WILLCOX SAVAGE

EMPLOYMENT LAW OUTLOOK

HEALTH CARE REFORM–EMPLOYER HEALTH PLAN ISSUES FOR 2010-2011 (PART 1)

Cher E. Wynkoop and Ruby W. Lee

On March 23, 2010, President Obama signed The Patient Protection and Affordable Care Act (PPACA) into law. A reconciliation bill was finalized on March 26, 2010. The new health care law introduces a number of employer health plan changes which become effective on January 1, 2011, for calendar year health plans. These changes are described below and apply generally to both insured and self-insured plans, except that certain of the changes marked with an "*" are not applicable to "grandfathered plans" (i.e., group plans or individual coverage in place as of March 23, 2010) according to current guidance:

- No Lifetime Limits. Plans may no longer impose lifetime limits on coverage.
- Restrictions on Annual Limits. Plans are restricted in the annual limits they may impose through 2013 (beginning in 2014, no annual limits may be imposed).
- Coverage for Employees' Adult Children. If a plan offers dependent coverage, it must offer coverage to employees' children up to age 26 regardless of student or marital status. This applies to grandfathered plans only to the extent that such dependents are not eligible for coverage under another health plan.
- Pre-Existing Condition Exclusions on Children. Plans may not impose pre-existing condition exclusions on children under 19.
- *Preventive Care Services. Plans must cover certain preventive care services, including immunizations and infant care screenings and preventive screenings for women, at no cost to the employee.
- *Primary Care Physicians. Plans must allow enrollees to select any covered doctor as a primary care doctor or pediatrician.
- *OB/Gyn Care. Plans cannot require authorization or referral for a participant to obtain OB/Gyn care.

(CONTINUED ON PAGE 4)

LAY EVIDENCE MAY SUPPORT FMLA LEAVE

William E. Rachels, Jr.

A March 2010 Opinion from the U.S. Court of Appeals for the Third Circuit finds that a combination of expert and lay testimony can establish that an employee was incapacitated for more than three days as required by FMLA regulations. *Schaar v. Lehigh Valley Health Systems, Inc.*, ___ F.3d ___, 2010 WL 825257 (3d Cir. March 11, 2010).

Ms. Schaar worked as a medical receptionist for Lehigh Valley for approximately three years before she was fired. On September 21, 2005, her physician diagnosed her with a urinary tract infection, fever and low back pain. He prescribed medications and an antibiotic for the infection which was to be taken once a day for at least three days. He testified that it was "possible, although very unlikely" that she would not be fully recovered enough to work after three days. The doctor wrote a note advising Schaar's supervisor that she was under his care and that her illness prevented her from working Wednesday, September 21, and Thursday, September 22.

Ms. Schaar took paid sick leave on September 21 and 22 and was in bed with her conditions. Coincidentally, she had previously scheduled vacation days for Friday, September 23 and Monday, September 26. She claimed that she also spent Friday and Saturday in bed. On Sunday she felt well enough to go to the couch but was still ill. On Monday she was well enough to do some housework and returned to Lehigh Valley on Tuesday. The termination explanation was that her doctor's note only provided for a two day excuse and also referred to certain performance issues.

(CONTINUED ON PAGE 4)

After 42 years we decided to move!

On June 4 our Norfolk office will move to the new Wells Fargo Center in downtown Norfolk. Please note our new address.

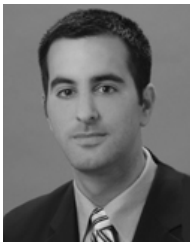
440 Monticello Avenue, Suite 2200
Norfolk, Virginia 23510

Phone numbers and fax remain the same.

© 2010 Willcox & Savage P.C.

HEALTHCARE LAW INCLUDES FLSA AMENDMENT MANDATING BREAKS FOR NURSING MOTHERS

David A. Kushner



Unless you have been living on a deserted island for the last year, you are already aware that the recent Patient Protection and Affordable Care Act, or PPACA, creates numerous new rules regarding the role of employers in the American healthcare system. However, with the PPACA's insurance mandates dominating the headlines, many employers may not know that the healthcare law also creates a new break entitlement for nursing mothers.

In a little known provision of the PPACA, Congress amended the Fair Labor Standards Act to require employers to provide "a reasonable break time so that an employee may express breast milk for her nursing child." Employers must provide such breaks for one year after the child's birth. The PPACA provides no guidance as to the number of breaks which an employer must provide, or the appropriate duration of such breaks.

In addition to requiring breaks for nursing mothers, the PPACA requires employers to provide a private place, other than a bathroom, for a nursing employee to express milk. This private area must be "shielded from view and free from intrusion from co-workers and the public."

While the FLSA applies to nearly all employers regardless of number of employees, the nursing mothers amendment provides an exemption for any employer with less than 50 employees. However, this exemption only applies if providing the break or the private area would impose an "undue hardship" on the small employer. The PPACA defines "undue hardship" as "causing the employer significant difficulty or expense" when considered in relation to the size, financial resources, and nature of the employer's business.

Interestingly, the new provision provides that the employer is *not* required to compensate employees for these nursing breaks. The unpaid status of nursing breaks is in direct conflict with the Department of Labor's regulations regarding other short breaks. Under the DOL's regulations, employers generally must compensate employees for breaks of less than 20 minutes. In theory, the new law permits an employer to adopt a policy under which it compensates employees for all short breaks, *except* breaks for nursing mothers. While such a policy may be explicitly permissible under the PPACA, we would expect plaintiffs' lawyers to attempt to use such a disparate policy as circumstantial evidence of gender discrimination. Thus, until the DOL or the courts provide additional guidance on the new nursing mother provisions of the FLSA, employers should consult with counsel before

(CONTINUED ON PAGE 3)

WORKERS' COMPENSATION COVERAGE FOR RECREATIONAL ACTIVITIES

Stephen R. Jackson

Fundamental to workers' compensation coverage, in order for an injury to be compensable, it must have arisen "out of and in the course of employment." This standard has created an untold number of opinions exploring the facts surrounding a particular injury. Injuries that occurred during an employee's normal workday might be compensable, depending upon the particular facts surrounding the injury. But what about injuries occurring when an employee may be technically "off the clock," but is participating in employer sponsored recreational event?

At first glance, your answer might be that the employee has engaged in recreational activity, such as a softball league or company picnic, and therefore outside the scope of their employment. However, as with injuries that occurred during work hours, the issue of injuries that occur during recreational activities is from clear. The Court of Appeals of Virginia has weighed in on this issue in an effort to provide employers with some guidance. In *Mullins v. Westmoreland Coal Company*, 10 Va. App. 304, 391 S.E.2d 609 (1990), the Court held that a broken ankle resulting from a "two on two" basketball game on the employer's premises before a work shift was not a compensable injury. According to the Court, in order to be compensable, the injury had to occur during an activity that is "an accepted and normal activity within the employment." The Court found that the pick-up basketball game subjected the claimant to dangers of his own choosing, independent of his employment requirements.

Contrast the *Mullins* decision with a 1997 Virginia Workers' Compensation Commission decision in *Morgan v. City of Norfolk School Board*, 76 O.W.C. 359 (1997). In *Morgan*, a teacher's death while participating in a student-faculty basketball game was held to be compensable because the teacher was expected to participate in and support after school activities. For that reason, the teacher's participation in the student-faculty game was an "accepted and normal" activity within the meaning of *Mullins*. In short, where an employer sponsors a recreational activity and employees are expected to participate or attend that activity as part of their employment, the odds are that injuries sustained as a result of their participation will be covered by workers' compensation.

What about purely social functions, like holiday parties or company picnics? Here again, the notion that an employer "expects" employees to attend weighs heavily in favor of coverage. In *Kim v. Sportswear*, 10 Va. App. 460, 393 S.E.2d 418 (1990), the Virginia Court of Appeals held that an employee's death during an employer sponsored Korean New Year's

(CONTINUED ON PAGE 3)

THE NEW MENTAL HEALTH PARITY ACT – EFFECT ON GROUP HEALTH PLANS

Cher E. Wynkoop and Ruby W. Lee

On October 3, 2008, the Paul Wellstone and Pete Domeneci Mental Health Parity and Addiction Equity Act of 2008 (the "Act") became law as part of the Emergency Economic Stabilization Act of 2008. The Act builds on the Mental Health Parity Act of 1996, which requires parity coverage for annual and lifetime benefits. The Act makes those requirements permanent and imposes additional requirements on covered group health plans with respect to mental health and substance abuse benefits.

The Act will end health insurance benefits inequity between medical and surgical benefits and mental health and substance abuse benefits for covered group health plans. Although the Act does not require group health plans to provide mental health or substance abuse benefits, if the health plan does provide such benefits, it must provide them on the same terms as it provides medical and surgical benefits. In other words, covered group health plans may no longer impose limitations of any kind on mental health or substance abuse benefits that are not also imposed on medical and surgical benefits. Requirements, such as co-pays and deductibles, and limitations, like number and frequency of visits, may be no more restrictive on mental health and substance abuse disorder benefits than those requirements or limitations on health and surgical benefits.

The Act requires Plan Administrators, upon request, to provide the criteria used for medical necessity determinations made with respect to mental health benefits and substance abuse disorder benefits. It also requires plans that cover medical and surgical services provided by out-of-network providers to do the same with respect to mental health and substance abuse disorders.

The Act does not apply to employers with fewer than fifty employees or employees who can establish that their costs increase by at least two percent in the first year and one percent in each subsequent year due to the Act's requirements. However, an application for an exemption brings various administrative burdens that may be costly and time-consuming. Even if an employer receives an exemption, it is only valid for one year and the employer must re-apply the following year. In addition, even if a group health plan is properly exempt from the Act, it may still be subject to any state laws that provide greater protection.

Employers who have not already done so should update group health plans and other policies to ensure that they are in compliance with the Act. The Act becomes effective for plan years beginning after October 3, 2009, except for plans subject to collective bargaining agreements (CBA) ratified before the October 3, 2008 enactment date, to which the Act will then apply when the CBA terminates on January 1, 2009, whichever is later. ■

HEALTHCARE LAW INCLUDES FLSA AMENDMENT MANDATING BREAKS FOR NURSING MOTHERS

(CONTINUED FROM PAGE 2)

adopting a policy requiring nursing mothers to clock-out for short breaks related to nursing.

While some provisions of the PPACA do not become operative until 2014, the PPACA's nursing mother provisions went into effect immediately on March 23, 2010. Employers should consider identifying the "private areas" required by the law, as well as adding an appropriate policy to their employee handbooks. It is important that supervisors be made aware of the new nursing mother provisions. Until the DOL or the courts provide further guidance, employers should avoid taking an overly rigid approach regarding the frequency or duration of these breaks. ■

WORKERS' COMPENSATION COVERAGE FOR RECREATIONAL ACTIVITIES

(CONTINUED FROM PAGE 2)

Party was covered by workers' compensation. In arriving at its decision in *Kim*, the Court noted that the party was held on the employer's premises at the end of the work day, that the factory manager directed the preparations for the party and that the employer underwrote the costs, including the purchase of gifts distributed to employees. The Court found that although attendance at the party was voluntary, employees were expected to attend and the employer used the event to its benefit. The Court held that where a "social or recreational function is so closely associated with the employment to be considered an incident of it," such functions are covered by workers' compensation.

If, as an employer, you sponsor a recreational or social activity and create the expectation that your employees attend or participate in that activity, then it is likely that any injuries will be deemed to have arisen out of and in the course of employment. ■

Labor & Employment Law Contacts

William M. Furr, Chair	wfurr@wilsav.com	757/628-5651
Wm. E. Rachels, Jr.	wrachels@wilsav.com	757/628-5568
Samuel J. Webster	swebster@wilsav.com	757/628-5518
Susan R. Blackman	sblackman@wilsav.com	757/628-5646
David A. Kushner	dkushner@wilsav.com	757/628-5668
Luba I. Seliavski	lseliavski@wilsav.com	757/628-5624
Bryan C.R. Skeen	bskeen@wilsav.com	757/628-5509

Employee Benefits

James R. Warner, Jr.	jwarner@wilsav.com	757/628-5570
Cher E. Wynkoop	cwynkoop@wilsav.com	757/628-5581
David A. Snouffer	dsnouffer@wilsav.com	757/628-5678
Ruby W. Lee	rlee@wilsav.com	757/628-5605

Workers' Compensation

Stephen R. Jackson	sjackson@wilsav.com	757/628-5642
Robert L. "Bo" Foley	bfoley@wilsav.com	757/628-5547

HEALTH CARE REFORM–EMPLOYER HEALTH PLAN ISSUES FOR 2010-2011 (PART 1)

(CONTINUED FROM PAGE 1)

- *Emergency Care. Plans cannot require preauthorization or greater cost sharing for emergency services, even if such emergency services are out-of-network.
- FSAs/HSAs. Employer flexible spending accounts may no longer reimburse over-the-counter drugs; higher penalties for nonqualified health savings account distributions.
- *Nondiscrimination Requirements. Insured health plans may not provide more favorable coverage, benefits or premiums for highly compensated employees (currently applies only to self-funded plans).
- Rescission. Employers may not rescind health plan coverage except in the case of fraud or intentional misrepresentation.
- *Appeals Process. Plans must follow a new appeals process with guaranteed receipt of benefits during the appeals process and external review required in certain situations.
- Reporting. Employers must report the cost of employer-provided health care coverage on the Form W-2 related to the 2011 calendar year (and beyond).
- Auto-Enrollment. Requires employers to automatically enroll new full-time employees in group health plans (similar to auto enrollment in a 401(k) plan where the employee may elect out of participation), but more guidance is needed regarding implementation and effective date.
- Early Retiree Coverage. Temporary program in 2010 to reimburse employers who offer retiree medical benefits to retirees between age 55-64. Eligibility for reimbursement is broad, but currently only funded with an initial federal seed of $5 billion. Work with your tax advisor and APPLY EARLY! Applications for reimbursement should be available within the next month or two.

This Part I of our Health Care Reform coverage for employer health plans, primarily addresses those issues which will impact employer plans in 2010 and 2011 calendar years. In our next edition of the newsletter (Part II), we will report on those issues which will impact employer health plans beyond 2011.

Employers should consult with their advisors to review their existing plans and ensure legal compliance. Stay tuned for further developments. ■

LAY EVIDENCE MAY SUPPORT FMLA LEAVE

(CONTINUED FROM PAGE 1)

Ms. Schaar sued Lehigh Valley claiming interference and discrimination in violation of FMLA. Lehigh Valley received summary judgment in the District Court on the basis that Ms. Schaar did not establish a serious health condition because she failed to present medical evidence that she was incapacitated for more than three days.

The Court of Appeals reversed the District Court. The focus on appeal was on the DOL regulation that defines "continuing treatment by a health care provider" as a "period of incapacity . . . of more than three consecutive calendar days . . . that also involves . . . [t]reatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider." 29 C.F.R. § 825.114(a) (2005). The Court rejected the District Court's position that Ms. Schaar had presented a doctor's note that established incapacitation for only two days and could not rely upon her own testimony about the remaining days.

The Court recognized that many district courts have held that a health care provider's professional medical opinion is the only evidence that can establish incapacity. However, it reviewed that all of the Circuit Courts of Appeals which have addressed the question have held that lay testimony can create a genuine issue of material fact regarding incapacitation. When so referring to the Fifth, Seventh, Eighth and Ninth Circuits, it noted that the Fifth and Ninth Circuits have held that lay testimony is sufficient, by itself, to establish incapacitation. The Ninth Circuit has gone even farther, holding lay testimony creates a genuine issue of material fact even when all medical evidence is to the contrary.

The Court noted that under 29 C.F.R. § 825.114, the "ambiguous" statutory language of "continuing treatment by a health care provider" in 29 U.S.C. § 2611(11)(b), can be satisfied by showing at least three days of incapacitation. The Court noted that such regulation does not speak to whether medical testimony is required. The Court recognized that in the very next regulation, § 825.115 requires a "health care provider" to determine that an employee is "unable to perform the functions of the position." The Court reasoned that because the incapacitation regulation, § 825.114, does not require or even mention a health care provider determination, the Court could find no support in the regulations to exclude categorically all lay testimony regarding the length of an employee's incapacitation.

It may be recognized that the doctor's note in *Schaar* did not directly address that she was under his supervision for continuing treatment. It just referred to her being "under his care" during those two days and also did not state that she was unable to perform her job for more than three consecutive days.

The Fourth Circuit has not addressed the use of lay testimony to establish the period of incapacity. It would seem likely that the Fourth Circuit will allow lay testimony to some degree in view of the positions of the other Courts of Appeals which have ruled on this issue. Prior to an opinion from the Fourth Circuit, caution would suggest not dismissing lay evidence in conjunction with medical evidence to establish more than three days of incapacity. However, it would seem that medical evidence can be required to establish that the employee could not perform the job for such period. ■