

STATE OF OHIO
STATE EMPLOYMENT RELATIONS BOARD

SEEB OPINION 89-026

In the Matter of
State Employment Relations Board,
Complainant,

and

Ohio Health Care Employees Union, District #1199,

Intervenor,

v.

State of Ohio, Office of Collective Bargaining,

Respondent.

CASE NUMBER: 88-ULP-04-0216

OPINION

Sheehan, Chairman:

I

On Thursday, June 8, 1989, the State Employment Relations Board convened to hear oral argument in the above-styled case. The hearing was in response to a motion for the Board to hear oral argument filed by the Ohio Health Care Employees Union, District #1199 on April 12, 1989, and granted by the Board on May 25, 1989. The hearing was not to gather facts. The record was closed and was incorporated as it stands on the testimony of record and the hearing officer's report.

II

The issues in the case arose during the term of a collective bargaining agreement between the Ohio Health Care Employees Union, District #1199 (Union or Intervenor) and the State of Ohio, Office of Collective Bargaining (Employer or Respondent).

Negotiations for the original contract at issue began in January 1986, and an agreement was reached on June 12, 1986.¹ The agreement included a provision calling for the Employer to provide an employee health care plan. This provision set a maximum amount that the Employer agreed to contribute to the plan for each year of the three-year agreement.² It was a straight dollar amount. No other language was included in the health care provision and no reopener clause was made part of the agreement.³

There were two types of state health insurance plans, traditional and optional. The traditional plan provided the usual broad insurance coverage. The optional plan had more limited coverage with deductible and co-payments, and with lower premiums. The premiums charged by the plans were set by the State. The State set the rates, collected the payments and paid out the benefits. The plans were administered by a Blue Cross Company which operated solely on a fee-for-service basis.⁴ Blue Cross made no determinations as to premium rates or extent of coverage.

At the time of the effective date of the agreement, the plan appeared actuarially sound.⁵ By early 1987, however, the plan faced financial

¹Admission (Adm.) #7 - Concurrent negotiations with all unions representing state employees were conducted during the approximately same time frame.

²Finding of Fact (F.F.) #2; Art. 15 of the Collective Bargaining Agreement. The Employer set maximum contribution to the health care plan was common to all state employees' collective bargaining agreements.

³F.F. #3.

⁴F.F. #1.

⁵Adm. #8; F.F. #7.

problems necessitating an increase in premiums. The Respondent initiated talks with the unions in early 1987 regarding the state of the health care plans. These talks produced an agreement with the unions calling for increases in both the Employer and employee contributions, thus amending in mid term the respective collective bargaining agreements' health care provisions. The agreement also provided for the establishment of a joint task force to review:

- a) Current plan provisions and proposals for any modification in the benefit plan;
- b) An additional cost containment measure that may alter the delivery of health care services, while maintaining quality, and not shifting any costs from the plan to the employees;
- c) The current ancillary plan benefits and possibilities for improvement.

In October 1987, the Task Force agreed to have an actuarial study done so options could be identified and a joint decision made regarding the health care plan. The firm of Touche-Ross was selected to conduct the study. The Task Force did not meet pending the release of the Touche-Ross Study.

The study was completed and sent to the Employer sometime in March 1988.⁷ Copies of the study were provided to the unions by the Respondent on/or about April 1, 1988. The study presented several modification options the Task force could consider toward seeking acceptable solutions. The study also recommended that, given the projected deficits, any corrective

⁷Intervenor's Exhibit #1; F.F. #8.

⁸Adm. #9.

measures are likely to involve significant changes and will require the cooperation of labor, management and the administrator.⁸

The Respondent notified the unions of a meeting to be held April 8, 1988, for the purpose of announcing the Respondent's revised health insurance plan. The Intervenor's President objected to the date, but the meeting was held as scheduled.⁹ At the meeting, the Respondent informed the unions that a 16% increase in health insurance premiums for employees would be imposed.¹⁰ Although the Intervenor voiced objections to the Respondent's announcement, no other options of the Touche-Ross Study were discussed. Effective July 1, 1988, the Respondent's plan went into effect. The rate premium change was not¹¹ negotiated by the Respondent with the Intervenor and the other unions that were affected by it.

III

These questions are raised by the Respondent's actions:

- 1) Did the Union waive its right to bargain on the modifications of the health care plan?
- 2) Did the Employer violate O.R.C. §4117.11(A)(1) and (E) by unilaterally increasing the employees' contributions to the health care plan?

IV

The answer to the first question is No. A waiver of a statutory right

⁸Touche-Ross Report.

⁹Adm. #11.

¹⁰Adm. #12.

¹¹F.F. #6. This change affected not only employees represented by the Intervenor, but state employees represented by all other unions.

must be clear and unmistakable. "Precise terminology is a threshold requirement before a provision of a collective bargaining agreement may be construed as overriding a clear and basic statutory right." In re City of Lakewood, SERB 88-009 (7-11-88). While the language of the contract was clear in setting forth the maximum contribution the Employer was delegated to make toward the health care plan premium, it was silent as to the employees' contributions. Does this mean, as the Employer argues, that the remainder of any premium cost not covered by the Employer's set contribution is to be made up by the employees? If that is what is meant by the language in the contract, then it should have clearly said so. It did not. Since the Employer is self-insured and sets the premium rates, it is just as reasonable to assume that the employees' contributions were purposely not spelled out because those rates were considered bargainable. Whatever the intent of the contract language, it falls far short of constituting a clear and unmistakable waiver. Assuming, arguendo, that the contract's language did, in fact, constitute a waiver, the waiver nevertheless would have been effectively disannulled in 1987 when the Employer voluntarily reopened the issue to modify the health care provision. In order to modify the agreement, the Employer was obligated to bargain with the Unions. The Employer recognized that obligation, bargaining occurred and an agreement was reached.

The answer to the second question is Yes. It should be noted here that there is no dispute between the parties with respect to health care benefits being mandatory subjects of bargaining. The Respondent's defense, however, is that Article 15 of the collective bargaining agreement negotiated in 1986 permitted the unilateral premium increase it imposed in 1988. This defense

might have been vested with more substantive formidability had the Respondent not previously acknowledged its obligation to bargain on this issue when it voluntarily reopened the health care provision for modification in 1987. This acknowledgment of its obligation to bargain,¹² and the subsequent bargaining, resulted in a modified health care provision which included an agreed-to task force venture with the unions, as well as an increase in both Employer and Employees' contributions. The Task Force consulted Touche-Ross and the resultant study produced several options which were presented for the parties' consideration. Once the Touche-Ross Report was available, the Task Force members should have had the opportunity to study and consider fully its recommendations and then determine through bargaining the course of action the Employer and the Unions would follow. This, of course, did not happen. Instead, the Respondent elected to unilaterally implement its own health care terms. In doing so, the Respondent violated the duty to bargain in good faith regarding the modification of the collective bargaining agreement. Therefore, where no waiver of the right to bargain on the mandatory subject of health care exists, where no specific contract clause allows the Employer to unilaterally increase the premiums, where no need for the specific increase is established, and where in the past the Employer did negotiate the changes it wanted to make in the contractual terms of the health care insurance - the Employer had a duty to bargain on the decision and the amount of raising the premiums in 1988.

¹²In re Cuyahoga County Commissioners, SERB 89-006 (3-15-89).

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A review of the record indicates that insufficient information is available upon which to shape a complete and proper remedy in this action. Therefore, the Board remands the matter to hearing for the parties to present evidence and arguments solely on the limited issue of the appropriate remedy. This is consistent with the request made by the Respondent at the oral argument that if a violation were found, it be given the opportunity to be heard on the issue of remedy. The hearing officer will issue a recommendation to which exceptions may be filed pursuant to procedures set forth in O.R.C. §4117 and O.A.C. Rule 4117-1-02(A)(3).

Davis, Vice Chairman, and Latané, Board Member, concur.

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