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STATE OF MICHIGAN

DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH

EMPLOYMENT RELATIONS COMMISSION

In the Matter of Fact Finding

Ingham County Road Commission,

Employer,

-and- MERC Case No. L07 J4007

AFSCME Council 25,

Union.

FACT FINDING REPORT

STATEMENT OF THE CASE

AFSCME Council 25 (Union), filed a petition for Fact Finding on July 28, 2008. The On February 4, 2009, MERC appointed Kenneth P. Frankland pursuant to Act 176 of 1939 as Fact Finder. A pre-hearing conference was held on March 18, 2009 and the parties resolved many issues and agreed to continue settlement discussions leading up to a scheduled May 15 hearing on the merits of remaining issues. The Employer made a written Last Best Offer dated April 27, 2009 and the Union presented a package proposal dated May 15, 2009. Based upon the possibility of settlement from these documents, the hearing was postponed indefinitely.

The discussion continued and a draft agreement was prepared on July 16, 2009 (U-Tab B) Prior to ratification by both parties, the Employer received a letter dated July 30, 2009 from MERS Premier Health stating that effective January 31, 2010, it would discontinue group health coverage. This announcement made Article 13, Section 9(a), HEALTH INSURANCE of the tentative agreement inoperative. The parties negotiated a substitute Health Insurance paragraph without

success necessitating a hearing on the one issue on November 3, 2009 at the Road Commission offices in Mason, Michigan.

Numerous exhibits were introduced and testimony was taken. Other than Exhibits F and H all Union exhibits in its binder were accepted. There was no objection to all the Employer exhibits. Briefs were filed on November 13, 2009. The parties have agreed to incorporate all prior tentative agreements into a new agreement.

BACKGROUND INFORMATION

Before going into the merits of the one issue, a few prefatory comments are in order. Fact Finding is a process to present the facts to a neutral third party, along with the respective positions of the parties and thereafter a report is generated by the fact finder with recommendations to resolve the disputes and develop a new collective bargaining agreement. By bringing the issues to public scrutiny with public discussion, it is thought as a way to reach an accord.

Similar to mandatory police and fire arbitration, each party designates communities it believes to be comparable and uses data from those alleged comparable communities to support its position. More often than not, the communities that are selected will have provisions in existing collective bargaining agreements that mirror or at least support the position that the party is taking in this proceeding.

The Union has offered Eaton, Clinton and Livingston County Road Commissions as comparabe being three contiguous counties to Ingham. No other information was provided why they are comparable.

The Employer offered Livingston, as did the Union, as well as Berrien, Jackson, Kalamazoo, Saginaw and St Clair. The Employer used Michigan Transportation Fund (MTF) revenues as its basis for comparablity. (E-20, 21) Of these, Kalamazoo and Saginaw receive

more money than Ingham and all others about 80% less. The Union comparables of Clinton and Eaton receive 47% and 59% respectively less than Ingham. (E-21)

Comparability is not a major factor in this case since we have but one issue. The Union also points out, correctly, that the sole issue is really which proposal will be more cost effective and thus comparability is not as significant. Since Livingston is suggested by both parties it would be accepted. While I normally would have some problems with using just revenue or just contiguity as the qualifying factor rather than other factors such as primary and secondary road mileage, or personnel in the unit, I can accept all the suggested communities in this case given the limited subject matter involved and eight entities would not be unmanageable. While Eaton and Clinton receive significantly less money they are contiguous and would compete with Ingham in the same market for workers and supplies. While Berrien and Saginaw are somewhat distant, for this case that does not by itself disqualify them.

ARTICLE 13, SECTION 9(a) PROPOSALS

In Article 13, the tentative agreement calls for the Employer to pay for the full premium for single, 2 person and full family health coverages subject to employee cost sharing of 2% effective January 1, 2008; 3% effective January 1, 2009. This is a two year contract that will expire December 31, 2009.

The parties have the same proposal for Dental and Vision in Sections 9(b) and 9(c).

The dispute is Section 9(a).

The Union proposal is

> **HEALTH INSURANCE: Beginning December 31, 2009, the plan will be BCBS CB15,wrapped (self-insured) to CB1 benefit levels through MEBS. Employee benefits will be OVS10; MT100%/OCM-24; ET$50; PCM$500;**

MH100%. Rx co-pays $10/$20. The Employer shall pay the premiums for each regular full-time employee and his/her dependents effective the first day of the month following employment.

The Employer proposal is

Health Insurance change to the PHP Plan 3, effective December 31, 2009. However, if the employee desires, he/she can select Plan 1 or Plan 2, provided the employee pays the difference in premium cost between the selected plan and Plan 3 through payroll deduction.

If the PHP Plan 3 is not implemented on or before December 31, 2009, any cost above the below monthly insurance premium rates shall be paid by the employee by payroll deduction and, if necessary, subtracted from any retro pay for 2008 and 2009.

Single	**$511.69**
2 Person	**$1,151.31**
Full Family	**$1,381.57**

The health insurance program shall be effective from December 31, 2009, through December 31, 2010. Thereafter, the health insurance program is subject to negotiations and, in the interim, prior to an Agreement being reached by the parties, the health insurance program shall be the same as non-union employees receive.

DISCUSSION OF ISSUE

The Employer through E-11 states the cost for all medical expenses (Medical, Rx, Dental and Vision) for all employees in 2006 was $1,054,313; for 2007 $1,299,572; for 2008 $1,548,767. Employees did contribute 1% of the premium cost in 2007 and the tentative

agreement calls for 2% in 2008 and 3% in 2009. This will obviously reduce the Employer cost and the Union members are commended for this effort. The fact remains that health care costs are a significant item in the annual budget. The Union argues its proposal is more cost effective and the Employer counters that the Union MEBS plan is too risky; that the Employer must self-fund claims and if utilization is greater than projected, any potential cost saving disappears.

HISTORY OF SECTION 9(a) NEGOTIATIONS

The Section 9(a) health concern is fairly recent. Starting in February 2008 (E-8) and again in May 2008 (E-9), the Employer proposed the MERS Premier Health Medical Plan 6 and Prescription Drug Plan 3 instead of the option in the current contract. The Union consistently asked for continuation of existing language namely the option of PHP Plus or MERS Premier Health Plan. Other issues dragged on the negotiations through 2008 and into 2009 and the parties were working on a global settlement when the pre-hearing was held and thereafter. As to Section 9(a), as of June 2009, the Union agreed to the Employer carrier and plan and at that time also agreed to the premium cost sharing.

Unfortunately, the July 30, 2009 letter from MERS set the parties back to square one. On August 3, 2009 the Employer proposed the MERS plan through December 31, 2009 with negotiations for a successor and in the interim, in absence of agreement, the same benefits as non-union employees receive. (E-10) This was not acceptable to the Union and on August 11, 2009 the Union sent a PERA request for insurance quote information to the Employer. It noted the information would go to Associated Mutual and MEBS for quotes. (U. Tab D). MEBS made a proposal to the Union on October 22 (U. Tab F) and Mr. Martin Stemen, risk manager for MEBS testified and explained the Union proposal at our hearing.

The Employer opted to return to PHP and formulated the proposal set forth above. This plan has been substituted for the MERS plan for the SEIU and OPEIU units who each had

agreed to the MERS plan when the contracts were renewed; OPEIU in June 2008 (U. Tab U) and SEIU in May 2009 (U. Tab V). This plan is also being implemented for non-union employees. (E-24;25)

SECTION 9(a) ARGUMENTS

The Union makes two arguments. The first is that PHP is proposed to be purchased by Blue Care Network and the purchase is subject to state regulatory consent and the purchaser has not identified how existing PHP insureds would be treated. Being on unstable ground and with the possibility of shifting employees to a new insurer in mid-stream, PHP is very risky.

On the merits, Union argues that the MEBS plan will cost less and thus should be accepted. E-14 shows 20 family policies, 11 two person and 6 single with 17 employees taking the cash buy out. Per E-13, the total cost of PHP for these employees would be $520,391 and $95,490 for the cash outs or a total of $615,881. In contrast, the Union argues that per U. Tab J. at 29% utilization the MEBS plan would cost $491,331 and the same cash out for a total of $585,822 a savings of $29,059. At 36% utilization, the total cost is $610,957, still a $4,924 saving.

Mr. Stemen explained that MEBS purchases the Blues Community 15 plan from Blue Cross and then offers a package to the Employer to "wrap" the benefits to a C-1 plan under a high deductible and the plan pays 80/20. The Employer assumes the cost of claims including the entire amount of deductibles and co-insurance attributable to the "wrap" portion of the plan. Additionally, there is a one-time start up cost of $1,667 and $810 monthly administrative fee or $9720 annually. U. Tab G was based upon the claims experience from 10/1/07 to 9/30/08 for all employees not just bargaining unit members. The total self-funded cost per TAB J. is based upon an assumed utilization of 29% or 36% of all active employees that Mr. Steman characterized as medium and high usage based upon his review of one year of claims.

The Employer notes that none of the comparables, even those proposed by the Union,

has a MEBS plan. They argue the Employer comparables offer essentially the same kind of benefits offered here and more importantly that the majority of those counties have employees contributions to premiums greater than the current 1% and the agreed 2% and 3% for 2008 and 2009 thus saving those counties money.

The Employer argues the Commission is operating on less revenues and higher cost for all materials and supplies. This necessitates as much cost savings as possible from items such as health insurance.

It further argues that PHP is a fixed premium and the Employer knows what the cost will be. In contrast, the MEBS plan is highly speculative and the Union projections of cost are flawed by use of all Commission employees for prior claims experience and by excluding 10 high claimants without knowing if they are in or out of this unit. Ms Barnhart testified that based upon her seven years of service as the Benefits Coordination for the Commission that the Union estimates of utilization were very low. She also said that GASB requires the Commission book as a liability 100% of the possible cost under the MEBS plan.

RECOMMENDATION

I have listened to all the testimony, reviewed all the exhibits and carefully analyzed the briefs in this matter. I conclude that the Employer proposal, with a sight modification, should be adopted by the parties for the following reasons.

One of the most significant factors here is the absence of any other MEBS plan in any of the comparables so that we might have a benchmark upon which to compare MEBS assumptions. Indeed, if MEBS is accepted, the parties would be entering uncharted waters.

Looking at the MEBS proposal, I am struck by the fact that the projected savings are based upon assumptions that appear optimistic at best. First, only one year of claims experience was used, 10/1/07 - 9/30/08. Perhaps that was all that was made available by the

Employer or there may be another explanation.

Second, all employees including those in other units and the non-union personnel were used. It would be more useful in my opinion to know the utilization history of this unit as that is what we are dealing with here, not all employees.

Third, 10 high claimants were identified and the gross amount of those claims were subtracted from the gross claims paid to start the self-funded wrap claims analysis. (U. Tab G.) With other subtractions, the total expected deductible liability (less high claimants) was $165,113. With capped $5,000 per high claimant added back in and services not applied to deductibles of $46, 590 added in the total expected self-funded liability is estimated at $261,703 or about $3,000 per employee using all Commission employees. Again, these number were extrapolated from the claims review of what Tab G says are "average non-medicare enrollees - 89", far more than in this unit. We also have no way of knowing if the services not applied to underlying BCBSM deductible (Tab G) would be high, low or just right for this unit. Ms Barnhart did testify that she thought the utilization in this unit would be much higher than projected by this exhibit and thus the assumptions would be flawed.

The Employer argument that it would assume all the risk if any of the assumptions proved unrealistic is well taken. While I don't agree with the maximum exposure stated in its Brief, if any assumptions are awry the alleged savings disappear.

The Union Brief, at page 6, apparently recognizes the all-employee anomaly and uses only the unit employees in E-14. Then using E-13 for PHP rates it calculates the cost as $615, 881. Using the 29% utilization rate for MEBS and the same number of covered employees they claim a savings of $29,059 and using 36% a savings of just $4,924. I question the validity of the claimed savings for the reasons above, and if any assumptions are askew, then these alleged savings disappear. In this regard, the testimony of Ms Barnhart that utilization rates are understated seems very relevant and her seven years history with the Commission and

observation of what actually is occurring within the unit is given significant credibility.

I am also struck by the argument that other internal unions will not have the MEBS plan but rather the PHP plan as will the non-union employees. Usually, governmental units strive for consistency among unionized units so the benefits of one are not greater or less than their fellow workers. By accepting the PHP plan the symmetry would be maintained among all employees.

Finally, the PHP quote is for one year, Apparently, they require 50% of all employees to be enrolled per Ms Barnhart's unchallenged testimony. If this is so, then placing this unit in a MEBS plans would seem to disqualify the Employer from the PHP plan.

There is something to be said for certainty in health care cost. Even if the paper cost of the PHP plan might be somewhat higher, when balanced against the potential entire self-funded risk, the better choice is to opt for stability and certainty.

I am troubled to some degree by the Employer position that if no agreement is reached for a successor plan after December 31, 2010 then the non-union plan then in effect would be applied to this unit. If the non-union plan at that time was less beneficial, created new deductibles or co-pays or imposed greater employee contributions, then this unit would not be achieving similar benefits to what they had and this would be imposed irrespective of what happened in bargaining. This would be an undesirable result. While the Employer could say this wouldn't happen as the Union has been the intransigent bargainer not the Employer up to now, why take the risk. Better to have compromising language to forego that possibility. Thus, I would **RECOMMEND** adopting the continuation conecpt of the OPEIU contract (U. Tab U, p. 40). I suggest, "CONTINUE COMPARABLE COVERAGE TO WHAT IS IN EXISTENCE ON DECEMBER 31, 2010 UNTIL A SUCCESSOR SECTION 9(a) IS NEGOTIATED.

Thus, my RECOMMENDATION for Section 9(a) is

Health Insurance change to the PHP Plan 3, effective December 31, 2009. However, if the employee desires, he/she can select Plan 1 or Plan 2, provided the employee pays the difference in premium cost between the selected plan and Plan 3 through payroll deduction.
If the PHP Plan 3 is not implemented on or before December 31, 2009, any cost above the below monthly insurance premium rates shall be paid by the employee by payroll deduction and, if necessary, subtracted from any retro pay for 2008 and 2009.

Single	**$511.69**
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The health insurance program shall be effective from December 31, 2009, through December 31, 2010. Thereafter, the health insurance program is subject to negotiations and, in the interim, prior to an Agreement being reached by the parties, CONTINUE COMPARABLE COVERAGE TO WHAT IS IN EXISTENCE ON DECEMBER 31, 2010 UNTIL A SUCCESSOR SECTION 9(a) IS NEGOTIATED.

CONCLUSION

I wish to acknowledge the effort of the parties as they produced significant material for their exhibit. The Briefs were very helpful to assist in understanding the issue. Needless to say fact finding is an imperfect science. The recommendation may not make a party happy but that is the very nature of the process. However, it is hoped the comments and recommendation will be of benefit to the parties and that they will be able to reach an accommodation and quickly develop a new Section 9(a). At least it may give the parties food for thought and the ability to alter their positions and reach an accord.

Respectfully submitted

Kenneth P. Frankland
Fact Finder

November 18, 2009