ARBITRATION OPINION AND AWARD

In the matter of arbitration	*	FMCS No.: 101105-00194A
Between	*	Hearing Date: February 11, 2010
KANSAS CITY AREA TRANSPORTATION AUTHORITY	*	Briefs Received: March 18, 2010
And	*	Award Date: May 10, 2010
AMALGAMATE TRANSIT UNION, Local 1287	*	

Appearances:

For the Authority: Jeffrey M. Place, Esq.
For the Union: Scott A. Raisher, Esq.

Before the Board of Arbitration:

Fern Kohler (Authority member)
Freddy L. Ersery (Union member)
Josef Rohlik (neutral arbitrator)

BACKGROUND

This grievance comes from the Kansas City Area Transportation Authority (hereinafter referred to as the Authority). The Union claims that the Authority stopped payment of full single employee health insurance contribution to certain employees and started to require a proof of their premium contribution to outside coverage in violation of Section 1.22(b) of the 2008 Agreement between the Parties. The outside coverage is usually but not exclusively covered by spouses (see infra).

The hearing was held in Kansas City, Missouri. The Parties stipulated that the issue is "does the Authority's refusal commencing on January 1, 2010 to pay the Authority's full single

employee premium contribution to all employee who waived health insurance coverage, and [the requirement that they] show proof of outside coverage, violate the Agreement, and, if so, what is the appropriate remedy?

The 1986-1989 Agreement between the Parties (ratified in 1987) (Jt. E 4) reads in part:

Section 1.22. Group Insurance-Welfare

(a) Medical Insurance:

(...)

The Authority shall increase its contribution by ten percent (10%) each year for medical insurance or Health Maintenance Organizations with any excess payable by the employee. This increase shall be effective November 1 each year of this Agreement. (1) Employees who elect to waive Authority offered insurance coverage may request reimbursement for the employee only, at the Authority's level of contribution; (2) An employee receiving insurance coverage by a spouse, who is also employed by the Authority will not be eligible for reimbursement; (3) Employees who wish to purchase medical insurance outside the Authority, or who live outside the covered area, and who can show proof of purchase, may be eligible for reimbursement up to the amount of the Authority's level of contribution. In the event the outside premium is less than the Authority's level of coverage, the Authority will only pay the amount required to purchase coverage. In no event shall the Authority contribution exceed the actual premium. . . .

The current Agreement (Jt. E 1) reads in part:

Section 1.22. Group Insurance – Welfare.

(...)

(b) Basic Health Insurance – Active Employees.

(...)

Full-time employees who elect to waive Authority offered insurance coverage may request reimbursement for the employee only, at the Authority's level of contribution. An employee receiving insurance coverage by a spouse, who is also ~~employed by the Authority, will not be eligible for reimbursement.~~ Employees who wish to purchase medical insurance outside the Authority, or who live outside the covered area, and who can show proof of purchase, may be eligible for reimbursement up to the amount of the Authority's level of contribution. In the

event the outside premium is less than the Authority's level of coverage, the Authority will only pay the amount required to purchase coverage. In no event shall the Authority contribution exceed the actual premium.

(...)

There has been no change of substance in this provision in the intervening Agreements.

The Union stated at the hearing that since 1987 until January 1, 2010 the Authority has paid to the employees who waived health insurance the "employee only" amount of reimbursement, and has not required the proof of employee's addition to outside insurance by a different employer. The Authority stated that it did not have any evidence to the contrary. The multitude of exhibits and the testimony confirm the Union statement.

The Agreement also contains the following provision:

Section 1.4. Past Practices.

A past practice is an agreement either oral or written, to handle a particular factual situation in a given manner. In order for such past practice to exist it must be (1) unequivocal; (2) clearly enunciated and acted upon; (3) readily ascertainable over a reasonable period of time.

All past practice agreements between the parties that have not been reduced to writing and signed by the parties shall be considered void as of July 1, 1979.

No past practice may be established after the execution of this contract unless reduced to writing at the time of the establishment of the practice.

It may be instructive in this case to quote from the briefs of both Parties.

The Union brief reads in part (at 3):

With respect to an appropriate remedy, the Union would respectfully request that its grievance be sustained, that the Arbitrator find the Authority to have violated the Agreement and enter an award providing the following prospective and "make-whole" relief:

(1) directing the Authority to accept, as appropriate documentation, proof of coverage under an alternate plan, as it has for the past twenty-three (23) years, and not require the employee to provide proof of purchase;

(2) upon the employee providing proof of coverage, directing that the Authority pay to the employee, as reimbursement for having waived Authority offered insurance, that amount representing the Authority's full "employee's only" premium contribution;

(3) directing the Authority to pay to those employees who, for 2010, chose to remain on an alternate (i.e., spouse's) plan, the Authority's full "employee only" premium contribution - $440.13 – beginning January 2010 (less any amount that may have been already paid by the Authority as reimbursement.);

(4) directing the Authority to "reopen" the enrollment process for those employees who chose to take Authority offered insurance, so as to give those employees the opportunity to enroll in an alternate plan if they so choose; and in the event they are able to do so, directing the Authority to pay them the Authority's full "employee only" premium contribution ($440.13) beginning with date of their enrollment in an alternate plan.

In addition, the Union would respectfully request that the Arbitrator retain jurisdiction to assist the parties with any questions or concerns that might arise regarding an appropriate remedy or in connection with the implementation of any award.

The brief of the Authority reads in part (at 2):

Broadly speaking, from 1987 through 2009 KCATA paid employees who waived KCATA health insurance coverage and showed proof of alternate coverage a monthly amount equal to the contribution KCATA would have made to the employee's individual health insurance premium, had the employee elected to be covered under KCATA's health insurance with the "employee only" coverage option. Beginning in 2010, KCATA began enforcing a requirement that employees who seek premium reimbursement present documentation showing the employee's out-of-pocket cost for obtaining alternate insurance coverage. KCATA then reimburses the employee in an amount equal to the lesser of the employee's out-of-pocket cost for obtaining alternate health insurance coverage or the contribution KCATA would have made to the employee's individual health insurance premium, had the employee elected to be covered under KCATA's health insurance plan with the "employee only" coverage option.

The Union filed a grievance challenging KCATA's decision to change the way in which it determines employee benefit eligibility under the health insurance premium reimbursement program. KCATA responded that the change did not violate the labor agreement in any way, and that the labor agreement itself expressly provides that employee "reimbursements" cannot exceed the employee's out-of-pocket costs in obtaining alternate health insurance coverage.

The memo to employees from General Manager Mark Huffer dated October 6, 2009 (Jt. E 46) reads in part:

> Subject: Changes to 2010 Waived Medical Insurance Reimbursement Option
>
> (...)
>
> The current economic conditions gripping our nation and our region continue to present real and significant budget challenges to employers of all sizes, in both the public and private sectors. KCATA is not immune to those challenges. We anticipate that sales tax revenues available to KCATA in 2010 could be as much as $10 million less than in 2008.
>
> (...)
>
> As you may know, KCATA offers a medical reimbursement program for those employees who select medical coverage outside of the KCATA network. This program has been administered equally for both Union and management personnel.
>
> Beginning with the 2010 benefit year, employees who wish to receive reimbursement payments for health insurance purchased outside of KCATA will need to present both 1) proof of current insurance coverage and 2) proof of their actual out-of-pocket expense for obtaining the coverage.
>
> Employees who spend as much as or more than the Authority's contribution amount to obtain individual coverage will receive reimbursement to the full KCATA contribution amount. Employees who spend less will receive reimbursement for the actual cost to the employee for obtaining their individual health insurance coverage. In no event will the Authority contribution exceed the actual premium paid by the employee who obtains his or her own coverage outside of KCATA.
>
> We recognize that for some, this may represent a change, and for some, it may result in a reduction in the amount of reimbursement previously received. These changes will impact only a minority of KCATA employees, and will apply for both Union and management personnel.
>
> (...)

It cannot be disputed that the Authority was well aware of what it was paying to employees who elected to waive insurance. For instance, the November 7, 2003 letter of Deputy General Manager Fern Kohler to the Union Business Agent (Jt. E 39) reads in part:

> Section 1.22 (b) ¶ 4 of the labor contract, makes it clear that employees who purchase health insurance outside of ATA and can show proof of purchase, may be eligible for reimbursement up to the amount of the Authority's "employee only" contribution. That same paragraph states, "... the Authority will only pay the amount required to purchase coverage."
>
> However, you believe the contract states that if an employee's spouse covers the employee, the ATA will give the employee ATA's amount for employee only, even if the spouse is not required to pay for the additional coverage. You stated that the contract prescribes different treatment for employees covered outside of ATA by a spouse and employees living outside the covered area and purchasing insurance on their own, allowing payments to those individuals only if they spend money for the insurance. I can find no such distinction in the contract language. The entire paragraph provides for "reimbursement" only. A "reimbursement" is a repayment for money spent, and where neither the employee nor the employee's spouse has spent any money, there cannot be any reimbursement.
>
> You stated that you have received the "personalized insurance" payment for the last 10 years, even though your spouse received the coverage free of charge from a previous employer. Assuming KCATA has made such payments, they were made in error. Nevertheless, we agreed that KCATA will handle "personalized insurance" under your interpretation for the 2004 plan year only. It is my understanding that the language in question will be renegotiated as the first item in the upcoming contract negotiations, giving us the chance to resolve our differences in contract interpretation at the bargaining table. ATA agrees to continue the payments during the 2004 plan year without waiving its right to adhere to the contract language as written at any time after the end of the 2004 plan year (for example, if the contract automatically renews or if the language is adopted without amendment in a new contract).

It is undisputed that the employees here under consideration who waived their insurance by the Authority have had to submit proof that they were covered by an outside insurance, and had to sign a waiver.

From 1987 to 1992 the Authority used waiver forms to be filled in by the employees in question (Jt. E 45). For instance, the form filled in by employee Rusher includes the following paragraph:

> I would like to receive a monthly cash reimbursement (added to my pay) equal to the lesser of (1) the amount of monthly contribution I and/or my spouse makes toward the costs of any other group medical coverage, and (2) the amount of monthly subsidy for which I am eligible.

The form for Marvin Shackelford (id.) dated 9-27-90 includes the following:

> The Authority requires me to provide proof, acceptable to the Authority, that I and/or my dependents have other group medical coverage.
>
> The Authority can confirm the other group medical coverage by contacting my and/or my spouse's other employer or health care carrier.

There is nothing in this record which would indicate that any other form was used after 1992. There is also nothing in this record which would show that the Authority ever inquired with a spouse's employer about a portion of that insurance attributable to the Authority employee. There is nothing in this record to show that the Authority ever insisted that its employees in fact provide such information. The Union witnesses testified that they never provided such information. This testimony was not disputed.

The witnesses agreed that the Authority insisted that all of its employees have insurance coverage. Employees living far away may have wanted to buy their own insurance elsewhere because of the location of their HMO, etc. There has been no dispute on the limit of the Authority's payment for such insurance. There is also no dispute on the situation involving an employee whose spouse is also an employee of the Authority. In fact, the only dispute herein is whether the last one and half sentence of the quoted paragraph of Section 1.22(b) of the Agreement applies to the employees identified in the first sentence of that provision.

President of the Union Wilson testified that the Authority never required proof of the spousal insurance attributable to its own employee. He testified that in the 1986 negotiations the three categories in Section 1.22(b) were discussed separately.

Javier Perez echoed this testimony. He has worked for the International since 1995 and has been receiving the "employee only" contribution until 2010 even though the International provided his insurance.

Gayle Holliday was the only witness of the Authority. She worked there from 1976 to 1996; she was Deputy General Manager. She testified that she learned of the Authority payment to the employees in question only a few days before the arbitration hearing. She testified that it must have been "personnel" which has devised the payments in question. She testified that it was certainly not the Authority's intention to pay beyond the provision in the last one and half sentence of the quoted paragraph of Section 1.22(b).

Both Parties agree that the issue is one of the interpretation of the quoted paragraph of Section 1.22(b). Both Parties also claim that the relevant contract language is clear and unambiguous.

The Union claims that the first sentence of Section 1.22(b) in question clearly states that "the employees who elect to waive Authority offered insurance coverage" shall be entitled to receive reimbursement for "the employee only at the Authority's level of contribution." This language is crystal clear. There is no issue of and no qualification on the employee's portion of the outside insurance. This unequivocal language, supported by the bargaining history, is the best evidence of both, the Authority's obligation and the Parties' intention. The Union points out that this language and its implementation have been in effect for some twenty-three years. The last sentence of the paragraph here in question must be understood to mean that each employee was

entitled to such contribution as set forth in the preceding provisions on the level of insurance amount payable by the Authority.

The Union points out that any financial problems of the Authority could provide a reason for negotiations rather than a unilateral modification of the Agreement.

The Union claims that the term "reimbursement" must be broadly understood as providing for "compensation" rather than for "reimbursement" for expenses only. In addition, this term must be also read as reimbursement for the waiver. The Union points out that there is no evidence on any meaning of the term "reimbursement" in negotiations.

The Union points out that the record evidence eliminates any suggestions that the Authority was unaware of a mistake in its payments.

The Union remedial request appears above. The Union request that the grievance be denied.

The Authority claims that the language of the quoted paragraph of Section 1.22(b) is clear and unambiguous. The Authority Brief reads in part (at 4,5):

> The first sentence establishes the maximum amount of "reimbursement" an employee "may request." That sentence doe not establish how much reimbursement the employee will receive. Rather, the second sentence goes on to provide that the employee will not receive any reimbursement if the employee's alternate source of coverage is insurance provided by a spouse who also works at KCATA. The third sentence explains that employees who purchase alternate coverage, or who live outside the coverage area for KCATA's insurance plan, "may be eligible for reimbursement up to the amount of the Authority's level of contribution" if they show "proof of purchase." Next, the fourth sentence establishes clearly and unequivocally that "in the event outside premium is less than the Authority's level of coverage, the Authority will only pay the amount required to purchase coverage." The effect of this sentence is not limited by its terms to any sub-group of employees, but instead applies to all reimbursement requests. If that were not clear enough, the paragraph concludes with a prohibition: "In no event shall the Authority's contribution exceed the actual premium." Again, this language is quite clear. It does not state "in certain events," or "if the employee purchases coverage independently rather than buying it through a spouse's employer," the employee will be limited to his or her out-of-

> pocket cost as a reimbursement. Rather, the contractual language states that "in no event" shall the employee receive more money as a reimbursement than he or she paid to obtain alternate coverage.
>
> Additionally, the Arbitrator should keep in mind that the payment at issue herein is described as a "reimbursement." "Reimburse" means "to pay back to someone," "to make restoration or payment of an equivalent," "to repay," or "to pay back or compensate (a person) for money spent, or losses or damages incurred." *See* Webster's New Collegiate and The American Heritage Dictionary definitions, submitted as Joint Exhibit 44. Employees who have free health insurance coverage through a spouse or some other source, and who would otherwise have had double insurance coverage, but who therefore choose to waive KCATA insurance coverage not spent any money, incurred losses, or been damaged in any way. Rather, they have saved the money they would have spent as their portion of the KCATA insurance premium, and they still have health insurance coverage, in the form of their free alternate coverage. Employees who are required to pay some amount in order to obtain their alternate coverage have incurred an expense, but only to the extent of the premium cost to them of the alternate coverage. They can claim a "reimbursement," up to the lesser of the amount they actually paid for their alternate coverage or the amount KCATA would have paid for single-employee KCATA insurance coverage. Any payment that exceeds the expense to the employee cannot rationally be characterized as a "reimbursement" at all.

The Authority claims that the term "reimbursement" means compensation for money spent.

The Authority claims that the provision in question does not establish three categories of employees. "It introduces a general concept and then provides the specifics..." (Union Brief at 6).

The Authority claims that the length of time the Authority paid higher amount has nothing to do with "the express contractual language" (id. at 8).

The Authority further claims that "the union cannot rely on parole evidence to create an ambiguity that does not exist..." (id. at 10). Even if the arbitrator considered the practice of the Parties, the bargaining history does not support it since the evidence shows that the Parties were concerned only with each employee having an insurance. The Authority claims that its intention

is evidenced by the text in forms which are Joint Exhibit 45, and in the 2003 letter (Jt. E 39). The Authority points out that there is no binding past practice under the Agreement. The Authority prays that the grievance be denied.

Both Parties agree that the arbitrator retain jurisdiction for the remedial phase of this dispute, if any.

FINDINGS

1. The outside insurance covering the employee will typically be that of a spouse, but as Perez's testimony demonstrates, it could be any source.

2. There are obviously three categories of employees and they are clearly three different and distinct categories. Quite apart from the text of Section 1.22(b) there are different rates for "employee," "employee + spouse," "employee + children," and "family," and the corresponding different amounts of the Authority's contribution (e.g. Jt. E 34). There cannot be any doubt that in the medical insurance context there is an obvious difference between married employees covered by Authority's insurance, a single employee, a married employee who is covered by is spouse's insurance elsewhere (or a single employee who is covered by insurance from a different source), and a single employee who is himself buying his own – different—insurance. While there is nothing in the record on the number of employees who buy their own insurance, it is very likely that such an insurance would be more expensive than group insurance obtained by the authority, and, consequently, the Authority would pay up to the level of its coverage only. In case of a couple working for the Authority they both receive maximum coverage by the Authority.

3. Medical insurance is an important fringe benefit which is a part of employee's compensation, and which is negotiated in collective bargaining. When it comes to one employee – called single employee in this arbitration – who may prefer, for whatever reason, to be covered by a different entity such as the spouse's employer, the parties to a collective bargaining may decide that he or she is not eligible for any compensation for the benefit he or she is not taking. The employer then realizes the value of the benefit. Or the parties may decide that that employee – the only one of the three categories who would not be getting any benefit – should be compensated, and how much he or she should be compensated for not using the fringe benefit in question. The point is that if there is such an agreement it is not at all unnatural and strange if the employee is compensated by the full amount of the fringe benefit or if the employee is compensated only by the cost incurred e.g. by the spouse.

4. The next question is the textual interpretation of the paragraph in question of Section 1.22(b). The first sentence applies to an employee who waives the Authority's coverage. He is entitled to "reimbursement for the employee only, at the Authority's level of contribution." This sentence is unequivocal. It is not accompanied by any qualification. The next sentence applies to a couple unemployed by the Authority. They are entitled to employee + spouse insurance, they are "not ... eligible for [any] reimbursement." The next sentence applies to an employee who purchases (his own) insurance from outside sources. The following sentence is an obvious qualification of that employee's reimbursement. He or she cannot get more than the cost of his or her insurance, but, under the last sentence, he or she will not get more than the Authority pays to others even if his or her insurance would cost more. This is the standard textual interpretation. ~~For the sake of argument it may be said that it may not be argued that the last sentences apply to~~ the preceding text because they obviously do not apply to the second category.

5. The arbitrator is well aware that the forms used from 1987 to 1992 and the 2003 letter support the Authority's intention as posited in this arbitration. But, they are also conclusive evidence that the Authority knew what it was paying; further, the continued reimbursement along the lines of the Union interpretation not only shows that the Authority did nothing to change the situation, but must be viewed as acceptance of the Union position.

6. The Company invokes parole evidence rule. First, there is no such thing in connection with collective bargaining agreements.[1] Second, if the Authority's original intention made the interpretation of Section 1.22(b) ambiguous – which this opinion rejects – consistent practice of over twenty years would determine the proper interpretation of the provision in question. Not as past practice creating new right or obligation or filling in a gap, but simply interpreting the contractual language.

7. The above conclusions also dispose of the issue of the kind of proof the waiving employee must submit. He or she must submit a proof that he or she are covered, nothing more.

8. For all the above reasons the grievance must be sustained. As the specific remedy the arbitrator orders that the Authority complies with the Union request numbers (1), (2), (3) above. The situation may be different for those employees who freely accepted the Authority position. This issue was not developed at the hearing, and, at any rate, it is a remedial issue which falls within the arbitrator's retention of jurisdiction.

[1] See USWA v. Warrior & Gulf Navigation Co. 363 U.S. 574, 578, 579 (1960). This in fact is not unique to labor law and arbitration. See, e.g., UCC 202 and 209 and comments.

AWARD

1. The grievance is sustained as set forth in paragraph 8 of the Findings.

2. The arbitrator retains jurisdiction for any remedial dispute for six months from the date of this award.

Fern Kohler, Authority Arbitrator

Freddy L. Ersery, Union Arbitrator

Josef Rohlik, Neutral Arbitrator

In University City, Missouri
May 10, 2010