

UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD  
DIVISION OF JUDGES  
WASHINGTON, DC

OAKLAND PHYSICIANS MEDICAL CENTER, LLC  
d/b/a DOCTORS' HOSPITAL OF MICHIGAN

Respondent

and

Case 07-CA-120931

MICHIGAN ASSOCIATION OF POLICE (MAP)

Charging Union

*Scott Preston, Esq.*,  
for the General Counsel.  
*K. C. Hortop, Esq.*,  
for the Respondent.  
*Catherine Farrell, Esq.*,  
for the Charging Party.

DECISION

STATEMENT OF THE CASE

Christine E. Dibble, Administrative Law Judge. This case was tried in Detroit, Michigan on June 17, 2014. The Michigan Association of Police (MAP or Charging Union) filed the charge on January 21, 2014, and an amended charge was filed on January 31, 2014.<sup>1</sup> On April 4, 2014, the General Counsel issued the complaint against the Oakland Physicians Medical Center, LLC d/b/a Doctors' Hospital of Michigan (Respondent).<sup>2</sup> Respondent filed a timely answer denying all material allegations. (GC Exhs. 1-A to 1-J).<sup>3</sup>

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<sup>1</sup> All dates are in 2013 unless otherwise indicated.

<sup>2</sup> Abbreviations used in this decision are as follows: "Tr." for transcript; "GC Exh." for General Counsel's exhibit; "R Exh." for Respondent's exhibit; "CU Exh." for Charging Union's exhibit; "ALJ Exh." for administrative law judge's exhibit; "Jt. Exh." for joint exhibit; "GC Br." for General Counsel's brief; "R Br." for Respondent's brief; and "CU Br." for Charging Union's brief. My findings and conclusions are based on my review and consideration of the entire record.

<sup>3</sup> In its answer, Respondent denied pars. 2, 6, 7, 8, 9, and 10 of the complaint. During the hearing, however, Respondent amended its answer to admit to these allegations. (Tr. 17-21, 55, 106-107.)

The complaint alleges that since about January 1, 2014, Respondent failed to continue in effect all the terms and conditions of its current collective bargaining agreement with the Charging Union by changing its health care insurance plan, “Health Advantage, Tier Green,” to a dissimilar plan, and by changing the employee premium contribution percentage, both without the Charging Union’s consent.<sup>4</sup>

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

## FINDINGS OF FACT

### I. JURISDICTION

Respondent, a limited liability company, operates a hospital providing inpatient and outpatient medical care at its facility in Pontiac, Michigan.<sup>5</sup> During the 12-month period ending December 31, 2013, Respondent derived gross revenue in excess of \$250,000. During this same period, Respondent also purchased and received at its Pontiac, Michigan facility goods, materials, and supplies valued in excess of \$50,000 directly from points outside the State of Michigan. The Respondent admits, and I find, that at all material times it has been an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act and has been a health care institution within the meaning of Section 2(14) of the Act.

Respondent admits, and I find, that the following employees of Respondent constitute a unit appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

All full-time, regular part-time, and non-regular security officers and security customer service representatives employed by Respondent at its Pontiac, Michigan facility; but excluding all supervisors, temporary and contingent employees, and as defined by Respondent.

Further, at all material times Respondent has recognized, and the Charging Union has been, the exclusive collective bargaining representative of the unit within the meaning of Section 9(a) of the Act.

### II. ALLEGED UNFAIR LABOR PRACTICES

#### A. OVERVIEW OF RESPONDENT’S OPERATION

Since 2008, Respondent has owned and operated a full-service acute care hospital, employing healthcare professionals, administrative staff, security officers, and employees in

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<sup>4</sup> This allegation is alleged in par. 11 of the complaint.

<sup>5</sup> Respondent also owns and operates an outpatient clinic, Waterford Ambulatory Care Center in Waterford, Michigan, that is not part of this complaint. Therefore, all references to Respondent’s facility, unless otherwise specified, pertain to its hospital in Pontiac, Michigan.

other job classifications. During the period at issue John Ponczocha (Ponczocha) was the chief executive officer (CEO), Dr. Short (first name unknown) was an owner and board member, and Robert Chiaravalli (Chiaravalli) was Respondent's attorney. Respondent also employed Mukul Kumar (Kumar) as its chief financial officer (CFO).

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The complaint at issue pertains to Respondent's security officers. During the relevant timeframe, Respondent employed approximately seven security officers. Their bargaining unit consists of two job classifications: security officer and customer service security officer.<sup>6</sup> The customer service security officer's primary responsibility is to greet visitors and secure the lobby area of the hospital, while security officers in the other classification oversee the entire facility. Since October 18, 2007, the Charging Union has been the exclusive bargaining representative for both classifications of security officers. Donnell Reed (Reed) is and has been for the period at issue, the Charging Union's labor relations specialist. He represents the Charging Union's members in contract negotiations, enforcement proceedings, grievance hearings, arbitrations, and other duties. John Hanson (Hanson) and Andrew Anzures (Anzures) are the union stewards for the security officers' bargaining unit.

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American Federation of State County and Municipal Employees (AFSCME) and Unite Auto Workers (UAW) also represent various classifications of employees at Respondent's facility. Melvin Brabson (Brabson) is the field staff representative for AFSCME. The UAW labor representative is Mary Gamble (Gamble).

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#### *B. Article 16 of the Collective Bargaining Agreement*

The Charging Union's most recent collective bargaining agreement (CBA) with Respondent was effective from April 10, 2012 to April 10, 2014.<sup>7</sup> (GC Exh. 7.) The health insurance provision of the CBA in Article 16 provides in relevant part:

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16.1 For the duration of this Agreement, employees will be eligible to enroll in Health Advantage, Tier Green, health insurance. Health insurance benefits are governed by the Plan Document, and the Union shall be given a copy of the Plan Document. The Hospital reserves the right to amend the plan design of health insurance benefits other than the premium co-share schedule listed below. The Union will be given notice of any plan design amendments.

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Employees will be required to pay the following health insurance premium co-share:

Full-time single	10% per pay
Full-time two person	10% per pay
Full-time family	10% per pay

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<sup>6</sup> Reed gave undisputed testimony that currently none of the security officers are classified as customer service security officer. According to Reed, the final customer service security officer was promoted to security officer within the last year. (Tr. 31.)

<sup>7</sup> Since the expiration of the most recent CBA, the Charging Union has attempted to engage Respondent in contract negotiations but it has refused. (Tr. 32-33.)

60-79 single	25% per pay
60-79 two person	25% per pay
60-79 family	25% per pay

5	40-59 single	50% per pay
	40-59 two person	50% per pay
	40-59 family	50% per pay

(GC Exh. 7.)

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The remaining portion of 16.1 addressed prescription drug coverage. Article 16 provision 16.4 is also relevant to the complaint at issue. It provides: “The Hospital reserves the right to select and change insurance carriers and administrators, provided that similar coverage is maintained.” Id.

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### *C. Cancellation of and Amendments to Employees’ Health Insurance Plan*

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Since 2008, Respondent has contracted with Compass Benefit Group (CBG), located in Birmingham, Michigan, to solicit the best health insurance plan for its employee benefit program. Edward Maitland (Maitland) is the president of CBG. Prior to January 1, 2014, Respondent had the majority of its employees in a self-funded health insurance plan. As part of its self-funded healthcare plan, Respondent rented the list of doctors in the Health Alliance Plan (HAP) preferred provider organization (PPO) network in order to get the discounts provided by them.<sup>8</sup> (Tr. 76-79) In 2013, HAP was administered by Northern Group Services (NGS), which was later acquired by CoreSource.<sup>9</sup> Respondent also contracted with Blue Cross Blue Shield (BCBS) to provide health insurance for a “handful” of employees who had been grandfathered into that plan. Maitland described these employees as “old-timers within the hospital” that consisted of union and non-union members. (Tr. 76-77.) In June or July 2013, BCBS notified CBG that it would cancel the health insurance for those employees because it was not cost effective for BCBS. Immediately following BCBS notification, Maitland informed the President of Respondent’s facility of the future cancellation of the healthcare plan.<sup>10</sup>

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In August, Respondent started getting behind on paying health insurance claims through NGS. Therefore, in August, September, and October, Maitland had continuing discussions with Respondent and NGS on ways to continue the self-funded employee health insurance plan and pay the claims. In mid-November, Respondent’s ability to timely pay its claims did not improve so NGS notified Maitland that it would terminate its contract with Respondent. Maitland informed Ponczocha that same day of NGS’ intention to terminate the contract. Respondent instructed CBG to find a replacement plan that was cost effective and fully insured. Consequently, in November CBG began searching for a new health insurance plan for

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<sup>8</sup> Hereinafter, I will refer to Respondent’s self-funded health insurance plan as HAP.

<sup>9</sup> NGS is a third-party administrator for self-funded health insurance plans. Respondent contracted with NGS to adjudicate their insurance claims, but Respondent was responsible for paying the claims from its own funds. Hereinafter, I will refer to NGS/CoreSource as NGS.

<sup>10</sup> Maitland was unsure if Ponczocha was president of the facility at that time. (Tr. 78.) Since none of the parties called Ponczocha as a witness, no evidence was presented to clarify the length of his tenure as president. Regardless, the information is not necessary for me to rule on the merits of the complaint.

Respondent's employees and discovered Blue Care Network Health Maintenance Organization (BCN HMO). BCN is a "fully insured" plan. (Tr. 82.) On November 29, Maitland emailed Ponczocha, Kumar, and Chris Lucander (Lucander)<sup>11</sup> with the cost associated with the BCN HMO plan. He provided them with the cost to Respondent for choosing a plan with a \$1500 employee deductible or a \$3500 employee deductible. (GC Exh. 6.) The \$1500 deductible plan was called the core plan, and the \$3500 deductible plan was referred to as the buy-up plan. By choosing to place the employees in the BCN HMO network (with either the core plan or buy-up plan), Respondent would have a fixed cost for insurance each month. (GC Exh. 6.) The final plan that Respondent chose included a core plan with a \$2000 employee deductible and a buy-up plan with a \$3500 employee deductible. (GC Exh. 27, 28.)<sup>12</sup> Maitland gave undisputed testimony that the HAP PPO plan was a "richer" benefit plan than the BCN HMO plan which replaced it. (Tr. 90.) Although the BCN HMO plan has the same medical coverage as the HAP PPO, it costs employees more in out-of-pocket expenses.<sup>13</sup> Maitland gave Respondent the final BCN HMO plans to review on about December 19, and Respondent signed documents committing to the plans on December 24. (Tr. 87-88.) The BCN HMO plan was effective January 1, 2014, for all of Respondent's employees.

*D. Notice to Unions of Changes in Employee Health Insurance Plan*

After being told by unnamed sources that BCBS was notifying employers that their health plans would be terminated effective January 1, 2014, in June or July Reed asked Ponczocha if Respondent had received a termination notice and was told no. The conversation occurred in a meeting called by Ponczocha in the hospital's boardroom. In attendance were Reed, Ponczocha, Chiaravalli, Anzures, and other unnamed individuals.

In July or August, Reed attended another meeting initiated by Respondent with Ponczocha, Anzures, Brabson, Lewis, and Gamble. Reed again asked Ponczocha if Respondent had been notified of any possible year end changes or cancellations in the employees' healthcare plans. Again, Respondent's management told him they were unaware of any changes or cancellations being proposed by their current health insurance plans.

Another meeting was called by Respondent in September. Those in attendance were Reed, Ponczocha, Short, Anzures, Brabson, Lewis, and Gamble. At the end of the meeting, Reed inquired about the status of the employees' healthcare plans going into 2014 and whether Respondent had verified the plan year. Respondent had not verified the plan year, and Ponczocha denied receiving notice of plan changes or cancellation from their health insurance plans.

In November, Ponczocha and Short organized a meeting with representatives from the 3 unions to discuss modifying the contract language on the utilization of compensatory time off (CTO). Respondent's attorney, Chiaravalli, also attended the meeting. Ponczocha and

<sup>11</sup> Lucander was Respondent's CFO at the time Maitland sent the email.

<sup>12</sup> Credible testimony was offered at the hearing to show that GC Exh.28 was signed and dated in 2013. (Tr.95.)

<sup>13</sup> The PPO network allows employees the option to choose medical providers outside of the network, usually at an increased out-of-pocket cost. Under the HMO plan, employees are limited, with few exceptions, to treatment by healthcare professionals within the HMO network.

Chiaravalli explained that the current agreement on the usage of CTO was creating a financial difficulty for Respondent. Reed noted, "...[T]hey asked us to enter into an agreement as to how many days [employees] would be allowed to use for the month of November and December for CTO." (Tr. 42.) Ultimately, the unions agreed to modify the contract on employees' utilization of CTO. After addressing the CTO issue, Reed again asked if Respondent was going to discuss possible changes to the healthcare plans, and Ponczocha responded "they were okay with healthcare, they were just focused on this CTO at the time." (Tr. 43.)

On December 16, Reed received an email from Ponczocha noting that a change in the employees' healthcare carrier and a significant increase in employees' premium contribution was required. The email continued, "We anticipate making a final decision [on changes to the employees' healthcare plan] by December 20, 2013, per the memo of understanding (MOU) recently signed." (GC Exhs. 8, 9, & 10.) Ponczocha offered to meet with Reed if he had concerns regarding the changes. Reed had not signed a MOU addressing healthcare. Nonetheless, he sent Ponczocha a response via email and regular mail that MAP would not agree to the proposed healthcare changes because it was not interested in increasing its members' healthcare costs, and there was a current CBA which MAP expected Respondent to honor.<sup>14</sup> (GC Exh. 11, 12.) Soon after sending the correspondence to Ponczocha, Reed went on vacation until January 6, 2014.

In mid-December, Ponczocha approached Anzures in the lobby and informed him that he was scheduling a meeting with the union representatives to discuss possible changes to the employees' health insurance plan.<sup>15</sup> Ponczocha, Maitland, Short, Gamble, Lewis and Anzures attended the meeting where they were informed that employees' current health insurance would lapse December 31, but Respondent was trying to obtain new coverage for them. The attendees were not given details of the upcoming changes.

On December 26, Ponczocha sent an email to Reed, Brabson, Gamble, and Chiaravalli notifying them of a meeting to be held on December 30, to discuss "the 2014 Benefit Plan and employee contribution levels." (GC Exh. 13.) Reed did not receive the email until he returned from vacation. Consequently, he was unable to attend the meeting but Anzures went in his

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<sup>14</sup> Reed provided undisputed testimony that the CBA between MAP and Respondent gives Respondent the right to change the plan design but any changes must provide benefits of similar or equal value to the current plan. Reed also testified that under the CBA in effect during the period at issue, Respondent was not allowed to change the premium sharing. His testimony was corroborated by Maitland, who explained that although the health insurance carrier changed, the benefit coverage remained the same as under HAP. Likewise, the evidence is undisputed that the BCN HMO plan resulted in increased out-of-pocket expenses to the employees. (Tr. 83-86, 89-90; GC Exhs. 7, 18, 22, 25, 26.)

<sup>15</sup> Respondent argues Anzures credibility as a witness is "suspect as he testified he was present in mid-December (when Reed was not yet on vacation) and also testified that he was not presented with any information regarding the new health insurance plan that was being proposed at the mid-December meeting (even though Reed had been given GC EX 8, 9, and 10, detailing the plan on December 16)." (R Br. 3-4.) Respondent is correct that the record does not explain why Anzures attended the mid-December meeting without Reed. However, this fact is not a persuasive reason for discrediting Anzures testimony. Key portions of his testimony were corroborated by Reed, Maitland, and Brabson. Also, there is no evidence that in the mid-December meeting Anzures received any of the documents that Ponczocha sent to Reed via email on December 16. Therefore, I find no basis for discrediting his testimony.

absence. Ponczocha, Kumar, Chiaravalli, Brabson, Lewis, Gable, and Anzures attended. During the meeting, the union representatives were given the enrollment worksheet for the BCN core and buy-up plans and a chart detailing the benefits provided by the two plans. The worksheet also contained the new employee premium deductibles. Ponczocha tried to get the Union  
 5 representatives to sign a document agreeing to the changes on behalf of their respective memberships. (GC Exh. 20.) None of the Union representatives would sign the agreement, and they complained to Ponczocha that the initial proposal of an employee 50% premium co-share was too costly. After the meeting, Anzures shared with Reed the information Respondent gave them at the meeting about the health insurance changes.

10 On January 6, 2014, Reed received an email from Ponczocha proposing a January 8, 2014, meeting with management and the Union representatives. Chiaravalli and Kumar were also copied on the email. In attendance at the meeting were Ponczocha, Maitland, Reed, Anzures, Lewis, Brabson, Gamble, and possibly Hanson. Ponczocha began the meeting with his  
 15 belief that they were solidifying an agreement he thought had been reached with the Unions at the December 30 meeting. Since Reed had not been present at that meeting and Anzures could not enter into agreements on his or the membership's behalf, Reed made it clear to the meeting's participants that he had not consented to any agreement. Brabson echoed Reed's objections to the agreement referenced by Ponczocha. (Tr. 149-153.) There is no evidence that any of the  
 20 union representatives agreed to sign or signed a MOU accepting Respondent's proposed changes to the employees' healthcare plan and premium contributions.<sup>16</sup> Ponczocha informed them that employees' healthcare premiums were fully paid for by Respondent only through January 1, 2014. Shortly after the meeting with Ponczocha and Maitland, Reed met with his membership about Respondent's proposed health plan changes, and they informed him that they were  
 25 unanimously opposed to modifying their current CBA to allow changes to the health insurance plan.

30 On January 20, 2014, Ponczocha held another meeting with Reed, Anzures, Brabson, Lewis, Gamble, Hanson, and Maitland to again discuss the healthcare changes. During the meeting, Reed learned that Respondent had started deducting the new increased premium amounts from employee paychecks.<sup>17</sup> He informed Ponczocha that his members had roundly rejected any premature changes to their CBA. Ponczocha became distraught and stated "he knew that this wasn't handled properly, that he did not meet with the unions and keep – bring

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<sup>16</sup> Reed testified that the MOU signed by the unions and referenced by Ponczocha was to allow Respondent to temporarily furlough certain employees for the months of November and December and restrict the use of CTO. The MOU expired on December 31. It did not address the issue of employee health insurance plans. (Tr. 65-66). Although Respondent's attorney argued that the MOU pertained to Respondent's proposed healthcare changes, he failed to present substantive evidence in support.

<sup>17</sup> Prior to January 1, 2014, Anzures was covered by the HAP plan. Although he did not sign-up for the new health insurance plan, Respondent began deducting the higher premium amount from his paycheck for the pay period January 5 to 18, 2014. (GC Exh. 24.) Anzures also attended another meeting held by Ponczoch on January 3, 2014, to discuss modifications Respondent made to the employees' health plan. Instead of Respondent's initial proposal of employee contribution towards premiums of 50%, Respondent changed it to 45% for singles and 35% for families. Respondent notified them that the changes had already been implemented and the employees had until January 10, to sign up for the new plan. Respondent also informed them that it would pay 100% of the employees' premium costs for January 2014.

them within the fold in the circle in handling this matter, that he made the change without speaking and negotiate (sic) with the unions like he was supposed to, but he was doing it as directed by the owners, the board of directors.”<sup>18</sup> (Tr. 60.) The meeting ended without a resolution. Following the meeting, Reed sent Ponczocha an email demanding that Respondent stop violating the CBA as it pertains to the healthcare provision. This was the last discussion he had with Respondent’s management team before filing two grievances on the issue on January 13 and 28, 2014. (R Exh. 1, 2.)

Brabson provided corroborating evidence that Respondent and the union representatives had several meetings where the possibility of healthcare change was discussed. He attended the December 30, meeting because Lewis called him on December 17 or 18, to tell him that Respondent had notified the employees that it was changing their health insurance plan. Prior to December 30, Respondent had also sent him an email explaining that it was experiencing financial difficulties and needed to increase employee health insurance premium contributions to 50% for full-time employees, and change the healthcare plan it offered to them.<sup>19</sup> (GC Exh. 17.) Brabson contacted Ponczocha to demand Respondent not implement any changes until Ponczocha had met with the employees’ unions. Ponczocha agreed to meet on December 30, with representatives from MAP, AFSCME, UAW, and Kumar. During the meeting, the Union representatives questioned Ponczocha about Respondent’s proposed changes to the healthcare plans. Ponczocha told them that Respondent was undergoing a financial crisis which necessitated the changes. The Unions asked Respondent to provide them with financial information to confirm that the changes were financially necessary. Respondent refused to provide the documentation and claimed “their computers were in a shambles or whatever and they couldn’t pull the information up and they couldn’t get us the information.” (Tr. 142.) Brabson confirmed that none of the Union representatives ever agreed to Respondent’s proposed healthcare changes.

As previously noted, in the January 8, 2014, meeting the attendees rehashed the subject of Respondent’s change to the healthcare insurance, and again the union did not get specific information from Respondent on its financial condition. By the end of the meeting, the Unions continued to agree to the health insurance changes. Nonetheless, Respondent implemented the amendments.

### III. DISCUSSION AND ANALYSIS

#### *A. LEGAL STANDARDS*

Section 8(d) of the Act provides that the employer and the employees’ representative have a mutual obligation to bargain collectively and as such must meet at reasonable times and confer in good faith with respect to “wages, hours, and other terms and conditions of employment, or the negotiation of an agreement or any question arising thereunder, and the

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<sup>18</sup> Anzures also provided undisputed testimony that at one of the meetings called by Respondent, Ponczocha told the Union representatives he “was upset that the Hospital had never made an effort to speak with the unions on the insurances and how they had basically just signed us all up without our consent; it wasn’t something that sat right with him.” (Tr. 122.)

<sup>19</sup> Brabson could not recall the deductible amount part-time employees would have to pay.

execution of a written contract incorporating any agreement reached if requested by either party...” The section goes on to note:

5 “That where there is in effect a collective-bargaining contract covering employees in an industry affecting commerce, the duty to bargain collectively shall also mean that no party to such contract shall terminate or modify such contract, unless the party desiring such termination or modification-

10 (1) serves a written notice upon the other party to the contract of the proposed termination or modification sixty days prior to the expiration date thereof, or in the event such contract contains no expiration date, sixty days prior to the time it is proposed to make such termination or modification;

(2) offers to meet and confer with the other party for the purpose of negotiating a new contract or a contract containing the proposed modifications;<sup>20</sup>

15 The good faith standard is used by the courts and the Board to determine if the parties have met their obligation to bargain under the Act. The Board takes a case-by-case approach in assessing whether parties have met, conferred, and negotiated in good faith. *National Licorice Co. v. NLRB*, 309 U.S. 350 (1940) (the Court adopted the “good faith” standard for an employer’s conduct); *St. George Warehouse, Inc.*, 349 NLRB 870 (2007) (the Board reviews the totality of the employer’s conduct in deciding if the employer has satisfied its obligation to confer in good faith).

25 Likewise, an employer to a contractual agreement cannot unilaterally take certain actions that result in changes to the terms and conditions of employment unless there has been a “clear and unmistakable” waiver of the union’s right to bargain over the changes. *Pavilions at Forrestal*, 353 NLRB 540 (2008) (impasse irrelevant where employer unilaterally implemented new health insurance plan without providing union information, notice and opportunity to bargain concerning new plan); *Laurel Bay Health & Rehab. Ctr.*, 353 NLRB 232 (2008) (employer prematurely declared impasse and unilaterally implemented changes in health insurance and other benefits where union requested and employer agreed to schedule subsequent bargaining session, union indicated willingness to “look at other plans,” and union stated that it would prepare counterproposal). The “clear and unmistakable” standard requires that the contract language is specific, or it must be shown that the subject alleged to have been waived was fully discussed by the parties and the party alleged to have waived its rights did so explicitly and with the full intent to release its interest in the matter. *Allison Corp.*, 330 NLRB 1363, 1365 (2000); *Metropolitan Edison Co. v. NLRB*, 460 U.S. 693, 708 (1983).

40 In order to find that Respondent made unilateral changes to an employee benefit in violation of the Act, it must be shown that (1) material changes were made to the employees’ terms and conditions of employment; (2) the changes involved mandatory subjects of bargaining; (3) Respondent failed to notify the Union of the proposed changes; and (4) the Union did not have an opportunity to bargain with respect to the changes. *Alamo Cement Co.*, 281 NLRB 737 (1986); *Beverly Health & Rehab. Servs., Inc.*, 317 F.3d 316 (D.C. 2003) (unilaterally replacing HMO coverage).

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<sup>20</sup> Because the collective bargaining involves employees of a health care institution, section 8(d)(1) notice is 90 days pursuant to 8(d)(4)(A).

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## *B. Complaint Allegation*

### 1. Respondent's Request to Defer the Matter to Arbitration

10 Prior to addressing the merits of the allegation at issue, I must first rule on the Respondent's motion for dismissal and deferral of the instant case to the parties' grievance/arbitration procedure.<sup>21</sup> See *L.E. Myers Co.*, 270 NLRB 1010, 1010 fn. 2 (1984).

15 Under *Collyer Insulated Wire*, 192 NLRB 837 (1971) and *United Technologies*, 268 NLRB 557, 558 (1984), deferral of an unfair labor practice charge to the parties' grievance/arbitration procedure is appropriate when:

20 [T]he dispute arose within the confines of a long and productive collective-bargaining relationship; there is no claim of employer animosity [or "enmity"] to the employees' exercise of protected rights; the parties' agreement provides for arbitration of a very broad range of disputes; the arbitration clause clearly encompasses the dispute at issue; the employer has asserted its willingness to utilize arbitration to resolve the dispute; and the dispute is eminently well suited to such resolution [by arbitration].

25 *United Technologies*, supra at 558. As the moving party, Respondent bears the burden of proving that deferral to the parties' contractual grievance/arbitration procedure is appropriate. *Rickel Home Centers*, 262 NLRB 731, 731 (1982).

30 Respondent has failed to support its burden of proof. Some evidence in the case support deferral. Since 2007, Respondent and the Charging Union have had a stable and productive collective bargaining relationship; there is no claim of animosity to employees' exercise of their Section 7 rights; and Respondent is willing to submit to arbitration. However, I find that the substantive question in this case is not a question of contract interpretation that is well suited for resolution through arbitration.

35 Article 16.1 of the CBA reads in part:

The Hospital reserves the right to amend the plan design of health insurance benefits other than the premium co-share schedule listed below. The Union will be given notice of any plan design amendments.

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45 The CBA sets out in unambiguous language the employees' share of the health insurance premium and that Respondent does not have the right to unilaterally change the premium co-share schedule. While the parties' may dispute the interpretation of the contract related to amending the plan design, the contract language addressing premium co-share needs no interpretation. Therefore, the special expertise of an arbitrator is unnecessary to interpret the

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<sup>21</sup> See Sec. 102.35(a)(9) of the Board's Rules.

contract. *Caritas Good Samaritan Med. Ctr.*, 340 NLRB No. 6 (2003). Addressing the issue of the Respondent's right to amend the plan design, I likewise find it is not appropriate for arbitration. Although Respondent eventually gave the Charging Union notice of the health plan design amendments, it did not do so until after their implementation. Therefore, the violation of the contract appears so obvious that there can be no contrary interpretation by an arbitrator. See *R.T. Jones Lumber Co.*, 313 NLRB 726, 727 (1994); *Oak Cliff-Golman Baking Co.*, 202 NLRB 614 (1973); *Alfred M. Lewis, Inc.*, 229 NLRB 757 (1977), enforced in pertinent part, 587 F.2d 403, 408 (9th Cir. 1978). Further, the contract interpretation as it relates to the health plan design is so intertwined with Respondent's unilateral change in the employees' premium contributions that they cannot be separated. Consequently, I find that deferring this case to arbitration would be inappropriate. Thus, the Respondent's motion for dismissal and deferral to arbitration is denied.

## 2. Respondent's Implementation of Changes to Health Insurance Plan

The General Counsel alleges that Respondent violated Section 8(a)(1) and (5) of the Act when, since about January 1, 2014, without prior notice to the Union and without giving the Union an opportunity to bargain with Respondent, Respondent unilaterally changed its health care insurance plan to a dissimilar plan, and changed the employee premium contribution percentage. (GC Br. 3.) Respondent contends that the complaint should be dismissed because the allegations "lack merit". (R Br. 1)

For the following reasons, I conclude that since about January 1, 2014, Respondent has unilaterally changed the employees' health insurance plan and health insurance premium contribution without providing the Union prior notice, and an opportunity to bargain over the change.

The law is well-settled that an employer may not change the terms and conditions of employment of represented employees without providing their representative with prior notice and an opportunity to bargain over such changes. See *NLRB v. Katz*, 369 U.S. 736, 747 (1962). In *Axelson, Inc.*, 243 NLRB 414, 415 (1978), the Board defined mandatory subjects of bargaining as:

those comprised in the phrase "wages, hours, and other terms and conditions of employment" as set forth in Section 8(d) of the Act. While the language is broad, parameters have been established, although not quantified. The touchstone is whether or not the proposed clause sets a term or condition of employment or regulates the relation between the employer and its employees.

The duty to bargain only arises if the changes are "material, substantial and significant." *Alamo Cement Co.*, at 738; *Flambeau Airmold Corp.*, 334 NLRB 165, 171 (2001). The General Counsel bears the burden of establishing this element of the prima facie case. *N. Star Steel Co.*, 347 NLRB 1364, 1367 (2006). Moreover, the Board has consistently held that change to employees' health benefits is a mandatory subject of bargaining and, hence, a unilateral change which constitutes a refusal to bargain. *Mid-Continent Concrete*, 336 NLRB 258, 259 (2001). See also *BP Amoco Corp. v. NLRB*, 217 F.3d 869 (D.C. Cir. 2000) (modifications to health plan).

5 In June or July Respondent notified its benefits coordinator to find a new health care plan  
for its employees that would not cost it more than \$70,000 per month to purchase. Maitland  
admitted that the BCN HMO plan Respondent purchased is not as “rich” as the HAP PPO plan,  
and he admits and the documents show that the costs the employees, including the security  
10 officers, are required to pay towards their health insurance premiums substantially increased  
under the new plan. (GC Exh. 7, 19, 23-28) The new plan requires the employees to use a  
healthcare provider in the BCN HMO network, whereas under the former HAP PPO plan  
employees could visit healthcare providers whether inside or outside the HAP PPO network.  
Although choosing someone outside the PPO network under the NGS and HAP PPO plans could  
15 potentially increase an employee’s out of pocket expenses, the BCN HMO plan did not even  
afford the employee the option of choosing a healthcare provider outside the BCN HMO  
network. Thus, their options for choosing medical providers were more limited under the BCN  
HMO plan and their premium co-shares were more expensive. Accordingly, I find that material  
changes were made to the employees’ terms and conditions of employment.

20 Moreover, I conclude that Respondent failed to notify the Charging Union prior to  
making the changes to the employees’ health insurance plan. It is undisputed that BCBS notified  
Respondent in June or July 2013, it was terminating the employees in the plan effective January  
1, 2014. However, there is no evidence that prior to December 16, Respondent notified the  
Charging Union of the impending termination. The evidence is undisputed that on December 24,  
Respondent entered into a contract to change the employees’ health insurance plan and premium  
25 contribution costs effective January 1, 2014. The evidence also established that this occurred  
prior to Respondent meeting with MAP or any of the other union representatives informing them  
that the contract with BCN HMO had been signed.

30 Next, I turn to the question of whether after notifying the Charging Union of the  
unilateral change to the health insurance plan if the Charging Union was provided a reasonable  
opportunity to bargain over the change. Based on the evidence, I conclude that Respondent did  
not provide the Union an opportunity to bargain over the change prior to its implementation.

35 Despite Respondent’s denials to Reed that it had no plans to change health benefits, it had  
already made a decision to do so in June. Although Respondent notified Reed on December 16,  
of proposed changes to the plans, the contract between BCN HMO and Respondent was signed  
on December 24, about a week before Respondent met with the unions to notify them of the  
contracted changes. The unilateral change at issue was accomplished approximately 1 week  
prior to its notification to the Charging Union. More importantly, it is undisputed that  
Ponczocha admitted that changes to the health insurance plan were made prior to speaking and  
negotiating with the unions.<sup>22</sup> Although Respondent held a series of meetings with MAP and the  
40 other unions to discuss the health care changes, they were conducted after BCN HMO had been  
contracted to be the new carrier, and a decision had been made to increase the employees’  
contribution towards health insurance premiums. Also, at the last meeting with the unions on

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<sup>22</sup> Respondent did not call Ponczocha as a witness to dispute Anzures’ and Reed’s testimony that he admitted he made the changes to the health plan without notifying and negotiating with the unions. (Tr. 60, 121). Finding nothing in the record to discredit Anzures’ and Reed’s testimony on this point, I have accepted it as an undisputed fact.

January 8, Respondent had already started deducting increased amount of money from employees' paychecks to pay for the new health plan.

Based on the evidence of record, I find that Respondent violated Section 8(a)(1),(5) and 8(d) of the Act, when since January 1, 2014, it unilaterally changed its health insurance plan and the employee premium contribution percentage without prior notice to the Charging Union and, or giving the Charging Union an opportunity to bargain over the issue.

#### CONCLUSIONS OF LAW

1. The Respondent, Oakland Physicians Medical Center, LLC d/b/a Doctors' Hospital of Michigan, is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act and has been a health care institution within the meaning of Section 2(14) of the Act.

2. The Michigan Association of Police is a labor organization within the meaning of Section 2(5) of the Act.

3. By unilaterally and without prior notice to the Charging Union changing its health care insurance plan to a dissimilar plan, and by changing the employee premium contribution percentage, the Respondent has violated Section 8(a)(1),(5) and 8(d) of the Act.

4. The above violations are unfair labor practices that affects commerce within the meaning of Section 2(6) and (7) of the Act.

10. The Respondent has not violated the Act except as set forth above.

#### REMEDY

Having found that the Respondent has engaged in certain unfair labor practices, I shall order it to cease and desist therefrom and to take certain affirmative action designed to effectuate the policies of the Act.

The Respondent having discriminatorily made changes in the employees' health care insurance plan and the employees' premium contribution percentage must rescind any and all changes to their health insurance benefits and make them whole for any loss of earnings and other benefits they suffered as a result of the discrimination against them from the date of the discrimination to the date remedy is effectuated. Backpay shall be computed in accordance with *F.W. Woolworth Co.*, 90 NLRB 289 (1950), with interest as provided in *New Horizons for the Retarded*, 283 NLRB 1173 (1987), compounded daily as prescribed in *Kentucky River Medical Center*, 356 NLRB No. 8 (2010) enf. denied on other grounds sub. nom., *Jackson Hospital Corp. v. NLRB*, 647 F.3d 1137 (D.C. Cir. 2011).

Respondent shall file a report with the Social Security Administration allocating backpay, if applicable, to the appropriate calendar quarters. Respondent shall also compensate the employees for the adverse tax consequences, if any, of receiving one or more lump-sum backpay awards covering periods longer than 1 year, *Don Chavas, LLC d/b/a Tortillas Don Chavas*, 361 NLRB No. 10 (August 8, 2014).

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended<sup>23</sup>

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## ORDER

The Respondent, Oakland Physicians Medical Center, LLC d/b/a Doctors' Hospital of Michigan, Pontiac, Michigan, its officers, agents, successors, and assigns, shall

10

## 1. Cease and desist from

15

(a) Unilaterally and without prior notice to the Michigan Association of Police changing its health care insurance plan to a dissimilar plan, and changing the employee premium contribution percentage.

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

20

(a) Within 14 days from the date of the Board's Order, rescind any and all changes to their health insurance benefits and premium contribution percentages.

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(b) Make the employees whole for any loss of earnings and other benefits they suffered as a result of the discrimination against them, in the manner set forth in the remedy section of the decision.

30

(c) Within 14 days from the date of the Board's Order, rescind any and all changes to the employees' health insurance benefits and premium contribution percentages, and within 3 days thereafter notify the employees in writing that this has been completed.

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(d) 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.

(e) Within 14 days after service by the Region, post at its facilities in Pontiac, Michigan, copies of the attached notice marked "Appendix."<sup>24</sup> Copies of the notice, on forms provided by the Regional Director for Region 7, after being signed by the Respondent's authorized

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<sup>23</sup> 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.

<sup>24</sup> 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."

representative, shall be posted by the Respondent and maintained for 60 consecutive days in conspicuous places including all places where notices to employees and members are customarily posted. In addition to physical posting of paper notices, the notices shall be distributed electronically, such as by email, posting on an intranet or an internet site, and/or other  
5 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. In the event that, during the pendency of these proceedings, the Respondent has gone out of business or closed the facility involved in these  
10 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 January 1, 2014.

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

20 Dated, Washington, D.C. August 15, 2014

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Christine E. Dibble (CED)  
Administrative Law Judge

## APPENDIX

### 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 refuse to make any changes in wages, hours and working conditions, including health insurance, that are set forth in our collective bargaining agreement with the Michigan Association of Police without the consent of the Michigan Association of Police.

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

WE WILL NOT in any like or related manner refuse to bargain collectively and in good faith with the Michigan Association of Police.

WE WILL, within 14 days from the date of the Board's Order, rescind any and all changes to your terms and conditions of employment that we made without the consent of the Michigan Association of Police.

WE WILL, make whole employees for any loss of earnings and other benefits suffered as a result of the discrimination against them, in the manner set forth in the remedy section of the decision.

WE WILL, upon request, bargain collectively and in good faith with the Michigan Association of Police as the exclusive collective bargaining representative of the Unit.

WE WILL, within 14 days from the date of the Board's Order, rescind any and all changes to the employees' health insurance benefits and premium contribution percentages, and within 3 days thereafter notify the employees in writing that this has been completed.

**OAKLAND PHYSICIANS MEDICAL CENTER, LLC**  
**d/b/a DOCTORS' HOSPITAL OF MICHIGAN**  
**(Employer)**

**DATED:** \_\_\_\_\_ **BY** \_\_\_\_\_  
**(Representative)** **(Title)**

The National Labor Relations Board is an independent Federal agency created in 1935 to enforce the National Labor Relations Act. It conducts secret-ballot elections to determine whether employees want union representation and it investigates and remedies unfair labor practices by employers and unions. To find out more about your rights under the Act and how to file a charge or election petition, you may speak confidentially to any agent with the Board's Regional Office set forth below. You may also obtain information from the Board's website: [www.nlr.gov](http://www.nlr.gov).

477 Michigan Avenue, Room 300, Detroit, MI 48226-2543  
(313) 226-3200, Hours: 8:15 a.m. to 4:45 p.m.

The Administrative Law Judge's decision can be found at [www.nlr.gov/case/07-CA-120931](http://www.nlr.gov/case/07-CA-120931) or by using the QR code below. Alternatively, you can obtain a copy of the decision from the Executive Secretary, National Labor Relations Board, 1099 14<sup>th</sup> Street, N.W., Washington, D.C. 20570, or by calling (202) 273-1940.



**THIS IS AN OFFICIAL NOTICE AND MUST NOT BE DEFACED BY ANYONE**  
THIS NOTICE MUST REMAIN POSTED FOR 60 CONSECUTIVE DAYS FROM THE DATE OF POSTING AND MUST NOT BE ALTERED, DEFACED, OR COVERED BY ANY OTHER MATERIAL. ANY QUESTIONS CONCERNING THIS NOTICE OR COMPLIANCE WITH ITS PROVISIONS MAY BE DIRECTED TO THE ABOVE REGIONAL OFFICE'S COMPLIANCE OFFICER, (313) 226-3244.