**IN THE MATTER OF THE INTEREST ARBITRATION**
**PROCEEDINGS BETWEEN**

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MILWAUKEE BOARD OF SCHOOL
DIRECTORS,

Employer,

and

ARBITRATOR'S AWARD
Case 416 No. 63170 INT/ARB-10102
Decision No. 31105

MILWAUKEE TEACHERS EDUCATION
ASSOCIATION,

Union.

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Arbitrator: Jay E. Grenig

Appearances:

For the Employer: Donald L. Schriefer, Esq.
Assistant City Attorney
City of Milwaukee

For the Union: Barbara Zack Quindel, Esq.
Hawks Quindel Ehlke & Perry S.C.

# I. BACKGROUND

## A. Introduction

This is a matter of final and binding interest arbitration for the purpose of resolving a bargaining impasse between the Milwaukee Board of School Directors ("Board," "MPS," or "Employer") and the Milwaukee Teachers' Education Association ("MTEA" or "Union"). The Board is a municipal employer. The Association is the exclusive collective bargaining representative for certain employees of the Board.

The parties exchanged their initial proposals and bargained on matters to be included in a collective bargaining agreement. On January 6, 2004, a petition was filed requesting the Wisconsin Employment Relations Commission to initiate arbitration pursuant to Section 111.70(4)(cm)6 of the Wisconsin Municipal Labor Relations Act. A member of the Commission's staff conducted an investigation reflecting that the parties were deadlocked on their negotiations. By September 30, 2004, the parties submitted their final offers as well as a stipulation on matters agreed upon.

The parties selected the undersigned as the Arbitrator. Arbitration hearings were conducted on February 1, 2, 21, March 2, 7, 14, 16, 21, April 18, and 25, 2005. Upon receipt of the parties' briefs, the hearing was declared closed on June 28, 2005. The hearing resulted in ten loose leaf binders of evidence, ten volumes of transcript, and nearly 200 pages of briefs.

**B. Milwaukee Public Schools**

The Employer is the largest school district in Wisconsin, serving approximately 95,000 children attending more than 170 schools throughout Milwaukee. The Employer employs approximately 17,000 employees and there are thirteen bargaining units. The largest bargaining unit is the MTEA teachers' unit, with approximately 6,710 members.

In fiscal year 2001, MPS experienced a budgetary shortfall of $13.8 million, primarily as a result of increased compensation and health care costs. In fiscal year 2004, another budgetary shortfall necessitated the Employer's identifying 663 positions for elimination. The summer school program had to be significantly downsized in fiscal year 2004 and significant cuts were made in art, music, and physical education programs. In fiscal year 2005 approximately 450 full-time jobs were slated for elimination. MPS received a four million dollar reduction in general state aid rather than an anticipated 60 million dollar increase that would have occurred if the State had continued funding at the same level as in fiscal year 2004. The Employer's Fund Balance or Reserve is an accumulation of surplus that can be drawn upon in cases of emergency. The Employer's Fund Balance has been declining over the years because it has had to dip into the Fund Balance because of budgetary shortfalls. In 2004 an accounting firm advised the Employer that its fund balance had dropped to less than 5.4% of its revenues, and that further drops could negatively impact the Employer's bond rating. Unlike other Wisconsin school districts, the District has no authority to borrow and must rely upon the City of Milwaukee's borrowing in order to bridge periods each year.

**C. WAGES**

Salary schedules for teachers have numbered steps as well as lanes corresponding to a teacher's level of education. Annually teachers advance down one numbered step in the schedule. If a teacher qualifies for a lane change because of additional education, the teacher enters the next lane at a step level that ensures an increase in pay compared with what the teacher was receiving before the lane change.

## D. FRINGE BENEFITS

Employee benefits (excluding salaries) account for approximately one-fourth of the Employer's $1.1 billion budget. Benefit costs have risen at a pace exceeding increases in revenue under the state formula. Fringe benefits represented 45.5% of salary costs in fiscal year 2002, 51% of salary costs in fiscal year 2003, 55% in fiscal year in 2004, and 61% in fiscal year 2005. Most of these increases are due to rapidly increasing health and medical benefit costs. Since 2000, the cost of health benefits has increased in double-digit percentages each year. At MPS, the cost of health benefits has increased from approximately ten percent of the total spending in 1999 to approximately seventeen percent of total spending in 2005. The start and end dates for health, vision, and dental coverage at MPS are currently inconsistent, requiring multiple processing of enrollments.

The Employer's pension obligations are also rising faster than increases in revenue. The Employer's Supplemental Early Retirement Plan for teacher's (a pension plan that bridges the period between early retirement and eligibility under the state teacher's pension plan and continues to pay benefits until death) shows a steadily increasing ratio of unfunded liability to payroll from 23.47% as of July 1, 2000, to 34.34% as of July 1, 2003. As of July 1, 2003, the plan was 68.32% unfunded. Contributions to the plan represented nearly four percent of the payroll in 2005 (in addition to contributions of twelve percent of salary that the Employer makes on behalf of teachers to the State Pension Fund).

The Employer has two health plans: a Preferred Provider Organization (PPO) administered by Aetna and an Exclusive Provider Organization (EPO) administered by UHC. Both plans are self-funded. The EPO has a narrower network than the PPO, but the EPO discounts with providers are substantially deeper than the PPO discounts. As of November 1, 2004, the PPO had over 8,000 active and retired teachers enrolled in it. The EPO had 1,325 active and retired teachers enrolled in it. PPO premiums are significantly higher than the EPO premiums. Both plans pay nearly everything at 100%. Although employees are given a $500 payment for opting out of health coverage, very few employees have opted out.

The Greater Milwaukee Annual Report on Health Care singled out the Employer's "as perhaps "the most generous of all [public sector] plans." The Report singled out what it characterized as the extraordinarily high level of services in the areas of mental health and substance abuse.

Employees in positions regularly scheduled to work more than 20 hours per week are eligible for Employer health coverage. Except for retirees, coverage is free. Dependents are covered up to age 25 without regard to student status so long as the covered parent is responsible for more than 50% of their care.

Teachers are eligible for retirement at age fifty-five with fifteen years of service. If they have retained at least 70% of their sick leave upon retirement, the Employer con-

tributes the amount of the PPO premium in effect as of their date of retirement to their premium costs for the rest of their lives. The retirees pay the difference between the Employer's share and the PPO rate established each year. The number of retirees in the health plans is increasing because of an acceleration in the number of retirements and longer life expectancy.

There are four separate groups of retirees. For non-Medicare retirees who reside in network, benefits are currently the same as active employees. For the small group of non-Medicare retirees who reside out-of-network, benefits are provided in a separate plan providing lower out-of-pocket annual coinsurance limits, higher mental/nervous/substance abuse limits at the in-network level, and an annual out-of-pocket for these expenses that is capped. For Medicare retirees with A and B coverage, benefits are currently at out-of-network levels coordinated with Medicare, but subject to lower coinsurance limits. The fourth group, a small group of Medicare retirees without A coverage but with B coverage, receives current benefits that are the same as for non-Medicare retirees.

Rather than reimbursing employees for "usual and customary" retail pharmacy expenditures, the Employer's plan provides for payment of "100% of submitted costs" after an 80% co-pay for a 30-day supply of drugs. This has resulted in at least one area pharmacy submitting bills for charges higher than the "usual and customary" charges and waiving the employee co-pay. This pharmacy markets itself to teachers on the basis that it waives the coinsurance and then submits costs that are generally substantially higher, frequently twice as much, than the normal costs charged to a prescription benefit plan. Under the current language in the prescription benefit, the Employer is obligated to pay the amount billed by this pharmacy. If teachers using this pharmacy had used one of the in-network pharmacies in the area, the Employer estimates that the savings to MPS would have been more than $140,000.

The present health benefit plan reimburses health care providers for usual, customary and reasonable charges. The plan administrator computes the usual, customary, and reasonable charge at the 85th percentile. Some suburban districts pay a higher rate. The City of Milwaukee pays at the 80th percentile.

The health benefit plan contains a hold harmless provision requiring the Employer to pay the difference between reasonable and customary charges and the actual cost of out-of-network services billed. The plan also contains a provision requiring the Employer to cover services and supplies employees may receive that are not medically necessary. Both of these hold-harmless provisions require the third-party administrator to attempt to resolve disputes between participants and medical providers and to contact collection agencies and law firms to protect participants' credit records. The Employer is required to cover the cost of legal representation for an employee in a lawsuit involving unpaid charges because the charges exceed the usual, customary, and reasonable charge or because the services or supplies were not necessary. The third-party administrator is

also required to provide expert witnesses in any legal proceeding. The hold harmless provision requires the Employer to pay up to $150,000 per fiscal year for legal representation provided by the Association where the usual, customary, and reasonable or medical necessity disputes result in negative information being entered in an employee's credit report. The Employer pays the third-party administrator $70,000 a year to administer the hold-harmless provisions. There are approximately 30 new hold harmless cases each week. In 2003 and 2004 legal fees for hold harmless cases exceeded $23,000. In one case, legal fees exceeded $6,000 for a claim resolved with a payment of $725. Differences between the amounts billed and the amounts allowed are approximately $80,000 per year.

The present plan contains a coordination of benefits provision providing that the Employer's plan will pay as the secondary carrier when an employee's dependent has his or her own health insurance. The Association contends that coordination of benefits has never applied to pharmacy benefits.

The record shows utilization of emergency room services by EPO and PPO participants at a surprisingly high rate. It is estimated that this excessive use is in excess of $500,000 per year in the PPO alone.

In 1999 the mail order pharmacy plan did not address medications for erective and sexual dysfunction. Because no exclusion addressed them, they wound up automatically covered under the mail order and retail plans of the PPO pharmacy and under the EPO pharmacy. The parties reached an agreement to exclude them under the mail-order program and to permit purchases only on the retail side where slightly higher co-pays existed. Costs for this class of drugs increased from $64,587 in 2002 to $207,491 in the PPO alone.

The collective bargaining agreement presently provides that an employee may file a grievance over a health benefit claim denial "except when the MTEA agrees that the denial is based on the proper application of medical necessity criteria and/or general plan exclusions" in which case arbitration is available.

The health benefits plan presently provides that categories of employees in "self-pay status" for premium purposes "shall pay a premium as determined by the past practice of the district."

## II. FINAL OFFERS

### A. Employer

The Employer proposes changing from the current UHC "Select" EPO health plan to UHC's CHOICE EPO. The CHOICE EPO has a national network with relaxed access to specialists. The Employer proposes cost sharing features based on an employee's contributing a portion of the premium cost and co-pays. It is intended to encourage migra-

tion from the high-cost Aetna/PPO plan to the lower-cost UHC/EPO plan. It includes provisions intended to enhance steerage within the PPO so that employees are encouraged to use in-network, discounted providers rather than out-of-network, nondiscounted providers. The Employer's proposal is also intended to reduce features that burden administration of the plan with the result that the Employer is excluded from many groups seeking to form health-care purchasing coalitions.

The Employer's offer imposes a new $100/$300 front-end deductible and ten percent in-network co-insurance payments up to a $200/$600 annual limit in the PPO. These deductible and co-insurance payments would apply to all medical services except those for which co-pays are charged. The Employer's offer would also impose a ten percent co-insurance payment for employees on medical services, subject to co-pays, subject to a $150/$450 annual limit.

The Employer proposes continuation of the coordination of benefits provision, ensuring that the Employer's plan will pay as a secondary carrier when an employee's dependent has his or her own health insurance. The Association proposes elimination of coordination of benefits with respect to pharmacy benefits.

Under the Employer's final offer, the benefits for non-Medicare retirees who reside in-network will continue to be the same as those received by active employees. The Employer's final offer changes the benefits for non-Medicare retirees who reside out-of-network to the same benefits as active employees and non-Medicare retirees, with higher co-insurance limits, lower out-of-network mental health/substance abuse benefits and no caps on outpatient mental/nervous/substance abuse benefits. Non-Medicare retirees who reside out-of-network will have two plans to choose from as a result of the addition of a national network to the Choice EPO plan.

For Medicare retirees with A and B coverage, the Employer's final offer changes benefits to the out-of-network benefit level, and removes the cap on outpatient coinsurance payments. For Medicare retirees with A coverage but without B coverage, the Employer's final offer results in a higher co-insurance limit as these retirees do not have Medicare A hospitalization coverage. All other proposed changes are the same as those for Medicare retirees with A and B coverage.

The Employer's final offer provides for an effective date of February 1, 2005, or upon issuance of the arbitration decision, whichever comes first. The Employer's Director of Employment Relations testified that the complications of implementing the health proposal retroactively would probably not make this worthwhile, but she testified that if the Union wanted this, it could and would be done.

The Employer's final offer requires active employees enrolled in the PPO plan to contribute 2.5% of the PPO single or family premium. This proposal applies only if there is a seventeen percent increase in PPO single or family rates over the prior year's PPO single or family rate. The Employer's final offer for a $50 co-pay for in- and out-of-

network PPO and EPO emergency room services and a 50% coinsurance requirement for non-emergency use of emergency room services.

The Employer proposes a combined lifetime maximum of $2,382,000 indexed to a medical CPI.

The Employer's final offer contains a proposal to exclude medications for erectile and sexual dysfunction.

The Employer proposes deleting the quoted language in the dispute resolution section providing that an employee may file a grievance of a claim denial "except when the MTEA agrees that" the denial is based on the proper application of medical necessity criteria and/or general plan exclusions.

The Employer proposes changing the premium language regarding employees in self-pay status to provide that those employees "shall pay the full premium (after tax) as determined by the District."

The Employer's final offer eliminates, effective July 1, 2004, the shared savings provision that was intended to allow savings associated with design changes that became effective in 2001 with Association employees.

The Employer's proposal contemplates a health and productivity management program. The Employer proposes sharing savings by waiving co-insurance, co-pays, and deductibles as an incentive for high health cost employees involved with program features such as disease management. The Employer's proposal provides that the health and productivity management program vendor must not release any protected health information to any other entity, including the Employer and the Association, without the expressed written permission of the individual.

The Employer's complete final offer is contained in Appendix A.

### B. Association

The Association's final offer provides for a premium contribution based on a percentage of the employee's base salary deducted from biweekly paychecks: one percent for single, and two percent for family coverage. The deduction is made on a tax and FICA-exempt basis which provides tax savings to the employees and benefits the Employer by reducing the Employer's FICA costs. Because the Board's offer would not be implemented retroactive to February 2005, the Association points out that there are no savings from the Employer's offer during the term of the contract.

The Association proposes that employee premiums be reduced by one-half if and when health and productivity management programs for the prior fiscal year save $20

million or more. The Association's offer includes a lifetime maximum of $2,276,000 for the EPO.

The Association's final offer is contained in Appendix B.

## III. STATUTORY CRITERIA

**111.70(4)(cm)**

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> 7. 'Factor given greatest weight.' In making any decision under the arbitration procedures authorized by this paragraph, the arbitrator or arbitration panel shall consider and shall give the greatest weight to any state law or directive lawfully issued by a state legislative or administrative officer, body or agency which places limitations on expenditures that may be made or revenues that may be collected by a municipal employer. The arbitrator or arbitration panel shall give an accounting of the consideration of this factor in the arbitrator's or panel's decision.
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> 7g. 'Factor given greater weight.' In making any decision under the arbitration procedures authorized by this paragraph, the arbitrator or arbitration panel shall consider and shall give greater weight to economic conditions in the jurisdiction of the municipal employer than to any of the factors specified in subd. 7r.
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> 7r. 'Other factors considered.' In making any decision under the arbitration procedures authorized by this paragraph, the arbitrator or arbitration panel shall also give weight to the following factors:
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> a. The lawful authority of the municipal employer.
>
> b. Stipulations of the parties.
>
> c. The interests and welfare of the public and the financial ability of the unit of government to meet the costs of any proposed settlement.
>
> d. Comparison of wages, hours and conditions of employment of the municipal employees involved in the arbitration proceedings with the wages, hours and conditions of employment of other employees performing similar services.
>
> e. Comparison of the wages, hours and conditions of employment of the municipal employees involved in the arbitration proceedings with

the wages, hours and conditions of employment of other employees generally in public employment in the same community and in comparable communities.

f. Comparison of the wages, hours and conditions of employment of the municipal employees involved in the arbitration proceedings with the wages, hours and conditions of employment of other employees in private employment in the same community and in comparable communities.

g. The average consumer prices for goods and services, commonly known as the cost of living.

h. The overall compensation presently received by the municipal employees, including direct wage compensation, vacation, holidays and excused time, insurance and pensions, medical and hospitalization benefits, the continuity and stability of employment, and all other benefits received.

i. Changes in any of the foregoing circumstances during the pendency of the arbitration proceedings.

j. Such other factors, not confined to the foregoing, which are normally or traditionally taken into consideration in the determination of wages, hours and conditions of employment through voluntary collective bargaining, mediation, fact-finding, arbitration or otherwise between the parties, in the public service or in private employment.

## IV. POSITIONS OF THE PARTIES

### A. The Employer

The Employer argues that it made the general wage offer it did, as quid pro quo for making changes in its health plans. The Employer says that its wage offer was made in an attempt to ensure that health plan changes it seeks could not be rejected on the grounds of an inadequate quid pro quo.

It is the Employer's position that, considered in relation to the significant percentage increase in salary provided under the Association's wage proposal, the Association's health insurance premium contribution is not much of a bargain. The Employer argues that the Association is proposing to exchange a nine percent increase over nineteen months for a modest employee contribution to health insurance premiums.

Asserting that in-network coverage at 100% was introduced in the mid-1990s during a period of rather modest increases in health benefit costs, the Employer says condi-

tions have changed dramatically and the Employer cannot afford such "luxurious" plans. According to the Employer, a major problem with 100% coverage is that free care results in significant overutilization of many services.

The Employer states it has structured its proposal to encourage some migration to the less costly EPO plan. It says that five percent migration to the EPO is estimated to save the Employer between $600,000 and $900,000 in health care costs. The Employer claims that design features encouraging migration include enhanced EPO mental health and alcohol/drug abuse benefits, implementation of a mail-order drug program in the EPO allowing EPO members to receive 90-day supplies of drugs at steep discounts as in the PPO, expansion of the EPO network to a national network allowing retirees and employees with dependents in college that are out of the area to enroll in the EPO, inclusion of a deductible only in the PPO and not in the EPO plan, lower EPO than PPO out-of-pocket single/family coinsurance limits, and allowing EPO participants to see EPO-provider specialists without a referral from their primary physicians.

The Employer argues that the "submitted cost" language in the current plan, allows certain pharmacies to price gouge with impunity. The Employer asserts that the current language is inconsistent with the fundamental PPO principle that there should be financial disincentives for utilizing out-of-network services. According to the Employer, its proposal to limit reimbursement is reasonable.

With respect to the hold harmless provisions, the Employer points out that only two plans (Sheboygan and the State of Wisconsin) have a hold harmless provision regarding usual, reasonable, and customary charges. It says that no other plan among the comparables has a hold harmless provision with respect to medical necessity. The Employer claims that the credit rehabilitation provision is not even necessary as it is rare where a person is denied credit because of a notation by a medical provider.

The Employer stresses that the hold harmless provisions are inimical to the core PPO concept of steerage. It points out that benefit levels are set at different levels in the PPO for in and out of network services as an incentive to encourage in-network use so the Employer can save on healthcare costs. When the Employer is liable for the entire cost of undiscounted out-of-network services, the Employer asserts that the most fundamental cost-sharing feature of the PPO is negated. The Employer contends that employees have no particular incentive to choose wisely.

The Employer observes that a plan administrator can often intercede on an employee's behalf in a usual, customary and reasonable dispute and get a discount for the participant. Recognizing that participants may receive services from non-network providers under circumstances where they have no choice (such as radiology, anesthesiology, or pathology services, otherwise known as RAPS), the Employer points out that the plan already pays non-network RAPS who provide services in hospitals as if they were in network.

The Employer argues that the Association's proposal proscribing Medco from including any network or utilization management changes, or from changing benefits in any way as compared to Aetna compels Medco to do every aspect of its pharmacy claims management, network maintenance, and administration exactly as Aetna did. Asserting that pharmacy management standards change, new drugs come on board, old drugs go out of fashion, it is unreasonable to require Medco to do everything the same as Aetna did it. On the other hand, the Employer contends its proposal turns management of the retail pharmacy network over to Medco and authorizes Medco to administer the program in accordance with its standards and practices.

The Employer denies that its proposal would eliminate retirees' guaranteed access to network retail and mail-order pharmacies. It points out that retirees will receive the benefit of lower PPO premiums if the Employer's proposal is approved. The Employer also denies that it may seek to disaggregate non-Medicare retirees from active employees for premium purposes.

According to the Employer, the start and end dates for health, vision, and dental benefits should be coordinated so that they start and end on the same date. The Employer says that under its proposed contract language new employees will have coverage earlier in most instances than under the current language. The Employer states that the commencement of health, vision, and dental coverage on a different date for new employees before the regular open enrollment effective date would not create any problems. The Employer's proposal changes the time to complete the enrollment process from thirty to sixty days. The Employer says that this is a benefit for employees, because those who opt for first-day coverage will not have to pay for two full months of premiums to obtain coverage and those who do not opt for first-day coverage will have a shorter waiting period before coverage begins.

It is the Employer's position that its proposal for emergency room co-insurance is only prudent given what it characterizes as the overutilization of emergency room services for non-emergencies. Acknowledging that its proposal provides for a $10 co-pay for office visits, a $35 co-pay for urgent care visits, and a $50 co-pay for emergency room visits, the Employer states that the intent is to encourage utilization of lower-cost services and to discourage utilization of higher-cost services. The Employer suggests that, if treatment at an urgent care facility continues to be free, employees would tend to use that higher-cost facility in lieu of office visits as a matter of course.

The Employer contends that its proposal regarding mental health/alcohol and drug services provides a high level of treatment while encouraging prudent use of the benefits. The Employer says that exempting outpatient services in this area from the co-insurance cap reflects simple, sensible plan design intended to control the overutilization that is occurring under the 100% benefit level for these "highly elastic services."

The Employer says that its proposal for a combined lifetime maximum of $2,382,000 indexed to a medical CPI is quite substantial and reflects sound fiscal responsibility on its part.

According to the Employer, the proposed change in the dispute resolution language has little practical effect. The Employer says that should it refuse to arbitrate on the basis that it believes a claim is not arbitrable, the Association could file a prohibited practices complaint with the WERC.

The Employer contends its proposed change in the premium payments by self-pay status employees is not intended to affect premium calculation methodology, but merely to allow the Employer to respond automatically to legislation and regulatory changes impacting self-pay employees.

The Employer argues its proposal is preferable to the Association's proposal, because the Association's proposal, which maintains status quo, free coverage for virtually everything, the value of employee premium contributions will be severely eroded in a very short period of time and the Employer caught in the stranglehold of free healthcare and rising costs will be in a very sorry state.

The Employer says the proposal to eliminate effective July 1, 2004, the shared savings provision is irrelevant as no shared savings close to the level required for sharing are anticipated. It claims there have not been any shared savings and there will not be any.

The Employer claims that an economic comparison of the two health benefit proposals shows the first full year savings of the two proposals are almost identical. According to the Employer, $2.43 million of the $7.05 million saved by the Employer's proposal comes out of the teachers' pockets through cost shifting; $5.38 million of the $7.03 million saved by the Association's proposal comes from out of the teachers' pockets through cost shifting. Disagreeing with the Association that the Employer's proposal is a drain upon MPS finances with no commensurate benefit in return, the Employer asserts that the total savings to MPS from the Association's proposed premium contributions and the pharmacy copays totals $12 million while the salary increases proposed by the Association total $61 million (excluding service increments), resulting in a net loss of $49 million over three years.

The Employer contends that, if the Association's proposal for a health and productivity management program is accepted, the Association's proposal could potentially result in the formal institutionalization of certain features that might place them off limits to modification or that potentially could give the Association excessive bargaining leverage. The Employer argues that the Association's incentive proposal distributes savings to employees who did nothing to contribute to savings to the same extent as it does to those who did.

The Employer argues that its proposal with respect to health and productivity management provides a more meaningful incentive than the Association's. It claims that its proposal provides an independent, stand-alone incentive value. The Employer states that its proposal regarding confidentiality is more reasonable than the Association's, because it is very difficult to implement a meaningful health and productivity management program if the vendor does not have information about the persons involved.

According to the Employer, the Association's claims that the Employer's design changes should be delayed and are unjustified under traditional quid pro quo analysis ignores the Employer's economic crisis and the impact upon this crisis of the Association's proposal. The Employer characterizes the Association's offer as a mass infusion of cash into teacher pockets out of the Employer's already insufficient revenues. It stresses that health cost increases have averaged $15.51 million per year since fiscal year 2000, and that the effects of significant, ongoing budget deficits have had serious impact on the MPS' educational programs.

The Employer argues that its proposal offers the same substantial wage increase as the Association's and that first year savings under the Employer's proposal are almost identical to the claimed savings under the Association's proposal. However, the Employer contends that its proposal achieves substantive changes that have an economic significance going well beyond full first-year savings.

The Employer asserts that the Association's claim that the Employer's proposal seeks to overturn recently bargained plan features is without merit. Rather, the Employer says that the focus of its proposal is to modify the "free-care" model that came into effect in the mid-1990s during a period of relatively flat medical inflation, before health care costs took off commencing in 1999. The Employer recognizes that the parties negotiated changes that led to the current plan in October 2000 in the hope that savings would occur as a result of those changes. The Employer says that total savings fell approximately $5 million below what the parties expected. The Employer claims that its proposal represents a completely appropriate response in the present time of economic crisis, because the plan changes bargained in October 2000 have not contributed to savings, crippling costs continue to rise, and something needs to be done sooner rather than later.

It is the Employer's position that the Association's claims that bargaining would help clarify aspects of the Employer's offer is without merit. The Employer contends that the Association never made an effort to engage in any serious discussion of the Employer's offers during negotiations. The Employer also reject's the Association's claim that the Employer's proposed design changes will undermine employee health.

The Employer asserts that its wage offer is more reasonable than the Association's, stressing that the only difference between the two is that the Employer eliminates the zero step for new hires in the fall of the 2005-2006 school year. By eliminating the zero step, the Employer contends that new teachers will start one step higher than would have been the case, making it easier for the Employer to recruit teachers. The Employer

states that its wage proposal is reasonable in light of its health proposal. The Employer claims that the Association's proposal will result in an additional $16.33 million in educational program budget cuts per year by a school system that has already made cuts to the bone.

For these reasons, the Employer concludes that its offer is more reasonable than the Association's, and it asks the Arbitrator to select the Employer's offer.

### B. The Association

The Association says that its offer better strikes the balance by providing the Employer with more than $5 million in financial relief during the term of the contract, while maintaining the framework of recently bargaining comprehensive health care benefits. According to the Association, its proposal shifts some costs to employees in the form of a substantial premium contribution, while working on a long-term solution by developing a comprehensive health and productivity management program. The Association claims that its offer better supports development of an effective health and productivity management program because its proposal provides that any plan design changes will be implemented in conjunction with the design of the health and productivity management program—not before it is fully designed.

The Association asserts that it is concerned that, with the introduction of HMOs (EPOs), healthier members would become concentrated in the HMO and drive up the per-unit premium cost of the traditional indemnity PPO plans. The Association explains that, to retain less costly members in the PPO, it has worked to avoid premium and other cost differentials that would induce migration of members to the EPO, thereby leaving the PPO vulnerable to escalating premiums.

Pointing out that the hold harmless provision has been in the parties' contract since 1971, the Association says the costs of have been minimal and the provision has been extremely effective in challenging providers who charge excessive fees. According to the Association the total cost of the hold harmless provision has been about $39,000 and the cost of the credit rehabilitation provision has been approximately $12,000.

With respect to retiree benefits, the Association claims the Board's final offer eliminates guaranteed access to the network retail and mail-order pharmacy, increases the annual co-insurance from $250 to $500 per calendar year, reduces the benefit limit for mental health and substance abuse, and removes the co-insurance limit for mental health and substance abuse services. The Association asserts that the Employer's proposal increases the out-of-pocket costs for retirees on top of the premium share they already pay.

It is the Association's position that the Employer's offer to require new employees to apply for health insurance within the first 60 days of their employment is unreasonable. The Association contends that this proposal creates an obstacle to making certain that all new employees receive health care coverage for their first year of work. The

Association also contends that the Board's offer eliminates the provision allowing an employee on the payroll half or more of the paid days in the month eliminates a provision carefully negotiated to preserve the long-standing practice for determining the continuation of Board-paid health coverage.

The Association objects to the Employer's proposal to delete the language requiring the Employer to pay the "submitted cost" for prescription drugs. The Association says the problem was created by a "single rogue provider." While recognizing this problem, the Association claims the Employer's proposed solution would allow unilateral changes in plan payments for all out-of-network providers in a manner that would reduce the benefit to members.

According to the Association, the Employer's proposal permits the Board to unilaterally determine whether a benefits claim can go to arbitration under the arbitration agreement. The Association asserts that the Employer's proposal effectively precludes access to the negotiated dispute resolution procedure. Likewise, the Association says the Employer's proposal gives it too much control over retail pharmacy administration.

The Association claims that the Employer intends to cease aggregation of non-Medicare retirees with active employees. The Association states that this would significantly increase the premium for these retirees.

According to the Association, its proposal regarding distribution of savings resulting from the health and productivity management program is more reasonable than the Employer's. The Association stresses that its proposal results in a reduction in employee-premium contributions after the program has produced an annual savings of $20 million.

The Association asserts that its offer is closer to the health care benefits provided in comparable school districts. The Association also claims its offer is more reasonable because it addresses the need for cost sharing with minimal changes to the status quo. It is the Association's position that, since the negotiated changes implemented in March 2001, there has not been the kind of significant long-term and unanticipated change justifying a departure from the status quo.

Claiming that the current plan design is working, the Association argues that the Employer has not provided a compelling, persuasive basis for accepting its approach to cost sharing. The Association also argues that there is no evidence of inappropriate utilization of employee benefits that would justify the imposition of out-of-pocket costs, and it says there is no evidence showing health care costs in MPS are driven by excessive use of discretionary services. In any event, the Association contends the Employer's design changes are not tailored to reduce inappropriate or unnecessary utilization. It is the Association's position that there is no compelling reason to impose differentiated cost sharing in the PPO and the EPO. The Association is concerned that the migration induced by the differentiated out-of-pocket costs is likely to have an adverse impact on teachers.

With respect to the hold harmless provision, the Association contends that the Employer has not provided compelling, persuasive reasons to eliminate the hold harmless provisions of the contract. The Association declares that elimination of the hold harmless provision is not needed to avoid steerage. It says that elimination of the hold harmless provision would leave employees to individually confront an overcharging provider, resulting in the employee's paying whatever excessive amount was charged.

The Association says that the Employer has not offered sufficient quid pro quo for the substantial change in the status quo. Where a party seeks to significantly change recently bargained provisions, the Association argues that a significant quid pro quo is required as the party opposing the change has just achieved the benefits in the course of give-and-take bargaining.

As to the wage offers, the Association states there was no evidence showing that eliminating the zero step is necessary to address a hiring problem. The Association says there is no evidence that an increase in entry level salary would address the shortage of qualified applicants in the areas that have been perpetually hard to fill.

Noting that the Employer's offer is more costly than the Association's, the Association declares that the Employer cannot claim inability to pay. The Association asserts that any argument that the Employer's offer results in greater long-term savings than the Association's must be rejected because of the speculative nature of determining future savings. Similarly, the Association contends that the greater weight factor supports its offer because the Employer's offer is more expensive than the Association's.

The Association claims that the Employer erroneously annualizes the costs of the two offers rather than presenting their actual costs. By comparing the offers on an annualized basis, the Association argues that the Employer excludes from its analysis the $5 million premium contribution that will never be recaptured with its design changes. The Association also claims that the Employer's claim that the annualized savings of the two offers are equal is wrong. On the other hand, the Associations says that the savings in its proposal are definite and immediate. It is the Association's position that its offer provides the ability to mitigate against revenue shortfalls affecting educational needs of the Employer.

For these reasons, the Association concludes that its final offer is more reasonable than the Employer's, and it asks the Arbitrator to select its final offer.

## V. FINDINGS OF FACT

### A. State Law or Directive (Factor Given the Greatest Weight)

In order for this factor to come into play, employers must show that selection of a final offer would significantly effect the employer's ability to meet State-imposed restrictions. *See Manitowoc School Dist.*¸ Dec. No. 29491-A (Weisberger 1999). No state law or directive lawfully issued by a state legislative or administrative officer, body or agency placing limitations on expenditures that may be made or revenues that may be collected by a municipal employer is at issue here.

However, the parties recognize that the District faces reduced revenues caused by a number of factors, including declining State aid. In fiscal year 2005, MPS experienced its first actual reduction in State aid since the current finance law took effect in 1993. As a result of its losing State aid needed to meet its regularly rising costs, the Employer made a number of cuts in program and staff over the past several years. These cuts have resulted in larger class sizes and fewer classroom resources.

### B. Economic Conditions in the Jurisdiction of the Municipal Employer (Factor Given Greater Weight)

This factor relates to the issue of a municipal employer's ability to pay. The population of the city of Milwaukee has fallen consistently since 1990. City employment has fallen consistently since the 1990s. The evidence shows that the Employer has been taxing to the maximum of its authority since the 1990s and has had serious budget shortfalls for five years. Health care costs have risen 69% since fiscal year 2001 and each year health care benefit costs consume an increasingly larger percentage of the Employer's budget.

### C. The Lawful Authority of the Employer

There is no contention that the Employer lacks the lawful authority to implement either offer.

### D. Stipulations of the Parties

While the parties were in agreement on many of the facts, there were no stipulations with respect to the issues in dispute. They have reached agreement on a number of issues not in dispute here.

### E. The Interests and Welfare of the Public and the Financial Ability of the Unit of Government to Meet these Costs

This criterion requires an arbitrator to consider both the employer's ability to pay either of the offers and the interests and welfare of the public. The interests and welfare

of the public include both the financial burden on the taxpayers and the provision of appropriate municipal services. The evidence shows that the Employer already taxes to the maximum allowed under the statutory revenue limit. A referendum to raise the revenue limits most likely would not pass.

The public has an interest in keeping the Employer in a competitive position to recruit new employees, to attract competent experienced employees, and to retain valuable employees now serving the Employer. Presumably the public is interested in having employees who by objective standards and by their own evaluation are treated fairly.

### F. Comparison of Wages, Hours and Conditions of Employment

#### *1. Introduction*

The purpose in comparing wages, hours, and other conditions of employment in comparable employers is to obtain guidance in determining the pattern of settlements among the comparables as well as the wage rates paid by these comparable employers for similar work by persons with similar education and experience.

#### *2. External Comparables*

One of the most important aids in determining which offer is more reasonable is an analysis of the compensation paid similar employees by other, comparable employers. Arbitrators have also given great weight to settlements between an employer and its other employees. See, e.g., *Rock Village (Deputy Sheriffs' Ass'n)*, Dec. No. 20600-A (Grenig 1984). Because Milwaukee is unique among Wisconsin school districts, there is good reason to question comparisons to smaller, suburban school systems. *Milwaukee Board of School Directors*, Dec. No. 19337-A (Fleischli 1982).

The only interest arbitration that has considered the issue of comparables is *Milwaukee Bd. of School Directors (Milwaukee Teachers' Ass'n)*, Dec. No. 19337-A (Fleischli 1982). In that case, the Association urged the arbitrator to use as comparables all K-12 school districts within and immediately bordering Milwaukee County. The Employer asserted that the ten largest school districts in the State were the most comparable. Finding that the uniqueness of the case (involving a six-month salary reopener) made comparisons to the annual salary of school districts faulty, Arbitrator Fleischli did not rely on comparability evidence, but on the respective annualized costs of the parties' offers.

The Association contends that, with the focus on health care in this arbitration, the comparable school districts most proximate to Milwaukee and within the Southeastern Wisconsin health care market provide the best basis for comparison. The Association notes that the health care costs in Southeastern Wisconsin are greater in comparison to other parts of the country and other parts of the state. The Employer compares MPS with the ten largest school districts in Wisconsin and the Chapter 220 school districts (districts that admit Milwaukee students in order to increase diversity).

Of the thirty-one health benefit plans in Southeastern Wisconsin school districts with networks, only eight at this time impose a deductible on in-network medical services. These districts generally do not have deductibles, co-insurance on in-network medical services, as well as co-pays for office visits, urgent care, and emergency room. The health care costs for the six largest districts outside of Southeastern Wisconsin are lower than the costs of the four Southeastern Wisconsin districts. Where cost sharing has occurred in these districts, it has generally been in the form of a premium share.

In terms of overall employee benefit expenditures per student among the 23 Chapter 220 schools, MPS is sixth highest. Of the five Chapter 220 schools with higher overall employee benefit expenditures, all have equalized value per student significantly higher than the Employer's. The Employer's wage offer lifts MPS from twelfth among the five Chapter 220 schools to sixth place.

Of the five other local taxing units, Milwaukee County, the State of Wisconsin, and the City of Milwaukee each charge premiums that vary in cost depending upon the plan chosen. The premium contribution requirement of the County and the City is in excess of those in either party's proposal. The MATC, the City of Milwaukee, and the County of Milwaukee have deductibles, co-insurance, and co-pay features in one or more of their plans.

Regardless of the comparable districts used, the record shows that only two Wisconsin employers have a usual, customary and reasonable hold harmless clause and none has a medical necessity hold harmless clause. Among other things, the customary and usual charges at MPS are determined at the 85 percentile level, lower than the percentile used in many of the suburban districts, but higher than that used in the City of Milwaukee.

### ***3. Internal Comparables***

#### **a. Introduction**

Generally, internal comparables have been given great weight with respect to basic fringe benefits. *Rio Community School Dist. (Educational Support Team)*, Dec. No. 30092-A (2001 Torosian); *Winnebago Village*, Dec. No. 26494-A (Vernon 1991). Significant equity considerations arise when one unit seeks to be treated more favorably than others. Ordinarily, employers try to have uniformity of fringe benefits for all their bargaining units because it avoids attempts by bargaining units to whipsaw their employers into providing benefits that were given to other bargaining units for a very special reason. *Village of Grafton*, Dec. No. 51947 (Rice 1995). Compensation of nonunionized employees is of little persuasion in an interest arbitration. An employer can unilaterally make changes for nonunionized employees, while an employer must bargain those changes for unionized employees. See *Columbia County (Professionals*), Dec. No. 28987-A (Krinsky 1997).

The Employer has approximately 12,531 employees represented by eleven bargaining units. The Employer has resolved questions regarding health care benefits with approximately ten percent of these employees. Four of the Employer's bargaining units have accepted the Employer's health proposal: the Milwaukee Building and Trades Council (196 employees), AFSCME Local 1616 (205 employees), AFSCME Local 1053 (521 clerical employees), and the Operating Engineers (287 employees). In addition, the Administrators and Supervisors Council (559 employees) has also agreed. The Association represents four of the remaining bargaining units. The health proposal has also been applied to non-represented employees and officers, including the MPS Board Directors (nine persons), the Superintendent's Cabinet (30 employees), and ASC-exempt personnel (70 persons).

### G. Changes in the Cost of Living

The governing statute requires an arbitrator to consider "the average consumer prices for goods and services, commonly known as the cost of living." While a number of arbitration awards suggest that changes in the cost of living are best measured by comparisons of settlement patterns, such settlements, do not reflect "the average consumer prices for goods and services." Despite its shortcomings, the Consumer Price Index ("CPI") is the customary standard for measuring changes in the "cost of living." Settlement patterns may be based on a number of factors in addition to changes in the "average consumer prices for good and services." The wage increases provided by both parties' offers are greater than the CPI.

### H. Overall Compensation Presently Received by the Employees

In addition to their salaries, employees represented by the Union receive a number of other benefits. While there are some differences in benefits received by employees in comparable employers, it appears that persons employed by the Employer generally receive benefits equivalent to those received by employees in the comparable employers.

### *I.* Changes During the Pendency of the Arbitration Proceedings

The parties have not brought any changes during the pendency of the arbitration hearings to the Arbitrator's attention.

### J. Other Factors

This criterion recognizes that collective bargaining is not isolated from those factors comprising the economic environment in which bargaining takes place. See, e.g., *Madison Schools*, Dec. No. 19133 (Fleischli 1982). Good economic conditions mean that the financial situation is such that a more costly offer may be accepted and that it will not be automatically excluded because the economy cannot afford it. *Northcentral Technical College (Clerical Support Staff)*, Dec. No. 29303-B (Engmann 1998). See also *Iowa Village (Courthouse and Social Services)*, Dec. No. 29393-A (Torosian 1999) (con-

clusion that employer's economic condition is strong does not automatically mean that higher of two offers must be selected or, conversely, a weak economy automatically dictates a selection of the lower final offer).

## VI. ANALYSIS

### A. Introduction

While it is frequently stated that interest arbitration attempts to determine what the parties would have settled on had they reached a voluntary settlement (See, e.g., *D.C. Everest Area School Dist. (Paraprofessionals)*, Dec. No. 21941-B (Grenig 1985) and cases cited therein), it is manifest that the parties' are at an impasse because neither party found the other's final offer acceptable. Realistically, if the parties reached a negotiated settlement, the final resolution would probably be the result of compromise and the outcome would be contract provisions somewhere between the two final offers here.

The arbitrator must determine which of the parties' final offers is more reasonable, regardless of whether the parties would have agreed to that offer, by applying the statutory criteria. In this case, there is no question regarding the ability of the Employer to pay either offer. In terms of the final offers, the total cost differences over the life of the contract are slight. Under both proposals, the employees net out ahead during the life of the contract after the tax effects are taken into account.

Both parties recognize the impact of revenue limitations and the reduced commitment of State funding. Both have made final offers that attempt to balance the Employer's financial condition with the need to compensate employees fairly and adequately. Both offers have similar approaches to the issues, but differ in a number of details. Ideally, the parties would have voluntarily resolved the differences between the two final offers and agreed upon a contract that is better than either of the two final offers alone. Unfortunately, the Arbitrator is required to select the entire final offer of one of the parties.

### B. Wages

The key difference between the parties' final offers lies with health insurance. Thus, analysis of the wage offers is not determinative of the outcome in this arbitration proceeding.

The parties' final wage offers are relatively similar. Under both proposals, all cells in the salary schedule are increased by two percent on the first day of the contract period. On January 30, 2004, all cells are increased by $500. On July 1, 2004, all cells are increased by $200 and these increased amounts are then increased by an additional two percent. On January 28, 2005, all cells are increased by $600. The three-year impact of each party's wage offer is approximately $60.5 million.

The Employer's offer eliminates the zero step on the salary schedule effective March 1, 2005. That step is applicable to new hires. The two offers also differ slightly with respect to increases for teachers performing various ancillary duties. Because these wage offers are relatively similar and because of the major significance of the health benefit proposals, this portion of the final offers is not determinative of the outcome.

### C. Group Health Proposals

#### 1. Introduction

As a result of major increases in the cost of medical care and employee health benefits in the last decade, health care benefits have become the most costly single employee benefit. Health care benefits have a considerable effect on employees' sense of well being and personal and family security. Health care benefits probably have become the most significant issue in public sector collective bargaining today.

Because it is taxing at the maximum rate and income from other sources is declining, the Employer has a responsibility to explore ways to reduce costs, including the costs of health care, to help reduce projected deficits and to avoid unnecessary reductions in educational programs and staffing levels. The Association has a duty to not just consider health insurance costs and benefits, but to look to the long term welfare of its members. The problem is that health care costs, including prescription costs, nationally and in Wisconsin, are out of control.

In both the public and private sectors, employers and employees are struggling to afford the rapidly increasing costs of health care. No one can predict what the increases will be in the next year or the next five years. Continued health insurance coverage without some employee contribution and without provisions controlling or reducing costs is no longer a reasonable option. Typically, employers need to change the system of delivery to include cost containment measures, while employees are asked to shoulder some portion of the escalating health insurance costs and agree to provisions that limit or reduce the costs of health care benefits.

Unfortunately, there are no simple solutions. The Employer cannot continue to absorb increasing health benefit costs and employees who need health benefits cannot afford to pick up these costs. While cost sharing is inescapable, ways must be found to contain and control these costs. Arbitrator Weisberger recognized this in *Kenosha County (Jail Staff)*, Dec. No. 30797-A (Weisberger 2004), in which she wrote:

> In this area of rapidly escalating health costs, which are producing a spreading crisis throughout our nation, it is not unreasonable to expect that all County employees, including members of this bargaining unit, will absorb some of the increases for their health care. It is also not unreasonable that the County wishes its employees to be covered by a health plan that promotes turning patients into knowledgeable and cost-conscious con-

> sumers of health care services. Whether this consumerism approach will become a significant key to controlling future health care costs is yet to be determined but steps taken in this direction hold out some promise.
>
> In light of rapidly rising costs for health care services and prescription drugs the County's effort to enlist assistance from all its employees to help control this large—and rapidly escalating—County budget item is a common route taken by many public as well as private sector employers who continue to provide the bulk of funding for these key job benefits. (Given the costs involved, it is no longer appropriate to consider this benefit a "fringe benefit.") Given the very high cost of health care . . . the County would be remiss if it failed to explore seriously ways to contain at least some of its rapidly rising health care expenditures.

Both parties recognize the importance of these health benefits and the impact of increasing costs on both the Employer and employees. Both final offers introduce employee cost sharing of health benefits. In addition, both parties propose health and productivity management programs that are relatively similar and are intended to aid in controlling and containing costs. Both proposals contemplate the establishment of a health and productivity management committee that, with assistance from a consultant, will establish a program to improve health and productivity with, hopefully, a concomitant reduction in health care costs. Both proposals contains additional benefit provisions that are intended to control and contain costs.

In considering the respective final offers of the parties, the Arbitrator has considered all the arguments of the parties in their thorough briefs; ten days of testimony from school administrators, union officers and members, actuaries, benefit consultants, and university professors; and boxes of documentary evidence. While the evidence and arguments have been thoroughly examined, this analysis focuses on what the Arbitrator believes are the determinative factors.

Looking at external comparables, it is apparent that many of the suburban school districts presently offer benefits at lower cost to employees than the Employer's offer. However, these suburban districts, for the most part, have higher equalized value per student than the Employer has, requiring less "effort" to raise the same amount of income through taxation of property owners. Furthermore, the comparison does not consider the future. It appears that the trend is toward requiring school employees and other public employees to pay a portion of the cost of health benefits through premium sharing, copays, deductibles, and the like—as is the norm in the private sector.

More importantly, in the other taxing entities located in Milwaukee County, including Milwaukee Area Technical College, the City of Milwaukee, and the County of Milwaukee, each have deductibles, co-insurance, and co-pay features in one or more of

their plans. Because these taxing entities exist in the same economic environment as the Employer, this comparison is significant.

Because of the importance of reasonable uniformity in benefit plans, internal comparables involving represented employees are given great weight with respect to basic fringe benefits. See *City of Appleton*, Dec. No. 30668-A (Torosian 2004) (uniformity among employees city-wide is most persuasive consideration in an insurance benefit change case). Of the MPS bargaining units (including the Administrators and Supervisors Council that is not a certified bargaining unit but is a unit that bargains collectively) that have agreed on health benefits packages similar to the one proposed by the Employer, all have agreed to a package very similar to the Employer's. The vast majority of MPS employees who have not agreed to the health benefits changes proposed by the Employer are represented by the Association.

Arbitrators have not generally favored premium contributions as a means of addressing the health care crisis. *See, e.g.*, *Northshore Fire Dept.*, Dec. No. 30481-A (Bard 2003) (employer's proposal to require premium contributions would have little impact on underlying causes of sky rocketing health care costs); *City of Onalaska*, Dec. No. 30550-A (Engmann 2003) (problem of sky rocketing insurance premium costs is impacted but a little by passing the cost on to the bargaining unit employees); *Whitewater School Dist.*, Dec. No. 380740-A (Yeager 2004) (both parties chastised for proposals involving varying premium percentage contributions, noting that cost shifting through premium contributions would have "little impact on the continually escalating cost of health insurance"). *See also Village of McFarland*, Dec. No. 159385 (Grenig 2002) (village's proposal addressed only premium sharing not the use of higher deductibles and co-pays to encourage more prudent use of health care services; thus, village's proposal was more in the nature of cost shifting, transferring more costs to employees, than a proposal that would give employees more incentive to hold down health care costs.

In this case, the use of deductibles, co-pays, and co-insurance in the Employer's proposal, although not ideal, is better crafted towards giving employees an incentive to hold down health care costs than the Association's proposal. Of particular significance, the Employer's final offer eliminates the hold harmless provision (including hold harmless for charges exceeding usual, customary and reasonable charges, medical necessity hold harmless, and credit rehabilitation) requiring, among other things, that the Employer to pay the difference between usual, reasonable and customary charges and the actual charges is an important step in encouraging employees to use in-network health care providers. Not only is the present hold harmless provision an uncommon provision in health benefit plans, it does provide any negative consequences for an employee's not using discounted in-network providers. Because providers can get paid in full even if they are not in the network, the hold harmless language does not give providers an In addition, the hold harmless provision, and the related provision protecting employees' credit ratings, imposes significant costs on the Employer.

The problem of out-of-network radiologists, anesthesiologists, and pathologists (RAPs) providing services in in-network hospitals is a genuine problem that affects anyone in a PPO program. However, the current hold harmless language is not limited to RAPs and cannot justify continuation of a contract provision that is inconsistent with the necessary trend to networks of health care providers that provide deep discounts. The Employer's final offer attempts to mitigate the problem of out-of-network RAPs providing services in in-network hospitals. The RAPs issue is certainly a problem that must be addressed by health care providers, insurers, employers, and unions. The Employer's proposal provides a process for addressing this issue.

Although the usual, customary and reasonable provision in the Employer's PPO is based on 85%, this does not justify continuing the hold harmless provision. Although many of the suburban districts determine the usual, customary and reasonable cost at a percentile higher than the eighty-fifth percentile, the City of Milwaukee pays at the eightieth percentile. (The usual, customary and reasonable provision is mainly of concern where a health care provider is out-of-network.) The Employer's use of the eighty-fifth percentile is not unreasonable and does not make its proposal to terminate use of the hold harmless provision unreasonable.

With respect to prescription benefits, the existing provision requiring the Employer's health benefit plan to reimburse employees for 100% of submitted costs after a co-pay cannot be justified in light of the rapid increase in prescription charges and the cost of health benefits. At the present time, it appears that only one pharmacy is taking advantage of this generous provision to bill the health plan for inflated amounts. However, a large number of employees have taken advantage of this pharmacy's willingness to waive the co-pay so it can submit an inflated bill. Additionally, it would not be surprising if other enterprising pharmacies, after learning of this provision, submitted higher charges, or if more employees took advantage of that pharmacy's willingness to waive the co-pay. Additionally, the Employer's coordination of pharmacy benefits proposal is an appropriate way of controlling and containing its health benefit costs while maintaining a high level of employee benefits.

The Association's proposal preventing Medco from making any changes involving any network or utilization management changes, or from changing benefits as compared to Aetna is inconsistent with the need for cost containment and control. The Association's proposal fails to recognize that pharmacy management standards change, new drugs come on board, and old drugs are withdrawn or replaced. The Employer's proposal permits Medco to administer the pharmaceutical program efficiently while still providing employees with pharmacy benefits.

While some retirees may pay more in deductibles and co-pays than they are presently paying, the Employer's proposal expands the networks' geographic coverage. As a result, retirees will receive the benefit of lower PPO premiums if the Employer's final

offer is adopted. The Employer's proposal does not eliminate retirees' guaranteed access to network retail and mail-order pharmacies.

The Employer's change in the language of the dispute resolution clause creates some ambiguity and uncertainty with respect to arbitration of disputes. Accordingly, the Association's proposal to maintain the status quo is more reasonable with respect to this provision. However, the other matters discussed above are more significant in controlling and containing the costs of health benefits.

Both parties propose the implementation of health and productivity programs. In general, both proposals require further action by committees and the parties to finalize the implementation of such a program. They do differ to some degree with respect to incentives, but it is not possible to predict what incentive will actually be most effective in encouraging participation. Both proposals on this issue are reasonable.

Many arbitrators have concluded that the undisputed economic impact of rising health insurance costs has reduced the employers' burden of establish a traditional quid pro quo where health insurance benefits are at issue. In *Village of Fox Point*, Dec. No. 30337-A (Petrie 2002), Arbitrator Petrie stated:

> [T]he spiraling costs of providing health care insurance for its current employees is a mutual problem for the Employer and the Association . . . . In light of the mutuality of the underlying problem, the requisite quid pro quo would normally be somewhat less than would be required to justify a traditional arms-length proposal to eliminate or modify negotiated benefits or advantageous contract language.

*See also Pierce County (Human Services)*, Dec. No. 28186-A (Weisberger 1995) (where employer has shown it is paying increased health-care costs, its burden to provide quid pro quo for health care changes is reduced significantly); *Marquette County (Highway Dept.)*, Dec. No. 31027-A (Eich 2005) (same). In this case, the Employer's proposed wage increase provides sufficient quid pro quo for the changes in health benefits. Among other things, the Employer's wage offer lifts MPS from twelfth among the five Chapter 220 schools to sixth place.

In conclusion, the Employer's final offer is more reasonable than the Association's. With its use of co-insurance, co-pays, and deductibles, the Employer's final offer is more likely to result in cost controls and cost containment while continuing to provide employees with a reasonable level of health benefits. It eliminates current health benefit plan provisions inimical to controlling health benefits costs, including the hold harmless clause, the provision requiring the plan to pay "submitted costs" for pharmaceuticals, and the maintenance of past practices relating to pharmaceuticals. Retirees will receive the benefit of lower PPO premiums and the Employer's proposal does not eliminate retirees' guaranteed access to network retail and mail-order pharmacies.

Undeniably there are some provisions in the Association's final offer that are more reasonable than some provisions in the Employer's final offer. However, the Arbitrator is required to select one party's final offer; the Arbitrator cannot choose some provisions in one offer and some provisions in the other offer. Nor can the Arbitrator modify or edit final offers. Clearly, a negotiated agreement in which the parties select the best individual offers, modify them so they are mutually acceptable, and work together to clarify the language would be preferable to imposing one final offer on the parties. Unfortunately, the parties were unable to reach a negotiated settlement and it was necessary to have the matter resolved in arbitration.

## VII. AWARD

Having considered the applicable statutory criteria, all the relevant evidence and the arguments of the parties, it is concluded that the Employer's final offer is more reasonable than the Association's final offer. The parties are directed to incorporate into their collective bargaining agreements the Employer's final offer.

Executed this twenty-seventh day of August, 2005.

__________________________

Jay E. Grenig

## APPENDIX A

## EMPLOYER'S FINAL OFFER

TENTATIVE AGREEMENT

MTEA
(Teachers)

Part III, Section B(11)

Create a new Part III, Section B(11), to read as follows and renumber subsequent sections:

11. **HEALTH AND PRODUCTIVITY MANAGEMENT.** A health and productivity management (H&PM) program shall be established to promote the health and well-being of MPS employees, retirees, and their family members. The program shall contain the following components: annual health risk assessment (HRA), benefit communications, medical self-care, consumer health education, injury prevention, advanced directives, preventive medical benefits, voluntary targeted at-risk intervention, voluntary high-risk intervention, voluntary disease management, voluntary condition management, wellness incentives, and other components developed by the Joint Health and Productivity Management Committee.

The MPS Health and Productivity Management Program shall be planned and implemented as follows:

a. MPS shall retain a consultant to assist in developing a plan for a comprehensive, well-integrated health and productivity management program for MPS and to assist in making program adjustments

b. A Joint Health and Productivity Management Committee shall be established, comprised of nine (9) representatives, 1/3 of whom are designated by the Superintendent, 1/3 by the MTEA, and 1/3 by other MPS unions to work with the consultant to design the MPS Health and Productivity Management Program and to provide ongoing oversight of the program. Committee meetings shall be jointly scheduled. Whenever possible, decisions shall be made by consensus among members present. If consensus is not reached, decisions shall require a majority vote of members present. MPS shall provide technical assistance and data required to develop the program.

c. The Board shall develop an RFP and solicit bids from among third party vendors qualified to implement the MPS Health and Productivity Management Program. Vendors to be considered shall include, but not limited to, Gordian Health Solutions, Inc.; Health Trac, Inc.; and Stay Well, Inc. Upon conclusion of the bidding process, the Board and the MTEA shall meet to negotiate the selection of an H&PM vendor giving due consideration to MBSD Board policies in this area.

d. Employees, retirees, and their spouses shall be strongly encouraged to select a personal physician (family practice, general practice, or internal medicine) and, when appropriate, obtain a periodic physical examination. The physical examination will help provide information for completing the annual Health Risk Assessment (HRA) questionnaire such as: systolic/diastolic blood pressure reading in mmHg, body mass index, total cholesterol in mg/dl, and HDL (high density lipoprotein) reading in mg/dl.

e. During the open enrollment period for health insurance in September, 2005, and annually thereafter, MPS employees, retirees, and spouses shall be asked to complete a HRA. The HRA will be mailed in by late August, and will also be available for online completion on the H&PM vendor's website. If an employee and/or spouse fail to return a completed HRA by September 30 of each year, the employee shall be deducted $100 from his/her first paycheck in December and $100 from the first paycheck in January. If an employee is off-payroll, a deduction will be made on the first paycheck in December. If an employee is off-payroll, a deduction will be made on the first paycheck of subsequent months until a total of $200 is deducted. New hires after September 15, will have thirty (30) days to complete the HRA after MPS sends him/her notice of the HRA requirement. Failure to complete the HRA within thirty (30) days of such notice will result in a $100 deduction from the first paycheck of each subsequent month until a total of $200 is deducted. The parties agree that the timelines of this paragraph shall be adjusted in 2005 if implementation of the H&PM is delayed beyond July, 2005.

The parties agree that if the $200 payment does not produce 95 percent or greater completion of the HRA by MPS employees/spouses, the payment shall be increased in subsequent school years as necessary until 95 percent or greater completion is achieved. The parties shall meet in May of each school year to agree upon the amount of the payment for the following fiscal year.

Employees out ill or on medical leave during the September open enrollment period shall be asked to complete an HRA at the same time as active

employees. If, however, the HRA is not completed, the $200 penalty shall not be imposed in November and December. The employee shall be given 30 calendar days after return to work to complete the HRA. If the HRA is not submitted within the 30-day period, the employee shall be deducted the $200 penalty during the next two following months.

If a spouse is medically unable to complete an HRA, the $200 penalty shall not be imposed. If requested by MPS, the employee shall provide written certification from a physician that the spouse is medically unable to complete an HRA. If certification is requested and not provided, a $100 deduction shall be made from the first paycheck thirty (30) days after the request was sent to the employee and a second $100 deduction shall be made from the paycheck one month later.

f. Each retiree/spouse shall receive a twenty-five dollar ($25) cash payment equivalent for completing an annual HRA.

g. Employee/spouse responses to the HRA shall be submitted directly to third party vendor(s) retained by MPS to implement the Health and Productivity Management Program. Responses to the HRA shall be held in strictest confidence and shall be accessible only to the vendor and only for the purpose of providing information and assistance to employees/spouses on health and wellness issues. The H&PM vendor shall not release any Protected Health Information (PHI) to any other entity including MPS and the MTEA without the expressed written permission of the individual employee/retiree or spouse. The Board's third party plan administrators shall not have access to individual HRA responses nor to individual information obtained from a completed HRA.

3

h. Prior to each school year, the Joint Health and Productivity Management Committee shall develop a series of high-quality information modules on wellness, health, and health care. Each module shall be from fifteen (15) to forty-five (45) minutes in length. A minimum of three (3) and a maximum of five (5) modules shall be presented to employees each school year.

The modules may be presented to employees during faculty meetings subject to the 2.5 hour per month provision or during the principal's portion of banking time days as determined by the principal or immediate supervisor. The modules shall also be made available for viewing upon the request of the teacher on parent-teacher conference days and the teacher's portion of banking day.

i. The program incentive for employees enrolled in an MPS health who meet eight (8) out of ten (10) established wellness criteria shall be two hundred fifty dollars ($250) cash reward for the 2005/06 school year. Thereafter qualifying employees shall receive three hundred ($300) annually subject to available net savings.. If sufficient annual net savings from H&PM are not realized, the payment shall be pro-rated accordingly.

j. Any annual net savings attributable to H&PM, over and above that needed for cash reward payments, will be shared equally between the District and employees.

k. The parties agree that the H&PM vendor will be required to cooperate in periodic audits of its performance and the H&PM program, as well as any actuarial needs required by the parties for costing and budgeting purposes. Audits shall comply with all provisions of HIPPA.

l. Any health and productivity management initiative developed by the Joint H&PM Committee which would change the administration, benefits or plan design features of the comprehensive indemnity/PPO or the HMO plan shall not be implemented until thirty (30) days after a written agreement is reached between the Board and the MTEA.

TENTATIVE AGREEMENT

MTEA
(Teachers)

SALARY

| | | |
|---|---|---|
| Effective 7/01/03 | - | 2% |
| Effective 1/30/04 | - | $500 per bargaining unit member (base building) |
| Effective 7/01/04 | - | $200 per cell plus 2% (base building) |
| Effective 1/28/05 | - | $600 per cell (base building) |
| Effective 3/01/05 | - | Eliminate Step 0 on the salary schedule (for new hires beginning employment with the 2005-2006 school year) |

Red circled employees shall receive increases equal to the dollar increase of Step 12 of their respective divisions.

Schedule A, Schedule E, part-time certificated rate, administrative duty, other additional pay provisions shall be increased by 2% effective 7/1/03, and 2% effective 7/1/04.

**HIGHLIGHTS OF CHANGES TO MOU ON HEALTH - BOARD PROPOSAL**
**CONTRACT NEGOTIATIONS 2003-2005**
**MTEA/TEACHER CONTRACT — SEPTEMBER 29, 2004**

Note: All changes are effective 2/1/05 or upon issuance of the arbitration award, unless otherwise noted

## ELIGIBILITY FOR ACTIVE HEALTH INSURANCE

- Earlier eligibility for health insurance by one month to be concurrent with dental

## CHANGES INVOLVING ONLY THE AETNA PPO HEALTH PLAN

- Upfront in network deductibles, coinsurance and co-payments on an integrated/cross-application basis (see 9/29/04 benefit highlights)
- Elimination of UCR Hold Harmless provision
- Elimination of Medical Necessity Hold Harmless provision
- Increase mail order drug co-payments from $5/$7 to $10/$20
- Prescription drug carve out to Medco
- Put out of area and Medicare retirees on same plan as actives — out of network benefit level for deductibles, co-payments and coinsurance
- Exclude erectile dysfunction drugs

## CHANGES INVOLVING ONLY THE UHC EPO PLAN

- Expand network to national network
- Upfront coinsurance and co-payments (see 9/29/04 benefit highlights)
- Include a mail order prescription drug benefit at $10/$20 co-payments
- Increase mental nervous/substance abuse benefits from state mandate level to 45/45 days/visits in calendar year
- Modify Lifetime Maximum to $2,382,000 in 2005 (same as Aetna PPO/Indemnity Plan) and link to one combined limit for benefits paid by any MPS self-funded health plan
- Exclude erectile dysfunction drugs

## OTHER

- Eliminate Shared Savings Provision as of 7/1/04
- Possible PPO premium share conditioned on excessive future cost increase

Highlights of Milwaukee Board of Sch irectors Proposed Health Plan Design Changes- as of Se ber 29, 2004

| | Current PPO Plan (Aetna) | | EFFECTIVE FEBRUARY 1, 2005 New PPO Plan (Aetna)-Standard plan | | Current EPO-United Healthcare | EFFECTIVE FEBRUARY 1, 2005 New Choice EPO-United HealthCare |
|---|---|---|---|---|---|---|
| | In-Network | Out of Network | In-Network | Out of Network | In-Network only | In-Network only |
| Deductible | | | | | | |
| Individual | None | $100 | $100 | status quo | None | status quo |
| Family | None | $300 | $300 | status quo | None | status quo |
| | | | Note: In-network and Out of network deductibles are cross applied (integrated). | | | |
| rance leductible) : Employee co-pays nalties are paid in n to annual rance limit | Plan pays 100% Employee pays 0% | Plan pays 80% Employee pays 20% | Plan pays 90% Employee pays 10% up to annual co-insurance limit (noted below) and then plan pays 100% | status quo | Plan pays 100% Employee pays 0% | Plan pays 90% Employee pays 10% up to annual co-insurance limit (noted below) and then plan pays 100% |
| il Coinsurance Limit (after deductible) | | | | | | |
| Individual | None | $750 | $200 | $500 | None | $150 |
| Family | None | $1,500 | $600 | $1,500 | None | $450 |
| | | | Note: In-network and Out of network co-insurance limits are cross applied (integrated). | | | |
| me Maximum Limit* | $2,382,000 (2005) | $2,382,000 (2005) | status quo * | status quo * | Unlimited | $2,382,000 (2005) * |
| cian Services | | | | | | |
| Office visits | 100% | 80% after deductible | $10 copay | status quo | 100% | $10 co-pay |
| Routine Physicals | 100% | 80% after deductible | $10 copay | status quo | 100% | 100% |
| Urgent Care | 100% | 80% after deductible | $35 copay | status quo | 100% | $35 copay |
| Inpatient Physician | 100% | 80% after deductible | 90% after deductible | status quo | 100% | 90% |
| Surgery | 100% | 80% after deductible | 90% after deductible | status quo | 100% | 90% |
| ital Services | | | | | | |
| Inpatient | 100% | 80% after deductible | 90% after deductible | status quo | 100% | 90% |
| Emergency Room | 100% | 100% deductible waived | $50 co-pay | $50 copay | 100% after $25 copay | $50 copay |
| Non Emergency Use | 80% | 50% after deductible | 50% after deductible | status quo | 100% after $25 copay | 50% |
| gnostic X-ray and Lab | 100% | 80% after deductible | 90% after deductible | status quo | 100% | 90% |
| cription Drugs | | | | | | |
| Retail Pharmacy | 10% co-pay at time of purchase (30 day supply) | 20% copay | status quo | status quo | 10% co-pay at time of purchase (30 day supply) | status quo |
| Mail Order | $5 generic/$7 brand copay (90 day supply) | n/a | $10 generic/$20 brand copay (90 day supply) | status quo | None | $10 generic/$20 brand copay (90 day supply) |
| ntal Health Services | | | | | | |
| Inpatient | 100% up to 120 days per calendar year | 80% after deductible up to 40 days per calendar year | 90% after deductible up to 120 days per calendar year | status quo | 100% up to maximum of 15 days per calendar year** | 90% up to 45 days per calendar year |
| Outpatient | 100% up to 120 visits per calendar year | 80% after deductible up to 30 days per calendar year | 90% after deductible up to 120 visits per calendar year | status quo | 100% up to 26 visits per calendar year** | 90% up to 45 visits per calendar year |
| | | | | | **Any combination of mental health service and/or alcohol/drug abuse inpatient hospital, outpatient and transitional treatment cannot exceed $6300 and/or day maximums per calendar year. | |
| cohol and Drug Abuse (Maximums are a combined limit for in and out of network services) | | | | | | |
| Inpatient | 100% up to 120 days per calendar year | 80% after deductible up to 40 days per calendar year | 90% after deductible up to 120 days per calendar year | status quo | 100% up to combined maximum of $6300 per calendar year** | 90% up to 45 days per calendar year |
| Outpatient | 100% up to 120 visits per calendar year | 80% after deductible up to 30 days per calendar year | 90% after deductible up to 120 visits per calendar year | status quo | 100% up to maximum of $1800 per calendar year** | 90% up to 45 visits per calendar year |
| old Harmless Provisions | | | | | | |
| UCR protection | not applicable | included | status quo | excluded | not applicable | status quo |
| Medical Necessity | excluded | inc̃luded | status quo | excluded | not applicable | status quo |

*Effective February 1, 2005, the Lifetime Maximum is a combined limit for benefits paid by any MPS self-funded health plan.*

his is intended to provide only the highlights of the Board's current bargaining position on health plans.

9/29/2004

TENTATIVE AGREEMENT

Health and Dental Benefits
(Teachers)

Part III, Section B

The following proposal is made by the Milwaukee Board of School Directors to the Milwaukee Teachers' Education Association concerning modification of Part III, Section B (health and dental benefits), effective February 1, 2005 or upon the issuance of the arbitrator's decision, whichever comes first, and is subject to the following:

**B. HEALTH AND DENTAL BENEFITS**

Eligible MTEA-represented employees of the Milwaukee Public Schools shall have the right to enroll in any of the negotiated health plan options described in this section.

1. The Board shall provide medical benefits for its employees/dependents who elect to enroll in the health plans offered by the Board in accordance with the following:

a. **PPO INDEMNITY HEALTH PLAN.** Effective February 1, 2005, the current PPO indemnity health plan shall be modified as indicated herein.

1) The plan document for the PPO indemnity health plan, which shall be negotiated by the parties, provides a description of important details of the new plan and is incorporated by reference into this contract and shall be enforceable through the grievance procedure (Part VII) and in accordance with Part III, Section B(3). Unless required by state law or federal regulations, the Board shall not make any changes in the plan document without the express written agreement of the MTEA. The Board shall notify the MTEA of any changes made in the plan document resulting from changes in state law or federal regulation within thirty (30) days of the change.

2) **SUMMARY DESCRIPTION.** A summary description of some of the more important covered medical services and plan design features of the PPO indemnity health plan are listed below. Where there is a difference between negotiated contract language (contained herein) and language in the plan document, the negotiated contract shall govern. Where the contract is silent, the plan document shall govern.

| Covered Medical Services/ Plan Design Features | In-Network Payment* | Out-of-Network Payment* |
| --- | --- | --- |

| | | |
|---|---|---|
| **Plan Deductible** (per calendar year; applies before co-insurance is payable) | $100 individual<br>$300 family | $100 individual<br>$300 family |
| **Annual Co-Insurance Limit** (excludes deductible; once family co-insurance limit is met, all family members will be considered to have met their co-insurance limit for the remainder of the calendar year.) | $200 individual<br>$600 family | $500 individual<br>$1,500 family |
| **Lifetime Maximum** | $2,382,000**** per covered individual in calendar 2005 (indexed to the medical CPI adjusted each January 1 thereafter)*** | $2,382,000**** per covered individual in calendar 2005 (indexed to the medical CPI adjusted each January 1 thereafter)*** |
| **Hospital Services** | | |
| Inpatient coverage | 90% after deductible | 80% after deductible |
| Outpatient coverage | 90% after deductible | 80% after deductible |
| Emergency room (for emergency as defined by the third party administrator) including in- and out-of-network physician services | $50 co-pay | $50 co-pay |
| Non-emergency use of the emergency room | 50% after deductible | 50% after deductible |
| **Physician Services** | | |
| Office visits (non-surgical) to non-specialists | $10 co-pay | 80% after deductible |
| Routine physicals/immunizations: well-baby care to age 2 (up to 10 routine exams annually); children | $10 co-pay (immunizations at 100% with co-pay waived for children, | 80% after deductible (immunizations at 100% with |

| | | |
|---|---|---|
| age 2+ to age 7 (2 routine exams annually); children age 7+ to adult (1 routine exam annually); adults (1 routine exam annually) | birth to age 6) | deductible waived for children, birth age 6) |
| Routine ob/gyn exam (1 routine exam per calendar year; including 1 pap smear and related fees) | $10 co-pay | 80% after deductible |
| Routine mammography (One mammogram per calendar year for covered females 40 and over) | 90% after deductible | 80% after deductible |
| Specialist (office visits) | 90% after deductible | 80% after deductible |
| Surgery | 90% after deductible | 80% after deductible |
| Physician in-hospital services | 90% after deductible | 80% after deductible |
| Allergy testing and treatment | 90% after deductible | 80% after deductible |
| Allergy injections | 90% after deductible | 80% after deductible |
| Immunizations and injections | 90% after deductible (immunizations at 100% with deductible waived for children, birth to age 6) | 80% after deductible (immunizations at 100% with deductible waived for children, birth to age 6) |
| Other physician services | 90% after deductible | 80% after deductible |
| **Maternity** (coverage includes voluntary sterilization and voluntary abortion) | 90% after deductible | 80% after deductible |
| **Contraceptives** (including injectable contraceptives that are not self-administered and | 90% after deductible | 80% after deductible |

| | | |
|---|---|---|
| inserted and implanted contra-ceptive devices) | | |
| **Infertility Treatment**<br>Artificial insemination (6 cycles lifetime maximum). Advanced reproductive technology, including in vitro fertilization, GIFT, ZIFT to lifetime maximum of $30,000. | 90% after deductible | 80% after deductible |
| **Diagnostic X-Ray & Laboratory** (other than physician's office) | 90% after deductible | 80% after deductible |
| **Durable Medical Equipment** | 90% after deductible | 80% after deductible |
| **Prescription Drugs** | | |
| Retail pharmacies (local and nationwide)<br><br>Oral contraceptives, fertility drugs (oral and injectable), and diabetic supplies included<br><br>No mandatory generics | 100% after 10% co-pay off discounted charge, for 30-day supply at Medco participating pharmacies. | 100% after a 20% co-pay for 30-day supply. |
| Mail-order pharmacy program (Medco) | 100% after $10 generic and $20 brand co-pay for a 90-day supply | N/A |
| **Mental Health Services** | | |
| Inpatient coverage | 90% after deductible up to 120 days per calendar year*** | 80% after deductible up to 40 days per calendar year*** |
| Outpatient coverage (including all mandated providers) | 90% after deductible** up to 120 visits per calendar year*** | 80% after deductible** up to 30 visits per calendar year*** |
| **Alcohol/Drug Abuse** | | |
| Inpatient coverage | 90% after deductible up to 120 days per calendar year*** | 80% after deductible up to 40 visits per calendar year*** |
| Outpatient coverage | 90% after deductible** | 80% after |

| | | |
|---|---|---|
| (including all mandated providers) | up to 120 visits per calendar year*** | deductible** up tc 30 visits per calendar year*** |
| **Ambulance** (covers medically necessary transportation only – if ambulance called unnecessarily, no coverage is provided) | 100% (deductible waived) | 100% (deductible waived) |
| **Short-Term Rehabilitation** (acute conditions only) | 90% after deductible | 80% after deductible |
| **Organ Transplants** (see National Program for Medical Excellence) | 90% after deductible | 80% after deductible |
| **Physical/Speech/Occupational Therapy** (inpatient and outpatient) | 90% after deductible | 80% after deductible |
| **Radiation Therapy** (inpatient and outpatient) | 90% after deductible | 80% after deductible |
| **Chemotherapy** (inpatient and outpatient) | 90% after deductible | 80% after deductible |
| **Blood/Blood Plasma** | 90% after deductible | 80% after deductible |
| **Chiropractic** | 90% after deductible up to 50 visits per calendar year*** | 80% after deductible up to 50 visits per calendar year*** |
| **Oral Surgery** (procedures covered by Aetna U.S. Healthcare on October 27, 2000) | 90% after deductible | 80% after deductible |
| **TMJ** (surgical and non-surgical diagnosis and treatment) | 90% after deductible | 80% after deductible |
| **Prosthetic/Orthotic Appliances** | 90% after deductible | 80% after deductible |
| **Podiatrist Services** | 90% after deductible | 80% after deductible |
| **Weight Loss** | 90% after deductible | 80% after deductible |

| | | |
|---|---|---|
| **Urgent Care/Walk-In Clinic** (not considered an emergency) | $35 co-pay | 80% after deductible |
| **Skilled Nursing Facility** | 90% after deductible up to 120 days per calendar year*** | 80% after deductible up to 120 days per calendar year*** |
| **Home Health Care** | 90% after deductible up to 120 visits per calendar year*** | 80% after deductible up to 120 visits per calendar year*** |
| **Private Duty Nursing** | 90% after deductible up to 70 eight-hour shifts per calendar year*** | 80% after deductible up to 70 eight-hour shifts per calendar year*** |
| **Hospice Care** | | |
| Inpatient coverage | 90% after deductible up to 45 days*** | 80 after deductible up to 45 days*** |
| Outpatient coverage | 90% after deductible up to a maximum benefit of $10,000*** | 80% after deductible up to a maximum benefit of $10,000*** |
| **National Program for Out-of-Network Discounts** | N/A | Included |
| **A National Program of Medical Excellence** (Coordinates medical care with nationally respected doctors, clinics, and hospitals. Travel expenses for the member and a companion are covered – up to a maximum of $10,000 per episode.) | Included | N/A |
| **Inpatient Precertification and Concurrent Review** (applies to inpatient hospital, treatment facility, skilled nursing facility, home health care, hospice care & private duty nursing care) | Provider initiated | Member initiated (Not required for employees/ dependents enrolled in Medicare as primary) |

| | | |
|---|---|---|
| Penalty to employee for failure to precertify | None | $300 penalty. Applies per occurrence (Does not apply to employees/ dependents enrolled in Medicare as primary) |
| **Claim Submission** | Provider initiated. Two (2)-year filing requirement | Member initiated, member ultimately responsible. Two (2)-year filing requirement. |

The following provisions apply both in- and out-of-network:

| | |
|---|---|
| **Private Room Limit** | Semi-Private (Private room covered when medically necessary as determined by Aetna; private room covered at semi-private rate when only room available is private.) |
| **Pre-Existing Conditions Rule** | Does not apply. Employees/dependents who enroll during the annual September open enrollment period or when they first become eligible under the Plan are enrolled without pre-existing condition limitations. See Section B(3). Enrollment at other times is not allowed. |
| **Continuation** | Standard COBRA continuation applies. |
| **Extension of Benefits** | Twelve months extension if totally disabled when coverage ceases – extension applies to all covered expenses for the conditions causing such disabilities. |
| **Coordination With Other Benefits Including Medicare** | Maintenance of Benefits (MOB) per transaction without a bank applies to dependents of active employees (including employees on leave) and retirees/dependents not Medicare primary. See Section B(1)(a)(10). Coordination of Benefits (COB) 100% without a bank applies when retiree/dependent is Medicare primary. See Section B(1)(a)(10). |

| Order of Benefit Determination | Standard rules apply (parent birthday, divorced or separated parent, retired or laid off, continuation, cost containment). |
|---|---|

The in-network and out-of-network deductibles and co-insurance limits cross-apply between in-network and out-of-network.

*Once both the annual (calendar year) deductible and the co-insurance limit have been reached, all medical services received for the remainder of the calendar year are benefited at one hundred percent (100%) (except for: office visits, urgent care, emergency room, and prescription co-pays; co-insurance payments for outpatient mental health, outpatient alcohol/drug abuse, and non-emergency use of emergency room services; and penalty payments).

**Does not apply to co-insurance limit and expenses continue to be subject to co-insurance.

***Maximums are a combined limit for in-network and out-of-network.

****Lifetime maximum is a combined limit for benefits paid by any MPS self-funded health plan.

3) **PLAN DESIGN**

a) **In-Network.** The PPO indemnity health plan shall be subject to an annual one hundred dollar ($100) per individual/three hundred dollars ($300) per family deductible, after which all covered medical services and supplies obtained in-network shall be subject to a ten percent (10%) individual-paid co-insurance amount until the annual in-network co-insurance limit of two hundred dollars ($200) per individual/six hundred dollars ($600) per family is reached. Once the in-network co-insurance limit is reached in a calendar year, all covered medical expenses provided in-network will be paid at one hundred percent (100%) for the remainder of that calendar year, in accordance with the following:

Co-insurance limits (excluding outpatient mental health, outpatient alcohol/drug abuse, and non-emergency use of emergency room services) are the maximum amount of out-of-pocket expenses (other than office visits, urgent care, emergency room, and prescriptions co-pays; deductibles and penalty payments) that an employee/family will have to pay for in-network medical services in a calendar year.

Only those out-of-pocket expenses resulting from the applications of the co-insurance percentage (except outpatient mental health, outpatient alcohol/drug abuse, and non-emergency use of emergency room services) may be used to satisfy the calendar year co-insurance limit.

The in-network and out-of-network deductibles and co-insurance limits cross-apply between in-network and out-of-network.

b) **Out-Of-Network.** The PPO indemnity health plan shall be subject to an annual one hundred dollar ($100) per individual/three hundred dollars ($300) per family deductible, after which all covered medical services and supplies obtained out-of-network shall be subject to a twenty percent (20%) individual-paid co-insurance amount until the annual out-of-network co-insurance limit of five hundred dollars ($500) per individual/one thousand five hundred dollars ($1,500) per family is reached. Once the out-of-network co-insurance limit is reached in a calendar year, all covered medical expenses provided out-of-network will be paid at one hundred percent (100%) for the remainder of that calendar year, in accordance with the following:

Co-insurance limits (excluding outpatient mental health, outpatient alcohol/drug abuse, and non-emergency use of emergency room services) are the maximum amount of out-of-pocket expenses (other than office visits, urgent care, emergency room, and prescriptions co-pays, deductibles and penalty payments) that an employee/family will have to pay for out-of-network medical services in a calendar year.

Only those out-of-pocket expenses resulting from the applications of the co-insurance percentage (except outpatient mental health, outpatient alcohol/drug abuse, and non-emergency use of emergency room services) may be used to satisfy the calendar year co-insurance limit.

The in-network and out-of-network deductibles and co-insurance limits cross-apply between in-network and out-of-network.

c) The plan design description contained in a and b above applies to active employees and non-Medicare retirees who reside in an Aetna network area.

d) The plan design in b above (out-of-network) of this section applies to non-Medicare retirees who do not reside in an Aetna network area and Medicare retirees.

4) **COVERED MEDICAL SERVICES.** The summary description (2 above) lists some of the medical services and supplies covered by the PPO indemnity health plan, but is not intended to be an exhaustive list of all services and supplies covered by the plan. The PPO indemnity health plan shall cover all medically necessary services and supplies which are not excluded by the plan, subject to the following:

a) **Medical Necessity** shall mean: The definition of medical necessity as contained in the memorandum of understanding dated July 22, 2002.

b) **General Exclusions.** The general exclusions as contained in the memorandum of understanding dated July 22, 2002, and effective February 1, 2005, any medication that is used for the treatment of erectile dysfunction or sexual dysfunction, and all subsequent negotiated amendments.

c) **Applicable Policies.** All medical services and supplies covered by the PPO indemnity health plan shall be benefited in accordance with the standard policy and coverage decisions of the negotiated third party administrator.

d) **The Negotiated Plan Document.**

5) **SELF-FUNDING.** The PPO indemnity health plan shall be a self-funded health plan of the Milwaukee Board of School Directors. All state of Wisconsin mandated health insurance benefits as promulgated now or in the future by the Wisconsin Commissioner of Insurance which are applicable to a fully insured health insurance plan shall be included in the PPO indemnity health plan even if such mandated benefits apply to health insurance plans generally and exclude self-funded plans. The effective date of any benefit change will be the first date that the plan would be required, under present laws or regulations or as such laws or regulations may be enacted in the future, to implement the change had the plan been fully insured.

6) **THIRD PARTY ADMINISTRATION.** Effective March 1, 2001, the Board's PPO indemnity health plan third party administrator shall be Aetna, Inc. Effective February 1, 2005, the third party administrator for the phar-

macy network for the PPO indemnity health plan shall be Medco Health Solutions, Inc. (Medco).

a) The MTEA shall be provided with a copy of the administrative services contract between the Board and its third party administrator(s) as soon as they becomes available.

b) The third party administrator(s) shall be solely responsible for establishing, revising, and administering local and national PPO and pharmacy networks.

Effective November 1, 2002, and until at least October 31, 2007, Columbia St. Mary's, Inc., and Columbia St. Mary's Community Physicians and their affiliates (hereinafter CSM) shall be included in the Aetna Open Choice PPO network and be available to MTEA-represented employees/dependents on an in-network basis. After CSM is included in the Aetna Open Choice PPO network, this provision shall not be interpreted to prevent CSM or Aetna from terminating their agreement because of material changes occurring after November 1, 2002, by giving proper notice to the other party in accordance with the terms of their contract. Further, this provision shall not be interpreted to require the Board to make CSM available to employees/dependents on an in-network basis following such termination of the CSM/Aetna contract.

c) The Board agrees to provide MTEA staff persons with unrestricted access to any employee/official of the third party administrator(s) (or its subsidiaries) or any other benefit, administrator/vendor for the purpose of representing the interests of MTEA-represented employees/ dependents.

d) After notice and discussion with the MTEA of the rationale for the need to rebid, the Board may rebid the third party administrator for the PPO indemnity health plan. Should the MTEA raise demonstrable and substantive performance deficiencies on the part of the third party administrator, the Board shall rebid the third party administrator. Any new administrator considered in the rebidding process must provide benefits that conform to all provisions of this contract and the negotiated plan document. The Board will provide the MTEA copies of proposed bid specifications for review and analysis for conformance to plan benefits prior to bids being solicited. Upon conclusion of the rebidding process, the Board and the MTEA will meet to negotiate the selection of a new third party

administrator.

7) **PREFERRED PROVIDER OPTION (PPO) NETWORK**

a) Effective March 1, 2001, the Aetna Open Choice PPO Network shall be available to MTEA-represented employees/dependents locally and nationally.

b) Participants in the PPO indemnity health plan shall continue to have the option to use any provider, whether in the network or out-of-network. Participants in the PPO indemnity health plan shall be provided with a booklet listing the doctors, hospitals, and other providers which belong to the PPO network. A current booklet shall be provided to new participants upon enrollment and once per year (during August) to all participants.

c) Participants in the PPO indemnity health plan shall not be responsible for the precertification requirements when the attending/admitting physician is a member of the PPO network. Participants shall not be penalized if a network physician fails to precertify.

d) Participants in the PPO indemnity health plan shall not be subject to the claim filing requirements when health care services are obtained from a provider who is a member of the PPO network. Claims for services and supplies from network and out-of-network providers must be submitted to the plan administrator within two (2). years from the date of service.

d) Other than for deductible, co-insurance, and co-payments, participants in the PPO indemnity health plan shall not be responsible for paying a balance bill for covered services from an in-network provider, when the covered services were provided by an in network provider.

e) PPO indemnity health plan participants who are eligible for Medicare as their primary coverage are not required nor eligible to participate in the PPO network.

8) **PHARMACY NETWORK.** The pharmacy management prescription drug program offered by the third party administrator, containing a Milwaukee and national network of pharmacies, shall be made available to all participants in the PPO indemnity health plan. Prescription medications ob-

tained from pharmacies in the network shall be subject to a ten percent (10%) co-pay off the discounted amount payable to the network pharmacy at the time medications are received. The third party administrator is solely responsible for establishing, revising, and administering the pharmacy network. Participants in the PPO indemnity health plan shall be provided with a booklet listing the pharmacies which belong to the pharmacy network. The booklet shall also be provided to new plan participants upon enrollment and periodically to all participants as updates are prepared.

Effective February 1, 2005, the third party administrator for the pharmacy network shall be Medco Health Solutions, Inc. (Medco).

Effective July 1, 2002, Viagra and similar medications shall not be covered through the mail-order pharmacy program. Effective February 1, 2005, Viagra and similar medications shall no longer be covered by the PPO indemnity health plan.

Effective February 1, 2005, appetite suppressant medications shall be covered only through participating pharmacies of the Medco pharmacy network and shall require precertification. Appetite suppressant medications shall not be covered through the mall-order pharmacy program.

Growth hormone medications shall be covered only through participating pharmacies of the Medco pharmacy network and shall require precertification. Growth hormones shall not be covered through the mail-order pharmacy program.

9) **MAIL-ORDER PHARMACY PROGRAM.** Effective February 1, 2005, the mail-order prescription medication program offered through Medco, Inc., shall be offered to MTEA-represented employees enrolled in the PPO indemnity health plan and shall require a ten dollar ($10) generic and twenty dollars ($20) brand name co-payment by employees/ dependents for a ninety (90)-day supply of medication per prescription. Medication shipments shall continue to be provided at no cost to employees/dependents.

If it is determined by the Board's consultant that a majority of the seventy-five (75) most utilized prescription medications are more expensive when obtained from the mail-order program than when obtained from the pharmacy management prescription drug program (8 above) and the MTEA's consultant concurs with this finding, the MTEA agrees to reopen negotiations on the mail-order pharmacy program, within ten (10) workdays of such concurrence, to explore and agree upon ways to control costs in this

program.

Dispute Resolution Procedure:

> a) Disputes between the Board's consultant and the MTEA's consultant as to whether the identified prescription medications are more expensive in the mail-order program shall, within ten (10) workdays after such dispute becomes known, be submitted to an arbitrator selected by the parties. If the arbitrator agrees with the Board's position, then within ten (10) workdays after the decision, the parties shall commence negotiations and attempt to reach agreement on mail-order program modifications.
>
> b) If the parties are unable to reach agreement within twenty (20) workdays after commencement of negotiations, the arbitrator shall be scheduled to conduct a hearing within thirty (30) days. The arbitrator shall select either the Board's offer or the MTEA's offer based upon its reasonableness.

10) **COORDINATION OF BENEFITS.** Coordination of benefits, as it applies to dependents of active employees (including employees on leave) and retirees/dependents not Medicare primary enrolled in the PPO indemnity health plan shall be administered in accordance with Maintenance of Benefits (MOB) per transaction without a bank. The parties agree that inclusion of this provision is a specifically negotiated limited exception to Part III, Section B(1)(a)(5), of the contract.

Coordination of benefits, as it applies to retirees/dependents who are covered by Medicare as primary and enrolled in the PPO indemnity health plan shall be administered in accordance with Coordination of Benefits (COB) one hundred percent (100%) without a bank. In implementing this provision, the Medicare primary retiree/dependent shall be covered under the PPO indemnity health plan with access to any provider and with medical benefits provided on an out-of-network basis subject to the following modification: Effective February 1, 2005, the National Program of Medical Excellence benefit shall be included.

11) **UTILIZATION MANAGEMENT.** The following utilization management provisions shall apply to administration of the PPO indemnity health plan. Only those utilization management procedures described in this contract shall apply to administration of the plan.

> a) Precertification and Concurrent Review. All non-emergency inpatient admissions (in-network and out-of-network) to a hospital,

skilled nursing facility, or other treatment facility and services for home health care, hospice care, and private duty nursing care must be precertified and are subject to concurrent review by the third party administrator. The provider (usually the admitting/attending physician) is responsible for initiating precertification when the employee/ dependent uses network providers. If the employee/dependent uses out-of-network providers, the employee/dependent must telephone the third party administrator (phone number on the identification card) in advance of the admission and provide the name and address of the treating physician and the name of the facility of admission.

In the event of an emergency admission, an in-network provider/ facility is responsible for initiating concurrent review. However, when using an out-of-network provider/facility, the employee/dependent must contact the third party administrator within forty-eight (48) hours of an emergency admission (extended to seventy-two [72] hours if confinement begins on a Friday or Saturday) to initiate concurrent review. If the employee/dependent using an out-of-network provider/ facility fails to comply with these requirements, a penalty of three hundred dollars ($300) per occurrence shall apply.

Employees/dependents who are enrolled in Medicare are not required to initiate precertification and are not subject to a penalty.

b) Any and all utilization management procedures used by the third party administrator with network providers under standard administration of its PPO indemnity health plan (in effect March 1, 2001), may be utilized to administer the PPO indemnity health plan. The Board agrees to negotiate a provision in its administrative services contract with its third party administrator (TPA) which requires the TPA to inform the Board and the MTEA of any changes in its standard utilization management procedures and which prohibits the TPA from making any changes which change benefits without approval of the Board.

The Board further agrees not to make, nor to agree with the third party administrator to make, any changes in standard utilization management procedures which change benefits without the express written agreement of the MTEA.

If the third party administrator makes changes in the utilization

management procedures which change benefits without agreement of the MTEA, the Board shall rebid its third party administrator upon the request of the MTEA.

12) **USUAL, CUSTOMARY, AND REASONABLE (UCR) ALLOWANCE.** The plan administrator shall process out-of-network claims at a UCR rate of eighty-fifth percentile (85%) HIAA (INGENIX). A UCR cutback of less than ten dollars ($10) shall be waived.

13) **UCR HOLD HARMLESS.** Effective February 1, 2005, the UCR hold harmless provision is eliminated.

14) **MEDICAL NECESSITY HOLD HARMLESS.** Effective February 1, 2005, the medical necessity hold harmless provision is eliminated.

15) **MEDICARE DIRECT.** As plan participants become eligible for Medicare, they shall be enrolled in the Medicare direct program to coincide with the effective date of their enrollment in Medicare.

16) **CONVERSION POLICY.** The Board shall make available the third party administrator's standard conversion policy to eligible employees/ dependents. A copy of the conversion policy and associated rates shall be provided to the MTEA.

17) **RAPS AND OTHER PROVIDER COVERAGE.** When out-of-network radiology, anesthesiology, and pathology (RAPS) services are provided at an in-network facility (hospital or outpatient surgical facility), claims from these out-of-network providers shall be benefited after the deductible at ninety percent (90%) of the negotiated UCR allowance in accordance with Part III, Section B(1)(a)(12).

When an employee/dependent receives medical services at an in-network facility (hospital or outpatient surgical facility) and the admitting or attending physician is an in-network physician and it is medically necessary to use the services of a consulting, assisting, or other physician and out-of-network physicians are used, claims from these out-of-network physicians shall be benefited after the deductible at ninety percent (90%) of the negotiated UCR allowance in accordance with Part III, Section B(1)(a)(12). The provisions of this paragraph shall not apply if it is determined that the out-of-network physician was selected at the request or direction of the employee/dependent. The third party administrator shall process claims in accordance with the provisions of this paragraph. Benefits paid under this paragraph shall be capped at one hundred thousand dollars ($100,000) per fiscal year for 2002-03, 2003-04, and 2004-05. Commencing July 1, 2005,

and until June 30, 2008, the MPS administration shall manually benefit claims in accordance with the provisions of this paragraph as claims are presented by employees/dependents or union representatives. Benefits paid under this paragraph shall be capped at up to fifty thousand dollars ($50,000) per fiscal year for 2005-06 (twenty thousand dollars [$20,000] plus up to an additional thirty thousand dollars [$30,000] of carryover from unexpended funds from the 2004-05 fiscal year). Benefits paid under this paragraph shall be capped at twenty thousand dollars ($20,000) per fiscal year for 2006-07 and 2007-08. As soon as practicable after July 22, 2002, representatives of the MPS administration, the third party administrator, and MPS unions shall meet with representatives of provider networks to attempt to insure that when employees/dependents use network hospitals and network admitting or attending physicians, that out-of-network consulting, assisting, and other physicians are not used unless specifically requested by employees/ dependents.

In addition, the standard policies of the third party administrator shall apply to RAPS and other provider claims, as appropriate, when not specifically addressed above.

When an in-network physician provides office-based medical services but uses out-of-network diagnostic or other provider services, the following shall apply:

a) If notified of such a circumstance by the employee/dependent, the employer, or the MTEA, or the third party administrator shall contact the network physician and remind him/her of the contractual obligation to use network providers.

b) Where deemed appropriate and to the overall benefit of creating a seamless provider network, the third party administrator shall initiate steps to bring the out-of-network provider into the network.

c) The third party administrator, the Board, and the MTEA shall use whatever means and take whatever steps are necessary to persuade the network physician and the out-of-network provider to write-off any deductible and co-insurance charges accruing to the employee/ dependent.

18) **DEPENDENT DAUGHTERS COVERED.** Dependent daughters of employees shall be covered for all prenatal and maternity benefits provided by the plan.

b. **HEALTH MAINTENANCE ORGANIZATION (HMO)/CHOICE EPO**

**OPTIONS.** As a voluntary option to the PPO indemnity health plan, employees may enroll in health maintenance organization (HMO) coverage offered by Compcare Blue and United Healthcare. Family Health Plan (FHP) shall not be available to MTEA-represented employees after March 1, 2001. Employees enrolled in Family Health Plan on November 1, 2000, will be required to select a new health plan during the 2000-01 school year open enrollment period. Compcare Blue shall not be available to MTEA-represented employees effective November 1, 2002. Employees enrolled in Compcare Blue on September 1, 2002, will be required to select a new health plan during the September, 2002, open enrollment period. Any employee/dependent enrolled in Compcare Blue on September 1, 2002, who does not select a new health plan during the September open enrollment shall be enrolled in United Healthcare.

1) The group master contracts which provide a detailed description of the benefits of the Compcare Blue and United Healthcare HMO plans agreed upon by the parties to be in effect on and after March 1, 2001, are

incorporated by reference into this contract and shall be enforceable through the grievance procedure (Part VII) and in accordance with Part III, Section B(2). Employees who enroll in one of the HMO plans shall be provided with a detailed description of their plan by the HMO. The MTEA shall be provided with a copy of each group master contract after they are executed.

The HMO plans offered to employees/retirees and dependents effective March 1, 2001, shall contain the following features:

a) Each plan shall provide a standard high option level of benefits as modified by the parties (as indicated in the benefit summary dated October 19, 2000). Effective February 1, 2005, Choice EPO benefits shall be provided as noted in benefit highlights summary dated September 22, 2004. Effective February 1, 2005, Viagra and similar medications shall not be covered under the Choice EPO plan (retail and mail-order).

b) The retail prescription medication co-pay shall be ten percent (10%) from a participating pharmacy for a thirty (30)-day supply.

c) Effective February 1, 2005, the mail-order prescription medication program offered through the Choice EPO third party administrator shall be offered to MTEA-represented employees enrolled in the Choice EPO plan and shall require a ten dollar ($10) generic and twenty dollars ($20) brand name co-payment by employees/ dependents for a ninety (90)-day supply of medication per prescription. Medication shipments shall continue to be provided at no cost to employees/ dependents.

If it is determined by the Board's consultant that a majority of the seventy-five (75) most utilized prescription medications are more expensive when obtained from the mail-order program than when obtained from the pharmacy management prescription drug program (b above) and the MTEA's consultant concurs with this finding, the MTEA agrees to reopen negotiations on the mail-order pharmacy program, within ten (10) workdays of such concurrence, to explore and agree upon ways to control costs in this program.

Dispute Resolution Procedure:

(1) Disputes between the Board's consultant and the MTEA's consultant as to whether the identified prescription medications are more expensive in the mail-order program shall, within ten (10) workdays after such dispute becomes known, be submitted to

an arbitrator selected by the parties. If the arbitrator agrees with the Board's position, then within ten (10) workdays after the decision, the parties shall commence negotiations and attempt to reach agreement on mail-order program modifications.

(2) If the parties are unable to reach agreement within twenty (20) workdays after commencement of negotiations, the arbitrator shall be scheduled to conduct a hearing within thirty (30) days. The arbitrator shall select either the Board's offer or the MTEA's offer based upon its reasonableness.

d) The mental health and alcohol/drug abuse benefits shall be provided at the state-mandated level as standardly provided by the HMO plans. Effective February 1, 2005, mental health and alcohol/drug abuse benefits shall be provided as follows.

| | |
|---|---|
| Mental Health | |
| Inpatient coverage | 90% up to 45 days per calendar year |
| Outpatient coverage | 90% up to 45 visits per calendar year |
| | |
| Alcohol/Drug Abuse | |
| Inpatient coverage | 90% up to 45 days per calendar year |
| Outpatient coverage | 90% up to 45 visits per calendar year |

Outpatient services do not apply to annual co-insurance limits and covered expenses for outpatient services will continue to be subject to co-insurance.

e. Effective February 1, 2004, once the annual (calendar year) co-insurance limit has been reached, all medical services received for the remainder of the calendar year are benefited at one hundred percent (100%) (except for: office visits, urgent care, emergency room, and prescription co-pays; co-insurance payments for outpatient mental health, outpatient alcohol/ drug abuse, and non-emergency use of emergency room service; and penalty payments).

2) The MTEA and the Board will annually meet to agree upon which HMO's will be offered to bargaining unit employees. Only HMO's which offer experience, industry rating, class rating, or demographic rating will be considered. The rate selected will be the one most cost efficient. Each year the Board and the MTEA will review changes in coverage proposed by each HMO along with the rates. HMO's will be considered for exclusion if the demographic mix selecting an HMO would generate costs on the comprehensive indemnity/PPO plan less than the cost of the HMO

premium or if the rate projected is more than five percent (5%) higher than the mean or median of other HMO rates, whichever is less, except if these rates could be explained by differing demographic concentration within an HMO. HMO's meeting the above criteria would continue to be offered unless there were demonstrable quality complaints against the HMO or if there were structural changes in the HMO's such as a change in IPA groups or if there are changes in benefits. If an HMO is not selected for continuation, the Board will provide assistance to employees in selecting another HMO offering the same IPA groups.

3) Should the Board elect, commencing July 1, 2003, or on a subsequent July 1, United Healthcare HMO shall be a self-funded health plan of the Milwaukee Board of School Directors. All state of Wisconsin mandated health insurance benefits as promulgated now or in the future by the Wisconsin Commissioner of Insurance which are applicable to a fully insured health insurance plan shall be included in the UnitedHealthcare HMO plan even if such mandated benefits apply to health insurance plans generally and exclude self-funded plans. The effective date of any benefit change will be the first date that the plan would be required, under present laws or regulations or as such laws or regulations may be enacted in the future, to implement the change had the plan been fully insured.

Effective February 1, 2005, the self-funded EPO health plan shall be converted to the Choice EPO (United Healthcare). The Choice EPO health plan allows participants the freedom to see any physician or other health care professional from the network, including specialists, without a referral. With this plan, participants will receive the benefits as specified in the SPD when participants seek care from a network physician, facility, or other health care professional.

2. **DISPUTE RESOLUTION.** Individuals, who believe they have been improperly denied benefits under the provisions of the PPO indemnity health plan or an HMO/EPO plan, shall first utilize and exhaust the appeal procedures available under their health plan.

If a claim denial is upheld in the plan appeal process, the individual may then file a grievance under the provisions of the contract except that where the denial is based on the proper application of medical necessity criteria and/or general plan exclusions, it shall not proceed to arbitration.

The MTEA may file a grievance over any matter involving a claim denial or any other matter involving a violation of the contract including:

a. Matters impacting a group of bargaining unit members.

b. Matters having a substantial impact on benefits provided under the plan.

3. **SEPTEMBER OPEN ENROLLMENT.** During September of each year, there shall be an annual open enrollment period in accordance with the long standing past practice of the district with plan coverage effective November 1. The open enrollment period allows active employees to enter a health plan, add dependents, or change health plans without pre-existing condition limitations. The open enrollment period also allows retirees/surviving spouses to change health plans and retirees to add dependent children without pre-existing condition limitations.

**4. PREMIUM PAYMENT**

a. Except as provided in 4(b) below, the Milwaukee Board of School Directors shall pay the full premium cost (single or family), including vision, for eligible employee participation in the PPO indemnity health plan or one hundred percent (100%) of the premium for the health maintenance organization (HMO)/exclusive provider option (EPO) plan, whichever the employees chooses. Employees on unpaid leave,. self-paid retirement, and COBRA extension shall pay the full premium (after tax) as determined by the district.

b. If the PPO indemnity health plan premium rate increase for either the active single or active family plan is more than seventeen percent (17%) above the previous fiscal year, the share paid by active employees enrolled in the PPO indemnity health plan will become two and a half percent (2.5%) of the premium commencing November 1 of that fiscal year.

5. **DEPENDENT ELIGIBILITY.** Dependent coverage shall be provided to employee spouses/dependents under the PPO indemnity health plan or the optional health maintenance organization/exclusive provider option (HMO/EPO) plan in accordance with the following:

a. Spouse - is the person to whom the subscriber is legally married.

b. Dependent Child - includes the following:

1) Natural or adopted child of the subscriber.

2) Stepchild - is the natural or adopted child of the subscriber's spouse for whom the subscriber and/or spouse provides more than fifty percent (50%) of the child's support during a calendar year.

Legal Ward - is a child for whom the subscriber or current spouse is the legal guardian and for whom the subscriber and/or spouse provides more than fifty percent (50%) of the child's support during a calendar year.

3) Grandchild - is a child of the subscriber's dependent child for whom the subscriber and/or spouse provides more than fifty percent (50%) of the grandchild's support during a calendar year when the grandchild's parent is under age eighteen (18).

c. Coverage Ceases

1) Spouse - coverage ends at the end of the month in which the spouse is no longer legally married to the subscriber.

2) Dependent Child

a) Marriage - coverage ends at the end of the month in which the child marries.

b) After the child attains age nineteen (19), coverage ends at the end of the month the subscriber and/or spouse last provided more than fifty percent (50%) of the child's support. If the child is the natural or adopted child of the subscriber and the subscriber is divorced, the fifty percent (50%) support test includes support provided by the subscriber's ex-spouse.

c) Age twenty-five (25) - coverage ends at the end of the month in which the child attains age twenty-five (25), regardless of support, unless prior to attaining age twenty-five (25), the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical disability and chiefly dependent upon the subscriber and/or subscriber's spouse for support and maintenance and provided, however, that proof of such incapacity and dependency must be furnished by the subscriber to the employee's health plan, at no expense to the employee's health plan, within thirty-one (31) calendar days of the child's attainment of age twenty-five (25) and subsequently, when and as often as the employee's health plan may reasonably require, but not more frequently than annually after the two (2)-year period following the child's attainment of age

twenty-five (25).

d) Grandchild - coverage ends at the end of the month when the grandchild's parent loses dependent status or the grandchild's parent

turns 18 or the subscriber and/or spouse no longer provide more than fifty percent (50%) of the grandchild's support.

e) Loss of Legal Status – coverage ends at the end of the month in which the child no longer meets the definition of stepchild or 1) legal ward . For example, a stepchild's parent is no longer legally married to the subscriber.

f) Emancipation – coverage ends at the end of the month in which the child is legally emancipated, even if the emancipation occurs prior to the attainment of age nineteen (19).

d. Addition of Dependent

1) Adding a Dependent – to add a dependent, the MPS Division of Benefits and Insurance Services must be notified within thirty-one (31) calendar days of the event which allows a new person to be eligible for coverage. If notification is received within thirty-one (31) calendar days, dependent coverage shall be effective on the date of the qualifying event. Otherwise, the new dependent may be added only during an open enrollment period. Examples of the above would be a marriage or return of a child to dependent status.

2) Birth or Adoption of a Child – commencing on the date of birth or placement, the child will be covered during the first sixty (60) calendar days under his/her own name. For coverage beyond sixty (60) calendar days, the parent must file a new application with the MPS Division of Benefits and Insurance Services, adding the child, within sixty (60) calendar days of the date of birth or placement. Otherwise, the child may be added only during an open enrollment period.

6. **SHARED SAVINGS**. Sharing savings language shall sunset effective July 1, 2004.

7. The Board shall pay its portion of the premium as outlined in Part III, Section B(4), single or family coverage of regularly employed personnel. Family coverage shall continue to be provided to single persons who become married or who become parents without any waiting period or pre-existing condition limitations, provided the single person submits a family coverage application form within thirty-one (31) calendar days of the marriage date, sixty (60) calendar days of the birthdate or adoption date. If application is made in this fashion, the family coverage shall begin on the date of the marriage, birth, or adoption.

8. Effective February 1, 2005, medical and dental coverage for a new or returning employee begins on the first day of the month following one (1) month of employment, provided the employee applies for coverage within thirty-one (31) days of hire or return to work. Applications received later than thirty-one (31) days after the first day of employment shall not be accepted and the employee may become covered by applying during the next open enrollment period. An ap-

plicant who wishes health coverage to become effective on the first day of employment may have such coverage by paying to the Board a sum equivalent to one (1) month's premium, along with an approved application, within fifteen (15) days of employment. New teachers who were MPS employees in another capacity and who were covered by health and/or dental plan on a Board provided basis immediately prior to becoming employed as teachers shall have no break in coverage. Teachers who were employed through the end of their regularly scheduled school year and who return within the first ten (10) paid days of the next school year shall have no break in coverage.

Effective February 1, 2005, medical and dental coverage for the employee and all dependents ceases on the last day of month following the month in which the employee becomes ineligible due to non-payment of premiums, termination, retirement, unpaid leave of absence, or reduction in hours. However, for employees who lose eligibility at the end of the school year, medical and dental coverage ceases on August 31 following the loss of eligibility.. Nothing in this paragraph is intended to modify the dental eligibility criteria outlined in Section B(20)(d).

An employee on a paid leave of absence will continue to be covered if they make any required employee contributions. An employee on an unpaid leave of absence may continue coverage by paying the full cost of coverage.

9. Employees shall not be entitled to duplicate coverage under any other group health insurance plan offered by the Board.

10. Employees shall not receive duplicate coverage under the present policy and under Medicare.

11. Where both husband and wife, or other members of the family are employed by the Board, the Board shall only pay for one (1) family coverage or two (2) single plans.

12. If two (2) teachers are employed by the Board and one (1) is the subscriber for family health plan coverage, but due to a leave or resignation or retirement the dependent spouse wishes to become a subscriber, he/she shall be allowed to assume the family coverage without the need for a health statement or being subject to any waiting period.

13. The Board will provide family or single health plan coverage and pay the full premium for the surviving spouse of an employee who dies in active service with at least fifteen (15) years of service until the surviving spouse remarries. After the attainment of age sixty (60), the surviving spouse shall be covered in the same manner as a surviving spouse of an employee who retired that year.

14. RETIREE HEALTH. Employees retiring, who have been employed for fifteen (15) years by the Board and who are either at least fifty-five (55) years of age or qualify for a disability pension, shall be allowed to continue in the health plan of his/her choice on a self-paid basis.

If the employees described above have seventy percent (70%) or more of the maximum allowable full-day accumulation of sick leave, they shall be allowed to continue in the PPO indemnity health plan or the HMO/EPO plan with the Board paying its share of the premium at the rate in existence for the PPO indemnity health plan at the time of retirement:

Board-paid contribution is the Board contribution in effect at time, of retirement for the PPO indemnity health plan.

Those employees retiring at the end of their regularly scheduled work year shall be allowed to continue in the PPO indemnity health plan or the HMO/EPO plan with the Board paying its share of the full premium at the rate in existence for the PPO indemnity health plan on either June 30 or July 1, whichever is higher, provided such employee has submitted his/her written resignation on or before April 1.

All half-day balances will be converted into full-day equivalents in making the seventy percent (70%) determination. In the event of the death of such retired employee, the spouse of such employee, at the time of retirement, shall be allowed to continue in a single plan of his/her choice with the Board paying its share of the full premium at the single rate for the PPO indemnity health plan in existence at the time of the deceased retiree's retirement. If such retired employee did not have the required accumulation of sick leave, at the death of the employee, the spouse shall be allowed to continue in a single plan .of his/her choice on a self-paid basis. Such surviving spouses shall not be eligible for coverage if otherwise covered because he/she remarries or is employed and is covered by another group health insurance plan or HMO.

Those employees who retire prior to age sixty-five (65) shall have their health plan premiums paid to the extent that such premiums do not exceed the amount of the Board's portion of the group rate paid for the employee enrolled in the PPO indemnity health plan (as applicable) at the time of retirement. When the retiree attains age sixty-five (65), he/she shall receive the Medicare Carveout Plan provided by the Board and Medicare "B" paid to the employee by the Board provided that such total payment shall not exceed the total amount paid for the Board's portion of premium group coverage for the PPO indemnity health plan (as applicable) at the time of retirement.

Those employees who retire after the attainment of age sixty-five (65) shall have their health plan premium paid and Medicare "B" paid to the employee by the Board to the extent that such payment does not exceed the amount of the Board's portion of the group rate for the PPO indemnity health plan (as applicable) at the time of such retirement.

In unusual circumstances, adjustments to the seventy percent (70%) requirement may be recommended by the superintendent.

Retired employees/spouses who elected not to enroll in social security and who, therefore, are not eligible for Medicare "A" coverage shall be provided with hospitalization coverage and Medicare "B" coordination coverage under the PPO indemnity health plan (as applicable) with access to any provider and with medical benefits provided on an out-of-network basis.

15. Retirees/dependents not Medicare primary who enroll in the PPO indemnity health plan (as applicable) and whose permanent residence is located in a service area of any of the national PPO networks offered by the third party administrator shall be in the active employee group and shall have access to in-network and out-of-network providers and benefits on the same basis as active employees. Effective February 1, 2005, this paragraph is eliminated.

Retirees/dependents not Medicare primary who enroll in the PPO indemnity health plan and whose permanent residence is not located in a service area of any of the national PPO networks shall be covered under the PPO indemnity health plan with access to any provider and with medical benefits provided on an out-of-network basis subject to the following modifications: 1) a calendar year deductible of one hundred dollars ($100) individual/three hundred dollars ($300) family and a calendar year co-insurance limit of two hundred fifty dollars ($250) individual/five hundred dollars ($500) family (a combined total of three hundred fifty [$350] per individual or eight hundred dollars [$800] per family per calendar year); 2) access to network and out-of-network retail and mail-order pharmacy services with co-pays not subject to the annual co-insurance limit; 3) non-emergency use of emergency room services and penalty amounts not be subject to the annual co-insurance limit; 4) both inpatient and outpatient mental health and alcohol/drug abuse services provided at up to one hundred twenty (120) days/visits per calendar year; 5) the annual co-insurance limit shall apply to all covered medical services and supplies, including inpatient and outpatient mental health and alcohol/drug abuse services; and 6) the National Program of Medical Excellence benefit shall be included. This group of retirees/dependents may elect to enroll in the active employee group with access to in-network and out-of-network providers and benefits on the same basis as active employees. Such election may be made only during the annual September open enrollment with new

coverage effective November 1. Effective February 1, 2005, this paragraph is eliminated.

16. In the event an employee retires on duty-incurred disability pension, the Board will continue to pay his/her group health plan coverage for a period of five (5) years after his/her worker's compensation settlement; thereafter, such retired employee shall be allowed to continue in the health plan group on a self-paid basis. The definition of duty-incurred disability shall be that applied to classified employees.

17. Any employee, who elects not to enroll in or to drop the PPO indemnity health or EPO plan or any negotiated health maintenance organization (HMO) by virtue of being covered by another employer's health plan, shall receive a payment of five hundred dollars ($500) per year prorated on a ten (10)-month basis. If the employee's coverage under the other employer's health plan is canceled, or there is an increase in the amount of premium which must be paid by the employee or his/her spouse under the other health plan, or there is a reduction in the level of benefits provided by the other health plan, the employee may enroll in the PPO indemnity health or EPO plan, single or family as appropriate, on an open enrollment basis, provided an application for health coverage is received by the Division of Benefits and Insurance Services within thirty-one (31) calendar days after such event occurs. Such coverage shall be retroactive to the date such event occurred. Voluntary cancellation of coverage by the other employer's subscriber while continuing to be actively employed by that employer does not constitute cancellation of other insurance. These employees shall retain the right to re-enroll in the PPO indemnity health or EPO plan or any negotiated HMO during the annual September open enrollment period. Employees should be aware that in order to be eligible to receive MPS health coverage during retirement, in accordance with paragraph 14 above, they must be enrolled in an MPS health plan at the time of retirement.

17. If any audit of an insurance carrier requires a covered employee or his/her dependents to execute a waiver of confidentiality to examine individual claims documents for auditing purposes only, such waiver of confidentiality is voluntary. The Board and the MTEA will agree upon those aspects of the audit design which relate to confidentiality. The Board will provide the MTEA a list of all employees identified to be audited.

18. **VISION CARE.** The Board shall continue to pay the full premium, single or family as appropriate, for participation in the vision plan described below:

Participants may only obtain plan benefits from providers, including ophthalmologists, listed in the "Directory of Participating Vision Care Providers."

The vision plan shall be provided on the same basis to all active employee (including employees on leave) in the PPO indemnity health plan and to all employees (including

employees on leave) and retirees enrolled in the HMO/EPO option offered by the Board.

The vision plan administrator shall be National Vision Administrators.

| Benefits | Frequency | Covered Amount |
| --- | --- | --- |
| Exam | Once every 12 months | Paid in full |
| Frames | Once every 12 months | Effective 3/01/01 - $35 acquisition cost (approx. $82 frames at no cost to employee) |
| Standard Lenses (glass or plastic) | One pair every 12 months | Paid in full |
| Type: a. Single focus b. Bifocal c. Trifocal d. Lenticular | | |
| Tints (Solid-any color) | | Paid in full |
| Dispensing (Professional Service) | Once every 12 months | Paid in full |
| Contact Lenses (in lieu of frames and lenses) | One pair every 12 months Disposals up to $100 | $100 |

20. **DENTAL INSURANCE**:

a. The Board shall provide dental benefits for bargaining unit employees comparable to the following schedule of benefits.

b. Indemnity Plan. The Board shall pay 93.9 percent of the premium for employees with a family dental plan and 97.4 percent of the premium for employees for the single dental plan.

**SCHEDULE OF DENTAL BENEFITS**

| | |
|---|---|
| Maximum per participant<br>Per calendar year | $1,500 |
| Deductible | $25 |
| Maximum number of deductibles per family per calendar year | 3 |

| | Co-Insurance % |
|---|---|
| *Diagnostic | |
| Diagnostic x-rays | 80% |
| Oral examinations | 80% |
| *Preventive | 80% |
| Ancillary | |
| Anesthesia and injections | 80% |
| Emergency palliative treatment and denture repairs/ adjustments | 80% |
| Restorations | |
| Direct fillings (regular) | 80% |
| Indirect fillings (cast restorations) | 80% |
| Oral Surgery | 80% |
| Endodontics | 80% |
| Periodontics | 80% |
| Prosthodontics | 50% |
| Orthodontics (separate maximum) to age 19 | 50% |

The lifetime maximum for orthodontia shall be increased to one thousand five hundred dollars ($1,500).

*Deductible does not apply to diagnostic or preventive services.

c. Prepaid Plan. The Board shall pay ninety-five percent (95%) of the premium for both family and single plans of the prepaid group dental insurance. The Board and the MTEA shall meet to negotiate carriers. Each year prior to the renewal, the Board and the MTEA shall meet to review the carriers. A change in rate of more than ten percent (10%) shall result in consideration of exclusion of the carriers.

d. Dependent Eligibility. Effective February 1, 2005, dependent coverage shall be provided to employee spouses/dependents under the indenmity and prepaid dental plans in accordance with the following.

1) Spouse – is the person to whom the subscriber is legally married under Wisconsin law.

2) Dependent Child – includes the following:

a) Natural or adopted child of the subscriber.

b) Stepchild – is the natural or adopted child of the subscriber's spouse for whom the subscriber and/or spouse provides more than fifty percent (50%) of the child's support during a calendar year.

c) Legal Ward – is a child for whom the subscriber or current spouse is the legal guardian and for whom the subscriber and/or spouse provides more than fifty percent (50%) of the child's support during a calendar year.

d) Grandchild – is a child of the subscriber's dependent child for whom the subscriber and/or spouse provides more than fifty percent (50%) of the grandchild's support during a calendar year when the grandchild's parent is under age eighteen (18).

e) The limiting age for a natural or adopted child or stepchild is:

(1) Nineteen (19) years.

(2)_ Twenty-five (25) years if such child is a regular full-time student for whom the subscriber and/or spouse provide more than fifty percent (50%) of such child's support during a calendar year.

3) Coverage Ceases

a) Spouse – coverage ends at the end of the month in which the spouse is no longer legally married to the subscriber.

b) Dependent Child

(1) Marriage – coverage ends at the end of the month in which the child marries.

(2) After the child attains age nineteen (19), coverage ends at the end of the month in which the ~~child loses full-time student status or~~ the subscriber and/or spouse last provided more than fifty percent (50%) of the child's support. If the child is the natural or adopted child of the subscriber and the subscriber is divorced, the fifty percent (50%) support test includes support provided by the subscriber's ex-spouse.

(3) Age twenty-five (25) – coverage ends at the end of the month in which the child attains age twenty-five (25), regardless of ~~full-time student status or~~ support.

(4) Grandchild – coverage ends at the end of the month when the grandchild's parent loses dependent status or the grandchild's parent turns 18 or the subscriber and/or spouse no longer provide more than fifty percent (50%) of the grandchild's support.

(5) Loss of Legal Status – coverage ends at the end of the month in which the child no longer meets the definition of 1) legal ward subject to fifty percent (50%) support eligibility requirements or 2) the definition of stepchild subject to the aforementioned full-time student status and fifty percent (50%) support eligibility requirements. For example, a stepchild's parent is no longer legally married to the subscriber.

(6) Emancipation – coverage ends at the end of the month in which the child is legally emancipated, even if the emancipation occurs prior to the attainment of age nineteen (19).

4) Addition of Dependent

a) Adding a Dependent – to add a dependent, the MPS Division of Benefits and Insurance Services must be notified within thirty-one (31) calendar days of the event which allows a new person to be eligible for coverage. If notification is received within thirty-one (31) calendar days, dependent coverage shall be effective on the date of the qualifying event. Otherwise, the new dependent may be added only during an open enrollment period. Examples of the above would be a marriage or return of a child to dependent status.

b) Birth or Adoption of a Child – commencing on the date of birth or placement, the child will be covered during the first sixty (60) calendar days under his/her own name. For coverage beyond sixty (60) calendar days, the parent must file a new application with the MPS Division of Benefits and Insurance Services, adding the child, within sixty (60) calendar days of the date of birth or placement. Otherwise, the child may be added only during an open enrollment period.

**21. HEALTH/VISION AND DENTAL COVERAGE POLICY**

a. Whenever "paid days" is used in this section, it shall mean regularly scheduled workdays and paid holidays of the particular employee.

b. New employees and employees re-enrolling in a health/vision plan and dental plan, at work prior to September 16 of a school year, who submit an application during the September open enrollment period, shall be provided health/vision plan and dental plan coverage effective November 1.

c. New employees (including twelve [12]-month employees) hired at any time other than at the beginning of the school year and who submit an application on or before the thirty-first day of employment, shall be provided health/vision plan and dental plan coverage effective on the first day of the second month following the date of employment. Late applicants (application received after the thirty-first day of employment, but prior to sixty (60) calendar days following employment) shall be provided health/vision plan and dental plan coverage effective on the first day of the third month following the first month of employment. Applications received later than sixty (60) calendar days after the first day of employment shall not be accepted and the employee must apply during the next September open enrollment period in order to receive health/vision plan and dental plan coverage.

d. All employees on the payroll one-half or more of the paid days in a month (September through June) shall receive health/vision plan and dental plan coverage for the second month following such month (November through August).

e. An employee on the payroll for one-half or more of the paid days in June and returning to the payroll within the first ten (10) paid days in September shall receive Board-paid health/vision plan and dental plan coverage through September and October.

f. Effective February 1, 2005, subsections b, c, d, and e of this section shall expire.

22. Commencing on July 22, 2002, MTEA shall be informed in advance of any change in any benefit of any health or dental plan contained in this collective bargaining agreement. In addition, MTEA shall be provided with a copy of any communication or any directive to a third party administrator or vendor which changes any benefit of any health or dental plan contained in this collective agreement. Should an arbitrator determine that this agreement has been violated, the Board shall pay the full cost of arbitrating each dispute, including reasonable attorney's fees incurred in enforcing this provision.

# APPENDIX B

# UNION'S FINAL OFFER

## TEACHER PROPOSAL

### Salaries
### Application of Appendix A, L, N and 200 Day Employees

1. Effective July 1, 2003, all schedules and all cells on all the second semester 2002/2003 salary schedules shall be increased by two percent (2.0%).

2. Effective January 29, 2004, all schedules and all cells on all the July 1, 2003 salary schedules shall be increased by five hundred dollars ($500).

3. Effective July 1, 2004, all schedules and all cells on all second semester 2003/2004 schedules shall be increased by two hundred dollars ($200). Effective July 1, 2004, all schedules and all cells on all second semester 2003/2004 schedules which have increased by two hundred dollars ($200) shall be increased by two percent (2.0%).

4. Effective January 28, 2005, all schedules and all cells on all first semester 2004/2005 salary schedules shall be increased by six hundred dollars ($600).

5. Red circled employees shall receive increases equal to the dollar increase of Step 12 of their respective division.

**Appendix A** **1528 Hour**

**Increase Appendix A**

**Section 12**
Effective 7/1/03 by 2.0%
Effective 1/29/04 by 1.1%
Effective 7/1/04 by 2.0%
Effective 1/28/05 by 1.25%

**Section 13**
Effective 7/1/03 by 2.0%
Effective 1/29/04 by 1.1%
Effective 7/1/04 by 2.0%
Effective 1/28/05 by $1.25%

**Section 14**
Effective 7/1/03 by 2.0%
Effective 1/29/04 by 1.1%
Effective 7/1/04 by 2.0%
Effective 1/28/05 by 1.25%

**Appendix B**
Increase all coaching, equipment manager and cheerleader advisor salaries:
Effective 7/1/03 by 2.0%
Effective 1/29/04 by 1.1%
Effective 7/1/04 by 2.0%
Effective 1/28/05 by 1.25%

**Appendix D**
Effective 7/1/03 by 2.0%
Effective 1/29/04 by 1.1%
Effective 7/1/04 by 2.0%
Effective 1/28/05 by 1.25%

**Appendix E**
Effective 7/1/03 by 2.0%
Effective 1/29/04 by 1.1%
Effective 7/1/04 by 2.0%
Effective 1/28/05 by 1.25%

**Appendix H**
Increase the minimums, maximums and increments in the following manner:

Effective 7/1/03 by 2.0%
Effective 1/29/04 by 1.1%
Effective 7/1/04 by 2.0%
Effective 1/28/05 by 1.25%

**Appendix J**
Increase the minimums, maximums and increments in the following manner:

Effective 7/1/03 by 2.0%
Effective 1/29/04 by 1.1%
Effective 7/1/04 by 2.0%
Effective 1/28/05 by 1.25%

Modify Part III, Section B (1) (h) to read as follows:

h. **Pharmacy Network.** Effective after issuance of the arbitration award, the pharmacy management prescription drug program offered by Medco Health Solutions, Inc., containing a Milwaukee and national network of pharmacies, shall be made available to all participants in the comprehensive indemnity/ppo plan. The coverage provided by Medco shall be equivalent to or greater than the coverage provided by Aetna and shall include no changes to a more restrictive network, no formulary, no changes in utilization management, no COB or changes in benefits. The MTEA shall be provided with a copy of the MPS/Medco Drug Coverage Selection Form and the MPS/Medco Installation Status Report one month prior to implementation and a copy of the group master contract and plan design documents when they have been executed. Prescription medications obtained from pharmacies in the network shall be subject to a ten percent (10%) copay off the discounted amount payable to the network pharmacy at the time medications are received. Medco is solely responsible for establishing, revising and administering the pharmacy network. Participants in the comprehensive indemnity/ppo plan shall be provided with a booklet listing the pharmacies which belong to the pharmacy network. The booklet shall also be provided to new plan participants upon enrollment and periodically to all participants as updates are prepared.

Viagra and similar medications shall be covered only through participating pharmacies of the Medco pharmacy network in accordance with Medco policies. Viagra and similar medications shall not be covered through the mail-order pharmacy program.

Appetite suppressant medications shall be covered only through participating pharmacies of the Medco pharmacy network in accordance with Medco policies and shall require precertification. Appetite suppressant medications shall not be covered through the mail-order pharmacy program.

Growth hormone medications shall be covered only through participating pharmacies of the Medco pharmacy network in accordance with Medco policies and shall require precertification. Growth hormones shall not be covered through the mail-order pharmacy program.

Modify the first paragraph of Part III, Section B (l) (i) to read as follows:

i. **Mail-order Pharmacy Program.** The mail-order prescription medication program offered through Medco Health Solutions Inc., shall continue to be offered to MTEA-represented employees enrolled in the comprehensive indemnity/ppo plan and (effective after issuance of the arbitration award) shall require a ten dollar ($10) generic and twenty dollar ($20) brand name co-payment by employees/dependents for a ninety (90)-day supply of medication per prescription. If a generic equivalent is not available for a particular prescription, a ninety (90)-day supply of the brand name medication shall be provided to employees/dependents for ten dollars ($10). Medication shipments shall continue to be provided at no cost to employees/dependents.

Add a new sentence at Part III, Section B (2) (a) (4) to read as follows:

4. Effective after issuance of the arbitration award, the lifetime maximum shall be $2,276,000 per covered individual and indexed to the medical CPI adjusted each January 1 thereafter.

Modify Part III, Section B (5) to read as follows:

5. **Premium Contribution**. Except for the employee premium contribution defined below, the Milwaukee Board of School Directors shall pay the full premium cost (single or family) for eligible employee participation in the comprehensive indemnity/ppo plan or the Health Maintenance Organization (HMO) plan, whichever the employee chooses. Employees on unpaid leave, self-paid retirement, and COBRA extension shall pay a premium as determined by the past practice of the district.

   Effective November 1, 2004, a premium contribution shall be deducted from the base salary earnings ("contract pay") on each paycheck of employees enrolled (as contract holders) in the comprehensive indemnity/ppo plan or in the HMO plan, subject to the following.

   a. An employee with single health insurance coverage shall contribute one percent (1.00%) of base salary earnings. An employee with family coverage shall contribute two percent (2.00%) of base salary earnings.

   b. Premium contributions shall not be deducted from earnings beyond the employee's normal workday and work year.

   c. Employee health and dental premium contributions shall automatically be deducted from the employee's biweekly paychecks on a tax and FICA exempt basis in accordance with IRS regulations.

   d. Employees who do not receive a paycheck shall be billed on an after tax basis for the appropriate premium contribution amount.

   e. The employee premium contribution provision shall not apply to employees who retire with Board-paid health insurance benefits from the Milwaukee Public Schools and shall not alter Part III Section B (17) **Retiree Health.**

   f. At the completion of each fiscal year, the Board's consultant(s) and the MTEA's consultant shall jointly determine the net savings generated by the H&PM program – see Part III, Section B(11). When the total MPS net H&PM program savings for the prior fiscal year is twenty (20) million dollars or more, employee premium contributions for the following year (November 1 – October 31) shall be reduced to 0.5% for single coverage and 1.0% for family coverage.

Create a new Part III, Section B(11), to read as follows and renumber subsequent sections:

11. **HEALTH AND PRODUCTIVITY MANAGEMENT.** Effective after issuance of the arbitration award, a health and productivity management (H&PM) program shall be established to promote the health and well-being of MPS employees, retirees, and their family members. The program shall contain the following components: annual health risk assessment (HRA), benefit communications, medical self-care, consumer health education, injury prevention, advanced directives, preventive medical benefits, voluntary targeted at-risk intervention, voluntary high-risk intervention, voluntary disease management, voluntary condition management, wellness incentives, and other components developed by the Joint Health and Productivity Management Committee.

    The MPS Health and Productivity Management Program shall be planned and implemented as follows:

    a. MPS shall retain a consultant to assist in developing a plan for a comprehensive, well-integrated health and productivity management program for MPS, and to assist in making program adjustments and in measuring savings derived from the program.

    b. A Joint Health and Productivity Management Committee shall be established, comprised of ~~nine (9) or twelve (12)~~ eight (8) representatives, ~~1/3 of whom~~ four (4) shall be designated by the Milwaukee Board of School Directors, ~~1/3~~ and four (4) by the MTEA, ~~and 1/3 by other MPS unions~~, to work with the consultant to design the MPS Health and Productivity Management Program and to provide ongoing oversight. Committee meetings shall be jointly scheduled. Whenever possible, decisions shall be made by consensus among members present. If consensus is not reached, decisions shall require an affirmative ~~majority~~ vote of at least six members. ~~present~~. MPS shall provide technical assistance and data required to develop the program. The MPS Health and Productivity Management Program developed by the joint committee shall be incorporated by reference into the contract and shall be enforceable through the grievance procedure.

    c. The Board shall develop an RFP and solicit bids from among third party vendors qualified to implement the MPS Health and Productivity Management Program. Vendors to be considered shall include, but not limited to, Gordian Health Solutions, Inc.; Health Trac, Inc.; and Stay Well, Inc. Upon conclusion of the bidding process, the Board and the MTEA shall meet to negotiate the selection of an H&PM vendor giving due consideration to MBSD Board policies in this area.

    d. Employees, retirees, and their spouses shall be strongly encouraged to select a personal physician (family practice, general practice, or internal medicine) and, when appropriate, obtain a periodic physical examination. The physical examination will help provide information for completing the annual Health Risk Assessment (HRA) questionnaire such as: systolic/diastolic blood pressure reading in mmHg, body mass index, total cholesterol in mg/dl, and HDL (high density lipoprotein) reading in mg/dl.

e. During the open enrollment period for health insurance in September of each year, MPS employees, retirees, and spouses shall be asked to complete an HRA. The HRA will be mailed in late August, and will also be available for online completion on the H&PM vendor's website. If an employee and/or spouse fail to return a completed HRA by September 30 of each year, the employee shall have $100 deducted from his/her first paycheck in December and $100 from the first paycheck in January. If an employee is off-payroll, a deduction will be made on the first paycheck of subsequent months when the employee is back on payroll until a total of $200 is deducted.

A new hire after September 15 shall complete the HRA within thirty (30) days after MPS sends him/her notice of the HRA requirement. Failure to complete the HRA within thirty (30) days shall result in a $100 deduction on the first paycheck of the month for two months after the HRA deadline.

The parties agree that if the $200 ~~penalty~~ payment does not produce 95 percent or greater completion of the HRA by MPS employees/spouses, the ~~penalty~~ payment shall be increased in subsequent school years as necessary until 95 percent or greater completion is achieved. The parties shall meet in May of each school year to agree upon the amount of the ~~penalty~~ payment for the following fiscal year.

Employees out ill or on medical leave during the September open enrollment period shall be asked to complete an HRA at the same time as active employees. If, however, the HRA is not completed, the $200 ~~penalty~~ payment shall not be imposed in December and January. The employee shall be given 30 calendar days after return to work to complete the HRA. If the HRA is not submitted within the 30-day period, the employee shall be deducted the $200 ~~penalty~~ payment during the next two following months.

If a spouse is medically unable to complete an HRA, the $200 ~~penalty~~ payment shall not be imposed. If requested by MPS, the employee shall provide written certification from a physician that the spouse is medically unable to complete an HRA. If certification is requested and not provided, a $100 deduction shall be made from the first paycheck 30 days after the request was sent to the employee and a second $100 deduction shall be made from the paycheck one month later.

f. Each retiree/spouse shall receive a twenty-five dollar ($25) cash payment equivalent for completing an annual HRA.

g. Employee/spouse responses to the HRA shall be submitted directly to the third party vendor retained by MPS to implement the Health and Productivity Management Program. Responses to the HRA shall be held in strictest confidence and shall be accessible only to the vendor and only for the purpose of providing information and assistance to employees/spouses on health and wellness issues. The H&PM vendor shall not release any Protected Health Information (PHI) to any other entity including MPS and the MTEA. ~~without the expressed written permission of the individual employee/retiree or spouse.~~ The Board's third party health plan administrators shall not have access to individual HRA responses nor to individual information obtained from a completed HRA.

h. Prior to each school year, the Joint Health and Productivity Management Committee shall develop a series of high-quality information modules on wellness, health, and health care. Each module shall be from fifteen (15) to forty-five (45) minutes in length. A minimum of three (3) and a maximum of five (5) modules shall be presented to employees each school year. The modules shall be presented to employees during faculty meetings subject to the 2.5 hour per month provision or during the principal's portion of banking time days on a schedule determined by the principal or immediate supervisor.

i. The program incentive for employees enrolled in an MPS health plan who meet eight (8) out of ten (10) established wellness criteria shall be a two hundred fifty dollars ($250) cash reward for the first year of the program. Thereafter, qualifying employees shall receive three hundred ($300) annually subject to available net savings. If sufficient annual net savings from H&PM are not realized, the payment shall be prorated accordingly.

j. The parties agree that the H&PM vendor will be required to cooperate in periodic audits of its performance and the H&PM program, as well as any actuarial needs required by the parties for costing and budgeting purposes. Audits shall comply with all provisions of HIPPA.

k. Any health and productivity management initiatives developed by the Joint H&PM Committee which would change the administration, benefits or plan design features of the comprehensive indemnity/PPO or the HMO plan shall not be implemented until thirty (30) days after a written agreement is reached between the Board and the MTEA.

l. Shared savings language contained in Part III, Section B of the contract shall sunset effective July 1, 2005 or coincidental with implementation of health and productivity management, whichever is later.