

**UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD**

E. I. DU PONT DE NEMOURS AND COMPANY

and

AMPTHILL RAYON WORKERS, INC., LOCAL 992,
INTERNATIONAL BROTHERHOOD OF DUPONT
WORKERS

Case 5-CA-90984

FREON CRAFTSMAN UNION, LOCAL 788,
INTERNATIONAL BROTHERHOOD OF DUPONT
WORKERS

Case 9-CA-91793

INTERNATIONAL BROTHERHOOD OF DUPONT
WORKERS (IBDW), LOCAL 593, OLD HICKORY
EMPLOYEES COUNCIL

Case 26-CA-92629

ANSWERING BRIEF OF COUNSEL FOR THE GENERAL COUNSEL

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I. INTRODUCTION

In this case, Respondent, E. I. Du Pont De Nemours and Company, eliminated secondary Medicare coverage for all Medicare-eligible retirees (MERs), gave them a voucher, and told them to contact a third party to obtain their own insurance. This third party, Extend Health, steered each MER to yet another party, an insurance carrier, from which the MER now receives his or her secondary health and dental benefits. Extend Health and these 75 different insurance carriers control all aspects of the benefits. Respondent doesn't even know who the insurance carrier is for any particular individual, and has no idea what benefits its MERs actually receive. No longer available to MERs are benefits such as stop/loss protection, high annual limits, and rights of appeal. The Unions, Ampthill Rayon Workers, Inc., Local 992, International Brotherhood of Dupont Workers, (Local 992 or the Union in discussions about the Richmond, Virginia case), Freon Craftsman Union, Local 788, International Brotherhood of Dupont

Workers (Local 788 or the Union in discussions about the Louisville case), International Brotherhood of Dupont Workers (IBDW), Local 593, Old Hickory Employees Council (Local 593 or the Union in discussions about the Nashville case), have no collective-bargaining relationship with these other parties, which precludes them from even making information requests about these benefits, let alone bargaining requests. Thus, Respondent forever extricated itself from the bargaining table concerning a mandatory subject of bargaining (future retirement benefits), without bargaining.

Respondent contends that its frequent premium increases, tinkering with eligibility formulas, and occasional improvement of benefits justified its abandonment of the bargaining table on this mandatory subject of bargaining. Judge Rosas found Respondent had engaged in no past practice justifying its overhaul and withdrawal from the table on future retirement benefits. The record and Board law support his decision.

What these changes did was to effectively eliminate Respondent's retiree secondary coverage for health and dental benefits. MERs received secondary health benefits under Respondent's MEDCAP plan, and dental benefits under the DAP or Dental Plan. A very similar case, 05-CA-033461, is pending at the Board. In that case, the same judge, Judge Rosas, determined that Respondent's unilateral elimination of MEDCAP and the DAP for new hires violated Section 8(a)(5) of the Act. The General Counsel filed several briefs in that case, all of which are applicable in this case because this case concerns the same location, Richmond, Virginia. Additionally, this case concerns Respondent's sites in Louisville, Kentucky and Nashville, TN. The same change was made at each location. The analysis in this case is very similar to 05-CA-033461, and the General Counsel requests that an Order rescinding the changes and returning the parties to the status quo is in order.

II. FACTS

A. Respondent Announces and Implements Sweeping Changes to Health and Dental Benefits for Medicare-Eligible Retirees

1. Respondent announces an important change

On August 15, 2012, DuPont sent an email to its employees, the substance of which was also mailed to its retirees. The letter from Benito Cachinero-Sanchez, the Senior Vice President for Human Resources, stated at the top that “DuPont Retiree Health Care Benefits are Changing.” J-11a.¹ These changes will be referred to in this brief as the 2013 Changes. The letter stated that all Medicare-eligible retirees (MERs) would have their DuPont coverage replaced with a Health Reimbursement Arrangement (HRA). *Id.* The letter told retirees that they would be choosing new supplemental coverage from up to 75 different health plan carriers. *Id.* The letter informed retirees that they had until December 31, 2012 to make their choices. *Id.* Mr. Cachinero told retirees that “[w]e know that this is an important change for you.” *Id.*

Additional information sent to retirees explained that an HRA is a “tax-free, DuPont-annually funded account for use by each Medicare-eligible participant who enrolls through Extend Health.” J-11b. The information stated that funds in the HRA could be used to reimburse the MER for eligible health care expenses, such as premiums, deductibles, copays, prescription expenses, and dental and vision expenses. *Id.*

DuPont has never used HRAs or Extend Health before. Irvin Tr. 37. The Unions have no collective-bargaining relationship with Extend Health. *Id.*

DuPont put up more information on its retiree website. J-11c. One document available on this website is “New Health Care Choices for 2013 -- Key Resources for DuPont Medicare-Eligible Retirees and Dependents.” J-11d. This document gave information about the changes

¹ J-[number] refers to Joint Exhibits, GC-[number] to General Counsel Exhibits, R-[number] to Respondent Exhibits, Tr. [name] to the transcript and the witness providing testimony.

and contact information for Extend Health. Id. This document stated that MERs would receive an HRA of \$1200 for health care, and \$200 for dental, per individual. Id. at DUPMD000230. DuPont made clear to retirees that this amount of money would not increase. J-11g at DUPMD000225. “Will the HRA increase every year? No. The HRA is a flat amount and is not indexed to increase every year.” Id. As DuPont has always done in the past, it offered a very positive spin on this provision of its change.

What if costs go up? Will the HRA contribution amount increase proportionately?

No one knows what the health care insurance market will be like in the future. However, given the fact that the Medicare supplement insurance market has been in place for many years, it has become highly efficient at providing insurance at a reasonable price. Based on this fact, the HRA contribution provides an adequate subsidy to assist retirees with meeting their health care insurance expenses. Therefore the HRA contribution will not increase.

MERs had to choose a plan by the end of 2012, and the failure to do so was to decline coverage, which was “permanent and irrevocable.” Id. at DUPMD000237.

In the past, DuPont has told its employees and retirees that health care costs were continuously rising. See, e.g., J-26, Tab 11 at DUPMD001241.²

2. Third party, Extend Health, begins mailing information about the change to MERs

MERs were mailed by DuPont a Getting Started Guide from Extend Health. J-13a. This guide takes MERs through the process of enrolling for new insurance. A major part of this process was compiling the lengthy information MERs had on their current medical condition. For example, pp. 7-11 of this guide provide for the MER to list all their prescriptions (including form of prescription, dosage, frequency), doctors, and contact information for doctors to provide to Extend Health. Id. There was no guarantee that the new plan would be as good as the old DuPont plan. Id. at 16.

² “The dramatic rise in health care costs in recent years has affected companies and employees throughout the U.S. Virtually all companies have made changes in their medical plans, including our competitors and customers. To respond to this environment, we too [sic] need to make changes to DuPont’s health care package.”

After receiving the Getting Started Guide, Extend Health sent to MERs an Enrollment Guide. J-13b. This guide provided more information to the MERs about what types of plans there might be available through Extend Health. In outlining some of the broader concerns MERs should have, the guide stated that MER who enrolled in a Medigap plan would be guaranteed coverage during the first enrollment period. *Id.* at 8. However, after this enrollment period, MERs might later be rejected for pre-existing conditions if the underwriter, i.e., the new insurance company, changed its terms. *Id.* In MEDCAP, there is no danger of losing coverage because of a pre-existing condition. “There are no exclusions or limitations for **pre-existing** conditions.” J-10, Tab F at 41 (emphasis in original). Additionally, only during the initial enrollment period were MERs guaranteed issue in the desirable Medigap plans. *Id.* Extend Health told MERs that they needed to start this process three months in advance before the actual changeover away from DuPont insurance. *Palmore Tr.* 128.

Extend Health’s Enrollment Guide was less upbeat than DuPont about the future cost of health care. “Nearly every plan will increase its premiums each year, primarily due to the rising cost of medical care.” *Id.* at 9. After insurance was chosen, there was no guarantee that the MER could continue seeing his or her current doctor. *Id.* at 25.³

Jay *Palmore*, the Vice President of ARWI, Local 992 in Richmond, Virginia, testified about his efforts to obtain insurance through Extend Health for his father. *Palmore* first learned about the need to contact Extend Health when the information was mailed to his father, around the end of September. *Palmore, Tr.* 112. After receiving the information, MERs were instructed to call to make an appointment for another phone call. *Id.* Before the second phone call, MERs

³ See J-32, Tab15 at DUPMD000870 (in discussions about Beneflex, an employee benefits plan, Respondent told the Neoprene Craftsman Union, a predecessor union at the Louisville facility, essentially that healthcare costs will always be going up) (“The Union wanted to know what would the Company do if there were a surplus? Will it be refunded? Barbara stated that with the ever-rising cost of healthcare, she doubted if there would ever be a surplus.”).

were supposed to gather information on their doctors and other medical information, as described above. *Id.* at 113; J-13a at 7-11.

Prior to the 2013 Changes, DuPont had not required MERs to gather this information during their annual enrollment period. *Palmore*, Tr. 113. In prior years, if MERs were satisfied with their MEDCAP coverage, they did not have to do anything during the enrollment period. *Id.* In fact, before the 2013 Changes, when an employee retired from DuPont, the retiree simply had to “fill[] out a piece of paper saying that he intended to keep DuPont’s insurance once retired and the premium would come out of his check.” *Id.* at 125.

Palmore spoke to Extend Health for at least two hours during this second call. *Id.* During this call, *Palmore* provided to the Extend Health representative all the information he had collected beforehand. *Id.* at 114. The representative made recommendations to *Palmore* for his father. *Id.* *Palmore* made no recommendations to the Extend Health representative, but rather the representative made recommendations to him, the ones he and his father chose. *Id.* at 115.

Palmore also testified that the health insurance card he got from American Consolidated Life did not have his father’s correct name. *Palmore* Tr. 116. *Palmore* called Extend Health, but they told him not to worry about it. *Id.* Concerned that a hospital could potentially challenge his father about the discrepancy, *Palmore* asked Extend Health for contact information for American Consolidated. *Id.* at 116-17. *Palmore* called Extend Health about two times to get this problem resolved, and American Consolidated once. *Id.* at 117. *Palmore* further testified about his difficulties in getting any dental insurance card for his father. *Id.* at 119-19. He called Extend Health at least three times, and then had to call Humana, the insurance company to give them his father’s information again, as they had nothing from Extend Health. *Id.* at 119. That process took three months. *Id.* *Palmore* additionally testified about the difficulties he had in getting

Extend Health to take the prescription drug premium out of his father's Social Security check.

Id. at 121. Extend Health never fixed the problem, and his father changed his mind and decided to take the premium out of his bank account. Id.

B. MEDCAP Plan Document Illustrates Significant Nature of 2013 Changes

MEDCAP is Respondent's DuPont insurance plan, which is most clearly shown by the fact that "premiums under this Program during each Plan Year will be determined by the Company." J-12b at 21 (Section XVI). The new provisions of MEDCAP, outlining the scheme to shunt MERs away from Respondent and into Extend Health and other third parties, are in Appendix B of the Plan document. Id. at DUPMD000123. In addition to the provisions already described about the enrollment process and reimbursement through HRAs, the new plan required MERs to submit to Extend Health all claims for expenses by March 31 following the plan year in which the expenses were incurred. Id. at DUPMD000124. What this means is that an expense incurred in December, would have to be submitted by March 31, three months later. This change contrasts starkly to the regular provisions within MEDCAP, which provide for a two-year period for the retiree to file a claim. J-10, Tab F at 41. The MEDCAP plan document also makes clear that Extend Health, not DuPont, will control reimbursement of MERs for eligible expenses. ("The Contract Administrator has the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement." J-12b at DUPMD000125, Section 3.4. This section lists a large number of information that "[e]ach request for reimbursement shall include:")

the amount of the Health Care Expense for which reimbursement is requested;

the date the Health Care Expense was incurred;

a brief description and the purpose of the Health Care Expense;

the name of the HRA Participant for whom the Health Care Expense was incurred;

the name of the person, organization or other provider to whom the Health Care Expense was or is to be paid;

a statement that the HRA Participant has not been and will not be reimbursed for the Health Care Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Health Care Expense under Code Section 213; and

a written bill from an independent third party stating that the Health Care Expense has been incurred and the amount of such expense and, at the discretion of the Plan Administrator, a receipt showing payment has been made.

Id. Compare this list of requirements to the list in MEDCAP Summary Plan Document, which is what MERs would have had to show prior to the 2013 Changes:

These items must be submitted when filing a claim:

- a description of the service provided including the dates of service and diagnostic (ICD-9) and treatment (CPT) codes for treatment received in the U.S.
- proof of payment such as an original receipt or a cancelled check
- the name and identification number of the person receiving the services

J-10, TabF, at 41.

Before the 2013 Changes, MERs had a right to appeal claim denials to Respondent, the company they worked for and retired from: “Your final **appeal** is to DuPont.” Id. at 43 (emphasis in original). MERs were no longer able to contact DuPont to get their questions resolved – “[t]he packet said to call Extend Health.” Palmore Tr. 123. Before the 2013

Changes, MERs had an annual stop-loss provision in which once the MER “reach[ed] the individual or family stop-loss, the Medical Plan covers 100% of R&C or, if applicable the Network Negotiated Rate, for the remainder of the Plan Year.” J-10, Tab F at 13. Before the 2013 Changes, MERs could receive a maximum \$1.5 million “for all covered medical expenses incurred on account of any one person in any one Plan Year.” Id. at 14. In addition to the fact that MERs no longer have any stop-loss or annual benefit maximum with Respondent, there is no evidence in the record that any MER currently enjoys these coverage provisions with any of the possible thousand different plans they could choose from.

Similar provisions covered MERs before the 2013 Changes under the Dental Plan. See J-10g.

C. Extend Health Held Education Sessions across the Country to Teach MERs about the New Benefit Regime

Respondent also engaged in an unprecedented education campaign to teach MERs how they would have to find different coverage from a different company. Respondent and Extend Health coordinated to provide numerous Education Sessions in 18 different states where MERs likely lived. J-11f.⁴ As the slides state, Extend Health is an independent company that is able to enroll MERs in a plan from more than 75 different insurance companies. Id. at 4. The Extend Health benefit advisor was the person who would suggest to the MER the plans they could enroll in. Id. at 14. The slides state that these advisors attend “Extend University,” but give no indication what training that includes. Id. MERs had to speak to the benefit advisor in order to enroll in some kind of insurance to replace MEDCAP. Id. at 15. The slides emphasized that Extend Health would be administering their HRA, which was supposed to reimburse them for eligible health expenses. Id. at 24. As to what constitutes eligible expenses, the “HRA

⁴ These slides curiously contain “Updated 5/9/2012” on the first page. This is over three months before the change was even announced to the Unions.

Enrollment Kit” would be mailed in December to describe them to MERs. Id. at 23. The slides also made clear to MERs that Extend Health would “verif[y] receipt of payment and eligibility” concerning expenses. Id. at 25, 27. Extend Health told MERs at these sessions that Extend Health would continue to be the point of contact for all issues they had concerning their insurance, including “claims issues, appeals and network questions.” Id. at 31.

Thus, on January 1, 2013, MERs no longer received any coverage from Respondent, but from one of over a thousand different possible plans.

D. Over the Last 20 Years, Respondent Has Raised Premiums for the Plans, Increased Coverage, Decreased Coverage, and Changed Eligibility Standards

Over the years, Respondent has made different changes to employee benefits that have affected MEDCAP and the Dental Plan. Here are the examples highlighted by Respondent during the trial in 05-CA-033461, and supplemented by the new exhibits from this case.

Respondent made changes to the premiums for the plans almost every year since 1993. J-2 at 89. On December 31, 1992, Respondent sent a letter to employees telling them that Respondent would be using an 80/20 cost sharing formula for premiums under the plan, and would be moving to a 50/50 split for future costs. J-2 at 182; R-2 at DUP009080.⁵ In September 1993, Respondent changed the plans so that a retiree who took early retirement would pay higher premiums under the plans. J-2 at 179; R-11, Tab 12 at D000713.

On January 1, 1998, Respondent raised premiums for the plans. R-11 at Tab 18. On January 1, 2001, Respondent raised premiums under the plans. J-2 at 185; R-11 at Tab 30 at DUP001058. In 2001, Respondent modified the plans to eliminate the requirement that dependent children “live with the employee in a regular parent-child relationship.” J-2 at 193; R-

⁵ See R-4 Tab 6, which states that Respondent recognized it had a bargaining obligation over the details of this cost sharing split.

11, Tab 31. On January 1, 2002, Respondent raised premiums under the plans. J-2 at 186; R-11, Tab 34, at DUP001134. Also in 2002, Respondent began charging a deductible for prescription drugs. J-2 at 189; R-11, Tab 49 at DUP002155. Beginning in January 2003, Respondent began splitting retirees off from active employees in calculating premium increases. J-2 at 187; R-11, Tab 37 at DUP002445. Respondent also imposed caps on retiree costs that year. Id. at DUP002451. Respondent did not expect that this would have any effect on retirees for at least four years, J-2 at 188), and Respondent was prescient because DuPont has never implemented this change. Id. at 189. In 2004, Respondent modified the plans so that dependent children over the age of 19 and less than 25 had to be a full-time student to receive benefits, in response to a change in tax laws. J-2 at 192; R-11, Tab 44. In 2004, Respondent increased premiums for retirees. J-2 at 85; R-3, Tab 69 at last page. In 2005, Respondent modified the plan so that same-sex partners would be eligible for benefits under the plans. J-2 at 191; R-11, Tab 47.⁶ Almost every year starting in the 1990s, Respondent required that spouses of employees receive benefits under the spouse's insurance plan, if there was one, and if that premium was below a certain threshold. J-2 at 195; R-11, Tab 27. Many times Respondent raised that threshold amount. In 2005, Respondent began charging retirees a premium for the cost of dental restorative work. J-2 at 80; R-3, Tab 68 at 5. Respondent also increased premiums for retirees that year. J-2 at 82. Respondent raised premiums for the plans in 2006. J-3 at 266.

Since 2007, other changes to MEDCAP have been made by Respondent. In 2008, Respondent made the following changes as seen in J-10, Tab F: increased premiums, M-SPD at p. 10, increased prescription drug deductible \$10, Tab F, M-SPD at p. 35; and added a lifetime orthodontic maximum of \$1200, Tab E, BG p. 24; Tab G, D-SPD at p. 9. In 2009,

⁶ This change did not decrease or eliminated any benefits and there is no evidence that it had any effect on employees. J-3 at 206.

Respondent made the following changes: added preventative tests and immunizations, Tab H-SMM p. 1, limited chiropractic benefits to \$1,000 per person per year, and expanded certain chiropractic services, Tab H, SMM p. 1, and increased prescription drug deductibles by \$20, Tab H, SMM p. 1. In 2010, Respondent made the following changes: modified the policy so that deductibles applied in-network and out-of-network, Tab I, SMM p. 1, increased prescription drug annual stop-loss from \$2,500 per person to \$4,550 per person for retirees, survivors and their covered dependents, Tab I, SMM p.1, increased annual medical stop-loss from \$1,600 to \$2,000, Tab I, SMM, p. 2, increased the prescription drug deductible \$15, Tab I, SMM p. 3, modified the policy so that prescription strength versions of medications available "over-the-counter" no longer covered, Tab I, SMM p.4. In 2011, Respondent made the following changes: revised the definition of "eligible children" and "dependent children," Tab J, SMM p.2, applied primary coverage requirement to dependent children, Tab J, SMM p. 2, added preventative tests and immunizations, Tab J, SMM p.3, revised the process associated with coverage of "specialty medications," Tab J, SMM p.4-5, and adopted a "coverage gap" for brand-name medications for Medicare Part D prescription drug coverage, Tab J, SMM p. 5. In 2012, Respondent made the following changes: made Health Savings PPO available to pre-Medicare Retirees and Survivors, Tab K, SMM p. 1, Tab L, BG at p.3, increased premiums, Tab K, SMM p. 2, modified coverage for organ transplants, Tab K, SMM p. 2, increased the annual prescription drug stop-loss \$150, Tab K, SMM, p. 3, modified the prescription refill policy for maintenance drugs, Tab K, SMM p. 3, increased the annual prescription deductible \$10, Tab K, SMM p. 4, expanded preventative coverage for certain immunizations, Tab K, SMM p. 4, and modified the Dental Plan to expand periodontal maintenance, Tab K, SMM p. 4.

E. Many of the Changes Made to the Plans Were Positive, or at Least Were Communicated to the Employees and the Employees' Representatives as Positive

One change highlighted by Respondent in an attempt to show a practice of unilateral changes to benefits was in 1993, expanding medical pre-certification to 14 medical and surgical procedures. R-11, inside summary. However, when communicated to the employees this change was noted as quite beneficial, as it “may save you unnecessary time and effort, and help eliminate doubt when you’re faced with any one of 14 medical or surgical procedures.” R-11, Tab 7 at D000676.⁷ DuPont routinely told the employees how much better they were faring than employees at other companies. Medical care increases in 2001 were communicated to the employees as a relative gain – “[t]his trend compares favorably with the 8-12% increases reported by many health insurers,” and “our 2001 premiums will continue to be low relative to most other large companies.” R-11, Tab 30 at D001058.

On April 4, 2002, when the parties were discussing health care costs, Respondent insisted to the Union that Respondent’s total benefit package was “pretty good.” GC-14 at DUP0017850. In 2003, 2004 increases were communicated to employees as favorable outcome: “Compared to the double-digit increase medical plan cost increases reported nationally, *this is great news.*” R-11, Tab 41 at D001287 (emphasis added).⁸

Some changes were obviously beneficial. For example, in 2004 Respondent added a network of 58,000 dentists. R-3, Tab 69 at DUP008932. The Union told Respondent that “overall it is not displeased with this year’s changes and this is not as bad as it though it would be.” Id.

Indeed, DuPont reassuringly told retirees that their HRA, scheduled to never increase

⁷ Company witness Mary Jo Andersen reluctantly testified that this change was both positive and insignificant. (Tr. 211).

⁸ Respondent intended that employees rely on the truthfulness of what was stated in Plain Talk. (Tr. 212).

from \$1400 annually, would still be adequate to cover their healthcare needs because the Medicare supplemental insurance market had become so efficient. J-11g at DUPMD000237.

F. Union Has No Information on Actual MER Benefits and None Is Available Anymore from Dupont

Respondent presented several witnesses who testified that they were at least generally familiar with DuPont benefits. Scurry Tr. 210; Black Tr. 332; Bergthold Tr. 333; Waddell Tr. 393; Kelley Tr. 417; Kelsey Tr. 495; Anderson Tr. 540. None of these witnesses provided any information about what the actual benefits that MERs have. Scurry testified that he thought DuPont did have this information. Scurry Tr. 238. However, his testimony suggests he is referring to the Extend Health website that anyone can access. *Id.* Dickerson does not know what MERs' benefits are and testified that DuPont has no information to give to the Union about it. Dickerson Tr. 177, 187-88. Dickerson testified that R-17, a summary of insurance plans, aren't actually anyone's benefits. *Id.*⁹ Bergthold doesn't "know much about the current plan," Tr. 380, doesn't know what premiums MERs pay now, Tr. 381, and doesn't know who the carriers are, Tr. 381. Bergthold doesn't actually know if MEDCAP is in the CBA. *Id.* at 382-83. Waddell doesn't know who sets MER premiums anymore. Tr. 411. Waddell offered the following ambiguity:

Q. BY MR. BEATTY: Well, I read the question. I'll just read number 1 again. DuPont plans to continue to offer prescription drug coverage to retirees. I think my question was that's no longer true for Medicare-eligible retirees.

A. I don't recall. I know that most of the benefits for those who are Medicare, who are Medicare, that are covered are with Extend Health, and generally now they're taking more of an active stand and role in terms of the Medicare-related benefits.

Q. And DuPont has no role in the Medicare-eligible retirees choosing the plan that they want, right?

A. What DuPont does is provide them with, you know, through Extend

⁹ Dickerson candidly admitted that DuPont plays a "small role" now in only providing "money towards their healthcare." *Id.* at 180.

Health, will certainly provide them with the information. Okay. We'll share information, but it's Extend Health from what I understand who manages the care now.

Q. The information comes from Extend Health, right?

A. Now, it does, I believe so.

Kelley also has no information on current premiums for MERs. Tr. 427. Kelley admitted that to find that out, “we’d have to ask the retirees what they’re paying Correct.” Id. Kelley has no information about what carriers are available or plan details. Id. at 428.

When Scurry was once asked if he had provided MER premium information to the Union, he thought he had. Scurry Tr. 237. Now, however, the Union has no information on what benefits MERs have, and what MERs are paying for them. Irvin Tr. 37; White Tr. 263; Lowman Tr. 292. The information that the unions in Richmond, Louisville, and Nashville previously asked for on a routine basis, DuPont has effectively placed out of reach.

III. BOARD LAW REQUIRES DUPONT TO BARGAIN OVER FUTURE RETIREMENT BENEFITS OR PROVIDE EVIDENCE OF CLEAR AND UNMISTAKABLE WAIVER OF UNION’S RIGHT TO BARGAIN OVER ELIMINATION OF MEDCAP AND THE DAP

A. Employers Must Bargain over Changes to Future Retirement Benefits, Insurance Carriers, and Insurance Plans

A collective-bargaining representative has a statutory duty to bargain over future retirement benefits. *Allied Chem. & Alkali Workers of Am., Local Union No. 1 v. Pittsburgh Plate Glass Co., Chem. Div.*, 404 U.S. 157, 180, 92 S. Ct. 383, 398, 30 L. Ed. 2d 341 (1971) (“To be sure, the future retirement benefits of active workers are part and parcel of their overall compensation and hence a well-established statutory subject of bargaining.”). Further, changes in insurance carriers and insurance plans are also mandatory subjects of bargaining. *Larry Geweke Ford*, 344 NLRB 628 (2005). (“The judge found, and we agree, that the Respondent violated Section 8(a)(5) of the Act by failing to bargain with the Union regarding a change in

health care plans and the Respondent's contribution to health care plans, and by implementing a new health care plan without bargaining with the Union.”); *Mount Hope Trucking Co., Inc.*, 313 NLRB 262, 262 (1993) (“We adopt the judge's finding that the Respondent violated Section 8(a)(5) of the Act in August 1992 when it unilaterally changed the insurance carrier for the unit employees' health insurance plan.”); *Josten Concrete Products Co.*, 303 NLRB 74, 76 (1991) (“Suffice it to say that insurance coverage is a mandatory subject for bargaining and the Union was given no opportunity to bargain over the changes.”). In *The Connecticut Light & Power Co.*, 196 NLRB 967, 969 (1972), the Board explained why unions must be able to bargain over a change in carriers:

The method used in the processing of employee claims under a medical-surgical policy, the practices and procedures of the insurance carrier in allowing or disallowing claims, and the dispatch and efficiency of its personnel in processing such claims are factors connected with a carrier's administration of a health insurance program which intimately effect the employees under a contract and are matters about which the employees have cause to be greatly concerned. An employer violates Section 8(a)(5) of the Act when it makes unilateral changes to

benefits that are a mandatory subject of bargaining without bargaining. *NLRB v. Katz*, 369 US 736 (1962).

B. Employers Who Fail in Their Statutory Duty to Bargain Must Prove That Union Clearly and Unmistakably Waived Its Right to Bargain

A collective-bargaining representative may waive a statutory right to bargain; however, this waiver must be clear and unmistakable. *Metropolitan Edison Co. v. N.L.R.B.*, 460 U.S. 693, 710, fn. 12 103 S. Ct. 1467, 1478, 75 L. Ed. 2d 387 (1983) (“The Courts of Appeals have agreed that the waiver of a protected right must be expressed clearly and unmistakably.”).

The party asserting waiver bears the burden of establishing the existence of the waiver. *Pertec Computer*, 284 NLRB 810, fn. 2 (1984). If a party asserting waiver contends that the waiver was effected through bargaining history, it must show that the issue was “fully discussed”

and “consciously explored.” *Davies Medical Center*, 303 NLRB 195 (1991) (finding no waiver of right to information even though Union did not always previously ask for information because waiver subject was not “fully discussed” and “consciously explored”); *Reece Corp.*, 294 NLRB 448, 451 (1989) (bargaining history can only establish a waiver if “fully discussed” and “consciously explored” or “consciously yielded”); *General Electric Co.*, 296 NLRB 844, 857 (1989) (“Additionally, Respondent has not demonstrated that the Union expressly, at the bargaining table, made a conscious relinquishment, clearly intending and expressly bargaining away its statutory right [to bargain over subcontracting].”).

Moreover, the Board and the courts have recognized that a Union’s failure to request bargaining on a topic does not constitute a clear and unmistakable waiver of its right to bargain on that topic at a later time. *Brewers and Maltsers, Local Union No. 6 v. NLRB*, 414 F.3d 36, 45 (D.C. Cir. 2005) (quoting *Verizon New York v. NLRB*, 360 F.3d 206, 209 (D.C. Cir. 2004), quoting *Owens-Corning Fiberglass*, 282 NLRB 609) (“a union’s acquiescence in previous unilateral changes does not operate as a waiver of its right to bargain over such changes for all time”) (finding no waiver where employer claimed that union had known for a long time that Company used surveillance cameras). It is not enough to show, “[a]t most...the Union’s silent acquiescence to certain prior changes in retiree benefits.” *Midwest Power Systems, Inc.*, 323 NLRB 404, 407 (1997), enforcement denied on other grounds, remanded 159 F.3d 636 (D.C. Cir. 1998) (unpub.).

Lastly, a waiver by a predecessor union does not bind a newly-certified union: In affirming the decision, we make the following modification of the rationale set forth in the above-referenced decision. While we affirm the finding that the Respondent failed to establish that it had a past practice of unilaterally laying off employees either prior to or after the Union’s 1993 certification, we further find that even had the Respondent established that such a past practice existed prior to 1993, when another union represented its employees, this would not privilege its action here. Thus, we agree with the judge that the Respondent may not establish

a past practice defense privileging its unilateral changes based on the acquiescence of a union that previously represented the unit employees, where—as here—the Union has not acquiesced to such unilateral changes. See, e.g., *Eugene Iovine, Inc.*, 328 NLRB 294, 297 (1999), *enfd.* 1 Fed.Appx. 8 (2d Cir. 2001). The judge's discussion and resolution of this issue are fully consistent with Board precedent.

Eugene Iovine, Inc., 356 NLRB No. 134 (Apr. 7, 2011).

C. Employers' Plan Documents That are Not Part of Parties' Agreement Do Not Privilege a Failure to Bargain

The Board has applied these standards in several cases where it found that an employer had violated Section 8(a)(5) of the Act by making a unilateral change to future retirement benefits. In *Mississippi Power Co.*, 332 NLRB 530, 531-32 (2000), enforcement granted in part and remanded, 284 F.3d 605 (5th Cir. 2002), the Board found a violation where Respondent unilaterally changed future retirement benefits without bargaining with the union. In that case, the Board found no waiver from the medical plan document, “an employer-created document” that was “in no way an ‘explicit’ statement by the Union about any subject, much less a permanent waiver of the Union’s right to bargain over the future retirement benefits of active workers.” *Id.* at 531. Further, the Board was unmoved by Respondent’s bargaining waiver argument, holding that the union’s failure to request bargaining over prior changes did not “betoken a surrender of the right to bargain the next time the employer might wish to make yet further changes, not even when such further changes arguably are similar to those in which the union may have acquiesced in the past.” *Id.* At 532 (citing *Exxon Research & Engineering Co.*, 317 NLRB 675, 685-686 (1995), *enf. denied on other grounds* 89 F.3d 228 (5th Cir. 1996)).¹⁰

In *Southern Nuclear Operating Co.*, 348 NLRB 1344 (2006), enforced in part, remanded in part, 524 F.3d 1350 (D.C. Circuit 2008), the Board adopted the judge’s finding that the union

¹⁰ The judge’s discussion of the facts in that case makes clear that several times in prior years, Respondent simply announced to the union that changes were coming and the union did not object to the changes. *Id.* at 537 (“Frequently the Union simply did not object to the proposed changes.”).

did not waive its right to bargain over changes to future retirement benefits because past acquiescence to unilateral changes “does not irrevocably waive its right to bargain over such changes in the future,” *id.* at 1352, and also because plan documents containing reservation of rights language were not part of the collective-bargaining agreement and thus not binding on the union’s statutory right to bargain. *Id.* at 1354. On appeal, the D.C. Circuit rejected Respondent’s assertion that the reservation of rights language in the benefit plan documents, though not part of collective-bargaining agreement, were binding on the union:

[The companies] contend that their collective-bargaining agreements with the unions incorporated the benefit plans’ reservation-of-rights clauses on the basis of the unions’ ‘course of conduct.’ For instance, the Companies suggest that because the unions have copies of the benefit plans and have relied on the benefits provided by those plans, the unions have also incorporated the reservation-of-rights clauses in those plans into the collective-bargaining agreements. Our cases, however, imply that it is only express language in the collective-bargaining agreement that incorporates a reservation-of-rights clause.

Southern Nuclear Operating Co. v. N.L.R.B., 524 F.3d 1350, 1358-59 (D.C. Cir. 2008).

D. Evidence of Past Minor Changes Does Not Prove Waiver of Right To Bargain over Major Change

More recently, in *Caterpillar, Inc.*, 355 NLRB No. 91, slip op. (2010), the Board found that Respondent violated Section 8(a)(5) when it unilaterally implemented a generic-first prescription drugs program without bargaining with the union. In that case, the Board found that Respondent failed to establish that it had a past practice of implementing changes to its prescription drug program. *Id.* at 3. Importantly, the Board found that even if there had been a “practice,” the change at issue “represented a material departure from that past practice.” *Id.* In that case, prior changes were made to certain families of generic prescription drugs, but the change at issue there affected all generic drugs. *Id.* Accordingly, the change was not “limited in scope” as the prior changes. *Id.* Finally, the Board reiterated its long-held waiver analysis, that

“[i]t is well settled ...that a union’s acquiescence in previous unilateral changes does not operate as a waiver of its right to bargain over such changes for all time.” (quoting *Owens-Corning*, supra).

The D.C. Circuit upheld the Board’s findings in *Caterpillar*.

The Board also reasonably concluded that Caterpillar's prior changes to its employees' prescription drug benefits did not establish a past practice such that its employees could have expected further changes like the “Generic First” program. At most, Caterpillar demonstrated that the union had waived its right to bargain over several prior changes to the prescription drug program. Board precedent is clear that a “union's acquiescence in previous unilateral changes does not operate as a waiver of its right to bargain over such changes for all time.” *Owens–Corning Fiberglas Corp.*, 282 N.L.R.B. 609, 609 (1987). The facts before the Board were easily distinguishable from precedent in which an employer's past practice occurred with such regularity and frequency that it became the status quo. *See, e.g., Post–Tribune Co.*, 337 N.L.R.B. at 1280; *Daily News of L.A.*, 315 N.L.R.B. 1236, 1236–37 (1994); *A–V Corp.*, 209 N.L.R.B. 451, 452 (1974).

Caterpillar Inc. v. National Labor Relations Bd., 10-1269, 2011 WL 2555757 (D.C. Cir. May 31, 2011).

The Board also recently rejected the same defense raised by Respondent here in *Firstenergy Generation Corp.*, 358 NLRB No. 96, slip op. at 1 (Aug. 6, 2012). In that case, the Board found that the unilateral changes to future retirement benefits of current employees violated the Act, relying on the fact that the union had objected to the last major change, “acquiescence alone [to minor programmatic changes] does not establish a surrender of the right to bargain over future changes,” and that the unlawful changes were “significantly different from those minor programmatic changes.”

Respondent also relies on the *Courier-Journal* cases, 342 NLRB 1093 (2004), and 342 NLRB 1148 (2004), in which the Board held that a past practice of making unilateral changes to benefit plans might privilege the employer to continue to make similar changes without bargaining with the employees’ collective-bargaining representative. The Board revisited

Courier-Journal in *E.I. DuPont De Nemours*, 355 NLRB 1084 (2010). In *E.I. DuPont*, the Board restricted *Courier Journal* to unilateral changes made to benefit plans during a hiatus between CBAs and noted that it was “in tension with previously settled principles” concerning waiver as noted above. *Id.* at fn. 5. Further, *E.I. DuPont* distinguished *Courier-Journal* on its facts, finding that the record in *E.I. DuPont* did not show that there was any history of making changes during the hiatus between CBAs. *Id.* 1086.¹¹ In *Courier-Journal*, the change at issue were premium increases. 342 NLRB at 1095. *DuPont* is not clear, because it was not at issue in the case, but the changes appeared to be typical premium increases. *Id.* at 1099. The D.C. Circuit denied enforcement in *DuPont*, and it is now pending at the Board again. 682 F.3d 65 (D.C. Cir. 2012).

E. Information Requests Are Pivotal Part of Collective-Bargaining Process and Constitute a Request to Bargain

The Board has also stated that there is no duty to furnish information on subjects over which there is no duty to bargain. *Embarq Corp.*, 356 NLRB No. 125, slip op. at 17 (Mar. 31, 2011);¹² see also *BC Indus., Inc.*, 307 NLRB 1275 fn. 2 (1992) (finding no duty to furnish information about partial closure “[b]ecause Respondent BCI had no statutory obligation to bargain about the partial closure decision”).

¹¹ *Manitowoc Ice, Inc.*, 344 NLRB 1222 (2005), is also inapposite and appears to be *sui generis*. In that case, a Board majority found the union was estopped from objecting to unilateral changes to a profit-sharing plan because at recent negotiations the subject of modifying the plan was raised and nothing was added to the parties’ contract. Further, there was a history of unilateral changes with no requests for bargaining, no information requests from the union, and no other objections from the union. In this case, there is an abundance of evidence of requests to bargain from the Union, information requests positively responded to by Respondent, and no immediately prior negotiations on the subject of the elimination of MEDCAP and the DAP for new employees. Accordingly, this case is inapposite.

¹² “[T]he “decision” to close the Las Vegas call center was not a mandatory subject of bargaining. The Respondent’s refusal to bargain over the closure “decision” was not unlawful. It, therefore, logically follows that the Respondent was not legally required to comply with the Union’s information request, to the extent that it dealt with the “decision” to close. The Board has so held in a number of cases. See *BC Industries*, 307 NLRB 1275 (1992), citing *Cowles Communications*, 172 NLRB 1909 (1968).”

An information request sent to an employer constitutes a request for bargaining.

Eldorado, Inc., 335 NLRB 952, 954 (2001).

IV. RESPONDENT'S CONTENTIONS THAT THE UNIONS WAIVED THEIR RIGHT TO BARGAIN OVER THE 2013 CHANGES LACKS FOUNDATION IN FACT AND LAW

A. MEDCAP and DAP Reservation of Rights Language Are Not in the CBAs and Board Law Precludes Finding a Waiver Merely Because Employees Received Benefits under a Plan

Respondent's argument really begins on p. 16, when it states that Local 992 in Richmond waived its right to bargain over any changes to the plans as the "price of admission" for its members' participation in the plans. Respondent points to discussions in 1976 when the parties bargained over inclusion of the DAP into the collective-bargaining agreement, and Respondent's statements that plan language, including the reservation of rights, would govern administration of the benefits. R. Br. at 17. Respondent further contends that in 1986 Local 992 agreed to MEDCAP and expressly agreed to be bound to its reservation of rights language, and that bargaining notes reflect this *quid pro quo*. R. Br. 18-21.

First, this contention ignores the stipulated fact that MEDCAP and the DAP aren't in the CBA anymore. J4, Stipulations 60, 65, and 76. The Unions are not signatory to the plan documents. Respondent's contention that a waiver of rights was the "price of admission" for continued participation in the plans after they dropped out of the CBAs is a dressed up "course of conduct" argument invalidated by *Southern Nuclear*. *Southern Nuclear* is very clear that "only express language in the collective-bargaining agreement incorporates a reservation of rights clause." *Southern Nuclear*, supra at 1359. Here the CBAs do not even mention the plans, let alone incorporate any language, and therefore plan documents do not bind the Unions.¹³

¹³ Additionally, the reservation of rights language does not state that the Unions still do not have the right to bargain over any change.

Respondent argues, at 30, that the point of *Southern Nuclear* is whether the parties had a meeting of the mind on a waiver. However, it is clear that the Board in *Southern Nuclear* answered this question by looking at the contract language:

As shown above, it is evident that Southern Nuclear Operating Company and the Union anticipated future bargaining during the life of the 1991 Memorandum of Understanding. Paragraph (2) concludes with the sentence, “Insured benefit changes negotiated after this agreement shall also be included.” That sentence obviously anticipates negotiations between the Company and the Union over “insured benefit changes.”

Southern Nuclear, 348 NLRB at 1254. Moreover, the statement regarding “meeting of the minds” is dicta, as the Board found that the contracts contained no incorporation of the plan documents and therefore there was no waiver, and only addressed the next question “in an abundance of caution.”

Therefore, I find that the parties did not include any plans in their agreements and, consequently, the parties did not intend to incorporate reservation of rights language from plan documents in their collective-bargaining agreements. Nevertheless, out of an abundance of caution, I shall question whether the insurance plans alone serve to block any rights the employees' representatives may have to negotiate over changes.

Id.

B. Judge Correctly Found That Record Does Not Show Local 992 Waived Its Right to Bargain in 1986 When It Discussed an Aetna Plan but Did Not Put Reservation of Rights Language in the CBA

This point has been extensively briefed by the General Counsel in 05-CA-033461, which has already been incorporated by reference in the GC's cross-exceptions in this case. Judge Rosas found that Local 992 did agree to MEDCAP in 1986, but that the record did not show that the Union had agreed to be bound to the reservation of rights. The record supports the judge's finding that Respondent failed to prove that Local 992 agreed to be bound to the plan documents' reservation of rights language in 1986.

A close reading of all the bargaining notes that Respondent cites will show that the parties never used the word “MEDCAP.” The record further shows that, although the parties discussed the reservation of rights provision in the Aetna plan that they *were* negotiating in 1986, it is not clear that the contract bound the Union to that provision. The Union continually stated its lack of agreement with a management rights provision during negotiations. R-3, Tab 19 at DUP008437, Tab 20 at DUP008451-52, Tab 21 at DUP008476, and Tab 22 at DUP008481. After the parties appeared to have come to an agreement in September 1986 on a CBA, they continued to negotiate where the HMS (hospital-medical-surgical coverage) section would go. The Union argued that the HMS provision should go in Article VII where the other benefit plans were expressly subject to a management rights provision, since Respondent insisted that was the case. R-3, Tab 23 at DUP008492, Tab 24 at DUP008502; see also R-6(b) at 16 (“All existing privileges... “subject to the provisions of such Plans”). Respondent did not want HMS to appear there because it did not want to be bound by other provision of Article VII, including the one-year notice provision before a change could be made. R-3, Tab 24 at DUP008499. Importantly, the final agreement, Article XIV in the P&M contract, does not expressly reference Aetna or MEDCAP, stating that “[t]he COMPANY may make available to employees alternate hospital and medical-surgical coverage plans.” R-6(b) at 36. Further, this clause, unlike Article VII, contains no express incorporation of any HMS plan documents. Therefore, given the Union’s continuing disagreement with the management rights provision, the parties’ express incorporation of reservation of rights in other parts of the contract (Article VII), the record supports the judge’s finding that the Union did not agree to be bound by the “Aetna” plan’s reservation of rights provision. Accordingly, if the “Aetna” plan was MEDCAP, the bargaining

notes from 1986 do not prove that Local 992 clearly and unmistakably waived its right to bargain over the 2013 Changes.

Thus, the judge's finding that Local 992 never agreed to the incorporation of a management-rights, or reservation of rights clause for MEDCAP, into the CBA in Richmond is fully supported by the record. Respondent's elaborate argument about negotiations in 1986 cannot evade the fact that the resulting CBA in Richmond did not mention MEDCAP (it never has there), and the CBA provision concerning the Aetna plan for which Respondent wanted a reservation of rights clause, does not state that the Aetna plan is governed by its plan documents.

There is an illustrative example in the bargaining notes on how the parties interpreted reservation of rights language. On September 9, 1987, Respondent presented to the Union a "proposal" to change the DAP, which apparently was just a "clearing up of the Plan language." GC-3 at 3. The DAP Plan document does not discuss whether Respondent has an obligation to bargain over any changes to the Plan. R-8 at DUP008260- Article XIII, Section A. However, Respondent's internal notes following this September 9, 1987 meeting state that the DAP changes "must be bargained with Union(s) before implementation; therefore, discussion must be limited to exempt employees until bargaining is initiated." GC-2 at DUP0015270. This internal note does not appear in R-3, Tab 29, which is the same meeting minutes offered by Respondent.

Respondent contends that, at 20 of its Brief, "[t]he parties negotiations, as reflected in Respondent's credited notes, constitute powerful evidence confirming Local 992's express waiver." This is backwards. The parties' negotiations were reflected in the CBA, which contained no reference to being bound to MEDCAP's plan documents.

More importantly, all of this is irrelevant because the current CBA does not contain any reference to MEDCAP.

C. Only Evidence of Whether Local 788 and Local 593 Waived Their Rights Is in CBAs, and Given That the CBAs No Longer Contain MEDCAP and the DAP, There Is No Evidence of any Waiver

Respondent's contentions, at 21-23 of its Brief, that Locals 788 and 593 also waived their right to bargain over the 2013 Changes, further demonstrate the infirmity of its position. The only evidence cited by Respondent are the CBAs in effect *at the time*, which expressly incorporated the reservation of rights in the plan documents. There are no bargaining notes discussing the Unions' agreement to MEDCAP and the DAP in Nashville and Louisville. Thus, Respondent has posited contradictory positions. First, the CBA language, which Respondent ignores concerning the Richmond case, now becomes fraught with meaning in the Nashville and Louisville cases. Second, the CBA language in Richmond, with no reservation of rights language for MEDCAP, shows nothing regarding a waiver, but in the other two locations, the CBA language proves a waiver clear and unmistakably. Third, the lack of this language in the *current* CBAs in Nashville and Louisville, again proves nothing regarding a waiver. To sum up, Respondent argues that the incorporation of the reservation of rights language in the expired CBAs in Nashville and Louisville means everything, and its omission from the expired CBA in Richmond and current CBAs in all locations means nothing. The Board should reject this theory.

Respondent's shifting application of the various expired CBAs also undercuts its attempt to distinguish *Southern Nuclear* and *Mississippi Power*. Respondent contends, at 30, that those cases did not concern a history of acceptance at the bargaining table of reservation of rights language, as they contend the record shows. However, in those cases, there was a history of unchallenged benefit changes. *Mississippi Power Co.*, 332 NLRB 530, 534 (2000) ("The changes were proposed by Respondent and the Locals, having no objections, agreed to the

changes.”). Additionally, there is no bargaining history showing what the Unions in Louisville Nashville thought about reservation of rights language, except for the CBAs themselves. And *Southern Nuclear* and *Mississippi Power* hold that without express incorporation language, the CBA does not contain the plan documents. See *Southern Nuclear*, 524 F.3d at 1358-59; *Mississippi Power*, 332 NLRB at 531-32.

D. Record and Board Law Demonstrate That There Is No Past Practice at any of the Three Sites Showing That Unions Waived Their Right to Bargain over the 2013 Changes

Next, Respondent contends, at 25-29 of its Brief, that it had an established past practice of making changes to the plans, and that this practice implies the existence of a waiver. This argument lacks merit for a number of reasons.

First, Board law is clear that even if the Union waived its right to bargain over prior changes, the Union has not waived its right to bargain over future changes. This is long-standing Board precedent. *Brewers and Maltsters, Local Union No. 6 v. NLRB*, 414 F.3d 36, 45 (D.C. Cir. 2005) (quoting *Verizon New York v. NLRB*, 360 F.3d 206, 209 (D.C. Cir. 2004), quoting *Owens-Corning Fiberglass*, 282 NLRB 609) (“a union’s acquiescence in previous unilateral changes does not operate as a waiver of its right to bargain over such changes for all time”). The Board has also explicitly held so in prior cases concerning future retirement benefits. *Mississippi Power*, supra (finding no waiver where union had acquiesced in prior changes); *Midwest Power*, supra.

Second, the changes Respondent has made over the years, mostly cost increases, never concerned the creation of a voucher to cover the cost of new coverage enrolled in and controlled by outside third parties. Thus, the parties never began to discuss the issue of ending DuPont coverage for MERs and farming them out to Extend Health, let alone “consciously explore” or

“fully discuss” them as required for a waiver. *Davies Medical Center*, 303 NLRB 195 (1991). Accordingly, the Union’s alleged acquiescence to any prior change does not constitute a waiver under Board law.

1. 2013 Changes are materially different from anything done in the past and do not constitute a waiver under *Caterpillar*

The Board’s decision in *Caterpillar*, supra, is dispositive of this issue. The Board found that the prescription drug change at issue there was “a material departure” from prior changes and thus required bargaining. *Caterpillar*, 355 NLRB, slip op. at 3. In this case, Respondent may have made programmatic changes in the past, such as raising premiums and altering some eligibility formulas in the past, *Firstenergy*, supra, but after each change, the Unions were still able to engage in the collective-bargaining process over MEDCAP and the DAP. The record shows that the changes in this case are of a different kind from prior ones, such that the Unions’ alleged prior acquiescence was not sufficient to waive its right to bargain over the 2013 Changes.

Respondent contends, at 46, that in *Caterpillar* the Board only had three instances of changes, and in this case there are years of changes which demonstrate a past practice. However, this analysis misses the point – the past practice was not the 2013 Changes, but a history of premium increases and slight alterations of eligibility formulas. The 2013 Changes were materially different from anything done before, as shown below, and thus Respondent has failed to meet its burden. *Caterpillar*, supra, at 522-523.

A review of the changes discussed above shows that the vast majority of them are simply premium increases, or other increases in cost that employees were going to have to pay. See Section II.D. above for a review of the premium increases and minor changes. However, there was never the wholesale elimination of coverage for MERs and consequent shunting of them

toward a third party where they could obtain new insurance. Further, there was no testimony that the changes in eligibility standards had any effect on any employees at any location.¹⁴

The details of the 2013 Changes illustrate their game-changing nature. As Respondent's own information points out, there is no longer any DuPont coverage. Respondent simply provides money, \$1400, and it will not increase. J-11g at DUPMD00225. Any increase in healthcare premiums will be shouldered 100% by MERs, and retirees were told by Extend Health that "[n]early every plan will increase its premiums each year." J-13b at 9. Thus, the increasing costs will eat away the flat amount of the HRA, resulting in a falling value of the HRA that Respondent is providing. See Dickerson Tr. 179. At some point, when that value reaches 0, the 2013 Changes have effectively eliminated MEDCAP and the DAP. Judge Rosas already found, for good reason, in 05-CA-033461, that the elimination of such benefits without bargaining violates the Act.

However, even before Respondent's HRA credits cease to provide for any benefits, the 2013 Changes as currently constituted are so significant that they demand bargaining. For example, DuPont, which before January 1, 2013 was liable to pay up to \$1,500,000 annually in MEDCAP coverage, has now cut its cap figure to \$1,400. J-10, Tab F at 14. That is a staggering potential cost savings that could have been bargained with the Unions. Additionally, there is no evidence that any MER has any stop-loss coverage anymore, like they enjoyed before January 1, 2013. J-10, Tab F at 13. Combined with DuPont's unlawful 2007 change to eliminate MEDCAP and the Dental Plan for new employees hired after January 1, 2007, the 2013 Changes will achieve what Mary Jo Anderson referred to as a "more predictable cost." Anderson Tr. 552. That cost will zero.

¹⁴ Indeed, the same-sex partner issue did not even cut benefits, but rather liberalized them. Union resistance to this particular change focused on the failure to liberalize the benefits ever further. See R-3, Tab 70 at DUP008955-56,

Further, Jay Palmore testified about the hoops he had to jump through to secure benefits for his father. Palmore Tr. 112-125. Palmore endured numerous phone calls to Extend Health in order to enroll, re-enroll, get his father's name right on one insurance card, and track down a missing insurance card from another company. Palmore also called the actual insurance companies themselves after Extend Health could no longer help. All of this was simply to secure benefits. Previously, as Palmore testified, retirees simply had to sign up for retirement and automatically be enrolled in MEDCAP. Palmore Tr. 125. If a retiree was satisfied with his MEDCAP coverage, he didn't have to do anything to keep them during the annual enrollment period. Id. at 113. The judge credited this testimony. ALJD fn. 43. Again, the numerous tasks MERs were required to undertake in order to get benefits further demonstrate the significance of the change inflicted on them. Perhaps this is why DuPont immediately implemented in August a massive education campaign in August 2012 in 18 states, J-11f, comforting MERs by telling them "you're not alone – Extend Health will guide you and your Medicare-eligible dependents through every step of the enrollment process." J-11e at 1.

Furthermore, before the 2013 Changes, MERs had a final right of appeal to DuPont concerning benefit claims. J-10, Tab F at 43. Now, Extend Health has the final right of appeal. J-12b at DUPMD000125. Even worse, the right to appeal in some cases might only be three months, as opposed to the two year right of appeal prior to the 2013 Changes. Compare J-10, Tab F at 43 to J-12b at DUPMD000125. Previously, DuPont blunted Union proposals concerning non-Company health plans by reminding the Union that under Beneflex and MEDCAP, the final right of appeal was to DuPont. J-25, Tab 38 at DUPMD001293.

2. 2013 Changes have eviscerated the Unions' ability to represent unit employees concerning MER future retirement benefits

Before the 2013 Changes, the Unions could bargain with DuPont and ask for information about the right of appeal for claim denials. Now, it is impossible. Before the 2013 Changes, DuPont set premiums for MERs' coverage. Anderson Tr. 553-54; see also J-12b at 21 (MEDCAP plan document with section entitled "Premiums," stating that "the Company" sets the premiums). Now, whatever insurance company the MER enrolls with will have the right to set premiums, and the Unions have no collective-bargaining relationship with those carriers. See J-12b, Appendix B, and lack of "Premiums" section. Before, the Unions could bargain with Respondent about premiums and ask for information about them, find out the amount, ask why, review cost data, and determine for themselves whether an increase was reasonable. See, e.g., Irvin Tr. 34-35; J-25, Tab 41 at DUPMD001329 (asking about effect on retirees); J-32, Tab 19 at DUPMD000904 (asking for MER premiums). Now, it is impossible. Respondent has entirely removed from the bargaining table, forever, a major mandatory subject of bargaining, future retirement health benefits. Accordingly, the 2013 Changes are unprecedented in their nature and scope.

An additional way to analyze this question of the effect on the Union's ability to bargain about a mandatory subject of bargaining, is to consider whether there is any difference between eliminating a benefit and eliminating the ability to even discuss the benefit. In terms of the effect on the Union's bargaining representative status, there is no difference. Accordingly, the 2013 Changes are just as violative of the Act as the 2007 Changes now pending before the Board in 05-CA-033461..

As the Union presidents credibly testified, there is no longer anywhere for them to turn to get information on MER health and dental benefits, short of asking a retiree about his individual

situation. Irvin Tr. 37; White Tr. 263; Lowman Tr. 292. This is a momentous change. The Unions cannot even assess the extent of the 2013 Changes because they have no information. It is possible that employees may lose their current doctors, J-13a at 16, and that pre-existing conditions may after a year cause them to lose their coverage, J-10, Tab F at 41. Because each retiree is unique and can pick his own insurance, J-11a, there is no way for the Unions to know what premiums are and what the extent of coverage is. Current employees do not know what their benefits will be when they become MERs. Lowman Tr. 292. The Union has no collective-bargaining relationship with Extend Health, so the Union cannot make an information request. The 2013 Changes were a “material departure” from anything done in the past, and so there is no past practice of eliminating MEDCAP and the DAP.

Further, Respondent cannot rely on the fact that information about various plans is available from Extend Health’s website and DuPont’s website. As Dickerson admitted, the information available there does not reflect anybody’s *actual* benefits. Dickerson Tr. 177; R-17. Respondent expects the Unions to navigate the “thousand,” J-11a, potential plans on these websites to get information about premiums. Again, even if the Unions were to do this, there is no way for them to know what benefits MERs actually have right now. Further, the Unions have no collective-bargaining relationship with Extend Health or any of the 75 different insurance carriers, and so cannot bargain about the benefits, even if they did find out what they were. The 2013 Changes are different in kind from anything Respondent has done in the past.

There is no evidence that the Unions ever “consciously yielded,” *General Electric*, supra, or “fully discussed,” *Reece Corp.*, supra, the complete gutting of their ability to discuss MER healthcare. Accordingly, the past changes do not constitute a waiver of the Union’s right to

bargain over the creation of the HRA, and transfer of MERs to Extend Health and other third parties for the purchase of their own insurance.

3. Cases cited by Respondent find a waiver either on demonstrated past practice that was continued with the changes at issue or on express language in a CBA

This analysis also demonstrates why *Courier-Journal* is distinguishable. As the Board has explained, that case turned on finding a past practice of similar unilateral changes. *E.I. DuPont*, 355 NLRB, slip op. at 2. The transformation of MER benefits into a voucher and channeling of MERs into the hands of strange third parties is a “material departure” from any alleged past practice, and thus the past practice cannot privilege the 2013 Changes. *Courier-Journal* concerned mere premium increases, and thus to satisfy that test Respondent would have had to maintain its annual minor change of benefits. In this case, however, the 2013 Changes upended the way MERs receive benefits, and changed the substance of the benefits as well. Accordingly, *Courier-Journal* is inapposite to the issue here.¹⁵

The Respondent cites several other cases, at 30-33, all of which are distinguishable or have no bearing on this case. First, Respondent misstates the holding in *Omaha World-Herald*, 357 NLRB No. 156, slip op. (2011), arguing that a history of unilateral changes must be understood by examining relevant plan documents. Respondent asserts, at 31, that the pension plan in that case “was not described” in the CBA and so the Board had to look at the plan documents. However, in that case, the CBA did reference the pension plan, and the Board expressly relied on the CBA language, and the practice of the parties, to find a waiver of the right to bargain over the retirement plan:

¹⁵ *Post-Tribune Co.*, 337 NLRB 1279, 1281 (2002), is also inapposite. In that case, the employer simply passed on healthcare increases in exactly the same ratio as it had in the past. In this case, the 2013 Changes are unprecedented in their scope and application.

The Company acknowledges that bargaining unit employees are eligible to participate in the *retirement plan*, group hospital, loss of time and life insurance programs provided the requirements for participation are met. The Company will advise the Union of proposed changes and meet to discuss and explain changes if requested. Inasmuch as the plans cover all employees, not just bargaining unit employees, changes in these plans are not subject to Article Five of the Agreement [the grievance and arbitration clause]. Employees may retire at age 65.

(emphasis added) *Omaha World-Herald*, 357 NLRB No. 156, slip op. at 1 (2011). Additionally, in *Omaha*, the CBA referenced a 401(k), but it lacked “sufficient specificity,” and so the CBA did not constitute a waiver of the right to bargain those changes, either. *Id.* at fn. 14 (citing *Southern Nuclear*). The CBAs in this case make no reference at all to MEDCAP or the DAP.

Mt. Clemens General Hospital, 344 NLRB 450 (2005), at 31, has no holding concerning waiver. The judge’s finding of waiver in that case was never excepted to and thus never reviewed or adopted by the Board. *Id.* at fn. 2; *Budd Co.*, 348 NLRB 1223, fn. 3 (2006). Moreover, the judge based his finding of waiver first and foremost on a finding that “this specific contract language shows that the matter asserted to be waived was fully discussed and consciously explored.” *Id.* at 460. In this case, there is no contract language of a waiver.

California Pacific Med. Ctr., 337 NLRB 910, 914 (2002), does not stand for the proposition that a union waives its right to bargain over a subject if it continuously acquiesces to similar changes. Instead, the Board found that the contractual language itself, under either the Board’s standard of clear and unmistakable waiver, or the contract coverage standard, privileged the company’s actions and precluded a finding of an unfair labor practice. *Id.* at 910, fn. 1. *Litton Microwave Cooking Products v. NLRB*, 868 F.2d 854, 858 (6th Cir. 1989), expressly held that the management rights clause of the collective-bargaining agreement allowed the company to engage in the actions at issue there (and bolstered its conclusion with the observation that the union had a history of acquiescing to the same conduct). There is no management rights clause

here in any of the CBAs and the plans are not referenced in them. *Uforma/Shelby Business Forms v. NLRB*, 111 F.3d 1284, 1291 (6th Cir. 1997), Br. at 29, purportedly holding that “previous acquiescence *suggests* that the union acknowledged the right of the employer to act without notice or bargaining,” (emphasis added) is a Sixth Circuit decision and not Board law. Further, the underlying Board decision found that the employer had violated the Act. Furthermore, that case also concerned the interpretation of contractual language and whether a zipper clause in the collective-bargaining agreement constituted a clear and unmistakable waiver. 111 F.3d at 1291; 320 NLRB 71, 72 (1995). In this case, there is no zipper clause at issue, and no contractual language to interpret.

Finally, the Respondent’s reliance on the *Courier-Journal* cases, 342 NLRB 1093 (2004) and 342 NLRB 1148 (2004), and *Manitowoc Ice*, 344 NLRB 1222 (2005), Br. at 48, is misplaced. In *Courier-Journal*, the Board found that the employer had established that it had a past practice of making changes to healthcare premiums even when there was no governing management rights clause in effect. *Courier- Journal*, 342 NLRB at 1094. The Respondent contends, Br. at 38, that it also has established that it has a past practice of making changes to its healthcare plans, and therefore it may safely eliminate coverage under MEDCAP and the Dental Plan, create a voucher, and transfer MERs to third parties to find new insurance. This contention lacks merit. Section IV.D.1 and 2 demonstrate why the changes here are a material departure from any of the minor, programmatic changes in the past. This is discussed further below.

Manitowoc Ice also is distinguishable. In that case, the Board found that the union was equitably estopped from challenging the employer’s changes to its profit-sharing plan because the parties had recently negotiated the subject, the union did not challenge the company’s statement that the plan was non-negotiable, and that there was a “clear understanding” that the

plan was a management prerogative. *Manitowoc Ice*, 344 NLRB at 1224. In this case, there were no immediately prior negotiations on MEDCAP and the Dental Plan (the parties never negotiated MEDCAP), and there is nothing in the record showing that there was a “clear understanding” that the Respondent could eliminate MEDCAP and the Dental Plan without bargaining. The Unions challenged many of Respondent’s changes, in some cases the parties have bargained, Respondent admitted that it had bargained, and information requests were honored. Accordingly, there is no reason to estop the Unions from challenging the elimination of these benefits.

E. Judge Correctly Found That the Parties Have Engaged in Bargaining over the Years Concerning Changes to Health Benefits

Respondent takes issue, at 34-35, with the judge’s finding that Respondent and Unions did engage in some form of bargaining over the years concerning changes to the plans.

1. Local 992 in Richmond engaged in bargaining with Respondent over benefit changes, including requesting and receiving information about topics that Respondent claims it had no duty to bargain

The bargaining history in Richmond was covered in briefs filed with the Board concerning 05-CA-033461; however, in order to address similar contentions raised by DuPont in this case, this brief will repeat some of that history.

From 1992-94, Respondent told employees it was bargaining or had bargained premium increases with Local 992. R-4, Tab 3; see also *id.* at Tab 4 and Tab 5, announcing upcoming 1994 changes (“There are no hard and fast details yet, and once details become available, they will be subject to bargaining a Spruance.”). Sometimes the Union insisted on information being heard in the Contract Committee, where the Union preferred to bargain on what it considered a

contractual issue.¹⁶ See GC-8 at DUP0015456-57; GC-2 at 4; J-3 at 249-250. Other exchanges between Respondent and Union also exemplified typical bargaining sessions, such as the Union objecting to a situation that affected the employees' terms and conditions of employment and Respondent responding that it would look into the matter. See R-3, Tab 56 at DUP008737 (regarding change to physicians group); GC-4 at DUP0015378 (psychiatric care); GC-5 at DUP0015413 (gynecologist). On September 22, 1998, the Union asked Respondent why it had chosen CIGNA as an insurance carrier. R-3, Tab 61 at DUP008795. Although former labor relations manager Linda Derr testified in 05-CA-033461, pending at the Board, that Respondent had no obligation to bargain over this matter, in 1998 Respondent answered the question. J-3 at 255; Id. On October 13, 1999, at an Executive Committee meeting discussing changes to Beneflex for 2000, the Union asked how plan rates were set and Respondent answered that question as well. R-3, Tab 64 at DUP008823. Then the Union expressly requested bargaining on the subject and Respondent refused because of the Beneflex plan language. Id. On October 12, 2000, at an Executive Committee meeting, the Union asked Respondent if Respondent's announcement of changes to Beneflex was bargaining or just telling them information. R-3, Tab 65 at DUP008840. Respondent responded that it was not bargaining. Id.

Thus, contrary to Respondent's contention, at 34-36, Local 992 did engage in bargaining with Respondent, both over decisions concerning health benefit changes, as is noted above from 1992-94, and in effects bargaining, as is noted in the bargaining over which doctors would be included in a network. The record supports the judge's finding in this regard. ALJD:8-9.

The General Counsel has already filed briefs with the Board in 05-CA-033461 demonstrating the numerous information requests that Local 992 made over the years about

¹⁶ Although MEDCAP and the DAP were not in the contract, benefit changes were almost always announced as a change to Beneflex benefits, which were in the contract.

health benefits. From 2007-2012, this pattern continued. Over the last five years, every time that DuPont announced changes to benefits, the Union asked about retirees. Palmore, Tr. 122. Vice President Jay Palmore credibly testified that the reason they did so was because “[o]ur members need to know what it’s going to cost them to retire because it’s an added expense that they take on when they retire.” Id. Respondent never refused to provide information to the Union regarding retirees. Id. Another Union official, Donnie Irvin, testified similarly:

It will depend on the nature of the change. But, typically, we will always request plan language. And if the reason for the increase is because of the amount of money that DuPont has paid in benefits, health care, we will request that data. We will want to see actuarially why they claim that the increase was justified. So we will have an informational meeting. And then we will always follow up through the exec with these type of questions. Typically, management will say they will provide it to us when it becomes available. Sometimes they will compare it to area -- local firms within the area and say that this is justifiable based on what's going on nationally. One year it was prescriptions went up. So they said that was as a result of the highest cost of the health care being with prescriptions. So we requested that data. So it could vary from year to year depending on what the increase would be.

Irvin Tr. 34. Irvin also testified about the Union’s interest in asking about retirement benefits at these meetings.

Typically, every year we will ask about the cost because management will say that the retiree health care cost is lumped in with ours and that's a reason for our increases. So we will ask about how much money the retirees cost us versus how much of the money DuPont paid was ours versus retirees. We will always ask what their increases are going to be in comparison to our increases. Management typically will tell us. And when they have the data, they will give it to us. The retirees' enrollment period is after ours. So a lot of those numbers are not available until after we get through with ours.

Irvin Tr. 35. See *E.I Du Pont de Nemours and Co.*, 05-CA-033461, JD-49-11, slip op. at 7, fn.43 (“Irvin credibly testified as to the Union’s practice of requesting information, verifying the information Respondent provided, and acquiescing to favorable changes.”).

The documentary evidence supports this testimony that the Union typically asked for cost data to confirm the premium increases. See the following exhibits illustrating the Union's information requests:

1988 - GC-47 at DUP008584
1996 -- R-3, Tab 54 at DUP008720
2000 -- R-3, Tab 65 at DUP008841
2001 -- R-11, Tab 66 at DUP008847
2002 -- GC-14 at DUP0017850
2003 -- R-3, Tab 69 at DUP008931¹⁷
2006 -- GC-36 at DUP005274 (internal document noting Union may be entitled to information to bargain)
Local 992 currently has "no idea" who MERs receive their secondary insurance benefits

from now. Irvin Tr. 37. "DuPont has always prided themselves of taking care of their employees and retirees. So with this most recent change, they got rid of all responsibility for Medicare-eligible people. There is no one within the DuPont organization that these retirees can go to for help. They are just at the mercies of an independent carrier." Id. at 38.

2. Local 788 in Louisville engaged in bargaining with Respondent over benefit changes, including requesting and receiving information about topics that Respondent claims it had no duty to bargain

The Freon Craftsman Union was certified on May 24, 2010 as the exclusive collective-bargaining representative of the employees at the Louisville facility. GC65. The Union attained this certification after defeating the United Steel Workers of America and its Local 8-2002 in an election. Id.; Lowman Tr. 283. Prior to USW Local 8-2002, the union representing employees in Louisville was PACE Local 5-2002, and prior to that was the Neoprene Craftsman Union, or NCU. Greg Lowman has held positions with each of these unions. Lowman Tr. 280-82.

¹⁷ Respondent did tell Local 992 that it would not provide financial information if not relevant.

Respondent and the various unions in Louisville have long sparred over benefits. It should be noted that on May 14, 1997, Respondent told the Neoprene Craftsman Union, that Respondent was “committed to sharing health care costs with employees. This is an important factor in the overall approach to controlling costs.” J-32, Tab 14 at DUPMD000831; see also J-33, Tab3 at DUPMD000861 (concerning “objective for equal cost-sharing of increase”). There is no longer any cost sharing with employees concerning the MER health and dental benefits.

It should also be noted that the parties at Louisville did bargain changes over plan language. See J-33, Tab 2 at DUPMD000842. The following facts illustrate the Louisville unions’ active participation in the bargaining process concerning MER benefits.

The Neoprene Craftsman Union demanded bargaining over changes to health benefits in 1996, J-32, Tab 11 at DUPMD000818, in 1999, J-32, Tab15 at DUPMD000870-72, during which the union also made an 11 point, highly-detailed information request, including questions about pensioners. Respondent provided a detailed response to the NCU’s information request. J-32, Tab 4. In 2001, Respondent conceded to the NCU that “Management can negotiate the impact of the cost of the premiums for this plan for local employees.” J-32, Tab 17 at DUPMD000895. In 2002, Respondent refused the NCU’s demand to bargain over changes to the plans, but did indicate it would respond to the corresponding information requests. See GC58-60. PACE and Respondent essentially repeated this same interplay in 2003, 2004, and 2009, with the Union demanding bargaining before Beneflex changes were implemented and Respondent stated it had no obligation to do so. GC-61-64; J-32, Tab 32 at DUPMD001000. Respondent replied that it could make the changes based on plan language. *Id.*¹⁸

¹⁸ Brenda Kelsey, an official of Respondent in Louisville, testified that Lowman’s statement that the Union believed management must bargain over changes in 2009, only referred to the last set of changes announced, concerning vacation. Kelsey Tr. 510. Lowman credibly testified on rebuttal that the Union always listens to the whole

The unions in Louisville filed charges contesting changes to health benefits in 2001, 2003, 2004, 2005, 2006, 2007, and the current charge. GC-51A through H.

In 2000, Respondent did bargain with the union to add a Long Term Care plan to Beneflex. J-32, Tab 16 at DUPMD000884-85, because “this offering is different from the Union contract.” Id.

FCU Local 788 President Greg Lowman corroborated this bargaining history, that the Union consistently asked questions over these changes and demanded bargaining. Lowman Tr. 288-91; see also Irvin Tr. 37. Respondent has never used Extend Health before, or allowed MERs to pick their own insurance carrier or plan before the 2013 Changes. Irvin Tr. 37; Lowman Tr. 291.

In Louisville, in addition to what is already noted above, the Union made many information requests. In 1994, the NCU asked Respondent for “a list of AHDS network members.” J-32, Tab 7 at DUPMD000803; provided at J-32, Tab 8 at DUPMD000807; see also J-32, Tab 20 at DUPMD000909. NCU made very long detailed information requests about healthcare changes. See GC-54-57. Most importantly, in 2001, the Union asked for the very information Respondent’s 2013 Changes has eliminated: **“The Union asked Management to give them the monthly healthcare premiums for Medicare-eligible retirees and survivors. Management said they would get these rates and include them in the minutes of today’s meeting.”** J-32, Tab 19 at DUPMD000904 (emphasis added). The minutes reflect the premium information was provided. Id.

presentation by management, and then responds, in this case stating that all the changes to Beneflex needed to be bargained:

Q. How do you know you were referring to all the changes?

A. That's something that is always said in all the meetings. We give them an opportunity to present the changes, and at the end of it we let them know that we feel that it should be bargained.

Lowman Tr. 561.

3. Local 593 in Nashville engaged in bargaining with Respondent over benefit changes, including requesting and receiving information about topics that Respondent claims it had no duty to bargain

As in the other locations, Local 593 asked questions each year when changes were announced, including retirees. White Tr. at 260. J-25, Tab 41 at 2. In 1984, Local 593 questioned increases and costs to pensioners, and made an information request. J-25, Tab 2 at DUPMD001026-27. In 1986, the Union made a major information request about health benefit changes, J-25, Tab 4 at DUPMD001031-32, and again in 1987. J-25, Tab 5 at DUPMD001033-35 (Respondent noted that Local 593's proposal required extra scrutiny because union was proposing to change carriers). In 1988, the Union asked "how many plants now had MEDCAP." J-25, Tab 8 at DUPMD001051. In 1990, the Union again demanded a large amount of detailed information about dental health benefits, which Respondent provided. J-25, Tab 9 at DUPMD001073-74, and Tab 10 (response). In 1991, the Union asked about retiree coverage in the context of Beneflex. J-25, Tab 14 at DUPMD001102. In 1992, Respondent offered detailed information on retiree healthcare costs. See J-25, Tab 18 at DUPMD001155. In 1992, 1994, 1997, the Union objected to changes to MEDCAP, and Respondent stated it did not have to bargain. J-25, Tab 19 at DUPMD001161; J-25, Tab 25 at DUPMD001182; J-25, Tab 32 at DUPMD001566. In 2000, "[m]anagement stated that they would be willing to provide as much information as they could to help employees understand the reasons for higher health [sic] care premiums." J-25, Tab 36 at DUPMD001236. In 2002, the Union again wanted bargaining on changes, management stated it did not have to, and then management promised it would address their corresponding information requests. J-25, Tab 37 at DUPMD001239-40. In 2006, the Union stated its dislike of the changes and asked about retiree healthcare. J-25, Tab 38 at DUPMD001293; J-25, Tab 39

at DUPMD001296. The Union asked about specific prescription drug benefits in 2008, and asked again about retiree healthcare in 2009. J-25, Tab 40 at DUPMD001327; J-25, Tab 41 at DUPMD001329.

Like Richmond and Louisville, MEDCAP and the DAP are no longer in the CBA in Nashville. J-8. There are no bargaining notes concerning the Union's adoption of any plan documents governing MEDCAP or the DAP in prior CBAs.

The record shows that the Unions continually engaged in bargaining with Respondent. Respondent states that it never sought agreement with the Union, which is true. That does not mean bargaining did not take place. In every instance, Respondent presented the change to the Unions and the bargaining process began. The Unions sought information, a fundamental element of bargaining, in order to understand the change. Respondent knew it had a bargaining obligation and gave the information to the Unions so that the discussions could continue. Respondent wants to believe that it was never bargaining, but Board law says otherwise, as seen below.

4. Respondent's cases concerning information requests are waiver cases, ignore Board law that information requests are requests to bargain, and do not address point for which Respondent cites them

Respondent's cases, *Ingham Regional Medical Center*, 342 NLRB 1259, (2004), *Western Summit Flexible Packaging*, 310 NLRB 45 (1993), and *Budd Co.*, 348 NLRB 1223 (2006), do not support its position that the constant give and take over information requests did not constitute bargaining. In none of those cases did the Board hold that a union had clearly and unmistakably waived its right to bargain despite the employer's acquiescence to an information request. In *Ingham*, the Board found that the CBA language evidenced a waiver, and there was no discussion whether providing information obviated that waiver.

Similarly, in *Western Summit*, supra at 53, the Board found a waiver based on express language in a letter conceding the employer's right to make the change at issue, and engaged in no discussion, let alone holding, that a subsequent provision of information obviated that finding. In *Budd*, supra at 1224, the Board found that a management rights clause, and other express CBA provisions concerning how to challenge a work rule, demonstrated a waiver, and did not discuss the provision of information to the Union. None of these cases implicate the General Counsel's argument, that information requests constitute bargaining. *Eldorado*, supra. In this case, unlike Respondent's cases, where there is no express waiver, and Respondent seeks to show a past practice of acquiescence, these cases have no applicability. Further, these cases do not dispute Board law that where there is no duty to bargain, there is no duty to provide information. *BC Indus., Inc.*, 307 NLRB 1275 fn. 2 (1992) (finding no duty to furnish information about partial closure "[b]ecause Respondent BCI had no statutory obligation to bargain about the partial closure decision").

F. 2013 Changes Violated Dynamic Status Quo That Respondent Claims Existed, and Respondent's Attempts to Downplay 2013 Change Mischaracterize Seriousness of Events

As demonstrated above in Section D, concerning the materially different nature of the 2013 Changes, Respondent's assertions at 38-41, that the 2013 Changes were consistent with the "dynamic status quo" of its yearly premium increases and eligibility tinkering has no support in the record. As shown above, the 2013 Changes substantially changed the nature and manner of the employees' future retirement benefits. Employees no longer know what their benefits will be when they reach 65, and Respondent can't tell them because it doesn't know, either. Not only have the benefits have changed, but the rupture of the bargaining relationship also demonstrates that change.

Respondent's downplaying of the seriousness of the 2013 Changes, at 41-46, have no merit. First, the 2013 Changes *did* eliminate benefits. Respondent no longer provides benefits; it provides money and an known third party provides the benefits. Respondent may retain the name "MEDCAP" and "DAP" for MERs in its plan documents, but the documents demonstrate that Respondent has abandoned the field. MERs go to Extend Health to enroll in their benefits from a different company. J-13a and 13b. MERs file claims with Extend Health. J-12b at DUPMD000124. MERs appeal denials of claims to Extend Health and Extend Health has the final say. *Id.* at DUPMD000125. Respondent does not set premiums anymore, the individual unknown insurance carriers do. Contrast J-12b at 21 with lack of corresponding provision in Appendix B of MEDCAP plan document; ALJD:15. Respondent's contention that MERs cannot be denied coverage for pre-existing conditions, just like previously under MEDCAP, is true for one year only. J-13b at 8. Also misleading is that MERs will continue to appeal claims to the carrier, not Respondent, because before the 2013 Changes, Respondent had the final right of appeal. J-10, Tab f at 43. No more. J-12b at DUPMD000125.

Respondent implicitly concedes, at 43, that it has removed these benefits from the bargaining table, but contends that is not significant because they never were on the bargaining table. Section IV.E. above demonstrates that is not the case, that the Unions bargained these benefits, and did not concede their right to do so. Respondent offers that it is still willing to bargain over site-specific plans, but this is hollow, as the judge found. ALJD:22. The Unions have no information about current MER benefits and Respondent doesn't, either, making bargaining impossible. The Unions' ability to make their traditional inquiries and information requests has been destroyed. Respondent's pointing

to Extend Health's website as the repository of information for MER benefit also rings hollow. This website lists potential benefits, available opportunities, but does not show anyone's actual benefits. Dickerson Tr. 177; R-17.

Likewise, Respondent's contention, at 44, that MERs and employees in the past have had to choose different benefit options ignores the gravity of the 2013 Changes. Individuals aren't choosing high-premium or low-premium options. See, e.g., R-3, Tab 45 at D005255 (allowing retirees to choose options including individual only, plus spouse, plus children, etc.). Under the 2013 Changes, MERs aren't just choosing which option, they are choosing the insurance carrier, and then choosing an insurance plan, and then choosing an option within that plan. See Palmore testimony beginning at Tr. 112. MERs have had to go to great lengths to assemble information in order to talk to an unknown benefits advisor from Extend Health. Respondent's contention also ignores Board law on changing carriers. If it is unlawful to switch to one carrier without bargaining with the union, *a fortiori* it is unlawful to switch to 75 without bargaining. *The Connecticut Light & Power Co.*, 196 NLRB 967, 969 (1972) (discussing need to bargain over change of carrier).

Respondent's further contention that it has always used third party administrators to administer benefits, ignores that a third party may administer payroll, but Respondent controls payroll. A third party payroll administrator doesn't decide how much someone makes; Respondent does. The 2013 Changes have delegated all the control over MER's secondary health and dental benefit control that it used to have in MEDCAP and the DAP to a third party. Additionally, Respondent may have contracted with Merrill Lynch to administer its 401(k), but there is nothing in the record to indicate that Respondent no longer determines what the options are in the 401(k), and Respondent has offered no

evidence that it does not exercise such control. Accordingly, Respondent's use of third parties in the past in no way resembles its transfer of authority to Extend Health and the other third party carriers.

G. There Is No Waiver in Louisville

Finally, there is no waiver in the Louisville case because Respondent cannot escape *Eugene Iovine*, 356 NLRB No. 134, fn. 3 (2011):

In affirming the decision, we make the following modification of the rationale set forth in the above-referenced decision. While we affirm the finding that the Respondent failed to establish that it had a past practice of unilaterally laying off employees either prior to or after the Union's 1993 certification, we further find that even had the Respondent established that such a past practice existed prior to 1993, when another union represented its employees, this would not privilege its action here. Thus, we agree with the judge that the Respondent may not establish a past practice defense privileging its unilateral changes based on the acquiescence of a union that previously represented the unit employees, where—as here—the Union has not acquiesced to such unilateral changes. See, e.g., *Eugene Iovine, Inc.*, 328 NLRB 294, 297 (1999), enfd. 1 Fed.Appx. 8 (2d Cir. 2001). The judge's discussion and resolution of this issue are fully consistent with Board precedent.

Accordingly, after the Freon Craftsman Union became the new, certified bargaining representative in Louisville 2010, any waiver that could have existed from predecessor unions no longer could have privileged Respondent's conduct. GC-65. Further, after any changes that may have happened in 2010 and 2011, the Union filed the instant charge in 2012, so there is no basis to find that in two years Respondent demonstrated a past practice justifying its 2013 Changes. The judge was correct when he so found. ALJD:18.

V. CONCLUSION

The record supports the judge's finding that Respondent violated Section 8(a)(5) of the Act when it implemented the 2013 Changes without bargaining. The record further supports the judge's finding that Respondent failed to carry its burden of proof that any of the Unions involved in this

case waived their right to bargain over those changes. The General Counsel respectfully requests that an appropriate Order issue rescinding these unlawful changes and returning the parties to the status quo.

Respectfully submitted,

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CERTIFICATE OF SERVICE

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