STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC GROWTH
EMPLOYMENT RELATIONS COMMISSION
FACT FINDING

CITY OF DETROIT,
Employer

And

MERC CASE NO. D 06-K-1948
Thomas W. Brookover, Fact Finder

ASSOCIATION OF PROFESSIONAL AND TECHNICAL EMPLOYEES (APTE),
Union

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FACT FINDERS REPORT, FINDINGS OF FACT AND RECOMMENDATIONS

The Association of Professional and Technical Employees ("APTE") represents approximately 225 employees of the City of Detroit. APTE and the City entered negotiations for a contract for the period July 1, 2005 through June 30, 2008 but did not come to an agreement. On April 22, 2008 the City filed a petition for Fact Finding pursuant to Public Act 176 of 1939 and the undersigned was appointed Fact Finder on June 27, 2008.

The fact finding proceedings were bumpy. Pre-hearing conferences were held on July 30 and August 13, 2008. The parties exchanged position statements on October 16, 2008 and hearings were held on October 28, November 3, and December 16, 2008 and March 11, 12 and 13, 2009.

At the conclusion of the hearings the parties were to submit briefs thirty days after receipt of the final transcripts. APTE determined that although it had participated in the

hearings without counsel, it needed counsel to prepare its brief and its brief was submitted July 15, 2009. The City asked for an extension and was to submit its brief in early September, but ultimately in lieu of a brief, the City provided a transcript of a closing argument which counsel presented to a court reporter on March 11, 2010.

THE ISSUES

There were three issues presented to fact finding: health care, wage reduction through days off without pay, and modification to the subcontracting language of the contract. The City had been in poor financial health and in 2006 when it was bargaining it sought major structural changes in the health care plans. To address immediate cash flow problems it sought a 10% wage concession through "Days Off Without Pay" commonly known as DOWOPS, and it sought changes in subcontracting language in the contract.

APTE opposed all of these changes, asserting that since a proportion of its employees were "grant funded", any changes would not benefit the City's General Fund balance.

DETROIT'S FINANCIAL CONDITION

The City called Pamela Scales as a witness. She is the City Budget Director, a position she has held for several years. She is a graduate of the University of Michigan with a degree in Economics and she has an MBA from University of Detroit-Mercy. She testified as to Detroit's financial condition.

The City of Detroit over the past several decades has been in a state of economic decline. Population has declined from about 1.8 million in 1950 to 900,000 today.

Together with this loss of population has been a loss of about 65% of the City's businesses. Those who leave the City are those who are financially able to leave and who are employed. This results in a high proportion of the remaining residents unemployed, living in poverty, and unable to contribute to the City's finances. In 2005, while the unemployment rate for the country was 5.1% and for Michigan as a whole was 6.7%, it was 14.2% in Detroit. There has been a steady decline in income tax returns, with the City processing 652,000 in 1963 and 314,000 in 2005. In addition, non-residents pay half the rate of residents, so the population exodus hurts there too.

The decline in population also results in a decrease in the housing stock and a decline in property taxes, with many vacant homes and buildings. Property taxes are a city's most stable revenue source because they do not vary as much with economic conditions, while income taxes decrease when people get laid off or unemployed. But Detroit has suffered here. For example, while 79% of Dearborn's revenue comes from property taxes, and Pontiac, which would be considered distressed, has 48% of its revenue from property taxes, only 12% of Detroit's revenue is from property taxes. The State Equalized Value of real estate in the City has gone from $4.8 billion in 1975 to $1.5 billion.

This history has been exacerbated by the decline in Michigan's economy, with a decline of revenue sharing from the State.

Detroit had budget deficits of $69 million in 2002-3, $95 million in 2003-4, $144 million in 2004-5, and $170 million in 2005-6.

In the past the City has had similar problems and has tried to address them in a number of ways. In the 1980 recession the City had a 20 % reduction in population with

four consecutive deficits and asked for and got $76 million in concessions from the Unions. 2700 employees were laid off and in 1984 cost sharing was implemented in the hospitalization plans.

In the early 1990's there was an additional population loss of 14.9%, five consecutive deficits, 2,100 layoffs between 1990 and 1992, and two years of DOWOPS. The pension funds began to have unfunded liability resulting in increased cost to the City

The period beginning around 2000 started another economic contraction. Population again decreased, unemployment began to rise, and the State reduced the City's share of revenue sharing. This was also when hospitalization costs began double digit increases every year. The City reduced positions 6% in 2003-4, 3.4% in 2004-5 with a 13% reduction in overtime, and laid off 977 employees in 2005 including 61 firefighters and 150 police officers

Ms Scales testified that the only thing that has kept the City out of bankruptcy is the income from casinos, but even that has declined with the decline in the economy. Forecasts are for continued decline in the future.

I find Ms. Scales' testimony persuasive.

THE CITY'S ORIGINAL PROPOSALS

As it began negotiations for the 2005 labor contracts, and the City was faced with double digit increases in health care costs, it determined it needed to make structural changes to the health care plans. As Ms. Scales testified:

> When we were looking at health care specifically, we saw that we had double-digit increases and that it was going to exceed our ability to pay. So the goal was to get some reduction in the rates that we

had going in the future so that it was something that we could pay. Tscpt p. 216

Barbara Wise-Johnson is the City's Labor Relations Director and started in the Labor Relations Department in the 1990's. She testified about the efforts to reduce health care costs.

In bargaining for the 2005-2008 contract period she was directed to achieve structural changes to the health care plans which would achieve cost savings in the future.

In order to evaluate the entire health care program, the City hired a consultant, Mercer, which proposed significant changes to the health care plan, resulting in what was called the "Mercer Plan". The City estimated that if the Mercer Plan was adopted by all the non-Act 312 employees, it would save $42 million over the current health care plan.

Ms. Wise-Johnson discussed the Mercer Plan changes at pp. 242-252 of the transcript. Employees have a choice of plans, including a PPO, HAP, Community Blue and a traditional Blue Cross plan. Her testimony is quoted at length to show, in part, the richness of the current City plan. She testified from one of the exhibits.

> In 2005 when we came up with the Mercer design plan, we asked Mercer, our health care consultant, to identify the changes that would be made in the plan.
> This document purports to do just that. It shows -- the first column that is called Plan Design describes the benefit. We are looking at the PPO plan which has the in-network and out-of-network.
>
> So the first column is split into two sections. One tells you what the benefit currently is, and the second one says what the plan design would be if we make the Mercer changes.
> Then the same applies for the out-of-network benefit.
> Then the final column, which is the Rate Decrement, tells you the percentage of cost change as determined by the health care provider.
> ARBITRATOR BROOKOVER: Is that an English word, "decrement"? I have never seen that.

THE WITNESS: These carriers all come up with their own words.

ARBITRATOR BROOKOVER: They are as bad as lawyers.

Q (By Ms. Colbert-Osamuede) All right, so?

A So, as you review the chart and you look at the Annual Deductible under the PPO plan, our Community Blue PPO plan, currently, there is no deductible.

Under the Mercer plan, we proposed to make a $250 deductible if you have an individual contract.

If you have a family contract, we were proposing that it would be twice that amount for the entire family, and a family is defined as two people or more. It would be a $500 deductible where, currently, there is no deductible.

Under the Co-Insurance, currently, the City pays 100 percent for outpatient services. They were proposing that we drop that down to 80 percent.

Q Let me just stop you for one minute. You say "currently." You mean as of 2006 during the negotiations?

A Yes, from back in 2005, back in time.

Q All right, go ahead.

A The office visits for the Community Blue Plan were $5, and they were recommending that we would have an office visit of $15 co-pay, and then the plan would pay 100 percent after that.

On the Outpatient Mental Health Services, we were paying 90 percent for inpatient and I think 50 percent for outpatient. They were proposing that we change that benefit over to 80 percent/50 percent.

Because there was no deductible or co-insurance under the PPO plan, there would be no annual out-of-pocket limit for the individual or for the family. But under the new design, there would be $1,000 maximum out-of-pocket expenses and $2,000 for the family.

When you go in the hospital for in-hospital patient services, currently, the plan paid 100 percent. Mercer was proposing that we drop that down to 80 percent.

Under the Emergency Room Community Blue, it was a $50 co-pay. They were proposing that we increase that to $75, and then it would pay 100 percent. But that co-pay would be waived if in fact you were admitted to the hospital.

In 2005, there was no hospital admission deductible. So they were proposing that we go to a $250 co-pay deductible if you go into the hospital.

As regards to generic drugs, under the Community Blue plan for generics, they were $5. For brand name, they were $10, and they have a single-source formula as well as a

multi-source formula. We only paid $5 and $10, $5 for generics, $10 for brands.

They were proposing that we, on generics, go to a 20 percent deductible with a minimum amount paid at $15 and a maximum amount at $30.

For the brand name, we would take a 20 percent co-pay also with a minimum of $25, a maximum of $50. Then for the brand name multi-source, it would still be 20 percent, but the minimum would be $40, and the maximum would be $80, and that would be for a 30-day supply if you would go to the drug store.

If in fact you did the mail order prescription drugs, it would be two times that amount. So just by way of example, for generics if you go to the drug store, it would be a minimum of $15 and $30 maximum.

If you go to get your prescription drugs through mail order, you would get a 90-day supply, but the minimum would be $30 and $60 maximum.

That was for the in-network benefits. The out-of-network benefits run exactly the same way except that, for the deductible, instead of $250, it would be $500.

Again, these were what Mercer believed were the most cost-aggressive type features in our plan. As you can see, we were not paying anything hardly there, and they estimated that we would make a tremendous cost savings if we were to make those changes.

That was just for the PPO plan. The HMO plan, basically, their benefits, as I had described before, were free. If you go for office visits, anything that you had to do except for prescription drugs, you paid nothing.

I am on page two now. As you look at the current plan design, you see that there is no office visit currently. There is no inpatient co-pay. There is no emergency room co-pay. There is no urgent care co-pay. There is no co-pay in terms of mental health or substance abuse.

They were proposing that we put into place a $15 co-pay for office visit, $250 for admission to the hospital, $75 emergency room, $50 for urgent care, and outpatient mental health and substance abuse would be a $15 co-pay.

The prescription drugs is as I described under the Traditional Plan on page one. It operates the same way with a 20 percent and a minimum and maximum amount.

This would be applied to all of our HMO plans. That would be Blue Care Network, that is what the BCN is for, HAP, that is Health Alliance Plan, and THC is the Total Health Care Plan.

Those were the rate decrements that they indicated we would save as a result of the changes that we were making in the plan.

The third page is the Traditional Plan. Currently, there is a $50 deductible under that plan, and again I am speaking of 2005. Actually, I guess I am speaking of the plan designs that are in effect right now today.

When I say current, I am talking about the plan design that is in effect for the Association of Professional and Technical Employees right now, because they have not agreed to any of the changes that we have proposed.

Q So just let me back up then. Any member that is in APTE currently, an APTE member that is currently under any of the HMO's pays nothing as it relates to office visits, inpatient admissions, emergency care, urgent care or outpatient mental health or substance abuse?

A That is correct.

Q You can go on to continue with the third page.

A Under the Traditional Plan, there is a $50 co-pay for individuals. It is double, twice that amount if you have a family coverage plan, so that would be $100. We were proposing that deductible go up to $250 for an individual, $500 for a family.

The office visit examination, which would be equivalent to the co-pay amount in the PPO plan and the HMO plan, is at 80 percent now. We were not proposing any change in that particular benefit.

Outpatient Mental Health is 100 percent paid for the first six visits and then 50 percent. We were recommending no changes there.

There currently is an out-of-pocket maximum of $1,000. We made no changes in that plan design either for the individual or the family.

As regards to inpatient hospital services, the plan currently pays at 100 percent. We were proposing to reduce that to 80 percent.

It would be the same for semi-private room and board including -- that would be changed from 100 percent to 80 percent.

Right now, they do not have a co-pay on emergency room. We were proposing to go to $75 co-pay unless you are admitted.

Urgent care is at 80 percent, and we had proposed that that would go to 50 percent. But I have to acknowledge, this document is dated April of -- there is no date on that sheet.

I have to double-check on that urgent care, because I believe that Blue Cross informed us that they would have to use a percentage amount. So that may be at 80 percent still. I will have to double-check that one.

Hospital Admission, there is none, but we were proposing $250.

Then the prescription drug amount would be the same.

Now, again, Mercer had proposed that we make these changes because of a couple of reasons. One of them was to try to deter abuse in our plan.

For example, on the emergency room, there was no co-pay at all, and we found that a lot of our employees, as a result of that, did not go to the doctor. If the baby had an earache, they would just wait until the middle of the night until the baby is crying all night, and then they run to emergency instead of going to the doctor for an office visit where the cost would be a little bit less.

The cost for emergency room, our emergency room cost was, I believe, 33 percent higher than the average employer. So part of it was to put in a co-pay to deter the cost.

We also wanted to encourage urgent care instead of emergency room, because urgent care, although we put a co-pay on it a little bit higher than an office visit, urgent care was certainly less expensive than emergency.

The same thing with prescription drugs. People weren't using generic drugs because they had a flat co-pay amount of $3. It made no difference if it was generic or if it was brand name. Because there was no difference, people made no difference when they went for the prescription drugs as well.

So we found or I should say Mercer found that there was what we might call some abuse of the plan, and that typically happens when you have what they call a very rich plan.

Where there is no monetary sacrifice that the employee has to make, that generally causes an increase in your cost. So part of what we were doing was to try to encourage our employees to use the plan appropriately so that it would reduce our costs.

If you did not use the plan, these co-pay amounts would not be of consequence to you.

THE ALTERNATIVE HEALTH CARE PLAN

AFSCME represented the largest number of City employees and negotiations began with AFSCME in 2005. Through negotiations there developed what was known as

the Alternative Health Care Plan (the "Alternative Plan"). Ms. Wise-Johnson described the differences at pp. 261-266:

> As you can see, the annual deductible, we originally proposed $250. We reduced that to $175. If it was a family, it was still twice that amount, but it would be $350.
>
> The office visit co-pay was $15 under the Mercer Design Plan. We reduced it to $10 under the Alternative Health Care Plan Design.
>
> The outpatient mental health substance abuse, we left it alone. It was
> 80 percent and 50 percent. We left it to where it currently is at 90 and 50 percent.
>
> There was no change from the Mercer to the Alternative under the annual maximum amount that would come out for an individual or for a family.
>
> For inpatient hospitalization, we had wanted to drop it down to 80 percent. We agreed to leave inpatient hospitalization at 100 percent.
>
> The emergency room co-pay stayed at $75 under both proposals.
>
> The urgent care we had originally proposed at $50. It was reduced to $10 under the Alternative Health Care Plan Design.
>
> Under the Mercer Plan Design, we had wanted a hospital admission deductible but, under the Alternative Health Care Plan, we eliminated that, so there was no hospital admission deductible.
>
> Under the prescription drugs where we had consistently asked for 20 percent with a minimum/maximum, we decided to go with a $5 generic prescription drug and $15 for brand name, and it would be twice that amount for mail order with the 90-day supply.
>
> Those were the changes that we made through the negotiation process. It evolved over a period of time but, ultimately, this is what we ended up with with the Alternative Health Care Plan.
>
> Q That was just showing the example between the Blue Cross/Blue Shield PPO in-network benefits?
>
> A That is correct.
>
> Q Without belaboring the point, we can go to the next set, which is the HMO plans. Walk us through the changes between the Mercer Plan and the Alternative Health Care Plan?
>
> A The Mercer Plan under HMO asks for a $15 co-pay. Under the Alternative Health Care Plan, it was $10.

Again, the inpatient hospital co-pay was eliminated under the Alternative Health Care Plan.

We retained the $75 emergency room. The urgent care went from $50 to $10.

The outpatient mental health and substance abuse co-pay went from $15 to $10.

The same change that was made on the Traditional Plan was made on the HMO plan for prescription drugs, that is $5 for generic, $15 for brand name, twice that amount for mail order with a 90-day supply.

Q Then if you would just walk us through the differences in the Traditional Plan?

A Under the Traditional Plan, the deductible went from $250 to $175 and remained twice that amount. It would have been $350 under the family plan.

The next change I see is in the inpatient hospital services. We had proposed originally that it drop down to 80 percent but, under the Alternative Health Care Plan, we were willing to leave that at 100 percent.

There would be no hospital admission deductible. Again, that $50 co-pay, I would have to check that one under the Mercer Plan. It may very well be at 80 percent, and it remained the same.

Prescription drugs was changed the same consistently as it was under the Traditional Plan and HMO, $5 generic, $15 brand name and twice that amount for mail order.

AGREEMENT WITH AFSCME AND OTHER UNIONS

The City reached tentative agreement with AFSCME and when their membership did not ratify it the parties went to Fact Finding. The Fact Finder recommended that AFSCME accept the Alternative Plan by July 1, and accept the 10% reduction through DOWOPS, by July 1, and if it did not, that the City should implement the Mercer Plan. AFSCME accepted the recommendations. The Building Trades also went to Fact Finding with the same recommendation, and accepted the recommendation.

The City had offered other unions, including APTE, a proposal including the Alternative Plan, DOWOPS, and at the end of the contract the 4% wage increase. But the City's offer had a deadline. For Unions which accepted the Alternative Health Care plan by July 1, 2006, and DOWOPS, the City would offer the 4% wage increase at the end of the contracts. If a Union did not accept that proposal by July 1, then the offer of the

Alternative Health Care plan and the 4% wage increase would be removed from the table and only the Mercer Plan would be offered.

This was communicated to all groups, including APTE.

Most major unions settled. The Teamsters reached agreement before the July 1 deadline. Building Trades went to fact finding and accepted the recommendation for the Alternative Health Care Plan and DOWOPS.

If a Union did not accept the City proposal by the deadline the City was to take the proposal off the table, and the City position would be that there would be no 4% increase and only the Mercer plan would be offered. Unions would not be able to take the Alternative Plan, but instead were given the original Mercer plan, as described by Ms. Wise-Johnson at pp. 285-6

> Q And Ms. Johnson, Barbara Wise-Johnson, how many groups -- there are a few groups out there that is just like this particular bargaining unit, APTE, who has not settled that particular contract for '05/'08. Correct?
> A Correct.
> Q Have any of them received the Alternative Health Care Plan?
> A No, they have not.
> Q Okay, and have any of them received the 4% increase?
> A No, they have not.
> Q And did any of those individuals take a DOWOP?
> A We did settle with a couple of the groups afterwards. They received the Mercer design plan. They did not receive the 4% increase, and they were scheduled -- we did agree to a 10% reduction in the form of DOWOPS.
> Q But those were groups who did not sign or settle their contract in that time frame that the City was pushing for, when it was collectively bargaining for the '05/'08 contract with the bulk of their City unions. Correct?
> A That is correct.
> Q And because they missed that deadline, they missed out on the ability to have the Alternative Health Care Plan, which was important to our savings. Correct?
> A Correct.
> Q They missed out on receiving the 4% wage increase in '08. Correct?
> A That is correct.
> Q And they did have to do the 10% reduction in hours. Correct?
> A That is correct.

CURRENT POSITION OF THE CITY

The City continues in a precarious financial condition. It asks for a recommendation that APTE accept the Mercer Plan as other groups which did not accept the Alternative Plan did, that APTE employees make a 10% wage concession through DOWOPS, and that the City's subcontracting language be adopted. In its closing argument the City indicated that it is currently seeking a 15% wage concession from employees.

CURRENT POSITION OF APTE

APTE offers to accept the 10% DOWOPS wage concession but continues to request the 4% increase. It asks for implementation of the Alternative Health Care plan, but with changes which apparently would be applicable only to it. It proposes that the subcontracting language not be changed.

DISCUSSION

Approximately 8,500 of the 9,000 non-Act 312 employees reached agreement with the City on health insurance and DOWOPS. APTE is the largest of the non-agreeing groups.

APTE asks the fact finder to differentiate between employees who are in grant funded positions and those who are not. It does this by saying that savings in grant funded positions would not affect the General Fund deficit, so if the goal is to reduce the deficit, employees in grant funded positions should not be asked to contribute.

The City counters that it does not want differences between employees who happen to be in grant funded positions and employees who are not. Employees are assigned to positions and moved around where needed and whether a position is grant funded or not should not matter. If there are layoffs they would be done based on classification and total City seniority, irrespective of an employee's department or how the position was funded. When a person applies for a job, for instance as an accountant, with the City and are hired, he or she might be assigned to a number of positions, some of which are grant funded and some of which are not.

In addition the City wants a uniform health care plan for all non-Act 312 employees for various administrative and cost saving reasons, and to treat every employee the same when it comes to health care design and cost. Otherwise that same accountant who is transferred from a grant funded position to a non-grant funded position would change health care plans under APTE's proposal.

The desire for uniformity was demonstrated when the City went back to at least one Union which had settled before the AFSCME contract with a slightly less generous health benefit and offered them the more generous benefits negotiated by AFSCME.

Although there is superficial logic in APTE's position, that of the City is more reasonable and appropriate.

If APTE had accepted the Alternative Plan, the City estimates it would have saved approximately $629,000 through June 30, 2009. Now, not only has the City lost those savings, but APTE employees have enjoyed the benefits of their old plan for almost two years beyond the expiration of the contract.

HEALTH CARE

Where other unions and employees either adopted the Alternative Plan by July 1, 2006, or wound up with the Mercer Plan, APTE seeks now to have the Alternative Plan, but still seeks modifications to it. Its members have enjoyed the benefits of the original plan not only for the contract period, but now for almost two years after the expiration of that contract. As noted above, that has resulted in an additional cost to the City, just through June 2008, of over $600,000. Health care costs have not decreased over the past five years.

FACT FINDERS' RECOMMENDATION ON HEALTH CARE

I recommend the Mercer Plan, not the Alternative Health Care plan, effective as soon as possible.

DOWOPS

Again, while the vast majority of employees took a 10% wage reduction in the 2006-2008 period, APTE employees did not. Those employees who agreed to DOWOPS by July 1, 2006 were given a 4% increase June 30, 2008. APTE is now willing to take the 10% reduction, but still wants the 4% increase. In its closing argument the City has stated that currently employees are being asked for another 15% wage cut for 2008-2012.

FACT FINDER'S RECOMMENDATION ON DOWOPS

I recommend at least a 10% wage concession though DOWOPS, for the next two years, beginning no later than June 1, 2010. If the City is currently seeking and obtaining further wage concessions, since APTE members have not given concessions in the past,

the parties might agree to an additional concession or an extension of the two year term. I do not recommend any 4% wage increase. No other employee groups who failed to reach agreement by July 1, 2006 received an increase and there is no justification for one for APTE.

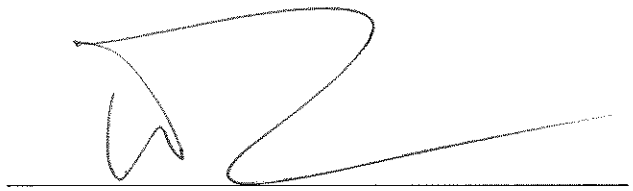
SUBCONTRACTING LANGUAGE

The change in subcontracting language was proposed for the contract which has now expired. In its presentation, the City did not emphasize this as a crucial part of the contract bargaining. APTE opposed the change because of fears that it would significantly change the City's practices.

FACT FINDER'S RECOMMENDATION ON SUBCONTRACTING

Since the parties have lived with the original language for the past five years, any recommendation for a change would be futile. I take no position on whether the language should be modified in the next contract.

I am well aware that this Fact Finding is for a contract which was set to expire almost two years ago. I was appointed three days before the scheduled contract expiration date. My recommendations of necessity are prospective, and cannot affect the past, but are an attempt to reflect not only the facts at the time of negotiations but also what happened with other City employees at that time and since.



Thomas W. Brookover, Fact Finder

April 15, 2010