4. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452–3204. You may call (202) 452–3207, beginning at approximately 5 p.m. two business days before the meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Date: August 30, 1988.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 88–20022 Filed 8–30–88; 3:28 pm]

BILLING CODE 6210–01–M

FEDERAL RESERVE SYSTEM BOARD OF GOVERNORS

"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT: Notice forwarded to Federal Register on August 30, 1988.

PREVIOUSLY ANNOUNCED TIME AND DATE OF THE MEETING: 9:30 a.m., Tuesday, September 6, 1988.

CHANGES IN THE MEETING: Deletion of the following open item(s) from the agenda:

Proposed project regarding development of an electronic payments production system.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452–3204.

Date: August 30, 1988.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 88–20021 Filed 8–30–88; 3:28 pm]

BILLING CODE 6210–01–M

POSTAL SERVICE BOARD OF GOVERNORS

Meeting

The Board of Governors of the United States Postal Service, pursuant to its Bylaws (39 CFR 7.5) and the Government in the Sunshine Act (5 U.S.C. section 552b), hereby gives notice that it intends to hold a meeting at 1:00 p.m. on Monday, September 12, 1988, in Washington, DC, and at 8:30 a.m. on Tuesday, September 13, 1988, in the Benjamin Franklin Room, U.S. Postal Service Headquarters, 475 L'Enfant Plaza, SW., Washington, DC. As indicated in the following paragraph, the September 12 meeting is closed to the public. The September 13 meeting is open to the public. The Board expects to discuss the matters stated in the agenda which is set forth below. Requests for information about the meeting should be addressed to the Secretary of the Board, David F. Harris, at (202) 268–4800.

At its meeting on August 1, 1988, the Board voted to close to public observation its meeting scheduled for September 12, 1988, to consider a temporary mail classification change affecting certain second-class mail matter (See 53 FR 30511, August 12, 1988). By telephone vote on August 29, 1988, the Board voted to add to the September 12, 1988, closed session agenda, consideration of additional funding for the Mid-Island, New York, Mail Processing Facility.

Agenda

Monday Session

September 12—1:00 p.m. (Closed)

1. Consideration of Temporary Mail Classification Change Affecting Certain Second-Class Mail Matter. (Mr. Heselton)
2. Mid-Island, New York, Mail Processing Facility Increased Funding Requirements. (Mr. Smith)

Tuesday Session

September 13—6:30 a.m. (Open)

1. Minutes of the Previous Meeting, August 1–2, 1988.
2. Remarks of the Postmaster General.
3. Postal Rate Commission FY 89 Budget.
4. U.S. Postal Service Tentative FY 90 Revenue Forgone Appropriation Request. (Mr. Coppie)
5. Review of Legislative Matters and Government Relations.
6. Tentative Agenda for October 3–4, 1988, Meeting in Richmond, Virginia.

David F. Harris,

Secretary.

[FR Doc. 88–20023 Filed 8–30–88; 3:40 pm]

BILLING CODE 7710–12–M

POSTAL SERVICE BOARD OF GOVERNORS

Vote To Close Meeting

By telephone vote on August 29, 1988, a majority of the members contacted and voting, the Board of Governors voted to close to public observation its meeting scheduled for September 12, 1988, at United States Service Headquarters, 475 L'Enfant Plaza, SW., Washington, DC. The meeting will involve consideration of a management proposal to increase funding requirements for the Mid-Island, New York, Mail Processing Facility.

The meeting is expected to be attended by the following persons: Governors Alvarado, del Junco, Griesemer, Hall, McConnell, Nevin, Pace, Ryan and Setrakian; Postmaster General Frank; Deputy Postmaster General Coughlin; Secretary for the Board Harris; and General Counsel Cox.

The Board determined that, pursuant to section 552b(c)(9)(B) of Title 5, United States Code, and section 7.3(i) of Title 39, Code of Federal Regulations, the discussion of this matter is exempt from the open meeting requirement of the Government in the Sunshine Act [5 U.S.C. 552b(b)], because it is likely to disclose information, the premature disclosure of which would likely significantly frustrate implementation of a proposed procurement action.

In accordance with section 552b(f)(1) of Title 5, United States Code, and section 7.6(a) of Title 39, Code of Federal Regulations, the General Counsel of the United States Postal Service has certified that in his opinion the meeting may properly be closed to public observation, pursuant to section 552b(c)(9)(B) of title 5, United States Code, and section 7.3(i) of title 39, Code of Federal Regulations.

Requests for information about the meeting should be addressed to the Secretary for the Board, David F. Harris, at (202) 268–4800.

David F. Harris,

Secretary.

[FR Doc. 88–20024 Filed 8–30–88; 3:40 pm]

BILLING CODE 7710–12–M

RAILROAD RETIREMENT BOARD

Public Meeting

Notice is hereby given that the Railroad Retirement Board will hold a meeting on September 8, 1988, 9:00 a.m., at the Board's meeting room on the 8th floor of its headquarters building, 844 North Rush Street, Chicago, Illinois, 60611. The agenda for this meeting follows:

Portion Open to the Public

(1) Repayment of the RUIA Loan
(2) Proposal to Reorganize the Bureau of Retirement Claims
(3) Proposed Part 203, Employees Under the Act, of the Board's Regulations
(4) Proposed Disability Regulations
(5) Registration for Unemployment Benefits by Mail
(6) Proposed Changes in the RUIA Regulations
(7) Payment of Unemployment Insurance During Work Stoppages under the Federal Railroad Safety Act

Portion Closed to the Public

(A) Appeal of Nonwaiver of Overpayment, Ora R. Dicks
(B) Appeal from Referee's Denial of Disability Annuity, Richard O. Carmack
(C) Appeal from Referee's Denial of Disability Annuity, Adam J. Shakir
(D) Freels v. U.S. Railroad Retirement Board

The person to contact for more information is Beatrice Ezerski, Secretary to the Board, COM No. 312–751–4920, FTS NO. 386–4920.

Dated: August 29, 1988.

Beatrice Ezerski,

Secretary to the Board.

[FR Doc. 88–20009 Filed 8–30–88; 3:27 pm]

BILLING CODE 7905–01–M

Corrections

Federal Register
Vol. 53, No. 170
Thursday, September 1, 1988

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents and volumes of the Code of Federal Regulations. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 672

[Docket No. 80745-8145]

Groundfish of the Gulf of Alaska

Correction

In proposed rule document 88-18809 beginning on page 31728 in the issue of Friday, August 19, 1988, make the following corrections:

1. On page 31730, in the second column, under **Classification**, in the second paragraph, in the fourth line, remove "MRM".

PART 672—[CORRECTED]

2. On the same page, in the third column, in amendatory instruction 2, in the second line, remove "MRM".

§ 672.23 [Corrected]

3. On page 31731, in the first column, in § 672.23(b), in the sixth line, remove "MRM".

BILLING CODE 1505-01-D

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. ER88-559-000 et al.]

Niagara Mohawk Power Corp. et al.; Electric Rate, Small Power Production, and Interlocking Directorate Filings

Correction

In notice document 88-19104 beginning on page 32100 in the issue of Tuesday, August 23, 1988, make the following correction:

On page 32101, in the first column, under **6. GWF Power Systems Company, Inc.**, the first line should read:

"[Docket No. QF85-588-002 *et al.*]"

BILLING CODE 1505-01-D

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[PP 6F3453/R978; FRL-3428-9]

Pesticide Tolerances for Bifenthrin

Correction

In rule document 88-18375 beginning on page 30676 in the issue of Monday, August 15, 1988, make the following correction:

PART 180—[CORRECTED]

§ 180.442 [Corrected]

On page 30678, in the second column, in § 180.442, the fifth line should read "trifluoro-1-propenyl)-2,2-".

BILLING CODE 1505-01-D

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 761

[OPTS-62035G; FRL 3366-6]

Polychlorinated Biphenyls in Electrical Transformers

Correction

In rule document 88-16194 beginning on page 27322 in the issue of Tuesday, July 19, 1988, make the following correction:

On page 27326, in the third column, in the second complete paragraph, in the eighth line, "§ 761.3](a)(1)(xv)(D)" should read "§ 761.30(a)(1)(xv)(D)".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 88N-0242]

Hydrocortisone Acetate and Pramoxine Hydrochloride; Drugs for Human Use; Proposal To Withdraw Approval; Opportunity for a Hearing

Correction

In the correction to document 88-14876 appearing on page 27450 in the issue of Wednesday, July 20, 1988, make the following correction:

In the third column, in the first paragraph, in the second line, the page number should read "25013"

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 88M-0159]

IOLAB® Intraocular; Premarket Approval of Models 85JS, 85JM, and 85JL Anterior Chamber Intraocular Lenses

Correction

In notice document 88-16300 appearing on page 27400 in the issue of Wednesday, July 20, 1988, make the following correction:

In the second column, under **Opportunity for Administrative Review**, in the sixth line, "360e(b)" should read "360e(g)".

BILLING CODE 1505-01-D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Revised Chapter in Regulatory Procedures Manual; Recall Procedures; Availability

Correction

In notice document 88-16297 beginning on page 27400 in the issue of Wednesday, July 20, 1988, make the following correction:

On page 27401, in the first column, under **SUPPLEMENTARY INFORMATION**, in the 13th line, "or" should read "of".

BILLING CODE 1505-01-D

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NM-940-08-4220-11; NM NM 056534, NM NM 016634, NM NM 0556981, NM NM 10388, NM NM 12780, NM NM 46827]

Proposed Continuation of Withdrawals; Baca Recreation Area et al., New Mexico

Correction

In notice document 88-17607 appearing on page 29392 in the issue of Thursday, August 4, 1988, make the following correction:

In the second column, under *Elder Canyon Administrative Site*, the second line should read "Sec. 35, NW¼NE¼N W¼, NE¼NW¼NW¼."

BILLING CODE 1505-01-D

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

49 CFR Part 571

[Docket No. 81-11; Notice 25]

RIN 2127-AC45

Federal Motor Vehicle Safety Standards; Lamps, Reflective Devices, and Associated Equipment

Correction

In rule document 88-18537 beginning on page 31007 in the issue of Wednesday, August 17, 1988, make the following correction:

PART 571—[CORRECTED]

On page 31009, in the first column, in amendatory instruction 2, the first line should read: "2. Paragraphs (b)(1), (b)(2), and (b)(3) of".

BILLING CODE 1505-01-D

federal register

Thursday
September 1, 1988

Part II

National Labor Relations Board

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry; Second Notice of Proposed Rulemaking

NATIONAL LABOR RELATIONS BOARD

29 CFR Part 103

Collective-Bargaining Units in the Health Care Industry

AGENCY: National Labor Relations Board.

ACTION: Second notice of proposed rulemaking.

SUMMARY: This Second Notice of Proposed Rulemaking provides for appropriate bargaining units for various types of facilities in the health care industry. The Board has determined that establishing bargaining units by rulemaking will better effectuate the purposes and policies of the National Labor Relations Act than continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case.

DATE: Comments must be received on or before October 17, 1988.

ADDRESS: Comments should be submitted in eight copies to: Office of the Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254–9430.

FOR FURTHER INFORMATION CONTACT: Curtis A. Wells, Associate Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254–9430.

SUPPLEMENTARY INFORMATION: The following is an outline of the contents of this Notice:

I. Background
II. Validity and Desirability of Rulemaking
III. Standard to be Applied in Determining Appropriate Units
IV. Two Units: All Professionals/All Non-Professionals
V. Registered Nurses
VI. Physicians
VII. Other Professionals
VIII. Technicals
IX. Skilled Maintenance
X. Business Office Clericals
XI. Other Non-Professionals
XII. One Hundred Bed Distinction
XIII. Nursing Homes
XIV. Specialized Hospitals
XV. Partially Organized Facilities
XVI. Facilities Covered
XVII. Decisions to Which Rule Applies
XVIII. Non-Conforming Stipulations
XIX. Combined Units
XX. Extraordinary Circumstances Exception
XXI. Proliferation
XXII. Docket
XXIII. Regulatory Flexibility Act
XXIV. Regulatory Text
XXV. Dissenting Opinion

I. Background

In our original Notice of Proposed Rulemaking (NPR), we set forth at considerable length the reasons prompting the Board to embark on rulemaking to establish appropriate bargaining units in the health care field. These reasons are set forth fully at 52 FR 25142–25145, July 2, 1987.

Following the Notice, the Board conducted the three hearings announced in the Notice, as well as a fourth hearing requested by several interested parties and announced at 52 FR 29038. At these hearings, all who wished to testify were given an opportunity to do so, and all who wished to ask questions of the various witnesses were given that opportunity. Summaries (cited below as WS) submitted in advance by most of the prospective witnesses facilitated the questioning process.

The first hearing was held in Washington, DC on August 17 and 18, 1987; 20 witnesses appeared, and 496 pages of testimony were taken.

The second hearing was in Chicago, Illinois on August 31 and September 1, 1987; 27 witnesses appeared, and 521 pages of testimony were taken.

The third hearing was in San Francisco, California on September 14, 15, and 16, 1987; 39 witnesses appeared, and 762 pages of testimony were taken.

The final and longest hearing was back in Washington, DC on October 7, 8, 9, 13, 14, 15, and 16, 1987; 58 witnesses appeared, and 1766 pages of testimony were taken.

The comment period, which was originally to last through October 30, 1987, was thereafter extended three times upon the request of various parties [52 FR 36589, 43919, and 47029]. The evidence received by the Board at the hearings and during the comment period substantially exceeded, in both detail and exhaustiveness, what the Board had expected. The transcript of hearing totals 3545 pages, and the 144 individuals who came in person to testify included employees from virtually every broad classification under consideration: registered nurses, physicians, other professionals, technicals, skilled maintenance employees, service and related employees, and business office clericals. In addition, there were union and management negotiators from around the country; a number of professors of nursing, health care management, and other academic disciplines; hospital administrators; health care associations such as the American Medical Association (AMA); representatives of numerous unions including the American Federation of Labor and Congress of Industrial Organizations (AFL), Service Employees International Union (SEIU), International Brotherhood of Teamsters (IBT), United Food and Commercial Workers International Union (UFCW), International Union of Operating Engineers (IUOE), American Nurses Association (ANA) and several of its state associations, Hospital Employees' Labor Program of Metropolitan Chicago (H.E.L.P.), United Nurses' Association of California (UNAC), Communication Workers of America (CWA), Union of American Physicians and Dentists (UAPD), New York State Federation of Physicians and Dentists; and representatives of various employer groups such as the League of Voluntary Hospitals and Homes of New York, American Hospital Association (AHA), New Jersey Hospital Association (NJHA), Metropolitan Chicago Healthcare Council, Missouri Hospital Association, Ohio Hospital Association, Affiliated Hospitals of San Francisco, California Association of Hospitals and Health Systems, Associated Hospitals of the East Bay, Hospital Council of Southern California, American Health Care Association, and Hospital Council of Western Pennsylvania.

During the comment period, the Board received written comments from 315 individuals and organizations, representing diverse points of view and offering information to supplement what the Board had learned from the oral testimony. These comments alone totalled approximately 1500 pages.

In addition, following the close of the hearings, lengthy comments in the nature of briefs were submitted by the AHA; the ANA; the Building and Construction Trades Department of the AFL–CIO; the IUOE; and the AFL, on behalf of SEIU; National Union of Hospital and Health Care Employees (NUHHCE); Local 1199, Drug, Hospital and Health Care Employees Union, Retail, Wholesale, Department Store Union (Local 1199); Federation of Nurses and Health Care Professionals, American Federation of Teachers (AFT); American Federation of State, County and Municipal Employees (AFSCME); CWA; International Union, United Auto Workers; UFCW; and United Steelworkers of America.

The Board is gratified at, and appreciative of, the interest shown in these proceedings by all segments of the industry, including its employees and their representatives. The Board has spent a great deal of time reviewing the evidence collected and the comments received, and believes it is now far better qualified to resolve the issues

raised in the Notice of Proposed Rulemaking.

On July 1, 1988, the Board met in open session to discuss further the issue of appropriate bargaining units in the health care industry. The rules tentatively decided upon in that meeting and proposed below have been derived from our analysis of the empirical evidence and comments received during the rulemaking proceeding. The rules now proposed differ in several important respects from the rules proposed in our original Notice of Proposed Rulemaking. Because this is the Board's first major effort at substantive rulemaking, and because the Board is desirous of giving all interested parties a further opportunity to comment on the proposed rules, including the substantial revisions, we have provided for another period of comment. See, e.g., Note, *The Need for An Additional Notice and Comment Period When Final Rules Differ Substantially From Interim Rules*, 1981 Duke L.J. 377 (1981). This Second NPR contains a lengthy Supplementary Information Sec., addressing the major issues presented and containing numerous citations to the rulemaking record. We wish to emphasize that these citations are merely illustrative of the testimony upon which we relied and are not represented as the entirety of the record. We have carefully studied the complete rulemaking record, including the transcript, the witnesses' statements, the comments and briefs, and the exhibits, and have based our proposed rules on the entirety of this record, and not solely on the testimony specifically cited.

II. Validity and Desirability of Rulemaking

A. Introduction

The Board's statutory authority to engage in rulemaking is derived from section 6 of the National Labor Relations Act, which expressly gives the Board power to make "such rules and regulations * * * as may be necessary to carry out the provisions of this Act * * *."

In response to several commentators' concerns (e.g., AHA Br. 48; Comment 289, Ross WS Albanese, Charter Medical) and also to the concern expressed by our dissenting colleague, the fact that the language of section 9(b) requires a separate determination "in each case" does not in our opinion mean that the Board cannot promulgate rules to assist it (See discussion at 52 FR 25144.) It has long been the Board's practice to formulate "rules" to guide it in representation matters. See, e.g., the "contract bar rules," discussed in *Appalachian Shale Products Co.*, 121 NLRB 1160 (1958); the "Excelsior Rule," enunciated in *Excelsior Underwear Inc.*, 156 NLRB 1236 (1966); and the *Peerless Plywood* rule, 107 NLRB 427, 429 (1953). Although these rules were formulated by adjudication rather than APA rulemaking, and a majority of the Supreme Court in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969), upheld the validity of the particular rule (the *Excelsior* rule) as applied to the respondent in that case, the plurality implied, and the two dissents explicitly stated, that the Congressionally-preferred course for such prospective pronouncements would be APA rulemaking. To our knowledge, no court or academic commentator has ever made the contrary suggestion, that section 9(b) forbids utilization of APA procedures to formulate generally applicable representation case rules. As Kenneth Culp Davis observed with specific reference to the language of section 9(b), "The mandate to decide 'in each case' does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of 'deciding in each case' are classifications, rules, principles, and precedents. Sensible men could not refuse to use such instruments and a sensible Congress would not expect them to." Davis, *Administrative Law Text* 145 (3d ed. 1972).[1]

In the Notice of Proposed Rulemaking, we set forth at length our reasons for embarking on this procedure in the health care industry. Initially, we noted that thirteen years had elapsed since the health care amendments were passed, but none of the Board's previously enunciated doctrinal formulas for determining appropriate health care units had yet met with general judicial acceptance. Moreover, in numerous cases it had proven necessary to engage in lengthy, costly litigation over the appropriate bargaining unit or units. In retrospect, it appeared to the Board that there had been relative uniformity of workforce configurations and job classifications from facility to facility, and even under adjudication the various Board members had reached virtually identical results from case to case. Hence, it did not appear that what some have termed "sensitive, case-by-case adjudication" was serving any useful purpose. The Board also acknowledged that for years it had been urged to engage in APA rulemaking by numerous scholars and judges. In making the decision to engage in rulemaking, the Board expressed the expectation that this type of proceeding would produce the type of empirical evidence most appropriate for a determination as to which of the requested groups warranted separate bargaining units, while not creating such undesirable results as excessive proliferation, interruption in the delivery of health care services, jurisdictional disputes, wage whipsawing, and the like. A fuller exposition of the Board's initial reasons for undertaking rulemaking can be found at 52 FR 25143–145.[2]

Following its issuance of a Notice of Proposed Rulemaking, the Board permitted the parties to comment on this matter, and to present testimony in support of their positions. A significant number of health care providers, including the American Hospital Association, opposed the Board's rulemaking efforts. We have carefully considered all their arguments and the evidence submitted in support thereof.

B. Industry's Position

1. *Dynamics and diversity of health care industry.* One argument advanced by a number of employers in opposition to rulemaking was that the dynamics and diversity of the industry preclude it. Thus, the imposition of diagnostic related groups (DRGs) has required new efforts at cost containment (WS Rhodes [AHA] at 1,4; Comment 108, Bonaventure; Comment 130, St. Vincent's Hosp. Ala; Comment 193, Dolly Vinsant Memorial Hospital; Comment 268, Kane). Inflationary pressures have increased while revenues, particularly for in-patient stays, have either decreased or have been governed by ceilings. (Comment 76, South Suburban Hosp; AHA Br. 3–4; Comment 81, Jordan Hospital; Comment 146, Kennebec Valley Medical Center.) Severe shortages in certain categories of

[1] See also *Continental Web Press v. NLRB*, 742 F.2d 1087, 1093–94 (7th Cir. 1984), in which Judge Posner suggests that the Board's decision in that case with respect to lithographic units would have been more acceptable had the Board used "its dormant rulemaking powers;" and *NLRB v. Majestic Weaving Co.*, 355 F.2d 854, 859–61 (2d Cir. 1966) (Friendly, J.), cited by the court in *Continental Web Press*.

[2] In the NPR, we observed that a number of states, including Florida and Massachusetts, had engaged in rulemaking to formulate appropriate bargaining units for their own employees. 52 FR 25145, fn. 39. We take official notice that, as of November 1987, of the 22 states with comprehensive collective bargaining legislation for state employees, ten (Alaska, California, Connecticut, Florida, Iowa, Maine, Massachusetts, Michigan, New York and Ohio) set their units by administrative rulemaking, and four (Hawaii, Minnesota, Nebraska, and Wisconsin) designate them by statute. Only eight (Illinois, Montana, New Hampshire, New Jersey, Oregon, Pennsylvania, Rhode Island and Vermont) establish units through case-by-case adjudication.

employees have required hospitals to be flexible, which, it is alleged, is inconsistent with the relative inflexibility of rules (Comment 133, Beth Israel Hosp.).

At the same time, there has developed an increasing diversity in hospitals and the services they provide (King, 4232; Comment 19, Johnson City Medical Center Hosp.). Thus, hospitals of all types and sizes are establishing new types of related health care services on outpatient as well as inpatient bases (AHA Br. 5; Dauner, 3217; Comment 44, McDonough District Hosp.; Comment 71, St. Mary Hosp.; Comment 76, South Suburban Hosp.; Comment 174, High Plains Baptist Hosp., etc.). Many hospitals are expanding their markets by developing a number of specialty units, such as arthritis units (AHA Br. 7, citing *Modern Healthcare*, July 31, 1987, p. 42); intensive cardiac care, intensive medical/surgical, and neonatal units (Comment 71, St. Mary's Hosp.); trach units, dialysis units, etc. (Comment 78, Greater Cincinnati Hosp. Council). Another change is that hospitals are using part-time workers in increasing numbers to accommodate rapid fluctuations in inpatient census and reduction in full-time employee schedules (AHA Br. 7). One large group of proprietary hospitals, National Medical Enterprises, has extensively analyzed services provided in its hospitals to determine what allegedly professional services could be handled by non-professionals; in some of its facilities, it has implemented the "caregiver" concept to replace traditional job labels, within the limits of the classifications' competency. (Donnelly, 4063–80.) It is alleged that rulemaking is not suited for today's diverse and complex institutions (AHA, King, 4232).

2. *Changing structure.* The industry's witnesses presented evidence that the structure of the industry is changing in that hospitals are becoming parts of larger systems encompassing intermediate care facilities, urgent care centers, nursing homes, surgery centers, clinics, etc. (Rhodes, 9–11; NJHA, 320–324, 325; Dauner, 3194; Comment 66, Holy Cross Health Sys.; Comment 203, Deaconess Hosp.). It is alleged that an inflexible rule will impede the Board's ability to respond quickly to rapid changes in the industry (AHA, pos. st. 2). It is claimed that, because of the myriad of recent changes, this is an inopportune time to engage in rulemaking, which would be better done after the industry has had time to settle down from the current changes (Robfogel, Chi II 233).

3. *Prospects for litigation.* A number of representatives of the industry contended that rulemaking will not reduce the amount of litigation, partly because it will still be unclear into what category various occupations fall (Rhodes, 14; Stickler, 49; Owley, 4379–80; Comment 213, Mulhall, AtlantiCare Medical Center); there will be continuing litigation over the "special situations" exception (Comment 148, Moeller, Mississippi Hosp. Assn.); and, in general, the industry anticipates more litigation rather than a conservation of agency resources (Stickler, letter dated June 19, 1987, RM 2–10; Comment 289, Ross).

C. Opposing Position

1. *Litigation.* Though the vast bulk of industry commentators opposed rulemaking, two did not oppose it. Thus, one hospital agreed with the observation that unit determinations in the industry were confused and hard to follow, deeming rulemaking a "welcome relief." (Comment 5, Kane, Holy Redeemer Health System.) Kaiser also does not oppose rulemaking, having observed protracted litigation elsewhere in the industry. (Comment 313, addendum to Kaiser comment.) One student with prior experience as a department head in several hospitals observed that rulemaking may help reduce costs in the industry, so that parties can spend fewer dollars on legal maneuvering and less time on organizing campaigns, leading to more industrial stability. (Comment 122, Shumlas.)

The unions participating in these proceedings supported the Board's rulemaking efforts. (ANA Br. 192–93; New York State Federation of Physicians and Dentists, 79–80; Health Professionals and Allied Employees of New Jersey (HPAE), 122, 127; Union of American Physicians and Dentists, 3649; SEIU, 5155; IUOE, Br. 106; IBT, Saporta, 5101.) They acknowledged the protracted litigation that had theretofore ensued (e.g., Saporta, 5141–42; HPAE, 122, 24; Minnesota Nurses Assoc., WS Patek; Federation of Nurses and Health Profs, WS Owley & 4379–80), producing lengthy delays and great difficulties in organizing (e.g., Lumpkin, 84–85; Nathan, 79–80; Union of American Physicians and Dentists, 3649). One management-side consultant is reported to have admitted that such delays were often part of management's strategy in contesting health care units:

> At a workshop on unions, Raymond Mickus, president of Raymond F. Mickus & Associates in Bannockburn, Ill., predicted that the NLRB rules will spark much more union activity. . . . Under the rules there will be much, faster elections, he said, adding that employers won't have access to hearings or briefs which used to delay the proceedings * * *. There also will be less costs for the unions because they will not have to spend the "megabucks" associated with the hearing process, he said. (Current Developments, BNA Daily Labor Report, Aug. 6, 1987, p. A–2.)

Shortly thereafter, another health care industry representative is reported to have said something very similar: "Delaying representation elections. The greater the time between the initial union petition and the election the less chance there is that the union will win." (Metzger, vice president of labor relations for Mount Sinai Medical Center, discussing management's strategy, though not necessarily advocating it himself. Reported in Current Developments, BNA Daily Labor Report, Sept. 29, 1987.)

2. *Diversity.* There is some variation between institutions. No two hospitals are exactly alike, but this is true of all institutions. The relevant question, however, is whether, despite surface differences, there are such similarities that certain institutions may properly be grouped as a class. AHA data from 1986 show that while there are a number of different types of health care providers, the overwhelming majority of private, acute care hospitals are general medical and surgical hospitals. Of the 4,381 registered, private acute care hospitals in the U.S., almost 90% are classified by AHA as general hospitals; less than 9% are classified as psychiatric. Of the general hospitals, 98% are medical and surgical hospitals, while only 2% are pediatric, obstetric, or rehabilitation hospitals. (AFL Exh. 7,8.) Inpatient activity accounts for 84% of hospital revenues, and 88% of inpatient beds are allocated to general medical and surgical care, obstetrics, pediatrics, and intensive care. (AFL Exh. 9,10.) The unions contend that the industry has not shown that such diversity as does exist is reflected in different functions for business office clericals, skilled maintenance employees, unskilled service workers, etc. at the different types of facilities.

The unions concede the presence of cost pressures which have changed the climate in which hospitals must operate today (AFL Br. 134; WS Berliner; Comment 293(i), Feldsine). However, they argue that change is endemic in the health care field, and contend that recent changes are not qualitatively different from changes brought about by the advent of private health insurance or introduction of Medicare and Medicaid, equally profound and dramatic changes (Kennedy, 5549–50). As reflected in the

testimony about particular job classifications. DRGs are an accounting and financing mechanism that has nothing to do with the organization of the hospital labor force, and that has not resulted in employees performing jobs that were traditionally performed by other groups of employees (Kennedy, 5551–53; Berliner, 5628–29). In fact, business office clericals' skills have been upgraded because of increased complexity of their work caused by financial pressures (Berliner, 5600). The unskilled workforce has become even less skilled and more vulnerable to layoffs caused by financial shortfalls (Berliner, 5603–04). Similarly, technical employee ranks have declined in the least skilled technical positions while increasing in the most skilled positions as a result of industry changes (WS Berliner at 11–12; WS Schoen at 14–15). Skilled maintenance employees continue to maintain the physical plant (AFL Br. 132). Neither has the role of RNs changed; they continue to provide direct care to patients and clients as in the past (ANA Br. 163).

3. *Changing structure.* There was evidence that, at least in California, the trend toward consolidation of ownership and management of hospitals into multi-hospital organizations appears to have ended (AFL Exh. 17 at p. 2, from California Assn. of Hospitals and Health Systems Report). Further, corporate mergers and larger organizational changes have not affected relationships between traditional job classifications; rather, the changes are in the corporate officers, locus, and method of corporate decision-making (Federation of Nurses and Health Profs, WS Owley; Patek, Chi I 48; Twomey, 126–127). In any event, the proposed rule does not purport to address the issue of the appropriateness of a single facility when an employer owns a number of facilities, which the Board will continue to address through adjudication. *Manor Healthcare Corp.*, 285 NLRB No. 31 (Aug. 6, 1987).

D. Conclusion

1. *Agency discretion.* The choice between deciding an issue through adjudication or APA rulemaking is, in the final analysis, within the informed discretion of an administrative agency. *SEC v. Chenery Corp.*, 332 U.S. 194, 203 (1947); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974); *NLRB v. Children's Baptist Home*, 576 F.2d 256, 260 (9th Cir. 1978); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 414 (9th Cir. 1979). Here, we have carefully reconsidered our initial decision in light of all the evidence adduced at the hearings. After examining all this evidence, we remain convinced that rulemaking for establishing appropriate bargaining units in health care institutions is both fair and desirable. The record of these proceedings has supported and amplified our original reasons, set forth in our first NPR, for engaging in rulemaking.

2. *Past adjudicatory decisions.* Our adjudicatory decisions as to appropriate units in the health care industry, where the facts of each case were painstakingly examined in numerous lengthy and costly representation case proceedings, have been remarkably uniform in results, varying only when the Board changed doctrinal formulations, e.g., from "community" to "disparity" of interests. (NLRB Exh. 5, revised.) Thus, for example, from 1975 to 1984, despite lengthy adjudicatory proceedings the Board found RN units appropriate in 24 out of 25 published cases;[3] technical units appropriate in 18 out of 18 cases; business office clerical units appropriate in 8 out of 8 cases; etc. Though adjudication led to varying results for skilled maintenance units, that was largely a function of a single Board member, Member Jenkins, reaching different results on different records. Other members were, individually, remarkably uniform, despite alleged differences in the records. E.g., Member and Chairman Fanning found the separate maintenance unit appropriate 29 out of 29 times; Chairman Murphy, 26 out of 26 times. Continuing to determine appropriate units in this way seems unproductive, especially considering the lack of universal judicial approval of any single doctrinal approach. (See NPR, 52 FR 25143.)

3. *Financial constraints.* It cannot be denied that health care institutions are at this time operating under serious financial constraints. However, the evidence fails to disclose that these constraints have significantly changed the manner in which individual employee classifications perform their specialties or relate to one another. For example, the record shows that maintenance employees continue to maintain the physical facilities, and RNs continue to provide direct patient care under state nursing practice acts. If anything, the work of the business office clericals has been shown to have become more specialized and discrete, due to the increasing complexity of reimbursement arrangements, and also the increasing use of computers and word processing equipment. It is our judgment that the increased predictability which rulemaking will bring to the process of determining bargaining units will, in the long run, be a resource saver and, hence, result in cost savings not only for the Board but also for health care institutions as well as for employee organizations. Money expended on the *procedure* of determining appropriate units is not productively spent, except insofar as it leads to a greater understanding by the Board of the realities of the workplace; we believe the understanding of the health care industry we have achieved through this rulemaking proceeding has been greater than it was through adjudication, where each party presented a very narrow view of the evidence in order to achieve victory in that particular case. Lastly, insofar as adjudication enabled employers to delay and in that sense save additional costs that might be associated with unionization, we do not think that is an appropriate factor to be considered by the Board in support of continuing adjudication.

4. *Diversity of institutions.* Just as this proceeding has not shown that new cost constraints have made rulemaking inappropriate, neither do we find that any new diversification of institutions has had this result. Such diversity as exists has not been shown to be sufficiently significant to preclude uniform treatment for purposes of establishing the general contours of appropriate bargaining units [4] for acute care hospitals in all but truly extraordinary facilities. In fact, one witness, the Vice President of Human Resources, Hospital Council of Western Pennsylvania, testified that, even beyond acute care facilities, "the delivery of health care and the functional integration of services of those providing the care is similar if not nearly identical throughout the health care industry." (Cammarata, 4394). That same witness pointed out that this similarity in the way health care is delivered is "indeed mandated by various accreditation agencies throughout the health care field" (WS Cammarata at 3). The evidence discloses that the vast numbers of hospitals still perform acute care; insofar as other diverse facilities have developed, such as ambulatory facilities, freestanding emergency centers, etc., these will be considered *infra*, and in our definition of the types of facilities

[3] The sole exception was *Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981), involving a psychiatric hospital. In each category, unpublished cases exhibited the same uniformity of result.

[4] See Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 9 (1987), at 105–108.

covered by this rulemaking or, alternatively, excluded. Recognizing the diversity of facilities other than acute care hospitals and nursing homes, as well as our limited experience with them, the original NPR excluded such other facilities from consideration in the rulemaking proceeding. These other health care facilities continue to be excluded from coverage.

5. *Litigation.* As described above, the Board anticipates that rulemaking will ultimately result in less, rather than more, litigation about the boundaries of appropriate units. It is acknowledged that there will still be litigation about the placement of individual job classifications within the broadly defined appropriate units. This was referred to in our initial NPR (52 NPR 25146), and in the proposed new rule itself (§ 103.30(a)); the Board does not see this as a reason not to engage in rulemaking in order first to establish the larger boundaries of the appropriate units. The Board believes it may well be legally necessary, and in any event is wise, to retain an exception for extraordinary circumstances. However, the Board intends to define that exception narrowly, so that it cannot be used as an excuse for unnecessary litigation and delay. See section XX, The Extraordinary Circumstance Exception, *infra.*

6. *Flexibility.* The Board's engaging in rulemaking has no logical connection with the industry's retention of complete flexibility in responding to the needs of the times. Rulemaking is rather a response to a perception that the industry's workforce is susceptible to rules of general applicability about the contours of bargaining units. Health care providers remain as free as they ever were to respond to external events except, of course, as limited by the constraints of any collective-bargaining obligations that may result from unionization; that, however, is a policy set by Congress, not the Board. If, for some reason we cannot now foresee, employers' flexibility to respond is inhibited, any party could, of course, petition for amendment or repeal of the rules, or the issuance of new rules. Board's Rules and Regulations, § 102.114.

7. *Other considerations.* Our colleague dissents and would not engage in rulemaking. However, were we to continue to decide the appropriateness of units in acute care hospitals solely by adjudication, we would not have the advantage of the great mass of evidence presented to us in this rulemaking proceeding. Indeed, the production of relevant information is one of the chief advantages of rulemaking over adjudication. In addition, as noted above, adjudication itself has resulted in non-fact-sensitive, virtually uniform results, but at great cost in terms both of time and money. These problems, which we have observed in appropriate unit adjudications in this industry since the 1974 amendments, would not necessarily disappear, even were the Supreme Court to grant certiorari and endorse the "community of interests," "disparity of interests," or some other standard. Lengthy hearings would still be required, and the Supreme Court is unlikely to involve itself in particularized, detailed factual inquiries over various appropriate unit determinations. Finally, it is by no means certain that the Supreme Court would grant certiorari on this issue, having declined to do so in *NLRB v. Mercy Hospital Association,* 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980). On another occasion, the Solicitor General refused to file petitions for certiorari, despite the Board's request that he do so, in *NLRB v. Frederick Memorial Hospital,* 691 F.2d 191 (4th Cir. 1982), and *NLRB v. HMO International,* 678 F.2d 806 (9th Cir. 1982). The court in the most recent relevant case, *IBEW, Local Union No. 474, AFL–CIO v. NLRB,* 814 F.2d 697 (D.C. Cir. 1987), remanded to the Board for further consideration, leaving any petition for certiorari susceptible to the argument that the court's disagreement with the Board's result was in any event not final.

III. Standard To Be Applied in Determining Appropriate Units

The Supreme Court has acknowledged on many occasions since the Act's passage that, under section 9, the Board possesses broad discretion to determine employee units "appropriate" for the purposes of collective bargaining.[5] Of course, even the Board's discretion is not without limits; if the Board's decision as to appropriate unit "oversteps the law," it must be reversed.[6] Within this limit, however, the Supreme Court has noted that any decision as to appropriate units "involves of necessity a large measure of informed discretion, and the decision of the Board, if not final, is rarely to be disturbed." [7]

It has been observed that, in exercising its discretion to determine appropriate units, the Board must steer a careful course between two undesirable extremes: If the unit is too large, it may be difficult to organize, and, when organized, will contain too diversified a constituency which may generate conflicts of interest and dissatisfaction among constituent groups, making it difficult for the union to represent; on the other hand, if the unit is too small, it may be costly for the employer to deal with because of repetitious bargaining and/or frequent strikes, jurisdictional disputes and wage whipsawing, and may even be deleterious for the union by too severely limiting its constituency and hence its bargaining strength.[8] The Board's goal is to find a middle-ground position, to allocate power between labor and management by "striking the balance" in the appropriate place, with units that are neither too large nor too small.[9]

As if this task, committed to the Board's discretion, were not already sufficiently difficult, in the health care field there may be, as one court has phrased it, a "joker in the deck." [10] Much has been written, especially by reviewing courts, about the effect of the legislative history of the 1974 health care amendments on the Board's discretion to decide appropriate bargaining units. As the D.C. Circuit recently observed, in passing the 1974 amendments "Congress, in the final analysis, decided against modifying section 9 of the Act; [11] * * * hence, the same statutory standards that had existed before the enactment of the 1974 Amendments with respect to unit determinations and certification procedures remained in the statute, entirely unmodified." [12] Even

---

[5] *Allied Chemical & Alkali Workers, Local No. 1 v. Pittsburgh Plate Glass Co.,* 404 U.S. 157, 171–72 (1971); *NLRB v. Hearst Publications,* 322 U.S. 111, 132–35 (1944); *Pittsburgh Plate Glass Co. v. NLRB,* 313 U.S. 146 (1941); *Phelps Dodge Corp. v. NLRB,* 313 U.S. 177, 199 (1941). Not all administrative agencies engaged in regulating labor-management relations possess such broad unit-making discretion. Morris, *The Developing Labor Law,* Second Edition, 415 at fn. 12.

[6] *Allied Chemical & Alkali Workers, supra,* 404 U.S. at 171–72.

[7] *Packard Motor Car Co. v. NLRB,* 330 U.S. 485, 491 (1947).

[8] See Gorman, *Basic Text on Labor Law,* 66–69 (1976); Abodeely *et al, The NLRB and the Appropriate Bargaining Unit* 12–13 (rev. ed. 1981); *NLRB v. Hillview Health Care Center,* 705 F.2d 1461, 1469–70 (7th Cir. 1983).

[9] *NLRB v. Hillview Health Care Center,* 705 F.2d at 1469.

[10] *Id.*

[11] *IBEW, Local Union No. 474, AFL–CIO v. NLRB,* 814 F.2d 697, 699 (D.C. Cir. 1987).

[12] *Id.* at 701. The Supreme Court in *Packard, supra,* declined in that case to look at legislative history regarding whether "foremen" could appropriately constitute a bargaining unit, noting that "we are invited to make a lengthy examination of views expressed in Congress while this and later

Continued

the D.C. Circuit recognized, though, that other Courts had disagreed.[13] Two Circuits [14] have required the Board to apply a "disparity of interests" test, based largely on the legislative history, while eight others [15] have made it clear the Board should follow the committee's admonition to give "due consideration * * * to preventing proliferation of bargaining units in the health care industry," though they fail to "dictate the precise weight to be accorded the admonition." [16] We believe that rulemaking renders it unnecessary to resolve this conflict, or pick one doctrinal formulation over the other, since rulemaking eschews doctrinal applications in favor of greatly expanded information gathering, to be followed by unit determinations based on empirical judgments of the type that Congress expected an expert, informed administrative body to make.[17]

Under adjudication the Board has typically stated it was applying either the "community of interests" or "disparity of interests" standard to the facts of the particular case, as indicated reaching virtually the same result in every case, depending on which doctrine was being applied (NLRB Exh. 5, revised). Under the "community of interests" test, the Board has found five or six units appropriate (not including a statutorily-required separate unit of guards, seldom if ever sought, and a separate unit of physicians, sought in only one published decision since 1974 [18]): RNs, other professionals, technicals, service and maintenance, and business office clericals. In addition, some individual Board members have consistently found skilled maintenance units appropriate; others consistently found them inappropriate. (NLRB Exhibit 5, revised.) Under the "disparity of interests" test, the Board has uniformly found three units appropriate, aside from the two seldom-sought units mentioned above: All professional employees, including RNs; technical employees; and service and maintenance employees, including business office clericals.

Though it had consistently reached different results under the two tests, the Board in *St. Vincent Hospital and Health Center,* 285 NLRB No. 64 (Aug. 19, 1987), minimized the conceptual difference between them. Both, the Board stated, looked at the same factors:

> * * * the "disparity-of-interests" standard to a significant extent embodies the "community-of-interests" approach. That is, even under the disparity approach, the Board judges the appropriateness of the unit sought in terms of, traditional community-of-interests criteria: employees' wages, hours, and working conditions; qualifications, training, and skills; frequency of contacts and extent of interchange with each other; frequency of transfers into and out of the unit sought; common supervision; degree of functional integration; collective-bargaining history; and area bargaining patterns and practices. Under the "disparity-of-interests" standard—as under the "community-of-interest" approach—the Board looks at the above factors as they are shared by employees in the unit petitioned for, and as they tend to set those employees apart from other employees. Where the "disparity-of-interests" formulation differs from the "community-of-interests" standard, according to the Board's *St. Francis II* decision, is in the significance afforded the above factors. Because of Congress admonition to avoid unit fragmentation, the "disparity-of-interests" test requires more in the way of "disparities" or differences between the employees requested and those in an overall unit to grant a separate unit in the health care industry than would be required under a "community-of-interests" formulation. (Slip op. at 10–11, footnotes deleted.)

It is difficult to weigh or quantify the requirement of "more" as it applies to separate, different interests, i.e., how much would be enough more to satisfy the "disparities" test? Regardless, as we observed in the NPR, "these tests over the past decade or so have developed a 'life of their own,' and have been taken to refer to more or fewer units, respectively * * *." (52 FR 25143.) As the Board stated in *Newton-Wellesley Hospital,* 250 NLRB 409, 411 (1980), various courts' "disagreement with our approach may be largely semantic." And, as the Second Circuit said in *Masonic Hall v. NLRB,* 699 F.2d 626, 637 (1983), a court sometimes enforces the Board's decision if it "can infer from the Board's result that it has taken the nonproliferation policy into account." The court suggested that perhaps courts "focus * * * on what the Board did as much on what it said." *Id.* As noted in the NPR (52 FR at 25143), and in our discussion above, our decision to determine units by rulemaking reflected a desire to replace earlier doctrinal applications with formulations of units based on the facts, or realities, of the workplace, as learned from evidence presented to the Board by interested parties during the rulemaking proceedings.

Under rulemaking as under adjudication, we intend at all times to be mindful of avoiding undue proliferation, not only because this desire was expressed in the legislative history, but also because it accords with our own view of what is appropriate in the health care industry. It would be most undesirable to create or permit a large-scale splintering of the workforce into the numerous trades, technical disciplines, and professions typically found in health care institutions.[19] To give each such grouping a separate voice for organizing and negotiating would create a never-ending round of bargaining sessions and individualized demands not conducive to stability, industrial peace, or the smooth delivery of services to the public. We have entered the rulemaking endeavor with an intention to create a reasonable number of units that will realistically reflect pronounced natural groupings to be found in health care facilities: groupings that will not be so large that organizing them is exceedingly difficult, and representing them even harder because of inherent conflicts of interest within the groups; but large enough that unnecessary, repetitious rounds of bargaining are avoided along with such undesirable results as frequent strikes, wage whipsawing, and jurisdictional disputes. We have not begun with a preordained number, but at the end of our examination will consider whether the numbers of units found appropriate are, in fact, too numerous. See section XXI, Proliferation, *infra.* In any event, there will be no units found appropriate besides those permitted in the final rule.

Although under rulemaking we shall attempt to avoid the doctrinal formulations utilized under adjudication, many of the factors we consider will be similar. Thus, among the factors to be considered will be uniqueness of

---

legislation was pending to show that exclusion of foreman was intended. There is, however, no ambiguity in this Act to be clarified by resort to legislative history * * *." *Id.* 330 U.S. at 492.

[13] 814 F.2d at 704.

[14] The Ninth and Tenth. See discussion by concurring Judge Buckley in *IBEW Local Union 474 v. NLRB,* 814 F.2d at 717.

[15] The Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, and Eleventh. See cases cited *id.* at 703–05.

[16] *Id.* at 717.

[17] See, e.g., Estreicher, *Policy Oscillation at the Labor Board: A Plea for Rulemaking,* in proceedings of NYU Annual National Conference on Labor (1984), reprinted in 37 Ad. L. Rev. 163, 172 (1985).

[18] *Ohio Valley Hospital Assn.,* 230 NLRB 604 (1977). See also *Montefiore Hospital & Medical Center,* 235 NLRB 241 (1978), where a separate unit of physicians and dentists was found appropriate, but largely because there were no other professionals employed at the employer's health center, which was deemed to constitute a separate appropriate location.

[19] As Abodeely notes, "the health care industry was believed to be particularly vulnerable to the formation of a multiplicity of bargaining units. From the doctors in the top echelon to pot washers on the bottom, the labor force of a large health care facility is composed of a highly stratified, complex myriad of occupational classifications." This was, Abodeely states, the purpose behind the proliferation language referred to in the legislative history. Abodeely, *supra,* at 245. See also *NLRB v. Hillview Health Care Center,* 705 F.2d at 1470.

function; training, education and licensing; wages, hours and working conditions; supervision; employee interaction; and factors relating to collective bargaining, such as bargaining history, matters of special concern, etc. Location and scope of the job market may be relevant: i.e., whether the classification is part of a job market external to the facility or even to health care, or rather shares a job market with others in the facility or, perhaps, in the areawide health care community; job market is a factor not extensively considered under adjudication, probably because evidence regarding it is not likely to be introduced during the litigation of a particular case. In addition to these factors, should the evidence reveal the possibility of a separate unit, we shall examine the likelihood that such a separate unit would result in interruption in the delivery of health care, wage whipsawing, or jurisdictional disputes, matters with which Congress expressed concern during the deliberations that preceded the 1974 amendments. (See, e.g., 52 FR 25145; *St. Francis Hospital (St. Francis I)*, 265 NLRB 1025, 1027, 1035 (1982) (dissent, Chairman Van de Water); but cf. *Manor Healthcare Corp.*, 285 NLRB No. 31, n.7 (Aug. 6, 1987).) [20] The emphasis, during our rulemaking deliberations, has been and will be on the empirical—what, according to the mass of evidence presented, is warranted and will facilitate collective bargaining without jeopardizing the public interest—as opposed to prior, more doctrinal, more conceptually oriented, determinations. We are confident we are now a better informed administrative body in exercising the substantial discretion which we possess in the area of unit determinations.

[20] Senator Taft, in opening the Congressional debate on the health care amendments, said: "The issue of proliferation of bargaining units in health care institutions has also greatly concerned me. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care. . . . I believe this is a sound approach and a constructive compromise as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented." *Legislative History of the Coverage of Non-Profit Hospitals Under the National Labor Relations Act*, at 113–14.

IV. Two Units: All Professionals/All Non-Professionals

Some members of the hospital industry have argued to us that if the Board engages in rulemaking, it should find only two units appropriate—all professional and all non-professional employees (in addition to guards). Upon consideration of the record, we determine that the evidence does not warrant limiting the number of units to two broad units.

A. Generally; History of the 1974 Amendments

While the industry generally supports two broad units of employees, the support is not universal. Some employers suggest other configurations including a wall-to-wall unit, a separate doctors' unit, and a separate technical unit. (Comment 1, Lancaster Fairfield Community Hospital; Comment 17, Middletown Regional Hospital; Comment 306, Herrin, attorney for health care associations.) Indeed, one employer felt that several separate units was equitable as each had its own characteristics. (Comment 2, Grays Harbor Community Hosp.) The position of some, in favor of two units, is inconsistent with evidence which shows that until *St. Francis II*, employers seldom requested all-professional or all non-professional units (Friedman, 5057), and that where employers did request broad units for elections they sometimes opposed such units during election campaigns or at the bargaining table (see Registered Nurses, section V). On the other hand, unions fully support more than two broad units for organizing (AFL Br. 112; IUOE Br. 8; Local 1199, 3742; FNHP, 3; UFCW, 4457; NUHHCE, 4778; IBT, 5100; SEIU, 5161). These unions' position is consistent with the evidence presented of organizing history (see section V, Registered Nurses; section IX, Skilled Maintenance; section X, Business Office Clericals; etc.).

Contrary to some employers' claim that the legislative history of the hospital amendments supports a two-unit configuration, the history shows that Congress chose not to amend section 9(b) (assuring employees the fullest freedom in exercising rights guaranteed by the Act) in a way that would enact special representation case rules for the health care industry. Even Senator Taft's proposal, which embodied the proposal advanced by *employer* associations in the health care industry but which died in committee, contained special rules establishing as presumptively appropriate three non-professional units (technical, clerical, service and maintenance), in addition to a professional unit and guards, for a total of five. Furthermore, the hospital industry agreed, in a negotiated compromise with organized labor, to abandon its request for special statutory rules limiting the number of hospital units in return for provisions governing strikes. (See Legislative History, *supra*, at 91 (Sen. Cranston); 256 (Sen. Taft); 288 (Rep. Thompson), cited in AFL Br. 18–27.) The arguments of many employers that all professionals interact on the job, and that there are insufficient distinctions between classifications of non-professional employees to warrant their separation into different units, and the unions' argument that the record supports separate associational interests, are dealt with under specific unit categories.

B. The Record Shows That Multiple Units Do Not Undermine Functional Integration of Work; Do Not Result in an Increase in Proliferation, Strikes, Jurisdictional Disputes, or Wage Whipsawing; and Do Not Substantially Increase Industry Costs

The industry's concerns with having more than two units are the following:

1. *Changes in the industry.* The industry has failed to support its claim by concrete evidence that the DRG method of government payments to hospitals has resulted in restructuring of hospital workforces away from traditional departments and toward a product-line organization that requires greater integration of employee functions. It is claimed that product line management (where different types of employees work in a service related group, for example cardiology) is used increasingly in hospitals and requires that traditional lines of employment be crossed to provide appropriate patient care as employees in a department cooperate (Abramovitz, 325; Comment 54, Gepford Hosp.; Comment 192, Chicago Healthcare Human Resources Assn; Comment 108, Resurrection Health Care Corp.). However, the evidence shows that product line management has less to do with actual practice on the wards than it does with financial operations performed in the business office (WS Kennedy at 6–7). There is no more interaction between professionals than under other forms of financial control. New financial requirements have not resulted in changes in interaction among hospital workers. (WS Kennedy at 6–7.) Even in hospitals where RNs and other professionals are subject to dual lines of control (combining authority under own licensure and under team or functional

department), RNs continue to report to nursing on clinical issues, and retain traditional responsibility for nursing (Comment 293(i), Feldsine; Thompson, Chi II 107; Kennedy, 5561; Fine, 3146–48). Contrary to the generalized claim (Comment 105, Mass. Hospital Assn.) that multiple units would be divisive since one department might contain employees from several units, specific evidence shows that separate units have not prevented effective use of product line management (Houston, 4031, 4048).

In arguing that hospital workforces have moved away from a traditional structure, the industry relies heavily on the team concept, claiming that its use has resulted in greater integration among employees requiring integration of units (Rhodes, 11–12). However, the team concept dates back many years in this industry (AFL Exh. 12, 13, 14; AMA, 4348). Hospital representatives relied on the existence of teams in their unsuccessful attempt to defeat the 1974 amendments (ANA Br. 126). The record does not demonstrate a substantial increase in the use of interdisciplinary teams since then (AFL Exh. 15, study by Temkin-Greener; WS Kennedy at 8–9).

Although the industry argued that the team approach is widespread in the country and gave examples of many types of teams such as discharge planning, and special unit teams like oncology, diabetes, and cardiac rehabilitation (Mixon, Chi II 275; Gallagher, 3543–45; Comment 191, Trinity Lutheran Hosp.), the weight of the evidence shows that utilization of team care is neither widespread among hospitals, nor extensively used within hospitals (Bachus, Chi I 132; Lumpkin, 89–90; Dauner, 3236–40; McCullough, 4819–20; Gilmore, 4910). A study of 60 randomly selected hospitals showed fewer than half used discharge planning teams; a minority of the hospitals had special unit teams such as diabetes, oncology, and cardiac rehabilitation (Attachment to AFL Br. from Supplemental Testimony of L. Kennedy). Some hospitals do not utilize the team concept at all (Gilmore, 4910). Most hospitals with teams have no more than six or seven teams, with two to eight members on a team (Coney, 162; Thompson, Chi II 14–15, 72; Mixon, Chi II 277, 294–296), and a majority of employees do not participate on those teams (Bachus, Chi I 129–132). Specialized hospitals, such as children's hospitals, which may use multi-disciplinary teams to a greater extent, are atypical (AFL Br. 104).

The evidence does not support the industry's claim that participation on teams changes the employee's role. Collaboration among professionals is not new (Ballard, 56). For example, one of the most common teams is discharge planning which historically involves nursing and social work. But the team approach does not alter each licensed professional's responsibilities or scope of practice (Ballard, 56; Willman, 4461; Twomey, 131). For example, use of physicians, assistants and nurse practitioners does not alter physicians, scope of practice. Nor does participation on a team affect an employee's wages, hours of work, employment benefits, qualifications, training, skills, job functions, or history of bargaining (AFL Br. 104–105; Graybill, 4174–75; Houston, 4044–45). Where teams are used, only a small proportion of the professional employees are involved. Contact between the members of the team is limited; each member continues to perform the specialized work of his or her profession. The time spent on a team is limited: team members may perform their work separately and then exchange information; team members are not likely to engage in more than fleeting communication regarding collective bargaining matters. (Thompson, Chi II 107, 109, 118–119, 121; and see section V, Registered Nurses, *infra.*) Recognition by the Joint Commission on Accreditation of Hospitals (JCAH) of the need for collaboration on the interdisciplinary level (AHA Br. 16 citing JCAH sec.) does not itself demonstrate that any change in scope of practice occurs.

There is evidence that various employees interact on hospital committees to evaluate hospital programs, but the evidence failed to demonstrate that the interaction affects the professionals' responsibilities or scope of practice (see, e.g., AHA Position Statement p. 8).

The industry made general, unsupported claims that separate units would interfere with the development or use of the team approach (Graybill-Subrin colloquy, 4185–86; Donnelly, 4131; Coney, 162). There is no evidence that separate units have resulted in failure of professional integration and cooperation on teams (ANA Br. 139; Bullough, 4651–53). On the contrary, teams were shown to be compatible with presence of RN-only units (ANA Br. 123; Thompson, Chi II 86–87; Houston 4048; Bullough, 4651–52).

The industry's emphasis on teams and product lines focused almost exclusively on professional employees. There was no claim that these teams brought technical employees and unskilled service employees together in a single group. Nor was it claimed that business office clericals were involved in health care teams. (AFL Br. 75.) The evidence shows that interdisciplinary teams do not include skilled maintenance employees (IUOE Br. 92; Mixon, Chi II 275).

The industry contends that the use of multi-skilled employees is widespread and on the increase as hospitals seek cost-cutting measures, address the needs of rural hospitals with limited full time staffing needs and large facilities with changing patient loads, and as employee shortages, aging and declining population lead to fewer workers; further, that adoption of the proposed units will abrogate the ability of facilities to effectively utilize multi-trained employees whose skills cut across unit lines (AHA Br. 8, 9; AHA Br. attachment 3 attaching survey by CAHEA; Rhodes, 11; Houston, 4025–26, 4040–42; Comment 137, McDonough District Hospital; Comment 189, Memorial Health System, Inc.; Comment 193, Dolly Vinsant Memorial Hospital). However, the evidence shows that cross-training *between job groups* was not substantial and did not result in blurring lines between separate units. There are no examples of any group of professionals being cross trained to perform work of RNs either in organized or unorganized settings (Stickler, 22–25; Twomey, 130–131). The interchange of RN functions is not a viable concept because state licensing statutes preclude cross-training of other health professionals in patient care duties and responsibilities of RNs (Ballard, 56–57; Dumpel, 3277–78; Lipari, 3702–03; Rosen, 4665–67; Comment 293(j), paper on licensure of health care personnel).

The evidence shows that multi-competency programs are overwhelmingly aimed at technical employees. They developed because of a perceived need to provide technicians with a broader range of technician skills (WS Schoen, attaching article by F. Morgan). These programs are mainly confined to acquisition of additional technical skills by employees already holding technical jobs as shown by the operation of the programs referred to in the record. Participants in the Methodist Hospital "Add-A-Comp" program which provides employees with laboratory, respiratory therapy, electrocardiograph, emergency medical technician, and similar skills are already licensed or credentialed and include employees having some of the listed skills (Stickler, 19–21 & Chi I 36). Although the Multi-Competency Technical Program at the University of Alabama provides training in medical office skills, it is basically designed to add basic x-ray skills or

extend laboratory skills for technicians who are already licensed (Stickler, 19–21, Chi I 36–38). There is no showing that students trained in medical office skills actually perform technical tasks. Furthermore, the mere existence of the program does not show widespread participation, since the record fails to show there are many students involved (Stickler, Chi I 38–39). Moreover, even if these programs turn out a number of multi-competent graduates, they are generally employed in physicians' offices or outpatient facilities rather than in hospitals (Schoen, 5236 and WS Schoen, attaching article by F. Morgan) and their use therefore has little relevance to units in acute care hospitals.

We conclude from the record evidence that cross-training programs extending beyond the technical workforce are rare. Unskilled service workers cannot be readily trained to become technical employees because they lack the advanced education required and because of state licensure laws (AFL Br. 35–36; IUOE Br. 42, fn 5). Service workers cannot be easily trained for business office clerical jobs because of the specialized skills required in the business office (AFL Br. 57–58). Cross training from service to skilled maintenance or technical positions is virtually unknown (O'Cleireacain, 5467; McKinney, 5481). Business office clericals do not transfer into skilled maintenance positions (IUOE Br. 42). Nor are skilled maintenance employees being cross-trained into other job groups (Stickler, Chi I 9, 35–37). The few examples of individuals having interchange of functions (emergency technician starting IVs, RNs doing work after daytime hours normally performed by respiratory therapist or physical therapist, medical technologist trained to watch the heart monitor while RN is on break—Houston, 4026–27, 4042) are very limited. Evidence does show that separate RN units are compatible with limited interchange of function (ANA Br. 153, citing Houston, 4040.)

There is no evidence to support the industry's general claim that cross-training has been inhibited by collective bargaining in separate units (ANA Br. 151; IUOE Br. 45; Stickler, 45–49). The suggestion (Comment 142, St. Anthony's Health Corp.) that use of multi-competent workers would be hurt by turf battles between professional groups, separate bargaining unit designations, and existing legal restrictions on practice patterns is speculative and is undercut by finding that most multi-competent workers are within one unit—the technical unit. Any problems raised by legal restrictions such as licensure requirements do not derive from the Board's proposal to allow multiple units. Industry testimony on interchange of functions between professionals and non-professionals (Donnelly, 4073–74; AHA Br. 11) is not relevant because the Act would not permit a unit combining professionals with non-professionals, absent a self-determination election by the professionals.

Countering the claim of increasing integration of health care employees is evidence of increasing fragmentation as a result of greater sophistication of work, decrease in the full time equivalent work force and rise in part-time and temporary jobs, increase in the use of subcontracting, growing gaps between patient care and non-patient care jobs (such as business office clericals), and growing gaps between RNs and other professionals because of the RN shortage (WS Schoen).

2. *Proliferation, strikes, jurisdictional disputes, and wage whipsawing.* There is little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation such as strikes, jurisdictional disputes, and wage whipsawing.

First, the record shows that most hospitals that are organized have few units (Robfogel, Chi II 223; Comer, Chi II 329; Cammarata, 4424–4425). Logically, the potential for a number of units does not mean that every hospital will be faced with this number of organizing campaigns. Indeed, a successful organizing effort of one unit in a hospital does not appear to have had a ripple effect on further organization (Gilmore, 4894; Splain, 5252–53; IUOE Br. 69–70). Statistics over the last ten years show little organizing in residual units. Health care workers organize no more frequently in facilities where some workers are already engaging in collective bargaining than in facilities where no employees are represented (WS Splain at 14–17). A vast number of organized hospitals have only one unit (WS Schwarz at Table 1 & 264; Sockell, 4520; Shea, 5163). AFL analysis of all hospital contract renewal notices received by the FMCS from hospitals from 1983 to 1987 shows that 55% of all organized hospitals are party to only one collective-bargaining agreement; almost 80% negotiate no more than two contracts; and almost 90% negotiate no more than three contracts (AFL Exh. 5 p. 1). In an SEIU survey of 200 private hospitals, 74% have 3 or fewer bargaining units (WS Shea, SEIU, Table 2).

Evidence shows that, with the exception of New York State, where pre-1974 practice was to permit each employee group to have its own unit, recognition of RN-only units has not led to organizing efforts by other professionals (King, Chi II 38: In Ohio there is only one unit in which professionals other than RNs are represented separately; Gilmore, 4894: No hospital represented by Maine State Nurses' Association has another professional unit in addition to RN unit). Existence of a physicians' unit is rare; some states, like Texas, do not permit physicians to be employees of health care facilities (IUOE Br. 64, 99; see section VI, Physicians, *infra*). There is no evidence that the existence of a separate skilled maintenance unit has led to the organization of other units (IUOE Br. 62–65 and section IX, Skilled Maintenance, *infra*).

Some witnesses' statements that multiple units lead to strikes, jurisdictional disputes, and wage whipsawing were, for the most part, general and speculative, and not supported by examples. See, for example, Graumann, 397, 409; Dauner, 3199; Corbett, 3369; Emanuel, 3503–04; Weinrich, 4254, 4256; Cammarata, 4403, 4405–06. The industry did not submit data with respect to the degree of organization, number of organized units per hospital, or incidence of strikes or sympathy strikes, nor evidence that a particular type of unit has proven to be strike prone (AFL Br. 118–19).

In fact, the evidence submitted by unions shows there is a low incidence of strike activity in the health care industry; the rate is lower than in other industries (IUOE Br. 75; NLRB Exh. 1; AFL Exh. 6). The ANA had a voluntary no-strike policy until 1968 (Shepard, 4931–32). The California Nurses' Association (CNA) offers binding arbitration (WS Absalom at 16). According to available data, only 3.3% of all contract negotiations, including nurse bargaining, resulted in strikes. From 1984–1987, strikes in the health care industry occurred substantially less often than in all other industries (FMCS data reprinted in WS Schoen at 28 and AFL Exh. 6). The minimal level of strike activity is confirmed by studies done by several health care unions. Since 1938, SEIU has had a strike incidence of 1.4% in over 2700 hospital contracts (WS Shea at 10). Of over 1,000 hospital contracts negotiated since 1975 by the NUHHCE, only 43 involved strikes (Muehlenkamp, 4776). IUOE, which represents almost 300 hospital

bargaining units, has had only 25 strikes in its history (IUOE revised Exh. 2).

Industry witnesses who testified about collective bargaining experiences in the industry confirmed the infrequency of strikes (Comer, Chi II 320; Corbett, 3374–75; Henry, 3026, 3062, 3085–86). Indeed, Kaiser specifically stated that its observation that there is a greater likelihood of work stoppages in facilities with multiple units was limited to craft-specific units, not the broader, traditional unit groupings (Comment 311). The industry's claim that the Board should discount the lack of strike activity in professional units because few facilities have multiple units supports our finding that in fact few facilities have multiple units.

One study showed there is generally no correlation between the number of units in a hospital and the frequency of strikes (AFL Br. 118, fn citing FMCS study). Other evidence suggests, however, that the likelihood of strikes decreases as the number of units in a hospital increases (IUOE Exh. 2 revised). Strikes also tend to occur more frequently in units with more employees than in smaller units (AFL Exh. 5). For example, only 16.4% of hospital contracts covered 300 or more employees, yet these units account for 45.5% of all strikes, while 51.52% of all hospital contracts covered 100 or fewer employees, but accounted for only 17.7% of all strikes. The average size of a striking unit in the 1984–87 period was three times the size of a non-striking unit. (AFL Exh. 5 citing FMCS data.) See also WS Shea at 11–12 with similar variation in size of striking SEIU units. Strikes in broader units have the greatest impact on health care. Strikes in New York City by Local 1199 encompassing many worker classifications including other professionals, technicals, service, and clericals closed down most health care in the city. (Abelow, 229.) Strikes in broader units also draw in groups of employees who, if in their own smaller unit, might have no reason to strike (Dumpel, 3291: Strike over nurse practice issues would have no importance to other groups of employees; Viat, 3466; Shea, 5188: Skilled maintenance employees, technical employees enmeshed in strikes over issues related to other groups of employees).

The evidence shows that sympathy strikes are virtually nonexistent. No-strike clauses in hospital contracts forbid sympathy strikes, and the pattern in the industry is for covered employees to obey their contracts. (Schloop, Chi II 169; Sackman, 3585; Ahmed, 3708–09; Muehlenkamp, 4777.)

We cannot accept the argument that multiple strike notices alone, even absent actual strikes, are disruptive, since the purpose of the notice is to minimize possible disruptive impact by giving hospitals time to prepare for a strike. In any event, there was no showing of widespread frequency of strike notices and no evidence that notices caused disruption in health care delivery. Hospitals have not generally sought common expiration dates, which would be a possible solution to recurring near strikes. (Sackman, 3586; Schmidt, 3625; Willman, 4496; Muehlenkamp, 4771; Henry, 3074–75; Corbett, 3359–60; Weinrich, 4282).

Some hospitals' argument that they do not have the same defensive measures as do employers in other industries, for example, because it is difficult to replace striking professionals, is essentially an argument that hospital employees not be allowed to exercise their statutory right to strike. The record does not show in any event that they engage in strikes frequently.

Industry's general claim (AHA Br. 26–27) that multiple units will inevitably result in jurisdictional disputes is not supported by the record. The record shows a low frequency of jurisdictional disputes in hospitals and no correlation between the occurrence of disputes and the number of units. Jurisdictional issues that have arisen are often resolved on an informal basis without resorting to arbitration (Absalom, 3282–83; Sackman, 3585; Schmidt, 3625; Viat, 3471; IUOE Br. 78–79). There was no record evidence of jurisdictional disputes in hospitals between units of professional employees (Emanuel, 3503–4); such disputes are usually fought and resolved in the public arena (Absalom, 3282). Jurisdictional disputes between non-professional groups are rare, apparently because traditional unit lines separate functional groupings and the unit employees do not view the other units' duties as being within their purview (AFL Br. 124–25). The few disputes specifically referred to by the industry, such as accusations of mistakes on the job, and conflict between duties of RNs and LPNs assigned by the hospital (Krasovec, 413–415; Giblin, 5389–90; Graumann, 396–399, 408), encompassed disagreements that could arise even under all-professional and all non-professional units. The approval of an overall skilled maintenance unit, *infra*, should help reduce the risk of jurisdictional disputes between different skilled crafts.

The industry failed to support its general contention (Rhodes, 13) that multiple units result in employees' competing for the best settlement, burdening negotiations, and inflating settlements. The record shows that wage whipsawing and leapfrogging rarely, if ever, occur in the hospital industry. This is apparently the result of separate labor markets for RNs, clericals, technicals, skilled maintenance, and doctors (ANA Br. 174; AFL Br. 37–38, 59–60, 86–88, 121–22; IUOE Br. 83 citing record), and the method of setting Medicare and Medicaid rates which limits the pass-through of spiralling wage increases (Friedman, 5044–45). In view of the unorganized nature of the health care industry as a whole, separate unit contracts tend to follow wage patterns set by non-union employers (WS Shea at 13).

3. *Costs.* Some unions question the relevance of costs in determining hospital bargaining units. In view of Congressional concern in the health care amendments with the ability of health care institutions to deliver uninterrupted health services, it is relevant to consider whether multiple units increase costs to health care institutions so as to disrupt the stability of the institutions. However, to the extent the industry's contention regarding costs is an argument that employers cannot afford collective bargaining with their employees, we note that the health care amendments were passed in response to Congress' concern with low wages and poor working conditions in the hospital industry. *Beth Israel Hospital* v. *NLRB*, 437 U.S. 483, 497 (1978). It was anticipated by Congress that the amendments might lead to increased union organizing and bargaining which in turn might improve employee wages and working conditions. Costs associated with these anticipated improvements are not relevant to the Board's decision as to appropriate bargaining units.

Some commentators claimed that multiple units would increase costs by increasing expenses for contract negotiations, wage and benefit increases, administration and legal fees, grievances, supervision, and accounting (Comment 62, St. Mary's Hosp.; Comment 153, Sturdy Memorial Hosp.; Comment 140, Park City Hosp.; Comment 130, St. Vincent's Hosp., Birmingham; Comment 224, St. Luke's/Roosevelt; Comment 311, Hosp. Council of Southern Calif.). There was no empirical or specific evidence showing comparative labor costs in hospitals with different numbers of units. For example, one witness stated that facilities in Ohio with three or more

units devoted more time and resources to collective bargaining than hospitals with fewer units, but had no specific examples (Weimer, Chi II 7, 65–66, 77–79). Another industry witness testified generally that increased costs were associated with negotiating in multiple units in Pennsylvania, but gave no specifics (Cammarata, Hosp. Council of W. Pa., 4392–4430). In fact, studies have found minimal cost impact, 3%–5%, of labor unions on hospital costs. This rate is low when contrasted with the overall rate of health care cost inflation (WS Schoen at 31). The example relating to the costs for negotiations at a public hospital in Massachusetts with eight bargaining units (Robfogel, Chi II 222–23, 228, where out-of-state as well as local attorneys appeared for each negotiating session) was not shown to be typical.

The industry contends that small hospitals are particularly vulnerable to increased costs and cannot afford the money and staff resources needed for dealing with multiple units. However, we were not provided with empirical data for comparison. We note also that few health care facilities have more than two or three units.

The industry's claim that hospitals generally treat each bargaining unit as a separate cost accounting center, thereby adding to the complexity of operating a hospital, is unsupported in the record (Dauner, 3233–34), and in any event is irrelevant.

One witness claimed that multiple units would limit an employer's ability to secure significant cost reductions in employee benefits available now by marketing large groups of employees to third party providers and that the cost of administering multiple employee benefit plans is higher. No specific examples were cited of increased costs (Cammarata, 4402–03). Moreover, benefits may be negotiated across-the-board even in multiple units (Jacquin, 5366–68).

The claim by some that multiple units will result in limiting opportunities for job advancement and security are not supported by the record; neither is the claim that multiple units hamper affirmative action because departmental seniority and separate bargaining deter hiring and career development. To the contrary, there is record evidence (set forth in Sec. V, Registered Nurses and other sections), that there is limited career movement in hospitals regardless of whether or not the hospital is organized because promotions, layoffs, etc. are done by department and because of the distinct skills and education of the various groups of employees which restrict interchange and mobility. There is also evidence that in organized facilities, unions have sought career ladders, training, and upgrading, and have not acted to limit movement among workers. (WS Schoen at 15; Supplemental Statement of Schoen.)

Some employers argue that multiple contracts limit their flexibility in job assignments, scheduling, and performance evaluation. This appears to be an argument that the industry does not wish to have to bargain since bargaining limits the employer's flexibility. However, the statute gives employees the right to bargain for more favorable terms of employment, and employers have the opportunity at the bargaining table to seek terms giving them flexibility.

Arguments that multiple contracts will result in confusion for management as to which contract covers which employees (Comment 104, St. Francis Hosp., Hartford), that it would be hard for employees to understand and deal with many units (Comment 51, O'Bleness Memorial Hosp.), and that multiple units work against cohesiveness among smaller groups like business office clericals (Comment 138, Rice Memorial Hosp.) were not supported by specific examples.

Finally, the record demonstrates some countervailing considerations to any increased costs as a result of multiple units. At least some of the administrative costs of unit determinations come from the hospitals' opposition to organizing. In 1981 Congress banned the use of Medicare funds for anti-union consultants on estimates that this activity cost $30 million dollars a year (WS Shea at 15, citing Medicare Manual). There are presently industry costs for prolonged hearings and appeals in many units, which we are confident rulemaking will substantially reduce. Bargaining in large units may prolong negotiations and increase costs as employees are involved who would otherwise have no interest in certain demands (WS Shea at 15). Employers can face increased costs even if there is only one unit, since there may be separate negotiations for different major employee classifications (Owley, 4375–76) or separate contract provisions (Emanuel, 3499–3501). Costs might be contained by combining separate units for bargaining purposes or having common expiration dates for contracts, but the record shows lack of employer support for such union proposals (See Sec. IV(B)(2), *supra*).

C. Broad Units Militate Against Health Care Employees, Organizing and Bargaining, Contrary to Congress' Intent

1. *The impact of broad units on organizing and bargaining is a relevant consideration.* As shown above, Congress passed the health care amendments, in part, to improve conditions for health care industry employees by extending to them the rights of the National Labor Relations Act which permits organizing and collective bargaining. *Masonic Hall* v. *N.L.R.B., supra,* 699 F.2d at 634. While, as the industry correctly contends, the extent of union organization cannot be controlling in unit determinations, it is a factor, and in view of Congress' concerns, the ability of health care employees to organize and bargain is an important consideration in determining whether more than two units are appropriate in the industry.

2. *Historically, health care workers organize and engage in initial bargaining in occupationally homogeneous units.* The evidence shows that broad units militate against organizing by health care workers (AFL Exh. 4, AHA Report on Union Activity in the Health Care Industry). Although there were examples of broad-based bargaining, particularly in New York City, the record shows that organizing and initial bargaining among health care workers has historically been by occupationally-homogeneous units (AFL Appendix A; WS Shea, Table 1, SEIU Survey; and section V, Registered Nurses; section VI, Physicians; and section VII, Other Professionals). For example, in the AFL survey of all private sector hospitals in which an AFL affiliate has organized one or more units, there were 920 homogeneous non-professional units, and only 104 heterogeneous units (AFL Br. Appendix A). The ANA constituent state nurses' associations represent 363 all-RN bargaining units; only 4 all-professional units were organized before *St. Francis II* (Comment 240, ANA, Stull Affidavit). Evidence prepared by the industry confirmed that occupationally diverse bargaining units are found only in a minority of contracts (AFL Exh. 1, [Hospital Industrial Relations Information Services, p. 5]).

The industry contends that unions have requested or agreed to all-professional and all non-professional units, have successfully organized and bargained in these units, and that therefore a Board decision to find appropriate only two broad units (plus guards) would not negatively impact on organizing and bargaining. The record

shows that most union requests for broad-based units occurred after *St. Francis II*, at a time when the Board would have rejected most occupationally-homogeneous units. Broad bargaining, where it does occur, appears to develop over time, after individual employee unit concerns are addressed and the bargaining relationship has matured (WS Shea at 8; WS Pastreich; Friedman, 5046). Even then, the record shows that employers may meet separately with one or more subunits on their concerns and that there may be separate contract provisions for different concerns. See *e.g.* section VIII, Technicals; section X, Business Office Clericals. Thus, in New York City, where Local 1199 engages in citywide bargaining with the League of Voluntary Hospitals on behalf of its Professional, Technical, and Clerical Division (professionals other than RNs), Hospital Division (service and maintenance employees) and Drug Division (pharmacists, social workers, therapists), the individual units in these divisions were separately organized and negotiated their first contracts separately; joint bargaining of these divisions developed over twenty years (Olson, 4694–4700, 4706, 4716–19; Ratner, 3710, 3725–33, 3738). Proposals are submitted by each separate division; each classification has at least one representative at the bargaining table; and there are local negotiations for specific issues at some hospitals after the master negotiations (Ratner, 3739, 3742, 3757–59; Olson, 4702; Muehlenkamp, 4782). At Michael Reese Hospital, the service and maintenance unit and the business office clerical unit bargain jointly but have separate committees, contracts, and stewards (WS Gray).

There is no evidence of a trend toward coordinated bargaining (Shea, 5217–18). In New York City, there has been some movement away from the citywide approach of Local 1199; there is pressure to go back to each hospital after the master agreement to get separate provisions on local issues (Ratner, 3739).

Although some industry commentators now request broad-based units, there are a number of instances in the record in which employers sought, for example, to have RNs in a broad unit with other professionals, and then raised the question of effectiveness of bargaining representation, or appropriateness of unit. See section V, Registered Nurses, *infra*. To the extent that employees represented in different units may wish a number of years later to re-group as a single larger entity for purposes of conducting negotiations, nothing in the rule would interfere.

In sum, the record fails to demonstrate that finding a limited number of occupationally-homogeneous units to be appropriate would inhibit functional integration on the job, increase strikes, jurisdictional disputes, or wage whipsawing, or substantially increase costs to industry or to workers. Rather, we believe that finding only two broad units appropriate would unduly hamper organizing and effective bargaining, and would not carry out Congress' intent in the health care industry.

V. Registered Nurses

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that RNs constituted a separate appropriate bargaining unit in acute care hospitals having more than 100 beds. 52 FR 25146. Among the reasons assigned were that RNs:

(a) Work around the clock, 7 days a week;

(b) Have constant responsibility for direct patient care;

(c) Are subject to common supervision by other nurses;

(d) Share similar education, training, experience and licensing not shared by other employees;

(e) Have the most contact with other RNs; and

(f) Have a lengthy history of separate organization and bargaining.

Much of the evidence taken at the rulemaking hearings concerned the RN classification. As discussed in more detail *infra*, we have decided not to differentiate between hospitals having more than 100 beds and those having fewer. However, in other respects, after carefully considering the evidence amassed, we have determined that RNs appropriately constitute a separate bargaining unit.

B. The Record Supports a Finding That RNs Constitute a Separate Appropriate Unit

1. *Work schedules.* There was some evidence of selected other professionals who, at certain hospitals, might be scheduled to work evening and nighttime shifts (Comment 72, McCarthy; Comment 82, Humana). However, the evidence was overwhelming that only RNs have a professional responsibility which requires them as a group to be on duty 24 hours a day, 7 days a week (Chow, 3107–08; Ballard, 55; Schauer, 3155; Ratner, 3735; Graham, 4841–42). They are the only professionals regularly required to work overtime, including as much as two 8- or 12-hour shifts (Bachus, Chi I 144; Wilson, 5074, 5091).

2. *Responsibilities.* Each professional classification obviously possesses its own singular job function and responsibility. However, whereas other professionals specialize, and have intermittent contact with patients, nurses are unique in that their profession demands continuous interaction with patients (Dumpel, 3277–78; Chow, 3108; Ballard, 55, 57–58, WS at 7; Foley, 446). Nursing practice involves the nursing process by which nurses assess patients, as reflected in the nursing practice acts (Comment 240, ANA, Kalisch; WS Foley at 4; WS Ballard at 9–10). RNs continually monitor all patients to be sure that physicians' orders are being carried out and that treatment procedures are not proving harmful (Ballard, 55–56; Bullough, 4627–30). RNs must be alert for errors made by other professionals; for example, if another professional, e.g. a pharmacist, dispenses medication in an improper dosage, the overall responsibility rests with the RN who, if she administers it, is also responsible (Reierson, 3606–07; Sackman, 3586). The RNs' special responsibility is based on a cluster of knowledge which they possess, as opposed to a single skill (Bullough, 4629–30). One 1982 study by Posavac showed that the "perception of nursing care is the single most crucial aspect in the overall rating of hospitals by patients" (Fine, 3143).

3. *Supervision.* All acute care facilities have an organized department of nursing, and that department is supervised by a nurse (Ballard, 52–53). For this reason, the vast majority of nurses in hospitals are ultimately responsible to the director of nursing (Ballard, 67; Lipari, 3703; Gilmore, 4909–10; Comment 293(b), Jones: 3 RNs out of 99 not in nursing department; Comment 293(g), Soltis: 11 out of 200 not in nursing department). The evidence did indicate that in some instances nurses work in departments other than nursing and are subject to supervision by these other departments, such as ambulatory services, discharge planning, home health care, and anesthesiology (Graybill, 4149; Comment 139, S. Baltimore Hospital). However, even in the few instances where a nurse might be hired into another department and report to someone other than the director of nursing, the director of nursing is still responsible for the delivery of nursing care (Ballard, 67–68; Indelicato, 3680).

Product line management is a system of organization by type of service and in response to the DRG method of payment

(Dalstrom, 332; Houston, 4024; Kennedy, 5552). It is argued that, with this type of structure, nurses have more in common with those in their product line than with other RNs with whom they have little contact (Dalstrom, 336–339). Ordinarily however, it results in some RNs' being responsible to a functional manager of a project and to nursing heads for clinical issues (Comment 293(i), Feldsine, at 2–3). Product line management is a financial tool; it does not result in changes in interaction among hospital workers (Kennedy, WS at 6–7). As noted *supra*, nurses overwhelmingly continue to report to nurses (Dalstrom, 335: Only 10% of RNs not members of nursing division, but no showing that not supervised by an RN).

4. *Wages.* The labor market for nurses is distinct from that for other professionals (Gonzalez, 4356). Thus, nurse salaries are low, even within the framework of hospital compensation (Corbett, 3332, 3335). There is no pressure from outside the hospital industry forcing up wages, as for example is the case with pharmacists (ANA Br. 97). Moreover, the overwhelming percentage of nurses are women, and there is evidence that this has contributed to the separateness of the RN wage structure and the distinctiveness of their concerns (Muehlenkamp, 4779; Saporta, 5114–15). When nurses and employers bargain about wages, they look to wages of RNs at other hospitals, not at wages of other professionals (Patek, Chi I 78–79; Absalom, 3316–18). Finally, RN career ladders are very short in terms of pay, quickly levelling out after relatively brief experience (Rosen, 4671). Hospitals recognize the separate RN market by having nurse recruiters; no similar position exists for other professionals (Ballard, 65; Reierson, 3608–09).

Nurses traditionally conduct wage negotiations from these unique disadvantages despite the demand for their services (ANA Br. 99). In fact an employer may insist on a separate wage scale for RNs in an all-professional unit (Comment 51, Castrop: employer re-opened wall-to-wall contract at O'Bleness to increase RN wages only).

5. *Wage whipsawing or leapfrogging.* The record evidence based on actual experience shows that wage leapfrogging has not occurred in the hospital industry (Ratner, Local 1199, 3744; Friedman, Local 1199, 5041, 5045; Absalom, CNA, 3316–3317; Muehlenkamp, NUHHCE, 4775; Twomey, WS at 6, Hosp and Prof Allied Employees of NJ; Schmidt, Oregon Federation of Nurses, AFT, WS at 4; Shea, SEIU, WS at 13–14). The one example offered by the industry as evidence of leapfrogging (involving RNs) occurred 20 years ago in California and concerned the adjustment of wages for RNs who had been underpaid for a long period of time as compared to other hospital employees (as found by a fact-finding panel appointed by the governor). Even this adjustment did not result in any disruption of patient care. Moreover, other professionals did not obtain higher wages or benefits thereafter as a result of the RN unit adjustment (WS Absalom, at 7–8; 3286–87).

The fact that RNs are in a different labor market mitigates against leapfrogging (Shepard, 4959–60). Special considerations such as the nursing shortage, recruitment, and retention are not concerns of other professions and have not been carried over into other units (Absalom, 3316–3318). In addition, there are certain limitations or rigidities in the financing system which preclude the pass-through of spiraling wage increases. A significant limitation is found in the Medicare and Medicaid reimbursement rates. These rates play a prominent role in the economics of hospitals, and are set in a regional area in accordance with the general wage pattern set by the most influential local union and its employers. Thus, there is little incentive for unions to engage in whipsaw strikes and efforts to leapfrog the pattern of wage increases. (Friedman, 5044–45.) Finally, it appears that concern about the potential for leapfrogging could be ameliorated by uniform contract expiration dates. However, the evidence shows that hospitals have declined to accept union proposals to this end. (Henry, 3074–76; Absalom, 3318–19; Sackman, 3586; Willman, 4480–82; Clark, 4685.)

6. *Education, training, experience and licensing.* All professions require specialized education and training (AHA Br. 15; Mixon, Chi II 274), and are subject to prescribed standards of practice (California Health And Safety Code Sec., cited in AHA Br. 15; Comment 248, Cedars-Sinai Medical Center). However, in addition, nurses must pass state licensing exams, which are uniform throughout the country, after graduating from an accredited nursing school. A candidate who passes the exam is competent to practice throughout the country. (Reierson, 3597.) Nurses are required to follow, inter alia, state nurse practice acts, and no other health care worker may function as a nurse under nurse practice acts (Ballard, 56, 57).

RNs' licensing requirements may actually conflict with the requirements and practices of other professions. For example, as previously indicated, RNs fill out incident reports on mistakes in medication dosages made by other workers (Reierson, 3603; Sackman, 3586). This type of responsibility may result in antagonism between the RNs and other professionals which might impede collective bargaining by the professionals as a group.

Several states mandate continuing education for nurse relicensure. Only social workers and pharmacists are subject to such requirements in more states than RNs. (ANA Br. 48; Ballard, 54; Lumpkin, 87.)

7. *Interaction.* RNs work in close and continuous contact with one another within the same hospital (WS Foley; Owley, 4377–78). Moreover, sometimes RNs at different hospitals have more contact with one another than with the other professionals in their own institutions (Owley, 4378; Schauer, 3156–58). With respect to RNs' interaction with non-nurse professionals, while there is some contact, it is not regular and recurring. There are a variety of factors which help to explain why interaction among RNs and non-nurse professionals is limited. For one thing, while there was testimony that there is a crossover of duties between RNs and other professionals (Thompson, Chi II 55–58), there was also testimony that licensing and other regulations clearly prevent RNs from doing much of the work of other professionals and other professionals from doing RN work (Lipari, 3702; WS Dumpel & 3279). Moreover, non-nurse professionals generally are located away from patient units where RNs are located. For example, in Local 1199-organized hospitals, most pharmacists are located in self-contained units, usually in the hospitals' basements. (Crisafulli, 3712–14.) Moreover, RNs typically have different working hours (Indelicato, 3681; Ahmed, 3707). As noted by the ANA, the contact RNs may have with respiratory therapists is not material since respiratory therapists consistently have been found to be non-professionals. See for example *Samaritan Health Services,* 238 NLRB 629, 638 (1978); *Barnert Memorial Hospital Center,* 217 NLRB 775, 779 (1975).

The point is made that RNs in many cases have more frequent contact with other professions than those other professions that the Board proposes to place together have among themselves (AHA Br. 20–21, citing *Long Island Hospital,* 256 NLRB 202 (1981), and other Board cases). However, this point militates more against grouping of the

different professionals than it does toward grouping the RNs with other professionals.

8. *The team concept.* Much evidence was offered during the proceeding concerning the team concept. See also section IV (B)(1), *supra.* After carefully considering this evidence and the parties' arguments in connection therewith, we conclude that the fact that some hospitals utilize the team concept does not detract from the separate appropriateness of RN units.

There are two types of teams found in hospitals. The first is the nursing team which consists of RNs, LPNs, and aides. This type of team is found throughout the industry. However, as this team contains only nurses and non-professionals, and the Act provides that professionals are entitled to a separate unit if they choose, the nursing team is not relevant to the issue presented.

The second type is the multidisciplinary team which contains various classifications of professionals and non-professionals and has been utilized in the health care industry since the early 1900's. Employers unsuccessfully relied on the existence of teams in an attempt to defeat the 1974 Amendments. (ANA Br. 126, citing Ohio Hospital Association testimony.) The team concept remains non-persuasive for several reasons. First, the evidence at the hearing established that many hospitals do not even use the team concept (e.g., McCullough 4819; Gilmore 4910). Moreover, except for some specialized hospitals, e.g., children's hospitals (Sokatch 4194, 4199; Gallagher, 3539, 3543–46), those hospitals with teams often have no more than six or seven teams (Thompson, Chi II 14–15; Mixon, Chi II 294–96; Graybill 4172–86; Comment 283, Leavenworth), with two to eight members on a team (Thompson, Chi II 72; Mixon, Chi II 277; Gallagher, 3543–45). Thus, within the limited number of hospitals that use teams, only a minority of nurses and other professionals participate on the teams (Bachus, Chi I 129–132, most teams are on the management level). Although one comment stated generally that the downsizing of staff has led to more teamwork (Comment 263, Huntsville Mem. Hosp), this was not supported by other specific examples.

While members of teams may have daily interaction and weekly formal meetings (Comment 78, Greater Cincinnati; Comment 288, Graybill, Children's Medical Center, Akron), there was also testimony that the interaction of RNs and other professionals is limited in certain ways. For example, team members only interact with the few other members on their teams. Additionally, other duties of RNs may prevent or limit their actual participation in an assigned team program (Schmidt, 3627, 3635; Bachus, Chi I 129–130; Reierson, 3609–10). More importantly, the fact that the RNs may interact and work with other professionals on teams does not alter the separateness of their identity. The team approach is a process to ensure that the elements of patient care are organized. The evidence was uncontradicted that it does not alter each licensed professional's responsibility for his or her individual scope of practice. (Ballard, 56; Twomey, 131; Wilson, 5095; Bachus, Chi I 129–130.) Nor does participation by some RNs in team care affect wages, hours, benefits, training, skills, or functions of RNs on or off the teams (Graybill, 4174–75; Houston, 4044–45).

Conversely, separate RN units were not shown to have interfered with team care (Gallagher, City of Hope, 3540; Bullough, 4651 and 4653; Houston, Sacred Heart, 4031, 4038, 4048). The industry offered only unsubstantiated speculation that team care would be adversely affected; e.g., one witness testified that the amount of interplay, the exchange that goes on minute-to-minute in critical situations, could be damaged significantly (4185–86). However, at City of Hope, a specialized cancer hospital with a large number of teams and a separate RN unit, the teams remained able to deliver a very high level and quality of care. (Gallagher, 3540 & 3543; Bullough, 4653. See also Thompson, Chi II 9, 86–87: no evidence that separate RN representation at her Ohio hospital has made nurses less able to function as a team.)

9. *Cross-training and interchange.* Because of licensure limitations, cross-training does not take place between RNs and other employees (Lipari, 3702; Dumpel, WS & 3279). Hospital codes also preclude replacement of RNs by other professionals (Rosen, 4666). It logically follows that the extent of interchange between RNs and other non-nursing professionals is limited not only because of RN licensing limitations but also because of the licensing requirements of other professional employees. There was testimony that RNs will perform functions of other "professionals" when the latter are not available, e.g., moving patients instead of physical therapists, or doing respiratory therapist work at night and on weekends (Comment 78, Greater Cincinnati; Comment 198, Marshalltown Medical Center). With respect to the first example, the performance of non-professional tasks such as transferring patients to wheelchairs is not relevant to interchange between professionals. Similarly, respiratory therapists consistently have been held by the Board to be non-professionals. Finally, other examples of interchange, such as medical technologists' watching the heart monitor while a nurse is on break (Houston, 4041–42, 4026–27), appear to be minimal. It was also stated that both pharmacists and RNs dispense drugs and medications; however, pharmacists typically formulate medications and advise on proper medications while RNs administer them (Thompson, Chi II 55–58).

10. *History of representation and collective bargaining.* The ANA, representing RNs, stated that the RNs' desire to be organized to protect their interests as well as their patients' interests began nearly 100 years ago, and persisted through the onset of collective bargaining and the original Taft-Hartley exclusion of employees of non-profit hospitals from federal labor law (ANA p. 74; see Comment 240, attachment, Kalisch, Twelve Key Steps in the Process of Professionalization of American Nursing, 1854–1987; Comment 293, ANA, Flanagan). AHA contends that separate bargaining by RNs does not reflect a freely established pattern because, prior to the 1974 amendments, it was to some degree based upon considerations of the then-current law in each state and because collective bargaining primarily existed only in a few isolated parts of the country and thus could not be deemed representative. Moreover, the AHA contends, subsequent to the 1974 amendments such bargaining was established pursuant to the direction of the Board.

Regardless of what might first have provided the impetus, RNs have for many years exhibited a strong desire for separate representation. Even during the period following *St. Francis II*, RNs consistently sought separate RN units but were forced to organize into units with other professionals or face lengthy, costly, and fruitless litigation (Saporta, 5127–28; Splain, 5273–74; Muehlenkamp, 4764–67; Wilson 5069). Although forced to include other professionals, the organizing drives were strikingly similar to prior nurses-only campaigns. Testimony indicates that the campaigns were led by nurses, issues prompting organization were nurses' issues, and the bargaining was performed by nurses, often with no participation by other hospital professionals. (Gonzalez 4356; Splain, 5293; Lumpkin, 99–100; Patek, Chi I 54–55; Chow, 3108; McCullough, 4811; Gilmore, 4894; Shepard, 4927.) Moreover, comments from a number of hospitals

indicated they have not had problems bargaining with separate RN units (Comment 79, Baptist Hospital; Comment 105, Mass. Hosp. Assn: 2 examples; Comment 121, Central Michigan).

The AHA makes the point that the more recent history of collective bargaining shows that all-professional units nonetheless are viable, and the record offers some support for this position. Thus, even some RN-only unit proponents have testified that the interests of all professional groups have been adequately represented in bargaining for an all professional unit.[21] (AHA Br. 24.) However, while bargaining could undoubtedly proceed in any one of a number of configurations, this does not necessarily answer the question whether a separate unit of RNs might not also be appropriate; or better reflect the wishes, needs and interests of RNs, other professionals, and perhaps even health care providers themselves.

The testimony shows that not only have the RNs desired separate representation (Saporta, 5127–28; Splain, 5273–74; Muehlenkamp, 4764–67; Wilson, 5069), but other professionals do not appear to react favorably to their inclusion with RNs. As noted *supra*, the other professionals often do not participate in the organizing campaigns and are hostile to being included in bargaining units with RNs. As an example, when Capitol Hill Hospital demanded inclusion of other professionals, the other professionals complained, became hostile, and some even requested separation (Gonzalez, 4351–53). In Langlade Memorial Hospital, Wisconsin, other professionals forced into a unit with RNs tried to decertify the union but were outvoted by the RNs (Owley, 4376).

The main concern of the non-nursing professionals is of being overwhelmed by the large number of nurses and not having their concerns given priority. RNs are the largest professional group in any hospital. In fact, RNs constitute approximately 23% of the hospital workforce (WS Schoen, Table 1, citing data from AHA publication and BLS Hospital Wage Survey.) They may outnumber other professionals by a ratio of 4 to 1 or more. (AFL Br. 92; Twomey, 123–125, 128–129; Gafni, 133–135; Thompson, Chi II 58.) The non-nurse professionals are also concerned that RNs could ignore their interests when they conflict with RNs' (Comment 134, American Physical Therapists Assn). A number of non-nursing professionals who testified at the hearings confirmed the lack of interest which RNs exhibited toward their circumstances, and the fact that, despite their different professions, they were able to achieve collective bargaining in all-professional units, excluding RNs and physicians. See section VII, Other Professionals, *infra*. Evidence showed that even when made part of a unit which wins an election, other professionals sometimes do not participate in negotiations or come to union meetings (Schauer, 3154; Wilson, 5070; Patek, Chi I 54, 55–67 and WS 6–7). Issues discussed during bargaining tend to be those of interest to nurses (Wilson, 5073). Moreover, most grievances at one hospital were from nurses on nurse issues (Bachus, Chi I 122). There is a concern that if forced into units with RNs and RNs do not want representation, other professionals would not have enough votes to obtain representation (Owley 4376–77; Ahmed, 3707–08).

The AHA argues that the size of the RNs' group relative to other professionals should not be a consideration in determining whether to have an all-inclusive unit, and that this is a clear departure from the Board's general unit determination analysis in which the Board routinely has included small ancillary groups in units with one or more large classifications that constitute the bulk of the unit. We acknowledge that units frequently are an amalgam of other special interest categories. See, e.g., *Airco*, 273 NLRB 348 (1984). Nonetheless, the Board routinely also finds appropriate separate groups whose interests have been shown to be sufficiently distinctive. See, e.g., *Pacesetter Corp.*, 241 NLRB 1150 (1979) (separate unit of over-the-road drivers found appropriate); *Newburgh Mfg. Co.*, 151 NLRB 762 (1965) (separate unit of garment cutters found appropriate.)

Some employers argued that the real reason unions want separate RN units is that their constitution and by-laws do not permit them to organize other professionals (Comment 306, Herrin). However there was testimony that some nurses' associations have amended their by-laws to allow organization and representation of other professionals (Gonzalez, 4362; Sackman, 3578). In addition, there was testimony that some employers' true concern with allowing separate RN units is not unit fragmentation but defeating unions. Several witnesses testified that their employer demanded inclusion of other professionals with nurses when nurses wanted separate representation, but then told the RNs they should not include other professionals who did not have their interests. These same employers told the other professionals that they should vote against the "nurses' " union because they would be a minority and nurses could not adequately represent them, thus contradicting the argument of many employers in this proceeding. (Gonzalez, Capitol Hill Hospital, 4351–53; Gilmore, 4896–97; Absalom, 3315; Saporta, 5134, Sackman, 3580–84; WS Splain at 18–19; Wilson, 5096–97.) Employers have also requested the inclusion of lab technicians with RNs, then challenged their inclusion (Wilson, 5087–89).

In several instances, employers who earlier had insisted on the inclusion of all professionals later opposed bargaining with the RNs and other professionals in a single unit when the nurses' union was selected as bargaining representative of an all-professional unit. For example, after the D.C. Nurses Association won an election in a broader unit demanded by the employer, the employer at negotiations proposed removal of non-RNs from the agreement, saying its earlier position had been based on "tactics." (Gonzalez, Capitol Hill Hospital, 4355; see also Lumpkin, Shands Hospital, 95: hospital asked to amend unit to separate RNs from non-RNs; because of problems with recruiting and retaining RNs, the employer needed to set innovative scheduling, overtime pay for shifts, premiun pay.)

11. *Collective bargaining interests.* There are a number of issues of unique concern to nurses in collective bargaining (See Comment 240(b), submission of David Martin, RN, ANA senior staff specialist for labor relations, affidavit analyzing 190 RN-only unit contracts representing nearly every such contract negotiated in 1986). While there may be examples of how special concerns of the RNs have been addressed in all-professional units, this does not necessarily demonstrate that RNs and other professionals have large numbers of common interests. Nurses can emphasize these issues in bargaining regardless of the concerns of non-RN professionals because RNs would constitute 80% or more in a typical unit (WS Shea at 22), and often 100% of those willing to participate in bargaining (Gonzalez, 4355–4356).

Moreover, that unions are capable of addressing special concerns of the RNs in all-professional units does not negate

[21] That other professionals have not filed unfair labor practice charges or grievances against unions where nurses predominate, charging breach of duty of fair representation, does not mean other professionals are satisfied with representation. A breach of the duty of fair representation is found only where conduct is arbitrary, discriminatory or in bad faith. *Vaca v. Sipes*, 386 U.S. 171, 190 (1967).

the fact that many of these issues are unique to RNs and that separate representation would frequently provide a more efficacious and just means for responding to their concerns. For example, RNs alone have recurring concerns with respect to floating, i.e. being temporarily transferred from one unit to another to cover understaffed units (Schauer, 3115). RNs have bargained for mandatory orientation both in their own unit and before floating to other units (Schauer, 3115; Comment 240(b), Martin affid.: orientation provision found in 83 of 1986 contracts). Some organizations representing nurses have created "Assignment Despite Objection" forms to be used when nurses are asked to work in a unit or perform a function for which they feel unprepared (Graham, 4827; Shepard, 4929–31). Floating and orientation generally do not concern other hospital professionals since they typically are not required to float to areas where they may be unqualified (Saporta, 5114; Indelicato, 3681). Moreover, other hospital professionals are not as concerned with staffing in general because they do not have constant patient care responsibilities like the RNs and because they are not in critically short supply (Gonzalez, 4364: at Capitol Hill, staffing was a major concern for RNs, not at all for other professionals).

The evidence shows that scheduling issues are of much greater concern to RNs than to other non-nursing professionals. RNs are virtually alone in their concerns with respect to mandatory overtime and double or rotating shifts, or evening, night and weekend shifts, all of which are said to increase the likelihood of nurse error. (Bachus, Chi I 144; Lipari, 3697; Korn 4860–61; Chow 3111, Ballard, 62, 75.) There were only isolated examples of non-nurse professionals working late shifts or weekends. Many other professionals, like social workers, work primarily day shifts during the weekdays. (Roth, 3151: no pharmacist, social worker or physical therapist at night, skeleton crew for respiratory therapy; WS Foley at 6–9: social work, physical therapy, doctors, offices are all closed by 6 p.m., some evenings only RNs provide primary care.)

Collective-bargaining agreements have addressed these issues by, e.g., attempting to limit mandatory overtime, rotating shifts, etc. (Comment 240(b), Martin affidavit; Chow 3110–11.) Collective bargaining agreements covering other professionals do not usually include such provisions (Friedman, 5055: Local 1199 contracts for medical technologists do not prohibit mandatory overtime).

Hospitals have difficulties attracting nurses to work the less desirable evening and night shifts. Ninety-eight percent of contracts in the ANA study provided higher wages on evening and night shifts; 57% offer some form of alternative scheduling designed to attract RNs. (Comment 240(b), Martin affidavit.) Other professionals generally view issue of premiun pay and alternative scheduling as less important or irrelevant. This in part is due to the fact that non-nursing professionals usually do not work night shifts and many do not work evening shifts (Patek, Chi I 55: non-RN professionals had grave concerns about bargaining over premium pay for fear that this would mean that they would be required to work shifts they had not worked before. See also WS Lumpkin, supra at 8: re: innovative scheduling for RNs; Gilmore, 4907.)

12. *Education.* Nearly every surveyed contract has provisions for continuing education which is mandated in 15 states (Comment 240(b), Martin affidavit). Continuing education typically presents different issues for nurses, who work around-the-clock schedules and have difficulty attending the courses, which are often given evenings, nights, or weekends. Thus, other professionals typically bargain about continuing education by seeking more money; RNs seek time off to attend as well as tuition. (Lumpkin, 86–88; Foley, 449–450.) This in itself would not justify a separate unit as such concerns could, of course, be accommodated in larger-unit bargaining; however, they are but one of a congery of concerns and special problems that make nurses a substantial, unique group.

13. *RN bargaining units and strikes.* There is testimony that there have been many strikes by nurses (King, Chi II 41, 46, 28; Whelan, Chi II 59–61, 85; Comment 304: one-third of 20 strikes at Kaiser since 1974 amendments are in RN-only units), and that some of these strikes have lasted for a long time (e.g., Ashtabula Hospital, Ohio, 572 day strike: King, Chi II 28, 59–61). However, according to available FMCS data, only 3.3% of all health care contract negotiations, including nurse bargaining, resulted in strikes. The strike percentage in any given year never exceeded 5.1% and fell below 2% in several years. Moreover, during the 1984–1987 period, strikes in the health care industry occurred far less often than in other industries, 1.5% v. 2.4%. (WS Schoen at 28; AFL–CIO Exh. 6.)

There was testimony that RN strikes are particularly disruptive because RNs constitute the largest group of hospital employees. For example, there was a strike of 6,000 nurses in Minneapolis-St. Paul in 1984 over job security (Patek, MNA, Chi I 51, 63). But there was also testimony that where strikes occurred, the hospitals continued operation (Whelan, Chi II 59–60; Viat, 3471). Moreover, we must also be mindful that in an all-professional unit, RNs, because of their predominance, could generally obtain an affirmative strike vote even if all the other professionals were opposed. Because such a strike would involve all professionals in the hospital, greater disruption of hospital services would result than with a separate RN unit. (ANA Comments 173.) Finally, for 18 years ANA had a no-strike policy (Shepard, 4931–32; Comment 293(k), Flanagan, *Collective Bargaining and the Nursing Profession* at 14–15), and CNA has adopted a standing policy that in the event of an impasse in arbitration, it will offer binding arbitration before resorting to strike action (Absalom, WS at 8–9, 12–13, 15–16 & 3286–98: 1974 strike resolved by FMCS; 1978 shift rotation disagreement resolved by advisory arbitration; 1980 disagreement on nursing shortage resolved by mediation-arbitration).

The AHA argues that the history of the RN-only unit bargaining does not support a conclusion that potential work disruptions are not increased by creation of multiple professional bargaining units, since the overwhelming majority of facilities where RN units exist have no other professional units (AHA Br. 24). However, because in all likelihood the latter phenomenon would continue to exist, this argument is not entitled to great weight.

Some commentators argued that multi-professional units may lead to sympathy strikes (Bennett, 3045; Comment 13, Corkin). However, most no-strike clauses in hospital contracts forbid sympathy work stoppages, and there was evidence it is common for RNs to cross picket lines set up by non-nurse health care workers (Sackman, 3585; Lipari, 3696; Korn, 4889; Roth, 3152–53). If sympathy strikes were a problem, it appears that they could be significantly reduced by mandating common expiration dates for all hospital contracts, a proposition which, the evidence showed, hospitals frequently or even universally have rejected (Absalom, 3318–19: Affiliated Hospitals refused to allow new expiration date to coincide with expiration of other contracts; Clark, 4683–85: no common

expiration dates for initial contracts; Abelow, 249–50: no push from any parties to coincide RN contract expiration with master contract of League of Voluntary Hospitals; Lipari, 3697: employer opposes common expiration dates).

14. *Jurisdictional disputes.* The record does not reveal a single jurisdictional dispute between unions of professional employees (Fine, 3156–3158). Witnesses who asserted that such jurisdictional disputes would arise did not substantiate their claims (Dalstrom, 339; O'Connell, 440; Dauner, 3199; Emanuel, 3503–04; WS Cammarata at 7). In fact, the most typical job duty issues involving jurisdictional lines are between RNs and nonprofessionals, i.e., LPNs and nurses' aides (WS Shea at 14). These types of issues would arise even if the RNs were placed in an all-professional unit.

As was the case with regard to strikes, the AHA argues that an assessment of the impact of multiple professional units on jurisdictional disputes can only exist where there are two or more units represented by labor organizations in a facility, and there are very few such instances (AHA Br. 24). For this same reason, we believe the argument that there is a potential for jurisdictional disputes among professionals where a separate RN unit is given, is speculative. To the extent the record deals with this matter, it shows that any issues regarding the possible overlapping duties of professionals have in the past been fought out in the public arena. For example, attempts by other groups to perform some of the nurses' duties under their scope of practice in California were dealt with by the legislature. (Dumpel, 3278–79.) In any event, as noted *supra*, (see subsection (B)(9) on cross-training and interchange), interchange of duties between professionals appears minimal.

15. *Nursing shortage.* It is common knowledge, and the record substantiated, that currently there is an unprecedented and severe nursing shortage (Absalom, 3295; Shea, 5235; WS Schoen at 16, citing ANA Report on Hospital Nursing Supply). Some hospitals have delegated some traditional RN functions, not reserved to RNs by law, to employees with no RN training. Additionally, hospitals currently have more seriously ill patients (higher acuity) than historically reported. Less qualified nurses, and fewer nurses, will be forced to attend to more seriously ill patients, leading to a lower level of care and more stress for the remaining RNs who may then opt out of nursing. (ANA Br. 101, and articles cited therein.)

Nurses testified that they view collective bargaining, in their own unit, as the vehicle for improvement in their working conditions and for allowing them a voice in patient care (Ballard, 72; Lumpkin, 85–86). Additionally, hospitals are trying innovative proposals for nurses: opening contracts for them alone, raising wages, setting weekend differentials. Some think that if other professionals are included in units with RNs, problems could arise if such changes are also not implemented for non-nursing professionals. (Wilson, 5071; Saporta, 5116.)

It has been argued that the Board should not give special consideration to a group in temporary crisis or other groups will also make demands for separate units (Comment 65, Milford Hospital). However, while the evidence establishes that the situation is a serious one and appears to be growing more serious with time (ANA Br. 100–101, and articles cited therein), we view this as only one valid factor in determining the appropriateness of a unit limited to RNs. The concern that this will lead other professionals to follow suit is speculative, and insufficient reason to deny RNs, who have already established their unique concerns and a highly separate identity, a separate bargaining unit.

16. *Proliferation of units.* As has been documented elsewhere, the evidence in the record does not support the assumption that the recognition of RN-only units will lead to a demand by other professional groups to organize as separate units. In fact, as previously indicated, the AHA acknowledges in its brief that in the overwhelming majority of facilities where RN units exist, other professionals have not been represented in separate units. (AHA Br. at 24.) SEIU health care organizing director Splain concluded that 10 years of statistics show relatively little organizing in residual hospital units. There are 16 hospitals in Ohio that have a separate RN unit, and only one unit in which professionals other than RNs are represented separately. (King, Chi II 38–39; Shepard 4927.) Health care workers organize no more frequently in facilities where some workers engage in collective bargaining than they do in facilities where no bargaining units have been represented (WS Splain at 14–17). One witness testified that a typical hospital has an RN unit, an LPN unit or technical unit, a service and maintenance unit, and sometimes an operating engineers unit (WS Patek at 4).

C. Conclusion

We have carefully considered the evidence in the hearings as to how a separate RN unit, or, in the alternative, an all-professional unit including RNs, might fare, based on the realities of hospital operations, organizing, and collective bargaining. We conclude based on this evidence and the arguments advanced that a separate RN unit is appropriate for collective bargaining purposes.[22]

For many years, RNs, who constitute a significant portion of the health care workforce, have demonstrated their commitment both to their careers in the health care industry as well as their patients' well-being. During the time period following *St. Francis II*, it appears that RNs consistently desired separate RN units but were compelled to organize into all-professional units in order to avoid prolonged litigation. However, even when the RNs were forced to include other professionals in their units, the organizing drives were quite similar to prior nurses-only campaigns.

Moreover, it is apparent from testimony taken at the hearings that non-nursing professionals did not wish to be included in a unit with RNs. If we ignore the perspective of the smaller, non-nursing professionals group, i.e., the animosity expressed toward their inclusion with RNs as well as their concern that their "voice" will not be heard, then we are disregarding, at least in part, one of our major objectives. As previously indicated, the Board seeks to avoid finding too large a unit appropriate, as this may result in "too diversified a constituency which may generate conflicts of interest and dissatisfaction among fringe groups, making it difficult for the union to represent * * *." See section III, Standard To Be Applied, *supra*. This

[22] In making our decision on this issue, we have considered *St. Vincent Hospital and Health Center*, 285 NLRB No. 64 (Aug. 19, 1987), a fairly recent case in which we held in an adjudicatory proceeding that a separate RN unit was inappropriate. In so doing we found, *inter alia*, that all of the employer's professional employees "share common personnel policies and procedures and fringe benefits and have sufficient contacts and interaction to support the finding that the smallest appropriate bargaining unit is one consisting of all of the Employer's professional employees." *Id.*, slip op. at 13. Having now had the opportunity to consider the substantial empirical evidence adduced in this rulemaking proceeding, we have a far better understanding of the RNs' training, functions, interests, and involvement in hospital operations, and of the actual and potential ramifications of each type of unit. For the reasons stated in this section, were we to apply the empirical evidence presented in these hearings, we might well reach a different result in *St. Vincent*.

latter point appears to be a concern of nursing and non-nursing professionals alike, and is one reason we have decided to permit RNs to seek bargaining rights apart from other health care professionals.

There was also testimony that would lead us to believe that some hospital employers' true concern with prohibition of separate RN units was not possible fragmentation but rather defeating organization. This was demonstrated by evidence of, *inter alia*, employer opposition to bargaining with the RNs and other professionals in one unit when an all-professional unit was finally certified, despite these same employers' earlier efforts to require that all professionals be included.

The distinct functions and collective bargaining interests of RNs compel the conclusion that a separate RN unit is warranted. RNs are a unique group in that their profession demands continuous interaction with patients. Additionally, because of licensure limitations, other professionals may not perform RN work and vice versa. RNs have a separate labor market, and scheduling issues are more of a concern. These factors and others discussed *supra* support a finding that collective bargaining by RNs as a separate unit should be permitted.

The industry has contended that adverse consequences would follow having separate RN units, such as strikes, jurisdictional disputes, and proliferation of units. The testimony proffered at the hearings has satisfactorily alleviated any concern we had over these possibilities.

Finally, we are mindful of the growing problem involving the nursing shortage. While separate representation for the RNs does not provide the complete solution to this problem, we believe that it is an important step toward making the nursing profession a more attractive employment opportunity as the separate concerns of RNs are addressed more directly in a separate RN unit.

VI. Physicians

In our Notice of Proposed Rulemaking, we provided for separate units of physicians in acute care hospitals having more than 100 beds. Although we did not anticipate the formation of many such units, we stated we would permit them because of physicians' separate education, training, and skills, and particularly because of physicians' unique position as the ultimate supervisors of patient care.

As discussed *infra*, we have decided not to differentiate between hospitals having more than 100 beds and those having fewer. However, as with RNs, see section V, *supra*, the evidence produced during this proceeding supported the proposed separate unit of physicians.

Doctors have considerably more training than other professionals, i.e., four years of medical school plus two to six years of post-graduate residence training, working as student residents in hospitals under the tutelage of licensed physicians (WS Cornfield).

Doctors have the singular responsibility of directing all other patient care employees; the JCAH charges doctors with overall responsibility for the quality of professional services (Robinson, 3650–51; WS Todd at 4–5, citing 1987 Accreditation Manual). Malpractice claims are filed against doctors because they are responsible for medical treatment (Robinson, 3652). The AHA contends that all professionals are held responsible for malpractice (AHA Br. 30); while we do not doubt the truth of this assertion in some circumstances, the AHA offered no details.

It is common knowledge that doctors earn substantially more than other professionals. They are frequently salaried, entering into individual employment contracts with hospitals rather than having an overall wage scale applied to them. (Comment 94, Somers; Robinson, 3652; NYS Federation of Physicians' and Dentists' position paper Exh. D.)

Supervision of doctors is limited and is generally done by other doctors (Robinson, 3651; Comment 293, Feldsine). While we recognize that other professionals are also commonly supervised by their peers (Comment 71, Kowalski, St. Mary's Hospital), as indicated doctors are ultimately responsible for the care given patients.

Doctors, of course, work with other employees, particularly on teams, or committees (Comment 137, McDonough Hospital; Mixon, Chi II 291; Comment 248, appending statement from Spitzer of Cedars-Sinai). However, we are persuaded by the evidence that the team approach does not change the duties of doctors, which are limited by law. Other employees are not permitted to do work within doctors' scope of practice. (Todd, 4348; Comment 269, Todd, AMA.)

Aside from the other factors noted, doctors have particular interest in bargaining about medical education, malpractice insurance, and input into patient care decisions (Robinson, 3655). They have little interest in the issues of special concern to RNs, such as floating, per diem, uniform allowances, overtime, etc. (NYS Federation of Physicians' and Dentists' position paper, Exhs. B, D, E, and F), and are outnumbered by nurses at a ratio of at least 15:1 (Todd, 4324, 4328), and perhaps 20:1 (AHA Br. 28). We are concerned that if doctors were forced to be included in the same unit with nurses and other professionals, doctors' interests would be overwhelmed (Todd, 4324). Florida, after 10 years, removed doctors from an all-professional unit in state facilities because of money considerations (Lumpkin, 100, 111–12). In one wall-to-wall unit including doctors, the hospital wanted raises just for doctors because of recruitment problems; the union opposed this because it would give raises just to one group in the unit (Robinson, 3654–55). A number of employers similarly expressed concerns about putting physicians in units of other professionals (Comment 94, Somers, attorney to many health care facilities; Comment 304, Kaiser Permanente; Comment 1, Lancaster Fairfield Community Hosp.; Comment 17, Middletown Regional Hosp.; Comment 48, St. Vincent's Medical Center, Bridgeport; Comment 141, Ayres). A wall-to-wall unit at O'Bleness Hospital did not include doctors (AHA Exh. 8D).

While the number of doctors employed in hospitals is small, and the percentage of employed doctors compared to other employees remains about the same, the actual number of employed doctors is increasing (Todd, 4335), and there is some evidence that doctors are organizing at increasing rates (AFL Exh. 4).

We are persuaded that the evidence weighs in favor of a separate unit for physicians, where sought. Thus, to include them with RNs and other professionals seems likely to lead to divisiveness and quite possibly to conflicts of interest. We have found no evidence that to grant doctors a separate unit would lead to repetitious bargaining, frequent strikes, or jurisdictional disputes. We believe the proper balance is struck in favor of a separate unit for all physicians, where requested.

VII. Other Professionals

In our original Notice of Proposed Rulemaking, we tentatively provided for a separate unit of all professional employees, excluding registered nurses and physicians, in acute care facilities having over 100 beds. We noted that section 9(b)(1) of the Act mandated separate representation for professional employees unless a majority of those employees vote for inclusion in a unit with non-professionals. In view of the provision for separate RNs' and physicians' units, it was and continues

to be necessary to provide for a separate unit of professionals excluding these two classifications although, as noted *supra*, we have decided to abandon the proposed 100-bed differentiation.

A number of so-called "other professionals" appeared in person at the hearings to testify. In general, they confirmed the lack of interest which RNs exhibited towards their circumstances, and the fact that, despite their different professions, they were able to achieve collective bargaining in all-professional units, excluding RNs and physicians. (Indelicato, social worker, 3673, 3678; Ahmed, laboratory technologist, 3705–06; Crisafulli, pharmacist, 3711, 3737.) In a comment, physical therapists expressed a preference for their own separate unit, but if placed with other professionals they would prefer that unit did not include RNs (Comment 134). Some fear was expressed that, because of their numbers, RNs (and also technicals) would overwhelm the other professionals if included in the same unit with them (Ratner, 3731–32; WS Cornfield, Table 1).

A number of "other professional" classifications work relatively independently, and have no immediate direct supervision (Ratner, 3735). They generally work the day shift, on weekdays (Indelicato, 3681), though some work on other shifts (see, e.g., Comment 275, Presbyterian Hospital). As a group they have high prestige within the hospital because of their superior education and training (WS Cornfield, Table 6).

Despite the desire expressed by some other professionals for their own separate units, and despite some history of separate representation of each profession, mainly in New York (see, e.g., Friedman, 5038), it seems clear to us that to provide for such additional units might create the proliferation which Congress meant to avoid. Moreover, despite the existence of some units combining technicals with other professionals (see, e.g., Willman, 4480, 4483, 4485, 4486; Shea, 5208; Robfogel, Chi. II, 224), Sec. 9(b)(1) of the Act prohibits such a combined unit, unless the professionals separately vote for inclusion with the non professionals. Accordingly, based on the above, we affirm the appropriateness of a separate unit of all professional employees, other than RNs and physicians.

VIII. Technicals

A. Introduction

In our Notice of Proposed Rulemaking, we tentatively determined that technical employees constituted a separate appropriate bargaining unit. Among the reasons we expressed were:

(a) That, in comparison with other non-professionals, they typically have significantly higher levels of skill and training, and are paid substantially more;

(b) That it has been the Board's consistent practice to approve separate units of technical employees; and

(c) That these separate units generally have met with approval from the courts of appeals.

After carefully considering the evidence presented during the rulemaking proceedings, we have determined that technical employees appropriately constitute a separate bargaining unit.

B. Technical Employees Are Separate and Distinct From Other Non-Professional Employees

1. *Education, licensing, training, and skills.* Technical employees are found in major occupational groups including: medical laboratory, respiratory therapy, radiography, emergency medicine, and medical records.[23] (WS McKinney, 2.) The evidence presented at the hearings demonstrates that technical employees perform jobs involving the use of independent judgment and specialized training, as opposed to service and maintenance employees who generally perform unskilled tasks and need only a high school education (AFL Br. 32, citing *Southern Maryland Hospital Center*, 274 NLRB 1470 (1985); McKinney, 5502–03, 5523–24; Colbert, 5020; WS Shea at 20). Testimony indicated that the gap between technical employees and service and maintenance workers actually is widening, with higher levels of technical skills more closely aligned to professional job categories rather than to other non-professional categories (WS Shea at 20; WS Schoen at 14 and 5175–76). Thus, technical employees occupy a high-prestige status distinct from other categories of non-professional employees because of the training requirements for their jobs (WS Cornfield at 12–13).

Technical employees further are distinguished by the support role they play within the hospital, and by the fact that they work in patient care. Examples of their work include: routine clinical tests performed by medical laboratory technicians; general respiratory care administered by respiratory therapists; and x-rays, ultrasound procedures, and CAT scans performed by various technicians. (WS Briguglio at 3.)

Contrary to the AHA's statement that "no evidence of separate or distinct employment attributes of technical employees was presented at the hearings" (AHA Br. 33), the evidence shows that all health care technical employees have significant additional education and/or training beyond high school, including: community college associate degree programs which provide math and science background beyond that which high schools offer (WS McKinney at 5); vocational training programs run by hospitals (WS McKinney at 7); programs at accredited schools of technology (WS Briguglio at 2); and, in some fields, a full 4-year college degree (Schoen, 5176; McKinney, 5477).

Further, the evidence indicates that most hospital technical employees are either certified (usually by passing a national examination), licensed, or required to register with the appropriate state authority (Willman, 4474), although laws regarding such licensure, registration, training and qualifications vary throughout the country (Ahmed, 3709–11).

There was evidence that some deskilling is occurring in the technical categories, reducing the need for higher skills in operating some equipment; however, the evidence further shows that it is not across-the-board (McKinney, 5485). Further, hospitals must purchase expensive and complicated equipment to deskill a task (McKinney, 5486); and where, for example, a technologist's work may be deskilled, it then would be performed by a technician rather than by a service worker (McKinney, 5513–14; Berliner, 5633–34).

2. *Wages, hours, and working conditions.* Although, in general, hospitals apply similar benefit and labor relations policies to technical and other non-professional employees, the evidence shows that the wages and hours of technical employees differ significantly from those of the other non-professionals (Mass. Hospital Assn., Comment 105). Technicians were shown to occupy the middle ranks in the hierarchy of health care workers, and the evidence presented regarding hospital pay scales reflects this standing (WS Schoen at 15). On the average, technicians earn $2,000 per year more than service workers in this industry (WS Schoen at 15, Table 1; Henry, 3084–85). While the wages of service workers are tied to the unskilled labor market,

[23] Although we note that historically, those employees who enter and decode patient data in medical records have been placed in service and maintenance units or overall non-professional units (see e.g., *Levine Hospital of Hayward*, 219 NLRB 327 (1975); Duke University, 226 NLRB 470 (1976)), the inclusion of "medical records technicians" in a separate technical unit may be litigated as a unit placement issue when it arises, on a case-by-case basis.

and those of business office clericals and skilled maintenance workers are similar to those of comparable jobs outside the industry, technicians' wages are tied to the earnings of the more highly skilled technologists with whom they work, and they generally earn approximately 75% of what the technologists earn (WS McKinney at 12–13, & 5479). Thus, management needs to provide higher entry wages for technicians than for service workers (Shea, 5238–39; Briguglio, 5300–01; Henry, 3084–88).

Technical employees work daytime hours, with evening, night, and weekend skeleton crews, while business office clericals work daytime hours and service and maintenance employees are staffed on a 24-hour basis (Colbert, 5016–17).

3. *Supervision.* The evidence indicates that technical employees usually have separate supervision from other non-professional employees; however, this may differ from facility to facility. For example, a supervisor of some technical employees may also supervise business office clericals; or a laboratory manager who supervises technical employees also may supervise some service and maintenance employees. (Mass. Hosp. Assn., Comment 105; Briguglio, 5300.)

4. *Contact with other employees.* Technical employees typically perform their work in laboratories or in technical departments, and not in patient care areas (AFL Br. 41; Booth, 3693), although the AHA's brief states that more hospitals are beginning to locate some laboratory facilities in patient care areas and technicals may have direct and continuing involvement with other categories of employees as well as with patients (AHA Br. 33). The tasks that technicals perform, such as processing and reviewing patient specimens, taking x-rays, EKGs and EEGs, are considered ancillary services, diagnostic in nature (AFL Br. 41). Technicals have no contact with business office clericals, and only minimal contact with service employees, but in a typical laboratory, work with doctors, technologists, clericals, and messengers (WS Briguglio, 4–5; Colbert, 5017–18; AHA Br. 33). The evidence shows that LPNs do work in patient care areas and provide direct patient care; however, the Board has found them to be appropriately included with technicals in light of their skill level and the requirement that they be licensed (AFL Br. 41 citing NLRB Exh. 5, revised).

5. *Cross training.* There is no temporary interchange, and little permanent interchange between technical employees and other non-professionals because of the difference in skills, the specialized functions of the technicals, and the differences in their education (Shea, 5221–22). Service workers typically have only a high school education or less and cannot be placed in technical positions in the absence of elaborate training programs (McKinney, 5481). Contrary to statements of industry witnesses who maintain that a service worker could take a six-week training program and be able to read EKG equipment (King, 5488), we are persuaded that technical training requires full or nearly fulltime education, and a high school education does not provide the mathematics and science background necessary (WS Shea at 21).

The evidence shows that cross-training programs are being offered at some hospitals and colleges; however, training prograns and funds to provide classroom instruction for hospital employees are rare in hospitals that are not unionized (Schoen Supplemental Statement). Thus, the majority of cross-training that occurs is among the technical categories themselves (LPNs doing EKG work formerly done by EKG technicians; medical technologists administering blood gases previously administered by respiratory technicians) (St. Anthony's Health Corp., Comment 142; St. Joseph Mercy Hospital, Iowa, Comment 243). Moreover, new technology has brought about a decline in technician jobs requiring only minimal training, while increasing the need for more intensely-trained technicians, thus widening the gap between technical employees, who are becoming more skilled and sophisticated, and service and maintenance workers (WS Schoen, 14–15; WS Shea at 21).

6. *Career paths and the labor market.* Technical employees have a separate career path and labor market. They do not seek to transfer into other types of non-professional jobs; rather, technicians may seek to become technologists in the same line of technical work; or LPNs may seek to become RNs. (O'Cleireacain, 5426; Ryan, 4738–39.) While some LPNs may become RNs through training programs, progression to technologist is more difficult for technicians because of the 4-year college requirement for many technological positions (WS Schoen at 15; McKinney, 5477). Their existing training is not considered a "building block" toward technologist status, without successful negotiations with licensing and accreditation boards (Schoen, Supplemental Statement). Thus, in addition to little mobility in their immediate workplace, it is also difficult for technicians to move out of that workplace. As long as they wish to practice their specialities, they must remain in the health care industry. (WS McKinney at 12.) Statistics show that 100% of job placements from technical programs are in health care occupations (Ryan, 4744). In contrast, business office clericals and skilled maintenance workers have great mobility outside the industry, as do unskilled service employees (O'Cleireacain, 5427; Marshall, 4018–19).

Evidence presented at the hearings shows that the labor market for technicians, which until recently was expanding steadily, is contracting (McKinney, 5474, 5478). Witnesses testified that with the introduction of cost containment techniques into the industry, the future of technical workers is in a state of flux. Further, even though new technology and equipment continue to be developed, at the same time hospitals are seeking to save on labor costs by replacing expensive, skilled employees, closing laboratories, and contracting out laboratory services. (WS McKinney at 13; Berliner, 5598.) Certificate of Need programs impose limits on the addition of new technology, further reducing the need for new technicians. For all of these reasons, training programs have become an important bargaining issue. (Schoen, Supplemental Statement.)

C. Organizing and Bargaining

The health care industry's bargaining unit proposals in 1973–74 would have allowed a separate unit for technical employees in hospitals (AFL Br. 31); and since 1974, the Board has continued to find separate technical units appropriate (NLRB Exh. 5, revised; *Southern Maryland Hospital Center,* 274 NLRB 1470 (1985)). As we noted in our proposed rule, court decisions have approved the Board's determinations as to technical units. See, e.g., *Watonwan Memorial Hospital v. NLRB,* 711 F.2d 848 (8th Cir. 1983); *NLRB v. Sweetwater Hospital Association,* 604 F.2d 454 (6th Cir. 1979). See also *Vicksburg Hospital v. NLRB,* 653 F.2d 1070, 1075 (5th Cir. 1981). Further, the evidence shows that technicals choose to organize in technical groups and not with other non-professionals (Booth, 3686–88). In the 588 hospitals in which a union affiliated with the AFL represents at least one bargaining unit, there are 311 separate technical units (including LPN units), and only 52 units in which technical employees and other non-professionals are combined into a single bargaining unit (AFL Br. 44 and Appendix A; Booth, 3688–90). In addition, LPNs organize with technicals who have the same training, education, licensure, and

certification requirements (Muehlenkamp, 4787).

Organizing drives are initiated by employees with specific concerns and grievances (WS Splain at 4; Sackman, 3592; Schmidt, 3628; Muehlenkamp, 4784). Other interests include professional conferences, training, and rotations (Colbert, 5019). At the hearings, no union organizer who was asked could recall any situation in which technical employees sought to include business office clericals or unskilled service workers, or vice versa (Olson, 4718; Muehlenkamp, 4784).

Technical employees generally choose to have separate initial contracts; however, they may agree, after the initial agreement expires, to engage in joint bargaining, but retain separate delegates for negotiations and for presenting separate issues (Booth, 3688; Colbert, 5021–22). Although industry witnesses maintain that the fact that technical employees organize and bargain their first contract as a separate unit does not justify finding a separate technical unit appropriate where subsequent bargaining history shows that they now bargain in broader units (St. Luke's/Roosevelt, Comment 224; AHA Br. 32–33), there is evidence that difficulties have arisen occasionally where technicals have been included with maintenance employees and clericals because of their different training, duties, and wages (Logan, Comment 150, pp. 3–4).

D. Proliferation

Technical units generally encompass a wide range of classifications, including LPNs, and they constitute approximately 17% of the health care work force—a substantial complement of workers (WS McKinney at 2; WS Schoen at 3, 5). What evidence there is shows that strikes involving technical employees alone are rare. In New York City, for example, strikes involving technical employees occur in broader units of clericals, service and maintenance, and professional employees. (Long Island Jewish (LIJ) Medical Center, Comment 270.)

E. Other Issues

The label "technical" may no longer define a particular group of jobs, and indeed, the union witnesses who appeared at the rulemaking hearings often did not distinguish between technicians and technologists (Schoen, 5175; Ahmed, 3709–11; McKinney, 5471–79; WS Briguglio at 2–3.) Technologists often have been included as professional employees in professional-only units. See, e.g., *Children's Hospital of Pittsburgh*, 222 NLRB 588 (1976); *Mercy Hospitals of Sacramento*, 217 NLRB 765, 769 (1975). Although industry witnesses urge the Board to consider the practical effect of the difficulties of resolving issues of unit placement, and caution that there may be "intense litigation" over unit placement which could be avoided by the inclusion of technicals in a broad non-professional unit (AHA Br. 34), we note that, even with such inclusion, litigation could continue to occur over which technicians were professional employees. Individual placement issues always have been present in the consideration of health care and other cases. In our opinion, their existence should not deter the Board from taking the first step, i.e., determining the threshold appropriateness of a separate technical unit.

F. Conclusion

For the above reasons, we determine that separate technical units are appropriate for collective bargaining. The evidence clearly demonstrates that the varied technical employees employed in the health care industry are appropriately grouped into a single unit by virtue of their education, training, and specialized skills, and do not constitute a unit so large as to be overly diversified and hence unwieldy for organizing and collective bargaining.

IX. Skilled Maintenance

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that service and maintenance employees constituted a separate appropriate unit and that skilled maintenance employees should be included in that unit rather than represented in separate skilled maintenance units. Among the reasons we expressed for including skilled maintenance employees in the broader service and maintenance units were:

(a) That their skill levels do not, at times, greatly exceed those of other service and maintenance unit employees;

(b) That they work throughout hospital's facilities, and thus frequently come into contact with other service and maintenance employees;

(c) Their inclusion in broader units will help to prevent unit proliferation; and

(d) As a practical matter, the Board's approval of separate maintenance units had fared poorly in the courts.

After carefully considering the evidence amassed during the rulemaking hearings, we have determined that, contrary to our earlier impressions, skilled maintenance employees can and should constitute a separate appropriate bargaining unit.

B. Relationship to Other Employees

1. *Functions and skill level.* Evidence from the rulemaking hearings shows that skilled maintenance employees perform functions apart from those of unskilled service, maintenance, and clerical employees in that these employees deal with highly complex and sophisticated systems and equipment (Carrick, 3448–3450; Jacquin, 5354–55; Lake, 146–148). While they occasionally perform routine, unskilled tasks, skilled maintenance employees are generally engaged in the operation, maintenance, and repair of the hospital's physical plant systems, such as heating, ventilation, air conditioning, refrigeration, electrical, plumbing and mechanical (Lake, 150–151; Viat, 3457–59, 3476–77; Hach, 5318; Giblin, 5382–83). Work on these systems requires abstract skills and knowledge at levels considerably higher than those of other non-professional hospital employees (Marshall, 4010–4012; Hammond Exh. 1, pp. 340–45, 580–623; Cornfield, 5698; WS Cornfield at 4–6, citing Dictionary of Occupational Titles of U.S. Employment and Training Administration). Skilled maintenance employees are rated more highly, for example, even than physicians on the manipulation of "things" (WS Cornfield at 5). Skilled maintenance employees are frequently required to have postsecondary training in their field, such as vocational or trade school. Even the lower skilled maintenance employees in plant operations and maintenance are required to have higher skills than those required of service employees. (Jacquin, 5363–64, 5374, 5377; Viat, 3459–60; Giblin, 5384.)

2. *Education, licensing, and training.* Contrary to virtually all nonsupervisory service classifications, which require only a grade school education, skilled maintenance classifications require completion of high school; at least some trade or vocational school experience, if not graduation therefrom; completion of formal or informal apprenticeship programs, which may take several years; or an associate's or bachelor's degree (Hammond, 5404–05, 5409–12; AHA Health Care Occupations: A Comprehensive Job Description Manual pp. 340–45, 385–88, 394–402, 499–501, 561–62, 567–70, 573–74, 580–623; Marshall, 4010). Skilled maintenance employees also need continuing education to keep abreast of technological changes in building maintenance, such as computers and remote controls (Carrick, 3454; Marshall, 4011–12; Schloop, Chi II 165; Schwemm, Chi II 186–89; Hammond, 5408; WS

Schwemm, Exh. 5–9; WS Fowler at 4; WS Denevi at 7–9). Moreover, the amount of training available in skilled maintenance classifications compares favorably to that offered in various technical classifications, such as lab technician and medical records technician (WS McKinney at 6–7), and access to the programs and the upward mobility they bring provide a common concern to employees largely unshared by those outside the skilled maintenance group (Schloop, Chi II 165; Ryan, 4739). Another distinction between skilled maintenance and unskilled service employees is that at least seven skilled maintenance classifications, but no service classifications, require licenses. (Hammond, 5404–06; WS Cornfeld, at 6–8)

3. *Supervision.* The distinct nature of skilled maintenance functions is underscored by the frequent placement of skilled maintenance employees in separate departments, usually coinciding with the hospitals' plant engineering or maintenance departments (Carrick, 3448; Viat, 3457, 3478; Marshall, 4014; Hach, 5342, 5354). Thus, skilled maintenance employees frequently have their own supervision (Hammond, Exh. 1, pp. 581–590). Moreover, skilled maintenance employees are not supervised by any supervisors from outside their own departments (see, e.g., WS Fowler at 8).

4. *Wages, hours, working conditions.* While it appears that certain terms and conditions of employment, i.e., fringe benefits and personnel policies, are similar among non-professional employees (Jacquin, 5368–70; Comer, Chi II 326–29; Comment 129, Hall), wage rates paid to skilled maintenance employees underscore their higher skills and training. Thus, the most recent Industry Wage Survey: Hospitals, Aug. 1985, BLS of the DOL, shows that skilled maintenance employees in private hospitals in 23 metropolitan areas averaged $11.89/hour whereas, in comparison, employees in six service classifications averaged $6.84/hour, office clericals in five classifications averaged $7.56/hour, and employees in ten technical classifications averaged $9.89/hour. (Lake, 154–55; IUOE, Exh. 4.) Thus, on the average, skilled maintenance employees earn 25% more than technicians, almost 60% more than business office clericals, and 76% more than service employees. Moreover, the wage rate of lesser skilled maintenance employees, while lower than that of the most skilled maintenance employees, almost always exceeds that of even the highest-paid service employees and often exceeds the rate of employees in other classifications as well.

5. *Interaction with other employees.* Though they primarily work in maintenance areas, skilled maintenance employees do perform work throughout the hospitals (Kelly, Chi II 178; Carrick, 3453; Hach, 5330). As a result, skilled maintenance employees have contact with just about every other employee in a hospital. However, these contacts are brief, limited, and incidental as it appears that the only employees with whom skilled maintenance employees actually work are others from the maintenance department (Carrick, 3453–54; Jacquin, 5360; Kelly, Chi II 212–13), and that the contacts with non-maintenance employees typically consist of other employees' identifying the maintenance problem to the skilled maintenance employees (Kelly, Chi II 178, 213; Jacquin, 5360; WS Fowler at 8).

6. *Labor market and career paths.* Skilled maintenance employees have separate labor markets and highly mobile cross-industrial career paths as the operation and maintenance of physical plant systems are the same no matter in which industry they are performed (Marshall, 4014; Schloop, Chi II 163; Kelly, Chi II 177; Fox, 3436–37; O'Cleireacain, 5427; WS Denevi at 4). Easy mobility in skilled maintenance classifications tends to orient these employees toward their skills rather than the industry in which they are employed (Lake, 144, 490; Marshall, 4010, 4019). The external skilled maintenance labor market also affects the hiring and wage scales in the health care industry since hospitals compete with other industries, such as hotels and office buildings, for these employees (Berliner, 5645; Hach, 5344–45; WS Schoen at 23; Corbett, 3344–45).

Skilled maintenance employees are in a separate internal labor market within the hospital in terms of career path, training, and promotion. There are formal and on-the-job training programs to permit lower level maintenance employees who have acquired skills and knowledge to move into more highly skilled positions; yet, there is virtually no transfer of clerical or service employees into maintenance classifications. (Schloop, Chi II 204–05; Kelly, Chi II 216–17; Giblin, 5400; O'Cleireacain, 5427, 5468; WS Shea at 18.) Even entry level jobs are filled by those with skilled maintenance backgrounds (Hach, 5327; Schloop, Chi II 203–04).

C. History of Representation

The appropriateness of separate skilled maintenance units is supported by a history of separate representation, especially by labor organizations specializing in the separate representation of skilled maintenance employees (IUOE Exh. 2 revised; Holland, Chi II 305–09; Friedman, 5036, 5040–41; Peters, Chi II 131–34; Comer, Chi II 320, 327–28; Hach, 5328; Giblin, 5395). For example, the IUOE currently represents at least 237 separate skilled maintenance units in both private and public health care institutions nationwide (IUOE Br. 56). Twenty percent of IUOE health care units date from the 1940's and '50's, and 85% of them predate the 1974 amendments (IUOE Exh. 2 revised). Admittedly, there are skilled maintenance employees represented in combined service and maintenance units, or in a handful of broader non-professional units, but inclusion of skilled maintenance employees with these other employees does not necessarily show a voluntary grouping as some combined units are the result of stipulations so that elections could be held without further delay, or are atypical situations (Stickler, Chi I 16–26; Twomey, 131–34; Emanuel, 3497; Ratner, 3728; AHA Exh. 4–9; Willman, 4491–92; Muehlenkamp, 4767; Friedman, 5041; King, 4244, 4249, 4251–52). In addition, the evidence regarding combined units is equivocal in that the "maintenance" employees in "service and maintenance" units are frequently unskilled rather than skilled maintenance employees (Silberman, 5651; IUOE Br. 58; Shea, 5227–28; Splain, 5302–04).

D. Organizing and Bargaining Interests

1. *Organizing.* Though clearly not impossible, it appears that because of the variety of personal interests involved it is more difficult to organize larger, combined units than to organize separate smaller units of employees (Viat, 3465; Sackman, 3578; Schwarz, 265; WS Schwarz, Koziara study pp. 1, 4, Figure 1; Delaney, 4517–18, 4525; Silberman, 5686; AFL Exh. 2). Larger heterogeneous units deter decertifications of unions as well (Delaney, 4523). In addition, skilled maintenance employees usually do not wish to organize with other groups, and it is unusual for different groups of non-professional employees to seek to organize in the same unit (Muehlenkamp, 4785; Olson, 4698–99; Ratner, 3730). There is evidence that, where combined units are sought, separate interests of the diverse groups may make it difficult, or impossible, to hold organizing meetings of the entire group (Viat, 3465).

2. *Bargaining interests.* While all employees have some similar bargaining

concerns, i.e., wages, hours, and fringe benefits, skilled maintenance employees have additional interests different from those of other non-professional employees. They seek wage levels commensurate with those of skilled maintenance employees in other industries; access to craft-related education and training programs; tool supply allowances; safety equipment and practices; portable pensions, because of their cross-industrial mobility; and input with respect to subcontracting of work. (Kelly, Chi II 175; Marshall, 4011; Willman, 4492–93; Schloop, Chi II 164–65; Schwemm, Chi II 209; Viat, 3466–67; Giblin, 5388.) Service employees and business office clericals have specialized bargaining interests as well (Schloop, Chi II 168; Viat, 3466–67; Gregory, 5746). These differences lead to difficulties in bargaining in a heterogeneous group, and may result in the smaller group of skilled maintenance employees getting lost in the shuffle in negotiations relating to the more numerous lesser skilled employees (Schloop, Chi II 168–69; Olson, 4729–30; Viat, 3465; Willman, 4492; Ratner, 3734; Shea, 5187; Muehlenkamp, 4795–96). Negotiating in a broader unit may also serve to broaden the scope of labor disputes by involving employees whose personal interests are not of concern in disputes relating to the interests of other unit employees (Viat, 3466). For example, in one hospital in which two unions jointly represented a combined unit of service, skilled maintenance, technical, and plant clerical employees, the skilled maintenance employees were forced to join other employees in a strike over unresolved bargaining issues that affected only the other employees even though all issues involving the skilled maintenance employees had already been settled (Viat, 3466).

E. Proliferation

Contrary to our concern, as expressed in our NPR, there was no evidence adduced at the rulemaking hearings that establishing a separate unit of skilled maintenance employees will lead to proliferation of bargaining units in the industry (Kelly, Chi II 180; Gilmore, 4894; Splain, 5252). No labor organizations have sought or demonstrated the appropriateness of other small units (IUOE Br. 64–65). Moreover, the skilled maintenance employee unit may be viewed as a consolidation of specialized employees inasmuch as it combines such employees as carpenters, painters, plumbers, and electricians (IUOE Br. 65). The only employee classification performing work similar to that performed by traditional craft or trade-type maintenance employees are biomedical technicians (Marshall, 4018–20; Hach, 5346–49; Jacquin, 5377; Viat, 3480–81; Giblin, 5396–98). Biomedical technicians work on and repair sophisticated computer-based equipment, and because of both their skills and training share a community of interest with other skilled maintenance employees and in many instances have already been included in some such units (Fox, Exh. 1 and 2; Hammond, Exh. 12; Viat, 3458, 3460, 3480; Giblin, 5495–97; Marshall, 4019–20; McKinney, 5497, 5525; Hach, 5347–49; Jacquin, 5377; Schloop, Chi II 203–04; Carrick, 3448).

F. Strikes, Sympathy Strikes, Jurisdictional Disputes, and Wage Leapfrogging or Whipsawing

1. *Primary strikes.* The evidence taken at the rulemaking hearings shows that the presence of separate skilled maintenance units has not resulted in a large number of strikes by these units (Lake, 157; IUOE Exh. 2; Viat 3468; Schloop, Chi II 169; Kelly, Chi II 180; Hach, 5323; Giblin, 5389; Hammond Exh. 12, attached affidavits). The hospitals contend that the number of strikes is low because the number of employees involved is small and therefore the cost of a strike exceeds the potential increase in labor costs of the union's demands thereby making it more likely that hospitals will give in to those demands. Nonetheless, the fact remains that in the 237 skilled maintenance units represented by the IUOE, in which hundreds of contracts have been negotiated, there have been only about 25 strikes ever (Lake, 157; IUOE Exh. 2). In addition, the incidence of strikes by skilled maintenance employees has not increased in proportion to the number of other represented units of hospital employees (IUOE Exh. 2; Viat, 3468–69; Fox, 3442). The few strikes that have occurred have been almost exclusively in support of bargaining demands, and have not been disruptive to health care delivery; indeed, skilled maintenance employees have offered to provide skeleton crews to assure uninterrupted service in the event of a work stoppage (Henry, 3059; Fox, 3442; Viat, 3467–68, 3470; Hammond Exh. 12, affidavits of Bess, Tighe, and Scheb.) Moreover, other hospital employees, whether represented or not, generally have not engaged in work stoppages in support of striking skilled maintenance employees (Hammond Exh. 12, affidavits of Bess, Tighe, and Scheb).

2. *Sympathy strikes.* While the strike rate in the health care industry in general is low (Subrin, Chi I 119–20; Schoen, 5181; Silberman, 5659), there is evidence that hospitals have not availed themselves of the opportunity to limit the possibility of successive multiple strikes by supporting union proposals for common contract expiration dates of different units' contracts; indeed, hospitals have opposed such proposals. (Henry, 3075; Absalom, 3318–19; Corbett, 3359–60; Schmidt, 3625; Weinrich, 4274; Muehlenkamp, 4771, 4774). Moreover, there have been virtually no sympathy strikes by skilled maintenance employees in support of other striking hospital employees (Schloop, Chi II 169; Kelly, Chi II 180; Fox, 3442; Friedman, 5060; Hach, 5323; Jacquin, 5361; Giblin, 5389; WS Fowler at 7; Hammond Exh. 12, affidavits of Bess, Tighe, and Chambers). No-strike clauses, which are generally honored, appear to have contributed to the infrequency of such strikes (Fox, 3442; Friedman, 5060–61). And, while the evidence shows that bargaining in broad, heterogeneous groups may serve to expand the scope of a strike by involving employees whose personal interests are not of concern in disputes relating to the interests of other unit employees (Viat, 3466; see above discussion in subsection (d)(2), Bargaining Interests), it also shows that the absence of sympathy strikes in the industry makes it unlikely that such expansions of strikes will occur where employees with separate and distinct interests are represented in separate units.

3. *Jurisdictional disputes.* In general, industry witnesses were unable to support the allegation that allowing separate skilled maintenance units would increase the number of jurisdictional disputes in the industry (Graumann, 409; Weinrich, 4254, 4281; Cammarata, 4406). Instead, the evidence shows that jurisdictional disputes over work assignments involving skilled maintenance employees are, like those in the hospital industry in general, rare and nondisruptive (Roth, 3153; Muehlenkamp, 4775; WS Shea at 14). Moreover, we are persuaded that the types of jurisdictional disputes which do arise, i.e., disputes over job classification, content, and responsibility, occur regardless of whether the employees are represented in one unit or several different units (Krasovec, 420–22; Hach, 5324; Giblin, 5389–90; WS Shea at 14). Finally, the few disputes which have arisen have been resolved informally, minimizing disruption of normal operations (Schloop, Chi II 170–71; Kelly, Chi II 181, 206, 207; Fox, 3442–43 & Exh. 2; Viat, 3471; Hach, 5323; Jacquin, 5361; Giblin, 5389).

4. *Wage whipsawing and leapfrogging.* Wage whipsawing or leapfrogging virtually never occurs with

skilled maintenance units inasmuch as the wages of skilled maintenance employees are generally based on the wages of skilled maintenance employees in other industries, rather than on the wages of other health care industry employees (Corbett, 3344; Hach, 5344–45).

G. Changes in the Industry

The alleged trend toward specialized hospitals and integration of employee functions would appear to have no impact on skilled maintenance units because the physical plant systems will essentially remain the same and will require skilled maintenance employees to operate and maintain them (Viat, 3470). Any move toward interdisciplinary teams also appears to have had no effect on skilled maintenance employees as virtually every team that was described by the industry included only health care personnel (Mixon, Chi II 275; Gallagher, 3541–42; Houston, 4025, 4050–55; Donnelly, 4064, 4080; Sokatch, 4195; Weinrich, 4268–69; Comment 62, Achterhof; Comment 78, Olman Greater Cincinnati Hospital Council). The one example provided at the hearings of skilled maintenance employees' participating on a team involved the skilled maintenance employees' voluntarily critiquing vocational training projects of rehabilitation patients (Coney, 165). This one example of an incidental function undertaken by a maintenance group at one hospital is, so far as we know, unique, but in any event does not involve direct patient care and is clearly insufficient to obliterate their distinct functions. Finally, the industry gave no examples of skilled maintenance employees being cross-trained into other job groups such as clericals or service employees and, cross-training from service to skilled maintenance positions or technical positions is virtually unknown. (Stickler, Chi I 9, 33–37; Houston, 4026; O'Cleireacain, 5467–68; McKinney, 5481.)

H. Other Issues

1. *Costs of multiple units with reference to skilled maintenance.* Assuming the relevance of the potential cost to the industry of negotiating in additional units, the evidence does not support the conclusion that units of skilled maintenance employees would necessarily have any adverse effect on hospitals' expenses. The evidence there is shows that contract negotiations for skilled maintenance units tend to be relatively short, which means relatively inexpensive (Comer, Chi II 328; Viat, 3469; Jacquin, 5378).

2. *Congressional admonition against proliferation.* The admonition against proliferation of units was directed toward problems that could be caused by having many separate bargaining units, i.e., substantial numbers of strikes interfering with the delivery of health care services, wage whipsawing, and jurisdictional disputes. As shown above, there is little or no evidence that the existence of separate skilled maintenance units has resulted, or would in the future result, in these problems. As a practical matter, permitting separate skilled maintenance units would not necessarily result in the creation of still additional bargaining units since most hospitals have substantially fewer organized units than the number proposed by either the Board or the unions. (Schwarz, 264, WS Table 1; Robfogel, Chi II 223; Comer, Chi II 329; Cammarata, 4425; Delaney, 4520; Muehlenkamp, 4770–71; Shea, 5163.)

During the 1973 legislative hearings on S. 794, the fear expressed by a number of witnesses was that Board precedent might permit a separate unit for each trade or craft found in hospitals. Thus, e.g., Sidney Lewine, testifying on behalf of AHA, and Richard V. Whelan, Jr., representing the Ohio Hospital Association, noted with apprehension the proliferation that would result if the Board were to grant a separate unit to each construction craft such as stationary engineers, carpenters, plumbers, electricians, pipefitters, and painters. (Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1973, Hearings on S. 794 and S. 2292, at 128–29, and 465–66, respectively.) The Board's proposal directly takes into account this concern, which was called to Congress' attention, by putting all such separate skilled crafts into *one* skilled maintenance unit.

3. *The most recent Board decision.* In *St. Francis Hospital,* 286 NLRB No. 123 (Nov. 30, 1987) (*St. Francis III*), the Board held that a separate maintenance unit was inappropriate. In so doing, the Board found that the hospital's maintenance employees constituted less than 10% of the hospital's 438 service and maintenance employees, and spent approximately 80–95% of their time working throughout the hospital, thus bringing them in frequent contact with all other hospital employees. The Board further found that the hospital used independent contractors to perform difficult work, and that the sought employees shared the same basic terms and conditions of employment as service employees, including departmental supervision. The Board also noted that its finding that these particular maintenance employees did not constitute a separate appropriate unit was based on the particular facts of the case and was in no way an expression of its view concerning the appropriateness of maintenance units in general. Based on the evidence obtained during the rulemaking hearings, it is unlikely that we would reach the same result. Thus, the evidence from the hearings shows that, in virtually all health care facilities which were the subject of testimony at the hearings, skilled maintenance employees constitute a discrete and distinct group of employees. They perform functions apart from those of unskilled service, maintenance, and clerical employees. Skilled maintenance employees were shown to be highly skilled as evidenced by higher educational, licensing, and training requirements. While they share some common terms and conditions of employment with other hospital personnel, these employees uniformly have higher wages than service and clerical employees and have a number of bargaining interests separate and distinct from those of non-maintenance employees, such as access to craft related education and training programs, tool supply allowances, safety equipment and practices, portable pensions, and the like. Moreover, while skilled maintenance employees do work throughout the entire hospital, their contact with non-maintenance employees is brief and limited. Finally, the hearing evidence shows that transfers are rare in the industry and that skilled maintenance employees have a separate internal and external labor market.

I. Conclusion

For the above reasons, we find that a unit of skilled maintenance employees is separately appropriate for collective bargaining purposes. Although the number of employees in such a unit will be relatively small, their work bears little relationship to that of other hospital employees. It is, essentially, a non-health care occupation involving skills, interests, and job markets largely separate from the hospital itself. For that reason, to require unions to organize and represent skilled maintenance employees as part of a larger group of unskilled employees performing health-related jobs within the hospital is both unrealistic and inefficient. Hence, we have decided that the final rule should provide for separate skilled maintenance units.

The IUOE contends (IUOE Br. 9), and we find, that skilled maintenance units should generally include all employees

involved in the maintenance, repair, and operation of the hospitals' physical plant systems, as well as their trainees, helpers, and assistants. However, evidence from the hearings shows that it may not always be possible to identify in advance those employees properly included in this unit, partly because employees performing essentially the same functions are classified differently in different hospitals. Thus, for example, in Los Angeles and San Francisco all employees represented by the IUOE in skilled maintenance units are classified as stationary engineers regardless of their particular job functions (Viat, 3457–58; Hach, 5318) whereas in Chicago, New York, and New Jersey most health care employers have retained craft titles for their employees. (Schloop, Chi II 203; Schloop affidavit; Hach, 5318; Giblin, 5383.) In addition, many skilled maintenance classifications are subdivided by skill or experience level, e.g., master level, journeyman level, apprentice, and/or helper. Among the employee classifications which should generally be included in such units are carpenter, electrician, mason/bricklayer, painter, pipefitter, plumber, sheetmetal fabricator, automotive mechanic, HVAC [heating, ventilating, and air conditioning] mechanic, maintenance mechanic, chief engineer, operating engineer, fireman/boiler operator, locksmith, welder, and utility man. (Health Care Occupations: A Comprehensive Job Description Manual, Chapter XXXII; Hammond, Exh. 12, affidavits of Bowen, Tighe, Chambers, Scheb, McWade, Scadden, Kelly, Schloop, Gindorf, Fox, Lane, Belfi, and Bess.) As noted above, sometimes relatively unskilled utility workers are included, either if they are involved in the maintenance, repair, and operation of hospitals' physical plant systems (Viat, 3460), or if they are part of a separate maintenance department. This list is not exhaustive; rather, it is illustrative of the types of employee classifications exhibiting the characteristics which the rulemaking record shows are typical of employees included in skilled maintenance units. Because of this variation, in some instances it may be necessary to decide by adjudication the unit placement of individuals in particular job classifications. However, this is also true with respect to technical and business office clerical units, for example. It does not defeat the basic appropriateness of the unit as found in this rulemaking proceeding.

X. Business Office Clericals

A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that business office clericals should be included in a unit of service and maintenance employees, rather than represented in a separate unit. 52 FR 25147. Among the reasons for including business office clericals in the broader service and maintenance unit were that they:

(a) Often share many terms and conditions of employment with service and maintenance employees;
(b) Have regular and frequent contact with service employees;
(c) Are engaged in recordkeeping as are ward clericals, technicians, nurses, and physicians;
(d) Have not been represented historically by labor organizations specializing in representing business office clericals; and
(e) Their inclusion in the broader unit will help unit proliferation.

After carefully considering the evidence amassed during the hearing, contrary to our tentative determination we have concluded that for the following reasons the business office clericals constitute a separate appropriate bargaining unit.

B. The Record Supports a Finding That Business Office Clericals Constitute a Separate Appropriate Unit

1. *Job duties and functions.* Evidence from the rulemaking hearings shows that although many hospital employees perform some recordkeeping functions, business office clericals perform substantially different functions from those performed by other employees (WS Holtz at 8–9; WS O'Neil at 1 & 5526–29). Business office clericals are primarily responsible for a hospital's financial and billing practices (WS Winn at 6–7), and deal with Medicare, DRGs, varying price schedules, multiplicity of insurance types, and new reimbursement systems (WS Schoen at 9; Berliner, 5599–5600). Increasing computerization of financial management has led to specialization and has reduced the clerical duties of other hospital employees (WS Schoen at 11).

One argument advanced by some employers is that many different professional and non-professional classifications use computers; 2/3 of the hospitals are considering information systems technology which will enable nurses to enter and read programs reporting patients' test results, medication, and scheduling (AHA Br. 45 citing article in *Modern Healthcare*). Unlike these employees, however, business office clericals do not engage in any form of patient care and are not responsible for the patients' physical or environmental health (Wilkinson, 4973–76; Bryant, 116–118). Moreover, although other clerical and professional employees may be utilizing information systems technology and video display terminals (VDTs), and despite the existence at the University of Alabama (Birmingham) of a training program for "clerical technicians" who learn to do billing, perform blood tests, and take x-rays (AHA Br. attachment 5), it has not been shown that service workers or clinical technicians perform functions similar to those performed by the business office clericals, i.e., they are responsible for selecting, completing, or interpreting business forms using computers, keyboard terminals, and typewriters. Nor was it shown that the University of Alabama program was duplicated elsewhere in the country, or that any person from the program was ever placed in a hospital. (AFL Br. 77). Moreover, the evidence indicates that this program was clearly intended for technical employees (Stickler, Chi I 37–38).

2. *Education.* Business office clericals generally are required to have a higher level of education than service and maintenance employees, i.e., a high school diploma and specific clerical skills, and a majority of business office clericals have some college background and formal clerical training (WS Nussbaum at 2; WS Cornfield at 6). Moreover, because of the increased complexity of the hospitals' financial operations, including the introduction of DRGs, hospitals have begun to require more training for business office clericals, and to require skills in such areas as programming, coding, abstracting, and billing procedures (WS Schoen at 9; WS Ryan at 1–2). By contrast, service workers have minimal educational requirements, prior work experience is unnecessary, and they are not required to possess special business-oriented skills (AFL Br. 53; WS Cornfield at 8). There is some evidence that admitting clerks and medical records librarians receive vocational training at many of the same business or trade schools as purchasing clerks and accounts receivable clerks (WS Coney at 5). However, no specific evidence was provided regarding the type of training each receives. The fact that some employees are attending the same schools does not establish that they are receiving identical training. Consequently, we do not place great weight on this factor; in any event, whether some of these other

classifications are also business office clericals is a matter we do not here decide. Further, business office clericals undergo constant retraining to update current skills or acquire new skills as financial operations are updated (WS Holtz at 5, 9–10).

3. *Terms and conditions of employment.* Although clericals often share some terms and conditions of employment with non-professional employees, especially benefits, evidence from the rulemaking proceeding clearly shows other, significant differences between the business office clericals' terms and conditions of employment and those of the service and maintenance employees. Salaries paid to business office clericals reflect their higher skills and training; a 1985 BLS wage survey shows that business clericals on average earn $2,000 more than the top service jobs (WS Schoen at 12; WS O'Neil at 3). Unlike service and maintenance employees, business office clericals may be permitted to smoke and eat at work stations, and have different dress requirements and health and safety concerns. In addition, unlike most service employees who work varying shifts and weekends, business office clericals generally work one shift, 5 days per week. (AFL Br. 59; WS Nussbaum at 5; Bryant, 116–118; Booth, 3686; WS O'Neil at 2.)

4. *Supervision.* The differences in skills and functions are underscored by the separate supervision of business office clerical departments, which has resulted from the almost universal centralization of business office functions (Berliner, 5597; WS Schoen at 9–10 & 5173). The SEIU survey of 250 facilities showed that at 100% of the facilities, business office clericals have separate supervision. Although clericals occasionally may share supervision with other non-professionals (Briguglio, 5300), the evidence establishes that business office clericals regularly have a separate supervisory hierarchy; ultimate supervisory responsibility generally rests with financial administrators as compared to the ultimate supervisory authority for service employees which rests with administrators overseeing patient care (WS O'Neil at 2; WS Holtz at 4, 6–7). Two examples were given in which clericals and other employees report to the same individual (Briguglio, 5300; Comment 157, Halifax Medical Center). Nevertheless, we are persuaded that, with few exceptions, business office clericals are separately supervised. Moreover, in one important respect, the nature of the supervision received by the business office clericals is unlike the traditional supervision received by service and maintenance employees. Technology enables supervisors to monitor closely the output of the business office clericals, measured in keystrokes, paper output, volume of bills processed, time on terminals, and phone calls; this monitoring increasingly is used for purposes of discipline. (WS Holtz at 6–7; WS Nussbaum at 2–3.)

5. *Interaction.* Contrary to our original impression, the evidence shows that business office clericals are physically isolated from other non-professional employees and, therefore, have little contact or interaction with them. (Dretchan, 5002; Bryant, 116–118; Booth, 3689–90; WS Nussbaum at 4). The ballooning costs of new construction, as well as increased technology, have resulted in many instances in hospitals' moving administrative offices outside the health care facility into existing buildings at other locations (Berliner, 5602; WS Schoen at 10). Of 250 hospitals surveyed, 35% of the business offices are located in a separate building, 25% are located in a separate wing of the hospital, and 28% are located on a separate floor (WS Shea at 17; WS McKenna at 3–4). Further, centralized processing of information and the increasing use of computerized communication of data continue to reduce even further the potential for physical interaction (WS Schoen at 14).

6. *Career paths and job mobility.* Business office clericals have few avenues of advancement within health care facilities; rather, they have a separate and increasingly well-defined external labor market (Wilkinson, 4980; WS Ryan & 4749–50). Business office clericals are hired almost exclusively from the external labor market, and hospitals hire business office temporaries as replacements rather than using other hospital personnel. The external market also influences salary scales since hospitals compete with other industries for these employees. (WS Schoen at 11–12; hospitals use BLS wage surveys in determining salaries for business office clericals.) Consequently, while service employees generally remain in health care facilities (WS Berliner at 9–10), business office clericals look elsewhere for other positions if they are dissatisfied.

There is minimal interchange, either permanent or temporary, between employees in service, maintenance, technical or professional jobs and those in business office clerical positions (Ryan at 1–2). Moreover, although one witness testified generally that some clericals receive training to provide direct patient care (Stickler, 16–17 & WS Rhodes at 7), there were no examples of instances where this had actually occurred. There would appear to be little cross-over from clerical positions to patient care positions. Further, the evidence reveals that job mobility between service employees and business office clericals is basically nonexistent and, with the upgrading of skills and additional training received by business office clericals, it is becoming even less feasible (WS Lewis at 2–3; WS Blake at 2; WS O'Neil at 2; WS Berliner at 7). In some hospitals, admitting clerks and medical records librarians, and purchasing clerks and accounts payable clerks are interchangeable and may substitute for each other, and technicals and professionals may handle clerical operations on the night shift (WS Coney at 5; Comment 263, Huntsville Memorial Hospital). Nevertheless, for the most part, even clinical clerical workers cannot shift into business office clerical positions without a substantial degree of retraining and reskilling (WS Berliner at 7). There was testimony that hospitals prohibit or discourage bidding between the business office clerical and service and maintenance positions; however, even where hospital-wide posting of vacancies is required and employees use their seniority to bid, there is little cross-over between service and maintenance employees and business office clericals (WS Shea at 18; WS Roitman at 1.)

7. *History of representation.* The appropriateness of separate business office clerical units is supported by a history of representation separate from service and maintenance employees. For example, at 250 hospitals surveyed by SEIU, business office clericals sought representation in 71 hospitals, of which 46 were separately organized, compared with service employees who organized in 195; a survey conducted by NUHHCE of 200 post-1974 elections in 100-plus bed hospitals showed 37 involved business office clericals, of which 33 were separate units (WS Shea at 15–16; Muehlenkamp, 4767–70). There are 92 separate business office clerical units represented by AFL affiliates in private sector hospitals. (AFL Br. App. A). Local 1199 had no combined non-professional units until *St. Francis II* (Friedman, 5035–41). Although there are business office clericals represented in combined service and maintenance units (Stickler, Chi I 23–31 giving examples), some combined units may have resulted from an effort to minimize delay or to comply with *St. Francis II* (AFL Br. 70). The weight of the evidence establishes that business office clericals predominantly have been separately represented.

8. *Bargaining interests.* While all employees have some similar bargaining concerns, i.e., wages, hours, and fringe benefits, business office clericals have a number of different interests, e.g., pay equity, performance monitoring, productivity standards, career mobility, automation, and VDT stress, as opposed to concerns of service employees such as job security, subcontracting, economic survival, supplies, shift rotations, infectious disease, injuries, and patient care (WS Nussbaum at 3; WS Lewis at 2; WS Holtz at 12–13; WS Barton at 1; AFL Br. 64–65).

Despite the differences, in some instances business office clericals have bargained jointly with other non-professional employees and contracts have covered both non-professional employees and business office clericals. In 1987, Mercy Hospital negotiated a contract which included over 50 classifications in one overall non-professional unit (AHA Br. attach. 15) (One classification included such jobs as accounting clerk and lab department secretary and both received identical wage rates and wage increases for the duration of the contract). See also Comment 162, AMI; Saporta, 5142; Comment 154, Michael Reese Hospital, for other examples. However, in some cases where business office clericals negotiated together with service employees and the resulting contract provided for identical terms and conditions of employment, wages and upgrade negotiations often remained separate, and clericals had different bargaining representatives. In one instance incentive bonuses tied to receivables were offered only to business office clericals, and in others the contracts contained separate wage schedules for business office clericals. (WS Holtz at 10; WS McKenna at 3–4.) At Roosevelt Hospital, although the union bargained jointly for clericals, technicians, and service and maintenance employees, the clericals had their own bargaining delegates, contracts for business office clericals and service and maintenance employees were administered separately, and there was no interchange of delegates or exchange of grievance handling (Colbert, 5020–22).

9. *Proliferation.* Contrary to our concern, as expressed in the NPR, there was no evidence adduced at the rulemaking hearings indicating that a separate unit of business office clericals will lead to the proliferation of bargaining units in the industry. The admonition against proliferation of units was directed toward problems that might be caused by having many separate bargaining units, i.e., substantial numbers of strikes interfering with the delivery of health care services, wage whipsawing, and jurisdictional disputes. There is no evidence that the existence of a separate unit of business office clericals would result in such problems. There were no examples of sympathy strikes by business office clericals in support of service and maintenance employees, and no examples of leapfrogging because of a separate business office clerical unit. (WS Wynn at 3.) In one hospital as to which there was testimony about separate units, there was no evidence of jurisdictional disputes. (WS Gray at 4; Michael Reese Hospital). One argument advanced was that because a business office clerical unit will not include all clerical classifications, e.g., ward clerks, there is a potential for conflicts between clerical groups. There was no evidence of specific examples, and we accord no weight to the theoretical possibility of a conflict.

10. *Legal Precedent.* Legal precedent supports finding separate business office clerical units appropriate. The Board has recognized the appropriateness of separate business office clerical units in every other industry covered by the Act, and until *St. Francis II,* in the health care industry. See e.g., *Armour & Co.,* 15 NLRB 268 (1939); *Legal Services for the Elderly Poor,* 236 NLRB 485 (1978); and cases cited in AFL Br. pp 71–72. From 1974–1984, the Board did not find any business office clerical unit to be inappropriate (See NLRB Exh. 5, revised). Moreover, Senator Taft's industry-sponsored bill would have explicitly provided for separate office clerical units.

In *Baker Hospital,* 279 NLRB No. 38 (Apr. 16, 1986), the Board required the inclusion of business office clericals in a unit of service and maintenance employees. In so doing, the Board found that business office clericals and service and maintenance employees received the same fringe benefits and were covered by the same personnel, salary, promotion, seniority, transfer, and disciplinary policies. The Board also found that there was a significant amount of contact between clericals and unit employees. The Board held, therefore, that there was an insufficient disparity of interests between business office clericals and service and maintenance employees to justify excluding the clericals from the unit. After considering the substantial empirical evidence adduced in the rulemaking proceeding, we find it unlikely that we would reach the same result. The evidence from the hearings shows that business office clericals constitute a distinct group of employees. They perform substantially different functions, have a greater degree of education and training, utilize different skills, are separately supervised, receive higher wages, have a number of distinct bargaining interests, have little or no interaction or interchange with other employees, and frequently are located in geographically separate offices.

11. *Identification of business office clericals.* The evidence from the hearings indicates that there may be other clericals, e.g., ward clericals, medical records clericals, physicians' secretaries, and admitting office clericals who perform functions similar to those performed both by service employees and business office clericals or else perform a combination of functions such that they cannot be readily classified as one or the other. To date, however, the Board has decided the placement of these categories of employees on a case-by-case basis, generally excluding these classifications of employees from business office clerical units. See *Mercy Hospital of Sacramento,* 217 NLRB 765 (1975). There, the Board found a separate unit of business office clericals appropriate, and placed ward clericals in another unit because their work was more closely related to the function performed by personnel in the service and maintenance unit. The precise placement of particular classifications which may be disputed in a particular case is, for the time being, left to the case-by-case adjudicative approach.

C. Conclusion

Business office clericals share some terms and conditions of employment with all other service and maintenance employees, have occasionally participated in joint bargaining, and may even have been covered by the same contracts. However, we are more persuaded by the evidence developed at the hearing as to their separate supervision, their different and specialized skills and education, their minimal interchange and contact, their different career paths and job markets, their maintenance of a separate identity even where bargaining was in a larger group, and, finally, the recent development whereby more and more business office clericals are being moved out of the hospital to different buildings or facilities. We believe that the weight of the evidence strongly supports finding separate business office clerical units appropriate.

XI. Other Non-Professionals

Based on our analysis of the evidence adduced, we have found appropriate separate units of technicals, business office clericals, and skilled maintenance employees. All remaining service and non-professional employees [24] shall, therefore, constitute a separate appropriate unit, where requested.

XII. One Hundred Bed Distinction

The proposed rule suggested establishing a different unit configuration for hospitals over 100 beds than for those of 100 beds or fewer based on the Board's belief that hospital size (as determined by the number of beds) was correlated with integration of labor, and that smaller hospitals were more functionally integrated than larger hospitals, and could function with fewer, broader units. However, the record does not support that belief, and the Board has concluded that its rule regarding units in acute care hospitals should apply regardless of hospital size.

The vast majority of representatives of both unions and employers appeared to agree that hospital size is not well correlated with integration or division of labor, and opposed a rule differentiating between large and small hospitals. Examples of unions opposing the distinction were: AFL Br. 139–140; ANA 4919–20; SEIU, 5215; Hospital Professionals and Allied Employees of New Jersey, 125. Over 40 employers registered specific or general criticism of use of a 100 bed distinction, including AHA, Br. 48; League of Voluntary Hospitals, 226–229, 254; Hospital Council of Western Pennsylvania, 4395; Comment 5, Holy Redeemer Health Systems; Comment 15, Methodist Health Systems; Comment 25, Bradley Memorial Hospital; Comment 78, Greater Cincinnati Hospital Council; Comment 82, Humana, Inc.; Comment 104, St. Francis Hospital. Experts in the field agreed with the parties' position (Rosen, 4663; McKinney, 5519–20). Only a handful of commentators supported the use of any distinction based on the number of beds. For example, Comment 11, National Rehabilitation Hospital; Comment 105, Mass. Hosp. Assn.

A survey by UFCW comparing the number of beds and the staffing in hospitals of varying sizes in five states showed a wide variation in staff size (UFCW Exh. 6–11). For example, in New York State, among 46 hospitals surveyed with 20–100 beds, one hospital with 20 beds had over 200 employees, one with 21 beds had 50 employees, one with 20 beds had 209 employees, while another with 129 beds had 181 employees. (UFCW Exh. 11). In California, one hospital with 107 beds had 1011 employees, while another with 110 beds had 299 (UFCW Exh. 6). In Illinois, hospitals with 77 and 91 beds had 279 and 429 employees, respectively, while another hospital with 129 beds had 126 employees (UFCW Exhs. 5, 6). Similar variations, and lack of correlation, appeared throughout the exhibits.

Lack of correlation between number of beds and number of employees may be attributable to specialization or the amount of outpatient services (UFCW Exh. 1–11; WS Willman & 4500; Rosen, 4663; AFL Exh. 20). Thus, it appears that staffing size and patterns might correlate more closely with the nature of services than with bed number (AHA Br. 47; New Jersey Society for Health Care Human Resources Administrators, 439).

The AHA correctly noted that the Board's proposal for a 100 bed distinction did not clarify how it defined the term "bed" (AHA Br. 47). The record shows that there are several meanings of the term in health care facilities. A bed may be licensed or unlicensed; if licensed a bed may be occupied or unoccupied (AHA Br. 47; Comment 52, Hillcrest Baptist Medical Center). Hospitals may change the number of licensed beds more than once a year (California Association of Hospitals and Health Systems, 3229). Occupancy rates vary; a hospital may have occupancy substantially below the number of its licensed beds (Comment 1, Lancaster Fairfield Hospital; Comment 115, National Healthcare, Inc.: rural areas may have only 25–30% patient census). The number of staffed beds (based on average projected occupied beds and patient acuity) can differ from the number of occupied beds (Comment 186, Hiawatha Community Hospital; Comment 191, Trinity Lutheran Hospital.) Beds may also include swing beds (beds that swing between acute care and nursing or long-term care) (Missouri Hosp. Assn., Chi II 265).

The Board also notes that to the extent unions and employers addressed the standard to be used if the Board determined to have a bed-number distinction, they rejected the use of 100 beds as an appropriate bed measure but did not reach a consensus as to the appropriate number of beds to use. For example, some unions suggested using the definition of small hospitals employed by the U.S. Department of Health and Human Services in calculating reimbursements under Medicare, which is those hospitals with fewer than 50 licensed beds. (AFL Br. 141; WS Sweeney.) The AHA suggested a 400 bed cutoff (AHA Br. 141), but other employers suggested 250 beds (Comment 169, Columbus Hospital); 300 beds (Comment 126, Arlington Memorial Hospital); 450–500 beds (Comment 1, Lancaster Fairfield Hospital); and 500 beds (Comment 11, National Rehabilitation Hospital).

The Board's decision to drop the 100 bed distinction is based on the evidence provided by the parties regarding the lack of correlation between bed number and hospital staff, the multiplicity of definitions for the term "bed" in health care, the lack of consensus on the number of beds dividing large and small hospitals, and the parties' general opposition to use of a distinction based on the number of beds.[25]

XIII. Nursing Homes

The only health care facility, other than hospitals, covered by our proposed rule was nursing homes. In so doing, we tentatively determined that the appropriate bargaining units for this type of health care facility should be the same as that for small hospitals, i.e., (1) all professionals, (2) all technicals, (3) all service, maintenance, and clericals, and (4) all guards. After careful consideration of all the evidence presented at the hearings, however, we have concluded that the rule should not apply to nursing homes.

To a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered. Generally speaking, there are three basic types of nursing home facilities: skilled nursing, intermediate care, and residential care. Skilled nursing homes provide 24-hour inpatient nursing care to chronically ill or stable convalescent patients, are state licensed, and are eligible for both Medicare and Medicaid. Intermediate care facilities also provide 24-hour inpatient care, but care is less intensive and more oriented to daily living. These homes are also state licensed or certified but are eligible only for Medicaid. Residential care facilities meet only social needs, not medical, and are not licensed. (Durham, 3164–66, 69, 71, 83; Comment 155, Indiana Healthcare Assn. (IHA).) The facilities range in size from 10–500 patients (Harris, 4294; Comment 284, Ryan). One-third have a capacity for fewer than 50 residents,

[24] Excepting guards, of course, who must be placed in a separate bargaining unit. See section 9(b)(3) of the Act.

[25] We note, parenthetically, that the information we have acquired as to the relationship between staffing and number of beds most likely would not have been acquired in an adjudicatory proceeding, and provides further evidence of the value of rulemaking in obtaining industry-wide information unavailable in a case-by-case approach.

one third for 50–99, and one-third for over 100 (Harris, 4304).

Unlike hospitals, nursing homes are populated primarily by the elderly and provide long term care rather than medical treatment of a specific illness. Consequently, nursing home staff are concerned not only with their residents' physical well-being but also their social and psychological needs. Accordingly, there is less diversity in nursing homes among professional, technical and service employees, and the staff is more functionally integrated. (Harris, 4294–95; Willman, 4501–02.) Generally, nurses provide a less intensive, lower level of care to patients in skilled and extended care facilities, and thus receive lower salaries than that paid in acute care hospitals (AHA Br. 6–7 citing *Modern Healthcare,* Jan. 3, 1986). In addition, RNs in most nursing homes never administer oxygen or assist in surgery, and therefore generally have no interest in or need for acute care pay differentials or for specialization (Comment 155, IHA; Shepard, 4962). Also, there is for the most part little difference in the duties of LPNs and nurses' aides (Comment 155, IHA). Both are primarily responsible for providing nursing care to patients (Comment 155, IHA, affidavits of Miller and Price; AHA Br. 6 citing *Modern Healthcare,* Jan. 3, 1986). Indeed, almost no aspect of nursing home care is in the exclusive domain of any one group of employees (Harris, 4295). Thus, there appears to be a greater overlap of functions as well as greater work contact between the various nursing home non-professionals (Willman, 4501–02; Comment 155, IHA, affidavits of Townsend and Turner-Simpson).

Skilled care homes also differ from hospitals in that a ratio of 50 patients per nurses' station is ideal for nursing homes, whereas the typical ratio for acute care units is half that number (AHA Br. 7 citing *Modern Healthcare,* Jan. 3, 1986).

Also unlike hospitals, there are few professionals employed at nursing homes, and of those, most are RNs who serve as head nurses or charge nurses primarily performing administrative duties (Durham, 3190; Willman, 4501–02; Saporta, 5145–46; Bullough, 4656–57; Comment 155, IHA, affidavits of Davy, Townsend, Turner-Simpson, and Higdon). There are also few business office clericals. In a typical 100 bed nursing home, the business office will have one or two employees. In a 100 bed acute care hospital, the office consists of payroll employees, accounts receivable and payable employees, data processing employees, and others. (Comment 155, IHA.)

Greater differences in the size and purpose of nursing homes have resulted in greater differences in their organization, regulation, and staffing patterns. For example, in very large homes, business office clericals may be physically separated from the home, and have little employee or patient contact. In very small homes, the business office is located next to the patient care areas and there is continuous contact with the patient care staff. (Comment 155, IHA; Durham, 3166–67). Duties of staff also vary with the size of the institution. In a small, 10-resident facility, the staff will have overlapping responsibilities, and thus an overall unit would be appropriate. In a large, skilled care facility with specialized units (see *infra*), more than one unit might be appropriate (Harris, 4298). In an intermediate care facility which also cares for the mentally disabled as a result of trauma, there may be a separate group of employees, such as psychiatrists, who have distinct supervision and little contact with other professionals (Durham, 3170).

Although most homes are regulated by the state, regulations with respect to staffing patterns and employee qualifications vary widely from state to state (Harris, 4296–97; Comment 284, Ryan). For example, Connecticut requires more skilled nursing care than Iowa, and in some states, skilled nursing facilities must have 24-hour RN coverage. Seventeen states have mandated nurses aide training programs ranging from 20 hours to over 100 hours. A majority of states have no specific training requirements. In Massachusetts, the activity director and the social service director must have baccalaureate degrees; in other states, their formal qualifications are less than those of a nurses' aide. (Harris, 4297; Comment 284, Ryan; Comment 155, IHA.) Also in Massachusetts, as in other states, homes must be staffed by LPNs or RNs, and they are required to provide substantial direct patient care. In contrast, in Indiana, with lesser staffing requirements, nurses' aides provide direct patient care, and LPNs perform RN-type duties such as distributing medication and assisting doctors. (Comment 155, IHA.)

The nursing home industry is also in a period of rapid transition. It is currently undergoing enormous growth as the population of older persons increases and family responsibility for older parents lessens. In addition, many long term facilities will increasingly offer nontraditional specialized services, i.e., head and spinal cord injury units, intensive rehabilitation, sub acute care, Alzheimers, respiratory therapy, hospice care, nutrition, AIDS, home health care, and care for ventilator dependent patients. (Harris, 4299; Comment 284, Ryan; Durham, 3161; AHA Br. 6 citing *Modern Healthcare,* Jan. 3, 1986.) These services require different staffing needs. For example, in most Alzheimers' units, nurses' aides receive psychological training in order to respond properly to their patients' behavior, and LPNs are required to perform recreational, educational, and social activities that are normally done by service employees such as recreational aides. A head injury unit requires many more professionals than are usually present in a nursing home facility. An AIDS facility might need more counselors. (Harris, 4300–4301; Comment 284, Ryan.) The professional and technical staff in a specialized service area such as a coma unit may also be far more integrated than RNs and LPNs who work in the nursing area (Comment 306, Harris).

For some or all of the reasons discussed above, numerous witnesses were opposed to applying the rule to nursing homes (Durham, 3179; Harris, 4293–94; Comment 284, Ryan; Comment 155, IHA; Comment 155, IHA, affidavit of Miller; Comment 3, Jefferson Davis Nursing Home). Three witnesses would support a two unit approach (Comment 22, Louisiana Nursing Home Assn; Comment 27, Jefferson Manor Nursing Home; Comment 34, Lewisburg United Methodist Homes). Several commentators thought the Board lacked sufficient experience with respect to nursing homes to formulate a rule as to such facilities (IUOE Br. 2, fn 1; Durham, 3179; Harris, 4304). Board statistics show that only 20% of the elections in the health care industry have involved long term care facilities (Harris, 4302). Also, case-by-case determinations of appropriate units in nursing homes have not caused undue litigation (Comment 155, IHA). In fact, to the best of our knowledge there is not a single published case since the health care amendments in which the Board had to decide appropriate units in nursing homes, and no party testified that it had experienced problems with case-by-case determinations as to this issue.

In view of the evidence set forth above, we have decided to exclude nursing homes from the rule. The evidence shows that there are not only substantial differences between nursing homes and hospitals but also significant differences between the various types of nursing homes which affect staffing patterns and duties. In the absence of a

measure of uniformity of operation, it would be difficult to establish uniform rules with respect to appropriate bargaining units. It also appears that there is no need at this time for a rule with respect to nursing homes as there has been no prolonged litigation and no party has expressed any problems in this area. We, therefore, conclude that it is best to continue a case-by-case approach with respect to nursing homes. For those facilities which provide both hospital and nursing home services, if the facility is primarily an acute care hospital, it will be treated in its entirety as a hospital; if primarily a nursing home, it will be considered a home, and outside the rule. To do otherwise would further fractionalize bargaining within the facility, and cause more, rather than less, proliferation.

XIV. Specialized Hospitals

Some employers suggested that the Board make a separate rule for specialty hospitals, arguing that they are neither acute care hospitals nor nursing homes (Comment 172, New England Sinai Hospital; King, 4230–31). The evidence with regard to most of the specialty hospitals which participated in the rulemaking did not support a conclusion that there are fewer traditional distinctions between employee groups. However, the evidence demonstrated that psychiatric hospitals, are, for a number of reasons, in a category apart, and the Board has decided to exclude psychiatric hospitals from application of the rule.

Initially, the industry's claimed trend toward one-specialty hospitals is not supported by statistics. The AHA classifies 90% of U.S. private, acute care hospitals as general; of these, 98% are general medical and surgical hospitals and only 2% are pediatric or rehabilitation hospitals. Nine of the remaining ten per cent are psychiatric, a category apart. (AFL Exh. 7, 8.) In California, where the industry contends the trend is particularly strong (Dauner, 3206), there are relatively few specialized hospitals (Silberman, 3209–12).

Most of the comments submitted to the Board from specialty hospitals apart from psychiatric hospitals did not argue that these hospitals should be treated differently from general acute care hospitals. See for example, Comment 4, Le Bonheur Children's Medical Center; Comment 10, National Rehabilitation Hosp.; Comment 123, Children's Memorial Hosp.; and Comment 303, Children's Medical Center, Akron, regarding childrens' hospitals. Although Children's Medical Center of Dallas (Comment 276) states that in that hospital RNs integrate patient care with some other professionals, and Cardinal Glennon Children's Hospital (Comment 271) discusses use of the team approach, neither suggests that childrens' hospitals differ from general acute care hospitals for purposes of rulemaking. While Shriners Hospitals For Crippled Children (Comment 238) were unique in their method of obtaining funds and charging patients, they operate like other acute care hospitals, subscribing to the same rules of licensure and accreditation.

Two hospitals, Children's Hospital of Dayton and Children's Hospital of Cincinnati presented more details regarding the operation of childrens' hospitals (Testimony of Graybill, Sokatch; Comment 288, Graybill). There is evidence that childrens' hospitals have higher acuity and outpatient activities than general acute care hospitals, and as a result have more full time equivalent positions and higher budgets than comparably sized general acute care hospitals (Comment 288). There is also evidence that RNs have a somewhat higher level of interaction with other professionals, for example, interacting with respiratory therapists on ICU units and transports (Graybill, 4183), working on special teams like bone marrow transplants, interacting with pharmacists regarding allergies, and tube sequencing (Comment 288). Even assuming that respiratory therapists are professionals, a status the Board has rejected on some occasions, (see for example, *Samaritan Health Services*, 238 NLRB 629, 638 (1978)), the interaction of RNs with other professionals, including presence on teams, is similar to that shown in other hospitals, and RNs' duties were not shown to be different merely because they may work on teams. As in other acute care hospitals, most nurses in childrens' hospitals are directly or indirectly supervised by other nurses (Graybill, 4147–48, 4164).

Comments from rehabilitation hospitals show similar arguments to those made by general acute care hospitals: that there is increased contact between RNs and other professionals, that there is some cross-training and utilization, that teams are used, that a hospital has across-the-board personnel policies (Comment 172, New England Sinai Hospital; Comment 131, The Institute for Rehabilitation and Research). These commentators did not request special treatment for their hospitals. Of course, to the extent rehabilitation hospitals may be long term, they will not fall within the parameters of the Board's rule, *infra*, which applies only to hospitals whose average patient stay is less than 30 days.

Nor was there a suggestion made by commentators of other, non-psychiatric, single specialty hospitals that their type of hospital merited special rules. For example, the Board received evidence from Springfield General Hospital (Comment 201) and Oklahoma Osteopathic Hospital (Comment 300), both osteopathic hospitals, in opposition to the rulemaking, but not claiming a special status for specialty hospitals.

As noted above, the evidence received on psychiatric hospitals supports an exception for this specialty. Psychiatric hospitals constitute a substantial portion (9%) of private hospitals in the U.S. (AFL Exh. 7). Even the AFL, the only union which took a position on psychiatric hospitals, provided a mixed case for including these hospitals under the rule. Thus, while the AFL argued that psychiatric hospitals which provide short term care are acute care hospitals, it recognized that there is evidence to suggest that at least some professionals play different roles in psychiatric hospitals than in acute care hospitals (citing Albanese/Caswell, Chi I 148–165). Further, the AFL noted that the Board has treated psychiatric facilities differently from other hospitals. Thus, *Mt. Airy Psychiatric Center*, 253 NLRB 1003 (1981), was the only pre *St. Francis II* case in which the Board refused to find appropriate a separate RN unit. Finally, even the AFL acknowledged that the Board might wish to exclude exclusively psychiatric facilities from the rule. (AFL Br. 140, fn.).

The two main industry representatives who presented evidence on psychiatric hospitals strongly urged that psychiatric hospitals not be considered acute care hospitals for purposes of rulemaking. Most of the evidence submitted with regard to psychiatric hospitals came from the National Association of Private Psychiatric Hospitals (Comment 307, Thomas) and from Charter Medical Corporation (Albanese/Caswell, Chi I 148–165). The National Association represents a substantial majority of private psychiatric hospitals in the U.S. Charter Medical represents about 60 psychiatric hospitals. Therefore, the Board considers their evidence to be representative of psychiatric hospitals in general. The other employers representing psychiatric hospitals agree that psychiatric hospitals operate in a distinct manner (Comment 110, Charter Lakeside Hosp.; Comment 35, Massachusetts Chapter of the National

Association; Comment 29, Glen Eden Hospital; Comment 120, HCA Belle Park Hospital; Comment 168, Camelback Hospitals; Comment 298, Palo Verde Hospital).

The evidence showed that unlike other acute care hospitals, psychiatric hospitals do not provide patient care for the physically ill. RNs are not the primary facilitators of health care in psychiatric hospitals. Many professionals participate hands-on with patients. Regardless of which of three basic models a psychiatric hospital follows: medical, milieu, or combined, the programs are highly integrated. RNs' work is closely integrated with the work of clinical psychologists, counselors, social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators.

There are more professionals other than doctors and RNs in psychiatric facilities than in other acute care facilities. The ratio of RNs to other professionals is about 1:1 regardless of facility size. It appears that non-RN professionals would not have the same concerns about being outnumbered in an all-professional unit as they have expressed regarding organization in acute care hospitals.

Psychiatric hospitals also differ from other acute care hospitals in that there are more paraprofessionals (mental health workers), and all employees are specially trained in relating to the patients as all employees' actions have an impact on patient treatment.

Further, the evidence shows that Congress has distinguished between acute care general and psychiatric hospitals under Medicare by setting special Medicare certification requirements with respect to staffing, treatment planning, teams, etc.

For all these reasons, the Board has decided to exclude "primarily" psychiatric hospitals from its rule for units in acute care hospitals and to proceed as to them on a case-by-case basis. A number of acute care hospitals have psychiatric sections, however, and such hospitals are not thereby excluded from application of the rule unless the psychiatric sections predominate. Nor do we adopt the suggestion of the AFL that the exclusion be limited to hospitals that are "exclusively" psychiatric, as we deem such an exclusion to be too limited. See the definition of "psychiatric hospital" contained in 42 U.S.C. 1395 x (f).

XV. Partially Organized Facilities

In the first Notice of Proposed Rulemaking, we limited the applicability of the rule to petitions for initial organization, and commented that "historically the Board has required decertification petitions to be filed in the certified or recognized unit." (52 FR at 25145). By way of further explanation, the Board added that "when institutions are partially organized we assume that petitions for new units will follow the proposed rules, insofar as possible." (*Id.*)

As indicated *infra*, in Sec. XIX, Combined Units, the principle of *Campbell Soup Co.*, 111 NLRB 234 (1955), will continue to apply to decertification petitions. See also *Westinghouse Electric Corp.*, 115 NLRB 530 (1956). With respect to other types of petitions in partially organized facilities, we wish to amplify our previous remarks.

In the Second Notice of Proposed Rulemaking, "insofar as practicable" language [changed from "insofar as possible"] is now part of the proposed rule. However, there are two different possible situations we can envisage:

(1) Where existing units are in conformity with the new proposed final rule, we can foresee no reason that new petitions, for the same or other units, should not also be in conformity with the new rule.

(2) Where existing units are not in conformity with the new proposed final rule, we can anticipate a number of questions arising with respect to the applicability of the new rules. Where units smaller than those permitted by the rules already exist, may the incumbent petition for a residual unit? May another labor organization? What will be the continued viability of the principles enunciated in *Levine Hospital of Hayward*, 219 NLRB 327 (1975)? In Comment 304, Kaiser Permanente raised a number of these questions, claiming that "many health care employers, including Kaiser Permanente, currently have bargaining relationships with unions in units that are narrower than those set forth in the proposed rules." These issues have not been extensively addressed during the rulemaking proceeding, and it is the Board's judgment that their resolution should, for the time being, be deferred pending the adjudication of particular cases that present these issues. The Board will, in the adjudication of cases, attempt to apply the new rules to these situations insofar as practicable.

XVI. Facilities Covered

The Board stated in its proposed rule that the rule would apply to acute care hospitals, but did not define the term. Noting the concern of some commentators during the Board hearings with the absence of a specific definition, the Board has carefully reviewed a variety of sources in order to reach a definition. In particular, the Board has extensively searched Federal health care legislation, agency regulations, legislative history, industry reference materials, and hearing testimony for an authoritatively based and commonly understood distinction suitable to the goals of rulemaking in the health care industry. Research reveals that there is a commonly understood distinction between acute and long term care facilities, but that the terms are not statutorily defined as such.

The Public Health Service, for example, draws a distinction between acute care and long term care facilities for the purpose of administering special projects and grants (42 U.S.C.S. 296k(a)(4) and (7) (1985)), and for administering grants to nurse practitioners and midwife programs (42 U.S.C.S. 296m(a)(2)(A) (1985)). Various sections of the Social Security Act make the same distinction: e.g., for purposes of determining the scope of review of peer group organizations (42 U.S.C.S. 1320c–3(a)(4)(A) (1986)), and for determining the application of payment in accordance with state reimbursement control systems (42 U.S.C.S. 1395ww(c)(1)(A) (1983)). Despite the repeated use of the terms acute care and long term care, however, no statutory definition is provided.

In regulations promulgated by the Department of Health and Human Services, the agency principally responsible for administering health care legislation, there is also a distinction between acute and non-acute care facilities. The term "like [similar] hospital", for example, is used in reference to the special treatment given sole community hospitals and is defined as a "hospital furnishing short-term, acute care." (42 CFR 412.92(c)(2) (1987)).

Finally, a review of the extensive legislative proceedings surrounding health care legislation and related issues likewise reveals regular use of the acute care/long term care distinction, with the terms "short term hospital" and "acute care hospital" used interchangeably. Here again, though, the use of these terms is so commonplace that no specific definition is provided.

In light of this commonplace usage, but lack of statutory or legislative definition, the Board has adopted the definition of an "acute care hospital" provided by the Dictionary of Health Services Management, edited by Thomas Timmreck, Ph.D., 1982, National Health Publishing, Owings Mills, Maryland.

The Dictionary of Health Services Management defines an "acute care hospital" as a short term care hospital with an average length of patient stay of less than 30 days. This definition was also referred to with apparent approval by the AFL in this proceeding and is used by the American Hospital Association (AFL Exh. 20, AHA Guide to the Health Care Field, 1987).

The definition of a "psychiatric hospital" for the purposes of this rule shall be that set forth in 42 U.S.C. 1395x(f). According to that definition, a psychiatric hospital is an institution which:

(1) Is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) Satisfies the requirements of paragraphs (3) through (9) in the definition of a "hospital" in that statute [§ 1395x(e)];

(3) Maintains clinical records on all patients; and

(4) Meets certain staffing requirements found necessary by the Secretary.

Coverage for the purpose of this rule, then, will include all acute care hospitals as defined. A hospital is covered if its primary service is acute care, regardless of the presence of other non-acute care units at the same facility. Psychiatric hospitals, defined above and dealt with in section XIV, are specifically excluded from coverage. Also excluded are nursing homes.

As previously indicated, rehabilitation and drug-alcohol hospitals that meet the 30-day standard are tentatively included as the Board did not receive sufficient information during the proceedings to distinguish these facilities for the purposes of this rulemaking.

XVII. Decisions To Which Rule Applies

The NPR suggested that the Board's new health care rule would be effective "on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule)." In *St. Vincent Hospital and Health Center*, 285 NLRB No. 64 (Aug. 19, 1987), the Board indicated that while its proposed rulemaking procedure was pending, it would continue to make unit determinations in health care cases on a case-by-case basis utilizing the criteria set forth in *St. Francis Hospital*, 271 NLRB 948 (1984) ("*St. Francis II*"). The Board also reiterated that it would apply its new rule prospectively only to cases in which petitions were filed after the rule became effective. Based on comments received in the record, and upon further consideration, the Board has concluded that its rule regarding appropriate units in the health care industry shall apply to all decisions made on and after the effective date of the rule.

Representatives of unions urged the Board to revise the proposed prospective application of the new rule. One union suggested that the rule should be effective for all cases decided after the rule was published, even if the petition was filed prior to that date (ANA Br. 197). Unions suggested that it would be unsound, if not arbitrary, to disregard the rule in pending cases, considering the vast body of knowledge the Board now possessed by virtue of its rulemaking proceedings (ANA Br. 198, AFL Br. 145–146). The AFL asserted that to apply preexisting law would deny employees the right of self organization. The AFL noted that applying the rule retroactively would not have an ill effect on pending representation cases. The AFL also noted that the Board recently gave retroactive application to its decision in *John Deklewa & Sons*, 282 NLRB No. 184 (Feb. 20, 1987), enfd. *sub nom Iron Workers Local 3 v. NLRB*, 843 F.2d 770 (3d Cir. 1988). Further, the AHA and AFL noted that the Board applied its *St. Francis II* decision retroactively, and remanded many bargaining unit cases to regional directors for further consideration. (AHA Br. 203–204; AFL Br. 145.) ANA also noted the incongruity that could result if the Board enacted a rule that conflicted with pre-rule standards, e.g., finding a unit inappropriate that previously was appropriate. (ANA Br. 204 at n.115.)

The Board has decided that its rule on appropriate bargaining units in the health care industry should be applied to all decisions made on and after the effective date of the rule, which will be 30 days after publication of the final rule in the **Federal Register**. See APA, 5 U.S.C. 553(d). The Board agrees that it would be incongruous to apply the rule as originally stated; that is, only to petitions filed 30 days after publication. Such a rule would arbitrarily affect petitions filed just 1 or 29 days after the rule is published, and could conceivably lead to vastly different results based solely on the timing of the petition. However, the Board will apply its pre-rule standards to cases that issue prior to the effective date of the rule. As we indicated in *St. Vincent*, we deem it unwise either to decline to take any action on pending petitions, or to promulgate a new standard while rulemaking proceedings are pending. We continue to deem it contrary to statutory policy to hold cases pending effectuation of the Board's new rule. Accordingly, all cases that issue prior to the effective date of the rule will be analyzed under *St. Vincent*. If cases currently pending before the Board do not issue prior to the rule's effective date, the Board will not apply the rule *de novo* to such cases. Rather, the Board will, where necessary, remand such pending cases to regional directors to determine the need for a hearing or other appropriate course of conduct in order to permit parties to address the rule.

XVIII. Non-Conforming Stipulations

In the initial proposed rule, the Board stated that it would approve consent agreements providing for elections in accordance with the units set forth in the rule, and that no other agreements would be approved. Several commentators urged the Board to permit stipulated units even when they do not comport with those specified in the rule. We have been persuaded that permitting non-conforming stipulations, which are not prohibited by the Act, may, in many instances, better serve the interests of the parties, and perhaps even the Board. The Board therefore has tentatively decided to allow its regional directors to approve stipulations providing for elections in units not provided for in the rules.

It is the Board's established practice in other areas to permit parties to stipulate to the appropriateness of units and to various inclusions and exclusions if the agreement does not violate any express statutory provision or established Board policies. See, e.g., *SCM Corporation*, 270 NLRB 885, 886 (1984). This policy on stipulated units was extended to the health care industry in *Otis Hospital*, 219 NLRB 164 (1975). The Board there reasoned that it is consonant with the design of the Act to give the parties in representation proceedings the broadest permissible latitude to mutually define the appropriate unit. The Board stated that when the parties' perceptions coincide regarding unit appropriateness, in the absence of a statutory command or policy considerations within the Board's expertise, the Board is not the better judge. The Board noted in *Otis Hospital* that the legislative history of the 1974 health care amendments supports the application of general policy regarding stipulated units to the health care industry.

Our expertise acquired throughout this rulemaking proceeding gives us considerable pause with regard to stipulations not in accordance with our proposed rules. Thus, stipulations in conformity with these rules would surely be preferable. However, we recognize the possibility that the parties have their own reasons for preferring to bargain in some other configuration.

Moreover, we note that the majority of certifications issued in representation cases in the health care industry following enactment of the amendments followed either a consent or stipulated election and that these elections gave rise to challenges less often than directed elections. Annual Reports of the National Labor Relations Board, Tables 9, 11B. In view of Congress' concern with stability in health care labor relations, the importance of reducing unnecessary litigation, and expeditiously proceeding with elections, permitting stipulations, even when they do not conform to the Board's explicitly drawn units, seems warranted. For these reasons, we have decided that the reasoning of *Otis Hospital* should remain applicable despite this rulemaking proceeding.

To the extent a stipulation may later result in the creation of a residual group of unrepresented employees, the Board will address their representation concerns as it would those of other groups of residual employees present in partially organized acute care hospitals—on a case-by-case basis applying the rules insofar as practicable.

Despite our tentative decision to accept non-conforming stipulations, we expressly invite any interested party to comment further on this problem during the period provided for comments.

XIX. Combined Units

The Notice of Proposed Rulemaking provided that, in addition to the specified units, "any combination will also be appropriate, at the union's option and so long as the requirements of section 9(b) (1) and (3) are met." The reason for the reference to the union's option was that the union, as petitioner,[26] need seek only *an* appropriate unit. *Morand Brothers Beverage Co.*, 91 NLRB 409, 417–18, enfd. on other grounds 190 F.2d 576 (7th Cir. 1951); *Parsons Investment Co.*, 152 NLRB 192, 193 at fn. 1 (1966). It does not benefit an employer to have the option of showing that another unit, perhaps a combined unit, is also appropriate, or even more appropriate, since the appropriateness of an alternative unit is not the issue. *Parsons Investment Company, supra; Federal Electric Corporation*, 157 NLRB 1130, 1131-32 (1966). We therefore reject arguments by some employers that it is unfair to give only unions the option of combining units. (See, e.g., AHA Br. 49; Comment 258, Durham, attorney for California Association of Health Facilities.)

However, upon reflection, we believe that we defined too broadly a union's option to seek, alternatively, combined units. In the NPR, as indicated, we implied that *any* combination of the enumerated units would also be appropriate; after giving this matter further thought, we believe that we have insufficient evidence at this time to say that, *per se*, all combinations will be found appropriate. We believe this is a matter we will have to decide in the course of individual cases, by adjudication. While there are some combinations that, while not required under these rules, would obviously be appropriate, such as all professionals, or all non-professionals, there may be other, more unusual combinations that need to be examined for appropriateness. We meant to say only that combinations of the enumerated units are not thereby precluded, and we have therefore modified the rule to provide that combinations "may" be appropriate.

XX. Extraordinary Circumstances Exception

The Board has, in order to ensure satisfaction of parties' due process rights,[27] included in both the proposed rule and the final rule an exception for "extraordinary circumstances." The exception has been provided to allow for the possibility of individual treatment of uniquely situated acute care hospitals, so as to avoid accidental or unjust application of the rule.[28] However, the Board wishes to emphasize that while the rule does not, therefore, conclusively establish invariable parameters of bargaining units in the industry, our intent is to construe the extraordinary circumstances exception narrowly, so that it does not provide an excuse, opportunity, or "loophole" for redundant or unnecessary litigation and the concomitant delay that would ensue. The Board has considered fully and at length all evidence presented and arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between acute care hospitals, some of which are enumerated below, are matters which would qualify for litigation under the special circumstances exception; rather, they are merely minor differences, inherent in the industry due to the multiformity of individual constituent institutions. The Board deems such variations to be ordinary, and hence by definition not extraordinary,[29] even in situations in which such variations may be highly unusual.[30]

Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nation-wide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building. Except as specifically noted elsewhere (e.g., exclusion of psychiatric hospitals and nursing homes from coverage by the rule), the Board has concluded that none of the arguments raised in the course of the rulemaking procedure, including those listed above,[31] alone or in combination, constitutes an "extraordinary circumstance" justifying an exception from the rule.

The Board is well aware that facilities will, and do, differ in some respects; however, as we observed in the NPR (52 FR 25144), it is the Board's considered judgment, after issuing health care decisions by adjudication for more than

[26] If the employer is the petitioner (RM petition), its petition must seek the unit requested by the union. *Wm. Wood Bakery*, 97 NLRB 122 (1951); *Restaurant & Tavern Owners Association of Salem*, 126 NLRB 671 (1960). If the petition seeks decertification, it must be filed in the certified or recognized unit. *Campbell Soup Co.*, 111 NLRB 234 (1955).

[27] See *Chemical Manufacturers Assn. v. Natural Resources Defense Council*, 470 U.S. 116, 133 n.25 (1985); *Heckler v. Campbell*, 461 U.S. 458, 467 (1982); *FPC v. Texaco, Inc.*, 377 U.S. 33, 40 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956); *National Broadcasting Company v. United States*, 319 U.S. 190, 225 (1943); *WAIT Radio v. FCC*, 418 F.2d 1153, 1157 (D.C. Cir. 1969); 1 C. Koch, *Administrative Law and Practice* § 4.112 at 321–23 (1985).

[28] Cf. *National Nutritional Foods Assn. v. FDA*, 504 F.2d 761, 784 (2d Cir. 1974), cert. denied 420 U.S. 946 (1975), citing *The New England Divisions Case*, 261 U.S. 184, 204 (1923).

[29] See *Bollman v. Indianapolis Machinery Co.*, 150 Ind. App. 296, 276 N.E.2d 606, 613 (1971); *Black's Law Dictionary* 527 (rev. 5th ed. 1979), and cases cited therein.

[30] See *Kugler v. Helfant*, 421 U.S. 117, 125 (1975).

[31] The arguments listed were selected by way of example and not by way of limitation, and were chosen merely as being illustrative of the Board's intent.

13 years, that acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units.[32] Moreover, to the extent that the rulemaking hearings demonstrated that at least in some respects acute care hospitals do vary, the Board has made a judgment that, in this area of establishing appropriate units, "[d]etailed analyses of all the facts of the particular case are just not that enlightening," [33] and that the policies of the Act would better be effectuated by the establishment of appropriate units in the enumerated segments of this industry by exercise of the Board's section 6 rulemaking authority.[34]

To satisfy the requirement of "extraordinary circumstances," a party would have to bear the "heavy burden" to demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding," [35] as, for instance, by showing the existence of such unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, that it would be unjust [36] or an abuse of discretion [37] for the Board to apply the rules to the facility involved.

The Board, contrary to some industry representatives (e.g., Comment 148, Mississippi Hosp. Assn.), anticipates that litigation under the "extraordinary circumstances" exception will be rare; the AHA, representing the largest group of health care employers in this proceeding, has indicated it understands that the Board intends to limit exceptions to "truly extraordinary situations" (AHA Br. 55–56), and neither the AHA nor any other employer (or union) representative has raised objections to the Board's stated intent.

In most instances, should a facility claim it comes within the "extraordinary circumstances" exception, it should present an offer of proof to the Hearing Officer, who will then either permit the requested evidence to be adduced or, we anticipate far more commonly,[38] refer the offer to the Regional Director, and, if requested, ultimately to the Board, for ruling.

XXI. Proliferation

As set forth in considerable detail, *supra*, the evidence taken during the rulemaking proceeding has convinced the Board, contrary to its earlier belief, that eight possible units (seven plus guards) should be found appropriate in acute care hospitals. In reaching this conclusion, the Board has carefully considered the Congressional admonition against proliferation set forth in the legislative history of the 1974 health care amendments as well as its own strongly-held view that the number of units found appropriate should not be so many as to lead to a splintering of the workforce into the myriad of occupations and professions found within the industry. The Board has examined the units found appropriate to ensure they are not so numerous as to create a never-ending round of bargaining sessions, and that each unit represents truly distinctive interests and concerns. A number of groups of employees found appropriate have separate labor markets. A thorough examination of the record in this rulemaking proceeding has satisfied us that the health care units established by the Board do not constitute proliferation either in terms of the legislative history of the amendments or in the context of the history or realities of the industry.

We believe that Congressional and industry concern with proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately. IUOE Br. 96–97: Legislative History of the Coverage of Non-Profit Hospitals Under the National Labor Relations Act at 113–114 (Senator Taft); Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973 at 175 (David Brekke, Colorado Hospital Association), 181 (O. Ray Hurst, Texas Hospital Association), 188 (William Whelan, California Hospital Association), Sidney Lewine, 138–139 (American Hospital Association), 563–564 (exchange between Senator Taft and Andrew Biemiller of the AFL–CIO). See also testimony in 1971 and 1972 hearings, cited in IUOE Br. 96–97.

By 1974, a number of state and agency decisions with respect to non-profit hospitals, and Board decisions with respect to proprietary hospitals, had permitted each profession, and in some cases each craft, to form a separate bargaining unit (See discussion in AFL Br. 2–3, 28). As stated in Senator Taft's proposal, Congress feared that patterns such as developed in construction and newspaper industries—wherein units were permitted for each craft, resulting in 15–20 or more units—would result in separate units for the equally, if not more, numerous classifications in a hospital. We find no evidence that Congress opposed a smaller number of units. Thus, Senator Taft's proposal, containing special rules for the health care industry, would have established five units as presumptively appropriate: Technical, clerical, service and maintenance, all professional, and guards, two more than the statutorily mandated three units (professional, non-professional, and guards). The Board's addition of three units, RNs, physicians, and skilled maintenance, raising the total number of proposed possible units to eight, still constitutes half or fewer of the number of units that seem to us to have concerned Congress.

Furthermore, the record shows that the hospital industry understood proliferation to mean a much greater multiplicity of units than is proposed here. The League of Voluntary Hospitals of New York, an association of 54 nonprofit medical centers, hospitals, and nursing homes, and the largest organization of its kind in the country, supported the 1974 amendments because the League wished to remove itself from New York State health care coverage under which there were potentially 15–20 or more units in a health care facility (WS Abelow). Indeed, the American Hospital Association proposed a five-unit configuration: Professional, technical, clerical, service and maintenance, and guards. Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973, Sidney Lewine, 140.

There is little evidence that the number of units proposed by the Board will result in proliferation or in the problems perceived to arise from proliferation. The units proposed by the Board are only potential units. Indeed,

---

[32] See, e.g., NLRB Exhibit 5, revised, showing that for the 13 years since passage of the health care amendments, variations among facilities and their methods of operation had virtually no effect on the Board's ultimate decisions reached following frequently lengthy, case-by-case adjudications as to appropriate units.

[33] Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105, 107 (1981).

[34] See *Cummins* v. *Schweiker*, 670 F.2d 81, 83 (7th Cir. 1982).

[35] *Basic Media, Ltd.* v. *FCC*, 559 F.2d 830, 834 (D.C. Cir. 1977). Accord, *P & R Temmer* v. *FCC*, 743 F.2d 919, 930 n.11 (D.C. Cir. 1984); *Industrial Broadcasting Co.* v. *FCC*, 437 F.2d 680, 683 (D.C. Cir. 1970). See also *WAIT Radio* v. *FCC*, 459 F.2d 1203, 1207 (D.C. Cir. 1972), cert. denied 409 U.S. 1027 (1972); *WAIT Radio v.* FCC, 418 F.2d 1153, 1157 (D.C. Cir. 1969).

[36] *National Nutritional Foods Assn. v. FDA*, 504 F.2d 761, 763 (2d Cir. 1974), cert. denied 420 U.S. 946 (1975).

[37] *P & R Temmer* v. *FCC*, 743 F.2d 919, 929 (D.C. Cir. 1984); *Ashland Exploration, Inc.* v. *FERC*, 631 F.2d 817, 823 (D.C. Cir. 1980).

[38] See 1 C. Koch, *Administrative Law and Practice* section 4.112 at 323 (1985).

two of the units, physicians and guards, are rarely sought. A successful organizing effort in one unit in a hospital does not appear to have a ripple effect causing further organization. The record shows that from the 1974 health care amendments until the Board's 1984 decision in *St. Francis II*, most health care units fell into the categories now proposed by the Board. However, the majority of organized hospitals only had one unit, and about 80% had three or fewer units. (AFL Exh. 5 p. 1; SEIU, WS Shea, Table 2.) Nor, as detailed *supra*, was there a showing that the configuration of units proposed by the Board have resulted in an increased number of strikes, jurisdictional disputes, or other disruptions in the delivery of health care services.

Finally, as shown above, the empirical evidence submitted in these proceedings strongly supports the appropriateness of each of the units proposed by the Board.

For all the above reasons, we conclude that our proposal for seven units plus guards is not only well within our discretion, but also consistent with both our own and Congress' concerns about proliferation.

XXII. Docket

The docket is an organized and complete file of all the information submitted to or otherwise considered by the NLRB in the development of this proposed rulemaking. The principal purposes of the docket are: (1) To allow interested parties to identify and locate documents so they can participate effectively in the rulemaking process; and (2) to serve as the record in case of judicial review. As provided in the first NPR (52 FR 25148), the docket, including a verbatim transcript of the hearings, the exhibits, the written statements, and all comments submitted to the Board, is available for public inspection during normal working hours at the Office of the Executive Secretary in Washington, DC.

XXIII. Regulatory Flexibility Act

As required by the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, the Board certifies that the proposed rule will not have a significant economic impact on small entities. Prior to this rule, parties before the Board were required to litigate the appropriateness of a unit for election purposes if they could not reach agreement on the issue. Upon enactment of this rule, parties will no longer be required to engage in litigation to determine the appropriateness of units, thereby saving all parties the expense of litigation before the Board and the courts. To the extent that organization of employees for the purpose of collective bargaining will be fostered by this rule, thereby requiring small entities to bargain with unions, and that employees may thereby exercise rights under the National Labor Relations Act, as amended (29 U.S.C. 151 *et seq.*), the Board notes that such was and is Congress' purpose in enacting the Act and the health care amendments thereto.

XXIV. Regulatory Text

List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

For the reasons set forth in the prior pages, it is proposed to amend 29 CFR Part 103 as follows:

PART 103—OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: 29 U.S.C. 151, 156; 5 U.S.C. 500, 533.

2. Subpart C, consisting of § 103.30, is added to read as follows:

Subpart C—Appropriate Bargaining Units

Sec.
103.30 Appropriate bargaining units in the health care industry.

Subpart C—Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of this section: Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that various combinations of units may also be appropriate:

(1) All registered nurses.
(2) All physicians.
(3) All professionals except for registered nurses and physicians.
(4) All technical employees.
(5) All skilled maintenance employees.
(6) All business office clerical employees.
(7) All guards.
(8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.

(b) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate units set forth in paragraphs (a) (1) through (8) of this rule.

(c) Nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules about such matters.

(d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable.

(e) This rule will apply to all cases decided on or after the effective date of the final rule.

(f) For purposes of this rule, the term "acute care hospital" is defined as a short term care hospital in which the average length of patient stay is less than thirty days. The term "acute care hospital" shall include those hospitals primarily operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, or psychiatric care, but shall exclude facilities that are primarily nursing homes or primarily psychiatric hospitals. The definition of "psychiatric hospital" shall be as set forth in 42 U.S.C. Sec. 1395 x (f), Social Security Act. A "non-conforming unit" shall be defined as a unit not in conformity with paragraphs (a) (1) through (8) of this rule.

(g) Appropriate units in all other health care facilities: The Board will establish appropriate units in other health care facilities, as defined in section 2(14) of the National Labor Relations Act, as amended, on a case-by-case basis.

XXV. Dissenting Opinion

Member Wilford W. Johansen, dissenting:

As amply documented in the Notice of Proposed Rulemaking in the **Federal Register** on July 2, 1987, there has been no universal acceptance in the circuit courts of a standard for formulating appropriate units in the healthcare industry. Some courts have simply substituted their own judgment for that of the Board on the question of what constitutes an appropriate unit. Frequently a court has apparently supported its conclusion by a selective reading of portions of the legislative history of the 1974 Amendments. The

Board in turn has reacted first by trying to explicate that the differences might be "largely semantic" (*Newton-Wellesley Hospital*, 250 NLRB 409 (1980)), then by reversing field and adopting the test advocated by the Ninth Circuit (*St. Francis Hospital*, 271 NLRB 948 (1984) (*St. Francis II*)). That course in turn was roundly criticized by the D.C. Circuit. (*Electrical Workers IBEW Local 474* v. *NLRB (St. Francis Hospital)*, 814 F.2d 697 (1987)). The Board's reaction was to try yet a different approach—i.e., rulemaking.

With all due respect, I disagree. Rulemaking in regard to healthcare units is neither desirable nor appropriate.

First, it is my view that the appropriate method for resolution of questions surrounding the interpretation of Congress' intent, the proper scope of review, and the Board's duty and authority under the statute, is to submit these questions to the Supreme Court, which is the final arbiter on issues of this nature. Submission to the Court is especially appropriate in this area. Second, the Board has received criticism from the courts at both ends of the spectrum. Most of the criticism and disagreement has centered around application of the traditional community of interest standard, versus a separately derived "disparity of interest" test for evaluating units in the healthcare industry.

Thus, the Ninth Circuit, in an early *St. Francis* hospital case, faulted the Board for applying what the court deemed a too rigid presumption *in favor* of a registered nurses unit; and enunciated a "disparity of interest" standard which it deemed necessary for assessing healthcare units. More recently, after the Board itself decided to adopt the disparity of interest standard, the District of Columbia Circuit in yet another *St. Francis* case, severely criticized the Board's action, and strongly "suggested", that some form of the historically accepted community of interest standard is required. Hence the Board is faced with some courts which have indicated a definite preference for the so-called "disparity of interest" analysis. Other courts are equally adamant that nothing in the 1974 Amendments indicates that the Board was to abandon the community of interest standard which had served well for the previous forty years, and of which Congress was cognizant at the time of the Amendments.

It is apparent that the disagreements involve questions concerning the meaning of the statute, analysis of the legislative history, and the deference to be properly accorded to the Board's reading and interpretation of the Act, which is the Board's primary function and responsibility. These questions are all particularly appropriate for submission to, and final resolution by, the Supreme Court. This avenue is also the one which best serves the interests of the parties, the general public, and the Board itself.

Section 9(b) of the Act provides that

> The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof * * *.

I do not read the above language as permissive. It is mandatory. The Board cannot satisfactorily fulfill its statutory obligation by relegating its specialized decisional function in this area to rulemaking procedures. That is not to suggest that I disapprove of rulemaking per se. On the contrary, I agree that rulemaking is desirable, and even a necessary part of the Board's function, in some areas. This is not one of those areas. I believe it is important to keep in mind that Congress did *not* amend Section 9 when it enacted the Healthcare amendments in 1974. Had Congress intended that the Board abandon the decisional approach and utilize a wholly new procedure for determining appropriate units in the healthcare industry, Congress would have told us so explicitly. It did not. Nor did it even implicitly suggest such action. The rule changes cited by the majority (e.g. contract bar, *Excelsior* list, etc.) in support of this radical departure from 50 years of Board precedent, (a) were arrived at decisionally, and; (b) did not involve unit determinations.

There are additional factors which make rulemaking on particular units, at best, inadvisable. Units established by rulemaking will continue to be criticized by courts that deem the Board's approach to healthcare unit determinations to be too rigid. Indeed, as unit specifications derived from a predetermined set of rules are inherently less flexible than those arrived at by decision in individual cases, criticism by some courts may even intensify on the ground that the Board has not arrived at a result through the application of its institutional expertise to a particular fact pattern.

Contrary to the stated expectations of my colleagues, setting unit configurations by rulemaking will not in fact substantially reduce the amount of litigation in this area. It may serve to change part of the focus of that litigation, while at the same time creating more. The amount of evidence produced in rulemaking is not the point. The difficulties encountered over the last several years have not been for lack of evidence. Rather, they have revolved around differing interpretations of the statute and, particularly, the legislative history and the deference to be accorded the Board and its expertise in its role as the primary decision maker under the Act. I do not see that announcing rules by administrative fiat will resolve the divergent views on these fundamental questions. We still will not have obtained a definitive resolution of the basic issues which is so sorely needed.

I would, therefore, vacate the notices of proposed rulemaking and submit the extant issues to the Supreme Court for resolution.

Dated, Washington, DC, August 25, 1988.

By direction of the Board.

National Labor Relations Board.

John C. Truesdale,

Executive Secretary.

[FR Doc. 88-19688 Filed 8-31-88; 8:45 am]

BILLING CODE 7545-01-M

federal register

Thursday
September 1, 1988

Part III

Environmental Protection Agency

40 CFR Parts 264 and 265

Standards Applicable to Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities; Liability Coverage; Final Rule

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 264 and 265

[FRL-3361-6]

Standards Applicable to Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities; Liability Coverage

AGENCY: Environmental Protection Agency.

ACTION: Final rule.

SUMMARY: On August 21, 1985, the Environmental Protection Agency (EPA or the Agency) published a Notice of Proposed Rulemaking to amend the financial responsibility requirements concerning liability coverage for owners and operators of hazardous waste treatment, storage, and disposal facilities (TSDFs) permitted under the Resource Conservation and Recovery Act (RCRA) (50 FR 33902). The proposal set forth several regulatory options, including the authorization of additional financial mechanisms for covering third-party liability requirements, under consideration by the Agency to provide relief for owners and operators who encounter difficulties in obtaining liability insurance. On July 11, 1986, EPA published an interim final rule allowing use of a corporate guarantee as an additional financial responsibility mechanism (51 FR 25350). This rule was issued in final form on November 18, 1987 (52 FR 44314).

EPA is today adopting other financial mechanisms for liability coverage for RCRA TSDFs. These mechanisms are letters of credit, surety bonds, trust funds, and guarantees provided by firms that are not the direct parent of the owner or operator. In addition, the Agency is clarifying the liability insurance requirements to ensure that other firms can purchase insurance for owners and operators of hazardous waste management facilities.

EFFECTIVE DATE: October 3, 1988.

ADDRESSES: The regulatory docket for this rulemaking is available for public inspection at Room S-212-E, U.S. EPA, 401 M Street, SW., Washington, DC 20460, from 9:00 a.m. to 4:00 p.m., Monday through Friday, excluding Federal holidays. The docket number is F-88-CGF1-FFFFF. The public must make an appointment to review docket materials by calling (202) 475-9327. The public may copy a maximum of 50 pages from any one regulatory docket at no cost. Additional copies cost $0.20 per page.

FOR FURTHER INFORMATION CONTACT: The RCRA Hotline, toll free, at (800) 424-9346 or, in Washington, DC, at (202) 382-3000. For technical information, contact Carlos M. Lago, Office of Solid Waste (WH-563), U.S. Environmental Protection Agency, 401 M Street, SW., Washington, DC 20460, (202) 382-4780.

SUPPLEMENTARY INFORMATION: The contents of today's preamble are listed in the following outline:

I. Authority
II. Background
  A. Current Liability Coverage Requirements
  B. August 21, 1985, Notice of Proposed Rulemaking
  C. Rulemaking Authorizing the Corporate Guarantee
  D. Justification for Today's Rule
  E. Key Provisions of Today's Rule
III. Additional Financial Responsibility Mechanisms Being Authorized for Liability Coverage
  A. Letter of Credit
  B. Surety Bond
  C. Guarantee
  D. Trust Fund
  E. Purchase of Insurance by Other Firms
  F. Allowable Combinations of Mechanisms
IV. Special Provisions of Additional Mechanisms
  A. Beneficiaries
  B. Payment Trigger
  C. Certification of Validity and Enforceability
  D. Cancellation
  E. Exclusions
V. Other Issues Presented in the Notice of Proposed Rulemaking
  A. Maintain, Suspend, or Withdraw Existing Liability Coverage Requirements
  B. Revise Scope and Levels of Coverage
  C. Mechanisms Considered But Not Adopted
  D. Authorize Waivers
VI. Consistency with Other Existing and Proposed Financial Assurance Requirements
VII. Technical Correction to 40 CFR 264.151(b)
VIII. Effective Date
IX. State Authority
  A. Applicability of Rules in Authorized States
  B. Effect of Rule on State Authorizations
X. Executive Order 12291
XI. Regulatory Flexibility Act
XII. Supporting Documents

I. Authority

This regulation is being adopted under the authority of sections 2002(a), 3004, and 3005 of the Solid Waste Disposal Act; as amended by RCRA, as amended (42 U.S.C. 6912(a), 6924, and 6925).

II. Background

A. Current Liability Coverage Requirements

Section 3004(a)(6) of RCRA, as amended, requires EPA to establish financial responsibility standards for owners and operators of hazardous waste management facilities as may be necessary or desirable to protect human health and the environment.

On April 16, 1982, EPA promulgated regulations requiring owners or operators to demonstrate liability coverage during the operating life of the facility for bodily injury and/or property damage to third parties resulting from accidental occurrences arising from facility operations (47 FR 16554). Under these regulations (40 CFR 264.147 and 265.147), an owner or operator of a hazardous waste treatment, storage, or disposal facility must demonstrate, on a per-firm basis, liability coverage for sudden accidental occurrences in the amount of $1 million per occurrence and $2 million annual aggregate, exclusive of legal defense costs. An owner or operator of a surface impoundment, landfill, or land treatment facility used to manage hazardous waste is also required to demonstrate, on a per-firm basis, liability coverage for nonsudden accidental occurrences in the amount of $3 million per occurrence and $6 million annual aggregate, exclusive of legal defense costs. (A "nonsudden accidental occurrence," as opposed to a "sudden accidental occurrence," is defined by 40 CFR 264.141 and 265.141 as an occurrence that takes place over time and involves continuous or repeated exposure.) "First-dollar" coverage is required; that is, the amount of any deductible must be covered by the insurer, who may have a right of reimbursement of the deductible amount from the insured.

The requirements for coverage of sudden accidental occurrences became effective on July 15, 1982. The requirements for nonsudden accidental occurrences were phased in gradually according to annual dollar sales or revenue figures of the owner or operator. January 16, 1985, was the final phase-in date.

Financial responsibility for third-party liability currently can be demonstrated by obtaining insurance, by passing a financial test, or by obtaining a corporate guarantee from a parent corporation that passes the financial test. The regulations (40 CFR 264.147(a)(3), 264.147(b)(3), 265.147(a)(3), and 265.147(b)(3)) also allow an owner or operator to meet the liability requirements through a combination of the financial test and insurance, or a combination of the corporate guarantee and insurance.

B. August 21, 1985, Notice of Proposed Rulemaking

In 1984–1985, the availability of pollution liability insurance policies began to decline. A number of insurers who previously had offered coverage ceased to write pollution liability policies. Those still offering coverage raised their premiums substantially while reducing the coverage provided. As a consequence, some owners and operators of hazardous waste TSDFs began to experience difficulties in obtaining necessary coverage and/or paying the increased cost of such coverage.

In response to this situation, EPA took a number of steps, including issuing on August 21, 1985, a Notice of Proposed Rulemaking (NPRM) (50 FR 33902) requesting comment on five possible regulatory options as responses to the problem of reduced availability and increased cost of pollution liability insurance: (1) Maintain the existing requirements; (2) clarify the required scope of coverage and/or lower the required levels of coverage; (3) authorize other financial responsibility mechanisms; (4) authorize waivers; and (5) suspend or withdraw the liability coverage requirements.

EPA received numerous comments from four major categories of commenters on the August 21, 1985, NPRM: Owners and operators of hazardous waste TSDFs; members of the insurance industry; representatives of State and local governments; and members of the public at large. A majority of commenters encouraged the Agency to retain the existing coverage limits and encouraged the Agency not to suspend or withdraw the liability coverage requirements. Numerous commenters did, however, ask EPA to consider waivers in certain circumstances. Some commenters requested EPA to clarify the scope of coverage required or to lower the required limits of coverage, but many commenters urged EPA to authorize additional financial mechanisms that would provide an alternative to insurance. Commenters specifically mentioned mechanisms such as corporate guarantees, surety bonds, letters of credit, and trust funds for use for liability coverage. The commenters, however, did not discuss in detail any of these mechanisms.

Upon analysis of comments received, studies of the cost and availability of the instruments, analysis of the suitability of proposed financial instruments for liability coverage, and consultation with banks and State insurance commissioners, EPA has decided to maintain the existing coverage requirements, while authorizing additional financial responsibility mechanisms for liability coverage. Sections III and V of this preamble discuss the mechanisms being authorized and existing approaches to waivers. The Agency's summary of and responses to comments urging it to change existing requirements on the scope and levels of coverage are provided in Section V of this preamble. Additionally, more specific discussion and response to comments is found in documents included in the docket for today's rule.

C. Rulemaking Authorizing the Corporate Guarantee

In response to the commenters on the August 21, 1985 NPRM who argued that EPA should authorize other financial instruments for liability coverage, EPA examined several additional mechanisms for liability coverage. Commenters particularly encouraged EPA to authorize a corporate guarantee for liability coverage, noting that such guarantees were already authorized as financial assurance mechanisms for closure and post-closure care (40 CFR 264.143(f), 264.145(f), 265.143(e), and 265.145(e)). In response, on July 11, 1986, the Agency issued an interim final rule revising 40 CFR 264.147, 264.151, and 265.147 to authorize, in addition to insurance and the financial test, the use of a corporate guarantee for liability coverage (51 FR 25350). The Agency subsequently made minor revisions to the rule authorizing the corporate guarantee for liability coverage, and finalized that rule on November 18, 1987 (52 FR 44314). As discussed in Section III of this preamble, today's rule further expands the availability of the guarantee by allowing firms that are not the direct corporate parent of the owner or operator to be the guarantor.

D. Justification for Today's Rule

The Agency believes that additional mechanisms for liability coverage are desirable in order to provide a broad set of options for owners or operators who must demonstrate liability coverage but who cannot use one of the existing mechanisms. Although commentary concerning the insurance industry in the Insurance Trade Press and in other sources suggests that underwriting losses in property-casualty insurance peaked around the end of 1985 and that the outlook for the future is more favorable,[1] the market for Environmental Impairment Liability (EIL) insurance has remained constrained.[2] Accordingly, the Agency is seeking to ensure that as many alternative financial assurance mechanisms as possible are available to the regulated community, to reduce the problem created by the constrained insurance market.

Section 3010(b) of RCRA provides that regulations promulgated under Subtitle C of the statute and revisions to existing Subtitle C regulations generally take effect six months after promulgation. However, the period prior to the effective date may be shortened if the Administrator finds the regulated community does not need six months to come into compliance or for other good cause. As the regulation does not add any additional compliance requirements and a six-month period prior to implementation would be contrary to the interest of the regulated community and public by delaying the availability of other compliance mechanisms, the regulatory changes are being issued as a final rule effective 30 days after publication.

E. Key Provisions of Today's Rule

In today's rule, EPA authorizes owners or operators of hazardous waste TSDFs to use the following additional financial assurance mechanisms for liability coverage: A letter of credit; a surety bond assuring payment of liability claims; a fully-funded trust fund; and a guarantee provided by a firm that is not the direct parent of the owner or operator. The Agency is generally not revising the scope and levels of coverage required for third-party liabilities. However, today's rule includes amendments clarifying the liability coverage requirements to allow other firms to purchase insurance for owners and operators. Finally, EPA is specifying more clearly the aggregate amount of coverage that must be provided by financial responsibility mechanisms that offer combined coverage for sudden and nonsudden occurrences.

III. Additional Financial Responsibility Mechanisms Being Authorized for Liability Coverage

In determining which additional financial assurance mechanisms to

[1] United States General Accounting Office, Statement by William J. Anderson before the House of Representatives on "Profitability of the Property/Casualty Insurance Industry," March 13, 1986.

[2] National Association of Insurance Commissioners, "Report of the NAIC Advisory Committee on Environmental Liability Insurance," September, 1986; and "Business Insurance," April 16, 1987, p. 58; May 4, 1987, p. 22; and May 11, 1987, p. 71.

approve for liability coverage, EPA reviewed the other financial assurance programs within EPA, other Federal agencies, and several States. The Agency first analyzed the financial mechanisms already approved for use for closure or post-closure care financial assurance since the regulated community could be expected to be familiar with them. Many of these mechanisms were mentioned by commenters on the August 21, 1985 NPRM as potentially useful. Other EPA financial assurance requirements or proposed requirements, such as the requirements for underground injection wells and underground storage tanks, were also reviewed to identify the mechanisms, if any, used in those programs for third-party liability coverage.

The Agency considered several characteristics of the mechanisms that could affect their suitability for the coverage of third-party liability claims, including (1) availability; (2) cost; (3) whether they are likely to be valid and enforceable contracts under special provisions of State law, such as laws regulating the business of insurance; and (4) whether they are capable of being set up in ways that do not require EPA to act as a "claims adjuster" or otherwise act to determine the merits of third-party liability claims brought against TSDF owners or operators.

On the basis of these analyses, EPA determined that letters of credit, surety bonds, guarantees, and trust funds provide adequate third-party liability coverage. The rationale for authorization of these instruments is described below in the discussion of each instrument.

Other mechanisms suggested by the commenters on the August 1985 NPRM and analyzed by EPA included security interests, indemnity contracts, reserve funds, captive insurance pools, and government-supplied insurance or loan guarantees. As discussed in Section V of today's preamble, EPA has concluded that these instruments are inappropriate, with the exception of captive insurance pools and risk retention groups. Captive insurance pools and risk retention groups are authorized under the current regulations.

The financial mechanisms authorized in today's rulemaking, with the exception of the guarantee, are currently approved mechanisms for closure or post-closure care under 40 CFR Parts 264 and 265, Subpart H. (Performance bonds, which are authorized for use by owners or operators of permitted facilities for assurance for closure and post-closure care, are not included because they are not adaptable to liability coverage; instead, an analogous mechanism, the payment bond, is allowed.) The requirements for these financial mechanisms parallel the requirements for financial mechanisms authorized for closure or post-closure care. However, some provisions of the mechanisms have been adjusted to address issues that arise only in the context of liability claims. Features of the mechanisms that differ include the designation of the beneficiary, exclusions for categories of damages and obligations, the claims-payment trigger, the certification of validity and enforceability, and cancellation provisions. These features are described more fully in Section IV of today's preamble.

A. Letter of Credit

Today's rule authorizes owners or operators of hazardous waste TSDFs to use letters of credit to satisfy the RCRA third-party liability coverage requirements (40 CFR 264.147(a)(3), 264.147(b)(3), 265.147(a)(3), and 265.147(b)(3)). Letters of credit are commitments by a financial institution (e.g., a bank), whose letter of credit operations are regulated and examined by a State or Federal agency, to provide funds if appropriate documents are presented. In general, letters of credit are instruments that can be adapted for various purposes.[3] Banks contacted by EPA have indicated that they would consider issuing letters of credit for liability claims for their established customers. EPA believes that letters of credit may be more readily available to owners or operators than many other mechanisms, if the owner or operator has an established relationship with a qualifying financial institution and can provide adequate collateral.

1. *Features of Mechanism.* A letter of credit is a financial instrument under which an issuing institution (the issuer), generally a bank, undertakes to meet a monetary obligation of its customer (the account party) if the bank is presented with specified documents. The issuer, in return for a fee, becomes the primary obligor. A third party, the beneficiary, initiates payment by making a claim directly on the issuer. Thus, a letter of credit is an instrument that substitutes the issuer's superior credit for the account party's credit.

The instrument authorized in today's rule is an irrevocable stand-by letter of credit in which the third-party beneficiaries are any and all persons who may be damaged by a hazardous waste release from the facility whose owner or operator has secured the letter of credit. The irrevocable nature of the instrument precludes its cancellation prior to the end of a required one-year term by the issuer or the owner or operator. After the one-year term, the letter of credit will automatically renew for another year unless, 120 days before the expiration date, the issuer notifies the owner or operator and the Regional Administrator of a decision not to renew the credit (40 CFR 264.151(k)).

2. *Who May Provide A Letter of Credit.* Today's rule provides that letters of credit for liability coverage must be provided by an authorized financial institution regulated by a Federal or State agency (40 CFR 264.147(h)(2) and 265.147(h)(2)). EPA has established these requirements, which parallel the requirements for letters of credit providing assurance for closure or post-closure care, to ensure the financial viability of the issuer of the letter of credit. The viability of the commercial banks and savings and loan institutions that may issue letters of credit is scrutinized by several oversight organizations, including the Federal Reserve, the Federal Deposit Insurance Corporation, the Federal Savings and Loan Insurance Corporation, the Comptroller of the Currency, and State banking commissioners. These regulatory bodies attempt to ensure that regulated institutions take actions necessary to avoid bankruptcies. EPA concluded that it would be duplicative to establish additional requirements to ensure the solvency of bank and savings and loan institutions issuing letters of credit.

3. *Validity of Letter of Credit Providing Liability Coverage.* To ensure that letters of credit may be used to provide liability coverage, EPA reviewed the status of legal doctrines that might call into question the authority of a bank to issue a letter of credit for liability coverage, and concluded that no significant legal obstacles currently exist to such use of letters of credit. EPA believes that the proposed use of letters of credit in today's rule is analogous to the use of a letter of credit in situations that courts have approved. The Agency, therefore, concluded that use of a letter of credit for financial assurance for third-party liability coverage is both valid and enforceable.

B. Surety Bond

Today's rule authorizes owners and operators of hazardous waste TSDFs to use surety bonds to satisfy the RCRA

[3] U.S. General Accounting Office, Staff Study, "Financial Services—Developments in the Financial Guarantee Industry," GAO/GGD-87-84, June 25, 1987, pp. 9-13, 17-18 discusses letters of credit as financial guarantees.

third-party liability requirements (40 CFR 264.147(a)(4), 264.147(b)(4), 265.147(a)(4), and 265.147(b)(4)). The adoption of surety bonds as an additional assurance mechanism for liability coverage was widely advocated by the commenters on the August 21, 1985, NPRM.

1. *Features of Mechanism.* Surety bonds represent agreements between three parties: The principal (i.e., the facility owner or operator); the obligee (i.e., third-party liability claimants) to whom the principal promises to complete a specific act; and the surety, who assures the obligee that the principal will fulfill its obligation and, if the principal fails, that the surety will fulfill the principal's obligation to the obligee. Thus, the surety bond authorized today guarantees that if the owner or operator fails to satisfy valid third-party claims, the surety will pay such claims. A surety company is entitled to reimbursement from the principal when it makes a payment under a bond.

There are two types of surety bonds: payment bonds and performance bonds. Payment bonds guarantee that the principal will pay a certain sum to identified parties under the conditions named in the bond, and if the principal fails to make the payment or payments, the surety will make the payment or payments. Performance bond guarantees that the principal will perform a certain act and, if the principal fails, that the surety will either perform the act for the principal or pay someone else to perform it. The surety bond provided in today's rule is a payment bond, because the obligation it guarantees is limited to the principal's payment of third-party liability claims to satisfy the Subtitle C liability requirements.

A surety company's liability under a payment bond is limited to the "penal sum," which is the amount of coverage guaranteed by the bond. The penal sum of the payment bond being authorized by today's rule has two parts, the per-occurrence limit and the annual aggregate limit (40 CFR 264.151(1)). If the payment bond covers claims resulting from both sudden accidental occurrences and nonsudden accidental occurrences, a separate penal sum will be identified for each type of coverage (i.e., such a bond would have four penal sums).

The payment bond authorized in today's rule will remain in effect unless and until the surety notifies the owner or operator and the Regional Administrator of proposed cancellation by certified mail. Cancellation will become effective 120 days from the receipt of notification (40 CFR 264.151(1), conditions clause (7)).

2. *Who May Provide Surety Bonds.* Today's rule requires that surety companies issuing payment bonds to assure liability coverage must be listed by the Department of Treasury in Treasury "Circular 570" as surety companies that may issue bonds to the Federal government (40 CFR 264.147(i)(2) and 265.147(i)(2)). This requirement parallels the closure and post-closure care financial assurance regulations and other financial assurance requirements involving surety bonds and assures that the surety company is subject to regulatory oversight by some government agency. To qualify for such a listing, surety companies must comply with the law and regulations of the Department of Treasury (as specified in sections 9304 and 9308 of Title 31 of the United States Code). The names of the companies meeting these Treasury requirements are published on July 1 of each year by the Department of the Treasury in "Circular 570; Surety Companies Acceptable on Federal Bonds."

3. *Validity of Surety Bond Providing Liability Coverage.* EPA has contacted several State insurance commissions to determine if States would view a surety bond for third-party liability coverage as subject to the State insurance laws. In a number of States, surety companies are already regulated by the State agency that is responsible for insurance. EPA found that in other States, the issue of whether the surety bond constitutes insurance may be examined on a case-by-case (i.e., facility-by-facility or bond-by-bond) basis. Many States may consider it necessary for the firm providing the surety bond to qualify under the State's surety or insurance laws as an insurer. To address this issue, the rule does not allow owners or operators to use a surety bond to demonstrate financial assurance unless the Attorneys General or Insurance Commissioners in the States in which the surety is incorporated and in which the facilities covered by the bond are located certify that the mechanism is valid and enforceable (40 CFR 264.147(i)(4) and 265.147(i)(4)). (See Section IV.C of this preamble for further discussion.)

C. Guarantee

Today's rule extends the use of guarantees for liability coverage to allow guarantees provided by firms that are not the direct parents of facility owners or operators (40 CFR 264.147(g)(1) and 265.147(g)(1)). The use of a parent corporate guarantee for liability coverage was authorized in an interim final rule on July 11, 1986 (51 FR 5350) and promulgated as a final regulation on November 18, 1987 (52 FR 44314). Under this rule, liability coverage may be provided by parent firms that directly own at least 50 percent of the voting stock of a subsidiary firm. Several commenters on the interim final rule urged EPA to allow non-parent firms to provide guarantees. After analyzing the validity and enforceability of guarantee contracts by non-parent firms, the Agency is authorizing guarantees provided by corporate grandparents and by a corporate "sibling" firm (a firm whose parent corporation is also the parent corporation of the owner or operator). The Agency also is allowing guarantees by other related and unrelated firms, provided that such firms have a substantial business relationship with the owner or operator.

The guarantee in today's rule incorporates the features of the November 18, 1987 rule for parent guarantees with minor revisions necessary to address non-parent guarantees and to ensure consistency with the other instruments allowed by today's rule. Since today's rule incorporates the features of this earlier rule, an extensive discussion of the guarantee has not been included in this preamble. Only the distinctive features of the non-parent corporate guarantee, the definition of who may provide the guarantee, and the basis upon which EPA concluded that it would be a valid and enforceable mechanism are discussed below.

1. *Features of Mechanism.* The authorized guarantee is an instrument by which a firm promises to pay the liability obligations of the owner or operator is the owner or operator does not do so. The firm providing the guarantee (the guarantor) must submit proof that it passes the financial test requirements of §§ 264.147(f)(1) or 265.147(f)(1). If the guarantor subsequently becomes unable to pass the financial test, the owner or operator must obtain another financial assurance mechanism for liability coverage.

2. *Who May Provide Guarantees.* Today's rule extends EPA's authorization of corporate guarantees beyond the previously allowed parent guarantee to include multi-tier guarantees by corporate grandparents, cross-stream guarantees by corporate siblings, and guarantees by firms with a "substantial business relationship" with the owner or operator. In general, today's rule authorizes three types of guarantees between corporations: (1) A guarantee by a parent corporation or

principal shareholder of a subsidiary (a "downstream" guarantee), (2) a guarantee by a sibling corporation (a "cross-stream" guarantee), and (3) a guarantee by a firm that has a "substantial business relationship" with the corporation that receives the guarantee (40 CFR 264.147(g)(1) and 265.147(g)(1)).

A simple single-tier downstream guarantee is one where the direct parent corporation guarantees the obligation of its subsidiary. A multi-tier downstream guarantee (consisting of three tiers of ownership, for example) is a guarantee by which the corporate grandparent or great grandparent (i.e., the ultimate owner of the subsidiary) provides a guarantee for the subsidiary. A cross-stream guarantee is a guarantee between sibling corporations, e.g., a "brother" subsidiary's guarantee of a "sister" subsidiary where the siblings are owned by the same parent. Both of these categories of guarantees have been tested in legal actions and are considered strong and binding legal obligations although analyses of guarantees between siblings typically assume that some economic relationship exists between the two corporations aside from the guarantee.

If the guarantee is being provided by a corporate grandparent or sibling, the guarantor must provide the guarantee to the owner or operator directly, irrespective of the number of intervening levels of ownership that exist in the corporate structure (40 CFR 264.147(g)(1) and 265.147(g)(1)). For example, a corporate grandparent would provide a guarantee for the owner or operator's firm directly, not through the corporate parent.

Today's rule also authorizes unrelated firms and other related firms, aside from parents and siblings, that have a "substantial business relationship" with the owner or operator of a hazardous waste facility to provide guarantees (40 CFR 264.147(g) and 265.147(g)). In authorizing guarantees by these other related and unrelated firms, EPA sought to ensure that a valid and enforceable contract was created. To this end, the Agency is requiring these firms to demonstrate a substantial business relationship with the owner or operator to ensure that the guarantee is a valid contract. Under fundamental principles of contract law, contracts must be supported by "consideration." Consideration is generally defined as a legal detriment that has been bargained for and exchanged for the promise. The general principle underlying the concept of consideration is that the law will not enforce gratuitous promises.

The issue of consideration arises in the context of all guarantees; however, parent and sibling firms authorized to issue guarantees under today's rule can demonstrate consideration by the inherent benefits or detriments that accrue to the guarantor firm by virtue of its corporate relationship with the owner or operator. As noted above, courts have generally recognized that guarantees offered by a parent or sibling corporation are valid and enforceable. EPA believes that other related and unrelated firms should be able to demonstrate sufficient consideration for the contract if they have a substantial business relationship with the owner or operator.

The Agency's review of legal literature indicated that a sufficiently close business relationship between two firms could be comparable to the shared economic interests that typify the relationship between corporate siblings and between a parent and its subsidiary. Because it is these mutual economic interests that underlie the validity and enforceability of downstream and cross-stream guarantees, the existence of such interests between other types of firms should enable guarantees between these firms also to be valid and enforceable. No single legal definition exists of what constitutes a business relationship between two firms that would justify upholding a guarantee between them. Furthermore, such a determination would depend upon the application of the laws of the States of the involved parties. Thus, in defining the underlying business relationship that produces an acceptable guarantee, the Agency provides a broad framework for analyzing business relationships while acknowledging the primary role of State law.

In today's rule, EPA is defining substantial business relationship to mean "the extent of a business relationship necessary under applicable State law to make a guarantee contract issued incident to that relationship valid and enforceable. A 'substantial business relationship' must arise from a pattern of recent or ongoing business transactions, in addition to the guarantee itself, such that a currently existing business relationship between the guarantor and the owner or operator is demonstrated to the satisfaction of the applicable EPA Regional Administrator" (40 CFR 264.141(h)). A guarantee contract, by itself, would be inadequate to demonstrate a substantial business relationship between two parties. However, an existing contract to supply goods or services, separate from the guarantee contract, could supply evidence of such a relationship. An example of such an arrangement might be a contract for hazardous waste disposal between a generator and a disposal facility. Evidence demonstrating such a substantial business relationship is required to be provided in the letter from the Chief Financial Officer of the guarantor.

In addition to demonstrating the existence of a substantial business relationship, these other related and unrelated guarantors must describe the value that they received in consideration for the guarantee contract. In some cases, preexisting business relationships, no matter how substantial, will be insufficient by themselves to demonstrate consideration because they will not have been bargained for to induce the promise in the guarantee contract. For this reason, these guarantors must also describe the consideration for the contract in the letter from their Chief Financial Officer.

EPA considered as a preliminary matter whether corporate guarantees would be regulated as insurance contracts under States' insurance laws. EPA was concerned that guarantors could subject themselves to States' insurance laws through the issuance of guarantees. This issue has arisen in other of the Agency's financial responsibility rulemakings, including the proposed financial responsibility requirements for underground storage tanks containing petroleum (52 FR 12786, April 17, 1987). A discussion of the applicability of State insurance laws to various mechanisms, including corporate guarantees, is contained in the docket for that rulemaking, in the "Supporting Document for Proposed Underground Storage Tanks Containing Petroleum—Financial Responsibility Requirements." That discussion indicates that States' insurance statutes and regulatory bodies have varying ways of describing their jurisdiction over guarantees, oftentimes dependent on the precise circumstances surrounding the transaction. Thus, the Agency cannot state with any certainty whether any particular guarantee would subject the guarantor to a State's insurance laws. Therefore, the responsibility rests on owners and operators to obtain guarantees that are valid and enforceable and on prospective guarantors to ascertain and comply with the State laws they would subject themselves to if they were to provide guarantees. As discussed in Section IV.C of today's preamble, the first responsibility cited is accomplished

by requiring a certification from the Attorney General or Insurance Commissioner of the State in which the guarantor is incorporated and of each State in which a facility covered by the guarantee is located.

3. *Validity of Non-Parent Guarantee Providing Liability Coverage.* Some commenters questioned whether non-parent guarantees would provide assurance equivalent to that provided by a parent guarantee. The Agency concluded that adequate assurance will be provided by these "intercorporate" guarantees. Intercorporate guarantees are a common means of assuring a lender that its loan will be repaid. In particular, "cross-stream" guarantees, which are from a "brother" subsidiary to a "sister" subsidiary where both firms are owned by the same corporate parent, are a typical business practice. Normally, collection of funds assured by intercorporate guarantees is a comparatively simple matter of contract enforcement.

In unusual circumstances, such as the situation where the guarantor declares bankruptcy, efforts could be made to avoid the guaranteed obligation. Certain provisions of the Federal bankruptcy code (11 U.S.C.A. 544(b) and 548(a)(2)) allow avoidance of obligations that deplete the debtor's assets to the detriment of its creditors. If, while the guarantor was involved in bankruptcy proceedings, a liability claim was presented to it for payment, a question could arise over whether bankruptcy laws would enable it to avoid satisfying the claim because the payment would deplete its assets to the detriment of its creditors. Under section 548(a)(2) of the Federal bankruptcy code, a trustee in bankruptcy may avoid payments made to any party within a year before the debtor filed bankruptcy if (1) the debtor was insolvent at that time and (2) the debtor did not receive "reasonably equivalent value" in return for the transfer. Section 544(b) essentially enables similar actions to be pursued under applicable State laws.

Intercorporate guarantees, however, should not be vulnerable to such actions if the owner or operator receives reasonably equivalent value in return for the guarantee. In effect, this reasonably equivalent value serves as consideration supporting the guarantee contract, similar to the guarantor having a "substantial business relationship" with the owner or operator. According to most authorities, there is no difficulty in finding reasonably equivalent value in downstream guarantees, where the guarantor is higher in the corporate hierarchy (e.g., a direct or higher-tier parent) than the subsidiary receiving the guarantee. The subsidiary relationship of a firm to its direct or higher-tier parent is almost always considered a benefit to that parent. In cross-stream guarantees from one subsidiary of a parent to another subsidiary of that same parent, demonstrating reasonably equivalent value is more difficult because the subsidiary to which the guarantee is given is not an asset of the other subsidiary serving as the guarantor. In order to obviate any question about reasonably equivalent value in cross-stream guarantees, therefore, the Agency is requiring a cross-stream guarantor to describe in the Chief Financial Officer's Letter (§ 264.151(g)) the value of the consideration that accrued to it from the guarantee.

The Agency has also concluded that adequate assurance that obligations will not be avoided in the event of bankruptcy will be provided by guarantees made by other related firms (i.e., not corporate siblings or parents) and unrelated firms which demonstrate a substantial business relationship with the owner or operator. As with intercorporate guarantees, collection of funds in most cases will merely be a matter of contract enforcement. In the event of bankruptcy of the guarantor, however, it is particularly important that the guarantee be written so as to demonstrate clearly that the guarantor has received reasonably equivalent value in consideration for the guarantee. As discussed above, the Agency is requiring these guarantors to describe in the Chief Financial Officer's Letter (§ 264.151(g)) both the nature of the substantial business relationship and the value derived from the guarantee.

D. Trust Fund

Today's rule authorizes owners or operators of hazardous waste facilities to use trust funds to demonstrate financial responsibility for third-party liability coverage (40 CFR 264.147(a)(5), 264.147(b)(5), 265.147(a)(5), and 265.147(b)(5)), if assets sufficient to cover the full amount of the assurance to be provided by the trust fund are placed in the fund before it becomes effective (i.e., the trust must be fully funded "up-front") (40 CFR 264.147(j)(3) and 265.147(j)(3)). Several comments received on the August 21, 1985 NPRM supported the use of trust funds to demonstrate financial responsibility for third-party liability coverage.

1. *Features of Mechanism.* A trust fund is an arrangement in which a separate legal entity, the trust, is created to hold property or funds for the benefit of another. At least three parties are necessary under trust agreements: the grantor, who establishes and funds the trust; the trustee, who has a fiduciary responsibility over the property placed in the trust by the grantor; and the beneficiary, the person (or group of people) for whom the arrangement is made. The most significant feature of a trust fund is the shift of legal ownership of the property in the trust from the grantor to the trustee when the trust is established and funded.

The trust document or trust agreement determines the allocation of rights, duties, and responsibilities among the parties to any trust. The trustee, in return for a fee, has a fiduciary responsibility to manage the fund according to the rules specified in the agreement. This agreement also defines the limits of a trustee's liability. In addition, a trust agreement states the manner in which payments are made into and out of the trust, as well as the grounds upon which the trust can be terminated.

2. *Validity of Trust Fund for Liability Coverage.* A trust used as a financial assurance mechanism should have a fund balance equal to the amount of coverage being demonstrated. The trust agreement may allow a pay-in period during which the grantor makes payments of specified amounts into the trust until the trust is fully funded. The length of the pay-in period typically is designed such that the trust fund balance equals the required amount of coverage before funds are needed for the assured activity. Because liability coverage may be needed immediately, the trust in today's rule must be fully paid up at the time it is relied upon for financial assurance. The trust also may not be cancelled unless and until an alternate financial assurance mechanism is in place. A fully funded trust provides a high degree of assurance because funds, up to the required amount of coverage, are set aside specifically for the purpose of liability coverage.

To ensure that the full amount of coverage is available each year in which owner or operator must provide financial assurance, the Agency is requiring both that the trust fund be fully funded immediately and, in addition, if a liability claim is paid out of the trust fund balance, the owner or operator is required to refinance the trust annually up to the amount of the required coverage on or before the anniversary date of the establishment of the fund to satisfy the annual aggregate requirement of §§ 264.147 and 265.147.

Although some owners and operators may conclude that the cost of funding a

trust as the sole financial assurance mechanism is prohibitive, they may find it desirable to use a trust fund in combination with one or more other mechanisms. For example, owners and operators who purchase insurance policies that do not provide the full amount of aggregate coverage might use trust funds to demonstrate financial responsibility for the amounts of the aggregate not covered by the insurance policy.

E. Purchase of Insurance by Other Firms

Under the current liability requirements, proof of adequate insurance coverage can be provided by either a certificate of insurance or an endorsement. A certificate of insurance is a statement obtained from the insurer certifying that it has issued insurance as represented in the certificate. The certificate is not a part of the policy, but can be used to demonstrate the existence of the policy. An endorsement is a form attached to the policy that describes the original terms of the policy and any amendments to those terms. An endorsement is a part of the policy and also evidences that insurance has been issued as described in the endorsement.

The Agency is today making minor revisions to the insurance certificate and endorsement to clarify that other firms may purchase insurance on behalf of owners or operators and to ensure that EPA receives proper notice of actions affecting the policy, such as attempted cancellation, where the policy has been purchased by another firm. These changes are reflected in paragraphs 2(d) of the "Hazardous Waste Facility Liability Endorsement" and of the "Hazardous Waste Facility Certificate of Liability Insurance" in §§ 264.151(i) and 264.151(j), respectively.

Currently, 40 CFR 264.147(a) and 265.147(a) require that an owner or operator must "have and maintain" coverage for bodily injury and property damage to third parties resulting from operation of a hazardous waste management facility. These regulations do not state explicitly that a party other than the owner or operator may purchase or obtain the necessary insurance coverage on behalf of the owner or operator. To clarify in the regulations that such insurance may be purchased by a third party, however, requires only that the language of the notice of cancellation provision in these insurance policies be amended.

To ensure that the cancellation provision in the Endorsement and Certificate covers a situation in which another company has purchased a policy for the owner or operator, the Agency has modified the language of the cancellation provision of both the Certificate and Endorsement to state explicitly that another firm providing insurance for an owner or operator must notify the Regional Administrator and the owner or operator by certified mail 60 days before insurance is cancelled (40 CFR 264.151(i)(2)(d) and 264.151(j)(2)(d)). In addition, the revised cancellation provision also states that another firm providing insurance for an owner or operator must notify EPA in writing (1) whenever claims are made against the firm or the owner or operator for third-party damages and (2) before any changes are made in the policy. The Agency is concerned that reductions in the level of coverage available to the owner or operator, due to claims made against the firm providing the insurance or changes in the insurance policy by the firm providing the insurance, otherwise may not be reported to EPA.

F. Allowable Combinations of Mechanisms

The Agency will allow an owner or operator to demonstrate the required liability coverage through the use of combinations of financial assurance mechanisms (40 CFR 264.147(a)(6), 264.147(b)(6), 265.147(a)(6), and 265.147(b)(6)). Owners or operators may use any combination of insurance, the financial test, the corporate guarantee, a letter of credit, a surety bond, and a trust fund. In allowing combinations of instruments, EPA is extending the general approach of Subtitle C liability coverage requirements. An owner or operator can use its own financial strength to cover some costs and another financial assurance mechanism to cover the remainder, provided that in combining the mechanism assets are not double-counted. To prevent double-counting, combinations of the corporate guarantee and financial test are allowed only if the financial statement of the guarantor and the owner or operator are not consolidated (40 CFR 264.147(a)(6), 264.147(b)(6), 265.147(a)(6), and 265.147(b)(6)). In a consolidated financial statement, the assets and liabilities of a subsidiary are included in the parent company's financial statement. If the financial statements of the guarantor were consolidated with the statement of the owner or operator, the owner or operator could count its own assets once for the financial test and they could be counted again in the corporate financial statement which is used to support the corporate guarantee. Such double-counting of assets would negate the value of the financial test by overestimating the assets of the guarantor.

Today's rule includes a provision requiring owners and operators to specify which of several combined instruments should be drawn upon first in the event of a claim by designating instruments as "primary" or "excess" coverage. Under closure and post-closure care financial assurance rules, priorities may be established by the Regional Administrator either by selecting one instrument and drawing upon it, or by drawing upon all instruments simultaneously and then drawing funds from the standby trust without regard to their source (see 40 CFR 264.143, 264.145, 265.143, and 265.145). The Agency considered giving the Regional Administrator similar authority in today's rule. However, the Agency is seeking in this rule to minimize the role of the Regional Administrator in payment of claims. Consequently, under today's rule the Regional Administrator does not establish the order in which financial assurance mechanisms are drawn upon in cases when owners or operators use more than one mechanism to satisfy the liability coverage requirements.

The Agency also considered the option of establishing standardized priorities for drawing upon mechanisms. This option was not adopted, however, because the Agency believes that priorities can better be established on a case-by-case basis.

While rejecting these two approaches, EPA believes that establishing priorities is necessary to avoid delays in the payment of claims and to define clearly the extent of coverage. For example, priority arrangements are often specified when insurance is combined with another mechanism. Insurers typically include language within policies limiting their obligations in the event that other coverage exists and preventing the "stacking" of policies except in the case of designated "primary" and "excess" coverage. Such language generally specifies that the coverage provided is "primary" (meaning that it is to be drawn upon first) and that if other coverage exists, payment of claims will be shared, or that payment will be made after the other coverage is exhausted up to the liability limits of the policy.

Today's rule requires an owner or operator to specify which of several mechanisms that are being used in combination to satisfy the coverage requirements should be drawn upon first in the event of a claim. The actual determination of priority is, however, left with the owner or operator and may involve negotiation with the providers of the assurance mechanism.

To facilitate the establishment of priorities, the financial assurance instruments adopted in today's rule include language specifying whether the coverage is primary or excess. In addition, the guarantee under § 264.151(h)(2) has been amended to indicate whether it provides primary or excess coverage.

IV. Special Provisions of Additional Mechanisms

This section discusses several special provisions that are common to several of the additional mechanisms for liability coverage authorized by today's rule, and that differ from requirements for closure and post-closure financial assurance.

A. Beneficiaries

In contrast to the mechanisms authorized or proposed under Subtitle C for closure and post-closure care and corrective action, the liability coverage mechanisms authorized today do not name EPA as their beneficiary. In today's rule, the issuer of the mechanism assumes the obligation to satisfy third-party liability claims for personal injury or property damage arising from operation of the facilities covered by the mechanism if the owner or operator does not do so.

Third parties, and not EPA, are designated beneficiaries to ensure that the third parties are paid directly for liability claims without involvement by EPA. The issuer of the mechanism must honor all valid certified claims or judgments upon the mechanism up to the limit of the amount covered.

B. Payment Trigger

To ensure that only valid claims are paid, the mechanisms specify that before making payment the issuer must receive either (a) a certificate of valid claim signed by the third-party claimants and by the owner or operator, or (b) a final court judgment. This provision allows for the resolution of third-party claims without the involvement in the dispute of either the issuer of the mechanism or EPA. Each of the mechanisms authorized today contains a provision that incorporates the payment trigger requirements, including the "certificate of valid claim" (40 CFR 264.151(h)(2), section 13; 264.151(k), clause 2; 264.151(1), condition (4); and 264.151(m), section (4)).

The purpose of this payment trigger is to avoid placing either the provider of the mechanism or the Regional Administrator in the position of deciding the merits of disputes between the owner or operator and the third-party claimant. The payment trigger is also set up so that claims do not have to be litigated for a final judgment. The certification is designed to allow an owner or operator to settle a claim with a third party without conceding liability in a document accessible by the public, which could be used against the owner or operator in future claims.

The requirement to submit the signed and notarized certification assures that the parties have either agreed that the claim is valid and in the correct amount or they have settled any disputes related to the validity or amount of the claim before coming to the provider for payment. The procedure is designed to reduce administrative burdens and to allow efficient payment of valid claims. The Agency does not expect the requirement to submit a signed and notarized certification of claim to place undue burdens on owners or operators or third-party claimants.

Alternatively, if the owner or operator and the third-party claimant cannot agree on the validity and amount of the claim, a final judgment by a court must be submitted by the third-party claimant, indicating that the claim should be paid. Whether payment of a judgment shall be made is a matter of applicable State law and shall be determined by the laws of the jurisdiction in which the action was brought.

Unlike the requirements for closure and post-closure care and corrective action, EPA is not requiring the establishment of a standby trust for mechanisms issued for liability coverage. A standby trust is necessary when funds are payable to EPA, because by law monies paid to the Federal government must be deposited in the United States Treasury. Because the mechanisms will pay third parties directly, a standby trust is not necessary for liability coverage.

C. Certification of Validity and Enforceability

The surety bond and guarantee authorized in today's rule may be subject to the insurance laws and regulations of certain States. To ensure that these instruments are valid and enforceable, EPA has contacted several State insurance commissions to ask how they would view these mechanisms for liability coverage. The results of those contacts are described in the docket for this rulemaking.

Most of the State commissions contacted said they would probably require a firm providing a surety bond to qualify as an insurer under State insurance laws unless the firm was related to the owner or operator in a corporate structure or it was providing the bond incident to its business relationship with the owner or operator. Two factors may influence the State's determination: whether a premium is charged and whether the firm would make such bonds available to the general public. To be certain that any bonds used as financial assurance mechanisms will be valid and enforceable, the Agency will not approve a surety bond for liability coverage unless the Attorneys General or Insurance Commissioners of the State in which the surety is incorporated, and of each State in which a facility covered by the bond is located, submits a written statement that a surety bond written and executed as required is a legally valid and enforceable obligation (40 CFR 264.147(i)(4) and 265.147(i)(4)). The certification by each State is required only once, and need not be obtained on a case-by-case basis by the owner or operator; instead it is provided to EPA or to a State agency. Accepting certifications provided to a State agency may be necessary in some circumstances even if EPA is administering the financial assurance requirements, because in many States officials such as the Attorney General will not issue opinions except to State agencies.

Guarantees for liability coverage also may come within the jurisdiction of a State's insurance laws and regulations. Accordingly, EPA is requiring that the guarantee may be used to fulfill liability coverage requirements only if the Attorney General or Insurance Commissioner of the State in which the guarantor is incorporated, and of each State in which a facility covered by the guarantee is located, submits a written statement that a guarantee written and executed as required is a legally valid and enforceable obligation (40 CFR 264.147(g)(2) and 265.147(g)(2)). The corporate guarantee rule provides a parallel requirement for this guarantee. To date, EPA has received evidence from 28 States that the parent guarantee would be acceptable.

D. Cancellation

Today's rule includes cancellation procedures for the authorized mechanisms. These procedures vary somewhat depending on the instrument. For the surety bond and guarantee provided by an unrelated firm, cancellation is allowed 120 days following notification by certified mail to the owner or operator and to the Regional Administrator(s) of the Region(s) in which the affected facilities are located (40 CFR 264.151(h)(2) and 264.151(1)). The Agency believes that

120 days is sufficient time for an owner or operator to locate a new financial assurance mechanism, and that any more stringent requirement, such as one requiring an in-place alternative prior to cancellation, would limit the availability of these mechanisms and would require extensive involvement of the Agency in the claims process.

The cancellation provisions for guarantees provided by some guarantors related to the owner or operator (i.e., corporate parents, siblings, or grand parents) require the guarantor to continue to provide the guarantee until an alternate mechanism is in place (40 CFR 264.151(h)(2)). This more stringent requirement is currently required for the corporate parent guarantee and is today being extended to guarantees provided by some of the other firms that are related to the owner or operator.

The distinctions in the cancellation provisions are based on the nature of the relationship between the provider of assurance and the owner or operator. EPA believes that a corporate parent or some of the other related corporations, due to their close relationship with the owner or operator, will have a continuing interest in the financial condition of the owner or operator and therefore should bear more responsibility for continued financial assurance than a less related or completely unrelated firm. When guarantees are provided by guarantors closely related to the owner or operator, permitting cancellation only when an alternative has been approved ensures that coverage for liability costs will be continuously available. Similarly, because the owner or operator provides a trust fund directly, it is not allowed to cancel that mechanism until another form of financial assurance has become effective. EPA is not promulgating a similarly stringent cancellation requirement for providers of insurance, surety bonds, or guarantees by less related and unrelated firms, because it believes that third-party providers would not provide coverage if they were unable to cancel that coverage, with reasonable notice, at some later date.

Today's rule does not amend the current provisions (40 CFR 264.151 (i) and (j)) allowing an insurer to cancel an insurance policy 60 days after the notice of cancellation is received by the Regional Administrator. Insurance providers argued that not allowing cancellation until at least 120 days after notice is given exposes them to considerable risk when the insured fails to pay the premium for the final period of coverage. In consideration of this concern, the Agency is maintaining the current 60-day requirement for insurance policies.

E. Exclusions

The mechanisms in today's rule contain a provision that they do not apply to certain categories of damages or obligations (see 40 CFR 264.151(h)(2), paragraph (4); 264.151(k); 264.151(l), conditions clause (l); and 264.151(m), section 3). These exclusions are patterned on existing standard exclusions found in insurance coverage (see, for example, the Insurance Services Office pollution liability coverage form CG 00 39 11 85). They are intended to ensure that the coverage is not exhausted by the payment of claims that are covered by other compensation systems or that are otherwise not intended to be included within the scope of coverage.

The Agency did not adopt all the standard Commercial General Liability (CGL) and Environmental Impairment Liability (EIL) exclusions, but included only those exclusions it considered relevant to the financial assurance mechanisms for liability. EPA has also recently issued guidance on the acceptability of site-specific pollution exclusion within insurance policies. This guidance memorandum is applicable only to insurance policies.

Exclusion (a), for bodily injury or property damage for which the owner or operator is obligated to pay damages by reason of the assumption of liability in a contract or agreement, is intended to exclude liabilities assumed by contract that do not involve the hazardous waste treatment, storage, and disposal facility or facilities of the owner or operator. It does not exclude settlements or other agreements to pay damages in connection with accidental occurrences resulting in bodily injury or property damage caused by hazardous waste.

Exclusion (b), for obligations under workers' compensation, disability benefits, or unemployment compensation law or similar law, is intended to ensure that liability coverage is available for non-employee third parties and does not duplicate coverage provided under these other programs or forms of assurance.

Exclusion (c), for bodily injury to the employees, or the immediate family of employees, of the owner or operator, is also intended to ensure that coverage is available for "third parties" and does not duplicate coverage provided under other forms of assurance.

Exclusion (d), for bodily injury or property damage arising out of the ownership or use of any aircraft, motor vehicle, or watercraft, is to prevent use of an authorized financial assurance mechanism for routine accidents that are not directly related to management of hazardous waste.

Exclusion (e), for property damage to property owned, occupied, rented, or in the care, custody, or control of the owner or operator, is intended to ensure that coverage will be available to compensate third parties, and not the owner or operator, for property damage as a result of activities at TSDFs.

V. Other Issues Presented in the Notice of Proposed Rulemaking

In the August 21, 1985, NPRM, EPA suggested several additional approaches that could be taken to promote compliance with the financial responsibility requirements. Alternatives, other than authorizing additional financial assurance mechanisms, included the suspension or withdrawal of the liability coverage requirements, clarification of the scope of coverage, revision of the required levels of coverage, or authorization of waivers. Numerous comments were received on these alternatives. After considering these comments, the Agency has decided to retain the liability coverage requirements at their present levels, to maintain the present scope of coverage, and to reject the option of generic waivers. This section discusses briefly the comments received on these alternatives in response to the NPRM and explains the reasons why EPA is not adopting them. A more complete discussion of these comments is included within the docket accompanying today's rule.

A. Maintain, Suspend, or Withdraw Existing Liability Coverage Requirements

The Agency received comments from State governments and the public that generally argued in favor of maintaining the requirements. Supporters of the existing requirements argued that the insurance market for EIL coverage would not recover without such requirements; that maintaining the requirement would increase public confidence in hazardous waste facilities and decrease opposition to siting and permitting such facilities; and that low-risk owners and operators were able to obtain coverage. Commenters from State and local governments in particular argued that suspension or withdrawal of the liability coverage requirements would severely damage the chances for an eventual solution to the problem of insurance availability, that suspension would not be acceptable to the public and would undermine the strength of programs to regulate hazardous waste

management, and that liability coverage is necessary to protect human health and environment. Facilities that are unable to obtain such coverage, in these commenters' opinion should not continue in operation.

In contrast, a number of firms in the regulated community argued that EPA should not maintain the existing liability coverage requirements, but rather should suspend or withdraw the requirements, because of the difficulty many firms faced in obtaining insurance. Commenters also argued that the liability coverage requirements could be suspended or withdrawn because they were redundant with permitting conditions and that EPA should concentrate on achieving risk control rather than post-loss compensation. They also pointed out that even if the liability coverage requirements were abolished, third parties harmed by hazardous waste management activities could still sue the owner or operator for damages. Finally, commenters argued that the constraints on insurance availability made a short-term suspension necessary, even if the requirements for liability coverage were later reinstituted.

After considering these comments and suggestions made in response to other questions in the NPRM, EPA has concluded that the current liability coverage requirements should be maintained. The Agency believes that the requirements are an important component of the RCRA management system and are necessary to protect human health and the environment. Further, Congress in the Hazardous and Solid Waste Amendments of 1984 (HSWA) has stressed the importance of satisfying all financial assurance requirements, including liability coverage. Finally, by authorizing the use of additional financial mechanisms for liability coverage, the Agency believes that the problems of insurance availability cited by some commenters as reasons to suspend or withdraw the rule should become less important in the future.

B. Revise Scope and Levels of Coverage

A number of issues were considered by EPA in connection with the scope and levels of coverage. They included coverage levels, distinction between sudden and nonsudden coverage, exclusion of legal defense costs, and deductibles. Each is discussed in this section.

1. *Coverage Levels.* EPA established the sudden accidental and nonsudden accidental liability coverage requirements in 1982 at $1 million per occurrence and $3 million per occurrence, respectively, on the basis of the Agency's investigation of existing third-party damage cases. To account for the possibility that the same firm might experience more than one claim in a year, the Agency also established annual aggregate coverage requirements at twice those amounts, or $2 million and $6 million, respectively.

In July 1986, EPA again reviewed third-party damage claims, awards, and settlements for sudden and nonsudden accidental occurrences involving hazardous chemicals as well as hazardous waste to determine whether the required levels of coverage are adequate. Data were limited, however, for several reasons, including the fact that few cases have been litigated to completion. Thus, available data were generally data on amounts claimed, rather than amounts recovered in awards or settlements. Because final awards and settlements often differ significantly from initial claims, it is difficult to draw conclusions based on this data. In addition, commenters did not supply any additional information indicating that the currently required coverage levels should be changed. The Agency concluded, in light of the limited data, that it had insufficient basis to change the requirements at this time.

2. *Distinction Between Sudden and Nonsudden Coverage.* 40 CFR 264.147(a) and 265.147(a) require all owners or operators of hazardous waste facilities to have "sudden accidental" coverage. Owners and operators of surface impoundments, landfills, or land treatment facilities used to manage hazardous wastes also are required to have "nonsudden accidental" coverage (40 CFR 264.147(b) and 265.147(b)).

A number of commenters on the August 21, 1985, NPRM suggested that the Agency no longer distinguish between sudden and nonsudden accidental coverage. They argued that nonsudden coverage was difficult to obtain, and that insurers were beginning to issue combined policies for sudden and nonsudden coverage. (A more complete discussion of comments on this point is provided in documents accompanying today's rulemaking.)

EPA has decided to maintain the distinction between sudden and nonsudden coverage. The Agency believes that maintaining distinct coverage requirements is still appropriate. Further, the insurance industry continues to write policies that distinguish between sudden and nonsudden events. EPA recognizes, however, that in some cases, courts have interpreted coverage for sudden events broadly to include damage from a gradual release occurring over long periods of time. As a result, some insurers do not distinguish between sudden and nonsudden events, but offer "combined coverage": coverage for both sudden and nonsudden events on the same policy with single aggregate and per-occurrence limits. Today's rule includes a change to the coverage requirements citation specifying that the Agency will accept "combined coverage" policies, but to provide equivalent levels of coverage, the limits must be at least $4 million per-occurrence ($1 million sudden plus $3 million nonsudden) and $8 million annual aggregate ($2 million sudden plus $6 million nonsudden).

3. *Exclusion of Legal Defense Costs from Policy Limits.* Currently, Subpart H requires an owner or operator of a TSDF to maintain liability coverage for sudden and nonsudden accidental occurrences at specified levels, exclusive of legal defense costs (40 CFR 264.147 (a) and (b) and 265.147 (a) and (b)). The Agency decided to exclude legal defense costs for two reasons: (1) The insurance industry standard for CGL policies excluded legal defense costs from the coverage, and (2) legal defense costs could absorb a major portion of the required coverage, leaving an inadequate amount to cover actual damages. The Agency continues to believe that these reasons remain valid and do not affect the availability of insurance.

In its August 21, 1985 NPRM the Agency requested comment on whether, in an effort to increase the availability of EIL coverage for TSDFs, legal defense costs should be included in coverage limits. A number of commenters supported including legal defense costs. They argued that the EIL coverage currently available to TSDFs is written to include defense costs within policy limits. The Agency contacted insurance companies known to provide EIL coverage to ask whether their EIL policies included or excluded legal defense costs. Although some companies stated that defense costs are included in the coverage limits, others said that defense costs were excluded, or that the policy could be written to conform to the RCRA requirements; that is, policies could be written to exclude legal defense costs. Furthermore, current industry practice, including the present industry standard form for this type of insurance, still excludes defense costs from the coverage limits. In addition, while recently there have been attempts by insurers to limit defense cost exposure by including at least some defense costs within policy limits, the trend appears to be toward some other

method of limiting costs outside of policy limits.

The second reason commenters presented for changing the RCRA requirements to include legal defense costs was that the assurance of the availability of defense costs is an important element of claims litigation and further that there were insufficient RCRA claims data to warrant requiring coverage excluding legal defense costs.

The Agency continues to believe that it is important for the full amount of liability coverage to be available to cover claims against owners or operators of TSDFs. The Agency decided on the current coverage levels after a thorough investigation of reported third-party damage cases from hazardous waste accidents and these levels do not account for legal defense costs. Because the size of legal defense costs in this area is somewhat uncertain, the most secure method of ensuring that sufficient funds will be available to cover actual damages is to retain the requirement that defense costs be excluded.

Other commenters stated that including legal defense costs should be permissible, as long as the full amount of RCRA liability coverage was available to claimants. EPA agrees. If the total coverage includes the full amount required for third-party liability plus additional coverage earmarked for legal defense costs, the policy would be acceptable under current regulations. Thus, for example, a policy would provide acceptable assurance for a surface impoundment if the total coverage was $5 million per occurrence and $10 million annual aggregate if legal defense costs covered under the policy were limited to a maximum of $1 million per occurrence and $2 million annual aggregate. A $5 million per occurrence, $8 million annual aggregate policy without an earmarked limit on legal defense costs would not provide adequate assurance.

4. *Deductibles.* A number of commenters argued that EPA should not require "first-dollar" coverage for liability costs. If deductibles were allowed, according to these commenters, insurance coverage might be easier to obtain or be less costly.

Although the insurer must provide first-dollar coverage, EPA notes that the regulations do not prevent insurers from requiring reimbursement from owners or operators for first-dollar expenditures. The owner or operator can agree in the insurance contract that the insurer will be reimbursed for these expenditures. The regulations do not, however, allow self-insurance retention. Policies cannot require the owner or operator to cover first-dollar expenditures. Such self-insurance is available to an owner or operator under the regulations only if it can pass the requirements established in the financial test for liability coverage.

EPA contacted a number of insurers to determine whether self-insurance retention could help to alleviate problems of insurance availability and affordability. In general, however, their responses indicated that current problems with EIL insurance are related to other factors, such as difficulty in predicting the size of the risk being covered, and that deductibles would not significantly enhance insurance availability. Therefore, the Agency is retaining the current first-dollar coverage requirement.

C. Mechanisms Considered But Not Adopted

1. *Security interests.* Security interests are a special procedure, authorized under State law following a pattern established by the Uniform Commercial Code, for creating collateral to serve as a support for the repayment of loans or other financial obligations. Security interests were considered but rejected for liability coverage because of the complicated legal requirements that have to be satisfied to ensure that they provide effective financial assurance. For example, security interests ordinarily must be perfected by filing papers with appropriate agencies in each jurisdiction where collateral exists, and these filings must be kept up to date. EPA would be required to verify that proper filings had occurred. In addition, the Agency would also have to determine that the collateral underlying the agreement had been valued properly. If not, the proceeds from sale of the collateral might fail to supply the amounts required to satisfy valid claims. Finally, the need to satisfy specific legal processes prior to liquidation of collateral could delay payment of valid third-party claims. Because of these problems, EPA has decided not to adopt security interests at this time.

2. *Indemnity contracts.* Indemnity contracts are legally binding commitments by a third party or "indemnitor" to pay a debt or obligation of another party. The duty of the indemnitor generally is to repay the primary debtor after it has satisfied the debt or obligation. The Agency was not willing to adopt such a mechanism because of the administrative difficulties and lengthy time needed to enforce such contracts.

An indemnity contract also may be established in which the indemnitor agrees to assume the obligation even if the primary debtor does not pay. Such a contract, however, so closely resembles a guarantee that EPA determined that in effect no additional financial assurance option would be added to the regulations by inclusion of the indemnity. Therefore the Agency has not added an indemnity contract to the set of options authorized in today's rule.

3. *Reserve funds.* As a temporary measure pending the growth of the insurance market, some commenters suggested that owners or operators set aside the equivalent of insurance premiums in a reserve fund. Such a mechanism could function in a manner similar to trusts, if control over the fund were given to an independent fiduciary agent. Alternatively, however, some commenters suggested that the reserve fund be only a separate bookkeeping entity under the control of the owner or operator. EPA believes that neither approach would ensure that the reserve would contain sufficient funds when required to satisfy claims. Liability coverage funds may be needed at any time after implementation of the mechanism. Because a reserve fund based on the estimated equivalent of insurance premiums, rather than the amounts equal to the required coverage levels, would accumulate slowly, it would be unlikely to contain adequate funds to satisfy liability claims, especially in the early years.

In addition, EPA is convinced that a reserve fund that is not under the control of an independent trustee but instead remains under the control of the TSDF owner or operator will not provide satisfactory financial assurance. No independent third party would administer the reserve fund, including assessing its value and controlling payments from the fund. The Agency determined, therefore, not to authorize the use of reserves. Today's rule authorizes a fully funded trust fund, for owners and operators who want to use a similar mechanism.

4. *Federal Insurance or Loan Guarantees.* Some commenters pointed to other financial assurance programs utilizing Federal insurance or loan guarantees as possible models for EPA. Establishment of insurance or loan guarantees requires specific statutory authority that has not been granted to the Agency. Further, EPA does not believe that as an agency whose primary mandate is protection of human health and the environment, it currently possesses the expertise or resources to administer either an insurance or a loan guarantee program. Such programs or approaches would require the Agency to assess financial characteristics of owners or operators, and to make

decisions concerning the validity of claims, when those assessments and decisions can be made more accurately and efficiently by existing institutions that provide financial assurance.

5. *Captive Insurance Pools and Risk Retention Groups.* EPA believes it is unnecessary in today's rulemaking explicitly to authorize the use of captive insurance pools and risk retention groups. Such instruments are already authorized as forms of insurance. If the policies offered by a pool or risk retention group satisfy EPA requirements, such policies provide acceptable financial assurance.

D. Authorize Waivers

A number of commenters, particularly those from industry, supported granting temporary waivers on a case-by-case basis if a firm can demonstrate that it has made a "good faith effort" to obtain the required liability insurance. However, the Agency believes that the authorization of additional mechanisms, existing enforcement policies, the somewhat improved insurance market for TSDFs and the increased potential of insurance offered by risk retention groups, provide a better solution than simply waiving the liability coverage requirements. Also, existing regulations enable Regional Administrators to grant variances (§§ 264.147(c) and 265.147(c)) or adjustments (§ 264.147(d) and 265.147(d)) to the required liability coverage amounts, if this is justified by the degree and duration of risk associated with a TSDF. The Agency believes that justifiable modifications in the amount of coverage needed are more consistent with the objectives of the liability coverage requirements than would be relieving owners or operators of these requirements entirely, solely because they made a "good faith" effort to obtain coverage.

VI. Consistency With Other Existing and Proposed Financial Assurance Requirements

EPA currently allows owners or operators of hazardous waste TSDFs to use the mechanisms being approved in today's rule, including trust funds, letters of credit, surety bonds, and corporate guarantee contracts, to provide financial assurance for the costs of closure and post-closure care (40 CFR 264.143, 264.145, 264.151, 265.143, and 265.145), and has proposed their use for corrective action (51 FR 37854, October 24, 1986). As described above, certain features of the assurance mechanisms are different because of the differences between these programs and liability coverage.

In addition, EPA has proposed financial assurance rules applicable to owners and operators of underground storage tanks (USTs) containing petroleum under sections 9003 (c) and (d) of RCRA as amended by HSWA (RCRA Subtitle I), and by the Superfund Amendments and Reauthorization Act of 1986 (SARA) (52 FR 12662, April 17, 1987). The proposed rule would establish requirements for demonstrating financial responsibility for taking corrective action and compensating third parties for bodily injury and property damage caused by sudden and nonsudden accidental releases arising from operating an underground storage tank containing petroleum. As in today's rule, under the UST proposal, owners and operators of underground storage tanks containing petroleum would be allowed to use letters of credit, surety bonds, and expanded guarantees to demonstrate financal responsibility for the costs of corrective action and third-party liability claims (52 FR 12786, 12844, April 17, 1987).

VII. Technical Correction to 40 CFR 264.151(b)

The May 2, 1986 rule amending the closure, post-closure care, and financial assurance regulations mistakenly omitted a portion of the required language for the financial guarantee bond found in 40 CFR 264.151(b) (see 51 FR 16422, 16450). Today's rule makes a technical correction to the regulation to restore the required wording of the bond.

VIII. Effective Date

This regulation is being published as a final rule, effective in 30 days.

Section 3010(b) of RCRA provides that EPA's hazardous waste regulations and revisions thereto generally take effect six months after their promulgations. The purpose of this requirement is to allow sufficient time for the regulated community to comply with major new regulatory requirements. The statute allows for a shorter period prior to the effective date, if (i) the Administrator finds that the regulated community does not need six months to come into compliance; (ii) the regulation responds to an emergency situation, or (iii) other good cause. The Agency believes that since the regulation does not add any compliance requirements, but rather expands the number of mechanisms owners or operators may use to come into compliance, a six-month period prior to the effective date is unnecessary.

Today's amendment adopts additional mechanisms for complying with third-part liability coverage requirements and thus makes it easier for some owners and operators to act in accordance with the RCRA liability coverage regulations. An effective date six months after promulgation for the amendment promulgated today would substantially delay the implementation of the regulations and would be contrary to the interest of the regulated community and the public. Accordingly, the Agency believes that it makes little sense to delay needed relief to owners or operators by an additional five months.

IX. State Authority

A. Applicability of Rules in Authorized States

Under section 3006 of RCRA, EPA may authorize qualified States to administer and enforce the RCRA program within the State. (See 40 CFR Part 271 for the standards and requirements for authorization.) Following authorization, EPA retains enforcement authority under RCRA sections 3008, 7003, and 3013, although authorized States have primary enforcement responsibility.

Prior to HSWA, a State with final authorization administered its hazardous waste program entirely in lieu of EPA administering the Federal program in that State. The Federal requirements no longer applied in the authorized State, and EPA could not issue permits for any facilities in a State where the State was authorized to permit. When new, more stringent Federal requirements were promulgated or enacted, the State was obligated to enact equivalent authority within specified time frames. New Federal requirements did not take effect in an authorized State until the State adopted the requirements as State law.

In contrast, under section 3006(g) of RCRA, 42 U.S.C. 6926(g), new requirements and prohibitions imposed by the HSWA take effect in authorized States at the same time that they take effect in non-authorized States. EPA is directed to carry out those requirements and prohibitions in authorized States, including the issuance of permits, until the State is granted authorization to do so. While States must still adopt HSWA-related provisions as State law to retain final authorization, the HSWA requirements and prohibitions apply in authorized States in the interim.

B. Effect of Rule on State Authorizations

Today's rule promulgates standards that will not be effective in authorized States since the requirements are not being imposed pursuant to HSWA.

Thus, the requirements will be applicable only in those States that do not have interim or final authorization. In authorized States, the requirements will not be applicable until the State revises its program to adopt equivalent requirements under State law.

In general, 40 CFR 271.21(e)(2) requires that States that have final authorization to modify their programs to reflect Federal program changes and subsequently submit the modifications to EPA for approval. It should be noted, however, that authorized States are only required to modify their programs when EPA promulgates Federal standards that are more stringent or broader in scope than the existing Federal standards. Section 3009 of RCRA allows States to impose standards more stringent than those in the Federal program. For those Federal program changes that are less stringent or reduce the scope of the Federal program, States are not required to modify their programs (see 40 CFR 271.1(i)). The standards promulgated today are less stringent than or reduce the scope of the existing Federal requirements. Therefore, authorized States will not be required to modify their programs to adopt requirements equivalent or substantially equivalent to the provisions listed above. If the State does modify its program, EPA must approve the modification for the State requirements to become Subtitle C RCRA requirements. States should follow the deadlines of 40 CFR 271.21(e)(2) if they desire to adopt this less stringent requirement.

X. Executive Order 12291

Under Executive Order 12291 (section 3(b)) the Agency must judge whether a regulation is major and thus subject to the requirement of a Regulatory Impact Analysis. The notice published today is not major because the rule will not result in an effect on the economy of $100 million or more, will not result in increased costs or prices, will not have significant adverse effects on competition, employment, investment, productivity, and innovation, and will not significantly disrupt domestic or export markets. Therefore, the Agency has not prepared a Regulatory Impact Analysis under the Executive Order.

This regulation was submitted to the Office of Management and Budget (OMB) for review as required by Exective Order No. 12291.

XI. Regulatory Flexibility Act

Under the Regulatory Flexibility Act of 1980 (5 U.S.C. 601 *et seq.*), Federal agencies must, in developing regulations, analyze their impact on small entities (small businesses, small government jurisdictions, and small organizations). This rule relaxes the existing financial assurance requirements and thus reduces costs associated with compliance. Accordingly, I certify that this regulation will not have a significant economic impact on a substantial number of small entities.

XII. Supporting Documents

Supporting documents available for this interim final rule include comments on the August 21, 1985 Proposed Rule, summary of the comments on the July 11, 1986 Interim Final Rule, and background documents on the finanical test for liability coverage. In addition, background documents prepared for previous financial assurance regulations, as well as documents prepared for this rulemaking, are also available as are letters received from State Attorneys General concerning the corporate guarantee for liability.

All of these supporting materials are available for review in the EPA public docket (RCRA docket #F–88–CGF1–FFFFF), Room S–212, Waterside Mall, 401 M Street, SW., Washington, DC 20460.

List of Subjects

40 CFR Part 264

Hazardous waste, Insurance, Packaging and containers, Reporting and recordkeeping requirements, Surety bonds.

40 CFR Part 265

Hazardous waste, Insurance, Packaging and containers, Reporting and recordkeeping requirements, Surety bonds.

Date: August 19, 1988.

Lee M. Thomas,

Administrator.

For the reasons set out in the preamble, Title 40, Chapter I of the Code of Federal Regulations is amended as set forth below.

40 CFR Part 264 is amended as follows:

PART 264—STANDARDS FOR OWNERS AND OPERATORS OF HAZARDOUS WASTE TREATMENT, STORAGE, AND DISPOSAL FACILITIES: LIABILITY COVERAGE

1. The authority citation for Part 264 continues to read as follows:

Authority: 42 U.S.C. 6905, 6912(a), 6924, and 6925.

2. In § 264.141, new paragraph (h) is added to read as follows:

§ 264.141 Definitions of terms as used in this subpart.

* * * * *

(h) "Substantial business relationship" means the extent of a business relationship necessary under applicable State law to make a guarantee contract issued incident to that relationship valid and enforceable. A "substantial business relationship" must arise from a pattern of recent or ongoing business transactions, in addition to the guarantee itself, such that a currently existing business relationship between the guarantor and the owner or operator is demonstrated to the satisfaction of the applicable EPA Regional Administrator.

3. In § 264.147, paragraph (h) is redesignated as paragraph (k); paragraphs (a) introductory text, (a)(2), (a)(3), (b) introductory text, (b)(2), (b)(3), (b)(4), (g) heading and (g)(1) introductory text are revised, and by removing and reserving paragraph (g)(1)(ii); paragraphs (g)(2)(i) and (g)(2)(ii) are amended by removing "corporate;" and new paragraphs (a)(4), (a)(5), (a)(6), (a)(7), (b)(5), (b)(6), (b)(7), (h), (i), and (j) are added, to read as follows:

§ 264.147 Liability requirements.

(a) *Coverage for sudden accidental occurrences.* An owner or operator of a hazardous waste treatment, storage, or disposal facility, or a group of such facilities, must demonstrate financial responsibility for bodily injury and property damage to third parties caused by sudden accidental occurrences arising from operations of the facility or group of facilities. The owner or operator must have and maintain liability coverage for sudden accidental occurrences in the amount of at least $1 million per occurrence with an annual aggregate of at least $2 million, exclusive of legal defense costs. This liability coverage may be demonstrated as specified in paragraphs (a) (1), (2), (3), (4), (5), or (6) of this section:

* * * * *

(2) An owner or operator may meet the requirements of this section by passing a financial test or using the guarantee for liability coverage as specified in paragraph (g) of this section.

(3) An owner or operator may meet the requirements of this section by obtaining a letter of credit for liability coverage as specified in paragraph (h) of this section.

(4) An owner or operator may meet the requirements of this section by obtaining a surety bond for liability coverage as specified in paragraph (i) of this section.

(5) An owner or operator may meet the requirements of this section by obtaining a trust fund for liability coverage as specified in paragraph (j) of this section.

(6) An owner or operator may demonstrate the required liability coverage through the use of combinations of insurance, financial test, guarantee, letter of credit, surety bond, and trust fund, except that the owner or operator may not combine a financial test covering part of the liability coverage requirement with a guarantee unless the financial statement of the owner or operator is not consolidated with the financial statement of the guarantor. The amounts of coverage demonstrated must total at least the minimum amounts required by this section. If the owner or operator demonstrates the required coverage through the use of a combination of financial assurances under this paragraph, the owner or operator shall specify at least one such assurance as "primary" coverage and shall specify other assurance as "excess" coverage.

(7) An owner or operator shall notify the Regional Administrator in writing within 30 days (i) whenever a claim for bodily injury or property damages caused by the operation of a hazardous waste treatment, storage, or disposal facility is made against the owner or operator or an instrument providing financial assurance for liability coverage under this section and (ii) whenever the amount of financial assurance for liability coverage under this section provided by a financial instrument authorized by paragraphs (a)(1) through (a)(6) of this section is reduced.

(b) *Coverage for nonsudden accidental occurrences.* An owner or operator of a surface impoundment, landfill, or land treatment facility which is used to manage hazardous waste, or a group of such facilities, must demonstrate financial responsibility for bodily injury and property damage to third parties caused by nonsudden accidental occurrences arising from operations of the facility or group of facilities. The owner or operator must have and maintain liability coverage for nonsudden accidental occurrences in the amount of at least $3 million per occurrence with an annual aggregate of at least $6 million, exclusive of legal defense costs. An owner or operator who must meet the requirements of this section may combine the required per-occurrence coverage levels for sudden and nonsudden accidental occurrences into a single per-occurrence level, and combine the required annual aggregate coverage levels for sudden and nonsudden accidental occurrences into a single annual aggregate level. Owners or operators who combine coverage levels for sudden and nonsudden accidental occurrences must maintain liability coverage in the amount of at least $4 million per occurrence and $8 million annual aggregate. This liability coverage may be demonstrated as specified in paragraphs (b) (1), (2), (3), (4), (5), or (6), of this section:

* * * * *

(2) An owner or operator may meet the requirements of this section by passing a financial test or using the guarantee for liability coverage as specified in paragraphs (f) and (g) of this section.

(3) An owner or operator may meet the requirements of this section by obtaining a letter of credit for liability coverage as specified in paragraph (h) of this section.

(4) An owner or operator may meet the requirements of this section by obtaining a surety bond for liability coverage as specified in paragraph (i) of this section.

(5) An owner or operator may meet the requirements of this section by obtaining a trust fund for liability coverage as specified in paragraph (j) of this section.

(6) An owner or operator may demonstrate the required liability coverage through the use of combinations of insurance, financial test, guarantee, letter of credit, surety bond, and trust fund, except that the owner or operator may not combine a financial test covering part of the liability coverage requirement with a guarantee unless the financial statement of the owner or operator is not consolidated with the financial statement of the guarantor. The amounts of coverage demonstrated must total at least the minimum amount required by this section. If the owner or operator demonstrates the required coverage through the use of a combination of financial assurances under this paragraph, the owner or operator shall specify at least one such assurance as "primary" coverage and shall specify other assurance as "excess" coverage.

(7) An owner or operator shall notify the Regional Administrator in writing within 30 days (i) whenever a claim for bodily injury or property damages caused by the operation of a hazardous waste treatment, storage, or disposal facility is made against the owner or operator or an instrument providing financial assurance for liability coverage under this section and (ii) whenever the amount of financial assurance for liability coverage under this section provided by a financial instrument authorized by paragraphs (a)(1) through (a)(6) of this section is reduced.

* * * * *

(g) *Guarantee for liability coverage.* (1) Subject to paragraph (g)(2) of this section, an owner or operator may meet the requirements of this section by obtaining a written guarantee, hereinafter referred to as "guarantee." The guarantor must be the direct or higher-tier parent corporation of the owner or operator, a firm whose parent corporation is also the parent corporation of the owner or operator, or a firm with a "substantial business relationship" with the owner or operator. The guarantor must meet the requirements for owners or operators in paragraphs (f)(1) through (f)(6) of this section. The wording of the guarantee must be identical to the wording specified in § 264.151(h)(2) of this part. A certified copy of the guarantee must accompany the items sent to the Regional Administrator as specified in paragraph (f)(3) of this section. One of these items must be the letter from the guarantor's chief financial officer. If the guarantor's parent corporation is also the parent corporation of the owner or operator, this letter must describe the value received in consideration of the guarantee. If the guarantor is a firm with a "substantial business relationship" with the owner or operator, this letter must describe this "substantial business relationship" and the value received in consideration of the guarantee.

* * * * *

(h) *Letter of credit for liability coverage.* (1) An owner or operator may satisfy the requirements of this section by obtaining an irrevocable standby letter or credit that conforms to the requirements of this paragraph and submitting a copy of the letter of credit to the Regional Administrator.

(2) The financial institution issuing the letter of credit must be an entity that has the authority to issue letters of credit and whose letter of credit operations are regulated and examined by a Federal or State agency.

(3) The wording of the letter of credit must be identical to the wording specified in § 264.151(k) of this part.

(i) *Surety bond for liability coverage.* (1) An owner or operator may satisfy the requirements of this section by obtaining a surety bond that conforms to the requirements of this paragraph and submitting a copy of the bond to the Regional Administrator.

(2) The surety company issuing the bond must be among those listed as acceptable sureties on Federal bonds in the most recent Circular 570 of the U.S. Department of the Treasury.

(3) The wording of the surety bond must be identical to the wording specified in § 264.151(1) of this part.

(4) A surety bond may be used to satisfy the requirements of this section only if the Attorneys General or Insurance Commissioners of (i) the State in which the surety is incorporated, and (ii) each State in which a facility covered by the surety bond is located have submitted a written statement to EPA that a surety bond executed as described in this section and § 264.151(1) of this part is a legally valid and enforceable obligation in that State.

(j) *Trust fund for liability coverage.* (1) An owner or operator may satisfy the requirements of this section by establishing a trust fund that conforms to the requirements of this paragraph and submitting an originally signed duplicate of the trust agreement to the Regional Administrator.

(2) The trustee must be an entity which has the authority to act as a trustee and whose trust operations are regulated and examined by a Federal or State agency.

(3) The trust fund for liability coverage must be funded for the full amount of the liability coverage to be provided by the trust fund before it may be relied upon to satisfy the requirements of this section. If at any time after the trust fund is created the amount of funds in the trust fund is reduced below the full amount of the liability coverage to be provided, the owner or operator, by the anniversary date of the establishment of the fund, must either add sufficient funds to the trust fund to cause its value to equal the full amount of liability coverage to be provided, or obtain other financial assurance as specified in this section to cover the difference. For purposes of this paragraph, "the full amount of the liability coverage to be provided" means the amount of coverage for sudden and/or nonsudden occurrences required to be provided by the owner or operator by this section, less the amount of financial assurance for liability coverage that is being provided by other financial assurance mechanisms being used to demonstrate financial assurance by the owner or operator.

(4) The wording of the trust fund must be identical to the wording specified in § 264.151(m) of this part.

§ 264.151 [Amended]

4. In § 264.151 paragraph (b) is amended by adding the following text to the end of the "Financial Guarantee Bond" to read as follows:

(b) * * *

Financial Guarantee Bond

* * * * *

Or, if the Principal shall provide alternate financial assurance, as specified in Subpart H of 40 CFR Part 264 or 265, as applicable, and obtain the EPA Regional Administrator's written approval of such assurance, within 90 days after the date notice of cancellation is received by both the Principal and the EPA Regional Administrator(s) from the Surety(ies), then this obligation shall be null and void; otherwise it is to remain in full force and effect.

The Surety(ies) shall become liable on this bond obligation only when the Principal has failed to fulfill the conditions described above. Upon notification by an EPA Regional Administrator that the Principal has failed to perform as guaranteed by this bond, the Surety(ies) shall place funds in the amount guaranteed for the facility(ies) into the standby trust fund as directed by the EPA Regional Administrator.

The liability of the Surety(ies) shall not be discharged by any payment or succession of payments hereunder, unless and until such payment or payments shall amount in the aggregate to the penal sum of the bond, but in no event shall the obligation of the Surety(ies) hereunder exceed the amount of said penal sum.

The Surety(ies) may cancel the bond by sending notice of cancellation by certified mail to the Principal and to the EPA Regional Administrator(s) for the Region(s) in which the facility(ies) is (are) located, provided, however, that cancellation shall not occur during the 120 days beginning on the date of receipt of the notice of cancellation by both the Principal and the EPA Regional Administrator(s), as evidenced by the return receipts.

The Principal may terminate this bond by sending written notice to the Surety(ies), provided, however, that no such notice shall become effective until the Surety(ies) receive(s) written authorization for termination of the bond by the EPA Regional Administrator(s) of the EPA Region(s) in which the bonded facility(ies) is (are) located.

[The following paragraph is an optional rider that may be included but is not required.]

Principal and Surety(ies) hereby agree to adjust the penal sum of the bond yearly so that it guarantees a new closure and/or post-closure amount, provided that the penal sum does not increase by more than 20 percent in any one year, and no decrease in the penal sum takes place without the written permission of the EPA Regional Administrator(s).

In Witness Whereof, the Principal and Surety(ies) have executed this Financial Guarantee Bond and have affixed their seals on the date set forth above.

The persons whose signatures appear below hereby certify that they are authorized to execute this surety bond on behalf of the Principal and Surety(ies) and that the wording of this surety bond is identical to the wording specified in 40 CFR 264.151(b) as such regulations were constituted on the date this bond was executed.

Principal

[Signature(s)] _____

[Name(s)] _____

[Title(s)] _____

[Corporate seal] _____

Corporate Surety(ies)

[Name and address]

State of incorporation:] _____

Liability limit: $ _____

[Signature(s)]

[Name(s) and title(s)]

[Corporate seal]

[For every co-surety, provide signature(s), corporate seal, and other information in the same manner as for Surety above.]

Bond premium: $ _____

5. In § 264.151, paragraph (g) is revised to read as follows:

(g) A letter from the chief financial officer, as specified in § 264.147(f) or § 265.147(f) of this chapter, must be worded as follows, except that instructions in brackets are to be replaced with the relevant information and the brackets deleted.

Letter From Chief Financial Officer

[Address to Regional Administrator of every Region in which facilities for which financial responsibility is to be demonstrated through the financial test are located.]

I am the chief financial officer of [firm's name and address]. This letter is in support of the use of the financial test to demonstrate financial responsibility for liability coverage [insert "and closure and/or post-closure care" if applicable] as specified in Subpart H of 40 CFR Parts 264 and 265.

[Fill out the following paragraphs regarding facilities and liability coverage. If there are no facilities that belong in a particular paragraph, write "None" in the space indicated. For each facility, include its EPA Identification Number, name, and address.]

The firm identified above is the owner or operator of the following facilities for which liability coverage for [insert "sudden" or "nonsudden" or "both sudden and nonsudden"] accidental occurrences is being demonstrated through the financial test specified in Subpart H of 40 CFR Parts 264 and 265: _____.

The firm identified above guarantees, through the guarantee specified in Subpart H or 40 CFR Parts 264 and 265, liability coverage for [insert "sudden" or "nonsudden" or "both sudden and nonsudden"] accidental occurrences at the following facilities owned or operated by the following: _____. The firm identified above is [insert one or more: (1) The direct or higher-tier parent corporation of the owner or operator; (2) owned by the same parent corporation as the parent corporation of the owner or operator, and receiving the following value in consideration of this guarantee _____; or (3) engaged in the following substantial business relationship with the owner or operator _____, and receiving the following value in consideration

of this guarantee _____.] [Attach a written description of the business relationship or a copy of the contract establishing such relationship to this letter.]

[If you are using the financial test to demonstrate coverage of both liability and closure and post-closure care, fill in the following four paragraphs regarding facilities and associated closure and post-closure cost estimates. If there are no facilities that belong in a particular paragraph, write "None" in the space indicated. For each facility, include its EPA Identification Number, name, address, and current closure and/or post-closure cost estimates. Identify each cost estimate as to whether it is for closure or post-closure care.]

1. The firm identified above owns or operates the following facilities for which financial assurance for closure or post-closure care or liability coverage is demonstrated through the financial test specified in Subpart H of 40 CFR Parts 264 and 265. The current closure and/or post-closure cost estimate covered by the test are shown for each facility: _____.

2. The firm identified above guarantees, through the guarantee specified in Subpart H of 40 CFR Parts 264 and 265, the closure and post-closure care or liability coverage of the following facilities owned or operated by the guaranteed party. The current cost estimates for the closure or post-closure care so guaranteed are shown for each facility: _____.

3. In States where EPA is not administering the financial requirements of Subpart H of 40 CFR Parts 264 and 265, this firm is demonstrating financial assurance for the closure or post-closure care of the following facilities through the use of a test equivalent or substantially equivalent to the financial test specified in Subpart H of 40 CFR Parts 264 and 265. The current closure or post-closure cost estimates covered by such a test are shown for each facility: _____.

4. The firm identified above owns or operates the following hazardous waste management facilities for which financial assurance for closure or, if a disposal facility, post-closure care, is not demonstrated either to EPA or a State through the financial test or any other financial assurance mechanisms specified in Subpart H of 40 CFR Parts 264 and 265 or equivalent or substantially equivalent State mechanisms. The current closure and/or post-closure cost estimates not covered by such financial assurance are shown for each facility: _____.

5. This firm is the owner or operator of the following UIC facilities for which financial assurance for plugging and abandonment is required under 40 CFR Part 144. The current closure cost estimates as required by 40 CFR 144.62 are shown for each facility: _____.

This firm [insert "is required" or "is not required"] to file a Form 10K with the Securities and Exchange Commission (SEC) for the latest fiscal year.

The fiscal year of this firm ends on [month, day]. The figures for the following items marked with an asterisk are derived from this firm's independently audited, year-end financial statements for the latest completed fiscal year, ended [date].

[Fill in part A if you are using the financial test to demonstrate coverage *only* for the liability requirements.]

Part A. Liability Coverage for Accidental Occurrences

[Fill in Alternative I if the criteria of paragraph (f)(1)(i) of § 264.147 or § 265.147 are used. Fill in Alternative II if the criteria of paragraph (f)(1)(ii) of § 264.147 or § 265.147 are used.]

ALTERNATIVE I

1.	Amount of annual aggregate liability coverage to be demonstrated.	$.....	
*2.	Current assets	$.....	
*3.	Current liabilities	$.....	
4.	Net working capital (line 2 minus line 3).	$.....	
*5.	Tangible net worth	$.....	
*6.	If less than 90% or assets are located in the U.S., given total U.S. assets.	$.....	
		Yes	No
7.	Is line 5 at least $10 million?	.....	
8.	Is line 4 at least 6 times line 1?	.....	
9.	Is line 5 at least 6 times line 1?	.....	
*10.	Are at least 90% of assets located in the U.S.? If not, complete line 11.	.....	
11.	Is line 6 at least 6 times line 1?	.....	

ALTERNATIVE II

1.	Amount of annual aggregate liability coverage to be demonstrated.	$.....	
2.	Current bond rating of most recent issuance and name of rating service.	.....	
3.	Date of issuance of bond.	.....	
4.	Date of maturity of bond.	.....	
*5.	Tangible net worth	$.....	
*6.	Total assets in U.S. (required only if less than 90% of assets are located in the U.S.).	$.....	
		Yes	No
7.	Is line 5 at least $10 million?	.....	
8.	Is line 5 at least 6 times line 1?	.....	
9.	Are at least 90% of assets located in the U.S.? If not, complete line 10.	.....	
10.	Is line 6 at least 6 times line 1?	.....	

[Fill in part B if you are using the financial test to demonstrate assurance of both liability coverage *and* closure or post-closure care.]

Part B. Closure or Post-Closure Care and Liability Coverage

[Fill in Alternative I if the criteria of paragraphs (f)(1)(i) of § 264.143 or § 264.145 and (f)(1)(i) of § 264.147 are used or if the criteria of paragraphs (e)(1)(i) of § 265.143 or § 265.145 and (f)(1)(i) of § 265.147 are used. Fill in Alternative II if the criteria of paragraphs (f)(1)(ii) of § 264.143 or § 264.145 and (f)(1)(ii) of § 264.147 are used or if the criteria of paragraphs (e)(1)(ii) of § 265.143 or § 265.145 and (f)(1)(ii) of § 265.147 are used.]

ALTERNATIVE I

1.	Sum of current closure and post-closure cost estimates (total of *all* cost estimates listed above).	$.....	
2.	Amount of annual aggregate liability coverage to be demonstrated.	$.....	
3.	Sum of lines 1 and 2	$.....	
*4.	Total liabilities (if any portion of your closure or post-closure cost estimates is included in your total liabilities, you may deduct that portion from this line and add that amount to lines 5 and 6).	$.....	
*5.	Tangible net worth	$.....	
*6.	Net worth	$.....	
*7.	Current assets	$.....	
*8.	Current liabilities	$.....	
9.	Net working capital (line 7 minus line 8).	$.....	
*10.	The sum of net income plus depreciation, depletion, and amortization.	$.....	
*11.	Total assets in U.S. (required only if less than 90% of assets are located in the U.S.).	$.....	
		Yes	No
12.	Is line 5 at least $10 million?	.....	
13.	Is line 5 at least 6 times line 3?	.....	
14.	Is line 9 at least 6 times line 3?	.....	
*15.	Are at least 90% of assets located in the U.S.? If not, complete line 16.	.....	
16.	Is line 11 at least 6 times line 3?	.....	
17.	Is line 4 divided by line 6 less than 2.0?	.....	
18.	Is line 10 divided by line 4 greater than 0.1?	.....	
19.	Is line 7 divided by line 8 greater than 1.5?	.....	

ALTERNATIVE II

1.	Sum of current closure and post-closure cost estimates (total of *all* cost estimates listed above).	$.....	

2.	Amount of annual aggregate liability coverage to be demonstrated.	$.....
3.	Sum of lines 1 and 2.....	$.....
4.	Current bond rating of most recent issuance and name of rating service.	.....
5.	Date of issuance of bond.	.....
6.	Date of maturity of bond.	.....
*7.	Tangible net worth (if any portion of the closure or post-closure cost estimates is included in "total liabilities" on your financial statements you may add that portion to this line).	$.....
*8.	Total assets in the U.S. (required only if less than 90% of assets are located in the U.S.).	$.....
		Yes / No
9.	Is line 7 at least $10 million?	.....
10.	Is line 7 at least 6 times line 3?	.....
*11.	Are at least 90% of assets located in the U.S.? If not, complete line 12.	.....
12.	Is line 8 at least 6 times line 3?	.....

I hereby certify that the wording of this letter is identical to the wording specified in 40 CFR 264.151(g) as such regulations were constituted on the date shown immediately below.

[Signature] _____

[Name] _____

[Title] _____

[Date] _____

6. Section 264.151(h)(2) is amended by revising the heading for the "Corporate Guarantee for Liability Coverage" to read "Guarantee for Liability Coverage" and by removing "corporate" from paragraph (h)(2); and by removing paragraph 12 of the "Guarantee for Liability Coverage"; redesignating paragraphs 4 through 11 as paragraphs 5 through 12, adding new paragraphs 4, 13 and 14; and revising paragraph 10; to read as follows:

* * * * *

(h) * * *

(2) * * *

Guarantee for Liability Coverage

* * * * *

4. Such obligation does not apply to any of the following:

(a) Bodily injury or property damage for which [insert owner or operator] is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages that [insert owner or operator] would be obligated to pay in the absnce of the contract or agreement.

(b) Any obligation of [insert owner or operator] under a workers' compensation, disability benefits, or unemployment compensation law or any similar law.

(c) Bodily injury to:

(1) An employee of [insert owner or operator] arising from, and in the course of, employment by [insert owner or operator]; or

(2) The spouse, child, parent, brother or sister of that employee as a consequence of, or arising from, and in the course of employment by [insert owner or operator]. This exclusion applies:

(A) Whether [insert owner or operator] may be liable as an employer or in any other capacity; and

(B) To any obligation to share damages with or repay another person who must pay damages because of the injury to persons identified in paragraphs (1) and (2).

(d) Bodily injury or property damage arising out of the ownership, maintenance, use, or entrustment to others of any aircraft, motor vehicle or watercraft.

(e) Property damage to:

(1) Any property owned, rented, or occupied by [insert owner or operator];

(2) Premises that are sold, given away or abandoned by [insert owner or operator] if the property damage arises out of any part of those premises;

(3) Property loaned to [insert owner or operator];

(4) Personal property in the care, custody or control of [insert owner or operator];

(5) That particular part of real property on which [insert owner or operator] or any contractors or subcontractors working directly or indirectly on behalf of [insert owner or operator] are performing operations, if the property damage arises out of these operations.

* * * * *

10. [Insert the following language if the guarantor is (a) a direct or higher-tier corporate parent, or (b) a firm whose parent corporation is also the parent corporation of the owner or operator]:

Guarantor may terminate this guarantee by sending notice by certified mail to the EPA Regional Administrator(s) for the Region(s) in which the facility(ies) is(are) located and to [owner or operator], provided that this guarantee may not be terminated unless and until [the owner or operator] obtains, and the EPA Regional Administrator(s) approve(s), alternate liability coverage complying with 40 CFR 264.147 and/or 265.147.

[Insert the following language if the guarantor is a firm qualifying as a guarantor due to its "substantial business relationship" with the owner or operator]:

Guarantor may terminate this guarantee 120 days following receipt of notification, through certified mail, by the EPA Regional Administrator(s) for the Region(s) in which the facility(ies) is(are) located and by [the owner or operator].

* * * * *

13. The Guarantor shall satisfy a third-party liability claim only on receipt of one of the following documents:

(a) Certification from the Principal and the third-party claimant(s) that the liability claim should be paid. The certification must be worded as follows, except that instructions in brackets are to be replaced with the relevant information and the brackets deleted:

Certification of Valid Claim

The undersigned, as parties [insert Principal] and [insert name and address of third-party claimant(s)], hereby certify that the claim of bodily injury and/or property damage cuased by a [sudden or nonsudden] accidental occurrence arising from operating [Principal's] hazardous waste treatment, storage, or disposal facility should be paid in the amount of $[ ].

[Signatures]
Principal

(Notary) Date

[Signatures]
Claimant(s)

(Notary) Date

(b) A valid final court order establishing a judgment against the Principal for bodily injury or property damage caused by sudden or nonsudden accidental occurrences arising from the operation of the Principal's facility or group of facilities.

14. In the event of combination of this guarantee with another mechanism to meet liability requirements, this guarantee will be considered [insert "primary" or "excess"] coverage.

I hereby certify that the wording of the guarantee is identical to the wording specified in 40 CFR 264.151(h)(2) as such regulations were constituted on the date shown immediately below.

Effective date: _____

[Name of guarantor]
[Authorized signature for guarantor]
[Name of person signing]
[Title of person signing]
Signature of witness of notary:

---

7. In § 264.151(i), paragraph 2.(d) of the "Hazardous Waste Facility Liability Endorsement" is revised to read as follows:

* * * * *

(i) * * *

Hazardous Waste Facility Liability Endorsement

* * * * *

(2) * * *

(d) Cancellation of this endorsement, whether by the Insurer, the insured, a parent corporation providing insurance coverage for its subsidiary, or by a firm having an insurable interest in and obtaining liability insurance on behalf of the owner or operator of the hazardous waste management facility, will be effective only upon written notice and only after the expiration of 60 days after a copy of such written notice is received by the Regional Administrator(s) of the EPA Region(s) in which the facility(ies) is(are) located.

8. In § 264.151(j), paragraph 2.(d) of the "Hazardous Waste Facility Certificate of Liability Insurance" is revised to read as follows:

* * * * *

(j) * * *

Hazardous Waste Facility Certificate of Liability Insurance

(2) * * *

(d) Cancellation of the insurance, whether by the insurer, the insured, a parent corportation providing insurance coverage for its subsidiary, or by a firm having an insurable interest in and obtaining liability insurance on behalf of the owner or operator of the hazardous waste management facility, will be effective only upon written notice and only after the expiration of 60 days after a copy of such written notice is received by the Regional Administrator(s) of the EPA Region(s) in which the facility(ies) is(are) located.

* * * * *

9. In § 264.151, a new paragraph (k) is added to read as follows:

* * * * *

(k) A letter of credit, as specified in § 264.147(h) or § 265.147(h) of this chapter, must be worded as follows, except that instructions in brackets are to be replaced with the relevant information and the brackets deleted:

Irrevocable Standby Letter of Credit

Name and Address of Issuing Institution
Regional Administrator(s)
Region(s)
U.S. Environmental Protection Agency

Dear Sir or Madam: We hereby establish our Irrevocable Standby Letter of Credit No. _____ in the favor of any and all third-party liability claimants, at the request and for the account of [owner's or operator's name and address] for third-party liability awards or settlements up to [in words] U.S. dollars $_____ per occurrence and the annual aggregate amount of [in words] U.S. dollars $_____, for sudden accidental occurrences and/or for third-party liability awards or settlements up to the amount of [in words] U.S. dollars $_____ per occurrence, and the annual aggregate amount of [in words] U.S. dollars $_____, for nonsudden accidental occurrences available upon presentation of a sight draft, bearing reference to this letter of credit No. _____, and (1) a signed certificate reading as follows:

Certification of Valid Claim

The undersigned, as parties [insert principal] and [insert name and address of third-party claimants], hereby certify that the claim of bodily injury [and/or] property damage caused by a [sudden or nonsudden] accidental occurrence arising from operations of [principal's] hazardous waste treatment, storage, or disposal facility should be paid in the amount of $_____. We hereby certify that the claim does not apply to any of the following:

(a) Bodily injury or property damage for which [insert principal] is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages that [insert principal] would be obligated to pay in the absence of the contract or agreement.

(b) Any obligation of [insert principal] under a workers' compensation, disability benefits, or unemployment compensation law or any similar law.

(c) Bodily injury to:

(1) An employee of [insert principal] arising from, and in the course of, employment by [insert principal]; or

(2) The spouse, child, parent, brother or sister of that employee as a consequence of, or arising from, and in the course of employment by [insert principal].

This exclusion applies:

(A) Whether [insert principal] may be liable as an employer or in any other capacity; and

(B) To any obligation to share damages with or repay another person who must pay damages because of the injury to persons identified in paragraphs (1) and (2).

(d) Bodily injury or property damage arising out of the ownership, maintenance, use, or entrustment to others of any aircraft, motor vehicle or watercraft.

(e) Property damage to:

(1) Any property owned, rented, or occupied by [insert principal];

(2) Premises that are sold, given away or abandoned by [insert principal] if the property damage arises out of any part of those premises;

(3) Property loaned to [insert principal];

(4) Personal property in the care, custody or control of [insert principal];

(5) That particular part of real property on which [insert principal] or any contractors or subcontractors working directly or indirectly on behalf of [insert principal] are performing operations, if the property damage arises out of these operations.

[Signatures]
Principal

[Signatures]
Claimant(s)

or (2) a valid final court order establishing a judgment against the principal for bodily injury or property damage caused by a sudden or nonsudden accidental occurrence arising from operation of the principal's facility or group of facilities.

This letter of credit is effective as of [date] and shall expire on [date at least one year later], but such expiration date shall be automatically extended for a period of [at least one year] on [date] and on each successive expiration date, unless, at least 120 days before the current expiration date, we notify you, the USEPA Regional Administrator for Region [Region #], and [owner's or operator's name] by certified mail that we have decided not to extend this letter of credit beyond the current expiration date.

Whenever this letter of credit is drawn on under and in compliance with the terms of this credit, we shall duly honor such draft upon presentation to us.

In the event that this letter of credit is used in combination with another mechanism for liability coverage, this letter of credit shall be considered [insert "primary" or "excess"] coverage.

We certify that the wording of this letter of credit is identical to the wording specified in 40 CFR 264.151(k) as such regulations were constituted on the date shown immediately below.

[Signature(s) and title(s) of official(s) of issuing institution]
[Date]

This credit is subject to [insert "the most recent edition of the Uniform Customs and Practice for Documentary Credits, published by the International Chamber of Commerce" or "the Uniform Commercial Code"].

10. In § 264.151, a new paragraph (l) is added to read as follows:

* * * * *

(l) A surety bond, as specified in § 264.147(h) or § 265.147(h) of this chapter, must be worded as follows: except that instructions in brackets are to be replaced with the relevant information and the brackets deleted:

Payment Bond

Surety Bond No. [Insert number]

Parties [Insert name and address of owner or operator], Principal, incorporated in [Insert State of incorporation] of [Insert city and State of principal place of business] and [Insert name and address of surety company(ies)], Surety Company(ies), of [Insert surety(ies) place of business].

EPA Identification Number, name, and address for each facility guaranteed by this bond: _____

	Sudden accidental occurrences	Nonsudden accidental occurrences
Penal Sum Per Occurrence.	[insert amount]	[insert amount]
Annual Aggregate.	[insert amount]	[insert amount]

Purpose: This is an agreement between the Surety(ies) and the Principal under which the Surety(ies), its(their) successors and assignees, agree to be responsible for the payment of claims against the Principal for bodily injury and/or property damage to third parties caused by ["sudden" and/or "nonsudden"] accidental occurrences arising from operations of the facility or group of facilities in the sums prescribed herein; subject to the governing provisions and the following conditions.

Governing Provisions:

(1) Section 3004 of the Resource Conservation and Recovery Act of 1976, as amended.

(2) Rules and regulations of the U.S. Environmental Protection Agency (EPA), particularly 40 CFR ["§ 264.147" or "§ 265.147"] (if applicable).

(3) Rules and regulations of the governing State agency (if applicable) [insert citation].

Conditions:

(1) The Principal is subject to the applicable governing provisions that require the Principal to have and maintain liability

coverage for bodily injury and property damage to third parties caused by ["sudden" and/or "nonsudden"] accidental occurrences arising from operations of the facility or group of facilities. Such obligation does not apply to any of the following:

(a) Bodily injury or property damage for which [insert principal] is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages that [insert principal] would be obligated to pay in the absence of the contract or agreement.

(b) Any obligation of [insert principal] under a workers' compensation, disability benefits, or unemployment compensation law or similar law.

(c) Bodily injury to:

(1) An employee of [insert principal] arising from, and in the course of, employment by [insert principal]; or

(2) The spouse, child, parent, brother or sister of that employee as a consequence of, or arising from, and in the course of employment by [insert principal]. This exclusion applies:

(A) Whether [insert principal] may be liable as an employer or in any other capacity; and

(B) To any obligation to share damages with or repay another person who must pay damages because of the injury to persons identified in paragraphs (1) and (2).

(d) Bodily injury or property damage arising out of the ownership, maintenance, use, or entrustment to others of any aircraft, motor vehicle or watercraft.

(e) Property damage to:

(1) Any property owned, rented, or occupied by [insert principal];

(2) Premises that are sold, given away or abandoned by [insert principal] if the property damage arises out of any part of those premises;

(3) Property loaned to [insert principal];

(4) Personal property in the care, custody or control of [insert principal];

(5) That particular part of real property on which [insert principal] or any contractors or subcontractors working directly or indirectly on behalf of [insert principal] are performing operations, if the property damage arises out of these operations.

(2) This bond assures that the Principal will satisfy valid third party liability claims, as described in condition 1.

(3) If the Principal fails to satisfy a valid third party liability claim, as described above, the Surety(ies) becomes liable on this bond obligation.

(4) The Surety(ies) shall satisfy a third party liability claim only upon the receipt of one of the following documents:

(a) Certification from the Principal and the third party claimant(s) that the liability claim should be paid. The certification must be worded as follows, except that instructions in brackets are to be replaced with the relevant information and the brackets deleted:

Certification of Valid Claim

The undersigned, as parties [insert name of Principal] and [insert name and address of third party claimant(s)], hereby certify that the claim of bodily injury and/or property damage caused by a [sudden or nonsudden] accidential occurrence arising from operating [Principal's] hazardous waste treatment, storage, or disposal facility should be paid in the amount of $[ ].

[Signature]
Principal

[Notary] Date

[Signature(s)]
Claimant(s)

[Notary] Date

or (b) A valid final court order establishing a judgment against the Principal for bodily injury or property damage caused by sudden or nonsudden accidental occurrences arising from the operation of the Principal's facility or group of facilities.

(5) In the event of combination of this bond with another mechanism for liability coverage, this bond will be considered [insert "primary" or "excess"] coverage.

(6) The liability of the Surety(ies) shall not be discharged by any payment or succession of payments hereunder, unless and until such payment or payments shall amount in the aggregate to the penal sum of the bond. In no event shall the obligation of the Surety(ies) hereunder exceed the amount of said annual aggregate penal sum, provided that the Surety(ies) furnish(es) notice to the Regional Administrator forthwith of all claims filed and payments made by the Surety(ies) under this bond.

(7) The Surety(ies) may cancel the bond by sending notice of cancellation by certified mail to the Principal and the USEPA Regional Administrator for Region [Region #], provided, however, that cancellation shall not occur during the 120 days beginning on the date of receipt of the notice of cancellation by the Principal and the Regional Administrator, as evidenced by the return receipt.

(8) The Principal may terminate this bond by sending written notice to the Surety(ies) and to the EPA Regional Administrator(s) of the EPA Region(s) in which the bonded facility(ies) is (are) located.

(9) The Surety(ies) hereby waive(s) notification of amendments to applicable laws, statutes, rules and regulations and agree(s) that no such amendment shall in any way alleviate its (their) obligation on this bond.

(10) This bond is effective from [insert date] (12:01 a.m., standard time, at the address of the Principal as stated herein) and shall continue in force until terminated as described above.

In Witness Whereof, the Principal and Surety(ies) have executed this Bond and have affixed their seals on the date set forth above.

The persons whose signatures appear below hereby certify that they are authorized to execute this surety bond on behalf of the Principal and Surety(ies) and that the wording of this surety bond is identical to the wording specified in 40 CFR 264.151(1), as such regulations were constituted on the date this bond was executed.

PRINCIPAL

[Signature(s)]
[Name(s)]
[Title(s)]
[Corporate Seal]

CORPORATE SURETY[IES]

[Name and address]
State of incorporation: _____
Liability Limit: $ _____
[Signature(s)]
[Name(s) and title(s)]
[Corporate seal]
[For every co-surety, provide signature(s), corporate seal, and other information in the same manner as for Surety above.]
Bond premium: $ _____

11. In § 264.151, a new paragraph (m) is added to read as follows:

* * * * *

(m)(1) A trust agreement, as specified in § 264.147(j) or § 265.147(j) of this chapter, must be worded as follows, except that instructions in brackets are to be replaced with the relevant information and the brackets deleted:

Trust Agreement

Trust Agreement, the "Agreement," entered into as of [date] by and between [name of the owner or operator] a [name of State] [insert "corporation," "partnership," "association," or "proprietorship"], the "Grantor," and [name of corporate trustee], [insert, "incorporated in the State of _____" or "a national bank"], the "trustee."

Whereas, the United States Environmental Protection Agency, "EPA," an agency of the United States Government, has established certain regulations applicable to the Grantor, requiring that an owner or operator of a hazardous waste management facility or group of facilities must demonstrate financial responsibility for bodily injury and property damage to third parties caused by sudden accidental and/or nonsudden accidental occurrences arising from operations of the facility or group of facilities.

Whereas, the Grantor has elected to establish a trust to assure all or part of such financial responsibility for the facilities identified herein.

Whereas, the Grantor, acting through its duly authorized officers, has selected the Trustee to be the trustee under this agreement, and the Trustee is willing to act as trustee.

Now, therefore, the Grantor and the Trustee agree as follows:

Section 1. *Definitions.* As used in this Agreement:

(a) The term "Grantor" means the owner or operator who enters into this Agreement and any successors or assigns of the Grantor.

(b) The term "Trustee" means the Trustee who enters into this Agreement and any successor Trustee.

Section 2. *Identification of Facilities.* This agreement pertains to the facilities identified on attached schedule A [on schedule A, for each facility list the EPA Identification Number, name, and address of the facility(ies) and the amount of liability coverage, or portions thereof, if more than one instrument affords combined coverage as demonstrated by this Agreement].

Section 3. *Establishment of Fund.* The Grantor and the Trustee hereby establish a trust fund, hereinafter the "Fund," for the benefit of any and all third parties injured or damaged by [sudden and/or nonsudden] accidental occurrences arising from operation of the facility(ies) covered by this guarantee, in the amounts of _____ [up to $1 million] per occurrence and _____ [up to $2 million] annual aggregate for sudden accidental occurrences and _____ [up to $3 million] per occurrence and _____ [up to $6 million] annual aggregate for nonsudden occurrences, except that the Fund is not established for the benefit of third parties for the following:

(a) Bodily injury or property damage for which [insert Grantor] is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages that [insert Grantor] would be obligated to pay in the absence of the contract or agreement.

(b) Any obligation of [insert Grantor] under a workers' compensation, disability benefits, or unemployment compensation law or any similar law.

(c) Bodily injury to:

(1) An employee of [insert Grantor] arising from, and in the course of, employment by [insert Grantor]; or

(2) The spouse, child, parent, brother or sister of that employee as a consequence of, or arising from, and in the course of employment by [insert Grantor].

This exclusion applies:

(A) Whether [insert Grantor] may be liable as an employer or in any other capacity; and

(B) To any obligation to share damages with or repay another person who must pay damages because of the injury to persons identified in paragraphs (1) and (2).

(d) Bodily injury or property damage arising out of the ownership, maintenance, use, or entrustment to others of any aircraft, motor vehicle or watercraft.

(e) Property damage to:

(1) Any property owned, rented, or occupied by [insert Grantor];

(2) Premises that are sold, given away or abandoned by [insert Grantor] if the property damage arises out of any part of those premises;

(3) Property loaned to [insert Grantor];

(4) Personal property in the care, custody or control of [insert Grantor];

(5) That particular part of real property on which [insert Grantor] or any contractors or subcontractors working directly or indirectly on behalf of [insert Grantor] are performing operations, if the property damage arises out of these operations.

In the event of combination with another mechanism for liability coverage, the fund shall be considered [insert "primary" or "excess"] coverage.

The Fund is established initially as consisting of the property, which is acceptable to the Trustee, described in Schedule B attached hereto. Such property and any other property subsequently transferred to the Trustee is referred to as the Fund, together with all earnings and profits thereon, less any payments or distributions made by the Trustee pursuant to this Agreement. The Fund shall be held by the Trustee, IN TRUST, as hereinafter provided. The Trustee shall not be responsible nor shall it undertake any responsibility for the amount or adequacy of, nor any duty to collect from the Grantor, any payments necessary to discharge any liabilities of the Grantor established by EPA.

Section 4. *Payment for Bodily Injury or Property Damage.* The Trustee shall satisfy a third party liability claim by making payments from the Fund only upon receipt of one of the following documents:

(a) Certification from the Grantor and the third party claimant(s) that the liability claim should be paid. The certification must be worded as follows, except that instructions in brackets are to be replaced with the relevant information and the brackets deleted:

Certification of Valid Claim

The undersigned, as parties [insert Grantor] and [insert name and address of third party claimant(s)], hereby certify that the claim of bodily injury and/or property damage caused by a [sudden or nonsudden] accidental occurrence arising from operating [Grantor's] hazardous waste treatment, storage, or disposal facility should be paid in the amount of $[ ].

[Signatures]
Grantor

[Signatures]
Claimant(s)

(b) A valid final court order establishing a judgment against the Grantor for bodily injury or property damage caused by sudden or nonsudden accidental occurrences arising from the operation of the Grantor's facility or group of facilities.

Section 5. *Payments Comprising the Fund.* Payments made to the Trustee for the Fund shall consist of cash or securities acceptable to the Trustee.

Section 6. *Trustee Management.* The Trustee shall invest and reinvest the principal and income, in accordance with general investment policies and guidelines which the Grantor may communicate in writing to the Trustee from time to time, subject, however, to the provisions of this section. In investing, reinvesting, exchanging, selling, and managing the Fund, the Trustee shall discharge his duties with respect to the trust fund solely in the interest of the beneficiary and with the care, skill, prudence, and diligence under the circumstance then prevailing which persons of prudence, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims; *except that:*

(i) Securities or other obligations of the Grantor, or any other owner or operator of the facilities, or any of their affiliates as defined in the Investment Company Act of 1940, as amended, 15 U.S.C. 80a–2.(a), shall not be acquired or *held* unless they are securities or other obligations of the Federal or a State government;

(ii) The Trustee is authorized to invest the Fund in time or demand deposits of the Trustee, to the extent insured by an agency of the Federal or State government; and

(iii) The Trustee is authorized to hold cash awaiting investment or distribution uninvested for a reasonable time and without liability for the payment of interest thereon.

Section 7. *Commingling and Investment.* The Trustee is expressly authorized in its discretion:

(a) To transfer from time to time any or all of the assets of the Fund to any common commingled, or collective trust fund created by the Trustee in which the fund is eligible to participate, subject to all of the provisions thereof, to be commingled with the assets of other trusts participating therein; and

(b) To purchase shares in any investment company registered under the Investment Company Act of 1940, 15 U.S.C. 81a–1 et seq., including one which may be created, managed, underwritten, or to which investment advice is rendered or the shares of which are sold by the Trustee. The Trustee may vote such shares in its discretion.

Section 8. *Express Powers of Trustee.* Without in any way limiting the powers and discretions conferred upon the Trustee by the other provisions of this Agreement or by law, the Trustee is expressly authorized and empowered:

(a) To sell, exchange, convey, transfer, or otherwise dispose of any property held by it, by public or private sale. No person dealing with the Trustee shall be bound to see to the application of the purchase money or to inquire into the validity or expediency of any such sale or other disposition;

(b) To make, execute, acknowledge, and deliver any and all documents of transfer and conveyance and any and all other instruments that may be necessary or appropriate to carry out the powers herein granted;

(c) To register any securities held in the Fund in its own name or in the name of a nominee and to hold any security in bearer form or in book entry, or to combine certificates representing such securities with certificates of the same issue held by the Trustee in other fiduciary capacities, or to deposit or arrange for the deposit of such securities in a qualified central depositary even though, when so deposited, such securities may be merged and held in bulk in the name of the nominee of such depositary with other securities deposited therein by another person, or to deposit or arrange for the deposit of any securities issued by the United States Government, or any agency or instrumentality thereof, with a Federal Reserve bank, but the books and records of the Trustee shall at all times show that all such securities are part of the Fund;

(d) To deposit any cash in the Fund in interest-bearing accounts maintained or savings certificates issued by the Trustee, in its separate corporate capacity, or in any other banking institution affiliated with the Trustee, to the extent insured by an agency of the Federal or State government; and

(e) To compromise or otherwise adjust all claims in favor of or against the Fund.

Section 9. *Taxes and Expenses.* All taxes of any kind that may be assessed or levied against or in respect of the Fund and all brokerage commissions incurred by the Fund shall be paid from the Fund. All other expenses incurred by the Trustee in connection with the administration of this

Trust, including fees for legal services rendered to the Trustee, the compensation of the Trustee to the extent not paid directly by the Grantor, and all other proper charges and disbursements of the Trustee shall be paid from the Fund.

Section 10. *Annual Valuations.* The Trustee shall annually, at least 30 days prior to the anniversary date of establishment of the Fund, furnish to the Grantor and to the appropriate EPA Regional Administrator a statement confirming the value of the Trust. Any securities in the Fund shall be valued at market value as of no more than 60 days prior to the anniversary date of establishment of the Fund. The failure of the Grantor to object in writing to the Trustee within 90 days after the statement has been furnished to the Grantor and the EPA Regional Administrator shall constitute a conclusively binding assent by the Grantor barring the Grantor from asserting any claim or liability against the Trustee with respect to matters disclosed in the statement.

Section 11. *Advice of Counsel.* The Trustee may from time to time consult with counsel, who may be counsel to the Grantor with respect to any question arising as to the construction of this Agreement or any action to be taken hereunder. The Trustee shall be fully protected, to the extent permitted by law, in acting upon the advice of counsel.

Section 12. *Trustee Compensation.* The Trustee shall be entitled to reasonable compensation for its services as agreed upon in writing from time to time with the Grantor.

Section 13. *Successor Trustee.* The Trustee may resign or the Grantor may replace the Trustee, but such resignation or replacement shall not be effective until the Grantor has appointed a successor trustee and this successor accepts the appointment. The successor trustee shall have the same powers and duties as those conferred upon the Trustee hereunder. Upon the successor trustee's acceptance of the appointment, the Trustee shall assign, transfer, and pay over to the successor trustee the funds and properties then constituting the Fund. If for any reason the Grantor cannot or does not act in the event of the resignation of the Trustee, the Trustee may apply to a court of competent jurisdiction for the appointment of a successor trustee or for instructions. The successor trustee shall specify the date on which it assumes administration of the trust in a writing sent to the Grantor, the EPA Regional Administrator, and the present Trustee by certified mail 10 days before such change becomes effective. Any expenses incurred by the Trustee as a result of any of the acts contemplated by this section shall be paid as provided in Section 9.

Section 14. *Instructions to the Trustee.* All orders, requests, and instructions by the Grantor to the Trustee shall be in writing, signed by such persons as are designated in the attached Exhibit A or such other designees as the Grantor may designate by amendments to Exhibit A. The Trustee shall be fully protected in acting without inquiry in accordance with the Grantor's orders, requests, and instructions. All orders, requests, and instructions by the EPA Regional Administrator to the Trustee shall be in writing, signed by the EPA Regional Administrators of the Regions in which the facilities are located, or their designees, and the Trustee shall act and shall be fully protected in acting in accordance with such orders, requests, and instructions. The Trustee shall have the right to assume, in the absence of written notice to the contrary, that no event constituting a change or a termination of the authority of any person to act on behalf of the Grantor or EPA hereunder has occurred. The Trustee shall have no duty to act in the absence of such orders, requests, and instructions from the Grantor and/or EPA, except as provided for herein.

Section 15. *Notice of Nonpayment.* If a payment for bodily injury or property damage is made under Section 4 of this trust, the Trustee shall notify the Grantor of such payment and the amount(s) thereof within five (5) working days. The Grantor shall, on or before the anniversary date of the establishment of the Fund following such notice, either make payments to the Trustee in amounts sufficient to cause the trust to return to its value immediately prior to the payment of claims under Section 4, or shall provide written proof to the Trustee that other financial assurance for liability coverage has been obtained equalling the amount necessary to return the trust to its value prior to the payment of claims. If the Grantor does not either make payments to the Trustee or provide the Trustee with such proof, the Trustee shall within 10 working days after the anniversary date of the establishment of the Fund provide a written notice of nonpayment to the EPA Regional Administrator.

Section 16. *Amendment of Agreement.* This Agreement may be amended by an instrument in writing executed by the Grantor, the Trustee, and the appropriate EPA Regional Administrator, or by the Trustee and the appropriate EPA Regional Administrator if the Grantor ceases to exist.

Section 17. *Irrevocability and Termination.* Subject to the right of the parties to amend this Agreement as provided in Section 16, this Trust shall be irrevocable and shall continue until terminated at the written agreement of the Grantor, the Trustee, and the EPA Regional Administrator, or by the Trustee and the EPA Regional Administrator, if the Grantor ceases to exist. Upon termination of the Trust, all remaining trust property, less final trust administration expenses, shall be delivered to the Grantor.

The Regional Administrator will agree to termination of the Trust when the owner or operator substitutes alternate financial assurance as specified in this section.

Section 18. *Immunity and Indemnification.* The Trustee shall not incur personal liability of any nature in connection with any act or omission, made in good faith, in the administration of this Trust, or in carrying out any directions by the Grantor or the EPA Regional Administrator issued in accordance with this Agreement. The Trustee shall be indemnified and saved harmless by the Grantor or from the Trust Fund, or both, from and against any personal liability to which the Trustee may be subjected by reason of any act or conduct in its official capacity, including all expenses reasonably incurred in its defense in the event the Grantor fails to provide such defense.

Section 19. *Choice of Law.* This Agreement shall be administered, construed, and enforced according to the laws of the State of [enter name of State].

Section 20. *Interpretation.* As used in this Agreement, words in the singular include the plural and words in the plural include the singular. The descriptive headings for each section of this Agreement shall not affect the interpretation or the legal efficacy of this Agreement.

In Witness Whereof the parties have caused this Agreement to be executed by their respective officers duly authorized and their corporate seals to be hereunto affixed and attested as of the date first above written. The parties below certify that the wording of this Agreement is identical to the wording specified in 40 CFR 264.151(m) as such regulations were constituted on the date first above written.

[Signature of Grantor]
[Title]
Attest:
[Title]
[Seal]

[Signature of Trustee]
Attest:
[Title]
[Seal]

(2) The following is an example of the certification of acknowledgement which must accompany the trust agreement for a trust fund as specified in §§ 264.147(j) or 265.147(j) of this chapter. State requirements may differ on the proper content of this acknowledgement.

State of _____
County of _____

On this [date], before me personally came [owner or operator] to me known, who, being by me duly sworn, did depose and say that she/he resides at [address], that she/he is [title] of [corporation], the corporation described in and which executed the above instrument; that she/he knows the seal of said corporation; that the seal affixed to such instrument is such corporate seal; that it was so affixed by order of the Board of Directors of said corporation, and that she/he signed her/his name thereto by like order.

[Signature of Notary Public]

40 CFR Part 265 is amended as follows:

PART 265—INTERIM STATUS STANDARDS FOR OWNERS AND OPERATORS OF HAZARDOUS WASTE TREATMENT, STORAGE, AND DISPOSAL FACILITIES: LIABILITY COVERAGE

1. The authority citation for Part 265 continues to read as follows:

Authority: 42 U.S.C. 6905, 6912(a), 6924, and 6925.

2. In § 265.141, new paragraph (h) is added to read as follows:

§ 264.141 Definitions of terms as used in this subpart.

* * * * *

(h) "Substantial business relationship" means the extent of a business relationship necessary under applicable State law to make a guarantee contract issued incident to that relationship valid and enforceable. A "substantial business relationship" must arise from a pattern of recent or ongoing business transactions, in addition to the guarantee itself, such that a currently existing business relationship between the guarantor and the owner or operator is demonstrated to the satisfaction of the applicable EPA Regional Administrator.

3. In § 265.147, paragraph (h) is redesignated as paragraph (k); paragraphs (a) introductory text, (a)(2), (a)(3), (b) introductory text, (b)(2), (b)(3), (b)(4) and (g) heading and (g)(1) introductory text are revised, and by removing and reserving paragraph (g)(1)(ii); paragraphs (g)(2)(i) and (g)(2)(ii) are amended by removing "corporate;" and new paragraphs (a)(4), (a)(5), (a)(6), (a)(7), (b)(5), (b)(6), (b)(7), (h), (i), and (j) are added, to read as follows:

§ 265.147 Liability requirements.

(a) *Coverage for sudden accidental occurrences.* An owner or operator of a hazardous waste treatment, storage, or disposal facility, or a group of such facilities, must demonstrate financial responsibility for bodily injury and property damage to third parties caused by sudden accidental occurrences arising from operations of the facility or group of facilities. The owner or operator must have and maintain liability coverage for sudden accidental occurrences in the amount of at least $1 million per occurrence with an annual aggregate of at least $2 million, exclusive of legal defense costs. This liability coverage may be demonstrated as specified in paragraphs (a) (1), (2), (3), (4), (5), or (6) of this section:

* * * * *

(2) An owner or operator may meet the requirements of this section by passing a financial test or using the guarantee for liability coverage as specified in paragraph (g) of this section.

(3) An owner or operator may meet the requirements of this section by obtaining a letter of credit for liability coverage as specified in paragraph (h) of this section.

(4) An owner or operator may meet the requirements of this section by obtaining a surety bond for liability coverage as specified in paragraph (i) of this section.

(5) An owner or operator may meet the requirements of this section by obtaining a trust fund for liability coverage as specified in paragraph (j) of this section.

(6) An owner or operator may demonstrate the required liability coverage through the use of combinations of insurance, financial test, guarantee, letter of credit, surety bond, and trust fund, except that the owner or operator may not combine a financial test covering part of the liability coverage requirement with a guarantee unless the financial statement of the owner or operator is not consolidated with the financial statement of the guarantor. The amounts of coverage demonstrated must total at least the minimum amounts required by this section. If the owner or operator demonstrates the required coverage through the use of a combination of financial assurances under this paragraph, the owner or operator shall specify at least one such assurance as "primary" coverage and shall specify other assurance as "excess" coverage.

(7) An owner or operator shall notify the Regional Administrator in writing within 30 days (i) whenever a claim for bodily injury or property damages caused by the operation of a hazardous waste treatment, storage, or disposal facility is made against the owner or operator or an instrument providing financial assurance for liability coverage under this section and (ii) whenever the amount of financial assurance for liability coverage under this section provided by a financial instrument authorized by paragraphs (a)(1) through (a)(6) of this section is reduced.

(b) *Coverage for nonsudden accidental occurrences.* An owner or operator of a surface impoundment, landfill, or land treatment facility which is used to manage hazardous waste, or a group of such facilities, must demonstrate financial responsibility for bodily injury and property damage to third parties caused by nonsudden accidental occurrences arising from operations of the facility or group of facilities. The owner or operator must have and maintain liability coverage for nonsudden accidental occurrences in the amount of at least $3 million per occurrence with an annual aggregate of at least $6 million, exclusive of legal defense costs. An owner or operator who must meet the requirements of this section may combine the required per-occurrence coverage levels for sudden and nonsudden accidental occurrences into a single per-occurrence level, and combine the required annual aggregate coverage levels for sudden and nonsudden accidental occurrences into a single annual aggregate level. Owners or operators who combine coverage levels for sudden and nonsudden accidental occurrences must maintain liability coverage in the amount of at least $4 million per occurrence and $8 million annual aggregate. This liability coverage may be demonstrated as specified in paragraph (b) (1), (2), (3), (4), (5), or (6) of this section:

* * * * *

(2) An owner or operator may meet the requirements of this section by passing a financial test or using the guarantee for liability coverage as specified in paragraphs (f) and (g) of this section.

(3) An owner or operator may meet the requirements of this section by obtaining a letter of credit for liability coverage as specified in paragraph (h) of this section.

(4) An owner or operator may meet the requirements of this section by obtaining a surety bond for liability coverage as specified in paragraph (i) of this section.

(5) An owner or operator may meet the requirements of this section by obtaining a trust fund for liability coverage as specified in paragraph (j) of this section.

(6) An owner or operator may demonstrate the required liability coverage through the use of combinations of insurance, financial test, guarantee, letter of credit, surety bond, and trust fund, except that the owner or operator may not combine a financial test covering part of the liability coverage requirement with a guarantee unless the financial statement of the owner or operator is not consolidated with the financial statement of the guarantor. The amounts of coverage demonstrated must total at least the minimum amounts required by this section. If the owner or operator demonstrates the required coverage through the use of a combination of financial assurances under this paragraph, the owner or operator shall specify at least one such assurance as "primary" coverage and shall specify other assurance as "excess" coverage.

(7) An owner or operator shall notify the Regional Administrator in writing within 30 days (i) whenever a claim for bodily injury or property damages caused by the operation of a hazardous waste treatment, storage, or disposal facility is made against the owner or operator or an instrument providing financial assurance for liability coverage under this section and (ii)

whenever the amount of financial assurance for liability coverage under this section provided by a financial instrument authorized by paragraphs (a)(1) through (a)(6) of this section is reduced.

* * * * *

(g) *Guarantee for liability coverage.* (1) Subject to paragraph (g)(2) of this section, an owner or operator may meet the requirements of this section by obtaining a written guarantee, hereinafter referred to as "guarantee." The guarantor must be the direct or higher-tier parent corporation of the owner or operator, a firm whose parent corporation is also the parent corporation of the owner or operator, or a firm with a "substantial business relationship" with the owner or operator. The guarantor must meet the requirements for owners or operators in paragraphs (f)(1) through (f)(6) of this section. The wording of the guarantee must be identical to the wording specified in § 264.151(h)(2) of this chapter. A certified copy of the guarantee must accompany the items sent to the Regional Administrator as specified in paragraph (f)(3) of this section. One of these items must be the letter from the guarantor's chief financial officer. If the guarantor's parent corporation is also the parent corporation of the owner or operator, this letter must describe the value received in consideration of the guarantee. If the guarantor is a firm with a "substantial business relationship" with the owner or operator, this letter must describe this "substantial business relationship" and the value received in consideration of the guarantee.

* * * * *

(h) *Letter of credit for liability coverage.* (1) An owner or operator may satisfy the requirements of this section by obtaining an irrevocable standby letter of credit that conforms to the requirements of this paragraph and submitting a copy of the letter of credit to the Regional Administrator.

(2) The financial institution issuing the letter of credit must be an entity that has the authority to issue letters of credit and whose letter of credit operations are regulated and examined by a Federal or State agency.

(3) The wording of the letter of credit must be identical to the wording specified in § 264.151(k) of this chapter.

(i) *Surety bond for liability coverage.* (1) An owner or operator may satisfy the requirements of this section by obtaining a surety bond that conforms to the requirements of this paragraph and submitting a copy of the bond to the Regional Administrator.

(2) The surety company issuing the bond must be among those listed as acceptable sureties on Federal bonds in the most recent Circular 570 of the U.S. Department of the Treasury.

(3) The wording of the surety bond must be identical to the wording specified in § 264.151(l) of this chapter.

(4) A surety bond may be used to satisfy the requirements of this section only if the Attorneys General or Insurance Commissioners of (i) the State in which the surety is incorporated, and (ii) each State in which a facility covered by the surety bond is located have submitted a written statement to EPA that a surety bond executed as described in this section and § 264.151(l) of this chapter is a legally valid and enforceable obligation in that State.

(j) *Trust fund for liability coverage.* (1) An owner or operator may satisfy the requirements of this section by establishing a trust fund that conforms to the requirements of this paragraph and submitting an originally signed duplicate of the trust agreement to the Regional Administrator.

(2) The trustee must be an entity which has the authority to act as a trustee and whose trust operations are regulated and examined by a Federal or State agency.

(3) The trust fund for liability coverage must be funded for the full amount of the liability coverage to be provided by the trust fund before it may be relied upon to satisfy the requirements of this section. If at any time after the trust fund is created the amount of funds in the trust fund is reduced below the full amount of the liability coverage to be provided, the owner or operator, by the anniversary date of the establishment of the Fund, must either add sufficient funds to the trust fund to cause its value to equal the full amount of liability coverage to be provided, or obtain other financial assurance as specified in this section to cover the difference. For purposes of this paragraph, "the full amount of the liability coverage to be provided" means the amount of coverage for sudden and/or nonsudden occurrences required to be provided by the owner or operator by this section, less the amount of financial assurance for liability coverage that is being provided by other financial assurance mechanisms being used to demonstrate financial assurance by the owner or operator.

(4) The wording of the trust fund must be identical to the wording specified in § 264.151(m) of this part.

[FR Doc. 88-19410 Filed 8-31-88; 8:45 am]

BILLING CODE 6560-50-M