

<b>In the Matter of Arbitration</b>	)	<b>OPINION AND AWARD</b>
	)	
<b>Between</b>	)	
	)	
<b>Human Development Center, employer</b>	)	<b>BMS case no. 11-RA-0711</b>
	)	
<b>And</b>	)	
	)	
<b>American Federation of State, County and</b>	)	
<b>Municipal Employees, Minnesota</b>	)	<b>JULY 2, 2011</b>
<b>Council 5, local 3558, union</b>	)	

**Appearances:**

For the Employer---Joseph J. Roby, Jr., Johnson, Killen & Seiler, PA, Duluth, Minnesota

For the Union---Ken Loeffler-Kemp, field representative

**Procedures**

The undersigned was chosen as Arbitrator in the present matter through the procedures of the Minnesota Bureau of Mediation services. A Hearing was held in the Edgewater Resort, Duluth, Minnesota, on May 9, 2011, commencing at 8:30 a.m. With simultaneous exchange of post-Hearing Briefs on June 3, 2011, the Record in this Matter was closed.

**The Parties**

The Employer is a relatively large mental health clinic, with operations in northern Minnesota and northern Wisconsin, and is operated as a non-profit organization. The Union, as its name suggests, typically organizes sub-federal units of government, but in this case has organized a private non-profit. The Parties are signatories to a collective bargaining agreement running from Jan. 1, 2010 Through December 31, 2012. This is their third such agreement. Article 36 of that agreement, which deals with medical insurance, will be the center of our attention.

Prior to organization by AFSCME in 2002, there had been a Labor Management committee, whose primary function was to review and propose medical plans and providers for staff health insurance. Subsequent to negotiation of the first CBA in 2003, this committee has been called the Insurance Committee. Its membership includes bargaining unit employees, non-bargaining unit employees and management. It is appointed by the Executive Director. The recommendations of this committee have never been rejected, at least during Gruba's tenure as executive director. [testimony of Jim Gruba, recently retired executive director]

### **Article 36 – Health Insurance**

This article reads in relevant parts, as follows:

The Employer shall provide group health insurance coverage to the employees based upon the eligibility criteria as outlined in the summary of benefits as attached. .... The Employer may change carriers or administrators, provided that the change does not result in a material detriment to the employees. Effective January 1, 2007, a participating employee shall pay twenty percent (20%) of the monthly premium for all coverages selected by the employee. .... The Employer shall pay the balance of the premium. If either party wishes to explore changes in the health insurance plan design in order to reduce premiums, the Insurance Committee shall meet and discuss the issue. Failing agreement on the issue within ninety (90) days of the first Committee meeting on the issue, either party may call for binding interest arbitration to resolve the disagreement over the issue. .... The interest arbitrator's power shall be limited solely to the issue of how to change the health insurance plan in order to reduce premiums.

The Employer contends repeatedly that the exclusive remedy for disagreement about the proposed changes in the health insurance plans is through the compulsory interest arbitration process envisioned in Article 36. By failing to follow this process, the union has forfeited any rights over the

insurance issue. This argument has a certain surface plausibility: a special procedure to resolve the divided views of all the members of the Insurance Committee (union-represented employees, non-bargaining unit employees and management) inserted in the Agreement at exactly the right place. It also has the novel notion of giving non-unionized employees the power to (e.g.) force their employer to arbitrate the disagreement.

But this Arbitrator notes the extreme limitations on the interest arbitrator's power: "limited solely to the issue of how to change the health insurance plan in order to reduce premiums." The interest arbitrator could never consider reallocation of existing premium costs from employees to employer or the more nuanced way the employer casts the question: "if we offer multiple plans, so long as one of them meets the 80/20 split mandated in part of Article 36, we're OK." As human resources director Merle Peterson testified: "But if employees wanted to pay more, they should have that option."

The interest arbitration process of Article 36 is not the appropriate place to resolve such issues. A grievance arbitration proceeding is the right place. No discussion, however learned and citation-filled, of forward-looking processes versus backward looking, or whether the arbitrator is acting as a legislator or as a judge, can obscure that reality. This grievance is properly before this arbitrator.

### **What did the Employer do?**

The Employer, acting through the Insurance Committee, created a set of three distinct health insurance plans. The Committee was said to make decisions by consensus; no testimony was offered about their 2010 deliberations of the Committee, so we don't know if current and former union officers who were on the Committee opposed its conceptualization of the issues. In any event, Table 1 below

reproduces Employer Exhibit 7 down to the Arbitrator's hand-written notations.

Of the three plans, the Health Savings account had the lowest premium and the 80/20 cost split mandated by Article 36 was applied to this plan. The resulting dollar figure (\$147.32 for single coverage) was then applied to the other two (more costly) plans. This was also done for the other two coverage groups (employee plus one and employee plus family). This procedure resulted in the cost sharing for the two more traditional, non- health savings account plans being substantially different from the 80/20 sharing apparently envisioned by Article 36.

The language of Article 36 appears straightforward: "a participating employee shall pay twenty percent (20%) of the premium for the coverages selected by the employee. .... The Employer shall pay the balance of the premium." A possible choice by each employee is clearly envisioned by the language "selected by the employee." The plural term "coverages" reminds us that coverage has at least two dimensions: who is covered (employee, employee plus one and employee plus family) and how that person or family unit is covered (what is covered and how is it covered). To attempt to reduce coverage to a single issue of "who is covered"---as is attempted in footnote 4 of the employer's Brief---would remove any meaning from "coverages:" no one would ever choose more than one such coverage. Arbitrators endeavor to ensure that all words in the Agreement are given meaning and this Arbitrator is no exception.

At various stages in the processing of this grievance, the Union has sought as a remedy the reinstatement of the 2010 health insurance plan. This is, of course, not the appropriate remedy for a violation of the 80/20 cost sharing mandated by Article 36. The appropriate remedy is to apply the plain reading of the language in Article 36 and impose the 80/20 cost sharing on all three plans offered by the employer. The employer estimates the cost of doing this for both non-HSA plans combined at \$84,940 per year. This is not a negligible sum, but should be seen in the context of an organization with

# TABLE 1.

All \$Costs are Per Pay Period

Name of Plan	\$5000/\$10,000 Health Savings Account Single		\$5000/\$10,000 Health Savings Account Employee + One		\$5000/\$10,000 Health Savings Account Family	
	January \$500 contribution	Percent with July \$500 contribution	January \$500 contribution	Percent with July \$500 contribution	January \$500 contribution	Percent with July \$500 contribution
Full Cost of Plan	\$184.15	100%	\$325.60	100%	\$498.00	100%
Employee Cost	\$36.83	20%	\$65.12	20%	\$99.60	20%
Employer Cost	\$147.32	80%	\$260.48	80%	\$398.40	80%
Optional Plans						
Name of Plan	Blue Cross Blue Shield \$1000/\$2000 Single		\$1000/\$2000 Employee + One		\$1000/\$2000 Family	
Full Cost of Plan	\$225.64	100%	\$394.62	100%	\$605.27	100%
Employee Cost	\$78.32	35%	\$134.14	34%	\$206.87	34%
Employer Cost	\$147.32	65%	\$260.48	66%	\$398.40	66%
Name of Plan	Blue Cross Blue Shield \$500/\$1000 Single		\$500/\$1000 Employee + One		\$500/\$1000 Family	
Full Cost of Plan	\$236.26	100%	\$421.89	100%	\$631.12	100%
Employee Cost	\$88.94	38%	\$161.41	38%	\$232.72	37%
Employer Cost	\$147.32	62%	\$260.48	62%	\$398.40	63%

DRAIVES THESE

N 8 3 2

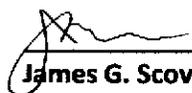
some 300 full and part-time employees.

The employer then raises the argument that the employer should be limited to 80 percent of the cost of the HSA plan—because of 2 semi-annual contributions of \$500 to each HSA, the employer is frequently out-of-pocket 100 percent (or more) of the annual premium. This will probably be seen as funny math by the employees, who do pay (via payroll deduction) 20 percent of the premium. The employer will need to consider whether encouraging the use of HSAs through a \$1000 annual contribution per account has enough effect on employee behaviors and choices to be worth it. Since the dollar amount was not arrived through the collective bargaining process, it would seem to be under the employer's unilateral control.

#### AWARD

The grievance is sustained. The employer will apply the 80/20 premium costs sharing to all group health plans offered and make affected employees whole.

**Given at St. Paul, Minnesota this second day of July, 2011.**

  
\_\_\_\_\_  
James G. Scoville, Arbitrator.