UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

ESSENTIA HEALTH, ***Employer,*** **and** **MINNESOTA NURSES ASSOCIATION,** ***Petitioner.***	**Case No. 18-RC-330714**

BRIEF OF AMICUS CURIAE AMERICAN HOSPITAL ASSOCIATION

INTEREST OF AMICUS CURIAE

The American Hospital Association ("AHA") represents nearly 5,000 hospitals, health systems, and other health-care organizations across all fifty states, many of which now operate within integrated systems that encompass both acute-care and non-acute-care facilities. AHA was the petitioner in *Am. Hosp. Ass'n v. NLRB*, 499 U.S. 606 (1991), in which the Supreme Court upheld the Health Care Rule, and AHA participated in every stage of the rulemaking that produced it. AHA's members have relied on the Rule's composition framework for more than three decades, and the Board's decision whether that framework governs unit composition at the acute-care hospitals within integrated systems will directly affect how these members organize their workforces and deliver patient care. If the Board displaces the Rule through adjudication based on a single employer's record, every integrated health system in the country will face profound legal uncertainty. What's more, if the Board displaces the Rule at all, it will harm patients by disincentivizing the kind of hospital integration that has been proven to improve health outcomes, increase quality of care, and lower costs (*see infra* at § II).

No counsel for a party authored this brief in whole or in part, and no person other than *amicus curiae* or its counsel made a monetary contribution intended to fund its preparation or submission.

INTRODUCTION

This case asks whether a union can plead around a binding regulation by adding non-acute-care facilities to a petition that includes acute-care hospitals. It cannot. The Health Care Rule governs which classifications must be grouped together at a covered hospital — a composition question — regardless of how many other facilities appear in the petition. The Regional Director held otherwise by conflating that composition question with the separate question of which locations may be grouped — a scope inquiry the Rule leaves to ordinary multi-facility precedent.

ARGUMENT

I. The Rule's Validity and the Composition/Scope Distinction Answer the First Question.

A. The Binding Health Care Rule Cannot Be Amended Through Adjudication.

The Health Care Rule is a binding regulation that fixes unit composition at acute-care hospitals. The Supreme Court upheld it, and the Board cannot displace it through adjudication — nor can a petitioner draft around it by adding non-acute-care facilities to the petition. In *Am. Hosp. Ass'n v. NLRB*, 499 U.S. 606, 608, 618-19 (1991), the Court described the Rule as providing that, subject to limited exceptions, "eight, and only eight" employee units are appropriate in acute-care hospitals and rejected the argument that the Rule was arbitrary and capricious because the Board relied on an extensive rulemaking record and years of health-care adjudicatory experience.

That history matters here. The Rule is not a background policy preference. It is not a guideline. It is a legislative rule, adopted through notice-and-comment rulemaking. *See id.* at 609–10; 29 C.F.R. § 103.30. The Board must apply the Rule unless and until it changes it through lawful rulemaking. The Court grounded the Rule in the Board's statutory authority "to make, amend, and rescind" rules, an authority that "expressly contemplates" that the Board "will reshape its policies" through that process rather than by ad hoc departure in adjudication. *Am. Hosp. Ass'n*, 499 U.S. at 618–19.

An agency may not amend or effectively repeal a duly promulgated legislative rule through adjudication; it must use notice-and-comment rulemaking. *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954) (agency must adhere to its own duly promulgated regulations while they remain operative); *Perez v. Mortgage Bankers Ass'n*, 575 U.S. 92, 101 (2015) (agencies must use the same APA procedures to amend a legislative rule as to adopt one); *Marseilles Land & Water Co. v. FERC*, 345 F.3d 916, 920 (D.C. Cir. 2003) ("[A]n administrative agency may not

slip by the notice and comment rule-making requirements needed to amend a rule by merely adopting a *de facto* amendment to its regulation through adjudication"); *Tribune Co. v. FCC*, 133 F.3d 61, 68 (D.C. Cir. 1998) ("[I]t is hornbook administrative law that an agency need not — indeed should not — entertain a challenge to a regulation, adopted pursuant to notice and comment, in an adjudication or licensing proceeding"). The Regional Director's application of *American Steel* to circumvent the Rule's mandatory unit configurations is precisely the kind of *de facto* regulatory amendment that *Accardi* and its progeny forbid.

B. The Composition/Scope Distinction.

1. The Rule Governs Composition, Not Scope.

The Rule governs composition, and composition must be decided before scope. The Board's first certified question asks whether the Health Care Rule "govern[s] unit composition in cases where a petitioned-for multi-facility unit includes both acute-care hospitals and non-acute-care facilities." *Essentia Health*, 374 NLRB No. 140 (2026). It does. The Rule fixes what classifications belong at a covered hospital, regardless of what other facilities the petition includes. Composition asks which classifications must be grouped together at a covered acute-care hospital; scope asks which locations may be joined in a single unit, a question the Rule leaves to ordinary multi-facility precedent. The two are independent, and composition comes first — the Rule fixes the permissible classifications at each covered hospital before the Board turns to scope.

That distinction resolves this case. The petition seeks to represent approximately 400 APPs across nine stipulated acute-care hospitals and roughly fifty-one non-acute clinics. *Id.* Because nine of those facilities are stipulated acute-care hospitals, the Rule requires that the employees at each be grouped into its enumerated units; a petitioned-for APP-only unit conforms to none of them and is not appropriate absent a recognized exception. Whether the clinics may be joined with the hospitals is a separate scope question for ordinary multi-facility adjudication. The Board itself

cabined the issue this way in granting review, describing "a substantively different issue: what classifications must be included in a hybrid unit where some of the facilities fall under the Health Care Rule and others do not." *Essentia Health*, 374 NLRB No. 140, slip op. at 2 n.3.

In the same order granting review, the Board emphasized that "the Health Care Rule, as a rule of unit composition, does not concern whether certain locations may or must be included in a petitioned-for unit," and that the Rule "does not govern whether acute-care hospitals may be included in the same unit as nonacute-care facilities; rather, the Board would apply its traditional multi-facility precedent … to ascertain whether the acute-care and nonacute-care facilities share a community of interest." *Essentia Health*, 374 NLRB No. 140, slip op. at 1–2 n.3.

The Board articulated this division not only in granting review, but when it first wrote the Health Care Rule. In *NPR II*, the Board expressly stated that the 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." 53 Fed. Reg. 33,900, 33,906 (Sept. 1, 1988). The Rule's text mirrors this division. Section 103.30(a) addresses composition: eight enumerated units "shall be appropriate units, and the only appropriate units" for petitions involving acute-care hospitals; the Board restated that mandate in its order here, noting that "the eight units enumerated in the rule will constitute the only appropriate units in acute-care hospitals." 29 C.F.R. § 103.30(a); *Essentia Health*, 374 NLRB No. 140, slip op. at 1 n.2. Section 103.30(g) addresses scope: bargaining units in "all other health care facilities" are determined by adjudication. 29 C.F.R. § 103.30(a), (g); *see also* 53 Fed. Reg. at 33,958; 52 Fed. Reg. 25,142, 25,155 (July 2, 1987) (same provision in both NPRs).

2. The Composition Command Reaches Every Covered Hospital, However Many the Petition Includes.

The Rule's use of the singular — "an acute care hospital" — does not confine it to single-hospital petitions. The singular defines the coverage unit: it identifies which facilities the Rule reaches, and each acute-care hospital is one. It is not a limitation that dissolves the Rule whenever a petition happens to span two or more covered hospitals. The Supreme Court confirmed as much in holding that, even under the Rule, the Board "must still apply the rule 'in each case,'" including deciding "whether a given facility is properly classified as an acute care hospital and whether particular employees are properly placed in particular units." *Am. Hosp. Ass'n*, 499 U.S. at 613. That facility-by-facility approach shows that the Rule applies wherever a covered hospital appears in a petition — not only when the petition is limited to one. Applying the Rule's classifications at each covered hospital is thus the very "in each case" adjudication that § 9(b) contemplates, not an evasion of it. Reading the singular differently would let a petitioner escape a binding regulation simply by aggregating covered hospitals into a larger multi-facility unit.

Adding more facilities to the petition does not change the composition answer because the Rule applies hospital by hospital — it does not become inapplicable merely because the petition also reaches clinics. The number of facilities cannot determine whether a binding regulation applies. If it could, the Rule would have no force at all. *Am. Hosp. Ass'n*, 499 U.S. at 609–10. The Board may still consider, under its multi-facility precedent, whether the clinics share a community of interest with the hospitals — but that is a scope question, separate from composition, and decided after it. 53 Fed. Reg. at 33,906; 29 C.F.R. § 103.30(a), (g).

That is not a hypothetical concern. As the Regional Director's own decision documents, roughly 70 percent of nonfederal general acute-care hospitals now operate within integrated systems that also encompass non-acute-care facilities. Dec. & Dir. of Election at 20 n.21. If the Rule ceases to apply whenever a covered hospital is part of such a system, it ceases to apply at

roughly 3,500 of the nation's 5,000 acute-care hospitals — nullifying a Supreme-Court-approved regulation for the majority of the industry it was designed to govern.

Nor does the hybrid character of many APP roles change the answer. An APP who provides services at one of the nine stipulated acute-care hospitals is an employee whom the Rule assigns to one of the enumerated units at that facility, and an APP-only subset conforms to none of them. That APP's additional clinic work bears on scope, not composition.

This reading serves the congressional policy the Rule was built to advance. In extending the Act to acute-care hospitals, Congress admonished the Board to give "due consideration … to preventing proliferation of bargaining units in the health care industry," and the Board designed the all-professionals unit precisely to keep professional employees from splintering into sub-specialty units. *Am. Hosp. Ass'n*, 499 U.S. at 615–16. An APP-only unit carved out of the professionals at an acute-care hospital is the very fragmentation Congress warned against and the Rule was adopted to prevent. Reading the Rule to evaporate whenever a petition spans more than one covered hospital would defeat the very purpose the Rule serves — opening precisely the kind of drafting loophole the Board refused to allow.

3. The Rule Requires a Conforming Unit at the Nine Hospitals.

The enumerated units include "all professionals except for registered nurses and physicians." 29 C.F.R. § 103.30(a)(3). To the extent an APP is a professional who is neither a registered nurse nor a physician, the Rule places that APP in that unit; to the extent the APP is a registered nurse, the Rule places the APP in the "all registered nurses" unit. 29 C.F.R. § 103.30(a)(1), (a)(3). Either way, the Rule fixes the APP's classification, and a petitioned-for APP-only unit spanning these categories conforms to none of the enumerated units. Nothing in the Rule creates an exception for a petition that combines acute-care hospital employees with employees at non-acute-care facilities. *See* 29 C.F.R. § 103.30(a). Nor does the combination proviso create a

hybrid-facility exception: it permits combinations among the eight specified units and defines any resulting non-conforming unit by reference to those same eight units — thus presupposing, rather than displacing, the eight-unit framework. 29 C.F.R. § 103.30(a), (f)(5); 53 Fed. Reg. at 33,954 (combinations "not thereby precluded" but appropriateness decided "in the course of individual cases, by adjudication").

This petition proves the point. No one disputes that if the same APP-only unit were sought at just one of the nine stipulated acute-care hospitals, the Rule would require the Board to ask whether APPs are part of the "all professionals except for registered nurses and physicians" unit and whether any Rule exception applies. 29 C.F.R. § 103.30(a)(3). The rulemaking commentary reinforces that professional sub-specialty concerns do not justify carving out a separate professional subset: the Board declined to create a separate physical-therapist unit, stating that physical therapists, if professional, belong with other non-RN, non-physician professionals. 54 Fed. Reg. at 16,345. *NPR II* confirmed that "it was and continues to be necessary to provide for a separate unit of professionals excluding these two classifications," and that granting individual professions their own units "might create the proliferation which Congress meant to avoid." 53 Fed. Reg. at 33,931. The all-other-professionals unit is "required by the Act" if RNs and physicians are separate appropriate units. 54 Fed. Reg. at 16,345–46.

The Regional Director's own findings reinforce why a Rule-conforming grouping is the sensible one. She found that APP credentialing, privileging, compensation, hiring, and personnel policies are centralized across the Employer's system, and that APPs are "functionally integrated with other healthcare staff." Dec. & Dir. of Election at 9, 25, 27. Hospital-based professionals are thus not walled off from the broader professional workforce; they belong in the unit the Rule prescribes for their classification.

C. The Regional Director's Integrated-System and Outpatient-Volume Rationales Fail.

Both of the Regional Director's rationales for finding the Rule inapplicable fail — one on the Rule's text, the other on the history and justification in the Rule's preamble. The Regional Director found the Rule inapplicable on two grounds: Essentia is an "integrated health system" rather than a free-standing hospital, and many petitioned-for employees work in ambulatory settings. The Union defended that reasoning by pointing to the Regional Director's finding that, at most, 32 percent of APP-billed patient services occurred within hospital walls. Dec. & Dir. of Election at 19.

The error begins with how the Regional Director framed the question. She found the Rule inapplicable not by analyzing composition at the acute-care hospitals, but by holding that the system as a whole is not "an acute care hospital": "By its own description, the Employer is an integrated health system, not a free-standing 'hospital.' It operates nine acute-care hospitals among approximately 50 ambulatory care service locations." Dec. & Dir. of Election at 19. That blurs the two questions the law keeps separate — treating the Rule as an all-or-nothing coverage question about the entire multi-facility system rather than applying the Rule's composition requirement to the employees at the nine stipulated acute-care hospitals. And the Regional Director never reached the composition question at all, holding that "the Employer's argument about the exclusion of other professionals at each hospital being contrary to the Rule is not relevant and will not be addressed." Dec. & Dir. of Election at 22 n.22. The composition issue now before the Board was thus sidestepped, not decided on the merits.

That framing is a threshold legal error, independent of the composition/scope distinction. The Rule operates at the level of the facility, not the employer: its coverage definition classifies a "hospital … in which the average length of patient stay is less than thirty days," 29 C.F.R. §

103.30(f)(2), and the Supreme Court confirmed that the Board "must still apply the rule 'in each case,'" deciding facility by facility "whether a given facility is properly classified as an acute care hospital." *Am. Hosp. Ass'n*, 499 U.S. at 613. The Regional Director asked the wrong question — whether the Employer, the integrated system as a whole, is "an acute care hospital" — when the Rule directs the Board to ask whether each of the nine stipulated hospitals is. The parties stipulated that each one is. Dec. & Dir. of Election at 4. The Rule's coverage inquiry ends there; the system-wide character of the Employer does not remove any covered hospital from the Rule.

The Regional Director's second rationale — that the petitioned-for employees largely work in ambulatory settings — fails for a related reason: the presence of outpatient services does not strip a hospital of its acute-care character. The Rule defines "acute care hospital" to include hospitals operating as acute-care facilities even if they provide long-term care, outpatient care, psychiatric care, or rehabilitative care, and excludes only facilities that are *primarily* nursing homes, *primarily* psychiatric hospitals, or *primarily* rehabilitation hospitals. 29 C.F.R. § 103.30(f)(2). Outpatient or clinic-based services therefore do not remove an otherwise covered acute-care hospital from the Rule. *See id.*; 54 Fed. Reg. 16,336, 16,347 (Apr. 21, 1989) (final rule).

NPR II makes the point unmistakable: the definition covers 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," excluding only facilities that are "primarily nursing homes or primarily psychiatric hospitals." 53 Fed. Reg. at 33,958. And the Board stated the coverage principle in the plainest possible terms: "[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." *Id.* at 33,952.

The rulemaking record makes clear when an ancillary service displaces coverage: it must *predominate*. The Board stated that "if the facility is primarily an acute care hospital, it will be

treated in its entirety as a hospital," and that hospitals with psychiatric sections are "not thereby excluded from application of the rule unless the psychiatric sections predominate." 53 Fed. Reg. at 33,949, 33,951. The Regional Director's outpatient-volume rationale never found — and on this record could not find — that outpatient services predominate over the hospitals' acute-care operations. That is unsurprising: the parties stipulated that all nine facilities are acute-care hospitals. The Regional Director's own decision confirms as much, marking nine East Market facilities with an asterisk and stating that each facility so marked "is an acute care hospital under the definition set forth in the Board's Healthcare Rule." Dec. & Dir. of Election at 4.

The final-rule commentary disposes of the Union's 32-percent argument. The Board stated that it "did not intend to exclude such hospitals from coverage of the rule unless any one of the excluded ancillary services predominated" and that a hospital should not avoid the Rule merely because "the number of its outpatient visitors exceeded the number of its over-night (acute care) patients." 54 Fed. Reg. at 16,347. Nor does the Union's billing figure track the Rule's coverage metric: the Rule defines an acute-care hospital as "a short term care hospital in which the average length of patient stay is less than thirty days," 29 C.F.R. § 103.30(f)(2); 53 Fed. Reg. at 33,958, and the commentary states that in the normal case it will be obvious whether a hospital is acute care and stipulations should usually be obtainable, 54 Fed. Reg. at 16,347. Here, the parties stipulated that the nine hospitals are acute-care hospitals. That stipulation is the Rule's metric. A billing percentage is not.

D. The Rule's History Forecloses a Petition-Drafting Exception.

The Rule's history forecloses a petition-drafting exception for hybrid units. The Board adopted the Rule precisely to end "laborious, costly, case-by-case record-making and adjudication in this remarkably uniform field" that had "proved to be an unproductive expenditure of the parties' and the taxpayers' funds." 52 Fed. Reg. at 25,147; *see Am. Hosp. Ass'n*, 499 U.S. at 609. The

Board's adjudicatory decisions had been "remarkably uniform in results" — RN units found appropriate in 24 out of 25 published cases, technical units in 18 out of 18, and business-office clerical units in 8 out of 8. 53 Fed. Reg. at 33,907. The Board explained that, absent a rule, it would have to "continually relitigate issues that may be established fairly and efficiently in a single rulemaking proceeding." 54 Fed. Reg. at 16,345. Allowing a petitioner to avoid the Rule by adding non-acute-care employees to a unit that includes acute-care hospital employees would recreate the very litigation the Rule was designed to end — and the Board should not bring it back.

This is not abstract. The rulemaking record — four public hearings, 144 in-person witnesses, a 3,545-page transcript, and approximately 1,500 timely comments — was the most extensive empirical foundation the Board had ever assembled for a unit-determination proceeding. 53 Fed. Reg. at 33,902–03; 54 Fed. Reg. at 16,336. The Board weighed concerns about hospital size, service variation, team care, cross-training, functional integration, cost containment, and unit proliferation — and still adopted a categorical rule. *Am. Hosp. Ass'n*, 499 U.S. at 619.

Critically, the industry presented the very arguments the Regional Director now credits — that hospitals were "becoming parts of larger systems encompassing intermediate care facilities, urgent care centers, nursing homes, surgery centers, clinics, etc." — and the Board rejected them. 53 Fed. Reg. at 33,904. The Board concluded that "corporate mergers and larger organizational changes have not affected relationships between traditional job classifications" and reiterated that the rule "does not purport to address the issue of the appropriateness of a single facility when an employer owns a number of facilities." *Id.* at 33,906.

The Board anticipated exactly this kind of argument — and closed the door. It crafted the extraordinary-circumstances exception narrowly, stating that it must not "provide an excuse, opportunity, or 'loophole' for redundant or unnecessary litigation." *Id.* at 33,955. To satisfy the

exception, a party must bear a "heavy burden" to demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding." *Id.* at 33,956.

The Board then adopted a categorical rule for acute-care hospitals, subject only to narrow, enumerated exceptions. *Am. Hosp. Ass'n*, 499 U.S. at 609; 29 C.F.R. § 103.30(a). A case-by-case exception for integrated health systems or hybrid petitions would amend the Rule in substance — without the process the Board used to adopt it. The Regional Director's factors prove the point. Her integrated-system and outpatient-volume concerns belong, if anywhere, within the narrow extraordinary-circumstances exception, not outside it: the Board weighed those very factors — outpatient volume, ambulatory operations, integrated-system structure — and found them insufficient to escape the Rule even inside the exception, so they cannot carry greater force outside it. Indeed, the Supreme Court confirmed that a party's ability to "point to a hypothetical case in which the rule might lead to an arbitrary result does not render the rule 'arbitrary or capricious,'" because the extraordinary-circumstances exception exists precisely for the unusual case. *Am. Hosp. Ass'n*, 499 U.S. at 619–20.

Extraordinary circumstances are not the Rule's only exception, but each of the others is likewise enumerated in the regulation and presupposes the eight-unit framework rather than escaping it. *First*, the Rule accommodates stipulations, but only where a variance is "not repugnant to the Act or policy underlying this rule." 29 C.F.R. § 103.30(d). *Second*, it preserves existing recognized or certified bargaining relationships. *Third*, where "existing non-conforming units" are already in place, it still requires that any petition for additional units "comport, insofar as practicable," with the enumerated unit. 29 C.F.R. § 103.30(c). Each exception confirms the default rather than displacing it: absent a recognized exception, the eight-unit framework governs.

None applies here. The Rule's composition command therefore controls at each of the nine hospitals.

E. The Board's Cited Precedents Are Consistent with the Rule's Application.

None of the Board's cited precedents holds that the Rule's composition requirements yield whenever a petition crosses the acute/non-acute line. Examined through the composition/scope framework, each affirmatively supports the Rule's continued application.

Stormont-Vail was a *scope* case, not a *composition* case — and its outcome is entirely consistent with the Rule's continued application to the composition question. The Board did not pass on the Regional Director's Rule analysis and instead resolved the dispute on facility-scope grounds, reversing the Regional Director's main-campus unit as an "arbitrary grouping of employees" and holding that it "arbitrarily excludes" the RNs at the off-campus facilities, who shared a community of interest with the hospital nurses. *Stormont-Vail Healthcare, Inc.*, 340 NLRB 1205, 1205–09 (2003).

The Board's silence on Rule applicability is not a holding of inapplicability; it reflects that the case turned on a question the Rule does not address. Indeed, the unit the Board ultimately approved — all RNs system-wide — was *composition*-compliant: an all-RN unit is one of the eight enumerated categories. *See* 29 C.F.R. § 103.30(a)(1). That the Board rejected a petition-drawn subdivision of RNs as arbitrary — even without invoking the Rule — reinforces that an APP-only subset should not be permitted where the Rule requires the broader professional grouping.

Virtua was a *composition* case — and it reached the same result the Rule would have required. The Board found it "unnecessary to reach" the Rule's applicability because the petitioned-for paramedic-only unit was inappropriate even under the broader non-acute-care standard of *Park Manor Care Center, Inc.*, 305 NLRB 872 (1991): a paramedic-only unit excluded most technical employees and was therefore underinclusive under either framework. *Virtua*

Health, Inc., 344 NLRB 604, 605–06 (2005). The Board added that "[t]he factors relied upon in the Rulemaking also support a single technical unit," because grouping the technical classifications together "met Congressional concerns to avoid proliferation of bargaining units" — confirming that the Rule's intent carries over even when the Board proceeds under *Park Manor*. *Id.* at 605. The *Virtua* majority also expressly declined to decide whether the Rule applies to multi-facility systems, *id.* at 605–06, so the decision resolves nothing against the Rule's application to the composition question here. *Virtua* thus reinforces that an underinclusive subset of a Rule-defined classification is inappropriate when the Rule requires the broader grouping.

Child's Hospital was a *coverage* case — it asked whether the Rule's threshold for facility coverage was met, not whether the Rule's composition requirements apply once coverage is established. The Board declined to apply the Rule because of the extraordinary circumstances presented by a single, physically joined hybrid facility: the physical joinder of the hospital, nursing home, and shared service corporation, the substantial nature of both operations, and the integrated support services that made it infeasible to separate the components for unit-determination purposes. *Child's Hospital, Inc.*, 307 NLRB 90, 91–92 (1992). Outpatient ambulatory surgery accounted for roughly 95 percent of the hospital's medical services, underscoring the hybrid character of the facility. *Id*. at 91.

That case is the opposite of this one in every material respect. In *Child's Hospital*, the Board affirmed that the hospital *itself* met the acute-care definition and found it unnecessary only to decide whether the *combined* hospital-and-nursing-home facility did, *id.* at 92 n.14 — declining the Rule only at the coverage threshold for that anomalous facility. It therefore says nothing about the composition question presented here — what classifications must be included once coverage

is established. Here, the parties have stipulated that all nine facilities *are* acute-care hospitals, and no party contends that outpatient services predominate at any of them.

Indeed, *Child's Hospital* cuts in the Employer's favor. Even after finding extraordinary circumstances and declining to apply the Rule "automatically," the Board held that "at the very least" the smallest appropriate unit had to include all RNs — a result that conforms to one of the Rule's enumerated categories. *Child's Hospital*, 307 NLRB at 91–92; *see* 29 C.F.R. § 103.30(a)(1). If the Rule's composition categories governed the result even in that anomalous hybrid facility, they must govern here, where coverage is stipulated at nine acute-care hospitals and no party contends that outpatient services predominate. A petitioned-for APP-only subset that conforms to none of the enumerated units cannot survive that *a fortiori* logic.

In sum, none of these cases holds that the Board may disregard the Rule's *composition* requirements when a petition spans acute-care and non-acute-care facilities. At most they address coverage at a particular facility — a question the parties' stipulation resolves here. The Regional Director's reliance on these cases is misplaced.

F. *American Steel* Does Not Displace the Rule.

American Steel does not justify bypassing the Rule. If anything, it requires the Board to apply it. *Am. Steel Construction, Inc.*, 372 NLRB No. 23 (2022), supplies the Board's general standard for petitioned-for subdivisions of employee classifications. But the decision itself expressly states that its test "does not disturb or displace any preexisting rules or presumptions applicable to specific industries or occupations." *Id.*, slip op. at 13.

American Steel's industry-specific carve-out is not an aside, but a vital, recognized component of the framework: the Board treats consideration of the "guidelines that the Board has established for the specific industry involved" as a "well-established component of unit-determination jurisprudence." *Am. Steel*, 372 NLRB No. 23, slip op. at 13. That step requires the

decisionmaker to consult the Board's industry-specific rule — here, the Health Care Rule's mandatory unit categories. It is a command to apply the Rule, not permission to ignore it. *American Steel* thus offers no escape from the Rule; it routes the decisionmaker straight back to it.

The Regional Director took a wrong turn, however. She applied *American Steel's* general community-of-interest test as though no industry-specific rule existed.

The Health Care Rule is precisely such a preexisting, industry-specific rule — a binding regulation that establishes mandatory unit compositions for a specific industry. 29 C.F.R. § 103.30(a). Where the Rule controls, *American Steel* does not apply. Nine stipulated acute-care hospitals are involved here. The Rule controls.

Even accepting the Regional Director's community-of-interest findings, they cannot salvage the APP-only unit — because those findings address the wrong question. The Regional Director found the APPs "readily identifiable," "sufficiently distinct," and possessed of an internal community of interest. Dec. & Dir. of Election at 24–25. But community-of-interest analysis — including interchange — applies only if the Rule does not; it cannot be used to displace the Rule at the threshold. The Rule groups all non-RN, non-physician professionals together by category — regardless of their community of interest or interchange — precisely to spare the Board the kind of case-by-case inquiry the Regional Director undertook. That an APP-only group might satisfy *American Steel* in the abstract is therefore beside the point: at the nine stipulated acute-care hospitals, the Rule — not community of interest — supplies the unit.

Applying the Rule here also requires no reconsideration of *American Steel* itself, because the two frameworks operate in different domains. In fact, *American Steel* itself invokes *Am. Hosp. Ass'n* in explaining the Act's "in each case" requirement, confirming that the two frameworks are complementary rather than in conflict. 372 NLRB No. 23, slip op. at 13 (citing *Am. Hosp. Ass'n*,

499 U.S. at 609–10). And as the Board explained in granting review, its "grant of review in this case does not extend to whether *American Steel* should be overruled"; the Board is deciding only "the more limited question of whether the Health Care Rule, the *American Steel* standard, or some other standard should apply" to the subset of cases involving "both acute-care hospitals and non-acute facilities." *Essentia Health*, 374 NLRB No. 140, slip op. at 1–2 n.3. The Board can hold that the Rule governs composition here while leaving *American Steel* fully intact for the cases it properly reaches.

The Board's own recent practice confirms this coexistence. In *Montefiore Nyack Hospital* — decided by the same Board only six days before it granted review in this case — the Board resolved a *composition* question at an acute-care hospital by applying the Rule's unit categories. The Board held that RN care managers shared a community of interest with the existing RN unit "because they fall under the same category for purposes of the Board's Health Care Rule" — specifically, the "all registered nurses" unit. *Montefiore Nyack Hosp.*, 2026 NLRB LEXIS 435, at 1–2 (July 9, 2026) (unpublished) (citing 29 C.F.R. § 103.30(a)(1)). The Board did not reach any scope question about whether additional locations or facilities should be included. Nor did it apply *American Steel*; to the contrary, it held *American Steel* "inapplicable" where the Rule's classifications govern. *Id*. at 1.

Although *Montefiore Nyack* is unpublished, it shows how the Board currently (and correctly) understands the relationship between the Rule and *American Steel*: the Rule resolves composition; *American Steel* steps aside. That is the sequencing the Board should follow here. If *American Steel* does not displace the Rule in a self-determination election at a single acute-care hospital, it cannot displace the Rule in an initial-organization petition that includes nine stipulated acute-care hospitals.

For these reasons, the Board should reverse the Regional Director and hold that the Health Care Rule governs unit composition whenever a petitioned-for multi-facility unit includes employees at one or more acute-care hospitals. The Rule applies. The stipulation confirms it. A petition cannot open a loophole in a binding regulation simply by spanning more than one covered hospital. Any unit including employees at Essentia's stipulated acute-care hospitals must conform to the Rule's eight-unit framework absent a recognized exception. *See* 29 C.F.R. § 103.30(a), (g). If the Board nonetheless concludes otherwise, it cannot and should not fashion a replacement standard through this adjudication — for the reasons set forth below.

II. If the Board Reaches the Second Question, It Should Not Resolve It Through Adjudication.

The Board need not reach the second question. Indeed, the question itself — "If not, what unit composition standard should apply? Should the Board apply the standard articulated in *American Steel*, or some other standard?" *Essentia Health*, 374 NLRB No. 140, slip op. at 2 — proves the point. The very complexity of choosing a replacement standard shows that case-by-case adjudication on the record of a single employer's system is not suited to the challenge.

The Rule's own history shows that any modernizing change requires broad participation by the regulated community. The final-rule commentary considered — and declined — a suggestion that multi-site units be treated as an extraordinary-circumstances exception, preserving the narrow framework instead, and treated the industry's diversification into multi-site systems not as a reason the Rule could not apply but as a reason it should coexist with adjudicatory resolution of facility-scope questions. 54 Fed. Reg. at 16,345–46; 53 Fed. Reg. at 33,904, 33,906. The Board expressly anticipated that any reexamination would come through rulemaking: "any party could, of course, petition for amendment or repeal of the rules, or the issuance of new rules." 53 Fed. Reg. at 33,908.

Adjudication also is structurally incapable of resolving a question of this scope. The health-care industry is vast and diverse: roughly 5,000 acute-care hospitals operate in the United States, and — as the Regional Director's own decision documents — the share in a health system climbed from 53 percent in 2001 to roughly 70 percent by 2016. These systems vary considerably, so a standard suited to a nine-hospital rural system may not fit a two-hospital urban system or a national chain. The Board cannot gather the industry-wide evidence a workable replacement standard would require in an adjudication built on one employer's record, conducted on a compressed timeline, and with only a few *amici* confined to 20-page briefs. *Park Manor* illustrates the point: there, the Board in part declined to fashion a rule for non-acute-care facilities because it lacked "a sufficient body of empirical data." *Park Manor*, 305 NLRB at 875. For acute-care hospitals, by contrast, the Board had that data — the four-hearing, 3,545-page record described above — and made a rule. Any new hybrid standard would demand the same empirical foundation the Board found wanting in *Park Manor*, which only rulemaking can supply.

The stakes are enormous, affecting patients and communities throughout the country. A decision displacing the Rule's composition framework would affect every integrated health system in the country, not just Essentia, implicating the fragmentation concerns — work stoppages, jurisdictional disputes, wage whipsawing, and cost — that drove the Rule and persist today. 53 Fed. Reg. at 33,955–56; *Am. Hosp. Ass'n*, 499 U.S. at 609, 615. But the concerns are not merely procedural. Integrated care demonstrably improves patient outcomes, increases quality, and lowers costs. *See* GAO, *Health Care Delivery: Features of Integrated Systems Support Patient Care Strategies and Access to Care* (GAO-11-49) (2011); HHS ASPE, *Outcomes for Duals in Integrated Care* (2023). A standard that penalizes integration — by stripping hospitals of the Rule's predictable composition framework whenever they participate in a multi-facility system —

would create a perverse disincentive to the care-delivery models that serve patients best. That tradeoff is one only rulemaking, informed by the full range of voices in the health-care industry, can properly evaluate.

Proceeding by adjudication also would raise the same *Accardi* problem identified in Section I. Replacing the Rule's composition framework with a different standard — whether openly or by declaring the Rule inapplicable and adopting a new standard in the same order — would be a *de facto* amendment of a notice-and-comment regulation, impermissible under settled law. *See* supra at I.A. That is no hypothetical: having set the Rule aside, the Regional Director applied *American Steel* to approve the APP-only subdivision, displacing the Rule's mandatory all-professionals composition through adjudication in precisely the manner these cases forbid.

Under *Accardi*, the legally required vehicle for any change to the Rule's composition framework is a new rulemaking. If the Board concludes that the existing Rule does not answer the first question — a conclusion we urge it not to reach — it must initiate rulemaking rather than fashion a standard from the record of a single case. Before even taking that step, it should consider issuing a Request for Information that asks whether the existing Rule should be revisited.

CONCLUSION

For the above reasons, the Board should reverse the Regional Director and hold that the Health Care Rule governs unit composition at the nine stipulated acute-care hospitals.

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Respectfully submitted,
JACKSON LEWIS P.C.

/s/ David A. Kelly
David A. Kelly
JACKSON LEWIS P.C.
11790 Sunrise Valley Drive, Suite 400
(703) 483-8322
David.Kelly@jacksonlewis.com