STATE OF MICHIGAN
EMPLOYMENT RELATIONS COMMISSION
LABOR RELATIONS DIVISION

In the Matter of:

CITY OF SOUTHFIELD,
Respondent-Public Employer,

-and-

SOUTHFIELD POLICE OFFICERS ASSOCIATION,
Charging Party-Labor Organization in Case No. C11 L-220;
Docket No. 11-000663-MERC,

-and-

SOUTHFIELD COMMAND OFFICERS ASSOCIATION,
Charging Party-Labor Organization in Case No. C11 L-223;
Docket No. 11-000665-MERC,

-and-

POLICE OFFICERS ASSOCIATION OF MICHIGAN
(PUBLIC SAFETY TECHNICIAN SUPERVISORS),
Charging Party-Labor Organization in Case No. C11 L-224;
Docket No. 11-000666-MERC,

-and-

POLICE OFFICERS ASSOCIATION OF MICHIGAN
(PUBLIC SAFETY TECHNICIANS)
Charging Party-Labor Organization in Case No. C11 L-225;
Docket No. 11-000667-MERC.
____/

APPEARANCES:

Keller Thoma, by Dennis B. DuBay, for Respondent

Martha Champine, Assistant General Counsel, for Charging Parties

DECISION AND ORDER

On August 7, 2013, Administrative Law Judge (ALJ) David M. Peltz issued his Decision and Recommended Order in the above matter finding that Respondent, City of

Southfield, did not violate § 10(1)(e) of the Public Employment Relations Act (PERA), 1965 PA 379, as amended, MCL § 423.210(1)(e), by unilaterally implementing increased health insurance premium rates on January 1, 2012 in compliance with the Publicly Funded Health Insurance Contribution Act, 2011 PA 152, MCL §§ 15.561-15.569. Finding that the phrase "medical benefit plan coverage year" in the Act was undefined, the ALJ concluded that the Commission had no independent authority to interpret the language itself and, therefore, Respondent had only to act reasonably in complying with it. Since Respondent fulfilled this criterion, the ALJ found that Respondent did not breach its duty to bargain in good faith under PERA. In accordance with these findings, the ALJ recommended that the charges be dismissed.

The Decision and Recommended Order was served upon the interested parties in accordance with § 16 of PERA. After filing a request, Charging Party was granted an extension of time to file exceptions and filed its exceptions on September 30, 2013. Respondent requested an extension of time to file its response to Charging Party's exceptions and filed a response to the exceptions, as well as cross-exceptions, on November 6, 2013. Charging Party did not respond to the cross-exceptions.

Charging Party takes exception to the ALJ's findings that the Commission had no independent authority to interpret PA 152; that Respondent reasonably interpreted the language of PA 152 to correspond to a calendar year; and that Respondent did not breach its duty to bargain in good faith. Alternatively, Charging Party argues that the agreements between Respondent and its healthcare providers constituted "other contracts" under § 5(1) of PA 152 and were inconsistent with §§ 3 and 4 of that Act.

Respondent requests that the Commission adopt the ALJ's decision except as it may be modified by Respondent's cross-exceptions. In its cross-exceptions, Respondent takes exception to the ALJ's failure to find that PA 152 is not a mandatory subject of bargaining and failure to rule on whether the City bargained over its implementation.

On reviewing the record carefully and thoroughly, we find Charging Party's exceptions are without merit. We also find Respondent's cross-exceptions to be without merit except as noted below.

Factual Summary:

We adopt the facts regarding the underlying merits of this case as set forth fully in the ALJ's Decision and Recommended Order and repeat them only as necessary.

The Police Officers Association of Michigan (POAM) represents four separate bargaining units of Respondent's employees: the Southfield Police Officers Association, the Southfield Command Officers Association, the Public Safety Technician Supervisors and the Public Safety Technicians. Each collective bargaining agreement contained a similar health insurance provision on the basis of which benefit plan coverage is provided on a calendar year basis. The four collective bargaining agreements involved in this

dispute all expired in June 2009. No new agreements were reached during the time period relevant to this dispute.

On September 27, 2011, Public Act 152 of 2011 became effective. Act 152 was enacted to limit public employers' expenditures for employee medical benefit plans. Section 3 of Act 152, MCL 15.563, sets specific dollar limits, referred to as "hard caps," on the amounts public employers may pay for employee medical benefit plans, commencing with medical benefit plan coverage years beginning on or after January 1, 2012. Upon the majority vote of its governing body, a public employer may choose to comply with the requirements of § 4 of Act 152 instead of § 3. Section 4, MCL 15.564, limits a public employer's share of health care costs to eighty percent of the total annual costs of all of the medical benefit plans it offers. Pursuant to § 5 of Act 152, MCL 15.565, parties are prohibited from entering into collective bargaining agreements after September 15, 2011, that contain terms inconsistent with the requirements of the Act. With a two-thirds vote of its governing body, a local unit of government, such as Respondent, may exempt itself from the requirements of Act 152 for the next succeeding medical benefit plan coverage year pursuant to § 8 of the Act, MCL 15.568. Public employers that fail to comply with the requirements of Act 152 are subject to a substantial financial penalty under § 9.

After Public Act 152 was passed in September 2011, Respondent informed each of the POAM Unions, via letters dated November 3, 2011, that it was implementing the hard cap option under Section 3 of PA 152, effective January 1, 2012. Charging Party did not dispute Respondent's right to unilaterally select the hard cap option.

On December 7, 2011, however, Charging Party General Counsel Frank Guido wrote Respondent and asserted that the provisions of PA 152 should not be applied until October 1, 2012, when the City's contracts for medical benefit coverage renew. Guido's letter provided, in relevant part:

> It has come to the attention of the POAM, COAM and TPOAM that the City of Southfield, effective January 1, 2012, is intending to apply the provisions of P.A. 152 to the various bargaining unit members. The City's intent to apply P.A. 152 on January 1, 2012 is in violation of the statute and, if not corrected, will result in the filing of unfair labor practice charges as well as litigation seeking declaratory and injunctive relief.

On December 13, 2011, Respondent's attorney, Dennis Dubay, wrote Guido and took issue with Guido's contention that the "medical benefit plan coverage year" commences on October 1st, the date the City's contracts for medical benefit coverage renew. According to Dubay, coverage for purposes of PA 152 was provided on "a calendar year basis, i.e. January 1st through December 31st of each year." Consequently, January 1, 2012 was the proper date for implementation of the Act's requirements.

The four POAM Unions responded by filing the instant unfair labor practice charges alleging that the City of Southfield acted improperly by unilaterally imposing

increased health insurance premium rates prior to the beginning of the "medical benefit plan coverage year" as described in Sections 4 and 5 of the Public Funded Health Insurance Contribution Act, 2011 PA 152.

Subsequent to this, the parties agreed that there were no material questions of fact in dispute and that the case could be decided pursuant to a stipulated set of facts. On August 23, 2012, the parties filed their stipulation of facts, as well as twenty-one (21) joint exhibits. The parties stipulated that:

> "…the only issue pending before MERC in these four consolidated cases is whether the City of Southfield violated the PERA when it made deductions in employees' wages attributed to healthcare premiums. The City maintains that January 1, 2012 is the appropriate implementation date of PA 152 of 2011. The Charging Party-Labor Organizations maintain that it is October 1, 2012."

Discussion and Conclusions of Law:

Between the effective date of Act 152 and the beginning of its next medical benefit plan coverage year, which started on or after January 1, 2012, Respondent was required to determine whether it would comply with § 3 or § 4, or exempt itself from the requirements of Act 152 pursuant to § 8. While Respondent could have chosen to bargain with Charging Party over these options, it had no obligation to do so. As we explained in *Decatur Pub Sch*, 27 MPER 41 (2014):

> By basing the public employer's share of health care costs on the total amount to be paid for health care costs for all employees and public officials, PA 152 makes it clear that the public employer's costs are not determined by the amount the public employer pays for particular bargaining units or other groups of employees, but for all employees and public officials as a single group. Therefore, it is evident that the public employer must choose with respect to all of its employees and public officials whether it will use the hard caps under § 3 or the 80% employer share under § 4. Moreover, the fact that § 4 requires a majority vote of the public employer's governing body indicates that the choice between the hard caps and the 80% employer share is a policy choice to be made by the employer. Thus, while not expressly making this issue a prohibited subject of bargaining, it is clear the Legislature intended that the choice between the hard caps and the 80% employer share be left to the public employer.

We concluded that the ALJ in *Decatur* "erred by finding that the choice between the hard caps and eighty percent employer share is a mandatory subject of bargaining." *Id*. We went on to explain that in making this policy decision, "[p]ublic employers may bargain with the labor organizations representing their employees over the choice between the hard caps and the eighty percent employer share, but are not required to do

so." *Id.* Respondent therefore did not breach its duty to bargain by unilaterally selecting the hard cap option.

Charging Party admits that an employer has the option of choosing either a dollar amount cap or percentage cap on the total amount of annual costs that the public employer pays for employee medical benefit plans. Charging Party, nonetheless, maintains that Respondent violated PERA when it decided that the premium sharing mandated by PA 152 commenced on January 1, 2012, the beginning of the coverage year, instead of October 1, 2012, the date on which the City's contracts for health insurance renewed.

In *Shelby Township*, Case No. C12 D-067 (2014), the Respondent argued that the Charging Party's January 6, 2012 bargaining demand was untimely because it was not made before the beginning of the medical benefit plan coverage year. At the time involved in the dispute, Act 152 did not include a definition of "medical benefit plan coverage year."[1] Moreover, the Attorney General and the Department of Treasury had different definitions for "medical benefit plan coverage year." Respondent in that case argued that the medical benefit plan coverage year began on January 1, 2012, the date that the newly elected or newly renewed coverage was to begin. The Charging Party, however, maintained that the medical benefit plan coverage year began on February 1, 2012, the date on which the benefit plan renewed. The Commission noted that both parties had reasonable bases for their interpretation of "medical benefit plan coverage year" and that, "[i]n light of Charging Party's reasonable belief that the medical benefit plan coverage year began on February 1, 2012, its January 6, 2012 demand to bargain was timely." *Id.* The Commission further held that Respondent did not breach its duty to bargain by implementing health care cost sharing on January 1, 2012:

> Here, the parties' collective bargaining agreement had expired and they were negotiating a successor agreement. After the contract's expiration, Respondent was obligated to maintain existing terms and conditions of employment with respect to mandatory subjects of bargaining until the parties reached agreement or impasse. Despite their efforts, the parties had not reached agreement or impasse by January 1, 2012, the date that Respondent had determined to be the beginning of the medical benefit plan coverage year. Inasmuch as Respondent had a reasonable basis for believing that January 1, 2012 was the beginning of the benefit plan coverage year, Respondent did not breach its duty to bargain by implementing the health care benefit cost sharing on the first employee pay date following January 1, 2012, to the extent required by Act 152.

In the present case, as in *Shelby Township*, the parties' collective bargaining agreements had expired and they were negotiating successor agreements. After the

[1] Act 152 was amended by 2013 PA 269, effective December 30, 2013, which added the definition of medical benefit plan coverage year at § 2(g) providing: "'Medical benefit plan coverage year' means the 12-month period after the effective date of the contractual or self-insured medical coverage plan that a public employer provides to its employees or public officials."

contracts expired, Respondent was obligated to maintain existing terms and conditions of employment with respect to mandatory subjects of bargaining until the parties reached agreement or impasse. Despite their efforts to negotiate new agreements, the parties had not reached agreement or impasse by January 1, 2012, the date that Respondent had determined to be the beginning of the medical benefit plan coverage year. Inasmuch as Respondent had a reasonable basis for believing that January 1, 2012 was the beginning of the benefit plan coverage year, Respondent did not breach its duty to bargain by implementing the health care benefit cost sharing on January 1, 2012, to the extent required by Act 152.

We have also considered all other arguments submitted by the parties and conclude that they would not change the result in this case. Accordingly, we agree with the ALJ that the facts alleged in the charge do not support a finding that Respondent breached its duty to bargain. The ALJ's Decision and Recommended Order is affirmed.

ORDER

IT IS HEREBY ORDERED that the Order recommended by the Administrative Law Judge shall become the Order of the Commission. The unfair labor practice charge is hereby dismissed in its entirety.

MICHIGAN EMPLOYMENT RELATIONS COMMISSION

/s/
Edward D. Callaghan, Commission Chair

/s/
Robert S. LaBrant, Commission Member

/s/
Natalie P. Yaw, Commission Member

Dated: November 18, 2014

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
EMPLOYMENT RELATIONS COMMISSION

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CITY OF SOUTHFIELD,
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SOUTHFIELD POLICE OFFICERS ASSOCIATION,
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Docket No. 11-000667-MERC.
____/

APPEARANCES:

Keller Thoma, by Dennis B. DuBay, for Respondent

Martha Champine, Assistant General Counsel, for the Charging Parties

DECISION AND RECOMMENDED ORDER OF ADMINISTRATIVE LAW JUDGE

This case arises from unfair labor practice charges filed on December 20, 2011, by the Southfield Police Officers Association, the Southfield Command Officers Association, the Police Officers Association of Michigan (Public Safety Technician Supervisors) and the Police Officers Association of Michigan (Public Safety Technicians) against the City of Southfield. Pursuant to Sections 10 and 16 of the Public Employment Relations Act (PERA), 1965 PA 379, as amended, MCL 423.210 and 423.216, the charges were consolidated and assigned to David M. Peltz, Administrative Law Judge (ALJ) for the Michigan Administrative Hearing System (MAHS), acting on behalf of the Michigan Employment Relations Commission (MERC).

The Charges and Procedural History:

The charges assert that the City of Southfield acted improperly by unilaterally imposing increased health insurance premium rates prior to the beginning of the "medical benefit plan coverage year" as described in Sections 4 and 5 of the Public Funded Health Insurance Contribution Act, 2011 PA 152, MCL 15.561 *et seq*. Act 152 of 2011 (PA 152) and, with respect to the Southfield Police Officers Association, during the pendency of arbitration proceedings under the Compulsory Arbitration of Labor Disputes in Police and Fire Departments Act, 1969 PA 312, MCL 423.231 *et seq*. (Act 312).[2]

The instant case was initially held in abeyance so that the ALJs assigned to hear disputes arising under PERA could determine whether the matter should be heard separately or in conjunction with multiple other cases then pending before the Commission involving the interpretation of Sections 3 and 4 of PA 152. After myself and the other ALJs jointly decided that consolidation of cases involving different public employers would not be practical in this instance, I issued an order on January 5, 2012 directing the City of Southfield to file a substantive and fact specific answer to the charges or a position statement which fairly met each of the substantive factual assertions set forth by the Unions in the charges.

The City filed its position statement on February 22, 2012. Thereafter, the parties agreed that there were no material questions of fact in dispute and that the case could be decided pursuant to a stipulated set of facts. On August 23, 2012, the parties filed their stipulation of facts, along with twenty-one (21) joint exhibits. On that same date, the Unions and the City each filed extensive briefs setting forth their various legal arguments in this matter.

Findings of Fact:

[2] The allegation concerning a unilateral imposition of increased health insurance premiums during the pendency of compulsory arbitration proceedings under Act 312 was later withdrawn by Charging Parties and is not addressed in this decision.

The following factual findings are derived from the stipulated facts and the documentation attached thereto. The Police Officers Association of Michigan (POAM) represents four separate bargaining units of employees of the City of Southfield: the Southfield Police Officers Association, the Southfield Command Officers Association, the Public Safety Technician Supervisors and the Public Safety Technicians. The most recent collective bargaining agreements between the City and the four POAM bargaining units all expired on June 30, 2009.

Health insurance provided by the City of Southfield under the expired collective bargaining agreements has generally been the same for all four POAM units. The contracts give employees the option of enrolling in either Blue Cross/Blue Shield (BCBS) Traditional Master Medical, BCBS Community Blue PPO or Health Alliance Plan (HAP) HMO. At the time the stipulation of facts was filed in this matter, 151 members of the POAM bargaining units were enrolled in one of the two BCBS plans, while 15 employees opted for HAP HMO coverage.

The HAP HMO is a fully insured healthcare plan. The City pays premiums to HAP with annual rate adjustments effective October 1st of each year. The City is self–insured for purposes of the BCBS Traditional Master Medical and BCBS Community Blue PPO plans and, therefore, no "premiums" are paid. Rather, every three months, the City pays an amount reflective of actual claims during the prior three months, plus an administrative fee charged by BCBS. On October 1st of each year, BCBS implements its new administrative fee and catastrophic stop/loss premium (insurance above $200,000 per claim). These rates remain in effect for twelve months. According to the stipulation of facts, illustrative rates are calculated by BCBS effective on October 1st of each year.

Each health care benefit plan specifies the coverage provided by the plan, including the applicable copays, maximum copays, coinsurance payments, deductibles and limits on the number of specific services. In each case, the benefit plan coverage, medical benefit deductibles and copays are calculated on a calendar year basis. For example, the BCBS Traditional Master Medical Plan requires a deductible of $50 for one person or $100 for two or more persons in a "calendar year" and the plan defines a "benefit period" as a "calendar year, beginning on January 1st and ending December 31st of that year." The BCBS Community Blue PPO and HAP HMO Plans also contain language describing coverage and deductibles in terms of dollars or visits "per calendar year." For example, the HAP HMO plan limits coverage for outpatient mental health services to "20 visits per member per calendar year." Similarly, enrollees in the Community Blue PPO are eligible for a stay in a skilled nursing facility of "up to a maximum of 120 days per member, per calendar year."

Open enrollment for health insurance for POAM unit members has generally occurred in September of each year, with changes effective October 1st. The City offers as an option for its employees a health insurance opt-out program pursuant to which employees can waive coverage for employer provided medical benefits in exchange for an incentive bonus. This opt-out program is specifically referenced in two of the POAM contracts with the City. The Public Safety Technician Supervisors and the Public Safety

Technicians contracts both specify that "employees, other than new hires, must complete the application and documentation process during the annual open enrollment period in September of each year." Pursuant to those contracts, the incentive is to be spread equally over bi-weekly pay periods "on a calendar year basis." For the year 2012, the opt-out program enrollment period for all City employees was November 28, 2011 through December 9, 2011.

On June 8, 2011, Public Act 54 of 2011 (PA 54) went into effect. PA 54 amended PERA to cap wages and benefits following contract expiration. MCL 423.215b(1) provides that after the expiration date of a collective bargaining agreement and until a successor contract is in place, employees shall bear any increased cost of maintaining health, dental, vision, prescription or other insurance benefits that occurs after the expiration date. On October 14, 2011, the City provided the Unions with the 2010 and 2011 health insurance rates to show the increases which were to be paid by employees as a result of PA 54. The City further advised Charging Parties that there would be an open enrollment period beginning in early December, with a January 1, 2012 effective date.

PA 152 took effect on September 27, 2011. As explained more fully below, Section 3 of PA 152, MCL 15.563, mandates that public employers "shall pay no more" than a statutorily set dollar amount for health insurance during a "medical benefit plan coverage year beginning on or after January 1, 2012." PA 152 provides local municipalities with two additional options for compliance: "80/20" (Section 4 of the statute) and "opt-out" (Section 8 of the statute). The Act also permits the public employer to deduct additional sums from employees' compensation, if necessary, to cover the remaining costs for its employees and elected officials.

After PA 152 took effect, Charging Parties requested that the City indicate whether it would be implementing the hard cap, the 80-20 cost-sharing option or the opt-out. The City responded to each of the POAM Unions via individual letters dated November 3, 2011. In the letters, the City indicated that it was selecting the hard cap option under Section 3 of PA 152. The letters, which were substantively identical, provided, in pertinent part:

> As you are aware, P.A. No. 152 of 2011 took effect on September 27, 2011. Pursuant to state law, effective January 1, 2012, the dollar caps in Section 3 of the statute shall be in effect. The dollar caps are as follows:
>
> | | |
> |---|---|
> | Single | $ 5,500 |
> | Employee and Spouse | $11,000 |
> | Family | $15,000 |
>
> The employee's portion of the cost of a medical benefit plan shall be deducted from compensation due to the employee each bi-weekly pay period. In addition to the assessed cost of the increased medical, dental and vision premiums under PA 54 of 2011, the required employee contribution per pay period for each medical benefit plan offered under

your collective bargaining agreement will be implemented as of January 1, 2012, and is as follows:

	Blue Cross Traditional	Community Blue 1	BCBS Preferred PPO	HAP
Single	$104.28	$68.11	$105.36	$71.59
Employee & Spouse	$334.89	$248.09	$337.46	$235.13
Family	$370.54	$262.03	$373.76	$116.70

As you are also aware, new health insurance plans (Blue Cross/Blue Shield Community Blue PPO-10, and a corresponding HAP-10 option) are in place with a number of City groups. The required contributions per pay period for the Blue Cross/Blue Shield Community Blue PPO-10 medical plan and the HAP-10 medical plan (which includes the required additional charge for dental and vision premium increases per PA 54) are as follows:

	Community Blue 10	HAP-10
Single	$3.04	$6.50
Employee and Spouse	$37.12	$43.61
Family	$56.40	$53.57

The City is hereby offering the Blue Cross/Blue Shield Community Blue PPO-10 plan and the HAP-10 plan, including the required employee contributions as set forth above, as additional options available to the members of each bargaining unit with unsettled contracts upon the labor organization's concurrence. For this purpose we are enclosing an agreement to provide the Blue Cross/Blue Shield Community Blue PPO-10 medical plan and HAP-10 as additional options available to members of your bargaining unit, effective January 1, 2012. Open enrollment will commence in the next several weeks, so it is imperative that, if you concur with this proposal, you return to the undersigned the executed agreement no later than November 14, 2011. If we do not receive the executed agreement by that date, we will assume the Union is not in agreement and the additional options will not be offered to members of your unit.

Included with each copy of the above letter was a document entitled, "Agreement to Add Additional Medical Plan Options" which identified the two new healthcare plans offered by the City, described a December 2011 open enrollment period and specified a January 1, 2012 effective date for the new plans. Representatives for all four of the POAM bargaining units signed copies of the agreement in early November of 2011. The open enrollment period took place between November 28, 2011 and December 9, 2011 and all employees signed an authorization for payroll deduction and/or an enrollment form. Health care premium deductions commenced at the beginning of the first pay period after January 1, 2012.

In a letter to Respondent dated December 7, 2011, Frank Guido, general counsel for the POAM, asserted that the provisions of PA 152 should not be applied on January 1, 2012, but rather on October 1, 2012, when the City's contracts for medical benefit coverage renew. The letter, which was sent to the city administrator by regular mail, provides, in pertinent part:

> It has come to the attention of the POAM, COAM and TPOAM that the City of Southfield, effective January 1, 2012, is intending to apply the provisions of P.A. 152 to the various bargaining unit members. The City's intent to apply P.A. 152 on January 1, 2012 is in violation of the statute and, if not corrected, will result in the filing of unfair labor practice charges as well as litigation seeking declaratory and injunctive relief.
>
> * * *
>
> [T]he City must refrain from taking unilateral action and must comply with not only the correct interpretation of P.A. 152, but also bargaining obligations which remain in effect pursuant to both the Public Employment Relations Act and the Compulsory Arbitration Act.
>
> By this correspondence, the City is placed on notice that litigation will be instituted in the event the City goes forward with its unilateral action, as well as the filing of an unfair labor practice charge with the Michigan Employment Relations Commission.

The City's attorney, Dennis Dubay, responded to Guido by letter dated December 13, 2011. In the letter, Dubay disputed Guido's contention that the "medical benefit plan coverage year" commences on October 1st of each year, the date the City's contracts for medical benefit coverage renew. Rather, Dubay opined that coverage for purposes of PA 152 is provided on "a calendar year basis, i.e. January 1st through December 31st of each year" and that, therefore, January 1, 2012 was the proper date for implementation of the Act's requirements. The four POAM Unions responded by filing the instant unfair labor practice charges.

<u>Arguments of the Parties</u>:

Charging Parties contend that the City violated PERA by arbitrarily using January 1, 2012 as the implementation date for the premium sharing increases mandated by PA 152. According to Charging Parties, the proper date for commencement of the statutorily mandated changes was October 1, 2012 because that is the date upon which the City's contracts with its health insurance carriers renewed and because that is the effective date for the implementation of changes to coverages selected by employees during the open enrollment period which generally occurs in September of each year. The Unions contend that this interpretation is consistent with the purpose of the statute, as the timeframe for calculation of the employer's annual costs is inextricably linked to the contract year. Charging Parties further assert that Respondent's implementation of premium sharing increases on January 1, 2012 was unlawful because, at that time, the City's healthcare plans with BCBS and HAP were still in effect. According to Charging Parties, each of those healthcare plans constitute a "contract" for purposes of Section 5 of PA 152, which requires a delay in the implementation of changes to health insurance premium sharing where there is a "collective bargaining agreement or **other contract** that is inconsistent with sections 3 and 4" of the Act in effect (emphasis supplied). As a remedy, Charging Parties seek an order requiring the City to restore the status quo ante of medical insurance coverage and premium sharing as it existed prior to the unilateral changes imposed on January 1, 2012. In addition, the Unions request that the Employer be ordered to make employees whole for any losses and damages incurred as a consequence of the premature implementation of the PA 152 requirements.

Respondent asserts that the charges should be dismissed because the Unions actually bargained for and agreed to the various changes to health insurance effective January 1, 2012. In support of this contention, the City refers to the document signed by representatives of each of the four POAM Unions entitled, "Agreement to Add Additional Medical Plan Options" which specified a January 1, 2012 effective date for the new plans offered by the City. Respondent contends that dismissal of the charges is also appropriate because the Unions never demanded bargaining over its decision to increase premium sharing costs beginning on the first of the year. In any event, the City alleges that January 1, 2012 was the proper implementation date for health insurance premium sharing under PA 152 because that is the date upon which deductibles and co-pays are calculated. In support of this contention, the City references language in its various healthcare plans describing coverage and deductibles in terms of dollars or visits "per calendar year." According to the City, this interpretation is consistent with the "Reform Alert" in which BCBS concluded that "plan year" under the federal Patient Protection and Affordable Care Act refers to the date upon which deductibles reset. Even if the employee enrollment period is used in determining the beginning of the "medical benefit plan coverage year," the City contends that January 1, 2012 is the appropriate date for purposes of PA 152. In support of this contention, the City refers to the fact that it held an open enrollment between November 28, 2011 and December 9, 2011, just prior to the implementation of the premium increases mandated by the Act. Finally, the City contends that without clear statutory guidance as to the meaning of the term "medical benefit plan coverage year", its decision to use the calendar year as the date for commencement of the changes was made in good faith and, therefore, was not a violation of PERA.

Discussion and Conclusions of Law:

PA 152 provides for certain limitations on the amount that public employers may contribute toward the annual cost of medical benefit plans that cover their employees. The provisions of PA 152 which are of particular relevance to this dispute are as follows:

> Section 2. As used in this act:
>
> * * *
>
> e) "Medical benefit plan" means a plan established and maintained by a carrier, a voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code of 1986, 26 USC 501, or by 1 or more public employers, that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, for public employees or elected public officials. Medical benefit plan does not include benefits provided to individuals retired from a public employer.
>
> Section 3. Except as otherwise provided in this act, a public employer that offers or contributes to a medical benefit plan for its employees or elected public officials shall pay no more of the annual costs or illustrative rate and any payments for reimbursement of co-pays, deductibles, or payments into health savings accounts, flexible spending accounts, or similar accounts used for health care costs, than a total amount equal to $5,500.00 times the number of employees with single person coverage, $11,000.00 times the number of employees with individual and spouse coverage, plus $15,000.00 times the number of employees with family coverage, for a medical benefit plan coverage year beginning on or after January 1, 2012. A public employer may allocate its payments for medical benefit plan costs among its employees and elected public officials as it sees fit. By October 1 of each year after 2011, the state treasurer shall adjust the maximum payment permitted under this section for each coverage category for medical benefit plan coverage years beginning the succeeding calendar year, based on the change in the medical care component of the United States consumer price index for the most recent 12-month period for which data are available from the United States department of labor, bureau of labor statistics.
>
> Section 4. (1) By a majority vote of its governing body, a public employer, excluding this state, may elect to comply with this section for a medical benefit plan coverage year instead of the requirements in section 3. The designated state official may elect to comply with this section instead of section 3 as to medical benefit plans for state employees and state officers.

(2) For medical benefit plan coverage years beginning on or after January 1, 2012, a public employer shall pay not more than 80% of the total annual costs of all of the medical benefit plans it offers or contributes to for its employees and elected public officials. For purposes of this subsection, total annual costs includes the premium or illustrative rate of the medical benefit plans and all employer payments for reimbursement of co-pays, deductibles, and payments into health savings accounts, flexible spending accounts, or similar accounts used for health care but does not include beneficiary-paid copayments, coinsurance, deductibles, other out-of-pocket expenses, other service-related fees that are assessed to the coverage beneficiary, or beneficiary payments into health savings accounts, flexible spending accounts, or similar accounts used for health care. Each elected public official who participates in a medical benefit plan offered by a public employer shall be required to pay 20% or more of the total annual costs of that plan. The public employer may allocate the employees' share of total annual costs of the medical benefit plans among the employees of the public employer as it sees fit.

Section 5. (1) If a collective bargaining agreement or other contract that is inconsistent with sections 3 and 4 is in effect for a group of employees of a public employer on the effective date of this act, the requirements of section 3 or 4 do not apply to that group of employees until the contract expires. A public employer's expenditures for medical benefit plans under a collective bargaining agreement or other contract described in this subsection shall be excluded from calculation of the public employer's maximum payment under section 4. The requirements of sections 3 and 4 apply to any extension or renewal of the contract.

* * *

Section 6. A public employer may deduct the covered employee's or elected public official's portion of the cost of a medical benefit plan from compensation due to the covered employee or elected public official. The employer may condition eligibility for the medical benefit plan on the employee's or elected public official's authorizing the public employer to make the deduction.

* * *

Section 9. If a public employer fails to comply with this act, the public employer shall permit the state treasurer to reduce by 10% each economic vitality incentive program payment received under 2011 PA 63 and the department of education shall assess the public employer a penalty equal to 10% of each payment of any funds for which the public employer qualifies under the state school aid act of 1979, 1979 PA 94, MCL 38.1601 to 338.1772, during the period that the public employer fails to

> comply with this act. Any reduction setoff or penalty amounts recovered shall be returned to the fund from which the reduction is assessed or upon which the penalty is determined. The department of education may also refer the penalty collection to the department of treasury for collection consistent with section 13 of 1941 PA 122, MCL 205.13.

Almost immediately after PA 152 became effective, disputes arose over the meaning and scope of the Act, including the extent to which public employers must negotiate with the labor organizations representing their employees over the changes contemplated by the legislation. In *Decatur Pub Sch,* Case Nos. C12 F-123 & C12 F-124, issued December 20, 2012 and currently pending on exceptions before the Commission, ALJ Doyle O'Connor held that there continues to be a duty under PERA to maintain conditions of employment as to health insurance issues after expiration of a collective bargaining agreement, as well as a duty to bargain over the mechanism by which Act 152's mandate will be accomplished, and that this duty is excused only to the extent necessary to implement those changes required by the Act. At the same time, however, Judge O'Connor recognized that the Legislature imposed on public employers engaged in negotiating new collective bargaining agreements a deadline for implementing the changes and threatened significant financial penalties for noncompliance. Describing the deadline as a "statutorily imposed impasse over health insurance cost sharing," O'Connor concluded that if the public employer and the union have not entered into an agreement on a new contract by the beginning of the "medical benefit plan coverage year" following expiration of the previous agreement, the public employer must institute the premium sharing mandated by PA 152. In *Genesee County*, 26 MPER 48 (2013) (no exceptions), I concurred with Judge O'Connor's analysis, at least with respect to there being no duty to bargain over implementation of the hard cap if the employer and union have not entered into a new contract by the statutory deadline.

In the instant case, there is no dispute concerning the City's decision to impose a hard cap on its employees rather than the 80-20 or opt-out options. In their brief, Charging Parties concede, "The employer has the option of choosing either a dollar amount cap or percentage cap on the total amount of annual costs that the public employer pays for employee medical benefit plans." Rather, the issue to be decided here is whether the premium sharing mandated by PA 152 commenced on January 1, 2012, the beginning of the coverage year for purposes of deductibles and benefits; October 1, 2012, when the City's contracts for health insurance renewed; or on some other date. Resolution of this issue is dependent on the meaning of the term "medical benefit plan coverage year" as used in Sections 3 and 4 of PA 152, MCL 15.563 and MCL 15.564. In reviewing the language of PA 152, the primary goal must be, as it is in all matters of statutory construction, to ascertain and effectuate the intent of the Legislature. *Lakeview Comm Sch*, 25 MPER 37 (2011); *Castco Twp v Sect of State*, 472 Mich 566 (2005). The starting point is to review the statute's wording, which provides the most reliable evidence of the Act' s intent. *Neal v Wilkes*, 470 Mich 661, 665 (2004); *Sun Valley Foods Co v Ward*, 460 Mich 230, 236 (1999). Where there is no statutory definition of the words used in the statute, those words and phrases must be given their plain and

ordinary meaning. *Western Mich Univ Bd of Control v State*, 455 Mich 531, 538-539 (1997); *Bingham v American Screw Products Co*, 398 Mich 546, 563 (1976).

Although PA 152 contains a definition section, MCL 15.561, the term "medical benefit plan coverage year" is not defined within that section or clarified elsewhere within the statute. That specific term does not have any plain or ordinary meaning; it is neither a term of art for purposes of labor relations law nor is there any indication in the record that it is an established phrase routinely used within the health insurance industry. The legislative history of PA 152 is also silent with respect to the meaning of "medical benefit plan coverage year." Beginning even before the effective date of the Act, governmental agencies and other entities set forth various and conflicting interpretations of the term, the most prominent of which are explained in detail below.

A. Blue Cross Blue Shield

Attached to the charge in this matter was an email from Kathy McAttee, Senior Marketing Relations Representative for Blue Cross/Blue Shield of Michigan (BCBSM) addressed to several individuals, including the Unions' attorney, Frank Guido. The email, dated November 30, 2011, references Senate Bill 7, which ultimately was passed into law as PA 152. In the email, McAttee opines:

> Public Policy at BCBSM has coordinated outreach efforts with our Government Affairs team to answer your question on SB 7. We reached out to the state Treasury Department and, unfortunately, they were unable to provide us with any additional information. We did reach out to the Legislature to inquire again regarding legislative intent.
>
> Key legislative staff involved with the bill agreed with our interpretation of the language in this matter. As you recall, our interpretation of the timeline is a "medical benefit plan year" for purposes of this legislation is the period of time of the contract of the plan (i.e. October 1 to September 30 or July 1 to January 1, 2012.) The inclusion of "on or after" implies that the legislature contemplated that a plan's coverage period does not begin and end every year on January 1 and that different groups may have different start or end dates for coverage.

After receiving a copy of the McAttee email from Charging Parties, the City of Southfield, through its insurance agents, contacted BCBSM to verify the assertions set forth therein. On February 7, 2012, the City received a written response from Matthew A. Case, Assistant General Counsel for BCBSM. The letter, which is dated February 2, 2012, states, in pertinent part:

> I am writing to clarify the position of Blue Cross and Blue Shield of Michigan ("BCBSM") regarding the issue of what a "medical benefit plan coverage year" is under Senate Bill No. 7, which was enacted as Act No. 152 of 2011 effective September 27, 2011 ("Act"). I have been informed

> that you may have the impression that BCBSM has provided a formal position on that issue; however that is not correct.
>
> The Act does not define the term "medical benefit plan coverage year," and, unfortunately, there is little available that helps clarify it. Because of the lack of clear statutory language or other authority, BCBSM has no definitive position on that term's meaning that it can share with its customers. Rather, that would fall within the realm of legal interpretation, which we leave to our customers and their own legal counsel.
>
> I sincerely apologize for any confusion or inconvenience that may have been caused to the City.

The parties in this matter submitted as a stipulated exhibit a "Reform Alert" issued by the BCBS Office of National Health Reform on July 19, 2010, prior to the passage of PA 152 by our Legislature. The document addresses the meaning of the term "plan year" as that term is used in the federal Patient Protection and Affordable Care Act of 2010 (PPACA), commonly referred to as "Obamacare." The BCBS document provides, in part:

> Many reforms in the [PPACA] will be implemented for plan years beginning on or after Sept. 23, 2010. "Plan year" is not synonymous with "renewal date" or "enrollment date," although there are circumstances where those dates could be the same.
>
> There are many criteria to determine "plan year," but we believe that for most BCBSM and BCM group and individual customers, "plan year" will be Jan. 1 through Dec. 31, because that is when the deductibles reset. BCBSM and BCN are moving forward with implementation of near-term reforms, such as extended dependent coverage to age 26, removing lifetime limits, and ending waiting periods for pre-existing conditions for children under age 19, based on this definition of "plan year" in most cases.

B. Michigan Department of Treasury

After PA 152 went into effect, the Michigan Department of Treasury posted a list of "Frequently Asked Questions" concerning the statute on its website. The first question listed addressed the meaning of the term "medical benefit plan coverage year" as used in Sections 3 and 4 of PA 152. The website states:

> Q1. **When does the benefit plan year begin?**
>
> A1. The Publicly Funded Health Insurance Contribution Act provides for certain limitations on the amount that public employers may contribute toward the annual cost of medical benefit plans that cover their employees.

> The act applies to "coverage years" beginning on or after January 1, 2012. The Act does not use the term "plan year."
>
> Although "coverage year" is not defined in the Act, Treasury has interpreted this term to mean the one-year period beginning on the date that newly elected or newly renewed coverage begins for a group of persons under a medical benefit plan. Usually, this date is shortly after the annual benefit enrollment period during which employees choose coverage. Therefore, the first "coverage year" under the Act would be the one-year period beginning on the date on or after January 1, 2012 that new medical insurance begins.

C. Michigan Attorney General

On December 20, 2011, Richard A. Bandstra, Chief Legal Counsel for the Michigan Attorney General's office, issued an informal advise letter discussing the meaning of the term "medical benefit plan coverage year."[3] In the letter, which was apparently written in response to questions posed by Amanda Price (R) State Representative, District 89, Bandstra concluded, in pertinent part:

> Because the term "medical benefit plan coverage year" is used in the Act to indicate when the employer's contribution caps become effective, it appears that the Legislature intended "medical benefit plan coverage year" to coincide with the Employer's obligation to make premium payments for its employee medical benefit plans. The premiums payable for a medical benefit plan are generally determined at the time that the plan is issued or renewed, at which time the "coverage year" also becomes effective.
>
> * * *
>
> In your example, if a "medical benefit plan coverage year" began on January 1 when covered benefits adjust, but the premiums payable for the plan were subject to increase in an undetermined amount when the plan renews six months later on July 1, public employers would have extreme difficulty determining the plan's total annual costs and structuring their contributions in a manner that complies with the Act's contribution caps. The problem is avoided when the "medical benefit plan coverage year"

[3] As an informal advice letter, the Bandstra letter is not binding on a State agency such as MERC. Whether governmental agencies are bound even by formal opinions of the Attorney General was referred to as "questionable" by the Michigan Supreme Court in *Danse Corp v City of Madison Hts*, 466 Mich 175, 182 n 6 (2002). In that matter, the Court compared *East Grand Rapids Sch Dis v Kent Co*, 415 Mich 381, 394 (1982) (a state agency is not bound by an Attorney General opinion that a statute is unconstitutional) with *Traverse City Sch Dist v Attorney General*, 384 Mich 390, 410 n 2 (1971) (an opinion of the Attorney General commands the allegiance of state agencies).

> begins on the same date that the plan renews and any premium adjustments for the plan's new term become effective.
>
> In summary, under the Publicly Funded Health Insurance contribution Act, 2011 PA 152, a "medical benefit plan coverage year" begins on the date that a public employer renews an existing medical benefit plan (and premiums likely adjust), or, for a new plan, on the date that the plan issues. At that time, the renewed or newly-issued plan becomes subject to the total dollar or total percentage cap elected by the public employer.

D. *Michigan Association of Police v City of Sterling Heights*

On March 28, 2012, Macomb County Circuit Court Judge John C. Foster issued an Opinion and Order granting a preliminary injunction against the City of Sterling Heights in a case involving the implementation of premium sharing increases on members of a bargaining unit represented by the Michigan Association of Police. *MAP v City of Sterling Hts*, unpublished opinion of the Macomb Circuit Court, issued March 28, 2012 (Case No. 2011-5400-CL). The dispute arose after the employer announced that pursuant to its understanding of the obligations imposed by PA 152, it would begin requiring employee contributions to health insurance beginning on January 1, 2012. The union filed unfair labor practice charges with MERC on December 15, 2011, arguing that the employer was attempting to prematurely take advantage of the "hard cap provision" of PA 152. Five days later, the union filed a complaint and motion for preliminary injunction in Macomb County Circuit Court asserting that the Court had the authority under PERA to issue a temporary restraining order to preserve the status quo.

In granting the union's motion for a preliminary injunction, Judge Foster focused on language in Section 5 of PA 152 which states, "If a collective bargaining agreement **or other contract** that is inconsistent with sections 3 and 4 is in effect for a group of employees on the effective date of this act, the requirements of sections 3 or 4 do not apply to that group of employees until the contract expires." (Emphasis supplied.) The circuit court judge determined that although the parties' collective bargaining agreement had expired by January 1, 2012, the date the premium increases were scheduled to take effect, the contractual agreements between the employer and the various healthcare providers offering coverage to the union's members constituted "other contracts" inconsistent with the requirements of PA 152. In concluding that the union had a strong likelihood of success on the merits, Judge Foster wrote:

> As a general matter . . . the term "contract" is defined as "[a]n agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law < a binding contract >." Black's Law Dictionary (8th ed). Given this definition of the term "contract," an "other contract" must be understood as an agreement between two or more parties apart from the collective bargaining agreement.

> In the case at bar, there is no question that defendant had entered into agreements with the various health insurance providers which provide coverage to plaintiff's members. To wit, medical benefits are available to plaintiff's members through Coalition of Public Safety Trust ("Cops Trust"), Health Alliance Plan ("HAP"), and Blue Cross Blue Shield ("BCBS"). According to the affidavit submitted by Fred Timpner, Executive Director of the Michigan Association of Police, the "medical plan year" for each of these policies is from July 1, 2011 to June 30, 2012. According to defendant, and consistent with the documents submitted to this Court, the BCBS, HAP and COPS Trust plans do not expire per se, but continue in effect from year-to-year subject to rate changes. Based upon the parties' representations to this Court and the documents submitted in accordance with this Court's instructions, it further appears that each of the health insurers set their rates in July of 2011, with such rates to remain in effect until June of 2012.
>
> Based on the foregoing, it appears that the health insurance contracts were in effect "on the effective date" of [PA 152]. Specifically, each of the health insurers had already negotiated its rates with defendant at the time that [PA 152] went into effect.
>
> * * *
>
> Having determined that there were "other contracts" in effect at the time that [PA 152] went into effect, the next question before this Court is whether these contracts were "inconsistent" with [PA 152]. The agreements themselves do not contain any provisions with respect to *who* was to pay the healthcare premiums. However, the parties acknowledge that defendant had paid these premiums in the past. According to defendant, this was done pursuant to the union contract, which expired in [sic] on June 30, 2011. Nevertheless, defendant continued paying the full premiums from June 30, 2011 until January of 2012. Defendant thus operated as if it was required to pay the premiums. This course of dealing appears to establish a contractual obligation on the part of defendant to pay the premiums for the duration of the medical benefit plan coverage year. Further, plaintiff's members were third-party beneficiaries of the contracts between defendant and the health insurers. Therefore, the existing contracts between defendant and the health insurers appear to be inconsistent with the provisions of [PA 152]. Accordingly, the Court finds that plaintiff is likely to succeed on the merits of its claim. [Emphasis in original.]

Thus far, it appears that *MAP v City of Sterling Heights* is the only court decision which has been issued touching upon the question of when a public employer may lawfully implement premium sharing increases under PA 152.

With respect to this agency, ALJ Julia C. Stern recently issued a decision in *Shelby Twp*, Case No. C12 D-067; Docket No. 12-000635-MERC (May 31, 2013) addressing the precise issue before the undersigned; i.e. whether an arguably premature implementation of premium sharing increases under PA 152 can establish a violation of the duty to bargain under Section 10(1)(e) of PERA. In *Shelby Twp*, a case which is currently pending on exceptions to the Commission, the employer increased the premium share it deducted from the paychecks of the charging party's members to 20% of the total amount of the BCBS illustrative rate for their coverage effective January 1, 2012. The union filed a charge asserting that the premium share increase imposed by the employer violated PERA, in part, because the employer implemented the increase before the beginning of the "medical benefit plan coverage year" as used in PA 152. After reviewing the statutory language and the seemingly conflicting interpretations of "medical benefit plan coverage year" set forth by the Michigan Department of Treasury and the Attorney General's office, Judge Stern concluded that none of the existing theories were clearly contrary to the language of PA 152 and that, in the absence of a ruling by a controlling court, it would be inappropriate for the Commission to attempt its own interpretation of the term. Since the interpretation of the term "medical benefit plan coverage year" adopted by the employer was reasonable, Judge Stern declined to find that its decision to impose the PA 152 premium sharing on January 1, 2012 violated the employer's duty to bargain under PERA.

Having carefully reviewed language of PA 152, the legislative history of the Act, the briefs submitted by the parties, along with the stipulated facts and exhibits, I reach essentially the same conclusion as Judge Stern and find that no PERA violation has been established by Charging Parties in this matter. In analyzing this issue, we must start by recognizing that the Commission has no independent authority to interpret the language of PA 152 or jurisdiction to enforce or administer the statute itself. The Commission's authority in this area is limited to determining whether the terms of PA 152 excuse a public employer from what would be, in the absence of that statute, its obligation to bargain in good faith under PERA. In other words, the Commission may interpret PA 152 only as necessary to determine whether an unfair labor practice has been committed. In the instant case, Charging Parties contend that the City violated its duty to bargain under PERA essentially by misinterpreting the term "medical benefit plan coverage year" as used within Sections 3 and 4 of PA 152. In fact, the Unions contend that there is "no justification under the statute for [the Employer's] interpretation" of the Act. As evidenced by the various conflicting interpretations of the term "medical benefit plan coverage year" described above, however, the language of the statute is so ambiguous as to render its application with any certainty a virtual impossibility. It is not the role of the Commission to fill in the gaps of an otherwise vague statute.

As noted, PA 152 itself provides no guidance with respect to the meaning of the term "medical benefit plan coverage year." Despite the inclusion of a "Definitions" section, the term is not defined or explained anywhere within the statute itself or within any of the various bill analyses which comprise the legislative history of the Act. The specific term has no plain or ordinary meaning and no universally accepted definition of the term exists within the health care industry or for purposes of labor relations law. The

Michigan Department of Treasury reviewed the statute and came to the seemingly reasonable conclusion that the pivotal date for purposes of implementation of the Act's premium sharing requirement is the date upon which newly elected or renewed coverage begins for a group of persons under a medical benefit plan. According to the Attorney General's office, which presented an equally plausible interpretation of PA 152, the "medical benefit plan coverage year" coincides with the employer's obligation to make premium payments for its employee medical benefit plans. In granting a temporary injunction preventing the City of Sterling Heights from implementing premium increases at the beginning of the calendar year, Macomb County Circuit Court Judge John C. Foster focused on the date the employer's contracts with its health insurance providers expire. Notably, BCBS, the recognized industry expert on health insurance matters, has refused to take a public position as to the meaning of the term "medical benefit plan coverage year" citing the "lack of clear statutory language or other authority."

Such efforts to parse meaning out of objectively incomprehensible statutory language underscore the difficult position with which the City was faced at the end of 2012. Absent a negotiated agreement to the contrary prior to the effective date of the Act or a decision by 2/3 of its governing body to opt-out of the statute's requirements, PA 152 obligated the City to unilaterally impose premium sharing on its employees in the form of a hard cap or percentage limits by the start of the "medical benefit plan coverage year." If the City was determined to have failed in its obligation to comply with that requirement, it would be subject to a significant financial penalty in the form of a 10 percent reduction in economic vitality incentive payments received under 2011 PA 63. This amounted to what Judge O'Connor correctly described in *Decatur Pub Sch, surpa,* as a "statutorily imposed impasse" which both entitled and obligated the Employer to take steps to comply with PA 152. The City acted upon that obligation by announcing its intention to impose premium sharing on its employees in the form of a hard cap effective January 1, 2012. The City's stated justification for implementing the new premium sharing amounts at the beginning of the calendar year was that January 1st is the date upon which deductibles and co-pays are calculated. This was not an unreasonable interpretation of the statute. In fact, the City's decision to implement premium sharing effective on the first of the year is consistent with BCBS's interpretation of the similar, but not identical, phrase "plan year" in the federal Patient Protection and Affordable Care Act of 2010.

The City notified Charging Parties of its decision to implement hard caps on November 3, 2011, almost two full months before the effective date of the change and provided to each of the POAM Unions a detailed breakdown of the new employee portion of the cost of the various medical benefit plans. At the same time, the City voluntarily offered two additional, lower cost plans as an option to help lessen the impact of the statute on its employees. Notably, it took the Unions until December 7, 2011, more than one month after Respondent first provided notice of the change and less than thirty days before what the City determined to be the deadline for implementation of the changes, to state their objections to the January 1st implementation date. At that time, the Unions presented their own, equally reasonable, interpretation of the term "medical benefit plan coverage year" focusing on October 1, 2012, the date upon which the City's

contracts for medical benefit coverage were scheduled to renew. Facing a statutorily imposed deadline and the risk of substantial financial penalties, and in the absence of guidance from the Legislature or a controlling court decision, the City reasonably decided to reject the Charging Parties' analysis and rely upon its own interpretation of a decidedly vague statutory provision.

As Judge O'Connor described in *Decatur Pub Sch*, *surpa*, bargaining disputes under PERA are "resolved on what is essentially a reasonableness analysis, because the duty in collective bargaining is to 'bargain in good faith', not to bargain to perfection, or without error, or without arguable flaw. It is to 'bargain in good faith'." In the instant case, there is no suggestion that the City's actions were driven by an improper motive. To the contrary, the record overwhelmingly establishes that the City acted reasonably in responding to the changes mandated by the Legislature. Regardless of whether the City's interpretation of the term "medical benefit plan coverage year" was technically a violation of PA 152, a question which I leave to a more appropriate tribunal to decide, it would be contrary to the purposes of PERA to conclude under these circumstances that the City breached its duty to bargain in good faith by implementing the increased premium sharing costs on January 1, 2012.

I have carefully considered all other arguments set forth by the parties in this matter, including the Employer's assertion that the Unions waived their right to bargain by agreeing to two additional health care plans with a January 1, 2012 effective date, and conclude that they do not warrant a change in the result. Accordingly, I recommend that the Commission issue the order set forth below.

RECOMMENDED ORDER

The unfair labor practice charges filed by the Southfield Police Officers Association, the Southfield Command Officers Association, the Police Officers Association of Michigan (Public Safety Technician Supervisors) and the Police Officers Association of Michigan (Public Safety Technicians) against the City of Southfield are hereby dismissed in their entireties.

MICHIGAN EMPLOYMENT RELATIONS COMMISSION

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David M. Peltz
Administrative Law Judge
Michigan Administrative Hearing System

Dated: August 7, 2013