NOTICE: This opinion is subject to formal revision before publication in the bound volumes of NLRB decisions. Readers are requested to notify the Executive Secretary, National Labor Relations Board, Washington, D.C. 20570, of any typographical or other formal errors so that corrections can be included in the bound volumes.

Connecticut Institute for the Blind, Inc., d/b/a Oak Hill *and* New England Health Care Employees Union, District 1199, SEIU. Case 34–CA–013016

February 27, 2014

DECISION AND ORDER

BY CHAIRMAN PEARCE AND MEMBERS HIROZAWA AND JOHNSON

On February 22, 2013, Administrative Law Judge Steven Fish issued the attached decision. The Respondent filed exceptions and a supporting brief. The General Counsel filed an answering brief.

The National Labor Relations Board has delegated its authority in this proceeding to a three-member panel.

The Board has considered the decision and the record in light of the exceptions and briefs and has decided to affirm the judge's rulings, findings, and conclusions[1] and to adopt the recommended Order as modified.[2]

ORDER

The National Labor Relations Board adopts the recommended Order of the administrative law judge and orders that Connecticut Institute for the Blind, Inc., d/b/a Oak Hill, Hartford, Connecticut, its officers, agents, successors, and assigns, shall take the action set forth in the Order as modified.

Substitute the following for paragraph 2(c).

"(c) Preserve and, within 14 days of a request, or such additional time as the Regional Director may allow for good cause shown, provide at a reasonable place designated by the Board or its agents all payroll records, social security payment records, timecards, personnel records and reports, and all other records, including an electronic copy of such records if stored in electronic form, necessary to analyze the amount of backpay due under the terms of this Order."

Dated, Washington, D.C. February 27, 2014

Mark Gaston Pearce, Chairman

Kent Y. Hirozawa, Member

Harry I. Johnson, III, Member

(SEAL) NATIONAL LABOR RELATIONS BOARD

Rick Concepcion, Esq., for the General Counsel.
Miguel A. Escalera, Esq. and *Diana Garfield, Esq. (Kainen, Escalera & McHale PC),* of Hartford, Connecticut, for the Respondent.

DECISION

STATEMENT OF THE CASE

STEVEN FISH, Administrative Law Judge. Pursuant to charges and amended charges filed by New England Health Care Employees Union, District 1199, SEIU (the Union or Local 1199), the Regional Director for Region 34 issued a complaint and notice of hearing on March 30, 2012, alleging that Connecticut Institute for the Blind, Inc. d/b/a Oak Hill (Respondent or Oak Hill) violated Section 8(a)(1) and (5) of the National Labor Relations Act (the Act) by failing and refusing to furnish information to the Union and unilaterally implementing changes in employees' healthcare insurance benefits.

The trial with respect to the allegations in the complaint was held before the me in Hartford, Connecticut, on June 11–15 and July 9 and 10, 2012. Excellent briefs have been filed by both the General Counsel and Respondent, which accurately and comprehensively detailed the facts adduced at trial and presented well-researched arguments in support of their respective legal positions, which were most helpful to me in reaching my decision.

On the entire record, including my observation of the demeanor of the witnesses, and after considering the briefs filed, I make the following

FINDING OF FACT

I. JURISDICTION AND LABOR ORGANIZATION

Respondent is a not-for-profit corporation that provides daily living, vocational, and residential support to individuals with developmental disabilities in its 91 Connecticut-based facilities, including residential group homes and day programs through-

[1] Member Johnson joins in affirming the judge's finding that the Respondent failed to establish economic exigency excusing its unilateral implementation of health insurance changes. He notes that this finding does not foreclose the possibility under different circumstances that economic exigency could justify such unilateral changes.

[2] We shall modify the judge's recommended Order to conform to the Board's standard remedial language.

out the State as well as at its main campus in Hartford, Connecticut.

During the 12-month period ending February 29, 2012, Respondent derived gross revenue in excess of $100,000 and purchased and received goods at its Connecticut facilities valued in excess of $50,000 directly from points outside the State of Connecticut.

Respondent admits, and I so find, that it is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

It is also admitted, and I so find, that the Union is a labor organization within the meaning of Section 2(5) of the Act.

II. THE ALLEGED UNFAIR LABOR PRACTICES

A. Background and Respondent's Operations

Respondent originated 118 years ago to service the blind and visually impaired and has subsequently branched to also service children and adults, who suffer from other developmental and physical disabilities.

Patrick Johnson is Respondent's executive director, who is primarily responsible for its overall operations in conjunction with Respondent's board of directors.

Reporting to Johnson are Gayle Wintjen, general counsel and secretary to the board of directors, James Jones, vice president of finance, as well as Donna Shears, director of human resources.

B. Bargaining History

Since the early 1980s, the Union has represented employees in a unit composed of regular full time, regular part time, and per diem (also known at Respondent as "substitutes"), teaching and "direct care" staff (also known as residential program workers and day service workers), plus maintenance employees, employed by Respondent and assigned to one or more of Respondent facilities.

Respondent employs approximately 1300 employees, 875 of whom are employed in bargaining unit positions and have been represented by the Union.

The parties bargaining relationship has been embodied by a series of collective-bargaining agreements, the most recent of which had an effective date of March 31, 2007, through March 31, 2011.

Linda Vannoni, a vice president of the Union, was the Union's chief negotiator for the above contract and also participated in negotiations for the prior agreement, which had expired in 2007. She continued in the role of chief negotiator during the present set of negotiations for the expiring contract in 2011.

Gayle Wintjen was the chief negotiator for Respondent for the 2007–2011 contract as well as for the contract reopener in 2009. In January 2011, Respondent retained Attorney Patrick McHale as its chief negotiator for the negotiation for the expiring contract, in large part due to McHale's experience negotiating with the Union on behalf of agencies similar to Respondent.

C. The 2007–2011 Contract

Article 17 of the 2007–2010 contract had the following provisions regarding health insurance:

1. The present health insurance plan or one providing equivalent benefits shall continue, subject to the following provisions.

2. Eligibility

(a) An employee who is regularly scheduled for at least twenty hours but fewer than thirty-five hours a week is eligible for part-time insurance benefits.

(b) An employee who is regularly scheduled for at least thirty-five hours a week is eligible for full-time insurance benefits.

(c) An employee who was receiving insurance benefits on June 30, 1992, whose regularly scheduled hours are not sufficient to make him or her eligible for the same level of benefits under section 2(a) or 2(b) above, shall retain the level of benefits he or she was receiving on June 30, 1992. An Employee's right to retain benefits or benefit eligibility under this subsection shall expire permanently upon the occurrence of any of the following events:

(1) He or she applies for and is granted a transfer to another position.

(2) His or her employment is terminated at any time or for any reason after June 30, 1992, or

(3) If an employee (i) returns from layoff, (ii) returns to a different position following a leave of absence, (iii) is involuntarily transferred, or (iv) accepts a materially changed or significantly changed position or bumps a less senior Employee in lieu of layoff. In the event of any of these occurrences, (i), (ii), (iii) or (iv), for as long as he or she remains in the position he or she obtained as a result of the occurrence, he or she shall have his or her eligibility for benefits determined under section 2(a) or 2(b) or shall be eligible for part time insurance benefits if that position is one of fewer than twenty regularly scheduled hours a week but of at least two full shifts a week or he or she shall be eligible for full time benefits if that position is one of at least twenty-six regularly scheduled hours a week but fewer than thirty-five scheduled hours a week.

3. Part-time insurance benefits shall include individual medical insurance.

4(a) Full-time insurance benefits shall include individual and family medical insurance, individual and family dental insurance, individual life, accidental death and dismemberment insurance, and short-term disability insurance. Employees electing to enroll their families in the dental plan shall contribute $5.00 per month.

(b) The Employer reserves the right to eliminate the CIGNA Health Plan which it currently offers and require Employees to select of the other options that are currently being offered.

(c) Any time on or after July 1, 1995, the parties, by mutual agreement, may meet to discuss possible modifications to the current group health insurance plan. Any change would be made only by agreement of the parties.

(d) Effective July 1, 2006, specialist office visit co-pay will increase to Twenty-five Dollars ($25) and prescription co-

pays shall increase to Ten Dollars ($10) generic, Twenty Dollars ($20) formulary brand and Thirty Dollars ($30) non-formulary brand.

(e) All Employees who are eligible for and elect individual health insurance shall contribute twenty ($20.00) dollars per month toward the cost of health insurance premiums and all Employees who are eligible for and elect family health insurance shall contribute forty ($40.00) dollars per month toward the cost of health insurance premiums.

(f) Effective the first pay period beginning after ratification and for fiscal year 2008, all Employees who are eligible for and elect health insurance benefits shall make contributions as follows:

$35.00 per month for individual coverage
$70.00 per month for family coverage

Effective July 1, 2008, Employees who are eligible for and elect health insurance benefits shall make contributions as follows:

$40.00 per month for individual coverage
$80.00 per month for family coverage

Employees who elect the Point of Service ("POS") plan currently available for out-of-network access shall continue to pay the differences between a basic HMO plan and the POS, as well as any applicable health insurance contributions.

5. The Employer shall continue the current life insurance program for Employees eligible for full-time insurance benefits, but shall pay the full cost of such life insurance without contribution from Employees.

6. Pension benefits for members of the bargaining unit shall continue to be provided under State Statute as amended from time to time.

7. All eligible Union Employees, hired after December 31, 1992, who are not participants in State Employee Retirement System (and new Employees after one (1) year of service and attaining age 21), will participate in Oak Hill's Defined Contribution Retirement Plan, in accordance with Plan terms and conditions, with Oak Hill making five percent (5%) of compensation contribution for eligible Employees effective January 1, 2006.

8. The Employer shall continue to provide a short-term disability plan for Employees eligible for full-time insurance benefits. The plan shall have the following features:

(a) Benefits shall commence with the eighth day of disability (excluding disability covered by workers' compensation).

(b) The benefits shall be two-thirds of basic weekly earnings, to a maximum of $215 per week. Effective August 1, 2002, this maximum shall be increased to $275.00 per week.

(c) The maximum benefit period is twenty-six (26) weeks.

Articles 23, paragraph 10 of the agreement provides as follows:

10. Except as otherwise provided in this contract, all past practices, policies and procedures which constitute material conditions of employment shall remain in effect and may not be changed by the Employer without satisfying its obligation to negotiate with the Union pursuant to the National Labor Relations Act. In the event of impasse, the matter shall be submitted to the American Arbitration Association, which shall render a decision based on a balancing of the justification for the change against the impact on the bargaining unit.

Consistent with the provision, there is no evidence that Respondent ever unilaterally changed insurance premiums or benefits prior to 2011.

The record reflects that the annual renewal rate for its medical insurance plans changes on July 1. In prior years, although there had been some increases in premium costs to Respondent, there had never been an enrollment for medical plans that the parties had not agreed to in some manner, regardless of the size of the premium increase. In the past, on occasion Respondent has changed insurance carriers, in part due to premium increases, but only with agreement of the Union, where Respondent demonstrated to the Union's satisfaction that the coverage in the new plan was "equivalent" to the coverage in the prior plan as is required in the parties' collective-bargaining agreement.

Respondent has historically offered the same medical benefits to unit and nonunit employees.

D. The 2009–2010 Reopener Negotiations

Pursuant to the terms of the contract, the parties met in 2009 to discuss modifications of the existing wage and insurance benefits for the unit employees. As noted above, Wintjen and Vannoni were the chief negotiators for the parties during these negotiations, which began in March 2009 and consisted of two meeting in March, two in May, and two in June.

Respondent, by Wintjen at the March 19 opening negotiation session, presented to the Union a Power Point presentation, detailing what she described as Respondent's "dire economic conditions that exist" that caused Respondent to make proposals, which included reductions in wages and health benefits. These factors included the fact that Respondent had been underfunded by the State for many years with no rate increases for the next 2 years, despite increasing expenses, an operating deficit of $6.6 million for the next fiscal year, its endowment lost 30 percent of its value due to stock market decline, and even using $4 million from the endowment income, a $2.6 million deficit would still exist with an additional $1.1 deficit expected for fiscal year 2010,[1] which represents a total projected deficit of $3.7 million for the 2009 and 2010 fiscal years.

Respondent proposed cuts in both wages and benefits in order to help overcome these deficits. With respect to wages, Respondent offered to pass along to employees a wage increase

[1] Respondent's fiscal year's end date is June 30.

if Respondent received an increase in funding from the State legislature, minus 10 percent. If Respondent was level-funded or its rates were cut, it offered several alternative cuts. They included a 5-percent wage cut, a 3-percent wage cut plus elimination of shift differentials and longevity pay, and a new rate structure for newly hired employees.

The Union requested 5-percent wage increase in each of the 2 years of the contract term and changes in language on implementation of layoffs.

With respect to healthcare, Respondent asserted that it has been notified that it would receive a 9.7-percent rate increase for health insurance premiums, effective July 1, which would amount to increased expenses of $800,000 for Respondent for the year. Respondent made a health insurance proposal, which it claimed was designed to eliminate 1/3 of the expected deficit. This proposal included offering bargaining unit employees an option of a high deductible health plan (HDHP plan), which had been enjoyed by nonbargaining employees. This plan provided for a deductible of $1500 for individual coverage and $3000 for family coverage. Additionally, to partially offset the deductible to employees, Respondent offered to make contributions into a Health Savings Account (HSA) for employees, who opt for that plan, of 66.5 percent of the deductible. Thus, employees' costs for this plan would be reduced from $1500 to $500 for individual coverage and from $3000 to $1000 for family coverage. This plan was offered by Respondent since it would result in lower premium costs to Respondent. Respondent also offered as another option that employees could remain in the existing ConnectiCare HMO Access Plan,[2] but, if so, these employees would have to pay 75 percent of the premium costs difference between the existing plan and HDHP. For 75-percent individual's coverage, this would have amount to $64.35 a month and for family coverage $174.[3] Additionally, employees choosing this option would incur some increases in copays on the doctor visits and for prescriptions. Respondent also offered a hybrid option, which was a continuation of Point of Service Plan (POS) then in effect, which provided for out-of-network access. This plan required that the employees pay the difference in premiums between the costs of the HMO plan and the POS plan.

Respondent was most anxious to reach an agreement on the healthcare proposals in 2009 and stressed, at that time, the time-sensitive nature of these proposals in view of the fact that Respondent's premium rates were due to increase by 9.7 percent as of July 1.

In that regard, Wintjen wrote a letter to Vannoni, dated March 30, 2009, reminding her of the time-sensitive nature of the issue and complaining about the Union's failure to schedule sufficient number of dates for negotiations. This letter is set forth below:

[2] This is the plan that the large majority of unit employees had chosen to enroll in.

[3] If employees chose the HDHP plan, then premiums would remain at $40 per month for individual and $80 for family coverage.

March 30, 2009

Via Facsimile & First Class Mail

Ms. Linda Vannoni
Vice President, Community Programs
NEHCEU District 1199, SEIU
17 Huyshope Avenue
Hartford, CT 06106

Re: Scheduling of Negotiations with Oak Hill

Dear Ms.Vannoni:

I write in response to your offer of dates to negotiate our wage and benefit reopener as represented at the bargaining table on March 24th and reiterated in your email to me dated March 25, 2009.

At the end of our last session on Tuesday evening, we discussed additional negotiating dates. You stated that you had no time in April to meet with Oak Hill but offered several dates in May. This substantial delay in negotiating is of grave concern to Oak Hill. Though we recognize that in years past the Union believed that waiting to reach a contract benefitted our employees, this year such a delay provides no such benefit.

As you are well aware, bargaining unit employees expressed great interest in the ConnectiCare High Deductible Health Plan ("HDHP") and are eager to learn more about it. We will need to hold open enrollment in early June in order to get employees on the plan for July 1. Waiting until May to have the informational sessions and to then negotiate all other remaining terms of our proposals leaves us little time, as our fiscal year and health plan contract begin again on July 1. If we do not have an agreement on healthcare by then, we will in all likelihood face a 9.7% rate increase and increased expense of approximately $800,000. Moreover, it would be unfortunate if our employees lose the opportunity to participate in the ConnectiCare HDHP due to scheduling issues.

We have held only two sessions thus far. The Union has not responded to Oak Hill's proposals, and we have not really engaged in the process of negotiating. Though the legislature may not timely pass a budget in June, we plan for the next fiscal year well ahead of any action by the State. As I explained in my opening presentation, even if we are level-funded, Oak Hill will need to make substantial cuts in its expenses, including wages and benefits, in order to eliminate its budget deficit. We are trying to save jobs, but in the absence of a contract agreement prior to June, we may have no choice but to close programs and eliminate positions.

In light of the above, I respectfully request that you take a fresh look at your calendar and find time to meet with us in April. We are available in April to meet as follows: Friday, April 3 during the day; Monday, April 6 and Tuesday April 7 in the morning only; April 14th, 20th, 23rd, 27th all day; and April 28th and 30th in the afternoon only. If you are not available, perhaps another Union representative can lead these meetings.

We are pleased that the Union has agreed to have our health insurance agent come to "informational" sessions with the Union to better describe the ConnectiCare HDHP proposal and to answer questions. You offered May 5th and May 7th as the first dates you are available. While we hope you will be able to find time in April, we will plan on holding these informational sessions on Tuesday, May 5, 2009. The sessions will begin promptly at 11:00 am and 4:30pm. Both sessions will be held in the Expo Hall in the NEAT Center. I would expect both meetings to last about an hour.

You have offered four dates in May and we are agreeable to the following: May 12th in the morning, May 19th in the morning and May 21st in the afternoon. Morning sessions will start at 11:00 am and afternoon sessions will start at 4:30pm with the Union meeting with members one-half hour prior to each session. All sessions will be held in the Expo hall at the NEAT Center.

I await your response.

Very truly yours,

Gayle C. Wintjen
General Counsel

CC: All staff

Although the parties did bargain over these plans, including meetings with representatives of Respondent's health insurance agent to describe and answer questions on the HDHP plan, no agreements were reached prior to the July 1, 2009 deadline. Respondent did not implement the HDHP plan for bargaining unit employees or make any of the other changes in premiums that it had offered at the time. It chose to absorb the increases in premium rates.

Wintjen wrote to Vannoni on June 29, expressing Respondent's dissatisfaction with the bargaining, particularly the Union's failure to agree to the HDHP proposal by the July 1 deadline, which she attributed, at least in part, to the Union's failure to schedule a sufficient amount of negotiations dates.

This letter is set forth below:

June 29, 2009

Via Facsimile & Electronic Mail

Ms. Linda Vannoni
Vice President, Community Programs
NEHCEU District 1199, SEIU
77 Huyshope Avenue
Hartford, CT 06106

Re: Status of Negotiations

Dear Ms. Vannoni:

I write regarding the status of our negotiations regarding our re-opener.

As you are aware, the parties first met on March 19, 2009. At that time, both sides presented their re-opener proposals. Oak Hill presented a slide show evidencing the amount of savings it needed to achieve in order to balance its budget, and the cost savings that its wage and benefits proposals would accomplish. Though alterative proposals were offered, it was clearly communicated that additional cost savings—either through renegotiating contract terms outside of the re-opener, or closing programs—would have to be achieved in addition to the savings anticipated from the wage and benefit proposals. Oak Hill also informed the Union that its health insurance proposals was time-sensitive insofar as the option for bargaining unit members to participate in the high deductible health plan ("HDHP") would have to agreed to prior to open enrollment and the new plan year starting July 1, 2009.

At our second negotiating session, on March 24, 2009, the Union offered two dates in May for further sessions. I wrote to you on March 30th to request that we meet sooner and more often and offered nine dates in April so that we might reach agreement in time for bargaining unit members to enroll in the HDHP. The Union never responded to that request.

At our negotiating session on May 21st, the Union offered two dates in June for negotiations. On May 28th, and June 17th I again wrote to you and offered dates for negotiations so we could meet sooner and more often. The Union never responded to those requests.

To date, the only agreement we have reached concerns the advocacy issue. The Union did not agree to the HDHP option in time during open enrolment and so bargaining unit members well not be able to participate in that plan. Negotiations are moving at a snail's pace. Moreover, notwithstanding the pressing need to reduce costs both within the bargaining unit and the agency as a whole, the Union remains steadfast in seeking increases in wages and decreases in health insurance costs, and has yet to offer any counterproposal with respect to Oak Hill's wage proposals regarding new hire rates and the shift differential.

As we have emphasized all along, Oak Hill needs to achieve cost savings. At out last meeting, we made a proposal to address the Union's demand that Oak Hill withdraw its proposals to cut wages. We urge the Union to come fully prepared on July 2nd with a complete response to this proposals and that we work hard towards agreement on all wage and benefit issues. We are quickly reaching a point, where if we do not implement negotiated savings, we will have no alternative except to close additional programs and eliminate positions. This is why I have been requesting that we meet more often and this is why we must seriously accelerate negotiations, starting on July 2nd.

Very truly yours,

Gayle C. Wintjen
General Counsel

CC: All staff

During the course of these negotiations, Respondent notified the Union by a letter from Wintjen, with a letter of May 8, 2009, that it had received a quote from Health Net, another insurance carrier for coverage that would represent a 3.7-percent increase over Respondent's premium rates for the next

year. Respondent indicated that in its view the coverage and out-of-pocket expenses for the employees were the same as in the current ConnectiCare plan. Thus, the plan would meet the contract's "equivalent benefits" requirement and would be saving Respondent money. Wintjen attached a two-page comparison of the two plans, detailing the costs, copays, services offered, and deductibles for both of these plans to demonstrate that they were equivalent. The letter is as follows:

May 8, 2009

VIA ELECTRONIC & FIRST CLASS MAIL

Ms. Linda.Vannoni
Vice President
NEHCEU, District 1199, SEIU
77 Huyshope Avenue
Hartford, CT 06106

Re: Health Insurance Renewal

Dear Ms. Vannoni:

In connection with our ongoing contract negotiations, I write regarding the renewal of our health insurance plan.

As I stated in the remarks related to Oak Hill's health insurance proposal, ConnectiCare, our current health insurance carrier, has advised Oak Hill that it will increase its premium rates for the plan year starting on July 1, 2009 by 9.7%. That translates to more than $800,000 in additional costs, in a year when Oak Hill has not received additional funding from the State of Connecticut and may well experience rate cuts as the State wrestles with mitigating the state budget deficit. ln light of this significant cost increase, Oak Hill asked its health insurance broker to rebid its health insurance contract to find out whether there was another carrier that offered a more affordable yet equivalent plan.

Oak Hill has received a quote from Health Net, an insurance carrier that was offered to its employees along with the ConnectiCare plan not too long ago. Health Net has proposed a 3.7% increase over Oak Hill's current rates for a health insurance plan that is equivalent to the current ConnectiCare plan. A side-by-side comparison of coverage and out-of pocket expenses is attached for your review. The network of physicians and hospitals is nearly identical as is the prescription coverage. The terms of the high deductible health plan/health savings account are the same. Most important, switching to Health Net will save Oak Hill approximately $350,000 due the fact that the premium increase is far less than that proposed by ConnectiCare.

The collective bargaining agreement states that "the present health insurance plan or one providing equivalent benefits shall continue, subject to the following provisions." (Art. 17,¶11). In order to take advantage of the cost reduction for the new policy period, and because this does not change the benefits being provided, Oak Hill considers the Health Net plan to be "equivalent" to the ConnectiCare plan and will make the change effective July 1. 2009. Oak Hill will be prepared to answer any questions you may have regarding these changes at our negotiating session on May 12, 2009.

This change would not effect our current contract negotiations or Oak Hill's proposals. While the cost savings to be achieved by changing to Health Net are significant, Oak Hill still needs to reduce its overall costs. District 1199 remains free to make any proposals it believes are appropriate with respect to health insurance. Oak Hill remains free to respond to those proposals and make others as we believe appropriate.

Please do not hesitate to call me if you have any questions.

Very truly yours,

Gayle C. Wintjen
General Counsel

During the course of the bargaining, the Union ultimately determined that the coverage was, as Wintjen had represented, "equivalent," and the Respondent changed carriers to Health Net for the plan year beginning July 1, 2009. There were no changes to employees' benefits, premiums, or copay payments resulting from this change.

During the course of the 2009 bargaining, the Union made multiple information requests in order to assist in bargaining over the issues in the negotiations, including Respondent's request to change carriers. The Union conceded that Respondent filed timely and complete responses to these information demands in 2009.

One of the Union's information requests, dated February 5, 2009, asked for "copy of the medical plan and dental plans, 'summary plan description,' which lists any and all copays, allowed service, allowed service, number of office visits, deductible, etc."

In response to that request, Respondent submitted three pages. The first page, entitled "What are the Benefits of Changing to Health Net," is as follows:

FACT SHEET: WHAT ARE THE BENEFITS OF CHANGING TO HEALTH NET

How does this change affect Oak Hill's financial condition?

ConnectiCare had informed Oak Hill that it intended to increase its rates by 9.7% effective July 1. Health Net offered Oak Hill a rate increase of 3.7% effective July 1. This results in a cost savings of approximately $379,000.

How does this change impact Oak Hill's proposal regarding HMO costs?

Oak Hill has proposed that employees pay 75% of the difference between the employer's cost of the HMO and the HDHP in each plan year. Applying this formula, the employee monthly premium costs under the ConnectiCare and Health Net plans for fiscal year 2010, which begins on July 1, 2009, would be:

	ConnectiCare	*Health Net*	*Difference*
Individual coverage:	$64.35	$49.00	$15.35
Family Coverage:	$174.00	$135.00	$39.00

How does this change impact the HDHP/HSA proposal?

The terms of the HDHP/HSA do not change. The employee monthly contributions will be kept, as promised, at

current levels ($40/month individual and $80/month family) for the next two fiscal years. The deductible levels and the amounts Oak Hill will deposit into the HSAs remain the same. Like the HMO, the only real difference would occur if an employee's medical provider is not on the Health Net network. Significantly, if an employee's medical provider is not on the Health Net network, the HDHP/HSA will be attractive because the medical expenses for that provider can be paid out of the HSA.

Does the new health insurance plan make any other changes?

Yes. Oak Hill was able to include within the plan coverage the outpatient procedures and hospitalization coverage that Oak Hill has been self-insuring since 2008. This means that after July 1, 2009, employees will no longer have to carry the additional insurance card. In essence, the coverage for outpatient procedures and hospitalizations will return to what it was prior to June 2008.

The benefits office will be scheduling open enrollment in the very near future. In the meantime, if you have any questions, please contact Rose Bolton, Director of Compensation and Benefits, at 769–3829.

Respondent also transmitted to the Union a two-page chart, reflecting comparisons of the existing ConnectiCare Medical plan with the proposed Health Net plan. These two pages are not entitled "Summary Plan Descriptions," as requested by the Union, and do not appear to be documents prepared by the insurance companies. Rather, it appears to be Respondent's efforts to compare the two plans as per the Union's inquiries, concerning "co-pays, allowed services, number of visits, deductibles, etc." As related above, these pages reflect that these plans were virtually identical in all aspects and persuaded the Union that Respondent would be in compliance with the equivalency language in the contract by changing carriers. I note also that at the time, although the Union had requested "Summary Plan Descriptions" of the plans, that Respondent did not inform the Union that there were no such documents. Instead it provided the Union with what it believed to be responsive to the Union's requested information concerning the copays, allowed services, number of visits, deductibles for the plans, which the Union had indicated would be included in the "Summary Plan Description" that it asked for.

Thus, as detailed above, despite Respondent's repeated assertions during the 2009 bargaining that its health insurance proposals were "time sensitive" and needed to be addressed prior to the July 1, 2009 deadline, resulting in substantial premium increases that the deadline came and went without an agreement on any of Respondent's proposals. Thus, there was no agreement on Respondent's proposals to increase premium payments by employees on the HMO plan, and no agreement on Respondent's proposal to offer the HDHP plan to bargaining unit employees. Respondent, therefore, did not offer to the HDHP to such employees but did offer it to nonbargaining unit employees with a 75-percent payment by Respondent with an HSA for such employees.

The additional premium increases for the existing bargaining unit plans were absorbed by Respondent, and these employees continued to be covered by existing plans with no changes in premiums or coverage for the plan year starting July 1, 2009.

Subsequent to July 1, 2009, the parties continued to bargain over the midterm modifications, including the Respondent's continuing efforts to include the HDHP plan as an option for employees. Respondent, during this bargaining, also proposed eliminating the "equivalency" language in the contract.

Additionally, in 2010, Respondent proposed changing carriers from Health Net to United Health Care/Oxford, again asserting to the Union that the benefits and coverage for the two plans were equivalent and that since Oxford's premiums were less, it wished to change to Oxford for the employees. Respondent continued to press for the acceptance of HDHP plan as an alternative, and the parties continued to bargain over that issue. In that connection, the Union proposed a reduction in employee premiums for employees,[4] who opted for the HDHP plan (plus the HSA as an incentive for employees to switch to that plan). The Union also proposed that Respondent pay 75 percent for the deductible for the HAS plan and that Respondent accept the Union's wage and economic proposals in exchange for the Union's agreement on the HDHP plan.

Ultimately, the Union withdrew its demands for agreements on its demands and agreed to the HDHP plan, and Respondent agreed to contribute 75 percent of the deductible into an HSA for employees. Respondent also agreed to withdraw its demands for other concessions and changes in the equivalency language.

In early June 2010, the parties reached agreement on healthcare issues, which was reflected in a document, entitled "Agreement regarding Health Insurance," signed by Respondent on June 11, 2010, and by the Union on June 10, 2010. The document is as follows:

AGREEMET REGARDING HEALTH INSURANCE PROPOSALS

Oak Hill (hereinafter referred to as "the Employer") and The New England Health Care Employees Union, District 1199, SEIU ("the Union") agree and resolve the following:

WHEREAS the parties' 2007–2011 collective bargaining agreement ("the Agreement") provides a "re-opener" effective April 1, 2009 for the purpose of renegotiating medical benefits and other matters as more fully set forth in the Agreement; and

WHEREAS both parties have made proposals concerning medical benefits;

NOW THEREFORE, the parties agree as follows:

1. Effective July 1, 2010, Oak Hill shall offer to members of the bargaining unit a High Deductible Health Plan ("HDHP") and Health Savings Account (""as") through United Health Care/Oxford (Freedom Plan) on the same terms and conditions as offered to all other Oak Hill employees, as more specifically set forth in paragraph 2. Participation in the HDHP/HSA shall be voluntary and shall be offered as an op-

[4] The Union proposed reductions of the $40/$80 premiums (single and family) to $30 and $70 per month.

tion in addition to the United Health Care/Oxford Freedom Plan HMO, which shall replace the existing Health Net HMO Plan.

2. The HDHP/HSA shall be offered to employees who elect benefits under the HDHP/HSA during the 2010–2011 Plan Year on the following terms:

a. Monthly employee premium contributions for the Plan Year starting July 1, 2010 shall be $40 for individual coverage and $80 for individuals with dependent coverage;
b. The annual deductibles shall be $1500 for individual coverage and $3000 for individuals with dependent coverage; and
c. Oak Hill shall fund *75%* of the deductible and shall make deposits into employees' HSAs on a quarterly basis starting on or about July 1, 2010.

3. Oak Hill formally withdraws all other proposals and counterproposals made to date regarding medical insurance coverage including but not limited to: premium cost-sharing and copayments; Oak Hill's proposal to eliminate the contract language which maintains any subsequent plan as "equivalent to" the current plan; Oak Hill's proposal to increase HMO copays in effect under the HMO plan; and Oak Hill's proposal to increase employee medical premiums for the HMO plan.

4. Employees shall have until June 22, 2010 to submit their insurance applications to Oak Hill's Benefits Department. So long as the applications are on file by that date, employees' benefits will not lapse and their new coverage will commence effective July 1, 2010.

For Oak Hill	For NEHCEU, District 1199, SEIU
Gayle Wintjen	Linda Vannoni

This agreement was to be effective July 1, 2010, the effective date of the new insurance year for the plans as in 2009. There was some discussion between Wintjen and Vannoni concerning the enrollment dates and issues in June 2010, particularly since there was an agreement on offering the HDHP plan, which was a new plan for Respondent's unit employees.

An email exchange between Wintjen and Vannoni concerning enrollment issues on June 9 is set forth below:

From: Linda Vannoni [mailto:lvannoni@seiu1199ne.org]
Sent: Wednesday, June 09, 2010 3:12PM
To: Gayle Wintjen
Subject: RE: AGREEMENT REGARDING HEALTH INSURANCE PROPOSALS, rev 6–8–10

HI gayle, looks good and thanks for modifying. Also, one more thing the parties agreed to. You said it would be fine to have an extended date for members to sign up and enroll. I would like to add a paragraph that reads. BU employees will have until July 1, 2010 to enroll in any of the plan options and maintain coverage without any lapse, or at least up until June 29th. Let me know and I will be happy to sign then. Thanks

---

From: Gayle Wintjen [mailto:wintjeng@ciboakhill.org]
Sent: 2010–06–09 3:22PM
To: Linda Vannoni
Cc: Donna Shears; Rose Bolton
Subject: RE: AGREEMENT REGARDING HEALTH INSURANCE PROPOSALS, rev 6–8–10

Linda,

I do not recall extending any enrollment date, as our Plan Year starts July 1. What we said is that we would offer additional informational sessions on the HDHP and information concerning those sessions has been distributed. Our benefits department does need time to get all paperwork prepared and reviewed for accuracy so that employees can have coverage starting July 1. Also, we stated that employees who are currently have coverage at Oak Hill through the HMO do not need to go through open enrollment unless they need to make a change in their coverage (e.g., individual to dependent coverage). So the only employees who are affected by this change are employees who wish to move from the HMO to the HDHP. They will still have until June 22 to submit their forms to the Benefits department. If you want me to add a sentence about that June 22 date in the agreement I am happy to do so, but I do not believe it is necessary.

Thanks, Gayle

Gayle C. Wintjen
769-3827

From: Linda Vannoni [mailto:lvannoni@seiu1199ne.org]
Sent: Wednesday, June 09, 2010 3:43 PM
To: Gayle Wintjen
Subject: RE: AGREEMENT REGARDiNG HEALTH INSURANCE PROPOSALS, rev 6–8–10

It would be helpful. June 22nd it is. It would be great if you could extend it to June 25th. I do know your people need time. But the employer didn't really give us much time negotiate. We will be helping to advertise signing up for the HSA so more time it is likely more people will be able to enroll. Thanks

Linda Vannoni
Vice President
District 1199 NE/SEIU
(860) 549–1199

Further, additional information requests were made by the Union and complied with by Respondent during the 2009–2010 bargaining that ultimately resulted in the modification agreement. As related above, Respondent proposed changing carriers form Health Net to Oxford but stated that the benefits were equivalent for the plans as the contract requires. The Union was interested in verifying that assertion and in that connection, the Union requested summary plan descriptions for the Oxford plan.

On May 28, 2010, Wintjen sent an email to Vannoni with the subject "FW: Oak Hill Benefit Summaries." These emails read, "Here are the SPDs for the new health insurance coverage. I

have not reviewed them thoroughly, but it appears that Oxford is even more attractive than Health Net. We can discuss these on Tuesday afternoon. Thanks Gayle."

Wintjen forwarded to Vannoni benefit summaries comparing the Health Net and the Oxford plans prepared by Respondent's insurance broker, Peter Wertsching. The summaries consisting of 12 pages, comparing the Oxford and Health Net plans in all three categories of plans that were being offered.[5] These summaries detailed cost including deductibles, coinsurance, descriptions of coverage for preventative care, in-patient care, out-patient care, emergency care, maternity care, mental healthcare, treating alcohol addiction home health and hospice care, eye care, and pharmacy. These pages also included the following footnote. "This is intended to be a general description and comparison of plan benefits. A complete listing of benefits and exclusions will be provided in the Oxford benefits summary and certificate of coverage."

Vannoni testified that the information provided in May 2010, although not entitled "Summary Plan Description (SPD)," contained most of the information that would be included in what she believed to be an SPD. Vannoni added that subsequent to receiving the above information, she still had some questions about some of the items that needed answering. Thus, Vannoni made several email and phone requests of Wintjen to answer the inquiries that Vannoni had about some of the benefits. Wintjen immediately forwarded the answers to Vannoni's questions from the brokers and promptly informed Vannoni of these responses. Vannoni provided some examples of additional questions that she asked, which were not elaborated upon in the summaries provided. These include what qualifies as durable medical equipment, whether the number of visits per year can or must be combined for physical, occupational, or speech therapy, more details about what allergy services are covered as well as questions about what OB/GYN services are included.

Upon receiving answers to these inquires from Respondent, Vannoni reviewed the information provided and concluded that the Oxford Plan's coverage appeared to be "equivalent" to the Health Net Plan, as Respondent had asserted and agreed that it could be substituted and implanted for bargaining employees as of July 1, 2010.

E. The 2011 Arbitration

In November 2009, after being unable to secure the concessions and agreements from the Union that it sought in the midterm bargaining, Respondent reduced the scheduled hours of unit employees, which resulted in 22 employees suffering a loss of medical benefits since their scheduled hours after the cuts rendered them ineligible for this benefit. The Union believed that the cut in hours was arbitrary and was done by Respondent in retaliation for the Union failing to agree to it bargaining proposals and filed a grievance on November 17, 2009, requesting that affected employees' lost wages be repaid, their former benefits be reinstated, benefits cuts be restored, and grievants be made whole for the uncovered medical bills.

The grievance ultimately proceeded to arbitration before Arbitrator Tim Bornstein on March 7 and June 7, 2011.

Arbitrator Bornstein issued his decision on September 7, 2011, finding the Respondent did not violate the collective-bargaining agreement by reducing the hours of some of its bargaining unit employees. He rejected the Union's arguments that Respondent's actions were arbitrary or in retaliation for the failure to obtain bargaining concessions. The decision reviewed much of the bargaining history, detailed below, including the failure of Respondent to obtain the concessions from the Union that it deemed necessary to meet is budget deficit. He essentially concluded the Respondent's actions did not violate the contract and were done for legitimate business reasons. His response to the Union's assertions sums up the essence of his decision.

Arbitrator Bornstein concluded:

> While there was no agreement in negotiations, that did not limit management's right to do what the contract expressly authorizes. Management sought wage concessions in bargaining because of its unquestioned fiscal crisis. Failing to achieve concessions in bargaining, it reduced some employees' hours in order to deal with its looming deficit. That was a decisional response to, not retaliation for, the parties' failure to reach agreement in bargaining. Management's financial crisis was real, and it responded to the crisis, not to the Union's refusal to make concessions…Of course, the 22 Oak Hill employees who lost benefits or who were forced to bump into other positions to maintain benefits suffered real harm. The loss of insurance benefits can be extremely painful, even catastrophic, to a family. Yet the record leaves little doubt that management's scheduling changes were prompted by its severely deteriorating financial situation. These are hard times for non-profit organizations, especially in the health care sector. Unfortunately, their employees are not exempt from the consequences. Management of Oak Hill was over a financial barrel, and the actions it took to meet its obligations to its mission were severe, but they did not violate the collective bargaining agreement.

F. 2011 Contract Negotiations

On December 14, 2010, the Union sent a letter to Respondent, informing it that the Union wishes to start negotiations for a new agreement to replace the contract due to expire on March 31, 2011, and asked for a meeting "as soon as possible." The Union also notified the Federal Mediation and Conciliation Service (FMCS) about the bargaining request.

By letter, dated December 23, 2010, from Vannoni to Donna Shears, Respondent's human resources director, the Union requested information in furtherance of such negotiations. The letter is as follows:

[5] POS plan, HMO plan, and HDHP plan.

December 23, 2010

Donna Shears, Human Resources
Oak Hill
120 Holcomb Street
Hartford, CT 06112
Fax (860)-769-6562

Dear Ms. Shears-

The Union is requesting the following information in electronic format, where available.

1. A current list of employees in the bargaining unit(s) represented by District 1199 at your facility that includes the following:

- Wage rate
- Regularly scheduled hours per week
- What type of health insurance plan/plans they are enrolled in and their level of coverage–ex. employee only, plus one, family.
- Cost to employee for these insurance plans
- Cost to employer for these insurance plans

2. For each of the insurance plans offered to unit employees (medical, life, short term disability, etc.) please provide us with a summary plan description.

3. A list of all insurance benefit plans offered that includes the number of employees eligible, the number of employees participating in each and the number of hours needed to qualify for each insurance benefit. Please indicate where there is a difference in cost to an employee based upon their status as full or part time, and what that cost difference is, if any.

Example-Dental insurance: 75 employees eligible; 43 employees participate; 25 are full time; 18 are part time; 12 have individual coverage at this cost. . . .

We request that you send us the information above *in electronic format* as soon as possible to Frances Boyes at fboye@seiu1199ne.org. If some of the requested items require time to compile please send us the information that is readily available first and forward other material at a later date. Please contact me by phone or letter if you anticipate any difficulty in complying with this request in full within ten business days.

Thank you in advance for your cooperation.

Linda Vannoni, Vice President,
NEHCEU District 1199, SEIU

Upon receiving this request, Shears assigned the task of compiling and forwarding the information to the Union to one of her subordinates, Rose Bolton, director of compensation and benefits. Bolton was involved with "year's ends" and the holidays were approaching, so Shears instructed Bolton to get to it after the holidays.

In late January 2011, Shears followed up and asked Bolton if she had complied with the Union's request. Bolton replied that she had not done it. Shears instructed Bolton to get it done as quickly as possible. However, Bolton never got around to complying with the request. Shears was retiring at that time and was in the process of training her replacement as well as other matters and simply did not get to it before she retired.

Shears never followed up and inquired if Bolton had done it because she assumed that Bolton had complied with her instructions in January to get it done as soon as possible. Thus, according to Shears, the request just "slipped through the cracks."

The Union did not renew its request for this information until after the bargaining actually started in March 2011, as will be described below.

Respondent did not respond to the Union's December 10, 2010 request to meet and bargain until a letter, dated January 28, 2011.[6] The letter was from Patrick McHale, who advised the Union that his law firm will be representing Respondent with regard to the upcoming contract negotiations with the Union, and asked the Union to "please contact me at your earliest convenience so that we can discuss mutually agreeable dates and times to begin negotiations."

The Union received McHale's letter on January 31. Vannoni responded by email on February 2 as follows:

> Dear Pat McHale,
>
> I am writing to schedule negotiations for a Successor Collective Bargaining Agreement at Oak Hill School. Below are a series of dates the Union is offering for negotiations:
>
> 3/1/11 10am–6 pm
> 3/8/11 10am–8 pm
> 3/10/11 10am–8 pm
> 3/15/11 10am–8 pm
> 3/16/11 10am–8 pm
> 3/17/11 10am–8 pm
> 3/23/11 10am–8 pm
> 3/24/11 10am–8 pm
> 3/29/11 10am–8 pm
> 3/30/11 10am–8 pm
> 3/31/11 10am–8 pm
> 4/5/11 10am–8 pm
> 4/7/11 10am–8 pm
> 4/12/11 10am–8 pm
> 4/13/11 10am–8 pm
> 4/14/11 10am–8 pm
>
> I propose that the parties hold our first session in the evening following day programs. When you respond to the above dates for availability please respond to ALL dates which work for your negotiating team as I am offering these dates to all employers I am negotiating with and I would like to expedite our ability to meet to reach successor agreement by having as many available dates as possible to work with.
>
> I will follow up this email with an information request to help prepare the Union's proposals. In the mean time, please respond to dates you are ready to negotiate as soon as possible. I appreciate your cooperation in advance.
>
> Sincerely,
>
> Linda Vannoni
> Vice President

McHale responded on behalf of Respondent by email in February, in which he offered to meet on nine of the dates proposed by Vannoni. The email is as follows:

> From: Patrick J. McHale <pmchale@kemlaw.com>
> Sent: Friday, February 04, 2011 1:37 PM
> To: Linda Vannoni
> Cc: Gayle Wintjen
> Subject: RE: Oak Hill Contract Negotiations - Union offer of dates
>
> Linda:
>
> Oak Hill's negotiating committee is available for negotiations on the following dates you offered:
>
> 3/8 beginning at 4pm
> 3/15 beginning at 1pm
> 3/17 beginning at 1pm
> 3/23 beginning at 1pm
> 3/29 beginning at 1pm
> 3/31 beginning at 1pm
> 4/7 beginning at 1pm
> 4/12 beginning at 1pm
> 4/14 beginning at 1pm
>
> Please confirm that these dates remain agreeable to District 1199. I and the other members of Oak Hill's negotiating committee look forward to meeting with you and your committee soon.

Vannoni responded to McHale by email on February 8, stating that she was "reviewing dates," but inquired about and discussed times for the meetings. The email is set forth below, along with McHale's response on February 13, discussing times and asking what dates are acceptable to the Union.

> **From:** Linda Vannoni [mailto:lvannoni@seiu1199ne.org]
> **Sent:** Tuesday, February 08, 2011 4:13 PM
> **To:** Patrick J. McHale
> **Subject:** RE: Oak Hill Contract Negotiations- Union offer of dates
>
> Pat:
>
> I am reviewing dates for negotiations. I notice in your email you said for most dates that beginning at 1pm when your team is available. I am not sure you are aware that the parties have routinely scheduled sessions such that they rotate every other session, evening morning. The evening sessions typically start at 5 pm and morning sessions would start at 11:30 am. There are virtually no members available to negotiate at 1pm they need to leave for work right around that time. The Union sees no reason to stray from our practice of having morning nego-

[6] All subsequent dates are in 2011, unless otherwise indicated.

tiations begin around 11:30 am. Please advise if your team is not available in the morning times beginning at 11:30 am.

Let me know

From: Patrick J. McHale <pmchale@kemlaw.com>
Sent: Sunday, February 13, 20114:51PM
To: Linda Vannoni
Cc: Gayle Wintjen
Subject: RE: Oak Hill Contract Negotiations - Union offer of dates

Linda:

In response to your request below my committee is willing to begin negotiations at 11:30am as you requested on any of the dates we proposed to begin at 1pm in my email to you dated February 4, 2011. Please let us know what dates are acceptable to you and your committee for negotiations.

On February 16, Vannoni emailed McHale and confirmed that the Union can meet on March 15 at 6 p.m. and March 23 at 11:30 a.m. McHale responded by email and fax on February 18, as follows:

February 18, 2011

VIA EMAIL AND FACSIMILE

Ms. Linda Vannoni
Vice President, Community Programs
NEHCEU District 1199, SEIU
77 Huyshope Avenue
Hartford, CT 06106

Re: Scheduling of Negotiations with Oak Hill

Dear Ms. Vannoni:

I am writing in response to your recent email "confirming" negotiation dates of March 15 at 6:00 pm and March *23* at 11:30 a.m. In my email to you of February 4, 2011, Oak Hill offered nine (9) dates in March and April for negotiation sessions starting at 1:00 p.m. I then wrote to you on February 13 advising that we were willing to start negotiation sessions at 11:30 a.m. instead of 1:00 p.m. to accommodate your request that we do so. At no time did we offer to meet on the evening of March 15 as members of my negotiating committee are not available that evening. We are also available on March 23 at 11:30 a.m. and will plan to meet with you on that date and are willing to meet on any of the other dates that were offered on February 4th.

Please let me now [sic] if you are available on any of the other dates that we offered besides March 23, 2011.

Sincerely,
Patrick J. McHale

Cc: Gayle C. Wintjen

On March 1, McHale sent an email to Vannoni clarifying that the only agreed upon date at the time was March 23 and offering April 12 and 14 as additional dates.

Vannoni responded by email of March 3, confirming March 23 and April 12. This email exchange is set forth below:

From: Patrick J. McHale
Sent: 2011–03–01 11:41AM
To: Linda Vannoni
Cc: Gayle Wintjen
Subject: RE: Oak Hill Contract Negotiations - Union offer of dates

Linda:

The purpose of this email is to attempt to clarify the dates we have agreed to hold negotiations on a successor contract. Of the 9 dates we offered you on February 4th, the only confirmed date you indicated was acceptable is March 23, 2011 beginning at 11:30am. Therefore we anticipate that will be our first negotiating session.

In an effort to schedule additional sessions on dates you indicated you were available this is to offer additional negotiating dates as follows:

April 12, 2011at 4:30pm
April 14, 2011at 11:30am.

From: Linda Vannoni
Sent: Thursday, March 03, 2011 10:47 AM
To: Patrick J. McHale
Cc: nness@seiu1199ne.org
Subject: RE: Oak Hill Contract Negotiations- Union offer of dates

Pat:

I am writing to confirm negotiations dates for the successor contract at Oak Hill:

3/23/11 at 11:30 am
4/12/11 at 5:30pm

Both at NEAT Market place.

These dates are acceptable.

Linda Vannoni
Vice President
District 1199 NE/SEIU
(860)–549–1199

Please confirm that these two additional dates are acceptable to the Union.

Thus, the first negotiation session took place on March 23. Vannoni testified that she was bargaining for a large number of contracts during the same period with many employers. Indeed, some of these employers, such as HARC, Connecticut Southpoint, and Connecticut Greenwich are employers, who are also represented by McHale. Therefore, although she offered 16 dates to Respondent in her initial letter, she also offered them to the other employers with whom she is bargaining. Indeed, her letter to Respondent so states.

Thus, by February 16, when she "confirmed" two dates out of the nine that McHale had proposed, the other dates that she

had initially proposed had been filled by other employers. There was also apparently some confusion about March 15. Both Parties had agreed to that date, but the time became a problem. The Union initially had proposed 10 a.m. to 8 p.m. for that date as the time. McHale responded that on March 15, Respondent could meet at 1 pm and then in another email notified Vannoni in response to her requests that Respondent could meet at 11:30 a.m. on any day that it agreed to start at 1 p.m., including March 15. Vannoni apparently assumed incorrectly that McHale, from these email exchanges, Respondent could meet on March 15 at 6 p.m. and that is why she "confirmed" that date. She was mistaken in that assumption as McHale had only agreed to meet on March 15 at 1 or 1:30 p.m. and not at 6 p.m. as Vannoni proposed.

The March 23 negotiation session took place as scheduled. McHale and Vannoni were the primary negotiators on behalf of Respondent and the Union. Respondent's negotiating team included Wintjen and Shears, who were also present and participated in the sessions. The Union also had various employee members of its bargaining committee present, who also contributed to the discussions.

Vannoni, on behalf of the Union, presented and explained the Union's proposal for a successor agreement. The proposals included 60 cents per hour wage increases on all rates and minimums each year of the contract, some changes in seniority, increases in full-time positions, plus a number of changes relating to Respondent's medical plans, primarily related to employees' eligibility for medical coverage. The Union proposed that employees, who work 20 hours on average a week in a 3-month period, shall be eligible for part-time medical insurance for the following month and that employees, who work 35 hours on average in a 3-month period, shall be eligible for full-time insurance for the following month. The expiring contract provided that employees scheduled for 20 hours for part-time insurance and those scheduled for 35 hours were eligible for full-time insurance.

However, at Respondent, the practice was that a number of employees would be scheduled for less than 20 or 35 hours a week but would, in fact, work these hours. Thus, the Union was interested in making more employees eligible for health insurance benefits and proposed this exchange in eligibility. This problem, according to Vannoni, became exacerbated when Respondent reduced scheduled hours for a number of employees, resulting in some cases, in reductions in medical insurance eligibility. As noted above, this resulted in the Union's arbitration demand, discussed above, where the Union felt that these reductions were in retaliation for the Union having to agree to its proposals to change medical coverage in the 2009 midterm negotiations. The arbitration was still ongoing at the time the negotiations started in March 2011, and the Union explained that it was seeking to make up for these cuts as well as to increase employee eligibility for insurance. A number of employee members of the Union's committee spoke up about this issue and what they perceived as the unfairness of their treatment by Respondent and how the cuts had adversely affected the employees' medical coverage and how unfair it was that employees not be eligible for medical coverage based on hours worked rather than the current system based on scheduled hours.

Vannoni explained that in her opinion that the Union had previously agreed to permit Respondent to make modifications in employee work schedules, but that Respondent had abused that when they cut hours for cost savings, which resulted in loss of medical benefit of eligible positions.

The Union also proposed that all who work over 20 hours a week be eligible for insurance, which would encompass per diem or casual employees, who were not eligible for any insurance, even though a number of them would actually work more than 20 hours a week.

Respondent had no questions about any of the Union's proposals and made no comment about the proposals.

Instead, McHale made a long "opening statement," in which he stated that Respondent appreciated the hard work that the employees perform and that their work is greatly valued by Respondent. However, McHale observed that the State of Connecticut is bankrupt and Respondent cannot expect any additional funding, which it has not received for the past 3 years. Thus, while Respondent was about to make proposals that employees would view as extremely concessionary, they were necessary and were not reflective of the fact that Respondent was not appreciative of their work. Indeed, they were reflective of the fact that Respondent had been experiencing operational deficits that would be expected to continue unless Respondent could get a handle on costs. He also noted that 78 percent of Respondent's costs are personnel related and that Respondent had lost between $3.5 and $6 million a year over the 3 years of the past contract and hasn't received any more funding.

McHale passes out a copy of Respondent's proposals for a new contract and explained each of them in some detail. With regard to wages, McHale emphasized again that there was no increases in funding from the state to be likely, so no increases can be offered. However, if Respondent receives increases in funding from the legislature, it would pass through the increases in wages, less 1 percent. Respondent also proposed, as it had in 2009, freezing longevity pay, eliminating shift differentials and creating a new wage structure for employees hired after March 31, 2011. Respondent also proposed deletion of current contract language requiring Respondent to negotiate the effects of subcontracting work and the requirement that if there is an impasse in negotiations, Respondent can implement such subcontracting only if affected employees be offered continued employment with Respondent or the contractor.

Article 17, Insurance and Pension received considerable discussion by McHale. He emphasized that Respondent was facing substantial increases in medical costs and added that he represented a number of unionized agencies, including HARC in Hartford, whose employees were envious of the medical benefits provided by Respondent.

In order to meet these substantial increases in costs, McHale stated that it would be necessary to propose several changes to the current medical benefits provisions. He proposed changing the current contract language, requiring that any changes in the current plan must be to a plan providing "equivalent" benefits to "comparable" coverage. Additionally, Respondent proposed

that if premium costs for Core medical insurance increased by more than 10 percent, effective July 1, 2012, Respondent can implement a different medical plan without regard to whether such plan is comparable to the one in effect, provided that Respondent agrees to provide employees with the same insurance plan terms as it offers to nonunion employees.

Respondent proposed four options for employees for medical coverage. The first option was the Core HMO plan, wherein employees would still pay the same current monthly premium rates of $40–$80 but with higher copays on doctor's visits, prescription drugs and other services. The second option was a buy-up HMO plan, where the employees would continue to maintain the same copays as the current plan, but employees would pay 100 percent of the increased cost in their monthly premiums. Option three was the existing POS plan, with an increase in premium costs to employees as compared to the Core plan. The final option was HDHP plan at the current rates but with a reduction in Respondent's contributions to the deductible from 75 to 67 percent.

McHale also stated that health insurance changes need to be negotiated and agreed to by July 1 and that Respondent was facing premium rate increases of 19 percent. He added that Respondent was still negotiating with carriers and did not have final cost number of premium increases.

The parties then confirmed that the next meeting, previously agreed to, was for April 12 at 5:30 p.m. Respondent proposed six additional dates for negotiations, two in April and four in May, and Vannoni stated that she would advise McHale of the dates that fit into her schedule.

Respondent did not supply the Union with information that it had previously requested at this meeting nor did the Union renew its request for the documents at the meeting.

Respondent introduced evidence and testimony from James Jones, Respondent's vice president of finance and administration, describing its financial condition and its reasons for making the proposals that it made, particularly concerning health coverage. The primary source of Respondent's income is funding from the State of Connecticut. Since 2008, the State had provided "level" funding (no increase or decrease) to Respondent and other similar not-for-profit providers. In addition to State funding, Respondent receives some funding from Federal grants, Medicaid money administrated by the State, income from tuition from its school programs and fee-based services. Respondent also annually received $1.2 to $1.3 million trusts and from $700,000 to $800,000 annually in donation and grants.

Respondent maintains a large endowment fund, which consists primarily of bequeathed gifts from families of disabled clients serviced by Respondent. The fund is overseen by Respondent's board of directors, which consists of Johnson, Wintjen, Jones, and three other board members. An investment committee advises the board on investments, which is currently weighted at 60 percent in equities and 30 percent in fixed investments. Based on advice from the investment fund, the Board utilizes a policy that established that 4.625 percent of preceding 12 quarters endowment market value can be used by Respondent to cover operations and deficits. Jones conceded that this policy is not mandated and can be changed by the board. However, according to Jones, the board believed, based on the investment fund's advice, that it would be "imprudent" to deviate from that percentage and the board has never done so and has followed that policy.

Thus, according to Jones, following this policy, the fund has distributed $3.6 to $3.8 million to Respondent which it then applies to cover operations. In this fiscal year 2010, covering July 1, 2009, to June 30, 2010, the fund held $90 million in liquid assets. That year the assets were $75 million due primarily to fluctuations in investment value. In 2007, the funding value was close to $94.6 million but as a result of financial reversals had been reduced to $69 million and then, as noted, had rebounded close to its $94.6 million high. Therefore, based on the formula, Respondent has been using to obtain disbursements from the fund, the amounts received by Respondent from the fund has increased each year since 2007.

Jones testified, and Respondent's records confirm, that for the fiscal years 2008 through 2011, Respondent experienced operational deficits of $7.3, $6.6, $4, and $5 million, respectively. These deficits resulted from increasing expenses, primarily escalating costs of medical insurance, in the absence of revenue increases. In 2008 and 2009, Respondent reduced operational deficits by eliminating and consolidating programs and eliminating from nonunit positions.

In 2010, Respondent reduced its deficit from $6.6 million to $4 million by, in part, making staffing and scheduling changes.

As noted above, these scheduling changes and reductions in hours resulted in the Union's grievance, which was sent to arbitration. As related above, the Union asserted at the arbitration that the cuts were in retaliation for the Union not agreeing to Respondent's proposals to change medical coverage due to increased premiums costs. The arbitrator ultimately did not agree with the Union's position that Respondent violated the contract by making the scheduling changes, finding that it was permissible due to financial issues caused at least in part by the increased in medical costs that Respondent had to absorb in 2009.

In the fiscal year 2011, Respondent's deficit increased by $1 million again due to the increase in medical costs, which went into effect on July 1, 2010. Respondent again absorbed these increases and did not propose the modifications in medical plans as it did in 2009 but did agree with the Union to offer the HDHP plan to unit employees. The hope was apparently that a number of employees would opt for this plan, which could result in savings for Respondent. In fact, very few unit employees chose to switch to this plan, even with the incentive of Respondent agreeing to fund 75 percent of their deductible.

In early March 2011, Respondent received information from its insurance broker as part of its normal progress of budget preparations concerning proposed medical costs for the period starting July 1, 2011. The broker reviewed marketing plans from five different insurance companies for coverage. His report, sent to Respondent on March 1, showed that Respondent faced increases of 18–19 percent in costs for the plans, with an 18.3-percent increase for Oxford, the incumbent carrier.

Jones then prepared Respondent's budget projections for the fiscal year, which incorporated the anticipated 18-percent in-

crease in healthcare costs.[7] This document also projected an operational deficit of $6.6 million for fiscal year 2012, an increase of $2 million over the $4.5 million deficit then begin projected for fiscal year 2011.

Jones shared this information with the members of Respondent's negotiating team in preparation for the pending negotiations. Meanwhile, Jones was continuing to negotiate with the broker and the insurance companies to attempt to see what changes the plan's design, premium contributions and/or copayments in order to reduce the substantial increase in insurance costs that was being project.

While, as noted above, the evidence disclosed that Respondent did have the option of increasing the contributions from its endowment fund in order to be reducing these operating deficits, it did not do so. According to Jones, that option was never even discussed or considered by the board since it traditionally follows its investment advisors' advice that it would be "imprudent" to increase the percentage of money from the endowment fund.

It was in that context that Respondent formulated its bargaining position and concluded that it would push for the changes in medical coverage that it proposed in order to help cover the substantial increases in their medical costs, starting July 1.

In this connection, Jones testified that the costs of medical coverage in Respondent's budget covers both unit and nonunit employees, who are both covered by these medical plans with identical costs to employees. Approximately 60 percent of Respondent's employees are in the bargaining unit. Thus 60 percent of the increased cost in medical coverage was attributable to unit employees.

According to Jones, there was no discussion among Respondent's team of separating unit and nonunit employees in terms of medical coverage since Respondent had always included both unit and nonunit employees, including management, under the same medical plan and preferred to continue that practice.[8]

The General Counsel adduced evidence, which it asserts demonstrates a different financial picture than described by Respondent's witnesses. Thus, Respondent's tax return, known as 990s,[9] show that in fiscal year 2011 (July 1, 2010, through June 30, 2011) Respondent had revenues of $86.2 million and expenses of $77.1 million, and in fiscal year 2010 (the prior year), it had revenues of $77.3 million and expenses of $76.1 million.

Additionally, Respondent's financial records revealed that its cash position increased each year from fiscal year 2007 through fiscal year 2011. Its cash position doubled during that period from $6.2 million in 2007 in excess of $13.5 million. Additionally, between fiscal years 2009 and 2011, the value of Respondent's endowment fund grew from $69 to $90 million, which increased Respondent's disbursement from the fund during each passing quarter. Further during the same period, Respondent's assets grew from $136 to $171 million and unrestricted endowment funds grew from $20 to $69 million. Respondent also maintains a $4 million line of credit that can be used to deal with emergent financial circumstances.

Finally, Respondent's financial statements and Jones's testimony reveal that a significant portion of the operational deficits cited by Respondent results from accounting principles that allows for the inclusion of items, such as depreciation and amortization into the operating expense category, but for which Respondent does not sustain any out-of-pocket expenditures during the fiscal year. In fiscal year 2011, Respondent's operating expenses included depreciation on $7.8 million worth of property, including 36 homes, which were donated at no cost to Respondent in 2011.[10]

By the close of the March 23 negotiation session, the parties had agreed on April 12 for an additional date. However, McHale, at the time, furnished the Union with six additional dates and asked Vannoni to let him know which of the additional dates would be agreeable to the Union. As of April 7, she had not responded. McHale then sent Vannoni the following email:

> From: Patrick J. McHale <pmchale@kemlaw.com >
> Sent: Thursday, April 07, 2011 5:31PM
> To: Linda Vannoni
> Cc: Gayle Wintjen
> Subject: Request for Additional Negotiating Dates for Oak Hill Negotiations
>
> Linda:
>
> I am writing to request that you provide me with additional dates for future negotiations.
>
> When we met on March 23, 2011 in our first and only session to date we provided you with eight additional dates for negotiations. We offered 4/12 at 5:30pm, 4/25 during the day, 4/27 during the day, 5/3 day or evening, May 4 day or evening, 5/5 day or evening, 5/9 in the morning and 5/12 in the morning. You promised to check your calendar a [sic] get back to us. The only additional date you have agreed to meet is April 12, 2011 beginning at 5:30pm.
>
> As we discussed on March 23, Oak Hill has made numerous, significant proposals which we feel we need to make to the contract which expired on March 31, 2011 to be competitive. We also have a closely approaching deadline related to our medical insurance plan renewal. Our current plan expires on June 30, 2011 and we expect that maintaining the current plan offerings will require a premium cost increase of just under 20%. Such an annual increase is enormous and unsustainable in the present environment. Since Oak Hill has made it clear that it does not intend to spend more in the future than it is spending presently for medical insurance benefits, together we are going to need to find a way to obtain future benefits in

[7] An anticipated raise from $7.9 to $9.3 million in healthcare costs from the prior year.

[8] I do note, though, that in 2009, when it first implemented the HDHP plan, it did so only for nonunit employees since the Union had not agreed by the July 1, 2009 deadline to offer bargaining unit employees this option.

[9] Because it is a not-for-profit entity, it does not pay income taxes.

[10] Respondent had made lease payments to an entity called Corporation for Independent Living for these payments until fiscal year 2011, at which time, Respondent took ownership of the properties.

> a way that avoids premium increases or in the alternative employees are going to end up paying more to keep the benefits they currently enjoy. For its part the Union has proposed no alternatives to the present medical insurance offerings and, in fact, has proposed to make Oak Hill's financial burden for medical insurance even more severe by extending benefits to employees who have never been eligible in the past.
>
> For these reasons we urge you to provide us with additional dates and times when the Union will be available for negotiations as soon as possible so that we set aside an appropriate amount of time to engage in collective bargaining about these important matters.
>
> I hope to hear from you soon.

The parties met on April 12, as scheduled. McHale began the meeting by repeating comments that he had made at the prior session about how Respondent believes that its work force is great and treats its workers with respect. However, costs are increasing, revenues are not, and Respondent needs to find ways to reduce costs with the least impact on the employees.

Vannoni responded that the work force had already undergone cuts in the past and that Respondent has sat on resources, including the endowment fund, and uses money on technology, GPSs, etc., rather than medical benefits. She added that there has been 4 years of Respondent making expenditures at the expense of the work force.

The Union submitted four new written proposals dealing with disciplinary action, vacations, unpaid leaves of absence, and substitutes. The latter proposal dealt with medical insurance in that it proposed to expand medical coverage to substitute employees, who work (as opposed to scheduled) 20 hours or more weekly.

The parties then discussed the Union's proposals and some of the bargaining committee expressed their views as to why these proposals were necessary.

Vannoni asked McHale for a response to the Union's proposals from the first meeting. McHale addressed the Union's demand for wage increases by stating that Respondent cannot increase wages, without increases in revenues and would honor pass through language in its proposals. Vannoni replied that Respondent spent money on other things that it would have spent on wages, including policing employees.

McHale asked the Union about costs of its medical proposal to base medical coverage eligibility on hours worked and added that this would be hard to administer. Vannoni replied that she did not know costs but would supply such information to Respondent.

McHale stated that medical insurance would increase by 18 percent and that Respondent can't afford an 18-percent increase. He added that Respondent had instructed its insurance broker to come with plans without any increases in costs to Respondent. Vannoni responded that any agreement on medical plans has to be mindful of not increasing employees' costs. McHale replied to that comment that employees at other agencies want what Respondent offers to its employees and that he represented employers at other agencies that negotiated with the Union and that they pay more and more than what Respondent's employees pay.

McHale then distributed a two-page document that compared the financial difference between the existing plans and Respondent's proposed new plans. The document is set forth in Appendix A.

The parties discussed and reviewed these documents. Vannoni had several questions about the plans and the benefits, and McHale answered them. McHale stated that the new plans are the same with the same providers and same benefits but different copays or premiums. He stated that the network of doctors and the same level of medical costs and services that were in place for the prior years would be available under the new plan.

Vannoni responded that the Union was appreciative of the fact that the benefits are the same, but the Union would need something in writing to confirm McHale's assertions. Vannoni stated that the Union was appreciative of that but that it needed greater detail from Respondent. Vannoni asked for copies in writing on the summary plan descriptions or some other plan document that describes a greater list of specific benefits and costs than what was contained in the documents presented by Respondent to the Union. McHale replied that it would not be a problem, "We'll get you whatever you need."

Respondent had modified its proposal regarding the "Core HMO" plan in response to concerns raised by the Union at the prior session over the substantial raise from $15 to $35 in copays for doctor's visits, plus new $75 copay for each high diagnostic test, such as an MRI. In between the two sessions, Respondent contacted its broker to see if it could find some way to reduce these payments in response to the concerns expressed by employees and the Union. The broker, consulting with the insurance company, informed Respondent that it would reduce the copay from $35 to $30 and eliminate high diagnostic test copay if the plan reduced payments for durable medical equipment from 100–50 percent of the costs. Therefore, Respondent's proposal on April 12, in the form of the documents discussed above, incorporated these changes and reduced the copayments from $35 to $30 and eliminated the high diagnostic costs while adding the reduction in payments for durable medical equipment.

McHale explained to the Union that Respondent cannot afford an 18-percent increase and that it had instructed its broker to send them proposals for plans without an increase in costs to Respondent. These plans were what the broker had come up with and that met Respondent's determination not to pay any more than Respondent was currently paying.

McHale added that issues regarding medical benefits need to be addressed before the deadline related to the health plan renewal as its current plans "expire on June 30th."

Vannoni responded that Respondent take all proposed cuts in economic terms off the table in order to get an agreement. She added that the Union would not change the contract language requiring the maintenance of "equivalent" coverage over the course of the contracts and that Respondent should absorb any increases in medical costs by, if necessary, using its endowment fund.

McHale stated that the change in the equivalency language proposed by Respondent is the same proposal the Union has agreed to with other agencies and adds that if the Union had alternative proposal on language, Respondent would be happy to listen. McHale explained that Respondent needed this change in language because each year there can be and usually are increases in costs in a multiyear contract. Vannoni responded once again that Respondent should absorb any cost increases, if necessary, by tapping into the endowment.

The parties then briefly discussed the Union's request to increase the number of full-time positions, and McHale said that Respondent cannot agree to that proposal.

After a caucus, the parties discussed a number of language proposals made by Respondent, and the Union had agreed to several of them.

The parties then discussed additional dates for negotiations. McHale proposed April 27 and May 3. The Union agreed to both dates and left the issue of where to meet for subsequent discussion.

Vannoni emailed McHale on April 14, stating that negotiations in Hamden, Connecticut, at the Construction Engineers Union Hall, which would be at no cost to Respondent, and the parties would meet at 11 a.m. at that location and on May 3 at the Neat Market Place.

The parties met in Hamden on April 27 as scheduled. Vannoni began the session by asking Respondent to prioritize its proposals. McHale replied that all of its proposals are important but the medical plan proposal is time-sensitive, and Respondent needed a response on its medical plan proposals. The parties then reviewed the Respondent's medical proposals, and McHale explained that Respondent had tried to find a plan that would allow unit employees to continue paying $40 and $80 per month, even with the 18-percent increase. McHale explained the increased costs to employees in premiums if they elected to continue $40 and $80 copays. He emphasized that the plans had the same medical networks of doctors and would go through the same carrier.

Vannoni then asked some questions about specific issues, such as what is the definition of durable medical equipment (DME), what is on the list of DMEs on these plans. She also asked about other items in the plans that were not specific in the documents presented by Respondent, such as occupational therapy, physical therapy, speech therapy, and prescription drug tiers. McHale was unable to provide answers to these questions. Vannoni stated that the Union needed a greater level of specificity with regard to plan details. Vannoni testified that the Union had still not received information from Respondent that it requested in its December 10 written request and her oral request at the prior meeting for the summary plan descriptions on the incumbent plans and had several questions about the details of the new plans being proposed by Respondent. The Union, therefore, submitted a written information request, dated April 27, 2011, which reads as follows:

> April 27, 2011
>
> Donna Shears, Human Resources
> Oak Hill
> 120 Holcomb Street
> Hartford, CT 06112
> Fax (860)–769-6562
>
> Dear Ms. Shears–
>
> The Union is submitting this *second request* for the following information in electronic format, where available. The information provided will be used by the Union to continue to advocate at the Capitol for increased funding that could lead to more affordable health insurance for our members as well as allow us to make informed proposals at the bargaining table. We appreciate your cooperation with us in this very important endeavor.
>
> 1. A current list of employees in the bargaining unit(s) represented by District 1199 at your facility that includes the following:
>
> - Wage rate
> - Regularly scheduled hours per week
> - What type of health insurance plan/ plans they are enrolled in and their level of coverage- ex. employee only, plus one, family.
> - Cost to employee for these insurance plans
> - Cost to employer for these insurance plans
>
> 2. For each of the insurance plans offered to unit employees (medical, life, short term disability, etc.), please provide us with a summary plan description.
>
> 3. A list of all insurance benefit plans offered that includes the number of employees eligible, the number of employees participating in each and the number of hours needed to qualify for each insurance benefit. Please indicate where there is a difference in cost to an employee based upon their status as full or part time, and what that cost difference is, if any
>
> Example- Dental insurance: 75 employees eligible; 43 employees participate; 25 are full time; 18 are part time; 12 have individual coverage at this cost.

I noted that this document refers to a "second" request. Respondent's representatives seemed surprised by the Union's assertion that it had made a previous request for some of these items. Indeed, Wintjen testified that she was not aware of the fact that the Union had made a request in December for the SPDs of the incumbent plans since the December 2010 request had not been addressed to her and she was not copied on it. As noted above, the request had been forwarded by Johnson to Shears, who had forwarded it to Bolton, her subordinate, and Shears assumed that it had been complied with, but Bolton retired before completing this assignment.

McHale responded to Vannoni's request by stating that he was unfamiliar with what a summary plan description was, but

if one existed, Respondent would forward it to the Union. McHale testified that he personally had never seen a document entitled "summary plan description" before.

Vannoni then asked how many of Respondent's employees were enrolled in each of the three current plans. Shears provided the answers, which reveal that 241 employees were enrolled in the single HMO plan, 168 family HMO, 4 employees single HDHP, 6 on family HDHP, and that 137 unit employees elected no coverage.

McHale stated that the POS plan offered is the same as in the past but no unit employees selected that plan.

McHale then explained that to the extent that the Union had questions about any of these plans, Respondent had a broker, Peter Wertsching, who would be willing to attend negotiations to provide such information. He asked Vannoni to let Respondent know, and Respondent would make Wertsching available.

Vannoni replied, according to McHale, that "she didn't like to meet with brokers." Vannoni denied making that comment but conceded that she replied that she was more accustomed to bargaining with the chief negotiator and that she doesn't bargain with insurance agents. However, Vannoni stated that she added McHale "can bring whoever you want. I can't tell you who to bring. You can't tell me who to bring."

The parties then talked about the HDHP plan, which the parties referred to the HSA plan since that is the funding mechanism for the plan. Vannoni explained that the employees still have reservations about the high deductible plan and wanted Respondent to fund 100 percent of the deductible up front.

McHale explained why Respondent could not agree to that proposal.

Vannoni then requested that Respondent obtain quotes from its broker for a plan with different copays, increased coverage of DMEs, or changes in hospitalization deductibles that might increase premiums for employees but might result in less of an increase than currently proposed. For example, Vannoni suggested rather than having copays increase from $15 to $30 that the increase could be up to $20–$25.[11]

The discussion then turned to other issues, such as the "equivalency" language that Respondent sought to change. Again, McHale explained that Respondent wasn't asking for anything that had not been agreed to by other agencies and the Union and reminded Vannoni that Vannoni herself had been the negotiator for the Union at these agencies, where similar language was agreed upon.

Vannoni replied that Respondent had been able to maintain equivalent coverage for employees in the past and that the Union expected it to continue to do so. McHale stated that 2011 is different from prior years, no one can predict increased costs, Respondent has not received new funding and it cannot continue to pay for all increases.

After a caucus, the parties discussed several of the Union's proposals, including increases in full-time positions and leaves of absence.

At the close of the meeting, Vannoni asked what Respondent's priorities were in reaching agreement. McHale replied that all proposals were important but detailed the priorities for Respondent. They included a new wage scale for new hires, eliminating shift differential, freezing longevity, and most importantly, due to the time-sensitive nature of the issue, healthcare.

In that regard, McHale stated that Respondent needed to enroll employees in the near future in order to assure continued coverage. He added that Respondent had responded to all of the union proposals.

Vannoni replied as follows: "It is hard to reach agreement while massive concessions are on the table." She added that the Union is willing to reach agreement but not with step wage cuts on the table and that the parties need to "jump over these hurdles before we get to July 1." Vannoni then observed that if "no agreement is reached by July 1, Oak Hill pays the full 18% increase. The Union will not pay any more."

The meeting ended with an agreement to meet again on May 3 at the Neat Center at Respondent's facility. The same parties were present in addition to Kevin Creane, attorney for the Union.

McHale provided the Union with information that it had requested at the April 27 session, concerning a quote for a modified Core HMO plan with lower copayments than what Respondent had previously offered and for a modified HDHP plan, which would substitute HRA for the HSA as a funding mechanism. He presented Vannoni with documents, detailing this information, and they were discussed. The modified "Core HMO" plan would have amounted to increase in premiums for employees of $48.85 for individuals and $141.85 for family, which would be an approximate 6-percent increase (as opposed to 18 percent in Respondent's plan). However, in order to pay these premiums, there would be increases for employees in copays for doctors, hospitals, and surgery. While McHale submitted this information to the Union concerning the costs of this modified Core plan, which, as noted above, became known as the "Hamden Plan," it did not offer it to the Union as an alternative at that meeting. Nor did the Union offer it as an alternative health insurance proposal after receiving the information concerning its costs as the Union had requested at the previous meeting.

McHale then discussed the HDHP/HRA plan and indicated that this plan was not a viable alternative because it did not reduce utilization costs, plus there would be higher administrative costs for the HRA plan that the Union suggested might be an alternative.

After a discussion of available dates for the next meeting, both sides agreed to meet on May 25 and again on June 20. Other dates were also discussed, such as June 8, 9, 17, and 21, which were not agreed to, and Vannoni stated that she would confirm with McHale the next day if any of these other June dates were acceptable.

The Union presented two sets of documents to Respondent. They were a response to each of Respondent's proposals and some additional proposals from the Union. In its response to Respondent's proposal on medical coverage, the Union's document stated that it wished to retain the current "equivalency"

[11] Subsequently, as will be discussed more fully below, Respondent did obtain a quote on a plan as suggested by the Union. This became known as "Hamden Plan" since it had been suggested by the Union at the Hamden meeting.

language and the Union was "considering proposal of employees of new medical plan." Some of the Union's proposals and its responses to Respondent's proposals were discussed, including short-term versus long-term disability, snow dates and changes in domestic partnership in the contract.

Respondent did not supply the Union with the SPDs that it had twice requested for the current plans or that it had requested orally at the previous meeting for the plans proposed by Respondent.

On May 6, Respondent's insurance broker wrote to McHale and stated as follows:

May 6, 2011

Mr. Patrick McHale
Attorney at Law
Kainen Escalera and McHale, PC
21 Oak Street, Suite 601
Hartford, CT 06106

RE: OAK HILL MEDICAL PLANS

Dear Pat:

I am writing this letter in response to a question on the enrollment timing for the Oak Hill medical plans for July 1, 2011. Oak Hill is not proposing changing medical insurance carriers but employees will have the ability to change plan options.

Oxford Health Plans has indicated they would need enrollment forms (for employees changing plan options or adding/deleting dependents) to be in their office by June 8, 2011. With this lead time they feel they would have new ID cards in the hands of any employees making changes therefore avoiding any dis-ruption/inaccuracies in service.

Please let me know if you need further information.

Sincerely,

Peter J. Wertsching
Senior Vice President

On May 11, McHale wrote to Vannoni the following correspondence:

May 11, 2011

VIA EMAIL AND FACSIMILE

Ms. Linda Vannoni
Vice President
NEHCEU District 1199, SEIU
77 Huyshope Avenue
Hartford, CT 06106

Re: *Oak Hill Negotiations*

Dear Ms. Vannoni:

As you know, representatives of Oak Hill and District 1199 have met on four (4) separate occasions to date in negotiations for a contract to succeed the one that expired on March 31, 2011. More specifically, the parties met in negotiations on March 23rd, April 12th, April 27th and most recently on May 3rd. When we concluded our negotiating session on May 3rd, the parties agreed to meet again on May *25,* 2011, since the Union did not have any other dates to offer in May. We also discussed the possibility of meeting on June 8th and June 20th. You said you would check your availability and let us know, but as yet we have not heard from you.

During each of our negotiating sessions beginning with the very first one, as well as in periodic email communications with you, Oak Hill has emphasized that the premium cost for the Core HMO medical insurance benefits currently in effect for bargaining unit employees will increase by approximately eighteen percent (18%) effective upon renewal (July 1, 2011). As we have communicated to District 1199, Oak Hill is not in a position to pay any more towards the cost of medical insurance premiums for its employees than it is paying presently. This means, of course, that we will need to find one or more alternative insurance plans that cost no more than our current insurance plan or our employees are going to need to pay more than they pay presently ($40 per month for single coverage and $80 per month for employee plus dependent coverage) to keep their current insurance plan benefits in force following June 30th. More specifically, in order to continue to receive benefits under the current Core HMO plan following June 30, 2011*,* employees who elect employee only coverage would need to pay an additional $111.13 per month. Those who elect employee plus dependent coverage would pay an additional $322.26 per month. As you are aware, this information has already been shared with District 1199 during our negotiations to date.

So that employees may avoid such increased costs, Oak Hill asked its insurance broker ("Willis") to price out alternative medical insurance plan designs, which would cost no more than the current Core HMO plan, while still offering competitive coverage. In our negotiations to date we have proposed and provided the Union with information regarding an alternative Core HMO Plan. Under Oak Hill's proposal, during at least the first year of the successor contract, employees would contribute the same amounts that they are paying today towards the premium costs of this plan. However, as we have discussed at great length in negotiations, employee co-pays would increase for primary care and specialist visits as well as emergency room and urgent care visits, hospitalization stays and outpatient surgeries and prescriptions as compared with the current Core HMO benefit terms. We have also offered other plan options which employees may elect provided they agree to pay the difference in cost between the proposed Core HMO Plan and the option elected, if any.

During the course of our negotiations we have offered to bring Oak Hill's insurance broker to our negotiations but the Union has declined all such invitations. If the Union would like us to bring our insurance broker to our next negotiating session, scheduled for May 25th to answer any questions you or any of your members may have about our proposal, please let us know and we will make sure that

our broker is available at that time, or any other time that is mutually convenient. We are quite concerned that despite the dramatic increases resulting from our current insurance renewal costs, at no time in negotiations has the Union responded to any of our proposals regarding medical insurance. Similarly, at no time has the Union offered any proposals of its own to mitigate the eighteen percent (18%) increase in medical insurance premiums which will take effect on July 1, 2011 for the current Core HMO Plan offering.

Recently, we were notified by our insurance broker that our insurance carrier, Oxford Health Plans, has indicated that they need us to provide them with insurance enrollments (for employees changing plan options and/or adding/deleting dependents) by no later than June 17, 2011 to ensure continuation of coverage following June 30th. Based on this information we will need to make some decisions very soon regarding the benefit plans that will be offered to Oak Hill employees beginning July 1, 2011 so employees will know the benefit options (and costs) from which they may choose at the time of enrollment.

Please let me know if the Union has any alternative proposals for dealing with the eighteen percent (18%) premium cost increase that will take effect on the current Core HMO Plan effective July 1, 2011 or if you have any other proposals to address this serious issue related to medical insurance cost increases in these negotiations. Also please let us know whether the Union would be available for negotiations on the other two dates we discussed when we last met (June 8, 2011 at 5:30 p.m. and June 20, 2011 at 5:30p.m.) or if the Union has any other availability for negotiations so we can plan accordingly.

Sincerely,

Patrick J. McHale

Cc: Ms. Gayle Wintjen

Vannoni responded by email on May 12 that she was available to meet on June 1 in the evening or June 8 either morning or evening. McHale replied by email a few minutes later stating that Respondent could be available on June 1 at 5:30 p.m. and on June 8 from 8 a.m. to noon.

Vannoni responded back that 5:30 p.m. on June 1 was fine, but she was uncertain about the morning of June 8 due to the possible unavailability of members of the negotiating committee. She stated that she would discuss with Wintjen possible issues of release of day-shift workers and get back to McHale with regard to June 8 in the morning as had been discussed.

Subsequently, emails between McHale and Vannoni dealt with the issue of the venue for the upcoming agreed-upon May 25 meeting since the Neat Market Place (previously agreed upon) became unavailable. The parties finally agreed to hold the meeting at the Lion's Den in Hartford.

On May 20, McHale sent to the Union some information that it had requested. His letter states that "I have enclosed all of the information that is responsive to your recent request for information pertaining to our ongoing collective-bargaining negotiations." Wintjen had sent McHale on May 12 a document entitled, "Response to Union's request for information," which McHale, in turn, forwarded to Vannoni. Wintjen's letter to McHale was a two-page summary of what was submitted as well as what proposals or issues that these documents referenced. These documents reveal that although Respondent submitted to the Union a significant number of documents responsive to the Union's request at that time, including 990 forms for 4 years, union leave data and annual reports, it did not provide the Union with the SPDs for the current plans (that the Union requested twice in writing) or the SPDs for the proposed plans that the Union had requested orally. McHale made no reference to these issues in his response to Vannoni. As noted, he stated that he enclosed *all* (emphasis added) of the information that is responsive to your recent request for information.

I note that in Wintjen's letter to McHale, which the Union apparently also received along with the accompanying documents, Wintjen stated as follows in reference to Proposal 16 (Medical Insurance), "We have already provided the Union with the information concerning the medical insurance."

Wintjen provided no testimony as to precisely what she meant by her comment that Respondent had "already provided the Union with information concerning medical insurance." She made no reference to SPDs, either with regard to the current or proposed plans. She also did not say that the Union had been provided this information in 2009 when it made an identical request for SPDs for the incumbent plans. It is not clear that is what Wintjen meant or that she had even recalled in 2011 that such information had been supplied in 2009. It may very well be that Wintjen believed that Respondent had supplied the Union with the information request by assuring it that benefits would be the same as in the prior plans but that only premiums or, in some cases, copays would be changed, the amounts of which had been shared with the Union.

Wintjen was asked on direct and on cross-examination about the Union's information requests and Respondent's responses, and she provided some answers although, as reflected above, did not explain what she meant in her letter to McHale that "we have provided the Union with the information concerning the medical insurance."

According to Wintjen, as the record has detailed above, in 2009, the Union requested copies of the SPDs for, at that time, the proposed "new" Oxford plans, which Respondent asserted were equivalent to the plans then in place. Wintjen responded on May 28, 2010, with an email stating, "Here are the SPDs for the new health insurance coverages." The documents that were submitted, though were not entitled SPDs, but instead consisted of detailed summaries of the two plans, presumably prepared by Respondent's broker, which set forth the prices, coverages, deductibles, copays, both plans in various areas, such as mental health, drug/alcohol, preventative care, in-patient and out-patient care and emergency care.

Further, as detailed above, after Vannoni received this information in 2010, she phoned Wintjen and had some additional questions about some issues with regard to the two plans and that Wintjen promptly provided Vannoni with responses. Thus, after receiving that information, Vannoni was satisfied that the two plans were "equivalent," and that the Union did not object to the change to Oxford.

Notably, Wintjen did not testify that she did not know what a SPD was or whether it existed but, in effect, stated that in her view SPDs are the equivalent of summaries of benefits, which is why she herself used the term SPDs when providing the summaries of benefits to the Union in 2010.

Wintjen further testified that she personally never saw or received a copy of the Union's information request, dated December 10, 2010, for the SPDs. Wintjen was vague and uncertain in her testimony as to what she recalled at that time and/or what she said to Shears or McHale about the Union's request for SPDs. Thus, although Wintjen testified that she had sent the Union what she herself "characterized" as SPDs for the current plans in May 2010, she did not recall if she told Shears, McHale or even the Union that Respondent had done so at that time when she became aware on April 27, 2011, that the Union was making a second request for that information. Indeed, Wintjen did not testify (nor was she asked) whether or not on April 27, 2011, she remembered that Respondent had provided the Union with SPDs regarding the current plans in May 2010.

In fact, it appears from her testimony that she did not remember that fact in April 2011 since she was asked by the General Counsel whether she told Shears (the representative of Respondent, who was assigned to respond to the request) that she already had these SPDs or that the Union had already been furnished them by Respondent. Wintjen replied, "I don't believe I did." When asked why not, she answered, "Because I didn't focus on that particular issue. I was looking at the whole thing and I wanted to make sure that we responded to everything." Wintjen later added that she had "no recollection as I sit here today whether or not I reviewed my computer files or previous documents to see whether or not I had previously produced that. I am looking to make sure that we provided all of the information that was being requested."

Further, Wintjen testified that she did not tell either Shears or McHale that Respondent had sent this information to the Union, and when asked if she knew why she didn't tell this to them, Wintjen replied no. From this testimony, I conclude that Wintjen simply did not recall in April 2011 that Respondent had sent SPDs to the Union in 2010 concerning the incumbent plans and this would have been responsive to the two union requests for the SPDs in the current negotiations.

Wintjen was further asked about the Union's request for SPDs for the proposed plans, which had been made orally by Vannoni and which Wintjen did not dispute. She was asked whether or not she had requested Respondent's broker to provide SPDs for these proposed plans. She replied that she had no recollection of doing that, explaining that Respondent didn't "know what plan we were going with at that point." She did recall asking the broker to provide answers to the Union's requests for cost information on alternative plans that Vannoni made at the meeting as well as questions Vannoni had about gym membership and DMEs. In fact, she recalled having conversations with the broker after the April 27 meeting about the Union's information requests but stated that these conversations to be used on the issues Vannoni raised across the table on April 23, i.e., the requests for alternative plan information. Wintjen was specifically asked by the General Counsel whether she had asked the broker during these 2011 conversations to send Respondent SPDs for the 2011 plans. Her response to that question is as follows:

> You know, I don't remember. You know—Look, as I sit here today, I know that I tried to do the best I could to comply with all of the information requests. Now, there's information that I needed to get to Pat. There were also conversations Pat McHale is having with Pete. It may well have been a situation of too any chefs spoiling the soup.
>
> But, what I did was, I—What I tried to do is to get information to Pat that I knew we had in our control, the information that he wouldn't be able to get from Willis. Whether there was some communication snafu that ultimately resulted in a document called and SP—SPD not getting into the union's hand, I'm willing to fall on my sword for that.

Shears, for her part, testified, as noted above, that she received (from Johnson) a copy of the Union's initial written request for the SPDs for the incumbent plans in December 2010 and that she asked Rose Bolton, an employee under her supervision, to respond. She further testified that on or about January 26, 2011, she followed up with Bolton and asked her for a copy of the information requested by the Union in 2010 and that Bolton responded that she had not done it yet. Shears instructed Bolton to get it done as quickly as possible.

This was the last Shears heard about the request until the request was renewed by the Union at the April 27, 2011 meeting. Shears testified that Bolton was retiring at the time and was overwhelmed with work, including training her replacement. Thus, according to Shears, Bolton simply did not get to it before she retired. Shears opined, "I just believe that it slipped through the cracks."

When Shears found out on April 27, 2011, that the Union had not received the documents, she inquired of Bolton's replacement, Jane Jones, to see if the request had been complied with by Respondent. Jones reported to Shears that there was no evidence that this information had been provided. Shears testified that she instructed Jones to respond to the Union's April 27 request and "make sure it gets out as soon as possible."

Further, according to Shears, Jones subsequently provided the information requested to Respondent's attorneys, which she believed was immediately turned over to the Union. Shears was unsure of what particular information Jones provided to Respondent's attorneys and was not certain whether Jones submitted it to Wintjen or to McHale or both.

Shears further testified that she was present at meetings of Respondent's negotiating team between April 27 and sometime in July, in which it was stated that the Union had been supplied with all information it had requested. However, she was uncertain as to specifically what documents were provided or were discussed or whether they included SPDs for either the incumbent or the proposed plans.

Shears was shown copies of documents ultimately submitted by Respondent to the Union in September 2011, which included detailed coverage for the incumbent Oxford plan. These documents were not entitled SPDs but were documents from Oxford, entitled "Your Oxford Coverage." It was further de-

scribed by the insurance company as a certificate of coverage and added that "the summary of benefits is pending approval and is not included in your plan documents at this time." There is no date on these documents nor any testimony as to when Respondent either asked for or received them from its broker or the insurance company. In any event, these particular documents provided detailed coverages, costs, benefits, networks, etc., and are, according to the Union, the information requested by the Union concerning the incumbent plans, which Vannoni referred to as SPDs.

Shears was not certain in her testimony as to when she saw these documents, but she testified that, in her view, they would be the equivalent of SPDs.

Shears also identified another document, which as ultimately submitted by Respondent to the Union on March 21, 2012, as, in her view, an SPD for the plans proposed by Respondent (and ultimately implemented on July 1). These documents were sent to the Union allegedly in response to the Union's request on February 17, 2012, for a "more detailed summaries of the medical plans offered to employees at Oak Hill." These summaries were not documents from the insurance companies nor were they entitled SPDs. Instead, they were summaries of benefits, coverages, payments, copays, deductibles, which detailed these matters for all types of services for all four plans in effect. Although the record is unclear, it appears that these documents were prepared by Respondent's broker in response to the Union's request orally and in writing on February 17, 2010, for this information. I note that in that written request, Vannoni stated, "At many bargaining sessions since before and after September 21, 2011, the Union has asked for more detailed benefit summaries. On February 17th when inquiring about the summaries of coverage provided to date, the Employer confirmed that these summaries were for marketing and to be used by the Employer in employee enrollment meeting but were not a complete summary and that another summary was available . . . . Please provide such detailed summaries of the 4 plans as was stated in our meeting."

When shown these documents, Shears confirmed that, in her view, they were SPDs for the ultimately proposed and implemented plans, but she was unsure when they were prepared or when she saw them. Vannoni, for her part, conceded that the information contained in these documents represented all of the information that the Union was seeking and that it would be contained in SPDs for these plans.

On May 24, Respondent provided some additional information to the Union that it had requested relating to payroll costs for employees, who work various hours per week, as well as annual costs of medical and dental insurance. However, Respondent did not supply to the Union the SPDs for either the current or the proposed plans that the Union had requested The session began with discussion of some of the information provided to the Union by Respondent, including issues of paid administrative leave, extenuating circumstances, and the issue of Respondent's proposal that employees contribute 10 percent to their pensions.

Vannoni then stated that the Union had presented new proposals at the last session but that Respondent had not responded to them.

McHale replied by stating that the deadline for enrollment in the healthcare plan for the new fiscal year is fast approaching and that the current plan expires on June 30. He further explained that Respondent needed to enroll employees prior to that date in order to avoid disruption of coverage and delays in receiving new medical cards. Vannoni replied, "We have been through this. We get it." Vannoni added that the Union understood that Respondent had concerns about the medical costs and the Union was listening to it. However, the Union needs to hear from Respondent on their response to the Union's concerns. McHale again asked if the Union had a counterproposal on medical today, and Vannoni again replied that the Union needs to see movement on everything and a total agreement and asked again for a response from Respondent on the Union's proposal.

Vannoni then suggested that perhaps the parties could resolve some less contentious issues and the parties then talked about the Union's proposals on grievance procedure, workmen's com-pensation, leave, work schedules, bereavement leave, domestic partnership language, snow days, substitute and temporary employees, weekend recertification, and layoff avoidance. Some tentative agreements were reached on some of these issues.

McHale again asked Vannoni if the Union had counterproposals on medical insurance. Vannoni repeated the Union's prior stance. She asked again if Respondent had any prior counters for the Union and continued by stating that the Union had indicated to Respondent that if it pulled or modified their stance on shift differential, wage cuts, and cut to longevity on new hires, the Union could find a way to make movement on the medical insurance. McHale replied that Respondent did not have a response to that and once more asked if the Union had a response on medical. Vannoni replied not at this time.

The parties then caucused. After the caucus, Respondent made counterproposals concerning administrative leave and temporary reassignments. After some discussion of these proposals, Vannoni brought up the issue of snow days, which produced some additional exchanges but no agreement.

McHale then asked once more if the Union had any response on medical insurance and reiterated that medical needs to be decided by June 30. Vannoni replied that the Union had no other proposals to make on medical insurance.

The parties then discussed additional dates for negotiations and agreed on June 1 and 20, plus a tentative agreement to meet on June 8 in an early start if possible. This issue was to be confirmed later that day. Subsequent emails on May 25 confirmed that June 8 in the morning as agreeable to both sides.

Wintjen issued a postsession memorandum entitled "Negotiations Updates\" to unit employees, describing the events on the May 25 meeting. It is set forth below.

TO: All Staff
FR: Gayle Wintjen, General Counsel
RE: Negotiations Update
DA: May 25, 2011

Oak Hill and 1199 met for our fifth negotiating session yesterday morning.

We started the session with the Union asking some clarifying questions regarding documentation we supplied in response to its last request for information. The Union also sought clarification of our pension plan proposal, which is to require employees to contribute 1% of income to the tax deferred annuity plan in order to get the 5% contribution from Oak Hill into the defined contribution plan. We explained that this will assist us administratively. While there was concern expressed that this was akin to "taking money away", in reality it means simply putting the employee's own money into the employee's retirement account. We further explained that employees can make the contributions on a pre-tax basis, which means that the amount of the actual deduction is less than one percent. The Union stated that it would reject the proposal.

Thereafter, we asked the Union if it had any counterproposals with respect to Oak Hill's medical insurance proposals, as we are fast approaching a June 30 deadline, when the plans expire. We explained that we need to be able to enroll employees prior to that date to avoid any disruptions in coverage and inconvenience with employees not having correct insurance cards by July 1. Notwithstanding the deadline, the Union stated that it was not interested in addressing medical insurance until we reached agreement on some contract language proposals.

We then spent some time discussing several proposals regarding the grievance process, administrative leave, temporary reassignments and substitutes. In order to properly respond to some of the issues raised, the parties caucused. We produced two counterproposals to the union regarding administrative leave and temporary reassignments when we returned from the caucus. We again asked the Union if it wanted to discuss medical insurance and it declined to do so. Instead, it wanted to discuss its proposal concerning snow days, which we rejected. We reiterated that the current health insurance plan goes away on June 30 and we want to avoid employees being without coverage. Nevertheless, the Union remained steadfast that it would not address the health insurance proposal.

The parties did agree to another meeting date on June 1st at 5:30 pm. Additional sessions are scheduled for June 8th at 9:00 am and 20th at 5:30 pm. All sessions will be held at NEAT.

The parties met again on June 1 as scheduled. Vannoni began the session by asking what proposals Respondent had for the Union. McHale replied that Respondent had been expecting a counterproposal regarding the medical plan, whose deadline is fast approaching. Vannoni answered that the Union needed to hear back on items that Respondent had rejected. Vannoni repeated that the Union needed resolution on contract language.

McHale then stated that perhaps he had not been clear about the deadline.

Vannoni, perhaps somewhat sarcastically, responded, "Deadline?"

McHale replied as follows:

> Oak Hill is facing a $1.5 million increase in the cost of providing healthcare to its employees. Coming to an agreement on the plan is a high priority. The employer wants to avoid having folks pay more. There is no legal obligation that we resolve the contract issues before health insurance. You have the right to choose, but a plan has to be implemented in order for people to be enrolled and obtain their plan documents in a timely manner.

Vannoni then proposed a series of counterproposals on various issues, which engendered considerable discussion, but no agreements were reached.

Vannoni asked McHale if Respondent had any proposals for the Union to consider. McHale answered that he did not have anything for the Union to review.

Vannoni observed, "How prepared are you really to negotiate today? You claim a big deadline of July 1, 2011, but you haven't brought us anything to caucus on." McHale then replied that there would be an 18 percent increase in July, and Vannoni answered, "We get it. We know. We are here to bargain. Part of that is reaching an agreement on these issues and responding to our proposals. Do you have anything for us to review, to caucus on?" McHale replied that Respondent did not have anything at that moment for the Union to review and caucus on. Vannoni suggested that Respondent caucus and come up with some counterproposals.

McHale agreed, and the parties caucused. During the caucus, the Union interrupted management and asked them what they had come up with so far. The parties then discussed several issues, and Respondent made some counterproposals, including possible agreements on some issues concerning assignments, scheduling, snow days, and minimum pay. After some discussion of these counterproposals, the meeting ended after another brief caucus, and the Union notifying Respondent that they were leaving, and Respondent stating that it would continue its caucus and share the results with the Union by email.

Respondent did not supply the Union with the SPDs for either the current or the proposed plans at this meeting nor did the Union renew its request for these documents at the meeting.

On June 3, Wintjen sent a "Negotiations Update" to unit employees, describing her account of the events of the meeting. This document is set forth below.

TO: All Staff
FR: Gayle Wintjen, General Counsel
RE: Negotiations Update
DA: June 3, 2011

Oak Hill and 1199 met for our sixth negotiating session Wednesday evening.

We opened the session by asking the Union if it had any responses to counterproposals we had made last week regarding temporary reassignments and administrative leave. We also

> asked if the Union had any counterproposals regarding the health insurance proposals we made at our very first bargaining session. The Union reiterated its position that it was unwilling to discuss the health insurance proposal until the parties resolved the various proposals on the table regarding changes to contract language. We acknowledged the Union's position, but reminded the Union that the law does not require that we address the language proposals first. We stated that we believed it was most prudent to address the health insurance proposals because the current health insurance plan expires at the end of the month and we need to make sure employees are enrolled prior to that expiration date. Notwithstanding our desire to discuss health insurance, and to receive a counterproposal from the Union, the Union returned to the topic of changes to contract language.
>
> The Union proposed what it characterized as six "exchange proposals", meaning that the Union was offering to withdraw or modify specified proposals if Oak Hill withdrew or modified other specified proposals. In addition, the Union sought responses from us on its proposals regarding: 1) "inclement weather" (which we had previously rejected); 2) union access and 3) the grievance procedure. We then caucused to discuss all of these items. We had not yet finished preparing our responses to each of the proposals when the Union asked us to return to the table to provide our answers. We explained that we had not completed our work, but we were able to offer a counterproposal regarding temporary reassignments. We also rejected several of the Union's "exchange proposals" that would have required us to keep the very language that we are seeking to change. We explained that we were rejecting those proposals because we need to reduce costs and improve efficiencies, so maintaining the *status quo* is simply not an option.
>
> The Union then asked us to take another caucus to consider the remainder of its proposals. While we were doing so, the Union informed us that it desired to end the session for the evening, so we were unable to provide a complete response to all of the proposals.
>
> We will meet again on Wednesday, June 8 from 9:00 a.m. to noon and on Monday, June 20 at 5:30 pm. Both sessions will be held at NEAT.

On June 7, McHale sent the following letter to the Union, entitled "Oak Hill Negotiations."

> June 7, 2011
>
> VIA EMAIL AND FACSIMILE
>
> Ms. Linda Vannoni
> Vice President
> NEHCEU District 1199, SEIU
> 77 Huyshope Avenue
> Hartford, CT 06106
>
> *Re: Oak Hill Negotiations*
>
> Dear Linda:
>
> When we last met in negotiations on June 1, 2011, Oak Hill's negotiating committee promised to provide the Union with written counterproposals to both our proposals in negotiations as well as those of the Union, where we are prepared to make counters. I have attached those written counterproposals for your review and will be prepared to discuss them when we meet again tomorrow at 9:00a.m. at the NEAT Marketplace at Oak Hill's campus.
>
> Including our most recent negotiating session held on June 1st, we have now held a total of six negotiating sessions to date. During each of our negotiating sessions beginning with the very first one, as well as in period email communications with you, Oak Hill has emphasized that the premium costs for the Core HMO medical insurance benefits currently in effect for the vast majority of bargaining unit employees (and the other plan offerings) will increase by approximately eighteen percent (18%) effective upon renewal (July 1, 2011). This premium increase alone amounts to an additional cost of approximately $1.5 million, or approximately 2.5% of bargaining unit wages, and Oak Hill has informed the Union that it is not in a position to pay any more than it is paying presently for these benefits.
>
> As we advised you through correspondence dated May 11, 2011 our insurance carrier, Oxford Health Plans, has indicated that they need us to provide them with insurance enrollments by no later than June 17, 2011 to ensure continuation of employee coverage following June 30th. Despite our best efforts to get the Union's attention regarding this matter, the Union has been unwilling to bargain over medical insurance to date in our collective bargaining negotiations. At no time has the Union made any proposals to address the eighteen percent (18%) premium increases that will take effect July 1 and in fact has made no specific medical insurance proposals in our negotiations to date.
>
> In the absence of an agreement between the parties prior to the deadline for notifying the insurance carrier of the plan offerings and allowing time for employee enrollments, Oak Hill will have no choice but to offer its employees the new Oak Hill-proposed Core HMO Plan beginning July 1, 2011. Oak Hill will contribute the same amount it is contributing presently for employees who elect to enroll in the new Core HMO Plan and employees shall be responsible for paying the remaining costs. Oak Hill will also offer the current HMO Plan and the POS 15/25 Plan offering as buy-up options with employees who elect benefits under those plans paying the additional costs for such benefits. Finally, Oak Hill will offer the High Deductible Health Plan ("HDHP") with a Health Savings Account, which deductible Oak Hill will fund at the rate of sixty-seven percent (67%) beginning July 1, 2011 as a fourth option from which employees may choose.
>
> Obviously, Oak Hill remains willing and eager to bargain over these insurance issues, but to date the Union has been unwilling to do so. Aside from our negotiating session set for tomorrow, we do not have another negotiating session scheduled until the evening of Monday, June 20, 2011, which falls

> after the deadline for providing the insurance carrier with enrollment data.
>
> Therefore, time is of the essence as the current medical benefit plans will expire on June 30, 2011 and in order to allow employees to have benefits effective July 1, 2011, final decisions need to be made as to what medical plan benefits will be made available and what employees will contribute to those benefits promptly so employees may elect their choice from the options offered. For this reason, I urge you to make this matter your highest priority and to provide Oak Hill with whatever insurance proposals the Union has, if any, when we meet tomorrow. If the Union has any proposals to suggest that would allow Oak Hill to offer medical insurance benefits to employees at no additional cost to Oak Hill, obviously we would be interested in learning of those proposals. None have been offered by the Union to date and so the only options we are considering at this time are the plans Oak Hill has identified and attempted to discuss with the Union throughout our negotiations as referenced above.
>
> I look forward to seeing you tomorrow in our next negotiating session and hope that the Union will find a way to devote some time to making proposals or otherwise addressing this important issue of medical insurance benefits that will be available to bargaining unit employees beginning July 1, 2011. Please let me know if the Union requires any additional information, would like to have our insurance broker attend a negotiating session to discuss Oak Hill's proposed plan options or if the Union has additional availability for negotiations aside from June 20th.
>
> Sincerely,
>
> Patrick J. McHale

On the same date, McHale sent several written counterproposals to the Union dealing with several issues, including grievance procedure, discipline, assignment transfers, and promotions, hours of work, and substitutes, but none dealing with health insurance.

The meeting on June 8 was held as scheduled at the Neat Center. Vannoni began the meeting by remarking that Respondent had not shown a serious willingness to meet the employees' concerns, had rejected all of the Union's proposals and made no substantive movement. McHale disagreed with this assessment of the bargaining.

Vannoni then presented a document consisting of proposals, including a proposal on health insurance. According to McHale, "This was good news."

The proposals modified its previous wage proposal by requesting a 40-cent-per-hour wage increase for the first year (retroactive to March 31, 2011, down from 60 cents) but continuing to request a 60-cent-per-hour increase for each of the three additional years of the contract, effective on March 31 of each year from 2012 through 2014.

On medical insurance, the Union proposed that unit employees be covered by the Union's health and welfare plan with Respondent contributing 24 percent of gross payroll towards the plan. The Union's plan was to be provided for all employees, who worked for 20 hours per week. Vannoni stated that it was the Union's belief that this proposal could save Respondent some money.

The Union's proposal also offered an option of an alternate HMO plan with copays and out-of-pocket expenditures that were higher than the existing plan. According to Vannoni, this proposal, in the Union's view, could represent lower cost increases to Respondent than the 18 percent but would not be a 0-percent increase that Respondent was pressing. The Union did not know what the additional premium costs of this proposed plan would be.[12]

Finally, the Union offered a modified HDHP plan, which enabled Respondent to recoup money from employees, who resigned, thereby, addressing a concern previously raised by Respondent but requesting that Respondent fund 75 percent of the deductible.[13]

The Union's medical proposal was contingent on Respondent withdrawing all wage cut proposals, including shift differentials, longevity start rates, and all other proposed costs to pay.

McHale, after examining the Union's proposals, asked for information about the Union's health and welfare fund. Vannoni responded that the funds are considered a separate company from the Union by law and that in order to obtain the information, the Union would need a written request directed to the executive director of the funds. McHale asked for the name and address for that person, and Vannoni supplied that information to McHale.

Vannoni then made reference to the June 7 letter specifically to his comment that Respondent "will have no choice but to offer its employees the new Oak Hill plan" beginning July 1, 2011, in absence of an agreement prior to the deadline for notifying the carrier and allowing time for enrollments. Vannoni asserted that Respondent could not do that, that it would be in violation of the contract and a violation of the law if Respondent did so.

McHale responded that the contract expired on March 31 and the Union must understand that Respondent cannot sustain the status quo. Respondent's operating deficit is $3.9 million and 78 percent of its costs are wages and benefits. He added that if there is no agreement on medical Respondent would need to enroll employees prior to July 1 to let them know what the plans are going to be. Respondent can't take the same plans and pay a million and a half more. McHale continued that Respondent did not even know if the plan that the Union is offering is available in the market place and repeated his assertion that the Union has refused to respond to Respondent's proposed healthcare plans. Vannoni disagreed and asserted that the Union has not refused. McHale then stated that Respondent would

---

[12] The plan was similar to, but not the same, as the Hamden plan, which the Union had proposed earlier, and the Respondent had costed and sent to the Union the cost of the plan. Neither side had actually proposed or rejected the Hamden plan. It had simply been proposed by the Union, costed by the Respondent, and the Union was so notified of the costs.

[13] Respondent's HDHP proposal provided reimbursement of 67 percent of the deductible.

review the Union's healthcare proposals to determine if they are valid options.

The discussion then moved to other issues, including snow days and breaks. Vannoni asked what the benefits were of the HDHP plan, and McHale explained that costs are maintained and once a deductible is met, the employee will incur no additional costs and it was beneficial to high users. A union employee replied that Respondent was trying to push employees into HDHP, and McHale answered that he was not trying to push anything on anyone, that employees make their own choices but Respondent was trying to control increases in costs.

The meeting adjourned with a confirmation that the next session was to be June 20.

Respondent did not produce to the Union at this meeting the SPDs for either the current or the proposed plans nor did the Union renew its request for these items at the meeting.

Following this meeting on June 8 at 1 p.m., Wintjen sent an email to Respondent's broker, attaching the Union's counterproposals in medical insurance. She asked him to review the option 2 and let Respondent know whether Oxford (or any other carrier) offers an HMO plan on the terms identified by the Union, and if so, provide costs for family and individual coverage.

On June 10, there was an email exchange between McHale and Wertsching (Respondent's broker), dealing with medical plan issues. The exchange is set forth below:

From: Patrick J. McHale [mallto:pmchale@kemlaw.com]
Sent: Friday, June 10, 2011 1:40 PM
To: Wertsching, Peter
Cc: Gayle Wintjen
Subject: Oak Hill

Pete:

Can you tell me the effect on HMO premiums if we make the following changes to our proposed new core plan:

1. Improve DME from 50% to unlimited to 100% to unlimited

2. Any other slight change that will make total premium costs equal to current rates, rather than the 1.9% savings we show now on the proposed plan design.

Our posture in negotiations has been we can pay what we are paying now but no more (except if you elect the HAS option) and so since I don't want to lower the already very modest employee contributions to premiums I am hoping to make one or, if necessary, two slight plan design improvements to get premiums to equate to where they are today on the core plan.

I hope my request is clear but if not feel free to call my cell (860–930–8080) and I will either take your call or will return your message as soon as I can.

Thank you.

From: Wertsching, Peter [peter.wertschlng@willis.com)
Sent: Friday, June 10, 2011 3:40PM
To: Patrick J. McHale
Cc: Gayle Wintjen; James Jones; Vashalifski, Denise
Subject: RE: Oak Hill

Pat,

The unlimited DME is worth 0.5%.

I would suggest bring outpatient surgery down from $250 to $100 would get us the other 1.4%.

Thoughts?

Pete

The General Counsel presented evidence that McHale, despite requesting information from the Union about its proposed fund plans, was familiar with these plans. Thus, McHale represented two different employers, who had contracts with which incorporated the Union's health and welfare plans. Further, McHale submitted to the Union that reduced the percentages that these employers would contribute to the Union's fund.

On June 14, Wertsching and McHale had another email exchange, pertaining to the Union's proposals and the costs to Respondent. This exchange is as follows:

From: Wertsching, Peter [mailto:peter.wertsching@willis.com]
Sent: Tuesday, June 14, 2011 11:25 AM
To: Patrick J. McHale
Cc: Gayle Wintjen; James Jones; Vashalifski, Denise
Subject: RE: Oak Hill—1199 Negotiations

Pat,

Here are the revised figures for the most recent union counterproposal.

The HMO plan rates would represent a 14.4% increase from current as the only things changing would be the office visits ($20/$30), $250 inpatient copay and $100 outpatient surgery copay.

The one outstanding question we have whether or not the per admission hospital copay can be limited to $250 per family per plan year. We are assuming at this point it is not limited so is per event as indicated here. We will confirm.

Please let us know if you need anything further.

Pete

From: Wertsching, Peter [peter.wertsching@willis.com]
Sent: Tuesday, June 14, 2011 1:49 PM
To: Patrick J. McHale
Cc: Gayle Wintjen; James Jones; Vashalifski, Denise
Subject: RE: Oak Hill—1199 Negotiations

Pat,

I got your voicemail as well.

We have confirmed that the pricing we are showing for the new plan DOES limit the family hospital copay amount to $250 per plan year. However, this has not been approved by the State of CT so the plan is not available at this time. Oxford

would need to do a single case filing with the State to be able to offer this option.

Also, the plan with a 14.4% increase would end up costing Oak Hill $1,102,033 per year more than current after taking into consideration employee contributions.

Please let us know if you need anything further.

Pete

From: Patrick J. McHale [mailto:pmchale@kemlaw.com]
Sent: Tuesday, June 14, 2011 11:39 AM
To: Wertsching, Peter
Cc: Gayle Wintjen; James Jones; Vashalifski, Denise
Subject: RE: Oak Hill -1199 Negotiations

Thank you Pete.

Could you provide me with the dollar values of these increases based upon our current enrollments so I can share these amounts with the union when I respond explaining why these options are unaffordable?

McHale responded to Vannoni by email concerning Respondent's positions on the Union's counterproposals on medical insurance. This email is as follows:

From: Patrick J. McHale
Sent: Tuesday, June 14, 2011 4:02PM
To: 'Linda Vannoni'
Cc: Gayle Wintjen
Subject: Oak Hill Negotiations - Medical Insurance Plan Options

Linda:

I am writing with regard to the two medical insurance proposals the union offered for the first time at our seventh negotiating session last Wednesday, June 8, 2011. Since the union was unable to supply us with any information as to whether the HMO plan the union proposed was available in the marketplace or the cost of the union's two medical insurance proposals we needed to investigate the matter and calculate the expected cost ourselves, which explains why we have been unable to communicate with you on your proposals until today.

Regarding the union's Option #1 proposal to replace the current medical insurance plan options with the 1199 Health and Welfare Fund, the union has indicated that Oak Hill would need to pay 24% of gross payroll to the Fund for employees who work 20 hours or more per week in order to participate in the Fund. Based upon our calculations, if we agreed to the union's proposal on Option #1, Oak Hill would need to pay in excess of $700,000 over and above what we are now paying for medical premium costs for bargaining unit employees. I say "in excess of" because we calculated this amount based upon employees' scheduled hours and note that the union has proposed requiring these payments based upon employees' actual hours, which will only serve to further increase the cost of this proposal to Oak Hill. As we have indicated since we began negotiations in March, 2011, Oak Hill is not in a position to pay more than we are paying presently for such costs and so we do not view the union's Option #1 proposal as a viable alternative.

Regarding the union's Option #2 proposal to replace the current Core HMO Plan with a new one with the terms as set forth in your written proposals dated June 8th, we have supplied this information to Oxford, our current insurance carrier, and they have advised us that the product the union proposed, due primarily to the request for a $250 annual cap on hospital copays, has not been approved by the State of Connecticut and so such plan is not available for purchase at this time. Even if Oxford could offer the plan described in union Option #2 the premium costs for the plan the union has proposed would be $1,102,033 more than our current rates for the Core HMO Plan. Further, taking into consideration the union's proposal to decrease employee premium contributions from $40 to $30 per month for single coverage and from $80 to $60 per month for employee plus dependent coverage the cost to Oak Hill under Option #2 would increase by an additional $71,000 per year. The combination of cost increases of just these aspects of the union's Option #2 would require Oak Hill to pay $1,173,033 more than it is paying presently for premium costs for these benefits and so due to the unavailability of the plan design and the extra cost, Option #2 also is not a viable alternative.

In the absence of any other proposals from the union that will allow Oak Hill to offer medical benefits to employees at no additional cost to Oak Hill beyond what it is paying presently, Oak Hill plans to offer employees the 4 plan alternatives we have proposed in our negotiations to date. More specifically eligible employees will be offered the following plan options from which they may elect:

1. The New Core HMO Plan as proposed by Oak Hill. Employees who elect this option will continue to contribute $40 per month ($480 per year) toward premium costs for employee only coverage and $80 per month ($960 per year) for employee and dependent coverage.

2. The current Core HMO Plan as presently in force with employees who elect such coverage paying the extra premium costs as compared with the premium costs for the New Core Plan for the level of coverage employees elect as set forth in the pricing information we provided the union previously.

3. The current POS Plan as presently offered with employees who elect such coverage paying the extra premium costs as compared with the premium costs for the New Core HMO Plan for the level of coverage employees elect as set forth in the pricing information we provided the union previously.

4. The current High Deductible Health Plan with Oak Hill funding 67% of the deductible amount via proportionate quarterly contributions to employees' Health Savings Accounts. Employees who elect this option will contribute $40 per month ($480 per year) toward premium costs for employee only coverage and $80 per month ($960 per year) for employee and dependent coverage.

We believe this offering will allow Oak Hill, at least for the next plan year, to contribute the same amount it is contributing today, based upon current enrollment data, for medical benefits for bargaining unit employees while at the same time, for employees who choose to enroll in the New Core HMO Plan, enable such employees to access such benefits at no addition premium costs than they are contributing today.

If the union has any other proposals on the subject of medical insurance to make please let us know immediately (along with the hard costs for each such proposal since we simply have no time to cost out any new proposals the union may make at this late date) since we will need to begin employee enrollment as soon as possible in order to get enrollment information to Oxford by as close to Friday, June 17th as possible (the date Oxford gave us as a deadline for providing this information) in order to ensure there are no lapses for employees who choose to elect to continue coverage under on the Oak Hill plans.

On June 16, Wintjen sent a memo to the staff announcing the new plan offerings and informing employees that they need to fill out new forms, no later than June 30 in order to select the coverage that he or she wishes. Otherwise, if employees do not enroll, they would not have coverage beginning on July 1. This document is as follows:

TO: All Staff
FR: Gayle Wintjen, General Counsel
RE: Medical Insurance Plan Offerings and Costs Effective July
1, 2011
DA: June 16, 2011

The purpose of this memorandum is to inform you of important developments regarding the medical insurance benefit plans we expect to offer Oak Hill employees effective July 1, 2011. Oak Hill will be holding open enrollments next week and continuing through June 30, 2011. More details regarding the process for open enrollment will be provided by Human Resources. All employees (bargaining unit and non-bargaining unit) who wish to have medical insurance under one of the plans offered by Oak Hill must complete an election form during the open enrollment period in order to have health insurance coverage starting July 1, 2011. This is true even if you currently participate in an Oak Hill plan. Employees who do not currently participate in one of Oak Hill's medical insurance plan offerings, or wish to make changes to their coverage, must also complete an election form no later than June 30, 2011.

During our current negotiations with District 1199, which began on March 23, 2011, we advised the Union that our health insurance carrier, Oxford/United, had notified us that the premium costs for our medical insurance benefits plans will increase by approximately eighteen percent (18%) effective July 1, 2011. This increase amounts to an additional $1.5 million in benefit costs. In addition, we informed the Union at that time, and throughout our negotiations, that Oak Hill is not in a position to contribute any more than it is paying presently towards the cost of medical insurance benefits. Unfortunately, at no time during our negotiations to date has the Union made a proposal regarding medical insurance that will allow Oak Hill to continue to offer benefits without significant cost increases to Oak Hill. Therefore, we are offering the four plans that we have previously informed you about. We will offer a new "Core" HMO Plan, which will allow employees to continue to elect medical benefits and pay the same monthly premium contributions that employees enrolled in the current HMO Plan pay today. We also will continue to offer the current HMO Plan as a "buy up" plan with employees who elect to stay in that plan paying any additional premium costs associated with that plan. In addition, we will offer the current Point of Service Plan with employees paying any additional premium costs as compared to the Core HMO Plan offering. Finally, we will continue to offer the current High Deductible Health Plan ("HDHP") with Oak Hill funding sixty-seven percent (67%) of the deductible amount through proportionate quarterly installments to employees' health savings accounts. Employees who elect this option will continue to contribute the same monthly premium contributions that employees enrolled in the current HDHP pay today.

We believe that these plan offerings will allow Oak Hill, at least for the next plan year, to contribute the same amount as Oak Hill is contributing today, based upon current enrollment data, for medical benefits for all employees. In addition, for employees who choose to enroll in the new Core HMO Plan, such employees will be able to access medical benefits at additional premium cost than they are contributing today.

Attached to this memorandum you will find a chart which explains the plans we expect to offer beginning July 1, 2011, a brief description of the benefits available (and co-pay charges under each of the plans and the amount employees will need to contribute each month if they elect to participate in an Oak Hill plan. If any last minute changes are negotiated in terms of plans that will be offered beginning July 1, 2011 and/or the amounts employees will need to contribute, we will let you know promptly.

Employees who fail to enroll in one of the health insurance plan offerings prior to June 30, 2011 will not have insurance coverage beginning July 1, 2011. As you know, normally we allow plenty of time for an orderly enrollment period. Unfortunately, due to the lack of an agreement on the medical insurance plan offerings, we have no choice but to enroll employees at the last possible time this year.

On June 17, Vannoni responded to McHale's June 14 email with a faxed letter, which sets forth the Union's position on bargaining over healthcare, and included an additional information request. This letter is as follows:

June 17, 2011

Pat McHale
Kainen, Escarla and McHale
21 Oak Street, Suite 601
Hartford, CT 06106

Re: Information request for Oak Hill School

Dear Mr. McHale:

With respect to bargaining over health care benefits, the Union is willing to consider the Employer's current proposals, as presented to the Union in your June 14, 2011 email. The Union would prefer the two Union proposed plans for many reasons and the Union is willing to discuss those reasons across the table. In order to consider the Employer's proposed plans, the Union needs the following information:

1. A copy of the summary plan description as well as the plan for each of the four plans being proposed by the Employer.

2. A copy of the form 5500 for each of the four plans being proposed by the Employer.

3. A copy of any rules, regulations, procedures, administrative manual or procedures or policies which affect or relate to any of the four proposed plans.

4. A cost breakdown of each plan to the Employer.

5. The name, address and principal contact of the office who administers the plan(s).

6. Copies of all claims for coverage under the plan made by employees during the last five years as well as copies of any correspondence or other documents with respect to the processing of those claims and the payment of those claims. The Union requests that any sensitive and confidential information be redacted.

7. A copy of any contracts with health care providers, insurers or health care plans.

In your email of June 14, 2011, you rejected the Union's proposals on health benefits. In your explanation you presented the Union with cost estimates that you claim prove that the Union proposals would impose significant increases to the Employer. The Union has done its own cost analysis of our proposals, based on information that was provided to us by the Employer, and our analysis produced different estimates. In order for the Union to accurately assess proposals that both parties are making, we will need the following information:

1. A detailed description of the Employer's total monthly cost for each of the following: Medical insurance, Dental insurance, Short term disability insurance, Vision insurance, Life insurance. Please provide separate totals for each benefit.

2. A detail of the Employer's calculation explaining how they arrived at the figures that were reported to the Union for gross bargaining unit payroll of all bargaining unit Employees working 20 hours or more.

We request that you send us the information above in electronic format to Linda Vannoni at lvannoni@seiu1199ne.org as soon as possible.

Finally, I believe that continued negotiations on health insurance in the context of an overall resolution of the entire economics of the contract can be fruitful. The proposal by the Union regarding health care which was presented at our last negotiating session was a starting point and I believe there is potential movement on the Union's behalf on this issue. I remind you, while you state that your proposals allow the Employer to contribute the same amount in the future that you are contributing now, this is not something provided for in the contract. There is nothing in the expired health insurance provision that guarantees the Employer's costs are capped. It does guarantee set costs and co-pays under the current plan or any successor plan which hold costs to employees equivalent to the plan in effect until June 30th, 2011. Regardless the parties have proposals on the matter of health insurance which we are negotiating about at the table. I urge to take those and any future proposals the union makes on health insurance in good faith.

Sincerely,

Linda Vannoni
Vice President, NEHCEU
District 1199, SEIU

I note that, although this letter is the first time that the Union requests in writing SPDs for the proposed plans, the Union had made such a request orally in two prior meetings, as I have detailed above.

Upon receipt of this letter, Wintjen and Wertsching had an email exchange between June 17 and 21 concerning the Union's information request, and Respondent requested Wertsching to help provide some of the information. The exchange is set forth below:

From: Wertsching, Peter (peter.wertsching@willis.com}
Sent: Friday, June 17, 20112:11 PM
To: Gayle Wintjen
Cc: Patrick J. McHale; James Jones; Yashalifski, Denise
Subject: RE: Response to email of June 14, 2011

Gayle,

We will get to work on this today. We are sending a request to Oxford for plan summaries, contact info, etc. and we will map out the cost information.

We have aggregated claim information that we will provide but it will not be broken out at employee level. The carriers will not provide this and I assume the union knows that.

Pete

Peter Wertsching
Client Executive, Employee Benefits Practice
Willis of Connecticut LLC
185 Asylum Stree25th Floor
Hartford, CT 06103-3708
Direct: 860–756–7364, Cell: 860–250–7973, Fax: 860–756–7364
E-mail:peter.wertschlng@willis.com, www.wiltis.com

____
–

From: Gayle Wintjen [mailto:wlntjeng@ciboakhill.org]
Sent: Friday, June 17, 201112:32 PM
To: Wertsching, Peter
Cc: Patrick J. McHale; James Jones
Subject: FW: Response to email of June 14, 2011

Hi Pete,

Pat asked that I forward the attached letter to you. We are hopeful that you might have some of the documentation that the Union is requesting. If so, please provide the information electronically to Pat at your earliest convenience.

We appreciate your ongoing assistance with this matter.

Have a great weekend,

Gayle

____
–

From: Wertsching, Peter (peter.wertsching@willis.com}
Sent: Tuesday, June 21, 2011 7:57AM
To: Gayle Wintjen
Cc: Patrick J. McHale; James Jones
Subject: RE: Info needed for Union negoations[sic]

Gayle,

We are working on the info.

Denise will send out the latest 5 years of premium and claim info by month which is thru November 2010. We have requested the next update which should bring us thru February 2011.

Pete

Peter Wertsching
Client Executive, Employee Benefits Practice Willis of Connecticut LLC
185 Asylum Street, 25th Floor
Hartford, CT 06193–3708
Direct: 869–756–7364, Cell: 860–259–7973, Fax: 860–756–7364
E-mail: peter.wertsching@willis.com, www.willis.com

____

From: Gayle Wintjen [mailto:wintjeng@ciboakhill.org]
Sent: Tuesday, June *21,* 2011 7:43 AM
To: Wertsching, Peter
Cc: Patrick J. McHale; James Jones
Subject: Info needed for Union negoations[sic]

Good morning, Pete.

I am writing to follow-up on the request for information that the Union gave us on Friday. We have the Form 5500s. If you could get us the SPDs, the aggregated claims data and the other requested information that you have in your possession as soon as possible, that would be great. Please provide the data electronically, if you have it in that form.

Thanks again for all of your assistance.

Gayle

Gayle C. Wintjen
General Counsel
Oak Hill
Phone. 869.769.382.7
Fax: 869.769.3831
Email:
wintieng@ciboakhill.org<mailto:wintieng@ciboakhill.org>

By email dated June 20, McHale responded to Vannoni by email and attached some of the information requested by the Union in its June 17 letter, although it did not include the SPDs for either the old or new plans. McHale also made some observations about Respondent's view of the bargaining and the Union's information requests. McHale's email is as follows:

From: Patrick J. McHale <pmchale@kemlaw.com>
Sent: Monday, June 20, 201112:23 PM
To: Linda Vannoni; Linda Vannoni
Cc: · Gayle Wintjen
Subject: 2009 IRS Form 5500
Attachments: 2009 IRS Form 5500 6–17–11 0166.pdf

Linda:

I am writing in response to your letter of July 17th.

I have attached the most recent Form 5500 which you requested at item 2 of your letter. Representatives of Oak Hill are working on gathering the numerous other documents that are responsive to the other requests contained in your letter and once the documents you have requested have been obtained we will forward them to you promptly.

We are both surprised and disappointed that you have waited until this late date to request this and other information related to our proposals on medical insurance since, as you know, our proposals regarding medical insurance were shared with the Union as early as March 23, 2011 at which time we explained the significant premium cost increase Oak Hill was facing effective July 1, 2011 and the fact that Oak Hill would not be in a position to pay any more than current contributions to these costs. Beginning on March 23 and consistently throughout our negotiations we have asked you if the union needed any additional information about our proposal and also regularly asked if the union wanted our insurance broker to attend any of our

negotiating sessions to answer any questions the union had about our proposals and in each instance the union declined our offers. Now with just 9 business days before our current medical insurance plans will expire the union is suddenly interested in viewing a variety of data regarding medical insurance costs. Again this Information will be provided to you as it is available. In the meantime we look forward to meeting with you this evening when we hope we can reach a settlement on the terms of a successor contract to the one that expired on March 31, 2011.

Patrick J. McHale

On June 20, the same day of the parties' negotiations session, the Union filed the instant charge.[14] The charge alleges that Respondent on or about June 16 and continually failed to bargain in good faith by unilaterally charging terms and conditions of employment of unit employees by altering cost of employee medical benefit premiums, copays, and other payments for medical, dental, and health benefits, which changes will occur effective July 1. The charge further alleges that Respondent violated Section 8(a)(1) of the Act by threatening employees with loss of medical coverage if they did not elect one of the unilaterally implemented medical plans at increased costs.[15]

On June 20, the negotiation session commenced at 5:40 p.m. Vannoni began the meeting by stating that as soon as the Union received the information that it requested concerning the health plans, the Union would consider modifying its proposal in that area, adding that the Union was interested in bargaining over medical benefits as well as all other aspects of collective-bargaining agreement to reach a total resolution.

McHale responded that the parties had met eight times and that they had repeatedly explained that Respondent lost $3.5 to $6 million in revenue per year and that 78 percent of Respondent's costs are employee wages and benefits. He continued that if Respondent did nothing on medical insurance costs alone will increase by $1.5 million. McHale then referenced an article in the newspaper reflecting that the average State employee pays 14 percent of their insurance while Respondent's employees contribute between 5–7 percent for coverage. He continued that Respondent cannot continue to operate with shortfalls. He recognized that employees had received increases for many years but that Respondent needed to stem the tide, and in order to do so needed to address shift differentials and overtime costs. He added that Respondent had received no responses from the Union on wages and benefits.

Vannoni disagreed, asserting that the Union had made several proposals. McHale countered that all the proposals submitted by the Union would increase Respondent's costs.

Vannoni responded that the Union had requested information on potential options during the Hamden session and the information shared by Respondent revealed that this plan would have cost only 6.8 percent more and added that the Union's last proposal would save Respondent money and that the Union intended to present more counterproposals. Vannoni noted that an increase in copays is an increase in employee costs and that it is not the Union's responsibility to save employer costs. She added that Respondent has not modified its proposal on medical and that the Union wanted a "serious counter." McHale replied that this is not true. Vannoni repeated that employees pay more due to increases in copays under Respondent's proposals and that employees should not have to bear the cost of Respondent's deficits. Vannoni then stated that Respondent was asking employees to incur serious increases in medical benefit costs and at the same time to cut the shift differential and cut new hire rates and longevity. Thus, the Union needs to hear from Respondent about these cuts so that the Union could consider further counters on medical.

McHale noted that the shift differential is unsustainable and no reasonable employer pays it. Vannoni urged McHale to make comprehensive proposals so that employees do not bear the costs. McHale then reviewed the savings that Respondent would experience if its proposals were adopted. They included $656,000, $85,000 on freezing longevity pay, $195,000 over the 4-year period of the contract for the new hire rate and $8000 for reduction in paid breaks and $106,000 per year by eliminating some holidays and paying for jury duty. McHale also described that losses incurred by Respondent from 2007 through 2010 ranging from $3.4 million (2010) to $6.5 million in 2008. McHale added that the changes proposed by Respondent do not come close to saving $3.5 million deficit and Respondent was not balancing on the backs of labor, but it needs to preserve the institution and save jobs.

Vannoni replied that Respondent has $74 million in its endowment and has used this money in the past to offset not getting monies from the State.

McHale responded that Respondent expects its costs to be labor intensive and the reality is that is where it can cut costs.

Vannoni then commented that Respondent's increased costs do not come solely from the bargaining unit but the cuts are being proposed from the bargaining unit. She then stated that the Union was there to bargain and focused on the Union's counterproposals to Respondent's proposals as set forth in the Union's written response. The parties discussed these issues, which included arbitration, discipline, paid administrative leave, temporary transfers, snow days, and medical certification.

After the discussion concluded, McHale asked Vannoni if the Union had an economic proposal.

Vannoni replied that the Union was prepared to negotiate but Respondent was only asking staff to make concessions and the Union needs responses to their proposals. She added that Respondent illegally implemented medical benefit changes and

[14] The charge was dated June 17 and apparently sent by mail on that date to the Region, which filed it and dated it on June 20 and served the charge on Respondent by fax and mail on that date.

[15] I note the complaint did not allege that Respondent violated the Act on June 16 by announcing its proposed changes effective July 1 as alleged in the charge or that it had violated the Act by threatening employees on June 16 with loss of medical coverage if they did not elect one of the unilaterally implemented plans.

Rather, the complaint alleges that Respondent unlawfully implemented changes to employee health benefits on July 1 without first bargaining with the Union to a good faith impasse in violation of Sec. 8(a)(5) of the Act.

has not provided information as to the costs of the Union's medical proposal and the Union needed a detailed account of insurance costs.

McHale responded that the parties had been negotiating since March, the Union made the request on Friday and here is why the Union's proposal costs more. In the Union's proposal, anyone, who works (rather than scheduled certain amounts of hours) is eligible for medical coverage based on 2.4 percent of gross payroll. Based on scheduled hours, Respondent calculated a difference in costs to it of $700,000 and the Union's proposal (based on hours worked) would cost even more. Vannoni disagreed with Respondent's calculations and again asked for the information requested. She reiterated that Respondent wanted only to discuss what the staff has to give up, had made only one wage and medical proposal, the Union made a proposal and Respondent needed to do more than just reject.

McHale countered that Respondent offered to pay 75 percent of the cost of family insurance.

Vannoni asked about cuts other than in the bargaining unit. McHale replied that health insurance cuts are across the broad and applies to all nonbargaining personnel. He reiterated that the Union has not offered one counter that would save Respondent money.

Vannoni responded that it Respondent would move off its wage cuts, the parties could reach agreement.

McHale repeated that the Union's counterproposal on medical was too costly.

Vannoni then stated that the Union had filed an unfair labor practice charge with the Board, alleging that Respondent illegally implemented medical plans and the employees were electing new plans under protest. She handed Respondent a letter, dated June 20, to this effect, as follows:

> June 20, 2011
>
> Pat McHale
> Kainen, Escarla and McHale
> 21 Oak Street, Suite 601
> Hartford, CT 06106
>
> Re: Unfair Labor Practice filed against Oak Hill School
>
> Dear Mr. McHale:
>
> The Union has filed an unfair labor practice charge against the Employer for implementing changes to employee terms and conditions of employment specific to employee medical benefits. The Employees have been advised by the Union to elect a new plan, under protest, in order that they have necessary medical coverage. This in no way waives the Employees' and Union's claim that the Employer's change in health insurance coverage violates the terms of the expired agreement and relevant federal labor law.
>
> On behalf of all bargaining unit members the Union reserves the right to continue to pursue a full and complete remedy of the Employer's unlawful actions including, but not limited to, making all affected employees whole. We look forward to bargaining further on this issue and others at our on-going contract talks.
>
> Sincerely
> Linda Vannoni
> Vice President, NEHCEU
> District 1199, SEIU

McHale explained that the Core plan proposed retained the same contribution if employees so elect and the parties discussed these amounts.

Vannoni stated that Respondent's notice to employees was threatening (as alleged in its charge). McHale answered that Respondent wanted to make sure that employees were aware of the June 30 deadline. Respondent was not threatening, they were merely informing them of the insurance election deadline. Vannoni repeated that Respondent had no right to impose the plans, it was an act of intimidation and employees are signing up under duress.

Vannoni mentioned that Respondent based its cost on an additional plan that costs 6.8 percent more, and McHale urged the Union to make a comprehensive proposal.

A caucus was called. After the caucus, there was some discussion about the high deductible plan, and McHale again brought up the deadline. One of the employee members then chimed in that the parties could reach agreement and "we could stay here all night." Vannoni added that yes we could stay all night to reach agreement.

McHale responded that Respondent had no counter proposals to offer that night since it did not receive any counters from the Union on economics. McHale reiterated that "we can no longer absorb $1.5 million in premium increases."

Vannoni replied that she was disappointed and asked why hadn't Respondent offered the plan discussed in Hamden as an alternative plan. McHale answered that the Union had never proposed that Respondent offer it and the Respondent merely costed out a plan the Union had asked about. McHale added that "if the Union wanted to make a proposal with that plan, Respondent can offer it if the employees pay the difference in premium."

After some additional discussion, Vannoni repeated again that the Union would be able to make a counteroffer on medical once it gets the information it is seeking.

McHale relied that Respondent had asked its broker to prepare responses to the Union's requests.

Vannoni stated that the Union's calculations are not consistent with the data Respondent has provided and that the parties will meet again once Respondent produces the information that the Union is requesting.

Wintjen, in her postsession summary of the meeting to employees, stated as follows. "There is nothing in our contract or the law that requires Oak Hill to absorb the $1.5 million increase in rates that it would face in the absence of offering our medical insurance proposals."

On June 22, McHale sent the following email to the Union.

From: Patrick J. McHale <pmchale@kemlaw.com >
Sent: Wednesday, June 22, 2011 10:51 AM
To: Linda Vannoni
Cc: Gayle Wintjen
Subject: Experience Information and Calculation of Cost of 1199 Health and Welfare Plan Proposal
Attachments: Oak hill experience.pdf

Linda:

In response to your request of last Friday I have attached the claims experience data covering the period of January 1, 2005 to November 30, 2010 as you requested. Our broker has also requested the data from December 1, 2010 to as close to the present as such claims data may be available and when we receive it I will send it to you promptly.

At our negotiating session yesterday I explained the calculation Oak Hill used to determine the expected cost of the proposal the Union made on June 8, 2011 (specifically the Option #1 proposal) that Oak Hill switch from offering its current medical insurance plan options to the 1199 Health and Welfare Fund which would require Oak Hill to contribute "24% of gross payroll for all employees who work twenty houses of more per week". This was another piece of information that you requested on Friday, June 17th. As discussed it is difficult to determine the exact cost of the Union's offer since some employees who are not regularly scheduled to work twenty hours per week may in fact work at least twenty hours from time to time but not always. For this reason we calculated our cost estimate conservatively by taking into consideration only the gross payroll for such employees amounts to $21,481,803 and 24% if that amounts to $5,155,633. This amount is significantly greater than the $4,445,764 which Oak Hill is currently contributing for medical insurance costs for the same groups of employees. If we add to the cost the additional workers who are not scheduled to work at least twenty hours each week but who sometimes do the cost disparity will only widen further.

During our negotiations last evening you asked why Oak Hill was not planning to offer employees the HMO option the Union requested that Oak Hill have priced out on April 27, 2011. More specifically you were referring to the plan the union wanted to see priced which involved an increase in office visit copays to $20 primary and $30 specialist; increase in hospital copay to $250 per admission; increase in outpatient surgery copay to $100; increase in emergency room copay to $150 and urgent care copay to $75; reduce the DME benefit to 50%; and increase in prescription drug copays to $15 Tier 1/$25 Tier 2/$40 Tier 3. This plan would increase current medical premium costs by 6.8% over current rates as further set forth in the cost comparisons we provided the Union at our bargaining session on May 3, 2011. As we explained on Monday night if the Union wants Oak Hill to offer the above-referenced HMO plan design as an alternate buy up option or even in lieu of the current HMO as a buy up plan option form which employees may choose please let us know. The Union has never made such proposal in our negotiations to date but we would have no objection to that optional plan choice if that is the Union's proposal.

Again at our meeting last night, as in each of our seven prior bargaining sessions, the Union made no proposals on medical insurance that would allow Oak Hill to offer medical insurance benefits to employees at no additional cost to Oak Hill or any of the other economic proposals Oak Hill has made in our negotiations which began on March 23, 2011. Further, the union indicated that it would not make any such proposals at least until the union received the information it just requested on June 17th. If the union has any such proposals to make please let us know as soon as possible since, at least with regard to medical insurance, we are at the point where the insurance carrier and our employees need to know what plan options will be available to them effective July 1, 2011.

I just received information that is responsive to each of the other requests contained in your letter of June 17, 2011 and so will forward that additional information to you, in electronic form as you requested, today.

McHale sent another email to the Union later that morning, stating that "I am hereby forwarding you responses to all the other requests for information made of Oak Hill on Friday, June 17." The information submitted by McHale to the Union was compiled by Respondent's broker, who sent an email to Respondent on June 21, stating that the broker had received a copy of the Union's June 17 letter and that Respondent's response to the questions asked by the Union were provided. The broker also attached various documents to be provided, which included "a copy of 2010 United Health Care/Oxford HMO PD5 and HDHP summaries," cost breakdowns of each plan to Respondent and copy of Respondent's monthly cost by coverage.

The "summary of coverage" forms provided by Respondent on that date, according to Vannoni are not the equivalent SPDs as requested by the Union. While she observed that important information is provided, including costs premium deductibles, and listed various services covered, it was not complete and many important issues are not explained. Vannoni provided some examples of some items that were not specific in these documents but should be included. For example, the Union needs: (1) to know whether or not physical therapy, occupational therapy and speech therapy are included under the plan, and if so, the limits of such care; (2) the limits of allergy care and the types of treatments allowed under the plan; (3) the number of annual visits paid for alternative medicine, including occupational and chiropractors; (4) the limits of short-term rehabilitation; (5) what DMEs are covered, and if so, how much; and (6) the limits of mail order prescriptions.

I also note that in several places on these documents the following footnote is provided:

> Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate. Refer to the Certificate of Coverage for a more complete listing of all benefits, limita-

tions, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions, or unless, otherwise stated, dental service and vision correction services and supplies.

Benefits are subject to final approval by the Department of Insurance and therefore may be subject to change.

I note further that these documents submitted by Respondent (through its broker) were dated July 1, 2010.

McHale responded to the Union's June 17 request for a "copy of the SPDs as well as the plan for each of the plans being proposed by the Employer" as follows. "A copy of the 2010 Benefit Summaries are attached. The full SPD is not available as Oxford is still waiting for state approval for some of the SPDs from 2010."

More significantly, McHale made no response or reference to the Union's request for the SPDs for Respondent's proposed plans nor did any of the attachments provided by Respondent include any information concerning these plans.

On June 29, McHale sent the following emails to the Union:

From: Patrick J. McHale
Sent: Wednesday, June 29, 2011 12:29 PM
To: Patrick J. McHale, 'Linda Vannoni'
Cc: 'Gayle Wintjen'
Subject: Oak Hill Negotiations

Linda:

As you know the Union has chosen not to reply to Oak Hill's offer as set forth in my email of June 22nd below. Accordingly Oak Hill has no reasonable choice under the present circumstances but to finalize the anticipated medical insurance plan offerings that will be made available to employees beginning July 1, 2011 as set forth in my prior communications with you both during negotiations and through written follow-up communications.

From the financial statements Oak Hill has provided the Union in our negotiations to date, you are aware that Oak Hill's operating costs have exceeded its operating revenues by anywhere from $3.4 million to $6.5 million during the term of the recently expired agreement. Oak Hill has explained that it can no longer afford to operate with such significant operating deficits and needs to reduce its operating costs since its revenues have not materially increased during the past 4 years and are not expected to increase in the foreseeable future. As we have explained during our negotiations, personnel-related wage and benefit costs make up just under 80% of Oak Hill's operating costs and so Oak Hill needs to find ways to reduce some of these costs in order to run its programs at closer to a break even margin. Accordingly, Oak Hill would like to resume negotiations on each of the open issues in our current negotiations and offers the following dates and times for future negotiations:

From: Patrick J. McHale
Sent: Wednesday, June 29, 2011 12:42 PM
To: 'Linda Vannoni'
Cc: 'Gayle Wintjen'
Subject: RE: Oak Hill Negotiations

Linda:

I sent my recent message below to you before including the offered dates and times for future negotiations. Here they are:

July 21 after 4pm, July 25 in the morning or early afternoon (I need to be in New Haven by 4pm), July 26 anytime or July 27 after 4pm.

As you know calendars fill quickly so please let us know at your earliest convenience if any of these offered dates are acceptable to the Union for future negotiations.

Thank you.

McHale testified concerning the above emails and Respondent's decision to implement the medical plans on July 1 as he had stated in his notification to the Union. McHale explained that his comments in his June 22 letter was meant to make it clear that Respondent (as it had expressed in the June 8 meeting) was willing to agree to the Hamden Plan if the employees would pay the difference in premiums. McHale stated that this means that this "is a final offer that we would extend. If you want this we will include this. The Union has never made such a proposal in negotiations to date, but we would have no objection to that optional plan if that's what the Union proposes. So we're expressing a willingness to incorporate that plan."

McHale further explained that had the Union responded that they wanted the Hamden Plan as one of the alternatives and an agreement was reached, Respondent would have had to re-enroll employees for such a plan if they so chose and it would have resulted in lots of confusion and delays in processing of claims. But Respondent was willing to do that for the sake of making a deal.

However, since the Union did not respond to this offer, Respondent did not believe that there was any reasonable possibility that further negotiations would result in an agreement with the Union on healthcare. McHale further testified, "We had reached the end of the rope. We worked at this as long as we could. July 1 was the date we had to have a new plan. Keeping the old plan would have meant us paying 18% more, annualized $1.5 million dollars. We couldn't do that. So there was no opportunity for further negotiations. We had offered our proposals. We had offered to substitute the Union's suggested plan at the last minute if that was agreeable to them. Not only did we not have an acceptance or rejection, we had no response. So there was no meaningful opportunity that further bargaining would be fruitful at that stage. We were 24 hours away from the end."

McHale further testified that Respondent has been hopeful that it would be able to obtain an agreement from the Union on healthcare before July 1 and continue bargaining on other subjects. He further was asked if the Union had agreed to something that Respondent could live with, such as, for example, the Hamden Plan with some concessions, what would happen.

McHale replied that if the Union had agreed to the Hamden Plan with "let's split the cost that would have been perfect." In such a case, the parties would have agreed to continue bargaining on other subjects and signed an agreement on the agreed-upon health plans.

McHale was subsequently asked why Respondent didn't propose splitting the cost of the Hamden Plan as he suggested Respondent would agree to. He replied that the Union never responded to whether the Hamden Plan was acceptable to them, so Respondent did not make that offer.

McHale also testified that it was clear from the bargaining stance of the Union that it wanted a total agreement on the entire contract, not just on healthcare and didn't want to move on medical until Respondent took the concessionary proposals that it made off the table.

McHale testified further that Respondent made the decision on June 29 that the parties were at impasse and that no further bargaining would be productive, again emphasizing that the Union wouldn't even tell Respondent if the Hamden Plan was an acceptable alternative. He conceded that Respondent never told the Union at that or any time for that matter that Respondent believed the parties were at impasse (on healthcare) but adds that "we told them what the consequences of where we stood."

Vannoni testified on rebuttal that, in her and the Union's view, the parties were not at impasse on June 29 and that she believed that the parties were still talking about medical benefits and looking at alternatives and that the Union was still waiting the receipt of additional information from Respondent. Thus, she believed that further bargaining on medical benefits could be useful and productive. She indicated that she did not believe that the parties were at impasse and that Respondent had not indicated that it believed that they were at impasse. When asked about McHale's June 22 letter, Vannoni testified that she did not take it as a proposal from Respondent, but merely an observation that the Union could propose it (the Hamden Plan) if it wanted to, which she knew. She also noted that McHale commented in his letter that Respondent had just received information that is responsive to the Union's requests for information, which he will forward on that day to the Union. Thus, according to Vannoni, this is a recognition that Respondent knew that the Union was awaiting information requested and that bargaining would resume and the Union could make some movement on medical at such future bargaining.

Vannoni was also asked why the Union did not reply to McHale's June 22 letter or to his suggestion that the Union propose the Hamden Plan. Vannoni testified there was nothing new in there that required a response. She asserts that she did not see any movement by Respondent and reminding the Union that it could make a proposal on the Hamden Plan was not, in her view, a proposal by Respondent. She adds that, in her opinion, a proposal is made across the table. As for replying to the letter, she states that it was clear at the last session as well as in McHale's own letter that the Union was seeking more information to understand further any further proposals it might make on medical benefits and still hadn't received it. Therefore, Vannoni did not believe that the Union should bargain against themselves and that she expected future sessions to be arranged, the information supplied and further bargaining on the medical issue.

G. Respondent Implements the New Plans

On July 1, consistent with Respondent's written communications to the Union and the employees, Respondent implemented the plans that it proposed. At that time, the three previous plans that the employees had previously been allowed to choose from were still in existence and had not "expired." Respondent decided not to offer them to its employees because Respondent did not want to incur the additional costs for premiums that would have resulted if these plans continued to be offered to employees after July 1.

These new plans resulted in either an increase in premiums for unit employees or increases in their copays or other out-of-pocket expenditures if they chose a plan with the same premiums or in the case of the HDHP, reduced the amount Respondent funded to that plan from 75–67 percent.

H. Post-July 1 Events

No bargaining sessions were held until the end of August. They met twice in August, once in October and on January 11, 2012.

> On July 6, Vannoni sent the following letter to McHale:
>
> July 6, 2011
>
> Pat McHale
> Kainen, Escarla and McHale
> 21 Oak Street, Suite 601
> Hartford, CT 06106
>
> Dear Pat McHale,
>
> You misrepresent the Union's position frequently in your letters and emails. The Union has made the Employer a counter proposal regarding medical. The Union has never refused to bargain over medical benefits. Additionally, at our last bargaining session we indicated very clearly we believed the Union would be able to make further counter proposals on the subject of medical benefits and in order to do so we needed information which had been previously requested on numerous occasions and had not received as late as the June 20th negotiations. After having received some of the information requested so far I am writing to inform you that the Union intends to make a counter proposal on the issue of medical in the near future. In order the Union to do so I will need the additional information you have yet to provide, please do so at your earliest convenience. Here is the information still needed as requested most recently in my letter to you dated June 17, 2011:
>
> - A copy of the summary plan description for the Oxford plan offered, as well as the actual plan description for each of the plans offered, not just the summary of benefits.
> - A copy of any rules, regulations, procedures, administrative manual or procedures or policies which affect or relate to any of the four proposed plans.

- A cost breakdown of each plan to the employer for coverage for bargaining unit employees only. The information provided by the employer includes non-union personnel as well.
- A detail of the Employer's calculation explaining how the employer has arrived at the figures that were reported to the Union for gross bargaining unit payroll of all bargaining unit employee working 20 hours or more.

As you know the Union has filed an Unfair Labor Practice Charge with the National Labor Relations Board because of your announcing and unilaterally implementing dramatic changes to workers' benefits over which you have failed to bargain in good faith. Specifically you have implemented the following alterations in existing benefit coverage and we demand you cease and desist in changes:

- For employees electing the HMO Medical plan with co-pays of $15 per routine office visit, $25/per visit to specialist office visits, prescription costs of $10/$20/$30, etc the employer has dramatically and illegally implemented premium increases of $151.13/month for employee only coverage, anywhere between $296.70–$402.26/month for family rather than the $40/month for individual only coverage or $80/month afforded for Employee plus coverage under the expired agreement.
- For employees electing to stay at a premium of $40/month or $80/month for individual or employee plus coverage, respectively, you have dramatically changed employee co-payments to amounts which are not equivalent to the HMO plan which prior to June 30th, 2011 was afforded individuals who signed up for $40/month or $80/month benefits.
- For employees electing to take the High Deductible Plan you are decreasing the employer funded up-front share of that High Deductible from 75% under the expired agreement to your illegally implemented amount of 67% of the upfront deductible.

Each of these changes should cease and desist immediately.

Lastly, I write to inform you that I have heard from your colleague, Gayle Wintjen, you are not available during the dates I offered yesterday. Therefore I have offered additional dates included in the email sent earlier this evening to her.

Please let me know when your team is available to meet next to continue negotiations for a new collective bargaining agreement.

Sincerely,

Linda Vannoni
Vice President, NEHCEU
District 1199, SEIU

McHale responded to the Union by email on July 14, stating as follows: "Linda: Here is another copy of the information pertaining to the other plan offerings. Again, if this is not what you seek, let me know and I will schedule a meeting with a representative of Oxford so you can explain what additional information you require." The information supplied by McHale on July 14 to the Union was, as indicated by McHale, simply another copy of the information supplied to the Union in June, and detailed below.

Thus, Respondent did not furnish SPDs for either the previous or the new plans on that date.

On August 25, the parties resumed negotiations at the Neat Center. Wintjen was not present at this session, so Respondent was represented by Stan Soby, Donna Shears, as well as by McHale, its primary negotiator. Vannoni was again the Union's primary negotiators, assisted by bargaining unit members, Clark Peters and Jeanette Bailey Spence.

The Union began this meeting by submitting a document entitled "Status Proposals (a) Oak Hill," which included some modifications of its previous proposals. These modifications included a modification of the wage proposal, reducing it to 40 cents per hour, effective July 1, 2011, from 60 cents an hour, effective April 1, 2011, as well as a modification of the Union's health insurance proposal. This modification, which as contingent on Respondent with drawing all of its other proposals to reduce costs, provided for unit employees to be covered under the Union's health and welfare fund but at a rate of 23 percent of scheduled payroll, down from 24 percent. The Union also provided copies of what it believed to be tentative agreements reached by the parties on grievance procedure and substitutes. These matters were reviewed and discussed by the parties.

With respect to the Union's proposals on the medical plan, McHale stated that, as he had noted previously, it would be too costly for Resident's employees to participate in the Union's plan whether at a rate of 27 or 24 percent.

Vannoni informed Respondent that the Union was still missing the plan descriptions that it had requested. McHale replied that it had already been sent. Vannoni answered that the Union needed a full broad descriptions of the plans that Respondent imposed.

McHale asked if the Union had any proposals to address Respondent's need to cut costs.

Vannoni protested that Respondent was proposing severe and drastic cuts and all the savings were on the back of its employees. McHale responded that Respondent cannot continue to operate unless it reduced its labor costs. Vannoni stated that Respondent was wasting its time repeating the same things and urged it to make modified economic proposal.

After further discussions, Peters chimed in that, in his view, Respondent was not really losing money, just making less and that employees deserve more. Vannoni again talked about the endowment and observed that Respondent does not have concern for the Union's proposals.

The meeting ended after some further discussion and confirmation that the next meeting will take place on August 31.

On August 26, McHale sent an email to its broker apparently in response to the Union's request for detailed descriptions of the implemented plans. The broker responded that he would get them over to McHale. The exchange is as follows:

From: Wertsching, Peter [mailto:peter.wertsching@willis.com]
Sent: Friday, August 26, 2011 1:57 PM
To: Patrick J. McHale
Cc: Vashalifski, Denise
Subject: RE: Oak Hill

Pat,

We will get these over to you.

Pete

Peter Wertsching
Client Executive, Employee Benefits Practice
Willis of Connecticut LLC
185 Asylum Street, 25th Floor
Hartford, CT 06103–3708
Direct:860·756–7364, Cell:860·250·7973Fax:860·756–7364
E-mail: peter.wertsching@willis.com..Willis.com

From: Patrick J. McHale [mailto:pmchale@kemlaw.com]
Sent: Friday, August 26, 2011 12:18 PM
To: Wertsching, Peter
Subject: Oak Hill

Pete:

I hope you have been well.

I need you to send me the full, detailed descriptions of the medical insurance plans that are presently being offered to employees at Oak Hill to respond to the Union's latest information request. Is there any chance you can provide me with those voluminous documents in advance of our next negotiating session on August 31st?

Best regards.

On August 30, Respondent sent to the Union a series of documents, which he described as "the subscriber agreements for each of the plans offered at Oak Hill." In fact, these documents were provided in error to Respondent by the broker, and in turn, to the Union. At the August 31 session, Vannoni showed these documents to McHale and pointed out that they do not contain information pertaining to the implemented plans. McHale looked at the documents, conceded that they were not correct and apologized and commented that these documents were sent in error.

On August 31, the parties met once more at the Neat Center. Most of this session was spent on discussing and memorializing the tentative agreements reached by the parties regarding grievance process and substitutes. The parties also discussed a counterproposal made by Respondent, deadline with administrative leave, but no agreements were reached.

Vannoni asked if Respondent had any counterproposal to the Union's wage increase proposals. McHale replied that Respondent could not agree to any increases since there is no increased funding or revenues. Thus, Respondent was holding to its previous pass through proposals on wages.

With respect to medical, McHale stated that Respondent already rejected the Union's request that employees participate in the Union's plan as too costly and that even with a reduction from 24 to 23 percent of payroll, the cost is more than Respondent was paying. Further, McHale observed that Respondent was in the middle of the year in its contract with the insurance carrier and the Union's proposal would force it to cancel that plan prematurely, which would not be feasible or economical.

Vannoni then proposed that Respondent end the current contract at the year's end to join the Union's plan and pointed out that 18-percent increases do not happen in the Union's plan, adding that there has been security in costs of these plans since 2003.

McHale responded that the Union erodes benefits in order to keep costs down and that employees are not happy with the Union's plans. He again asked the Union to propose plans that would represent cost savings, not more expensive proposals.

The parties then discussed some other language issues and returned to Respondent's request that the Union make proposals to lower Respondent's costs. Vannoni replied that "we have none. It is not our job to provide the employer with massive concessions; we will not shred the fabric of the contract." The meeting ended with a discussion of additional dates for meetings.

On September 20, Respondent's broker sent to McHale four documents, described as "The Genene UHC/Oxford certificates." McHale sent them to the Union on September 21, stating that these were "additional information the insurance carrier has recently provided further describing the terms of the benefit plans offered to employees at Oak Hill."

The documents provided By Respondent were entitled "certificates of coverage" and, although it provided useful information to the Union according to Vannoni, it was not completely responsive and was still not, in her view, SPDs, which would include the information that Vannoni believes should be included in a SPD. These documents were clearly documents from Oxford and provided detailed information about the four plans that were implemented. These documents are not dated, but on a number of pages of these documents, there are various dates appearing on the bottom of the pages, which appear to reflect some dates. These include "OH/PCT HMO/POS SELECT 1/98," "2810 Ct Freedom Plan Select Cert 12.09," "OHPCTBENRID 10/99," "Ct 2000 Ben/Leg POS Select Rider," "OHPBENRID 5.05," "Ct.OHP HMO/POS Select Benefits Update Rider 3.06," "Ct OHP Benefits Update Rider 12.06," "Ct.OHPPOS2007 Benefits Rider 10.07," "OHPCTHMO NGMH 11/09," "POS Select Handbook 2.10," "2810 Ct Freedom Plan Select Care 12.09," and "7437 Ct Large FP Direct HAS Certificate 12.08."

On October 19, the parties met once more. At this meeting, Respondent offered a package settlement, which included a 2-percent wage increase for all unit employees, effective upon the signing of a contract, contingent on agreement to all of Respondent's outstanding proposals, which included elimination of shift differentials, longevity increases and a new pay structure for new employees."

The union representatives characterized this proposal as "you insult us," again accused Respondent of cutting its employees

to meet its deficits and once more, urged Respondent to consider the endowment.

McHale urged the Union to propose an alternative medical plan that is less costly to Respondent.

The Union offered a counterproposal on wages and medical insurance. On wages, it proposed increases of 40 cents per hour, effective October 1, 2011, and March 31, 2012, and 60 cents per hour, effective March 31, 2013, and March 31, 2014.

On medical insurance, the Union offered similar, but slightly altered proposals from its prior proposal. It offered an option of switching employees to the Union's plans at a cost of 23 percent for the first year and 24 percent the second year, starting in July 2012. Option 2 was offering Buy Up plan as Core HMO plan with employee contributions of $40 per month for individuals and $80 for families and reimbursement of 75 percent but with modifications in when payments would be made of the deductible by Respondent.

Vannoni asked how Respondent had projected the costs of joining the union funds, contending that Respondent might not have calculated those benefits in addition to health insurance that the Union's funds provided. The parties agreed to exchange dates for future meetings by email.

On November 11, the Union sent a detailed information request to Respondent, noting among other things that the description of newly implemented plans provided by Respondent on August 30 listed various benefits and charges in its "Freedom Access Plan," which was significantly different from the summary of benefits for the "Core HMO plan" provided by Respondent to the Union on June 16. The Union listed some of these differences.

The Union's letter also asked once again for health insurance documents and more detailed descriptions of the plans in effect prior to June 30, 2011. The Union's letter is as follows:

> November 11, 2011
>
> Pat McHale
> Kainen, Escarla and McHale
> 21 Oak Street, Suite 601
> Hartford, CT 06106
>
> Re: Information requests for Oak Hill School
>
> Dear Mr. McHale:
>
> With respect to bargaining over health care benefits, the Union has filed an Unfair Labor Practice Charge against Oak Hill for failing to provide information we believe is necessary for making a full and comprehensive counter proposal on medical benefits and for illegally implementing radical changes to Employee benefits which you failed to negotiate with the Union in good faith. While at the table for negotiations on these and many other unresolved issues, the Union has demanded that the Employer cease and desist in the implementation of the medical plans and corresponding premium shares which you have failed to bargain in good faith over. To date you have failed to heed this demand.
>
> At our last three sessions in August and October, the Union made other counter proposals regarding medical and other issues open at negotiations, especially regarding modifications on our stance to switch to the Union Health & Welfare Fund. As requested since early on in our negotiations the Union has requested copies of the medical and other benefit plans in effect prior to 6/30/11. Of those benefits I am still in need of the following:
>
> 1. A copy of the health insurance plan documents, including the summary of benefits, the more detailed plan description, not just the "summary of coverage" for each of the plans in effect prior to 6/30/11 which delineates how many any limits to the number of chiropractic visits, what constitutes durable medical equipment.
>
> 2. A copy of any rules, regulations, procedures, administrative manual or procedures or policies which affect or relate to any of the four plans effective prior to 6/30/11. (On September 21, 2011 the employer sent some plan details for unspecified medical benefits. It is possible that these are "Certificates of Coverage" for these pre 6/30/11 plans. Please be explicit in your response if these Plan documents relate to our prior benefit plans.)
>
> 3. Copies of all claims for coverage under the plan made by bargaining unit only employees for the last 5 years and the summary of such claims akin to that one provided previous but for bargaining unit employees only and through the period through until July 1, 2011. The Union still is not in receipt of these.
>
> 4. Copies of any correspondence or other documents with respect to the processing of those claims and the payment of those claims for bargaining unit employees only. The Union requests that any sensitive and confidential information be redacted. The information provided to date on this is incomplete and contains aggregate numbers including non-union personnel.
>
> 5. As for non-medical benefits offered by the Employer prior to 6/30/11 your 7/14/11 failed to identify if the costs represented there in the attachment for "Life/AD&D," included only union employees or non-union as well, please specify. Also, there was no plan description included for this benefit. Please provide it.
>
> 6. As for the Short Term Disability information, please provide a list of bargaining unit employees who enroll for this benefit and a list of which bargaining unit employees that utilized this benefit, each year for the last 5 years. What was the length of Employee benefits received? What was the total financial amount of benefit received? What was the dollar amount the employer paid for each employee? What was the nature for the need for the STD? Provide a Summary Plan Description and plan documents related which describe the benefits received by employees who enroll and utilize this benefit?
>
> 7. As for Long Term Disability you provided a document which listed "Class 1—Non-Union Officers," and "Class 2—Non-Union Employees." Please specify what if any of the information provided on June 22, 2011 and July 14th, 2011 is under the title "LTD Provisions" are the benefits also provided to Union workers. Please provide a copy of any listing or

Summary Plan Description and plan documents related which describe the benefits received by employees who enroll and utilize this LTD benefit.

8. For dental and vision insurance prior to July 1, 2011, please provide the summary plan description for these benefits, what exact services are covered, and for what exact cost. Are there plan limits, co-pays, deductibles and exclusions of certain services? Please provide a copy of all such documents.

In your email dated July 14th, 2011 you provided a Summary of Coverage for the plans in effect prior to 6/30/11. However, you have, to date, failed to provide "Summaries of Coverage" and "Summaries of Benefits" for the Plans being offered effective beginning July 1, 2011 to employees. The names of those plans according to Wintjen's email dated 6/16/11 were: "Core HMO Plan," "Buy-Up Current HMO Plan," "POS Plan," and the "HDHP(HSA)"' plans. I request again that you provide a Summary Plan of Benefits, Summary Plan of Coverage and any and all Plan documents to the Union for each of the plans effective beginning July 1, 2011.

Since the Employer has illegally changed employee benefits the Union requests information regarding what Employees are now enrolled in. Please provide the following:

9. A list of insurance benefit plans elected by employees that includes the number of employees eligible at this point in time *(post 7/1/11 member enrollment),* the number of employees participating in each of the plans, the levels of coverage they elect in the new plans, the number of hours they are weekly regularly scheduled to work, what the employee pays monthly for the insurance, what the employer pays to cover that employees' insurance (for medical and dental separately). Include whether or not employees are eligible and have now elected Life/AD&D, STD, LTD as well, and if so, how much do they pay for these benefits now?

In your letter dated August 30, 2011 you provided the Union with what appears to be one plan "Summary of Benefits" for a plan called "Freedom Access Plan" which matches nothing like what the Employer has proposed anywhere to date. What is this document? What plan is this in reference to and why does it not match the co-pay structure proposed under any of the plans "implemented" July 1, 2011? Here are some examples from the one "Summary of Benefits" provided the union on August 30, 2011:

Example:
1) name of the plan appears no-where in your prior proposals "Freedom Access Plan"' exists
2) Physician visits say - Preventive Care= no Charge
3) Primary Care Treatment of Illness or Injury-= $25/visit
4) Specialist Visit = $40 co-payment
5) RX = $15/$25/$40
6) ER visits = $100/visit
7) Urgent Care = $40/visit
8) Durable Medical Equipment = No charge
9) Inpatient= $250
10) Outpatient= $100

Whereas your email whose attachment is titled "Oak Hill's Health Insurance Plans at-a-glance" emailed to me by Wintjen on June 16, 2011 lists a "Core HMO Plan" with a fee scheduled as follows:
1) Name of plan "Core HMO Plan"'
2) Physicians Visit/Routine = $30, doesn't specify if they are preventive if they cost $0, this implies it costs $30 for all visits, preventive or not
3) Specialist = $45
4) Rx: $15/$25/$40
5) ER Visits = $150
6) Urgent Care = $75
7) Durable Medical Equipment = 50%

These two plans are not remotely the same. It is unclear what the August 30th SPD is for. Please inform me as to how it relates to the Employer's proposals and implemented medical plans. None of the other medical plans listed on the Employer's June 16th list to workers, either the plans titled, "Current HMO Plan," "Core HMO Plan," "Buy-Up Current HMO Plan," "POS Plan," or the "HDHP(HSA)" has similar costs as I summarize above for the "Freedom Access Plan" provided 8/30/11.

Lastly, at our last negotiations on October 19, 2011 I asked you to provide me with your total costing of all the benefits which would be equivalent to the Union's Health & Welfare Fund. You admitted that you were not aware as to whether or not the Employer, when comparing the Union's Health & Welfare Fund to Oak Hill's own array of benefits, had included the cost of STD, LTD, Life/AD&D, dental and medical in the agency's total consideration. You claimed that the Union had never made you aware that this was the array of benefits offered by the Union's Fund. I pointed out to you that the Union had done so in writing prior to July 1, 2011 and yet you were completely unaware as to what the Employer's costing of the plan had been. I requested that you ask your team to fully cost out the cost of the total equivalent of the Union's Health & Welfare package in Oak Hill's current benefits which would include:

1) The cost to the Employer to provide Union Employees' cost of Life/AD&D annually
2) The cost to the Employer to provide Union Employees Cost of STD annually
3) The cost to the Employer to provide Union Employees Medical annually
4) The cost to the Employer to provide Union Employees Dental annually
5) The cost to the Employer to provide Union Employees Vision annually
6) The cost to the Employer to provide Union Employees Tuition benefits
7) What is 24% of Gross Union payroll for Employees ***regularly scheduled*** to work 20 hours/week, including overtime?

8) What is 24 %of Gross Union payroll For Employees who *regularly work* 20 hours/week, including overtime?

Please provide this prior to our next session. I offer the following dates:

Dec 8th - morning or evening
December 13th morning or evening
December 15th morning or evening

Sincerely,

Linda Vannoni
Vice President, NEHCEU
District 1199, SEIU

On December 1, Respondent granted a 2-percent wage increase to all nonunit employees. The Union responded by distributing a flyer, labeling Respondent's president, Johnson, as a "grinch" for giving nonunion staff a 2-percent increase with no strings attached while asking the union staff to take his offer of no shift differentials, freeze of longevity bonus, acceptance of illegal increased healthcare costs, and open all new homes as nonunion.

On December 4, McHale sent the Union a series of emails and document responsive to its November 11 information request, detailed above.

None of the documents provided to the Union were labeled SPDs but had various labels, including plan summary for Respondent's dental coverage for plan periods, 7/1/10–6/11 and 7/11–6/12, which provided detailed information about dental coverage for these periods of time. Additionally, Respondent provided, according to is broker, "2010 and 2011 plan summaries along with the certificated providing details of the plan coverage." Respondent provided copies of a two-page summary of the Oxford Freedom Select Plan Summary of Coverage, dated July 1, 2011, a two-page summary of coverage for the Oxford HSA Direct Plan, dated July 1, 2011, a two-page summary of coverage for the Oxford HMO Plan Select, dated July 1, 2010, and a two-page summary of coverage for the Oxford HMO Plan Select, dated July 1, 2011.

In addition to these summaries, Respondent provided the documents from Oxford, entitled "Certificate of Coverage" for the plans. The documents included a "2010 Benefits Update Rider," "2009 Amendment" and a "2011 Amendment."

According to Vannoni, this submission was the first time that the Union received detailed summaries of coverage and benefits for the old and new plans although, in her view, these were still not SPDs. Vannoni testified that "it's close" but still not SPDs.

The parties met once more on January 11, 2012. As the Union had request, Respondent passed out a written copy of its comprehensive settlement proposal, submitted at the prior session, which, as noted, reflected a 2-percent wage increase in exchange for the Union's agreement on all other outstanding Respondent's proposals. The Union did make a response to that proposal at the meeting.

Vannoni stated that Respondent had still not fully complied with the Union's information requests with respect to medical benefits and that some of the information provided was confusing. She referenced the August 30 documents supplied by Respondent and noted that the copays reflected in those documents did not appear anywhere else and did not match the documents supplied on December 4.

McHale replied that Respondent had supplied thousands of documents to the Union and suggested that the best way to resolve the Union's concerns in this regard was to schedule a meeting with Respondent's broker. Vannoni agreed to meet the insurance broker but added that the Union also wanted Jim Jones to be present so that the Union can understand how Respondent made its cost analysis of the Union's health and welfare fund.

Vannoni asserted that participating in these funds would save Respondent money and added that other providers had switched to the Union's fund and that increases are normally 1 percent.

McHale retorted that other employers are not pleased with the Union's funds and the benefits were eroded. He also stated that Respondent needed information about the fund. Vannoni answered that requests for information should be sent to the fund administrator, Cassandra Murphy.

The Union then modified its wage proposals to a 2-percent wage increase, effective October 1, 2011. McHale replied that Respondent had offered the Union such a wage increase in its October 19 offer. The Union responded that this offer was made along with a cut in other areas.

The Union questioned how Respondent could give a 2-percent increase to nonunit employees in view of the financial crisis and then state it is unable to provided wage increase to union personnel.

McHale replied that unit employees have been receiving longevity raises and step increases, which are not available to nonunit employees. McHale added that all employees had to absorb increased medical costs and that Respondent needed to reduce operating costs.

After a caucus, Vannoni stated that it was a priority to get resolution to the health insurance, and she wanted to schedule a negotiation session after a meeting with Jones and the broker. Vannoni emphasized that she wished to exhaust discussion of the Union's health plan. She again asked for explanations as to her questions and information requested in her November 11 letter.

Vannoni also commented that the Union's fund has some benefits that Respondent's plan does not have. McHale retorted that the increased cost of the Union's fund exceeded any additional benefits.

The parties discussed the logistics of setting up meetings with the broker and Jones.

The parties agreed to meet on February 17, 2012, as discussed, with Respondent's insurance broker and Jones being present to assist. On the morning of the meeting, McHale sent the following email to Vannoni:

From: Patrick J. McHale [mailto:pmchale@kemlaw.com]
Sent: 2012–02–17 8:58AM
To: Linda Vannoni; 'Gayle Wintjen'
Subject: RE: February 17th meeting

Linda:

As we have expressed to you previously during our negotiations in order for Oak Hill to be able to provide you with Oak

> Hill's "total costing of all the benefits which would be equivalent to the Union's Health and Welfare Fund" the Union will need to share with us all of the benefits offered through the Union's Health and Welfare Fund. You have been unwilling to provide us with any details about those benefits which would be offered under your proposal to date. When we have asked you for that information you have told us that if we want the specific information we will have to write to the Union's Fund and ask the Fund for it. Your response is unacceptable and constitutes bad faith bargaining. If you are truly making a benefit replacement proposal in our negotiations you need to supply a detailed description of the specific benefits you are offering as replacements for the benefits we currently offer. Without such information Oak Hill cannot seriously consider you proposal since we have no basis for comparison to the current benefit offerings.
>
> We look forward to meeting with you this morning and we hope you will have more information to provide us regarding the specific benefits offered under the Union's proposed "Health and Welfare Fund".

The parties meet on February 17, as scheduled, with Jones and Pete Wertsching, Respondent's broker. A number of issues were clarified with respect to the information requests and Respondent's calculations of the Union's plan's costs.

During this meeting, Wertsching conceded that prior plans sent by Respondent in August 2011 were sent in error and did not reflect the plans implemented. Wertsching also admitted, according to Vannoni, that the summaries of coverage previously sent were only for informational purposes but that SPDs did exist and could be provided.

On February 24, 2012, Vannoni sent an email to McHale, attaching a letter, dated February 17, 2012, but acknowledging it was not sent until February 24. The letter reads as follows:

> February 17, 2012
>
> Pat McHale
> Kainen, Escarla and McHale
> 21 Oak Street, Suite 601
> Hartford, CT 06106
>
> Re: Information requests for Oak Hill School Insurance Benefits
>
> Dear Mr. McHale:
>
> With respect to bargaining over health care benefits, the parties met recently on February 17th, 2012 to vet information provided to the Union over course of collective bargaining for a successor agreement which your team could not answer or clarify with the committee members present at those prior negotiations. As part of those discussions information came to light as did further questions the Union needed to be clarified. At the meeting, some of the Union's inquiries were not able to be answered and so the employer confirmed you would follow-up on those inquiries.
>
> Leading up to our meeting on February 17th, I asked the Employer to provide the Union with your total costing of all the benefits which would be equivalent to the Union's Health and Welfare Fund. You responded to those questions on 12/4/11 in an email. At our meeting February 17th you further clarified that information, which you were unable to do at our bargaining session in January, 2012. This was helpful in understanding the total costs of employee benefits to the employer.
>
> Regarding that 12/4/11 email response on question # 8 you stated that the $5,948,927 number was calculated based off of wages and bargaining unit employees from 10/1/10 through 9/30/11. When seeking clarification on February 17th, I inquired as to if any 12 month gross bargaining unit wages might fluctuate from any snap shot of 12 months within the 2011–2012 year, if the fluctuation could be even close to two hundred thousand, you replied that, in aggregate the fluctuation wouldn't likely even amount to a hundred thousand. I reminded the employer that the Union has been provided with a gross total bargaining unit wages on May 24th, 2011 of a total of $21,481,803 by the Employer. I pointed out the difference in those two 12 month periods amounted to a fluctuation of $3,303,395 based on the numbers provided to the Union by the Employer on two different occasions. When I asked you why those numbers might fluctuate the Employer responded that the information from that time was not available for your review at the February 17th, 2012 meeting. I asked the Employer to follow up and you said you would. The Union awaits the Employer's explanation. We have asked for such a further elucidation of the Employer's number since before July 1 of 2011 and still await to hear an explanation of the Employer's work which led the gross bargaining unit numbers provided from May 24th, an explanation of how the employer came up with the December bargaining unit numbers and why these figures in your costing are so different from your earlier projections.
>
> At many bargaining sessions since before and after September 21, 2011 the Union has asked for more detailed benefit summaries. On February 17th, when inquiring about the Summaries of Coverage provided to date, the Employer confirmed that those summaries were for marketing and to be used by the Employer in employee enrollment meetings but were not a complete summary and that another summary was available akin to the "mistakenly" provided summary given to the Union on August 30th, 2011. Please provide such detailed summaries for each of the 4 plans as was stated in our meeting February 17th which the Employer's representatives said were available.
>
> I am also writing to confirm another session on March 27th to consider alternatives over medical insurance. We are available to meet beginning at 9:30am. The Union had proposed 3/8, 3/9, 3/22 for which the Employer's team was not available. I am also interested in bringing the Union's Health & Welfare Fund's Executive Director to further discuss any questions you may have regarding the Union's medical plan.
>
> Your email dated February 17th sent to me a half hour prior to our meeting to discuss the Employer's plan was

inaccurate. The Union has never expressed an "unwillingness" to provide information regarding the Union's Health & Welfare Fund. At a prior bargaining session I asked you to put your request in writing to the Executive Director of the Fund and that I would facilitate getting it to her, and getting you the information you might request. I further offered that if you got the request to me prior to our next bargaining session I would personally meet with her to get the information and bring it to the next session. As I explained, the Fund is a separate organization, one regulated by the Federal Government under the Taft Hartley Act and for the Fund to release such information I would need the Employer to assist in requesting it. It is something we practice with all Employers and has never been an issue to date with any employer to ask them to put the request in writing. This response by me does not constitute bad faith bargaining, I was simply explaining the process and offering to assist your getting the information. You never submitted such a request. Please do not suggest that the Union has been unwilling to provide detailed information just because you have failed to seriously entertain the Union's proposal on our Health and Welfare benefits offerings. Despite not receiving that request from you, I provided the information and gave it to you on February 17th.

Since our February 17th meeting I met with the Executive Director of the Fund, Cassandra Murphy, and asked her to join us. Please advise me by March 1st if you are interested in having her at the March 27th meeting. She is available and intending to attending to come if you confirm you desire her to be present. I request that you prepare a list of information and questions you would like her to be able to answer and that you provide them no later than 16th so that she can best answer them on the date of March 27th.

Sincerely,

Linda Vannoni
Vice President, NEHCEU
District 1199, SEIU

Subsequent to the receipt of these documents, Respondent sent the Union an email with attachments, dated March 21, 2012. The email stated that he was attaching "more detailed summaries of medical plans presently offered to employees at Oak Hill which you requested when we last met on February 17, 2010."

The attached documents were still not labeled SPDs but instead were entitled "summary of benefits" for each of the plans. According to Vannoni, these documents finally provided all the information that the Union had been requesting for the implemented plans and are, in her view, SPDs.

There was apparently another informational meeting session with the broker set for March 27, 2012. The record is unclear whether this meeting was actually held.

The record does reflect that the parties had negotiation sessions since January and prior to the trial herein, but that no agreements have been reached. No details of those meetings have been placed into the record other than Vannoni's testimony that at a meeting in June 2011, the Union modified its health insurance proposal to require Respondent to contribute 20 or 21 percent of gross payroll for participation in the Union's plans.

III. ANALYSIS AND CONCLUSIONS

A. The Information Requests

It is well settled that an employer is obligated to supply relevant information to the union in a timely and complete manner. Absent evidence justifying an employer's delay in furnishing such information, such a delay is violative of the Act. The union is entitled to the information at the time it made its initial request, and it is the employer's duty to furnish it as promptly as possible. *Monmouth Care Center*, 354 NLRB 11, 41 (2009); *Woodland Clinic*, 331 NLRB 735, 737 (2000). An unreasonable delay in furnishing such information is as much of a violation of Section 8(a)(5) as a refusal to furnish the information at all. *Monmouth Care*, supra; *Woodland Clinic*, supra; *Valley Inventory Service*, 295 NLRB 1163, 1166 (1989).

The burden is on the employer, once relevance is established, to provide an adequate explanation or valid defense to its failure to provide the information in a timely manner. *Woodland Clinic*, supra, *Coca-Cola Bottling Co.*, 311 NLRB 424, 425 (1993).

In applying the above principles to the facts here, it is not disputed that the information sought by the Union and the information alleged to have been unreasonably delayed in submission, SPDs for the prior and proposed health insurance plans, was relevant to the pending negotiation for a collective-bargaining agreement. Indeed, the issue of health insurance was clearly the primary issue during the negotiations and the issue that the parties spent considerable time discussing, in view of Respondent's expressed desire to resolve that issue prior to the July 1 deadline, which would have required Respondent to incur significant increases in premium costs if the prior plans were to be continued in effect.

There also can be little question that Respondent failed to produce the information requested in a timely and complete manner.

Respondent contends that its conduct was not unlawful for several reasons, making a number of contentions, which attempts to provide adequate justification for its failure to produce the information requested in a timely and complete manner.

Respondent initially contends that no violation can be found because no documents existed entitled "summary plan descriptions." It further asserts that Vannoni conceded that she used the terms "summary of benefits" and "summary plan descriptions" interchangeably and there were a variety of things Respondent could send.

Further, while the General Counsel and the Union conceded that the SPDs were ultimately provided by Respondent in late 2011 and early 2012, none of these documents were entitled "summary plan descriptions" or SPDs.

In this connection, Respondent argues that neither Wintjen nor McHale had ever seen any document from Respondent's insurer entitled "summary plan descriptions." Therefore, Respondent argues that it "cannot be liable for failing to produce

'summary plan descriptions' when the evidence provides that no such documents ever existed."

I find this contention to be totally without merit. While it is true that no document entitled "summary plan description" for any of the plans was shown to have existed, in fact, it is clear that the information requested by the Union was included in other documents that were in existence and that were eventually turned over to the Union, albeit several months after they were requested. These documents had various names, such as certificate of coverage or summary of benefits, and Respondent's witnesses attempted to comply with the Union's requests by submitting these documents. No one from Respondent ever informed the Union that SPDs did not exist or that this was a reason for its delay in producing the information. Further, Wintjen, herself, used the term "SPDs" when replying to the Union's requests for similar information in May 2010 and when Wintjen asked Respondent's broker on June 21 to comply with the Union's request for such information, she stated, "If you could get us the SPDs . . . that you have, that would be great." Additionally, Shears characterized the documents ultimately submitted to the Union by Respondent as, in her view, "SPDs" or their equivalent. Thus, it is clear that Respondent's officials knew what information the Union was seeking regardless of the nomenclature and that the Union wanted detailed descriptions of the benefits and coverages provided in the various plans. Respondent, therefore, cannot excuse its tardy submission of the information that it knew the Union wanted based on the fact that no documents entitled SPDs existed.

Accordingly, this defense of Respondent in its failure to timely produce SPDs or equivalent documents containing the information requested by the Union is rejected.

Turning to the specific "SPDs" (or its equivalent documents) requested, I first consider the request for SPDs for the plans in effect for Respondent's employees prior to July 1, i.e., the current or incumbent plans. The Union requested in writing that Respondent produce these plans on December 23, 2010, prior to the scheduling of their first session. This request was ignored by Respondent, and no such information was provided to the Union at that time. The parties met for the first time on March 23, and this information still had not been supplied. The parties met again on April 12, and Respondent still did not supply this information at or prior to that meeting.

When the parties met again on April 27, the Union still had not received this information and submitted a second written request, specifically stating that it was a "second request" for this information. This request still did not produce an immediate response, and it was not until June 20, when Respondent sent any information attempting to comply with this request when it sent documents entitled "summaries of coverage" for the incumbent plans to the Union.

It, therefore, took approximately 6 months for Respondent to send anything in attempted compliance with the Union's request. Vannoni testified that these "summaries of coverage" were not the equivalent of SPDs since they did not provide detailed descriptions of the coverage and that the Union did not receive such documents until December 20 when it received documents entitled "certificate of coverage" from the insurance company, which, according to Vannoni, finally fully satisfied the Union's requests for this information.[16]

I agree with the General Counsel that the information supplied in June was not the equivalent of SPDs as testified by Vannoni since it did not include the detailed information included in the documents eventually supplied in December. But, even if it is concluded that Respondent fully complied with the request on June 20, this is way past an unreasonable time for submission since it was 6 months after the request was made and nearly 2 months after the request was renewed at the April 27 meeting. *Monmouth Care*, supra, 354 NLRB at 52 (6-week delay unreasonable); *Woodland Clinic*, supra, 331 NLRB at 737 (absent evidence justifying employer's delay, 7-week delay found unreasonable and violative of the Act); *Beverly California Corp.*, 326 NLRB 153, 157 (1998) (2-month delay unreasonable).

Respondent provide an alleged "explanation" for the delay in providing the information in a timely fashion, which it argues warrants a finding that the delay was not unlawful. It contends, in this regard, that any delay was "inadvertent and excusable." Respondent normally provides information in a timely fashion and that it does not "create obstacles" to providing information. It further points to the evidence that when the request was first received by Respondent in December 2010, it was turned over to an employee to comply with the information requested. However, due to the Christmas holidays and the fact that this employee was retiring and was busy training her replacement, she did not get to complying with the request. Shears followed up in January 2011 and asked the employees about it and instructed her to get to it as soon as possible. However, the employees did not do so and retired. Shears did not followup further about the issue because she assumed that the employee has compiled.

Further, Wintjen and McHale did not know about the request until it was renewed by the Union at the April 27 session, and Respondent was told that it was a "second request." Thus, as Respondent's witnesses testified, the request "slipped through the cracks."

While those facts may establish that the delay was "inadvertent" at least until that time, it cannot be construed as a legitimate or adequate explanation justifying the unreasonable delay. Respondent is responsible for complying with the Union's request and its officials were responsible for making sure that it was complied with promptly. It cannot rely on the failure of one of its employees, who did not carry out instructions to comply with the information, because she was too busy or was about to and, in fact, did retire.

Furthermore, even after this April 27 second notification of the failure to promptly comply with this request when Wintjen and McHale were made aware of the Union's request, Re-

[16] I note that the Union needed to send another written request, dated November 11, again requesting more detailed description of the healthcare plans for each plans in effect prior to June 30, 2011, and not just a summary of coverage, and Vannoni gave some examples of information that she expected to be included, such as how many limits to the number of chiropractic visits and what constitutes medical equipment.

spondent, nonetheless, did not comply with this request until June 20, nearly 2 months later, an unreasonable delay in itself. *Monmouth Care*, supra; *Woodland Clinic*, supra; *Beverly California*, supra.

As I have concluded above, these documents were not the equivalent of SPDs since they did not contain the comprehensive description of benefits and coverage contained in the "certificates of coverage," not turned over to the Union until December. However, even assuming that the June documents submitted were considered the equivalent of SPDs, as I have detailed above, Respondent's submission to the Union in June was clearly unreasonably delayed and violative of its obligation to submit information to the Union in a timely fashion.

Respondent also argues that the Union clearly had the requested information in its possession since Respondent had sent documents on May 28, 2010, to the Union containing information concerning the 2010 plans, which the Union used in ultimately concluding that the plans proposed by Respondent to be implemented on July 1, 2010, were, in fact, "equivalent" to the plans then in place.

This contention by Respondent fails for several reasons. First, the documents supplied to the Union in 2010 were not SPDs and did not contain the equivalent information. They were not even documents from the insurance company. They were instead summaries of coverage, apparently prepared by Respondent's broker, comparing these plans with the prior plans in effect at that time. Indeed, the broker included in these documents that states "this is intended to be a general description of the plan benefits. A complete listing of benefits and exclusions will be provided in the Oxford benefit summary and certificate of coverage." Further, Vannoni, while she conceded that she was able to conclude in 2010, based on these documents that the plans proposed by Respondent were "equivalent" to the plans then in effect, she also testified that she needed some questions answered orally from Wintjen about certain items not included in those documents. Thus, it was not until later in June 2010 that she was able to determine the plans were equivalent. Therefore, the 2010 documents submitted clearly cannot be considered SPDs.

Furthermore, even if they were to be construed as the equivalent of SPDs, it would not be a defense to Respondent that the Union may have had this information in its possession from a prior information request. Here, neither the Union nor Respondent recalled or was aware that such information had been supplied to the Union in May 2010, 6 months before the Union's request was made with respect to the current bargaining. Respondent neither produced the information nor advised the Union that it had previously provided a copy of the information requested. Thus, Respondent, in such circumstances, did not make a timely response to the Union's request for relevant information, it has violated the Act. *Postal Service*, 332 NLRB 635, 636 (2000) (no defense to refusal to turn over relevant information that information had been previously turned to union as part of earlier request).

Turning to the request for SPDs for the proposed and eventually implemented plans, the Union, by Vannoni, requested at the April 12 negotiation meeting that Respondent supply it with SPDs for the plans being proposed by Respondent. McHale responded no problem and "we'll get you whatever you need." Despite that reassuring comment by McHale, Respondent did not supply SPDs or any purportedly equivalent document to the Union at that time or in a timely fashion thereafter. This request was simply ignored, and the Union made a request in writing for the SPDs for these plans (as well as other information) on June 17. While Respondent did reply to the Union's request on June 20 and submitted information to the Union relative to other requests made by the Union, it made no reference to the request for SPDs for the current plans. On June 22, Respondent did furnish documents in attempted compliance with the Union's request, made orally on April 12 and in writing on June 17. However, these documents entitled "summaries of coverage" were for the old plans and not the new proposed plans. McHale responded to the Union's June request for SPDs for the proposed plans by stating that Respondent was including a copy of the 2010 benefit summary but the full SPD is not available as Oxford is still waiting for state approval of some of their SPDs for 2010. According to McHale, this was compliance with what Respondent had at the time since the summaries of coverage for the proposed plans were still not exist at that time. Further, McHale notes that these summaries of coverage for three of the plans were the same as for the proposed plans, only in terms of coverages, benefits, and copays. Only the premiums charged would have been different, but the Union already had information about the difference in premiums for the employees. While McHale admitted that with respect to the fourth plan that Respondent proposed with different copays and deductibles but the same premiums for employees, Respondent did not furnish a summary of coverage or any other documents. As to that document, McHale asserts that it did not exist as of June 22 and that is why it was not produced at that time.

I find it somewhat questionable that summaries of coverage for the 2011 implemented plans did not exist at that time, but even if true, Respondent's submission on June 22 for information first requested on April 12, was still untimely and would be violative of the Act. *Monmouth Care*, supra; *Woodland Clinic*, supra, *Postal Service*, supra.

Subsequent to June 22, Respondent made several attempts to comply with the Union's request for the SPDs for the implemented plans but these attempts were not successful until it finally produced the certificates of coverage for these plans in March 2012 after Vannoni met with Respondent's broker.

While Respondent certainly made efforts to comply with the Union's information request, which were numerous, the facts are that it simply did not comply in a timely fashion with the requests. It may not have been an intentional failure to comply, but rather, simply a matter of "too many cooks spoiling the broth" (testimony of Wintjen) or "slipping through the cracks" (testimony of Shears), but Respondent is ultimately responsible. It appears that there might have been some diffusion of responsibility for the Union's requests between Shears, Wintjen, and McHale, but this is Respondent's responsibility to sort out such confusion, and it cannot rely on that as an adequate justification for the failure for Respondent to submit to the Union the information requested in a timely fashion. Indeed, even when Vannoni requested at the April 12 negotiation session the Respondent turn over SPDs or other documents for the plans that

Respondent was proposing, McHale replied that it would not be a problem and "we'll get you whatever you need." However, despite that statement by McHale, Respondent furnished nothing to the Union in response to that request until June after the Union repeated its request for this information, which was still not fully complied with until March 2012.

Respondent's primary argument in defense of these complaint allegations is that the Union had no need of the SPDs requested since the Union was aware of the benefits, coverages, and costs of the plans. Thus, Respondent contends that the documents provided by the Union on April 12, which compared the plans, offered and explained the financial difference between the existing plans and Respondent's proposed new plans was adequate compliance. McHale repeatedly explained to the Union that the benefits, coverages, networks, and other plan details were unchanged from the plans then in place. The only differences were the increased premiums to be paid by employees if they chose to retain the same copays and deductibles or if employees pay the same premiums the plans would have different copays and deductibles. McHale assured the Union that the network of doctors and the same level of medical costs and services that were in place for the prior years would be available under the new plans. Therefore, Respondent argues that the Union had all the information that it needed in order to bargain over this issue by virtue of having received the documents from Respondent, plus assurances from Respondent that the benefits and coverages were unchanged in the proposed plans. However, when McHale made assurances to the Union, Vannoni replied that she appreciated McHale's statements but needed something in writing to confirm McHale's assurances that the benefits were the same. Thus, she asked for SPDs or some other plan documents that described a greater list of specific benefits than contained in the documents presented.

The Union is clearly entitled to this information and need not have to rely on McHale's oral assertions that the benefits and coverages were unchanged from the prior plans. Notably, at this point in the negotiations, the Union had also requested SPDs for the prior plans and had still not received these documents and another written request was necessary before Respondent complied with that request, also, as detailed above, in an untimely fashion.

In this regard, Respondent also argues that Respondent repeatedly offered to have its insurance broker attend negotiations to answer questions or provide information. The Union did not express any interest in that opportunity and, in fact, Vannoni stated that she does not negotiate with brokers. Therefore, Respondent contends that the "Union should not be heard to complain that it lacked information when it failed to entertain opportunities to obtain details and ask questions of the insurance broker."

I do not agree.

While the Union did not jump at that opportunity met with Respondent's broker, it never declined to do so. Indeed, as Vannoni correctly observed in her testimony, the Union cannot lawfully object to Respondent bringing anyone that it wanted to negotiations and if Respondent wanted to bring its broker, it could have done so. Further, the Union did eventually meet with the broker in January 2012 and ascertained that the certificates of coverage (equivalent of SPDs) for the new plans, which were available from the insurance company and were finally turned over to the Union in March 2012. I, therefore, find that the failure of the Union to affirmatively agree to meet with the broker not to be an adequate defense to Respondent's failure to produce relevant information to the Union in a timely manner. It is Respondent's responsibility to comply with that obligation, and if that entailed bringing its broker to the negotiations, Respondent should have and could have done so, and the Union's failure to specifically agree to his presence does not justify Respondent's conduct in failing to provide timely information to the Union.

Finally, Respondent also argues that the Union had sufficient information to make two alternative proposals to Respondent, one to participate in the Union's health and welfare fund with a 24-percent payment of gross salary of hours worked by Respondent and a second proposal for a modified HMO with different copays and employee contributions to premiums, Thus, Respondent contends that the Union was able to make these proposals on June 8 and that the Union never stated that it was unable to make a proposal on June 8 and that the Union never stated that it was unable to make a proposal because it lacked information. Therefore, Respondent asserts that the complaint allegation must be dismissed. Once again, I cannot agree.

The fact that the Union was able to make counterproposals on June 8, despite not having the information requests complied with, is not a defense to the failure to provide clearly relevant information to the Union. If the information requested was provided promptly as the law requires, the proposal could have been made earlier or might have been different. These are matters of speculation that need not and cannot be decided. It is not necessary for the Union to show specifically that the failure to produce the information hampered or affected its ability to make counterproposals. Such a requirement would eviscerate the duty to supply information. Once the finding made that the information is relevant, it must be supplied in a timely fashion. Absent adequate defenses, which have not been demonstrated here, such conduct is violative of Section 8(a)(5) of the Act.

Accordingly, based on the foregoing analysis and authorities, I conclude that Respondent has violated Section 8(a)(1) and (5) of the Act by failing to supply the SPDs to the Union for the prior and the new plans in a timely manner. *Monmouth Care*, supra; *Woodland Clinic*, supra; *Postal Service*, supra.

B. Respondent's Implementation of its Medical Insurance Proposals

It is well settled that an employer's duty to bargain under the Act includes the obligation to refrain from changing its employees' terms and conditions of employment without first bargaining to impasse with the employees' collective-bargaining representatives concerning the contemplated changes. *NLRB v. Katz*, 369 U.S. 736, 743–747 (1962); *Lawrence Livermore National Security*, 357 NLRB No. 23 slip op. at 3 (2011).

During negotiations for a collective-bargaining agreement, an employer may not unilaterally change any terms or conditions of employment without having bargained to impasse for

the agreement as a whole. *E.I. DuPont De Nemours*, 355 NLRB 1084 (2010*); RBE Electronics*, 320 NLRB 80, 81 (1995); *Bottom Line Enterprises*, 302 NLRB 373, 374 (1991). As the Supreme Court has recognized, "it is difficult to bargain, if, during negotiations, an employer is free to alter the very terms and conditions that are the subject of negotiations." *Litton Financial Printing Division v. NLRB*, 501 U.S. 190, 198 (1991).

The Board's view, with support from the courts, condemns piece-meal implementation during negotiations, recognizing that "collective bargaining involves give and take on a number of issues," and the effect of allowing implementation in absence of an overall impasse "would be to permit the employer to remove, one by one, issues from the table and impair the ability to reach an overall agreement through compromise on particular items. In addition, it would undermine the role of the Union's collective-bargaining representative effectively communicating that the Union lacked the power to keep issues at the tables." *Visiting Nurse Services of Western Mass. v. NLRB*, 177 F.3d 52, 58 (1st Cir. 1999), affg. 325 NLRB 1125, 1130–1131 (1998). Judge Posner's opinion in *Duffy Tool & Stamping LLC v. NLRB*, 233 F.3d 995 (7th Cir. 2000), provided a comprehensive analysis in support of the Board's view on this issue. Judge Posner observed the Board's rule promotes labor peace and that the contrary position (allowing implementation, if there is an impasse on one subject) interferes with the negotiation process and makes reaching agreement less likely, and interferes with the goal of labor peace. (233 F.3d at 997.) The judge further reasoned that the employer's position would empty "the duty of bargaining of meaning and this in two respects: (1) by removing issues from the bargaining agenda early in the bargaining process, it would make it less likely for the parties to find common ground; (2) by enabling the employer to paint the union as impotent, it would enable him to hold out for a deal so unfavorable to the union as to preclude agreement. A negotiation is more likely to be successful when there are several issues to be resolved (integrative bargaining) rather than just one because it is easier in the former to strike a deal that will make both parties feel they are getting more from peace than from war. . . . If by deadlocking on a particular issue, the employer is free to implement his proposals with respect to that issue, he signals to the workers that the union is a paper tiger." (Id. at 998.)

The Board, supported by the courts, has crafted exceptions to the general rule that an overall impasse in bargaining is required before an employer can lawfully implement changes in conditions of bargaining during negotiations. These exceptions are set forth in *Bottom Line Enterprises*, 302 NLRB 373, 374 (1991), enfd. 15 F.3d 1087 (1994), amplified in *RBE Electronics*, 320 NLRB 80, 82 (1995). The Board in *Pleasantview Nursing Home*, 335 NLRB 961, 962 (2001), enfd. 351 F.3d 747, 755–756 (6th Cir. 2003), summarized these exceptions as follows:

> In *Bottom Line*, the Board recognized only two exceptions to that general rule: when a union engages in bargaining delay tactics and when economic exigencies compel prompt action. Id. at 374.The Board has limited the economic considerations which would trigger the *Bottom Line* exception to "extraordinary events which are an unforeseen occurrence, having a major economic effect [requiring] the company to take immediate action." *Hankins Lumber Co.*, 316 NLRB 837, 838 (1995). In *RBE Electronics*, the Board made clear that "[a]bsent a dire financial emergency, economic events such as . . . operation at a competitive disadvantage. . . do not justify unilateral action." Id. at 81, citing *Triple A Fire Protection*, 315 NLRB 409, 414 (1994).
>
> However, in *RBE Electronics*, the Board also found that there may be other economic exigencies that, although not sufficiently compelling to excuse bargaining altogether, should be encompassed within the exigency exception. In those cases, the employer will "satisfy its statutory obligation by providing [the union] with adequate notice and an opportunity to bargain over the changes it proposes to respond to the exigency and by bargaining to impasse over the particular matter. In such time sensitive circumstances, however, bargaining, to be in good faith, need not be protected." Id. at 82. See generally *Naperville Ready Mix, Inc.*, 329 NLRB 174, 182–184 (1999).
>
> In defining the less compelling type of economic exigency, the Board in *RBE Electronics* made clear that the exception will be limited only to those exigencies in which time is of the essence and which demand prompt action. The Board will require an employer to show a need that the particular action proposed be implemented promptly. Consistent with the requirement that an employer prove that its proposed changes were "compelled," the employer must also show that exigency was caused by external events, was beyond its control, or was not reasonably foreseeable. Id. 335 NLRB at 962

Respondent does not dispute the above precedent but argues that the facts here demonstrate that both exceptions, described above, have been demonstrated here, and, therefore, it has not violated its duty to bargain by implementing its medical proposals. The General Counsel contends, not surprisingly, that neither of the exceptions set forth in *Bottom Line* and *RBE Electronics* are present in this case. It is to that issue that I now turn.

The first exception detailed in *Bottom Line* that permits unilateral implementation of changes in conditions of employment, absent an overall impasse, is "when a union, in response to an employer's diligent and earnest efforts to engage in bargaining, insists on continually avoiding or delaying bargaining."

Respondent contends that the Union has insisted on avoiding or delaying bargaining about medical insurance and relies heavily on Vannoni's comment at one of the negotiation sessions that if no agreement was reached on healthcare prior to June 30, Respondent could be forced to continue the plans then in existence and absorb the $1.5 million premium increases. It asserts further than the Union's strategy was to avoid bargaining over healthcare, since once July 1 arrived, Respondent would be fully responsible to paying the increased premium costs. Thus, in furtherance of that strategy, it notes that the Union did agree to meet at only three of the nine sessions that Respondent proposed and that despite Respondent's continued demand that

healthcare needed to be discussed and agreed to prior to June 30, the Union insisted that other issues be discussed first. Respondent also notes that the Union failed to make a counterproposal to Respondent's demands on healthcare until June 8, 2-1/2 months after negotiations began and a week before enrollment cards were due to enroll in the new proposed plans. Finally, Respondent notes that the Union stated on June 20 that there would be no further meetings or additional negotiations until it received a response to the information request that it made in June. Although some of the information was provided by Respondent on June 22, the Union scheduled no further negotiations and did not respond to Respondent's communication of June 22, offering to offer the "Hamden Plan" as an additional choice for employees.

I conclude, contrary to Respondent's assertion, that these facts did not come close to meeting the standard for pronounced delays and obstruction necessary to establish this exception. Cf. *M&M Contractors*, 262 NLRB 1472 (1982) (union refused to agree to schedule bargaining session with employer for over 7 months); *AAA Motor Lines*, 215 NLRB 793, 794 (1974) (union refused to meet for a period of 2-1/2 months after demand for bargaining and prior to contract's expiration; such conduct found to be violative of 8(b)(3) by the union in related case. 215 NLRB 789 (1974)).

Here, unlike the unions in these cases, the Union did agree to meet with Respondent to bargain, and the parties met for eight negotiations between March 25 and June 20. This can hardly be described as an obstructive, unreasonable failure to schedule meetings. I note that the failure to have more meetings can be equally attributed to Respondent's conduct. Thus, the Union requested that bargaining commence in its letter of December 29, 2010, "as soon as possible." Respondent ignored this request for over a month until January 28, 2011, when it responded but proposed no dates for bargaining. The Union immediately proposed 16 dates; Respondent rejected seven of them and agreed to nine of the Union's dates. The Union then agreed to only three of the original dates that it had proposed since Vannoni had proposed her available dates to all of the employers with whom she was negotiating at the time, and some of these dates had been agreed to by these other employers before Respondent had agreed to meet on nine of these dates. Significantly, at this point, the Union was unaware of Respondent's proposals or that it was asserting "time sensitive" requirement for agreeing to healthcare. Thus, it was not until the first meeting on March 25 when Respondent made its medical proposal and emphasized that the new plans must be in place by July 1 that the Union was on notice that Respondent was seeking to change the medical coverage for its employees. Thus, there can be no inference that the Union delayed meeting until March 25 because of any alleged interest in avoiding bargaining over healthcare as Respondent contends since the Union was not aware that Respondent would raise a "time sensitive" proposal to eliminate benefits prior to March 25. Indeed, as I noted above, it was Respondent's conduct in failing to respond to the Union's December request to meet "as soon as possible" that was primarily responsible for the failure to meet until March 25, more than 3 months after the Union's initial bargaining request.

Therefore, I reject Respondent's contentions that the Union's conduct in failing to agree to meet with Respondent on a few dates during this 2-month period when Respondent agreed to be available constituted unreasonable, obstructive, or unlawful conduct.

Further, I reject Respondent's contention that the Union refused to bargain over healthcare issues during the negotiations that did take place. While it is true that the Union did seek to delay bargaining over these health proposal made by Respondent until it could persuade Respondent to back off its wage cut proposals and bargain economics as a whole, such conduct is not unlawful or obstructive. The Union need not capitulate to Respondent's unchanged terms "since such a doctrine would encourage rigid, inflexible posturing in place of the give and take of true bargaining," *Grinnell Fire Protection*, 328 NLRB 585, 585 (1999).

The Union's position is perfectly lawful and not inconsistent with good-faith bargaining. As repeatedly explained by Vannoni, the Union did not want to divorce the insurance changes from an overall contract since the amount Respondent paid for insurance impacted the amount it had left over for wage increase and other economic matters, such as longevity and shift differentials, which Respondent was seeking to cut as well. Indeed, this position is consistent with the rationale for the Board's well-settled disfavoring of piece-meal bargaining and requiring impasse on all issues before unilateral implementations as explicated in the precedent detailed above. *Visiting Nurse*, supra; *Duffy Tool*, supra. Thus, the Union was acting consistent with this view of bargaining by demanding that Respondent withdraw its wage cut proposals in exchange for some agreement by the Union to Respondent's proposal for changes in healthcare coverage.

More significantly, the evidence discloses that notwithstanding the Union's statement, as detailed above, that the Respondent must withdraw its other proposals for wage cuts before agreeing to healthcare changes, the Union did, in fact, make several counterproposals to Respondent's healthcare proposal, including coverage for unit employees under the Union's plan, which the Union believed could result in a cost savings to Respondent. While Respondent disagreed with that assessment and rejected the Union's proposal, the issue was still under discussion, the Union was disputing Respondent's calculations of cost, and Respondent was still awaiting receipt of information from the Union's funds concerning the Union's proposed plans when Respondent decided to implement its proposed on July 1. The Union also proposed another modified plan with different copays, which Respondent also rejected.

The evidence with respect to the "Hamden Plan" is somewhat murky, but I do not find that the Union's conduct with respect to this plan can be viewed as unlawful, unreasonable or obstructive. Thus, the Union asked Respondent to cost out this plan at one meeting, which Respondent subsequently did and presented it to the Union. It is true that the Union never formally proposed this plan not did it agree to accept it after Respondent at the final meeting, and in McHale's letter informed the

Union that Respondent was willing to include that plan in its proposal for changes to healthcare coverage if the Union was agreeable. However, I note that this offer by Respondent and McHale did not include an offer to withdraw its wage cuts as requested by the Union, so the Union cannot be faulted for not agreeing to the inclusion of the "Hamden Plan" as Respondent proposed. Indeed, the Union expressed interest in the "Hamden Plan" even after it had been costed and had asked why Respondent did not propose that it be included since it would have resulted in reduced costs for Respondent and the employees if chosen by employees as an option. Notably, when Respondent implemented its plans, it chose not to include this "Hamden Plan" that it had agreed to include (if employees would absorb the differences in premiums) even though doing so would have resulted in less of a cost increase to employees, who chose that plan. I find it incongruous for Respondent to fault the Union for not agreeing to the "Hamden Plan" while at the same time, failing to implement that plan, which could have saved the employees some money and while costing the Respondent nothing.

Accordingly, based on the foregoing, I reject Respondent's contention that the Union has "insisted or continually avoiding or delaying bargaining," over healthcare cannot find that this exception as defined in *Bottom Line* does not apply to the facts here.

I now consider the second exception detailed in *Bottom Line* and expanded in *RBE Electronics* that of "economic exigency that compel prompt action." There can be little question that the facts, here, do not demonstrate the existence of compelling economic considerations that would excuse bargaining altogether, and indeed Respondent does not so contend.

Respondent does assert that the *RBE Electronics*' modification of *Bottom Line* to encompass "other economic exigencies" that while not sufficient to excuse bargaining, will permit unilateral action, if the parties reach impasse on the matter proposed for change, *RBE Electronics*, supra, 320 NLRB at 81–82, is applicable here.

Respondent argues that it faced an economic exigency caused by an external event with a time deadline that required prompt action with its significant operating deficits, resulting from increasing expenses and flat state funding. It further notes that due to the Union's refusal to agree to Respondent's medical proposals in prior years, Respondent absorbed all the medical insurance increases.

Respondent further notes that in March 2011, it became aware from its broker that continuing the same medical coverage for employees would result in an 18-percent increase in health insurance costs. Therefore, Respondent concluded that it could not continue to absorb the significant increases in medical insurance as it had been forced to do in the past. Thus, this was, in Respondent's view, "an external event" beyond Respondent's control and had to be dealt with by June 30, 2011, the last day of the existing plan contract. It further contends that impasse was reached in bargaining with the Union over health insurance that "the end of the rope had been reached" and that "implementation was the only reasonable option to insure uninterrupted insurance benefits for employees." In that regard, Respondent argues that it faced a "time deadline to reach agreement on medical because the medical contract in place for all 1300 employees, union and nonunion alike, would expire on June 30, 2011. Thus, Oak Hill could not wait until the entire contract was settled."

I disagree. I agree with the General Counsel's contrary contention that the circumstances, here, did not demonstrate an "economic exigency" due to the pending 18-percent increase in insurance premiums as "time was not of the essence" and Respondent's action was not "compelled." Rather, the evidence discloses that Respondent simply did not want to continue to pay any portion of the increased costs for health insurance, dictated by the contractual requirement to continue the Core HMO plan with no change in employee premiums. This is not an "economic exigency" under *RBE Electronics* that justifies unilateral implementation, absent overall impasse. *Maple Grove Care Center*, 330 NLRB 775, 779 (2000) (increased premiums in health coverage not an economic exigency, in which time was of the essence and which demands prompt action; Board concludes that, as here, it is highly unlikely that respondent would have been placed in straitened financial circumstances had it paid the entire premium increase until overall impasse had been reached); *Naperville Ready Mix Inc.*, 329 NLRB 174, 182–183 (1999), enfd 242 F.3d 744 (7th Cir. 2001) (refusal to bargain over sale of trucks not justified under *RBE Electronics*' economic exigency exception, although employer could save some money if scheme was implemented before July 1 when licenses for trucks were to be renewed, an expected event that occurred annually on that date; Board concludes that this argument that employer "might make in support of its proposals, but it in no way meets the economic exigency standard in advance of an impasse in contractual negotiations"); *L&L Wine & Liquor Corp.*, 323 NLRB 848, 851–852 (1997) (concern over high insurance costs does not warrant implantation prior to contract impasse); *United States Testing Co.*, 324 NLRB 854 (1997) (respondent failed to offer evidence that its financial situation was so dire that it either had to implement its final offer when it did or suffer financial ruin); *Sartorius Inc.*, 323 NLRB 1275, 1284–1286 (1997) (unilateral implantation of incentive bonus program not justified by alleged economic exigency of increases in scrap rate on machine and unexpected high orders); *Pleasantview Nursing Home*, 335 NLRB 961, 962 (2001), enfd. in pert part 351 F.3d 747 (6th Cir. 2003). See also *IFG Stockton*, 357 NLRB No. 118, ALJD slip op. at 7–8 (2011) (inadequately trained employees not an economic exigency under *RBE Electronics*, justifying unilateral implementation of subcontracting).

Furthermore, the anticipated premium increases cannot be characterized as an "unforeseen" economic emergency, justifying unilateral action, absent overall impasse. *Harmon Auto Glass*, 352 NLRB 152, 154 (2008) (substantial deadline in sales revenues, resulting in substantial net loss, plus placement into receivership, found not to be unforeseen economic emergencies excusing unilateral action); *Toma Metals, Inc.*, 342 NLRB 787, 801 (2004) (employer's 50-percent decline in revenue over 6 months not unforeseen emergency, justifying unilateral decision to lay off employees); *Hartford Head Start Agency*, 354 NLRB 164, 185–188 (2009) (funding decrease from city not

"unforeseen" and did not justify unilateral cuts in wages and schedules).

Here, the record establishes that there have been yearly increases in health premium costs, often in excess of 10 p. While the projected increase in 2011 was somewhat higher, 18 percent, it still cannot be characterized as "unforeseen." While Respondent's effort to avoid bearing the full brunt of this increase is understandable, it does not equate to an "economic exigency" under *RBE Electronics* warranting implementation, absent overall impasse in bargaining.

Respondent argues, as noted, that it established that the alleged exigency, rise in premium rates on July 1, demonstrates that "time was of the essence" and that it was "compelled" to make the proposed changes at that time. However, this contention overlooks several factors. The increases that Respondent was referring to represent an 18-percent increase for all of its employees since unit and nonunit employees are covered by the same plans. Thus, unit employees comprise 60 percent of the employees covered by the plans and nonunit employees comprise 40 percent. Therefore, Respondent need not have implemented the new plans for the unit employees but could have done so for the nonunit employees only, thereby, saving a substantial amount of the proposed increases. Moreover, Respondent concededly had substantial amounts of money in its endowment fund, which it could have drawn upon if it so chose to help meet these additional costs. Although its witnesses testified that financial advisors have advised it that exceeding the 4.6-percent threshold would not "be prudent," the fact is that the board of directors could have agreed to raise that percentage if it so chose.

Further, the assertions made by Respondent that the "time sensitive" nature of implementing its healthcare proposals is established by virtue of the fact that the current plans were "expiring" on June 30 is simply incorrect and a mischaracterization of the record. These plans were not expiring but would have continued without change (albeit with increased premiums for Respondent) but for Respondent's unilateral decision to implement an economic decision "seen as desirable by Respondent." *Beverly Health & Rehabilitation Services*, 335 NLRB 635, 637 (2001) (9.5-percent increase in healthcare premiums does not warrant unilateral change in increasing employees' premium costs); *Brannan Sand & Gravel*, 314 NLRB 282 (1994) (employer's unilateral changes in deductions, copayments and employee contributions in employee health insurance plan violative of Sec. 8(a)(5) of the Act); *Circuit Wise Inc.*, 308 NLRB 1091 (1992) (employer's act of unilaterally increasing employee contributions to the new plans).

Thus, the alleged deadline, here, is in reality a self-imposed deadline by Respondent in accordance with its desire to avoid incurring additional premium costs on July 1. That cannot be properly characterized as an "economic exigency" under *RBE Electronics*. It is rather than an economic exigency, simply an unlawful unilateral change, even if increases were merely passed along from the insurance carrier.

Here, bargaining could have continued past the July 1 deadline with the Union, and possible agreement with the Union might have resulted in some agreement by the Union to absorb some of the additional costs of premiums, thereby, saving Respondent at least some of the projected increases for any period subsequent to any agreement. Instead, Respondent chose to implement the proposed plans and placing all of the increased costs on the employees if they chose to retain the same copays and deductibles or if they chose to continue to pay the same premiums, substantial changes in copays and deductibles.

I, therefore, conclude based on the foregoing analysis and precedent that Respondent has not demonstrated the existence of any exceptions to *Bottom Line* and *RBE Electronics*, and it cannot justify its implementation of these healthcare changes, even if it had bargained to impasse with the Union over this issue.

I also conclude that even if I were to conclude that the pending 18 percent premium increase was an "economic exigency" as defined by *RBE Electronics*, I would not conclude that Respondent has established that an impasse existed on healthcare on July 1 when it implemented the new healthcare plans that it had proposed during bargaining.

A genuine impasse exists when the parties are warranted in assuming that further bargaining would be futile. *Monmouth Care*, supra, 354 NLRB at 57; *Essex Valley Visiting Nurses Assn.*, supra, 343 NLRB at840.. "An impasse exists at a given time when there is no realistic possibility that continuation of discussions at that time could have been fruitful." *NLRB v. WPIX*, 906 F.2d 898, 901 (2d Cir. 1990); *Cotter & Co.*, 331 NLRB 787 (2000).

Further, an impasse cannot be found unless both parties believe that they are at the end of their rope. *Monmouth Care*, supra; *Essex Valley*, supra at 890; *Cotter*, supra at 788; *Larsdale, Inc.*, 310 NLRB 1317, 1318 (1993).

The question of whether an valid impasse has been reached is a "matter of judgment" and among the relevant factors are the bargaining history, the good faith of the parties in negotiations, the length of the negotiations, the importance of the issue or issues as to why there is disagreement and the contemporaneous understanding of the parties as to the state of negotiations. *Taft Broadcasting*, 163 NLRB 475, 478 (1967), enfd. 395 F.2d 622 (D.C. Cir. 1968).

The Respondent as the party asserting impasse has the burden of proof on that issue. *Newcor Bay City Division*, 345 NLRB 1229, 1238 (2005); *L.W.D. Inc.*, 342 NLRB 965 (2004).

I conclude that, here, Respondent has fallen short of meeting its burden of proof that the parties were at impasse on July 1 when it implemented its healthcare proposals.

In order to establish the existence of impasse, Respondent must prove that there was a contemporaneous understanding by both sides that they had reached impasse. *Monmouth Care*, 354 NLRB at 57; *Essex Valley*, supra, 343 NLRB at 841. Here, Respondent had failed to establish that either party believed that they had "reached the end of their rope" when Respondent implemented its proposals.

While McHale did testify in this proceeding that he and Respondent believed that the parties were at impasse in view of the Union's failure to respond to Respondent's proposals and to its June 22 letter, it is significant that neither he nor anyone else from Respondent made such an assertion either during bargain-

ing or in its letters. Indeed, Respondent never even characterized its offer on healthcare as a final offer. Thus, it cannot even be seriously argued that both parties believed that they had reached impasse. *Monmouth Care*, supra; *Essex Valley*, supra. Respondent argues in this regard the Respondent did make it clear in its letter that it did intend to implement its proposals on healthcare, absent agreement or further counterproposals from the Union on the subject. However, that statement is not a declaration that Respondent believed that the parties were at impasse or that they reached the end of their rope. Rather, it is simply an assertion by Respondent that since the Union has not met Respondent's self-imposed deadline of June 30 to agree to healthcare changes, it would implement its proposals at that time.

Additionally, and more significantly, whatever can be said about Respondent's contemporaneous understanding, it is crystal clear that the Union did not believe that the parties were at impasse on June 30 or at any other time. Indeed, the Union's consistent position during negotiations and after when Respondent asserted its intention to implement on July 1 was that further negotiations could be fruitful and that the Union could have more movement on healthcare, especially if Respondent withdrew its other wage reduction proposals. Indeed, the Union filed unfair labor practice charges in mid-June, alleging that Respondent illegally implemented its proposals at that time by compelling employees to fill out new enrollment forms for the new plans, effective July 1. While no complaint allegation alleges that conduct to be violative of the Act, and I do not so find, this fact, nevertheless, is demonstrative that the Union did believe, as it repeatedly stated in negotiations and in writing, that further negotiations on healthcare could be fruitful and that no impasse existed.

While Respondent may have been impatient with the Union's pace in agreeing to concessions on healthcare, its frustration is not the equivalent of a valid impasse nor did it mean that a negotiated settlement was not within reach. *Newcor Bay City*, supra, 345 NLRB at 1230; *Grinnell Fire Systems, Inc.*, 328 NLRB 585 (1999), enfd. 236 F.3d 187 (4th Cir. 2000); *Powell Electrical*, 287 NLRB 969, 973–974 (1987), enfd. as modified 906 F.2d 1007 (5th Cir. 1990) (futility not some lesser level of discouragement or apparent gamesmanship is necessary to establish impasse).

The record shows that negotiations had not broken down on healthcare and that the Union had made counterproposals to Respondent's contemplated changes, including covering Respondent's unit employees in the Union's healthcare plans. While Respondent did reject that plan as too costly, the issue was still under discussion, particularly since the Union was disputing Respondent's calculations in that regard and requested information relative to that issue. Further, Respondent was still awaiting receipt of information that it had requested from the Union concerning the details of the Union's funds. Finally, the Union had still not received the information that it had previously requested concerning the SPDs for both the old and new plans.

In such circumstances, it is clear that an impasse cannot be found to have existed on July 1. *Newcor Bay City*, supra at 1238–1239 (union's continued assertion that movement is possible in future, depending in part on what information respondent provided, substantial evidence of finding no impasse).

That is so, despite the fact that the Union had not offered additional concessions on healthcare as demanded by Respondent, but merely declared its intention to be flexible and continue bargaining.[17] See also *Grinnell Fire Systems*, supra, 328 NLRB at 585–586 (no impasse where employer expressed unwillingness to move from its position and union had not offered specific concession, but had declared its intention to be flexible and sought further bargaining). See also *Cotter & Co.*, 331 NLRB 787, 788 (2000) (no impasse, where union attorney stated parties were not at impasse and respondent would act unlawfully if it implemented its offer); *Royal Motor Sales*, 329 NLRB 760, 773 (1999) (no impasse because union had insufficient time to analyze information that had been requested from employer).

Additionally, I would note again that the Union's position on healthcare after Respondent made its proposals was that the Union would agree to some changes and would make some movement on that issue if Respondent would agree to withdraw its other regressive proposals (to reduce wages, end shift differential and longevity pay). Thus, the Union's expressed demonstration of flexibility on healthcare, if other issues were satisfactorily resolved, is strongly indicative that further bargaining could be useful and that no impasse existed. *Royal Motor Sales*, supra, 329 NLRB at 770, where the Board observed as follows, which is applicable here:

> The very nature of collective bargaining presumes that while movement may be slow on some issues, a full discussion of other issues, which have not been the subject of agreement or disagreement, may result in agreement on stalled issues. "Bargaining does not take place in isolation and a proposal on one point serves as leverage for positions in other areas." *Korn Industries, Inc. v. NLRB*, 389 F.2d 117, 121 (4th Cir. 1967). Thus, had German "been willing to bargain further, much more might have been accomplished through the give and take atmosphere of the bargaining table." *NLRB v. Sharon Hats, Inc.*, 289 F.2d 628, 632 (5th Cir. 1961). [Id. at fn. 31.]

Respondent argues that impasse has been demonstrated by the Union's conduct with regard to the "Hamden Plan." Thus, Respondent notes that the Union asked Respondent on April 27 to find out about the availability of an alternative HMO plan with lower copays that would have ultimately resulted in a 6.8 percent increase rather than the 18-percent increase in Respondent's proposed plan. Respondent provided that information to the Union, but, subsequently, the Union never proposed implementing that plan. Although it made some further references to the Hamden Plan during negotiations, it never requested that it be offered. Respondent twice notified that Union that it would be willing to offer this plan as an alternative to or in addition to its proposed plan if employees were willing to absorb the additional premium costs. Notwithstanding these offers, the Union still did not respond and did not agree to this offer, even though its acceptance would have re-

[17] Indeed, at the parties' last bargaining session on June 20, the Union stated that it would be willing to stay all night in order to reach agreement.

sulted in a savings in premium costs to employees, who opted for that plan (as opposed to the plan offered by Respondent). Thus, Respondent argues, as testified to by McHale, that the "Union's conduct showed that it lacked any interest or willingness to try to reach an agreement before the insurance contact expired on June 30, 2011." Thus, Respondent reached the "end of the rope," and the Union's actions demonstrated the same conclusion by the Union. *ACF Industries*, 347 NLRB 1040 (2006).

I do not agree.

On the contrary, the evidence with respect to the "Hamden Plan" demonstrates, in my view, that no impasse had been reached. While it is true that the Union failed to respond to Respondent's offer to implement the "Hamden Plan" but even that offer did require that employees pay the additional premium costs and presumably did not include an agreement by Respondent to withdraw its wage cuts proposals as demanded by the Union. Thus, the Union cannot be faulted for not promptly responding to Respondent's offers. I emphasize again the inaccuracy of Respondent's assertion that the plans were "expiring" on June 30. In fact, they were not expiring but would have continued (albeit in increased costs to Respondent) had Respondent not unilaterally decided to implement the new plans because it did not want to incur these increased premium costs. Thus, the "self-imposed" deadline by Respondent cannot justify an impasse finding.

Significantly, in this regard, McHale testified that his June 22 letter reflected that Respondent was making it clear that it was offering the Hamden Plan as an alternative and that this was a "final offer" from Respondent.[18] McHale further testified that if the Union had agreed to incorporate that plan as an alternative, Respondent would have agreed to it for the sake of making a deal, even though it would have resulted in confusion and delays in processing of claims (due to the fact that employees had already enrolled in the proposed plans, and it would require new enrollment forms to be filled out for employees, who opted for the "Hamden Plan"). McHale further testified that if the Union "had agreed to the Hamden Plan, with let's split the cost, that would have been perfect." Thus, McHale's testimony established that fruitful bargaining was still possible and still in progress, and the parties had not reached the "end of the rope" as McHale asserted. I emphasize again McHale's further testimony that "we were 24 hours from the end," so no further bargaining would be fruitful. There is "no end" in 24 hours as there is no prohibition on bargaining after July 1. Respondent's self-imposed deadline cannot create an impasse, especially where, as here, the evidence suggests that further bargaining could be productive.

While McHale also notes in his testimony the Union's continued insistence that Respondent withdraw its regressive wage cuts before asking the Union to make concessions on healthcare, this testimony only reflects that there was still bargaining to be done, and only reinforces the wisdom of the Board's rejection of piecemeal bargaining (subject to limited exceptions). There was clearly still an opportunity for movement and agreement on healthcare if Respondent would agree to withdraw its wage cut proposal, so bargaining could still have been fruitful and Respondent's decision to implement its proposal "precluded further exploration of possible tradeoffs and foreclosed any finding that good faith bargaining exhausted the prospects of reaching an agreement. Having never fully tested the finality of the Union's bargaining positions, Respondent is in no position to argue that further negotiations would have been futile." *Newcor Bay City*, supra, 345 NLRB at 1239, citing *Royal Motor Sales*, supra, 329 NLRB at 763, and *Towne Plaza Hotel*, 258 NLRB 69, 78 (1981).

Respondent's reliance on *ACF Industries*, supra is misplaced as the facts therein are clearly distinguishable from the instant matter. The issue there was whether there was an overall impasse in bargaining rather than an impasse solely on healthcare as here. Further, in *ACF Industries*, the union's membership had twice voted to reject respondent's offers, after which respondent stated that it had nothing further to offer and would implement its last offer on August 21. The union, in an August 16 call, stated that it had additional proposals to make but did not divulge what the proposals would be and did not request any further negotiations. Respondent replied that it had nothing further to offer and was going to implement.

The Board majority[19] concluded that in these circumstances in agreement with the judge that the parties were at impasse. The Board majority agreed with the judge that the union's statement that it was prepared to make additional proposals does not preclude an impasse finding since he concluded that if the union had meaningful proposals to make, it would have done so and asked for further negotiations on these proposals. Thus, the judge concluded, and the Board majority agreed that the reason the union failed to do so was because it had no further (nonregressive) proposals to offer.

In contrast here, not only did the Union say that it was willing to make new proposals on healthcare, but it did request additional negotiations in order to further explore these issues, which could be fruitful, particularly, if Respondent withdraw its other regressive proposals that the Union had demanded.

Furthermore, as I have detailed above, Respondent had not fully complied with the information requests for the SPDs for both the old and proposed (and eventually implemented) health plans when Respondent , in fact, implemented the new health plans on July 1. Particularly, since the information requested was directly relevant to the issue (healthcare) upon which Respondent asserts impasse was reached, this precludes a finding of a good-faith impasse. *E.I. DuPont & Co.*, 346 NLRB 553, 558 (2006); *Monmouth Care*, supra, 354 NLRB at 57–58; *New Cor Bay City*, supra, 345 NLRB at 1291; *Essex Valley*, supra, 343 NLRB at 841–842; *U.S. Testing*, supra, 324 NLRB at 860; *Decker Coal*, 301 NLRB 729, 740 (1991).

A third exception to the overall impasse requirement before implementing a change in past practice terms of employment, set forth in *Bottom Line*, supra and *RBE Electronics*, supra is detailed in *Stone Container Corp.*, 313 NLRB 336 (1993), and amplified in *TXU Electric Co.*, 343 NLRB 1404 (2004).

[18] Notably, McHale did not use the term "final offer" either in his letters or at negotiations.

[19] Member Liebman dissented.

This precedent holds that where a particular term of employment involves a discrete annual event that occurs every year at a particular time, even if that event happens to occur while contract negotiations are in progress, an employer need not bargain to overall impasse before implementing that term. It needs only to provide the union with notice and opportunity to bargain as to these matters.[20]

These principles have been applied where the term and condition of employment changed was annual wage increases, *Stone Container*, supra; *TXU Electric*, supra; *Alltel Kentucky*, 326 NLRB 1350 (1988); as well as where the change involved health coverage. *St. Mary's Hospital of Blue Springs*, 346 NLRB 776 (2006); *Saint-Gobain Abrasives*, 343 NLRB 542 (2004); *Nabors Alaska Drilling*, 341 NLRB 610 (2004); *Brannan Sand & Gravel*, 314 NLRB 282 (1994).

Respondent asserts that it provided the Union an adequate notice and opportunity to bargain over the changes that it made and that, therefore, its implementation was not unlawful. However, I disagree since the *Stone Container* exception applies only to first contract negotiations and not to negotiations for successor contracts, as here.

Respondent argues that *RBE Electronics* and *Bottom Line* were both successor contract cases as well as other cases applying the *RBE Electronics* and *Bottom Line* analysis concerning exceptions to the overall impasse requirement before implementation. *IFG Stockton*, 357 NLRB No.118 (2011); *Pleasantville Nursing Home*, supra. While I note that *RBE Electronics* does make reference to *Stone Container* in footnote 15, it indicates that the *Stone Container* analysis is separate and apart from the *RBE Electronics* analysis although both involve exceptions to the overall impasse rule. In *RBE Electronics*, the Board remanded the case to the judge to issue a decision consistent with its opinion. No such decision issued thereafter, indicating that the case was subsequently resolved. Thus, *RBE Electronics* did not apply the *Stone Container* analysis to a successor contract situation.

Close examination of the opinions in subsequent cases, which did apply the *Stone Container* exception, make it clear that the analysis is applicable only to first contract situations, where the parties have not yet established their own practices through contract that they can rely upon in the future. I note that all of the cases cited above, where the Board applied the *Stone Container* analysis, involved first contracts.

In *TXU Electric*, the Board felt it significant to stress at the outset of its analysis that the case concerned "a situation in which the status quo of a mandatory subject at the commencement of a bargaining relationship." (Id. at 1405.) In its analysis, the Board further stressed that the employer did not violate the Act because its actions occurred "in the context of a new-collective-bargaining relationship." (Id. at 1407.) The Board added:

> We agree with the opinion in *Daily News of Los Angeles*, 315 NLRB at 1244, that where, as here, a discrete recurring event occurs every year at a given time, and negotiations for a first contract will be ongoing at that time, an employer can announce in advance that its plans to make changes as to that event. . . . As long as the union is given notice and opportunity to bargain to those matters. The employer can carry out the changes even where there is no overall impasse as of the time of the change.

Finally, the Board concluded by again stressing that the "discrete, recurring event" theory is limited to initial contracts by stating:

> That bargaining subject of wages is not removed from the table by the employer's interim unilateral action. . . . It provides a bargaining bridge to cross the transitional period when an employer must deal with that event while engaged in initial negotiations with a newly-recognized or certified union. The principle has no broad application or disruptive potential.

Further in *St. Mary's Hospital*, supra, where the Board applied the *Stone Container* analysis to changes in healthcare coverage, the Board observed as follows:

> As the judge found from the credited record, the Respondent gave the Union timely notice of the prospective changes at issue and an opportunity to bargain over them. In addition, the Respondent remained willing to bargain over the changes after implementation. The Respondent also established that the changes were consistent with a past practice, established when the unit's employees were unrepresented, under which the Respondent implemented changes in copremiums, copayments, deductibles, and other terms of health plan coverage on an annual basis. The parties were negotiating for a first contract but had not reached agreement on health coverage by the time the changes at issue would normally have been implemented. Moreover, if the Respondent did not take any action prior to January 1, the employees would have suffered a disruption in coverage. Under these circumstances, the implementation did not violate Section 8(a)(5) of the Act. [346 NLRB 776.]

See also *Rose Fence Inc.*, 359 NLRB No. 6 fn. 1 (2012) (applying *Stone Container* analysis to a decision to lay off employees and stating it applies to negotiations "for a first contract," "which is the kind of situation that calls for a balanced approach accommodating the legitimate need for an employer to continue making daily operational decisions necessary to the maintenance of its business during the initial stage of a collective bargaining relationship"). Id.

Furthermore, even apart from the first contract issue, the *Stone Container* exception applies only if the change in terms of conditions of employment was a discrete, recurring event, a necessary requirement under *Quality Roofing Supply Co.*, 357 NLRB No. 75 slip op. at 1 (2011). In *Quality Roofing*,[21] the Board rejected an employer's argument that is decision to implement changes in health insurance premiums was privileged by *Stone Container* as follows:

[20] Thus, under this precedent, it is not even necessary to bargain to impasse over these specific changes. Notice to the union and opportunity to bargain is sufficient to permit implementation.

[21] *Quality Roofing* was also a first contract situation.

Further, there is no merit in the Respondent's argument based on *Stone Container Corp.*, 313 NLRB 336 (1993), that it was privileged to implement the health insurance premium increases because a bargaining impasse had been reached on that issue. The employer in *Stone Container* had an established practice of conducting an annual wage and benefit survey and implementing an increase, if appropriate, each April. Id. at 336. In the instant case, the Respondent has not established that an increase in employees' health insurance premiums was a discrete, annually recurring event—a necessary requirement under *Stone Container*.

Further, both *St. Mary's Hospital* and *Saint Gobain Abrasives*, two other cases that applied the *Stone Container* analysis to healthcare changes, stressed that a past practice had been established when employees were unrepresented, under which the employer implemented changes in copremiums, copayments, deductibles, and other terms of health plan coverage on an annual basis, 346 NLRB at 776, or had an annual process of renewing and adjusting its health insurance programs, *Saint-Gobain Abrasives*, 343 NLRB at 542. Here, in contrast, there is no established practice of Respondent adjusting premiums or coverage on an annual basis, notwithstanding the fact that every year the insurance company can and had raised premium rates and changed policy terms or coverages. To the contrary, here, Respondent has, consistent with its contractual obligation to maintain equivalent coverage, absorbed any healthcare premiums increases from the insurance company and made changes in coverages or plans, only where the Union consented.

Finally, I note *Maple Grove Health Care*, supra, 330 NLRB at 775, a post-*Stone Container* case, involving a first contract, where the Board found, as detailed above, that the employer was not free to implement changes in healthcare premiums, despite its assertion that the union had notice and opportunity to bargain about the change.

The Board explained as follows, in response to a contention that the employer had not changed the status quo by making the changes:

> [I]f the employer's practice was to pay a specified amount for each employees' health insurance, and for the employees to pay the rest, the employer could lawfully require the employees to bear the entire weight to the premium increase. On the other hand, if an employer's practice was for employees to pay a set amount of the premium, and the employer to pay the rest, the employer could not lawfully impose any part of the increase on the employees without first bargaining to agreement or impasse with the union.
>
> Thus, when an insurance carrier imposes a premium increase, the employer may unilaterally require employees to shoulder part or all of the increase if it can show that the status quo ante is not changed as a result.

Therefore, *Stone Container* and its progeny provide no support for Respondent's position that it could lawfully implement the changes in healthcare, absent overall impasse.

Accordingly, based on the foregoing analysis and precedent, I conclude that Respondent has violated Section 8(a)(1) and (5) of the Act by unilaterally changing healthcare benefits for its employees.

Conclusions of Law

1. The Respondent, Connecticut Institute for the Blind, Inc. d/b/a Oak Hill, is an employer within the meaning of Section 2(2), (6), and (7) of the Act.

2. The Union, District 1199, New England Health Care Employees Union, SEIU, is a labor organization within the meaning of Section 2(5) of the Act.

3. At all material times, the Union has been the designated exclusive collective-bargaining representative of Respondent's employees employed at its principal office in Hartford, Connecticut, as well as at various other facilities throughout Connecticut in the following appropriate unit:

> All regular full-time and part-time assistant teachers, day program workers, job coaches, residential program workers, dietary workers and maintenance employees, excluding instructors, head custodian, maintenance mechanic, head cooks, guard, clerical employees, professional employees and supervisors as defined in the Act.

4. By failing to supply relevant information to the Union in a timely and complete fashion, Respondent has violated Section 8(a)(1) and (5) of the Act.

5. By unilaterally implementing health insurance changes on July 1, 2011, during collective bargaining, without bargaining to a lawful overall impasse in negotiations, Respondent has violated Section 8(a)(1) and (5) of the Act.

6. The unfair labor practices, described above, affect commerce within the meaning of Section 2(6) and (7) of the Act.

The Remedy

Having found that Respondent has engaged in certain unfair labor practices, it is necessary to order it to cease and desist and to take certain affirmative actions designed to effectuate the policies of the Act. Respondent shall be required to make whole its employees for any losses they suffered or expenses they incurred, including increased premium costs, that resulted from Respondent's unlawful changes in healthcare insurance. Such amounts shall be computed in the manner set forth in *Ogle Protection Service*, 183 NLRB 682 (1970), enfd. 444 F.2d 502 (6th Cir. 1971), with interest at the rate prescribed in *New Horizons for the Retarded*, 283 NLRB 1173 (1987), compounded daily as prescribed in *Kentucky River Medical*, 356 NLRB No. 8 (2010).

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended[22]

ORDER

The Respondent, Connecticut Institute for the Blind, Inc. d/b/a Oak Hill, Hartford, Connecticut, its officers, agents, successors and assigns, shall

---

[22] If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.

1. Cease and desist from

(a) Failing and refusing to bargain collectively with the New England Health Care Employees Union, District 1199, SEIU (the Union) by failing and refusing to timely and completely supply information that is relevant and necessary to the Union's performance as the exclusive collective-bargaining representative of its unit employees. The unit is:

> All regular full-time and part-time assistant teachers, day program workers, job coaches, residential program workers, dietary workers and maintenance employees, excluding instructors, head custodian, maintenance mechanic, head cooks, guard, clerical employees, professional employees and supervisors as defined in the Act.

(b) Failing and refusing to bargain collectively with the Union by unilaterally implementing changes in terms and conditions of employment of its employees employed in the above-described unit in the absence of an overall lawful bargaining impasse.

(c) In any like or related manner interfering with, restraining, or coercing employees in the exercise of the rights guaranteed them by Section 7 of the Act.

2. Take the following affirmative action necessary to effectuate the policies of the Act.

(a) Upon request of the Union, rescind the unilaterally implemented changes in employees' healthcare coverage, copays, and premiums and restore the coverage, copays, and premiums available to employees prior to July 1, 2011.

(b) Make all affected employees whole, with interest, in the manner set forth in the remedy section of this decision for any losses they suffered or expenses they incurred as a result of the unlawful action by Respondent.

(c) Preserve and, within 14 days of a request, make available to the Board or its agents for examination, all payroll records, social security payment records, timecards, personnel records and reports, and all other records, including an electronic copy of such records if stored in electronic form, necessary to analyze the amount of backpay due under the terms of this Order.

(d) Within 14 days after service by the Region, post at its Hartford, Connecticut facility and at all of its other facilities, where unit employees work, copies of the attached notice marked "Appendix B."[23] Copies of the notice, on forms provided by the Regional Director for Region 34, after being signed by the Respondent's authorized representative, shall be posted by the Respondent and maintained for 60 consecutive days in conspicuous places including all places where notices to employees are customarily posted. In addition to physical posting of paper notices, notices shall be distributed electronically, such as by email, posting on an intranet or an internet site, and/or other electronic means, if the Respondent customarily communicates with its employees by such means. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. If the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice to all current employees and former employees employed by the Respondent at any time since July 1, 2011.

(e) Within 21 days after service by the Region, file with the Regional Director for Region 34 a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

Dated, Washington, D.C. February 22, 2013

---

[23] If this Order is enforced by a judgment of a United States court of appeals, the words in the notice reading "Posted by Order of the National Labor Relations Board" shall read "Posted Pursuant to a Judgment of the United States Court of Appeals Enforcing an Order of the National Labor Relations Board."

OAK HILL

2010-2011 Current and 2011-2012 Proposed Plan Costs

	Oxford / United - Contribution Rates 7/1/10 to 6/30/11 Current Costs	Employee Contributions	2010/2011 Cost to Oak Hill	Oxford / United - Contribution Rates 7/1/11 to 6/30/12 Reducing HSA Funding w/ HMO Core Plan Proposed Costs		Proposed EE Contributions	2011/2012 Cost to Oak Hill
	Monthly Rates	Monthly Rates	Monthly Cost	Monthly Rates		Monthly Rates	Monthly Cost
Core HMO				*Core HMO*			
Employee				$545.88	-1.9%	$40.00	*$505.88*
Employee + Spouse				1,173.65	-1.9%	80.00	*1,093.65*
Employee + Child(ren)				1,064.46	-1.9%	80.00	*984.46*
Employee + Family				1,583.05	-1.9%	80.00	*1,503.05*
Current HMO				*100% Buy-Up From Core HMO*			
Employee	$556.69	$40.00	*$516.69*	$657.01	18.0%	$151.13	*$505.88*
Employee + Spouse	1,196.88	80.00	*1,116.88*	1,412.56	18.0%	318.91	*1,093.65*
Employee + Child(ren)	1,085.53	80.00	*1,005.53*	1,281.16	18.0%	296.70	*984.46*
Employee + Family	1,614.41	80.00	*1,534.41*	1,905.31	18.0%	402.26	*1,503.05*
POS 15/25				*100% Buy-Up From Core HMO*			
Employee	$605.25	$88.56	*$516.69*	$714.55	18.1%	$208.67	*$505.88*
Employee + Spouse	1,301.30	184.42	*1,116.88*	1,536.29	18.1%	442.64	*1,093.65*
Employee + Child(ren)	1,180.21	174.68	*1,005.53*	1,393.34	18.1%	408.88	*984.46*
Employee + Family	1,755.25	220.84	*1,534.41*	2,072.22	18.1%	569.17	*1,503.05*
HDHP/HSA	*$1500/3000 w/ 75% ER Funding*			*rate with 67% deductible funding*			
Employee	$535.11	$40.00	*$495.11*	$569.48	6.4%	$40.00	*$529.48*
Employee + Spouse	1,136.39	80.00	*1,056.39*	1,211.83	6.6%	80.00	*1,131.83*
Employee + Child(ren)	1,048.13	80.00	*968.13*	1,114.68	6.3%	80.00	*1,034.68*
Employee + Family	1,467.41	80.00	*1,387.41*	1,576.13	7.4%	80.00	*1,496.13*

Willis

OAK HILL

July 1, 2011 Oxford / United Healthcare Medical Plan Options - Current and Proposed

Plan Designs		
Core Oxford HMO		Core HMO
Gatekeeper/PCP Referral Requirement		none
Office Visit		$30 primary / $45 specialist
Lab Services		100%
High Cost Diagnostic (MRI, PET, CAT)		100%
Hospital Copay		$500 copay per admit
Outpatient Surgery		$250 copay
Emergency Room / Urgent Care		$150 copay / $75 copay
Disposable, Durable & Ostomy Supplies		DME - 50% to unlimited
Prescription Drugs		$15 Tier 1/$25 Tier 2/ $40 tier 3 unl. max.- Mac C
Current Oxford HMO	Current HMO	Current HMO
Gatekeeper/PCP Referral Requirement	none	none
Office Visit	$15 primary / $25 specialist	$15 primary / $25 specialist
Lab Services	100%	100%
High Cost Diagnostic (MRI, PET, CAT)	100%	100%
Hospital Copay	100%	100%
Outpatient Surgery	100%	100%
Emergency Room / Urgent Care	$50 copay / $25 copay	$50 copay / $25 copay
Disposable, Durable & Ostomy Supplies	DME - 100% unlimited maximum	DME - 100% unlimited maximum
Prescription Drugs	$10 Tier 1/$20 Tier 2/ $30 tier 3 unl. max.- Mac C	$10 Tier 1/$20 Tier 2/ $30 tier 3 unl. max.- Mac C
Oxford Point-of-Service	POS $15/25	POS $15/25
Gatekeeper/PCP Referral Requirement	none	none
Office Visit	$15 primary / $25 specialist	$15 primary / $25 specialist
Lab Services	100%	100%
High Cost Diagnostic (MRI, PET, CAT)	100%	100%
Hospital Copay	100%	100%
Outpatient Surgery	100%	100%
Emergency Room / Urgent Care	$50 copay / $25 copay	$50 copay / $25 copay
Disposable, Durable & Ostomy Supplies	50% to $1500	50% to $1500
Prescription Drugs	$10 Tier 1/$20 Tier 2/ $35 Tier 3 unl. max.- Mac C	$10 Tier 1/$20 Tier 2/ $35 Tier 3 unl. max.- Mac C
Out-of-Network Deductible	$1,000 / $2,000 deductible	$1,000 / $2,000 deductible
*Out-of-Network Out-of-Pocket Max **	30% to $5,000 / $10,000 max	30% to $5,000 / $10,000 max
Oxford Health Savings Account	HSA $1,500 / $3,000 w/75% HSA Funding	HSA $1,500 / $3,000 w/67% HSA Funding
Gatekeeper/PCP Referral Requirement	none	none
In-Network Deductible	$1,500 individual / $3,000 family ded	$1,500 individual / $3,000 family ded
In-Network Coinsurance	100%	100%
In-Network Out-of-Pocket Max	$1,500 individual / $3,000 family max	$1,500 individual / $3,000 family max
Preventive Care	Covered at 100%	Covered at 100%
Office Visit	subject to deductible	subject to deductible
Lab Services	subject to deductible	subject to deductible
Diagnostic X-Ray	subject to deductible	subject to deductible
High Cost Diagnostic (MRI, PET, CAT)	subject to deductible	subject to deductible
Outpatient Surgery	subject to deductible	subject to deductible
Emergency Room / Urgent Care	subject to deductible	subject to deductible
Disposable, Durable & Ostomy Supplies	subject to deductible	subject to deductible
Prescription Drugs	subj. to deductible; then covered at 100%	subj. to deductible; then covered at 100%
Out-of-Network Deductible	$2,500 / $5,000 deductible	$2,500 / $5,000 deductible
*Out-of-Network Out-of-Pocket Max **	20% to $4,000 / $8,000 max	20% to $4,000 / $8,000 max

* *Out-of-Network Out-of-Pocket Maximums include both deductible and coinsurance amounts*

OH-000146

APPENDIX B
NOTICE TO EMPLOYEES
POSTED BY ORDER OF THE
NATIONAL LABOR RELATIONS BOARD
An Agency of the United States Government

The National Labor Relations Board has found that we violated Federal labor law and has ordered us to post and obey this Notice.

FEDERAL LAW GIVES YOU THE RIGHT TO

Form, join, or assist a union
Choose representatives to bargain with us on your behalf
Act together with other employees for your benefit and protection
Choose not to engage in any of these protected activities

WE WILL NOT fail or refuse to bargain collectively with the New England Health Care Employees Union, District 1199, SEIU (the Union) as your exclusive collective-bargaining representative by failing to timely and completely supply information that is relevant and necessary to the Union's performance as the exclusive collective-bargaining representative of its unit employees. The unit is:

All regular full-time and part-time assistant teachers, day program workers, job coaches, residential program workers, dietary workers and maintenance employees, excluding instructors, head custodian, maintenance mechanic, head cooks, guard, clerical employees, professional employees and supervisors as defined in the Act.

WE WILL NOT fail to bargain collectively with the Union by unilaterally implementing changes in terms and conditions of employment of our employees employed in the above-described unit, in the absence of an overall lawful bargaining impasse.

WE WILL NOT in any like or related manner interfere with, restrain, or coerce you in the exercise of the rights guaranteed you by Section 7 of the Act.

WE WILL upon request of the Union, rescind the unilaterally implemented changes in unit employees' healthcare coverage, copays, and premiums and restore the coverage, copays, and premiums available to employees prior to July 1, 2011.

WE WILL make you whole for any losses that you suffered or expenses you incurred as a result of the unlawful action taken against you, with interest.

CONNECTICUT INSTITUTE FOR THE BLIND, INC. D/B/A OAK HILL