STATE OF WISCONSIN
WISCONSIN EMPLOYMENT RELATIONS COMMISSION

AFSCME LOCAL 2494,

Petitioner,

v.

WAUKESHA COUNTY,

Respondent.

Case 165
No. 60501
INT/ARB-9423
Dec. No. 30468-A

DECISION AND AWARD

The undersigned was selected by the parties through the procedures of the Wisconsin Employment Relations Commission. Hearings were held on December 16, 1992 and January 13, 2003. The parties were given the full opportunity to present evidence and testimony. At the close of the hearing, the parties elected to file briefs. The arbitrator has reviewed the testimony of the witnesses at the hearing, the exhibits and the parties' briefs in reaching his decision.

ISSUES

The parties reached agreement on most of the terms to be included in the successor agreement. All of those tentative agreements are incorporated into this Award. The remaining open issues are:

UNION OFFER:

1. Contract Term: January 1, 2002 through December 31, 2003.

2. Wages - 3% across each cell of the schedule, effective December 29, 2001 and, again 3% across each cell of the schedule effective December 28, 2002.

EMPLOYER OFFER:

Modify the co-pay structure for prescription drugs to include a $10.00 co-pay for generic drugs and a $15.00 Co-pay for brand drugs.

Add prescription drug coverage for non-formulary drugs with a $25.00 user co-pay.

Introduce an annual in-network deductible of $100.00 per person and $300.00 per family.

Introduce 10 percent co-insurance for in-network services beyond the deductible up to an out-of-pocket limit of $400.00 for individuals and $800.00 for families.

Increase wages by 3 percent in 2002 and 3 percent in 2003,

An additional $.35 per hour across the board, timed to start when health care design modifications take place,

A Section 125 medical reimbursement plan administered at County expense under which employees could set aside money on a pre-tax basis to pay for non-reimbursable medical expenses.

Modify the mileage reimbursement policy to reimburse employees at the IRS rate.

Modify the car pool incentive policy to award employees $.15/mile for three people in a vehicle, $.25/mile for four-five people in a vehicle, and $.35/mile for six or more people in a vehicle.

BACKGROUND

Waukesha County, hereinafter referred to as the Employer, has seven organized bargaining units. AFSCME Local 2494, hereinafter referred to as the

Association, represents the Master Unit, which is the unit involved in this proceeding. It also represents three other bargaining units. There are 445 employees in the Master Unit. The County overall employs approximately 1,344 employees, of which 425 are non-represented. The represented employees are in the following units: Master Unit; Deputy Sheriffs; Correctional Officers and Radio Dispatchers; Social Workers; Highway Operations and Central Fleet; Parks; and Public Health Nurses.

The County provides health insurance to its employees. Employees can choose an HMO Plan or a Point of Service ("POS") plan. The County's HMO is administered by CompCare, and is a prepackaged plan. CompCare provides a predetermined packaged level of benefits that cannot be adjusted or modified by the County. The POS Plan is partially self-insured. United Healthcare administers that Plan. The POS plan has both an in network and out of network component. Three hundred and forty-one of the Master Unit employees are enrolled in the POS plan. The HMO plan has fifty-five employees enrolled. 50 Master Unit employees have chosen not to participate in either health insurance plan.

The Employer, like many Employers, has experienced a huge increase in the cost of health insurance over the last few years. Premiums have almost doubled since 1999. Because of these increases, the Employer requested its actuary to find ways to lower health insurance costs. The health insurance proposals that are the subject of this proceeding came as a result of that review. The proposals were made after the Employer transferred millions of

dollars into the insurance program to cover losses. Without the transfer increases would have been even greater.

STATUTORY CRITERIA

111.70(4)cm(7), Wis. Stats., sets forth the criteria that the Arbitrator is to consider in making his award:

> 7. `Factor given greatest weight.' In making any decision under the arbitration procedures authorized by this paragraph, the arbitrator or arbitration panel shall consider and shall give the greatest weight to any state law or directive lawfully issued by a state legislative or administrative officer, body or agency which places limitations on expenditures that may be made or revenues that may be collected by a municipal employer. The arbitrator or arbitration panel shall give an accounting of the consideration of this factor in the arbitrator's or panel's decision.
>
> 7g. `Factor given greater weight.' In making any decision under the arbitration procedures authorized by this paragraph, the arbitrator or arbitration panel shall consider and shall give greater weight to economic conditions in the jurisdiction of the municipal employer than to any of the factors specified under subd. 7r.
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> 7r. `Other factors considered.' In making any decision under the arbitration procedures authorized in this paragraph, the arbitrator or arbitration panel shall also give weight to the following factors:
>
> a. The lawful authority of the municipal employer.
>
> b. Stipulations of the parties.
>
> c. The interests and welfare of the public and the financial ability of the unit of government to meet the costs of any proposed settlement.
>
> d. Comparison of wages, hours and conditions of employment of the municipal employes involved in the arbitration proceedings with the wages, hours and conditions of employment of employes performing similar services.

e. Comparison of the wages, hours and conditions of employment of the municipal employes involved in the arbitration proceedings with the wages, hours and conditions of employment of other employes generally in public employment in the same community and in comparable communities.

f. Comparison of the wages, hours and conditions of employment of the municipal employes involved in the arbitration proceedings with the wages, hours and conditions of employment of other employes in private employment in the same community and in comparable communities.

g. The average consumer prices for goods and services, commonly known as the cost of living.

h. The overall compensation presently received by the municipal employes, including direct wage compensation, vacation, holidays and excused time, insurance and pensions, medical and hospitalization benefits, the continuity and stability of employment, and all other benefits received.

I. Changes in any of the foregoing circumstances during the pendency of the arbitration proceedings.

j. Such other factors, not confined to the foregoing, which are normally or traditionally taken into consideration in the determination of wages, hours and conditions of employment through voluntary collective bargaining, mediation, fact-finding, arbitration or otherwise between the parties, in the public service or in private employment.

DISCUSSION

While the Statute lists numerous criteria that are to be considered by Arbitrators, not all of the criteria are always relevant. Only those criteria that have been raised by the parties will be addressed here. The position of the parties concerning each item will be described during the discussion of that particular factor. The Arbitrator will also address the two issues that under the

Statute must be given more weight than the other items listed in Section C(m).

Greatest Weight

The Law directs the Arbitrator to give the greatest weight to any Statute or Lawful Directive. Neither party has argued that this provision has any applicability to this dispute. The Arbitrator agrees. This factor has been considered and determined by the Arbitrator to be of no relevance to the ultimate outcome.

Greater Weight

The Association has not directly argued that the economic condition of the Employer is such as to have this factor favor its position. It has argued that the County is the wealthiest county in the State and one of the wealthiest in the Country. The Association also emphasizes that the average pay received by the County's workers is not commensurate with its stature as a wealthy County. To the extent that the Association argues that this factor favors its position, it is rejected. Arbitrator Vernon in Waukesha County (Public Health Nurses), Dec. No. 29622-A, was presented with a similar argument. He also rejected it. He noted that while Waukesha was an affluent County that:

> much the same thing could be said about Washington and Ozaukee County who are both in the parties comparable group for Section 7.R.d. purposes… None of the evidence presented by the parties under Factor 7g bears in any meaningful way on evidence on how much more Waukesha County can afford to pay. For lack of evidence, Factor 7g is inapplicable in this particular case.

There is a lack of evidence in this case, as well. The Association has not shown that the status of this County is such that it should be considered in a different light than the other Counties. This Arbitrator has dealt with this same issue before and noted that in his mind it is a change in status over time vis-à-vis

others that is significant. Is it fairing worse today relative to others than it did in the past or when the last contract was completed. Conversely, is it fairing far better in relation to others than was true a few years ago? There is no indication here that anything has changed in the last two years. While Waukesha may be at the top economically today, it was also at the top in the past. Therefore, it is my finding that this factor carries no weight in this proceeding.

Internal Comparables

Internal Comparables are generally considered to be one of the most significant of all factors when the subject of the dispute involves benefits, rather than wages. Health insurance issues would fall within that category. This case is complicated, however, by events that transpired subsequent to the close of the hearing. None of the other bargaining units had resolved their agreements at the time that the hearings were held. Subsequent to the close of the hearing, the County sent a letter to the Arbitrator notifying him that two of the other non-AFSCME units had accepted proposals similar to those offered here. The Association objected to the introduction of that information after the fact. This Arbitrator rejected the proposed evidence in a letter to the parties. It was rejected because the evidence at the hearing was that these same Unions had indicated during negotiations that they could accept the proposal only if the price was right. In other words, what would they get if they agreed. Since the Arbitrator had no way of knowing what they accepted in exchange for their subsequent acceptance of the health insurance proposal, the proffered evidence was rejected.

What now complicates this issue further is that the Association in its brief, which was submitted before the letter from the Employer, argued the following:

> Despite its protestations to the contrary, the County cannot avoid objective reality - none of its represented bargaining units has settled. None of the bargaining units has agreed to the Employer's proposal for benefit structure reductions. The solidarity displayed by Waukesha's unions is without historic precedent.
>
> The absence of any voluntary acceptance of the County's plan redesign by its County unions means that Waukesha County is asking the Arbitrator to do for it what it hasn't been able to do for itself. The County 's final offer requires the Arbitrator to transfer significant medical costs from Wisconsin's wealthiest County on to the backs of its workers.
>
> The probative value of internal comparability is regarded highly by interest arbitrators. In assessing the reasonableness of any substantive change in benefits, especially with respect to health insurance, the pattern of internal settlement is often determinative.

Four of the other bargaining units are represented by AFSCME and their agreements remain unsettled. The two non-AFSCME Units have now settled. While I noted it would be unfair to the Association to take into account those settlements for the purpose of establishing a pattern, it would be equally unfair to the Employer to pretend that there are no settlements and simply ignore the fact that there have been. The fact is that the Association argument is no longer true. There are settlements. Given this convoluted scenario, the only way to balance the rights of both parties is to treat this factor as a non-factor in this proceeding as to the organized employees.

The Employer has also pointed out that the non-represented employees are under the same requirements as are proposed here. It argues this also suggests a pattern. The difference here is that this change was not done as the product of negotiation. No trade-off was required to gain the non-represented employees

acceptance. It was simply imposed upon them. The fact that the non-represented employees pay the added costs carries little weight with this Arbitrator for this reason. Instead, for the reasons stated above, it is my finding that this factor favors neither party.

External Comparables

It was noted in the preceding section of this discussion that internal comparables are generally more persuasive than external comparables when benefits are involved. That does not hold true in this case as internal comparables have been discounted. Consequently, external comparables is of more importance in this dispute than it might otherwise have been. The parties offered exhibits to demonstrate how under each of their respective proposals health costs for the County's employees compares to what employees in other Counties are required to pay. Before any comparison can be made, the Arbitrator must first determine who the appropriate comparables are. That shall now be done.

Appropriate Comparables

The Employer would like the comparable counties limited to the contiguous counties of Dodge, Jefferson, Ozaukee, Racine, Washington and Walworth. The Association would like to add Kensha, Rock and Dane Counties to the list. The Association's proposed Counties include the same Counties that were used by Arbitrator Vernon in 2000. In his decision, he held that:

> What remains is the argument between the parties as to whether the internal settlements should prevail. The general well established rule is that an internal settlement pattern should control unless it can be demonstrated that adherence to the pattern would cause unreasonable and unacceptable wage relationships relative to the external comparables. In this case, based on the evidence and

influence of Arbitrator Mueller's award, the Arbitrator will use the following counties for comparison purposes:

Dane	Washington
Walworth	Ozaukee
Dodge	Jefferson
Rock	Kenosha

It is well settled that arbitrators should follow the list used by their predecessors unless there is some strong reason to deviate from that list. The fact that the Employer has proposed different comparables in some interest cases than it has proposed in this one tends to show this Arbitrator that there is no crying need to change Arbitrator Vernon's list. Furthermore, there is validity to the Association's argument that Waukesha is far larger in size than are the Counties contiguous to it. This County has a larger population than any of the contiguous Counties. As the Union notes "the mean population of these counties is 111,000 which is only about one third the population of Waukesha at 361,000." The Union's proposed addition of Dane, Kenosha and Rock to the list would raise the mean population to 243,000. The difference in size between Dane and this County is far smaller than the difference between this County and the smallest contiguous County, Jefferson. Jefferson's population is approximately 285,000 less than Waukesha's. Waukesha's population is only 65,000 less than Dane's. Kenosha and Rock County have larger populations than every one of the contiguous Counties, but Racine. Dane County is the wealthiest County in the State. Waukesha is near the top.

There is ample evidence in the record to support the Association's proposed list. There is certainly nothing in the record that would support a decision by this Arbitrator to deviate from his predecessors. The list established by Arbitrator Vernon shall be used here.[1]

[1] The case before Arbitrator Vernon involved nurses, not Court personnel. The County says the professional nature of the bargaining unit warranted inclusion of these other Counties and that is not true here. I do not find that this difference is enough of a reason to deviate from his finding.

A Comparison of the Comparables

The comparable Counties require varying degrees of employee participation in health care costs. Most of the comparable Counties, like this County, have more than one plan available to the employee. Each of the plans requires different levels of employee payments. Thus, it is not easy to precisely compare the costs under the proposals here with the cost to employees in other Counties. In this County most employees are under the United Health Plan, rather than the Compcare Plan. The Exhibits reveal that 341 employees are covered by the County's Point of Service Plan. Only 54 employees are under Compcare coverage.[2] Given those figures, only Point of Service Plans will be compared. It may very well be that in some Counties the POS plan may not be the plan of choice for the employees in that County. However, using this method will at least compare apples with apples. Where a County does not have a Point of Service Plan, the average costs of their various non-HMO Plans, will be compared. In addition, only the in-network costs will be compared, since the purpose of in-network and out-of-network provisions is to steer employees towards in-network providers. This then will be the framework for the comparison to follow.

The Association when addressing external comparables pointed out at the outset of its argument that this County pays less towards insurance premiums per employee than the other Counties. It believes that since this County pays less than others that the burden on the County is not so sufficient as to justify shifting even greater costs to employees. They already pay 10% of the premium.

[2] 50 employees have no coverage under the County Plan. Presumably they have coverage under their spouse's or someone else's plan.

To require them to now pay a deductible and a co-pay, would lower an already low burden on the County. Given this argument, premium costs will be the first item compared.

The average cost to the Employers in the nine comparable Counties in 2001 was $747.27. This County paid $546.11 or 74% of the average. In 2003, the Employers paid an average premium of $967.07. This County will pay $928.07 or 98% of the average under the County proposal in 2003. It will pay $1027 or 108% of the average under the Association's proposal.[3] The County was below the average at the end of the last contract, but under either proposal it approximates the average in 2003. The Association's argument would have carried more weight two years ago than it does now. Today, its payment is in line with others. For that reason, this argument must be rejected.

Employees at the Employer pay 10% of the cost of the premium each month. This Employer is not the only County that requires employees to pay a portion of the premium, but it is among the highest in terms of the percentage of premium that employees must pay. The average percentage among the comparables is slightly less than 5%. Employees here pay 10%. They are paying far more than the average.

The County wishes to impose a deductible and insurance co-pay on the employees. Currently they do not have any such requirements. It also seeks to increase the co-pay for drugs from $5 for all drugs to $10 for generic, $15 for

[3] This does not include Dodge, which changed its plan in 2003 or Ozaukee County. Ozaukee has not settled its agreement for 2003.

brand names and $25 for non-formulary drugs.[4] A review of the comparables in 2001 reveals that 6 of the 9 had plans that included a deductible and a co-pay for family coverage. The average deductible for a family was $216. The average family co-pay was $477. As noted, this Employer had no such provisions in 2001. Seven out of eight comparables had deductibles in 2003.[5] Five of seven had a co-pay provision. The average family deductible in 2003 is $375 and co-pay is $550.[6] Dodge had no deductible in 2001, but did have it in 2003. Rock and Walworth considerably increased the employee's co-pay portion for a single person and for a family in 2003. The absence of these provisions in this County distinguishes it from most of the comparables. Even some of those that did not have such a provision in the past have now included it. The proposed co-pay by the County is slightly higher than the average, but the deductible is less.

The average amount paid by employees towards generic drugs among the comparables in 2003 was $8.81. This was up from 2001. The average amount paid by employees for brand name drugs rose to $16.25. The proposal of the County here is higher than the average for generic and lower than the average for brand names. Kenosha, Ozaukee and Washington have the same $10 co-pay for generic drugs as is proposed here. All three Counties raised their amounts between 2001 and 2003. It does not appear that the proposals from the County for a drug co-pay by employees is not out of line in relation to the comparables.

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[4] Non-formulary drugs were not covered in the last agreement. Even though not covered, it was paid in each instance.

[5] The Jefferson agreement has not yet been settled so it was not included. Ozauke is not settled, but the Employer submitted information indicated that it did have a $500 family deductible. There is no indication as to what the co-pay in Jefferson was so it is excluded.

It is clear that employees in this County pay a higher percentage of the total premium than employees in most of the other comparable Counties. The extra cost that they incur is not fully offset by the savings from not having to pay a deductible and co-pay. Not every employee in other Counties that has to pay a deductible or co-pay has medical expenses. Only those with significant medical expenses in a given year pay the full amount. Many have no or only minor medical expenses. Their out-of-pocket expenses never reach the caps. Consequently, the vast majority of these employees fare better financially by paying a lower percentage payment for premiums and having to pay deductibles and co-pays. On the other hand, every employee in this County that has insurance coverage pays a portion of the premium, regardless of whether they have medical expenses in that year. There net out of pocket dollars is more than if they paid a lower percentage, but had to pay co-pays and deductibles. Thus, in reality the higher premium payments in the County are not dollar for dollar offset by the absence of these other payments.

For the reasons listed above, it is my finding that this factor slightly favors the Association. In the absence of any other considerations, the Employer proposal would be rejected since this factor turns out to be the only factor that comes into play in this proceeding. The question then is whether there is some other reason why the Employer proposal should be accepted? The Employer says there is another reason. Its other financial proposals were made for the purpose of tipping the scale towards its proposal. It says its quid pro quo is enough for it to carry the day here. That issue shall now be addressed.

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[6] For comparison this Employer proposed a $200 family deductible and $800 co-pay.

Status Quo & Quid pro Quo

The Association wants to maintain the status quo. The Employer wants it changed. The Employer has recognized that in order for it to obtain the change that it wants, that it needs to offer something in exchange. The most significant portion of its quid pro quo is the inclusion of an additional $.35 per hour for all employees. There are other aspects of the Employer proposal that also benefit the employee. The availability of the Section 125 Plan to employees would be incorporated into the agreement.[7] Employees would be guaranteed the I.R.S. rate for mileage reimbursement. Currently, they get $.35 per mile. The proposal would also increase the mileage reimbursement for carpools.

Wisconsin Arbitrators over the years have set forth a test that should be used to determine whether a proposal from a party to change the status quo should be accepted. In Village of Fox Point (Public Works Department), Dec. No. 30337-A 2002), Arbitrator Petrie repeated that test. The proponent of change must establish:

> a very persuasive basis for such change, typically by showing that (1) a legitimate problem exists which requires attention, (2) that the disputed proposal reasonably addresses the problem and (3) that the proposed change is accompanied by an appropriate quid pro quo.

There is no question that rising health care costs is a problem faced by employers throughout the Country.[8] The Employer notes that from 1999-2003 premiums have risen 78% even with the proposed modifications to the plan. Without the changes, they rise 95%. That is a substantial increase and one

[7] The Association argues that the employees already have this Plan available to them. That may be so, but it is not found within the current Agreement. The proposal would incorporate it.

[8] According to an Article in the May 5, 2003 Milwaukee Journel-Sentinel the problem is particularly acute in the Milwaukee Metropolitan area.

that could hardly be expected. Arbitrator Petrie in Fox Point had to address a similar problem. He noted that the data before him "clearly establish the existence of a legitimate and significant problem which requires attention." In that case, the rise in costs was not as severe as it is here.

The Employer has tried to explain how the costs have increased. It notes on page 16 of its brief.

> The increased claim costs have directly affected the cost of insurance premiums. The premium rates in 2003 needed to increase 28.3 percent because the rates in 2002 were not adequate to cover the increased plan costs. In other words, the 2003 premium increase was sufficient just to get the County to a break-even point and did not address trying to get money back from past losses covered by temporary transfers to reserve accounts.
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> As noted, the fund reserves for the self-funded POS plan had significantly decreased to the point that there was only about $400,000.00 left in the reserve fund. In order to continue to have that fund available to pay claims, the County, over the course of the next calendar year had to make two fund transfers into the reserve account totaling $3,250,000.00.

They are correct. Had they not done the fund transfer, matters would have gotten even more out of hand than they are already. This Arbitrator is satisfied that the Employer has demonstrated "a legitimate problem exists which requires attention." The first prong has been met.

The next question is whether the proposal "reasonably addresses the problem." The purpose of these proposals is to promote consumerism. The Employer actuary, Clark Slipher, testified that when employees have to pay a portion of their costs, they are more cost conscious. They may not go to the doctor for a cold or to the emergency room for a minor fever. Mr. Slipher testified that he believes that the changes proposed will cut usage by 8%. The addition of a differential for generic and brand name drugs he believes will also

promote consumerism, and lower costs. Employees would rather pay $10 than $15. He stated that currently 37% of the drugs purchased are generic. He expects this percentage to increase.

Conversely, Mr. Huttleston testified on behalf of the Association and he believed that the proposed changes merely shifted costs. As he testified:

> My comment concerning the plan changes was that I did not agree that the changes in co-payments in the form of deductibles and co-insurance on the PPO portion of the program will change the incidence of care, that is, the change as dramatic as it may be to the lower paid individuals in the County, it is not of a magnitude that will alter their care unless they have serious medical conditions. It hits at many of the wrong issues, because the co-pay or the deductible applies to all services, as opposed to, for example non-preventative(sic) services, so it is not truly changing the scope of the health care or the quality of the program, it is shifting the financial responsibility or a portion of that to the individual. (Tr. 71-72)

He felt the changes do little to promote consumerism. In particular, he noted that the difference between in-network and out-of-network costs drops from 20% to 10%. He felt this smaller differential made it less likely to steer employees towards in-network. Of course, he did not mention that one big difference between in and out-of-network is the portion of the bill paid through insurance. In-network providers charge a set pre-determined fee. They cannot charge employees more than that fee. The fee, less deductibles, is paid fully by insurance. Out-of-network providers are only reimbursed for reasonable and customary charges. The actual fee they charge could exceed the amount that insurance will cover. In that event, the employee is responsible for the difference. This potential additional fee does promote steerage, despite the drop in percentage differential. Finally, Mr. Huttleston felt that the increase in

charges for generic drugs was unwise. He agreed with the tier concept, but felt that an increase for generic drugs was also counter-productive.

No one can know for sure what savings would be derived from the proposed changes. Experts can simply give their best opinion in that regard. That opinion is derived from their experiences with other plans that made similar changes. This Arbitrator is satisfied from the evidence that the purpose of these changes is to promote consumerism and to steer employees towards network providers and towards lower cost prescription drugs. It is true that the imposition of these new charges does shift costs to employees. If that were all that they did, this Arbitrator would be inclined to find that the proposal does not reasonably address the problem. However, the purpose of the proposal is to do more than that. Its purpose is as stated by the Employer and Mr. Slipher i.e. encouraging consumerism. The Arbitrator has no doubt that there may also be other ways to address the need. Even so, the question is not whether the proposal is the only way to deal with a situation, but whether the proposal being made "reasonably addresses the problem." It is my finding that it does. The proposal has passed the second prong of the test.

Every employee under the Employer proposal will get an additional raise of $728.[9] This proposal would include the 50 employees who do not have coverage under the County plan. To them, the $.35 per hour is a windfall. 123 employees have single coverage. They receive the $728 and save an additional $36 in premium costs. The Employer proposal is worth a total of $764 to them.

[9] The Union asserts that in real dollars the raise is less since taxes are taken out. That is true of all raises. Uncle Sam always gets his cut. However, when comparing increases it is always the gross figure that is compared. Furthermore, the Section 125 Plan allows pre-tax dollars be used to cover the insurance costs.

If they reached the maximum they would have to pay $500 more towards medical care. That is the $100 deductible plus the $400 co-pay.[10] Under the worse case scenario, an employee with single coverage still has a $264 surplus under the Employer's proposal. An employee electing family coverage receives the $728 plus the employee saves $99.72 on premiums per year. This is a total savings of $827.72. This employee could lose money under the proposal. If more than one family member has substantial medical expenses, the employee could pay $1100 more than they pay at present. Thus, such an employee would be out-of-pocket $272.28.

The evidence showed that 12% of employees reach the maximum. The average out-of pocket expense is $210. Using these figures, the vast majority of employees will have a net increase in dollars under the proposal of the Employer. This is without factoring into the equation the other portions of the Employer's proposal. While the additional benefit from those other proposals is small, it should certainly be recognized when evaluating the quid pro quo.

The above analysis merely compared health costs, not drug costs. The Association had two employees testify. Their families experienced tremendous medical expenses. One witness had over 200 prescriptions filled. There is no cap on the amount an employee could be required to pay for prescription drugs. Medical out-of-pocket expenses are capped, but not prescription drugs. Mr. Huttleston was quite troubled by the absence of a cap. It was his belief that there should be a cap or that the out-of-pocket expense should go towards the

[10] All comparisons are for health costs alone. They do not yet take into account any additional drug costs.

deductible. This Arbitrator shares his concern. This is a weakness in the Employer proposal.

The question then is whether the prescription drug experience of two employees and the fact that up to 12% of the employees may suffer a financial loss under these proposals negate the positive financial aspects of the proposal to everyone else. The answer is no it does not. While it is impossible not to have compassion for the plight of these two employees and anyone else that may suffer, the Arbitrator must consider the overall impact of the proposals and not any isolated anomalies. While there will be some that suffer, they are few in number. Most employees show a net gain. When discussing external comparables, this same type of analysis favored the Association argument. Everyone paid premiums, but only a few had major expenses. The extra premiums paid exceeded savings from having no out of pocket costs for almost all. That same logic causes this Arbitrator to view the Employer proposal favorably here. Everyone gets the increase in monies, but only a few have major expenses. The proposal covers the whole unit, not just some. In those terms, the Employer proposal has met the third prong of the test.

The Employer cited extensively Arbitrator Petrie's decision in Fox Valley. As observed above, Arbitrator Petrie had to render a decision involving similar facts to those posed here. In doing so, he discussed the needed quid pro quo. He found that:

> In this connection, it is noted that certain long term and unanticipated changes in the underlying character of previously negotiated practices or benefits may constitute significant mutual problems of the parties which do not require traditional levels of quid pro quos to justify change. In the case at hand, the spiraling costs of providing health care insurance for its current employees is a mutual

> problem for the Employer and the Association, and the trend has been ongoing, foreseeable, anticipated, and open to bargaining by the parties during their periodic contract renewal negotiations. In light of the mutuality of the underlying problem, the requisite quid pro quo would normally be somewhat less than would be required to justify a traditional arms length proposal to eliminate or to modify negotiated benefits or advantageous contract language.

There is definitely merit to Arbitrator Petrie's analysis. Parties enter into negotiations with preconceived beliefs as to what a proposal will cost. Costing of proposals is a standard method used in negotiations when evaluating the other side's offer. There is no one who could have expected when they sat down at the bargaining table that insurance costs would get as out of hand as they have. Therefore, I agree with Arbitrator Petrie and his analysis in this type of situation. However, it is also my finding that even holding the County to the typically higher standard for a quid pro quo, the County has met that burden.

CONCLUSION

This Arbitrator has said in other cases that he wishes that the State Legislature had given him authority to adopt something other than all or nothing. There are aspects of the Employer proposal that are troubling to this Arbitrator. As has been already observed, the Association has raised a valid concern over the co-pay for drugs that has been proposed by the Employer. It has no cap. While it is true that there are very few employees that will be significantly impacted by the absence of a cap, there are a few. The Association and its witnesses suggested that it would have been far better to either put a cap on out of pocket expenses for medications or to have included those expenses as part of the deductible. This would have put a safety net under the

employees. Had the Arbitrator had such authority this proposal would have been modified to provide that needed cushion. Unfortunately, he does not have that power. One proposal must be adopted in its entirety and the other rejected. On balance, the Employer's proposal is favorable over the Association's.

AWARD

The County's proposal together with the tentative agreement is adopted as the agreement of the parties.

Dated: May 12, 2003

Fredric R. Dichter,
Arbitrator