

BEFORE THE ARBITRATOR

In the Matter of the Petition of

MADISON TEACHERS, INC.

To Initiate Arbitration Between Said
Petitioner and

**MADISON METROPOLITAN SCHOOL
DISTRICT**

Case 305 No. 66756

INT/ARB-10901

Dec. No. 32195-A

Heard: 10/31, 11/9, 11/20,
12/13, and 12/14/2007

Record Closed: 3/31/08

Award Issued: 6/8/08

Sherwood Malamud, Arbitrator

APPEARANCES:

Hawks, Quindel, Ehlke & Perry, S.C., Attorneys at Law, by Timothy E. Hawks, with Jeffrey T. Sweetland assisting on the briefs, 700 W. Michigan, Suite 500, P.O. Box 442, Milwaukee, Wisconsin 53201-0442, appearing on behalf of the Union.

Robert W. Butler, Staff Counsel, Wisconsin Association of School Boards, 122 W. Washington Avenue, Madison, Wisconsin 53703, appearing on behalf of the Municipal Employer.

ARBITRATION AWARD

Jurisdiction of Arbitrator

On September 10, 2007, the Wisconsin Employment Relations Commission appointed Sherwood Malamud to serve as the Arbitrator to issue a final and binding Award pursuant to Sec. 111.70(4)(cm), 6.c., Wis. Stats., to determine a dispute concerning health insurance. Hearing in the matter was held on October 31, November 9, November 20, December 13 and December 14, 2007, at the Administration Building of the Madison Metropolitan School District in Madison, Wisconsin. Original and reply briefs were received and exchanged by the parties by February 25, 2008. A dispute concerning the submission of additional evidence, exhibits and arguments after the filing of the parties' reply briefs was determined by the Arbitrator. He provided them with the opportunity to formally request the re-opening of the hearing for the submission of additional evidence. The Arbitrator gave the parties until March 31 to make such request. When no request was forthcoming, the Arbitrator

closed the record in the matter. Upon reviewing the evidence, testimony and arguments presented by the parties and upon application of the criteria set forth in Sec. 111.70(4)(cm)7., 7.g., 7.r., a.-j., Wis. Stats., to the issues in dispute herein, the Arbitrator renders the following Award.

THE FINAL OFFERS

The Union Offer

The Union proposes that the salary schedule as shown in Addendum A increase in base wages by **2.5%** over the salary schedule shown in Addendum B of the 2004-2006 Collective Bargaining Agreement and shall be in effect for the period commencing 8/13/06 and continuing through 8/11/07. It proposes that the rates generated for the 2006-2007 school year increase by **2.9%** effective August 12, 2007 and continue in effect through August 9, 2008.

In all other respects, the Union proposes that all other language and benefits included in the 2004-2006 agreement continue in accordance with the status quo and the stipulations agreed to during bargaining. The Union proposes no change to the health insurance plan in effect for this bargaining unit of clerical and technical employees. Employees in the MTI-SEE unit continue to have the choice of coverage in the GHC HMO or under WPS Policy Group No. 1202.

The Employer Offer

Wages

The Employer proposes that the salary schedule as shown in Addendum A is an increase in base wages of **2.5%** over the salary schedule shown in Addendum B of the 2004-2006 Collective Bargaining Agreement and shall be in effect for the period commencing 8/13/06 and continuing through 8/11/07. Further, the Employer proposes that the 2006-07 salary schedule increase by **2.9%** and shall be in effect for the period commencing 8/12/07 and continuing through 8/9/08.

Health Insurance

The Employer proposes that effective January 1, 2008 or the first of the month following 30 days from the issuance of the Arbitrator's award, whichever is later, WPS Group Policy number 1202 will no longer be available to employees in the MTI-SEE unit. In its place, the District offers, at no cost to the employee, the option of membership in one of the following qualified health maintenance organizations (HMO): Group Health Cooperative, Dean Health Plan, or Physicians Plus. The District will also provide employees the option of selecting for health coverage one of the approved Point of Service/Preferred Provider Organization (POS/PPO) plans offered to District employees by each of the three HMOs, with the employee paying the difference between the amount paid by the District toward the highest cost single or family HMO and the cost of the single or family POS/PPO plan.

BACKGROUND

The Record

_____The hearing in this matter extended over 5-days and generated 1020 pages of transcript. The parties submitted hundreds of exhibits and submitted briefs totaling 240 pages. This record reflects the importance of the health insurance issue to the parties.

The Arbitrator sets out the parties' arguments and responds to them in the course of the development of the award, rather than summarizing their arguments in one section of the award.

Context of This Dispute

The Agreement at issue, the 2006-07 and 2007-08 Collective Bargaining Agreement between the Madison Metropolitan School District (MMSD) and the Supportive Educational Employees (SEE)-Madison Teachers, Inc. (MTI), is the

successor agreement to the expired 2004-2006 contract. The parties agree that the contract at issue expires on August 9, 2008.

The historical bargaining patterns of these parties is a cross current underlying this bargain. For 32 years, the SEE-MTI insurance benefit has been tied to and established by the health insurance benefit negotiated between MTI and MMSD for the teacher unit. All 5 MTI units¹, 4 of whom have a long bargaining history with the District have the same health insurance. That is an important principal underlying the Union's bargaining philosophy.

As of September 2007 there were 247 FTE bargaining unit employees in the SEE unit and in excess of 2300 employees in the Teacher unit. The parties have conducted their bargaining in a manner such that the Teacher unit establishes the benefit level, particularly for health insurance for all MTI represented units. In this interest arbitration proceeding, the Employer attempts to sever the SEE unit from the health insurance program and plan design established by MTI and MMSD over the years and afford employees in the SEE unit the same health insurance benefit that the Employer offers to the AFSCME represented units of Custodians and Food Service employees. The Employer provides its administrators with the same health benefit it negotiated for the two AFSCME units.

The Employer attempts to have the tail wag the dog, instead of the dog wagging its tail. But for the interest arbitration statute, that is precisely how the benefit level for the SEE unit would have been established. The Employer and MTI would have established in bargaining the plan design and premium costs for the Teacher unit and for all of the other MTI represented units, including the SEE unit.

¹The MMSD bargaining units represented by MTI are: the teachers, the educational assistants, clerical/technical employees the SEE unit, the substitute teachers and the security assistants. MTI only recently began to represent the security assistants.

In May and June of 2007, the Employer and Union settled the successor agreement for the Teacher bargaining unit for the 2007-08 and 2008-09 school years. As part of that bargain, they entered into a memorandum of agreement in which they agreed that health insurance would not be an issue that the parties would be able to carry to interest arbitration should they fail to reach an agreement. The parties reached an agreement to continue the insurance plan design presently in effect. Teachers have a choice of coverage under two health plan models. The teacher could select to participate and take insurance provided under the statewide Preferred Provider Organization (PPO) WPS plan #1202, or participate in an HMO plan provided under the Group Health Cooperative (GHC) SCW plan. The employees who select WPS must pay 10% of the premium either for single or for family coverage. The District pays the entire premium for those who select the GHC HMO. In addition, as part of the parties' agreement the District and the MTI-teacher unit agreed to modify the WPS Policy Group No. 1202 effective January 1, 2008, by adding a \$10 office visit co-pay and an emergency room visit co-pay of \$75. These co-pay revisions were incorporated as part of the parties' tentative agreement of agreed upon items.

Both the Employer and the Union include the same wage increases for both years of the agreement that is the subject of this dispute. Both offer to increase the 2005-06 salary schedule of the expired agreement by 2.5% for the 2006-07 school year and to increase that schedule by 2.9% for the 2007-08 school year. The Union asserts that the 2.5/2.9% increases are internally consistent with the percentage increases granted to the Custodian unit represented AFSCME Local 60.

The District argues that it offers increases of 2.5% in the first year and 2.9% in the second year of this agreement as a *quid pro quo* to obtain the modification to the health insurance plan that it proposes in its final offer. The District emphasizes that the Custodian unit accepted a change in insurance from the Alliance plan to a plan design that offers a choice of three HMOs with

the Employer paying the premium of the most expensive HMO, thereby paying for whichever HMO the employee chooses.²

STATUTORY CRITERIA

Sec. 111.70(4)(cm)6.d. provides that:

The arbitrator shall adopt without further modification the final offer of one of the parties on all disputed issues . . .

The arbitrator applies the following criteria found in Sec. 111.70(4)(cm)7 to the issues in dispute. The criteria are:

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.

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.

7r. 'Other factors considered.' In making any decision under the arbitration procedures authorized

²In referencing exhibits, Union exhibits are referred to as UX and the particular number, Union Rebuttal exhibits are numbered as UR and the number. District exhibits are denoted by DX and the particular number.

by this paragraph, the arbitrator or arbitration panel shall also give weight to the following factors:

- 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 employes involved in the arbitration proceedings with the wages, hours and conditions of employment of other employes performing similar services.
- e. Comparison of the wages, hours and conditions of employment of the municipal employes involved in the arbitration proceedings with the wages, hours and conditions of employment of other employes 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 employes involved in the arbitration proceedings with the wages, hours and conditions of employment of other employes 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 employes, 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 and 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.

PART I

The Scope of the District's Final Offer

There is a threshold issue concerning the District's health insurance offer. To understand the nature of this dispute, it is necessary to set forth the precise language of the Employer health insurance proposal. In material part, it reads as follows:

Effective January 1, 2008 or the first of the month following thirty (30) days from the issuance of the arbitrator's award, whichever is later, the District shall offer, at no cost to the employee, the option of membership in one of the following qualified health maintenance organizations (HMO): Group Health Cooperative, Dean Health Plan, or Physicians Plus. The District will also provide employees the additional option of membership in one of the approved Point of Service/Preferred Provider Organization (POS/PPO) plans as offered to District employees by each of the three HMOs, with the employee paying the difference between the amount paid by the District toward the highest cost single or family HMO and the cost of the single or family POS/PPO plan.

The Union argues at great length that the Point of Service plan should not be available to employees in the service area of the Madison School District, i.e., Dane County and its immediate environs. The Union maintains that when final offers were certified, the Employer did not indicate that the Point of Service plan would be available to employees in the service area. The Employer made clear during bargaining that the PPO plan was available only to employees outside the service area. In the main, the PPO plan was made available by the Employer for retirees who moved outside of the service area. The Union ties the POS to the PPO just as the Employer proposed by linking

the two together with a slash, POS/PPO. The Union maintains that just as the PPO is available only to employees outside of the service area, so the Point of Service plan similarly should be available only to those residing outside of the service area.

The definition of a Point of Service Plan and a Preferred Provider Organization and the bargaining history leading to the submission of final offers further informs the nature of this dispute. The office of the Commissioner of Insurance of the State of Wisconsin defines Point of Service plan (POS), as follows:

A type of managed care plan that allows members to use out-of-network providers, but at additional cost (usually a higher co-payment or a deductible).

The glossary of insurance terms published by the Commissioner defines Preferred Provider Plan (PPP) as:

A type of managed care plan, where coverage for expenses incurred when services are provided by a network provider are paid at a higher level than the coverage available for services received from an out-of-network provider. (Dx 791)

The Union presented the testimony of consulting actuary David Huttleston, and the District presented the testimony of its insurance consultant Kevin Clougherty. Both agreed that a PPO plan is offered outside the main service area, in this case Dane County and its environs. A Point of Service plan could be provided within or without the service area. The benefits and network structure of the PPO and POS plans are similar in many respects.

The Preferred Provider Organization (PPO) comprises a preferred network of providers of medical service at advantageous rates to the subscribing insurance company. In the case of an HMO that has established a Preferred Provider Organization (PPO), it negotiates rates with networks outside of the

service area for a range of services to be offered subscribers to the particular plan. WPS maintains a statewide Preferred Provider Organization or network. It is that network that provides the structure for service offered to those who participate in the District offered WPS-MTI plan design.

The Point of Service plan takes on many of the characteristics of an indemnity insurance plan. However under a Point of Service plan, there is a cost differential between in and out-of-network providers. Obtaining out-of-network medical service is more expensive to the employee who has to pay co-pays and deductibles to access the out-of-network provider.

With these elementary definitions of the various plans in mind, the Arbitrator turns to the negotiation history that led to the submission of final offers to further explain the dispute between the parties as to whether Point of Service Plans (POS) provided by the three HMOs offered by the District should be considered as available to employees in this unit and costed as part of the Employer's final offer. Both the Union and the Employer placed in evidence chronologies of the negotiations and copies of e-mail exchanges between them documenting the dates that significant exchanges occurred. There is no significant difference between the parties' chronologies of the negotiations. It falls to the Arbitrator to infer from the evidence presented whether the POS proposal was contemplated by the Employer to be included in its offer, and even if it were contemplated to be part of its offer, whether the Employer's failure to fully advise the Union of its intent should serve as a basis for excluding POS plans as part of the plan design offered by the Employer to SEE employees.

The parties' negotiations began with the exchange of proposals on May 31, 2006, prior to the expiration of the 2004-2006 agreement. The parties met and exchanged proposals subsequent to May 31, 2006, that are not pertinent to the matter at issue here. On April 25, 2007, teacher bargaining began. Between January and April 2007, the SEE-MTI and District negotiators agreed to obtain the services of a mediator. They did not participate in mediation until after both the Employer and Union saw how teacher bargaining proceeded.

The teachers settled on June 13, 2007. At that juncture the Union proposed settlements for the MTI units, particularly the SEE unit, at the health insurance as settled by the teacher unit and wages at 2.2 and 3% across the board in each of the two years of the agreement, 2006-07 and 2007-08. One week later, on June 20, the District proposed that the health insurance settlement with the teachers, the continuation of WPS Plan 1202 with the \$10 office and \$75 emergency room co-pays effective January 1, 2008, be included in the SEE agreement and thus the pattern of negotiation concerning insurance would continue. However, with the continuation of the 32 year pattern of including the SEE-MTI unit employees under the Teacher negotiated health insurance plan, the District indicated its wage offer had to be 1.25% in the first and 2% in the second year of the agreement. The Employer communicated to the Union that in order to approach the Union's wage demands, it would be necessary, from the Employer's perspective, that the insurance plan design would need to change. The parties met with a mediator on July 10. Subsequently the parties exchanged final offers via e-mail. It is in the July 31, 2007 email offer to the Union that the Employer introduced, for the first time, the language that appears as part of its final offer as quoted above. The Union's Spokesperson in the SEE negotiations, Assistant to the Executive Director Keillor, posed the following question to the District in an email:

1. Are the HMO plans the same as that previously shared by the District in the benefit comparison guide provided us at an earlier session?
2. What are the current monthly costs of the PPO options available through the three HMOs?

The District responded to the questions posed. In its response on August 2, Hennessy, the benefits manager for the District, stated:

The PPO Costs are in the PPO summary document attached. I have listed the tentative POS costs which are not final yet. Dean single - \$537.71, family \$1424.93; P Plus single - \$491.56, family \$1312.47; GHC single \$488.13, family \$1303.32.

The Employer argues that its offer references the POS plans. The Union responds that the POS and PPO are noted together separated only by a slash. The District never indicated that the POS plan would be available to employees in the service area. The Employer in prior negotiation sessions made it clear that the PPO plan would not be available in the service area. Furthermore, the District settled the Custodian unit in the prior year by offering 3-HMO plans, GHC, Physicians Plus (P Plus) and Dean. At the time of settlement of the Custodian contract in 2006, the District did not propose the addition of POS plans. The District only offered the POS plans after it included those plans in its final offer to the SEE unit and the parties offers were certified in mid-August **2007**. Then in September 2007, the District offered, and Local 60 agreed to add the POS plans to the custodians in time for the October 2007 open enrollment period.

The Employer refers to the decision of the Wisconsin Employment Relations Commission in Clark County, Dec. No. 32094-B (Bellman 12/07). Arbitrator Bellman referred the final offers back to the Commission. He asked the agency whether work rules that were not set out in the agreement, but only referenced in it should be considered as part of the Employer's offer. The Commission answered that reference to the work rules, was sufficient for their inclusion as part of the Employer's final offer. The Employer cites Clark County as the basis for this Arbitrator including within its offer the Point of Service plans, plans available to employees in the Dane County service area.

The Union only learned of the full intent of the Employer's proposal one day before the first day of the five days of hearing held in this case. Neither side alleges that the other laid in the weeds to sandbag the other side in the course of the arbitration hearing. Rather, it is clear to the Arbitrator based on the careful consideration of the extensive evidence presented concerning bargaining history that a misunderstanding occurred as a result of the limited exchange that occurred, when the Employer introduced for the first time in its final offer the POS plan and noted the cost of those plans in response to the Union's inquiry. If either party wanted to go back to the Commission for

clarification or for an opportunity to open the investigation to modify their offers in response to information learned, they would have done so.

The Union argues that the Employer should not be heard or allowed to interpret the meaning of its final offer. Its final offer should be taken as proposed. The POS/PPO clearly indicates that the two are similar. Accordingly just as the PPO is available to employees outside the service area so should the POS plans be available only to those outside the service area.

The Union references Section 111.70(4)(cm)6.a; the statute provides that “each party shall submit in writing to the commission its single final offer containing its final proposals on all issues in dispute that are subject to interest arbitration under this subdivision.” The Union cites the decision of Arbitrator Rice in River Falls School District, Decision No. 26995-A (Rice, 2/92) at page 14. The River Falls School District interpreted its final offer that says that its offer will be effective on Union ratification to mean something more favorable in the context of the arbitration proceeding. Arbitrator Rice found the language clear and unambiguous. The Arbitrator concluded from this language that the River Falls School District did not intend to offer retroactive pay for the first year of the agreement either in the form of holiday pay or wages for the entire first year of the agreement. In this regard, the Arbitrator concluded that the Employer’s final offer was flawed.

The Union also references a case in which the Union attempted to correct a drafting error during the arbitration hearing. In Madison Area Technical College, Decision No. 29695-B (Petrie, 1/01) the Union that presented a final offer that was unclear, in that it failed to state that the longevity program it proposed was a substitute for the program in effect in the expired agreement. The Union notes that Arbitrator Petrie reasoned:

... Had the union intended the elimination of this program as a *quid pro quo*, in whole or in part, for its proposed changes in the wage determination and the work assignments components of the renewal labor agreement, it is reasonable to infer that it would have

clearly proposed, discussed, and emphasized this consideration during the parties' preliminary contract negotiations process. On the bases *of the ambiguity of its final offer and the lack of supporting bargaining history*, the undersigned has concluded that the final offer of the union neither explicitly nor implicitly proposes elimination of the longevity pay provisions contained in the prior agreement. [Italics in the original]

The Employer is unable to point to any bargaining history that supports its position. The District introduced the POS plans for the first time in its final offer. In the absence of any bargaining history, the District is unable to demonstrate that it intended to offer the POS plans to bargaining unit employees residing in the HMO service area, Dane County and its immediate environs. The ambiguity of connecting the POS plan to a PPO offering and connecting the two by a slash suggests that the POS plan has the same feature as the PPO plan, in that it is available only to those subscribers who reside outside the service area.

The Union correctly highlights the ambiguity of the Employer's final offer. Both the Union and the Employer arguments attribute a great deal of meaning to the slash. The Arbitrator concludes that the Employer proposes three HMO insurance plans, three PPO insurance plans and three POS insurance plans for the elimination of WPS-MTI plan. The plans are what they are.

The District's Benefits Manager, Hennessy in her August 2 email to Keillor was sent prior to the close of the investigation. The Union inquired and the Employer responded by noting the proposed premium costs of the POS plan. The availability of the plan in or outside the service area is not specifically mentioned in the August 2 e-mail. The question was not raised.

The Arbitrator notes that there are many plan details associated with health insurance proposals. In this case, some of those details were known prior to the close of the investigation; others were not. The Union asks the

Arbitrator to attach greater significance to the absence of explanation concerning the availability of the Point of Service plan in the service area that the Employer offers through the HMOs, GHC, Dean and P Plus. There is no basis in this record for singling that fact out from others.

The Union's argument has particular force, because the Employer first introduced the POS plan in its final offer. The Employer settled an agreement with the Custodians and implemented that agreement with administrators in what would be the first year of the agreement at issue here, back in the fall of 2006. The health insurance plan the District reached agreement with the Custodians substituted for the health insurance program in effect for the Custodian and administrators, the Alliance insurance program. During the period of open enrollment in October/November 2006, the custodian and administrative participants were afforded the choice of selecting among three HMOs, GHC, Dean and P Plus. No POS plan was offered to or available to the custodian and administrative group. Nonetheless, with the introduction of the POS plans in the Employer's final offer, the scope of those plans are clearly referenced in a shorthand manner similar to the manner in which the parties reference other health insurance products and programs that are described in many documents and brochures that are not incorporated in the four corners of the collective bargaining agreement. If the ambiguity of the Employer's proposal was a concern, the Union could have objected to the close of the investigation until the details associated with the proposed insurance program were fully in place and identified.

The Union raises another question concerning the District's offer and plan design. In the contract between the District and the Group Health Cooperative (GHC) HMO, there is a provision that allows GHC the opportunity to raise its premiums by 2% for each additional HMO that the District should offer to its employees. The District proposes an additional two HMOs. Under this provision GHC could increase its premiums by 4%. This is significant, because two thirds of the employees in the SEE-MTI unit who take health insurance have selected GHC. It is GHC premiums the Union argues that controls the District's costs.

During the hearing, the Employer introduced an e-mail from GHC indicating that it had no intention of raising the premiums it offers to SEE employees during the term of this agreement and during the period that the premium remains in effect June 30, 2008. This Award issues on the eve of the expiration of the premium commitment provided by GHC HMO. The Arbitrator relies on the GHC email. Otherwise, the Arbitrator would have to predict the future, or assume that GHC would increase its premium as a penalty to put itself in a competitive disadvantage. The Arbitrator has not included the additional costs of this potential increase in premium in the costing data and application of the criteria in the balance of the Award. With that said, there is a risk associated with the switch in plan design that the Employer proposes that GHC would continue to forebear imposing the 2% penalty. There is a risk that in the future, during the hiatus between this agreement and the parties' agreement on a successor that GHC could change its position. It is not under any contractual obligation to refrain from increasing its premium by 2% per additional HMO that the District offers its employees.

With the identification of the scope of the Employer's final offer, the Arbitrator now turns to apply the statutory criteria to the parties' final offers.

Costing of Offers

Both the Employer and the Union presented evidence concerning the costs of the District's proposals for the first six months of the 2007-2008 school year and the first four months of calendar year 2008 together with the costs for the balance of the contract in July and August 2008. The District's offer becomes effective on the first of the month following 30 days from the issuance of this Award. During the pendency of the Award, the health insurance plan design in effect in the expired 2004-2006 agreement and continued in the first year of the agreement at issue, herein, 2006-2007 continues in effect. Under the parties' stipulations, the modifications to the health insurance plan, the introduction of a \$10 office co-pay and a \$75 emergency room co-pay for both the WPS and GHC (SCW) plans were implemented that resulted in a reduction

in premium for both the GHC and WPS plans. To permit analysis of the parties' proposals, the Arbitrator uses the monthly cost to the District subsequent to January 1, 2008 and to the employees who take WPS insurance should the Arbitrator adopt the District offer. All of the insurance plans that are the subject of this arbitration increase their premium rates effective July 1, 2008. Where appropriate, the Arbitrator takes into account that increase.

Not all employees in the SEE unit take health insurance. Of the 247 bargaining unit employees, 191 take health insurance, either WPS or GHC. Approximately 20% do not take any health insurance. The distribution of employees in the WPS plan are: 13 single and 49 family. In GHC, 35 take single coverage and 94 family.

The full cost of premiums for WPS single coverage July 1, 2007, was \$724.81; for family coverage it totaled \$1900.87 per month. The cost of participating in the GHC HMO was \$364.82 for single coverage and the monthly cost for family was \$974.08. The Employer's cost of paying 90% of premium, July 1, 2007 through December 31, for single coverage with WPS is \$652.33; for family coverage, it is \$1710.78. The employee taking WPS insurance contributes 10% towards the cost of premium and paid \$72.48 for single coverage and \$190.09 for family coverage. Employees who elect to participate in the GHC HMO have their full premium paid for by the Employer.

These costs as noted above changed effective January 1, 2008. Both the WPS and GHC rates declined as a result of the introduction of the office and emergency room co-pays. The total premium for WPS single coverage decreased by \$11.06 to \$713.75. The cost of family premium declined by \$18.98 per month to \$1871.89. The Employer contributed 90% towards the cost of premium under the WPS plan. Single coverage contribution by the Employer amounted to \$642.38 and family \$1684.70 per month. The employee's 10% contribution amounted to \$71.38 for single coverage and \$187.19 for family coverage.

The rates in effect subsequent to January 1, 2008, are the premium levels the Arbitrator employs to calculate the per month cost to the Employer of maintaining the *status quo* health insurance plan design that covers the Teachers, the Educational Assistants and the SEE-MTI unit; the choice of participating in the GHC HMO or in the statewide preferred provider organization plan established by WPS. In the HMO, employees are afforded a narrow network of providers from whom they may obtain medical care. In the alternative, employees may elect coverage under the WPS plan that offers a very broad network of providers that are considered in network.

Subsequent to January 1, 2008, the monthly costs of WPS coverage for 13 singles and 49 families totals \$90,901.24. The cost of 35 single and 94 family GHC participants totals \$103,242.89 for a total monthly cost of premium to the Employer of \$194,144.13.

Should the Arbitrator select the Union's final offer, then the monthly cost of premiums will be \$194,144.13 through June 30, 2008. For July and August 2008, the parties projected that premium increase subsequent to the July 1 increase would be 8.5% for the GHC plan and 11.21% projected increase in premium for the WPS plan. The projected monthly cost of premiums for GHC increases to \$112,018.46 assuming the same number of participants taking single cover and family coverage as noted above for Group Health Cooperative continues. The cost of providing insurance for the 13 single and 49 family subscribers who take WPS would increase on a monthly basis to \$100,080.43. The total monthly cost subsequent to July 1, 2008 to the Employer to pay for the *status quo* plan amounts to \$212,098.89.

The other assumption that runs through the analysis that follows in the application of the statutory criteria to the matter in dispute concerns what will happen should the Arbitrator select the District's offer. Under the Employer's offer, it proposes the elimination of WPS as a choice. In its stead, the District proposes the introduction of nine insurance plans. The District offers three HMOs, two in addition to Group Health Cooperative. The GHC plan design offered by the District does not include the office and emergency room co-pays.

Consequently the cost of this plan is slightly more expensive than the GHC (SCW) plan in effect under the MTI insurance plan design. The other two HMOs offered are Physicians Plus and Dean HMO.

The Employer offers three POS plans. Each of the three HMOs GHC, P Plus and Dean offers a POS plan.

The District offers three PPO plans to individuals who reside outside of the greater Dane County service area. This group of subscribers is comprised primarily of retirees and a very small number of employees of the District who reside outside of the Dane County service area. In the analysis that follows in costing of these various plans, the evidence suggests that the PPO offerings play a small part in the cost of insurance. The Arbitrator notes the premium costs for PPO plans, but affords these plans little attention. The rate structure differs in terms of the premium in effect from July 2007 through June 30, 2008. The plan design is similar to the POS plans in that subscribers have access to providers in and out of prescribed networks. The total premium for the GHC PPO effective July 1, 2007 is \$488.13 for single coverage and \$1303.32 for family. The P Plus PPO plan has the lowest premium cost at \$484.92 for single coverage and \$1294.74 for family coverage. The Dean PPO is the most expensive at \$607.14 for single coverage and \$1601.49 for family coverage.³

The Employer's proposal to change the plan design and thereby reduce its costs includes cost shifting of some of the expense of premium by increasing the contribution level of employees towards the premium for the POS plans to a level both in dollar amount and percentage above the contribution level employees who take the WPS-MTI plan pay.

The Union argues that if the Arbitrator were to select the District offer, employees may migrate to the most expensive HMO from GHC, the lowest cost

³The premium costs and Employer and employee contribution levels are reproduced here from Ux 302.

HMO. In that case, the Employer's proposal would increase the cost of providing insurance over and above the cost of providing the *status quo* GHC/WPS plan design. Both the Union and the Employer introduced expert testimony on the plan design and projected costs of insurance under both the Union's and Employer's proposals. The Arbitrator concludes from the experts' testimony that it is unlikely that employee subscribers to GHC HMO will migrate en mass out of that plan into either one of the other two HMO offerings. The Arbitrator does not pursue that assumption in the analysis that follows.

The Employer proposes the elimination of WPS PPO statewide plan. The Arbitrator assumes that those who participate and subscribe to WPS-MTI plan must do so either, due to their need for flexibility to avail themselves of medical providers in the Dane County area who practice in more than one particular network such as Dean or P Plus, or who have children who reside in or attend college outside of the Dane County service area, or whose medical needs are such that a change of provider would be viewed by the subscriber as disruptive or life threatening if the plan subscriber or one of the family suffers from a particular disease or illness.

The group of WPS subscribers, at this point, reflects the operation of adverse selection. Accordingly, the Arbitrator assumes that with the elimination of WPS insurance, those subscribers would elect a POS plan that in some measure affords the flexibility offered by WPS. In this regard, in order to calculate the cost exposure of the change in plan design proposed by the Employer, the Arbitrator assumes that those who took WPS insurance would migrate to the most expensive of the POS plans which is offered by the Dean health plan.

Effective January 1, 2008, the monthly cost of single coverage in the Dean POS plan is \$537.71 and \$1424.93 for family coverage. The Employer, under its offer, would contribute the amount it would expend for the most expensive HMO, Dean, \$447.32 for single coverage and \$1185.42 for family coverage. The Employer's contribution would leave the individual employee to

pay \$90.38 for single coverage and \$239.50 monthly for family coverage. This represents an increase in employee contribution towards premium of \$19.45 per month for single coverage and \$52.31 per month for family coverage over what the employee taking WPS-MTI had to pay. With this cost structure and the assumption that the Arbitrator makes that subscribers to WPS-MTI plan would all select Dean, the most expensive POS plan, the Arbitrator now turns to address the statutory criteria and the arguments of the parties concerning the application of those criteria.

Greatest Weight

In this subheading, the Arbitrator addresses the greatest weight criterion the lawful authority of the employer criterion and the interests and welfare of the public criteria. The Madison Metropolitan School District has been subject to revenue limits legislation enacted in 1993, Section 121.90 of the Wisconsin Statutes that remains in force to date. The principal way in which a school district subject to revenue limits may increase its levy is to increase student enrollment. In 2006-07 the revenue limit per member (student) was \$9,256.93 (DX 801). The District has other sources of income, such as federal and other grants. The District receives small donations from individuals on a continuing basis. However the lion's share of its income derives from the tax levy and state aids, both of which are dependent on student enrollment. The District enrollment decreased in 2006 from 2005 levels. In 2007 it increased by 114. The District projects that enrollment will increase by 17 in 2008 and decrease by 5 in 2009. It projects an increase in enrollment of 182 in 2010, 404 in 2011 and 350 in 2012 (Dx 819). The District may levy a tax to the limit. However, it may not exceed that revenue cap. The income the District receives through the levy is based on enrollment rather than on the basis of the increase in value of property located in the District, the major measure for the amount of its levy prior to the passage of revenue caps. The District may exceed the cap provided the electorate of the school district approves.

Superintendent Rainwater testified at the arbitration hearing concerning the impact of the revenue cap on the ability of the District to continue to fund

and maintain programs and services from year to year at their current level without providing for any additional programs or projects. The Superintendent described how the District's budget is apportioned to pay for salaries, fixed costs (utilities, transportation and maintenance) and other items, such as supplies, equipment, etc. Salaries and fringe benefits account for 84% of the District's budget. Under the statute, the District may offer a 3.8% increase for wages and benefits and thereby avoid proceeding to interest arbitration with its teachers. The 3.8% figure represents the cost of continuing programs in effect at that time into the succeeding school year. However, because of the District's stagnant enrollment neither increasing nor decreasing significantly in the last several years, a revenue gap has developed between the amount that the budget may increase under the revenue cap statute, 2.6%, and the cost of continuing to provide those same services in the succeeding school year which increases by 3.8%.

The District attempted to obtain the approval of the electorate to allow it to exceed the cap to fund that budget gap, in perpetuity. This 2005 referendum failed.

The Union argues, in the first instance, the entire budget allocated for wages and fringe benefits for the SEE unit is insignificant in terms of the total District budget. However, the difference between the District and Union offers amounts to approximately \$25,000 per month. Even projected over a 12-month period, it represents a minimal percentage in the context of a budget that exceeds \$340 million. The Union relies on the oft-quoted observation of Arbitrator June Miller Weisberger who observed that when an arbitrator applies the greatest weight criterion and the impact revenue caps has on a particular interest dispute:

If these Employer arguments were to prevail in this proceeding, they would determine the outcome herein without further consideration of any other arguments made by both parties to support their final wage offers. Although the undersigned is able to conceive of circumstances in which there is unmistakable

evidence of some specific facts which would direct such a result due to the language of Section 111.70(4)(cm)7 and 7.g., she does not believe that the evidence and arguments in this proceeding are sufficient to require such a summary result. State imposed school district cost controls are applicable to all school districts. There is no specific state law or directive which limits implementation of the Union's final offer by the District. While state revenue controls must be considered in this proceeding, the undersigned concludes that their existence is insufficient by itself to mandate adoption of the Employer's final offer at this stage in her analysis of MERA's statutory factor. Manitowoc Public School District, Decision No. 29481 at page 9 (Weisberger, 5/99)

This Arbitrator agrees with Arbitrator Weisberger that the greatest weight standard does not serve as the sole basis for determining this dispute.

The Union argues on the basis of the observation of Arbitrator Grenig in Milwaukee Board of School Directors, Decision No. 31105 at page 17 (Grenig, 8/05) concerning the greatest weight criterion that:

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.

Furthermore, the Union limits the amount of the difference between the parties' offers to the period of May through July 2008. It argues that the difference over that time period amounts to \$111,184, that the Union proposal to maintain the *status quo* exceeds the District offer. The Union notes that this difference amounts to 27/1000 of 1%, i.e., 0.0027% of the District's total budget of in excess of \$412 million, only 38/1000 (0.0038% of its fund ten budget of \$291,802,000) and only 43/1000, 0.043% of its statutory revenue limit of \$260,578,000. The Union maintains that this expenditure will not significantly impact the District's ability to meet state-imposed restrictions.

Only the Teacher unit is one that amounts to a significant portion of the Employer's total budget. However, the Arbitrator finds that each unit must be considered on its own terms. The total budget for the SEE unit and the expenditures therein form the basis for considering the significance of any particular expenditure.

The Union argues that the SEE unit accounts for only \$1,003,353 of the District's total WPS cost of \$19,490,000 for the 2006-07 school year. The District's Teachers account for \$16,000,000 of those costs. Yet, the District agreed in bargaining with the teacher unit that for the 2007-08 and 2008-09 school years the insurance would not be an issue that either party could take to arbitration. The Union maintains that acceptance of the Union's offer would not hamper the District's ability to stay within its revenue caps citing Sturgeon Bay School District, Decision No. 30884-B at page 33 (Greco, 12/04) in which the arbitrator did not give the greatest weight criterion effect to either party's final offer because neither created a risk that the district would exceed its revenue cap.

The District anticipates the Union's argument in its initial brief. It sets out the costing of the total package offers of both the District and the Union at page 55 of its brief. Whichever costing methods are brought to bear, the budgetary costs of the 2006-07, first year of the agreement, are not in dispute. Both the District and the Union submit the same offer for the first year. The total salary and fringe benefit costs total \$12,878,550. The dollar increase over the 2005-06 school year for this unit is \$566,782 or 4.6%.

The calculation of the cost of the 2007-08 school year is a challenge. The District sets out its costing as if its offer were implemented on January 1. The Arbitrator notes that the health insurance cost differential between the parties' offers amounts to approximately \$25,000 a month in the period of January through June 2008, prior to the increases in premiums that are scheduled to

occur on July 1, 2008.⁴ If one were to project this differential at \$25,000 over a year, that amounts to \$300,000 or 2.2% of the total package costs. Within the context of a budget of \$360,000,000 this amount may indeed be insignificant.

However, the District has established in unrebutted testimony that there is a budget gap between the revenue that the District raises and the expense of continuing programs and services from year to year. The District had a budget gap last year and has one this year and projects one for next year. The District has taxed to the extent permitted by statute. However, the funds generated are inadequate to continue services provided in 2006-07 into 2007-08 without making cuts in program and staffing to bring programs and services within the confines of the District's statutory taxing authority. In the last three years, as measured by the employee count on September 1, 2005, the number of employees in this the SEE unit was 283. That number included 23 retired subs and 12 limited term employees. The following year, September 2006, the count fell to 263 with no limited term employees and 22 retiree subs. As of September 2007, the employee count for the SEE unit is 247 including 22 retiree subs (DX 625). This data demonstrates more than anything else the impact of the budget gap on this bargaining unit. In the scheme of things, \$250,000 may be a limited sum. However, since this District has hit the ceiling of its taxing authority, it meets its statutory obligation by making cuts in staffing, cuts that impact this unit. Over the term of this very agreement from September 2006 through September 2007, this unit has suffered a 6% reduction, the loss of 16 positions. Consequently, the Arbitrator accords weight to the greatest weight factor. However, the greatest weight factor is not, in and of itself, determinative. It supports the selection of the District offer. However, the significance of this factor is further moderated by the next statutory factor.

⁴The range of that differential between the cost of the final offers is between \$21,000 to \$27,000 per month. It is dependent on which POS plan WPS subscribers migrate to after WPS is eliminated as a choice under the District's offer.

Greater Weight

The statute requires the Arbitrator to give greater weight to the economic conditions in the jurisdiction of the municipal employer, Madison Metropolitan School District. The economic conditions are measured in Madison and Dane County. The District argues that since the Employer must conform to statutory revenue caps, it makes no difference what the economic conditions are in Madison and its immediate environs. The Union responds that the District asks the Arbitrator to ignore the greater weight factor because it supports the Union's offer.

The series of exhibits submitted by the Union (UX 1000-1009) well document the very favorable economic conditions present in Madison. As compared to the nine other largest school districts, the property value per student in Madison is \$711,511; the second place school district, Waukesha, has resources supporting each student valued at \$597,312. Only Middleton, of the seven unionized contiguous school districts to Madison, exceeds the property value per member in 2005-06 at \$712,392. Similarly, the change in median family income between 2000 and 2006, Madison leads in that income increased by \$9,869 over that period. The second place community, Appleton, saw median family income increase by \$6,558. In Madison the family median income increased from \$59,840 to \$69,709. In Appleton it increased from \$57,097 to \$63,655. In Madison, again number one, the per capita income in 1999 (2000) was \$23,498. In 2006 it increased by \$4,686 to \$28,184. The number two community, Waukesha, the per capita income increased from \$23,242 by only \$2,410 to \$25,652.

Madison ranks number one in median increase in home values between 2000 and 2006. In 2000 the median value of a home in Madison was \$139,300. In 2006 it increased by \$76,200 to \$215,500. Second place Waukesha, in 2000, the median value of a home exceeded that of Madison by \$600 at \$139,900. That median value increased by \$58,300 to \$198,200 by 2006. Finally, in UX 1004, the Union notes that Madison had the lowest

unemployment rate as of August 2007 at 3.7%. years 2000 and 2006. This factor supports the selection of the Union offer.

Cost of Living

The Union acknowledges that the total package final offer it submits for the 2007-08 school year exceeds the cost of living ((Ux 301 and Dx 302). The cost of living increases from September 2006 to 2007 is 2.8% to 3.1% depending on the index used (Ux 1010). The Union calculates that its total package final offer increases the wage and benefits cost to the District by 4.26% as the Union calculates this data.⁵ The Arbitrator concludes, therefore, that this criterion supports the selection of the District's final offer over that of the Union.

Overall Compensation

This criterion does not serve to distinguish between the final offers of the parties.

PART II

Introduction

In this part of the Award, the Arbitrator addresses the remaining statutory factors: comparability and the stipulations of the parties, changes in the foregoing and such other factors. The Arbitrator considers comparability

⁵The Arbitrator adopts the Union's costing. The District relies on a cast forward costing in this SEE unit in which historically the parties have not employed a cast forward method for purposes of costing. Because of the movements within the schedule and individuals between positions and the various varying lengths of terms of employment between ten and twelve months, the parties have employed a 1% factor in addition to the "per ??sell increase." The Union in its rebuttal exhibits demonstrates the soundness of the parties' bargaining decision to employ a rule of thumb rather than attempt to track all the individual movements that occur during the course of a school year among members of the SEE unit.

and the stipulations of the parties together as a result of the Union's decision to "accept" the District's wage offer of 2.5% in the first year and 2.9% in the second year of the agreement. For the Union, its acceptance of the District's 2.9% offer is consistent with the settlements achieved in three of the nine largest school districts in the 2007-08 school year: Green Bay 3%; Appleton at 2.75% and Janesville 2.49%. Waukesha settled for calendar year 2007 rather than on a school year basis at 2.75%. For the Union, this settlement falls within the pattern of percentage wage increases provided by comparable large school districts.

For the Employer, its offer represents the payment of a *quid pro quo* for the insurance changes it proposes. The Employer acknowledges that it settled with the Custodians at 2.9% for the 2007-08 school year and at 2.5% for the 2006-07 school year. However, the District reminds the Arbitrator that the Custodian unit accepted the health insurance change as part of the total bargain.

In the comparability discussion that follows below, the purpose of that discussion is to establish whether the Employer's offer is a *quid pro quo* for the change it proposes or whether its offer is simply one that is consistent with the percentage increase in wages offered by comparable employers and part of an internal pattern of settlement. The Arbitrator did not engage in an extensive analysis of the level of wage rates paid in Madison as contrasted to comparable school districts and wages paid for the variety of classifications represented in this bargaining unit as contrasted to the wage rates paid to such classifications by other public employers. The Arbitrator engages in the comparability analysis on wages to provide an answer to the key question concerning the payment of a *quid pro quo* in addressing the such other factors *status quo- quid pro quo* analysis in Part II of the Award.

Comparability

In 1993 interest arbitration between these parties the Madison School District and its SEE unit, Arbitrator Richard Tyson identified the comparability

pool of school districts to Madison, Decision No. 27611 (Tyson, 8/93). He identified the ten largest school districts in Wisconsin as the appropriate comparables to Madison.⁶ Arbitrator Tyson also recognized the role of the eight districts contiguous to Madison and used those as secondary comparables.

The Arbitrator looks to the ten largest districts as comparables to Madison for evaluating wage increases.

The District argues that the eight contiguous school districts to Madison should serve as the primary comparables on insurance:

The District asserts that these regional differences must be taken into account when comparing health insurance costs. District Exhibit 798 clearly demonstrates that the cost of health care premiums in Eau Claire are substantially higher than the cost of health care premiums in Madison. In order to assess whether the costing borne by the District are disproportionate to the comparables, one should look at the market in which the premiums are being purchased. If the regional purchase price for health insurance premiums is lower, as is the case in Dane County, this should correlate to a lower premium for the school districts in Dane County. Also, as was evidenced by District Exhibit 701 most of the employees are accessing services in the Dane County area (GHC's service area is Dane County and the majority of employees are enrolled in GHC). What a provider is providing in Eau Claire is of little importance to an employee receiving services at Meriter Hospital. For example, what a carrier such as United Health Care charges for a premium in the Eau Claire School District is irrelevant if such plan is not available in Dane County. Similarly, what Dean Care

⁶It is unclear from the Tyson award whether he included Madison in the list of ten. This Arbitrator, when calculating averages, excludes the subject of the comparison from the list of comparables. Some of the exhibits submitted by the parties include Madison. The Arbitrator looks at the nine largest school districts, when considering those exhibits.

charges is irrelevant to the Eau Claire School District if Eau Claire is outside of the Dean Care service area. [District original brief at page 107.]

The Employer confirmed its assertion concerning regional differences in the cost of health insurance in its Exhibits 721, 766, 768 and 770. Using the data from those exhibits that demonstrate the dollar cost expended by school districts contiguous to Madison on health insurance, the District argues:

When the cost to the District is used as the premium comparison, the District's family premium costs for the WPS PPO plan is nearly **46%** higher than any other district's premium costs in Dane County. In dollar terms, the WPS PPO plan's premium costs to the District is **\$533.60** more than the next highest cost borne by any district in Dane County. [District original brief at page 109.]

The Employer makes a telling point. Health insurance services are provided within a region. The cost of those services are regionally determined. Therefore, it follows that it is appropriate to take into account those regional differences. The study referenced in the District's argument, District Exhibit 798, is based on the relevant health insurance costs across regions and metropolitan areas of Wisconsin through an analysis of the 2008 rates paid by the State of Wisconsin's Group Health Insurance Plan. The State employs a three-tiered bidding process. As a result, the author of the study, Robert Kraig, Ph.D., asserts that:

As the tiered system creates a powerful incentive to make the lowest responsible bid, the rates that the State of Wisconsin was able to obtain through this annual process is a barometer of the private health insurance market in this region. In addition, as the program requires the uniform benefits package across all 22 participating health plans, it offers a rare opportunity to compare relative costs for the same

bundle of services.⁷ [Wisconsin Health Insurance Cost Rankings 2008, by Robert Kraig, Ph.D., published by Citizen Action of Wisconsin, 12/4/07 at page 5.]

The Arbitrator employs the traditional comparability analysis and looks to the wages and cost of wages and benefits and health insurance paid by the ten largest school districts to their clerical/technical employees. However, the Arbitrator looks as well to the amounts paid by the eight contiguous school districts to Madison for health insurance for their clerical employees. The Arbitrator considers the wage data in the section of the award headed *quid pro quo*.

The Health Insurance Proposals

As noted above, the District proposes the substitution of nine plans for the MTI-WPS GHC plan design. The parties presented extensive evidence on the plan design of the current health insurance plans, WPS PPO policy 1202 with the GHC (SCW) program and the features offered by the POS and GHC plan, the latter without the cost saving co-pays for office and emergency room visits.

The major features of the WPS PPO plan are as follows. It affords subscribers flexibility in choosing medical providers. The network is a statewide network that is highly inclusive of many providers, particularly in the Dane County service area. In many respects, it is similar to the WPS standard plan offered by the State of Wisconsin Group Health Insurance Program. The WPS plan in effect in Madison Schools has two very distinctive and important features to the Union and to those who subscribe to this plan. First, it is a negotiated plan between MTI and WPS. The carrier cannot unilaterally change benefits. MTI's Executive Director John Matthews sits on the Board of Directors

⁷It is this defined bundle of services that establishes the level of mental health services mandated by legislation. It affords an opportunity for a negotiated health insurance plan, such as the MPI-WPS PPO plan that the District attempts to eliminate through this arbitration proceeding, to provide an expanded mental benefit.

of WPS. As a result, the Union asserts that it has additional leverage in handling members' claims. The three HMO plans and the POS and PPO products that each of the three HMO/insurers offer under the District's final offer, may change on the unilateral initiative of the HMO/POS/PPO plan provider.

The Union notes that the Wisconsin legislature mandates minimum coverage for mental health or AODA treatment in all health insurance plans. The minimum mandate requires that a policy provide for \$7,000 of inpatient treatment, \$2,000 worth of outpatient services, and \$3,000 of transitional treatment that need not exceed \$7,000.

The Union notes that the District's expert witness and insurance consultant Clougherty testified that the carrier may stretch the mental health benefit by characterizing some treatments as medical before further treatment is covered under the mental health benefits. Such stretching is in contrast to the MTI-WPS plan that the District seeks to eliminate. It provides extremely generous coverage for psychiatric care both inpatient and outpatient, as follows:

Outpatient: 100% of first \$1,000 per policy year, subject to and in conjunction with the first 10-hour lifetime maximum benefit limit. 90% of the next \$1,000, then 75% of the remaining charges thereafter per policy year.

Inpatient: 100% of semi-private room and miscellaneous hospital expenses for 365 days per confinement less any state mandated benefit.

The MTI-WPS plan pays 75% of the remaining outpatient charges, after the \$2000 paid at 100% and 90% of mental health charges incurred for the balance of the policy year. The coverage of the balance of mental health outpatient charges incurred and paid at 75%-- is uncapped. In 2006, WPS paid 11 claims of SEE-MTI bargaining unit members, including one retiree and

for their dependents which together exceeded the state mandate by \$26,112. One claim exceeded the state mandate by \$12,218 in 2006. Where the Union sees this particular benefit as one that is important to protect, the District views it as a benefit that requires management and containment. From the District's perspective these claims impact premium rates.

The three main characteristics of the MTI-WPS plan that the Union attempts to preserve are the freedom of choice, the negotiated level of benefits that the carrier may not unilaterally change, and the generous mental health benefits afforded under the WPS plan.

The District proposes the three HMO, three POS, and three PPO plans to provide for managed care, no matter how employees choose to access the benefits afforded under their plan. The HMO model provides the most aggressive form of containment through a narrow network of providers. The POS plan affords employees greater flexibility in the form of a network that includes the particular provider's HMO network but other providers, as well that it treats as within network providers. It also affords subscribers access to out-of-network providers, but at additional cost through co-pays and deductibles.

The Arbitrator now turns to apply the comparability criteria to the insurance issue. The Arbitrator relies on Union Exhibit 603 and its Rebuttal Exhibits 701 and 702 which provides a weighted average comparison of premium paid by employers towards single coverage and family coverage for the 10 largest districts in the state.⁸ The Arbitrator finds that identifying the median cost of premium for single and family coverages provides a better basis

⁸As noted above, the data is not entirely complete for a weighted average comparison. The problem stems from the fact that like Madison, the comparable school districts offer several plans. A straight average of whatever the rates are for a particular plan does not accurately reflect the dollars expended by the district for health insurance for its employees. The better indicator would be the total budget outlay for health insurance. The premium contribution level by the Employer for single coverage and family coverage would then provide a parallel source that would explain the level of expenditure.

of comparison to the MTI WPS/GHC plan design and the plan designs afforded by comparable employers to their support personnel (Dx 765-767)

Looking at the 10 largest school districts excluding Madison, these employers offer a total of 14 plans. The range of premium for single coverage in 2007-08 is \$765.76 and \$362.92 , the median is \$554.92. For family coverage, the median is \$1,298.06. Then using the data in Union Exhibit 603, the weighted average paid for single coverage based on 13 employees taking WPS and 35 in Group Health that translates to \$462.32 which is second lowest only to the cost of premium for Milwaukee's UHC plan. Similarly, the cost for family coverage for 49 employees who take WPS and 94 who participate in the GHC HMO plans, the weighted average cost for family coverage is \$1,291.65 which is second only to Milwaukee's UHC plan. Again, the cost of premium to the District for the WPS plan is \$730.77 and the cost of the GHC single coverage is \$362.92. The total cost of premium for family coverage is \$1,916.51 and the GHC cost for family coverage is \$969.00. The cost for the WPS plan to the District is \$657.69 for single coverage and \$1,724.86 for family coverage.⁹ According to Union Rebuttal 702, taking the weighted average of the primary comparables only Sheboygan costs less than the weighted average paid in Madison.

The problem with the Union's weighted average is that it minimizes the impact of the more expensive WPS plan through the effect of extensive participation by SEE unit members in the GHC HMO. The July 1, 2007, cost of premium for single coverage under the WPS plan totals \$730.77. The Employer contributed \$657.69 towards that premium. The total cost of premium at the median was \$554.92 for single coverage. The difference between the cost of premium for single coverage in Madison under the WPS plan and the median is \$175.85. The total cost of premium under the WPS plan is \$1,916.51. The median cost for family coverage is \$1,298.06 and the difference between the cost of premium under the WPS plan and the median is \$618.45.

⁹These are the rates for Madison effective July 1, 2007. These rates go down in January 2008 when the office and ER co-pays go into effect.

Although the cost of premium for the WPS plan in Madison goes down effective January 1, 2008, its projected increase is 11.21% in July, 2008 which represents a higher increase than what is projected for GHC (8.5%), P Plus (9.5%) or Dean (9.9%). (Dx 727)

Both URx 701 and 702 and Dx 765 through 770 establish that the contiguous districts to Madison benefit from their Dane County location and the extent of market penetration of HMO participation. In this context the GHC HMO, the lowest premium cost among the contiguous school districts for single coverage is second only to McFarland in the premium cost that GHC, itself, charges in McFarland. However, the premium rates for WPS at \$730.77 is not the highest premium for single coverage. The WPS in the State Standard plan in the Monona Grove School District costs \$881.80 for single coverage and the Humana Eastern HMO carries a \$727.55 premium.

Only the Monona Grove State Standard plan for family coverage which carries the premium of \$2,201.25 per month exceeds the cost of premium in September 2007 for the WPS PPO plan. Sun Prairie and Verona offer Dean POS plans priced at \$541.50 for single coverage and \$1,212.96 for family coverage. What is most interesting concerning the District's series of exhibits 765 through 770 that detail the plans offered by contiguous school districts is the absence of a WPS plan, except for its counterpart as part of the State Standard plan that is offered in Monona Grove. All the other districts contiguous to Madison either offer HMO plans or POS plans.

Finally, the data indicates that the price of premiums for single and family coverage for the WPS PPO is so much more expensive than its less expensive alternative. There has been a steady migration of subscribers from the MTI-WPS PPO plan to the GHC HMO over the last several years. In 2000, 114 subscribers, 44.4% took WPS either single or family coverage. By 2006, that number fell to 62, 13 single and 49 family, 32.5% of those employees

taking health insurance with 67.5% electing to take GHC (Ux 401). The District argues that WPS plan is in a death spiral¹⁰ in the SEE unit.

The Arbitrator agrees with the Union argument that as a result of the participation of all MTI units in the WPS plan, particularly the Teachers, there is no possibility of a death spiral in the SEE unit in the near future. The migration of WPS subscribers to GHC under the plan design that represents the *status quo* in Madison suggests that employees in the SEE unit are voting with their feet.

The Union points to the impact that the Employer's plan design will have on the premium rates of the providers that the District proposes to substitute for the WPS plan. It bases its argument on Union Exhibits 409-410. The number of members with large claims are 1 taking single coverage under the GHC policy and 3.25 family. WPS has 1 participant with single coverage and 2.5 with family coverage. Union Exhibit 409 projects the impact of large claims on rates. The January 1, 2008 GHC single rate would decline from \$361.01 to \$343.65 net the large claim and its 5% adjustment for adjudication. The \$17.36 reduction in rate is the result of a large claim. The GHC family rate declines by \$56.41, of which \$53.72 is attributable to the large claim and the balance to the 5% adjustment for adjudicating the claim.

The impact of large claims in the case of WPS is more dramatic. The single member with large claims taking single coverage reduces the rate from \$713.75 by \$318.82 when the large claim and the 5% allocated for adjudicating the claim are deducted leaving a net rate of \$394.93. The impact on family coverage is even more dramatic. The \$1,871.89 rate declines by \$797.06 which includes \$759.11 attributable to a large claim plus its 5% adjustment bringing the net rate to \$1,074.83. The elimination of WPS coverage at the District will

¹⁰ A death spiral occurs when through adverse selection the costs to the insurer of providing coverage to employees with large claims exceeds the amount of premium the companies can realistically collect from others.

not eliminate large claims. The claims will follow the subscriber to the plans offered by the District (Union Exhibit 409).

In Union Exhibit 410, the Union projects the impact large claims has on rates in future years. It projects a rate change that after the first year of 13.1%. By the fifth year, the Union projects that the rate increase for the HMO would be 43.9% and for the PPO 56.1%. As noted above, the Arbitrator does not focus on the PPO rates but on the POS rates. Even with the assistance of expert testimony, this Arbitrator armed with the statutory criteria is a poor prognosticator of the future. The data of past and present experience provide the evidentiary basis for this Arbitrator's findings and conclusions.

Based on the above evidence, the Arbitrator concludes that the comparability criterion establishes that the cost of the WPS portion of the MTI/GHC plan design has increased at a rate to the point that unit employees are making the decision to switch coverage, if they are able to do so. This adverse experience has driven up costs to a point that it exceeds the level of premium paid by comparable employers at whatever percentage of the total premium that they pay for health insurance coverage for clerical/technical employees. This criterion supports the selection of the District offer.

Such Other Factors--*quid pro quo*

This Arbitrator discusses internal comparability and the *quid pro quo* analysis under this statutory criterion.

The evidence concerning internal comparability complicates the analysis. Union Rebuttal Exhibits 619A establishes a historical wage pattern of settlements for the SEE-MTI unit and the Custodial unit represented by AFSCME Local 60. From 1995-96 through 2007-08, including the contract in dispute in this case, with the exception of the 1996-97 and 1997-98 agreements, the two groups have settled wages at the exact same percentage. The Union argues that its offer of 2.5 and 2.9% over this two year agreement is identical to the wage settlement achieved with the Custodians over the same

contract term. The Union argument continues by noting that for 32 years, the parties have included the clerical employees, the SEE unit, as part and parcel of the three other MTI bargaining units, the teachers, the educational assistants for the purpose of establishing the level and substance of the insurance benefit. The Employer treated the Teacher unit as the unit that determined the health insurance plan and premium for all the MTI units. The Employer attempts through this final offer to terminate this bargaining history and remove the SEE unit from the MTI insurance design and premium plan to the plan negotiated by AFSCME and which the District offers to its administrators, as well. The Employer attempts an enormous change to the pattern of bargaining.

The District argues that the Custodians obtained wage increases of 2.5% in the 2006-07 first year of their two-year agreement and 2.9% in the second year, the 2007-08 school year, by accepting the change of insurance from a policy parallel to the WPS PPO called the Alliance to the substitution of two additional HMOs to GHC for the Alliance plan. The District settled the Custodial agreement without offering POS plans as part of its plan design. The District only added POS options in response to the negotiations between MTI-SEE unit and the District.

The District argument continues. It notes that the Teachers settled with a wage increase at 1% per cell as contrasted to the 2.5 and 2.9% per cell offer the Union makes in this case.

Has the Employer Proposed a *Quid Pro Quo* for the Change it Proposes to the Health Insurance Plan Design?

This question is the product of this Arbitrator's reliance on the *status quo, quid pro quo* analytical framework that he has followed for many years. The paradigm is quite simple. Is there a need for change? Has the party proposing change provided a *quid pro quo* for that change? Has the party

proposing the change established by clear and convincing evidence both a need for the change and that it offers a *quid pro quo* for that change?¹¹

The Union argues that the Employer has not demonstrated a need for change to the insurance plan design extant at Madison. It does not offer a *quid pro quo* for any such change. Certainly, the Employer has failed to establish either prong of the *quid pro quo* analysis by a clear preponderance of the evidence. The Union argues that the Arbitrator should apply the test accepted by most other arbitrators. Whether the proposal made by the party seeking the change actually accomplishes the change proposed. The Union maintains that the mere mention of health insurance should not automatically suggest that a problem exists.

Union Exhibit 501 tracks the contract modifications that the Union and the Employer have made to the health insurance plan design to moderate the increase cost of health insurance premiums. In 1976, the parties added the GHC HMO option. They agreed to employee cost sharing 10% of premium reducing the Employer's contribution from 95 to 90%. In 1990 and 1992 they agreed to the introduction of prepaid deductibles in the former and increased deductibles and prescription drug co-pays in the latter. In 2000, they agreed to an ASO (Administrative Services Only) self-insured health insurance plan as a cost savings. The District, however, elected not to proceed with the ASO plan and continued the indemnity plan with WPS. In 2003, the parties agreed to provide the WPS Preferred Provider network and increase employee cost sharing for those subscribers who elect to receive services outside of the large network agreed to. In addition to the plan changes made in 2003, the parties agreed to changes in 2004 and 2005 to contain or slow the rate of increase of premiums. In 2007, the parties agreed to office and emergency room co-pays, effective January 1, 2008 that resulted in a reduction in premium for the WPS plan and for the GHC HMO. The parties would not make changes as they have,

¹¹Middleton-Cross Plains School District, Decision No. 32021-A (Malamud, 10/07) at pages 27-30 and Monroe County (Sheriffs Dept.), Decision No. 31363-A (Malamud, 12/05); D.C. Everest School District, 24678-A (Malamud 2/88).

particularly since 2000, if the increase in the cost of health insurance premiums were not a problem. The projected increases in health insurance premiums take effect in July 2008, 8.5% for the GHC HMO, 10.5% for the GHC POS, 9.5% for the P Plus HMO, and 9.9% for the DeanCare HMO and 11.21% for WPS when salary increases in the Madison School District range between 1 and 2.9% for Teachers and the SEE unit, and where the cost of health insurance constitutes a greater percentage of the wage and benefits package. Furthermore, when the cost of premiums for family coverage over a year is equal to between one-third to one-half the earnings of a grade 1-6 clerical employee, even of this Employer, it suggests that health insurance is a problem.

The Union suggests that the Arbitrator determine whether the District's proposal will actually slow the rate of increase or reverse it. The Arbitrator has been reluctant to fully embrace that as an additional factor for the *quid pro quo* analysis, because it involves future predictions. In some cases, the prognostication is limited and the evidence is clear. In those cases, the Arbitrator examines the proposal to ascertain if it will do what the proposer claims. For the most part, the Arbitrator focuses on the question at issue. In this case, the question: has the District offered a *quid pro quo* or has it offered wage increases consistent with those paid by comparable school district employers to their clerical/technical employees?

The Union argues that the District proposed change suggests that the plan design is flawed. The Union argues if the plan design were flawed the District would have insisted on changing that plan design for the teacher unit and thereby changing it for all of the MTI represented bargaining units. This point suggests that a flaw in the *status quo* plan design is not the gravamen of this dispute. Nonetheless, the *status quo* plan design, particularly the WPS segment of the plan costs increase at a pace that has made the total plan expenditure expensive. The WPS plan is so expensive that in this unit of clerical employees the migration from WPS to an alternative is both steady and ongoing. From the District's perspective, it attempts to achieve greater managed care through the introduction of its additional HMOs to provide

greater choice to employees through Point of Service plans to allow employees access to out-of-network providers.

In this regard, the Union points to the additional out-of-pocket costs that employees electing WPS coverage would pay to obtain POS coverage should WPS be eliminated as an option through this interest arbitration proceeding. Union Exhibit 700 documents the increased out-of-pocket costs just for mental health claims in excess of the state mandate. In one case an employee's child had claims in the amount of \$12,218 in excess of the state mandate which the employee would have had to pay but for the WPS plan. The other 10 subscribers with claims in excess of the state mandate ranged from \$4,717 to \$333.

Furthermore, under the District's plan, there is cost shifting for those employees who elect a POS plan rather than participate in one of the three HMOs offered. The Arbitrator notes that the employee selecting the Dean POS plan single coverage pay \$19.45 per month more than they pay towards premium for single coverage under the WPS plan. The employee choosing the Dean POS plan for family coverage pays \$52.31 above the employee contribution levels for WPS coverage. Similarly, the Physicians Plus POS plan contribution exceeds the employee contribution level for WPS for single coverage by \$7.26 and for family coverage by \$31.72.

The Employer's health insurance costs decrease substantially from \$194,144 under the *status quo* and at the rates effective January 1, 2008, to \$167,144 assuming all those employees who elect WPS coverage choose to go to the Dean HMO and those employees in the GHC HMO continue with that coverage. Should employees elect to go to the Dean POS plan, the Employer's monthly costs for health insurance would decrease by 13.35% or \$25,911.¹² Assuming that SEE employees who take WPS coverage, 13 single and the 49 family plans, all elect the most expensive of the POS plans offered by Dean, the Employer's monthly health insurance costs would be reduced from \$194,144 to

¹²Dean is the most expensive of the three POS plans offered (UX 302).

\$167,144. It would save \$27,000 per month. Of that \$27,000, \$2,816 of that is the product of cost shifting.¹³

Part of the savings is the result of the differential between the discounts that an HMO backed POS plan charges WPS for patients who access their providers as compared to what the particular health plan charges for subscribers of their POS plan accessing their providers. In other words, Dean accords a greater discount to a subscriber in its POS plan accessing one of its providers, than it would provide to WPS for one of its subscribers accessing the same Dean provider.

The above discussion demonstrates that the Employer's proposal reduces the Employer's costs for providing health insurance coverage to its employees while maintaining choice, although a more limited choice than afforded by the WPS plan. The cost shifting increases the employees contribution by approximately 3 to 5% to 13 to 15% rather than the 10% share of premium cost that has been in effect for 25 years. The Arbitrator concludes, therefore, that the Employer has established the need to increase additional managed care to its health insurance plan design to effectively slow the rate of premium increases.

The more difficult question is whether the Employer offers a *quid pro quo* for this change. At the time that the evidentiary record in this matter was closed, four of the nine comparable districts listed in Ux 800 settled for 2007-08. The Arbitrator finds that it is insufficient data from which the Arbitrator may draw any inferences. According to Dx 606, the average wage increase in the 2006-07 school year for the ten comparable school districts was 2.79%.¹⁴ The Employer offered and the Union accepted 2.5% per cell in the first year, 2006-07 school year. The comparability data does not support a conclusion

¹³The Dean premium exceeds that contributed by employees to obtain WPS coverage by \$19.45 for the single plan and \$52.31 for the family plan per month.

¹⁴Both Racine and Sheboygan appear to eliminate the steps at the bottom of the schedule in order to increase the starting wage. As a result, the rates at 24 months and the maximum with longevity increased across the group on the average of 2.79%.

that the Employer's offer represents anything other than an increase in wages slightly below the average offered by comparable districts in the first year of this agreement.

The Union in URx 601A through G presents data that corrects the Employer's delineation of the wage rates paid at the various grades to clerical and technical employees employed by the District. In response to those rebuttal exhibits, the Employer corrected its exhibits. The first six grades, one through six, are grades in which the District's clerical employees are placed. Grades seven through eleven are the grades to which the District allocates its technical classifications. For purposes of comparison, the Arbitrator focuses on the first six grades to which clerical employees are allocated. Furthermore, the Employer in Exhibit Dx 603-605 ranks the various ranges of the primary and secondary comparables as compared to the wage rates paid at the various grades in Madison. For school year 2006-07, the District ranked the Madison pay grades one through eleven and contrasts those to the classifications allocated to those various grades and compared to wage rates paid by the 18 primary and secondary comparable school districts. Madison ranks between first and third for grades one through five at the hire rate. However, at the maximum with longevity, Madison ranks first or third when compared to the rates paid by comparable employers for employees in classifications similar to those allocated to grades one through six in Madison. Of the 18 primary and secondary comparable school districts settled for the 2007-08 school year, which are Appleton, Green Bay, Janesville and Sheboygan among the largest ten and Monona Grove, Verona, Sun Prairie, and McFarland. The Employer includes Waunakee in these series of exhibits (Dx 615-17), Madison ranks number one or number two at the top of the range including longevity for grades one through six.

Madison is a wage leader in the amount it pays its clerical employees. The District emphasizes that it increased and reached agreement with the teachers at a 1% per cell increase. It argues, therefore, that its offer of 2.5% in the first year and 2.9% in the second year represents a *quid pro quo* for its proposed health insurance changes.

The District settled one of its bargaining units at the exact same percent increase as it offered the clerical employees. Exhibit UR 619A establishes the pattern of settlements between the clerical employees and Custodians. The 1% per cell increase for teachers generates an approximately 4% increase in light of the step and lane movement. Although the per cell increase for teachers suggests that the 2.5 and 2.9% increases for the clerical employees does represent a *quid pro quo*, that evidence is not clear and convincing in light of the settlement reached with the Custodians and when compared to the settlements among the comparables, particularly the ten largest school districts for the 2006-07 school year. Accordingly, the Arbitrator concludes that the *quid pro quo* analytical paradigm does not justify the proposed change proffered by the Employer in its final offer.

At pages 119 through 126 of its original brief, the District addresses the *quid pro quo* issue. The District suggests that arbitrators do not always require a *quid pro quo* for change, particularly if other comparable employers have achieved what the proposer of change puts forth without a *quid pro quo*, City of Beaver Dam (Police Department), Decision No. 31704-A (McAlpin, 7/07). In City of Marinette, Decision No. 30872-A (Petrie, 11/04) the Arbitrator opines that it is not always necessary to provide a *quid pro quo* in a situation in which an employer faces rapidly increasing health insurance costs.

This Arbitrator employs the *quid pro quo* analytical framework to inject some real life bargaining experience in a process that tends to create its own reality. If there is ever a case that demonstrates that the interest arbitration process through its application of statutory criteria does not result in an outcome often described as “what the parties should have reached” this is that case. In this case, the Arbitrator contends with an employer proposal to change health insurance of a small unit while the insurance plan for the largest unit continues in force with agreed to minor changes. This dispute concerns the health insurance benefit for the tail rather than the dog. The Arbitrator applies the statutory standards, with the understanding that the Employer attempts to have the tail wag the dog.

The *quid pro quo* analytical framework injects a touch of reality to the process. This Arbitrator believes that is what the legislature intended by including factor (j) that provides for consideration of matters that are “normally and traditionally taken into consideration in the determination of wages, hours and conditions of employment through collective bargaining . . . in public service or in private employment.” The reality injected by *quid pro quo* stems from the observation that rarely do groups of employees and employers do something for nothing.

In the above analysis, it is unclear whether the Employer’s wage proposal serves as a *quid pro quo* for its proposed health insurance change. The District argues that the plan design change in and of itself generates a savings to employees that constitutes a *quid pro quo* for the change. The District reminds the Arbitrator of his award in Monroe County (Sheriffs Department), Decision No. 31363-A (Malamud, 12/05). This Arbitrator stated:

The Arbitrator has for many years strictly followed the *quid pro quo* paradigm in the application of a statutory criteria in determining interest arbitration disputes. This approach stems from this Arbitrator’s experience that in most situations there has to be a reason for change. In order to obtain change, one must make it worthwhile for the other party to agree.

The cost of health insurance has skyrocketed at such a pace and consumes so many employer dollars allocated towards increases in employee wages and benefits that with rare exceptions, health insurance is everyone’s problem, certainly both Employer and Union. Health insurance is no longer the benign benefit that may increase total package costs by half a percent. Unfortunately, those days are long gone. In an era of annual increases of between 10 and 20%, employers and unions must work together to attempt to identify strategy to slow the pace of the increase. **A formal *quid pro quo* may not be necessary to address the increase in health insurance costs.**

However proposals to deal with health insurance plan design and costs cannot be considered or evaluated in isolation. Proposals on plan design or contribution level must be considered together with the wage proposal. (Emphasis provided in the District's brief.)¹⁵

The District points to another element that should be taken into account in this *quid pro quo* analysis. It cites the decision of Arbitrator Bielarczyk in City of Chilton, Decision No. 31470-A (Bielarczyk, 4/06) who observed that all employees may not be affected by the proposed change and that should be taken into account when determining the adequacy of the *quid pro quo* and in some respects, the need for one. The District continues its argument:

Accordingly, the District asserts that there should be a reduced *quid pro quo* burden on an employer whose proposed change(s) will not affect all the employees in a bargaining unit. In this case, the employer has provided a *quid pro quo* to all employees even though only one-third of the employees will be affected by the change, i.e. the majority of the unit is already in the GHC HMO and will receive an additional wage increase in 2007-2008 even though they will not be required to change their insurance. . . .The District also believes that even within the one-third of employees who are affected by the change, a significant number of them will opt for one of the HMOs and will thereby receive a resulting increase in salary compensation. In addition, because these employees will no longer have the deductibles associated with the WPS plan, they will have additional disposable income due to the change.

Undoubtedly, the Employer is correct to assume that some of the 62 employees who take WPS coverage will elect one of the HMOs for which the Employer pays the full premium. However, for employees taking the Dean or

¹⁵The District notes that this Arbitrator failed to identify two of the three prongs of the analytical paradigm, both in Monroe County and in a recent award at Middleton-Cross Plains School District, Decision No. 32021-A (Malamud, 10/07).

Physicians Plus POS plan, there is an increase in the dollar contribution towards premium that the employee will have to make in order to be able to participate in the greater choice afforded by a Point of Service plan. In addition, should the employee select a provider that is out of network, the employee will incur deductibles and co-pays in addition to the increase in premium. For those employees who are able to select a provider or a range of providers all within one of the three HMOs, clearly they will achieve a net savings and an increase in net income as a result of the Employer's payment of the full cost of premium and from the elimination of deductibles and co-pays as part of participation in an HMO plan.

The premium for the GHC POS plan falls below what the Employer contributes to offset the premium cost of the most expensive HMO, Dean. The GHC POS would be available at not cost to the employee.

The District's plan design does encourage migration to an HMO plan, and it provides a selection of HMOs whose providers comprise most of the medical providers in the Dane County service area. The Arbitrator agrees with the District that the internal plan design does provide, in and of itself, a *quid pro quo* to the employees who would be confronted with the change from the WPS plan to an alternative. However, they would have to elect either the GHC POS plan or an HMO to obtain the benefit of insurance at no cost to the employee with the Employer paying the full premium.

Taking into account the Employer's arguments concerning the *quid pro quo* analysis including its argument that the plan it proposes generates a *quid pro quo*, the Arbitrator concludes that it has not established that it offers a *quid pro quo* by clear and convincing evidence. The Arbitrator concludes that this criterion supports the selection of the Union's offer.

Criterion Changes in the Foregoing

The Employer, attached what it marked as Exhibit 711C to its Reply brief. By letter dated February 29, the Union objected to the inclusion of this exhibit

in the Employer's reply brief. The Employer responded by an e-mail dated March 11 and then added information concerning the updated insurance renewal rates on March 13. The Union responded by e-mail on March 18 and supplemented its objection by letter dated March 21. On March 26, the Arbitrator ruled on the District's attempt to include Exhibit 711-C in the record and on the presentation of additional facts in the parties email arguments.

In his Ruling on March 26, the Arbitrator offered the parties the opportunity to supplement the record under the criterion, Changes in the foregoing provided that the evidence that they intended to submit may substantively impact the outcome of the case. The Arbitrator suggested that evidence that was merely supportive or amplified other evidence already in the record would not be admitted under the Changes criterion. The Arbitrator cited the decision of the Wisconsin Supreme Court in City of Manitowoc (Police Dept.), 91 LRRM 2890 (12/75). Although the parties were afforded the opportunity to present evidence that met this test, they elected not to do so. Accordingly, the record in the matter was closed effective March 31, 2008. This criterion does not distinguish between the parties' offers.

SELECTION OF THE FINAL OFFER

The Arbitrator concluded that the Greatest Weight criterion supports the selection of the District offer. However, the Greater Weight criterion offsets some but not all of the importance of the Greatest criterion in the determination of this case. The Employer is subject to cost controls. It cannot exceed its revenue cap. This factor is not aggravated by the state of the local economy. On the contrary, Madison has fared much better on many economic indicators than the rest of the State. It is in the context of considering these factors that the Arbitrator considered the factor, the interests and welfare of the public.

The Employer attempts to change a 30-year pattern of bargaining. The pattern complicates the resolution of this case. When insurance was treated independently and determined by settlements in the Teacher unit, the parties

resolved insurance independent of the wage issue. Insurance was resolved in the Teacher bargain and applied to the SEE unit. Wages were settled according to a pattern of settlement in which the SEE-MTI unit settled at the same wage percentage increase as the Custodial unit represented by AFSCME Local 60.

The Arbitrator is concerned that since the Employer attempts to have the tail wag the dog that the always prevalent law of unintended consequences will have a greater impact in this case. However, that Arbitral concern has no concrete statutory reference.

The Employer proposal to eliminate WPS-MTI plan causes a hardship on those employees who need this coverage. The Employer's proposal includes a number of plans from three providers that have almost total market dominance in the Madison service area. However, it is not certain that everyone will be able to select a plan that will meet all of their needs.

Turning from the Arbitrator's general concerns to the statutory criteria, the above analysis yields the following. The Arbitrator applied the comparability criterion to the insurance issue. It supports the selection of the Employer offer. The cost of the WPS plan exceeds the amount paid by comparable school districts. The move to the Employer's offer will eliminate a unique and generous mental health benefit. However, the evidence of the migration of SEE employees to the GHC HMO is the single piece of evidence that swayed this Arbitrator to conclude that this criterion supports the selection of the Employer offer. This evidence suggests that this unit differs from the Teacher unit. The bigger and dominant bargaining unit still has just under 50% of the unit who select WPS for their insurance coverage. Here, a third of the employees take WPS. The trend is declining with fewer SEE employees electing WPS after each open enrollment period.

The Arbitrator gives little weight to the cost of living criterion. It supports the selection of the District offer.

The parties both propose the same wage increase. The Arbitrator engages the comparability analysis on wages for the sole purpose of determining if the Employer offer contains a *quid pro quo* for its proposal to change the *status quo*. The Arbitrator concluded that the Employer demonstrated by clear and convincing evidence the need for a change, but it failed to establish by that standard that it offers a *quid pro quo* for the change. The Employer did demonstrate that employees could increase their net income under the Employer's plan design by selecting an HMO or the GHC POS plan. In the end, the Arbitrator concludes that this analytical paradigm does not support selection of the Employer's offer.

Summary

The Arbitrator concludes that the Greatest Weight/Greater Weight and the Interests and Welfare of the Public support the selection of the District's offer. The cost of living criterion supports the selection of the District's offer. The Comparability criterion supports the selection of the District's offer. The Such other factor criterion supports the selection of the Union offer. The application of the statutory criteria support the selection fo the District offer for inclusion in the successor 2006-07 and 2007-08 Agreement.

The Arbitrator issues the following:

AWARD

Based on the application of the statutory criteria to the matter in dispute, the Arbitrator selects the District offer, together with the stipulations of the parties, for inclusion in the 2006-07 and 2007-08 agreement.

Dated at Madison, Wisconsin, this 8th day of June, 2008.

Sherwood Malamud, Arbitrator