WILLCOX SAVAGE

Employment Law Outlook

Spring 2012

THE NLRB'S APRIL 30 REQUIREMENTS

William E. Rachels, Jr.

April 30, 2012, was to be the date on which two very significant procedural requirements were to take effect under the National Labor Relations Board (NLRB). As of this publication, one has been enjoined and the other is awaiting a court decision.

The item which is of most general impact is the NLRB's Final Rule entitled "Notification of Employee Rights Under the National Labor Relations Act." The Rule requires that all employers subject to the Act must post the Notification as of April 30. The poster can be viewed as going beyond notifying—perhaps encouraging—employees to exercise their rights under the Act to be involved in supporting union activities at the place of their employment.

However, on April 17, 2012 the U.S. Court of Appeals for the District of Columbia issued an order enjoining the NLRB from enforcing this Rule pending a decision by that Court on the merits of the challenge to the Rule.

Employers are relieved of the requirement to post the NLRB Notice subject to further developments.

Therefore, employers are relieved of the requirement to post the Notice subject to further developments. The Court has ordered oral arguments for September 2012. It appears that the Rule will not be enforceable until at least thereafter. It is also reasonable to speculate that the granting of the injunction suggests that the Court has doubts about the legality of the Rule.

Two federal district courts had found opposite results on the validity of the posting requirement. On March 2, 2012, the U.S. District Court for the District of Columbia upheld the Employee Rights Notice-Posting Rule. However, it further found to be invalid the Rule's provision deeming any failure to post the notice to be an unfair labor practice, and also the provision tolling the statute of limitations in unfair labor practice actions against employers who failed to post the notice. Such decision was appealed, resulting in the injunction by the Circuit Court of Appeals.

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Join Our Upcoming Seminar!

Demystifying HSA-Compatible Health Plans

Why Employers Should Care and How to Make it Work

Date/Time
Tuesday, May 15, 2012
8:00am - 10:00am

Location
Willcox Savage
Norfolk

Topics
- Reasons Companies are Offering Consumer-Directed Plans and Health Savings Accounts
- Legal Requirements
- Implementation Strategies/Case Studies

Speakers
- Cher E. Wynkoop, Willcox Savage
- Alexander "Sander" Domaszewicz, MERCER

Register
www.willcoxsavage.com
(Seating is limited)

The session has been submitted for 1.5 continuing education credits through HRCI.

In This Issue...

CONSIDER OFFERING YOUR EMPLOYEES A CONSUMER-DRIVEN HEALTH PLAN OPTION

Cher E. Wynkoop and Corina V. San-Marina

Many employers currently offer their employees PPO and HMO health insurance options, which in general have high premiums, low deductibles, minimal office visit and emergency room co-pays, tiered prescription coverage and relatively low out-of-pocket maximums. These common features of traditional health insurance tend to minimize thoughtful health care consumption by employees, as they neither require "comparison shopping" for health services by the employees nor do they incent employees to be cognizant of their consumption of health care services.

In response to the rapid increase in healthcare costs, various models of "consumer-driven health care" have emerged to encourage employees to have some "skin in the game" with respect to their actual health care consumption.

The models attempt to:

- Encourage and incent employees to comparison shop for identical health care goods and services;
- Engage in wellness activities for premium discounts and other valuable incentives;
- Utilize "no cost" preventive care services;
- Proactively manage chronic medical conditions; and
- Give some consideration to the cost and value of employer-provided health coverage.

It is uncontroversial and indisputable that where individuals engage in a more thoughtful approach to consuming health care, medical claims charged against the health care policy drop and the associated health care premiums drop as well.

High Deductible Health Plans (HDHP), a current model of consumer-driven health care which is growing in popularity among employers and employees, were first offered in the insurance marketplace some 10 years ago. HDHP premiums have drastically dropped over the last two to three years as a result of their increased usage in the marketplace, weighing in currently at about 30-35% lower premiums than traditional HMO and PPO plans.

An HDHP offers a high deductible in exchange for low premiums, and works best for relatively healthy individuals who tend to be low to moderate consumers of health care. After the high deductible is met, depending on how the HDHP is designed, expenses might be either 100 percent covered or subject to co-pay, just like a traditional health plan.

To help employees pay the high deductible, in general an HDHP is paired with a health savings account (HSA), which is basically a medical IRA that belongs to the employee at all times. An HSA can be funded with both employer and employee contributions that have the potential to accumulate from year to year to the extent there are any unused amounts at the end of each year. One reason many employers offer "seed" contributions to an employee's HSA is to encourage participation. The employer seed, along with employees' contributions of their "premium savings" amounts plus their normal "flexible spending account" contribution amount can often substantially fund an HSA to cover much of the HDHP deductible.

Here are some numbers/features:

- Typical employer "seed" contribution: $500–$750 (single); $1,000–$1,250 (family)
- Typical deductibles: $2,000–$3,000 (single) and $4,000–$6,000 (family)
- IRS-permitted annual contributions: $3,100 (single) and $6,250 (family)

There are many legal and administrative details to consider whether an HDHP/HSA combination is a valuable benefit for both you and your employees, and careful planning is crucial to a successful implementation process. Ultimately, employees must engage in a personal and critical analysis of their own recent and prospective health care usage as well as their desire to save more pre-tax dollars for a rainy health day – to decide whether the HDHP/HSA is a good value for them and their families in any particular year. As they say – "it is all in the math" as to whether an HDHP/HSA might work for you as the employer and your employees. As a result of the increased popularity of HDHPs, it is worth the investment of time of your human resources team to investigate and explore how they work in order to be able to make an informed decision as to the value of an HDHP/HSA and to explain such offerings to your employees.

If you would like to learn more about this topic, consider attending our complimentary breakfast seminar entitled, *Demystifying HSA-Compatible Health Plans - Why Employers Should Care and How to Make it Work.* The seminar is scheduled from 8:00 a.m. until 10:00 a.m. on Tuesday, May 15, 2012. Speakers from both Willcox Savage and MERCER will present legal and administrative aspects of offering an HDHP/HSA. Register to attend at http://www.willcoxandsavage.com (seating is limited). The session has been submitted for continuing education credit through HRCI.■

THE NLRB'S APRIL 30 REQUIREMENTS

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Then on April 13, 2012, the Federal Court in South Carolina struck down the Notice-Posting Rule. It found that the NLRB did not have the authority to require such Notice posting. An appeal by the NLRB to the Fourth Circuit is to be expected.

The second requirement, the NLRB's "Quick Election" Rule, takes effect on April 30, 2012. In addition to curtailing pre-election procedures, this Final Rule is intended to shorten the time employers have to respond to election petitions to as few as 10 days. The employer community resists such a short time period because it is often necessary to have more time to counter a union's organizational efforts. A union's campaign has usually taken place primarily before the petition for election is filed with the NLRB. The employer needs adequate response time to level the playing field.

As with the Notice-Posting Rule, a lawsuit was filed in the U.S. District Court for the District of Columbia challenging the NLRB's right to so proceed. As of this printing, motions are pending for Summary Judgment.

The Quick Election Rule has found its way into the legislative chambers, as well as the courts. In both the U.S. Senate and the House, joint resolutions have been introduced to nullify the Rule. The Senate resolution has been referred to the Committee on Health, Education, Labor, and Pensions. The House resolution has been referred to the Committee on Education and the Workforce.

In addition to the above activities, several Democratic senators have introduced a bill to narrow the definition of the term "Supervisor" under the NLRA. Such is intended to provide the opportunity for more workers to be eligible to join unions, since "Supervisors" are not eligible for union membership under the Act. Similar legislation has been floated previously, but has never become law.

The message for employers continues to be: Stay close to your employees, treat them fairly, remind them of how well off they are, encourage communications—even complaints—keep them at home, and stay very alert to developments. In a recessionary financial climate, unionization is less likely. But prepare now and maintain for what we hope are better financial times ahead.■

"ON CALL" EMPLOYEES MAY BE COVERED BY VIRGINIA WORKERS' COMPENSATION ACT

Stephen R. Jackson

Over the years, the Supreme Court of Virginia and the Court of Appeals of Virginia have spent considerable time and effort defining and redefining the boundaries of when an injury arises "out of *and* in the course of employment." This concept is integral to the Virginia Workers' Compensation Act, because if either of those components is absent, the injury is outside the Act's coverage and, therefore, not compensable.

It is not unusual for an injury to have occurred in the course of a person's employment, but not to have arisen out of it. In short, a person can be injured on the job. However, if that injury did not result from the employee's exposure to a particular danger of the employment, to which the general public was not equally exposed, it is not covered. This is called the "actual risk test."

Recently, the Virginia Court of Appeals wrestled with the issue of injuries to an "on call" employee who was injured while driving her personal vehicle. In *Wythe County Community Hospital v. Turpin*, the Court ruled that an "on call" hospice nurse was entitled to workers' compensation benefits for injuries she received when she lost control of her vehicle as a result of being distracted by the sudden illumination of her personal cell phone. The Court reasoned that the claimant used the phone as one of her principal modes of communication with her employer and her distraction resulted from her belief that she was being called by the employer. There was no evidence as to who the call was actually from. It was, apparently, sufficient for the Court that the claimant believed the call was from her employer.

This decision clearly pushes the boundaries of when an injury arises out of the employment. Indeed, the Court noted that when it was deciding the case "on the discrete facts before [it]" and one of the judges on the panel dissented. The *Turpin* decision makes it clear that the Virginia Workers' Compensation Commission and the courts will continue to wrestle with the notion of whether an injury does or does not arise out of the employment. However, for now, cell phones may further extend coverage to "on call" employees.■

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Return Service Requested

NEW SUMMARY OF BENEFITS COVERAGE FOR EMPLOYER HEALTH PLANS REQUIRED ON OR AFTER SEPTEMBER 23, 2012

Cher E. Wynkoop and Corina V. San-Marina

Sponsors of group health plans must provide a standardized, easy-to-understand summary of benefits and coverage (SBC) and a uniform glossary of coverage terms on the first day of the first open enrollment period that begins on or after September 23, 2012 for participants and beneficiaries who enroll through an open enrollment period. Participants and beneficiaries who are newly eligible for coverage and special enrollees must receive an SBC on the first day of the first plan year that begins on or after September 23, 2012. The SBC requirement applies to all plans, except for stand-alone dental and vision plans, and most flexible spending arrangements.

The SBC must be:

- Presented in a uniform format, cannot exceed four double-sided pages in length and must not include print smaller than 12-point font;
- Provided to participants and beneficiaries, but a single SBC can be provided to a family unless any beneficiaries are known to reside at a different address;
- Provided either as a stand-alone document or in combination with other summary materials, if the SBC information is intact and prominently displayed at the beginning of such materials;
- Provided electronically to participants and beneficiaries who are already covered under the group health plan, if it meets the Department of Labor electronic disclosure safe-harbor;
- Provided in a culturally and linguistically appropriate manner.

It also must:

- Include contact information for questions and obtaining a copy of the plan document. If the plan maintains a network of providers, an Internet address must be provided;
- Include a statement that the SBC is only a summary and that the plan document should be consulted to determine the coverage provision;
- Provide a thorough description of the coverage provided, and must include exclusions.

A group health plan that fails to provide a compliant SBC will be subject to a fine of not more than $1,000 for each participant or beneficiary. For complete instructions and guidance, visit the Department of Labor site at http://www.dol.gov/ebsa/.■