard for changing insurance plans has been, as it puts it in its brief, "well worn territory for litigation." They then cite four grievance arbitration awards where the arbitrator found that the employer's change in carriers violated that standard: *Douglas County, City of Sparta, City of New Berlin* and *St. Francis Hospital*. The Unions urge the arbitrator to rely on those cases. As for the cases that the District relies on, the Unions argue that the vast majority of them actually support their position here.

The Unions dispute the District's claim that the employees have benefited from the change in health insurance. The Unions emphasize that the coverage under DeanCare is not relevant to this case. As for the "so-called" improvements in the new plan, the Unions submit they are actually mandated by the Affordable Care Act or represent benefits that the employees would have enjoyed had their original 2011 WEA Trust plan not been discarded by the District in the first place.

Next, the Unions argue that the new plan is inferior to the old plan in that there are increased out-of-pocket maximums; increased copays for office visits and prescription drugs; and increased coinsurance. They elaborate as follows.

First, the Unions contend that one area where employees saw a drastic change in coverage from the old plan was in their out-of-pocket costs. To support that contention, they rely on the following chart which they created:

	2011 Plan	**2013 Plan**

In Network Out-of Pocket Maximum (single/family):	$1,000/$2,000	$2,500/$5,000
Out of Network Out-of-Pocket Maximum (single/family):	$2,750/$5,500	$5,000/$10,000
In Network Out-of-Pocket Max minus HRA Payment Offset (none provided for 2013):	$100/$200	$2,500/$5,000
In Network Out-of-Pocket Max minus HRA Payment Offset if funded to $900/$1,800:	$100/$200	$1,600/$3,200

They aver that under the 2011 plan, the employees' in-network out-of-pocket maximums were just $1,000 and $2,000 for single and family plans, while employees were receiving $900 and $1,800 contributions to their HRAs for single and family plans, respectfully. Under the 2013 plan, this in-network out-of-pocket maximum increased by $3,000, or 150 percent. They further aver that when you consider the effect of the HRA offset previously provided by the District, to an employee with a family that stays exclusively in-network, the out-of-pocket maximum liability has essentially gone from $200 to $5,000. They also note that the District has not provided HRA funding since switching health insurance plans, which has exacerbated the impact of the plan design changes. The Unions contend that even if the District were to fully fund HRAs to the established contractual amount, the employees' liability with regard to out-of-pocket costs has skyrocketed under the new plan. As the Unions see it, this one change alone is sufficient evidence that the coverage offered by the 2013 plan is not substantially equivalent to the coverage offered by the 2011 plan.

As part of their argument on this point, the Unions dispute the District's claim that the change in insurance plans achieved "cost savings for employees." They note in this regard that employees went from having no in-network coinsurance to paying 10 percent coinsurance in-network. According to the District, this was an improvement in benefits because it is "not diminution in plan coverage/benefits within the context of the reduction in the plan deductible and out of pocket maximum which was implemented as of July 1, 2013." The Unions disagree with this contention. First, they aver that the District is attempting to lead the arbitrator to believe that the out-of-pocket maximum has decreased, when the record evidence clearly indicates that the out-of-pocket maximum has increased from $1,000/$2,000 to $2,500/$5,000 in-network and from $2,750/$5,500 to $5,000/$10,000 out-of-network. According to the Unions, it defies explanation that the District is somehow confusing a 250 percent increase in in-network out-of-pocket maximum with a "reduction." Furthermore, the District's argument with regard to deductible ignores the HRA deductible offset previously provided under the contract ($900/$1,800), which limited employee exposure with regard to deductible to $100/$200. Those HRAs have not been made available to employees since July, 2013.

Second, the Unions assert that employees now pay more with every doctor visit. To support that contention, they rely on the following chart which they created.

	2011 Plan	**2013 Plan**
Employee Co-Insurance In Network:	0%	10%
Employee Co-Insurance Out of Network:	20%	30%
Employee In Network Office Visit	$10	$25

Copayment:		
Urgent Care Copayment:	$25	$75
Emergency Room Copayment:	$100	$150

They contend that where employees could previously visit an in-network provider and expect to pay a simple $10 copay, employees must now deal with an office visit copay that has more than doubled, to $25. Urgent care copays have tripled to $75, and emergency room copays have seen a 50 percent increase to $150. On top of these increased costs, the Unions further note that the 2013 plan now requires employees to pay 10 percent coinsurance in-network (where they previously paid no coinsurance at all), and out-of-network coinsurance has increased from 20 percent to 30 percent. To illustrate the impact of these changes, the Unions cite employee Adam Holzman's situation. They note that after various claims, his out-of-pocket expenses totaled $3,600. For comparison purposes, the Unions note that under the 2011 plan, with a $2,000 out-of-pocket maximum and an HRA contribution of $1,800 made to offset costs, Holzman would have seen his liabilities limited to $200, plus nominal copays. Now, though, under the 2013 plan, Holzman is on pace to bear the burden of the entire $5,000 out-of-pocket maximum. The Unions also note employee Brad Bille's situation. They note that after surgery and various other claims, his out-of-pocket medical expenses for his family were already totaling in the thousands. The Unions contend that even if the District finally provides HRA payments, Holzman's and Bille's financial exposure under the 2013 plan is far greater than it was under the 2011 plan.

Third, the Unions contend that another area where employees pay more is with prescription drug costs. To support that contention, the Unions rely on the following chart which they created:

Rx Tiers:	**2011 Plan**	**2013 Plan**
"Value" Tier:	n/a	$0
Tier 1:	$0	$10
Tier 2:	$5	$20
Tier 3:	$20	$50

For background purposes, they aver that when the District switched from WEA Trust to DeanCare in 2011, "the District agreed under DeanCare to reimburse prescription drug costs to match the 2011 WEA Trust plan." Building on that, the Unions aver that as of July 1, 2013, that reimbursement policy stopped, even though prescription drug copays went up under the new 2013 WEA Trust plan relative to the 2011 plan. The Unions acknowledge that both the 2011 plan and the 2013 plan include a tier of prescription drugs that require no copays. However, under the 2013 plan, this copay-free tier is no longer "Tier 1," but a limited "Value Tier" (which according to the testimony of the Employer's expert witness is made up of the most common lowest cost generics that are considered maintenance medications). As for the other tiers, the Unions submit they have increased dramatically, and this represents another recurring increased cost to employees. The Unions also cite employee Pat TerBeest's situation. A three-month supply of prescriptions for her family had gone from $15 to $228 per order.

As part of their argument on this point, the Unions dispute the District' claim that the prescription drug coverage is better under the new plan. While the District tries to portray the introduction of the new "Value Tier" as a benefit, the Unions point out that there already was a $0 tier under the old plan. The Unions submit that under the new plan, prescriptions that were formerly in the $0 "Tier 1" may be split between the new "Value Tier" and the new $10 "Tier 1." The Unions also contend that the District's claim that the parties agreed to a $5 copay for the lowest tier is inaccurate, unsupported and contradicted by the evidence and testimony provided at hearing. In sum then, it's the Unions' view that the prescription drug coverage has gotten comparatively worse under the new plan, not better as the District contends.

Fourth, the Unions respond as follows to the District's contention that under the new plan, the deductibles are lowered. They characterize that contention as disingenuous because no HRA contributions have been made since switching to the new health insurance plan on July 1, 2013. While they acknowledge that at the hearing a District representative said that the District will make the mandated $900/$1,800 HRA contributions referenced in the collective bargaining agreements, they opine that there was no reason for the District to withhold their contributions to the HRAs in the first place (and make the deductible come out of the employees' pockets). Aside from that, the Unions submit that they have no reason to trust that the District will make these contributions absent an arbitrator's award. The Unions ask the arbitrator to reject the District's contention that the new deductible is "lower" and a "benefit" to employees. They opine that "it does not take a math teacher to see that a $1,000 liability with regard to family deductible costs more than a $200 liability for family deductible.

Having made those points to show that the new plan is inferior to the old plan, the Unions also argue that the District's proposed interpretation of the relevant contract language is inconsistent, inaccurate and leads to harsh and excessive results. As the Unions see it, the District's case is essentially premised on the "odd concept" that having health insurance coverage is essentially an either/or proposition and is unrelated to the cost of services. Per the District's apparent argument, either you are covered or you are not, and as long as it can say you are "covered" for services X, Y and Z, it doesn't matter what level of coverage is provided, what the payment method is, or whether you are compensated at all – they are somehow equal. Said another way, the District's contention is that the cost to the employee is not important in determining whether coverage was substantially equivalent, just whether something is "covered"; something is "covered" whether insurance pays for the entire procedure or just offers the employee a penny in return. The Unions ask the arbitrator to reject this contention. The Unions cite Elkouri for the arbitral proposition that contract interpretations that lead to absurd or excessively harsh results should be avoided. According to the Unions, the idea that there is substantially equivalent coverage just because the same services covered before are still "covered on some level" leads to absurd and excessively harsh results.

Next, in response to the District's references to cost savings realized as a result of the switch in health insurance plans from the old plan to the new plan, the Unions contend that those references are both misleading and immaterial. They also aver that the District played fast and loose with the facts. To support that premise, they note that the District's initial brief references a

"12 percent" increase in costs projected by DeanCare, while the final figure was actually 10.1 percent. It sees that as significant.

The Unions therefore ask the arbitrator to sustain the grievances and make the adversely impacted custodial and clerical employees whole, and restore them to the position they would have been in had the contract been honored.

District

It's the District's position that it did not violate the parties' collective bargaining agreements when it changed health insurance plans on July 1, 2013. It avers that the new WEA Trust Base Plan is substantially equivalent to or better than the plan referenced in the collective bargaining agreements (i.e. the WEA Trust Preferred Plan 7). Building on that premise, the District argues that its change in health insurance was well within its reserved rights under the contracts and, as a result, the Unions' grievances have no merit.

At the outset, the District avers that the Unions bear the burden of proving a contract violation by clear and convincing evidence. It contends that the Unions have failed to meet this burden, whether by clear or convincing evidence or otherwise. In making this argument, the District points out that the Unions did not call any expert witness at the hearing to make its case that the WEA Trust Base Plan was not "substantially equivalent or better" than the WEA Trust plan which was in effect on January 1, 2011. The District points out that, in contrast, it did call an expert witness (i.e. Ms. Beaudry). According to the District, the Unions presented only "anecdotal, incomplete, and non-expert testimony from current and former employees, none of whom even offered any opinion as to the overall issue of plan equivalency."

Next, the District offers its opinion on the meaning of the phrase "substantially equivalent." Before doing so, though, it notes that that phrase is not defined in the collective bargaining agreements. It submits that when a term is not defined by an agreement, and in the absence of evidence of a mutual understanding to the contrary, words are to be given their usual and ordinary meaning as defined by a reliable dictionary. It then notes that in the *City of New Berlin*, the arbitrator used a dictionary to define "substantially equivalent" as "to a large degree, equal in substance, or practically equal." That's the definition the District urges the arbitrator to apply here. Building on that definition, the District contends that the coverage provided under two different health insurance plans does not have to be identical or equal in their entirety in order to be "substantially equivalent" because lesser coverage in one area may, in some degree, be offset by better coverage in another area. Said another way, the District maintains that the two plans must be compared as a whole, and "the determination as to whether two health insurance plans are substantially equivalent does not gravitate around one or two individual plan benefits; instead, the sum of the total of plan benefits must be weighed in making such a determination."

Next, the District avers that it is also crucial to determine what aspects of the plan are required to be "substantially equivalent." It contends that what is to be maintained as "substantially equivalent" is the "coverage." Building on that premise, it avers that the word

"coverage" refers to the benefits and services that are covered by the plan (such as office visits, surgeries, treatments, etc.) and not the payment mechanisms or cost to employees (e.g. copays). In other words, when comparing the coverage provided under the two WEA Trust plans, the District believes that the only relevant question is whether a benefit is provided by the plan, not how it is covered or how much it costs. The District contends that this interpretation is consistent with what it characterizes as "Wisconsin arbitral authority." It specifically cites and relies on *Douglas County* and *City of La Crosse*. Consequently, the District posits that the question for the arbitrator to answer is whether the benefits and services covered under the WEA Trust Base Plan are similar in substance, to a large degree, to the benefits or services that were previously provided under the WEA Trust Preferred Plan 7. The District answers that question with a resounding yes. Before it elaborates on why that is the case, though, the District notes that none of the Unions' three witnesses were able to identify any benefit which had been provided by the WEA Trust Preferred Plan 7 on January 1, 2011, which is not now provided by the WEA Trust Base Plan. The District sees that as significant.

Next, the District addresses why it believes that the coverage under the WEA Trust Base Plan is substantially equivalent to the coverage provided under the WEA Trust Preferred Plan 7. Before doing so, though, it acknowledges that there is no "easy bright line test" to apply to determine whether two health insurance plans provide substantially equivalent coverage. Thus, each case has to be decided on its own facts. It also submits that it is difficult to make a meaningful comparison between the benefits provided under two distinct health plans. Building on that premise, it posits that whether one benefit is superior to another will depend on an individual participant's unique circumstances. That said, it is the District's view that a comparison of the key benefits covered under the WEA Trust Preferred Plan 7 to the WEA Trust Base Plan can be made herein. To effectuate that, the District prepared the following chart to compare the "coverages" of the two plans:

Benefit/Service	**Covered under WEA Trust Preferred Plan 7?**	**Covered under WEA Trust Base Plan?**
Office Visit	Yes	Yes (primary and specialty care)
Urgent Care	Yes	Yes
Emergency Room	Yes	Yes
Preventative Services	Yes	Yes
Routine maternity care	Yes	Yes
Durable medical equipment	Yes	Yes
Home health care	Yes	Yes

Benefit/Service	Covered under WEA Trust Preferred Plan 7?	Covered under WEA Trust Base Plan?
Hospice care	Yes	Yes
Hospitalization	Yes	Yes
Laboratory	Yes	Yes
Physical, speech, and OT	Yes	Yes
Radiology	Yes	Yes
Diagnostic testing	Yes	Yes
Skilled nursing facility care	Yes	Yes
Specialty drugs	Yes	Yes
Specialty radiology (e.g., MRI)	Yes	Yes
Surgery and related services	Yes	Yes
Transplant evaluations and services	Yes	Yes
Treatment of temporomandibular disorders	Yes	Yes
Prescription drugs	Yes	Yes

According to the District, this chart establishes that the two plans provide "substantially equivalent" coverage.

Next, the District contends that the WEA Trust Base Plan provides additional advantages over the WEA Trust Preferred Plan 7, and is therefore arguably better than the WEA Trust Preferred Plan 7, for the following reasons. First, it notes that the WEA Trust Base Plan has a $500 single and $1,000 family deductible, while "the District was only contractually required to maintain a $1,000 single and $2,000 family deductible." Second, it argues that the vast majority of employees – particularly those without chronic health conditions – will be better off under the WEA Trust Base Plan because that plan "adds payment mechanisms which will likely result in cost savings for employees without chronic or serious health conditions." To support that premise, it avers that under the WEA Trust Preferred Plan 7, a participant with individual coverage had to satisfy a $1,000 individual deductible before the plan would begin to pay for a covered benefit. However, under the WEA Trust Base Plan, "a participant with individual coverage only has to satisfy a $500 deductible, at which point the plan would begin to pay for 90 percent of the covered items (and then 100 percent after the participant reached his or her

$2,500 maximum)." The District further avers that "if the participant is relatively healthy, paying $500 plus 10 percent of the cost for each office visit often ends up being more cost effective than paying a $1,000 deductible upfront." In addition, "paying 10% at a time allows plan participants to spread out their health care costs over the entire plan year instead of paying a $1,000 upfront at the beginning of the plan year." Third, it argues that the WEA Trust Base Plan clearly improves prescription drug coverage for employees. It notes that under the WEA Trust Base Plan, employees have access to the Value Choice Drug Tier, which allows 58 drugs (most maintenance medications) to be obtained with no copayment. It avers that "this benefit was not available under the WEA Trust Preferred Plan 7, and it was an improvement over the $5 prescription drug copay which had been required by DeanCare." Fourth, the District asserts that by selecting the WEA Trust Base Plan, the District voluntarily chose not to remain grandfathered and to comply with various Affordable Care Act requirements earlier than it would have otherwise been required to do so. In this regard, it avers that "the WEA Trust Base Plan complies with the Women's Contraceptive Act, which was not the case under the WEA Trust Preferred Plan 7, and with which the District would not have been required to comply if it had chosen to remain grandfathered for Affordable Care Act purposes."

Based on the above, it is the District's view that the WEA Trust Base Plan provides coverage that is "substantially equivalent," and arguably better, than the coverage provided under the WEA Trust Preferred Plan 7 which was in effect on January 1, 2011. Thus, the District believes it has met its obligations under the collective bargaining agreements, and the Unions' grievances are without merit.

DISCUSSION

In 2013, the District decided to change insurance carriers from DeanCare to WEA Trust to avoid a significant projected insurance cost increase. The Unions grieved, contending that that action violated their collective bargaining agreements. While the parties did not stipulate to the specific wording of the issue, they agree that the basic question to be answered is whether the District violated the collective bargaining agreements involved when it switched insurance carriers effective July 1, 2013. They further agree that given the wording of the applicable contract language, the case turns on whether the insurance coverage that was in place after July 1, 2013 was "substantially equivalent or better" than the coverage which was in place on January 1, 2011. If it was "substantially equivalent or better," then the change passes muster. The Unions argue that the new plan is not "substantially equivalent" to the old plan, while the District contends that it is. Based on the following rationale, I conclude that the new plan is "substantially equivalent" to the coverage in place on January 1, 2011. Thus, I find no contract violation occurred.

* * *

Since this is a contract interpretation case, the main part of my discussion will involve the applicable contract language. Before I address that contract language though, I've decided to comment on the following matters.

First, I'm going to comment on other arbitration awards and their applicability here. As noted by the Unions in their initial brief, the "substantially equivalent" standard for changing insurance plans has been "well worn territory for litigation." Pre-Act 10, the matter was the subject of numerous arbitration awards. Not surprisingly then, the parties cited some of those arbitration awards in their briefs. Then, the parties either analogize those cases to the facts and contract language involved here, or distinguish those cases from the facts and contract language involved here. I could do that too and go through all those awards and comment on their applicability, or lack thereof, to this case. Were I to do that, the likely result would be that I would say that decisions A, B and C support my conclusions, while decisions X, Y and Z are distinguishable. I've decided not to do that. In my view, I don't need to address the cited arbitration awards to decide this case. As a result, what the parties are going to get here – for better or worse – is simply my analysis without any reference to those other awards. Consequently, no other comments are going to be made about the various arbitration awards cited by the parties.

Second, I'm going to comment on a factual matter to put what happened here in an overall context. As noted above, these grievances involve the District's change of insurance carriers which occurred effective July 1, 2013. This was the second insurance change that occurred during the duration of the parties' 2010-2014 contracts. The first insurance change occurred in 2011. That's when the District switched from WEA Trust to DeanCare. After that switch occurred, the Unions had the contractual right to grieve it (just like they did here). However, the Unions didn't grieve that change. That's surprising, given the assertion in the District's initial brief – which the Unions do not challenge – that "the coverage provided by DeanCare was not identical to the WEA Trust Preferred Plan 7 [because of] DeanCare's limited provider network." (District's Initial Brief, pp.7, 10 and 14). In any event, it is the change back to the WEA Trust that is before the undersigned.

One final preliminary comment is in order. While the District changed from DeanCare to the WEA Trust on July 1, 2013, I'm not going to be reviewing the DeanCare coverage (even though DeanCare is explicitly referenced in the District's wording of the issue). That's because the DeanCare coverage is not referenced in either collective bargaining agreement. That being so, it is not relevant to the finding herein. Instead, as will be noted in more detail below, I'm going to be reviewing one WEA Trust plan with another.

* * *

The focus now turns to the contract language. In this case, the applicable contract language is found in Article 23 in the clerical collective bargaining agreement and Article 21 in the custodial/maintenance collective bargaining agreement. The pertinent language in both contracts is identical. Here's what it says:

> The Employer may from time to time change the insurance carrier and/or self-fund its health care program if it elects to do so, as long as coverage under such carrier or self-funded plan is substantially

> equivalent or better to the insurance coverage in effect **as of January 1, 2011, which is the WEA Trust Preferred Plan 7 with a $1,000/$2,000 deductible and 10/25/25/100 co-pays. The district (through a third party vendor) will reimburse the employee up to $900 for single and $1,800 for family with each calendar year. Savings from the HRA deductible self-insurance will be retained by the district.** (Bold in original.)

Let's start with the first sentence. In plain, unambiguous terms, this sentence gives the District the explicit and unilateral right to change health insurance carriers, provided that the new health insurance "coverage" is "substantially equivalent or better" than the "coverage" which was formerly provided under the WEA Trust Preferred Plan 7. I'll discuss the words I put in quotes in the previous sentence (i.e. "coverage" and "substantially equivalent or better") in the following paragraphs. Before I do so though, what needs to be emphasized is that this provision does not require that the parties negotiate and agree upon a proposed change of insurance carrier. Indeed, the whole point of the contract language at issue is to render such negotiation unnecessary when the contractual standard for such a change has been met by the District.

Prior to Act 10, it was common for Wisconsin public sector collective bargaining agreements to specify a standard that the employer had to meet if it changed insurance carriers. The standard which the parties mutually agreed on here (via the contract language just quoted) is the "substantially equivalent or better" standard. At the hearing, neither side produced evidence of bargaining history showing how or when this specific language came to be included, nor did either side produce any evidence of a mutual agreement to more specifically define the phrase "substantially equivalent." That being the case, all I've got to work with here is the language itself.

I'm first going to address the meaning of the phrase "substantially equivalent." It is noted at the outset that the phrase "substantially equivalent" does not mean equal. That should be self-evident, because interpreting "substantially equivalent" to require equality (or that the plans be equal in their entirety) would erroneously disregard the word "substantially," which modifies "equivalent." The Unions, citing the Merriam-Webster online dictionary, define "substantial" as "1. a: consisting of or relating to substance; b: not imaginary or illusory." (Unions' Initial Brief, p.8). In my view, there's another definition of "substantial" in that same dictionary that is even more relevant to this matter. I'm referring to meaning number five which provides: "being largely but not wholly that which is specified." *Merriam-Webster.com*, http://www.merriam-webster.com/dictionary/substantial (emphasis added). Applying that definition here means that the District can change health insurance carriers as long as the "coverage" is "largely" the same as that previously provided.

The focus now turns to deciding the scope of the term "coverage." The Unions essentially contend that "coverage" refers to something beyond the benefits or services that are provided by the plan; specifically, it includes the costs of those services to the employees. That's a broad interpretation of the word "coverage." It would be one thing if the Unions had given me something to hang my hat on, such as expert testimony or a statutory definition, which supported

their contention that the costs of those services to the employees are subsumed into the word "coverage." However, the Unions did not do that. Instead, the only testimony I've got to work with in the record on this point is that from Rae Ann Beaudry, the Executive Vice President of the Horton Group, and an expert in the healthcare industry and field of employee benefits. She testified without contradiction that the word "coverage" refers to the specific benefits which are provided by the plan document, not the payment provisions in the plan document. Aside from her testimony on that point, there's the fact that the phrase "health insurance coverage" is defined by federal statute as "benefits consisting of medical care." 42 U.S.C. § 300gg-91(b)(1). When these matters are considered collectively, they persuade me that the term "coverage" in the collective bargaining agreements refers to health care procedures and medical services that are covered by the plan (e.g. office visits, surgeries, treatments, etc.), and not the payment provisions or costs to employees (e.g. no copays).

Having so found, the next question is whether the health care procedures and services that are "covered" changed when the District switched to the WEA Trust Base Plan on July 1, 2013. I find they did not. The following analysis shows why. The plan referenced in the collective bargaining agreements (i.e. the WEA Trust Preferred Plan 7) "covered" the following health care procedures and medical services: office visits, urgent care visits, emergency room visits, maternity care, laboratory services, radiology services, inpatient hospitalization, surgery, advanced imaging, diagnostic testing, prescriptions drugs, durable medical equipment, hospice care, home health care, transplantation services, hearing aids, and treatment of temporomandibular disorders. At the hearing, the Unions did not provide any evidence that any employee's insurance claim that was previously provided or covered under the WEA Trust Preferred Plan 7 has now been denied under the WEA Trust Base Plan. That's not surprising, given that the new plan (i.e. the WEA Trust Base Plan) also covers those same health care procedures and medical services, albeit with certain plan design changes. The changes will be addressed next.

First, I'm going to address the Unions' contention that one area where employees have seen a drastic change in coverage from the old plan is in their out-of-pocket costs. In addressing that contention, I've decided to note at the outset that the WEA Trust Base Plan requires employees to pay a 10 percent copay and coinsurance (that they didn't have to pay under the WEA Trust Preferred Plan 7). However, the new copayments and coinsurance has been coupled with a lower deductible and other "payment mechanisms." I'm going to address the deductible first. The deductible in the (new) WEA Trust Base Plan is $500/$1,000 while in the (old) WEA Trust Preferred Plan 7 it was $1,000/$2,000. Thus, the official deductible was cut in half. The focus now turns to what I previously characterized as "payment mechanisms." Under the (old) WEA Trust Preferred Plan 7, a participant with individual coverage had to satisfy a $1,000 individual deductible before the plan would begin to pay for a covered benefit. However, under the (new) WEA Trust Base Plan, a participant with individual coverage only has to satisfy a $500 deductible, at which point the plan would begin to pay for 90 percent of the covered items (and then 100 percent after the participant reached his or her $2,500 maximum). The District avers that "if the participant is relatively healthy, paying $500 plus 10 percent of the cost for each office visit often ends up being more cost effective than paying a $1,000 deductible upfront." They further aver that "paying 10% at a time allows plan participants to spread out

their health care costs over the entire plan year instead of paying a $1,000 upfront at the beginning of the plan year." The undersigned has no objective basis upon which to dispute these assertions by the District, so they are accepted as true.

When comparing costs to employees under the two WEA Trust plans, the Unions assume that the District has permanently discontinued the HRA contributions. That assumption is not supported by the record evidence. While it's true that no HRA contributions have been made to employees since the District switched to the new plan on July 1, 2013, the testimony of District witnesses made it clear that the District had budgeted for these payments, and had already transferred the money to a liability account for that purpose. That testimony persuades me that the District will make the full $900/$1,800 payments which the District is contractually obligated to pay the employees of these two bargaining units. Consequently, the deductible has not increased by 400 percent as the Unions claim. I further accept the District's assertion that the reason the contributions have been delayed is due to complications arising from this grievance and the transition from a school year to a calendar year deductible year. The two collective bargaining agreements which are involved herein both require the District to provide, through an HRA mechanism, calendar year deductible reimbursements of $900 for single and $1,800 for family. The HRA contributions originated as a deductible reimbursement. Then the District selected the WEA Trust Base Plan, which has a lower deductible by half than the DeanCare plan which succeeded the 2011 WEA Trust Preferred Plan 7. Because the entire $900/$1,800 HRA contribution is no longer needed to reimburse employees for the WEA Trust Base Plan $500/$1,000 deductible, the excess amounts will be available to reimburse employees for other payments, such as copayments. As previously noted, the contracts clearly identify these HRA payments as "deductible self-insurance." The contracts say nothing regarding use of these HRA payments for any purpose other than reimbursement of deductibles. Not surprisingly, that creates uncertainty as to how these excess HRA amounts of $400 and $800 are to be applied by the District on behalf of these employees.

While the Unions assert that the District simply chose not to make the HRA payments, I'm persuaded that there were legitimate reasons for the delay in making those payments. Here's what I'm referencing. In selecting the WEA Trust Base Plan, the District switched from a fiscal plan year to a calendar plan year. This change from a school year to a calendar year deductible compounded the difficulties which surround HRA payments for two reasons. First, some employees may, because of this change, have already received all (or a portion) of their $900/$1,800 deductible as a result of incurring their deductible prior to the July, 2013 change to the WEA Trust Base Plan. Second, deductible credits from the DeanCare plan were granted by the WEA Trust as a part of the July, 2013 switch; without performing an individual audit of each bargaining unit employee, it is difficult to determine to whom these HRA payments are to be made and in what amounts. As District Exhibit 8 indicates, some employees may have no deductible costs to reimburse in 2013. In addition, there was confusion over how (and for what) to structure the contributions now that they would no longer be strictly deductible reimbursements. The District asserts that after it works through the complications described above, the HRA funds will be made available to employees. The arbitrator accepts that assertion at face value.

Next, I'm going to address the matter of prescription drugs. The Unions contend that employees now pay more for certain prescription drugs (than they did under the old plan). I agree; they do. The following chart shows this:

Prescription Tiers:	**2011 WEA Trust Preferred Plan 7**	**2013 WEA Trust Base Plan**
"Value" Tier:	n/a	$0
Tier 1:	$0	$10
Tier 2:	$5	$20
Tier 3:	$20	$50

Both the 2011 plan and the 2013 plan include a tier of prescription drugs that require no copay. However, under the 2013 plan, this free tier is no longer "Tier 1," but the "Value" tier. Under the new "Value" tier, 58 drugs can be obtained with no copayment. That's more than could be obtained with no copayment under the old plan. Thus, more drugs can be obtained with no copayment under the new plan than was the case under the old plan. However, there's a tradeoff for this improvement. The tradeoff is that the cost of prescription drugs in all the other categories have increased. Specifically, some Tier 1 drugs have gone from no copayment to $10, all Tier 2 drugs have gone from $5 to $20, and all Tier 3 drugs have gone from $20 to $50.

Finally, the focus moves to the matter of doctor visits. The Unions contend that employees now pay more with every doctor visit. I agree; they do. The following chart shows this:

	2011 WEA Trust Preferred Plan 7	**2013 WEA Trust Base Plan**
Employee In Network Office Visit Copayment:	$10	$25
Urgent Care Copayment:	$25	$75
Emergency Room Copayment:	$100	$150

The chart shows that where employees could previously visit an in-network provider and expect to pay a $10 copay, the copay for an office visit under the new plan is now $25. Additionally, urgent care copays have gone from $25 to $75, and emergency room copays have gone from $100 to $150.

* * *

The foregoing discussion demonstrates that the new WEA Trust Base Plan includes the following changes: increased out-of-pocket costs; a 10 percent copay; increased costs for certain prescription drugs; and increased doctor visit costs. The bottom line is that the employees now pay more for the foregoing than they did with the old plan.

That said, the critical question to be answered here is whether those changes – either individually or collectively – are sufficient to make the new insurance plan (i.e. the WEA Trust Base Plan) not be "substantially equivalent" to the old insurance plan (i.e. the WEA Trust Preferred Plan 7). In making this call, I need to compare the two plans as a whole and not just focus on the differences noted above. That's admittedly difficult, because whether the benefits provided under one health insurance plan are superior to the benefits provided under another health insurance plan will often depend on each individual employee's unique healthcare needs. What happened at the hearing was that the Unions called three employees as witnesses who testified about their own personal claims expenses with the new plan. It's fair to say that the Unions' three witnesses either have chronic health conditions or a family member with a chronic health condition. There's no question that the three employees were experiencing higher out-of-pocket costs than they did under the first plan. As has already been noted though, that was due, in part, to the District's failure to provide HRA payments until this case is finalized. While the Unions focused exclusively on the health care costs of those three employees, they did not establish that their experiences were a representative sample of the entire two bargaining units. That being so, I'm going to characterize their personal experiences as unique. This case though is not just about those three employees and how they have been adversely affected by the new insurance plan. Instead, it's about the big picture, so to speak. What's important in this regard is that the District's expert witness testified without contradiction that the vast majority of employees, particularly those without chronic health conditions, will be better off under the WEA Trust Base Plan. I'm persuaded that her assertion has merit because the lower deductible and new payment mechanisms allow employees to reduce their out-of-pocket expenses, and spread out their expenses over the entire year instead of paying a higher deductible up front. Additionally, although the WEA Trust Base Plan has a higher out-of-pocket maximum than the WEA Trust Preferred Plan 7, the Employer avers that the actual out-of-pocket costs will be lower for the average employee. Similarly, the Employer characterizes the out-of-pocket maximum as a "worst case scenario," and that the majority of employees will not come close to it. Once again, the undersigned has no objective basis upon which to dispute these assertions by the District, so they are accepted as true.

Having previously reviewed those parts of the WEA Trust Base Plan that can be considered as inferior to the WEA Trust Preferred Plan 7, here's a listing of positive features of the WEA Trust Base Plan: it lowers the official deductibles for single and family coverage from $1,000 single/$2,000 family to $500 single/$1,000 family; it maintains the HRA deductible reimbursement of $900 single and $1,800 family; it includes the "value" tier in the prescription drug benefits; it expands the network of providers; it adds those benefits that are mandated by the federal Affordable Care Act earlier than necessary; and it has no premium increase.

After comparing the two plans as a whole, I'm persuaded that the inferior features of the WEA Trust Base Plan are counteracted and/or offset by its positive features elsewhere. Said another way, I find that the coverage in the new plan is largely the same as the old plan. In so finding, I'm not saying that the new plan is "better than" the old plan. Instead, I'm just saying that it's "substantially equivalent." Accordingly, I conclude that the "coverage" provided under the WEA Trust Base Plan is "substantially equivalent" to the "coverage" which was provided

under the WEA Trust Preferred Plan 7 which was in effect as of January 1, 2011. Thus, the health insurance change which the District made on July 1, 2013 passes arbitral muster.

In light of the above, it is my

AWARD

That the Waupun Area School District did not violate either Article 23 of the 2010-2014 clerical collective bargaining agreement or Article 21 of the 2010-2014 custodial collective bargaining agreement when it changed health insurance carriers from DeanCare to WEA Trust in July of 2013. Therefore, the grievances are denied.

Dated at Madison, Wisconsin, this 29th day of August 2014.

WISCONSIN EMPLOYMENT RELATIONS COMMISSION

Raleigh Jones, Arbitrator