STATE OF MICHIGAN
EMPLOYMENT RELATIONS COMMISSION
LABOR RELATIONS DIVISION

In the Matter of:

CITY OF DETROIT (POLICE DEPT),
Public Employer - Respondent,

Case No. C07 E-110

-and-

DETROIT POLICE OFFICERS ASSOCIATION,
Labor Organization - Charging Party.
_____/

APPEARANCES:

Fraser, Trebilcock, Davis and Dunlap, PC, by Brandon W. Zuk, Esq., for Respondent

Kalniz, Iorio & Feldstein, LPO, by Donato S. Iorio, Esq., for Charging Party

DECISION AND ORDER

On January 29, 2008, Administrative Law Judge (ALJ) Julia C. Stern issued her Decision and Recommended Order on Motion for Summary Disposition in the above matter finding that Respondent City of Detroit did not violate Section 10(1)(e) of the Public Employment Relations Act (PERA), 1965 PA 379, as amended, MCL 423.210(1)(e), by refusing to bargain with Charging Party Detroit Police Officers Association over health insurance criteria and procedures in the parties' July 2004 through June 2009 collective bargaining agreement. The ALJ held that Respondent had no further duty to bargain with Charging Party over these issues after the Act 312 arbitration panel issued its award adopting Respondent's last best offer on health insurance. In reference to Charging Party's claim that Respondent repudiated the arbitration award by refusing to hold an open enrollment period to allow Charging Party's members to change health insurance plans before implementing the terms of the award, the ALJ found that Charging Party failed to state a claim under PERA. ALJ Stern recommended that we grant Respondent's motion for summary dismissal of the charge in its entirety. The Decision and Recommended Order on Motion for Summary Disposition was served on the interested parties in accordance with Section 16 of PERA.

After receiving an extension of time in which to file its exceptions, Charging Party filed exceptions to the ALJ's Decision and Recommended Order on March 20, 2008. Respondent requested and was granted an extension of time in which to file its response to the exceptions and, on April 30, 2008, filed a brief in support of the ALJ's Decision and Recommended Order. On the same day, Respondent filed a motion to reopen the record to permit entry and

consideration of the April 1, 2008 Umpire's Opinion and Award regarding the parties' disputed collective bargaining agreement terms.

On May 1, 2008, Charging Party requested an extension of time to file a memorandum in opposition to Respondent's motion to reopen the record and to reply to Respondent's brief in support of the ALJ's decision. The Commission granted the extension of time for filing the response to reopen the record, but did not expressly address the request for an extension for filing a reply to the response to the exceptions. Charging Party submitted, in a single document, its memorandum in opposition to Respondent's motion to reopen the record and its reply to Respondent's brief in support of the ALJ's decision on June 2, 2008. The Commission's Rules do not provide for the filing of a reply to a response to exceptions and MERC does not normally permit such filings. See *Washtenaw Co & Washtenaw Co Treasurer*, 21 MPER 38 (2008). Although the Commission has the discretion to consider such additional filings when it finds that such filings would enhance the reliability of its decision making in the case, we do not feel that this filing meets that criteria. See *Kent Co Sheriff & Kent Co*, 1996 MERC Lab Op 294, 300-301. Accordingly, we will limit our review of Charging Party's June 2, 2008 filing to the extent that it addresses Respondent's motion to reopen the record.

Respondent filed its response to Charging Party's June 2, 2008 memorandum on June 12, 2008. However, such additional filings are not permitted under the General Rules of the Michigan Employment Relations Commission, 2002 AACS, R 423.101 - 423.484. Although Rule 161, R 423.161 permits any other party to file a brief in opposition to its opponent's motion, there is no provision that permits the moving party to reply to the opposing party's brief in opposition to the motion. *Washtenaw Co & Washtenaw Co Treasurer*, 21 MPER 38 (2008). Therefore, we will not consider Respondent's reply to Charging Party's memorandum in opposition to Respondent's motion to reopen the record.

In its exceptions, Charging Party alleges that the ALJ erred by determining that the issuance of the Act 312 award ended Respondent's obligation to bargain over the subject matter covered by the award for the term of that award. Charging Party further alleges that the ALJ erred by failing to properly and thoroughly apply the law as developed by the National Labor Relations Board in *McClatchy Newspapers, Inc*, 299 NLRB 1045 (1990), and in *McClatchy Newspapers, Inc*, 321 NLRB 1386 (1996). Charging Party also cites as error the ALJ's conclusion that Charging Party failed to allege facts that would support a finding that Respondent repudiated the Act 312 award. We have reviewed Charging Party's exceptions and we find them to be without merit. Further, we do not find merit to Respondent's motion to reopen the record.

Factual Summary:

We adopt the findings of fact as set forth in the ALJ's Decision and Recommended Order and will not repeat them here, except as necessary. An award issued pursuant to the Compulsory Arbitration Act (Act 312), MCL 423.231 *et seq.*, established the terms of a collective bargaining agreement covering Charging Party's non-supervisory police officers' bargaining unit for the period July 1, 2004 through June 30, 2009. The Act 312 panel adopted Respondent's last best offer on health insurance, which requires Charging Party's members to pay either 10% or 20% of

the monthly premium, depending on the plan selected. Charging Party claims that it is illegal to enforce this requirement without further bargaining, because it lacks definable and objective criteria for determining the premium for plans for which Respondent is self-insured. It claims that Respondent violated Section 10(1)(e) of PERA by enforcing the new contribution requirements without bargaining with Charging Party and by implementing the plan without first offering employees the opportunity to change from one plan to another.

Before the award, members of Charging Party's unit could elect a health insurance plan administered by the Coalition of Public Safety Trust (COPS Trust), which purchases insurance from the US Health and Life Insurance Company. Under the terms of the parties' previous contract, Respondent paid the full amount of monthly premiums for single, joint, and family coverage for the first year. During the years to follow, the COPS Trust had the discretion to increase the premium to maintain the same level of benefits. The first eight percent of the increase was paid by Respondent, and any additional increase was divided between it and the subscribing employees.

Members of Charging Party's bargaining unit could also choose between various health maintenance organization (HMO) plans, a Blue Cross Traditional Plan, or a Blue Cross Preferred Provider (PPO) plan. Respondent self-funds the Blue Cross plans and negotiates with Blue Cross for the monthly premium, referred to as an "illustrative rate." Under the previous contract, Respondent's monthly contribution to any plan other than the COPS Trust plan was limited to the amount of its COPS Trust premium. Employees choosing a Blue Cross plan paid the difference between the COPS Trust monthly premium and the Blue Cross illustrative rate.

Respondent's last best offer in Act 312 arbitration, awarded by the Act 312 panel, included a health insurance proposal to require employees to pay 20% of the monthly premium for the COPS Trust plan. It also required employees choosing coverage under other plans to co-pay 10% or 20% of the monthly premium, depending upon the plan selected. Instead of seeking review of the Act 312 award in the circuit court (as is required under Section 12 of Act 312), Charging Party demanded to bargain over the premiums for the self-funded health care plans. Charging Party also demanded that there be an open enrollment period. Nevertheless, Respondent informed Charging Party of its intent to implement the health insurance provisions of the award on May 1, 2007.

Before the May 1 implementation date, Respondent provided a rate schedule to Charging Party's members indicating the employee's share of the required monthly premium payment for the various health insurance plans under the Act 312 award. Employees were given the option of switching to a different plan effective July 1, 2007, by participating in the open enrollment period held between May 15 and June 15, 2007.

Discussion and Conclusions of Law:

Charging Party takes exception to the ALJ's conclusion that an Act 312 award terminates the parties' obligation to bargain a subject covered by the award. Charging Party's objection is based on *McClatchy Newspapers, Inc*, 299 NLRB 1045 (1990), and *McClatchy Newspapers, Inc*, 321 NLRB 1386, 1390-92 (1996) ("*McClatchy II*"), *enfd*, 131 F3d 1026 (CADC, 1997), *cert*

denied, 524 US 937 (1998), decided under the National Labor Relations Act (NLRA), 29 USC 151–169. In *McClatchy*, the NLRB held that the employer's post-impasse implementation of its contract proposal, which gave the employer discretion to award pay increases on a merit basis, violated the employer's duty to bargain. The contract proposal gave the employer unlimited discretion over future pay increases, contained no explicit standards or criteria for such pay increases, and allowed the employer to make its determinations on pay increases without notice to or participation by the union. The NLRB explained that allowing the employer to implement such a proposal, giving it unfettered discretion over a mandatory subject of bargaining, would be contrary to the fundamental principles of collective bargaining.

Charging Party argues that the ALJ's failure to apply *McClatchy* to the facts presented here was error because the health insurance proposal awarded by the Act 312 panel did not include definable and objective criteria for determining the premiums for the plans for which Respondent is self-funded. We disagree as *McClatchy* is not applicable to the case before us. *McClatchy* did not address compulsory arbitration, for which there is no provision in the federal labor law. The NLRB dealt with the question of whether an employer's unilateral implementation of its contract proposal violated the duty to bargain. Here, we are asked to decide whether a provision awarded by an Act 312 panel is lawful, and whether implementation of that provision violated Respondent's duty to bargain.

An Act 312 award establishes the terms of the collective bargaining agreement that the parties were unable to achieve through negotiation and mediation. Although Charging Party never agreed to Respondent's health care proposal, it became part of a binding contract formed by the Act 312 award. Charging Party claims that the use of an illustrative rate to determine the contribution of an employee to a Blue Cross self-funded plan gives Respondent too much discretion in setting the premium. Charging Party opines that the Act 312 award might tempt Respondent to "recapture wage increases, overtime expenditures, pension contributions, and any other contractual benefit." Charging Party argues that Act 312 is supplemental to and does not control PERA, citing authority for the proposition that the Commission has authority to determine who is eligible to arbitrate under Act 312 and what issues may be arbitrated. It is true that we may entertain challenges to Act 312 submissions before they are ruled upon by an Act 312 panel, such as when we determine whether a bargaining unit is eligible for Act 312 arbitration or whether proposals involve mandatory subjects of bargaining. However, we have no authority to rule upon the validity of an Act 312 award. Section 12 of Act 312, MCL 423.242, expressly limits the review of the orders of the arbitration panel to the circuit court subject to the criteria for review outlined in Section 12.

Charging Party argues that its claim is properly before the Commission because it involves post-impasse rights under PERA where Respondent implemented the Act 312 award without bargaining to impasse or agreement over criteria for determining the health insurance premiums. In support of this argument, Charging Party cites *City of Highland Park*, 1992 MERC Lab Op 207, and quotes the Commission as determining that "[r]eview and/or interpretation of Act 312 arbitration awards is the business of the Michigan Employment Relations Commission . . . ." The quoted language is reported at 5 MPER 23032 (1992) and is from the Decision and Recommended Order of the ALJ, which the Commission adopted. However, in 1992 MERC Lab Op 207 it is reported that the ALJ in *City of Highland Park* wrote:

"Review and/or interpretation of Act 312 arbitration awards is [*not*] the business of the Michigan Employment Relations Commission . . ."[1] (Emphasis added.) In both instances, the sentence concludes with the ALJ's observation that "absent evidence of employer implementation because of any PERA prohibited reasons, the charges should be dismissed." In light of Section 12 of PERA, we hold that review of Act 312 arbitration awards is not within the jurisdiction of this Commission.

Charging Party also asserts that Respondent repudiated the contract awarded by the Act 312 panel and violated PERA by refusing to hold an open enrollment period before implementing the panel's award. The ALJ found that Respondent held an open enrollment period between May 15 and June 15, allowing employees to switch plans as of July 1, 2007. Whether and when an open enrollment period was necessary requires interpretation of the Act 312 award. We reiterate that this Commission does not interpret Act 312 awards. See *City of Highland Park.* We agree with the ALJ that there is a dispute over the interpretation of the Act 312 award, and Charging Party has not alleged facts upon which repudiation of that award can be found. In order to determine whether contract repudiation has occurred, the asserting party must prove that: (1) the contract breach is substantial, and it has a significant impact on the bargaining unit; and (2) there is no bona fide dispute over the interpretation of the contract. *City of Detroit*, 22 MPER 11 (2009). See also *Plymouth-Canton Cmty Sch*, 1984 MERC Lab Op 894, 897. Whether an open enrollment period was necessary requires interpretation of the Act 312 award, which is beyond the scope of this Commission's review. Therefore, we agree with the ALJ's conclusion that the charge should be dismissed.

We have also considered all other arguments submitted by the parties and conclude that they would not change the result in this case.

ORDER

The charge is dismissed in its entirety.

MICHIGAN EMPLOYMENT RELATIONS COMMISSION

_____
Christine A. Derdarian, Commission Chair

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Nino E. Green, Commission Member

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Eugene Lumberg, Commission Member

Dated: _____

[1] We conclude that Opinions Press, the publisher of MERC Labor Opinions, corrected an obvious error that was either not recognized or simply ignored by LRP Publications, publisher of the Michigan Public Employee Reporter.

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APPEARANCES:

Fraser, Trebilcock, Davis and Dunlap, PC, by Brandon W. Zuk, Esq. for Respondent

Kalniz, Iorio & Feldstein, LPO, by Donato S. Iorio, Esq., for Charging Party

DECISION AND RECOMMENDED ORDER
OF ADMINISTRATIVE LAW JUDGE
ON MOTION FOR SUMMARY DISPOSITION

On May 27, 2007, the Detroit Police Officers Association filed the above charge with the Michigan Employment Relations Commission (the Commission) against the City of Detroit pursuant to Section 10 of the Public Employment Relations Act (PERA), 1965 PA 379, as amended, MCL 423.210. The case was assigned to Administrative Law Judge Julia C. Stern. On September 20, 2007, Respondent filed a motion for summary disposition under Rule 165(2) (b) and (d) of the Commission's General Rules, 2002 AACS, R 423.165. Charging Party filed a brief opposing the motion on October 8, 2007. Oral argument on the motion was held on November 15, 2007. Based on the facts as set forth in Charging Party's charge and pleadings, and the arguments made by both parties in their briefs and at oral argument, I make the following conclusions of law and recommend that the Commission issue the following order.

The Unfair Labor Practice Charge:

Charging Party represents nonsupervisory police officers employed by Respondent in its police department. On or about March 8, 2007, a panel of arbitrators headed by Richard N. Block issued an opinion and award (the Block award) pursuant to the Compulsory Arbitration Act (Act 312), MCL 423.231 et seq. The award established the terms of a collective bargaining agreement covering Charging Party's bargaining unit for the period July 1, 2004 through June 30, 2009. Among the issues presented to the arbitration panel were proposals by both Charging Party and Respondent to modify the health insurance provisions of the parties' previous contract.

The panel adopted Respondent's "last best offer," which required Charging Party's members to pay either ten or twenty percent of the monthly "premium" for their health insurance, depending on the plan selected. Charging Party asserts that this portion of the award is illegal and unenforceable without further bargaining since it lacks definable objective procedures and/or criteria for determining the monthly "premium" for those health plans for which Respondent is self-insured. It alleges that Respondent violated its duty to bargain under Section 10(1)(e) of PERA by refusing to bargain with Charging Party over these criteria and procedures, and by enforcing the new contribution requirements on May 1, 2007 without bargaining to agreement or impasse with Charging Party over these issues. Charging Party also alleges that Respondent unlawfully repudiated the Block award by implementing changes in health benefits and contributions without first offering employees the opportunity to change from one plan to another.

Facts:

The following facts were alleged by Charging Party in its charge and/or response to the motion or set forth in exhibits attached to its response. Before the issuance of the Block award, the health benefits of bargaining unit employees were as set out in Article 21 of the parties' previous contract.[2] Under that contract, members of Charging Party's unit could elect a health insurance plan administered by the Coalition of Public Safety Trust (COPS Trust) and also made available to other uniformed employees of Respondent. The COPS Trust Board, which includes union representatives, purchases insurance from the US Health and Life Insurance Company. Article 21, paragraph C of the previous contract set out the COPS Trust monthly premiums for single, two person and family coverage for the first year of the contract. Respondent paid the full amount of those premiums. For each subsequent year of the contract, COPS Trust determined whether monthly premiums needed to be increased to maintain the same level of benefits, and, if so, how much they would be increased. Under Article 21, paragraph D, Respondent was responsible for the first eight percent of any premium increase. Premium increases above eight per cent were split between Respondent and the employee, with employees making their contributions by payroll deduction. Testimony during the Act 312 hearing established that under the previous contract, members of Charging Party's unit electing COPS Trust insurance bore approximately .9% of the monthly cost of their insurance.

In addition to the COPS Trust Plan, Charging Party's members could elect to enroll in any other insurance plan available to Respondent's employees. These included several health maintenance organization (HMO) plans and Blue Cross Traditional and Blue Cross Preferred Provider (PPO) plans. Respondent self-funds its Blue Cross Traditional and PPO plans, and is therefore ultimately responsible for covering the costs of benefits under these plans. Blue Cross and Respondent negotiate contracts which set out the monthly amounts Respondent is to pay Blue Cross under its self-funded plans. This amount, called an "illustrative rate," is based on a number of factors, including estimates of future claims, Blue Cross's administrative fee, and the amount of stop loss insurance Respondent chooses to purchase.[3] Under paragraph G of the previous contract, Respondent's monthly contribution on behalf of a member of Charging Party's

[2] This contract also came into existence as the result of an Act 312 proceeding.

[3] Self-funded employers typically purchase stop loss insurance to cover catastrophic claims over a certain level. Only the stop loss portion of an illustrative rate is technically a "premium."

unit to any plan other than the COPS Trust was limited to the amount of its COPS Trust premium. Therefore, bargaining unit employees opting for Blue Cross Traditional or PPO plans paid the difference between the COPS Trust monthly premium and the Blue Cross illustrative rate.

The Block award was preceded by forty-eight days of hearing, approximately six of which were devoted to the parties' health care proposals. Throughout hearing and in the negotiations leading up to it, Respondent presented its health care proposals in summary form, rather than in the form of new contract language. For example, the proposal on the table throughout most of the Act 312 hearing stated that Respondent proposed to "change current medical insurance to BC/BSM PPO or BC/BSM HMO medical plans" and "reduce co-insurance from 100% to 80%." The word "premium" did not appear anywhere in this proposal. As Act 312 permits, both parties submitted their last best offers (LBOs) on all economic issues at the conclusion of the hearing. Respondent's health insurance LBO consisted of six pages of contract language for a proposed new Article 21, with strikeouts and additions showing the changes from the prior contract. In Respondent's LBO, a new paragraph B replaced paragraphs C and D of the former Article 21. Paragraph B read as follows:

> The City shall make available the following hospitalization plans. All plans must include both active and retired employees when developing their monthly premium rates, and all plans must follow the benefits levels as described in Exhibit I. If at the end of any fiscal year an alternative hospitalization plan or program has failed to enroll 50 employees in the entire City, the City shall have the option of removing that plan or program from the list of eligible plans or programs.
>
> <u>COPS Trust/US Health</u>
>
> Employees selecting this plan will be responsible for 20% of the monthly premium for Single Person, Two Person and Family coverage.
>
> <u>Blue Cross/Blue Shield Traditional</u>
>
> Employees selecting this plan will be responsible for 20% of the monthly premium for Single Person, Two Person and Family coverage.
>
> <u>Health Alliance Plan, Blue Care Network, Total Health Care</u>
>
> Employees selecting any of these plans will be responsible for 20% of the monthly premium for Single Person, Two Person and Family coverage.
>
> <u>Blue Cross/Blue Shield Community Blue</u>
>
> Employees selecting this plan will be responsible for 10% of the monthly premium for Single Person, Two Person, and Family coverage.

Attached to the LBO was a schedule of benefits, including doctor's office visit, emergency room and prescription drug co-pays, deductibles, and out-of-pocket maximums for each of the plans listed above. The LBO reduced the benefits employees currently received under most, if not all, the listed plans.

Charging Party's health care LBO proposed few changes to Article 21. The LBO included a provision that would allow Charging Party to select an alternative health carrier. Charging Party also proposed to make Respondent wholly responsible for the first ten, rather than eight, percent of any increase in the COPS Trust or alternative health carrier's premium.

Both parties filed post-hearing briefs with the arbitration panel that addressed the other's health insurance LBOs. Charging Party attacked Respondent's argument that the per-employee cost of the COPS Trust plan was more than comparable plans. However, Charging Party also argued that Respondent's LBO should be rejected because the use of an illustrative rate to determine the contribution of an employee to a Blue Cross self-funded plan gave Respondent too much discretion in setting the "premium."[4] Charging Party asserted that the panel should reject Respondent's LBO because it neither defined when employees' "premiums" would increase or how these "premiums" would be calculated.

Act 312 requires the arbitration panel to adopt one of the parties' LBOs on all economic issues. The panel adopted Respondent's LBO on all health insurance issues. It concluded that Respondent's financial situation was far worse than it had been under the previous contract, that there was nothing in the record that indicated it would improve during the life of the award, and that the LBO would provide Respondent with cost relief over the life of the contract no matter what plan employees chose. The panel did not specifically address Charging Party's argument that Respondent's LBO gave Respondent too much discretion because it did not define how the "premiums" for the self-funded plans would be calculated.

Charging Party did not seek review of the Block award in the circuit court. After the award issued on March 8, 2007, Charging Party asked to meet with Respondent to discuss issues relating to the implementation of the award. The parties met on April 2 and again on April 27. At these meetings, Charging Party asserted that the LBO was illegal. It also demanded to bargain over the formula, methodology and/or factors used to determine or calculate the "premium" for the self-funded plans, including what demographic groups' claim experience would be considered in calculating the illustrative rate, whether prior year arrearages from other bargaining units with Blue Cross/Blue Shield insurance would be factored in, and how provider

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[4] On page 61 of its brief to the arbitration panel, Charging Party argued:

> The City's LBO must be denied because the premium amount is tied to BCBS illustrative rates, which can be manipulated to steer employees into a particular plan and/or to recoup lost dollars caused by undervaluing. It is for this reason that [Charging Party expert witness] Dan Gorczyca concluded:
>
> > I think it leads to a very significant opportunity for the City to manipulate that number to lower its cost over time and shift more of the burden to the member in a way that is going to be difficult to dispute and argue over time.

discounts and Medicare D rebates would be handled.[5] Respondent asserted that it had no obligation to bargain over these issues. Charging Party also demanded at these meetings that Respondent hold an open enrollment period before implementing any portion of the insurance provision, arguing that Respondent was required to do so by language in the award stating that it would "make available" the listed health care plans. Respondent told Charging Party that it intended to implement the health insurance part of the award on May 1, 2007.

Sometime before May 1, Respondent provided unit employees with a rate schedule showing what they would be required to contribute per pay period under each of the plans available under the award. For the Blue Cross Traditional and Community Blue plans, the employees' contribution was calculated using an illustrative rate. The new contribution rates and benefits went into effect in May 2007. Respondent held an open enrollment period between May 15 and June 15, and employees were allowed to switch to another available plan effective July 1, 2007.

Discussion and Conclusions of Law:

Section 12 of Act 312, MCL 423.242, states:

> Orders of the arbitration panel shall be reviewable by the circuit court for the county in which the dispute arose or in which a majority of the affected employees reside, but only for reasons that the arbitration panel was without or exceeded its jurisdiction; the order is unsupported by competent, material and substantial evidence on the whole record; or the order was procured by fraud, collusion or other similar and unlawful means. The pendency of such proceeding for review shall not automatically stay the order of the arbitration panel.

Respondent asserts that under Section 12, review of the terms of the Block award is vested entirely in the circuit court. According to Respondent, the Commission lacks jurisdiction to rule on Charging Party argument that a provision of the Block award was "illegal" or "unenforceable."

Charging Party does not dispute that the Commission has no authority under Section 12 of Act 312. It also concedes that the provision in the award to which it objects involved a mandatory subject of bargaining.[6] Charging Party maintains that its claim is properly before the Commission because it involves Respondent's "post-impasse rights" under PERA, i.e., whether Respondent violated PERA by implementing, after the parties had reached impasse, a health insurance proposal that lacked any definable or objective criteria for determining the health insurance "premium" to which employees were required to contribute, without bargaining to impasse or agreement with Charging Party over these criteria.

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[5] Charging Party also made a request for information at these meetings. Respondent's alleged failure to provide that information is the subject of a separate unfair labor practice charge.

[6] An Act 312 panel has no jurisdiction to issue an award on a nonmandatory subject of bargaining. The Commission has primary jurisdiction to determine whether a particular subject is mandatory under Section 15 of PERA and, therefore, whether an Act 312 panel has jurisdiction to issue an award on that subject. *Jackson Fire Fighters Ass'n, Local 1306, IAFF, AFL-CIO* v *City of Jackson* , 227 Mich App 520, 523, 575 (1998).

Charging Party's argument that Respondent's implementation violated its duty to bargain rests entirely on a line of cases decided by the National Labor Relations Board (NLRB or the Board) under the National Labor Relations Act (NLRA), 29 USC 150 et seq. *McClatchy* N*ewspapers, Inc,* 299 NLRB 1045 (1990) and *McClatchy Newspapers, Inc,* 321 NLRB 1386, 1390-92 (1996) ("*McClatchy II* "), *enfd,* 131 F3d 1026 (CADC, 1997), *cert denied,* 524 US 937 (1998) involved an employer's contract proposal under which nearly all pay increases would be awarded on a merit basis, without notice to or participation by the union. In *KSM Industries, Inc,* 336 NLRB 133 (2001), the employer proposed to give itself the sole discretion, during the term of the agreement, "… to change the method and/or means for providing for the medical/hospital and dental benefits, which includes the plan design, the level of the benefits and the administration thereof, provided the change is applied on a company-wide basis, the change is first discussed with the union and any deductibles and coinsurance limits for the medical/hospital benefit will not exceed [specified dollar amounts.]"

In both these cases, the parties reached impasse on their contracts, and the employers proceeded to implement their proposals. In *McClatchy*, the employer began awarding merit increases. The Board concluded that even though the parties had reached impasse over the employer's proposal, the employer could not award merit increases without bargaining with the union over the timing and amounts of the individual increases. Had the union agreed to the employer's proposal, the Board reasoned, its agreement would have constituted a waiver of its right to bargain over these issues. However, because the employer had failed to obtain the union's agreement to the waiver of its right to bargain, it did not have the right to act unilaterally. The Court of Appeals found fault with the Board's reasoning, and remanded to allow the Board another opportunity to explain why the employer in that case should not be permitted to implement its last best offer after impasse. *NLRB v McClatchy Newspapers, Inc,* 964 F2d 1153, 1157, (CADC, 1992). In *McClatchy II,* the Board reaffirmed its previous finding of a violation, but offered a different explanation. The Board, at 1389-1390, discussed the reasons for its rule allowing employers, after impasse, to make unilateral changes in working conditions. The Board first noted that when a bargaining impasse is reached, the duty to bargain is not terminated but only suspended. It concluded that the "impasse doctrine" was designed, in part, to allow an employer to exert unilateral economic force by establishing new terms and conditions of employment as set out in the employer's bargaining proposals. The "impasse doctrine," therefore, was justified as a method for breaking the parties' impasse. The Board emphasized that even after implementation, the parties remain obligated to attempt to negotiate an agreement in good faith. After analyzing the effect of the employer's implementation in *McClatchy* on the union's authority and ability to represent its members, the Board concluded that giving the employer "carte blanche authority over wage increases (without limitation as to time, standards, criteria, or the [union's] agreement) would be so inherently destructive of the fundamental principles of collective bargaining that it could not be sanctioned as part of a doctrine created to break impasse and restore active collective bargaining." *McClatchy II* at 1390-1391.

I do not agree with Charging Party that Respondent's "post-impasse" rights are at issue here. Because PERA is based on the NLRA, the Commission and courts regularly look to the Board's decisions for guidance in interpreting PERA. *Lamphere Schs* v *Lamphere Federation of Teachers,* 400 Mich 104, 120 (1977). However, there is no NLRA corollary to Act 312. Under

the NLRA, and under PERA for those employees not covered by Act 312, a collective bargaining contract can only be formed by agreement of the parties. Under Act 312, a neutral arbitrator determines the terms of the collective bargaining "agreement" when the parties themselves have been unable to reach one. Although Charging Party never agreed to Respondent's health care proposal in this case, Respondent did not "unilaterally implement" it. At the time Respondent put its health care proposal into effect, it was part of a binding contract formed by the Act 312 award.

As the Board stated in *McClatchy II*, a bargaining impasse is generally only a stage in a collective bargaining process which will not end until the parties reach actual agreement. However, under Act 312, the award is the culmination of the collective bargaining process. Review of the terms of the award by a circuit court is available under Section 12 of Act 312. However, in all other respects the award stands in the place of a collective bargaining agreement. It is well established that an employer fulfills its statutory duty to bargain by bargaining about a subject and memorializing resolution of that subject in the collective bargaining agreement. *Port Huron Ed Ass'n, MEA/NEA v Port Huron Area School Dist*, 452 Mich. 309, 317-318 (1996). In my view, an Act 312 award, like any other collective bargaining agreement, ends the parties' obligation to bargain over subjects covered by the award for the term of that award. I conclude that whether or not the Block award gave Respondent "carte blanche authority" to determine the amount of the health insurance "premium" to be divided between Respondent and employees, Respondent had no further duty to bargain with Charging Party over the criteria and procedures for determining those premiums after the arbitration panel issued its award. It follows that Respondent did not violate its duty to bargain in good faith by implementing the terms of the award in May 2007.

Charging Party's second allegation addresses Respondent's refusal to hold an open enrollment period to allow its members to change plans before implementing the changes in contributions and benefits provided for in the award. Respondent asserts that this allegation also fails to state a claim under PERA. I agree. The Commission does not involve itself in disputes over the interpretation an Act 312 award. For example, in *City of Highland Park*, 1992 MERC Lab Op 207, the Commission rejected a union's argument that an employer's implementation of changes allegedly beyond the scope of the award constituted an unfair labor practice. The Commission noted that Act 312 allows a neutral body to "provide a contractual agreement" for employees covered by that statute, and that Section 12 provides for appeal of the Act 312 panel's award to the circuit court. It held that issues of whether the employer had properly implemented the award should be addressed by the courts, the arbitration panel itself, or the grievance procedure. Similarly, the Commission has held that it will not find an unfair labor practice based on a breach of contract unless the facts indicate a repudiation of the contract. In order for there to be a repudiation of the contract: (1) the contract breach must be substantial, and have a significant impact on the bargaining unit, and (2) there must be no bona fide dispute over interpretation of the contract. *Gibraltar Sch Dist*, 16 MPER 36 (2003*); Plymouth-Canton Cmty Schs*, 1984 MERC Lab Op 894, 897. Assuming arguendo that a "repudiation" of an Act 312 award might constitute an unfair labor practice, I find that the parties have a bona fide dispute over the proper interpretation of the award and that Charging Party has not alleged facts upon which a repudiation finding could be based.

In accord with the discussion and conclusions of law set forth above, I conclude that Respondent's motion for summary dismissal of the charge should be granted. I recommend that the Commission issue the following order.

RECOMMENDED ORDER

The charge is dismissed in its entirety.

MICHIGAN EMPLOYMENT RELATIONS COMMISSION

_____

Julia C. Stern
Administrative Law Judge

Date: _____