UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

MILLER & ANDERSON INC.,	)	
	)	
	)	
Respondent,	)	
	)	Case No. 05-RC-079249
	)	
and	)	
	)	
SHEET METAL WORKERS	)	
INTERNATIONAL ASSOCIATION,	)	
LOCAL UNION NO. 19, AFL-CIO.	)	
	)	
Petitioner.	)	
	)	

BRIEF OF *AMICI CURIAE* THE AMERICAN HOSPITAL ASSOCIATION AND THE FEDERATION OF AMERICAN HOSPITALS

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TABLE OF CONTENTS

Page

STATEMENT OF INTEREST 1

QUESTIONS PRESENTED 3

SUMMARY OF ARGUMENT 4

I. AS DEMONSTRATED BY EMPLOYMENT STATISTICS IN HEALTH CARE, THE BOARD'S DECISION IN *OAKWOOD CARE CENTER* HAS NOT INFRINGED ON THE SECTION 7 RIGHTS OF CONTINGENT WORKERS 6

A. Contrary to the Concerns of the Dissent in *Oakwood Care Center*, the Board's Current Standards Have Not Accelerated the Expansion of a "Permanent Underclass of Workers," Especially In Health Care 6

1. Full-time jobs in health care are growing at a much faster rate than contingent worker jobs 7

2. Hospital and other workers who work part-time, independently, or through staffing agencies often prefer to do so due to the independence and flexibility offered by these positions 8

B. The Contingent Workforce Continued to Grow In the Years Between *M.B. Sturgis* and *Oakwood Care Center* 9

C. Contingent Workers Retain the Right to Organize In a Unit Consisting Solely of Jointly-Employed Employees 10

D. The Union Has Often Been the Party Seeking to Exclude Contingent Workers From Bargaining Units of Solely-Employed Employees 11

II. AS REQUIRED BY THE ACT, THE BOARD SHOULD CONTINUE ADHERING TO ITS HOLDING IN *OAKWOOD CARE CENTER* 13

A. The NLRA Prohibits the Non-Consensual Multi-Employer Bargaining That Would Result From Reversing *Oakwood Care Center* 13

B. Units of Jointly-Employed and Solely-Employed Employees Increase the Risk of Labor Disputes, Which in Health Care Would Disrupt Patient Care 15

III. SHOULD THE BOARD DECIDE TO OVERRULE *OAKWOOD CARE CENTER*, STANDARD PRINCIPLES THAT GOVERN THE ADDITION OF EMPLOYEES TO EXISTING BARGAINING UNITS SHOULD LIKEWISE APPLY TO CONTINGENT WORKERS 17

CONCLUSION 19

TABLE OF AUTHORITIES

Page

CASES & DECISIONS

Archer Daniels Midland Co.,
333 N.L.R.B. 673 (2001) 18

Arden Electric,
275 N.L.R.B. 654 (1985) 14

Bergdorf Goodman,
361 N.L.R.B. No. 11, 2014 NLRB LEXIS 587 (July 28, 2014) 11

Browning-Ferris Indus. of Ca., Inc.,
362 N.L.R.B. No. 186 (Aug. 27, 2015) 5

Carneco Foods LLC, No. 17-RC-12580 (Oct. 28, 2008) 12

Catholic Healthcare W.,
344 N.L.R.B. 790 (2005) 15

Danbury HCC,
360 N.L.R.B. No. 118, 2014 NLRB LEXIS 384 (May 22, 2014) 15

Engineered Storage Prods. Co.,
334 N.L.R.B. 1063 (2001) 11

Evening News Ass'n,
154 N.L.R.B. 1494 (1965) 14

Greenhoot, Inc.,
205 N.L.R.B. 250 (1973) 10, 11

Holiday Inn City Ctr.,
332 N.L.R.B. 1246 (2000) 12

Indyne, Inc., No. 15-RC-8709 (Aug. 27, 2007) 12

M.B. Sturgis,
331 N.L.R.B. 1298 (2000) 3, 5, 6, 9, 11

Mercy Hosps. of Sacramento, Inc.,
217 N.L.R.B. 765 (1975) 15

Neodata Prod./Distrib., Inc.,
312 N.L.R.B. 987 (1993) 11

Oakwood Care Ctr.,
343 N.L.R.B. 659 (2004) .... *passim*

Outokumpu Copper Franklin, Inc.,
334 N.L.R.B. 263 (2001) 11

PPG Indus., Inc.,
180 N.L.R.B. 477 (1969) 13

Paperworks Indus., Inc., No. 14-RC-108193 (July 18, 2013)...12

Park Manor,
305 NLRB 872 (1991) 16

Pittsburgh Plate Glass Co. v. NLRB,
313 U.S. 146 16

Resort Nursing Home,
340 N.L.R.B. 650 (2003) 14

Rush Univ. Med. Ctr. v. NLRB,
Nos. 15-1050, 15-1097 (D.C. Cir.) 18

Sheet Metal Workers Int'l Ass'n, Local Union No. 104, 323 N.L.R.B. 227 (1997)...14

Sole Tech., Inc., No. 21-RC-20855 (Nov. 18, 2005) 12

St. John's Hosp.,
307 N.L.R.B. 767 (1992) 18

St. Mary's Duluth Clinic Health Sys.,
332 N.L.R.B. 1419 (2000) 18

St. Vincent Charity Med. Ctr.,
357 N.L.R.B. No. 79 (2011) 18

United Clay Mines Corp.,
102 N.L.R.B. 1368 (1953) 16

STATUTES

29 C.F.R. § 103.30 18

29 U.S.C. § 158(d)(4) 15

29 U.S.C. § 158(g) 15

29 U.S.C. § 159(b) 13

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American Staffing Ass'n, *ASA Staffing Employee Survey* (2014),
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content/uploads/2014/08/Fact_Sheet_Aug_20141.pdf 9

H.R. 3020, 80th Cong. § 2(2) (as passed by Senate, May 13, 1947) 13

H.R. Rep. No. 80-510, at 32 (1947) (Conf. Rep.) 13

S. Rep. No. 93-766 at 3, 6 (1974), *reprinted in* 1974 U.S.C.C.A.N. 3946 15

The Center for Health Care Workforce Studies, *Health Care Employment Projections: An Analysis of Bureau of Labor Statistics Settings and Occupational Projections, 2012-2022*, at 7 (May 2014),
http://chws.albany.edu/archive/uploads/ 2014/08/blsproj2014.pdf 7

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http://data.bls.gov/pdq/SurveyOutput/Servlet 8

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http://www.gao.gov/assets/670/669766.pdf 7, 8

The American Hospital Association ("AHA") and the Federation of American Hospitals ("FAH") respectfully submit this brief *amicus curiae* in response to the invitation of the National Labor Relations Board (the "Board" or "NLRB") for interested *amici* to address whether the Board should continue to adhere to the holding of *Oakwood Care Center*, and other related questions. The Board's holding in *Oakwood Care Center* is consistent with both the National Labor Relations Act and decades of Board precedent, and has not infringed on the Section 7 rights of contingent workers. AHA and FAH thus urge the Board to continue to hold that solely-employed and jointly-employed employees cannot be included in the same bargaining unit absent the consent of both joint employers.[1]

STATEMENT OF INTEREST

The American Hospital Association is a national not-for-profit association that represents the interests of more than 5,000 hospitals, health care systems, and other health care organizations, plus 42,000 individual members. It is the largest organization representing the interests of the Nation's hospitals. AHA members are committed to improving the health of communities they serve. The AHA educates its members on health care issues and advocates on their behalf in legislative, regulatory, and judicial fora to ensure that their perspectives are considered in formulating health policy.

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[1] After the Board invited interested parties to file *amicus* briefs, one of the employers named in the representation petition moved to dismiss it as moot "because all work that was the subject of the Petition . . . ended more than three years ago," and "the petitioned-for unit of employees no longer exists." *See* Employer Tradesmen International's Motion to Dismiss Petition and Request for Review as Moot, at 1 (July 20, 2015). The petitioning union did not offer any evidence contrary to the employer's claims but nevertheless opposed the motion. AHA and FAH share Tradesmen's view that the Board should dismiss the petition as moot. Regardless of the Board's ruling on the Motion to Dismiss, it would be inefficient for the Board to use this case as a vehicle for overturning *Oakwood Care Center* given that the underlying petition could be held moot in future proceedings. That possibility would create unnecessary confusion as to the force of the Board's holding on the central legal issue and could lead to prolonged litigation arising from representation proceedings.

The Federation of American Hospitals is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

Both AHA and FAH have a vested interest in the outcome of this matter. Most of AHA's member hospitals, and all of FAH's member hospitals, are subject to the National Labor Relations Act. Additionally, contingent workers—defined broadly as individuals who work at the hospital but who are employed by another entity—play a vital role in the delivery of patient care and other services that AHA's and FAH's member hospitals provide. Hospitals, for example, may rely on traveler nurses supplied by third-party agencies to help provide uninterrupted medical care during spikes in patient census that are difficult to predict. These jobs do not benefit only the hospitals; the nurses who perform them gain valuable experience and enjoy the flexibility that the short-term nature of the job affords them. Some hospitals also contract out, for various reasons, highly specialized services such as anesthesiology, or functions unrelated to their core mission, such as food service or building maintenance. These contingent workers work alongside the hospital's own employees.

While contingent workers and hospital employees may perform similar work on any particular day, important differences exists between the two groups of employees. Hospital employees receive their wages and benefits from the hospital; contingent workers are compensated by the agency that supplies them. Hospital employees often work long-term at the hospital; contingent workers often work at any particular hospital for only a short period of time.

The hospital is directly involved in hiring its own employees; the supplying agency generally hires the contingent workers whom it refers to the hospitals.

In short, although the two groups of employees may share some interests, their interests on other important subjects diverge sharply. If the Board were to overrule *Oakwood Care Center*, AHA's and FAH's member hospitals could be forced to bargain related to a unit that includes both groups of employees even though they have competing interests and even though the hospitals may not exercise any actual control over the contingent workers' terms and conditions of employment. These non-cohesive units would make bargaining exponentially more difficult and thus increase the risk of potentially disruptive labor disputes.

QUESTIONS PRESENTED

For important reasons, the Board has required, virtually uninterrupted for decades, that a hospital's employees and jointly-employed contingent workers could not be in the same bargaining unit absent the consent of both the hospital and the supplying agency. In *M.B. Sturgis*, 331 N.L.R.B. 1298 (2000), however, the Board reversed course, holding for the first time that solely-employed and jointly-employed employees could be in the same unit regardless of employer consent. Four years later, the Board returned to its long-standing position, holding in *Oakwood Care Center*, 343 N.L.R.B. 659 (2004), that units of solely-employed and jointly-employed employees cannot exist without the consent of both joint employers.

The Board has adhered to the holding of *Oakwood Care Center* for the past 10 years. Now, however, the Board is reconsidering *Oakwood Care Center* and the decades of Board precedent with which its holding is consistent. For that reason, the Board has invited interested *amici* to address one or more of the following questions:

> (1) How, if at all have the Section 7 rights of employees in alternative work arrangements, including temporary employees,

part-time employees and other contingent workers, been affected by the Board's decision in *Oakwood Care Center*?

(2) Should the Board continue to adhere to the holding of *Oakwood Care Center*, which disallows inclusion of solely employed employees and jointly employed employees in the same unit absent the consent of the employers?

(3) If the Board decides not to adhere to *Oakwood Care Center*, should the Board return to the holding of *Sturgis*, which permits units including both solely employed employees and jointly employed employees without the consent of the employers? Alternatively, what principles, apart from those set forth in *Oakwood* and *Sturgis*, should govern this area?

AHA and FAH respond to each of these questions.

SUMMARY OF ARGUMENT

AHA and FAH urge the Board to continue to adhere to its holding in *Oakwood Care Center*. ***First***, the Board's decision in *Oakwood Care Center* has not infringed on the Section 7 rights of contingent workers in health care. The dissent in *Oakwood Care Center* expressed concern that the Board's decision would accelerate the expansion of a "permanent underclass of workers." That prediction has not come true, particularly in health care. Full-time jobs in health care are growing at a substantially faster rate than contingent worker jobs. Contingent worker jobs remain, however, in part because many health care workers—particularly those in professional and skilled positions—prefer to work part-time or through staffing agencies because of the flexibility and independence that those jobs afford them, as evident by, among other things, the growing number of registered nurse vacancies that exist at hospitals. Therefore, it is factually inaccurate, pejorative, and seemingly outcome-oriented to refer to all workers in a contingent position as part of an "underclass of workers." Certainly, the Board should not be making policy decisions as if they were.

Moreover, even if the contingent workforce has grown since *Oakwood Care Center*—something that is difficult to ascertain fully because of the different and sometimes conflicting definitions of contingent workers—the Board should not assume a relationship between the two. If the two were related, then the Board's decision in *Sturgis* should have stopped or slowed the growth of the contingent workforce. That, however, did not happen. Instead, the contingent workforce grew nearly 10% during that four-year period. This unrestrained growth suggests that external market forces—and not Board law—are driving the growth of the contingent workforce.

The Board should also recognize that its holding in *Oakwood Care Center* did not deprive contingent workers of their Section 7 rights. Both before and after *Oakwood*, contingent workers have had the right to organize in a unit of their peers with the same joint employers—a right that the Board has recently expanded by substantially lowering the evidentiary threshold required to establish joint employer status. *See Browning-Ferris Indus. of Ca., Inc.*, 362 N.L.R.B. No. 186 (Aug. 27, 2015). Contingent workers can also organize in a unit that contains individuals who have only one of their two employers in common provided both of the joint employers consent. Even when employers have consented to such units, however, unions have often sought to exclude contingent workers.

In sum, there is no evidence that the Board's decision in *Oakwood Care Center* has accelerated the growth of the contingent workforce, especially in health care. Even if it had, however, the Board should not overturn *Oakwood* on that basis because that decision does not deprive contingent workers of their Section 7 rights; it simply requires them to exercise those rights in a manner consistent with the Act.

Second, on the merits, the Board should continue to adhere to the holding of *Oakwood Care Center*. As the Board recognized in *Oakwood*—and as the Board acknowledged for

decades before that—the National Labor Relations Act prohibits non-consensual multi-employer bargaining that *Sturgis* allowed. This statutory consideration alone should dictate the outcome here. Nevertheless, even if the Board were to decide this case on policy grounds, those grounds do not counsel upending well-settled Board precedent yet again, particularly with respect to health care. Congress and the Board have each long recognized the need to balance hospital and other health care employees' Section 7 rights with the need for uninterrupted patient care. Overturning *Oakwood* would upset that balance because the non-cohesive units that would result would decrease the likelihood of the parties reaching agreement, thereby increasing the risk of disruptive labor disputes.

Third, even if the Board were to overturn *Oakwood*, the Board should clarify that standard principles that govern the addition of employees to existing bargaining units should likewise apply to contingent workers. Accordingly, the Board should not allow contingent workers to be added to existing units unless either (1) the contingent workers share a community of interest with the unit employees and vote in an appropriate *Armour-Globe* self-determination election to join the unit; or (2) the test for accretion is satisfied.

I. AS DEMONSTRATED BY EMPLOYMENT STATISTICS IN HEALTH CARE, THE BOARD'S DECISION IN *OAKWOOD CARE CENTER* HAS NOT INFRINGED ON THE SECTION 7 RIGHTS OF CONTINGENT WORKERS

A. Contrary to the Concerns of the Dissent in *Oakwood Care Center*, the Board's Current Standards Have Not Accelerated the Expansion of a "Permanent Underclass of Workers," Especially In Health Care

The dissent in *Oakwood Care Center* equated the contingent workforce with "the working poor," *see* 343 N.L.R.B. at 663, and warned that the Board's decision would "at worst accelerat[e] the expansion of a permanent underclass of workers." *Id.* at 668. Initially, the minority's broad-brush characterization of the contingent workforce does not fairly describe the breadth of employees who participate in the contingent workforce, particularly in health care,

many of whom are highly-skilled and well-compensated. Even if it did, however, the minority's prediction has not come to pass. Post-*Oakwood Care Center*, full-time jobs in health care are growing at a much faster rate than contingent worker jobs. Nevertheless, many part-time hospital employees and other health care workers turn down these full-time positions, apparently preferring the independence and flexibility that their "alternative work arrangement" affords them.

1. Full-time jobs in health care are growing at a much faster rate than contingent worker jobs.

The dissent in *Oakwood Care Center* expressed concern that the majority's holding would encourage employers to add contingent worker jobs at the expense of full-time jobs so as "to frustrate union organizing." *See* 343 N.L.R.B. at 664. We are not aware of any evidence that this fear has come to pass anywhere, but it certainly has not occurred in health care. Between 2002 and 2012, health care jobs increased by more than 22%. *See* The Center for Health Care Workforce Studies, *Health Care Employment Projections: An Analysis of Bureau of Labor Statistics Settings and Occupational Projections, 2012-2022*, at 7 (May 2014), http://chws. albany.edu/archive/uploads/ 2014/08/blsproj2014.pdf. This job growth has shown no signs of stopping; analysts estimate that between 2012 and 2022, health care jobs will increase by another 27%. *Id.* at 8.

Varying definitions of the contingent workforce make it difficult to determine precisely how much (or how little) job growth in the contingent workforce accounts for overall job growth in health care. *See* U.S. Gov't Accountability Office, *Contingent Workforce: Size, Characteristics, Earnings, and Benefits*, at 7, 11 (Apr. 20, 2015), http://www.gao.gov/assets/670/ 669766.pdf (hereinafter "GAO Report") ("[l]abor experts have not reached consensus on which arrangements represent contingent work"). It is clear, however, that full-time jobs in health care

are growing at a substantially faster rate than contingent worker jobs. From 2002 through 2012—the same time period in which health care jobs increased by more than 22%—temporary jobs in all industries increased by only 13.8%. *See* U.S. Dep't of Labor, Bureau of Labor Statistics ("BLS"), *Employment, Hours, and Earnings from the Current Employment Statistics Survey (National)* (hereinafter "Current Employment Statistics Survey"), http://data.bls.gov/pdq/SurveyOutput/Servlet (showing that jobs in the "Temporary Help Services" industry increased from a monthly average of 2,194,800 in 2002 to 2,497,500 in 2012). These statistics suggest that *Oakwood Care Center* has had little to no effect on the types of jobs that hospitals and other health care employers create.

2. Hospital and other workers who work part-time, independently, or through staffing agencies often prefer to do so due to the independence and flexibility offered by these positions.

The Board should not assume that individuals working in other than full-time jobs are forced to do so. In reality, many health care employees, most noticeably registered nurses, choose to work either part-time or through a staffing agency because of the flexibility that those options offer.[2] Nurses have an abundance of full-time options. From 2012 to 2022, analysts estimate that registered nursing jobs in hospitals will increase 15.8%, amounting to 262,000 additional jobs. *See* Center for Health Workforce Studies Report at 16 (citing BLS data). At the same time, BLS projects that more than 1,000,000 registered nurse jobs nationwide will open up due to growth and replacement needs. *See* U.S. Dep't of Labor, Bureau of Labor Statistics, *Employment Projections: 2012-2022 Summary*, at Table 8, www.bls.gov/news.release/ecopro.toc.htm. There is obviously no shortage of full-time jobs available for nurses who want them.

[2] Indeed, the GAO has acknowledged that labor experts disagree on whether independent contractors, the self-employed, and standard part-time workers should even be counted as part of the contingent workforce because "many of [them] choose those arrangements and may have long-term employment stability." *See* GAO Report at 11 n.16.

Nevertheless, hundreds of thousands of registered nurses work part-time or through a staffing agency. For these nurses, their "alternative work arrangements" are not jobs of last resort; these are the jobs they prefer.

Many contingent workers outside of health care likewise prefer their jobs over full-time options for the same reason that nurses do. *See* American Staffing Ass'n, *ASA Staffing Employee Survey* (2014), https://americanstaffing.net/wp-content/uploads/2014/08/Fact_Sheet_Aug_20141.pdf (showing that 22% of temporary or contract employees chose their jobs because of the flexible hours and schedule). In addition, many of these contingent workers chose their jobs because they offered a valuable opportunity for them to improve their skills. *See id.* (showing that 24% of temporary or contract employees chose their jobs to improve their skills). Thus, many workers seek contingent positions as a bridge to better positions, while thousands of others prefer their jobs to full-time alternatives. Certainly, it denies the facts to state that all workers in contingent positions are part of an "permanent underclass" of workers.

B. The Contingent Workforce Continued to Grow In the Years Between *M.B. Sturgis* and *Oakwood Care Center*

The dissent's prediction that the majority's holding in *Oakwood Care Center* would accelerate the growth of contingent worker jobs necessarily assumes that the Board's holding in *Sturgis* had restrained the growth of those jobs. That assumption, however, is unfounded. Between 2001—the year before the Board's decision in *Sturgis*—and 2005—the year after the Board's decision in *Oakwood Care Center*—the contingent workforce increased by 8.9%. *See* BLS, *Current Employment Statistics Survey*, http://data.bls.gov/pdq/SurveyOutputServlet (showing that jobs in the "Temporary Help Services" industry increased from a monthly average of 2,339,900 in 2001 to a monthly average of 2,548,100 in 2005). In comparison, from 2005 through 2014 (the 10 years after *Oakwood Care Center*), the contingent workforce increased at a

slower annual rate. *See id.* (showing that, during the time period of 2005-2014, jobs in the "Temporary Help Services" industry" increased 8.6% from a monthly average of 2,548,100 to a monthly average of 2,767,100). This data suggests that external market factors—and not a desire on the part of employers to make it more difficult for employees to unionize—are driving any growth in the contingent workforce. Therefore, based on the experience under the Board's prior oscillation on this issue, overturning *Oakwood Care Center* is unlikely to have any material effect on the number of contingent worker jobs.

C. Contingent Workers Retain the Right to Organize In a Unit Consisting Solely of Jointly-Employed Employees

Under existing Board law, contingent workers enjoy the same Section 7 rights as employees who have a more traditional employer relationship. *Oakwood Care Center* limits only how contingent workers may organize themselves absent consent of their joint employers. Even without their employers' consent, however, contingent workers are free to organize in units consisting of their peers with the same employers, and this could include those who share the same joint employers. *See Oakwood*, 343 N.L.R.B. at 662 ("a joint employer unit of A/B"—i.e., employees jointly employed by the same supplier and user employers—"is not a multiemployer unit"); *Greenhoot, Inc.*, 205 N.L.R.B. 250, 251 (1973).

Greenhoot illustrates this point. There, the Board held that a unit consisting of jointly-employed employees who each had the same supplier employer but who had one of 14 different user employers depending on where they worked was not appropriate absent the consent of both the supplier and user employers. *Id.* At the same time, however, the Board found that units consisting solely of jointly-employed employees at each location—i.e., employees who had the same supplier and user employer—were appropriate and directed an election in those units. *Id.*

Thus, the jointly-employed employees in *Greenhoot* were not deprived of their Section 7 rights; they were simply required to exercise those rights as part of an appropriate bargaining unit.

Such limits are not unique to contingent workers; the Board likewise limits the ways in which solely-employed employees may organize themselves. *See, e.g.*, *Bergdorf Goodman*, 361 N.L.R.B. No. 11, 2014 NLRB LEXIS 587, at *10 (July 28, 2014) (dismissing petition to represent unit of all women's shoe sales associates because, "notwithstanding the[ ] commonalities" between the employees, "the balance of the community-of-interest factors weigh[ed] against finding that the petitioned-for unit [was] appropriate"); *Neodata Prod./Distrib., Inc.*, 312 N.L.R.B. 987, 989 (1993) (dismissing petition to represent single-facility unit because, "in light of the symbiotic relationship" between that facility and another, "the appropriate unit . . . must include employees of both . . . facilities"). These limitations—like those imposed by *Oakwood Care Center*—do not infringe on the Section 7 rights of employees. Rather, these restrictions ensure that employees exercise those rights in a manner consistent with the Act.

D. The Union Has Often Been the Party Seeking to Exclude Contingent Workers From Bargaining Units of Solely-Employed Employees

Finally, the Board should not assume that overturning *Oakwood Care Center* will substantially affect the unionization rate of contingent workers. While *Sturgis* was in effect, unions often sought to exclude contingent workers from bargaining units of solely-employed employees. *See, e.g.*, *Engineered Storage Prods. Co.*, 334 N.L.R.B. 1063, 1063 (2001) (union petitioned for unit that excluded agency-supplied employees; employer sought unsuccessfully to include those employees in the unit); *Outokumpu Copper Franklin, Inc.*, 334 N.L.R.B. 263, 263 (2001) (union petitioned for unit that expressly excluded temporary employees supplied by staffing agencies; Board agreed with employer that those employees "must be included in the

unit found appropriate"); *Holiday Inn City Center*, 332 N.L.R.B. 1246, 1246 (2000) (union petitioned for unit that expressly excluded jointly-employed employees; employer sought unsuccessfully to have them added to the unit).

And, in the years since *Oakwood Care Center*, unions—perhaps recognizing the conflicts likely to arise in units of jointly-employed and solely-employed employees—have continued objecting to such units even when the employer consented to them. *See, e.g.*, *Paperworks Indus., Inc.*, No. 14-RC-108193, slip op. at 3 (July 18, 2013) (affirming exclusion of temporary employees from unit notwithstanding user employer's consent to include them because, "even if [the supplier employer] gave its consent, the [union] has clearly communicated its opposition"); *Sole Tech., Inc.*, No. 21-RC-20855, slip op. at 4 (Nov. 18, 2005) (excluding agency-supplied employees from unit in part because union "unequivocally stated that it [was] opposed to the[ir] inclusion"); *Carneco Foods LLC*, No. 17-RC-12580, slip op. at 4-7 (Oct. 28, 2008) (union successfully sought exclusion from bargaining unit of agency-supplied employees who "perform[ed] the same work, in the same classifications, with the same supervision, under the same working conditions as the Employer's regular employees"); *Indyne, Inc.*, No. 15-RC-8709, slip op. at 7-9 (Aug. 27, 2007) (directing election in unit consisting exclusively of solely-employed employees because union's opposition to inclusion of jointly-employed employees "standing alone preclude[d] a finding that it [was] appropriate to include [them]"). Thus, overturning *Oakwood Care Center* is unlikely to have a substantial effect on the organizing rate of contingent workers and certainly would not impair the right of contingent workers to organize themselves.

II. AS REQUIRED BY THE ACT, THE BOARD SHOULD CONTINUE ADHERING TO ITS HOLDING IN *OAKWOOD CARE CENTER*

A. The NLRA Prohibits the Non-Consensual Multi-Employer Bargaining That Would Result From Reversing *Oakwood Care Center*

Section 9(b) of the Act authorizes the Board to determine appropriate bargaining units. And, although the Board has broad discretion to do so, its discretion is not unlimited. Section 9(b) provides that an appropriate unit "*shall be* the employer unit, craft unit, plant unit, or subdivision thereof." 29 U.S.C. § 159(b). By definition, then, a unit that does not fall into one of those four categories is inappropriate.

Under the Act, the broadest unit that the Board may find appropriate is an employer unit; the three categories of appropriate units that follow in this statutory provision are subgroups of that unit. *See Oakwood*, 343 N.L.R.B. at 661. Both the plain language and the legislative history of Section 9(b) dictate that units consisting of solely-employed and jointly-employed employees are not employer units because they are not limited to employees who share the same employer. Amendments to the Taft-Hartley Act expressly excluded from the definition of employer in Section 9(b) "a group of employers except where such employers have voluntarily associated themselves for the purpose of collective bargaining." *See* H.R. 3020, 80th Cong. § 2(2) (as passed by Senate, May 13, 1947). That language was ultimately deemed unnecessary, however, because it mirrored existing Board practice, "and it [was] not thought that the Board will or ought to change its practice in th[at] respect." *See* H.R. Rep. No. 80-510, at 32 (1947) (Conf. Rep.).

A unit consisting of both solely-employed and jointly-employed employees may not be considered an appropriate subdivision of an employer's workforce. The phrase "subdivision thereof" in Section 9(b) has long been interpreted to modify the words "employer unit." *See PPG Indus., Inc.*, 180 N.L.R.B. 477, 483 (1969). This interpretation is consistent with the

legislative history, which demonstrates that "Congress included the phrase 'or subdivision thereof'" in Section 9(b) "to authorize other units 'not as broad as 'employer unit,' yet not necessarily coincident with the phrases 'craft unit' or 'plant unit.'" *See Oakwood*, 343 N.L.R.B. at 661 (quoting H.R. Statement on Conf. Rep. S. 1958). The term "employer unit" thus defines the outer bounds of a unit that the Board may deem appropriate under Section 9(b). Units consisting of both solely-employed and jointly-employed employees exceed those statutory bounds because they are not limited to employees of only one employer; they are multiemployer units.

Multiemployer units are "exception[s] to the normal single employer unit." *Resort Nursing Home*, 340 N.L.R.B. 650, 655 (2003). The Board has long held that multiemployer units are not appropriate absent the consent of each employer. *See id.* at 654 ("the existence of a multi-employer bargaining unit can exist only by virtue of the mutual consent of the Union involved and each separate employer that agrees to be bound by group bargaining"); *Sheet Metal Workers Int'l Ass'n, Local Union No. 104*, 323 N.L.R.B. 227, 231 (1997) ("forming or joining a multiemployer bargaining unit is consensual"); *Arden Electric*, 275 N.L.R.B. 654, 656 (1985) ("[i]t is axiomatic that the basis for multiemployer bargaining units is the parties' consent to be bound by group bargaining"); *Evening News Ass'n*, 154 N.L.R.B. 1494, 1496 (1965) ("the multiemployer unit is rooted in consent"). The Board has enforced this consent requirement "regardless of the desirability" of the multiemployer bargaining unit sought. *Evening News Ass'n*, 154 N.L.R.B. at 1496.

Reversing *Oakwood Care Center* would upend these long-held principles by permitting the creation of multiemployer units absent the consent of both joint employers. The Act prohibits this outcome.

B. Units of Jointly-Employed and Solely-Employed Employees Increase the Risk of Labor Disputes, Which in Health Care Would Disrupt Patient Care

Congress and the Board have each long recognized the importance of balancing health care workers' Section 7 rights with the need to avoid disruptions to patient care. *See, e.g.*, *Mercy Hosps. of Sacramento, Inc.*, 217 N.L.R.B. 765, 766 (1975) (the Board should avoid "administrative and labor relations problems becom[ing] involved in the delivery of health care"); S. Rep. No. 93-766 at 3, 6 (1974), *reprinted in* 1974 U.S.C.C.A.N. 3946, 3948, 3951 (expressing Congress' view that "the needs of patients in health care institutions require special consideration in the Act" and recognizing the "concern for the need to avoid disruption of patient care whenever possible"). Congress and the Board have therefore carefully tailored labor laws and rules so as to decrease the likelihood of disruptive labor disputes within health care employers. *See, e.g.*, 29 U.S.C. § 158(d)(4) (mandating longer notice periods for contract negotiations and stricter mediation requirements that apply only in the case of health care institutions); *id.*§ 158(g) (mandating strike notices that apply only to health care employees); *Danbury HCC*, 360 N.L.R.B. No. 118, 2014 NLRB LEXIS 384, at *5-6 (May 22, 2014) ("refin[ing] th[e] basic rule" that "employees have a protected right to wear union insignia at work" in the case of health care facilities "due to concerns about the possibility of disruption to patient care"); *Catholic Healthcare W.*, 344 N.L.R.B. 790, 790 (2005) (appropriateness of single-facility unit in health care depends not only on presumption that applies in other industries, but also on whether the unit "creates an increased risk of work disruption or other adverse impact upon patient care should a labor dispute arise").

Overturning *Oakwood Care Center* would increase the likelihood of labor disruptions and therefore would be contrary to these efforts. Non-cohesive units would make bargaining more difficult and thus increase the risk of potentially disruptive labor disputes. First, even

assuming solely-employed and jointly-employed employees share some interests, their widely divergent interests on other important subjects would generate potentially insurmountable internal conflicts. For example, contingent workers who receive benefits from a supplying agency rather than the hospital have no incentive to sacrifice any of their bargaining demands for improved hospital health benefits. Solely employed hospital employees, on the other hand, may desire to make that trade-off. Similarly, workers who are solely and regularly employed by a hospital may have significantly different interests in the role that seniority plays in granting time off and requiring overtime than contingent workers who are less likely to have long-term service with a particular hospital. This internal strife would make it more difficult for the union to reach agreement with its own members, let alone with the employer. *See Park Manor*, 305 NLRB 872, 876 (1991) (recognizing the danger that a constituency that is "too diversified . . . may generate conflicts of interest and dissatisfaction among constituent groups, making it difficult for the union to represent"); *see also Pittsburgh Plate Glass Co. v. NLRB*, 313 U.S. 146, 165 ("A cohesive unit—one relatively free of conflicts of interest—serves the Act's purpose of effective collective bargaining.").

Second, even assuming that the union is able to coordinate these divergent interests to allow it to present and respond to bargaining proposals, reaching an agreement would be exponentially more difficult. The "essence of the collective bargaining relationship" is the "give and take" in which the parties engage in an effort to reach an agreement. *See United Clay Mines Corp.*, 102 N.L.R.B. 1368, 1369 (1953). The injection into a bargaining relationship of a third party who controls *some* of the terms and conditions of employment of *some* of the employees in the unit—but who may not even be at the bargaining table—makes it harder to reach agreement because it limits the employer's ability to make tradeoffs necessary to successful bargaining.

Third, conflicts are likely to arise between the user and supplier employer because of their vastly different interests. Hospitals often pay supplying agencies a contractually-agreed-upon fee for workers whom the agency refers. The agency then has a separate arrangement with the worker regarding pay and benefits. Under these circumstances, the Board might find that both the hospital and the supplying agency exercise some control over the contingent worker's wages. Nevertheless, the hospital and the supplying agency's economic interests on this critical issue are not aligned. Whereas the hospital's primary concern may be ensuring that the contingent worker's compensation does not exceed the fee it has agreed to pay the supplying agency for the worker's services, the supplying agency must ensure that the wages and other forms of compensation are set at a level that allow it to recruit workers while continuing to operate in the short and long term. These competing interests could well lead to a stalemate between the hospital employer and the staffing agency that would hinder meaningful bargaining. All of these factors taken together decrease the possibility that the parties will be able to bargain successfully and efficiently, thereby increasing the risk of potentially disruptive labor disputes.

III. SHOULD THE BOARD DECIDE TO OVERRULE *OAKWOOD CARE CENTER*, STANDARD PRINCIPLES THAT GOVERN THE ADDITION OF EMPLOYEES TO EXISTING BARGAINING UNITS SHOULD LIKEWISE APPLY TO CONTINGENT WORKERS

For the reasons stated above as well as those provided by the Respondent and its *amici*, the Board should not overturn *Oakwood Care Center*. Doing so is unwarranted, would violate the Act, and would impair collective bargaining and promote labor disputes across the country. Nonetheless, if the Board decides to overturn *Oakwood Care Center*, the Board should ensure that longstanding principles related to the composition of bargaining units are not summarily discarded.

It is especially important to hospitals and other health care organizations—many of whom have substantially unionized workforces—to have predictability in the field of labor relations. Hospitals and other employers have entered into existing collective bargaining agreements with unions under the assumption that contingent workers cannot be included in units limited to solely-employed employees absent the consent of each joint employer. The parties thus had no need to be precise in addressing whether the bargaining unit includes contingent workers. Under these circumstances, it would amount to an unlawful modification of the contract for the Board to allow contingent workers to be added to an existing bargaining unit solely because those individuals perform the same type of work that is described in the unit scope provision. Instead, if the Board does overturn *Oakwood Care Center*, the Board should allow contingent workers to be included in existing units only under the same conditions that new employees may be included in an existing bargaining unit, i.e., when (1) the contingent workers share a community of interest with the unit employees and vote in an appropriate *Armour-Globe* election to join the unit; or (2) the test for accretion is satisfied.[3] This balanced approach would help ensure that both the employer and the union get the benefit of their bargain. It also ensures that "the right of [contingent workers] to determine their own bargaining representative is not foreclosed." *Archer Daniels Midland Co.*, 333 N.L.R.B. 673, 675 (2001).

[3] Until fairly recently, the Board had held that employees of acute care hospitals could not be added to an existing nonconforming bargaining unit unless those employees constituted all of the remaining unrepresented employees in one of the eight units listed in 29 C.F.R. § 103.30. *See, e.g.*, *St. Mary's Duluth Clinic Health Sys.*, 332 N.L.R.B. 1419, 1421 (2000) (noting that "Board precedent requir[es] that any residual unit include all unrepresented employees in the particular classification at issue"); *St. John's Hosp.*, 307 N.L.R.B. 767, 7687 (1992) ("the petitioned-for unit which includes only a portion of the remaining unrepresented skilled maintenance employees is inappropriate"; "the Board requires that all unrepresented employees residual to the existing unit or units be included in an election to represent them"). In *St. Vincent Charity Med. Ctr.*, 357 N.L.R.B. No. 79 (2011), however, the Board deviated from this long-settled principle. The Board's holding in *St. Vincent* is currently being examined on appeal in *Rush Univ. Med. Ctr. v. NLRB*, Nos. 15-1050, 15-1097 (D.C. Cir.). Regardless of the outcome of that appeal, however, AHA and FAH urge the Board to overrule *St. Vincent* at the earliest opportunity and return to the interpretation of the Health Care Rule that the Board espoused for decades.

CONCLUSION

For the foregoing reasons, *amici curiae* urge the Board to affirm *Oakwood Care Center*.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on September 18, 2015, I electronically filed the foregoing brief with the National Labor Relations Board's E-Filing System. In addition, a copy of the document was sent via electronic mail to the following:

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