BEFORE ARBITRATION BOARD NO. 602

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IN THE MATTER OF ARBITRATION **OPINION AND AWARD**

between

NATIONAL CARRIERS CONFERENCE COMMITTEE **(Unresolved Healthcare Issues From 2014 Section 6 Notices)**

and

BROTHERHOOD OF MAINTENANCE OF WAY EMPLOYES DIVISION, INTERNATIONAL BROTHERHOOD OF TEAMSTERS AND THE INTERNATIONAL ASSOCIATION OF SHEET METAL, AIR, RAIL AND TRANSPORTATION WORKERS – MECHANICAL DIVISION

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BOARD MEMBERS

Gil Vernon, Neutral Member
Thomas R. Roth, Union Member
A. Kenneth Gradia, Carrier Member

I. ISSUE

The instant dispute concerns issues (all surrounding the Parties' health and welfare plan) that remained unresolved after three-plus years of bargaining to replace the agreements the Parties reached subsequent to the issuance of a report by Presidential Emergency Board ("PEB") No. 243. That report outlined recommendations for the settlement of bargaining issues that arose out of the Parties' failure to reach agreements on collective bargaining matters covering the years of 2010 through 2014 (with little 'spillover' into 2015).

The "Parties" are (1) the National Carriers Conference Committee ("NCCC") which represents a host of Class I rail Carriers for purposes of collective bargaining which occurs pursuant to the Railway Labor Act, and (2) two Unions (the Brotherhood of Maintenance of Way Employees division of IBT ("BMWED") and the International Association of Sheet Metal, Air, Rail and Transportation-Mechanical employees ("SMART-M"). They are among the thirteen Unions that represent organized employees of the member Carriers of the NCCC.

Shortly after Section 6 notices were filed at the end of 2014 reflecting that the respective Parties were seeking changes in the status-quo labor agreements, the various Unions representing railroad workers formed coalitions for purposes of bargaining as groups rather than individual Unions. The two Unions party to this arbitration were one of three coalitions and will be referred to as the "MWSM". Between the two Unions, they represent a total of approximately 28,000 employees (or 20%) of which approximately 26,000 are in the BMWED.

The other two coalitions were called the Coordinated Bargaining Group ("CBG") and the Transportation Communication Union ("TCU") Coalition. The CBG consisted of the American Train Dispatchers Association ("ATDA"), International Brotherhood of Boilermakers, Blacksmiths, Iron Ship Builders, Forgers and Helpers ("IBB"), National Conference of Firemen and Oilers ("NCF&O"), Brotherhood of Railroad Signalman ("BRS"), Brotherhood of Locomotive Engineers and Trainmen ("BLET"), and SMART – Transportation Division (including Yardmasters). CBG represented roughly 80,000 employees. The TCU consisted of the Transportation and Communication Union, the Brotherhood of Railway Carmen ("BRC"), Internal Association of Machinists and Aerospace Workers ("IAM"), International Brotherhood of Electrical Workers ("IBEW"), and Transport Workers Union ("TWU"). The TCU Coalition represented about 31,000 employees.

The NCCC reached tentative agreements with the CBG Unions on October 6, 2017. The tentative agreements went out to members of the individual Unions and five of the six Unions ratified. The IBB did not. Those agreements which had a technical start date of January 1, 2015 went into effect January 1, 2018 with retroactive wage increases and a five-year Section 6 notice moratorium ending January 1, 2020.

The TCU Coalition reached tentative agreements in December, 2017. Membership of three of those Unions ratified. The IAM and IBEW did not. The

ratification process was not completed by the first of the year. The changes to the prior health and welfare plan (which included the same changes as the ratified CBG Agreements (such as increased deductibles, co-pays, co-insurance and out-of-pocket maximums) were implemented effective February 1, 2018.

The MWSM Coalition never reached a tentative agreement which was submitted to ratification. They did reach agreements that narrowed their differences to the general area of health and welfare and even then certain changes to the plan were agreed to.

The agreed-to items related to wages, work rules and some healthcare matters. These items are summarized below:

A. Wage Increases

1.	3%	January 1, 2015
2.	2%	July 1, 2016
3.	2%	July 1, 2017
4.	2.5%	July 1, 2018
5.	3.0%	July 1, 2019
	12.5% Total	

B. Work Rules

1. Status Quo (no changes)

C. Health Insurance

1. Monthly employee cost sharing contribution of $228.29 (no increase over the prior contract)
2. Certain plan design features such as but not limited to telemedicine, second opinions, specialty drugs, flexible spending accounts and solicitation of bids from pharmacy benefit managers.

Details concerning these "agreed terms" are set forth in Appendix B of the arbitration agreement creating this Board.

The still disputed healthcare matters (which will be discussed in more detail subsequently) are before the Board for resolution. The arbitration agreement was dated February 27, 2018, and the undersigned was selected to serve as the Neutral according to the agreed upon procedure therein set forth. He was informed of his selection on March 6, 2018. A hearing was scheduled for May 7 and 8. Submissions were filed in advance of the hearing reflecting the Parties' positions

and the evidence they intended to present and rely on. The Agreement provided that no post-hearing briefs would be filed and that a decision of the Board would be issued within 15 days of the close of the hearing (in this case May 24, 2018).

II. AUTHORITY OF THE BOARD

The Arbitration agreement in paragraph 9(a) sets forth the authority of the Board as follows:

> The Board's Authority
>
> (9) The scope of the arbitration shall be confined to resolution of the following issues:
>
> (A) Shall Article II ("Health and Welfare") of the Parties Arbitrated Agreements consist of (1) the terms proposed by the Carriers (Appendix C), or (2) the terms proposed by the Unions' (Appendix D)?
>
> (B) In the event that the Board selects the Carriers' terms, are the Carriers entitled to any adjustment in any terms or conditions of the Parties' Arbitrated Agreements based on the timing of implementation?
>
> (C) In the event that the Board selects the Unions' terms, what Adjustment, if any, shall be made to account for any difference between the value of the Unions' terms and the Carriers' proposed terms?

III. THE PROPOSALS (SUMMARY)

It cannot be stressed enough that this is a recitation of the Parties' positions capturing only the broad strokes of their arguments which were extensive. It represents only a glance at the voluminous and complex evidence. There were epic arguments about the history of railway collective bargaining as to the existence, nature and extent of "pattern bargaining". There was also enormously complex and highly controverted economic and actuarial evidence as well as arguments surrounding it. The manner in which the record is summarized herein should not be interpreted as the complete nature, depth and breadth of the Parties' presentations. The record of arguments and evidence in addition to the transcript will stand for that.

A. The Carriers' Proposal

Appendix C to the Arbitration Agreement details the Carrier's proposed terms for health and welfare for each Union party to this dispute. The changes from the status quo (those terms agreed to following the issuance of PEB 243 in 2011) largely relate to the typical features of health insurance plans such as deductibles, co-pays, co-insurance and out of pocket maximums. The Carrier submitted the following chart to summarize their proposals to the Managed Medical Care Program ("MMCP") segment of the health and welfare plan which covers about 90% of employees (note: the abbreviation in the chart 'INN' refers to in-network providers and 'OON' refers to out-of-network providers).

Table 1

MMCP Provisions		Pre-Existing Design		Pattern Plan Design 2018		Pattern Plan Design 2019 and later	
		INN	**OON**	**INN**	**OON**	**INN**	**OON**
Employee Coinsurance after Deductible		5%	25%	10%	30%	10%	30%
Annual Deductible	Individual	$200	$300	$325	$650	$350	$700
	Family	$400	$900	$650	$1,300	$700	$1,400
Annual Out-of-Pocket Maximum	Individual	$1,000	$2,000	$1,800	$3,600	$2,000	$4,000
	Family	$2,000	$4,000	$3,600	$7,200	$4,000	$8,000
Fixed-Dollar Copayments	Telemedicine	N/A	N/A	$10	N/A	$10	N/A
	Convenient Care Clinic Visit	$10	N/A	$10	N/A	$10	N/A
	Primary Care Physician Visit	$20	N/A	$25	N/A	$25	N/A
	Urgent Care Center Visit	$20	N/A	$25	N/A	$25	N/A
	Specialist Visit	$35	N/A	$40	N/A	$40	N/A
	Emergency Room Visit	$75	$75	$100	$100	$100	$100

They also provide a chart to summarize the changes to the 'CHCB' segment of the coverage which applies by its nature solely to areas with under-developed MMCP networks (and covers about 10% of employees):

Table 2

CHCB PROVISIONS		PRE-EXISTING DESIGN	PATTERN PLAN DESIGN 2018	PATTERN PLAN DESIGN 2019 AND LATER
Employee Coinsurance after Deductible		15%	20%	20%
Annual Deductible	Individual	$200	$325	$350
	Family	$400	$650	$700
Annual Out-of-Pocket Maximum	Individual	$2,000	$2,800	$3,000
	Family	$4,000	$5,600	$6,000

Additionally, the Carriers proposes a 'true-up' for the delay in implementation of their proposed changes (if accepted) as the inherent delay has reduced the corresponding savings to the plan cost. Section 3 of Appendix C of the arbitration agreement reads:

> The retroactive portion of wage increases payable to each eligible employee under the Arbitrated Agreement shall be reduced by the amount of $292.96 to make the Carriers whole for the four-month delay (February 2018 through May 2018) in H&W Plan benefits design implementation.

B. <u>The Unions' Proposal</u>

The Unions propose no changes to the plan features that were recommended by PEB 243 and adopted by the Parties' in 2011. Rather than limiting plan costs by raising these common benchmarks, the Unions propose changes in the administration of the health plans. In summary, the Unions proposal calls for the determination of which of the current plans (United Health Care, Aetna or Highmark BCBS) has the highest network provider discount in each Metropolitan Statistical Area ("MSA") and related zip codes and mandatorily assigning the

employee to that network. If the employee had at that time already been assigned to one of the other two MMCP networks, she or he would have to change to the network with the best discount. Because there are 357 Metropolitan Statistical Areas ("MSAs") in the country, the plan nickname is the '357 plan'. By assigning resident individuals to the lowest cost network the resultant savings (the Unions argue) will exceed the value of the agreed-to changes in benefits and exceed the employee contribution the Carriers seek to impose on employees.
The text of the Union's proposal reads as follows:

> Part B
> Section 2 — Plan Design Changes
>
> a) Employees residing in one of the three hundred fifty-seven (357) Metropolitan Statistical Areas ("MSA") identified in Appendix __ to this Agreement will be assigned to the lowest cost medical care network in that MSA. Such process shall be done by first assigning employees to a default network provider; one of United Healthcare ("UHC"), Aetna or Highmark BlueCross BlueShield ("Highmark") for that MSA, and then by assigning them to a default plan (i.e., managed medical care plan ("MMCP") or comprehensive health care benefit ("CHCB")) based on their residential 5-digit ZIP code.
>
> 1) For purposes of this section, a "managed medical care network" ("MMCP") shall mean: for UHC a "Choice Plus" network; for Aetna a "Choice POS II" network; and for Highmark its "BCBS PPO" network. If any of the network providers discontinues a specific named network, its equivalent shall be substituted. Employees in each 5-digit ZIP code will be assigned to a managed medical care network pursuant to the current Plan standards regarding access to in-network providers. If access meets such standards, MMCP enrollment will be mandatory.
>
> 2) Employees who do not reside in a 5-digit ZIP code within an MSA where MMCP enrollment is mandatory will be assigned to a CHCB plan provided by the network provider assigned to the MSA. Such employees may, but are not required to, enroll in an MMCP network operated by the selected provider.
>
> 3) An employee who provides a change of address that impacts his assigned network provider may change to a new network provider at his new address on the first day of the month following the date of move or defer that change until January 1 of the next calendar year.
>
> 4) This subsection shall become effective with respect to employees covered by this Agreement on July 1, 2018 or as soon thereafter as practicable.

Notable for what it doesn't say, it is not disputed that the Unions' proposal would retain the current level of annual deductibles, certain co-payments, co-insurance (after the deductible and the annual out-of-pocket maximums are met). As previously noted the current features can be found in Table No. 1 on page 5 under the column "pre-existing design".

IV. POSITIONS OF THE PARTIES (SUMMARY)

A. The Carriers

The Carriers' arguments to the Board stress and are centered around the fact it has reached voluntary collective bargaining agreements with eight different Unions representing approximately100,000 employees, or about 70 percent of the Carriers' unionized workforce. All of these agreements are virtually identical: they provide for general wage increases totaling 12.5 percent (uncompounded) over five years, plus modest changes in the design of the Carriers' healthcare plans--including incremental increases in copayments, co-insurance, out-of-pocket maximums, and deductibles--as well as several new benefit features. The new agreements maintain the current level of employee monthly contributions to healthcare, provide for a five-year moratorium, and preserve the status quo with respect to work rules.

Their offer to the Unions here is identical and should be selected as it is not only consistent with the internal pattern (which is a long-established determination in such matters) but it is fair and reasonable. The MWSM coalition has agreed to take the attractive wage increases, the freeze on work rules, the new healthcare features and the freeze on employee premium contributions. However, they have refused to accept or even submit for ratification the corresponding modest increases in employee plan cost-sharing. These changes are needed and are intended to moderate the growth in costs and address ongoing overuse of healthcare services under the plan.

The MWSM coalition--rather than accepting the quid pro quo in the form of the reasonable employee cost sharing features the other Unions had to give in order to get the attractive features of their respective deals-- proposes a system that would dramatically shift the current allocation of network providers causing many employees to have to change network administrators from UHC to Highmark BCBS. Consequently, the Unions' justification that the network remapping would generate savings to the overall cost of the national plan that are equivalent to those

produced by the change in employee cost-sharing features of the internal pattern is not reasonable.

Another reason the Carriers' proposal is justified is that--not only is it supported by the internal pattern--it is supported by comparisons to the employee benefits in employment external to the rail industry. A comparison of plans is made possible by calculating an "actuarial value". The higher the actuarial value is the more valuable the plan. The value of the pattern plan sits at 90% which exceeds other cohorts such as the general employment population at 84%, general Unionized employment at 88%, federal employees at 88% and non-Unionized railroad management employees at 84%. The employee cost-share under the pattern plan is 12% compared to much higher employee cost in same cohorts (general 36%, Unionized 27%, federal employees 42% and rail 23%). The same is true when a focused comparison of individual plan features is compiled. For example, the employee under the pattern has more valuable co-insurance and pharmacy benefits than employees in other sectors.

The internal pattern and external comparisons provide more than an adequate basis to accept the Carriers' proposal and thus no analysis of the Unions' '357' plan is necessary. However, even if the Board were to consider the Unions' proposed plan, they would find it has little merit. First, it does not produce equivalent value and does not in fact generate savings anywhere close to those under the pattern plan design. Just as important, it would not change behavioral usages necessary to keep costs from spiraling out of control.

The Carriers' actuarial and economic analysis is that the Unions' projections as to how much money the 357 Plan would save (which the Union claims is as much or more that the Carriers' Plan) are based on a number of overly aggressive and otherwise flawed assumptions. These include an unrealistic implementation period, unknown administrative challenges and costs as well as a dynamic convergence factor. Realistically, their plan couldn't be implemented until well into 2019 which severely limits any of the savings. There would, for example, be no savings in 2018. Thus, the theoretical savings to the 357 Plan are far less than the pattern plan. Moreover, much of the Unions' analysis is based on the entire population of the national plan but its impact is on a much smaller group (the membership of MWSM Coalition which only represents about 18% of total railway employment). Thus, the advantage of the economies of scale of a large group are lost. There are also other unpredictable elements because (1) a

disproportionate percentage of employees may turn out to live in MSAs where there is little or no network cost disparities, and (2) healthcare markets are in a dynamic state of flux.

The Unions' 357 Plan also ignores the fact the Joint Carrier and Union Plan Committee which governs the national plan already has been successful in narrowing the differences in network cost disparities. This was achieved without disruption to employees by possibly being forced into a new network requiring a change in doctors.

A pitch is made that the Board should recoup from employee monies that the plan has lost due to the delay in getting the healthcare issue resolved. Each month of the Unions' recalcitrance at the old employee sharing rate costs the Plan money. In addition to that, the Carriers argue the Board should also impose a further penalty--such as an additional deduction from retroactive wages--to discourage the sort of conduct exhibited by the Unions in this bargaining round. A punitive deduction is warranted on two grounds. First, by rejecting an overwhelming pattern, the Unions have taken a patently unreasonable position. Second, a penalty is justified in light of the BMWED's actions during the CBG ratification process which included attacks on another Union's leader.

B. The Unions

In the Unions' view the issue before the Arbitration Board is not whether the Carriers' healthcare cost should be reduced or the amount those costs should be reduced. This is true because the Unions agree costs should be limited. They assert their proposal results in the same or similar cost restraints as agreed to with other Unions and Carriers. The issue then is the manner in which the cost reductions are achieved.

The Unions contend their proposal achieves those cost restraints in a highly preferable way compared to the Carriers' arbitrary and punitive proposal which harms Union members while not producing better savings for the Plan. This harm comes in the form of unnecessary increases in cost to the employees' deductibles, co-pays, co-insurance and out-of-pocket maximums. These increases are the result of the Carriers' blind adherence to (and false narrative about) the so-called "pattern" of settlements. Even so, the Unions argue that their proposal meets the test of pattern bargaining as it is the same overall value and precedent does not require it to be the exact same terms particularly as to healthcare coverage. This

point is made in their brief through extensive evidence and argument in their submission about the history of pattern and healthcare bargaining in the industry.

The Unions' proposal--which does not "destabilize" railroad collective bargaining--keeps employee costs level and saves the plan money by scraping the decades old arbitrary allocation of employees to the UHC or Aetna network providers and instead assigns them to the lowest cost network provider (of the three, including now Highmark) in each of the 357 metropolitan statistical areas ("MSAs") in the country. In short, the lowest cost network provider is determined by competitive bidding which (because that has never been the case beyond the start of the plan) will result in significant restraint in the growth of the Carriers' health benefit costs.

The 357 Plan was developed by the healthcare experts at Cheiron who discovered that the arrangement for the provision of managed medical care health benefits through three vendors (United Health Care, Aetna and Highmark with UHC as overall administrator) had not been "re-bid" since the Plan took its current form, and that the division of coverage among the three vendors by geographic area had never been re-examined. In turn, its study revealed that the Plan was not taking advantage of the best health care provider network discounts currently available from each of the vendors in different areas, and that it should be possible for the Carriers to obtain their desired health care cost restraint without imposing additional costs on, or eroding benefits for, employees. The realignment of the National Plan could save about $100 million annually which exceeded the value of the concessions in benefits and employee contributions and payments for services made by the rail Unions in the prior round of bargaining. The Cheiron analysis is a major part of the Union's evidence.

Inexplicably, the Carriers turned a cold shoulder to this and are clinging to its alleged settlement pattern principle. The Carriers also asserted that the 357 Plan would not be acceptable to rail Unions in another bargaining coalition, the Coordinated Bargaining Group ("CBG"), which had expressed concerns that changes in the alignment of the vendors might necessitate changes in medical providers for some members of their Unions. But the MWSM coalition was prepared to take that risk in order to preserve employee benefits and payment rates, and to avoid penalizing the ill and injured for using their benefits. Moreover, those Unions made that deal to avoid work rule concessions where there was no demand for comparable work rule concessions to MWSM. Noted, as well, there are other Unions who have rejected the pattern. Indeed, it failed twice with the membership of the IBB.

To the extent that the 357 Plan produces greater or lesser cost restraint than the CBG deal, the Union suggests the difference can be addressed either way by modifications of some components of the health plan. Moreover, in direct reference to the Carriers' proposal for a punitive implementation to delay penalties the Union contends there is no basis for any penalty to members of BMWED and SMART-M because an agreement concerning health benefits will be obtained several months after implementation of the CBG deal. This is especially true since the NCCC simply refused to engage with the Unions' health benefits proposals from the outset, was uninterested in savings of $100 million a year, and regressed in their position when the Unions offered concessions on health benefits in February of 2017 in addition to the 357 Plan, and the NCCC seems more interested in extracting concessions from their employees than in achieving savings in the growth of their health care costs.

V. OPINION AND DISCUSSION

A. The Recent History of Health and Welfare Bargaining (Summary)

The history of health and welfare provisions in the rail industry Union contracts is rich and lengthy. Some of it is particularly helpful in understanding the present dispute. As a result of Presidential Emergency Board 219 ("PEB") and its fallout in April 1991 the funding structure of GA–23000 changed from fully insured indemnity policy to a self-insurance plan excluding life insurance and accident death and dismemberment benefits. Additionally, the Joint Policy Committee under the old indemnity policy was changed to the Joint Plan Committee ("JPC ") mirroring the structure identified in the related October 17, 1986 agreement. The agreed-upon governing plan structure had a single Carrier member carrying a single vote for all the participating Carriers, a single vote for all participating rail labor organizations, and a neutral casting a single vote to break deadlocks between the voting members of the JPC. The general purposes of the JPC flowing from PEB 219 was to oversee the administration of the plan and to review established managed-care networks or "MMCPs" throughout the United States for the purposes of improving medical care and controlling its related cost.

This establishment of MMCPs also known as preferred provider networks or PPOs in the healthcare field presented certain challenges. First, not all parts of the country had insurers or administrators who offered MMCPs. Thus, a more traditional option but a more expensive one was agreed to. The Comprehensive Health Care Benefit ("CHCB") was extended to employees residing in areas where

no MMCPs existed. Generally speaking these were less populated areas. It took a while but many of the rest of the non-CHCB employees were assigned to either United Health Care ("UHC") or Aetna although the benefit coverage was the same. Represented as colors on a map, the UHC areas were blue, the Aetna areas were red and CHCB areas were white. After that and continuing to present day, the JPC never sought a "rebid" to see if other network providers could extend and offer the Plan better discounts off the charges healthcare providers (doctors, clinics and hospitals etc.) typically charge single unaffiliated patients.

It is noteworthy and relevant that the NCCC and the United Transportation Union ("UTU") in the year 2000 agreed to a separate health and welfare plan as did (according to the Unions submission) the Brotherhood of Locomotive Engineers and as did the BMWED and the TCU. There were differences at the edges but the central core of each of the plans was effectively the same. While the JCP never sought to competitively test UHC or Aetna's network discounts, they did in the 2005 round of national bargaining expand some MMCP feature options. Most relevant to this case they added Highmark Blue Cross Blue Shield as a network provider option. This went into effect in 2007.

This change had at least two impacts. First, it enabled the extension of an MMCP option to some of the white colored areas of the map. While both UHC and Aetna remained "primary" in their respective blue and red areas of the map, an employee residing in a UHC or Aetna area could for the first time select an MMCP network provided by Highmark. Highmark would be an invisible provider for Blue Cross Blue Shield programs in the UHC and Aetna areas. Furthermore, an employee residing in a white area of the map now was free to enroll in any available managed care medical care network offered by UHC, Aetna or Highmark. As a quid pro quo for the network expansion, an employee who resided in a red or blue area network was required to enter MMCP and the parties reserved the right to subsequently agree that certain white areas be designated as mandatory MMCPs as well.

In the next round of national bargaining that started in 2010 there were two Union coalitions but the UTU decided to go it alone in bargaining with the NCCC. Ultimately, the Carriers reached a tentative agreement with UTU which was ultimately ratified. The changes included:

1. The introduction of employee coinsurance of 5% on eligible expenses paid for by the plan for any in network services for which a fixed dollar copayment did not apply at an out of pocket maximum of $1000 per individual and $2000 per family in each calendar year.
2. The emergency room copayment was increased to $75 from the previous $25 for each visit not resulting in a hospital admission.
3. The urgent care center copayments were reduced to $20 per visit from $25 per visit.
4. Convenient care clinic visit copayments of $10 were instituted rather than the $20 per visit charge by primary care physicians.
5. Prior authorizations for certain enumerated prescription drugs were instituted
6. Copayments for generic prescription drugs obtained both in retail pharmacies and by mail orders were reduced.
7. Copayments for brand-name formulary drugs obtained from retail pharmacies or mail-order were increased.
8. Employee monthly cost sharing amounts were set at $200 for January 1, 2010, $202.90 for January 1, 2011 and after January 1, 2012 an amount that was lesser than $200 or 15% of the Carriers' payment rate. On July 1, 2016, the cost-sharing was to be adjusted to the lesser of $230 dollars or 15% of the Carriers' payment rate.

The Carriers in its negotiations with the rest of the Unions did not offer more than what it settled for with UTU which contributed to an impasse and the creation of PEB 243. The Carriers also sought a recommendation from the PEB of what they viewed to be a controlling pattern set by the UTU settlement. The Unions opposed the notion that there was a pattern and argued against the Carrier proposal.

The end result was a recommendation dated November 5, 2011 which was followed by subsequent voluntary agreements that included health and welfare changes substantially the same as the Carriers proposed to the UTU with a phase-in of the MMCP design change in benefits. The recommendations led to subsequent agreements which included the creation of an in-network deductible and in-network coinsurance etc. for the first time in history of the MMCP plan. This set the stage for the negotiation of contracts to be effective January 1, 2015. It is this round of bargaining which sets the context for the instant dispute.

B. The Questions at Issue in Detail

Both Parties agree that health care costs are rising and must be addressed. Both Parties understand and accept that employees and the Carriers have a shared responsibility to respond to these increasing costs. More particularly, as a self-insured plan the Parties agree changes have to be made to reduce the cost of the plan benefits or put in a different way-- changes have to be made to create "savings" to the Plan. Both Parties agree that a very good, if not the best, yardstick

to measure those "savings" is the reduction in per qualified employee per month cost ("PQEPM"). Last, but not least the Parties agree that because the duration of contracts span into the future (the balance of 2018 and 2019) it requires some predictive analysis of what those future costs will be which generally speaking are based on what it took to pay bills from healthcare providers for employee healthcare in the past.

Predicting the future is hard enough in horse racing. But one of the most challenging jobs in the country is trying to predict the future of healthcare. It is particularly trying to predict the future of healthcare and healthcare expenses for approximately 140,000 railroad workers and even more dependents. We 'all knew that healthcare was complicated' and no one is better prepared for this task than the actuaries hired by the Unions and the Carriers.

One measurement component of the calculation of the Plan's costs is the employee monthly contribution (analogous to a premium under a typical third-party insured plan) which is paid regardless of the use of benefit. In other words, everybody pays this amount well or sick. It is known what this was in the past and in this case what it will be for the immediate future. The last time it changed was July 1, 2016 when it went up slightly to $ 228.89 per month and the parties have agreed to freeze it there for the duration of this agreement. That it has been relatively stable is somewhat remarkable.

Accordingly, on the employee side of the Plan's ledger, it is known that share will not go up during the duration of this agreement. On the other side of the ledger because the Plan is self-funded it is not known what the cost will be during the full duration of this agreement. It is known however, what the total payment rate has been and what the actual payment cost has been. From this, the actuaries can try to predict the future cost. The following history of the payment rate to the Plan per employee is derived from Figure 2 Appendix A of the Carrier submission:

2011 -$ 1363.73
2012 -$ 1318.26
2013 -$ 1273.44
2014 -$1265.56
2015 -$1265.56
2016 -$1449.00
2017- $1657.42

It was the jump in 2016 and 2017 that factored into the Carrier's present position. As previously noted the way they propose to address the rising costs is to

increase user-based components such as deductibles, copayments, co-insurance and out-of-pocket-maximums. The rationale for this approach was well documented in PEB 243 and in this record.

As noted, the Unions agree savings to the plan should be achieved and don't even quibble about how much the savings should be. Thus, by forcing the employee to the network with the biggest discount the plan enjoys a lower cost. These significant savings, the Unions point out can be generated without increasing user based components (except for the ones they already agreed to which will also generate savings).

Herein lies one of the most enormous challenges in this case. The actuary for the Carriers (Willis Towers Watson or "WTW") does not agree with the Unions' actuary's (Cheiron or "CRN") calculation of how much future savings would be produced by the "357 Plan". The flipside is not true. CRN (approximately speaking) accepts WTW's calculation of the savings created under the Carriers' proposal. However, CRN sharply disagrees with WTW's calculation as to the savings created by the 357 Plan.

The other challenge of course is not a math problem. It instead concerns the deep and wide divisions around the nature of the common law of interest arbitration and what a pattern means, how it is calculated and how it should be applied in this case. In short, the Union says the pattern is matched by any proposal which is the equivalent of the pattern in dollars. The Carrier says the pattern can only be met by a match in dollars as well as the design changes embedded in the contract settlements with other Unions. Additionally, the Board is challenged here by what to do about the fact that the savings to the plan have comparatively been reduced by the delay associated with this dispute.

Thus, unpacking the questions at issue is fair to say the parties are close to agreeing on an analytical framework to be applied to the sharply disputed facts. That framework is: (1) what constitutes a pattern? (2) even if equivalency has a role in a pattern analysis, are the competing proposals equivalent? and (3) is some retroactive adjustment appropriate given all the timing aspects of this matter?

C. Discussion

The road through the history of railway labor relations dispute resolution, détente and labor peace is littered with the thoughts, theories, and exasperations about pattern bargaining by many great thinkers, leaders, lawyers and neutral third-

parties. This Arbitrator's relatively feeble view is that other internal settlements are almost always relevant and the degree to which they are is not only related to the history of the parties as to the influence of other settlements but the present context and circumstances of any particular dispute. Indeed, there's been some variability in prior applications of pattern type factors by parties and neutrals. Some variability is inherent in different contracts based on the differences in work and working conditions from one craft and class to another. Some variability is also attributable to the participation of different neutrals over different periods of time.

The Unions focus their attention on the monetary equivalency of their proposal. They believe it is different but equal and that precedent in turn requires such an offer should prevail. They also believe their proposal is more than equivalent to the dollar savings under the Carriers' proposal and--when you add the value judgment that the savings can be achieved without increasing costs to the already financially stressed employees and which can be achieved by finding efficiencies within the current network providers--the Union contends the Board's decision is clear. On the other hand, the Carriers are wedded to a different view that dollar values don't matter (although they see CRN's analysis as significantly flawed).

As already hinted the Board takes a more unified or hybrid approach. Of course, it is true that the economic parity of the proposals deserves weight and consideration. The degree of that equivalency is just as important and so is the certainty or uncertainty of the underlying calculus surrounding that asserted equivalency or non-equivalency (more about that later.)

The Parties hired an Arbitrator--and at least for that reason--he is not an actuary. Regardless, it is helpful to understand the differences between the Parties' actuarial assessments of their own savings and the actuarial assessment of the savings in the competing plan. In this regard, it should be said that the sincerity of all the actuaries is unquestioned here. To get a sense of these differences the following table was created (from Union exhibit 52 pages 4 & 5) and offered not as an absolute calculation but one that shows the relative differences between the parties based on a consistent (but not necessarily preferred) methodology.

TABLE 3
Unreconciled Difference in PQEPM
Savings Calculation

Carrier Plan Proposal		357 Plan Proposal	
WTW	CRN	WTW	CRN
2018			
$73.24	$71.19	$52.41	$98.88
2019			
$87.03	$80.11	$57.00	$102.14

The actuarial calculation above for 2018 assumes a July 1 implementation and that the savings in that year are relatively close. CRN reconciled the differences with a revised trend analysis similar to what they thought WTW used (see page 4 Union Exhibit 52). WTW says the differences relate to CRN's misapplication of a data spreadsheet they provided. In any event and setting those technical arguments aside the cost savings of the Parties' proposal in 2018 are similar enough to get us almost halfway to a better understanding of the overall differences in the savings calculations.

Obviously, the relative differences are most stark in the estimated cost savings of the 357 Plan. There is a gaggle of technical arguments about methodologies used by the respective actuaries. Some of the debated actuarial points involved firm differences of opinion about projected versus executed contracts, correct usage of spreadsheets, appropriate margins of error, actuarial value versus benefit ratios, use of old data, unfounded assumptions, assumptions about discount convergence, differences in projected administrative costs, shifting assumptions regarding the impact of medical management and hearsay about implementation timing.

In spite of all this friction, the Arbitrator can make a few general observations. It is likely that the 357 Plan will save the Plan money. Indeed, it deserves consideration. However, the Arbitrator also believes there is a significant degree of uncertainty about just what the extent of those savings will be. This is true even when the debate about implementation timing is taken out of the analysis.

Of course, in the end that factor can't be set aside. The point is however even before getting to the implementation issue there are already cloudy skies over the 357 Plan. Implementation makes the forecast even more tenuous.

Moving toward a full analysis it cannot be lost that the total savings advantage calculated by CRN for 2018 and 2019 rests on the assumption that the 357 Plan can be implemented by July 1, 2018. They hedged a little bit in their presentation but still the projection of 30 to 45 days is not persuasive. This point is significant because for every month that savings are delayed it erodes the annual aggregate savings to the plan for 2018 by approximately $2 million. As for WTW's projection of an implementation date of April 2019 the Board does not find it persuasive either.

A reconciliation of these conflicting opinions is practically impossible based on this record. CRN acknowledges they never talked to UHC, the current central/general administrator of the Plan. And the Carriers only have verbal reports as to what UHC said as to the length of implementation. Of course, there is no reason to disbelieve WTW that the information they reported to the Board is the information that UHC reported to them. However, there is scant evidence in this record to judge the underlying accuracy of the Carriers' implementation projection.

This material difficulty in assessing the certainty over an implementation date is a major factor in this case. In this regard, the Board can't overlook the fact UHC and Highmark BCBS are competitors. If CRN is right about which network employees will end up under the 357 Plan, UHC stands to lose the most in the forced realignment. According to pages 26 and 27 of Volume IV of the Unions' submission the current enrollment in round figures for UHC is 173,000 and the enrollment for Highmark BCBS is 72,000. After implementation UHC enrollment is predicted to drop to 31,000 and Highmark BCBS would jump to 213,000. Thus, there may be some network turf battles influencing the underlying issues.

Indeed, the 357 Plan was born out of a Highmark boast about how much of a better discount they could offer if they were the exclusive network provider. Rarely

does a sales person or organization under sell their wonderfulness.

There's also uncertainty about the disruption that will be caused by employees having to change networks and the intangible dissatisfaction associated with it. There is an unaccounted-for potential of dissatisfaction just from having to change network providers. WTW asserts that the current enrollment in the National Health and Welfare plan shows that employees elect UHC and to a lesser degree Aetna over Highmark even though Highmark is currently available to every member in every market. According to WTW data, only 24% of those offered Highmark elected it whereas approximately 70% of those offered UHC took it. The forced network effect of the 357 Plan would raise Highmark BCBS membership to 74% involuntarily.

It is the Arbitrator's belief that the monetary savings is not the only factor to be weighed. There are generally recognized criteria by which to judge interest arbitration disputes and one factor should not be isolated onto itself. The savings of the 357 Plan are not being dismissed here and now. Nor should they be in the future. They are simply being accounted for along with other factors.

In addition to the dollars and cents of the savings of the competing plans the parties each raised what could be described as "philosophical" differences. Or in other words they're asking the Arbitrator to make some value judgments about their proposals. The underlying philosophy is as important to the Unions as the savings they think will come with the 357 Plan. More fundamentally they argue the Carrier proposal lacks heart because it requires sick people to pay more when they can least afford it. This is inconsistent with their heartfelt and sincere belief that "we are our brother's keeper".

The Carriers are wedded to a different philosophy and value judgment that's more economically based which they think benefits the plan and all its members in the long run. They present testimony from Dr. Dana Goldman, PhD (The Leonard D. Schaeffer Chair and Distinguished Professor of Pharmacy, Public Policy and Economics at the University of Southern California) about relevant studies that generally stand for the decades old proposition that user-based changes affect user behavior in such a way that reduces unnecessary cost without adverse impact on health outcomes. Dr. Goldman also studied the effect of user-based cost increases following PEB 243. He concluded increased user costs change utilization behaviors that reduced the overall usage, and therefore costs, without adverse impact on health outcomes.

So, what is the Board to do with the dollars and cents savings, the uncertainty about their extent and the competing philosophies? How are we to reconcile them?

First, as to the 'brother's keeper' argument, it must be noted that the very idea of insurance, by its nature, in large measure already incorporates this idea. Insurance is a matter of people pooling and sharing their risk regardless of the fact there will be different outcomes for different people. People who are well pay the same 'premium share' as sick people even though their usage may be none or slight. Their participation and base contribution, and rightly so, subsidizes other less fortunate employees. So, there is in the end no debate about the core value of insurance.

Beyond this the Board comes to the point of considering the internal settlements. However, we do not do so in a way consistent with the Carriers' strict pattern approach and not in the way the Unions interpret the pattern. We agree the other settlements in this case should not be used as an iron mold, die or forge to be hammered in such a way that it negates the Unions' independent voices. We understand that they have a right to make their case. However, the Board sits in a different position at the table. It is our job to decide which proposal is more reasonable and should do so guided by as much objective evidence as possible.

The Board's majority cannot escape the notion that the other settlements in these circumstances give us some objective guidance independent of our own personal values. We don't look at those settlements as a pattern belonging just to the Carriers. We look at them for exactly what they are: bilateral agreements. The reasons the Carriers entered into them are less important to us in this context as the fact that other Unions did. The other Unions--when faced with the same uncertainties, the same possible disruptions, the same company profits, the same wage increases, the same extended freeze on base employee contributions, and the same competing philosophies in the context of a total agreement-- concluded those agreements were a fair balancing of all the relevant facts and circumstances surrounding this round of national bargaining.

Acceptance of the changes in the user-based components in exchange for other positive features of the Carriers' proposal is reflective of a collective consensus that goes beyond the Arbitrator's ability to make his own value judgements for the Parties. Certainly, the leadership of the MWSM Unions are not

strictly bound by the decisions of other Union leaders. Yet it cannot be lost that other settlements were not only endorsed by leadership but it is a fact worthy of great weight that those settlements (which match the Carrier's offer here) were ratified by their membership in a democratic process. Unrebutted evidence in the record reflects that others Unions' membership thought the Carriers' proposal was reasonable given all the pros and cons. More specifically, a total of 70% of the industry's Unionized work force ratified by an average margin of 83%.

Accordingly, it is the majority opinion that there is, on balance, no convincing basis in this record to conclusively say those other workers were wrong. The Carriers' proposal will essentially prevail.

The remaining issues are whether there should be a "true-up" and whether there should be an "additional penalty". The true-up is something that Carriers contend is appropriate as it puts the MWSM employees on the same plain as the other settled Unions in terms of savings to the Plan. In most cases the changes started January 1, 2018 (with the exception of the TCU coalition which agreed to the plan changes February 1). The Carriers also advocate for an additional "punitive" deduction.

Taking the Carriers' last ask first (that a punitive penalty is in order) the short answer is "No". And a longer answer would be "No way". The MWSW have the same rights as the Carriers to take a position in bargaining and strongly advocate for it. The mere fact it differs from the "Carriers" pattern or other settlements does not make it unreasonable such that punishment for exercising lawful collective bargaining rights is appropriate. It is not appropriate in this case and it is hard to imagine circumstances where it would be. If a lesson needs to be taught, it is one for the Carriers. Matters internal to the Unions are the Unions' business. If the Carriers' point was that there should be a "cost" for going to arbitration, that cost is inherent in the process as the Unions are responsible for the cost of advocacy and one half the cost of arbitration.

The Board views the "true up" request as different. It is accepted as a measure of retroactivity which is extraordinarily common in collective-bargaining. The true-up generally mimics retroactivity under these circumstances and is specifically consistent with the implementation agreed to by the other Unions. Like the TCU coalition, it should date in this case to February 1, 2018 and cover four months at the same rate as all the other Unions and be deducted from the retroactive wages.

AWARD

A. ARTICLE II ("Health and Welfare") shall consist of the terms proposed in the Carriers (Appendix C).

B. Yes, the Carriers are entitled to an adjustment based on timing of the implementation as set forth above.

/S/ (Signature on Original)
Gil Vernon
Arbitrator

Thomas R. Roth
Union Member

A. Kenneth Gradia
Carrier Member

Dated: May 23, 2018