

Oakland Physicians Medical Center, LLC d/b/a Doctors' Hospital of Michigan and Michigan Association of Police. Case 07–CA–120931

July 22, 2015

DECISION AND ORDER

BY CHAIRMAN PEARCE AND MEMBERS JOHNSON
AND MCFERRAN

On August 15, 2014, Administrative Law Judge Christine E. Dibble issued the attached decision. The Respondent, Doctors' Hospital of Michigan, filed exceptions and a supporting brief. The General Counsel filed an answering brief.

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

The Board has considered the decision and the record in light of the exceptions and briefs and has decided to affirm the judge's rulings, findings, and conclusions as modified, and to adopt the recommended Order as modified and set forth in full below.

The judge found that deferral to arbitration was not appropriate in this case and further found that the Respondent violated Section 8(a)(5) and (1) of the Act by changing—without the Union's consent—the employees' health insurance benefits, including the premium co-shares the employees are required to pay. As explained below, we find that deferral is not appropriate and that the Respondent violated the Act, but we clarify that the changes the Respondent made constitute mid-term contract modifications within the meaning of Section 8(d), thereby violating Section 8(a)(5) and (1) of the Act.¹

Facts

The Union's most recent collective-bargaining agreement with the Respondent was effective from April 10, 2012 to April 10, 2014. Article 16.1 of the collective-bargaining agreement provides:

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

¹ We shall therefore amend the judge's conclusions of law and remedy, and modify her recommended Order and notice in accordance with this finding.

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

Full-time single	10% per pay
Full-time two person	10% per pay
Full-time family	10% per pay
60-79 ² single	25% per pay
60-79 two person	25% per pay
60-79 family	25% per pay
40-59 single	50% per pay
40-59 two person	50% per pay
40-59 family	50% per pay

Article 16.4 provides: "The Hospital reserves the right to select and change insurance carriers and administrators, provided that similar coverage is maintained."

Throughout 2013, the majority of the Respondent's employees were in a self-funded health insurance plan, the Health Alliance Plan (HAP).³ Under HAP, individuals had \$500 and \$1000 yearly deductibles for network and non-network providers, respectively, and families had \$1500 network and \$3000 nonnetwork deductibles. Medical expenses were covered at a rate of (a) 100 percent for Doctors' Hospital providers with no deductible, (b) 80 percent after the deductible for network providers, and (c) 50 percent after the deductible for non-network providers.⁴

In November 2013, the Respondent was informed that the HAP provider intended to terminate its contract with the Respondent. The Respondent contacted Compass Benefit Group (CBG), with which it has a contract to solicit health insurance plans for its employee benefit program, and instructed CBG to find a replacement plan. On November 29, 2013,⁵ CBG's president, Edward Maitland, provided the Respondent with a proposal from Blue Care Network Health Maintenance Organization (BCN HMO). Maitland gave the Respondent the final BCN HMO plan to review on about December 19, and the Respondent signed documents enrolling in the plan on December 24. The BCN HMO plan was effective January 1, 2014, for all of the Respondent's employees.

² "Sixty-79" and "40-59" refer to the number of hours a part-time employee works during a 2-week pay period.

³ The uncontradicted evidence in the record shows that, effective January 1, 2013, HAP became the operative plan, with the co-share schedule outlined in art. 16.1 remaining intact.

⁴ The policy contained a few specific exceptions to this coverage. For instance, nonnetwork infusion therapy/injections were not covered; Doctors' Hospital laboratory testing was subject to a \$10 copay, and network laboratory testing was subject to a \$30 copay.

⁵ All subsequent dates are in 2013, unless otherwise indicated.

The BCN HMO plan included a core plan with a \$2000 employee deductible, and another plan, called the "buy-up plan," with a \$3500 employee deductible. Further, the BCN HMO plan increased full-time employees' premium co-shares to 35 percent for family coverage and 45 percent for single coverage.

Meanwhile, on several occasions in 2013, the Union had asked the Respondent whether it anticipated any changes to health care coverage, and each time the Respondent stated that no changes had been proposed. On December 16, however, the Union's labor relations specialist, Donnell Reed, received an email from the Respondent's CEO, John Ponczocha, stating that a change in the employees' health care carrier and a significant increase in employees' premium contribution were required. The email continued, "We anticipate making a final decision [on changes to the employees' health care plan] by December 20, 2013[]" Reed responded that the Union would not agree to the proposed health care changes because it was not interested in increasing its members' health care costs, and there was a current collective-bargaining agreement that the Union expected the Respondent to honor.

Also in mid-December, Ponczocha informed Union Steward Andrew Anzures that there would be a meeting, with representatives from all three of the unions representing employees of the Respondent, to discuss possible changes to the health insurance plan. During that subsequent meeting,⁶ the union representatives were informed that employees' current health insurance would lapse on December 31 and that the Respondent was trying to obtain new coverage for them. At a meeting on December 30, the union representatives were provided information about the new health insurance plan and learned that it would require a 50-percent employee premium co-share. When the Respondent requested that the union representatives sign a document agreeing to the plan changes, they refused, stating that the 50-percent premium co-share was too costly.

At a meeting held January 3, 2014, to discuss modifications to the employees' health plan, Ponczocha informed Anzures that the Respondent had reduced the percentages for employee contributions to 45 percent for single coverage and 35 percent for family coverage. Ponczocha stated that the changes had already been implemented and that the employees had until January 10 to sign up for the new plan. Ponczocha also said that the Respondent would pay 100 percent of the employees' premium costs for January 2014.

⁶ The record does not indicate the exact date of the meeting.

On January 8, 2014, the Respondent held another meeting with the union representatives. Ponczocha stated that he believed the parties were solidifying the agreement the Respondent reached with the unions at their December 30 meeting. Reed objected, stating that he had not consented to any agreement. Ponczocha responded that the Respondent had fully paid for the employees' health care premiums only through January 1, 2014.

On January 20, 2014, Ponczocha again met with the union representatives and informed them that the Respondent had started deducting the new increased premium amounts from employee paychecks. Reed told Ponczocha that the Union's members had rejected any such changes. After the meeting, Reed sent an email to Ponczocha demanding that the Respondent stop violating the collective-bargaining agreement. Reed subsequently filed two grievances claiming that the Respondent had breached the collective-bargaining agreement's health care provision.

Discussion

The judge found that deferral to arbitration was inappropriate because the relevant provision of the collective-bargaining agreement was unambiguous. Specifically, the judge found that the provision in article 16.1 requiring the Respondent to adhere to the premium co-share schedule needed no interpretation. Likewise, the judge found that, because the Respondent did not give the Union notice of the health plan design amendments until after their implementation, this violation of the contract appeared so obvious that there could be no contrary interpretation by an arbitrator. The judge further found that the interpretation of the contract as it related to the health plan design was so intertwined with the Respondent's change to the employees' premium contributions that the two issues could not be separated. For these reasons, the judge found that deferral to arbitration was inappropriate. Finally, she found that the Respondent's changes to the employees' health insurance benefits violated Section 8(a)(5) and (1). We agree.

Article 16.1 of the parties' collective-bargaining agreement grants the Respondent the right to amend the plan design of the employees' health insurance benefits, provided it gives notice to the Union, but it explicitly states that the Respondent does not have the right to amend the premium co-share schedule listed therein. In changing its employees' healthcare coverage, the Respondent increased employees' premium co-share percentages for full-time employees from 10 to 35 percent for family coverage and 45 percent for single coverage.

The language prohibiting changes to the premium co-share schedule is unambiguous. Therefore, no issue of

contract interpretation is presented. See, e.g., *San Juan Bautista Medical Center*, 356 NLRB 736, 737–738 (2010). Article 16.1 also explicitly and unambiguously requires that the Union be given notice of any plan design amendments, but despite the Union’s repeated requests, the Respondent intentionally withheld information about the changes and did not notify the Union until after it implemented them. Among the plan design changes were increased employee deductibles, changes to the network of providers and employee copays. By altering premium coshares, and otherwise “amend[ing] the plan design of health insurance benefits,” without notice to the Union, the Respondent engaged in conduct expressly prohibited by the collective-bargaining agreement. These clear violations of the express terms of the parties’ agreement make deferral inappropriate. Further, as the Union refused to give its consent to these changes, it is clear that the Respondent’s conduct constituted an unlawful mid-term contract modification. See, e.g., *San Juan Bautista Medical Center*, above, slip op. at 3.

Our dissenting colleague contends that, because the Respondent changed to a new health insurance plan rather than making changes to the existing plan, article 16.1 is “inoperative,” and article 16.4 is the applicable provision. In his view, article 16.1 is only applicable to a specific plan (Health Advantage, Tier Green), and article 16.4 grants the Respondent the right to select and change insurance carriers and administrators. We find this to be a selective reading of article 16.1, as it places qualifications on the explicit prohibition of changes to the employees’ premium co-shares. That prohibition, however, is not qualified. Neither article 16.4 nor any other provision of the collective-bargaining agreement contains language suggesting that unilateral changes to the employees’ co-shares are permissible.⁷ Finally, our colleague contends that even if article 16.1 were the operative pro-

⁷ Contrary to our dissenting colleague, we have not ignored art. 16.4. Art. 16.4 says nothing about changes in co-share amounts, unlike art. 16.1, which could not be more explicit in prohibiting changes to the co-share amounts. Indeed, the provision regarding co-shares is “clear on its face and requires no construction or interpretation beyond its plain meaning.” *Meilman Food Industries*, 234 NLRB 698, 698 (1978), enfd. mem. 593 F.2d 1371 (D.C. Cir. 1979). Moreover, we find no force in our colleague’s contention that it would be “more reasonable” to read into art. 16.1 a wholly contradictory statement—found nowhere in the contract—that co-share amounts can be changed when the Respondent unilaterally changes insurance carriers.

Member McFerran notes that, assuming *arguendo* that art. 16.4, which allows the Respondent to change health insurance carriers provided it maintains similar coverage, were the operative provision, the explicit prohibition on changes to employee premium co-shares in art. 16.1 would foreclose the possibility that the new insurance, which dramatically increased employee premium co-shares, could be considered similar.

vision, deferral to arbitration would remain appropriate because it is not “obvious” that article 16.1 prohibits changes to employee premium co-shares. As discussed, given article 16.1’s explicit prohibition against changing the premium co-share schedule, there is no ambiguity for an arbitrator to interpret.⁸

With respect to the plan design changes, there is no question that the Respondent amended the plan design of health insurance benefits by, among other things, increasing employee deductibles and copays and that it did so without providing the notice required by article 16.1. Therefore, no issue of contract interpretation is required. Further, to the extent that article 16.4 has any bearing on amendments to the plan design, it is so obviously intertwined with the Respondent’s unlawful modifications to article 16.1 that it cannot be considered separately. Established Board policy is not to bifurcate cases involving both statutory and contractual questions. See, e.g., *Hospital San Cristobal*, 356 NLRB 699, 699 fn. 3 (2011) (citing *Avery Dennison*, 330 NLRB 389, 390–391 (1999)). For these reasons, we conclude, contrary to our dissenting colleague, that deferral is inappropriate.⁹ We

⁸ Indeed, these contractual obligations are so obvious that, as described above in fn. 3, when HAP became operative in 2013, the premium co-share schedule remained intact.

⁹ Member McFerran also finds deferral inappropriate because the Respondent argued at length before the judge that the Union consented to modify the contract to allow the Respondent to change the health plan. That is a statutory defense to an unlawful contract modification allegation, see, e.g., *Mike-Sell’s Potato Chip Co.*, 361 NLRB 205 (2014), but it is not a question that arises under the parties’ collective-bargaining agreement or requires any interpretation of the agreement. See generally *Granite Rock v. Teamsters*, 561 U.S. 287, 297–298 (2010) (employer’s defense that a collective-bargaining agreement was validly ratified on a particular date cannot fairly be said to arise under the collective-bargaining agreement and is not subject to arbitration). The applicable arbitration clause empowers the arbitrator only to interpret or apply the express provisions of the contract, and restricts the arbitrator from amending or modifying the contract. Thus, it does not appear that the question whether the parties agreed to modify the contract could be resolved through arbitration. See *Teamsters Local 85*, 206 NLRB 500, 509 (1973). In those circumstances, the judge appropriately declined to defer this case to arbitration because, at the time, one of the Respondent’s defenses was not susceptible to resolution through arbitration, and, as stated above, Board policy is not to bifurcate cases involving both statutory and contractual questions.

Member McFerran notes Member Johnson’s implicit suggestion that, with respect to the bifurcation issue, the Board may focus only on the complaint, not on whether a particular defense can be resolved through arbitration. In her view, his suggestion has been rejected by the Supreme Court’s decision in *Granite Rock v. Teamsters*, where the Court explained that the appropriate inquiry is whether the parties’ dispute can be resolved through arbitration. Moreover, contrary to Member Johnson’s assertion, courts refuse to defer questions over “the applicability of a specific arbitration clause,” not solely on issues of contract formation. *Granite Rock*, 561 U.S. at 297. Nor is she persuaded that a litigant could always avoid deferral by claiming there is a purely statutory issue that relates to a contract-based allegation; certain-

further find that the Respondent made mid-term modifications to the collective-bargaining agreement without obtaining the Union's consent, within the meaning of Section 8(d), in violation of Section 8(a)(5) and (1).

AMENDED CONCLUSIONS OF LAW

1. Substitute the following for Conclusion of Law 3.

"3. By making mid-term modifications to the health care coverage terms of the collective-bargaining agreement without the Union's consent, the Respondent has been failing and refusing to bargain collectively and in good faith with the exclusive bargaining representative of its employees within the meaning of Section 8(d) in violation of Section 8(a)(5) and (1) of the Act."

2. Delete Conclusion of Law 10.

AMENDED REMEDY

Having found that the Respondent violated Section 8(a)(5) and (1) of the Act by its mid-term modification of unit employees' health care coverage, we shall require the Respondent to restore and maintain the health insurance benefits, including the reduced employee premium co-shares, provided for unit employees under the collective-bargaining agreement. In addition, the Respondent shall reimburse unit employees for any expenses resulting from the modification of the collective-bargaining agreement, as set forth in *Kraft Plumbing & Heating*, 252 NLRB 891, 891 fn. 2 (1980), enfd. mem. 661 F.2d 940 (9th Cir. 1981), such amounts to be computed in the manner set forth in *Ogle Protection Service*, 183 NLRB 682 (1970), enfd. 444 F.2d 502 (6th Cir. 1971), plus interest computed as set forth in *New Horizons*, 283 NLRB 1173 (1987), compounded daily as prescribed in *Kentucky River Medical Center*, 356 NLRB 6 (2010).

In addition, we shall order the Respondent to compensate the bargaining unit employees for the adverse tax consequences, if any, of receiving lump-sum backpay awards and to file a report with the Social Security Administration allocating the backpay awards to the appropriate calendar quarters for each bargaining unit employ-

ly this concern does not arise here, where it is the Respondent that both asserts the defense and urges deferral. In addition, where a party points to one issue as the basis for not deferring another issue, the Board does not automatically reject deferral, but instead examines whether the issues are "closely related" to one another. *Clarkson Industries*, 312 NLRB 349, 352 (1993) (refusing to defer an 8(a)(3) allegation that was closely related to a nondeferrable 8(a)(1) allegation, but still deferring other unrelated 8(a)(5) allegations). This "closely related" standard sufficiently guards against the abuse Member Johnson fears. Finally, because the dispute (including the defense) in this case cannot be resolved through arbitration, deferral does not further any of the policy goals that inform the Board's discretionary deferral policy. In these circumstances, she finds Member Johnson's views unpersuasive.

ee. *Don Chavas, LLC d/b/a Tortillas Don Chavas*, 361 NLRB 101 (2014).

ORDER

The National Labor Relations Board orders that the Respondent, Doctors' Hospital of Michigan, Pontiac, Michigan, its officers, agents, successors, and assigns, shall

1. Cease and desist from

(a) Making mid-term modifications to the health care coverage terms of the collective-bargaining agreement with the Michigan Association of Police (the Union) without the Union's consent.

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

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

(a) Restore to employees in the bargaining unit represented by the Union the contractual health care coverage benefits they enjoyed before the Respondent unlawfully modified the benefits on January 1, 2014.

(b) Make all employees in the bargaining unit represented by the Union whole for all expenses incurred and all losses suffered as a result of the Respondent's unlawful modification of the collective-bargaining agreement, in the manner set forth in the amended remedy section of this decision.

(c) Compensate bargaining unit employees for the adverse tax consequences, if any, of receiving a lump-sum award, and file a report with the Social Security Administration allocating the backpay awards to the appropriate calendar quarters for each employee.

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

(e) Within 14 days after service by the Region, post at its facility in Pontiac, Michigan, copies of the attached notice marked "Appendix."¹⁰ Copies of the notice, on forms provided by the Regional Director for Region 7, after being signed by the Respondent's authorized repre-

¹⁰ If this Order is enforced by a judgment of a United States court of appeals, the words in the notice reading "Posted by Order of the National Labor Relations Board" shall read "Posted Pursuant to a Judgment of the United States Court of Appeals Enforcing an Order of the National Labor Relations Board."

sentative, shall be posted by the Respondent and maintained for 60 consecutive days in conspicuous places, including all places where notices to employees are customarily posted. In addition to physical posting of paper notices, notices shall be distributed electronically, such as by email, posting on an intranet or an internet site, and/or other electronic means, if the Respondent customarily communicates with its employees by such means. Reasonable steps shall be taken by the Respondent to ensure that the notices are not altered, defaced, or covered by any other material. If the Respondent has gone out of business or closed the facility involved in these proceedings, the Respondent shall duplicate and mail, at its own expense, a copy of the notice to all current employees and former employees employed by the Respondent at any time since January 1, 2014.

(f) Within 21 days after service by the Region, file with the Regional Director for Region 7 a sworn certification of a responsible official on a form provided by the Region attesting to the steps that the Respondent has taken to comply.

MEMBER JOHNSON, dissenting.

Contrary to my colleagues and the judge, I find that this case should be deferred to the parties' grievance/arbitration procedure in accordance with congressional intent and the Board's deferral policy set forth in *Collyer Insulated Wire*, 192 NLRB 837 (1971).¹

In *Collyer Insulated Wire*, the Board established the general rule that it would refrain from adjudicating an unfair labor practice issue that arises from the parties' collective-bargaining agreement if the agreement provides for arbitration as the method of resolving disputes over the meaning of its provisions. The Board considers an issue to be well-suited to arbitral resolution when "the meaning of a contract provision is at the heart of the dispute." *San Juan Bautista Medical Center*, 356 NLRB 736, 737 (2011). Deferral is not appropriate where the disputed contract provision is clear and unambiguous, so that the special competence of an arbitrator is not required. *University Moving & Storage Co.*, 350 NLRB 6, 20 (2007).

The judge found, and my colleagues agree, that deferral is inappropriate under *Collyer* because the substantive question in this case—whether the Respondent violated the Act by changing its health insurance plan to a dissimilar plan, and by changing the employee premium contribution percentage—is not a question of contract interpretation that is well-suited for resolution through arbitration. I disagree. The resolution of the complaint allega-

tion here turns on whether the Respondent had the right to replace its self-funded health insurance plan, the Health Alliance Plan (HAP), with the Blue Care Network Health Maintenance Organization (BCN HMO) under article 16.4 of the collective-bargaining agreement. I believe that article 16.4 of the contract is the operative clause because it addresses the Respondent's authority to change insurance carriers, as it did here. In my view, the far more reasonable approach to interpreting the contract would be to focus on that clause, as it pertains to the specific situation presented (a change of carriers) and the specific obligations that follow from that change (to maintain "similar coverage"). Article 16.4 provides that "[t]he Hospital reserves the right to select and change insurance carriers and administrators, provided that similar coverage is maintained." This contractual provision, even though it directly pertains to the operative facts, is not entirely clear and unambiguous on its face; the term "similar coverage" can reasonably be interpreted as open to at least two plausible interpretations. On the one hand, it is reasonable to construe "similar coverage" to include the level of health benefits. There is some testimony in the record to support this interpretation. In this regard, Donnell Reed, the Union's labor relations specialist, testified that the collective-bargaining agreement gives the Respondent the right to change the plan design, but any changes must provide benefits of similar or equal value to the current plan. And the evidence is undisputed that the BCN HMO plan resulted in increased out-of-pocket expenses for the employees. Thus, it is arguable that the BCN HMO plan did not provide similar coverage because it cost employees more in out-of-pocket expenses.

Conversely, the Respondent's assertion that similar coverage refers to the types of benefits provided under the health plans is equally plausible, and also supported by record evidence. Edward Maitland, the Respondent's benefit consultant, testified that the new health insurance plan has all the same coverage as the former plan. As he testified, "If you have a heart attack, they're going to be covered. If they have brain surgery, they're going to be covered. So coverage has not changed at all. . . . [W]e're not minimizing coverage; we're just changing how much the employee would have to pay out of pocket." Indeed, the judge found that "the BCN HMO plan has the same medical coverage as the HAP PPO . . ." In his posttrial brief, the General Counsel similarly acknowledged that the BCN HMO plan offered the same coverage. Because the term "similar coverage" is susceptible to different reasonable interpretations, an arbitrator is needed to determine what the parties intended by the term, and thus whether the Respondent maintained

¹ Accordingly, I do not pass on the merits of the complaint allegation.

similar health coverage when it implemented the BCN HMO health care plan.²

In finding deferral inappropriate, my colleagues agree with the judge that article 16.1 of the collective-bargaining agreement unambiguously prohibits the Respondent from changing the premium co-share schedule, and requires the Respondent to provide the Union with notice of health plan design amendments. My colleagues find that the Respondent violated this clear and unambiguous provision and therefore, it is unnecessary for an arbitrator to interpret the contract. It is my view that my colleagues and the judge have based their analysis on an inoperative provision of the contract. That provision, article 16.1, states,

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

² That the Respondent's right to unilaterally change the health plan under art. 16.4 of the collective-bargaining agreement is a matter that requires interpretation by an arbitrator is supported by labor arbitration decisions that have examined the term "coverage" in determining whether an employer violated the collective-bargaining agreement by making changes in its health insurance plan. In *Brimfield Township Board of Trustees*, 123 LA 1558 (2007), the labor arbitrator held that the employer violated the collective-bargaining agreement when it refused to continue to reimburse employees for copays and deductibles under the health plan. *Id.* at 1563. The contractual provision at issue provided, in relevant part, ". . . [t]he employer agrees to maintain this similar coverage during the term of this agreement, but in no way less coverage that is currently in effect." *Id.* at 1559. The employer maintained that the word "coverage" did not include co-pays and deductibles, reasoning that the definition of "coverage" as found in Black's Law Dictionary, sixth edition, defined coverage as the "extent of risk contractually covered by the insurer." *Id.* at 1561. The union argued that the term coverage did include copays and deductibles. The arbitrator found that there were equally plausible, reasonably based but contradictory interpretations for the meaning of the term "coverage," and resolved the ambiguity based on a prior settlement by the parties. *Id.* at 1561-1562. Similarly, in *Tarmac America Inc.*, 119 LA 235 (2003), the union filed a grievance, asserting that employees were being required to enroll in a new health care plan with higher out-of-pocket expenses. The employer argued that the new plan was not "dissimilar" because the full panoply of benefits offered was the same. *Id.* at 238. The arbitrator found that both plans provided the *same* coverage because the same benefit provisions were covered by both plans, but concluded that the parties intended that when the employer changed health plans, the *level* of benefits had to be the same or similar. *Id.* at 239-241. Here, as in the above arbitration decisions, an arbitrator can examine the extrinsic evidence, including the parties' bargaining history and past practice, to determine what the parties intended by the term "similar coverage."

Thus, article 16.1 addresses one specific plan, the Health Advantage, Tier Green. The record shows that prior to the Respondent's implementation of the BCN HMO health insurance plan on January 1, 2014, the employees had been enrolled in the HAP plan. It is unclear from the record when the Respondent replaced the Health Advantage, Tier Green health insurance plan with the HAP plan, but it had been replaced. Further, even assuming that article 16.1 applies to the HAP plan, the Respondent did not merely amend the HAP plan design, but replaced it with an entirely different plan. The HAP plan was not redesigned in any remotely arguable fashion, it was discontinued and entirely replaced by a completely different plan from a completely different carrier. When the Respondent changes insurance carriers, the operative provision is article 16.4, as set forth above. Tellingly here, in his posttrial brief, the General Counsel argued that the Respondent did not have the contractual right under article 16.4 to make the changes that it did because the BCN HMO plan did not provide a similar level of coverage to employees.

In addition, even assuming arguendo that article 16.1 is the operative provision for our purposes, it is my view that it is not clear and unambiguous. It is not obvious that article 16.1 prohibits the Respondent from changing the premium co-share schedule in any and every health insurance plan. Nor is it clear that the notice requirement applies to any and every new plan. Therefore, an arbitrator is needed to determine what the parties intended by this language in article 16.1, and how it relates to article 16.4.³ In sum, neither article 16.4 nor article 16.1 is free

³ My colleagues have misstated my position in saying that I have questioned whether it is obvious that art. 16.1 prohibits changes to employee premium co-shares. I do not question the meaning of the words "other than the premium co-share schedule listed below."

What is far from obvious is whether this language applies to any health plan because the first two sentences in art. 16.1 clearly refer to a specific plan that is not the HAP plan. My colleagues provide little explanation as to why they find that art. 16.1 is applicable to other health plans, and thus would apply to the BCN HMO plan. In a footnote, they argue that the premium co-share schedule remained the same when the Health Advantage, Tier Green plan was replaced with HAP in 2013. *Yet, the judge made no such finding.* My colleagues' assertion in this regard is not based on credible or admissible evidence.

The majority essentially ignores art. 16.4 other than to say that, if it has any relevance, it would have to be viewed in connection with the language in art. 16.1 regarding the Respondent's "right to amend the plan design." This argument is illogical. If art. 16.1 addressed the Respondent's authority to change health insurance carriers, which is what happened here, then there would be no need for the parties to have drafted and included art. 16.4 in the contract. The provision would be redundant. I believe that a more reasonable interpretation of the collective-bargaining agreement is that art. 16.1 refers to a specific health plan and sets forth restrictions that the Respondent must adhere to if it modified that specific plan's design. But if the Respondent changes

from ambiguity. Citing *Avery Dennison*, 330 NLRB 389, 390 (1999), my colleagues also find that deferral is inappropriate because this case involves both statutory and contractual questions, and the Board's established policy, under such circumstances, is not to bifurcate the case. I believe that my colleagues have misconstrued Board precedent. The Board looks at the actual allegations in determining whether the issue involves the application of statutory policy and bases deferral or nondeferral on those. *Avery Dennison*, 330 NLRB at 390. In *Hospital San Cristobal*, 356 NLRB 699, 699 fn. 3 (2011), relied on by my colleagues, the Board found that deferral to arbitration was not warranted on the holiday pay allegation, because, among other things, the allegation was interrelated with an allegation that the employer failed to provide relevant information, which raised a statutory issue. Unlike in *Hospital San Cristobal*, there is a single allegation in this case, which is solely a contract-based allegation. This is not a case where there is a separate statutory allegation intertwined with a contractual allegation.⁴

Finally, an arbitrator should resolve this contractual dispute for policy reasons. The Board has held that its deferral policy ensures that where the parties have volun-

health carriers, as it did here, then I believe that art. 16.4 is the relevant provision. Even if the majority is correct that art. 16.4 is somehow connected to 16.1, it does not follow that it is entirely subordinate or that, as Member McFerran argues, art. 16.1's co-share nonalteration provision controls what is or is not "similar coverage." The bottom line is that the resolution of this dispute involves the interpretation of several multifaceted contract provisions, and their bargaining history, appropriate for the special interpretive competence of an arbitrator.

⁴ Citing *Granite Rock v. Teamsters*, 561 U.S. 287, 297–298 (2010), Member McFerran argues that deferral is inappropriate because the Respondent raised a statutory defense, having argued that the Union consented to modify the contract. *Granite Rock vs. Teamsters*, which has never even been cited by the Board in a deferral case, is inapposite. The case has absolutely nothing to do with the Board's deferral doctrine. In that case, the parties' dispute was not arbitrable because the issue was one of contract formation. *Id.* at 296. There is no dispute that a labor contract was formed and existed here. There is also no dispute over "the applicability of a specific arbitration clause" here either, because the contract clearly consigns the "art. 16.1 vs. art. 16.4" issue to arbitration. Moreover, allowing a party to avoid deferral based on any issue or potential defense that might be statutory is too malleable a standard. In my view, litigants can always claim there is some purely statutory issue or defense that relates to a contract-based allegation at hand, and the result under Member McFerran's theory would mean that the Board would never defer. For example, although Member McFerran correctly points out that the "closely related" doctrine theoretically prevents unrelated claims under the Act from acting as an obstacle to deferral, the outcome reached by the majority in this case shows the weakness of that doctrine. Here, merely raising the alternative, potential defense that the contract may have been modified then results in the Board choosing to ignore the parties' contractual dispute resolution mechanism entirely to plunge in and interpret the contract itself. It is hardly sensible or fair to create a deferral doctrine that precludes alternative defenses to an unfair labor practice charge.

tarily created a dispute mechanism culminating in final and binding arbitration, "it is contrary to the basic principles of the Act for the Board to jump into the fray prior to an honest attempt by the parties" to resolve their conflict using their negotiated process for doing so. *United Technologies Corp.*, 268 NLRB 557, 558 (1984). Congress established labor arbitration as the most desirable means of achieving the final binding adjustment of contract disputes when arbitration has been agreed to by the parties.⁵ Further, the Supreme Court has held that the Board's contract interpretation will receive no deference from the federal courts. Specifically, in *Litton Financial Printing Division v. NLRB*, 501 U.S. 190, 202 (1991), the Supreme Court stated that "[a]rbitrators and courts are still the principal sources of contract interpretation," and "the Board is neither the sole nor the primary source of authority in such matters." Therefore, the fast, inexpensive, and final resolution of the contract dispute here by an experienced labor arbitrator, whose award will receive deference by the courts is the best outcome for the parties.

Accordingly, I find that the complaint allegation in this case should be deferred to the parties' contractual grievance-arbitration procedure.

APPENDIX

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

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

FEDERAL LAW GIVES YOU THE RIGHT TO

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

WE WILL NOT make mid-term modifications to the healthcare coverage terms of our collective-bargaining agreement with the Michigan Association of Police (the Union) without the Union's consent.

⁵ Sec. 203(d) of the LMRA states: "Final adjustment by a method agreed upon by the parties is hereby declared to be the desirable method for settlement of grievance disputes arising over the application or interpretation of an existing collective-bargaining agreement."

WE WILL NOT in any like or related manner interfere with, restrain, or coerce you in the exercise of the rights listed above.

WE WILL restore to our employees in the bargaining unit represented by the Union the contractual healthcare coverage benefits they enjoyed before we modified the benefits on January 1, 2014.

WE WILL make whole, with interest, all employees in the bargaining unit represented by the Union for all expenses incurred and all losses suffered as a result of our unlawful modifications of the collective-bargaining agreement.

WE WILL compensate bargaining unit employees for the adverse tax consequences, if any, of receiving a lump-sum award, and WE WILL file a report with the Social Security Administration allocating the backpay awards to the appropriate calendar quarters for each employee.

OAKLAND PHYSICIANS MEDICAL CENTER, LLC
D/B/A DOCTORS' HOSPITAL OF MICHIGAN

The Board's decision can be found at www.nlr.gov/case/07-CA-120931 or by using the QR code below. Alternatively, you can obtain a copy of the decision from the Executive Secretary, National Labor Relations Board, 1015 Half Street, S.E., Washington, D.C. 20570, or by calling (202) 273-1940.



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

DECISION

STATEMENT OF THE CASE

CHRISTINE E. DIBBLE, Administrative Law Judge. This case was tried in Detroit, Michigan, on June 17, 2014. The Michigan Association of Police (MAP or Charging Union) filed the charge on January 21, 2014, and an amended charge was filed on January 31, 2014.¹ On April 4, 2014, the General Counsel issued the complaint against the Oakland Physicians Medical

¹ All dates are in 2013, unless otherwise indicated.

Center, LLC d/b/a Doctors' Hospital of Michigan (Respondent).² Respondent filed a timely answer denying all material allegations. (GC Exhs. 1-A to 1-J).³ The complaint alleges that since about January 1, 2014, Respondent failed to continue in effect all the terms and conditions of its current collective bargaining agreement with the Charging Union by changing its health care insurance plan, "Health Advantage, Tier Green," to a dissimilar plan, and by changing the employee premium contribution percentage, both without the Charging Union's consent.⁴

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

FINDINGS OF FACT

I. JURISDICTION

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

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

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

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

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

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

⁴ This allegation is alleged in par. 11 of the complaint.

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

II. ALLEGED UNFAIR LABOR PRACTICES

A. Overview of Respondent's Operation

Since 2008, Respondent has owned and operated a full-service acute care hospital, employing healthcare professionals, administrative staff, security officers, and employees in other job classifications. During the period at issue John Ponczocha (Ponczocha) was the chief executive officer (CEO), Dr. Short (first name unknown) was an owner and board member, and Robert Chiaravalli (Chiaravalli) was Respondent's attorney. Respondent also employed Mukul Kumar (Kumar) as its chief financial officer (CFO).

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

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

B. Article 16 of the Collective-Bargaining Agreement

The Charging Union's most recent collective bargaining agreement (CBA) with Respondent was effective from April 10, 2012, to April 10, 2014.⁷ (GC Exh. 7.) The health insurance provision of the CBA in Article 16 provides in relevant part:

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

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

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

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

Full-time single	10% per pay
Full-time two person	10% per pay
Full-time family	10% per pay
60-79 single	25% per pay
60-79 two person	25% per pay
60-79 family	25% per pay
40-59 single	50% per pay
40-59 two person	50% per pay
40-59 family	50% per pay

(GC Exh. 7.)

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

C. Cancellation of and Amendments to Employees' Health Insurance Plan

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

In August, Respondent started getting behind on paying health insurance claims through NGS. Therefore, in August, September, and October, Maitland had continuing discussions with Respondent and NGS on ways to continue the self-funded

⁸ Hereinafter, I will refer to Respondent's self-funded health insurance plan as HAP.

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

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

employee health insurance plan and pay the claims. In mid-November, Respondent's ability to timely pay its claims did not improve so NGS notified Maitland that it would terminate its contract with Respondent. Maitland informed Ponczocha that same day of NGS' intention to terminate the contract. Respondent instructed CBG to find a replacement plan that was cost effective and fully insured. Consequently, in November CBG began searching for a new health insurance plan for Respondent's employees and discovered Blue Care Network Health Maintenance Organization (BCN HMO). BCN is a "fully insured" plan. (Tr. 82.) On November 29, Maitland emailed Ponczocha, Kumar, and Chris Lucander (Lucander)¹¹ with the cost associated with the BCN HMO plan. He provided them with the cost to Respondent for choosing a plan with a \$1500 employee deductible or a \$3500 employee deductible. (GC Exh. 6.) The \$1500 deductible plan was called the core plan, and the \$3500 deductible plan was referred to as the buy-up plan. By choosing to place the employees in the BCN HMO network (with either the core plan or buy-up plan), Respondent would have a fixed cost for insurance each month. (GC Exh. 6.) The final plan that Respondent chose included a core plan with a \$2000 employee deductible and a buy-up plan with a \$3500 employee deductible. (GC Exhs. 27, 28.)¹² Maitland gave undisputed testimony that the HAP PPO plan was a "richer" benefit plan than the BCN HMO plan which replaced it. (Tr. 90.) Although the BCN HMO plan has the same medical coverage as the HAP PPO, it costs employees more in out-of-pocket expenses.¹³ Maitland gave Respondent the final BCN HMO plans to review on about December 19, and Respondent signed documents committing to the plans on December 24. (Tr. 87-88.) The BCN HMO plan was effective January 1, 2014, for all of Respondent's employees.

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

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

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

¹¹ Lucander was Respondent's CFO at the time Maitland sent the email.

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

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

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

In November, Ponczocha and Short organized a meeting with representatives from the 3 unions to discuss modifying the contract language on the utilization of compensatory time off (CTO). Respondent's attorney, Chiaravalli, also attended the meeting. Ponczocha and Chiaravalli explained that the current agreement on the usage of CTO was creating a financial difficulty for Respondent. Reed noted, "... [T]hey asked us to enter into an agreement as to how many days [employees] would be allowed to use for the month of November and December for CTO." (Tr. 42.) Ultimately, the unions agreed to modify the contract on employees' utilization of CTO. After addressing the CTO issue, Reed again asked if Respondent was going to discuss possible changes to the healthcare plans, and Ponczocha responded "they were okay with healthcare, they were just focused on this CTO at the time." (Tr. 43.)

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

In mid-December, Ponczocha approached Anzures in the lobby and informed him that he was scheduling a meeting with the union representatives to discuss possible changes to the employees' health insurance plan.¹⁵ Ponczocha, Maitland,

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

¹⁵ Respondent argues Anzures' credibility as a witness is "suspect as he testified he was present in mid-December (when Reed was not yet on vacation) and also testified that he was not presented with any information regarding the new health insurance plan that was being proposed at the mid-December meeting (even though Reed had been given

Short, Gamble, Lewis and Anzures attended the meeting where they were informed that employees' current health insurance would lapse December 31, but Respondent was trying to obtain new coverage for them. The attendees were not given details of the upcoming changes.

On December 26, Ponczocha sent an email to Reed, Brabson, Gamble, and Chiaravalli notifying them of a meeting to be held on December 30, to discuss "the 2014 Benefit Plan and employee contribution levels." (GC Exh. 13.) Reed did not receive the email until he returned from vacation. Consequently, he was unable to attend the meeting but Anzures went in his absence. Ponczocha, Kumar, Chiaravalli, Brabson, Lewis, Gable, and Anzures attended. During the meeting, the union representatives were given the enrollment worksheet for the BCN core and buy-up plans and a chart detailing the benefits provided by the two plans. The worksheet also contained the new employee premium deductibles. Ponczocha tried to get the Union representatives to sign a document agreeing to the changes on behalf of their respective memberships. (GC Exh. 20.) None of the Union representatives would sign the agreement, and they complained to Ponczocha that the initial proposal of an employee 50 percent premium co-share was too costly. After the meeting, Anzures shared with Reed the information Respondent gave them at the meeting about the health insurance changes.

On January 6, 2014, Reed received an email from Ponczocha proposing a January 8, 2014, meeting with management and the Union representatives. Chiaravalli and Kumar were also copied on the email. In attendance at the meeting were Ponczocha, Maitland, Reed, Anzures, Lewis, Brabson, Gamble, and possibly Hanson. Ponczocha began the meeting with his belief that they were solidifying an agreement he thought had been reached with the Unions at the December 30 meeting. Since Reed had not been present at that meeting and Anzures could not enter into agreements on his or the membership's behalf, Reed made it clear to the meeting's participants that he had not consented to any agreement. Brabson echoed Reed's objections to the agreement referenced by Ponczocha. (Tr. 149–153.) There is no evidence that any of the union representatives agreed to sign or signed a MOU accepting Respondent's proposed changes to the employees' healthcare plan and premium contributions.¹⁶ Ponczocha informed them that employees'

GC Exh. 8, 9, and 10, detailing the plan on December 16)." (R. Br. 3–4.) Respondent is correct that the record does not explain why Anzures attended the mid-December meeting without Reed. However, this fact is not a persuasive reason for discrediting Anzures testimony. Key portions of his testimony were corroborated by Reed, Maitland, and Brabson. Also, there is no evidence that in the mid-December meeting Anzures received any of the documents that Ponczocha sent to Reed via email on December 16. Therefore, I find no basis for discrediting his testimony.

¹⁶ Reed testified that the MOU signed by the unions and referenced by Ponczocha was to allow Respondent to temporarily furlough certain employees for the months of November and December and restrict the use of CTO. The MOU expired on December 31. It did not address the issue of employee health insurance plans. (Tr. 65–66). Although Respondent's attorney argued that the MOU pertained to Respondent's

healthcare premiums were fully paid for by Respondent only through January 1, 2014. Shortly after the meeting with Ponczocha and Maitland, Reed met with his membership about Respondent's proposed health plan changes, and they informed him that they were unanimously opposed to modifying their current CBA to allow changes to the health insurance plan.

On January 20, 2014, Ponczocha held another meeting with Reed, Anzures, Brabson, Lewis, Gamble, Hanson, and Maitland to again discuss the healthcare changes. During the meeting, Reed learned that Respondent had started deducting the new increased premium amounts from employee paychecks.¹⁷ He informed Ponczocha that his members had roundly rejected any premature changes to their CBA. Ponczocha became distraught and stated "he knew that this wasn't handled properly, that he did not meet with the unions and keep—bring them within the fold in the circle in handling this matter, that he made the change without speaking and negotiate (sic) with the unions like he was supposed to, but he was doing it as directed by the owners, the board of directors."¹⁸ (Tr. 60.) The meeting ended without a resolution. Following the meeting, Reed sent Ponczocha an email demanding that Respondent stop violating the CBA as it pertains to the healthcare provision. This was the last discussion he had with Respondent's management team before filing two grievances on the issue on January 13 and 28, 2014. (R. Exhs. 1, 2.)

Brabson provided corroborating evidence that Respondent and the union representatives had several meetings where the possibility of healthcare change was discussed. He attended the December 30 meeting because Lewis called him on December 17 or 18, to tell him that Respondent had notified the employees that it was changing their health insurance plan. Prior to December 30, Respondent had also sent him an email explaining that it was experiencing financial difficulties and needed to increase employee health insurance premium contributions to 50 percent for full-time employees, and change the healthcare plan it offered to them.¹⁹ (GC Exh. 17.) Brabson contacted

proposed healthcare changes, he failed to present substantive evidence in support.

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

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

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

Ponczocho to demand Respondent not implement any changes until Ponczocha had met with the employees' unions. Ponczocha agreed to meet on December 30, with representatives from MAP, AFSCME, UAW, and Kumar. During the meeting, the Union representatives questioned Ponczocha about Respondent's proposed changes to the healthcare plans. Ponczocha told them that Respondent was undergoing a financial crisis which necessitated the changes. The Unions asked Respondent to provide them with financial information to confirm that the changes were financially necessary. Respondent refused to provide the documentation and claimed "their computers were in a shambles or whatever and they couldn't pull the information up and they couldn't get us the information." (Tr. 142.) Brabson confirmed that none of the Union representatives ever agreed to Respondent's proposed healthcare changes.

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

III. DISCUSSION AND ANALYSIS

A. Legal Standards

Section 8(d) of the Act provides that the employer and the employees' representative have a mutual obligation to bargain collectively and as such must meet at reasonable times and confer in good faith with respect to "wages, hours, and other terms and conditions of employment, or the negotiation of an agreement or any question arising thereunder, and the execution of a written contract incorporating any agreement reached if requested by either party . . ." The section goes on to note:

"That where there is in effect a collective-bargaining contract covering employees in an industry affecting commerce, the duty to bargain collectively shall also mean that no party to such contract shall terminate or modify such contract, unless the party desiring such termination or modification- (1) serves a written notice upon the other party to the contract of the proposed termination or modification sixty days prior to the expiration date thereof, or in the event such contract contains no expiration date, sixty days prior to the time it is proposed to make such termination or modification; (2) offers to meet and confer with the other party for the purpose of negotiating a new contract or a contract containing the proposed modifications;"²⁰

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

duct in deciding if the employer has satisfied its obligation to confer in good faith).

Likewise, an employer to a contractual agreement cannot unilaterally take certain actions that result in changes to the terms and conditions of employment unless there has been a "clear and unmistakable" waiver of the union's right to bargain over the changes. *Pavilions at Forrestal*, 353 NLRB 540 (2008) (impasse irrelevant where employer unilaterally implemented new health insurance plan without providing union information, notice and opportunity to bargain concerning new plan); vacated and remanded (D.C. Cir. 2010), adopted in relevant part 356 NLRB 5 (2010), enfd.684 F.3d 1310 (D.C. Cir. 2012); *Laurel Bay Health & Rehabilitation Center*, 353 NLRB 232 (2008) (employer prematurely declared impasse and unilaterally implemented changes in health insurance and other benefits where union requested and employer agreed to schedule subsequent bargaining session, union indicated willingness to "look at other plans," and union stated that it would prepare counterproposal vacated and remanded (D.C. Cir. 2010), adopted 356 NLRB 3 (2010), vacated 666 F.3d 1365 (D.C. Cir. 2012)). The "clear and unmistakable" standard requires that the contract language is specific, or it must be shown that the subject alleged to have been waived was fully discussed by the parties and the party alleged to have waived its rights did so explicitly and with the full intent to release its interest in the matter. *Allison Corp.*, 330 NLRB 1363, 1365 (2000); *Metropolitan Edison Co. v. NLRB*, 460 U.S. 693, 708 (1983).

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

B. Complaint Allegation

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

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

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

[T]he dispute arose within the confines of a long and productive collective-bargaining relationship; there is no claim of employer animosity [or "enmity"] to the employees' exercise of protected rights; the parties' contract provided for arbitration of a very broad range of disputes; the arbitration clause clearly encompassed the dispute at issue;

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

²¹ See Sec. 102.35(a)(9) of the Board's Rules.

the employer had asserted its willingness to utilize arbitration to resolve the dispute; and the dispute was eminently well suited to such resolution [by arbitration].

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

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

Article 16.1 of the CBA reads in part:

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

The CBA sets out in unambiguous language the employees' share of the health insurance premium and that Respondent does not have the right to unilaterally change the premium co-share schedule. While the parties' may dispute the interpretation of the contract related to amending the plan design, the contract language addressing premium co-share needs no interpretation. Therefore, the special expertise of an arbitrator is unnecessary to interpret the contract. *Caritas Good Samaritan Medical Center*, 340 NLRB 61 (2003). Addressing the issue of the Respondent's right to amend the plan design, I likewise find it is not appropriate for arbitration. Although Respondent eventually gave the Charging Union notice of the health plan design amendments, it did not do so until after their implementation. Therefore, the violation of the contract appears so obvious that there can be no contrary interpretation by an arbitrator. See *R.T. Jones Lumber Co.*, 313 NLRB 726, 727 (1994); *Oak Cliff-Golman Baking Co.*, 202 NLRB 614 (1973), decision supplemented 207 NLRB 1063 (1973), enfd. 505 F.2d 1302 (5th Cir. 1974), cert denied 423 U.S. 826 (1975); *Alfred M. Lewis, Inc.*, 229 NLRB 757 (1977), enfd. in pertinent part 587 F.2d 403, 408 (9th Cir. 1978). Further, the contract interpretation as it relates to the health plan design is so intertwined with Respondent's unilateral change in the employees' premium contributions that they cannot be separated. Consequently, I find that deferring this case to arbitration would be inappropriate. Thus, the Respondent's motion for dismissal and deferral to arbitration is denied.

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

The General Counsel alleges that Respondent violated Section 8(a)(1) and (5) of the Act when, since about January 1, 2014, without prior notice to the Union and without giving the Union an opportunity to bargain with Respondent, Respondent unilaterally changed its health care insurance plan to a dissimilar plan, and changed the employee premium contribution per-

centage. (GC Br. 3.) Respondent contends that the complaint should be dismissed because the allegations "lack merit." (R. Br. 1)

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

The law is well settled that an employer may not change the terms and conditions of employment of represented employees without providing their representative with prior notice and an opportunity to bargain over such changes. See *NLRB v. Katz*, 369 U.S. 736, 747 (1962). In *Axelsson, Inc.*, 234 NLRB 414, 415 (1978), enfd. 599 F.2d 91 (5th Cir. 1979) the Board defined mandatory subjects of bargaining as:

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

The duty to bargain only arises if the changes are "material, substantial and significant." *Alamo Cement Co.*, at 738; *Flambeau Airmold Corp.*, 334 NLRB 165, 171 (2001), modified 337 NLRB 1025 (2002). The General Counsel bears the burden of establishing this element of the prima facie case. *North Star Steel Co.*, 347 NLRB 1364, 1367 (2006). Moreover, the Board has consistently held that change to employees' health benefits is a mandatory subject of bargaining and, hence, a unilateral change which constitutes a refusal to bargain. *Mid-Continent Concrete*, 336 NLRB 258, 259 (2001), enfd. 308 F.3d 859 (8th Cir. 2002). See also *BP Amoco Corp. v. NLRB*, 217 F.3d 869 (D.C. Cir. 2000) (modifications to health plan).

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

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

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

Despite Respondent's denials to Reed that it had no plans to change health benefits, it had already made a decision to do so in June. Although Respondent notified Reed on December 16, of proposed changes to the plans, the contract between BCN HMO and Respondent was signed on December 24, about a week before Respondent met with the unions to notify them of the contracted changes. The unilateral change at issue was accomplished approximately 1 week prior to its notification to the Charging Union. More importantly, it is undisputed that Ponczocha admitted that changes to the health insurance plan were made prior to speaking and negotiating with the unions.²² Although Respondent held a series of meetings with MAP and the other unions to discuss the health care changes, they were conducted after BCN HMO had been contracted to be the new carrier, and a decision had been made to increase the employees' contribution towards health insurance premiums. Also, at the last meeting with the unions on January 8, Respondent had already started deducting increased amount of money from employees' paychecks to pay for the new health plan.

Based on the evidence of record, I find that Respondent violated Section 8(a)(1), (5), and 8(d) of the Act, when since January 1, 2014, it unilaterally changed its health insurance plan and

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

the employee premium contribution percentage without prior notice to the Charging Union and, or giving the Charging Union an opportunity to bargain over the issue.

CONCLUSIONS OF LAW

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

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

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

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

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

REMEDY

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

The Respondent having discriminatorily made changes in the employees' health care insurance plan and the employees' premium contribution percentage must rescind any and all changes to their health insurance benefits and make them whole for any loss of earnings and other benefits they suffered as a result of the discrimination against them from the date of the discrimination to the date remedy is effectuated. Backpay shall be computed in accordance with *F. W. Woolworth Co.*, 90 NLRB 289 (1950), with interest as provided in *New Horizons*, 283 NLRB 1173 (1987), compounded daily as prescribed in *Kentucky River Medical Center*, 356 NLRB 6 (2010).

Respondent shall file a report with the Social Security Administration allocating backpay, if applicable, to the appropriate calendar quarters. Respondent shall also compensate the employees for the adverse tax consequences, if any, of receiving one or more lump-sum backpay awards covering periods longer than 1 year, *Don Chavas, LLC d/b/a Tortillas Don Chavas*, 361 NLRB 101 (2014).

[Recommended Order omitted from publication.]