BEFORE THE ARBITRATOR

In the Matter of the Arbitration of a Dispute Between

INTERNATIONAL ASSOCIATION OF FIREFIGHTERS (IAFF) Local 321

and

City of Racine

Case IDs: 53.0023 and 53.0025
Award No. 7966

(Health Insurance Grievances)

Appearances:

Christopher MacGillis and Kevin Todt, MacGillis Wiemer, Attorneys at Law, 11040 W. Bluemound Road, Suite 100, Milwaukee, Wisconsin, appearing on behalf of the Union.

Mark Olson and Brian Waterman, Buelow, Vetter, Buikema, Olson & Vliet, Attorneys at Law, 20855 Watertown Road, Suite 200, Waukesha, Wisconsin, appearing on behalf of the City.

ARBITRATION AWARD

IAFF, Local 321, hereinafter referred to as the Union, and the City of Racine, hereinafter referred to as the City or the Employer, are parties to a collective bargaining agreement which provides for final and binding arbitration of all disputes arising thereunder. The Union made a request, with the concurrence of the City, that the Wisconsin Employment Relations Commission designate a member of its staff to hear and decide two health insurance grievances. The undersigned was so designated. A hearing was held via Zoom on September 21, 2020. The hearing was transcribed. The parties filed briefs and reply briefs, whereupon the record was closed on December 23, 2020. Having considered the evidence, the arguments of the parties and the record as a whole, the undersigned issues the following Award.

ISSUES

The parties did not stipulate to the issues to be decided. The Union frames the issues as follows:

Whether the City violated the CBA when it:

1. Increased the employee premium share for the high deductible plan to 7.5% from 5% for active members and those who will retire under this CBA?

2. Capped the Medicare Part B premium at $135.50?

The City frames the issues as follows:

1. Did the City violate the terms of Article XIV of the 2018-–2020 CBA with Local 321 when the City revised health insurance benefits, as specifically alleged in the two grievances, for all city employees and retirees as of January 1, 2020?

2. Did the City fail or refuse to meet with representatives of Local 321 prior to the implementation of these revisions?

I have not adopted either sides proposed wording of the issues. Instead, I frame the issue as follows:

> Did the City violate Article XIV of the CBA by its actions herein? If so, what is the appropriate remedy?

PERTINENT CONTRACT PROVISIONS

The parties' current collective bargaining agreement (hereinafter CBA) runs from January 1, 2018 to December 31, 2020. It contains the following pertinent provisions:

ARTICLE XIV – INSURANCE AND PEER FITNESS TRAINER PROGRAM

1. Medical Coverage: Full time employees shall be eligible for City paid health insurance following acceptance into the plan by the carrier. The employer shall define a notional health insurance premium. Employees shall be required to contribute 10% of the monthly notional premium as a premium share for Plan 06A or 5% of the monthly notional premium share for Plan 07A, as approved by the Racine Common council. All employees who retired after January 1, 1996 shall be subject to placement within the insurance program established for active bargaining unit employees.

   The Employer will continue to pay Medicare B and provide City health insurance and retirees will be required to enroll in Medicare B. Employees hired on, or after, 1/1/07 will not be eligible for Medicare B payments by the Employer. Employees hired on, or after, 1/1/07 will not be allowed to remain in the City of Racine's health insurance plan upon reaching the age of Medicare eligibility or federal retirement age, whichever occurs later.

However, any employee retiring on or after 1/1/07 shall be required to pay the premium contribution for insurance in effect at the time of the employee's retirement.

Employees may establish a Flexible Spending Account with voluntary employee contributions to a maximum of $2,500 per year for medical and $5,000 per year for dependent care.

Fitness Center Reimbursement: The City will reimburse full time employees and retirees that carry the City of Racine health insurance for 50% of the annual membership fee for a fitness center up to a maximum of $200 per employee.

2. Wellness Incentive: Employees, employees' spouses, retiree and retirees' spouses covered by the City health insurance plan who completed the wellness program requirements will be eligible to receive an incentive payment. An employee or retired employee shall be eligible for a $200 wellness incentive payment. Employees' spouses and retirees' spouses shall be eligible for a $100 wellness incentive payment. Employees and retirees will be eligible for no more than two payments per family per year. Wellness program requirements and incentives may be modified, by policy, at the City's discretion. Such payment shall be made by check and is taxable income subject to normal payroll deductions.

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BACKGROUND

The City operates a fire department for the public safety of its citizens. The Union is the bargaining representative for the City's firefighters (hereinafter referred to as the members of Local 321). The City and the Union are parties to a 2018–2020 CBA.

This case involves mid–contract term health insurance changes that the City made effective January 1, 2020. The following background information about health insurance is germane to this matter.

In 2019, the City offered all its employees, including the members of Local 321, a choice of picking from two health insurance plans. One plan required the employee to pay a higher percentage of the total premium but had a lower deductible, while the other plan required the employee to pay a lower percentage of the total premium but had a higher deductible. Both plans were administered by United Health Care. In late 2018, the City's Benefit Coordinator drafted and provided a document to City employees that explained these two health insurance plans and their corresponding benefits and premiums. This document identified the two plans as follows: "Option 1 is a lower deductible plan with a higher premium. Option 2 is a higher deductible plan with a lower premium." Option 1 provided for a $400 individual deductible and an $800 family

deductible, with a $3,000 individual maximum out-of-pocket and a $6,000 family maximum out-of-pocket for in-network medical expenses. Option 2 provided for a $2,000 individual deductible and a $4,000 family deductible, with a $3,000 individual maximum out-of-pocket and a $6,000 family maximum out-of-pocket for in-network medical expenses. For each of these plans, there were additional coinsurance amounts which were set forth in the document. Additionally, for both Option 1 and Option 2, there was a separate $3,450 individual maximum out-of-pocket and $7,700 family maximum out-of-pocket for prescription drug expenses. If the employee selected Option 1, their "premium share" was 10% of the monthly premium. If the employee selected Option 2, their "premium share" was 5% of the monthly premium.

The health insurance provision in the parties' 2018–2020 CBA is found in Article XIV. While the article is quite long, the language pertinent herein is just one sentence long. It provides as follows:

> Employees shall be required to contribute 10% of the monthly notional premium as a premium share for Plan 06A or 5% of the monthly notional premium share for Plan 07A as approved by the Racine Common Council.

Local Union President Jose Carbajal testified without contradiction that when these two plans (i.e., Plan 06A and Plan 07A) were discussed in bargaining, "Plan 06A" was the low deductible plan that required the employee to pay a 10% monthly premium for that plan and "Plan 07A" was the high deductible plan that required the employee to pay a 5% monthly premium for that plan. As he put it in his testimony, "You can ask any employee". There is no reference anywhere in Article XIV to either a "high deductible plan" or a "low deductible" plan.

FACTS

As the City began planning for fiscal year 2020, it was in severe fiscal constraints as the result of various factors. Specifically, the City was faced with a 5.5 million dollar budget shortfall and was, and continues to be, in a structural deficit. The City's two largest sources of revenue – its tax levy and state-shared revenue – are either capped or have been significantly reduced. While the City's revenue remained flat, its expenses are increasing between 2% to 3% a year. Healthcare costs alone were projected to increase between 1.5 and 2 million dollars in the 2019 budget. Total employee and retiree healthcare costs comprise about 25% of the City's entire budget. Because of the matters just noted, when planning for the 2020 fiscal year, the City decided it needed to evaluate ways to reduce its healthcare costs. To that end, the City began working with a consultant to identify ways to address its skyrocketing healthcare costs and possibly modify its health plans.

As part of this review process, the City analyzed its contractual obligations under its various CBAs, as well as its obligations under applicable labor laws. After doing so, the City's administration presented some recommended changes regarding the City's health plans to the City's Finance and Personnel Committee at its September 9, 2019 meeting. It was the City's view that the recommended changes were health plan design changes which were consistent with the various CBAs and labor laws.

One proposal was to make these changes to the employee health insurance plan: a) eliminate the existing Plan 07A/Option 2 and b) amend Plan 06A/Option 1 to a high deductible health plan for the active city employees and the pre-Medicare retirees. (Note: Per both the parties' CBA and the employee handbook, retired city employees have the same health insurance plan as active employees). This new plan, which would become the only available option, provided for a $3,000 individual deductible and a $6,000 family deductible, with a $4,000 individual maximum out-of-pocket and $8,000 family maximum out-of-pocket for in-network medical expenses. Under this proposal, there would be no separate additional deductible or out-of-pocket limit for prescription drug expenses. For this new Plan 06A, as amended, there were additional copay and coinsurance amounts as set forth in a document entitled "January 1, 2020 Benefit Summary Proposal for Active Employees and Pre Medicare Retirees." The administration projected that if this plan was adopted, the potential savings for 2020 would be approximately $3.2 million dollars.

Another proposal was to make these changes to the employee health insurance premium contributions: a) reduce the active employee premium share for Plan 06A from 10 % to 7.5% for 2020; b) institute City contributions to active employees Health Savings Accounts (HSA) with the amount of specific contributions per employee for 2020 to be determined by the Common Council; and c) the total City contribution to employee HSAs will be $915,000 in 2020.

Another proposal was to make this change to the retired employee health insurance program: cap the Medicare Part B reimbursement for retirees and retirees' spouses at $135.50/month. Here is some background germane to this matter. The City has about 550 retirees that receive Medicare Part B reimbursement from the City on a quarterly basis. 85% of these retirees are reimbursed the same rate of $135.50/month, while 15% are reimbursed more due to income levels and other factors. At the time, the City reimbursed based on rates issued by the federal government, and as such, the rates fluctuated from year to year. Additionally, the rates fluctuated based on income levels and other factors. In the last quarter, the City paid 56 different rates. Because of these factors, the administration proposed capping the Medicare Part B reimbursement at $135.50/ month.

The administration also recommended other changes to the City's health plans, but they need not be referenced here.

The Finance and Personnel Committee approved the recommended changes referenced above. It then went to the City's full Common Council for consideration on September 30, 2019.

On September 16, 2019, the Union requested the opportunity to bargain with the City over the City's proposed changes to health insurance.

At the September 30, 2019 meeting, the Common Council approved some, but not all, of the recommended changes to the City's health plans, to take effect January 1, 2020. These health insurance plan changes applied to **all** City employees, not just the members of Local 321. The changes pertinent to this matter which were approved are as follows.

First, it made these changes to the employee health insurance plan: a) it eliminated the existing Plan 07A/Option 2; and b) amended the existing Plan 06A/Option 1 from a low deductible plan to a high deductible plan.

Second, it made these changes to the employee health insurance premium contributions: a) it reduced the active employee premium share for Plan 06A from 10% to 7.5% for 2020; b) it instituted City contributions to active employees Health Savings Accounts (HSA) with the amount of specific contributions per employee for 2020 to be determined by the Common Council as of November 1, 2019; and c) the total City contribution to employee HSAs will be $915,000 in 2020. The HSA referenced in (b) can be used to pay medical expenses. The employee owns the HSA account, but both the employee and the City can contribute to the account. The City contributed funds on behalf of those employees who chose to have an HSA in 2020. This new benefit was for the purpose of offsetting some of the additional deductible costs related to the revised Plan 06A. As it related to the members of Local 321, the establishment of an HSA option was offered as an additional alternative to the optional FSA provided under the CBA. The FSA was not eliminated and remains available to the members of Local 321 at their option. As for the reduction of the premium share referenced in (a), this reduction did not apply to the members of Local 321 and their premium remained at 10% for Plan 06A.

Third, it made these changes to the retired employee health insurance program: a) it capped the Medicare Part B reimbursement at $135.50/month; b) all retirees will be required to pay a 7.5% premium share regardless of their previous group classification; and c) retirees on the Medicare Advantage plan may continue to use the City Wellness clinic, but appointment slots will be prioritized for active employees and active employees' dependents. After these changes were made, Medicare Part B payments are still available to eligible members of Local 321 and their spouses, who also still have access to the City's wellness benefits, including its wellness clinic.

As a result of the changes the City made to its health plans, the City is estimated to save approximately 3.2 million dollars. This savings helped the City obtain financial stabilization.

On October 30, 2019, the Common Council approved the recommendation related to the allocation of approximately $915,000 in HSA contributions on behalf of City employees.

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The week prior, on October 22, 2019, the Union filed the two grievances which are at issue in this matter. The first grievance came to be denominated as the "active member" grievance. It contended that the Common Council "unilaterally (1) modified the health insurance premiums for active members to 7.5%, and (2) eliminated active members' Flexible Spending Account." It also alleged that the City "did not bargain with us despite our request." The second grievance came to be denominated as the "members retiring under the CBA" grievance. It contended that the Common Council "unilaterally (1) modified the health insurance premiums for members who will retire under the contract to 7.5%; (2) capped Medicare Part B reimbursement for members who will retire under the contract and their spouses at $135.50 per month; and (3) modified the City

Wellness Program as it relates to members who will retire under the contract." It also alleged that the City "did not bargain with us despite our request."

That same day, City Attorney Scott Letteney contacted the Union's legal counsel, Chris MacGillis, with an offer to discuss the health plan changes which were to take effect on January 1, 2020. When Letteney did this, the City had not received a request from the Union to engage in bargaining.

On October 24, 2019, MacGillis sent an email to Letteney that averred that the Union had "asked to bargain these issues multiple times" and that the "City had unilaterally rejected that request." Letteney responded with an email dated October 25, 2019, reiterating that the City was willing to discuss the Union's concerns regarding certain aspects of the health plan changes, and noting that while the Common Council had approved the changes, they had not yet become effective as of that date. Letteney's offer to meet with the Union went unanswered, so Letteney sent another email on October 31, 2019 to follow-up on his offer, and to convey certain information regarding the health plan open enrollment period, which was to begin the next day.

On November 4, 2019, MacGillis sent Letteney some proposed meeting dates. Thereafter, the parties agreed to meet on November 13, 2019. The parties met on that date at the Racine City Hall and discussed the City's changes to its health plans and the Union's concerns regarding same. At that meeting, Union officials stated that they agreed that the City had no legal obligation to negotiate with the Union regarding plan design changes, as a result of legal changes which were the result of Wisconsin Act 32.

That same day, the Union filed a complaint with the WERC which alleged that the City refused to bargain with the Union on changes to health insurance benefits, had unilaterally modified health insurance benefits for Union members without first bargaining in good faith with the Union, and that the changes to the health benefits involved are mandatory subjects of bargaining.

On November 27, 2019, Letteney sent MacGillis an email which attempted to clarify certain issues related to the health plans and explaining some options the City would be willing to consider in an effort to address the Union's concerns. In this email, Letteney also addressed a claim MacGillis had made at the November 13 meeting, alleging that he had sent Letteney an email in September 2019 requesting to bargain over the City's changes to its health plans. Letteney stated that he had no record of receiving any such email. (Note: The City's IT department later determined that MacGillis' assistant had sent a request to bargain email to Letteney, but it was not delivered to Letteney because it had been caught in the City's spam filter, and thus had been treated as spam).

On December 6, 2019, Letteney sent another email to MacGillis which included an alternative to the other options described in Letteney's November 27th email. On December 10, 2019, Letteney sent another email to MacGillis which said that if the parties were going to come to some understanding regarding alternatives to the City's health plans, the timeline to do that was getting short. On December 11, 2019, MacGillis responded that the Union would not consider any

arrangement related to the health plans "that doesn't affirm that the active and retiree premium shares are calculated together." Letteney responded that the City was not willing to reconsider the issue of merged premium rates for active employees and retirees and provided the City's reasoning for its position. At the same time, Letteney shared with the Union the terms of an agreement the City had reached, subject to Common Council approval, with the Racine Police Association related to the City's health plan changes, and further indicated that the City would be willing to come to a similar arrangement with Local 321, given the similarities in the two unions' CBAs.

On December 13, 2019, MacGillis responded with a proposal that included a 0.25% pay increase for Union members, an increase in the City's contributions to Union members' HSAs, and submission of the issue regarding shared premiums for active members and retirees to arbitration. That same day, Letteney rejected this proposal based, in part, on the City's inability to incur the additional costs proposed and stated that the previous options offered by the City remained available if the Union wanted to accept them. The parties exchanged additional emails on December 16 and 18, 2019, but no progress was made toward an agreement. On December 27, 2019, Letteney again offered the same arrangement the City had reached with the police union. Local 321 did not accept the City's offer.

The City's health plan changes, as approved by the City's Common Council on September 30, 2019, took effect on January 1, 2020. Additionally, the employee premium share for Plan 06A for Local 321 members remained at 10%.

The new HSA benefit, which was provided to all City employees as a crucial part of the 2020 health plan changes which were implemented by the City's Common Council, specifically required that eligible participants be enrolled in a qualified high deductible health insurance plan.

Some additional facts are included in the DISCUSSION.

DISCUSSION

As noted above, on January 1, 2020, the City made various changes to the health insurance benefits for all City employees, including the members of Local 321. When it did that, the City and the Union were parties to a CBA. Thus, these changes were made mid-term, and were not made after the contract had expired.

When the Association gave their opening statement in this matter and averred therein that the City had made unilateral changes to the health insurance for members of Local 321 in the middle of the contract's term, my initial reaction was to rhetorically say to myself: "the City can't unilaterally do that; that surely violates the contract!" Then the City gave their opening statement and for the next five hours, I heard detailed testimony about the existing contract language and the specific health insurance changes the City made. That testimony illustrates the old adage that, like so many things in life, something that initially seems simple can sometimes be considerably more complex. Such is the case here.

Although most my discussion is going to focus on **what** the City did, I am going to devote some attention at the outset to **why** the City did what it did.

As the Union correctly notes, in the City's original brief, it devoted several pages to its dire financial condition. As the Union sees it, by doing that the City is implying that "public policy favors fiscally stable municipal governments and justifies its unilateral modification of insurance premium contributions based on its allegedly dire financial constraints." While I have had status quo cases where a municipal employer argued that their unilateral change was necessitated by an economic or business necessity, it is expressly noted that the City did not make that argument here. Instead, they simply tried to show me that their financial condition was dire and consequently there was a legitimate economic reason why the Common Council voted to make the health insurance changes they made. They were successful in showing that.

That said, I am not addressing the wisdom of the Common Council's public policy decisions here. That is a completely separate matter. Instead, I am addressing the question of whether the changes which were implemented violated the parties' CBA. The focus now turns to making that call.

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Here is how my discussion is structured. In Part 1, I am going to identify in an overview format all the claims that the Union makes in the two grievances being reviewed. In this section, I will address two minor claims. As for the Union's major claims, they will simply be identified in this section; I'll discuss them later. Next, in Parts 2A and 2B, I'll address the health plan changes made by the City and their interplay with MERA. Next, in Part 3, I'll address the health plan changes made by the City and decide whether those changes conflicted with the language in Article XIV of the CBA. Finally, in Part 4, I'll review the Union's final claim that the City did not bargain with the Union before it made those changes.

Part 1

The Union's two grievances allege that the City violated Article XIV of the CBA when it allegedly 1) modified the health insurance premium rate to 7.5% for active members of Local 321 and members who will retire under the current CBA; 2) eliminated active members' Flexible Spending Accounts (FSAs); 3) capped Medicare Part B reimbursement for members who will retire under the current CBA; and 4) modified the City's wellness program as it relates to members who will retire under the current CBA. The two grievances also allege that the City did not bargain with the Union before it made those changes.

In my discussion, I am not going to address these claims in the order just listed. Instead, I'm first going to address claims 2 and 4.

As noted above, the second claim raised in the grievances is that the City eliminated active members' Flexible Spending Accounts (FSAs). The applicable language in Article XIV states as follows:

> Employees may establish a Flexible Spending Account with voluntary employee contributions to a maximum of $2,500 per year for medical and $5,000 per year for dependent care.

In its initial brief, the Union did not mention this claim at all. In its reply brief, the Union essentially dropped this claim and avers that it "only serve[s] to obfuscate the issues that must be determined by the arbitrator." I therefore find that the Union has waived this claim. In the alternative, I also find that the Union did not prove that the City violated this provision. Here's why. While the City added the additional benefit of an HSA for employees who chose to open such an account, this new benefit did not replace the FSA benefit. Local 321 members retain the option to maintain an FSA if they choose not to open an HSA, following the 2020 revisions which form the basis for these grievances.

The Union's fourth claim raised in the grievances is that the City modified its wellness program as it relates to members who will retire under the current CBA. The applicable language is found in the last paragraph in Article XIV, Section 1 and all of Section 2. I've decided to not repeat all that language here. Instead, this language, which is from the last paragraph in Section 1, will suffice. It states as follows:

> Fitness Center Reimbursement: The City will reimburse full time employees and retirees that carry the City of Racine health insurance for 50% of the annual membership fee for a fitness center up to a maximum of $200 per employee.

Once again, in its initial brief, the Union did not mention this claim at all. In its reply brief, the Union essentially dropped this claim and avers that it "only serve[s] to obfuscate the issues that must be determined by the arbitrator." I therefore find that the Union has waived this claim. In the alternative, I also find that the Union did not prove that there was a change to the City's wellness program. Here's why. Under this program, active employees and retirees can obtain $200 for taking certain actions associated with improved wellness, such as visiting a physician, attending a health-related webinar, etc. Spouses of active employees and retirees can obtain $100 for engaging in the same activities. There was no change to this program for 2020, and there has been no reduction or diminishment in the wellness benefits to which retirees will have access. The Local 321 members who retire under the current CBA and their spouses will continue to have access to all of the City's wellness benefits, including the City's wellness clinic.

I therefore find that the City did not eliminate the FSA or change wellness benefits, as alleged in the Union's grievances. As a result, the Union's second and fourth claims referenced above are dismissed.

Although I just ruled on Union claims 2 and 4 in this section, I am not going to rule on claims 1 and 3 in this section. Instead, I'm just going to identify what the Union's remaining claims are. They will be discussed in subsequent sections.

The Union's first claim is that the City modified the health insurance premium rate to 7.5% for active members and members who will retire under the current CBA. According to the Union, the City improperly increased health plan premiums on the high deductible plan from 5% to 7.5%.

The Union's third claim is that the City improperly capped Medicare Part B reimbursement for members who will retire under the current CBA.

The Union's final claim is that the City did not bargain with the Union before it made those changes.

Part 2A

While the Union asserts that its two grievances involve a mandatory subject of bargaining, the City disputes that assertion. As the City sees it, the Union's two grievances involve an attempt to bargain over aspects of the City's health insurance plan which involve prohibited subjects of bargaining under Wis. Stat. § 111.70(4)(mc)6. Building on that premise, the City contends it was not required to, and in fact was prohibited from, bargaining with the Union on such matters.

Normally in my arbitration awards, I limit my comments to interpreting the CBA and do not address claims involving state or federal law. Here, though, in addressing the competing claims just referenced, I find it necessary to address a particular state law (namely Act 32) because it plays an indelible role here. The following discussion shows why I cannot ignore Act 32 in evaluating this case.

I begin with the following review of Wisconsin public sector labor law history for some context. Prior to 2011, Wisconsin municipal employers were required by the Municipal Employment Relations Act (MERA) to bargain over health insurance benefits with certified unions representing public safety employees (like the members of Local 321). In 2011, the Wisconsin Legislature enacted Act 32, which prohibited municipal employers from bargaining with unions over "[t]he design and selection of health care coverage plans by the municipal employer for public safety employees, and the impact of the design and selection of the health care coverage plans on the wages, hours, and conditions of employment of the public safety employee." *See* Wis. Stat. § 111.70(4)(mc)6. (2011 Wisconsin Act 32).

In the aftermath of Act 32, litigation ensued over exactly which subjects of bargaining fell under Act 32's prohibition. This litigation resulted in differing results. For example, in *Milwaukee Police Association, Local 21 v. City of Milwaukee*, 348 Wis. 2d 168 (Wis. Ct. App. 2013), the union disputed the city's ability to make changes to health plans without bargaining the direct financial impact on employees, such as contributions to deductibles or copays. The court held that, in the wake of Act 32, "the impact of the design and selection of the health care coverage plans on the wages, hours, and conditions of employment of the public safety employee is no longer a

subject that a municipality may bargain ….” Id. at pgs. 177-178. In contrast, the court in *Wisconsin Professional Police Association (WPPA) v. Wisconsin Employment Relations Commission (WERC)*, 352 Wis. 2d 218 (Wis. Ct. App. 2013), held that “deductible payment allocation” is not a prohibited subject of bargaining. The court held that deductible payment allocation was separate from plan design and therefore not a prohibited subject of bargaining. The court further concluded that bargaining over who pays the deductible is not considered bargaining over the impact of the plan design which would otherwise be prohibited by Wis. Stat. § 111.70(4)(mc)6.

In light of the above litigation and other similar disputes over the language of Wis. Stat. § 111.70(4)(mc)6., and as a clear rejection of the holding in *WPPA v. WERC*, the Wisconsin Legislature sought to clarify the meaning of the statute by enacting 2013 Wisconsin Act 20. In doing so, the Legislature revised Wis. Stat. § 111.70(4)(mc)6. to read as follows (underlined language indicating the addition of language):

> The municipal employer is prohibited from bargaining collectively with a collective bargaining unit containing a public safety employee with respect to any of the following: . . . (6) <u>Except for the employee premium contribution, all costs and payments associated with health care coverage plans and</u> the design and selection of health care coverage plans by the municipal employer for public safety employees, and the impact <u>of such costs and payments</u> and the design and selection of the health care coverage plans on the wages, hours, and conditions of employment of the public safety employee.

The above change to the language of Wis. Stat. § 111.70(4)(mc)6. was followed by a declaratory ruling of the WERC, in which the WERC broadly interpreted the statute’s prohibition. In *City of Monona (Fire Fighters)*, Dec. No. 36748 (WERC, 11/2016), addressing the bargaining obligation over existing and proposed contract language concerning payments in lieu of health insurance, the WERC stated as follows:

> Section 111.70(4)(mc)6, Stats., now prohibits public safety employee bargaining over the following three subjects/categories:
>
> 1. All costs and payments associated with health care coverage plans.
> 2. The design and selection of health care coverage plans.
> 3. The impact of costs/payments and design/selection on wages . . . .

Id. at page 5.

The Commission went on to find in that decision that payments in lieu of health insurance were a prohibited subject of bargaining under the statute. More importantly, the WERC’s decision confirmed that the only aspect of health insurance coverage and selection which is not a prohibited subject of bargaining is employee premium contributions.

Having given that context, the focus turns to whether the two grievances relate to a mandatory or prohibited subject of bargaining.

As already noted, the Union contends that its grievances relate to a mandatory subject of bargaining, to wit: the premium contributions Local 321 members pay for health insurance. Upon initial review, that does indeed seem to be the case because the City is now requiring members of Local 321 to pay a 10% premium contribution for a (new) high deductible plan while they previously paid a 5% premium contribution for the (old) high deductible plan. Since the 5% difference between these two numbers involves a premium contribution, the Union's claim that its grievances involve a mandatory subject of bargaining seemingly has merit.

However, it's not that simple and that's not the end of the analysis. That's because the above finding (i.e. that the Union's grievances involve a mandatory subject of bargaining) is based on the premise that the parties "agreed and intended" that Local 321 members would pay a 10% premium contribution for a low-deductible plan and 5% premium contribution for a high deductible plan. Although I will address this point in more detail below, it suffices to say here that the City contends that is not what it "agreed to" or "intended". While this case does involve the premium contribution that employees will pay going forward for the only plan now being offered by the City, it also involves the distinction just noted between a low deductible plan and a high deductible plan. That is important, of course, because whether a health plan is a low deductible plan or high deductible plan, and the components of each, is a matter of plan design. As noted above, the parties cannot legally bargain over plan design matters, and any agreement concerning such matters would be unenforceable. Instead, the City has the legal right under Wis. Stat. § 111.70(4)(mc)6. to modify or eliminate its various health plans unilaterally as it deems in its best interest.

By claiming that just employee premium contributions are involved here, the Union wants me to ignore the language of Wis. Stat. § 111.70(4)(mc)6. and its interpretation by the WERC. I can't do that because the City's decisions regarding the elimination or modifications of health plans, including the deductible amounts of those plans, are not permitted to be bargained under Wis. Stat. § 111.70(4)(mc)6., because they are not employee premium contributions. As just noted, in this case the Union attempts to use extrinsic evidence to show that the parties agreed upon specific plan designs (i.e. a high deductible plan and a low deductible plan). However, as noted above, health plans design is a prohibited subject of bargaining under section 111.70(4)(mc)6. That means that the City could not have agreed to be bound to such plan designs elements, and if it had, any such agreement would not be enforceable.

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In Part 3 of my discussion, I'm going to address those elements of the Union's grievances that involve a mandatory subject of bargaining (i.e. premium contributions which are to be made by employees), as well as those elements of the Union's grievances that involve a prohibited subject of bargaining (i.e. plan design).

Part 2B

Before I do that though, the City asks that I address the following. It contends that by pursuing these two grievances, the Union is attempting to engage in illegal "bargaining" with the City over prohibited subjects of bargaining under Wis. Stat. § 111.70(4)(mc)6. To support that premise, the City cites a prior decision of the undersigned in *Village of Menomonee Falls*, Dec. No. 34017-A (WERC, 5/2013). In that case, where I was serving as both examiner and arbitrator, I rejected the union's argument that Wis. Stat. § 111.70(4)(mc)6. did not relate to either the parties' grievance procedure or the union's prohibited practice complaint because the parties were not currently engaged in bargaining over health insurance issues. Finding in favor of the employer, I opined as follows:

> The Association's argument that Act 32 does not relate to either the grievance or the prohibited practice complaint is based on the premise that the parties are not currently engaged in bargaining over health insurance issues. As the Association sees it, Act 32 does not affect the parties until the parties sit down to bargain specific health care issues that are prohibited by the statute. I find that assumption to be flawed because it ignores the statutory definition of "collective bargaining" under Sec. 111.70(1)(a). While sitting down to bargain a successor collective bargaining agreement is certainly one common view of collective bargaining, the Wisconsin statute which defines collective bargaining has a more expansive view than that. Specifically, Sec. 111.70(1)(a) includes the grievance process within the definition of collective bargaining. Subsumed into that is grievance resolution (i.e. resolving questions which have arisen under a grievance procedure). Thus, while the Association believes "bargaining" can only occur during negotiations for a new/successor collective bargaining agreement, the section just noted includes a grievance resolution process within the definition of bargaining…. [T]he Association is indeed attempting to engage in "bargaining" with the Village over the health care plan and design by pursuing this grievance…such bargaining is prohibited under Act 32.
>
> *Id.* at page 24.

The City asserts that while the parties here were not in a contract hiatus period when the hearing was held, the holding in *Village of Menomonee Falls* is still applicable here because under both circumstances, the parties generally have a duty to process valid grievances under the parties' contractual grievance procedure. I concur. In Part 2A above, I found that the City had demonstrated that the changes which it made to the City's health plans were prohibited subjects of bargaining under Wis. Stat. § 111.70(4)(mc)6. Because of that, I find – just as I did in *Village of Menomonee Falls* – that since the pursuit of a grievance is a form of bargaining under the statutory definition, the Union cannot successfully seek relief through the parties' grievance procedure for prohibited subjects of bargaining.

Part 3

As I said at the end of Part 2A, in this section I'm going to address those elements of the Union's grievances that a involve a mandatory subject of bargaining (i.e., premium contributions)

as well as those elements of the Union's grievances that involve a prohibited subject of bargaining (i.e. plan design). In the course of doing that, I will also address Union claims 1 and 3 and decide whether any the changes referenced therein violated the language in Article XIV.

I'll focus initially on the Union's first claim referenced above (i.e., that the City modified the employee health insurance premium rate to 7.5% for active members of Local 321 and members who will retire under the current CBA.). According to the Union, the City improperly increased health plan premiums from 5% to 7.5%.

The contract language applicable to this claim is found in Article XIV, Section 1, and is one sentence long. It provides thus:

> Employees shall be required to contribute 10% of the monthly notional premium as a premium share for Plan 06A or 5% of the monthly notional premium share for Plan 07A, as approved by the Racine Common Council.

I begin my discussion of this language with the following general overview. This sentence identifies the plans by name and the premium percentages for each plan, and states that all are subject to approval by the Racine Common Council. However, it does not define either the term "Plan 06A" or "Plan 07A". Additionally, the sentence does not use the terms "high deductible" or "low deductible". A major question in this case is whether the absence of a contractual definition of the terms "Plan 06A" and "Plan 07A", and the non-inclusion of the terms "high deductible" and "low deductible" in this sentence make this contract language ambiguous. As already noted, the Union argues that it does and wants me to rely on the parties' past practice, their bargaining history, and their "intent" to interpret the contract language. The City disagrees with that claim and contends that the contract language involved here is clear and unambiguous, so I need not use any extrinsic evidence to interpret the language. I'll address these competing arguments later in my discussion.

First, though, I'm going to address the following. As noted above, prior to 2020 there were two health plans: the low deductible plan (Plan 06A) and a high deductible plan (Plan 07A). The employee premium contribution for the former was 10% and 5% for the latter. What the City did here was eliminate Plan 07A and reconfigure (old) Plan 06A from a low deductible plan to a high deductible plan. The City's action raises this rhetorical question: why didn't the City simply use the designation it had previously used for its high deductible plan (Plan 07A) to refer to the new high deductible plan? In its reply brief, the Union offered the following answer to that rhetorical question:

> The inescapable answer to this question is that at the time it made these modifications, Racine was aware it had agreed to a 10% premium contribution from Local 321 members for a LD [low deductible] plan (Plan 06A) and a 5% premium contribution for a HD [high deductible] plan (Plan 07A). Racine recognized that increasing the premium contribution would necessarily constitute a breach of its agreement with Local 321, so it did not take the simple direct route of eliminating the LD plan (Plan 06A) and then increasing the deductible and premium

> amounts for its pre-existing HD plan (Plan 07A). Instead, Racine attempted to disguise the fact that it was increasing premium contribution it had agreed Local 321 members would pay for an HD plan by calling the new plan by the name used to refer to the old LD plan – Plan 06A.

Assuming that the Union is correction about the City's motives, the question to be answered here is whether the City's motives in making this change matter. I find they do not. By that I mean that the City's motives and intent in making the change it made are not controlling. What matters is whether the City is still in compliance with Article XIV, Section 1 after it made this change. I find that it is. The City complied with the literal meaning of the words in Article XIV, Section 1. Said another way, the City followed the proverbial letter of the law, so to speak. The applicable language under Article XIV, Section 1 specifically states, "Employees shall be required to contribute 10% of the monthly notional premium as a premium share for Plan 06A…, as approved by the Racine Common Council." *Emphasis added*. After the City made the change involved here, the employee premium share for Plan 06A remained at 10%, as required by the contract language. Though the plan design of Plan 06A has changed, as is the City's right under Wis. Stat. § 111.70(4)(mc)6, the employee premium share for Plan 06A remains at 10%. The premium amount (rather than percentage) may change based on the Common Council's modifications to Plan 06A's design, but the City is not required or permitted to bargain over the plan design changes, and the CBA does not address premium amounts, only percentages. If the Union desired to secure a specific dollar amount which Local 321 members were to pay toward premiums for Plan 06A, it could have done so when it negotiated the contract. However, it did not and instead agreed to a percentage, which the City has not modified.

Both at the hearing and in their briefs, the Union emphasized that the parties used the terms "high deductible" plan and "low deductible" plan to describe Plan 07A and Plan 06A. The Union also emphasized that the City itself used those same terms in some informational documents that were produced by the City and disseminated to all city employees (including members of Local 321). The Union also cites the testimony of the Union president that the "06 plan was the low deductible plan", that "the 07 plan was the high deductible plan", that "everyone knew that's what it meant", and that the parties agreed that "for a high deductible plan, the Union would pay an employee premium share of 5% per month." The Union also notes that the City did not have a single witness testify regarding the intent of the language or the parties' bargaining history. It sees that as significant. Building on all of the foregoing, the Union contends that the parties' used the terms "high deductible" and "low deductible" as a shorthand way of referring to health plans 07A and 06A. The Union further avers that this bargaining history and past practice establishes that the parties agreed and intended that Local 321 members would pay a 10% premium contribution for a low deductible plan and a 5% premium contribution for a high deductible plan, but the City is now forcing Local 321 members to pay a 10% premium contribution for a high deductible plan. In short, the Union asks me to use all this extrinsic evidence to interpret what it contends is ambiguous language in Article XIV, Section 1.

I'm not going to do so for this reason. It is a basic contract and arbitral interpretation principle that parol evidence (such as oral agreements, bargaining history, past practice, or documents other than the contract itself) is only relevant to the extent that the language in question

is ambiguous or unclear. Here, the Union emphasizes that the two health plans referenced in Article XIV, Section 1 (i.e., Plan 06A and Plan 07a) are not defined, and that there is no reference therein to "high deductible" and "low deductible". As the Union sees it, that makes the language in Article XIV, Section 1 ambiguous and the arbitrator therefore needs to rely on extrinsic evidence (i.e., the parties' bargaining history and their past practice) to determine the parties' intent concerning the meaning of Article XIV Section 1. I disagree. In my view, the language in Article XIV, Section 1 is clear and unambiguous in stating that employees who are enrolled in Plan 06A are to pay 10% of the premium, which is what employees are now paying for that plan. That is its plain meaning. The fact that the City eliminated the (old) Plan 07A and modified the plan design of the (old) Plan 06A into a (new) Plan 06A does not change this interpretation. Nor does the fact that Article XIV, Section 1 does not contain the terms "high deductible" and "low deductible", and that the parties previously used those terms to refer to Plans 07A and 06A. In my view, if I used parol evidence to interpret the language in Article XIV, Section 1, I would be adding language to the provision that is not currently there.

Even if the relevant contract language in Article XIV, Section 1 is ambiguous, what the Union is attempting to do here is use extrinsic evidence to show that the parties agreed on specific plan designs (i.e., a high deductible plan and a low deductible plan). However, as was already addressed in Part 2A, any issues related to health plan design, including whether a plan is "high deductible" or "low deductible", are prohibited subjects of bargaining under Wis. Stat. § 111.70(4)(mc)6. That means that by law, the City could not legally bind itself to any specific plan design. What the Union wants me to do here is find that the parties bargained over the substance of Plans 06A and 07A and then enforce an (alleged) agreement between the parties concerning them. However, I cannot legally do that because they involve plan design. That, in turn, makes them prohibited subjects.

Moreover, as was referenced in the FACTS, above, the existence of a qualified "high deductible health plan" is a legally required condition precedent to the provision of an HSA. The HSA benefit, which was provided to all City employees as a part of the 2020 plan design revisions, could not have been provided by the City in the absence of a qualified high deductible plan. Thus, there is a legally required link between the two elements of the City's 2020 revisions to the health plan design. Additionally, it is relevant that the City incurred $915,000 in new costs in 2020, in order to provide the new HSA benefit to City employees, including members of Local 321.

Finally, while the Union alleges that City changed the employee premium rates to 7.5% for the members of Local 321, that is not what happened. While it will be addressed in more detail in Part 4 below, it is true that City Attorney Letteney offered to amend the premium share for members of Local 321 from 10% to 7.5% on numerous occasions between September 9 and December 31, 2019, but those proposals were consistently rejected by the Union. After the City's proposals were rejected, the premium contribution of Plan 06A remained at 10% (as specified in Article XIV, Section 1, of the parties' 2018 - 2020 CBA). Thus, the City's actions complied with the existing contract language. The fact that the City is now charging all other City employees 7.5% as a premium contribution for Plan 06A (while the members of Local 321 have to pay a 10% premium contribution for Plan 06A) does not alter the outcome of this decision.

I understand the Union's frustration in this matter. Prior to January 1, 2020, those members of Local 321 in the high deductible plan were paying a 5% premium and now they are paying 10% for a different high deductible plan. Additionally, those previously paying a 10% premium were getting a low deductible plan and now they pay the same premium for a high deductible plan. Thus, the employees either had their premiums increased, or their level of benefits reduced. That doesn't seem fair, particularly since the health insurance language did not change. Normally, making unilateral changes like that in the middle of a contract's term would subsequently be found to violate the contract. That's why at the beginning of this discussion, I shared that when the Union made their opening statement and told me what happened my initial reaction was to say to myself: "the City can't unilaterally do that; that surely violates the contract!" However, the outcome of this case turned out differently than I initially thought it would because of the very unique contract language involved. Although the City made a unilateral change on health insurance that doubled the premium contributions for certain members of Local 321, the City's actions nonetheless complied with the contract language. Consequently, that change did not violate Article XIV, Section 1 of the CBA.

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The focus now turns to the Union's third claim that was referenced above (i.e., that the City's capping of its Medicare Part B reimbursement for those Union members retiring under the current CBA violates Article XIV). This claim, of course, involves the City's capping of its Medicare Part B payment at $135.50 / month for 2020. Based the following rationale, I find that the City did not violate the CBA by its actions in that regard.

First, let's look at the contract language. The applicable language in Article XIV, Section 1, second paragraph, states as follows:

> The Employer will continue to pay Medicare B and provide City health insurance and retiree will be required to enroll in Medicare B. Employees hired on, or after, 1/1/07 will not be eligible for Medicare B payments by the Employer.

Before I delve into the meaning of this provision, it is noted at the outset that this provision refers to one part of Medicare, namely B, which is usually called Part B. Although this language does not explicitly say who gets Medicare, it is implicit that employees do not receive Medicare Part B reimbursement, only retirees receive this benefit once they become Medicare - eligible. Thus, this language dealing with Medicare Part B applies only to retirees, and not to employees.

The focus now turns to what the language means. Under this language, the City is obligated to make Medicare Part B payments to those future retirees who were hired prior to January 1, 2007; the language expressly provides that those employees hired after that date "will not be eligible for Medicare B payments by the Employer". While the above quoted sentence obligates the City to "continue to pay Medicare B", rhetorically speaking, does that mean **all** of the Medicare Part B payment or **some** of the payment? On its face, the language does not say how much or what percentage of the premium the City "will continue to pay." That means it is silent on the amount the City "will continue to pay" toward the Medicare Part B amount.

In deciding what amount of Medicare Part B the City "will continue to pay", it is noted at the outset that the City did not cease making reimbursement of Medicare Part B premiums for retirees. Instead, what the City did was limit the amount paid toward Medicare Part B in 2020 to $135.50/ month. The record shows that of the City's 550 retirees that receive a Medicare Part B reimbursement from the City, about 85% of them are reimbursed at the rate of $135.50, while 15% are reimbursed more due to income levels. In mid-2019, the City paid 56 different Medicare Part B rates. The City concluded that doing that was "administratively heavy", so it would henceforth pay a uniform monthly premium for Medicare Part B enrollees. A fact sheet issued by the US Centers for Medicare and Medicaid Services identified $135.50 as the "standard monthly premium for Medicare Part B enrollees" in 2019. This new limitation will impact future retirees who were hired prior to January 1, 2007.

The City's action raises this question: did the City violate this provision when it capped its 2020 Medicare Part B payment at $135.50/ month? I find there is nothing in either this language, or elsewhere in the CBA, that prohibits the City's actions. First, nowhere in Article XIV does it say that the City is required to pay a specific amount or percentage of the Medicare Part B premium to any retired Local 321 member, let alone the **full** or **entire** Medicare Part B premium. The Union's claim that this sentence requires the City to pay the "entire" amount of the Medicare Part B payment would certainly have a sound contractual basis if the language said that the City will pay "all" Medicare B, or "the full amount" of Medicare B, or "100%" of Medicare B", or the "entire" Medicare B. However, the sentence does not contain any word or descriptor which clearly identifies how much the City will pay of the Medicare Part B premium. That being so, I find that the existing language regarding Medicare Part B does not require the City to pay any specific amount or percentage of Medicare Part B premiums to any retired Local 321 member. Finally, the Union argues that since the existing language does not have any kind of cap on the City's obligation to pay the Medicare Part B premium that means there is no language that permits the City to impose a cap. I read the language differently. In my view, the existing language does not preclude the City from unilaterally imposing a cap. I therefore find that the existing Medicare Part B language does not preclude the City from capping Medicare Part B payments. It follows from that finding that the City did not violate Article XIV, Section 1, second paragraph, by capping Medicare Part B payments at $135.50/ month.

In so finding, it is noted that the Union wants me to consider the same "extrinsic" evidence that it cited earlier in this section. However, this argument by the Union fails for the same reasons as those which were identified above. In my view, the contract language referenced above is clear and unambiguous, and nowhere does it state that the City must pay **full** reimbursement or, for that matter, **any** specific amount of Medicare Part B reimbursement payments to retirees. The Union is attempting to hold the City to a certain standard (i.e., paying the **full** or **entire** Medicare Part B amount) that simply does not exist in the contractual language.

Even if my contractual interpretation is just plain wrong, there is another reason why the Union's claim fails. It is this. While the Union maintains that Medicare Part B payments are mandatory subjects of bargaining which involve employee premium contributions, in point of fact they are not. Medicare Part B payments are completely separate and distinct from employee health

insurance premiums. The reason that is an important distinction, of course, is because Sec. 111.70(4)(mc)6 expressly states that the only subject related to employee health insurance that a municipal employer may bargain over is employee premium contributions. As noted above, employees do not receive Medicare Part B reimbursement, only retirees receive that benefit once they become Medicare-eligible. Since Medicare Part B premium reimbursement applies only to retirees, and not to employees, this contractual benefit does not constitute employee premium contributions. That makes Medicare Part B premium reimbursement to retirees a prohibited subject of bargaining under Sec. 111.70(4)(mc)6. That, in turn, means that the City was prohibited by law from bargaining over any cap on Medicare Part B reimbursement to retirees, and any agreement in the CBA pertaining to such matters is unenforceable under Sec. 111.70(4)(mc)6.

Once again, although the City made a unilateral change when it capped its Medicare Part B payment at $135.50/ month, the City's actions nonetheless complied with the contract language. Consequently, that change did not violate Article XIV, Section 1, second paragraph.

Part 4

In this section, I'm going to address the Union's final claim that the City did not bargain with the Union before it implemented the health insurance changes involved here.

First, though, the following context is in order. On November 4, 2019, the Union filed what is commonly referred to in the labor relations community as a refusal to bargain complaint with the WERC against the City. That complaint, which was assigned Case Number 53.0021, has been held in abeyance since it was filed with the WERC. The reason for that, of course, was because the parties instead arbitrated the two instant grievances. While it is unlikely that the complaint would be reactivated after the issuance of this Award, that could conceivably happen. In the interest of bringing closure to all aspects of this dispute, I have decided to address the refusal to bargain claim in this Award. My reason for doing so is twofold. First, the Union expressly raised the duty to bargain claim in both grievances. It did so when it alleged that the City "did not bargain with us despite our request." While a refusal to bargain claim is not usually raised in a grievance, there is nothing that expressly precludes a Union from doing so. Since this claim was raised in both grievances, I have jurisdiction to rule on it. That, in turn, means I do not have to defer it to an examiner to be decided. Second, I am also doing it to save the Commission's limited financial resources. It is noted in this regard that the undersigned is one of just two Commission examiners. If I did not address this claim, and it was subsequently raised via the reactivation of the complaint, there is a 50% chance that I would be the examiner assigned to make that decision. Under these circumstances, it simply makes sense for me to review the claim now, rather than potentially review it later.

I find that even though no change was made to the employee premium contribution percentage stated in the contract language, and the parties were prohibited from bargaining over matters of plan design, the City made a good faith effort to meet with the Union, discuss its concerns over the City's changes to its health plans, and offer options to address the Union's concerns. The following shows this.

First, City representatives met twice in face-to-face meetings with Union officials, including the president of Local 321. At the first meeting on September 16, 2019, union representatives were given the opportunity to express their concerns and opinions about the contemplated changes, and the record shows that they did so. At the second meeting on November 13, 2019, the parties discussed various revisions to the contemplated plan design changes approved by the Common Council. At that meeting, union representatives acknowledged that the City was not legally obligated to bargain with the Union regarding matters related to health care design.

Second, in addition to those face-to-face meetings, the record also shows that the parties' representatives – City attorney Letteney and Union attorney MacGillis – exchanged numerous emails with each other. In those emails, Letteney offered the Union several alternatives to the health plan changes set to take effect on January 1, 2020. Letteney's efforts included offering alternatives to the planned health plan changes. Among those options was the same arrangement the City had reached with the City's police union. Specifically, Letteney offered to amend / change Local 321 members' premium share from 10% to 7.5% on numerous occasions between September 9 and December 31, 2019, but those proposals were consistently rejected by Local 321. When those emails are considered collectively, I find them sufficient to show that Letteney made numerous good faith efforts to try to come to a voluntary resolution with the Union. Because of that, I find that the Union did not prove that the City refused to bargain before the changes were implemented. Since no voluntary resolution was reached with the Union, the City implemented the health plan changes previously passed by the Common Council. These changes were implemented on January 1, 2020. The City had the legal right to do that. The fact that the Union never agreed to any of those health insurance changes is of no legal consequence.

I therefore find that the Union's refusal to bargain claim was not substantiated.

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In sum, the City's actions pass arbitral muster. In light of the above, it is my

AWARD

That the City did not violate Article XIV of the CBA by its actions herein. Both grievances are therefore denied.

Issued at Madison, Wisconsin, this 19th day of January, 2021.

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Raleigh Jones, Arbitrator