



October 28, 2015

Five Recent Developments in Labor and Employment Law That Health Care Employers Need to Know

Recent actions by federal agencies and courts will have a direct impact on employers in the health care industry. While still wrestling with the changes wrought by the Affordable Care Act, health care employers will now need to pay close attention to a new health care initiative by the Occupational Safety and Health Administration (“OSHA”); new minimum wage and overtime requirements for home health workers; the impact of the legalization of marijuana on workplace use; the possibility of doctors joining unions; and the impact of the new definition of “joint employer” espoused by the National Labor Relations Board (“NLRB” or “Board”) on their relationships with subcontractors, temporary agencies, and other staffing arrangements heavily in use in the industry.

For the latest news and insights concerning employment, labor, and workforce management issues affecting health care and life sciences employers, please visit Epstein Becker Green’s blog—[Health Employment And Labor](#).

In this month’s *Take Five*, we will analyze these issues and provide guidance in responding to these challenges:

1. **OSHA’s Aggressive Enforcement Initiative Against Inpatient Health Care Facilities and Nursing Homes**
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1. **OSHA’s Aggressive Enforcement Initiative Against Inpatient Health Care Facilities and Nursing Homes**

By [Valerie Butera](#)

OSHA has paid little attention to the health care and nursing care industries in the past. However, on June 25, 2015, everything changed. On that date, Dorothy Dougherty, Deputy Assistant Secretary of Labor for Occupational Safety and Health, announced the details of

OSHA's new health care enforcement initiative in a memorandum to OSHA Regional Administrators and State Plans. This memorandum is entitled "Inspection Guidance for Inpatient Healthcare Settings" ("Guidance Memo").

What Does the Guidance Memo Say?

The Guidance Memo requires federal OSHA Regional Offices and State Plans to evaluate the number of work-related injuries and illnesses at inpatient health care facilities and nursing homes in their areas and target facilities with high rates of injuries and illnesses for inspections. Compliance officers are instructed to focus on five major hazards:

- Musculoskeletal disorders ("MSDs") relating to patient or resident handling
- Workplace violence
- Bloodborne pathogens
- Tuberculosis
- Slips, trips, and falls

OSHA also reminded compliance officers that they can and should expand the scope of an inspection when additional hazards come to their attention during an inspection. For example, additional hazards may include exposure to multi-drug resistant organisms, such as Methicillin-resistant *Staphylococcus aureus* ("MRSA"), and exposures to hazardous chemicals, such as sanitizers, disinfectants, anesthetic gases, and hazardous drugs.

There are no OSHA regulations applicable to several of these hazards. However, OSHA officers may rely upon the general duty clause, which enables OSHA to issue citations whenever it finds that (i) an employer has failed to provide safe work and a safe work environment for its employees, or (ii) the agency's existing regulations are no longer sufficient to keep employees safe. In fact, the agency went so far as to include sample general duty clause citation language in the Guidance Memo that compliance officers may reference in issuing citations related to MRSA, MSDs, workplace violence, and other under-regulated hazards that they may identify in the workplace.

Who Is Covered?

It is important to understand that OSHA includes a broad range of inpatient facilities in its list of potential targets. For instance, among the facilities that OSHA designates as "hospitals" and "nursing homes" are a wide variety of workplaces, including psychiatric and substance abuse hospitals, continuing care retirement communities and assisted living facilities, hospices, skilled nursing facilities, and many others. Virtually any type of health care or nursing care facility that provides residential or inpatient services is at risk—particularly if the employer has a high rate of work-related injuries and illnesses.

More troubling still is that OSHA's heightened scrutiny of inpatient health care facilities and nursing homes has already expanded to outpatient facilities. Due to heightened union and employee awareness about OSHA's focus, employees from outpatient facilities are filing complaints with OSHA, and OSHA is taking them quite seriously.

Recently, for example, an employee at an ambulatory care company filed a complaint with OSHA. OSHA inspected the company, found multiple violations, and issued citations carrying

penalties in excess of \$200,000. This monetary penalty is noteworthy as OSHA generally does not demand penalties of this size unless a fatality took place at the facility. There were no fatalities involved with this inspection. Accordingly, *all* health care and nursing care employers should be prepared for the possibility of an OSHA inspection at any time and be mindful that OSHA is ready and willing to issue citations carrying heavy fines to employers in these industries.

What Steps Should Be Taken?

Employers operating inpatient health care facilities and nursing homes should be proactive and take several steps now to improve their safety and health programs and reduce the likelihood of receiving an OSHA citation.

First, conduct an internal OSHA compliance audit with the assistance of outside counsel—this audit is protected from disclosure by the attorney-client privilege. Audit reports prepared without the aid of outside counsel can be subpoenaed by OSHA and used as a guide to potential violations at a worksite. Defending an OSHA citation can cost hundreds of thousands of dollars. An audit, by comparison, costs a tiny fraction of that amount and can help you identify and resolve gaps in your safety and health programs. An added benefit of conducting an attorney-client privileged audit is the potential for a reduction in workers' compensation claims. When employers address the gaps identified in a safety and health audit, they usually also experience an enormous drop in workers' compensation costs.

Next, consult with counsel regarding preparation for an OSHA inspection. Many health care employers, like the ambulatory care employer discussed above, have never experienced an OSHA inspection. You need to know your rights during an OSHA inspection and those of your employees. For example, if you are selected for an inspection, you should know that your employees have a right to participate in most aspects of the inspection and are permitted to select a union representative to work with OSHA on their behalf, even if your facility is not already unionized. Employees and union organizers frequently use this right as a tool to aid in unionization efforts. Counsel can help you navigate this issue and many others that frequently arise during inspections.

Finally, be aware that consulting with counsel is particularly vital and relevant in this enforcement initiative. Many OSHA compliance officers have never inspected a health care facility or nursing home and are overburdened with heavy caseloads. It is unlikely that these compliance officers will have the time necessary to fully educate themselves about hazards and safety measures used in inpatient health care facilities or nursing homes. Making matters worse, compliance officers have been encouraged to liberally issue general duty clause citations. This combination of factors is likely to lead to a number of meritless citations—citations that may be avoided if you are well prepared.

Conclusion

Inspections of inpatient health care facilities and nursing homes have begun. Employers in the health care and nursing care industries should begin preparations for an OSHA inspection immediately in order to decrease their chances of receiving costly OSHA citations.

2. Elimination of the Minimum Wage and Overtime Exemptions for Home Health Companionship and Live-In Care Employees of Third-Party Providers

By [Brian W. Steinbach](#)

Due to a [recent decision](#) by the U.S. Court of Appeals for the District of Columbia Circuit, a new U.S. Department of Labor (“DOL”) requirement that home health care providers pay the federal minimum wage and overtime to employees providing companionship services and live-in domestic services took effect in late October 2015.

Background

The home health industry grew dramatically in recent years, both in private pay and as Medicaid waiver programs have encouraged care to be provided at home rather than in nursing homes and other institutional settings, to the extent possible. At the same time, individuals providing companionship services or live-in care for the elderly, ill, or disabled in their homes were exempt from the minimum wage and overtime requirements of the Fair Labor Standards Act (“FLSA”), whether hired directly by the home care recipients and their families or employed by third-party agencies.

As a result, absent applicable state minimum wage or overtime requirements, most state Medicaid plans typically set reimbursement rates without regard to federal minimum wage and especially overtime requirements. Indeed, they declined to reimburse for any overtime premium. The private pay industry generally followed suit.

Home Care Association of America v. Weil

However, on August 21, 2015, the D.C. Circuit in [Home Care Association of America v. Weil](#) upheld the [2013 amended regulations promulgated by the DOL](#), which, for the first time, barred third-party employers from using the minimum wage and overtime exemption for both companionship services and live-in domestic service employment and also narrowed the definition of “companionship services.” In so doing, the D.C. Circuit reversed two prior decisions issued by the District Court for the District of Columbia on [December 22, 2014](#), and [January 14, 2015](#), vacating the DOL’s regulations that originally were scheduled to go into effect on January 1, 2015, but were stayed by those decisions.

The D.C. Circuit thoroughly rejected the district court’s analysis and relied on the Supreme Court’s decision in *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158 (2007). The D.C. Circuit concluded that the decision to include workers paid by third parties within the scope of the statutory exemptions for companionship services and live-in domestic service employees was within the DOL’s discretion under its general grant of authority to promulgate implementation regulations.

The D.C. Circuit further found that the new, narrower construction of the statutory exemption was appropriate and consistent with Congressional intent. Specifically, the D.C. Circuit found that Congress intended to include within FLSA coverage employees whose vocation is domestic service, rather than the type of assistance provided by a neighbor or an “elder sitter.” Furthermore, the D.C. Circuit found that this construction was not arbitrary and capricious because DOL justified its shift in policy based on the changes in the industry since the prior regulation was issued in 1975.

Finally, the D.C. Circuit rejected arguments that the new regulations would make home care less affordable and create an incentive to re-institutionalize the elderly and disabled. In

particular, the D.C. Circuit relied on a stated lack of evidence that this had occurred in states that already had minimum wage and overtime protections for third-party-employed home care workers.

Although the Home Care Association plans to seek review by the U.S. Supreme Court, the D.C. Circuit recently [rejected a request](#) to stay its mandate pending the request for review, and, on October 6, 2015, Chief Justice Roberts also [denied a stay](#). Thus, the D.C. Circuit's mandate issued on October 13, the district court entered summary judgment in favor of DOL on October 21, and the previously vacated regulations have now gone into effect. Although DOL has announced that [it will not bring enforcement actions for the first 30 days](#), i.e., through November 12, 2015, and [previously stated that it would exercise "prosecutorial discretion" through the end of 2015](#) based on the extent to which there had been good faith efforts to bring home care programs into compliance, the new regulations will be immediately enforceable by private individuals and attorneys, so DOL's action is of little practical significance.

Impact of the New Regulations

Home health care providers therefore should begin planning for this transition immediately. Although most likely already pay the federal minimum wage to individuals providing companionship services (often called "home health aides"), many do not pay overtime. Notably, home health care providers already work on narrow margins and typically cannot recover overtime costs from the Medicare, Medicaid, or other government programs that pay for most of their services only at a flat hourly rate (which sometimes does not reflect recent increases in state and local minimum wages). Private pay individuals and families will likely also resist the increased cost of overtime.

This means providers in states where the exemption was previously available will now have to absorb the costs of any overtime pay. In many cases, this will mean changing schedules to limit the number of hours that a home health care provider works (thereby causing a reduction in the provider's income rather than an increase) and hiring additional staff (with attendant additional administrative costs) to cover the hours that a single provider previously worked.

These changes could also be disruptive to the persons receiving the services, who may resist having multiple providers, rather than having the same person come every day. Providers will have to explain to both their employees and customers that the new regulations effectively require them—as well as their competitors—to limit the number of hours that an employee works and use additional employees to fill the gaps. Private pay individuals and families can, of course, be offered the option of paying for overtime if they would prefer to limit visits from multiple providers.

3. Marijuana in the Workplace: The Growing Conflict Between Drug and Employment Laws

By [Nathaniel M. Glasser](#) and [Jonathan K. Hoerner](#)

Despite the growing number of states that have legalized the use of marijuana, the drug remains illegal under federal drug laws. The legal landscape is made more confusing when considering the differing levels of employment protection that these state laws offer to marijuana users. With this patchwork of state laws, employers are left to grapple with whether and how to accommodate their employees who use marijuana for medical purposes or for off-duty personal consumption.

The Legal Landscape

Twenty-three states and the District of Columbia have legalized medical and/or recreational use of marijuana. These jurisdictions provide marijuana users with varying levels of protection against employment discrimination. The majority—Alaska, California, Colorado, Georgia, Hawaii, Maryland, Massachusetts, Michigan, Montana, New Jersey, New Mexico, Oregon, Vermont, and Washington—merely decriminalize use. Other jurisdictions—Arizona, Connecticut, Delaware, the District of Columbia, Illinois, Maine, Minnesota, Nevada, New Hampshire, New York, and Rhode Island—in addition to decriminalizing use, also provide statutory protections against discrimination. Some of these jurisdictions even require accommodation of underlying disabilities.

However, marijuana is still classified as a Schedule I drug (high potential for abuse, no acceptable medical use) and remains illegal under the federal Controlled Substance Act (“CSA”). While last year Congress passed a bill to defund the Department of Justice’s efforts to challenge state-legal medical marijuana programs, the Obama administration’s public position is that it “[steadfastly opposes legalization of marijuana.](#)”

Federal precedent in this area has provided employers with broad rights to take adverse action against individuals who use marijuana, whether or not for medical purposes and/or protected under state law. For instance, under the Americans with Disabilities Act (“ADA”), courts have held that marijuana users—regardless of the legality of the use under state law—are not qualified individuals with a disability entitled to anti-discrimination protections. *See, e.g., James v. City of Costa Mesa*, 700 F.3d 394 (9th Cir. 2012).

Employers, however, must be careful not to rely on medical marijuana use as a pretext for firing an employee with an underlying disability. The U.S. Equal Employment Opportunity Commission (“EEOC”) recently took aim at a Michigan-based assisted living center that fired a nursing administrator who used medical marijuana to treat her epilepsy and thus failed a drug test on her second day of work. *EEOC v. Pines of Clarkston, Inc.*, No. 13-CV-14076, 2015 U.S. Dist. LEXIS 55926 (E.D. Mich. Apr. 29, 2015). The district court denied the employer’s motion for summary judgment on the individual’s ADA claim. Although acknowledging that a positive test for medical marijuana constituted a legitimate, non-discriminatory reason for discharge, the district court concluded that the EEOC raised a genuine issue of material fact as to whether the articulated reason was a pretext for disability discrimination, particularly because the employee had been questioned about her disability during her interview and subsequently after the positive drug test. The case eventually settled but should be heeded by employers as a warning that a positive drug test for marijuana may not insulate them from discrimination claims under the ADA.

Unresolved Conflict Between Employer and Employee Rights Under State Law

State law provides greater protections to marijuana users. However, while courts have infrequently addressed the conflict between state law employment protection and marijuana use, those that have considered such issues generally have found in favor of an employer’s right to take adverse action against an employee who tests positive for marijuana.

The Colorado Supreme Court highlighted this issue when, in *Coats v. Dish Network*, 350 P.3d 849 (Colo. 2015), it held that an employee may be fired for using marijuana even though he legally used the drug off duty. Colorado law prohibits termination for lawful off-duty conduct, and Coats was a registered medical marijuana patient who only consumed marijuana during non-work hours. Nevertheless, because smoking marijuana was still illegal under the federal CSA, the court held that such use did not constitute lawful conduct under the Colorado statute.

The decision in *Coats* is consistent with earlier decisions in California, Montana, Oregon, and Washington that have held that decriminalization laws do not confer a legal right to smoke marijuana and that employers may take adverse action against users. See *Ross v. RagingWire Telecomms., Inc.*, 174 P.3d 200 (Cal. 2008); *Johnson v. Columbia Falls Aluminum Co., LLC*, No. 08-0358, 2009 Mont. LEXIS 120 (Mont. 2009); *Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus.*, 230 P.3d 518 (Or. 2010); *Roe v. TeleTech Customer Care Mgmt. (Colo.) LLC*, 257 P.3d 586 (Wash. 2011). Of course, statutes in these states have decriminalized marijuana use but do not expressly provide employment protections to users.

Employers must tread more carefully in jurisdictions that grant express protections to marijuana users. Courts in these states have not decided whether an employee's rights under such a state statute trump the rights of an employer to take adverse action against the use of a drug categorized as illegal under federal law.

Advice for Employers

While many implications of legalizing marijuana use are yet to be decided by the courts, employers clearly may continue to prohibit the on-duty use of, or impairment by, marijuana. Employers, particularly federal contractors required to comply with the Drug Free Workplace Act, also may continue the implementation of workplace drug testing programs.

Employers, however, must treat positive tests for marijuana cautiously. Decisions in California, Colorado, Montana, Oregon, and Washington collectively provide support to take adverse action against employees who use marijuana, recreationally or medicinally, and may suggest that such employer-favorable rulings will issue even from courts reviewing state statutes providing employment protections. Thus, a bright-line approach to discharging or refusing to hire marijuana users may be defensible related to marijuana use. But given the uncertain state of the law, employers should consider taking the following steps to reduce potential liability:

- Engage in the interactive process to determine whether medical marijuana use can be accommodated.
- Particularly in jurisdictions providing employment protections for medical marijuana users, engage in a fact-based inquiry to determine whether the individual is a medical marijuana cardholder and whether the job can accommodate the individual's use of medical marijuana.
- Develop and/or review policies that expressly address the right to take adverse action upon a finding of marijuana use.
- When taking such adverse action, document the reasons to avoid a pretext argument.

Of course, employers should work with legal counsel to closely monitor the changing legal landscape in their jurisdictions as this area of unsettled law is ripe for future litigation.

4. Doctors, Unions, and Protected Activity

By [Michael F. McGahan](#) and [Daniel J. Green](#)

As the delivery of health care continues to change, fewer and fewer doctors open or continue private practices, and more and more become employees of major health care systems or large medical practices. As employees of private employers, including large voluntary hospital systems, doctors secure rights under Section 7 of the National Labor Relations Act ("NLRA" or

“Act”). Among those protected rights are the rights to form, join, or support labor unions, or to act collectively even in the absence of a union.

Physicians and the NLRA

The NLRB has long held that interns and residents are employees with the right to form or join unions. See *Boston Medical Center Corp.*, 330 NLRB 152 (1999). The NLRB, in its regulations defining appropriate bargaining units in acute care hospitals, finds that bargaining units of physicians are presumptively appropriate for organizing purposes. 29 C.F.R. § 103.30.

Not all employed physicians have protected rights under the Act. Doctors who hold managerial positions in which they have authority to make, change, or authorize exceptions to the employer’s policies are not “employees” under the Act. Similarly, the Act does not cover doctors who meet the statutory definition of “supervisor,” usually because they have the authority to hire, fire, discipline, or responsibly direct employees. Doctors with such authority do not have the right under the Act to form or join unions.

The Committee of Interns and Residents (“CIR”), an affiliate of the SEIU, has long represented interns and residents in major medical centers. Many young doctors who were represented by CIR during their residencies and are now employed in health care systems may recall that they had benefits or protections in their CIR collective bargaining agreements and look for continued union representation as employed physicians. There are other unions currently representing employed physicians, such as the Doctor’s Council SEIU. Many of these unions focus on doctors employed in the public sector, but as the number of doctors employed in private hospitals and health systems continues to increase, these unions may expand into the private sector as well.

Recent Developments

Recent rulings by the NLRB are designed to make it easier for unions to organize, and these changes could ease the way for union organizing of employed doctors. For example, outside of acute care hospitals, the NLRB’s ruling in *Specialty Healthcare & Rehabilitation Ctr. Of Mobile*, 357 NLRB No. 174 (2011), in which the NLRB held that it would find appropriate even a very small unit of employees that it deems a “discrete group,” could easily lead to findings by the NLRB that small bargaining units of doctors are appropriate for organizing, such as all the doctors at a particular office of a medical practice, or all the doctors in a particular specialty in a health care system. Such “micro units” make for easier targets for organizing by a union.

Further, under the NLRB’s new “quick election” rules, a health care employer may find itself faced with an organizing campaign in a unit of doctors with an election scheduled in a matter of a few weeks, giving that employer little time to make a case to the doctors opposing the union campaign.

Rights and Protections Under the Act

If a union is elected as representative of employed physicians, the employing institution would then have a duty to bargain in good faith with the union over terms and conditions of the physicians’ employment, such as wages, benefits, hours, schedules, vacations, holidays, and grievance and arbitration procedures.

Among the collective actions protected by the Act is the right to strike. This past April, doctors represented by the Union of American Physicians and Dentists engaged in a strike at the student health clinics at University of California campuses in Southern California. While the

NLRB may recognize the right of physicians to strike under the Act, the American Medical Association (“AMA”) has cautioned that there are ethical considerations that require that physicians engaged in collective action must ensure that the health of patients is not jeopardized and that patient care is not compromised. The AMA also advises that physicians should refrain from the use of a strike as a bargaining tactic. AMA Opinion 9.025 issued December 1998, updated June 2005.

Even in the absence of union representation, physicians have the protected right to engage in collective actions for their mutual aid and protection. Thus, for example, a group of doctors gathering together to protest wages, hours, and/or other terms and conditions of employment are engaging in activity protected by the Act, even if no union is involved.

Preventive Measures

So what should health care employers be doing now?

First, look at what unions representing doctors are promising them and then review where your organization stands on these issues:

- Wages/Benefits: Are your salaries and other forms of compensation, health insurance, retirement plans, vacations, education, leave, and malpractice coverage competitive?
- Job Security: Under what circumstances can an employed doctor be disciplined or terminated? What procedures are in place for the doctor to grieve a disciplinary action?
- Hours: Are the hours that your doctors work in line with the hours expected of doctors in similar institutions?
- Professional Development: Do you provide time off and reimbursement for continued medical education?
- Fairness: Do you ensure that workplace policies as applied to employed physicians are fair and enforced in an even-handed manner?
- Legal Compliance: Remember that as employees, doctors have protected rights under federal, state, and local laws. Is your organization complying with such laws as the Family and Medical Leave Act (“FMLA”), the ADA, the Age Discrimination in Employment Act (“ADEA”), and Title VII of the Civil Rights Act of 1964 with regard to your employed physicians?

Second, prepare now for the possibility of facing the new expedited NLRB election rules by identifying and defining potential bargaining units in which physicians might be included. Employers should identify those doctors holding managerial or supervisory authority and make sure that it is clear that they have and regularly exercise such authority.

5. The NLRB’s New Test for Determining “Joint Employer” Status: Consequences for Health Care and Life Science Employers

By [Steven M. Swirsky](#)

Employers in the fields of health care and life sciences have, in recent years, come to rely on an increasing number of employee leasing and staffing arrangements, outsourcing of an ever-growing number of functions and tasks to third-party service providers, and joint ventures and

other innovative arrangements to meet the challenges they face. Critical to success in these endeavors has been the ability to ensure that vital services and functions are performed in a manner that meets the health care employers' own standards and the requirements of governmental and independent regulators.

On August 27, 2015, the NLRB issued its long-anticipated decision in [Browning-Ferris Industries, 362 NLRB No. 186](#), establishing a new test for determining joint-employer status under the NLRA. This revised standard is aimed at the types of employee leasing and staffing arrangements and third-party service contracts that are commonly relied upon by health care and life science entities to supplement and flex their own workforces and to provide a range of services—such as laboratory operations, claims processing, food service, housekeeping, security, and the like—that they choose not to perform themselves. It is clear that unions are seeking to take advantage of the new joint-employer test to assert that the end user of the services is actually a joint employer of its vendors' and contractors' employees because they either directly or indirectly control or affect, or have the ability to control or affect, the vendors' and contractors' employees terms and conditions. For this reason, employers in these fields should be mindful of the decision's potential impact upon relationships with service providers that are supportive of, or critical to, their operations. The new standard will result in many more claims by unions, employees, and governmental regulators that health care employers, based on rights they reserve but may never exercise to ensure that contracted-for services are performed in a safe and appropriate manner, are joint employers with respect to their vendors' and contractors' employees.

By fashioning a new standard in *Browning-Ferris*, the Board springs open new questions of which legally distinct entities will bear responsibility in NLRB cases addressing union recognition and bargaining obligations, as well as for any unfair labor practices that may follow. Given the Board's lead in fashioning a new standard, described as based on common law principles, it is likely to be relevant to other agencies, such as the EEOC and DOL.

A New Standard for a Different Economy

Under the new standard, “[t]he Board may find that two or more entities are joint employers of a single work force if they are both employers within the meaning of the common law, and if they share or codetermine those matters governing the essential terms and conditions of employment.” *Browning-Ferris* jettisons the long-standing requirement that not only must a party have the means to influence such matters, but it must also have exercised that right in a meaningful way. If the decision is upheld when it is reviewed by the courts, no longer will the Board need to find that an employer retains and *exercises* direct control over another employer's employees to be liable as a joint employer of those employees.

In the decision and [press release](#), the Board suggests that “the current economic landscape,” which includes some 2.87 million people employed by temporary agencies, warrants a “refined” standard for assessing joint-employer status. As the majority states, “If the current joint-employer standard is narrower than statutorily necessary, and if joint-employment arrangements are increasing, the risk is increased that the Board is failing what the Supreme Court has described as the Board's ‘responsibility to adapt the Act to the changing patterns of industrial life.’”

What Is the New Test for Finding a “Joint Employer”?

So what exactly is changed? Previously, an employer had to *exercise* direct and immediate control over the terms and conditions of employment to be found to be a joint employer. Under

the new standard, what matters is whether the purported joint employer merely *possesses* the authority to control the terms and conditions of employment, either directly or indirectly.

In other words, the actual or potential ability to exercise control, regardless of whether the company has, in fact, exercised such authority, is the focus of the Board's inquiry. As the Board puts it, "*Reserved authority* to control terms and conditions of employment, *even if not exercised*, is clearly relevant to the joint-employment inquiry" (emphasis added). The Board's decision also extends joint-employer status to employers that only exercise a degree of *indirect control* over the work performed by the employees of another.

Why *Browning-Ferris* Matters

The majority opinion in this 3-2 decision makes clear that its objectives are far reaching: to address "the diversity of workplace arrangements in today's economy," including the increase in "[t]he procurement of employees through staffing and subcontracting arrangements, or contingent employment," and thereby fulfill a "primary function and responsibility" of the NLRB, which the Board describes as encouraging the spread of collective bargaining and union representation for employees.

One significant indicator of how broadly the *Browning-Ferris* decision will be applied can be seen by the Board's issuance of an Order Consolidating Cases and Complaint issued on October 19, 2015, in *Community Health Systems, Inc.* That case arises from a coordinated union organizing campaign targeting independently operated health facilities owned by Community Health Systems ("CHS") and assertions that CHS and seven wholly owned hospitals spread across the country comprise a "common integrated enterprise." Based on those allegations, each individual hospital allegedly is a joint employer of the employees of all of the other hospitals owned by CHS, and each hospital is alleged to be jointly responsible for the unfair labor practices of the other hospitals. In many respects, this is similar to the pending unfair labor practice charges in which McDonald's is alleged to be a joint employer of the employees of various franchisees.

While the full import of *Browning-Ferris* may unfold over years of administrative litigation and court review, we know that the obvious (and intended) effect of the decision is to permit the Board to find joint-employer status where it did not previously exist. Indeed, the Board majority notes that extending joint-employer status is necessary to "encompass the full range of employment relationships wherein meaningful collective bargaining is . . . possible." Notwithstanding the arrangements that employers and contractors have made in years past to guard against joint-employer exposure, unions will be at the ready with unfair labor practice charges and representation petitions as vehicles for the Board to apply its new standard and examine or reexamine relationships forged before the pronouncements of *Browning-Ferris*. Thus, employers should anticipate a role in newly filed proceedings alleging joint-employer status—even as they contemplate reforming or redefining terms by which they engage with contractors and other providers of services supportive of their business.

Given these circumstances, even those employers that do not exercise *any* direct or indirect control over the employees of their contractors should review carefully the terms of such arrangements, keeping in mind the Board's stated intention of expanding joint-employer status.

What to Do Now

It is not an exaggeration to say that the new standard for determining joint-employer status will impact employers in almost every industry across the country. As a first step, employers will want to closely examine their relationships with those who provide them with temporaries and

other contingent workers, and their contracts and relationships with those other businesses that provide integral services and support, to assess whether there is a vulnerability to findings of joint-employer status.

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For additional information about the issues discussed above, please contact the Epstein Becker Green attorney who regularly handles your legal matters or an author of this *Take 5*:

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